



Illinois Right to Life

Physician-Assisted Suicide in Illinois

A REFERENCE GUIDE FOR PATIENTS,
FAMILIES, AND PROFESSIONALS



Disclaimer

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This Guide uses “physician-assisted suicide” (PAS) to describe the practice authorized by the Illinois Act, under which a physician prescribes life-ending medication that a qualified patient intentionally self-administers. The Act uses different terminology and provides that such a death does not constitute “suicide” or “assisted suicide”; Chapter 1 explains the Guide’s terminology choice in greater detail.

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The Illinois Physician-Assisted Suicide Process

OVERVIEW OF THE END-OF-LIFE OPTIONS FOR TERMINALLY ILL PATIENTS ACT (PUBLIC ACT 104-0441)



KEY SAFEGUARDS

- ✓ Adult (18+)
- ✓ Illinois resident
- ✓ Terminal illness (expected death within six months)
- ✓ Mental capacity
- ✓ Voluntary request
- ✓ Two physicians
- ✓ Mental-health evaluation if capacity cannot be confirmed
- ✓ Multiple requests
- ✓ Self-administration required
- ✓ Written request with two witnesses

IMPORTANT LIMITATIONS

- ✗ Does not authorize euthanasia.
- ✗ Does not permit another person to administer the medication.
- ✗ Does not allow healthcare agents or family members to request medication on behalf of a patient.
- ✗ Healthcare professionals and institutions may decline direct participation, subject to certain notice, referral, record-transfer, and related obligations under Illinois law.



PHYSICIAN REPORTING TO IDPH

The attending physician submits required prescription and follow-up reports to the Illinois Department of Public Health (IDPH). IDPH must publish aggregated annual statistics beginning one year after the Act's effective date.

Why This Guide Exists

In 2025, the Illinois General Assembly enacted the **End-of-Life Options for Terminally Ill Patients Act** (“Deb’s Law”). Governor J.B. Pritzker signed the legislation into law, and it is scheduled to take effect on September 12, 2026. With its enactment, Illinois will become the first Midwestern state to authorize physicians to prescribe life-ending drugs to qualifying terminally ill adults.

Although the statute currently limits eligibility to Illinois residents who meet certain criteria, the experience of other jurisdictions demonstrates that assisted-suicide laws often evolve after enactment. In a number of jurisdictions, residency requirements have been removed, procedural safeguards have been modified, prescribing authority has expanded, and eligibility has been broadened or proposals have been introduced to do so. Whether Illinois ultimately follows that pattern remains to be seen. Because Illinois has no implementation history of its own, the experiences of states such as Oregon, Washington, and California, together with those of Canada and several European countries, provide the best available evidence for understanding the legal, medical, and public policy questions that may arise in the years ahead.

This Guide is written from a pro-life perspective. It proceeds from the conviction that every human life possesses inherent dignity and equal worth, regardless of age, disability, illness, suffering, or dependence on others. However, as an educational resource, it aims to present Illinois law, the history of physician-assisted suicide, the principal arguments on both sides of the debate, and the experiences of other jurisdictions accurately and fairly. Supporters generally emphasize patient autonomy and the relief of suffering, while opponents emphasize the equal dignity of every human person, the protection of vulnerable individuals, and the integrity of the medical profession.

Just as Illinois has become a regional destination for abortion services, some believe it could eventually become a destination for physician-assisted suicide if residency requirements are amended; Chapter 2 examines that possibility and the future of Illinois’ residency requirement in greater detail.

This Guide is intended to serve both as an introduction and as a reference work. It explains the history of physician-assisted suicide, summarizes Illinois law, compares Illinois with jurisdictions throughout the United States and around the world, examines the ethical and legal arguments surrounding assisted dying, and surveys alternatives such as hospice, palliative care, advance care planning, and disability supports.

How to Use This Guide

People will consult this guide for different reasons. Some are facing a serious illness. Others are caring for a loved one. Some want to understand Illinois' new physician-assisted suicide law, while others are seeking practical resources or exploring the broader ethical questions surrounding end-of-life care.

You do not need to read this guide from beginning to end. Use the sections that are most helpful to your current situation.

If You Have Recently Received a Serious or Terminal Diagnosis...

Begin with Chapter 3: Support, Alternatives, and Resources.

Use Chapter 3 for hospice, palliative care, pain and symptom management, mental-health and disability supports, caregiver resources, advance care planning, Illinois Quick Help, and practical next steps.

If You Want to Understand Illinois Law...

Begin with Chapter 2: Illinois Law and Public Policy on Assisted Suicide.

Use Chapter 2 for eligibility, the request process, physician responsibilities, reporting, conscience rights, death certification, pending legislation, and current litigation.

If You Want to Understand PAS and the Ethical Debate...

Begin with Chapter 1: Understanding Physician-Assisted Suicide.

Use Chapter 1 for terminology, history, the principal arguments offered by supporters and opponents, disability-rights concerns, medical ethics, and the broader legal and cultural debate.

If You Want to Evaluate the Safeguards...

Begin with Chapter 4: Safeguards and Their Limitations.

Use Chapter 4 for prognosis, mental-health screening, voluntariness, family and financial pressure, treatment-dependent prognosis, reporting limits, death certification, and the question of what can be independently verified.

If You Need Forms, Data, Role-Specific Guidance, or Sources...

Begin with Chapter 5: Reference Materials.

Use Chapter 5 for primary-source links, utilization and polling data, comparative-law tables, the "PAS: What It Means for You" role guides, Illinois resources, FAQs, and the research guide and bibliography.

Chapter 5's Resources Include:

- Illinois statutes, legislative history, official forms, and implementation links
- A cross-reference to the Illinois PAS process overview
- Advance directives and DNR/POLST medical orders
- Utilization statistics and public-opinion data
- Comparative U.S. and international law
- Seven role-specific audience guides
- Illinois resources and crisis/help contacts
- FAQs, research guidance, and bibliography

Simple Outline

Chapter 1 — What is physician-assisted suicide?

Chapter 2 — What does Illinois law say?

Chapter 3 — What care, support, and resources are available?

Chapter 4 — How reliable are the safeguards?

Chapter 5 — Where can I verify claims and find role-specific guidance and resources?

A Final Thought

Serious illness often brings uncertainty, difficult decisions, and profound emotions. Whatever questions brought you to this Guide, our hope is that it provides clear information, practical resources, and thoughtful guidance grounded in respect for the dignity and worth of your life and every other human life made in God's image.

Discuss important medical, legal, and end-of-life decisions with your healthcare providers, loved ones, clergy, and other trusted advisors.

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Understanding Physician-Assisted Suicide

What is physician-assisted suicide?

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- Physician-assisted suicide in America
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What Is Physician-Assisted Suicide?

Physician-assisted suicide is one of the most controversial medical, legal, and ethical issues of our time. Supporters argue that mentally competent adults facing terminal illness should have the right to determine the timing and manner of their death. Opponents contend that intentionally facilitating suicide is incompatible with the healing mission of medicine, places vulnerable persons at risk, and undermines the principle that every human life possesses inherent dignity and equal worth.

Over the past three decades, a growing number of U.S. states^[1] have legalized some form of physician-assisted suicide, often referring to the practice as “Medical Aid in Dying” or “Assisted Death.” In 2025, Illinois became the first state in the Midwest to legalize physician-assisted suicide through the End-of-Life Options for Terminally Ill Patients Act, which takes effect on September 12, 2026.^[2]

Before examining the law, the ethical debate, and the development of PAS laws in other jurisdictions, it is important to understand the terminology commonly used in discussions about physician-assisted suicide and end-of-life issues.

Key Terms and Definitions

Advance Directive

A legal document that allows a person to communicate healthcare preferences in advance should they later become unable to make medical decisions.^[3]

Assisted Death

A broad term often used by supporters of physician-assisted suicide to describe a situation in which a person intentionally ends his or her life with medical assistance. Critics argue that the term obscures the fact that the act involved is suicide.

Assisted Suicide

The act of intentionally helping another person end his or her own life. In the context of physician-assisted suicide laws, a physician provides a prescription for lethal drugs that the patient self-administers.^[4]

[1] See, e.g., Or. Rev. Stat. § 127.800 et seq.; Cal. Health & Safety Code §§ 443.1–443.22.

[2] End-of-Life Options for Terminally Ill Patients Act, Pub. Act 104-0441 (Ill. 2025) (effective Sept. 12, 2026).

[3] 755 ILCS 45/4-1 et seq.; 755 ILCS 35/1 et seq.

[4] 410 ILCS 22/1 et seq.; *Black’s Law Dictionary* (definition of “assisted suicide”).

Do Not Resuscitate (DNR) Order

A medical order directing healthcare providers not to perform CPR or other resuscitative measures if a patient's heart stops or breathing ceases. A DNR does not authorize physician-assisted suicide or euthanasia. In Illinois, DNR instructions may be documented through the Illinois Department of Public Health's Uniform POLST form, which can also contain medical orders concerning other forms of life-sustaining treatment.^[5]

Healthcare Power of Attorney

A legal document authorizing another person to make healthcare decisions on one's behalf if one becomes unable to do so.^[7]

Medical Aid in Dying (MAID)

A term commonly used by supporters of physician-assisted suicide. Depending on the jurisdiction, the term may refer specifically to physician-assisted suicide or more broadly to practices involving medically facilitated death.^[9]

Physician-Assisted Suicide (PAS)

A practice in which a physician provides a prescription for lethal medication to a qualified patient, who then self-administers the medication to end his or her own life.^[11]

Self-Administration

The act of a patient personally ingesting or otherwise taking a prescribed lethal medication. Most physician-assisted suicide laws require the patient—not another person—to perform the final act.^[13]

Euthanasia

The intentional ending of another person's life by a physician or other individual, typically through the administration of a lethal drug. Unlike physician-assisted suicide, the final act causing death is performed by another person rather than by the patient.^[6]

Hospice Care

A model of care focused on comfort, symptom management, and quality of life for individuals with terminal illnesses rather than curative treatment.^[8]

Palliative Care

Specialized medical care focused on relieving pain, symptoms, and suffering associated with serious illness. Unlike physician-assisted suicide, palliative care does not seek to cause death.^[10]

Right to Die

A philosophical, ethical, and legal concept asserting that individuals possess the right to choose the timing and manner of their death, particularly in cases involving serious illness or suffering.^[12]

Terminal Illness

A disease or condition that, within reasonable medical judgment, is expected to result in death within a specified period if it follows its ordinary course. Under Illinois law, eligibility for physician-assisted suicide generally requires a diagnosis of a terminal illness with a prognosis of six months or less.^[14]

[5] 210 ILCS 50/3.57; Illinois Department of Public Health, "POLST Guidance for Individuals," <https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives/polst-guidance-individuals.html>

[6] American Medical Association, *Code of Medical Ethics*, Opinion 5.8, "Euthanasia," <https://code-medical-ethics.ama-assn.org/ethics-opinions/euthanasia>; World Medical Association, *Declaration on Euthanasia and Physician-Assisted Suicide* (2019), <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide>

[7] 755 ILCS 45/4-1 et seq. (Illinois Power of Attorney Act).

[8] Centers for Medicare & Medicaid Services, *Medicare Hospice Benefits*, CMS Pub. No. 02154 (Mar. 2026), <https://www.medicare.gov/publications/02154-medicare-hospice-benefits.pdf>

[9] American Academy of Hospice and Palliative Medicine, "Physician-Assisted Dying," <https://aahpm.org/advocacy/where-we-stand/pad>; National Hospice and Palliative Care Organization, *Statement on Medical Aid in Dying* (2021), https://www.nhpco.org/wp-content/uploads/Medical_Aid_Dying_Position_Statement_July-2021.pdf

[10] World Health Organization, "Palliative Care" (Aug. 5, 2020), <https://www.who.int/news-room/fact-sheets/detail/palliative-care>; American Academy of Hospice and Palliative Medicine, "Physician-Assisted Dying," <https://aahpm.org/advocacy/where-we-stand/pad/>

[11] 410 ILCS 22/1 et seq.

[12] Raphael Cohen-Almagor, "Right to Die," in *Encyclopedia of Global Bioethics* (Springer), https://link.springer.com/referenceworkentry/10.1007/978-3-319-05544-2_386-1

[13] 410 ILCS 22/1 et seq.

[14] 410 ILCS 22/10 (definition of "terminal disease").

Types of End-of-Life Interventions

Physician-Assisted Suicide

Physician-assisted suicide is a practice in which a physician provides a prescription for a lethal medication to a qualified patient, who then intentionally uses the medication to end his or her own life.^[15] The patient—not the physician—performs the final act that causes death,^[16] usually by ingesting the medication. Supporters argue that physician-assisted suicide provides terminally ill individuals with greater control over the timing and manner of their death. Opponents argue that it transforms physicians from healers into facilitators of suicide, places vulnerable individuals at risk, and undermines society's commitment to suicide prevention. Physician-assisted suicide is legal in a growing number of states but remains illegal throughout much of the United States.^[17]

Euthanasia

Euthanasia occurs when one person intentionally causes the death of another person,^[18] usually through the administration of a lethal drug. Unlike physician-assisted suicide, the final act causing death is performed by someone other than the patient. Euthanasia is sometimes divided into voluntary, non-voluntary, and involuntary forms depending on the patient's level of consent.^[19]

Supporters argue that euthanasia may relieve suffering in situations where patients are unable to end their own lives. Opponents argue that intentionally killing a patient is fundamentally incompatible with medical ethics and creates significant risks for abuse and coercion. Euthanasia is illegal throughout the United States, although it is permitted under certain circumstances in several foreign countries.

Refusing Treatment

Patients generally have the legal right to refuse medical treatment, even when doing so may result in death.^[20] Examples include declining chemotherapy, dialysis, mechanical ventilation, surgery, or artificial nutrition and hydration. In these situations, death is caused by the underlying disease or condition rather than by a deliberate act intended to cause death.

Supporters and opponents of physician-assisted suicide often agree that competent adults should have the right to refuse unwanted medical treatment. The primary ethical distinction is that refusing treatment allows a disease to take its natural course, whereas physician-assisted suicide involves the intentional use of lethal drugs to cause death.

[15] 410 ILCS 22/1 et seq.; Or. Rev. Stat. § 127.800 et seq.

[16] 410 ILCS 22/10 (definition of "self-administer"); Or. Rev. Stat. § 127.880.

[17] As of Sept. 8, 2026, medical aid in dying is authorized by statute in 13 states and the District of Columbia; Montana recognizes a distinct judicial defense rather than a comparable statutory framework. See Compassion & Choices, "States Where Medical Aid in Dying Is Authorized," <https://compassionandchoices.org/states-where-medical-aid-in-dying-is-authorized>

[18] *Black's Law Dictionary* (definition of "euthanasia"); *The Oxford Handbook of Ethics at the End of Life*.

[19] A. Fontalis, E. Prousalis & K. Kulkarni, "Euthanasia and Assisted Dying: What Is the Current Position and What Are the Key Arguments Informing the Debate?," 111 *Journal of the Royal Society of Medicine* 407, 407–13 (2018).

[20] *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990); *In re Quinlan*, 70 N.J. 10 (1976).

Hospice Care

Hospice is a specialized model of care designed for individuals facing a terminal illness. Rather than focusing on curing a disease, hospice focuses on comfort, symptom management, emotional support, and quality of life. Hospice services often include nursing care, pain management, counseling, spiritual support, and assistance for family members and caregivers. One common misconception is that hospice seeks to hasten death. Hospice neither seeks to prolong life at all costs nor intentionally causes death. Instead, hospice seeks to provide compassionate care while allowing the natural dying process to occur with dignity and comfort.

Palliative Care

Palliative care is specialized medical care focused on relieving pain, symptoms, and other forms of suffering associated with serious illness. It can be provided alongside disease-directed or curative treatment and does not require a patient to forgo treatment intended to prolong life.

Like hospice, palliative care seeks comfort and quality of life rather than intentionally causing death. Chapter 3 examines both forms of care in greater detail.

Palliative Sedation

Palliative sedation is a medical intervention used in rare circumstances when a patient is experiencing severe suffering that cannot be adequately relieved through other treatments. A physician administers medications that reduce consciousness in order to alleviate otherwise uncontrollable symptoms. The goal of palliative sedation is symptom relief rather than death.

While critics sometimes compare palliative sedation to euthanasia or physician-assisted suicide, supporters argue that the two practices differ because the physician's intent is to relieve suffering rather than cause death. Palliative sedation is generally accepted within mainstream medical practice when used appropriately and is distinct from physician-assisted suicide because no lethal medication is administered for the purpose of ending a patient's life.

Do Not Resuscitate (DNR) Orders

A Do Not Resuscitate (DNR) order is a medical order directing healthcare providers not to attempt cardiopulmonary resuscitation (CPR) if a patient's heart stops beating or breathing ceases.^[21] In Illinois, a DNR instruction may be documented through the Illinois Department of Public Health's Uniform Practitioner Orders for Life-Sustaining Treatment (POLST) form, which can also contain orders concerning other forms of life-sustaining treatment.

A DNR concerns resuscitation and does not, by itself, require withdrawal of other medical treatment. Patients with DNR orders may continue to receive medications, oxygen, pain management, food and fluids, surgery, hospice care, palliative care, and other appropriate treatment unless separate orders or directives provide otherwise.

A DNR is fundamentally different from physician-assisted suicide or euthanasia. It does not provide lethal medication or authorize anyone to cause a patient's death; rather, it directs healthcare providers not to attempt to restart the heart or breathing after cardiac or respiratory arrest. If the patient dies without resuscitation, natural death results from the underlying illness or medical condition.

[21] 210 ILCS 50/3.57.

Chart of End-of-Life Interventions

How to read the chart: A decision not to begin or continue treatment allows the underlying condition to take its course. Hospice, palliative care, and palliative sedation seek comfort or symptom relief. Physician-assisted suicide and euthanasia differ because the intervention is intended to cause death; they differ from one another in who performs the final act.

PRACTICE	GOAL	CAUSES DEATH?	WHO PERFORMS THE FINAL ACT?	GENERALLY LEGAL?
Hospice Care	Comfort and support	No	N/A	Yes
Palliative Care	Symptom relief	No	N/A	Yes
Refusing Treatment	Declining unwanted medical intervention	Underlying illness	Patient	Yes
DNR/POLST (No CPR)	Avoid resuscitation	Underlying illness	N/A	Yes
Palliative Sedation	Relieve severe suffering	No (intent)	Physician administers sedation	Yes
Physician-Assisted Suicide	End life	Lethal drugs	Patient	Legal in some states
Euthanasia	End life	Lethal drugs	Another person	Illegal throughout the U.S.

The History of Physician-Assisted Suicide

Debates about suicide, suffering, and the value of human life are not new. Philosophers, physicians, and religious leaders have wrestled with these questions for thousands of years. In ancient Greece and Rome, attitudes toward suicide varied considerably. Some Stoic philosophers regarded suicide as a rational response to unbearable suffering, loss of honor, or the loss of personal autonomy. Others, including Plato and Aristotle, viewed suicide as inconsistent with an individual's duties to society or contrary to virtue. These competing ideas shaped early philosophical discussions about whether human beings possess the moral authority to end their own lives.^[22]

With the rise of Christianity in Europe, suicide came to be viewed not merely as a personal decision but as a moral wrong. Thinkers such as St. Augustine and later St. Thomas Aquinas argued that human life possesses inherent dignity because it is created by God and therefore may not be intentionally destroyed.^[23] These ideas profoundly influenced Western law and medical ethics for centuries, reinforcing the physician's traditional role as one who preserves life and relieves suffering rather than intentionally causing death.

The modern physician-assisted suicide movement began to emerge during the twentieth century.^[24] Advances in medicine enabled physicians to prolong life in ways previously unimaginable, creating new questions about end-of-life care, life support, pain management, and patient autonomy.^[25] At the same time, some advocates argued that individuals should have greater control over the timing and manner of their death, particularly when facing terminal illness. These ideas gained momentum in academic, legal, medical, and political circles throughout the latter half of the century.

During the 1960s and 1970s, advances in life-sustaining technology prompted a growing “right-to-die” movement. Cases involving mechanical ventilation, artificial nutrition and hydration, and prolonged life support raised difficult questions about patient autonomy and the limits of medical intervention. Landmark legal decisions concerning a patient's right to refuse or discontinue unwanted life-sustaining treatment—including decisions exercised through a surrogate when the patient lacked capacity—helped reshape end-of-life law.^[26] Although these cases did not authorize physician-assisted suicide, they significantly influenced later debates by emphasizing bodily integrity, patient choice, and the limits of unwanted medical intervention.

[22] Plato, *Phaedo* 61c–62c; Aristotle, *Nicomachean Ethics* bk. V, ch. 11; Seneca, *Letters from a Stoic* (Letters 70 & 77).

[23] Augustine, *The City of God* bk. I, chs. 17–27; Thomas Aquinas, *Summa Theologiae* II-II, q. 64, art. 5 (“Whether it is lawful to kill oneself?”).

[24] Ezekiel J. Emanuel, “The History of Euthanasia Debates in the United States and Britain,” 121 *Annals of Internal Medicine* 793, 793–802 (1994).

[25] President's Commission for the Study of Ethical Problems in Medicine, *Deciding to Forego Life-Sustaining Treatment* (1983), <https://scholarworks.indianapolis.iu.edu/server/api/core/bitstreams/73871839-0304-43c5-97c6-11879e96f1bf/content>

[26] *In re Quinlan*, 70 N.J. 10 (1976); *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

No individual did more to bring physician-assisted suicide into public consciousness than Dr. Jack Kevorkian, a Michigan pathologist who became known as “Dr. Death.” Beginning in 1990, Kevorkian assisted in the deaths of more than one hundred individuals, many of whom suffered from serious illnesses.^[27] His actions generated enormous controversy and national media attention. Supporters viewed him as a champion of patient autonomy, while opponents argued that he was normalizing suicide and undermining medical ethics. In 1999, Kevorkian was convicted of second-degree murder after directly administering a lethal injection to a patient on national television.^[28]

While Kevorkian’s activities captured public attention, a more organized legalization effort was underway. In 1994, Oregon voters approved the nation’s first physician-assisted suicide law, the Death with Dignity Act. After surviving legal challenges, the law took effect in 1997.^[29] Oregon’s experience became the model for subsequent legalization efforts across the United States. Over the following decades, a growing number of states adopted similar laws, generally limiting eligibility to competent adults diagnosed with terminal illnesses and expected to die within six months.

Oregon’s law established many of the safeguards that would later appear in other states, including a terminal-illness requirement, multiple physician evaluations, waiting periods, informed-consent procedures, and patient self-administration of the prescribed medication.^[30]

The shift in terminology reflected a broader debate over how the practice should be understood. Supporters argued that terms such as “Medical Aid in Dying” distinguish the practice from conventional notions of suicide because the individuals involved are terminally ill and already approaching death.^[31] Critics argue that changing the terminology does not alter the underlying act—intentionally ending one’s own life with medical assistance—and believe that the new language may influence public perception of the practice by presenting an intentional self-caused death as a medical procedure. Critics make a parallel argument about euthanasia, where the direct administration of lethal medication is described in medicalized terms rather than as intentional killing.

Today, physician-assisted suicide remains one of the most actively debated issues in medicine, law, and public policy. Some jurisdictions continue to expand eligibility and modify procedural safeguards, while others have rejected legalization altogether^[32] or continue to prohibit the practice. Illinois entered this national debate in 2025 when lawmakers enacted the End-of-Life Options for Terminally Ill Patients Act, making it the first Midwestern state to authorize physician-assisted suicide. The chapters that follow examine Illinois’ law in detail and place it within the broader historical and legal developments that preceded it.

[27] *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994).

[28] *People v. Kevorkian*, 639 N.W.2d 291 (Mich. Ct. App. 2001).

[29] Oregon Health Authority, “Death with Dignity Act FAQ,” <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATH-WITHDIGNITYACT/Pages/faqs.aspx> (1994 vote, injunction, and 1997 effective date).

[30] Or. Rev. Stat. §§ 127.800–127.897.

[31] American Academy of Hospice and Palliative Medicine, “Physician-Assisted Dying,” <https://aahpm.org/advocacy/where-we-stand/pad>

[32] Katie Moisse, “Advocates for Assisted Dying Deflated by Massachusetts Defeat,” *ABC News* (Nov. 9, 2012), <https://abcnews.go.com/Health/advocates-assisted-dying-deflated-massachusetts-defeat/story?id=17679697>

KEY DATES

IN THE HISTORY OF

PHYSICIAN-ASSISTED SUICIDE



The debate over physician-assisted suicide has evolved over more than two millennia. The timeline below highlights major philosophical, legal, medical, and legislative developments that have shaped the modern movement.

ANCIENT & MEDIEVAL FOUNDATIONS	ANCIENT GREECE & ROME	Philosophers debate the morality of suicide and self-determined death.
	4TH–5TH CENTURIES	Christian thinkers such as St. Augustine strongly condemn suicide.
	13TH CENTURY	St. Thomas Aquinas develops influential arguments against suicide.
THE MODERN END-OF-LIFE MOVEMENT	1967	The modern hospice movement begins with St. Christopher's Hospice in London, founded by Dame Cicely Saunders.
	1976	The New Jersey Supreme Court recognizes a right to discontinue life-sustaining treatment in <i>In re Quinlan</i> .
	1990	Dr. Jack Kevorkian publicly assists in the death of Janet Adkins, bringing national attention to assisted suicide.
	1990	The U.S. Supreme Court recognizes a liberty interest in refusing unwanted treatment in <i>Cruzan v. Director, Missouri Department of Health</i> .
THE RISE OF PHYSICIAN-ASSISTED SUICIDE	1994	Oregon voters approve the Death with Dignity Act, the first physician-assisted suicide law in the United States.
	1997	Oregon's Death with Dignity Act takes effect.
	1997	The U.S. Supreme Court holds there is no constitutional right to assisted suicide in <i>Washington v. Glucksberg</i> and <i>Vacco v. Quill</i> .
	1999	Jack Kevorkian is convicted of second-degree murder.
	2006	The U.S. Supreme Court rejects a federal attempt to block Oregon's law under the Controlled Substances Act in <i>Gonzales v. Oregon</i> .
	2008	Washington voters approve the Death with Dignity Act; the law takes effect in 2009.
EXPANSION OF LEGALIZATION	2013	Vermont becomes the first state to legalize physician-assisted suicide by legislation rather than ballot initiative.
	2015	California enacts the End of Life Option Act.
	2016	Colorado legalizes physician-assisted suicide by ballot initiative.
	2016	Canada legalizes Medical Assistance in Dying (MAID).
	2021	Canada expands MAID eligibility through Bill C-7.
	2023	Oregon and Vermont remove residency requirements. Oregon had already agreed in 2022 not to enforce its requirement.
	2025	Illinois enacts the End-of-Life Options for Terminally Ill Patients Act.
	SEPT. 12, 2026	Illinois' physician-assisted suicide law is scheduled to take effect.

Physician-Assisted Suicide in America

A Growing Legal Landscape

What began as an experiment in Oregon has become an active national movement. Supporters generally describe the practice as “medical aid in dying” and frame it as a matter of autonomy, compassion, and end-of-life choice. Opponents describe it as assisted suicide and warn that legalization creates risks for vulnerable patients, people with disabilities, the elderly, the poor, and those who lack adequate medical, mental health, family, or community support.^[33]

As of 2026, physician-assisted suicide has been authorized by statute in twelve states and the District of Columbia. Oregon, Washington, Vermont, California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Delaware, Illinois, New York, and the District of Columbia have enacted laws permitting some form of medical aid in dying for qualifying terminally ill patients. Montana is often included in national discussions because of a state court decision recognizing a legal defense for physicians in certain assisted-suicide cases, although it does not have the same kind of statutory framework as states such as Oregon or California.^[34]

Although the details vary, most American laws follow a recognizable model: eligibility is tied to serious end-of-life circumstances, the patient must possess decision-making capacity, clinicians must document specified steps, and the patient—not the physician—performs the final act. The major disputes increasingly concern where those boundaries should be drawn and whether provisions adopted as safeguards should later be revised.

Recurring policy differences among states include:

- residency requirements;
- waiting periods;
- who may prescribe;
- mental-health referral rules;
- reporting and oversight; and
- self-administration requirements.

The current legislative landscape remains active. Bills continue to be introduced in states that have not legalized the practice, while states that already authorize it continue to consider amendments involving eligibility, waiting periods, prescribing authority, reporting, and other safeguards.^[35]

[33] National Council on Disability, *The Danger of Assisted Suicide Laws* (Oct. 9, 2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws/>; National Council on Disability, *Letter to Illinois General Assembly Regarding Assisted Suicide Legislation* (May 1, 2025), <https://www.ncd.gov/letters/2025-05-01-ncd-letter-to-illinois-general-assembly-regarding-assisted-suicide-legislation/> see generally Patients Rights Action Fund, <https://patientsrightsaction.org>

[34] See, e.g., New York State Department of Health, “Medical Aid in Dying” (effective Aug. 5, 2026), https://www.health.ny.gov/health_care/medical_aid_in_dying/; *Baxter v. Montana*, 354 Mont. 234 (2009).

[35] Patients Rights Action Fund, “State Legislative Activity” (2026), <https://patientsrightsaction.org/legislation>.

Laws Change After Enactment

The national legal landscape has involved not only legalization but later amendment. In several states, limits originally enacted as safeguards have subsequently been shortened, revised, or removed. California reduced its waiting period from 15 days to 48 hours.^[36] Hawaii and Colorado expanded prescribing authority beyond physicians.^[37] Washington also expanded prescribing authority beyond physicians and reduced waiting periods.^[38] Oregon and Vermont formally removed their residency requirements in 2023; Oregon had already agreed in 2022 not to enforce its residency restriction.^[39] Opponents cite these developments as evidence that statutory boundaries may change after enactment. Supporters respond that each amendment should be evaluated on its own merits rather than treated as proof of an inevitable progression.

International Comparison

International experience has intensified this debate. Canada legalized Medical Assistance in Dying in 2016 and later created an eligibility track for some people whose natural deaths are not reasonably foreseeable.^[40] Health Canada reported 16,499 MAID provisions in 2024; 4.4 percent occurred under that non-reasonably-foreseeable-death track. Critics point to Canada's broader framework in debates about disability, mental illness, poverty, isolation, housing, and access to services. Supporters respond that the Canadian system differs materially from American statutes, which generally remain limited to mentally capable adults with terminal illnesses. Canada therefore provides a comparative example, not a direct description of how Illinois law operates.

Organized Advocacy and Professional Debate

The debate is also shaped by organized advocacy on both sides. Supporters include Compassion & Choices, Death With Dignity, state end-of-life options coalitions, and allied physicians, patients, and legal advocates. Opponents include Patients Rights Action Fund, Not Dead Yet, the Disability Rights Education and Defense Fund, National Right to Life, the National Council on Disability, Catholic and Protestant medical and religious organizations, disability rights advocates, and some associations of medical professionals. This diversity is important: opposition to physician-assisted suicide is not limited to religious or pro-life organizations.^[41] It also includes groups who focus on disability rights, suicide prevention, medical ethics, and patient protection arguments. Several professional medical organizations have adopted positions of neutrality on physician-assisted suicide, while others continue to oppose physician participation.

[36] Cal. S.B. 380, ch. 542 (2021) (effective Jan. 1, 2022), which reduced the interval between the first and second oral requests from 15 days to 48 hours; see California Department of Public Health, "End of Life Option Act — Important Updates," https://www.cdph.ca.gov/Programs/CHSI/Pages/important_updates.aspx

[37] Colo. S.B. 24-068, ch. 406 (2024) (authorizing advanced practice registered nurses to evaluate and prescribe and reducing the waiting period from 15 days to 7 days); Haw. H.B. 650, Act 43 (2023) (authorizing advanced practice registered nurses and reducing the waiting period from 20 days to 5 days).

[38] Wash. S.B. 5179 (2023) (amending the Washington Death with Dignity Act).

[39] Oregon formally repealed its residency restriction in 2023 after agreeing in a 2022 settlement not to enforce it; Vermont removed its residency requirement in 2023. See Or. Rev. Stat. § 127.860; Vt. Stat. Ann. tit. 18, §§ 5281–5293.

[40] Health Canada, *Sixth Annual Report on Medical Assistance in Dying in Canada, 2024* (2025), <https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2024.html>

[41] Patients Rights Action Fund, "Allies," <https://patientsrightsaction.org/allies>

The Ethical Debate

Few public policy issues involve more fundamental questions than physician-assisted suicide. The debate is not merely about healthcare, law, or end-of-life decision-making. At its core, it concerns competing views of human dignity, personal autonomy, suffering, compassion, and the proper role of medicine. Supporters and opponents often begin with many of the same concerns—a desire to reduce suffering, respect individuals, and care for vulnerable people—but arrive at very different conclusions about whether physicians should participate in intentionally ending a patient’s life.

Because physician-assisted suicide touches on deeply held beliefs about life and death, reasonable people can disagree about the issue. Understanding these competing perspectives is essential to understanding both the current law and the debates that are likely to follow.

1. The Case for Physician-Assisted Suicide

Autonomy and Self-Determination

The most common argument in favor of physician-assisted suicide is that competent adults should have the right to make deeply personal decisions about their own lives, including decisions regarding the timing and manner of their death. Supporters argue that individuals generally possess broad authority over their medical treatment and bodily autonomy, and that this authority should extend to end-of-life decisions.

Many advocates view physician-assisted suicide as an extension of existing rights to refuse medical treatment, decline life-sustaining interventions, or establish advance directives. From this perspective, allowing terminally ill patients to choose the circumstances of their death respects individual freedom and self-determination.

Relief of Suffering

Supporters also argue that some terminal illnesses produce suffering that cannot always be adequately alleviated. While modern medicine has made significant advances in pain management and palliative care, some patients continue to experience severe physical symptoms, progressive loss of bodily function, or profound psychological distress.

Advocates contend that physician-assisted suicide provides a compassionate option for patients who wish to avoid what they perceive as prolonged and unnecessary suffering.

Compassion

Many supporters frame physician-assisted suicide as an act of compassion. They argue that forcing individuals to endure a dying process they find intolerable may itself be cruel. From this perspective, allowing patients to choose the timing of their death can be viewed as a humane response to suffering.

Dignity

Supporters often define dignity in terms of independence, self-determination, and the ability to maintain control over one's life. Some fear becoming completely dependent on others, losing cognitive abilities, or experiencing a prolonged decline. Physician-assisted suicide is sometimes presented as a way of preserving personal dignity by allowing individuals to avoid circumstances they consider degrading or inconsistent with their values.

