



Dear neighbors and community,

We are already deep into budget season. I will be sending out a separate newsletter soon with a lay of the land on the budget process, highlights from the Governor’s Executive Budget proposal, links to budget hearings and recordings, and other budget-related updates. After that, I’ll return to a more regular schedule of legislative newsletters, so more to come.

I have dedicated this newsletter exclusively to the recently passed Medical Aid in Dying Act. This is a deeply emotional and complex issue, and I have heard from hundreds of constituents whose views span a wide range, from strongly supportive to strongly opposed. I respect all of these perspectives. My goal here is to make sure that, as we move forward, everyone has a clear understanding of what this law does and does not do, who is eligible and who is not, and the guardrails that were put in place. I hope you find this information helpful and valuable.



Medical Aid in Dying in New York: What the New Law Does and Does Not Do

HISTORICAL CONTEXT & NATIONAL LANDSCAPE

Earlier this month, New York enacted a Medical Aid in Dying law, joining a number of other states that have adopted similar end-of-life options over the past several decades. The modern history of medical aid in dying in the United States began more than thirty years

ago, when Oregon became the first state to approve a Death with Dignity law through a voter initiative in 1994. That law took effect in 1997.

Prior to New York's enactment, 11 states and the District of Columbia had passed Death with Dignity laws, including Oregon (1994), Washington (2008), Vermont (2013), California (2015), Colorado (2016), Hawaii (2018), Maine (2019), New Jersey (2019), New Mexico (2021), Delaware (2025), and Illinois (2025), as well as Washington, D.C. (2016). In addition, in 2009 the Montana Supreme Court issued a decision allowing medical aid in dying under certain circumstances. Because Montana has not adopted a follow-up statute, the state does not have a detailed statewide process defining eligibility or safeguards, and physicians rely on the court's guidance and their professional judgment rather than a comprehensive statutory framework.

While these laws share a common goal, allowing a narrow end-of-life option for some terminally ill adults, they are not identical. Each state has made different choices about who qualifies, what steps are required, and how to balance access with oversight.

WHAT THE NEW YORK STATE LAW ALLOWS: A SUMMARY

New York's law allows an eligible, terminally ill adult to receive a prescription for medication that the person may choose to self-administer. The medication must be taken by the patient themselves. No physician, nurse, or other person is permitted to administer the medication to the patient.

Medical aid in dying is an option, not an obligation. No patient is required to pursue it, and no health care provider or facility is required to participate.

WHO MAY BE ELIGIBLE

Under New York's law, eligibility is not based on who someone is, such as their age, disability status, or the fact that they live with a chronic or serious illness. Eligibility is based on a specific set of medical and decisional criteria, and all must be present at the same time.

To qualify, a person must be at least 18 years old and a resident of New York State. The person must have a terminal illness or condition that is incurable and irreversible and that, in the reasonable medical judgment of the physicians involved, is expected to lead to death within six months, whether or not treatment is provided.

The individual must also have decision-making capacity and be able to understand their medical condition, the available options, and the consequences of their decision. The request must be voluntary and informed. The patient must be told about their diagnosis, prognosis, and the nature of the medication. The statute also requires the physician to

discuss feasible alternatives, including comfort-focused care, hospice, and pain management, to ensure that the decision is made with full understanding.

A request for medication must come directly from the patient. It cannot be made by a health care proxy, family member, guardian, or through an advance directive.

THE REQUIRED PROCESS & BUILT-IN SAFEGUARDS

The law establishes a multi-step process designed to ensure that decisions are voluntary, informed, and free from pressure. **A patient must make both an oral request and a written request to their attending physician. Oral requests must be audio- or video-recorded** and preserved in the patient's medical record, with alternative communication methods available when a patient cannot speak in the usual way.

A written request must be signed by the patient and witnessed by two adults who meet conflict-of-interest and independence requirements. These requirements are intended to create a clear buffer against pressure, coercion, or even the appearance of undue influence at a moment when a person may be physically vulnerable.

To serve as a witness, an individual must not stand to benefit financially from the patient's death and must not be in a position of control over the patient's medical or legal decisions. For example, a witness cannot be someone who would inherit from the patient, a health care proxy or agent, or someone legally responsible for the patient's care or finances. The law also limits the ability of clinicians directly involved in the patient's treatment to serve as witnesses, to avoid blurring professional roles.

