**DEATH WITH DIGNITY**

# Testimony of Death with Dignity

**Bill: Lila Manfield Sapinsley Compassionate Care Act (H7760)**
**Organization: Death with Dignity National Center**
**Name: Geoff Sugerman, Legislative Director**
**Position: SUPPORT**

Chair Hagan McEntee and Members of the House Judiciary Committee,

This testimony is submitted on behalf of the Death with Dignity in support of H7760, the Lila Manfield Sapinsley Compassionate Care Act.

The bill you are considering today is, at its core, a medical standard of care designed to provide physicians and pharmacists with best practice guidelines for situations in which a terminally ill and competent patient with a prognosis of six months or less to live requests the right to control the timing and manner of their death. H7760 is modeled on legislation that has been enacted in 13 states, including Oregon, Vermont, Maine, New York, Delaware, Illinois, and New Jersey. Medical aid in dying (MAID) is also legal in Washington, D.C.

Beyond providing physicians with proven best practice guidelines, H7760 puts decision-making in the hands of the terminally ill patient, allowing them to engage family members, physicians, clergy members, and anyone else they choose, if they so choose. It sets aside government bans on a medical practice that is currently legal for over 100 million Americans—a practice that is validated, researched, effective, and full of safeguards to protect patients suffering at the end of their lives.

The multiple safeguards in H7760 include:

- A diagnosis of a terminal illness with a prognosis of six months or less to live, verified by a second physician. Six months is the same standard used for hospice care.
- A mandatory counseling referral if either the attending or consulting physician believes the patient does not have capacity to make their own health care decisions.
- The patient must self-administer the medication.

- The adult individual must be a resident of Rhode Island.
- Oral and written requests are required. The written request must be witnessed by at least two people, one of whom must be someone who is not a relative or an heir set to receive an inheritance from the individual. The physicians involved cannot be witnesses.
- The two required oral requests must be at least 15 days apart.
- Information must be provided to the patient on all forms of palliative care, hospice care, and other end-of-life options.
- The patient may opt out at any time and for any reason.
- Any health care professional or healthcare institution may choose not to participate.
- Coercion, fraud, euthanasia, lethal injection, and mercy killing are all specifically prohibited in this legislation, as it is in every state where the law is in effect.

To reiterate: No physician, pharmacist, nurse, or any type of care facility is required to participate. Whether by conscience, religious belief, or moral objection, every person potentially involved in this process may refuse to participate.

No person may receive the prescription unless they are deemed to be within six months of death, acting voluntarily, capable of making their own healthcare decisions, and able to self-administer the medication. People with disabilities, chronic illnesses, dementia, or mental health issues causing impaired judgment do not qualify to use MAID.

The policy you are considering has been subject to independent research protocols by individuals from a myriad of academic disciplines. Researchers have examined the safeguards and demonstrated there have been no instances of abuse or coercion of patients in the more than 25 years since all of these laws took effect.

Oregon has successfully implemented a Death with Dignity law for nearly 30 years. Statistics collected by the Oregon Health Authority (OHA) in the recently released 2025 report [1] demonstrate that since the law was implemented in Oregon, 3,691 individuals have ended their lives using the Death with Dignity law.

The report includes the following data:

- In 2024, 637 people were reported to have received prescriptions under the Death with Dignity Act (DWDA).
- As of January 23, 2026, OHA had received reports of 400 people who died in 2025 from ingesting the prescribed medications, including 42 who had received prescriptions in previous years.

- OHA made no referrals to the Oregon Medical Board for failure to comply with DWDA reporting requirements.

Demographic characteristics of DWDA patients mirror those of previous years:

- Most patients were 65 years or older (88%).
- The most common diagnosis was cancer (61%), followed by neurological disease (14%) and heart disease (11%).
- All patients had insurance, either private or government sponsored.
- Most patients died at home (80%),
- Most were enrolled in hospice care (92%).
- As in previous years, the three most frequently reported end-of-life concerns were loss of autonomy (89%), decreasing ability to participate in activities that made life enjoyable (89%), and loss of dignity (65%).

