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Illinois Medical Aid-in-Dying Law Takes Effect Amid Legal Challenges

Healthcare Alert | 10 min read

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Illinois' End-of-Life Options for Terminally Ill Patients Act, 410 ILCS 22 (P.A. 104-0441, also known as "Deb's Law"), took effect on September 12, 2026, making Illinois the first Midwestern state to authorize medical aid in dying. Below, we look at the law's legal requirements and legal challenges, and consider how healthcare organizations should evaluate whether and how they will participate, update applicable policies and protocols, and monitor the pending lawsuits for further developments.

Key Takeaways

- The Act permits Illinois-licensed physicians to prescribe medication that a qualified, terminally ill adult Illinois resident may self-administer to end his or her life, subject to detailed procedural safeguards and reporting obligations.
- A federal court declined to preliminarily enjoin the Act in a disability-rights challenge (Payne v. Pritzker), finding the plaintiffs lacked standing to obtain that relief.
- In two separate religious-liberty and free-speech challenges, stipulated temporary restraining orders now bar the State from enforcing the Act (and related Health Care Right of Conscience Act provisions) against the plaintiffs and, in one case, against members of several plaintiff associations, including the Illinois Catholic Health Association.
- Health care providers, particularly hospitals, hospices, long-term care facilities, and faith-based systems, should review their policies, staff training, and documentation practices now.

Overview of the Act

Governor JB Pritzker signed the Act in December 2025 after a two-year legislative effort. Like most other states' medical aid-in-dying statutes, the Act is modeled on Oregon's 1997 Death with Dignity Act. Its principal provisions

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are summarized below.

Eligibility

A "qualified patient" must be an adult Illinois resident with a terminal illness expected to result in death within six months, who has the mental capacity to make medical decisions and is able to self-administer (ingest) the medication. Both an attending physician and a consulting physician must confirm the patient's terminal illness, prognosis, and mental capacity.

A person does not qualify solely because of advanced age, disability, or a mental health condition, including depression. Illinois residency may be established by any of several means, such as an Illinois driver's license or state ID, Illinois voter registration, property ownership or a lease in Illinois, or an Illinois residence address on a prior-year tax return.

Patient-Initiated Requests

Only the patient may request aid-in-dying medication. A surrogate, health care agent, attorney-in-fact, guardian, or advance directive cannot make the request. The patient may also rescind the request at any time, and the physician must offer the opportunity to rescind at the time of the second oral request.

Patient-Initiated Request Requirements

- The patient must make an oral request, submit a written request on the Illinois Department of Public Health (IDPH) form, and repeat the oral request no fewer than five days after the first one. The waiting period does not apply if the patient is expected to die within five days.
- The written request must be signed by two witnesses attesting that the patient has capacity, is acting voluntarily, and is not being coerced. At least one witness must be independent: not a relative, not a person entitled to part of the patient's estate, and not an owner, operator, or employee of the health care entity treating or housing the patient. The attending physician and any interpreter may not serve as witnesses.
- Patients who cannot make an oral request because of a disability may use reasonable accommodations and auxiliary aids under Title III of the Americans with Disabilities Act.

Physician Obligations

- **The attending physician must be licensed to practice medicine** in all its branches in Illinois and have primary responsibility for treating the patient's terminal disease.
- **The physician must ensure the request is not the product of coercion and must inform the patient of all feasible end-of-life options**, including additional treatment, comfort care, hospice care, palliative care, and

pain control, along with their risks and benefits.

- **If the attending or consulting physician doubts the patient's capacity or suspects a mental health condition impairing judgment, the patient must be referred to a licensed mental health professional.** If that professional finds incapacity or impaired judgment, the medication may not be prescribed.
- **The physician must counsel the patient** on self-administration, safekeeping, and disposal of unused medication, the importance of having another person present, and not taking the medication in a public place. The medication must be ingested; it may not be given by injection or infusion.
- **The physician must submit an Attending Physician Checklist Form** to IDPH within 30 days of prescribing and a Follow-Up Form within 60 days after learning of the patient's death following ingestion. Willful failure to submit required records may result in discipline.
- **The death certificate must list the underlying terminal illness** as the cause of death and may not designate the death as a suicide or homicide.

Participation and Conscience

Participation is **voluntary.** The Act provides that only willing health care professionals will provide aid-in-dying care, and it sets out physicians' rights to decline without discipline. Health care institutions may prohibit the practice by clinicians acting on the institution's behalf.

However, a physician who is unable or unwilling to carry out a request must transfer the patient's medical record without delay if the patient transfers care. Objecting providers also remain subject to informational and referral obligations, which are now the main subject of the religious-liberty litigation described below.

Litigation Challenging the Act

1. Disability Rights Challenge: Payne v. Pritzker, No. 1:26-cv-06886 (N.D. Ill.)

Filed on June 11, 2026, this suit was brought by two individuals with life-threatening disabilities (quadriplegia and cerebral palsy), six disability-rights advocacy organizations, and a physician. The plaintiffs allege the Act discriminates against people with disabilities, will lead physicians to steer disabled patients toward aid in dying, and lacks adequate state oversight to prevent abuse or coercion.

On September 2, 2026, Judge John J. Tharp, Jr. denied a motion to intervene filed by supporters of the law, including Compassion & Choices Action Network.

On September 10, 2026, Judge Tharp denied the plaintiffs' motion for a preliminary injunction in a 25-page opinion. He held that the plaintiffs lacked standing to seek that relief because they had not shown a "concrete

and imminent future injury" traceable to the defendants.

The court reasoned that only the patient may initiate a request, no physician is required to participate, and the Act gives physicians broad discretion. The lead plaintiff's claimed injuries, the court said, rested on "speculation that physicians in Illinois will decide, en masse, to abandon their existing duties to their patients."