The attending physician must evaluate the patient, review relevant medical records, and confirm that all eligibility criteria are met. The law generally requires this evaluation to be conducted in person. Telehealth may be used only in limited circumstances, when an in-person visit would cause extraordinary hardship, such as significant pain, suffering, or difficulty with transport. **A second, consulting physician must independently confirm the diagnosis, prognosis, decision-making capacity, and voluntariness.**

In addition, **every patient seeking medical aid in dying must receive an evaluation by a licensed psychiatrist or licensed psychologist to assess decision-making capacity.**

This mental health evaluation is required for all patients, not only when concerns are raised.

At every stage of the process, the patient has the right to change their mind. A patient may rescind the request at any time and for any reason. Even after a prescription is written, the law requires a waiting period of 5 days before it may be filled, adding additional time for reflection.

If the patient ultimately chooses to proceed, **the medication must be self-administered by the patient.** No one else may administer it on their behalf.

WHAT THE LAW DOES NOT ALLOW

The law does not permit anyone other than the patient to administer the medication. It does not apply to minors. It does not apply to people who are not terminally ill, to people whose sole diagnosis is a mental illness, or to people seeking aid in dying based on disability or age alone. It does not allow requests through advance directives or by surrogate decision-makers. It does not apply to non-residents of New York.

The law also does not require any physician, nurse, hospital, hospice, or health care facility to participate. Participation is voluntary, and the law includes protections for providers and institutions that choose not to take part for ethical, religious, or professional reasons.

RESPONSIBILITIES & PROTECTIONS FOR CLINICIANS & FACILITIES

For clinicians who choose to participate, New York's law places clear responsibilities on how care must be provided over time. Participation does not involve a single judgment call or one-time decision. A clinician cannot simply meet a patient, determine they qualify, and write a prescription. Instead, the law requires clinicians to engage in an ongoing, documented process that includes revisiting the patient's situation, confirming eligibility at multiple points, involving independent professionals as required, and ensuring that every safeguard is met before proceeding.

Clinicians must stop the process if any required condition is not satisfied, and patients may stop it at any time by changing their mind. This structure is designed to ensure that medical aid in dying occurs only after careful review and continued confirmation that the patient's request remains informed and voluntary.

The law also makes clear that medical aid in dying exists within a broader continuum of end-of-life care. Palliative care and hospice services (including bereavement services) may continue alongside this decision, and many patients who consider or pursue medical aid in dying are already receiving comfort-focused care that supports both the patient and their family.

Participation by clinicians and facilities is voluntary. The law includes protections for physicians, nurses, hospices, hospitals, and other providers that choose not to participate. Clinicians who do participate must follow the law's requirements carefully, and failure to do so can result in professional consequences under existing licensing standards.

WHEN THE LAW TAKES EFFECT

The Medical Aid in Dying Act was signed into law on February 6, 2026, and will take effect in early August 2026. This implementation period allows time for the state to issue guidance, finalize required forms, and give health care systems and providers time to prepare to comply with the law's detailed requirements.

HOW NEW YORK'S LAW COMPARES TO OTHER STATES

New York's final law is among the most safeguard-heavy in the country and, in several respects, has more restrictive eligibility than earlier state models. Many of the provisions that contribute to these more restrictive criteria were added after the Legislature passed the original Medical Aid in Dying bill during the 2025 legislative session. Following that vote, the Governor and legislative leaders negotiated a series of chapter amendments that narrowed eligibility and added additional procedural requirements before the law was enacted.

As a result, the final law limits eligibility to New York residents, requires a mental health evaluation for every patient, mandates recording of oral requests, and generally requires an in-person evaluation by the attending physician. It also adds a mandatory waiting period after a prescription is written, tightens conflict-of-interest rules for witnesses and interpreters, clarifies opt-out protections for certain facilities, and explicitly ties violations of the law's requirements to professional misconduct under existing licensing standards.

Taken together, these changes make New York's final law more prescriptive and layered than the version originally passed by the Legislature. Supporters of these amendments view them as strengthening safeguards and public confidence, while critics have raised concerns that they add unnecessary complexity and potential barriers for seriously ill patients.

A FINAL NOTE

As the effective date approaches, additional guidance and patient-facing materials will be made available by the state and by health care providers.

This law addresses a narrow but deeply human circumstance: how to respond when a terminally ill person, facing the end of life, seeks comfort, dignity, and control. Being with someone during the final chapter of life, whether as a patient, a caregiver, or a loved one, can be one of the most profound and emotional experiences we have. People can and do disagree about this policy, and I respect those differences. My hope is that we continue to meet one another with empathy and humility in these conversations, remembering that

dignity, care, and human connection matter throughout life, including during our final transition.

In good health,



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