Oregon's law has worked exactly as intended: to give dying and suffering patients more control at the end of life.

Opponents of this legislation allege a lot of things this bill does and does not do. For more than two decades now, we have heard these same slippery slope arguments: statements that this law will target individuals who are poor, who are living with disabilities, chronic illnesses, or mental health issues. None of these claims have come true.

The data from independent researchers and from state reports prove that these arguments are based entirely on myths, falsehoods, and fears.

In 2007, Battin et al. [2] explored data out of Oregon to determine if there was a disproportionate impact of ten groups of potentially vulnerable patients. The data led the researchers to conclude

"...people who died with a physician's assistance were more likely to be members of groups enjoying comparative social, economic, educational, professional and other privileges...**there is no current factual support for so-called slippery-slope concerns about the risks of legalization of assisted dying—concerns that death in this way would be practiced more frequently on persons in vulnerable groups.**"

**MAID does not replace, but complements hospice and palliative care services.**

In a comprehensive study conducted with family members of 86 Oregonians who were participating in MAID, researchers [3] concluded:

"...another concern regarding the legalization of PAD [physician aid in dying] is that PAD would become a substitute for quality end of life care...Insofar as family rating of the quality of a loved one's death is an indicator of end of life care, this study adds to the evidence that the choice to pursue PAD does not appear to be due to, or a reflection of, poorer end of life care."

It is no coincidence that the very first state to pass Death with Dignity—Oregon—was identified in an article published in the *New England Journal of Medicine* [4] as a state with significant and positive differences in how people die, as compared with other states.

**Oregon does better than the rest of the country in such benchmarks as:**

- The percentage of people who die at home (as opposed to the hospital);
- The percentage of people using hospice; and,
- The percentage of people who received intensive palliative care services at the end of life.

The passage of Oregon's law and subsequent end-of-life policy changes sent a signal nationwide, that dying patients must be accorded more attention and better care. MAID is part of that equation.

By enacting this law, Rhode Island will send a strong message that a compassionate response to suffering is available in the state through MAID, provided that patients, families, and healthcare providers follow the carefully regulated safeguards you are considering today.

MAID will be rarely used, but a great source of comfort. Its safeguards will protect patients and ensure they are acting voluntarily and capable of making those decisions. Medical aid in dying will likely improve the quality of end-of-life care for the whole population, not just for people who contemplate or use MAID.

Many individuals with a terminal illness who have shared their stories have no control over the trajectory of their disease. But they should have control over the time and manner of their death: the right to die on their own terms, with autonomy and peace of mind. Please support H7760.

Thank you.

**About Death with Dignity**

Death with Dignity was at the forefront of the passage of the first Death with Dignity law in the country: Oregon's in 1994. Since then, Death with Dignity has continued highlighting the importance of ensuring everyone has the right to options in the face of terminal, painful death sentences, including cancer. Currently, Death with Dignity laws exist in fourteen jurisdictions, including Vermont, New York, Delaware, Illinois, New Jersey, New Mexico, Colorado, and Washington, D.C.

## References:

[1] Oregon Health Authority, Public Health Division, Center for Health Statistics. (2026). "Oregon Death with Dignity Act 2025 Data Summary". Available at www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf

[2] Battin, M.P., van der Heide, A., Ganzini, L, van der Wal, G., & Onwuteaka-Philipsen, B. D. (2007). "Legal physician-assisted dying in Oregon and the Netherlands: Evidence concerning the impact on patients in 'vulnerable' groups." *Journal of Medical Ethics*, *33*, 591-597.

[3] Smith, K.A., Goy, E. R., Harvath, T. A., & Ganzine L. (2011). "Quality of death and dying in patients who request physician-assisted death." *Journal of Palliative Medicine*, *14*(4), 1-6.

[4] Tolle, S.W., & Teno, J. M. (2017). "Lessons from Oregon in embracing complexity in end-of-life care." *New England Journal of Medicine*, *376*(11), 1078-1082.