The court also dismissed Governor Pritzker as a defendant, dismissed IDPH except as to the statutory claims, and ordered the plaintiffs to show cause within 30 days why the entire action should not be dismissed for lack of standing. Plaintiffs filed their response to the Order to Show Cause on October 13, 2026.

Readers should check the docket for the court's ruling on that issue. A parallel disability-rights challenge to New York's similar law was dismissed in July 2026.

2. Religious Providers' Challenge: Kirchoff v. Treto, No. 1:26-cv-09628 (N.D. Ill.)

The Thomas More Society filed this suit on August 11, 2026, against the Secretary of the Illinois Department of Financial and Professional Regulation (IDFPR) and the Director of IDPH. The original plaintiffs were four Illinois physicians, Bishop Thomas J. Paprocki of the Diocese of Springfield, and Lutheran Care Center.

They allege that the Act, together with the 2016 amendments to the Health Care Right of Conscience Act (745 ILCS 70/6.1), unconstitutionally compels religiously and morally opposed providers to inform patients about, refer for, or otherwise facilitate medical aid in dying, in violation of their free-speech and free-exercise rights.

On August 21, 2026, Judge Franklin U. Valderrama entered a stipulated TRO barring the State from enforcing the Act, and Section 6.1 (1) through (3) of the Health Care Right of Conscience Act as it relates to the Act, against the named plaintiffs and Catholic health care entities in the Diocese of Springfield under Bishop Paprocki's authority. The State also agreed not to treat their noncompliance as a basis for liability, discipline, or licensure action.

On October 5, 2026, the court vacated that order and entered a Stipulated Amended TRO. The plaintiffs now also include the Illinois Catholic Health Association, the Christian Medical and Dental Associations, the National Association of Catholic Nurses, and the Catholic Psychotherapy Association, along with additional individual providers. The amended order extends protection to:

A. The plaintiffs and those providing care on their premises
B. Catholic health care entities in the Diocese of Springfield
C. Any health care professional or entity that is a member of a plaintiff association.

To rely on the order, a member must provide IDPH or IDFPR with written confirmation that it was a member at the time of the alleged act or omission, after receiving written notice of a restrained enforcement action. The State may not later impose liability for covered conduct that occurred between September 12, 2026, and the order's expiration.

The TRO remains in effect until the Seventh Circuit issues its mandate in *NIFLA v. Treto and Schroeder v. Treto* (Nos. 25-1603, 25-1655, 25-1657, and 25-1659), a pending appeal concerning the Health Care Right of Conscience Act's referral and information requirements in the abortion context, and until the district court rules on the plaintiffs' anticipated motion for a preliminary injunction. The parties must notify the court within seven days after the mandate issues and propose a briefing schedule.

3. Archdiocese of Chicago Challenge: Carmelite Sisters for the Aged and Infirm v. Prince (N.D. Ill.)

On September 3, 2026, the Becket Fund for Religious Liberty sued on behalf of Cardinal Blase J. Cupich, the Carmelite Sisters for the Aged and Infirm, the Chicago Province of the Little Sisters of the Poor, and a pharmacist from Morrison, Illinois. The plaintiffs raise similar free-speech and religious-liberty claims, objecting to provisions that would require them to inform patients about aid in dying, make referrals, or face penalties for counseling against it.

On September 11, 2026, the court entered a stipulated TRO exempting the named plaintiffs from the Act's requirements, and from penalties for refusing to comply, while the case proceeds. The order applies only to the named plaintiffs. Counsel has indicated that this case and Kirchoff are likely to be consolidated.

Practical Considerations for Healthcare Providers

Determine Whether Your Organization Will Participate

- Institutions that will not participate should adopt and communicate a written policy, recognizing that the TROs cover only the specific plaintiffs, entities, and association members identified in the orders.

Confirm Coverage

- Entities and clinicians relying on the Kirchoff order should document their association membership as of the relevant dates and be ready to provide written confirmation to IDPH or IDFPR promptly.

Update Protocols for Participating Providers

Organizations that will offer aid-in-dying care should adopt written protocols that track each step the Act requires, including:

- **Request documentation:** using IDPH's written request form, the related witness attestations and, where needed, IDPH's interpreter attachment.

- **Waiting period:** confirming that the second oral request comes at least five days after the first, unless the patient is expected to die within five days.
- **Referrals:** referring every patient to a consulting physician. Patients must also be referred to a licensed mental health professional when either physician doubts the patient's capacity or suspects impaired judgment.
- **Prescribing and dispensing:** delivering the prescription to a licensed pharmacist, or dispensing directly if the physician is authorized by the DEA, and counseling the patient on safekeeping and disposal of unused medication.
- **Death certificates:** listing the underlying terminal illness as the cause of death, and not designating the death as a suicide or homicide.
- **IDPH reporting:** filing the Attending Physician Checklist Form within 30 days of prescribing, and the Follow-Up Form within 60 days after learning that the patient died after taking the medication.

Ensure Timely Record Transfers and ADA Accommodations

- Ensure that records are transferred without delay when patients move their care, and that ADA accommodations are available for patients who cannot make oral requests.

Monitor Ongoing Litigation

- Track the Seventh Circuit's decision in NIFLA/Schroeder, the show-cause proceedings in Payne, and any consolidation or preliminary injunction briefing in the religious-liberty cases. Each could change the scope of providers' informational and referral obligations.

Address Participation in Health Care Transactions

- In health care transactions, consider diligence on target policies and compliance with the Act, and address participation and conscience issues in affiliation, management, and joint venture agreements involving faith-based systems.

This alert reflects publicly available information as of October 23, 2026, and is provided for general informational purposes only. It is not legal advice. For questions about how the Act or the pending litigation may affect your organization, please contact your Hinshaw attorney.

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