2. The Case Against Physician-Assisted Suicide

Human Dignity

Opponents generally begin from a different understanding of dignity. Rather than viewing dignity as something dependent upon independence, health, or personal control, they argue that every human being possesses inherent dignity simply by virtue of being human.^[42]

Under this view, neither a person's dignity nor the worth of their life diminishes because of illness, disability, dependence, suffering, or age. Critics argue that physician-assisted suicide risks communicating that some lives are no longer worth living and that certain forms of suffering justify intentionally ending life, which can extend to devaluing the lives of people with disabilities, people experiencing homelessness, and others who are deemed to be in an undesirable position.

The Purpose of Medicine

Many opponents argue that physician-assisted suicide fundamentally changes the role of medicine. For centuries, physicians have been expected to heal when possible, relieve suffering when healing is not possible, and accompany patients through illness and death.^[43]

Critics contend that intentionally providing lethal drugs is inconsistent with medicine's healing mission. They argue that crossing the line from caring for patients to intentionally facilitating death may undermine trust between patients and healthcare professionals.

Protection of Vulnerable Persons

Another major concern involves vulnerable populations. Opponents argue that legal safeguards cannot fully eliminate pressures that may influence end-of-life decisions.

Individuals facing loneliness, disability, depression, financial hardship, inadequate healthcare, family pressure, or feelings of being a burden may be particularly vulnerable. Critics worry that a request may sometimes be shaped in part by inadequate support, treatment, or alternatives rather than by the medical condition alone.

[42] John Paul II, *Evangelium Vitae* §§ 19–23, 64–67 (1995).

[43] Lois Snyder Sulmasy & Paul S. Mueller, "Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper," 167 *Annals of Internal Medicine* 576, 576–78 (2017), <https://doi.org/10.7326/M17-0938>

Suicide Prevention Concerns

Opponents also question whether society can consistently promote suicide prevention while simultaneously approving physician-assisted suicide in certain circumstances. Every year, governments, schools, healthcare providers, and advocacy organizations invest substantial resources in preventing suicide.

Critics argue that distinguishing between suicides that should be prevented and suicides that should be facilitated creates ethical and practical tensions. Supporters respond that physician-assisted suicide involves fundamentally different circumstances than most other forms of suicide because it is limited to terminally ill individuals.

3. Perspectives from Different Communities

Disability Rights Perspectives

Some of the most significant opposition to physician-assisted suicide comes from disability rights advocates. Organizations such as Not Dead Yet, the Disability Rights Education and Defense Fund (DREDF), and the National Council on Disability have expressed concerns that assisted-suicide laws may expose people with disabilities to unequal treatment, bias, or inadequate safeguards.^[44]

These groups often argue that societal prejudice, inadequate services, and assumptions about quality of life can influence decisions about death. They caution that many conditions perceived as unbearable by people without those disabilities are lived with by disabled people who continue to find meaning and fulfillment in life. Disability communities are not monolithic, however; other disabled advocates and organizations support legal access to medical aid in dying.

Medical Ethics Perspectives

The medical community remains divided on physician-assisted suicide. Some healthcare professionals support legalization as an option for terminally ill patients. Others argue that physician participation in intentionally ending life is incompatible with medical ethics.

Professional organizations have adopted differing positions, reflecting the ongoing debate within medicine itself.

Religious Perspectives

Many religious traditions oppose physician-assisted suicide on the grounds that human life possesses inherent value and should not be intentionally destroyed. Others emphasize the importance of caring for those who suffer and accompanying them through the natural dying process.

Religious objections often rest on broader beliefs about human dignity, the meaning of suffering, moral responsibility, trusting one's life in the hands of God, and the relationship between life and death.

[44] National Council on Disability, *The Danger of Assisted Suicide Laws* (2019); National Council on Disability, *Letter to Illinois General Assembly Regarding Assisted Suicide Legislation* (May 1, 2025); Disability Rights Education & Defense Fund, "Assisted Suicide," <https://dredf.org/vertical/assisted-suicide/>

Secular Perspectives

Not all opposition to physician-assisted suicide is religious. Many secular critics base their concerns on disability rights, suicide prevention, medical ethics, or social justice considerations.

As a result, the debate frequently brings together unusual coalitions that cross traditional political, religious, and ideological boundaries.

4. Common Ethical Questions

Is suffering ever meaningful?

While suffering is never desirable in itself, many people believe it can possess meaning. Suffering can deepen relationships, foster compassion, strengthen character, inspire courage, and remind us of our dependence upon one another. Throughout history, individuals facing profound illness, disability, and hardship have often discovered purpose, love, reconciliation, and personal growth amid difficult circumstances. Recognizing that suffering can have meaning does not require celebrating it or refusing treatment. Rather, it means acknowledging that a person's value and purpose do not disappear simply because he or she is suffering.

Does autonomy have limits?

Autonomy is an important human good, but it is not the only good. Society routinely recognizes limits on individual freedom when choices harm oneself or others. We prohibit assisted suicide for healthy individuals, intervene when people are experiencing suicidal crises, and restrict many dangerous activities despite personal consent. From a life-affirming perspective, autonomy must be balanced against other principles, including the protection of vulnerable persons, the common good, and the inherent value of human life. The fact that a person wishes to do something does not necessarily make it morally right or socially beneficial.

Is there a difference between killing and letting die?

Many ethicists, religious traditions, and legal systems recognize a distinction between killing and allowing a person to die from an underlying illness.^[45] When a physician administers or prescribes lethal drugs with the intention of causing death, death is the intended outcome of the action. When a patient refuses burdensome treatment or when treatment is no longer effective, death results from the disease itself rather than from an intentional act designed to end life. While both situations may result in death, the intent, means, and moral character of the actions differ significantly.

Is refusing treatment the same as physician-assisted suicide?

No. A patient who refuses treatment is declining a medical intervention and allowing an illness to take its natural course. A patient who seeks physician-assisted suicide is intentionally using lethal medication to cause death. The distinction is not merely technical. In one case, the goal is to avoid unwanted treatment; in the other, the goal is to bring about death itself. For this reason, many people who support a patient's right to refuse treatment nevertheless oppose physician-assisted suicide.

[45] *Vacco v. Quill*, 521 U.S. 793, 800–08 (1997) (describing the distinction between refusing life-sustaining treatment and assisted suicide as important, logical, rational, and well established); American Medical Association, *Code of Medical Ethics*, Opinion 5.3, "Withholding or Withdrawing Life-Sustaining Treatment."

Does a terminal diagnosis change the ethics of suicide?

A terminal diagnosis changes many practical considerations, but it does not alter the inherent value of a human life. A person's dignity does not depend upon life expectancy, physical ability, or health status. While terminal illness may increase suffering and create difficult choices regarding treatment, many opponents of physician-assisted suicide maintain that intentionally ending an innocent human life remains wrong regardless of prognosis. The fact that death is approaching does not necessarily justify causing it.

Should mental suffering be treated differently than physical suffering?

Both physical and mental suffering deserve compassion, treatment, and support. At the same time, mental suffering often affects perception, judgment, hope, and decision-making in ways that may change over time. Depression, anxiety, trauma, loneliness, and hopelessness can significantly influence a person's desire to die. For this reason, many critics of physician-assisted suicide are particularly concerned about expanding eligibility to individuals suffering primarily from psychological conditions. They argue that society should respond to mental suffering with treatment, accompaniment, and support rather than death.

Can a person be a burden?

Is an infant a burden? People can experience burdens, but no person is a burden in the sense of their life possessing less worth or that they are not deserving the support they need from their fellow man. Human beings are inherently dependent upon one another throughout life. Infants, children, the elderly, persons with disabilities, and those suffering from illness all rely on others at various points. A society grounded in human dignity recognizes that dependence does not diminish value. The proper response to vulnerability is care and solidarity, not the suggestion that a person's life has become too burdensome to continue.

What obligations do families and communities owe those who are suffering?

Families and communities have a responsibility to accompany, support, and care for those who suffer. This includes providing practical assistance, emotional support, medical care, spiritual care, and human companionship. A life-affirming perspective holds that no one should face serious illness, disability, or the end of life alone. The measure of a compassionate society is not how efficiently it helps people die, but how faithfully it stands beside them during their most difficult moments.

5. Conclusion

The ethical debate surrounding physician-assisted suicide ultimately rests on competing answers to some of humanity's oldest questions: What gives life value? What makes a death dignified? What is the purpose of medicine? What obligations do we owe one another during times of suffering?

The answers people give to these questions often determine their views on physician-assisted suicide. Understanding these ethical foundations is therefore essential for evaluating Illinois' new law and the future debates that are likely to follow.

What Do People Actually Care About?

Debates over physician-assisted suicide often proceed as though the public is choosing between two clearly defined positions: support or opposition. Polling questions reinforce this impression by asking respondents whether physician-assisted suicide should be legal and reporting the resulting percentage as the level of public “support.”

But physician-assisted suicide is not a single proposition.

A person can support allowing a terminally ill adult in unbearable physical pain to obtain lethal medication while strongly opposing assisted death for someone suffering primarily from depression. Another person may support patient self-administration but oppose a physician directly administering the medication. Someone else may accept both practices but object to allowing minors to participate. Still another may support the practice in principle but oppose a law that lacks mandatory psychiatric evaluations or meaningful independent oversight.

Understanding public attitudes therefore requires a more basic question:

What features of physician-assisted suicide actually matter to people?

That question is important for opponents of physician-assisted suicide as well. Advocates can easily assume that the aspects of the practice they find most morally significant are also the aspects most likely to trouble the public. Polling suggests that assumption is not necessarily correct.

What We Think Matters May Not Be What the Public Thinks Matters

Consider one seemingly fundamental distinction: **Who actually causes the patient’s death?**

Under physician-assisted-suicide laws such as Illinois’s, the physician prescribes lethal medication and the patient must administer it. In euthanasia, by contrast, the physician directly administers the medication that causes death.

For many opponents of assisted suicide, that distinction is morally significant. One might therefore expect the public to be considerably more accepting of patient self-administration than of a physician directly ending the patient’s life.

Gallup’s polling suggests otherwise.

Sources and methodology: See Chapter 5, Part C, “Public Opinion on Physician-Assisted Suicide,” for the Gallup and Pew sources, question wording, response options, and methodological cautions used in this section.

In its 2024 report *Most Americans Favor Legal Euthanasia*, Gallup asked whether a physician should be permitted to assist an incurably ill patient who was living in severe pain “to commit suicide.” Sixty-six percent said yes. Gallup separately asked whether physicians should be allowed to end an incurably ill patient’s life “by some painless means” when the patient and family requested it. Seventy-one percent agreed.

The questions are not perfectly comparable: they differ in wording, the role of the family, and the conduct described. They therefore cannot isolate the effect of who performs the final act. But in this pair of questions, direct physician administration did not receive less support; it received slightly more.

This illustrates an important lesson for understanding public opinion: **we should not assume we already know where people’s moral boundaries lie.**

Instead, physician-assisted suicide can be broken into a series of separate dimensions. Each presents a different potential boundary.

1. Who Causes the Death?

The first dimension concerns the physical act that causes death.

Possible arrangements include:

- the patient self-administers lethal medication;
- a physician administers it;
- another healthcare professional administers it;
- or another person, such as a family member, assists.

To some people, the distinction between prescribing a lethal drug and injecting it may be fundamental. To others, both actions may appear to be different means of accomplishing essentially the same thing.

Existing polling suggests that this distinction may matter less to the general public than opponents of assisted suicide sometimes assume.

2. Why Does the Person Want to Die?

Perhaps a much more important distinction concerns the patient’s reason for requesting death.

Possible motivations include:

- | | |
|---|---|
| • uncontrolled physical pain; | • fear of future pain; |
| • loss of independence; | • loss of dignity; |
| • inability to participate in enjoyable activities; | • feeling like a burden on family or caregivers; |
| • financial concerns; | • depression or psychological suffering; |
| • loneliness; | • or a desire to control the timing and circumstances of death. |

These reasons are not necessarily equivalent in the public mind.

Earlier Pew polling illustrates the difference. In Pew Research Center's *Views on End-of-Life Medical Treatments* survey, fielded March 21–April 8, 2013, 62 percent of Americans said a person suffering great pain with no hope of improvement had a moral right to end his or her life. Fifty-six percent said the same about having an incurable disease.

Support was substantially lower when different reasons were presented. Thirty-eight percent recognized such a right when “living has become a burden,” and 32 percent did so when the person had become an extremely heavy burden on his or her family.

This distinction is particularly important because many familiar polling questions explicitly invoke severe physical pain. Gallup's 2024 assisted-suicide question, for example, specified an incurably ill patient “living in severe pain.”

A poll showing substantial support under that circumstance does not necessarily tell us what the same respondents think when a patient is not suffering severe physical pain but fears dependence, loss of dignity, or becoming a burden.

3. What Condition Makes Someone Eligible?

A related question concerns the medical condition necessary to qualify.

Possible eligibility lines include:

- terminal illness accompanied by severe physical pain;
- an estimated prognosis of six months or less;
- serious physical disability;
- dementia;
- terminal illness without severe physical pain;
- an incurable but nonterminal disease;
- mental illness alone;
- or advanced age and frailty without a terminal diagnosis.

Most major American polls do not test all of these possibilities. They generally present a much narrower scenario involving an adult with an incurable or terminal illness, often accompanied by severe pain or suffering.

Consequently, a finding that most Americans support assisted suicide for a terminally ill patient cannot reasonably be interpreted to mean that most Americans accept assisted death based on nonterminal disability, dementia or psychiatric suffering.

The public may draw sharp distinctions among them.

4. Who May Receive Assisted Death?

Eligibility can also be understood in terms of the person rather than the disease.

Relevant distinctions include:

- competent adults;
- adults with impaired decision-making capacity;
- adults who previously requested death through an advance directive;
- teenagers;
- younger children;
- and people who do not reside in the jurisdiction where assisted death is provided.

Age and capacity may prove considerably more important to public attitudes than the distinction between prescribing and administering lethal medication.

Again, existing American polling provides surprisingly little information. High-quality national polling has rarely tested public attitudes toward minors, dementia and advance requests separately from the conventional competent-terminal-adult scenario.

5. How Certain Must Doctors Be?

Terminal prognosis itself contains another potential dividing line.

People may have different attitudes depending upon whether they believe:

- the diagnosis is certain;
- the prognosis is certain;
- six months of remaining life is merely the physician's best estimate;
- the patient could substantially outlive the prognosis;
- or one versus multiple physicians must agree.

This matters because public support for a hypothetical person who is *certain to die within six months* may not be identical to support for a law based upon clinical prognosis.

Physician polling also suggests uncertainty about this question. In one national physician survey, 60 percent of respondents disagreed that physicians can predict with certainty that a patient has six months or less to live.^[46]

Whether that uncertainty matters to the public is a separate empirical question.

[46] Peter T. Hetzler III, James Nie, Amanda Zhou & Lydia S. Dugdale, "A Report of Physicians' Beliefs about Physician-Assisted Suicide: A National Study," 92 *Yale Journal of Biology and Medicine* 575, 580–82 (2019). The survey was mailed to 1,000 randomly selected U.S. physicians and produced 188 usable responses, an estimated response rate of approximately 22%.

6. What Mental-Health Safeguards Are Required?

Another potential boundary concerns mental health.

A system could require:

- psychiatric evaluation for every applicant;
- evaluation only when the treating physician suspects impaired judgment;
- treatment of depression before assisted suicide;
- or assisted suicide despite depression when clinicians conclude that decision-making capacity remains intact.

There is also a deeper question.

When an otherwise healthy person tells a physician, “I want to die,” the statement ordinarily prompts concern about suicide and mental health. Should the same statement be understood differently when made by someone diagnosed with a terminal illness?

People may support assisted suicide while nevertheless having very different intuitions about how medicine should respond to those two patients.

7. Must Alternatives Be Attempted First?

Public opinion may also depend on what has been done to alleviate the conditions causing the patient to seek death.

Possible alternatives include:

- hospice;
- improved pain management;
- disability services;
- and financial or social support.
- palliative care;
- mental-health treatment;
- caregiver assistance;

But there is another important distinction: **Must alternatives actually be tried, or must the patient merely be informed that they exist?**

Someone may support assisted suicide as a last resort after every reasonable alternative has failed while opposing it when a patient can obtain lethal medication without first attempting those alternatives.

Those positions would both register as “support” or “opposition” depending entirely upon how a conventional polling question was worded.

8. How Voluntary Is the Decision?

Nearly everyone involved in the assisted-suicide debate agrees that the decision should be voluntary. The harder question is what voluntariness means in practice.

Potential influences include:

- explicit coercion;
- feeling like a burden;
- an insurer declining to pay for expensive treatment while covering assisted suicide;
- or a physician suggesting assisted suicide before the patient raises it.
- subtle family pressure;
- financial pressure;
- caregiver exhaustion;

These scenarios occupy a spectrum between obvious coercion and circumstances that may influence a person's decision without eliminating legal capacity.

Where the public draws that line may tell us far more about its attitude toward assisted suicide than a generic support question.

9. What Should Physicians Be Required—or Permitted—to Do?

The physician's role can itself be divided into multiple questions.

Should a physician be permitted to:

- prescribe lethal medication;
- recommend assisted suicide;
- initiate the discussion with a patient?

And should a physician who morally objects to the practice be required to:

- discuss its perceived benefits;
- inform patients about its availability;
- refer patients to participating physicians;
- or participate in some other way?

Conversely, should physicians have a right to refuse any involvement?

These questions measure something different from whether assisted suicide should be legal. A person might support patient access while strongly supporting physicians' conscience rights.

10. What Safeguards and Procedures Are Necessary?

The term “safeguards” can encompass numerous separate requirements:

- waiting periods;
- witnesses;
- mental-capacity assessments;
- restrictions on telehealth;
- written requests;
- confirmation by a second physician;
- in-person examinations;
- and rules governing when procedural requirements may be waived.

Public support for assisted suicide with all of these protections cannot automatically be interpreted as support for assisted suicide without them.

The relevant question may therefore not be whether the public supports “safeguards,” but **which safeguards people regard as essential conditions of their support.**

11. What Happens When the Patient Takes the Drugs?

The circumstances surrounding the death itself may also matter.

Is a physician present?

Is the family present?

Can the patient take the medication while alone?

What happens if death takes much longer than anticipated?

What happens if complications occur?

What happens if the patient expresses a desire to live after beginning the process?

These details receive far less attention in public polling than the initial decision to request assisted suicide.

12. How Is the Death Officially Characterized?

Terminology is not merely rhetorical.

Possible descriptions include:

- suicide;
- physician-assisted suicide;
- medical aid in dying;
- assisted death;
- or death from the patient’s underlying disease.

The death certificate raises a related issue: What should the government officially record as the cause and manner of death?

Existing polling already demonstrates substantial sensitivity to terminology and question wording. Gallup itself has observed differences associated with describing the practice as suicide versus describing a painless death.

13. Who Ensures the Rules Were Followed?

A law can contain extensive safeguards on paper while leaving a separate question of enforcement.

Possible oversight systems include:

- independent review of every death;
- physician self-reporting;
- audits of medical records;
- investigations triggered by complaints;
- public reporting of violations and complications;
- and penalties for physicians who fail to comply.

Someone who supports assisted suicide under rigorous independent oversight may feel very differently about a system in which participating clinicians themselves supply most of the information used to determine compliance.

Thus, public attitudes toward assisted suicide may depend not merely on what the law promises but on **how violations could actually be discovered**.

14. Does It Matter What Happens to the Law Later?

Perhaps one of the least studied dimensions of American public opinion concerns future expansion.

Would someone support a law permanently restricted to competent, terminally ill adults but oppose it if eligibility were later extended to:

- people with nonterminal illnesses;
- people whose principal condition is mental illness;
- people with dementia;
- minors;
- physician-administered euthanasia;
- or patients subject to fewer procedural safeguards?

Most American polling cannot answer this question. The existing literature contains relatively little high-quality polling separately measuring attitudes toward mental illness, dementia, minors, non-terminal disability and removal of safeguards.

This creates an important distinction between **support for assisted suicide as currently proposed and support for the underlying principle if its boundaries change**.

A person might support a narrowly drawn law precisely because the person believes those boundaries will remain in place. Another might oppose legalization because the person doubts that they will.

Those are very different attitudes even if both individuals initially answer a conventional polling question about terminally ill adults.

15. What Moral Principle Is Doing the Work?

Finally, beneath all of these practical distinctions lies a more fundamental disagreement about why assisted suicide should or should not be permitted.

Several principles may be operating:

Autonomy. Does a competent adult possess a right to decide the timing and manner of death?

The role of medicine. Is helping cause death a legitimate function of physicians, or does it conflict with the physician's healing role?

Compassion. Can preventing suffering justify medical assistance in causing death?

Human worth. Should dependence, loss of abilities, disability, diminished enjoyment of life, or feeling burdensome ever become reasons for facilitating someone's death?

Equality. Why should medicine attempt to prevent the suicide of one person while facilitating the death of another based upon illness, disability or prognosis?

These principles may explain why apparently similar people draw very different lines.

They may also reveal apparent inconsistencies that a simple support-or-oppose question cannot detect. Someone might strongly endorse autonomy but oppose assisted suicide for a competent adult with a nonterminal disability. Another might emphasize relief of suffering but oppose assisted death for severe psychological suffering. Those positions suggest that some additional principle is determining where the person's boundary lies.

Finding the Public's Actual Red Lines

The most useful question may therefore not be:

“Do Illinoisans support physician-assisted suicide?”

It may be:

“Under exactly what circumstances do Illinoisans believe physicians should be permitted to help cause a patient’s death—and where do they draw the line?”

Existing polling gives us reasons to believe those questions may produce very different answers.

National majorities commonly support legal physician involvement in the deaths of terminally ill patients when presented with a narrow scenario. Yet legal support is higher than moral approval, wording affects responses, religious and political differences are substantial, and relatively little polling tests what happens when the conventional terminal-illness scenario is altered.

That should caution both sides against assuming that a single topline number captures public opinion.

For opponents of physician-assisted suicide, the lesson is particularly important. The feature that seems most morally troubling to an advocate may not trouble the average voter. The distinction between prescribing lethal medication and administering it directly, for example, may seem fundamental in moral argument while having relatively little effect on public opinion.

Conversely, distinctions that receive less attention in philosophical debate may prove decisive to ordinary people: whether the patient is actually in pain, whether depression is involved, whether the person feels like a burden, whether meaningful alternatives have been attempted, whether physicians can accurately predict remaining life, whether doctors can conscientiously refuse participation, whether safeguards are independently enforced, whether children could ever become eligible, and whether today’s limits will remain tomorrow’s limits.

The purpose of good public-opinion research should not be to assume which of these concerns matters most.

It should find out.

Once physician-assisted suicide is decomposed into its component parts, “support for PAS” becomes considerably less informative than the deeper question: **What exactly are people supporting, what conditions are essential to that support, and what would cause them to withdraw it?**

ADVOCACY ANALYSIS

Incremental Legal Change

A Lesson from Recent American History

One of the recurring features of modern public-policy debates is that major legal changes often occur incrementally rather than all at once. Advocates frequently pursue an initial reform that is presented as limited in scope and carefully confined to particular circumstances. Once that principle has been accepted in law, later debates shift from whether the practice should exist at all to how broadly it should be applied.

Critics of physician-assisted suicide argue that this pattern has appeared repeatedly in recent American legal history. They point to areas such as abortion, same-sex marriage, and transgender policy, where legal and cultural changes occurred through a series of successive steps rather than a single sweeping transformation. In each instance, assurances that a proposed change would be narrow and limited were later followed by efforts to broaden legal protections, expand recognized rights, or impose new legal obligations on governments and private citizens. Supporters of those movements often view these developments not as broken promises but as the logical and necessary application of the underlying principles of equality, autonomy, or individual rights.

Opponents of physician-assisted suicide believe a similar dynamic is likely to occur here. They argue that today's debate focuses on mentally capable adults with terminal illnesses because those cases evoke the greatest public sympathy. Once society accepts the principle that physicians may intentionally assist patients in ending their lives under some circumstances, however, future debates naturally shift to whether the same principle should apply to additional categories of patients. Questions concerning residency requirements, chronic illness, dementia, mental illness, mature minors, advance requests, self-administration, and provider eligibility become arguments about where to draw the line rather than whether the underlying practice should exist.

Supporters reject the characterization that this represents a "slippery slope." They argue instead that legislatures routinely amend laws in response to experience, medical advances, constitutional developments, and public opinion. From their perspective, subsequent changes reflect democratic governance rather than an inevitable progression toward broader eligibility.

Regardless of which view ultimately proves correct, several jurisdictions that legalized physician-assisted suicide have later revisited questions concerning eligibility, safeguards, oversight, and implementation. That record does not establish that every jurisdiction will follow the same path, but it does show that the statutory lines are not necessarily permanent. Understanding how these laws have evolved elsewhere is therefore relevant to evaluating what may lie ahead for Illinois.

Chapter 1's Key Takeaways

Ten concepts provide the foundation for understanding physician-assisted suicide and evaluating Illinois' new law.

1 Physician-assisted suicide differs from euthanasia, hospice care, palliative care, refusing treatment, and DNR/POLST medical orders.

2 Physician-assisted suicide involves a physician prescribing lethal medication that a patient self-administers to intentionally end his or her life.

3 The modern physician-assisted-suicide movement began in earnest during the late twentieth century. Oregon voters approved the nation's first physician-assisted-suicide law in 1994; after litigation delayed implementation, the law took effect in 1997.

4 A growing number of American states have legalized physician-assisted suicide, often using terms such as "Medical Aid in Dying" or "Assisted Death."

5 Other jurisdictions have continued to debate and modify their laws after legalization, including changes involving residency requirements, waiting periods, prescribing authority, and eligibility criteria.

6 Supporters generally emphasize autonomy, dignity, compassion, and relief of suffering, while opponents generally emphasize inherent human dignity, suicide prevention, medical ethics, and the protection of vulnerable persons.

7 Illinois became the first state in the Midwest to legalize physician-assisted suicide when lawmakers enacted the End-of-Life Options for Terminally Ill Patients Act in 2025.

8 Physician-assisted suicide is shaped by centuries of philosophical, religious, legal, and medical debates on suicide, suffering, autonomy, and the purpose of medicine.

9 The debate is not limited to religious or pro-life organizations. Disability-rights advocates, medical professionals, ethicists, and secular organizations have also raised concerns about its effects on vulnerable individuals and the practice of medicine.

10 Understanding physician-assisted suicide requires careful attention to legal terminology, medical practice, ethical principles, and the distinctions among different end-of-life interventions.

COMING NEXT

This is the foundation for evaluating Illinois' physician-assisted-suicide law and the debates likely to follow. Chapter 2 examines the End-of-Life Options for Terminally Ill Patients Act, including how it was enacted, who qualifies, and the rights and responsibilities of patients, families, healthcare professionals, and institutions.

02

Illinois Law and Public Policy on Physician-Assisted Suicide

What does Illinois law permit, how does the statutory process work, and what legal and public-policy questions does it create?

- The End-of-Life Options for Terminally Ill Patients Act
- Eligibility requirements and procedural safeguards
- Patient, physician, and institutional responsibilities
- Conscience rights and participation requirements
- Oversight, enforcement, reporting, and liability
- Unresolved legal and public-policy questions

The Illinois End-of-Life Options Act

Legislative History

Illinois legalized physician-assisted suicide through Senate Bill 1950, which became Public Act 104-0441. The law is formally titled the End-of-Life Options for Terminally Ill Patients Act and may also be referred to as Deb's Law.^[47]

The successful 2025 legislation was not the first attempt to legalize assisted suicide. In the prior General Assembly, Senator Linda Holmes introduced SB 3499. That bill would have created the End-of-Life Options for Terminally Ill Patients Act and authorized qualified patients with terminal diseases to request prescriptions for aid-in-dying medication. SB 3499 was sponsored by Senator Linda Holmes and cosponsored by Senators Cristina Castro, Laura Fine, Karina Villa, Mary Edly-Allen, Ann Gillespie, Laura Ellman, Adriane Johnson, and Javier Cervantes. The bill was not enacted before the 103rd General Assembly adjourned on January 7, 2025, and therefore died at the conclusion of the legislative session.^[48]

In the 104th General Assembly, supporters introduced new versions of the proposal. SB 9 was introduced in the Senate on January 13, 2025, by Senator Linda Holmes.^[49] Its Senate sponsors included Senators Linda Holmes, Laura Fine, Cristina Castro, Adriane Johnson, Mary Edly-Allen, and Laura Ellman. A companion bill, HB 1328, was filed in the House on January 14, 2025, by Representative Robyn Gabel and received its first reading on January 28.^[50] Its House sponsors included Representatives Robyn Gabel, Emanuel "Chris" Welch, Kelly Cassidy, Harry Benton, Mary Beth Canty, Janet Yang Rohr, Anne Stava, Amy Briel, Maura Hirschauer, Terra Costa Howard, Bob Morgan, Thaddeus Jones, Nicolle Grasse, Edgar González Jr., and Carol Ammons.

The bill that ultimately became law was SB 1950. As originally filed on February 6, 2025, by Senator Laura Ellman, SB 1950 was not an assisted-suicide bill.^[51] It concerned sanitary food preparation and meal-kit or ready-to-eat meal distribution facilities. The bill was later transformed through House Floor Amendment No. 2, filed by Representative Robyn Gabel on May 23, 2025.^[52] That amendment deleted the food-preparation language and replaced it with the End-of-Life Options for Terminally Ill Patients Act.^[53]

[47] End-of-Life Options for Terminally Ill Patients Act, Pub. Act 104-0441 (Ill. 2025) (codified at 410 ILCS 22/1 *et seq.*).

[48] Ill. Gen. Assemb., Bill Status of S.B. 3499, 103d Gen. Assemb. (2023–2024), <https://www.ilga.gov/legislation/billstatus.asp?GAID=17&DocTypeID=SB&DocNum=3499>.

[49] Ill. Gen. Assemb., Bill Status of S.B. 9, 104th Gen. Assemb. (2025).

[50] Ill. Gen. Assemb., Bill Status of H.B. 1328, 104th Gen. Assemb. (2025).

[51] Ill. Gen. Assemb., Bill Status of S.B. 1950, 104th Gen. Assemb. (showing original bill concerning sanitary food preparation).

[52] H. Floor Amend. No. 2 to S.B. 1950, 104th Gen. Assemb. (Ill. 2025).

[53] This procedure is commonly described in Illinois as "gut-and-replace" legislation. It involves removing a bill's original language and substituting substantially different language, often after the bill has already progressed through portions of the legislative process. See Peter Hancock, *GOP Lawsuit Seeks to End "Gut-and-Replace" Legislation*, Capitol News Illinois (June 18, 2025), <https://capitolnewsillinois.com/news/gop-lawsuit-seeks-to-end-gut-and-replace-legislation>.

SB 1950 moved quickly once the amendment was adopted. The Senate originally passed the bill, in its earlier amended form, on April 9, 2025, by a vote of 54–1. After the bill reached the House, Representative Maura Hirschauer initially served as Chief House Sponsor. On May 27, 2025, Representative Robyn Gabel became the alternate chief sponsor. House Floor Amendment No. 2 was adopted on May 29, 2025. The House passed the amended bill that same day by a vote of 63–42, with two members voting present.^[54]

Because the House amendment had replaced the bill’s substance, the Senate still needed to concur. On May 29, 2025, the Senate received the bill for concurrence in House Floor Amendment No. 2. Senator Linda Holmes became the Senate chief sponsor on that same day. Senators Adriane Johnson, Mary Edly-Allen, Laura Fine, Karina Villa, and Laura Ellman were added as sponsors on May 30, and Senator Cristina Castro was added on October 10. On October 31, 2025, the Senate concurred in House Floor Amendment No. 2 by a vote of 30–27. The bill then passed both houses.^[55]

SB 1950 was sent to Governor J.B. Pritzker on November 25, 2025. Governor Pritzker approved the bill on December 12, 2025, making it Public Act 104-0441. It goes into effect on September 12, 2026.^[56]

Purpose of the Law

The Act states that 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.^[57] The General Assembly’s stated position is that the availability of medical aid in dying provides an additional option for terminally ill individuals who seek autonomy, control over the progression of disease, or relief from pain and suffering.

The Act also identifies several Illinois advocates whose stories were used to support the legislation. These include Deb Robertson, after whom Deb’s Law is named; Andrew Flack, who reportedly could not return to Illinois after a terminal diagnosis because Illinois did not yet permit medical aid in dying; Miguel Carrasquillo, who advocated for changing Illinois law while suffering from cancer; and Lowell Sachnoff, who advocated for expanded end-of-life options alongside his wife, Fay Clayton.^[58]

The law frames aid in dying as an expression of a mentally capable adult’s right to determine medical treatment options according to personal values, beliefs, and preferences. The Act states that its intent is to uphold both the “highest standard of medical care” and the “full range of options” for individuals, particularly at the end of life.^[59]

The Act also provides in Section 100(b) that actions taken in accordance with the Act do not constitute “suicide” or “assisted suicide” under Illinois law. This Guide nevertheless uses *physician-assisted suicide* as a descriptive term for the practice, as explained in Chapter 1.

[54] Ill. Gen. Assemb., Bill Status of S.B. 1950, 104th Gen. Assemb. (recording House votes, sponsors, and legislative actions).

[55] Ill. Gen. Assemb., Bill Status of S.B. 1950, 104th Gen. Assemb. (2025).

[56] Pub. Act 104-0441 (Ill. 2025).

[57] 410 ILCS 22/5(a)(1)–(2).

[58] 410 ILCS 22/5(a).

[59] 410 ILCS 22/5.

Brief Overview of the Act

The End-of-Life Options for Terminally Ill Patients Act establishes a legal framework through which certain terminally ill Illinois residents may request and obtain a prescription for life-ending medication.^[60] While the law contains numerous procedural requirements, safeguards, reporting obligations, and conscience protections, its core provisions can be grouped into several major categories. The Act also expressly provides that nothing in it lowers the applicable standard of care for healthcare professionals participating under the Act.^[61] The following summary provides an overview of the law before examining each component in greater detail.

The Act:

- Limits eligibility to certain adult Illinois residents diagnosed with a terminal disease expected to result in death within six months.^[62]
- Requires that patients possess the mental capacity necessary to make informed healthcare decisions.
- Requires patients to make multiple requests for aid-in-dying medication, including both oral and written requests.^[63]
- Requires confirmation of the patient's diagnosis, prognosis, mental capacity, voluntariness, and freedom from coercion or undue influence by both an attending physician and a consulting physician.
- Requires referral to a licensed mental-health professional if either physician has doubts about the patient's mental capacity and cannot confirm that the patient is capable of making an informed decision. The evaluator must also determine whether a psychiatric or psychological disorder is causing impaired judgment.
- Requires that any prescribed aid-in-dying medication be self-administered by the patient.
- Prohibits surrogate decision-makers, guardians, healthcare agents, and family members from requesting aid-in-dying medication on behalf of a patient.^[64]
- Provides that physicians, pharmacists, licensed mental-health professionals, and healthcare entities may decline to participate in physician-assisted suicide, while leaving them subject in some circumstances to notice, disclosure, transfer, referral, and related obligations.^[65]
- Establishes physician reporting requirements and requires IDPH to publish an annual statistical report beginning one year after the Act's effective date.
- Provides confidentiality protections for information collected under the Act.
- Specifies that deaths occurring under the Act are attributed to the patient's underlying terminal disease rather than being classified as suicide or homicide.
- Provides that contracts and wills may not condition rights or obligations upon a person's decision to request or rescind aid-in-dying medication; protects life, health, and accident insurance and annuity benefits; and prohibits insurers from denying or altering otherwise available benefits based upon whether a patient requests or declines aid-in-dying medication.^[66]

The distinction between a right to decline direct participation and continuing obligations imposed on objecting professionals is now the subject of federal litigation in *Kirchoff v. Treto*.^[67]

[60] End-of-Life Options for Terminally Ill Patients Act, 410 ILCS 22/1 *et seq.*

[61] 410 ILCS 22/20.

