Anabella Mayorga

From: Michael McCarthy <mmccarthy@s.icom.edu>
Sent: Tuesday, April 28, 2026 8:39 PM
To: House Judiciary Committee
Subject: Written personal testimony AGAINST HB 7760

Follow Up Flag: Follow up
Flag Status: Completed

Dear Esteemed Representatives,

I write you today to provide written testimony against Bill HB 7760, which would allow physician assisted suicide in the state of Rhode Island. As a physician, I find this bill to be deeply troubling, both with regards to the vague wording of various terms in this bill as well as the likelihood that this legislation will have its largest and most negative impact on the most vulnerable among us. Particularly, I find it to be glaringly obvious that such an action as assisting patients in ending their lives to be a direct violation of the Hippocratic Oath to "do no harm" to our patients.

First of all, the wording of this bill seems overly vague and in significant ways impossible to interpret or apply in any repeatable, uniform or coherent manner. The definition of a "terminal condition" spans a mere 20 words, which falls comically short of truly defining what such a condition may be, leading to an astoundingly large loophole that nearly any condition could be molded to fit. An "irreversible" disease as the bill states is such an overly broad category that it is practically impossible to further clarify in any measurable or meaningful way, and may range from Stage IV pancreatic cancer to conditions as nebulously defined or understood as fibromyalgia. Equally troubling in the poor wording of this bill and the definition of a "terminal condition" is the use of a "medical judgment" for the specific estimated remaining life of "6 months." Anyone with an even cursory familiarity with medicine understands that prognoses of an estimated remaining life are not like in the movies or TV shows, where the doctor can tell you down to the day when you will pass away. Rather, estimated remaining lifespans are routinely off by months or even years, and even published data demonstrate that these estimates are frequently inaccurate. Tacking on an acknowledgement that the patient "may live longer" than this period seems a disingenuous effort to ignore using an often unreliable estimate on a life ending decision.

Yet another portion of this bill that I found to be troubling is rather what it does not say. While the bill focuses on ensuring a number of oral requests were made by the patient to the physician, this sequence of events is unrealistic and does not reflect how actual decision making takes place between physicians and patients. Specifically, this bill ignores the concept of shared decision making, when the physician and patient collaborate on care decisions, which is the current standard of medical care and what is taught in all medical schools and residencies with regards to capacity and medical decision making. As common sense suggests, unlike the wording of this bill, these actions will assume input from both

parties, and adds yet another moral quandary of a physician potentially suggesting suicide as an option to a patient, which in reality will be an eventuality should this bill become law.

Another deeply flawed aspect of this bill is the ways it is in direct contradiction to the standard of care for suicidal patients. We are trained that any patient who demonstrates suicidal ideation should be treated for this, with medications and therapy, rather than encouraged in the behavior regardless of the medical or psychosocial factors the patient also presents with. In fact, any patient who has suicidal ideation, intent, and a concrete plan is to be involuntarily committed to medical care in order to protect this patient. The paradigm shift of encouraging suicidal behavior based on an individual physician's potentially limited opinion, in the context of an amorphous and overly vague law, is frankly a terrifying and dystopian concept.

We do not need to look far for examples of how assisted suicide laws have been applied in other countries. In Canada, the MAiD program has expanded rapidly, with reports indicating the country is approaching 100,000 assisted suicide deaths before the program's 10 year anniversary in 2026, raising significant concerns about normalization and expansion beyond initial intent. In another reported case, an 84 year old woman in Canada stated she was offered assisted death during an emergency room visit for back pain despite not having a terminal condition, illustrating how such discussions can be introduced inappropriately in routine clinical settings. In Europe, in March 2026, Noelia Castillo, a young woman in Spain who was paralyzed after a prior suicide attempt following a traumatic assault, was ultimately approved for euthanasia after a prolonged legal battle, raising serious concerns about the intersection of psychiatric trauma, disability, and assisted death. Earlier widely reported cases, such as in the Netherlands and Belgium, have also demonstrated expansion into non terminal conditions and psychiatric illness. These examples illustrate how safeguards can erode and how eligibility can broaden over time.

As they have in places where this has already been legalized, these laws risk disproportionately impacting the most vulnerable, including those with disabilities, those facing social isolation, and those with limited financial resources. Concerns about being a burden, lack of support, or inadequate access to care are frequently cited reasons for pursuing assisted suicide, rather than uncontrolled physical pain. This raises a critical question of whether the appropriate response is to improve support systems and access to care, rather than facilitating death.

Finally, there are broader systemic concerns that cannot be ignored. In any healthcare system where cost pressures exist, there is an inherent risk that ending life may be viewed as less resource intensive than providing prolonged care. Even the perception of such incentives has the potential to undermine trust in the physician patient relationship and raises serious ethical concerns about how these policies may be applied in practice, particularly among economically disadvantaged populations.

I urge you to examine the full picture of what you are voting for, and to examine your conscience and to vote against this bill. It is sad to see physicians inexplicably supporting such poorly worded and overly morally reprehensible legislation. As stated in the Hippocratic Oath, “neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.”

Thank you for your time.

Sincerely,
Dr. Michael McCarthy, DO
Cranston, RI