[62] 410 ILCS 22/10 (definitions of "adult," "qualified patient," and "terminal disease"); 410 ILCS 22/50 (residency).

[63] 410 ILCS 22/25, 22/30.

[64] 410 ILCS 22/25(e).

[65] 410 ILCS 22/60, 22/65, 22/70; 745 ILCS 70/4, 70/6, 70/6.1.

[66] 410 ILCS 22/80, 22/85.

[67] Complaint, *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill. filed Aug. 11, 2026); Stipulated Temporary Restraining Order, ECF No. 14 (N.D. Ill. Aug. 21, 2026).

The Process of Physician-Assisted Suicide in Illinois

The End-of-Life Options for Terminally Ill Patients Act establishes a multi-step process that must be completed before a physician may prescribe aid-in-dying medication.^[68] The law's supporters describe these requirements as safeguards intended to ensure that requests are informed, voluntary, and made only by individuals who satisfy the Act's eligibility criteria. Opponents argue that no procedural safeguards can fully protect vulnerable patients from coercion, depression, feelings of being a burden, or other external pressures.^[69]

The process generally consists of six stages:

1 Initial Request	2 Attending Physician Review
3 Consulting Physician Review	4 Documentation Requirements
5 Prescription	6 Self-Administration

1. Initial Request

The process begins when a qualified patient makes an oral request to an attending physician for aid-in-dying medication.^[70] The request must come directly from the patient. No family member, healthcare agent, guardian, surrogate decision-maker, or holder of a healthcare power of attorney may make the request on the patient's behalf.

After making the initial oral request, the patient must submit a written request.^[71] The written request must be signed and dated by the patient and witnessed by two individuals who attest that the patient appears to be acting voluntarily, possesses mental capacity, and is not being subjected to coercion or undue influence.

At least one witness must be independent. That witness may not be a relative of the patient; a person entitled to any portion of the patient's estate upon death; or an owner, operator, or employee of a healthcare entity where the patient is receiving treatment or resides. In addition, the attending physician and any interpreter for the patient may not serve as witnesses.

[68] End-of-Life Options for Terminally Ill Patients Act, 410 ILCS 22/25–60; 410 ILCS 22/70(f).

[69] See, e.g., Am. Med. Ass'n, *Code of Medical Ethics* Op. 5.7 (Physician-Assisted Suicide); Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* (2019).

[70] 410 ILCS 22/25(a)(1)–(2).

[71] 410 ILCS 22/25(a)(3); 410 ILCS 22/30(a)–(d).

The patient must then make a second oral request.^[72] Ordinarily, it must occur at least five days after the initial oral request. If the attending physician medically determines that the patient will, within reasonable medical judgment, die within five days after the initial oral request, the written request and second oral request may be made at any time after the initial oral request. At the time of the second oral request, the attending physician must offer the patient an opportunity to rescind the request. The multiple requests are intended to ensure that the decision is deliberate and sustained rather than impulsive.

2. Attending Physician Review

After receiving the patient's request, the attending physician must conduct an evaluation to determine whether the patient satisfies the requirements of the Act.^[73]

The physician must determine:

- Whether the patient has a terminal disease;
- Whether the disease is expected to result in death within six months;
- Whether the patient possesses mental capacity;
- Whether the request appears voluntary; and
- Whether the patient is acting free from coercion or undue influence.^[74]

The attending physician must also provide extensive information to the patient.

This includes discussing:

- The diagnosis;
- The prognosis;
- The potential risks associated with the medication;
- The probable result of taking the medication;
- Feasible alternatives, including hospice and palliative care;
- The patient's right to rescind the request at any time;
- Information about the benefits of notifying next of kin, although the patient is not required to do so; and
- A recommendation that another person be present during self-administration and that the medication not be taken in a public place.^[75]

Importantly, the physician must inform the patient that obtaining a prescription does not obligate the patient to fill it and that filling the prescription does not obligate the patient to take the medication.^[76] Supporters view these discussions as an important informed-consent safeguard. Opponents view it as not enough.^[77]

[72] 410 ILCS 22/25(a)(4), (c)–(d).

[73] 410 ILCS 22/35(a).

[74] 410 ILCS 22/35(a)(1)–(3).

[75] 410 ILCS 22/35(a)(4)–(6), (11), (13)(C)(iii)–(iv).

[76] 410 ILCS 22/35(a)(5).

[77] See Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* (2019).

3. Consulting Physician Review

The Act requires a second physician—known as the consulting physician—to independently examine the patient and review the patient’s medical records.^[78]

The consulting physician must then determine whether the patient:

- Has a terminal disease;
- Is expected to die within six months;
- Possesses mental capacity;
- Is acting voluntarily; and
- Appears free from coercion or undue influence.^[79]

The consulting physician serves as an additional layer of review intended to reduce the risk of error and independently confirm the patient’s diagnosis and prognosis, mental capacity, voluntariness, and freedom from coercion or undue influence.

If either physician has doubts about the patient’s mental capacity and cannot confirm that the patient is capable of making an informed decision, the patient must be referred to a licensed mental-health professional.^[80] The evaluator must determine both whether the patient has mental capacity and whether a psychiatric or psychological disorder is causing impaired judgment. If the evaluator finds either that the patient lacks mental capacity or that such a disorder is causing impaired judgment, the patient is not a qualified patient and the attending physician may not prescribe under the Act.

4. Documentation and Final Verification

The Act requires substantial documentation throughout the process.^[81]

Among other things, the patient’s record must include:

- The diagnosis and prognosis;
- The determination of mental capacity;
- The date of each oral request;
- A copy of the written request;
- The consulting physician’s written determination;
- Any mental-health professional’s written determination;
- A notation that the attending-physician requirements were completed; and
- The medication and any ancillary medications prescribed.

[78] 410 ILCS 22/40.

[79] 410 ILCS 22/40(2).

[80] 410 ILCS 22/45.

[81] 410 ILCS 22/35(a)(8), (10), (12), (16).

The written request itself must satisfy specific statutory requirements and contain witness attestations regarding the patient's voluntariness and mental capacity.^[82]

These documentation requirements are intended to create a record demonstrating compliance with the law and to facilitate later reporting to the Illinois Department of Public Health.

5. Prescription

If all statutory requirements have been satisfied, the attending physician may prescribe aid-in-dying medication.^[83] Before providing the prescription, the physician must ensure that the statutory steps have been completed, confirm that the patient has made an informed decision, offer another opportunity to rescind, and provide information about self-administration, safe storage and disposal, having another person present, and avoiding use in a public place.

6. Self-Administration

The law requires that the medication be self-administered by the patient.^[84] Self-administration means an affirmative, conscious, and voluntary act by the patient to ingest the medication. The Act does not authorize euthanasia.^[85] Physicians, nurses, family members, or other individuals may not administer the lethal medication through injection, infusion, or other means. A physician who is present may prepare the medication for the patient, but the affirmative, conscious, and voluntary act of ingestion must still be performed by the patient.^[86]

Even after receiving the prescription, the patient retains the right to change his or her mind,^[87] and some do.^[88] The patient may choose not to fill the prescription, may fill it and never use it, or may rescind the request altogether. Nothing in the Act requires a patient to proceed once the medication becomes available. After a patient's death, a person who has custody or control of unused aid-in-dying medication must dispose of it through a qualified disposal facility or, if none is available, by other lawful means consistent with State and federal guidelines.^[89]

Only after the patient independently decides to self-administer the lethal medication does the process contemplated by the Act conclude.

[82] 410 ILCS 22/30.

[83] 410 ILCS 22/35(a)(13)–(15).

[84] 410 ILCS 22/10 (definition of "self-administer"); 410 ILCS 22/25.

[85] 410 ILCS 22/10 (definition of "self-administer").

[86] 410 ILCS 22/70(f).

[87] 410 ILCS 22/25(d); 410 ILCS 22/35(a)(4)(E), (13)(B).

[88] In Oregon, which has the nation's longest continuous reporting history, 5,520 people received prescriptions under the Death with Dignity Act from 1998 through 2025, and 3,691—approximately 67%—were reported to have died after ingesting the medication. Oregon Health Authority, *Oregon Death with Dignity Act: 2025 Data Summary* 7–8 (rev. June 17, 2026), Oregon Health Authority report.

[89] 410 ILCS 22/55.

Reporting and Oversight

Overview

The End-of-Life Options for Terminally Ill Patients Act creates a reporting system administered by the Illinois Department of Public Health. The system requires an attending physician to submit information after prescribing aid-in-dying medication and, if the physician is later notified that the patient died following self-administration, to submit a follow-up report.

Supporters view these requirements as a way to document how the law is being used while protecting patient privacy. Critics argue that the reporting system is limited because it relies heavily on physician self-reporting, restricts public access to underlying records, and does not create a robust mechanism for investigating mistakes, coercion, abuse, or noncompliance.^[90]

State Reporting Requirements

Within 45 days after the Act takes effect on September 12, 2026, the Illinois Department of Public Health must create and post two forms on its website: an Attending Physician Checklist Form and an Attending Physician Follow-Up Form. These forms are intended to collect information from physicians who participate in the aid-in-dying process.^[91]

If an attending physician prescribes aid-in-dying medication, the physician must submit the Attending Physician Checklist Form to the Department within 30 calendar days. The form must include the patient's name and date of birth, terminal diagnosis and prognosis, notice that the statutory requirements were completed, and notice that the medication was prescribed.^[92]

If the physician is later notified that the qualified patient died from self-administering the medication, the physician must submit the Attending Physician Follow-Up Form within 60 calendar days of being notified. That form must include the patient's name and date of birth, date of death, and whether the patient was enrolled in hospice at the time of death.^[93]

Willful failure or refusal to timely submit required records may result in disciplinary action.^[94]

[90] Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* 87–101 (2019), <https://ncd.gov/publications/2019/danger-assisted-suicide-laws>.

[91] 410 ILCS 22/75(a) (eff. Sept. 12, 2026).

[92] 410 ILCS 22/75(b).

[93] 410 ILCS 22/75(c).

[94] 410 ILCS 22/75(g).

Data Collection

The Department of Public Health must publish an annual public statistical report beginning one year after the Act's effective date and every year thereafter. The first report is therefore due on September 12, 2027.^[95]

The public report must include the:

- Number of prescriptions written;
- Number of prescribing physicians;
- Number of qualified patients who died following self-administration; and
- Number of people who died from use of an aid-in-dying drug, accompanied by aggregated demographic percentages for:
 - Age at death;
 - Education level;
 - Race;
 - Gender;
 - Type of insurance, including whether insured;
 - Underlying illness; and
 - Hospice enrollment.

This reporting may help Illinoisans understand broad patterns over time, including how often the law is used, what diagnoses are most common, whether most patients are enrolled in hospice, and which demographic groups are most represented.

Section 75 requires public reporting only of the categories listed above. It does not require the public report to include detailed information regarding complications, time from ingestion to death, whether a medical professional was present, whether the patient expressed concern about being a burden, whether prescribed medication was obtained but never used, the disposition of unused medication, or later allegations of coercion or pressure.^[96]

[95] 410 ILCS 22/75(e).

[96] 410 ILCS 22/75(e), 410 ILCS 22/75.

Transparency Concerns

The Act contains strong confidentiality protections. Information collected by the Department must be kept confidential and collected in a manner that protects the privacy of the patient, the patient's family, and healthcare professionals involved in the process. The information is privileged and strictly confidential. It cannot be disclosed, discovered, or compelled in civil, criminal, administrative, or other proceedings.^[97]

Except as otherwise required by law, information collected by the Department is not a public record, is not available for public inspection, and is not available through the Freedom of Information Act.^[98]

These confidentiality provisions create a tension at the heart of the reporting system. End-of-life decisions involve deeply personal medical information, and patient privacy is a legitimate concern. On the other hand, public oversight depends on access to reliable information. If the public can see only aggregated data, it may be difficult to evaluate whether the law is being followed in individual cases or whether problems are occurring behind closed doors.

Critics argue that many assisted-suicide reporting systems provide statistics but do not provide meaningful mechanisms for detecting coercion, identifying abuse, investigating mistakes, or reviewing disputed cases. Supporters respond that privacy protections are necessary and that annual reports can still provide useful information about how the law is being used.^[99]

The Act also limits the ordinary public record surrounding a death under the law. A death following self-administration does not, by itself, constitute grounds for a postmortem inquiry. The death is attributed to the patient's underlying terminal disease, is not designated as suicide or homicide, and self-administration of the medication is not indicated on the death certificate.^[100]

Similar death-certificate provisions appear in other states that authorize physician-assisted suicide. Supporters view this treatment as consistent with laws that classify a death under the statute as resulting from the underlying terminal disease rather than suicide. Critics argue that omitting self-administration from the death certificate reduces transparency by leaving the official record without an indication that life-ending medication was used.^[101]

[97] 410 ILCS 22/75(d).

[98] 410 ILCS 22/75(f).

[99] Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* 87–101 (2019); Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 Mich. L. Rev. First Impressions 7 (2008).

[100] 410 ILCS 22/90.

[101] See, e.g., Colo. Rev. Stat. § 25-48-109; Haw. Rev. Stat. § 327L-4.

Regulatory Oversight

Illinois law gives the Department of Public Health authority to create forms, collect reports, and publish annual statistical summaries.^[102] It also gives rulemaking authority to the Department of Public Health and the Illinois Department of Veterans Affairs for implementation and administration.^[103]

The Act does not create a dedicated investigative board, independent review commission, statutory public-complaint process, or mandatory case-by-case review body.^[104] Oversight therefore rests primarily on physician compliance, required reporting forms, existing professional-disciplinary systems, administrative rulemaking, and civil or criminal liability for specified misconduct.

The Act provides substantial immunity for good-faith compliance. Subject to its limitations, healthcare professionals and entities are protected from civil or criminal liability, licensing sanctions, and professional discipline for actions taken in good faith under the Act; a physician may also be present at self-administration and may prepare the medication as the Act permits. Those protections do not extend to intentional misconduct. The Act preserves liability for conduct including forging or altering a request, concealing or destroying a rescission, coercing or unduly influencing a request or refusal, and other intentional misconduct.^[105]

Many of the most serious concerns surrounding physician-assisted suicide involve conduct that may be difficult to detect through paperwork alone. Coercion, family pressure, depression, feelings of being a burden, insurance pressures, and subtle forms of undue influence may not appear in a checklist submitted after the fact.

The National Council on Disability has argued that safeguards in assisted-suicide laws are ineffective and that meaningful oversight of mistakes and abuse is absent in existing systems.^[106] The existence of reporting forms and annual statistics does not necessarily answer whether the law will be monitored in a way that protects vulnerable patients.^[107]

For Illinois families, healthcare professionals, policymakers, and advocates, the key oversight questions will include:

- Will the annual reports be detailed enough to evaluate how the law is operating?
- Will complications, prolonged dying, unsuccessful ingestion, or unused medication be tracked?
- Will the State create any mechanism for families or healthcare workers to report concerns?
- Will there be any independent review of disputed cases?

^[102] 410 ILCS 22/75.

^[103] 410 ILCS 22/105.

^[104] See generally 410 ILCS 22/75, 22/90, 22/105 (no provision establishing such a body).

^[105] 410 ILCS 22/70(a), (c)–(f), (h); 410 ILCS 22/95, 22/100.

^[106] See generally Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* (2019).

^[107] Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* 87–101 (2019).

Lessons from Other Jurisdictions

Illinois only recently legalized physician-assisted suicide.^[108] Because the Act does not take effect until September 12, 2026, Illinois has no operational experience with prescriptions, self-administration, annual reporting, or enforcement under the law. Litigation, administrative planning, institutional policymaking, and proposals to amend the Act have already begun, but Illinois has not yet developed an implementation record comparable to jurisdictions where assisted suicide has operated for decades. To understand how Illinois' law may develop over time, it is useful to examine the experience of jurisdictions that have confronted these issues over the years.^[109]

Although each jurisdiction has adopted its own legal framework, several recurring patterns emerge.^[110] Some jurisdictions authorized assisted dying through legislation or ballot initiative, while others did so initially through judicial decisions.^[111] Some authorize only physician-assisted suicide, whereas others also permit euthanasia. Several jurisdictions initially adopted narrowly defined eligibility criteria and procedural requirements and later amended—or debated amending—their laws to expand access by relaxing criteria related to residency, waiting periods, authorized providers, mental-capacity review, self-administration, advance requests, and other features.^[112] These developments have shaped many of the contemporary debates surrounding assisted dying and provide important context for evaluating future proposals in Illinois.

See **Chapter 5** for a jurisdiction-by-jurisdiction survey of assisted-dying laws.

Future Developments

The international legal landscape continues to evolve.^[113] Legislatures and courts in multiple jurisdictions analyze whether to authorize assisted dying or modify, restrict, or repeal existing legal frameworks. There remains questions involving eligibility, mental illness, advance requests, mature minors, provider participation, reporting and oversight, and access for non-residents. Meanwhile, some jurisdictions that have already authorized the practice continue to amend their statutes, refine administrative procedures, and evaluate their laws in practice.

[108] 410 ILCS 22/1 *et seq.*; American Academy of Hospice and Palliative Medicine, “Physician-Assisted Dying,” <https://aahpm.org/advocacy/where-we-stand/pad>.

[109] Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in “Vulnerable” Groups*, 33 J. Med. Ethics 591 (2007); see also Chapter 5.

[110] Chapter 5; see also Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800–127.897; Canada’s *Criminal Code*, R.S.C. 1985, c. C-46 (medical assistance in dying); *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (Neth.).

[111] Compare Or. Rev. Stat. §§ 127.800–127.897 (initiative statute), with *Carter v. Canada (Attorney General)*, 2015 SCC 5 (Can.), and *Baxter v. State*, 224 P.3d 1211 (Mont. 2009).

[112] See Chapter 5 (surveying subsequent amendments in Oregon, California, Colorado, Hawaii, Vermont, Canada, Belgium, the Netherlands, Spain, and other jurisdictions).

[113] See generally World Federation of Right to Die Societies, *Assisted Dying Around the World*; Australian Capital Territory, Voluntary Assisted Dying Act 2024; Parliament of the United Kingdom, Terminally Ill Adults (End of Life) Bill (as introduced).

What About Illinois?

For Illinois, these national and international developments matter because Illinois is the first state in the Midwest to legalize physician-assisted suicide. The law takes effect in 2026, and no neighboring state currently permits the practice.^[114] Whether Illinois retains its current resident-only framework or becomes a regional access point will depend on future legal challenges, legislative amendments, medical institutions, advocacy groups, and public opinion. Understanding the national landscape is therefore essential for understanding what may come next in Illinois.

Because Illinois is new to physician-assisted suicide, many of the most important questions about the law cannot yet be answered by looking at Illinois itself. Instead, we must examine the experiences of other states and countries that authorized physician-assisted suicide or euthanasia years before Illinois did.

Supporters of physician-assisted suicide often argue that legalization can remain limited to terminally ill adults who satisfy specified eligibility criteria and freely choose the option. Opponents argue that once the practice is accepted in principle, political and legal pressure often arises to expand eligibility, reduce procedural restrictions, or broaden access. Whether one agrees with either perspective, the experiences of other jurisdictions provide valuable insight into the future debates that are likely to occur in Illinois.

Most American assisted-suicide statutes have included residency requirements, although Oregon and Vermont later removed theirs, allowing individuals from other states to obtain lethal prescriptions.^[115] As a result, eligible patients may seek prescriptions in Oregon or Vermont even when their home states do not authorize the practice. Illinois currently limits eligibility to Illinois residents. The experience of Oregon and Vermont demonstrates that residency requirements may later become the subject of litigation or legislative reconsideration.

^[116]

^[114] See Chapter 5, Part D, “Comparing Laws Around the World” (surveying assisted-dying laws in U.S. jurisdictions).

^[115] Or. Rev. Stat. § 127.860 (residency requirement repealed); Vt. Stat. Ann. tit. 18, §§ 5281–5293 (as amended removing residency requirement).

^[116] 410 ILCS 22/50.

Another recurring debate involves who qualifies for assisted suicide. Most American laws were initially limited to adults diagnosed with a terminal illness and a prognosis of six months or less to live. In recent years, however, proposals have emerged to expand eligibility beyond traditional terminal illnesses. In 2024, California SB 1196 proposed replacing the six-month terminal-disease standard with a broader “grievous and irremediable medical condition” standard; the proposal did not become law.^[117] Similar expansions have occurred internationally, particularly in Canada, where eligibility has expanded beyond patients whose deaths are reasonably foreseeable.^[118]

Questions concerning mental illness have also become increasingly prominent.^[119] American assisted-suicide laws generally focus on physical illnesses. However, some European jurisdictions, including the Netherlands and Belgium, permit assisted death in limited psychiatric cases under their respective legal standards.

Canada has expanded MAID eligibility to some individuals whose natural deaths are not reasonably foreseeable. Parliament has also enacted a framework under which mental illness could eventually qualify as the sole underlying condition, but implementation has been postponed until March 17, 2027. Opponents point to these developments as evidence of a continuing expansion of eligibility criteria, while supporters argue that severe psychological suffering should not automatically be treated differently from severe physical suffering.

Further debate concerns the distinction between providing lethal drugs and directly administering them. Most American physician-assisted suicide laws require patients to self-administer the medication. Euthanasia, by contrast, involves another person directly causing death. Despite this distinction, efforts have emerged in some jurisdictions to permit administration through intravenous methods or to challenge self-administration requirements for individuals with significant disabilities.^[120] Critics argue that proposals allowing another person to perform the final act would blur or eliminate the distinction between physician-assisted suicide and euthanasia. Supporters respond that assistance short of performing the final act may be necessary to ensure equal access for patients with physical disabilities.

Particularly controversial debates concern dementia, advance requests, loss of capacity, and minors. Some European jurisdictions have adopted policies addressing advance directives, dementia, psychiatric suffering, or access by minors.^[121]

[117] S.B. 1196, 2023–2024 Reg. Sess. (Cal. 2024) (proposal to replace the six-month terminal-disease standard with a “grievous and irremediable medical condition” standard; bill did not become law).

[118] Criminal Code, R.S.C. 1985, c. C-46, §§ 241.1–241.4 (Can.); see also Government of Canada, *Medical Assistance in Dying*.

[119] Government of Canada, *Medical Assistance in Dying*; see also Chapter 5, Part D, “Comparing Laws Around the World.”

[120] See Chapter 5, Part D, “Comparing Laws Around the World,” for discussion of jurisdictions that dropped self-administration requirements, e.g., *ACSAT v. Minister of Health* (New Zealand litigation).

[121] See Chapter 5, Part D, “Comparing Laws Around the World”; Government of Canada, *Medical Assistance in Dying*.

A Major Conscience Challenge: *Kirchoff v. Treto*

In August 2026, before the End-of-Life Options for Terminally Ill Patients Act (EOLO) took effect on September 12, four physicians, Bishop Thomas J. Paprocki, and Lutheran Care Center filed a federal lawsuit challenging provisions they contend force conscientious objectors to assist the statutory process even though EOLO also says healthcare professionals and entities have no duty to participate in aid-in-dying care.^[122]

The dispute is therefore not simply whether an objecting physician may refuse to prescribe lethal medication. The deeper question is what “nonparticipation” means after a patient requests physician-assisted suicide. The plaintiffs object to duties involving information, referral, transfer, documentation, institutional policy, and death certification, arguing that these acts can themselves facilitate a result they believe medicine and their faith forbid.

How EOLO and the Conscience Act Interact

Illinois law contains an important tension. Sections 60 and 65 of the End-of-Life Options Act state that professionals and healthcare entities have no duty to participate in aid-in-dying care. Those same sections, however, expressly preserve the operation of the Illinois Health Care Right of Conscience Act (HCRCA). The HCRCA itself protects conscientious refusal in significant respects, but it also contains information and access-to-care provisions that can impose continuing duties on objecting professionals and facilities.^[123]

The complaint argues that the two statutes must be read together. EOLO declares aid in dying to be part of “general medical care” and an end-of-life option. HCRCA requires facilities to maintain written access protocols and addresses information concerning a patient’s condition, prognosis, legal treatment options, and risks and benefits. When a requested service is refused for reasons of conscience, HCRCA also provides for referral, transfer, or written information about another provider in specified circumstances.^[124]

EOLO then adds a more specific command. When a professional or entity is unwilling or unable to carry out a request for aid in dying, Section 70(b) says the objector must, at a minimum, inform the patient of that unwillingness, refer the patient either to a professional able and willing to evaluate and qualify the patient or to another person or entity that can assist the patient and document the request and refusal in the medical record.^[125]

[122] Complaint, *Mary Keen Kirchoff, M.D., et al. v. Treto*, No. 1:26-cv-09628 (N.D. Ill. filed Aug. 11, 2026); 410 ILCS 22/60(a), 22/65(a).

[123] 410 ILCS 22/60(g), 22/65(g); 745 ILCS 70/4, 70/6, 70/6.1.

[124] 410 ILCS 22/5(a)(1), 22/10, 22/15; 745 ILCS 70/6, 70/6.1; Complaint, *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill. Aug. 11, 2026), paras. 36–43.

[125] 410 ILCS 22/70(b).

The plaintiffs therefore argue that “no duty to participate” protects them from performing the final service but not necessarily from helping connect the patient to the process. Whether the statutes should be read that way—and whether any resulting duties are constitutionally permissible—are central questions in *Kirchoff*.

Compelled Speech

Count I alleges that the statutory scheme compels objecting professionals and institutions to communicate messages they reject and restricts the opposing message they wish to communicate. The complaint emphasizes that licensed professionals do not lose First Amendment protection merely because they are speaking within a professional relationship.^[126]

The asserted speech burdens are not limited to one sentence or one encounter. Plaintiffs identify several different forms of expression:

- discussing aid in dying as a legal end-of-life or treatment option and describing its asserted risks and benefits;
- telling a patient where or from whom the patient may seek qualification or assistance;
- recording the patient’s request and the objector’s refusal in the medical record;
- complying with the Act’s prescribed treatment of the death certificate; and
- avoiding speech that regulators might characterize as intentionally misleading, misinformation that obstructs access, coercion, or undue influence.

The first point depends heavily on the interaction between EOLO and the HCRCA. The complaint reasons that because EOLO declares aid in dying part of general medical care, HCRCA’s information duties may require an objecting clinician to discuss it as a legal option even when the clinician believes it should not be presented as beneficial medical care. That is the plaintiffs’ interpretation of the combined statutes, not a final judicial holding.^[127]

The lawsuit also attacks restrictions on the objector’s own message. EOLO bars certain false, misleading, or deceptive practices and treats specified conduct that obstructs access as coercion or undue influence. Plaintiffs contend that undefined terms such as “misinformation to obstruct access” may chill candid counseling—for example, distinguishing assisted suicide from hospice or palliative sedation, recommending continued treatment, or explaining why the physician believes assisted suicide is inconsistent with the goals of medicine.^[128]

[126] Complaint, *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill. Aug. 11, 2026), Count I, paras. 168–201.

[127] 410 ILCS 22/5(a)(1), 22/15, 22/60(g), 22/65(g); 745 ILCS 70/6, 70/6.1; Complaint, *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill. Aug. 11, 2026), paras. 36–46, 177–190.

[128] 410 ILCS 22/10, 22/60(f), 22/65(f), 22/95, 22/100(b); Complaint, *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill. Aug. 11, 2026), paras. 52–64, 179–195.

Compelled Association

Count II advances a related but distinct theory. Freedom of association protects the ability of expressive organizations to maintain a community that advances rather than contradicts their message. The complaint argues that EOLO can force religious healthcare entities to maintain professional relationships with personnel whose speech or off-premises conduct concerning assisted suicide conflicts with the institution's religious identity.^[129]

Plaintiffs also characterize referral as compelled association. In their view, an objector required to identify a provider who is able and willing to facilitate assisted suicide, maintain enough knowledge to make the referral, select among available providers, and formally connect the patient to one of them is not merely stepping aside. The objector is being required to form a functional link with the very practice the objector rejects. No court has yet issued a final merits ruling accepting or rejecting that theory.

Religious Institutions and Institutional Policies

The Act does permit a healthcare entity to prohibit its professionals from practicing aid-in-dying care while performing duties for the entity, but that authority is limited. The entity must give written notice of the prohibition when a professional is hired, contracted, or granted privileges and again annually. The Act also says the entity may not prohibit specified information about diagnosis, prognosis, recommended treatment, treatment alternatives, risks and benefits, or resources for obtaining care of the patient's choice. Nor may it bar specified off-premises conduct outside the professional's duties for the entity.^[130]

Those limitations are central to the claims brought by Lutheran Care Center and Bishop Paprocki. They argue that a religious healthcare ministry is itself expressive: its rules concerning end-of-life care communicate what the institution believes medicine is for. If the State requires the institution to permit employees to communicate or facilitate a contrary message in circumstances covered by EOLO, plaintiffs argue that the law burdens free speech, expressive association, free exercise, and church autonomy.^[131]

The complaint also invokes the interests of patients who intentionally choose religious physicians or facilities because they want care within a community that rejects assisted suicide. Count II alleges that forcing such patients and institutions into associations that contradict their shared message burdens their associational rights as well.^[132]

[129] Complaint, *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill. Aug. 11, 2026), Count II, paras. 202–223; see also 410 ILCS 22/65(e), 22/70(c)–(d).

[130] 410 ILCS 22/65(d)–(e).

[131] Complaint, *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill. Aug. 11, 2026), paras. 145–167, 196–223, Counts II, III, and V.

[132] Complaint, *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill. Aug. 11, 2026), paras. 215–220.

Disability and Suicide Prevention

The complaint separately challenges the different legal response to a desire for death once a patient satisfies EOLO's eligibility criteria. Outside the Act, suicidal intent ordinarily prompts prevention and treatment. Under EOLO, a qualifying terminally ill patient may instead enter a process leading to a prescription for life-ending medication. Plaintiffs invoke disability-discrimination principles and argue that terminal illness often brings disability, dependence, depression, isolation, financial strain, or fear of becoming a burden.^[133]

EOLO contains safeguards directed at some of these concerns: terminal diagnosis, mental capacity, voluntariness, repeated requests, and review by two physicians. The complaint nevertheless argues that legal capacity is not the same inquiry as whether treatable depression, social pressure, inadequate support, or burdensomeness is influencing a request.

What the Lawsuit Claims

The complaint pleads eight counts: free speech, freedom of association, free exercise, due process and vagueness, church autonomy, disability discrimination under the ADA, conflict with the federal Assisted Suicide Funding Restriction Act, and conflict with the Affordable Care Act. These are allegations and legal theories; none has yet produced a final merits judgment.^[134]

What the Plaintiffs Asked the Court to Stop

The requested relief shows the practical focus of the case. Plaintiffs seek protection from requirements they say would force them to: describe aid in dying or its asserted benefits as a legitimate treatment option; refer, transfer, or provide written information connecting patients to willing providers; refrain from counseling that might be characterized as misleading, obstructive, coercive, or unduly influential; record the request and refusal in the medical record; comply with the challenged death-certificate rule; and adopt institutional protocols requiring comparable conduct.^[135]

The lawsuit does not necessarily require the court to invalidate physician-assisted suicide for willing patients and willing providers. A narrower remedy could limit what Illinois may demand from objectors while leaving the basic statutory option in place. That distinction is important: the case is principally about compelled participation, speech, association, and religious governance rather than a facial claim that every application of EOLO must disappear.

[133] Complaint, *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill. Aug. 11, 2026), Count VI, paras. 271–280.

[134] Complaint, *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill. Aug. 11, 2026), Counts I–VIII; see also 42 U.S.C. §§ 18113, 14402.

[135] Complaint, *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill. Aug. 11, 2026), Prayer for Relief.

Temporary Restraining Order

On August 21, 2026, Judge Franklin U. Valderrama entered a stipulated temporary restraining order preventing state officials from enforcing specified EOLO and HCRCA requirements against the covered plaintiffs while the litigation proceeds.^[136]

The order is limited. It protects the four physician plaintiffs, Lutheran Care Center, Bishop Paprocki, and covered Catholic healthcare entities within the Springfield diocese under his authority. It does not create a statewide exemption for every conscientious physician, pharmacist, mental-health professional, nurse, hospital, nursing facility, or other objector.^[137]

The order is also preliminary and stipulated; it is not a final holding that the challenged provisions are unconstitutional. The parties tied the timing of further preliminary-injunction proceedings to related Seventh Circuit litigation over provisions of the HCRCA. The district court is expected to address the next stage of *Kirchoff* after that related appellate litigation is resolved.

Why *Kirchoff* Matters

Illinois has attempted to protect two interests at once: access for patients who seek physician-assisted suicide and conscience for people and institutions that reject it. *Kirchoff* tests whether the State has drawn that line in a constitutionally permissible place. A physician may be free not to prescribe the medication yet still face duties involving speech, records, information transfer, or referral. A religious institution may prohibit direct aid-in-dying practice within its employees' duties yet remain unable to control other speech or conduct that the institution believes contradicts its mission.

The central question is therefore not simply whether an objector must perform physician-assisted suicide. It is whether Illinois may make the practice available to willing patients by requiring unwilling people and institutions to provide some of the information, connections, documentation, or institutional cooperation that make access possible. **That distinction—between refusing the final act and refusing to facilitate the process—is the heart of the case.**

Other pending challenges. *Kirchoff* is not the only federal challenge to the Act. *Payne v. Pritzker* raises disability-focused claims; as of September 8, 2026, the court was considering a request to block the law before its effective date. *Carmelite Sisters for the Aged and Infirm v. Prince*, filed September 3, raises additional conscience claims by plaintiffs including Cardinal Blase Cupich, Catholic religious orders, and an Illinois pharmacist. This Guide focuses on *Kirchoff* because its claims directly concern the participation duties examined here.

[136] Stipulated Temporary Restraining Order, *Kirchoff v. Treto*, No. 1:26-cv-09628, ECF No. 14 (N.D. Ill. Aug. 21, 2026).

[137] Stipulated Temporary Restraining Order, *Kirchoff v. Treto*, No. 1:26-cv-09628, ECF No. 14 (N.D. Ill. Aug. 21, 2026).

[138] See Hannah Meisel, *Judge Weighing Arguments to Halt Illinois' "Medical Aid in Dying" Law Ahead of Sept. 12 Start*, Capitol News Illinois/NPR Illinois (Sept. 8, 2026); Becket, *Carmelite Sisters for the Aged and Infirm v. Prince* (case filed Sept. 3, 2026).

Future Questions for Illinois

Illinois' law initially limits eligibility to adult Illinois residents who have been diagnosed with an incurable and irreversible terminal disease expected to result in death within six months, possess mental capacity, and are capable of self-administering prescribed medication. Whether Illinois remains within those boundaries or follows the path of other jurisdictions remains an open question.

Based on the experience of other states and countries, several questions are likely to shape future debates in Illinois.

Those debates are already underway. Pending 2026 proposals include SB 3795, which would require a mental-health evaluation for every requesting patient and add an IDPH ombudsman and additional reporting and safeguards; HB 5764, which would remove the Act's referral requirement and repeal its death-certificate provisions; and SB 3937, which would require medical aid in dying to be listed on the death certificate.^[139]

Residency Requirements

Illinois currently limits eligibility to Illinois residents.^[140] However, Oregon and Vermont have removed their residency requirements, and similar legal challenges have emerged elsewhere.^[141] If Illinois later removes or loses its residency requirement, it could become an access point for eligible patients from neighboring states that do not authorize the practice.

Waiting Periods and Procedural Requirements

Other states have shortened waiting periods and modified procedural requirements that supporters of the original laws often described as safeguards.^[142] Future Illinois debates may focus on whether existing waiting periods, documentation requirements, or consultation requirements should be retained, modified, or eliminated.

Prescribing Authority

Several states have expanded eligibility to prescribe aid-in-dying medication beyond physicians.^[143] Illinois may eventually face questions regarding whether advanced practice registered nurses, physician assistants, or other licensed prescribers should play a larger role.

[139] S.B. 3795, 104th Gen. Assemb. (Ill. 2026) (referred to Senate Assignments Feb. 5, 2026); H.B. 5764, 104th Gen. Assemb. (Ill. 2026) (referred to House Rules May 6, 2026); S.B. 3937, 104th Gen. Assemb. (Ill. 2026) (referred to Senate Assignments Feb. 6, 2026).

[140] 410 ILCS 22/50.

[141] Or. Rev. Stat. § 127.860 (2025); Vt. Stat. Ann. tit. 18, §§ 5281–5293 (as amended); see also Chapter 5.

[142] See Chapter 5 (summarizing statutory amendments to waiting periods and procedural safeguards in Oregon, California, Colorado, Hawaii, and other jurisdictions).

[143] See Chapter 5 (summarizing states authorizing advanced practice registered nurses and physician assistants to participate in the prescribing process).

Eligibility Standards

Future debates may address whether eligibility should remain limited to terminal disease or be broadened to encompass nonterminal but incurable conditions, dementia, psychiatric illness, chronic suffering, or other “grievous and irremediable” conditions. Any proposal involving disability would also raise questions about whether disability itself, disability-related suffering, or an independently qualifying medical condition forms the basis for eligibility.

Self-Administration

American physician-assisted suicide laws have traditionally required self-administration by the patient. Legislative proposals and litigation in other jurisdictions have raised questions about how self-administration should apply to patients with significant physical disabilities. Illinois may eventually confront questions regarding patients who otherwise satisfy the law’s eligibility criteria but are physically incapable of self-administering the medication.

Oversight and Transparency

As Illinois begins collecting data under the Act, policymakers and advocates will likely debate whether existing reporting requirements provide sufficient transparency and accountability. Questions involving data collection, confidentiality, oversight, and enforcement are likely to become significant.

Implications for the Midwest

Illinois is currently the first Midwestern state to legalize physician-assisted suicide, so developments in Illinois may influence future legislative efforts throughout the region. Supporters may point to Illinois as a model for neighboring states, while opponents may cite Illinois as a reason for caution. Developments in Illinois may therefore influence both regional and national debates.

The Central Question

The most significant question facing Illinois is no longer whether the State has enacted physician-assisted suicide—it has. The more important question is how the law will be implemented and whether its present boundaries will remain in place.

Will physician-assisted suicide remain within the Act’s current eligibility and procedural boundaries, or will Illinois follow other jurisdictions in revisiting eligibility requirements, safeguards, and oversight mechanisms?

The answer to that question will likely shape Illinois’ end-of-life policies for decades to come.

Chapter 2's Key Takeaways

Eight lessons summarize Illinois' new law, the principal questions surrounding its implementation, and the conscience litigation already challenging aspects of the Act.

- 1** Illinois' End-of-Life Options for Terminally Ill Patients Act has an effective date of September 12, 2026. It permits qualifying patients to obtain and self-administer prescribed life-ending medication.
- 2** Eligibility is limited to mentally capable adult Illinois residents with an incurable and irreversible disease expected to cause death within six months.
- 3** Patients must make multiple requests and receive review from attending and consulting physicians. A mental-health evaluation is required if either physician has unresolved doubts about the patient's mental capacity. The evaluator must also determine whether a psychiatric or psychological disorder is causing impaired judgment.
- 4** The Act permits physician-assisted suicide, not euthanasia. The patient must personally perform the final act of ingesting the medication.
- 5** Healthcare professionals and institutions may decline direct participation, but objectors remain subject to certain notice, disclosure, record-transfer, referral, and related obligations. In *Kirchoff v. Treto*, objecting physicians and religious healthcare entities are challenging some of those duties. A federal court has temporarily restrained enforcement against the covered plaintiffs while the case proceeds, but the order is not a final ruling and does not automatically protect nonparties.
- 6** The Illinois Department of Public Health will collect physician reports and publish annual statistics while maintaining the confidentiality of underlying records.
- 7** Illinois lawmakers have already introduced bills proposing changes to mental-health screening, referral duties, oversight, and death-certificate rules. Those proposals remain bills rather than current law.
- 8** When a patient dies after self-administering medication under the Act, Illinois law attributes the death to the underlying terminal disease; self-administration is not identified on the death certificate.

COMING NEXT

Chapter 3 examines the care options, resources, and support available to Illinois patients, families, healthcare professionals, and communities navigating serious illness and end-of-life decisions.

03

Support, Alternatives, and Resources

What care, support, and practical resources are available to Illinois patients and families facing serious illness and end-of-life decisions?

- Hospice and palliative care
- Pain management and symptom relief
- Mental-health, spiritual, and community support
- Advance care planning and patient advocacy
- Resources for patients, families, caregivers, and professionals

START HERE

- Ask what is medically urgent today—and what can wait.
- Write down the diagnosis, prognosis, treatment options, and questions.
- Ask whether palliative care or hospice is appropriate.
- Bring a trusted person to important conversations when possible.
- Review any power of attorney, living will, DNR, or POLST.
- See **“What To Do Now”** later in this chapter for the full checklist.

ILLINOIS QUICK HELP

Crisis support: call or text **988** (24/7).

Disability rights: Equip for Equality, 800-537-2632.

Illinois forms: IDPH Advance Directives & POLST.

Senior HelpLine: 1-800-252-8966.

Hospice/palliative care: il-hpco.org.

Mobile crisis access: Illinois CARES, 1-800-345-9049.

Illinois Quick Contacts

A one-page starting point for patients and families who need help finding care, support, planning documents, or crisis assistance.

Immediate Crisis Support

988 Suicide & Crisis Lifeline

Call or text **988**, 24 hours a day.

For an immediate medical emergency, call 911.

Hospice & Palliative Care

Illinois Hospice and Palliative Care Organization

il-hpco.org

Ask a hospital social worker or physician about local palliative-care programs and how to verify Medicare-certified hospice providers.

Older Adults & Caregivers

Illinois Senior HelpLine

1-800-252-8966

Ask about Area Agencies on Aging, caregiver services, in-home support, respite, and the Community Care Program.

Disability Rights & Independent Living

Equip for Equality

800-537-2632

Centers for Independent Living can also help locate disability services, advocacy, community supports, and independent-living resources.

Illinois Planning Documents

Illinois Department of Public Health

Use the IDPH Advance Directives & POLST hub for the State's current Power of Attorney for Health Care, Living Will, Declaration for Mental Health Treatment, and Uniform POLST materials.

Mental-Health Support

For urgent emotional or suicide-related crisis support, call or text **988**.

For non-emergency care, ask your health system, primary physician, insurer, county behavioral-health system, or Illinois DHS mental-health resources about available services.

Start with the need in front of you. You do not have to solve every medical, legal, financial, emotional, and spiritual question at once. A physician, nurse, social worker, chaplain, disability advocate, or Area Agency on Aging can often help identify the next useful referral.

Hospice Care

What Hospice Is

Hospice is a model of care designed to improve the quality of life of individuals facing a terminal illness. Rather than focusing on curing a disease, hospice focuses on comfort, symptom management, dignity, and support for both patients and their families.

The goal of hospice is not to hasten death or prolong life at all costs. Instead, hospice seeks to help patients live as fully and comfortably as possible during the time remaining, while allowing the underlying illness to follow its natural course. Hospice care addresses not only physical symptoms, but also emotional, social, and spiritual needs.

Hospice services are typically coordinated by an interdisciplinary team that may include physicians, nurses, social workers, hospice aides, chaplains or spiritual-care professionals, counselors, therapists, and trained volunteers. Care is individualized to meet the unique needs of each patient and family.

Many patients enter hospice only during the final days or weeks of life. Earlier referral can provide more time to benefit from symptom management, caregiver support, advance-care planning, and meaningful time with loved ones. Studies of hospice care generally report better pain and symptom management and greater family satisfaction with end-of-life care.^[144]

What Hospice Is Not

Many misconceptions surround hospice care.

Hospice is not euthanasia. Hospice providers do not intentionally cause death or administer lethal medication to end a patient's life.

Hospice is not physician-assisted suicide. The purpose of hospice is comfort and support, not the intentional ending of life.

Choosing hospice does not mean abandoning care. It means shifting the primary goal of care from curing the terminal illness to controlling symptoms, supporting the patient and family, and maximizing comfort and quality of life.

Hospice is not limited to the final hours or days of life. Many patients receive hospice services for extended periods of time and may even improve sufficiently to leave hospice care if their condition stabilizes.

Hospice care is frequently provided wherever the patient lives, including a private home, assisted-living community, or nursing facility. It may also be provided in hospitals or dedicated hospice facilities.

[144] Centers for Medicare & Medicaid Services, *Medicare Hospice Benefits*, CMS Pub. No. 02154 (Mar. 2026), <https://www.medicare.gov/publications/02154-medicare-hospice-benefits.pdf>.

Eligibility

Under the Medicare hospice benefit, a patient generally qualifies when the hospice physician—and the patient's attending physician, if the patient has one—certifies that the patient's life expectancy is six months or less if the terminal illness follows its normal course. The patient must also elect hospice care and ordinarily forgo Medicare-covered treatment intended to cure the terminal illness, while continuing to receive comfort care and treatment for unrelated conditions.^[145]

Eligibility does not require the patient actually to die within six months. If the patient remains terminally ill and is properly recertified, hospice coverage may continue beyond six months.

Hospice is available to patients suffering from many different conditions, including cancer, heart disease, lung disease, neurological disorders, dementia, kidney disease, and other serious illnesses.

Patients retain the right to leave hospice at any time and may resume curative treatment if they choose. Likewise, patients who improve may be discharged from hospice and later reenroll if their condition worsens.

Services Provided

Hospice programs typically provide a wide range of services designed to support both patients and families.

Common hospice services include:

- Pain management.
- Symptom control.
- Nursing care.
- Physician oversight.
- Medication management.
- Medical equipment and supplies.
- Social work services.
- Spiritual care and chaplaincy services.
- Grief counseling.
- Caregiver education and support.
- Volunteer services.
- Bereavement support for family members after death.^[146]

One of hospice's most important functions is helping families navigate difficult medical decisions and providing support during a period that is often emotionally overwhelming.

Many hospice programs also offer respite services that provide temporary relief to family caregivers who may be experiencing physical or emotional exhaustion.

^[145] 42 C.F.R. pt. 418 (2026); Centers for Medicare & Medicaid Services, *Hospice*, <https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice>.

^[146] Centers for Medicare & Medicaid Services, *Hospice*, <https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice>.

Common Misconceptions

"Hospice means death is imminent."

- Not necessarily. Hospice indicates that clinicians believe the patient has a terminal prognosis, not that death will necessarily occur within hours or days. While hospice serves terminally ill patients, many individuals receive hospice care for months and occasionally longer. Some patients improve enough to leave hospice entirely.

"Hospice speeds up death."

- The purpose of hospice is comfort rather than hastening death. Hospice is intended neither to hasten nor artificially prolong death. Its purpose is to control symptoms and support the patient while the illness follows its course.

"Hospice means doctors stop caring."

- In reality, hospice often increases the amount of care and support available to patients and families. The focus simply shifts from curing disease to maximizing comfort and quality of life.

"Hospice is only for cancer patients."

- Hospice serves patients with many different illnesses, including heart disease, dementia, stroke, chronic lung disease, neurological disorders, and other terminal conditions.

"Entering hospice means giving up hope."

- Many hospice professionals encourage patients and families to think differently about hope. While hope for a cure may diminish, patients may continue to hope for comfort, meaningful time with loved ones, reconciliation, spiritual peace, or freedom from unnecessary suffering.

Why Hospice Matters

Because physician-assisted suicide is often discussed alongside hospice care, it is important to understand that they serve fundamentally different purposes. Hospice seeks to care for patients as they approach death, relieve suffering, support families, and affirm the dignity of the person throughout the dying process. For many patients and families, hospice represents one of the most important resources available during the final stage of life.

Understanding hospice care is therefore essential to understanding the broader conversation about end-of-life options in Illinois.

Questions to Ask a Hospice Provider

Choosing a hospice provider is an important decision. Not all hospice programs operate in exactly the same way, and patients and families should feel comfortable asking questions before enrolling. The following questions may help families better understand the care and support available.

About Eligibility and Enrollment

- Why does my loved one qualify for hospice?
- What services will be available immediately upon enrollment?
- Can a patient leave hospice and later return if circumstances change?
- What happens if a patient lives longer than six months?
- How quickly can hospice services begin?

About Medical Care

- How often will nurses visit?
- How are pain and symptoms managed?
- What happens if symptoms worsen at night or on weekends?
- Is a physician available for consultation?
- What medications, medical supplies, and equipment are covered?

About Emergencies

- Who should we call if a crisis occurs after normal business hours?
- Is someone available 24 hours a day?
- Under what circumstances should we call 911?
- How does hospice handle unexpected complications?

About Family Support

- What training is available for family caregivers?
- Are respite services available?
- What support is available for exhausted caregivers?
- How are difficult family disagreements handled?
- What bereavement services are offered after death?

About Emotional and Spiritual Care

- Are social workers available?
- Are chaplaincy or spiritual-care services available?

- Can patients continue receiving support from their own clergy?
- What counseling resources are available for patients and family members?

About the Dying Process

- What changes should families expect as death approaches?
- How can family members help keep a loved one comfortable?
- How does hospice support patients who are afraid or anxious?
- What signs indicate that death may be near?

About End-of-Life Decisions

- How does hospice differ from palliative care?
- How does hospice differ from physician-assisted suicide?
- What alternatives exist if symptoms become difficult to manage?
- What role does palliative sedation play in hospice care?
- How does hospice support patients who express a desire to die?

Questions for Reflection

- What are our loved one's goals for the time that remains?
- What fears or concerns need to be addressed?
- What support do we need that we do not currently have?
- What would a good final chapter of life look like for our family?
- Are there relationships that need healing, conversations that need to occur, or spiritual concerns that need attention?

No family should feel pressured to make decisions without understanding the resources available. Asking questions is not a sign of doubt—it is often the best way to ensure that patients and families receive the care, support, and information they need.

[147] Nat'l Inst. on Aging, *Frequently Asked Questions About Hospice Care*, National Institutes of Health, <https://www.nia.nih.gov/health/hospice-and-palliative-care/frequently-asked-questions-about-hospice-care>.

Palliative Care

What Palliative Care Is

Palliative care is specialized medical care focused on improving the quality of life of individuals living with serious illnesses. Its primary goal is to relieve pain, symptoms, stress, and suffering associated with disease, regardless of a patient's diagnosis, prognosis, or stage of treatment. ^[148]

Unlike hospice care, palliative care may be provided alongside curative or life-prolonging treatment. A patient receiving chemotherapy, dialysis, surgery, immunotherapy, or other treatments may simultaneously receive palliative care services.

Palliative care seeks to address the whole person rather than the disease alone. In addition to managing physical symptoms, palliative care teams often help patients and families navigate emotional, psychological, social, and spiritual challenges associated with serious illness.

Palliative care is typically delivered by an interdisciplinary team that may include physicians, nurses, social workers, chaplains, counselors, pharmacists, and other specialists. Care is individualized based upon the patient's goals, needs, and values.

Because palliative care focuses on improving quality of life, many patients benefit from receiving palliative services long before hospice care becomes appropriate. ^[149]

What Palliative Care Is Not

Many people mistakenly believe that palliative care is only for patients who are dying. This is not true.

Palliative care is not hospice care. While hospice care is a form of palliative care, palliative care itself may begin at any stage of a serious illness and may be provided alongside treatment intended to cure or control disease.

Palliative care is not physician-assisted suicide. The purpose of palliative care is to relieve suffering, manage symptoms, and improve quality of life—not to intentionally cause death.

Palliative care is not euthanasia. Palliative care providers do not administer treatments intended to end a patient's life.

Palliative care is not "giving up." In many cases, palliative care helps patients better tolerate aggressive medical treatment by improving symptom control and reducing suffering.

Finally, palliative care is not limited to cancer patients. Individuals with heart disease, lung disease, neurological disorders, dementia, kidney disease, liver disease, and many other serious conditions may benefit from palliative care.

^[148] National Consensus Project for Quality Palliative Care, *Clinical Practice Guidelines for Quality Palliative Care* (4th ed. 2018), <https://www.nationalcoalitionhpc.org/ncp>.

^[149] Nat'l Inst. on Aging, *What Are Palliative Care and Hospice Care?*, National Institutes of Health, <https://www.nia.nih.gov/health/hospice-and-palliative-care/what-are-palliative-care-and-hospice-care>.

Eligibility

Unlike hospice care, palliative care does not require a terminal diagnosis or a six-month prognosis.

A patient may be eligible for palliative care whenever he or she is experiencing significant symptoms, pain, stress, or reduced quality of life related to a serious illness.

Palliative care is commonly used by patients with:

- Cancer
- Heart failure
- Chronic lung disease
- Stroke
- Dementia
- Parkinson's disease
- Multiple sclerosis
- Kidney disease
- Liver disease
- Serious neurological disorders
- Other chronic or life-limiting conditions

Patients may receive palliative care while pursuing curative treatment, participating in clinical trials, recovering from surgery, or managing chronic disease.

Because eligibility is broad, many experts recommend considering palliative care much earlier than most patients currently do.^[150]

Services Provided

Palliative care programs offer a wide range of services designed to improve quality of life for both patients and families.

Common palliative care services include:

- Pain management
- Symptom management
- Medication review and optimization
- Emotional and psychological support
- Advance care planning
- Assistance with medical decision-making
- Family counseling and support
- Spiritual care
- Care coordination
- Communication with healthcare providers
- Referrals to community resources

Palliative care specialists often help patients clarify treatment goals and understand the risks and benefits of available medical options. This can be especially valuable when patients are facing complex decisions regarding surgery, chemotherapy, life support, hospitalization, or long-term care.

One of the most important functions of palliative care is helping patients align medical treatment with their personal goals, values, and priorities.^[151]

[150] American Society of Clinical Oncology (ASCO), *Integration of Palliative Care Into Standard Oncology Care*, <https://ascopubs.org/doi/full/10.1200/JCO.18.01154>; Ctrs. for Medicare & Medicaid Servs., *Palliative Care*, <https://www.cms.gov/medicare/palliative-care>; Nat'l Inst. on Aging, *What Are Palliative Care and Hospice Care?*, National Institutes of Health, <https://www.nia.nih.gov/health/hospice-and-palliative-care/what-are-palliative-care-and-hospice-care>.

[151] Ctr. to Advance Palliative Care, *About Palliative Care*, <https://getpalliativecare.org/whatis>.

Pain Management

Many people associate palliative care primarily with pain control, and pain management remains one of its most important functions.

Palliative care specialists are trained to evaluate and treat pain using a variety of approaches, which may include medications, physical therapy, counseling, relaxation techniques, interventional procedures, and other therapies.

The goal is not merely to reduce pain scores but to improve the patient's ability to engage in daily activities, spend meaningful time with loved ones, and maintain the highest possible quality of life.

Effective pain management can also reduce anxiety, improve sleep, and lessen feelings of hopelessness that sometimes accompany serious illness.^[152]

Symptom Management

Serious illnesses often produce symptoms beyond pain.

Palliative care teams commonly help patients manage:

- Shortness of breath
- Fatigue
- Nausea and vomiting
- Loss of appetite
- Difficulty sleeping
- Anxiety
- Depression
- Constipation
- Confusion
- Weakness
- Restlessness
- Other distressing symptoms

Because symptoms frequently occur together, palliative care providers take a comprehensive approach to treatment rather than addressing each symptom in isolation.

Quality of Life

Quality of life is a central focus of palliative care.

Different patients define quality of life differently. For one patient, quality of life may mean remaining at home with family. For another, it may mean maintaining independence, controlling pain, attending important events, continuing work, practicing one's faith, or simply being able to enjoy ordinary daily activities.

[152] World Health Org., *WHO Guidelines for the Pharmacological and Radiotherapeutic Management of Cancer Pain in Adults and Adolescents* (2018), <https://www.who.int/publications/i/item/9789241550390>.

Palliative care encourages patients to identify what matters most to them and helps develop treatment plans consistent with those goals.

In this way, palliative care focuses not merely on extending life or treating disease, but on helping patients live as well as possible despite serious illness.

Accessing Services

Palliative care services may be available through hospitals, outpatient clinics, cancer centers, healthcare systems, nursing facilities, home health agencies, and specialized palliative care programs.

Patients may request a referral from their physician, although referrals are not always required depending on the healthcare system.

Because awareness remains limited, many patients who could benefit from palliative care never receive it. Families facing serious illness should consider asking their healthcare providers whether palliative care services are available and appropriate.

Earlier involvement often allows patients and families to benefit from symptom management, communication, advance-care planning, and supportive services before a medical crisis occurs.^[153]

Common Misconceptions

"Palliative care means I'm dying."

- Not necessarily. Palliative care may be appropriate at any stage of a serious illness and can be provided for many years.

"Palliative care is the same as hospice."

- Hospice is a specific type of palliative care for patients with terminal illnesses. Palliative care is much broader and can be provided alongside curative treatment.

[153] Nat'l Inst. on Aging, *What Are Palliative Care and Hospice Care?*, National Institutes of Health, <https://www.nia.nih.gov/health/hospice-and-palliative-care/what-are-palliative-care-and-hospice-care>.

"Palliative care speeds up death."

- The goal of palliative care is symptom relief and quality of life, not hastening death.

"Palliative care is only for cancer patients."

- Patients with many different illnesses can benefit from palliative care services.

"My doctor already treats my symptoms."

- Palliative care specialists provide additional expertise and support that complements, rather than replaces, existing medical care.

"Accepting palliative care means giving up."

- Palliative care often helps patients remain stronger, more comfortable, and better able to pursue the treatments and goals that matter most to them.

Why Palliative Care Matters

Because physician-assisted suicide is frequently discussed in the context of pain and suffering, it is important to understand the role palliative care can play in addressing those concerns.

Many of the concerns that lead patients to consider physician-assisted suicide—including loss of autonomy, fear of future suffering, loss of independence, concerns about being a burden, and distressing physical or psychological symptoms—may often be addressed, at least in part, through high-quality palliative care and supportive services.^[154]

Palliative care does not eliminate every form of suffering, nor does it promise a cure. However, it provides patients and families with additional resources, expertise, and support at some of the most difficult moments of life.

For many patients, palliative care becomes one of the most valuable tools available for preserving comfort, dignity, and quality of life while living with serious illness.

[154] Oregon Health Authority, *Oregon Death with Dignity Act: 2025 Data Summary* 9, tbl. 1 (rev. June 17, 2026), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf>.

Questions to Ask a Palliative Care Provider

About Services

- What palliative care services do you provide?
- How does palliative care differ from hospice care?
- Can I continue receiving curative treatment while receiving palliative care?

About Symptoms

- What options are available for managing my symptoms?
- How will pain be assessed and treated?
- What can be done about fatigue, nausea, anxiety, or shortness of breath?

About Decision-Making

- Can you help me understand my treatment options?
- Can you help facilitate conversations with family members?
- How can I ensure that my care reflects my goals and values?
- Should I consider completing advance directives or appointing a healthcare power of attorney?

About Support

- What emotional, psychological, or spiritual support is available?
- Are social workers or counselors available?
- What resources exist for family caregivers?

Questions for Reflection

- What matters most to me right now?
- What are my goals for treatment and quality of life?
- What fears or concerns need to be addressed?
- What support would help me live more fully despite my illness?

Understanding palliative care is essential to understanding modern end-of-life care. For many patients, palliative care provides an opportunity to reduce suffering, improve quality of life, and receive support long before hospice or other end-of-life decisions become necessary.

Mental Health, Disability, and End-of-Life Suffering

Understanding Suffering at the End of Life

When people discuss physician-assisted suicide, the conversation often focuses on physical pain.^[155] However, studies from jurisdictions where physician-assisted suicide is legal suggest that physical pain is frequently not the primary reason patients seek life-ending medication.

In Oregon's 2025 report, physicians recorded loss of autonomy and decreasing ability to participate in activities that made life enjoyable for 89% of patients who died after ingesting the medication, and loss of dignity for 65%.^[156] These were nonexclusive, physician-reported concerns; they do not establish that any one concern caused a patient's decision or that additional hospice, palliative care, or support would necessarily have changed it.

Understanding these different forms of suffering is important because they may require different forms of care and support. Some forms of suffering respond well to medical treatment. Others may require counseling, family support, disability accommodations, community involvement, spiritual care, or practical assistance.

For patients, families, and healthcare providers, recognizing the many dimensions of suffering is an important step toward providing compassionate and effective care.

Depression

Depression is common among individuals facing serious illness, disability, chronic pain, or terminal disease.^[157] Symptoms may include sadness, hopelessness, loss of interest in previously enjoyable activities, fatigue, difficulty concentrating, changes in sleep patterns, and feelings of worthlessness.

Depression can sometimes be difficult to recognize because its symptoms may overlap with the effects of serious illness. Fatigue, appetite changes, sleep disturbances, and social withdrawal may result from either a medical condition or depression.^[158]

Importantly, depression is treatable,^[159] including in people living with chronic disease. Psychotherapy, medication, coordinated medical and mental-health care, social support, spiritual care, and treatment of contributing medical conditions may improve symptoms.^[160]

[155] Eric J. Cassell, *The Nature of Suffering and the Goals of Medicine* 31–49 (2d ed. 2004); Dame Cicely Saunders, *The Management of Terminal Disease* (1978).

[156] Or. Health Auth., *Oregon Death with Dignity Act: 2025 Data Summary* 8–9 (rev. June 17, 2026), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf>.

[157] Nat'l Comprehensive Cancer Network, *NCCN Clinical Practice Guidelines in Oncology: Distress Management* (Version 3.2025), https://www.nccn.org/professionals/physician_gls/pdf/distress.pdf.

[158] PDQ Supportive & Palliative Care Editorial Bd., *Depression (PDQ®): Health Professional Version*, Nat'l Cancer Inst. (updated July 25, 2024), <https://www.cancer.gov/about-cancer/coping/feelings/depression-hp-pdq>.

[159] World Health Org., *Depression*, <https://www.who.int/news-room/fact-sheets/detail/depression>.

[160] Nat'l Inst. of Mental Health, *Understanding the Link Between Chronic Disease and Depression* 1–4, NIH Pub. No. 24-MH-8015 (rev. 2024), <https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health>.

Because depression can influence judgment, decision-making, and perceptions about the future, it is an important consideration in discussions involving end-of-life decisions. If depression is accompanied by thoughts of suicide or self-harm, or someone is experiencing an acute mental-health or substance-use crisis, call or text **988** for confidential crisis support available 24 hours a day.

Anxiety

Serious illness often creates uncertainty. Patients may worry about pain, disability, loss of independence, financial burdens, family responsibilities, future medical procedures, or the dying process itself.

Anxiety may present as excessive worry, restlessness, panic attacks, difficulty sleeping, irritability, racing thoughts, or persistent fear about what lies ahead.

For some individuals, anxiety may stem from fear of future suffering rather than current suffering. A patient may be more afraid of what might happen than what is happening now.

Fortunately, anxiety often responds to treatment. Counseling, medication, support groups, spiritual care, mindfulness practices, education about the illness, and honest conversations with healthcare providers may help reduce fear and uncertainty.^[161]

Helping patients understand what to expect and what resources are available can often reduce anxiety significantly.

Existential Distress

Not all suffering is physical or psychological.^[162] Many individuals facing serious illness experience what healthcare professionals sometimes call existential distress.^[163]

Existential distress may involve questions such as:

- Why is this happening to me?
- What gives my life meaning now?
- Who am I if I can no longer do the things I once did?
- What will happen to my family?
- What happens after death?
- Has my life mattered?

People experiencing existential distress may feel hopeless, isolated, purposeless, or disconnected from others. They may struggle with changes in identity, loss of independence, or uncertainty about the future.

[161] PDQ Supportive & Palliative Care Editorial Bd., *Adjustment to Cancer: Anxiety and Distress (PDQ®): Health Professional Version*, Nat'l Cancer Inst. (updated May 14, 2025), <https://www.cancer.gov/about-cancer/coping/feelings/anxiety-distress-hp-pdq>.

[162] Viktor E. Frankl, *Man's Search for Meaning* (Beacon Press 2006) (1946).

[163] Patricia Boston, Anne Bruce & Rita Schreiber, "Existential Suffering in the Palliative Care Setting: An Integrated Literature Review," 41 *J. Pain & Symptom Mgmt.* 604, 604–18 (2011), <https://doi.org/10.1016/j.jpainsymman.2010.05.010>.

Unlike many physical symptoms, existential suffering is not always solved through medication. It often requires relationships, conversation, spiritual care, counseling, community support, and opportunities to find meaning even in difficult circumstances.

For many patients, addressing existential distress becomes one of the most important aspects of end-of-life care.

Fear of Being a Burden

One of the most frequently cited concerns in jurisdictions that permit physician-assisted suicide is fear of being a burden on others.^[164]

Patients may worry about:

- Financial costs
- Caregiving demands
- Loss of independence
- Needing assistance with basic activities
- Becoming a source of stress for loved ones
- Requiring long-term support

These concerns are understandable. Serious illness often changes family dynamics and creates new responsibilities for caregivers.

At the same time, many families view caregiving as an expression of love rather than a burden.^[165] Loved ones frequently report that the opportunity to care for a parent, spouse, sibling, or friend was meaningful despite the challenges involved.

Fear of being a burden should not be dismissed, but neither should it be accepted as an unavoidable reality. Practical support services, respite care, disability accommodations, community assistance, volunteer programs, faith communities, and caregiver resources can often reduce the pressures that contribute to these fears.

Some patients may discover additional sources of support they had not previously considered, although access can vary by location, healthcare system, insurance coverage, workforce availability, and individual circumstances.

Disability Rights Perspectives

One of the most significant and often overlooked aspects of the physician-assisted suicide debate is the role of disability rights advocates.

While public discussions sometimes portray opposition to physician-assisted suicide as primarily religious or political, many disability rights organizations have expressed concerns about legalization.

^[164] Or. Health Auth., *Oregon Death with Dignity Act: 2025 Data Summary* 8–9 (rev. June 17, 2026), <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx>.

^[165] National Academies of Sciences, Engineering, and Medicine, *Families Caring for an Aging America* (2016), <https://nap.nationalacademies.org/catalog/23606/families-caring-for-an-aging-america>.

Organizations such as the National Council on Disability, Disability Rights Education and Defense Fund (DREDF), Not Dead Yet, and other disability rights groups have argued that physician-assisted suicide laws may create risks for individuals whose lives are already undervalued by society.^[166]

Common concerns include:

- Assumptions that disability necessarily diminishes quality of life.
- Inadequate access to healthcare and support services.
- Social isolation.
- Economic pressures.
- Difficulty distinguishing between a desire to die and a desire for better support.
- Biases within healthcare systems regarding disability and dependence.^[167]

Some disability rights advocates argue that before society offers death as a solution to suffering, it should ensure that individuals have access to adequate housing, healthcare, caregiving support, transportation, employment opportunities, and community inclusion.

Other disability advocates support physician-assisted suicide and emphasize personal autonomy and self-determination.^[168] As a result, disability communities are not monolithic, and significant disagreement exists within the movement.

Nevertheless, disability rights perspectives have become an important part of modern discussions regarding physician-assisted suicide and end-of-life policy.

Available Supports

Suffering often has multiple causes and therefore often requires multiple forms of support.

Available resources may include:

Medical Support

- Primary care physicians
- Specialists
- Palliative care teams
- Hospice providers
- Pain management services

Mental Health Support

- Psychologists
- Psychiatrists
- Licensed counselors
- Support groups
- 988 Suicide & Crisis Lifeline and other crisis-intervention services^[169]

Disability Support

- Independent living centers
- Disability advocacy organizations

[166] See Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* 13–18, 43–56 (2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws/>; Disability Rts. Educ. & Def. Fund, *Assisted Suicide*, <https://dredf.org/vertical/assisted-suicide/> (last visited July 31, 2026).

[167] Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* 13–18, 43–56 (2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws/>; Disability Rts. Educ. & Def. Fund, *Key Objections to the Legalization of Assisted Suicide* (Oct. 30, 2012), <https://dredf.org/key-objections-to-the-legalization-of-assisted-suicide>.

[168] Us for Autonomy, *About Us*, <https://www.usforautonomy.org/about>; Compassion & Choices, *Medical Aid in Dying*, <https://compassionandchoices.org>.

[169] Substance Abuse & Mental Health Servs. Admin., *988 Suicide & Crisis Lifeline*, <https://www.samhsa.gov/mental-health/988> (24/7 call, text, and chat support).

- Assistive technology programs
- Caregiver support services
- Community-based support programs

Family and Community Support

- Family members
- Friends
- Volunteer organizations
- Faith communities
- Caregiver networks

Spiritual Support

- Clergy
- Chaplains
- Faith communities
- Spiritual directors
- Religious support groups

For many individuals, the most effective support comes from a combination of these resources rather than any single service.

Questions for Reflection

- What aspects of my illness concern me most?
- Am I primarily worried about pain, dependence, loneliness, finances, or something else?
- Have I discussed these concerns with my healthcare providers?
- What support systems do I currently have?
- What support systems am I missing?
- Have I spoken openly with my family about my fears and goals?
- Would counseling, spiritual care, or support groups be helpful?
- Am I receiving all available medical and supportive services?
- What gives my life meaning and purpose today?
- What would help me feel more supported?

Why This Matters

Serious illness often involves far more than physical symptoms. Depression, anxiety, loneliness, fear, loss of independence, financial concerns, disability-related challenges, and existential questions can profoundly affect a person's experience of illness and outlook on life.

Understanding these forms of suffering is important not only because they are common, but because many of them can be addressed through appropriate care, support, relationships, and community.^[170] Whether one supports or opposes physician-assisted suicide, meaningful end-of-life care requires recognizing the full range of human suffering and ensuring that patients and families have access to the resources they need.

For that reason, mental health support, disability services, family care, community involvement, and spiritual support remain essential components of compassionate end-of-life care.

[170] Eric J. Cassell, *The Nature of Suffering and the Goals of Medicine* 31–49 (2d ed. 2004); Dame Cicely Saunders, *The Management of Terminal Disease* (1978).

Family and Caregiver Support

The Importance of Family and Caregivers

Serious illness rarely affects only the patient. Spouses, children, parents, siblings, friends, and other caregivers are often deeply impacted by the physical, emotional, financial, and spiritual challenges that accompany a life-limiting condition.^[171]

In many cases, family members become the primary source of support. They may help coordinate medical appointments, provide transportation, assist with medications, communicate with health-care providers, manage finances, perform household tasks, and offer emotional companionship during difficult times.

While caregiving can be a meaningful expression of love and commitment, it can also be physically exhausting and emotionally overwhelming. For this reason, caring for caregivers is often just as important as caring for patients.

Strong family support is associated with improved quality of life, reduced feelings of isolation, and greater confidence as patients navigate serious illness with dignity. Conversely, strained relationships, unresolved conflicts, and caregiver exhaustion can increase stress for everyone involved.

Understanding the challenges families face—and the resources available to support them—is an essential part of compassionate end-of-life care.^[172]

Caregiver Burnout

Caregiving can be rewarding, but it can also be demanding. In 2025, AARP and the National Alliance for Caregiving estimated that 63 million U.S. adults—about one in four—were providing ongoing family care. Many caregivers also balance employment, childcare, financial obligations, household management, and their own health concerns.^[173]

Over time, these responsibilities can lead to caregiver burnout.

Common signs of caregiver burnout include:

- Physical exhaustion
- Chronic stress
- Sleep disturbances
- Anxiety or depression
- Irritability
- Feelings of isolation

[171] National Academies of Sciences, Engineering, and Medicine, *Families Caring for an Aging America* 1–15 (2016), <https://nap.nationalacademies.org/catalog/23606/families-caring-for-an-aging-america>.

[172] Nat'l Inst. on Aging, *Frequently Asked Questions About Caregiving*, National Institutes of Health, <https://www.nia.nih.gov/health/caregiving/frequently-asked-questions-about-caregiving>.

[173] National Alliance for Caregiving & AARP, *Caregiving in the U.S. 2025*, <https://www.caregiving.org/research/caregiving-in-the-us/>; Family Caregiver Alliance, *Caregiver Statistics*, <https://www.caregiver.org/resource/caregiver-statistics-demographics>.

- Difficulty concentrating
- Loss of interest in previously enjoyable activities
- Resentment or guilt
- Declining personal health ^[174]

Many caregivers feel pressure to remain strong for the patient and may hesitate to ask for help. As a result, burnout often develops gradually and may go unnoticed until it becomes severe.

Caregivers sometimes postpone their own medical appointments, neglect chronic health conditions, experience sleep deprivation, or develop anxiety and depression while focusing on a loved one's needs. Maintaining one's own physical and emotional health is not selfish; it helps ensure that caregivers remain able to provide safe and effective care over time.

Caregiver burnout is a recognized response to prolonged physical, emotional, and practical caregiving demands. It is not a sign of personal failure or lack of love.

Recognizing burnout early and seeking support can improve the well-being of both caregivers and patients.

Family Conflict

Serious illness often places strain on family relationships. ^[175]

Long-standing disagreements may resurface. Family members may have different opinions regarding treatment decisions, caregiving responsibilities, financial matters, living arrangements, or end-of-life preferences.

Common sources of conflict include:

- Disagreements regarding medical treatment
- Unequal caregiving responsibilities
- Financial concerns
- Communication breakdowns
- Differing religious or ethical beliefs
- Questions involving advance directives
- Tensions between family members and healthcare providers

Conflict is not uncommon, particularly when emotions are heightened by fear, uncertainty, grief, or exhaustion.

In many cases, disagreements arise not because family members care too little, but because they care deeply and have different views about what is best.

Open communication, social-work support, pastoral counseling, professional mediation when appropriate, and family meetings facilitated by the healthcare team can help reduce misunderstandings and improve decision-making. ^[176]

^[174] Nat'l Inst. on Aging, *Taking Care of Yourself: Tips for Caregivers*, National Institutes of Health, <https://www.nia.nih.gov/health/caregiving/taking-care-yourself-tips-caregivers>.

^[175] See generally: Institute for Patient- and Family-Centered Care, <https://www.ipfcc.org>.

^[176] Nat'l Cancer Inst., *Plans and Decisions for End-of-Life Care as a Cancer Caregiver*, National Institutes of Health, <https://www.cancer.gov/about-cancer/advanced-cancer/caregivers/planning>.

Grief and Anticipatory Grief

Most people associate grief with the period following a death. However, many individuals begin grieving long before death occurs.

This is often called anticipatory grief or anticipatory mourning.^[177]

Patients and family members may grieve:

- The loss of health
- The loss of independence
- Changes in family roles
- Future plans that may never occur
- Diminished abilities
- The anticipated loss of a loved one

Anticipatory grief can produce many of the same emotions associated with traditional grief, including sadness, anger, fear, guilt, loneliness, and confusion.

Importantly, anticipatory grief is a normal response to loss. It does not indicate weakness or inability to cope.^[178]

Many families find that acknowledging grief openly helps them prepare emotionally for what lies ahead and creates opportunities for meaningful conversations and reconciliation.

Following a death, grief continues in different ways for different people. There is no universally correct timeline for mourning. People experience grief differently, and the intensity and duration of mourning may vary substantially.^[179]

Compassion, patience, and support are often essential throughout the grieving process.

Communication Strategies

Honest and compassionate communication is one of the most important tools available to patients and families facing serious illness.

Unfortunately, difficult conversations are often delayed because family members fear causing distress or do not know how to begin.

While every situation is unique, several principles can help facilitate productive conversations.

Listen Before Responding. Family members sometimes focus on providing answers when a loved one is seeking understanding. Listening carefully and asking questions may be more helpful than immediately offering solutions.

[177] Therese A. Rando, *Clinical Dimensions of Anticipatory Mourning*, 4 Research Press (2000).

[178] PDQ Supportive & Palliative Care Editorial Bd., *Grief, Bereavement, and Coping With Loss (PDQ®): Health Professional Version*, Nat'l Cancer Inst., <https://www.cancer.gov/about-cancer/advanced-cancer/caregivers/planning/bereavement-hp-pdq>.

[179] Nat'l Inst. on Aging, *What To Do After Someone Dies*, National Institutes of Health, <https://www.nia.nih.gov/health/grief-and-mourning/what-do-after-someone-dies>.

Acknowledge Emotions. Fear, anger, sadness, frustration, and uncertainty are common reactions to serious illness. Acknowledging these emotions can help individuals feel heard and supported.

Discuss Goals and Priorities. Patients often benefit from discussing questions such as:

- What matters most to me right now?
- What am I hoping for?
- What am I worried about?
- What quality of life means the most to me?
- What tradeoffs am I willing—or unwilling—to make?

These conversations can help guide future decisions.

Avoid Unnecessary Assumptions. Family members may assume they understand what a patient wants without ever discussing it directly. Open communication helps reduce misunderstandings and clarify expectations.

Seek Assistance When Needed. Healthcare providers, social workers, chaplains, counselors, and mediators can often facilitate difficult conversations when communication becomes challenging.^[180]

Support Resources

No patient or caregiver should feel obligated to navigate serious illness alone.

A wide range of resources may be available, including:

Caregiver Support Services

- Caregiver support groups.
- Respite care programs.
- Home health services.
- Adult day programs.
- Volunteer assistance programs.

Professional Support

- Social workers.
- Counselors.
- Psychologists.
- Psychiatrists.
- Patient advocates.
- Care coordinators.

Community Support

- Faith communities.
- Volunteer organizations.
- Neighborhood support networks.
- Disability advocacy organizations.
- Disease-specific support groups.

^[180] Ctr. to Advance Palliative Care, *Communication Skills for Conversations About Serious Illness*, <https://www.capc.org/training/learning-pathways/communication-skills-conversations-about-serious-illness>.

Healthcare Resources

- Hospice programs.
- Palliative care teams.
- Home health agencies.
- Primary care physicians.
- Specialty clinics.

Spiritual Support

- Clergy.
- Chaplains.
- Faith-based counseling programs.
- Religious support groups.

Families are often unaware of the range of community resources that may be available until they begin asking healthcare providers, social workers, or local organizations for assistance. Often the greatest challenge is not the absence of support but the reluctance to seek it. ^[181]

Questions for Reflection

- What caregiving responsibilities currently exist within our family?
- Are those responsibilities being shared fairly?
- What concerns or fears have not yet been discussed openly?
- What support do caregivers need that they are not currently receiving?
- Are there unresolved conflicts that should be addressed?
- What practical assistance would make life easier right now?
- Who can we ask for help?
- Have we discussed our goals, priorities, and wishes as a family?
- What opportunities remain for meaningful conversations or reconciliation?
- What would it look like for our family to support one another well during this season?

Why Family and Caregiver Support Matters

Serious illness affects entire families, not just individual patients. The quality of support available to patients often depends upon the well-being of the people who care for them.

When caregivers receive adequate support, patients are more likely to remain comfortable, connected, and cared for. When families communicate openly, conflict is reduced and decision-making becomes easier. When grief is acknowledged and support is available, individuals are better equipped to navigate loss and uncertainty.

For these reasons, family and caregiver support is not merely an addition to end-of-life care—it is one of its most important components. Ensuring that families receive the resources, encouragement, and assistance they need helps create an environment in which both patients and caregivers can face serious illness with greater strength, dignity, and hope.

[181] Ill. Dep't on Aging, *Family and Caregiver Services*, <https://ilaging.illinois.gov/programs/caregiver/caregiver-links.html>.

Advance Care Planning

What Is Advance Care Planning?

Advance care planning is the process of thinking about, discussing, and documenting healthcare preferences before a medical crisis occurs.^[182]

Many people assume that advance care planning is only for the elderly or terminally ill. In reality, any adult can unexpectedly become unable to communicate because of illness, injury, dementia, stroke, or other medical conditions. When that happens, family members and healthcare providers may be forced to make difficult decisions without knowing what the patient would have wanted.

Advance care planning helps ensure that a person's values, goals, beliefs, and treatment preferences remain known even if he or she loses the ability to communicate.

At its core, advance care planning is about preserving personal autonomy. Rather than leaving important decisions to guesswork, it allows individuals to express their wishes in advance and designate trusted people to speak on their behalf when necessary.

Advance care planning often includes legal documents, but it also includes conversations with family members, healthcare providers, clergy, and trusted advisors.^[183]

What Advance Care Planning Is Not

Many misconceptions surround advance care planning.

Advance care planning is not physician-assisted suicide. Planning for future healthcare decisions does not involve intentionally ending life.

Advance care planning is not euthanasia. It does not authorize another person to intentionally cause death.

Advance care planning is not "giving up." Many people complete advance directives while healthy and active simply because they want to ensure their wishes are known if a future emergency occurs.

Advance care planning is not limited to end-of-life decisions. It may also address temporary periods of incapacity resulting from surgery, accidents, or illness.

Finally, advance care planning is not merely paperwork. While legal documents are important, conversations with loved ones are often just as valuable.

[182] Rebecca L. Sudore et al., Defining Advance Care Planning for Adults: A Consensus Definition from a Multidisciplinary Delphi Panel, 53 *J. Pain & Symptom Mgmt.* 821, 821–832.e1 (2017).

[183] Nat'l Inst. on Aging, *Advance Care Planning: Advance Directives for Health Care*, National Institutes of Health, <https://www.nia.nih.gov/health/advance-care-planning/advance-care-planning-advance-directives-health-care>.

Advance Directives

An advance directive is a general term describing legal documents that allow individuals to communicate healthcare preferences in advance. Directives can help guide healthcare decisions if a person later becomes unable to make or communicate those decisions personally.

Although the term "advance directive" is used in different ways, Illinois recognizes living wills, powers of attorney for health care, mental health treatment declarations, and POLST as advance-planning tools. A POLST is distinct from a living will or power of attorney because it is a practitioner-signed medical order that translates current treatment preferences into orders intended to be followed across care settings.

In practice, advance directives provide guidance to family members and healthcare professionals during difficult situations and can reduce uncertainty and conflict.^[184]

Living Wills

A living will is a written declaration concerning the use of death-delaying procedures if the person later has a terminal condition and cannot direct those decisions personally.

Under Illinois law, a living will becomes operative only if it was validly executed, remains unrevoked, the patient cannot give directions concerning life-sustaining or death-delaying procedures, and the patient is a qualified patient with a terminal condition. If an authorized healthcare agent is available to make those decisions, the living will is not operative and the agent's authority controls.^[185]

Illinois law also places important limits on a living will:

- Comfort care and treatment to alleviate pain remain available.
- Nutrition and hydration may not be withheld if doing so would cause death solely from dehydration or starvation rather than the terminal condition.
- A declaration has no force while a qualified patient is pregnant if, in the attending physician's opinion, continued death-delaying treatment could allow the fetus to develop to live birth.

A living will communicates the patient's own instructions rather than appointing another person to make decisions.

Because an available, authorized healthcare agent takes priority under current Illinois law, patients using a living will should also understand how it interacts with any power of attorney for health care.^[186]

^[184] Ill. Dep't of Pub. Health, *Advance Directives*, <https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives>.

^[185] 755 ILCS 35/2, 35/3, 35/3.5, 35/5, 35/9.5.

^[186] 755 ILCS 35/2(d), 35/3(c), 35/3.5, 35/9.5; Ill. Dep't of Pub. Health, *Advance Directives*, <https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives>.

Healthcare Powers of Attorney

A healthcare power of attorney allows an individual to appoint an agent to make healthcare decisions under the circumstances specified in the document. Illinois' statutory form allows the principal to choose when that authority begins, including only after the principal cannot make decisions or immediately while the principal still retains the right to make his or her own decisions.

The person appointed under a power of attorney is generally called an agent or healthcare agent. Some jurisdictions also use terms such as “proxy”; this chapter uses “agent” for the person appointed under the Illinois power of attorney.

Unlike a living will, which attempts to anticipate future situations, a healthcare power of attorney allows a trusted person to make decisions based upon circumstances that may not have been foreseeable when the document was created.

Choosing the right healthcare agent is one of the most important decisions in advance care planning.

A healthcare agent should ideally:

- Understand the individual's values and wishes
- Be willing to advocate for those wishes
- Be capable of making difficult decisions under stress
- Communicate effectively with healthcare providers and family members
- Be trusted by the individual making the appointment

Many healthcare and legal professionals regard a healthcare power of attorney as one of the most important advance planning documents because it allows an appointed decision-maker to respond to unforeseen medical circumstances consistent with the patient's wishes.^[187]

Do Not Resuscitate (DNR) Orders and POLST

A Do Not Resuscitate (DNR) instruction directs healthcare providers not to perform cardiopulmonary resuscitation (CPR) if a patient's heart stops beating or breathing ceases.

In Illinois, CPR preferences and other treatment orders may be documented on the Illinois Department of Public Health's Uniform Practitioner Orders for Life-Sustaining Treatment (POLST) form. POLST is broader than a DNR instruction: it is a portable medical order that can address CPR, mechanical ventilation, medically administered nutrition and hydration, and other life-sustaining treatment.

A DNR concerns resuscitation only. It does not, by itself, require withdrawal of other treatment, authorize physician-assisted suicide or euthanasia, or mean that healthcare providers stop caring for the patient. Medications, oxygen, pain management, hospice, palliative care, nursing care, and other appropriate treatment may continue unless separate orders or directives provide otherwise.

[187] 755 ILCS 45/4-1, 45/4-3, 45/4-4, 45/4-10; Ill. Dep't of Pub. Health, *Advance Directives*, <https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives>.

Because DNR and POLST orders serve different but related purposes, patients and families should discuss them carefully with healthcare providers.^[188]

End-of-Life Planning Conversations

Documents are important, but conversations are often even more important.

Family members frequently experience stress and conflict because they are uncertain about what a loved one would have wanted. Clear communication can reduce confusion and provide reassurance during difficult moments.

Important topics may include:

- Treatment goals
- Quality-of-life priorities
- Religious or spiritual beliefs
- Preferences regarding life-sustaining treatment
- Preferences regarding hospice or palliative care
- Desired decision-makers
- Fears and concerns about illness or dying

These conversations are rarely easy, but they are often among the most meaningful discussions families ever have. Discussing these issues before a crisis can give patients and loved ones greater clarity and help prepare them for future medical decisions.^[189]

Common Misconceptions

"Advance care planning is only for elderly people."

- Medical emergencies can occur at any age. Every adult should consider advance care planning.

"My family already knows what I want."

- Families often discover that assumptions and reality do not always match. Clear communication helps avoid confusion.

"Completing a living will means refusing all treatment."

- An Illinois living will concerns whether death-delaying procedures should be withheld or withdrawn if the statutory conditions are met. It does not mean refusing all medical treatment, and Illinois law preserves treatment for comfort and relief of pain.

"A healthcare power of attorney gives someone immediate control over my healthcare."

- Not necessarily. Illinois' statutory form allows the principal to choose when the agent's decision-making authority begins. It may begin only when the principal cannot make decisions or, if selected, may begin immediately while the principal retains the right to make his or her own decisions.

^[188] 210 ILCS 50/3.57; Ill. Dep't of Pub. Health, *POLST Guidance for Individuals*, <https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives/polst-guidance-individuals.html>.

^[189] Nat'l Inst. on Aging, *Advance Care Planning: Advance Directives for Health Care*, National Institutes of Health, <https://www.nia.nih.gov/health/advance-care-planning/advance-care-planning-advance-directives-health-care>; Nat'l Inst. on Aging, *Advance Care Planning Worksheets*, National Institutes of Health, <https://www.nia.nih.gov/health/advance-care-planning/advance-care-planning-worksheets>.

"A DNR means doctors stop caring for me."

- A DNR applies only to resuscitation efforts. Other medically appropriate treatment—including pain management, oxygen, medications, nursing care, hospice, and palliative care—may continue unless otherwise limited by the patient's wishes or another applicable medical order.

Questions for Reflection

- If I could not speak for myself, who would I trust to make healthcare decisions?
- Have I communicated my wishes to that person?
- What matters most to me if I become seriously ill?
- What treatments would I want? Which would I not want?
- Have I completed the necessary legal documents?
- Do my family members know where those documents are located?
- Have I discussed my wishes with my healthcare providers?
- Are there spiritual, family, or personal concerns I would want addressed if I became seriously ill?

Why Advance Care Planning Matters

Medical crises often occur unexpectedly. When they do, patients may lose the ability to communicate at the very moment important decisions must be made.

Advance care planning helps ensure that healthcare decisions reflect the patient's own values, wishes, and goals rather than assumptions made by others. It can reduce family conflict, improve communication, and provide clarity during some of life's most difficult moments.

Whether a person ultimately chooses aggressive treatment, comfort-focused care, hospice, or another path, advance care planning helps ensure that those decisions remain guided by the individual's own voice.

For that reason, advance care planning is one of the most valuable gifts a person can give both to loved ones and to future healthcare providers.

Resources

Illinois residents can obtain the State's official Power of Attorney for Health Care, Living Will, Mental Health Treatment Declaration, POLST form, and related educational materials from the Illinois Department of Public Health.^[190]

[190] Ill. Dep't of Pub. Health, *Advance Directives*, <https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives>.

What To Do Now: A Practical Guide for Patients and Families

Receiving a terminal diagnosis or facing a serious illness can be overwhelming and may bring fear, uncertainty, grief, anger, confusion, or anxiety. Patients and families may also feel pressure to make major decisions quickly.^[191]

Unless a healthcare professional explains that an immediate decision is medically necessary, patients and families should generally take enough time to understand the diagnosis, ask questions, and consider available options before making major end-of-life decisions.

Before making significant end-of-life decisions, consider the following steps.^[192]

Take a Breath

Serious diagnoses often trigger fear about the future. Give yourself permission to process the information when your medical condition allows. Initial reactions are not always permanent reactions.

Learn About Your Diagnosis

Ask questions.

Understand your diagnosis, prognosis, treatment options, and likely outcomes. Ask your healthcare provider what decisions are time-sensitive. Ask them what the expected course of the illness is with and without treatment. When substantial uncertainty exists or a major intervention is proposed, consider asking whether a second opinion would be useful.^[193]

Ask About Palliative Care

Palliative care focuses on improving quality of life by managing pain, symptoms, emotional distress, and other challenges associated with serious illness.

Many patients benefit from palliative care long before hospice becomes appropriate.^[194]

[191] Nat'l Cancer Inst., *Coping with Your Feelings*, <https://www.cancer.gov/about-cancer/advanced-cancer/feelings>; Nat'l Inst. on Aging, *Providing Care and Comfort at the End of Life*, <https://www.nia.nih.gov/health/providing-comfort-end-life>.

[192] Nat'l Inst. on Aging, *Making Decisions for Someone at the End of Life*, National Institutes of Health, <https://www.nia.nih.gov/health/end-life/making-decisions-someone-end-life>.

[193] Nat'l Cancer Inst., *Questions to Ask Your Doctor About Your Diagnosis*, National Institutes of Health, <https://www.cancer.gov/about-cancer/diagnosis-staging/questions>; Nat'l Cancer Inst., *Finding Cancer Care*, National Institutes of Health, <https://www.cancer.gov/about-cancer/managing-care/finding-cancer-care>.

[194] Nat'l Inst. on Aging, *What Are Palliative Care and Hospice Care?*, National Institutes of Health, <https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care>.

Ask About Hospice

Hospice care is designed to provide comfort, support, symptom management, and assistance for both patients and families during the final stages of life.

Because hospice is not limited to the final hours or days of life, patients and families may benefit from asking about eligibility and services before a crisis occurs.^[195]

Involve Trusted Family and Friends

Serious illness is difficult to navigate alone.

Invite trusted loved ones into important conversations. Allow others to provide practical help, emotional support, transportation, meals, companionship, and assistance with decision-making.^[196]

Complete Advance Care Planning

Consider discussing and completing appropriate Illinois advance-planning documents, which may include a power of attorney for health care, living will, declaration for mental-health treatment, or POLST form, depending on the person's circumstances and goals.^[197]

Seek Emotional Support

Depression, anxiety, grief, loneliness, and fear are common during serious illness.

Counselors, social workers, support groups, and mental-health professionals can help patients and families process these challenges.

[195] Nat'l Inst. on Aging, *Frequently Asked Questions About Hospice Care*, National Institutes of Health, <https://www.nia.nih.gov/health/hospice-and-palliative-care/frequently-asked-questions-about-hospice-care>; Ctrs. for Medicare & Medicaid Servs., *Medicare Hospice Benefits*, CMS Product No. 02154, <https://www.medicare.gov/publications/02154-medicare-hospice-benefits.pdf>.

[196] Nat'l Inst. on Aging, *Advance Care Planning and Health Care Decisions: Tips for Caregivers and Families*, National Institutes of Health, <https://www.nia.nih.gov/health/advance-care-planning/advance-care-planning-and-health-care-decisions-tips-caregivers-and>.

[197] Ill. Dep't of Pub. Health, *Advance Directives*, <https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives>; Nat'l Inst. on Aging, *Advance Care Planning Worksheets*, National Institutes of Health, <https://www.nia.nih.gov/health/advance-care-planning/advance-care-planning-worksheets>.

Seek Spiritual Support

Many people find strength in faith, prayer, religious communities, chaplains, clergy, or spiritual advisors during periods of serious illness.

Even individuals without strong religious commitments often find value in discussing questions of meaning, purpose, hope, and mortality.^[198]

Explore Available Resources

Many patients and families are unaware of the services available in their communities.

Ask your healthcare team or hospital social worker whether additional community resources are available in your area.

Hospice providers, palliative-care programs, disability organizations, caregiver-support programs, local agencies, veterans' services, faith communities, and nonprofit organizations may offer medical, practical, financial, emotional, or spiritual assistance.^[199] For additional Illinois and national organizations, official forms, and contact information beyond the quick-help list at the beginning of this chapter, see Chapter 5.

Remember That Decisions Can Be Revisited

Many end-of-life decisions are not permanent.

Healthcare preferences may change as medical circumstances, treatment options, symptoms, personal priorities, or available support change. Advance directives and care plans should therefore be reviewed periodically, and patients should ask which decisions can later be changed or revoked.^[200]

You do not need to have every answer today.

Focus on the next step rather than every step.

You do not have to navigate serious illness alone.

[198] Nat'l Inst. of Mental Health, *Understanding the Link Between Chronic Disease and Depression*, NIH Pub. No. 24-MH-8015 (rev. 2024), <https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health>; Nat'l Cancer Inst., *Spirituality in Cancer Care (PDQ®)—Patient Version*, National Institutes of Health, <https://www.cancer.gov/about-cancer/coping/day-to-day/faith-and-spirituality/spirituality-pdq>.

[199] Ill. Dep't on Aging, *In-Home Care*, <https://ilaging.illinois.gov/programs/caregiver/in-home-care.html>; Ill. Dep't on Aging, *Information and Assistance*, <https://ilaging.illinois.gov/programs/i-a.html>; Ill. Dep't on Aging, *Family and Caregiver Services*, <https://ilaging.illinois.gov/programs/caregiver/caregiver-links.html>; U.S. Dep't of Veterans Affs., *Palliative Care: Resources for Caregivers*, https://caregiver.va.gov/CAREGIVER/support/Palliative_Care.asp.

[200] Nat'l Inst. on Aging, *Advance Care Planning: Advance Directives for Health Care*, National Institutes of Health, <https://www.nia.nih.gov/health/advance-care-planning/advance-care-planning-advance-directives-health-care>; Ill. Dep't of Pub. Health, *Advance Directives*, <https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives>.

Chapter 3's Key Takeaways

1 Hospice and palliative care both seek to relieve suffering and support patients and families. Neither is intended to hasten death.

2 Hospice generally serves patients with a terminal prognosis, while palliative care may be provided at any stage of serious illness alongside disease-directed treatment.

3 Serious illness can involve emotional, psychological, social, spiritual, and practical suffering as well as physical symptoms. Good care addresses the whole person.

4 Depression, anxiety, existential distress, loneliness, and fear of becoming a burden can often be treated or better managed through medical care, counseling, social support, community resources, and spiritual care.

5 Disability-rights perspectives are an important part of the debate, particularly concerns about quality-of-life bias, discrimination, and whether patients have meaningful alternatives and supports.

6 Families and caregivers are central to end-of-life care. Caregiver support, respite, communication, and community resources can protect both the patient and those providing care.

7 Advance care planning helps people communicate healthcare wishes and designate trusted decision-makers before a crisis through conversations and Illinois planning documents.

8 Patients and families do not have to navigate serious illness alone. Hospice, palliative care, mental-health care, disability services, faith communities, caregiver programs, and public agencies can all provide practical help.

9 Before major end-of-life decisions, seek accurate information, ask questions, involve trusted people, and understand which choices can later be changed or revoked.

10 The goal is not to have every answer immediately. Focus on the next medically and personally important step, then revisit the plan as circumstances change.

Coming Next

Understanding available resources is only one part of navigating physician-assisted suicide. Chapter 4 examines Illinois' safeguards, concerns about how those safeguards operate, and the limitations critics believe remain.

04

Safeguards and Their Limitations

What safeguards does Illinois' physician-assisted suicide law contain, how are they intended to protect patients, and what concerns remain about their effectiveness and limitations?

- Eligibility requirements and physician assessments
- Mental capacity, informed consent, and voluntariness
- Patient requests, waiting periods, and self-administration
- Coercion, undue influence, and vulnerable patients
- Reporting, oversight, enforcement, and accountability

Why Disability-Rights Advocates Question the Safeguards

One of the most common misconceptions surrounding physician-assisted suicide is that opposition comes primarily from religious organizations or pro-life advocates. In reality, some of the longest-standing and most influential critics of physician-assisted suicide have been disability rights organizations. Their concerns arise not primarily from theology or partisan politics, but from decades of advocacy on behalf of people with disabilities who have experienced discrimination, unequal treatment, and assumptions that their lives are worth less than those of nondisabled persons.

Organizations that have opposed physician-assisted suicide laws or raised disability-based objections include the Disability Rights Education and Defense Fund (DREDF), Not Dead Yet, the National Council on Independent Living (NCIL), the American Association of People with Disabilities (AAPD), United Spinal Association, the National Council on Disability (NCD), and chapters or affiliates of ADAPT. The Arc has specifically opposed physician-assisted suicide for people with intellectual disabilities because of the risk of undue influence.^[201]

At first glance, this position may seem counterintuitive. Disability rights organizations have historically championed individual autonomy, self-determination, and equal treatment under the law. Many observers therefore assume they would naturally support physician-assisted suicide. Instead, numerous disability advocates have concluded that legalizing physician-assisted suicide may place people with disabilities at unique risk because it operates within healthcare and social systems that do not always treat disabled individuals equally.

Their concerns generally focus on five interconnected issues: quality-of-life bias, medical discrimination, societal prejudice, inadequate support services, and the human capacity to adapt to illness and disability.

Many disability rights organizations draw upon what is often called the "social model of disability." Under the social model, an impairment may involve a physical, sensory, intellectual, or psychological condition, while disability is produced or intensified by environmental, institutional, and attitudinal barriers that restrict participation. From this perspective, much of the suffering experienced by disabled persons arises from barriers that society can address rather than from disability itself.^[202]

[201] National Council on Disability, *The Danger of Assisted Suicide Laws* (2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws>.

[202] World Health Organization, *International Classification of Functioning, Disability and Health (ICF)* (2001), <https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health>.

During the COVID-19 pandemic, disability rights organizations challenged crisis standards of care that used categorical exclusions, long-term survival estimates, functional measures, or quality-of-life judgments in ways that could disadvantage disabled patients. Federal civil rights officials emphasized that treatment decisions must rest on individualized medical assessments rather than disability stereotypes or judgments about the relative worth of a person's life.^[203]

Quality-of-Life Bias

Disability rights advocates frequently argue that nondisabled people underestimate the quality of life experienced by people living with serious disabilities. When asked to imagine paralysis, blindness, dependence on others, or chronic illness, outside observers may assume that such a life would be intolerable, while people living with those conditions often report substantially better quality of life than observers predict.^[204]

Critics of physician-assisted suicide argue that this gap between perception and reality can influence medical decision-making. If physicians, family members, policymakers, or society generally assume that disability necessarily diminishes quality of life, those assumptions may subtly affect conversations about end-of-life choices.

Disability advocates caution that physician-assisted suicide laws operate within a culture that often equates independence with dignity and dependence with suffering. They argue that such assumptions risk treating disability itself as a reason for death rather than a condition that can be accommodated and supported.

Medical Discrimination and Unequal Treatment

Disability advocates also point to unequal treatment within healthcare. They have documented instances in which clinicians underestimated disabled patients' quality of life, made assumptions about suffering, or recommended less aggressive treatment based on disability. These concerns became especially visible in debates over healthcare rationing, organ transplantation, pandemic triage protocols, and long-term care.^[205]

Critics argue that physician-assisted suicide introduces another area in which these biases may influence outcomes. If a healthcare provider consciously or unconsciously views a disabled person's life as less valuable or less fulfilling, that perspective may shape discussions about treatment options, prognosis, or end-of-life care.

[203] U.S. Dep't of Health & Hum. Servs., Office for Civil Rights, *Bulletin: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19)* (Mar. 28, 2020), <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ocr-bulletin-3-28-20.pdf>.

[204] Albrecht, G. L. & Devlieger, P. J., *The Disability Paradox: High Quality of Life Against All Odds*, 48 Soc. Sci. & Med. 977 (1999), <https://www.sciencedirect.com/science/article/pii/S0277953698004400>.

[205] National Council on Disability, *The Danger of Assisted Suicide Laws* (2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws>.

Most healthcare professionals strive to avoid such biases. Nevertheless, disability advocates argue that safeguards must account for the reality that discrimination can exist even when no one intends harm.

Social Barriers and Unequal Support

Disability rights organizations emphasize that many hardships associated with disability are produced or intensified by social conditions rather than by impairment alone. Inaccessible environments, social isolation, unemployment, inadequate transportation, limited housing, and cultural stigma can create suffering that is then attributed to disability itself.^[206]

From this perspective, a safeguard system must distinguish suffering caused by the underlying disease from suffering that could be reduced through accommodation or support. Disability advocates therefore question whether a request for physician-assisted suicide may sometimes reflect unmet social needs as well as the patient's medical condition. The answer will differ from person to person, but the distinction is central to their critique.

Inadequate Support Services

Many disability rights advocates summarize the issue by arguing that meaningful choice requires meaningful alternatives. Patients with serious illness or disability may need housing, transportation, personal-care services, mental-health treatment, caregiver assistance, community integration, financial resources, and social support; when those services are unavailable, the practical choices available to the patient can narrow considerably.^[207]

Critics therefore argue that a formally voluntary choice may still be shaped by inadequate support, isolation, financial strain, or dependence on exhausted caregivers. They do not contend that every request has this explanation. Their narrower claim is that a safeguard focused on capacity and overt coercion may not fully capture the effect of unmet needs on the patient's decision.

Adaptation and the Disability Paradox

Research on the “disability paradox” and “response shift” provides another basis for caution. People with serious disabilities may report good or excellent quality of life even when outside observers predict otherwise, and a person's internal standards, values, and understanding of quality of life may change after illness or functional loss. Adaptation is neither automatic nor uniform, but these findings caution against assuming that an early reaction to disability will reliably predict long-term experience.^{[208][209]}

[206] World Health Organization, *World Report on Disability* (2011), <https://www.who.int/publications/i/item/9789241564182>.

[207] Disability Rights Education & Defense Fund, *Physician-Assisted Suicide*, <https://dredf.org/issues/assisted-suicide>.

[208] Albrecht, G. L. & Devlieger, P. J., *The Disability Paradox: High Quality of Life Against All Odds*, 48 Soc. Sci. & Med. 977 (1999).

[209] Mirjam A.G. Sprangers & Carolyn E. Schwartz, *Integrating Response Shift into Health-Related Quality of Life Research: A Theoretical Model*, 48 Soc. Sci. & Med. 1507, 1507–15 (1999), [https://doi.org/10.1016/S0277-9536\(99\)00045-3](https://doi.org/10.1016/S0277-9536(99)00045-3).

The National Council on Disability has highlighted cases involving individuals who initially believed their lives were effectively over following a serious diagnosis but later adapted and found meaning, fulfillment, and purpose they could not have imagined during the earliest stages of their illness or disability.^[210]

A Distinctive Voice in the Debate

The disability rights critique of physician-assisted suicide differs from many religious or philosophical objections. It does not primarily focus on theological claims or abstract moral principles. Instead, it focuses on how physician-assisted suicide laws operate in the real world for people who are already vulnerable to discrimination, isolation, inadequate services, and negative assumptions about quality of life.

Whether one ultimately agrees or disagrees with these concerns, disability rights organizations have fundamentally changed the physician-assisted-suicide debate. Disability communities are not monolithic. *Us for Autonomy*, for example, brings together advocates with disabilities who support equitable access to hospice, palliative care, and medical aid in dying.^[211] Longstanding disability-rights opposition nevertheless shows that the debate also concerns equality, discrimination, access to care, and the value society places on the lives of people with disabilities.

[210] National Council on Disability, *The Danger of Assisted Suicide Laws* (2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws>.

[211] Us for Autonomy, *About Us*, <https://www.usforautonomy.org/about>.

Can Eligibility Be Reliably Determined?

The Safeguard on Paper

Supporters of physician-assisted suicide often emphasize the safeguards built into the law. Before a prescription for life-ending medication may be written, patients must satisfy a series of eligibility requirements. Under Illinois law, physicians must determine that the patient has an incurable and irreversible terminal disease expected to result in death within six months, possesses mental capacity, is acting voluntarily and free from coercion or undue influence, and has made an informed decision after receiving information about available end-of-life alternatives.^[212]

These requirements are designed to confine physician-assisted suicide to a defined group of terminally ill patients making voluntary and informed decisions. The limitation is that each requirement depends on human judgment: diagnoses can be incomplete or incorrect, survival estimates are probabilistic, psychological conditions may go unrecognized, and social or caregiving pressures may be difficult to detect. Because the decision is irreversible, ordinary uncertainty in medical assessment carries unusual consequences.^[213]

Consider a patient who is told that she is expected to die within six months and obtains life-ending medication based on that prognosis, even though she might otherwise have lived substantially longer. Consider a patient who requests the medication during a period of depression, hopelessness, or demoralization that might have improved with treatment and support. Consider a patient who believes that he has become a burden to his family and concludes that others would be better off without him.

These concerns cannot be dismissed as logically impossible. Research confirms that prognostic and diagnostic errors occur, while depression, hopelessness, perceived burdensomeness, functional decline, and loss of meaning are associated with a wish for hastened death among some patients with advanced illness.^[214]

[212] End-of-Life Options for Terminally Ill Patients Act, 410 Ill. Comp. Stat. 22/10, 22/15, 22/35, 22/40 (2026), <https://www.ilga.gov/Legislation/ILCS/Articles?ActID=4646&Chapter=PUBLIC%20HEALTH&ChapterID=35&MajorTopic=HEALTH%20AND%20SAFETY>.

[213] Nat'l Acads. of Scis., Eng'g & Med., *Improving Diagnosis in Health Care* 1–4 (Erin P. Balogh et al. eds., 2015), <https://doi.org/10.17226/21794>; Paul Glare et al., A Systematic Review of Physicians' Survival Predictions in Terminally Ill Cancer Patients, 327 *BMJ* 195, 195–98 (2003), <https://doi.org/10.1136/bmj.327.7408.195>.

[214] Keith G. Wilson et al., Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer, 284 *JAMA* 2907, 2907–11 (2000), <https://doi.org/10.1001/jama.284.22.2907>; Peter L. Hudson et al., Desire for Hastened Death in Patients with Advanced Disease and the Evidence Base of Clinical Guidelines: A Systematic Review, 20 *Palliative Med.* 693, 693–701 (2006), <https://doi.org/10.1177/0269216306071799>.

Disability-rights advocates have long argued that physician-assisted-suicide laws operate within healthcare and social systems that remain susceptible to human error, inadequate support, unequal treatment, and negative assumptions about disability. The National Council on Disability, an independent federal agency, has repeatedly concluded that commonly cited safeguards do not adequately eliminate risks to vulnerable patients.^[215]

One frequently cited example involves Larry McAfee, a Georgia man with quadriplegia who obtained judicial recognition of his right to discontinue his ventilator. McAfee's case was **not** a physician-assisted-suicide case; its relevance here is the effect that information, peer support, services, and alternatives can have on perceived choices. After disability advocates helped him explore community living, McAfee decided not to discontinue ventilation, left institutional care, and obtained employment.^[216]

McAfee's experience therefore illustrates a broader question: can the process reliably determine that a patient seeking physician-assisted suicide understands the diagnosis, likely future course, and realistically available alternatives? The following sections examine the principal concerns raised about that determination.

Prognostic Error: Predicting Death Is Not an Exact Science

Most physician-assisted-suicide statutes in the United States rely upon a prognosis of terminal illness. Illinois requires an incurable and irreversible disease that will, within reasonable medical judgment, result in death within six months. The diagnosis must follow an in-person physician examination, be concurred in by another physician, and be documented in the medical record.^[217]

The six-month standard appears straightforward, but predicting an individual patient's remaining lifespan is inherently uncertain. Clinical estimates tend to be more reliable when death is near and less precise when measured in months, and prognostic accuracy varies across diseases such as cancer, heart failure, chronic lung disease, dementia, and neurodegenerative illness.^[218]

[215] Nat'l Council on Disability, *Assisted Suicide: A Disability Perspective* (Mar. 24, 1997), <https://www.ncd.gov/report/assisted-suicide-a-disability-perspective-position-paper/>; Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* (Oct. 9, 2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws>.

[216] Nat'l Council on Disability, *Assisted Suicide: A Disability Perspective*, (Mar. 24, 1997), pt. IV.B.1, <https://www.ncd.gov/report/assisted-suicide-a-disability-perspective-position-paper>.

[217] 410 Ill. Comp. Stat. 22/10 (2026), <https://www.ilga.gov/legislation/ilcs/fulltext?DocName=041000220K10>.

[218] Irene J. Higginson & Patrick Costantini, Accuracy of Prognosis in Advanced Illness, 17 *Palliative Med.* 295, 295–300 (2003), <https://doi.org/10.1191/0269216303pm744oa>.

A systematic review of physician survival predictions for terminally ill cancer patients found poor agreement between predicted and actual survival. Physicians generally overestimated survival, although some patients lived longer than predicted, and variability increased as the predicted period grew longer.^[219] Oregon's 2025 report likewise states that 24 of 400 reported DWDA deaths (6%) involved patients who lived more than six months after receiving the prescription.^[220] These data do not make six-month prognoses meaningless; they show that prognosis is a probabilistic medical judgment rather than a certain deadline.

This uncertainty raises an important question: What happens when a patient acts upon a prognosis that would later have proved inaccurate?

Critics argue that physician-assisted suicide transforms ordinary prognostic uncertainty into an irreversible life-or-death determination. A patient who continues living after an inaccurate prognosis may have time to benefit from additional treatment, changing circumstances, improved support, reconciliation, or meaningful experiences. A patient who self-administers life-ending medication does not have that opportunity.

The problem is not necessarily physician carelessness or incompetence. Rather, prognosis has inherent limitations, particularly when clinicians are asked to predict the course of an individual patient rather than describe average outcomes for a population.

Supporters may conclude that the remaining uncertainty is outweighed by respect for the informed choices of mentally capable adults. Opponents regard the possibility of death based upon an inaccurate prognosis as a fundamental limitation of the eligibility safeguard.

Misdiagnosis: What If the Diagnosis Itself Is Wrong?

Prognostic error concerns how long a person is expected to live. Diagnostic error concerns whether the patient's condition has been correctly identified in the first place.

Modern medicine is highly sophisticated, but diagnostic error remains a recognized patient-safety problem. The National Academies concluded that most people are likely to experience at least one diagnostic error during their lifetimes. Research cited by the National Academies estimates that approximately five percent of U.S. adults receiving outpatient care experience a diagnostic error each year.^[221]

A diagnostic error may involve a wrong, missed, or delayed diagnosis. Some errors are corrected after further testing, specialist consultation, review of medical records, disease progression, or a second opinion. Others may cause significant or permanent harm.

[219] Paul Glare et al., *A Systematic Review of Physicians' Survival Predictions in Terminally Ill Cancer Patients*, 327 *BMJ* 195, 195–98 (2003), <https://doi.org/10.1136/bmj.327.7408.195>.

[220] Or. Health Auth., *Oregon Death with Dignity Act: 2025 Data Summary* 6 (rev. June 17, 2026), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf>.

[221] Nat'l Acad. of Scis., Eng'g & Med., *Improving Diagnosis in Health Care* 1–4 (Erin P. Balogh et al. eds., 2015); Hardeep Singh et al., *The Frequency of Diagnostic Errors in Outpatient Care: Estimations from Three Large Observational Studies Involving U.S. Adult Populations*, 23 *BMJ Quality & Safety* 727, 727–31 (2014), <https://doi.org/10.1136/bmjqs-2013-002627>.

Physician-assisted suicide presents a distinctive concern because self-administration cannot be reversed after the diagnosis is corrected.

Supporters note that physician-assisted-suicide laws require review by more than one physician. Illinois requires concurrence concerning the terminal disease and a separate consulting-physician evaluation of the patient and relevant medical records.^[222] Multiple reviews may reduce the risk of error, but they cannot eliminate it. Physicians may rely on overlapping records, test results, specialists, assumptions, or prognostic models.

Patients facing serious diagnoses may also be experiencing fear, uncertainty, grief, or rapid changes in physical function. These reactions do not negate mental capacity, but they reinforce the importance of careful evaluation, adequate information, and access to second opinions when uncertainty exists.

Supporters argue that mentally capable adults routinely make consequential medical decisions under conditions of uncertainty. Opponents respond that uncertainty warrants additional caution when the intended result is irreversible death.

Regardless of one's position, physician-assisted-suicide laws ultimately depend upon medical judgments that are informed and professional but not infallible.

Depression and Demoralization: Are Requests for Death Always What They Appear?

One of the most difficult questions surrounding physician-assisted suicide involves the relationship between physical illness and emotional, psychological, social, and existential suffering.

Patients facing terminal or advanced illness may experience fear, sadness, grief, anxiety, loneliness, hopelessness, or loss of meaning. These reactions may be proportionate responses to extremely difficult circumstances, symptoms of a psychiatric disorder, manifestations of demoralization, or some combination of these factors.

The challenge is determining whether a request for physician-assisted suicide reflects a stable and enduring decision or is being significantly influenced by a condition or circumstance that may respond to intervention.

Depression occurs among some patients with advanced illness and may influence hopelessness, perceptions of the future, suicidal thinking, and the desire for hastened death. In one study of terminally ill cancer patients receiving inpatient palliative care, depressed patients were substantially more likely than nondepressed patients to report a strong desire for hastened death. Depression and hopelessness independently predicted that desire.^[223]

[222] 410 Ill. Comp. Stat. 22/10, 22/40 (2026), <https://www.ilga.gov/legislation/ilcs/fulltext?DocName=041000220K40>.

[223] Keith G. Wilson et al., Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer, 284 JAMA 2907, 2907–11 (2000), <https://doi.org/10.1001/jama.284.22.2907>.

This does not mean that every terminally ill person who requests physician-assisted suicide is depressed or lacks capacity. Depression and mental incapacity are not synonymous. It does mean that emotional suffering requires careful assessment rather than assumption.

Demoralization is related to, but distinct from, major depressive disorder. It may involve helplessness, hopelessness, loss of meaning, perceived failure, and difficulty coping with circumstances believed to be inescapable. Research has associated demoralization and other psychological, existential, and social factors with a wish for hastened death among some people with advanced disease.^{[224][225]}

Oregon's 2025 report illustrates the breadth of concerns recorded by physicians: loss of autonomy and reduced ability to engage in enjoyable activities were each reported for 89% of patients who died after ingesting the medication, and loss of dignity for 65%.^[226]

Those categories are nonexclusive and largely physician-reported. They do not establish that any one concern caused a request, but they show that requests often occur in a context involving functional, psychological, social, and existential concerns as well as physical symptoms.

Illinois does **not** require a mental-health evaluation for every request. Referral is required only when the attending or consulting physician has unresolved doubts about mental capacity and cannot confirm that the patient can make an informed decision. The evaluator must also determine whether a psychiatric or psychological disorder is causing impaired judgment. In Oregon, only 2 of the 400 reported 2025 DWDA deaths (0.5%) involved patients referred for psychological or psychiatric evaluation.^[227]

A pending 2026 proposal, **SB 3795**, would require a mental-health evaluation for every request. It has not been enacted and is not part of current Illinois law.^[228] The low Oregon referral rate does not establish that evaluations were missed or that the safeguard failed; it does show that formal referral was uncommon. Some forms of suffering may respond to psychiatric treatment, counseling, palliative care, symptom control, family or spiritual support, disability services, peer support, or other resources, while others may persist despite high-quality care.

[224] Sophie Robinson et al., A Systematic Review of the Demoralization Syndrome in Individuals with Progressive Disease and Cancer: A Decade of Research, 49 *J. Pain & Symptom Mgmt.* 595, 595–610 (2015), <https://doi.org/10.1016/j.jpainsymman.2014.07.008>.

[225] Cristina Monforte-Royo et al., *The Wish to Hasten Death in Patients with Life-Limiting Conditions: A Systematic Overview*, 67 *J. Pain & Symptom Mgmt.* e455, e455–e473 (2024), <https://pubmed.ncbi.nlm.nih.gov/38703862>.

[226] Or. Health Auth., *Oregon Death with Dignity Act: 2025 Data Summary* 15–16, tbl. 1 (rev. June 17, 2026), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf>.

[227] 410 ILCS 22/45; Or. Health Auth., *Oregon Death with Dignity Act: 2025 Data Summary* 9, 14 (rev. June 17, 2026), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf>.

[228] S.B. 3795, 104th Gen. Assemb. (Ill. 2026) (introduced Feb. 5, 2026; referred to Senate Assignments), Illinois General Assembly bill status.

The relevant question is therefore not whether every request is a symptom or “cry for help.” That formulation can improperly dismiss the stated wishes of mentally capable patients. The more precise question is whether clinicians can reliably distinguish a settled, informed request from one substantially influenced by treatable depression, demoralization, inadequate support, fear, or temporary circumstances.

Reasonable people disagree about the answer. Emotional, psychological, social, and existential suffering nevertheless deserve careful attention alongside physical symptoms when evaluating end-of-life requests.

The Adaptation Problem: Can We Predict Our Future Quality of Life?

As discussed above, research on the disability paradox and response shift cautions against assuming that a patient's initial reaction to illness or functional loss will predict long-term quality of life. Adaptation is neither automatic nor uniform, but some patients develop new routines, supports, relationships, and expectations that materially change their experience.

Critics therefore ask whether an irreversible decision may be made during a period when future quality of life is especially difficult to predict. Supporters respond that capable adults cannot be required to wait for an adaptation that may never occur.

The central question is not whether adaptation always occurs. It is whether the legal process can adequately account for the possibility that a patient's experience, support, or assessment of quality of life might change.

The Suicide-Prevention Question: Why Do We Respond Differently?

In most settings, an expression of suicidal intent prompts assessment and efforts to reduce immediate danger, identify contributing causes, and provide appropriate treatment or support. The response depends on the person's circumstances, level of risk, mental state, and legal rights; not every expression results in hospitalization or compulsory treatment.

Physician-assisted-suicide laws create a legally distinct framework for qualifying patients. When an eligible terminally ill patient makes an informed and voluntary request, the law permits a physician to prescribe medication intended to enable the patient to cause death through self-administration.

Critics therefore ask why a desire for death is treated differently when expressed by a person with a qualifying terminal disease.

Disability-rights advocates have been particularly vocal in framing this as a potential double standard. The National Council on Disability has argued that suicidal thinking ordinarily leads to prevention, assessment, and treatment, whereas people with disabilities or terminal illnesses may instead have their desire for death accepted as an autonomous medical choice.^[229]

Critics contend that this distinction may communicate that some lives warrant stronger suicide-prevention efforts than others.

Supporters reject that characterization. They argue that physician-assisted suicide involves mentally capable adults facing terminal disease, making repeated requests through a regulated medical process, rather than people acting impulsively during an ordinary suicidal crisis. From this perspective, physician-assisted suicide is a distinct end-of-life decision rather than a failure of suicide prevention.

Opponents respond that the distinction may be less clear in practice because concerns reported by some patients seeking physician-assisted suicide—including loss of autonomy, inability to engage in valued activities, loss of dignity, dependence, isolation, and perceived burdensomeness—overlap with factors associated with suicidal thinking and a wish for hastened death in other clinical settings.

The existence of overlapping concerns does not establish that conventional suicide and physician-assisted suicide are clinically or legally identical. It does explain why critics question whether requests for death are assessed according to consistent principles.

The disagreement ultimately concerns how prognosis, mental capacity, diagnosis, the nature of suffering, and the legal classification of the request should affect society's response to a stated desire to die. Supporters view physician-assisted suicide as a distinct end-of-life choice made by qualifying, capable adults; critics argue that the overlap with factors associated with suicidal thinking makes the boundary less clear in practice.

Second Opinions and Repeated Consultation: When Safeguards Depend on Physician Judgment

Physician-assisted-suicide laws generally require one or more physicians to determine that a patient satisfies specified legal criteria. Illinois requires an attending physician and a consulting physician to evaluate the patient, and it permits a patient to request the transfer of medical records to another physician.^[230]

^[229] Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* 34–36 (Oct. 9, 2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws/>; Nat'l Council on Disability, *Letter to Roger Severino, Director, Office for Civil Rights, U.S. Department of Health and Human Services* (Dec. 11, 2019), <https://www.ncd.gov/letters/2019-12-11-ncd-letter-to-hhs-on-assisted-suicide-medical-futility-and-qalys-reports>.

^[230] 410 Ill. Comp. Stat. 22/15(c), 22/35, 22/40 (2026), <https://www.ilga.gov/Legislation/ILCS/Articles?ActID=4646&Chapter=PUBLIC%20HEALTH&ChapterID=35&MajorTopic=HEALTH%20AND%20SAFETY>.

Supporters regard physician review as an important safeguard. Critics question how the safeguard operates when a patient may seek another physician after receiving an unfavorable opinion.

Critics sometimes use the pejorative phrase “doctor shopping” to describe repeated efforts to locate a clinician willing to approve a requested intervention. But obtaining a second opinion is ordinary medical practice and may protect against error or add expertise; consulting another physician does not itself demonstrate manipulation or abuse.

Physician-assisted suicide presents a specific policy question, however. Suppose one physician concludes that a patient does not meet the terminal-disease standard, cannot presently make an informed decision, or requires further mental-health evaluation. Depending upon the governing law and circumstances, the patient may transfer care or consult another physician. A later physician may reach a different conclusion.

Critics argue that repeated consultation could permit a determined patient to continue searching until finding a clinician with a more favorable interpretation of diagnosis, prognosis, capacity, or voluntariness. Supporters respond that patients should not be bound by the judgment of one clinician and that reasonable physician disagreement occurs throughout medicine.

Illinois law expressly requires medical records to be transmitted without undue delay when a patient requests transfer to an alternative physician. It also prohibits healthcare professionals from falsely or deceptively representing their willingness to qualify patients or provide aid-in-dying care.^[231] The Act does not expressly limit the number of physicians a patient may consult after an unfavorable assessment.

That does not establish that repeated physician-seeking will occur in Illinois or that later approvals will be improper. It means that the law relies on each participating physician to apply the statutory criteria independently and professionally.

The debate therefore centers on a difficult question: Is access to additional medical opinions a safeguard against erroneous denial, or can it provide a means of bypassing an unfavorable eligibility determination?

The answer often depends upon the relative weight assigned to two different risks: wrongfully denying access to a legally eligible patient and wrongfully approving an ineligible or vulnerable patient.

[231] 410 Ill. Comp. Stat. 22/15(c), 22/35, 22/40 (2026), <https://www.ilga.gov/Legislation/ILCS/Articles?ActID=4646&Chapter=PUBLIC%20HEALTH&ChapterID=35&MajorTopic=HEALTH%20AND%20SAFETY>.

Both sides can agree that physician judgment plays a critical role in determining access. The reliability of the safeguard therefore depends upon the statutory standards, the quality and independence of the medical evaluations, access to relevant records and expertise, and the consistency with which participating physicians apply the law.

Treatment-Dependent Prognosis: When Treatment Choices Affect the Six-Month Standard

Illinois law limits physician-assisted suicide to patients diagnosed with an incurable and irreversible disease that is expected, within reasonable medical judgment, to result in death within six months. The statute therefore appears to create a clear temporal limit on eligibility.

A more difficult question arises when a patient would likely live longer than six months if he or she continued available medical treatment, but would be expected to die within six months after refusing or discontinuing that treatment.

Patients generally have the legal right to refuse unwanted medical treatment, including treatment necessary to sustain life. Elsewhere in this Guide, examples include chemotherapy, dialysis, mechanical ventilation, surgery, and artificial nutrition and hydration.

The resulting eligibility question is whether a patient's six-month prognosis may be calculated on the assumption that the patient will refuse or discontinue treatment that would otherwise extend life beyond six months.

The issue is significant because the legal right to refuse treatment and the eligibility standard for physician-assisted suicide may interact in ways that are not obvious from the statutory definition alone.

Some serious conditions can be controlled for long periods with ongoing treatment yet become fatal much more quickly after that treatment is stopped. The legal question is therefore not whether a competent patient may refuse treatment, but what treatment assumptions physicians may use when applying the Act's six-month prognosis standard.

Illinois' Act does not expressly state whether the six-month prognosis must assume continuation of medically indicated treatment or may instead reflect the patient's chosen course of care. As of September 8, 2026, this Guide identifies no publicly available IDPH guidance resolving that question.^[232]

[232] 410 ILCS 22/10 (definition of "terminal disease"); Or. Health Auth., *Public Health's Role: Oregon's Death with Dignity Act* (stating that Oregon's Act does not specify whether all treatment options must be exhausted before a prescription is written and that participating physicians determine whether eligibility criteria are met), <https://www.oregon.gov/OHA/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ohdrole.aspx>.

Oregon offers a useful comparison without supplying a categorical answer. The Oregon Health Authority states that its Death with Dignity Act does not specify whether all treatment options must be exhausted before a prescription is written and that the attending and consulting physicians determine whether the terminal-illness criteria are met. That guidance illustrates how statutory silence can leave significant work to clinical judgment; it does not establish a universal Oregon rule for treatment-refusal cases.^[233]

For Illinois, the unresolved questions include:

- Does prognosis assume continued medically indicated treatment?
- May prognosis reflect a stated intention to discontinue treatment, or only treatment already discontinued?
- Does it matter whether treatment cures disease or merely sustains life?
- Will IDPH or the courts clarify the treatment assumptions physicians may use?

Until the issue is clarified, the practical scope of the six-month standard may depend in part on statutory interpretation, clinical judgment, and future administrative or judicial guidance.

^[233] 410 ILCS 22/10 (definition of “terminal disease”); Or. Health Auth., *Public Health’s Role: Oregon’s Death with Dignity Act* (stating that Oregon’s Act does not specify whether all treatment options must be exhausted before a prescription is written and that participating physicians determine whether eligibility criteria are met), <https://www.oregon.gov/OHA/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ohdrole.aspx>.

Can Voluntariness Be Reliably Assessed?

Voluntariness in Context

Supporters of physician-assisted suicide emphasize that the decision belongs to the patient and must be made voluntarily. The difficulty is that voluntariness is assessed in the context of ordinary human relationships and constraints. Serious illness may coincide with medical bills, loss of independence, family conflict, loneliness, caregiver exhaustion, housing concerns, fear of future suffering, or a sense of becoming burdensome; none of these circumstances necessarily defeats autonomy, but each can shape how available choices are perceived.

The safeguard question is therefore not whether a patient can make an entirely uninfluenced decision—few important decisions meet that description—but whether clinicians can reliably distinguish an informed and settled choice from one materially shaped by coercion, undue influence, treatable distress, or remediable circumstances.

This distinction matters because the reasons reported by patients often extend beyond uncontrolled physical pain. Oregon data, for example, frequently identify loss of autonomy, reduced ability to engage in valued activities, loss of dignity, and perceived burdensomeness. Supporters regard these as legitimate considerations for a capable adult; opponents argue that some are social, emotional, or relational concerns that may change with additional support.^[234]

The sections that follow examine family influence, economic pressure, perceived burdensomeness, isolation, and access to alternatives—not on the assumption that these factors invalidate every request, but because a safeguard based on voluntariness must have some way to assess their significance in individual cases.

Waiting Periods and Repeated Requests

Illinois ordinarily requires at least five days between the first and second oral requests, subject to an exception when the attending physician expects the patient to die within five days. Repetition and delay can test persistence and provide time for reconsideration, but they do not necessarily reveal whether family influence, financial pressure, isolation, or other contextual factors remain present. See Chapter 2 for the complete Illinois request process.^[235]

[234] In 2025, the three most frequently reported concerns were loss of autonomy (89%), decreasing ability to participate in activities that made life enjoyable (89%), and loss of dignity (65%). Or. Health Auth., *Oregon Death with Dignity Act: 2025 Data Summary* 11–12 & tbl. 3 (rev. June 17, 2026), <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx>.

[235] 410 ILCS 22/25(a)(4), (c); see also Cal. S.B. 380, ch. 542 (2021); Colo. S.B. 24-068, ch. 406 (2024); Haw. H.B. 650, Act 43 (2023) (examples of later statutory reductions in waiting periods).

Family Influence and Subtle Pressure

Most people facing serious illness make decisions in relationship with spouses, children, siblings, caregivers, and close friends. That involvement is usually beneficial: families provide emotional support, transportation, advocacy, financial assistance, caregiving, and companionship. The same relationships can also create pressures that are subtle, unspoken, and difficult to measure.

Coercion need not take the form of an explicit demand. A patient may observe caregiver exhaustion, overhear discussions about cost, experience strained relationships, or conclude independently that death would relieve loved ones of emotional, financial, or caregiving burdens. Supporters respond that capable adults remain able to make independent decisions in the presence of family influence; critics question how reliably the process can distinguish ordinary influence from pressure significant enough to compromise voluntariness.^[236]

Financial and Insurance Pressures

Serious illness can impose substantial economic costs, including medical bills, prescription expenses, transportation, home modifications, long-term care, lost income, and unpaid caregiving. Critics therefore ask whether financial circumstances can alter the choice environment even when no person or institution explicitly pressures the patient.^[237]

Opponents frequently cite the disputed 2008 Oregon Health Plan cases involving Barbara Wagner and Randy Stroup, in which requested cancer treatments were not covered under the Plan's rules while notices identified physician-assisted death as a covered benefit. Critics argue that such cases can create the appearance that death is easier to finance than continued treatment. Supporters respond that the coverage decisions turned on medical-effectiveness and benefit rules rather than a preference for assisted death and caution against treating these cases as simple proof of economic coercion.^[238]

The concern extends beyond insurance. Serious illness can deplete savings, reduce household income, interrupt future plans, and require family members to leave work or cut hours. No one may explicitly suggest death, and no overt coercion may occur; the patient may simply become aware of the strain and incorporate it into the decision. Critics argue that a legal test focused on competence and overt coercion may be poorly suited to measuring this kind of indirect economic influence.^[239]

[236] See Nat'l Council on Disability, *Assisted Suicide: A Disability Perspective*, pt. IV.B.9 (Mar. 24, 1997), <https://www.ncd.gov/report/assisted-suicide-a-disability-perspective-position-paper/> (discussing divergent interests, family pressures, caregiving burdens, and the difficulty of detecting coercive influences).

[237] Nat'l Acads. of Scis., Eng'g & Med., *Families Caring for an Aging America* 123–60 (2016), <https://doi.org/10.17226/23606>.

[238] Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* 19–20 (Oct. 9, 2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws/>; Susan Donaldson James, *Death Drugs Cause Uproar in Oregon*, ABC News (Aug. 6, 2008), <https://abcnews.com/Health/story?id=5517492&page=1>.

[239] Nat'l Acads. of Scis., Eng'g & Med., *Families Caring for an Aging America* 123–60 (2016), <https://doi.org/10.17226/23606>.

Disability-rights advocates therefore argue that access to healthcare, disability services, caregiver support, housing, mental-health resources, and financial assistance is relevant to whether the available alternatives are genuinely meaningful. Supporters agree that no patient should be driven toward death by poverty or lack of care, but maintain that economic hardship does not by itself eliminate autonomy. The safeguard question is whether the process can recognize when financial circumstances have become sufficiently powerful to undermine a voluntary choice.^{[240][241]}

Perceived Burdensomeness and Caregiving Strain

Perceived burdensomeness is especially important because it appears in reported patient concerns. Oregon's 2025 data recorded concern about burdening family, friends, or caregivers for 159 of 400 patients (39.8%), compared with 148 (37.0%) for inadequate pain control or concern about it; loss of autonomy, reduced ability to participate in enjoyable activities, and loss of dignity were reported still more often. These categories are nonexclusive and physician-reported, but they show that the decision often occurs in a context extending beyond physical pain.^[242]

Serious illness can alter family roles and routines. A spouse may become a caregiver, adult children may miss work for appointments, and financial or emotional strain may become visible to the patient. Families may willingly make these sacrifices, yet patients can still perceive the cost to those around them. In many cases no one explicitly recommends death; concern about burden may arise from the patient's own interpretation of the family's circumstances.^[243]

Supporters argue that a mentally capable adult may legitimately consider the effects of illness and caregiving on loved ones as part of an autonomous decision. Opponents respond that feelings of burdensomeness should prompt additional support and reassurance because dependence does not necessarily imply diminished worth. The policy question is not whether patients may care about the impact of illness on others, but how the safeguard should respond when that concern becomes a significant reason for requesting death.

[240] Nat'l Council on Disability, *Assisted Suicide: A Disability Perspective* pt. V (Mar. 24, 1997), <https://www.ncd.gov/report/assisted-suicide-a-disability-perspective-position-paper>; Nat'l Council on Disability, *Letter to the Illinois General Assembly Regarding Assisted Suicide Legislation* (May 1, 2025), <https://www.ncd.gov/letters/2025-05-01-ncd-letter-to-illinois-general-assembly-regarding-assisted-suicide-legislation>.

[241] Disability Rights Educ. & Def. Fund, *Physician-Assisted Suicide*, <https://dredf.org/issues/assisted-suicide/> (collecting reports involving Oregon Health Plan coverage decisions).

[242] Or. Health Auth., *Oregon Death with Dignity Act: 2025 Data Summary* 15–16, tbl. 1 (rev. June 17, 2026), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf>.

[243] Nat'l Acads. of Scis., Eng'g & Med., *Families Caring for an Aging America* 21–67 (2016), <https://doi.org/10.17226/23606>.

Disability-rights advocates further argue that cultural emphasis on independence, productivity, and self-sufficiency can cause ordinary dependence to be experienced as humiliation or loss of dignity. A statement of burdensomeness may reflect a settled value judgment, but it may also be associated with guilt, fear, depression, loneliness, or concern for loved ones. The practical challenge is determining when those influences are significant enough to warrant additional intervention or assessment.^[244]

Social Isolation and Loss of Connection

Serious illness can constrict a patient's social world as activities and travel become more difficult, friends visit less often, spouses die, children live far away, and employment or volunteer roles disappear. The resulting isolation may compound physical suffering even when medical treatment is otherwise effective.

Loneliness and loss of connection are difficult to measure clinically. A person may receive excellent medical care while feeling abandoned, have access to medication but little companionship, or be physically comfortable while experiencing a profound loss of purpose. Because physician-assisted suicide is framed as a medical decision, relational suffering can receive less attention than physical symptoms even though the two often interact.

Supportive relationships can alter how illness is experienced, while isolation can make the same diagnosis harder to bear. Available reports cannot determine how often loneliness or loss of connection materially influences a request, but several commonly reported concerns—including diminished autonomy, loss of dignity, inability to participate in valued activities, and perceived burdensomeness—have relational as well as medical dimensions. Critics therefore argue that social support is relevant to any serious assessment of voluntariness.

Access to Support Alternatives

A related question concerns the alternatives that are realistically available to the patient. As Chapter 3 explains, housing, transportation, personal-care services, caregiver support, counseling, disability services, community integration, spiritual care, and meaningful relationships can materially affect quality of life during serious illness. Critics argue that voluntariness is harder to evaluate when those supports exist in theory but are inaccessible in practice.^[245]
^[246]

This does not mean that adequate support will eliminate every request for physician-assisted suicide. Some patients may continue to prefer death despite extensive care and assistance. The narrower safeguard question is whether the process meaningfully distinguishes suffering that persists despite available support from suffering intensified by the absence of support.

^[244] Keith G. Wilson et al., Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer, 284 JAMA 2907, 2907–11 (2000), <https://doi.org/10.1001/jama.284.22.2907>.

^[245] Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* 8–18 (2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws>.

^[246] Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* 13–18 (2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws/>.

Supporters emphasize that the state cannot condition autonomy on the elimination of every social hardship. Opponents respond that a choice between death and circumstances made intolerable by preventable deprivation is not the same as a choice made after realistic alternatives have been made available. That disagreement connects the voluntariness inquiry to broader questions of disability policy, caregiving, and community responsibility.

Access to Pain Relief and Palliative Care

Fear of uncontrolled pain is an important reason some people support physician-assisted suicide, while hospice, palliative care, pain management, nursing, counseling, and spiritual care can relieve suffering for many patients. Chapter 3 discusses these alternatives in detail. Critics argue that public debate can underestimate the effectiveness of modern comfort care; supporters respond that even excellent care cannot eliminate every symptom, loss, or form of distress.^[247]

Access is also uneven. Patients may receive late referrals, live in areas with limited specialty care, face insurance or navigation barriers, or encounter clinician caution around opioid prescribing. These problems do not show that palliative care would change every request, but they complicate an assessment of whether alternatives were genuinely available rather than merely mentioned.^[248]

The disagreement is therefore not whether patients should receive effective symptom relief—both sides generally agree that they should—but what role physician-assisted suicide should play when suffering persists despite available interventions. For purposes of safeguards, the practical question is whether an informed decision requires only disclosure of alternatives or also meaningful access to them.

[247] Nat'l Consensus Project for Quality Palliative Care, *Clinical Practice Guidelines for Quality Palliative Care* (4th ed. 2018), <https://www.nationalcoalitionhpc.org/ncp>.

[248] U.S. Dep't of Health & Human Servs., *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics* (2019), <https://www.hhs.gov/opioids/treatment/clinicians-guide-opioid-dosage-reduction>.

Can Compliance and Final Consent Be Reliably Verified?

Verification and Oversight

Eligibility reviews, waiting periods, documentation, and reporting requirements are intended to regulate physician-assisted suicide and protect against abuse. Their effectiveness, however, depends not only on the rules themselves but on whether compliance can be verified. Unlike many medical processes, the final self-administration may occur without a clinician or independent witness present, and individual deaths do not ordinarily receive routine independent review.^[249]

Supporters point to the absence of evidence of widespread abuse and argue that existing reporting systems have functioned adequately. Critics respond that the strength of that inference depends on what the system is capable of observing and investigating. The central oversight question is therefore what can actually be verified after a prescription has been issued and a patient has died.

Independent Verification of Self-Administration

The requirement that the patient personally perform the final act distinguishes physician-assisted suicide from euthanasia: the prescribed medication must be self-administered rather than administered by another person. The legal rule is clear; the verification problem arises because a healthcare professional or independent witness may not be present when the medication is taken.

When no independent observer is present, regulators may have limited evidence about whether the medication was actually self-administered, whether the patient remained capable and willing, or whether anyone else was involved. In many cases, the public record depends principally on information submitted by participating clinicians after the prescription is issued or after they learn of the death.

Oregon's 2025 report illustrates the limits of direct observation. No healthcare provider or volunteer was reported present at the time of death in 177 of 400 cases (44.3%); at ingestion, presence information was unknown in 90 cases and 65 cases were reported with no provider or volunteer present. These figures do not establish improper self-administration, but they demonstrate that independent professional observation is not universal.^[250]

[249] National Council on Disability, *The Danger of Assisted Suicide Laws* 58–66 (2019), https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf.

[250] Or. Health Auth., *Oregon Death with Dignity Act: 2025 Data Summary* 16–17, tbl. 1 (rev. June 17, 2026), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf>.

Supporters argue that there is no evidence of widespread violations of self-administration requirements. Critics answer that some violations would be difficult to detect when the decisive event is not observed. The dispute is therefore about the evidentiary limits of the safeguard, not proof that abuse is common.

Consent at the Time of Self-Administration

The statute devotes substantial attention to eligibility before a prescription is written: clinicians assess diagnosis, prognosis, capacity, and voluntariness; requests and documentation are completed; and waiting periods may apply. Yet days, weeks, or months can pass before the patient decides whether and when to self-administer. During that interval symptoms, relationships, emotions, and the patient's own wishes can change.^[251]

A patient may experience improved symptom control, reconciliation, new support, spiritual comfort, renewed hope, increased fear, or simple uncertainty. Supporters correctly note that the patient remains free to rescind the request or never use the medication. Critics focus on a different question: whether anyone can know that the patient remained willing and capable at the moment of self-administration.

The right to change one's mind is an important safeguard, but the final act may occur without a physician, government official, or independent observer present. Family or friends may be present, or the patient may be alone. If hesitation, withdrawal of consent, impaired capacity, or an attempt to stop occurred at the last moment, those facts may be difficult or impossible to reconstruct afterward.

Consent in medicine is continuing rather than static; a patient who consented earlier retains the right to withdraw immediately before an intervention. Physician-assisted suicide creates a distinctive verification problem because the final decision may be unobserved and death prevents later clarification.

Supporters emphasize the lack of documented evidence that contemporaneous consent is a widespread problem, while opponents argue that the absence of observation limits what the evidence can establish. The concern is not that every patient changes his or her mind, but whether the system could reliably identify the cases in which one did.

Good-Faith Immunity and Accountability

Illinois, like other jurisdictions, provides legal protection for healthcare professionals and entities that act in good-faith compliance with the Act. Supporters regard those protections as necessary to permit clinicians to exercise professional judgment without facing liability merely because a disputed or adverse outcome occurs.

[251] Or. Health Auth., *Oregon Death with Dignity Act: 2025 Data Summary* 6, 17, tbl. 1 (rev. June 17, 2026) (reporting that 24 patients who died in 2025 lived more than six months after receiving their prescriptions and reporting a wide range between first request and death), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf>.

The protection is not absolute. Illinois separately preserves liability for specified intentional or knowing misconduct, including coercion or undue influence and the forging, alteration, concealment, or destruction of requests or rescissions. Critics nevertheless question whether a good-faith standard can make negligent mistakes or questionable judgments difficult to challenge; supporters respond that ordinary errors should not be treated as intentional misconduct. The policy tension is how to protect legitimate professional judgment without weakening accountability for an irreversible decision.^[252]

Investigation and Post-Death Review

A death under the Act does not automatically trigger the kind of independent investigation associated with an unexpected or suspicious death. That matters because, once the patient has died, concerns about coercion, impaired judgment, family pressure, or improper administration can become difficult to reconstruct and the patient cannot provide testimony.

Illinois does not require routine independent review of every death by a specialized board or law-enforcement body. A death following self-administration is attributed to the underlying terminal disease, is not classified as suicide or homicide, and self-administration is not indicated on the death certificate. Compliance therefore depends heavily on medical records and statutory reports.^[253]

Supporters argue that routine investigations would be burdensome and are not justified by evidence of widespread abuse; critics respond that the absence of routine investigation also limits the system's ability to identify disputed cases.

Confidentiality creates an additional tension. Supporters view privacy protections as important to patients, families, and participating clinicians. Critics argue that limits on access to records can make it harder for relatives, researchers, journalists, or investigators to evaluate allegations after a death. The relevant question is not whether abuse occurs in every case, but whether the system has adequate mechanisms to identify and investigate it when credible concerns arise.^[254]

Reporting Limits

Illinois requires attending physicians to submit prescription-related and follow-up information to IDPH, which must publish annual aggregate statistics specified by the Act. The underlying information is confidential and privileged, so the public report can reveal only the variables the system collects; comparative reports such as Oregon's are similarly useful but contain unknown values and depend on required forms and death records.^[255]

[252] 410 ILCS 22/70(a), (c)–(f), (h); 410 ILCS 22/95, 22/100.

[253] 410 ILCS 22/90; National Council on Disability, *The Danger of Assisted Suicide Laws* 58–71 (2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws/>.

[254] Cal. Health & Safety Code §§ 443.19–443.22 (West 2025).

[255] 410 ILCS 22/75; Or. Health Auth., *Oregon Death with Dignity Act: 2025 Data Summary* (rev. June 17, 2026), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf>.

These limits do not make the data inaccurate. They mean that family dynamics, subtle coercion, isolation, financial pressure, complications, and the circumstances of self-administration may be captured incompletely or not at all. Supporters emphasize the practical limits of any reporting system; critics caution against treating the absence of reported problems as proof that none occurred.

Data Transparency and Independent Evaluation

Independent evaluation is further limited by events that are never observed or documented, including coercion that is not reported, pressure that is not recorded, mistakes that are never discovered, and violations that leave no independent evidence. These possibilities do not prove that the law is failing; they define the limits of what available data can establish and therefore affect how confidently the system's safety can be characterized.^[256]

What These Limitations Do—and Do Not Establish

The concerns surveyed in this chapter do not prove that physician-assisted-suicide laws are being abused or that every request is the product of coercion, depression, misinformation, or inadequate support. They identify three recurring limits: eligibility depends on medical judgment under uncertainty; voluntariness may be shaped by pressures that do not amount to overt coercion; and final consent and compliance may be difficult to verify when self-administration is not independently observed.

Supporters may conclude that these limits are acceptable in a system that respects the decisions of mentally capable adults and that available evidence does not demonstrate widespread abuse. Opponents may conclude that the same limits matter precisely because an erroneous approval cannot be reversed and some problems may be difficult to detect after death. The central policy question is what level of reliability, verification, and support society should require before permitting an irreversible medical act.

[256] National Council on Disability, *The Danger of Assisted Suicide Laws* 64–69 (2019), https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf.

Chapter 4's Key Takeaways

1 Illinois' safeguards are intended to restrict physician-assisted suicide to eligible, mentally capable patients making informed and voluntary decisions. The central question is how reliably those safeguards can be applied in individual cases.

2 Diagnosis and prognosis are medical judgments, not certainties. Diagnostic mistakes occur, and a six-month prognosis necessarily involves uncertainty about an individual patient's future course.

3 Illinois does not require a mental-health evaluation for every request. Referral is required only when a physician has unresolved doubts about mental capacity, and the evaluator must also determine whether a psychiatric or psychological disorder is causing impaired judgment.

4 Serious illness and disability can involve adaptation that is difficult to predict in advance. Some people later experience their condition, dependence, priorities, or quality of life differently than they expected when illness or disability was new.

5 Legal capacity does not answer every question about voluntariness. Family dynamics, financial pressure, isolation, caregiver strain, perceived burdensomeness, and inadequate services can shape the choices a patient believes are realistically available.

6 Hospice, palliative care, mental-health treatment, disability services, caregiver assistance, pain and symptom management, and other supports may address important sources of suffering. Their availability and effectiveness, however, vary among patients and communities.

7 Some aspects of compliance can be documented but are difficult to verify independently after death. When no clinician or independent observer is present at self-administration, later review may depend heavily on medical records, required reports, and information supplied by those involved.

8 Illinois attributes a death following lawful self-administration to the patient's underlying terminal disease. The death is not designated as suicide or homicide, and self-administration is not indicated on the death certificate.

9 Section 70 provides significant protection for actions taken in good-faith compliance with the Act, but those protections do not eliminate liability for the forgery, concealed rescission, coercion, undue influence, and other intentional misconduct addressed by Section 95.

10 Identifying limitations in safeguards does not establish that widespread abuse or misconduct has occurred. The narrower question is whether the statutory process can reliably detect error, impaired judgment, coercion, inadequate alternatives, and noncompliance when they do occur.

COMING NEXT

Chapter 5 gathers legal materials, comparative data, official forms, frequently asked questions, and further resources for patients, families, clinicians, policymakers, and researchers.

05

Reference Materials

Where can readers verify claims, find Illinois forms and resources, compare utilization and public-opinion data, and locate guidance tailored to their role?

- Illinois statutes, official forms and implementation links
- Utilization data and reporting limitations
- Public-opinion research and survey methodology
- Comparative law and post-enactment changes
- Audience quick guides, Illinois resources, FAQs, and research sources

PART A

Illinois Law and Practice Guide

A practical starting point for Illinois law, official forms and live government links. Chapter 2 explains the statute in detail; this part is designed for readers who need to locate the governing text or the current State form rather than rely on a printed reproduction.

Illinois Law and Current Forms

Because implementation materials can change, use the live State source whenever a current form or statutory provision matters.

End-of-Life Options Act

(Public Act 104-0441). Illinois' physician-assisted suicide law (effective September 12, 2026).
[ilga.gov / Public Act 104-0441](https://www.ilga.gov/PublicAct/104-0441)

Illinois Compiled Statutes

The Act will be codified at 410 ILCS 22. Use the compiled-statute text together with the Public Act when checking section numbers after implementation.
<https://www.ilga.gov/legislation/ilcs/ilcs.asp>

Advance Directives

Health Care Power of Attorney, Living Will, Mental Health Treatment Declaration, and related planning documents.
[dph.illinois.gov / advance directives](https://dph.illinois.gov/advance-directives)

Illinois POLST

Official Practitioner Orders for Life-Sustaining Treatment form and guidance.
[dph.illinois.gov / advance directives](https://dph.illinois.gov/advance-directives)

Illinois aid-in-dying forms. As of September 8, 2026, this Guide did not locate a dedicated public IDPH aid-in-dying forms packet. The Act itself supplies the required written-request form in 410 ILCS 22/30.^[257] Until IDPH posts implementation forms or instructions, readers should use the statute and IDPH's official website for the most current materials.

Process overview. For the visual statutory process, see "The Illinois Physician-Assisted Suicide Process," p. 1. For legislative history, eligibility, physician duties, conscience provisions, reporting, and current litigation, see Chapter 2.

[257] End-of-Life Options for Terminally Ill Patients Act, 410 ILCS 22/30 (written-request form), <https://www.ilga.gov/documents/legislation/PublicActs/104/104-0441.htm>.

Government Agencies and Practical Resources

Use these sources to confirm current forms, statutory text, implementation guidance, and plain-language planning information. Bookmark the live page rather than relying on a downloaded copy that may become outdated.

Illinois Department of Public Health

Advance directives, POLST, DNR guidance, and implementation resources.

<https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives.html>

Illinois General Assembly

Enrolled text of Public Act 104-0441 and subsequent amendments.

<https://www.ilga.gov/documents/legislation/PublicActs/104/104-0441.htm>

Illinois Department on Aging

Advance care planning, caregiver resources, and senior services.

<https://ilaging.illinois.gov/aboutus/legal-advance-directives.html>

Illinois Legal Aid Online

Plain-language guidance on advance directives, healthcare powers of attorney, living wills, and related legal planning.

<https://www.illinoislegalaid.org/>

A Simple Verification Routine

1. Check the current statute.

Confirm the operative 410 ILCS 22 language and any amendments rather than relying only on the 2025 Public Act.

2. Check IDPH.

Use the State's current advance-directive, POLST, reporting, and implementation pages for live forms and instructions.

3. Check the date.

Forms, regulations, litigation, and administrative guidance may change after this edition's September 8, 2026 cutoff.

4. Separate explanation from authority.

Plain-language resources are useful, but the statute, official forms, court orders, and agency guidance control.

Primary authority

Statutes, Public Acts, regulations, court orders, and official State forms.

Official administration

IDPH and other agencies for implementation guidance, licensing, and current forms.

Plain-language help

Legal-aid and aging resources for explanation and practical planning; verify controlling law separately.

Current through the Guide's cutoff. The first edition is current through September 8, 2026. Readers using this chapter later should treat it as a map to primary sources, not as a substitute for checking those sources.

PART B

Physician-Assisted Suicide by the Numbers

Utilization data are useful only when the measure is clear. U.S. reports distinguish prescriptions, ingestion, and deaths after ingestion; Canada overwhelmingly reports clinician-administered MAID provisions. These systems should not be combined into one total.

Latest Official Snapshot

Jurisdiction	Latest official period	Reported cases or provisions
Canada	2024	16,499 MAID provisions
Netherlands	2025	10,341 euthanasia notifications
Belgium	2025	4,486 euthanasia registrations
Spain	2024	426 provisions of aid in dying
Oregon	2025	400 reported deaths following ingestion

Data vintage: latest official annual figures located as of September 8, 2026. These measures are not directly interchangeable. Sources: [Health Canada 2024](#); [Netherlands RTE 2025](#); [Belgium 2025](#); [Spain 2024](#); and [Oregon 2025](#). A single combined U.S. total is not shown because state reporting definitions and publication schedules differ.

Prescription

Medication was authorized; it does not establish that the patient obtained or used it.

Ingestion / self-administration

The patient reportedly took the medication; reporting may be incomplete when no professional is present.

Practitioner-administered MAID

A clinician performs the final act. This is the overwhelmingly used Canadian model and is not the same practice as U.S. self-administration.

Illinois has no utilization history yet. The Act takes effect September 12, 2026. Illinois data will therefore begin as implementation proceeds; readers should not infer Illinois outcomes from Oregon, Canada, or another jurisdiction.

Age and Demographic Snapshot

Oregon, 2025. Median age 76; age 65 or older 88%; female 53.5%; White 94.2%; approximately half held at least a bachelor's degree; most had Medicare, private insurance, or both.

Canada, 2024. Overall median age 77.9 (Track 1, 78.0; Track 2, 75.9). Track 1: 52.2% men and 47.8% women. Track 2: 43.3% men and 56.7% women. Among recipients answering race or ethnicity, 95.6% identified as White. Among those answering the disability question, 32.9% identified as having a disability. Canadian figures on race, Indigenous identity, and disability should be interpreted cautiously because of variation in collection and possible reluctance to self-identify.

United States: Oregon as the Longest Reporting Series

Measure	Most recent figure
U.S. jurisdictions authorizing PAS	13 states and D.C.
Oregon prescriptions reported in 2025	637
Oregon deaths following ingestion in 2025	400
Cumulative Oregon prescription recipients, 1998–2025	5,520
Cumulative Oregon deaths following ingestion, 1998–2025	3,691
Oregon median age in 2025	76 years
Oregon patients age 65 or older	88%
Oregon patients enrolled in hospice	91.8%
Oregon patients whose underlying illness was cancer	61.3%

Oregon provides the longest continuous American reporting series. Its 2025 report was the twenty-eighth annual report issued under the Oregon Death with Dignity Act. Oregon reported 637 prescriptions during 2025, an increase of approximately five percent from the 609 prescriptions reported in 2024. The State reported 400 deaths during 2025 following ingestion of prescribed medication.^[258]

Since Oregon’s law took effect, 5,520 people had received prescriptions and 3,691 were reported to have died after ingesting the medication as of the 2025 reporting cutoff. That cumulative figure equals approximately 67 percent of all reported prescription recipients. The remaining recipients include people who died without ingesting the medication, were alive when reporting closed, or whose ingestion status was unknown.

U.S. reporting limitation: state systems are not uniform. Washington continues to require statutory forms, but its Department of Health paused routine annual statistical reporting after the 2024 data year because of budget reductions. Washington’s statute page remains at [doh.wa.gov / Death with Dignity Act](https://doh.wa.gov/Death-with-Dignity-Act).

Prescriptions, Ingestion, and Death

A prescription means medication was authorized. Ingestion means the patient reportedly took it. A death following ingestion means the patient was reported to have died after taking it. A person may receive a prescription but never fill it, fill it but never ingest it, or die from another cause. Reporting agencies may not know what happened to every prescription.

For prescriptions written in Oregon during 2025, approximately 56 percent of recipients were known to have ingested the medication by the reporting cutoff; approximately 16 percent were known to have died without ingesting it; and approximately 28 percent had an unresolved or unknown ingestion status. The 56 percent figure should not be treated as the final ingestion rate for the 2025 cohort.

[258] Oregon Health Authority, *Oregon Death with Dignity Act: 2025 Data Summary* (rev. June 17, 2026), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf>.

Timing and Observation

Oregon reported a median time of approximately 46 minutes from ingestion to death in 2025. Known cases ranged from approximately three minutes to 123 hours. Timing data are incomplete because a healthcare professional is not always present.

Reported End-of-Life Concerns

Oregon asks participating physicians to report patients’ end-of-life concerns. The most frequently reported concerns in 2025 were not uncontrolled physical pain.

Reported end-of-life concern	Oregon, 2025
Loss of autonomy	89%
Decreased ability to participate in enjoyable activities	89%
Loss of dignity	65%
Feeling like a burden on family, friends, or caregivers	39.8%
Inadequate pain control or concern about it	37.0%

Source: Oregon Health Authority, *Oregon Death with Dignity Act: 2025 Data Summary*, table 1 (rev. June 17, 2026), [oregon.gov / year28.pdf](https://oregon.gov/health/2025/06/17/oregon-death-with-dignity-act-2025-data-summary).

These reports do not establish the sole or principal reason any individual sought physician-assisted suicide. Patients may report multiple concerns, and the percentages therefore do not add to 100 percent. Autonomy, activity, dignity, dependence, and relational concerns are commonly reported more often than inadequate pain control.

Hospice and Palliative Care

In 2025, 91.8 percent of Oregon patients reported to have died after ingesting aid-in-dying medication were enrolled in hospice. In 2024, 74.1 percent of Canadian MAID recipients were reported to have received palliative care (76.4 percent among Track 1 recipients and 23.2 percent among Track 2 recipients). These measures should not be compared as if they were identical.

How to Read These Numbers

American statutes generally require patient self-administration. Canada overwhelmingly uses clinician-administered MAID. Those figures should not be described as the same practice. Oregon’s reports rely on participating physicians and confidential death records. A prescription does not establish that medication was taken. Reported concerns are not exclusive categories. Oregon’s hospice-enrollment figure and Canada’s palliative-care figure describe related but distinct services. Complications, family dynamics, coercion, unused medication, presence at death, and consent at ingestion are not reported consistently.

Canada

Measure	Canada, 2024
Reported MAID requests	22,535
People who received MAID	16,499
Cumulative MAID provisions since 2016	76,475
Share of all Canadian deaths involving MAID	5.1%
Track 1: death reasonably foreseeable	95.6%
Track 2: death not reasonably foreseeable	4.4%
Median age	77.9 years
Received palliative care	74.1%
Self-identified as having a disability	32.9%
Annual growth, 2023–2024	6.9%

Canada reported 16,499 MAID provisions in 2024, bringing the cumulative number reported since legalization in 2016 to 76,475. MAID accounted for approximately 5.1 percent of all Canadian deaths in 2024.^[259]

Canada divides cases into two tracks. Track 1 applies when natural death is reasonably foreseeable; Track 2 applies when it is not. In 2024, Track 1 represented 95.6 percent of MAID provisions and Track 2 represented 4.4 percent. In every reported Canadian case during 2024, MAID was administered by a practitioner. Self-administration is legally available in most provinces and territories but has been used only rarely.

Growth in Utilization

Canadian MAID provisions have continued to increase, although the annual rate of growth has declined substantially from the early years of national reporting.

Year	Canadian MAID provisions	Annual increase
2019	5,461	—
2020	7,469	36.8%
2021	10,066	34.8%
2022	13,199	31.1%
2023	15,427	16.9%
2024	16,499	6.9%

Canadian MAID provisions continued to increase in 2024, although the annual rate of growth declined. Health Canada cautions that several additional years of data will be needed before concluding that utilization has stabilized.

[259] Health Canada, *Sixth Annual Report on Medical Assistance in Dying in Canada* (2024 data, published Nov. 2025), <https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2024.html>.

PART C

Public Opinion on Physician-Assisted Suicide

Public-opinion surveys regarding physician-assisted suicide do not all measure the same thing. Some ask whether the practice should be legal. Others ask whether it is morally acceptable, whether respondents would personally choose it, or whether physicians should participate. Surveys also use substantially different terminology, including “physician-assisted suicide,” “medical aid in dying,” “physician-assisted death,” “ending life,” and “painless means.”

These distinctions matter. A respondent may support legal access while believing the practice is morally wrong. Support for allowing a competent adult with terminal cancer to self-administer prescribed medication does not necessarily indicate support for euthanasia, psychiatric eligibility, advance requests for dementia, access by minors, or removal of residency requirements.

Every polling result should be read with the exact question wording, the population surveyed, the medical and legal scenario, whether the item concerns legality, morality, or personal participation, the response options, and the date and methodology of the survey.

National Public Opinion

In 2024, Gallup asked whether doctors should be permitted to assist a patient with an incurable disease who is living in severe pain “to commit suicide” when the patient requests it. Sixty-six percent said the practice should be allowed by law; 30 percent said it should not.^[260]

Gallup separately asked whether doctors should be permitted to end the life of a patient with an incurable disease “by some painless means” when the patient and family request it. Seventy-one percent said this should be allowed; 26 percent opposed it. The second item is closer to euthanasia. Gallup has observed that the word “suicide” may reduce support relative to language describing a painless death.

Gallup’s morality question produces lower support than its legality questions. In 2024, 53 percent called doctor-assisted suicide morally acceptable, 40 percent morally wrong, and 7 percent depends or no opinion. Thus 66 percent supported legal doctor-assisted suicide, but only 53 percent described the practice as morally acceptable.

[260] Rachael Yi, “Most Americans Favor Legal Euthanasia,” Gallup (Aug. 8, 2024), <https://news.gallup.com/poll/648215/americans-favor-legal-euthanasia.aspx>.

Question Wording, Morality, and Political Differences

Pew Research Center, in a survey conducted May 5–11, 2025, asked whether “patients choosing to end their lives with the help of a doctor” was morally acceptable (34%), morally wrong (35%), or not a moral issue (29%). Pew combined the first two non-objection categories when reporting that 63 percent of Americans did not express a moral objection. “Morally acceptable” and “not a moral issue” should remain separate for careful analysis.^[261]

In 2013, Pew asked whether respondents approved or disapproved of laws allowing physicians to prescribe lethal medication to terminally ill patients who chose to end their lives: 47 percent approved and 49 percent disapproved, almost unchanged from 2005 (46% / 45%).^[262] Those findings should not be treated as contradictory to Gallup’s higher results. The organizations used different wording, response structures, and survey contexts.

Gallup support for legal doctor-assisted suicide has remained above 50 percent in every reported survey since 1996, but the trend is not an uninterrupted rise. Support reached 68 percent in 2001, declined to 51 percent in 2013, and returned to the mid-to-upper 60s in several recent years. Moral approval rose above 50 percent around 2014 and has generally remained in the low-to-mid 50s.

In Pew’s 2025 survey, 48 percent of Republicans and Republican leaners called the practice morally wrong, compared with 23 percent of Democrats and Democratic leaners. Among Democrats and leaners, 76 percent described it as morally acceptable or not a moral issue; among Republicans and leaners, 51 percent did. Gallup’s 2024 morality measure found 69 percent of Democrats, 52 percent of Independents, and 38 percent of Republicans calling doctor-assisted suicide morally acceptable.

Religious identity and commitment are among the strongest predictors. In Pew 2025, 87 percent of the religiously unaffiliated expressed no moral objection, compared with 38 percent of White evangelical Protestants. Among those who said religion was very important, 59 percent called the practice morally wrong; among those who said it was not important at all, 8 percent did. Gallup 2024 found moral acceptability at 29 percent among weekly worship attendees and 67 percent among those who seldom or never attend.

[261] Rebecca Leppert, “About 6 in 10 Americans Don’t Have Moral Objections to Medical Aid in Dying,” Pew Research Center (Mar. 23, 2026) (survey of 8,937 U.S. adults conducted May 5–11, 2025), <https://www.pewresearch.org/short-reads/2026/03/23/about-6-in-10-americans-dont-have-moral-objections-to-medical-aid-in-dying/>.

[262] Pew Research Center, “Chapter 1: Opinion About Laws on Doctor-Assisted Suicide,” in *Views on End-of-Life Medical Treatments* (Nov. 21, 2013), <https://www.pewresearch.org/religion/2013/11/21/chapter-1-opinion-about-laws-on-doctor-assisted-suicide/>.

Gallup 2024 also found moral acceptability at 66 percent in the West, 60 percent in the Midwest, 57 percent in the East, and 39 percent in the South, and at 67 percent among college graduates versus 41 percent among those with no college. Education overlaps with politics, religiosity, income, and region; the association is not a causal claim.

Physician Surveys

A national survey mailed to 1,000 randomly selected U.S. physicians found that 60 percent believed PAS should be legal and 69 percent that it should be decriminalized, but only 9 percent overall—and 13 percent of legalization supporters—said they would unequivocally participate if it were legal. Fifty-eight percent believed current safeguards were generally adequate; 60 percent disagreed that nonpsychiatrist physicians are adequately trained to screen for depression; 60 percent disagreed that physicians can predict with certainty a six-month prognosis.^[263] Only 188 of 1,000 completed the survey (about 22 percent). The results are informative, not a census of all U.S. physicians.

Polling Method Snapshot

Gallup 2024	Legality question using “assist the patient to commit suicide” for an incurable patient in severe pain: 66% allowed, 30% not allowed.
Gallup 2024	Different legality question using “end the patient’s life by some painless means” at the request of the patient and family: 71% allowed, 26% not allowed.
Pew 2025	8,937 U.S. adults, May 5–11, 2025; “patients choosing to end their lives with the help of a doctor”: 34% morally acceptable, 35% morally wrong, 29% not a moral issue.

Key Polling Takeaways

- Question wording and the conduct described can materially change the result; “suicide,” “medical aid in dying,” “painless means,” and “physician-assisted death” are not interchangeable survey language.
- Legality, morality, and personal willingness are different constructs and should not be treated as one measure of “support.”
- Most national polls test a narrow terminal-illness scenario and do not establish public support for psychiatric eligibility, dementia advance requests, minors, nonresidents, euthanasia, or removal of safeguards.
- Representative polling focused specifically on Americans with disabilities is limited; organizational disability-rights positions are not substitutes for population surveys.
- Polling on broader eligibility or expansion is comparatively sparse and often uses different vignettes or policy descriptions, so labels such as “support for expansion” require caution.
- Physician support for legalization does not necessarily indicate willingness to prescribe or confidence in existing safeguards; the national physician survey discussed here had a low response rate.

[263] Peter T. Hetzler III, James Nie, Amanda Zhou & Lydia S. Dugdale, “A Report of Physicians’ Beliefs about Physician-Assisted Suicide: A National Study,” 92 *Yale J. Biology & Medicine* 575 (2019), <https://pmc.ncbi.nlm.nih.gov/articles/PMC6913834/>.

PART D

Comparing Physician-Assisted Suicide Laws Around the World

Assisted-death systems differ in who may qualify, who performs the final act, how suffering is defined, and how cases are reviewed. The point of comparison is not to treat unlike systems as identical, but to identify which legal boundaries have remained stable and which have later been revisited.

Netherlands

The 2001 statute permits euthanasia and physician-assisted suicide under due-care criteria that include a voluntary request and unbearable suffering. Later practice has included advance-directive, dementia, and psychiatric cases.

Belgium

Belgium legalized euthanasia in 2002 and extended eligibility to certain minors in 2014. Psychiatric suffering has also been addressed within the system.

Switzerland and Central Europe

Switzerland relies on Article 115's criminal-law exception for assistance without selfish motives. Germany and Austria developed important pathways through constitutional litigation rather than a Dutch-style model.

Spain, Portugal, and Italy

Spain enacted a statutory aid-in-dying system in 2021. Portugal enacted legislation in 2023, but a 2025 Constitutional Court decision invalidated key provisions. Italy has no general statute; constitutional decisions created a limited nonpunishability pathway under specified conditions.

Canada

Canada legalized MAID nationally in 2016 and later created a track for some patients whose natural death is not reasonably foreseeable. The federal system includes both clinician administration and, legally, self-administration.

South America

Colombia and Ecuador developed assisted-death rights principally through constitutional courts; Peru has had more limited, case-specific authorization.

Australia and New Zealand

New Zealand legalized by statute following a national referendum. Australia proceeded state by state beginning with Victoria; the laws generally use eligibility, capacity, assessment, and procedural requirements that vary by jurisdiction.

Why the distinctions matter

Euthanasia, physician-assisted suicide, and broader MAID systems should not be merged into a single legal category. Comparative claims should identify the jurisdiction, legal mechanism, eligibility rule, and year being discussed.

Canada and the United States

Canada's national MAID system and the American state-by-state model developed through different legal mechanisms. Both provide post-enactment experience, but their eligibility, administration, and reporting rules must be compared precisely.

In the United States, later amendments have changed waiting periods, eligible prescribers, or residency rules in several jurisdictions.

Jurisdiction	Authorized	Effective / implemented	Mechanism and later changes
Oregon	1994	1997	Ballot; residency later removed; waiting period modified
Washington	2008	2009	Ballot; provider expansion; waiting period reduced
Montana	2009	2009	Court-created homicide defense; no comprehensive statute
Vermont	2013	2013	Statute; residency later removed
California	2015	2016	Statute; waiting period later shortened
Colorado	2016	2016	Ballot; provider expansion and shorter waiting period
D.C.	2016	2017	Statute
Hawaii	2018	2019	Statute; later procedural and provider changes
New Jersey	2019	2019	Statute
Maine	2019	2019	Statute
New Mexico	2021	2021	Statute
Delaware	2025	Jan. 1, 2026	Statute
Illinois	2025	Sept. 12, 2026	Statute
New York	Passed 2025; signed 2026	Aug. 5, 2026	Statute; amended before effective date

Recent effective dates: Delaware, January 1, 2026; New York, August 5, 2026; Illinois, September 12, 2026. Montana remains distinct because authorization rests on a judicial defense rather than a comprehensive statute.

What the Comparative Record Shows

Oregon's original model used residency, a 15-day waiting period, physician-only participation, a six-month prognosis, and self-administration. Since enactment, multiple jurisdictions have revisited residency, waiting periods, or who may prescribe: Oregon and Vermont removed residency requirements, California shortened its waiting period to 48 hours, and Washington and Colorado broadened prescribing authority while shortening waits. These changes do not show what Illinois will do; they show that enacted safeguards are not necessarily permanent.

Illinois is only beginning implementation, so other jurisdictions remain the principal source of utilization and post-enactment experience. Comparisons should always identify material differences in law, administration, and reporting.

PART E

Audience Quick Guides and Illinois Resources

The next seven pages provide a role-specific orientation for patients, families, clinicians, mental-health professionals, faith leaders, attorneys, and lawmakers. Each page stands on its own and points back to the chapters where the underlying law, care options, and safeguard analysis are developed.

Patients

A patient must understand the care available, the Act's eligibility and request rules, the limits of surrogate decision-making, the requirement of self-administration, and the right to change course at any time.

Families

Families cannot make the PAS request or perform the final act, but they may influence the environment in which the decision is made. Their roles include caregiving, planning, listening, watching for pressure, and helping make alternatives real.

Medical Practitioners

Physicians and other clinicians may face eligibility review, informed-consent duties, documentation, reporting, self-administration questions, institutional policies, and conscience conflicts over what participation means.

Mental-Health Professionals

Counselors, therapists, social workers, psychologists, and other clinicians may need to distinguish crisis from a statutory request, assess capacity when referred, and explore depression, demoralization, burden, fear, identity, and unmet support needs.

Faith Leaders

Pastors, priests, rabbis, imams, chaplains, and other spiritual leaders may be asked to address suffering, meaning, dependence, moral teaching, family strain, crisis, grief, and the practical work of accompanying people through serious illness.

Attorneys

Lawyers may encounter PAS through estate planning, healthcare decision-making, witness rules, family conflict, coercion or undue influence, institutional counseling, conscience litigation, confidentiality, insurance, death certification, and liability.

Illinois Lawmakers

Legislators will decide whether the safeguards enacted in 2025 remain, change, or expand. Comparative experience, pending bills, litigation, reporting, conscience rights, disability concerns, and access to alternatives all bear on those choices.

How to use these guides. Start with the page that matches your role, then follow its “Go deeper” line. The quick guides summarize; Chapters 2–4 contain the fuller legal, care, and safeguard analysis.

GUIDANCE BY ROLE

For Patients

A serious or terminal diagnosis can narrow attention to the disease and the decisions immediately ahead. This page is a reminder to keep the full picture in view: your medical care, your legal rights, your relationships, and the supports that may affect what choices feel possible.

Start with the care available to you

Palliative care can begin at any stage of serious illness and may be provided alongside treatment. Hospice focuses on comfort near the end of life and may include nursing, symptom management, equipment, social work, counseling, spiritual care, and family support. Ask what each service can provide in your situation.

Make your wishes known

Talk with the people you trust about what matters most, what you fear, which treatments you would or would not want, what quality of life means to you, and who should speak for you if you lose capacity. A healthcare power of attorney, living will, and POLST can help with other healthcare decisions, but none can make a PAS request for you.

Speak up about the suffering you are experiencing

Serious illness can involve more than physical symptoms. Tell someone about pain, fear of future suffering, depression, anxiety, loneliness, hopelessness, grief, loss of independence, financial or caregiving worries, or questions about meaning and faith. Different problems may have different medical, psychological, practical, social, or spiritual responses.

Know the Illinois PAS rules

- You must personally satisfy the Act's eligibility requirements and make the required requests.
- Two physicians must confirm eligibility.
- A mental-health evaluation is conditional, not automatic.
- No family member, guardian, agent, or advance directive may request PAS for you.
- If medication is used, the final affirmative act of self-administration must be yours.

You may change your mind

You may rescind a request. Receiving a prescription does not require you to fill it, and filling it does not require you to use it. Before an irreversible decision, make sure you understand your diagnosis, prognosis, treatment choices, comfort options, hospice and palliative care, mental-health resources, disability supports, caregiver help, and spiritual or community support.

If you are afraid of becoming a burden

Say so directly. Needing help can change relationships, finances, independence, and identity, but there may be ways to reduce the demands on you and those caring for you: home services, respite, disability assistance, social work, counseling, hospice, palliative care, community programs, and help from family, friends, or faith communities.

Go deeper: Chapter 2 explains the Illinois PAS process. Chapter 3 covers palliative care, hospice, advance planning, mental health, disability support, caregiver resources, and Illinois Quick Help.

GUIDANCE BY ROLE

For Families

When one person is seriously ill, the entire family is affected. Families can become the patient's strongest source of care, advocacy, and protection—but they can also become part of the pressure surrounding an end-of-life decision. The goal is support without substitution or coercion.

Know the care options

Palliative care can address pain, symptoms, stress, communication, and goals at any stage of serious illness. Hospice can provide comfort-focused medical and nursing care, equipment, social work, spiritual care, caregiver support, and bereavement services. A family should not wait until the final days to ask whether either is appropriate.

Talk before a crisis

Ask what matters most now, what your loved one is worried about, which treatments would or would not be acceptable, who should speak if capacity is lost, and what religious or spiritual beliefs the care team should understand. Make sure the appropriate people have current advance-care documents.

If your loved one says, “I want to die”

Listen before arguing. Ask what is underneath the statement: uncontrolled symptoms, fear of future suffering, loss of independence, depression or anxiety, loneliness, grief, financial worries, caregiver strain, spiritual distress, or feeling like a burden. Different forms of suffering call for different kinds of help.

Know what family members cannot do under the Act

- A family member cannot request aid-in-dying medication for the patient.
- A healthcare agent, guardian, surrogate, or advance directive cannot make the request on the patient's behalf.
- A family member may not perform the patient's required act of self-administration.
- The patient may change his or her mind even after medication is prescribed.

Support without pressure

Family exhaustion, inheritance interests, finances, conflict, dependence, or repeated comments about the burden of care can shape a decision even without an explicit threat. Make sure your loved one hears clearly that the family wants to know what the patient needs—not what would be easiest or least expensive for everyone else.

Take caregiver strain seriously

“You are not a burden” can ring hollow if everyone is overwhelmed. Ask for respite, home-care help, social work, transportation, financial assistance, hospice, counseling, disability services, faith-community support, or redistribution of caregiving responsibilities. Supporting the caregiver can also protect the patient's sense of freedom.

Go deeper: Chapter 3 is the main family-care chapter. Chapter 4 examines voluntariness, burden, family pressure, adaptation, and safeguard limitations.

GUIDANCE BY ROLE

For Medical Practitioners

The Illinois Act creates a clinical pathway for participating physicians and a separate set of legal and conscience questions for professionals who object. Medical practitioners should know not only the eligibility rules, but also the points at which documentation, reporting, institutional policy, and conscience rights become important.

Know the basic eligibility requirements

A patient must be an adult Illinois resident, have an incurable and irreversible terminal disease expected within reasonable medical judgment to result in death within six months, possess the required mental capacity, act voluntarily and free from coercion or undue influence, complete the required requests, and be capable of self-administration.

Attending and consulting physicians have distinct duties

Both physicians must independently address diagnosis, prognosis, capacity, voluntariness, and coercion or undue influence. The attending physician also provides the required informed-consent information, discusses feasible alternatives, and before prescribing verifies that the patient still has capacity, is acting voluntarily, and wishes to proceed.

Mental-health referral is conditional

Illinois does not require an evaluation for every patient. If either physician cannot confirm the required mental capacity, the process pauses for evaluation by a licensed mental-health professional. The evaluator also considers whether a psychiatric or psychological disorder is causing impaired judgment.

Know your conscience rights—and residual duties

Illinois law protects refusal of direct participation in important respects, but nonparticipation does not necessarily end every obligation. Depending on role and circumstances, notice, disclosure, referral, documentation, or medical-record duties may remain. Read the Act together with the Health Care Right of Conscience Act and current *Kirchoff* litigation.

Self-administration, documentation, and reporting matter

The patient must perform the final affirmative, conscious, voluntary act. A physician may prepare medication as permitted by the Act but may not substitute for the patient's final act. Attending physicians also face statutory documentation and IDPH reporting duties, including post-prescription and follow-up reporting when notified of a death after self-administration.

Understand the death-certificate rule

A death following lawful self-administration is attributed to the underlying terminal disease, is not designated suicide or homicide, and self-administration is not indicated on the death certificate. The death does not, merely because the medication was used, trigger a postmortem inquiry.

Think carefully about where participation begins

An objecting physician may view eligibility evaluation itself as participation; another may believe evaluation permits careful assessment of prognosis, capacity, coercion, and treatable suffering without agreeing to prescribe. Know your employer's policy, define your own line before a crisis, document objections, and distinguish ordinary patient care from disputed participation.

Go deeper: Chapter 2 contains the six-stage process, §70 conscience provisions, §95 misconduct rules, reporting requirements, and *Kirchoff*. Chapter 4 examines the limits of prognosis, mental-health screening, voluntariness, and verification.

GUIDANCE BY ROLE

For Mental-Health Professionals

Mental-health professionals occupy a distinctive position because PAS discussions can involve legal capacity and voluntariness while also expressing fear, grief, depression, demoralization, burden, loss of identity, or existential distress. Taking the request seriously means exploring the suffering underneath it, not assuming that the first statement tells the whole story.

First distinguish crisis from a statutory PAS discussion

A person discussing physician-assisted suicide may also be experiencing suicidal ideation or an acute mental-health crisis. Imminent self-harm, intent, or a plan calls for ordinary clinical safety assessment and response. A statutory PAS discussion does not eliminate the clinician's responsibility to recognize an emergency.

Listen beneath the request

Ask what the request is communicating. Listen for depression, demoralization, perceived burdensomeness, loss of identity or autonomy, anticipatory anxiety, isolation, shame, grief, loss of meaning, family pressure, financial pressure, or fear of what is coming. A request can be multifactorial rather than reducible to pain alone.

Depression and demoralization are not the same

Depression may involve hopelessness, anhedonia, worthlessness, impaired concentration, sleep disturbance, and suicidal thinking. Demoralization can involve helplessness, loss of purpose, perceived failure, and difficulty coping with circumstances experienced as inescapable. A patient can be in profound distress without meeting criteria for major depressive disorder.

Do not confuse capacity with psychological well-being

A patient may retain legal capacity while experiencing grief, fear, loneliness, demoralization, family pressure, or a profound loss of meaning. Conversely, depression does not automatically establish incapacity. The statutory capacity question and the broader therapeutic inquiry overlap, but they are not identical.

Be careful with predictions about the future

People can mispredict how they will experience disability, dependence, or loss of function. Rather than promising that a patient "will get used to it," explore the feared future: What seems intolerable? Has the patient met people living with similar limitations? Could adaptation, assistive technology, changed roles, relationships, or new sources of meaning alter the prediction?

Explore burden, dependence, and agency

If a patient says, "My family would be better off without me," investigate rather than merely reassure. Caregiver exhaustion may be real. The response may involve family counseling, respite, home care, social work, financial help, disability services, peer support, or community resources. Dependence can coexist with meaningful agency over relationships, care, unfinished work, and how remaining time is used.

Do not work alone

Mental-health treatment may be only one part of the response. Depending on what emerges, involve palliative care, hospice, psychiatry, social work, disability services, family counseling, peer support, spiritual care, and practical community resources. The clinical goal is not to "win" an argument but to understand what hurts, what is feared, what is unmet, and what might still change.

Go deeper: Chapter 3 covers depression, existential distress, adaptation, caregiver strain, crisis resources, and support. Chapter 4 explains Illinois's conditional referral rule and the broader safeguard questions.

GUIDANCE BY ROLE

For Faith Leaders

Faith leaders may be asked to respond to questions that are simultaneously medical, moral, emotional, relational, and spiritual. Their distinctive role is not merely to state doctrine, but to help people understand what they are experiencing and to make accompaniment, community, and care tangible.

Know your tradition—and the practical distinctions

Major Christian, Jewish, and Islamic traditions differ in theology but commonly distinguish intentionally causing death from accepting natural death, affirm pain relief, and recognize duties to accompany the sick. Faith leaders should also understand that hospice, palliative care, DNR/POLST, refusal of burdensome treatment, and PAS are not the same thing.

Do not glorify suffering

Respond to suffering concretely: treat pain, address depression, relieve the caregiver, visit the lonely, repair relationships, and connect families with hospice and palliative care. Faith can affirm that life retains meaning in weakness and dependence without pretending that pain or fear is good in itself.

When someone says, “I want to die,” listen before you preach

If the person is in immediate danger of suicide, treat it as a crisis. Otherwise ask, “What is making you feel this way?” Listen for pain, fear, depression, demoralization, dependence, isolation, loss of purpose, burden, shame, family strain, financial pressure, or spiritual desolation before assuming the request has only one meaning.

Do not assume today’s despair predicts tomorrow

A newly diagnosed person may be imagining a future never yet experienced. Without minimizing suffering, a faith leader can resist the leap from “I fear that life” to “that life will have no meaning.” Adaptation, relationships, changed expectations, care, and spiritual growth can alter how dependence or disability is experienced.

Make the congregation part of the answer

A life-affirming community makes its teaching credible through action: home visits, meals, rides, respite, errands, financial help, caregiver support, prayer or sacraments, help finding hospice, and continued accompaniment through death and grief. It is hard to tell someone “you are not a burden” while leaving the family to carry every burden alone.

Help people finish their lives

There may still be important work to do: love and receive love, forgive and ask forgiveness, reconcile, express gratitude, tell stories, bless children and grandchildren, pass on faith and wisdom, prepare loved ones for goodbye, and prepare spiritually for death. The end of life can remain a period of relationship, responsibility, and meaning.

Prepare before the crisis arrives

Know your tradition’s teaching, local hospice and palliative-care resources, whom to call for medical, legal, and mental-health questions, and how your congregation can support caregivers. Talk about aging, dependence, suffering, death, and hope before someone faces a terminal diagnosis.

Go deeper: Chapter 1 addresses the ethical debate. Chapter 3 covers spiritual care, hospice, caregiver support, grief, crisis resources, and practical Illinois resources.

GUIDANCE BY ROLE

For Attorneys

Illinois attorneys may encounter PAS through estate planning, healthcare decision-making, family disputes, institutional counseling, conscience questions, or litigation. The legal issues extend beyond eligibility to witness rules, surrogate limits, coercion, confidentiality, insurance, death certification, and liability.

Know the law at a glance

Eligibility turns on adult status, Illinois residency, an incurable and irreversible terminal disease expected to result in death within six months, mental capacity, voluntariness, required requests, two-physician review, and self-administration. The request is personal to the patient; ordinary surrogate authority does not extend to PAS.

Watch the written request and witnesses

The written request requires two witnesses who attest to apparent capacity, voluntariness, and freedom from coercion or undue influence. One witness must satisfy statutory independence requirements involving family relationship, estate interests, and the healthcare entity. The attending physician and any interpreter used by the patient may not serve as witnesses.

Healthcare powers of attorney have limits

A properly appointed healthcare agent may make many healthcare decisions, but cannot request PAS for an incapacitated principal. Nor can a client use an advance directive to authorize future PAS after losing capacity. Counsel should keep PAS authority separate from POA, living-will, POLST/DNR, and ordinary surrogate-decision issues.

Counsel families about coercion and undue influence

Pressure may be overt or subtle. Warning signs can include inheritance interests, financial strain, caregiver exhaustion, family conflict, isolation, fear of dependency, or statements that the patient is becoming a burden. Capacity, voluntariness, financial interests, and undue influence should be documented carefully when an interested person is deeply involved in decision-making.

Counsel healthcare clients about conscience rights

Healthcare professionals and entities may decline direct participation in important respects, but residual notice, referral, documentation, or medical-record obligations can remain. Analyze the End-of-Life Options Act together with the Health Care Right of Conscience Act, institutional policies, and the current federal conscience litigation before a patient request creates an immediate dispute.

Know the unusual death, insurance, and confidentiality rules

Deaths under the Act are attributed to the underlying terminal disease; self-administration is omitted from the death certificate and does not by itself trigger a postmortem inquiry. The Act also addresses life, health, accident, and annuity consequences and gives IDPH-collected information substantial confidentiality and FOIA protections while requiring aggregate reporting.

Liability and enforcement still matter

Section 70 provides significant good-faith protections, but the Act does not immunize intentional misconduct. Counsel should understand the provisions addressing forgery or alteration, concealed rescission, coercion or undue influence, reporting duties, professional discipline, and the limits of a system that does not provide routine independent review of every PAS death.

Tailor the advice to the client

For a patient, focus on capacity, voluntariness, financial and family pressures, and the limits of surrogate authority. For a family, explain that the decision legally belongs to the patient and document suspected pressure. For a professional or institution, identify the disputed conduct, preserve records, and analyze conscience protections, residual duties, employment policies, and institutional rules.

Go deeper: Chapter 2 is the principal legal chapter, including the process, reporting, §§70 and 95, death certification, and *Kirchoff*. Chapter 4 addresses evidentiary and verification limits.

GUIDANCE BY ROLE

For Illinois Lawmakers

Enactment did not end the policy debate. Illinois lawmakers will decide whether the boundaries adopted in 2025 remain, are strengthened, or are relaxed. The disciplined question is not whether another jurisdiction changed a rule, but what purpose the rule served, what evidence supports changing it, and what followed elsewhere.

Know the current Illinois baseline

The enacted law uses adult Illinois residency, an incurable and irreversible terminal disease, a six-month prognosis, mental capacity, multiple requests, attending and consulting physicians, conditional mental-health referral, patient self-administration, physician reporting, confidentiality rules, and specific conscience provisions. It does not authorize euthanasia.

Expect pressure to revisit safeguards

Other jurisdictions have later changed provisions originally enacted as safeguards. Oregon removed residency after litigation; California shortened its waiting period from 15 days to 48 hours; Washington and Colorado expanded prescribing authority and shortened waiting periods. Comparative law does not prove Illinois will do the same, but it identifies the questions likely to return.

Broader eligibility is a separate policy choice

Canada and the Netherlands are not direct analogues to Illinois, but they show how assisted-death systems can extend beyond the original American terminal-illness model. Canadian policy has moved beyond reasonably foreseeable death for one track, while Dutch law includes euthanasia and cases outside terminal illness. Those differences should be described precisely rather than collapsed into one category.

Know the pending Illinois proposals

- **SB 3795:** would require a mental-health evaluation for every request and add other safeguards.
- **HB 5764:** would remove specified referral duties and repeal death-certificate provisions.
- **SB 3937:** would require medical aid in dying to appear on the death certificate.

Know the current litigation

Kirchoff v. Treto challenges conscience-related duties, with temporary relief limited to covered plaintiffs. Other federal challenges include *Payne v. Pritzker*, raising disability and constitutional claims, and *Carmelite Sisters for the Aged and Infirm v. Prince*, raising additional conscience and religious-liberty claims. See Chapter 2 for current procedural posture.

Ask what happens to oversight when a safeguard changes

Before changing residency, waiting periods, prescribing authority, eligibility, mental-health review, self-administration, reporting, or death certification, ask what problem the original rule was meant to address, what evidence supports changing it, what happened elsewhere, and whether Illinois can still detect error, coercion, impaired judgment, or noncompliance.

Do not separate PAS policy from alternatives

Availability of hospice, palliative care, mental-health treatment, disability supports, caregiver assistance, and home-based services affects the real choice environment. A useful legislative question is whether Illinois is expanding access to assisted death faster than it is expanding access to the supports that may address suffering, isolation, dependence, or caregiver burden.

Go deeper: Chapter 2 explains Illinois law, pending bills, and litigation. Chapter 4 analyzes safeguard limitations. Parts B–D of this chapter provide utilization data, polling, and comparative-law sources.

ILLINOIS RESOURCES

Finding Help in Illinois

A directory of organizations, government agencies, professional associations, and additional research materials.

Hospice and End-of-Life Care

Illinois Hospice & Palliative Care Organization (IL-HPCO) is the primary statewide association for hospice and palliative care providers. It maintains educational resources, provider information, policy updates, and referrals, and is often the best starting point for families seeking services. Website: www.il-hpco.org

Illinois Department of Public Health – Hospice Licensing. IDPH maintains information on licensed hospice providers and regulates hospice programs in the State. Families seeking to verify licensure may consult IDPH. Website: www.dph.illinois.gov

Among the better-known nonprofit and community-based hospice providers are Northern Illinois Hospice (Rockford region), Hospice of Southern Illinois, JourneyCare (Chicago metropolitan area), Lightways Hospice and Serious Illness Care (Will, Grundy, Kendall, DuPage, and surrounding counties), and Advocate Hospice (Northern Illinois). Patients and families should compare services, coverage areas, bereavement programs, caregiver support, and spiritual care.

These providers are listed as illustrative examples, not as endorsements by Illinois Right to Life or as a complete statewide directory. Patients and families may use IL-HPCO or IDPH to identify additional providers.

Palliative Care

Many Illinois hospitals operate specialized palliative care programs, including Northwestern Medicine, University of Chicago Medicine, Rush University Medical Center, Loyola Medicine, Endeavor Health, OSF HealthCare, and Advocate Health. Patients experiencing serious illness should ask their treating physician whether a palliative care consultation is available.

Get Palliative Care is a national educational initiative with a searchable provider directory and resources on symptom management, quality of life, caregiver support, and advance care planning. Website: www.getpalliativecare.org

Disability Organizations

Equip for Equality is Illinois' federally designated Protection and Advocacy organization. It provides legal advocacy, disability-rights education, self-advocacy support, and assistance for people facing discrimination or barriers related to disability. Main office: 20 North Michigan Avenue, Suite 300, Chicago, Illinois 60602. Phone: (312) 341-0022. Toll free: (800) 537-2632. Website: equipforequality.org

Access Living is a Center for Independent Living and disability-rights organization in Chicago offering advocacy, independent-living support, peer mentoring, housing assistance, and community integration. Website: accessliving.org

The Arc of Illinois provides advocacy, family support, and resources for people with intellectual and developmental disabilities. Website: thearcofil.org

Illinois also maintains a statewide network of Centers for Independent Living that provide peer support, skills training, information and referral, advocacy, and community-integration assistance. These centers are often useful for people facing serious illness, disability, or long-term care needs.

Mental Health Resources

988 Suicide & Crisis Lifeline. Twenty-four-hour crisis intervention and emotional support for people experiencing distress, suicidal thoughts, or mental-health emergencies. Call or text 988. Website: 988lifeline.org

Illinois Department of Human Services – Behavioral Health Services maintains information on community mental-health services, crisis programs, substance-use treatment, and behavioral health providers. Website: www.dhs.state.il.us

Many counties operate or coordinate community mental-health services that may include counseling, psychiatric care, crisis intervention, medication management, substance-use treatment, family counseling, support groups, case management, and referrals. Local health departments are often a practical starting point. IDPH maintains a directory of local health departments serving every county: www.dph.illinois.gov/about/lhd.html

Examples include Cook County Department of Public Health (cookcountypublichealth.org), Lake County Health Department, main (847) 377-8000 and 24-hour crisis care (847) 377-8088 (lakecountyil.gov), and Will County Health Department (willcountyhealth.org).

Caregiver Support

The **Illinois Department on Aging** administers caregiver support programs, resource centers, respite care, and senior assistance. The Senior HelpLine is 1-800-252-8966. Illinois' thirteen Area Agencies on Aging provide funding, referrals, caregiver assistance, respite, education, and support. The Community Care Program is intended to help older adults remain at home and avoid unnecessary nursing-home placement through in-home assistance, care coordination, adult day programs, emergency response, and medication-management support.

Grief, Clergy, and Spiritual Care

Most Illinois hospice providers offer grief counseling, support groups, educational programs, and bereavement services, often for up to thirteen months after a death. Families should inquire even if hospice was not used. GriefShare is a nationwide grief-support ministry with church-based groups throughout Illinois (www.griefshare.org). Licensed counselors, psychologists, social workers, and clergy also offer grief-specific counseling.

Churches, synagogues, mosques, and other faith communities often provide pastoral counseling, prayer support, home visitation, caregiver help, meal ministries, grief support, and end-of-life accompaniment. Most Illinois hospitals maintain chaplaincy services available regardless of religious affiliation. Most hospice organizations include chaplains or spiritual-care professionals on the interdisciplinary team.

Quick contacts: Illinois Department on Aging Senior HelpLine, 1-800-252-8966; 988 Suicide & Crisis Lifeline; Equip for Equality, (800) 537-2632; IL-HPCO, www.il-hpco.org.

Need Help Finding Resources?

Illinois Right to Life recognizes that navigating serious illness, disability, caregiving, and end-of-life decisions can be overwhelming. If you are unsure where to begin, we may be able to help connect you with hospice and palliative-care providers, mental-health services, disability organizations, caregiver-support programs, grief counseling, faith communities, and legal or advance-care-planning resources. Illinois Right to Life does not provide medical or legal advice but may be able to help identify relevant resources. Contact Illinois Right to Life for additional information and referrals at illinoisrighttolife.org or (312) 422-9300.

PART F

Frequently Asked Questions

- 1. What is physician-assisted suicide?** A physician prescribes life-ending medication to a qualified patient, who then voluntarily self-administers it. Under Illinois law, the patient—not the physician or another person—must perform the final act.
- 2. Is it the same as euthanasia?** No. In physician-assisted suicide the patient self-administers the medication. In euthanasia another person directly administers it. Euthanasia remains illegal in U.S. jurisdictions.
- 3. Is it the same as refusing medical treatment?** No. Refusing treatment allows an underlying illness to take its course. Physician-assisted suicide involves intentionally obtaining and taking medication in order to cause death.
- 4. Is it the same as hospice?** No. Hospice provides comfort-focused care during serious terminal illness and is not intended to cause death.
- 5. Is it the same as palliative care?** No. Palliative care seeks to relieve suffering and improve quality of life and may be provided at any stage of serious illness, including alongside disease-directed treatment.
- 6. Who qualifies under Illinois law?** Generally, an adult Illinois resident with an incurable and irreversible terminal disease expected, within reasonable medical judgment, to result in death within six months, who has mental capacity, acts voluntarily, completes the required requests, and can self-administer.
- 7. Can a family member or healthcare agent request the medication?** No. The request must come from the patient. A healthcare agent, guardian, family member, or advance directive cannot make the request on another person's behalf.
- 8. Can an individual healthcare professional be required to participate?** Illinois law protects refusal of direct participation in important respects, but objectors may remain subject to notice, disclosure, record-transfer, referral, documentation, or related duties depending on their role. Some of those obligations are being challenged in *Kirchoff v. Treto*; the temporary order discussed in Chapter 2 protects the covered plaintiffs and is not a statewide final ruling.^[264]
- 9. Can a healthcare institution prohibit participation?** The Act permits healthcare entities to decline participation and to prohibit specified conduct on their premises, subject to statutory limits and notice requirements. Chapter 2 explains those provisions and the related conscience litigation.
- 10. Can the patient change his or her mind?** Yes. A patient may rescind a request at any time and is under no obligation to fill or use a prescription.

[264] *Kirchoff v. Treto*, No. 1:26-cv-09628 (N.D. Ill.). Stipulated temporary restraining order (Aug. 21, 2026), order PDF. Current procedural posture is summarized in Chapter 2.

11. Do most patients request it because of pain? Not necessarily. Oregon's 2025 physician-reported concerns more often included loss of autonomy, reduced ability to engage in enjoyable activities, and loss of dignity than inadequate pain control or concern about it.^[265]

12. Is a mental-health evaluation required for every Illinois request? No. Referral is required when the attending or consulting physician cannot confirm the required mental capacity. The evaluator must also address whether a psychiatric or psychological disorder is causing impaired judgment.

13. Can depression, anxiety, grief, or fear matter even if the patient has capacity? Yes. Those experiences can shape outlook and decision-making without automatically eliminating legal capacity. Capacity, diagnosis, and psychological well-being are related but distinct questions.

14. What if I am afraid of becoming a burden? Say so directly. Caregiver support, respite, hospice, palliative care, disability services, financial counseling, faith communities, and other resources may reduce pressures on both patients and caregivers.

15. What is the difference between hospice and palliative care? Palliative care can begin at any stage of serious illness and may accompany disease-directed treatment. Hospice generally serves people with a terminal prognosis who elect hospice's comfort-focused model of care.

16. What is a healthcare power of attorney? It is a legal document appointing an agent to make healthcare decisions as authorized by the document. It does not authorize the agent to make a physician-assisted-suicide request for an incapacitated principal.

17. What is a DNR order? A DNR is a medical order addressing resuscitation if breathing or heartbeat stops. It does not authorize physician-assisted suicide or euthanasia.

18. Where can patients and families find help? Chapter 3 and Part E identify physicians, palliative-care teams, hospices, mental-health professionals, disability organizations, caregiver programs, clergy, grief support, local health departments, and Illinois agencies.

19. Why do some disability-rights organizations oppose physician-assisted suicide? Some argue that disability bias, inadequate services, financial pressure, or assumptions about quality of life can distort choice. Other disabled advocates support assisted dying as an expression of autonomy. Disability communities do not speak with one voice.^[266]

20. What should I do if my family is facing a serious illness now? Gather information, ask about prognosis and treatment, request palliative-care or hospice consultation when appropriate, review advance-planning documents, identify trusted decision-makers, and seek emotional, spiritual, disability, caregiver, or practical support.

[265] Oregon Health Authority, *Oregon Death with Dignity Act: 2025 Data Summary* 15–16, tbl. 1 (rev. June 17, 2026), [oregon.gov / DWDA 2025](https://oregon.gov/DWDA/2025).

[266] National Council on Disability, *The Danger of Assisted Suicide Laws* (2019), <https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws>; Disability Rights Education & Defense Fund, *Physician-Assisted Suicide*, <https://dredf.org/issues/assisted-suicide>.

PART G

Research Guide and Bibliography

This section identifies selected primary sources, professional statements, scholarly works, books, films, and websites. The list is selective. Priority is given to official reports, primary legal materials, major professional organizations, peer-reviewed scholarship, and works that represent differing perspectives.

Government and Annual Reports

National Council on Disability, [The Danger of Assisted Suicide Laws](#) (2019); the *Bioethics and Disability Report Series* (2019); and *Medical Futility and Disability Bias* (2019).

Health Canada, [Sixth Annual Report on Medical Assistance in Dying in Canada](#) (2024 data, published 2025), plus earlier annual reports from 2019 onward, Department of Justice materials on Bill C-7, and selected provincial reports.

International official reports include the Netherlands Regional Euthanasia Review Committees' 2025 annual report, Belgium's Federal Commission for the Control and Evaluation of Euthanasia 2025 figures, and Spain's Ministry of Health 2024 annual report on aid in dying. Because definitions and reporting periods differ, comparative totals should always identify both the jurisdiction and data year.

State annual reports: [Oregon Health Authority, Death with Dignity Act](#) (longest U.S. series); [Washington State Department of Health](#) (routine annual statistical reporting paused after the 2024 report because of budget reductions); [California End of Life Option Act](#) reports, 2016–2024; Hawaii Our Care, Our Choice Act reports (2025 report submitted May 2026). Readers researching another jurisdiction should use that state's health department.

Disability-rights materials: [NCD](#); [Disability Rights Education and Defense Fund](#); [Not Dead Yet](#); [National Council on Independent Living](#); United Spinal Association; and ADAPT. Organizational statements are the positions of those organizations and are not population surveys of all people with disabilities.

American Medical Association, Code of Medical Ethics [Opinion 5.7](#) (physician-assisted suicide), together with Opinion 5.3 (withholding or withdrawing life-sustaining treatment), Opinion 5.6 (sedation to unconsciousness in end-of-life care), and Opinion 5.8 (euthanasia). American College of Physicians, [“Ethics and the Legalization of Physician-Assisted Suicide”](#) (2017). [World Medical Association Declaration on Euthanasia and Physician-Assisted Suicide](#).^[267]

[267] American Medical Association, Code of Medical Ethics Opinion 5.7, <https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide>; American College of Physicians, “Ethics and the Legalization of Physician-Assisted Suicide,” <https://www.acpjournals.org/doi/10.7326/m16-2121>; World Medical Association, Declaration on Euthanasia and Physician-Assisted Suicide, <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/>.

Professional, Disability, and Religious Statements

Religious statements include the Dicastery for the Doctrine of the Faith, [Samaritanus Bonus](#) (2020); United States Conference of Catholic Bishops, [To Live Each Day with Dignity](#) and related collections; and the 1991 NCCB Statement on Euthanasia. Positions vary among and within traditions and should be attributed to the issuing institution.

Legal, Medical, and Ethics Literature

Comparative safeguard analysis includes Michaela E. Okninski, *Dalhousie Law Journal* (2018). Readers should also consult scholarship on [Washington v. Glucksberg](#), [Vacco v. Quill](#), and [Gonzales v. Oregon](#), plus comparative work on Canada, the Netherlands, Belgium, Switzerland, Australia, and New Zealand, and Illinois-specific writing on Public Act 104-0441.

Medical sources include NEJM Clinical Decisions on physician-assisted suicide (2013); Nuland (2000); Brody (1992); Goodwin on Oregon (1997); and Hetzler, Nie, Zhou, and Dugdale's national physician survey (2019). Ethics sources include the [AMA Code](#), Chapter 5; [ACP ethics materials](#); Battin, *Ending Life*; Young, *Medically Assisted Death*; and Kaczor, *Disputes in Bioethics*.

Books, Films, and Websites

Opposing legalization: Foley and Hendin, eds., *The Case Against Assisted Suicide*; Gorsuch, *The Future of Assisted Suicide and Euthanasia*; Kaczor, *Disputes in Bioethics*. Supporting or defending: Quill and Battin, eds., *Physician-Assisted Dying*; Young, *Medically Assisted Death*; Battin, *Ending Life*. Clinical narrative: Quill, *A Midwife Through the Dying Process*; Dworkin, Frey, and Bok, *Euthanasia and Physician-Assisted Suicide: For and Against*.

Documentary films include FRONTLINE's [The Suicide Tourist](#) (2010) and *The Suicide Plan* (2012); *Extremis* (2016), which concerns ICU decision-making rather than physician-assisted suicide; and [How to Die in Oregon](#) (2011). Films are journalistic or narrative works, not substitutes for empirical research.

Advocacy and reference sites include [Compassion & Choices](#), [Death with Dignity](#), and [Patients Rights Action Fund](#). Distinguish government sources, peer-reviewed research, professional guidance, and advocacy.

Illinois Sources and Reading Paths

Illinois primary materials: [Public Act 104-0441](#); [IDPH advance directives and POLST guidance](#) for individuals and professionals; Illinois Department on Aging; Illinois Legal Aid Online. The resource directory in Part E lists hospice, palliative-care, disability, mental-health, and independent-living organizations.

Suggested starting points: patients and families, the Part E quick guides plus Chapter 3; clinicians, the Medical Practitioner Quick Guide, the Illinois Act, AMA Opinions 5.3 and 5.6–5.8, ACP, and official annual reports; clergy, the Faith Leader Quick Guide plus Chapter 3 and relevant denominational materials; attorneys, the Attorney Quick Guide, Public Act 104-0441, *Glucksberg*, *Quill*, *Gonzales*, and current Illinois litigation; policymakers, the Lawmaker Quick Guide plus Chapters 2 and 4; researchers, official methodology, statutes, polling questionnaires, and clearly labeled advocacy sources.

Chapter 5's Key Takeaways

1 Illinois law should be checked against current primary sources. Statutes, court decisions, IDPH guidance, official forms, and administrative materials may change as the End-of-Life Options Act is implemented.

2 Assisted-death statistics cannot be compared without context. Jurisdictions use different legal models, reporting periods, definitions, and measures such as prescriptions, ingestion, practitioner administration, and deaths following ingestion.

3 Oregon provides the longest continuous American reporting history, but even its data require careful interpretation. A prescription does not establish ingestion, reported concerns are nonexclusive, and some information remains unknown or unavailable.

4 Canada should not be treated as simply a larger version of the American model. Canadian MAID overwhelmingly involves practitioner-administered death, while Illinois and other American statutes require the patient to perform the final act of self-administration.

5 Public opinion depends heavily on wording and methodology. Questions using “suicide,” “aid in dying,” “painless means,” legality, morality, or different patient scenarios can produce substantially different results.

6 Assisted-dying laws are not uniform or static. Jurisdictions differ on eligibility, residency, waiting periods, prescribing authority, self-administration, reporting, and oversight, and several states have changed those rules after enactment.

7 The audience quick guides translate the larger Guide into practical starting points for patients, families, medical practitioners, mental-health professionals, faith leaders, attorneys, and Illinois lawmakers.

8 Illinois patients and families have resources beyond the assisted-suicide statute itself, including hospice, palliative care, disability services, mental-health and crisis care, caregiver assistance, advance-care planning, legal resources, and faith or community support.

9 Questions about conscience rights require particular care. Illinois protects refusal of direct participation in important respects while also imposing some notice, disclosure, transfer, referral, documentation, and related duties that are now the subject of federal litigation.

10 No single report, poll, advocacy document, or jurisdiction answers every question. The strongest research begins with primary law and official data, then uses professional guidance, peer-reviewed research, and competing advocacy perspectives to understand what the evidence does—and does not—show.

USING THIS REFERENCE CHAPTER

Use these materials to verify claims made elsewhere in the Guide, find audience-specific guidance and Illinois resources, and return to primary sources as the law, litigation, administrative guidance, and utilization data develop.



Physician-Assisted Suicide in Illinois

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