Written Testimony in Support of H7760: an Act Relating to Health and Safety - Lila Manfield Sapinsley Compassionate Care Act,
Melissa Stacy, Regional Advocacy Director, Compassion & Choices and
Compassion & Choices Action Network
House Committee on Judiciary
April 30, 2026 at 4pm

Chair McEntee and members of the Committee on Judiciary:

My name is Melissa Stacy. I am the Regional Advocacy Director for Compassion & Choices. We are the nation's oldest and largest nonprofit organization working to improve care and expand options at life's end. We advocate for legislation to improve the quality of care for terminally ill patients and affirm their right to determine their own medical treatment options as they near the end of life. I am submitting this testimony in support of H7760: *An Act Relating to Health and Safety - Lila Manfield Sapinsley Compassionate Care Act*.

If passed, H7760 would allow mentally capable, terminally ill adults with 6 months or less to live the option to request, obtain and self-administer medication-should they choose- to die peacefully, on their own terms. H7760 includes strict eligibility criteria and practice requirements to ensure the highest standard of care. Patients can change their mind about utilizing the option at any time during the multi-step process. Participation is voluntary for patients and any healthcare providers. It is important to note that individuals are not eligible for medical aid in dying solely because of advanced age, disability or chronic health conditions.

This option is *not* taken lightly and the many safeguards in place ensure that the decision is not made in haste. The multi-step request process is robust, the eligibility requirements are clear on who may qualify, and how individuals may obtain the medication under this law. The many safeguards have proven to work over the past nearly 30 years in 14 authorized jurisdictions. While some authorized jurisdictions have made improvements to their laws including shortening waiting periods, removing the residency requirement, or allowing for other clinicians to act as the attending and consulting providers, none of these jurisdictions have changed or removed the core eligibility requirements.

United States "medical aid-in-dying" laws differ fundamentally from Canadian laws. In Canada, the definition of "medical assistance in dying," the legal landscape, and the Canadian healthcare system, are not the same as in the United States. Also, in Canada, euthanasia is allowed. To contrast, euthanasia is illegal in every U.S. state, and the core eligibility criteria for U.S. medical

aid-in-dying laws have remained the same since Oregon implemented the nation's first medical aid-in-dying law in 1997.

Opponents focus on sensationalized examples of diagnoses such as anorexia to perpetuate their "slippery slope" argument that individuals with psychological or psychiatric diagnoses are at risk for abuse. The reality is that the definition of "terminally disease" in the Rhode Island legislation is clear - "...an **incurable and irreversible disease** which would, within reasonable medical judgement, result in death within six (6) months or less." A determination of terminality relates to disease progression, not treatment options. Whether an individual has elected to pursue or forego disease-directed treatment does not impact whether the disease is terminal. Malnutrition or dehydration resulting from psychiatric illness or from voluntary cessation of eating and drinking are reversible, not "terminal," and do not qualify a person for medical aid in dying. In other words, a person eligible for medical aid in dying has a disease that cannot be cured and the person will eventually die from it, no matter what care or treatments are offered.

In an effort to ensure that the best possible legislation is passed, we have a few recommendations to make the bill stronger. They are:

1. Add a definition of "self-administration," which is referred to in certain sections of the bill.
   Recommendation: Add the following definition to Section 23-4.15-2.:
   "Self-administer" means a qualified individual performs an affirmative, conscious, voluntary act to ingest medication prescribed pursuant to this Act to bring about the individual's peaceful death. Self-administration does not include administration by parenteral injection or infusion.

2. Replace definition of "bona-fide physician-patient relationship" with "attending provider" and "consulting provider."
   a. As written, the bona-fide physician-patient relationship includes both the "attending" and "consulting" physician. It also requires that a "personal physical examination is completed." It is not clear if a "personal physical examination" can be done via telehealth.

   Recommendation: Replace "bona-fide physician-patient relationship" with the following:
   "Attending provider" means the provider who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
   "Consulting provider" means a provider who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the individual's disease.
3. Recommendation: Add a sentence at the end of the definitions section to explicitly say that a person is not eligible solely because of advanced age or disability.
   No person will be eligible under this Act solely because of advanced age or disability.
4. Recommendation: Add a definition of "Informed decision" as the term is used throughout the bill.
   "Informed Decision" means a decision by a mentally capable individual to request and obtain a prescription for medication pursuant to this Act, that the qualified individual may self-administer to bring about a peaceful death, after being fully informed by the attending provider and consulting provider of:
   a. The individual's diagnosis and prognosis;
   b. The potential risk associated with taking the medication to be prescribed;

c. The probable result of taking the medication to be prescribed;
d. The feasible end-of-life care and treatment options for the individual's terminal disease, including but not limited to comfort care, palliative care, hospice care and pain control, and the risks and benefits of each; and
e. The individual's right to withdraw a request pursuant this Act, or consent for any other treatment, at any time.

In the nearly 30 years since the Oregon law was enacted, "there appears to be no evidence to support the fear that [medical aid in dying] disproportionately affects vulnerable populations."[1] Instead, terminally ill people in these jurisdictions have been given the peace of mind to know that they have access to this option.[2] Limiting access to the full scope of end-of-life care does not protect vulnerable populations or reduce healthcare disparities. Medical aid in dying is an option, not a mandate.

The data from the jurisdictions that have authorized medical aid in dying and subsequently published statistical reports demonstrates that less than 1% of people who die annually in an authorized jurisdiction will decide to use the law.[3] However, awareness of the law has a palliative effect, relieving worry about end-of-life suffering. Individuals report experiencing enormous relief from the moment they obtained the prescription because it alleviated their fears of suffering.[4] Quite simply, medical aid in dying is a prescription for peace of mind.

Researchers and legal scholars have confirmed that the experience across the authorized jurisdictions "puts to rest most of the arguments that opponents of authorization have made — or at least those that can be settled by empirical data. The most relevant data — namely, those relating to the traditional and more contemporary concerns that opponents of legalization have expressed — do not support and, in fact, dispel the concerns of opponents."[5]

The evidence is clear: medical aid-in-dying laws protect terminally ill individuals, while giving them a compassionate option to die peacefully and ensuring appropriate support and legal protection for the care providers who practice this patient-driven medicine.
We each live our lives with our individual ideals, values, and ethics. Our last days and death should reflect these principles. Terminally ill people who are eligible under this act are dying. They deserve access to the full breadth of legal end-of-life options including the right to choose curative

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[1] *Gopal, A. (2015). Physician-Assisted Suicide: Considering the Evidence, Existential Distress, and an Emerging Role for Psychiatry*. Journal of the American Academy of Psychiatry and the Law, 43(2). http://jaapl.org/content/43/2/183.
[2] Compassion & Choices. (2023). Shelby Marcuse. https://www.compassionandchoices.org/stories/shelby-marcuse; Compassion & Choices. (2022). Rita Florea. https://www.compassionandchoices.org/stories/rita-florea.
[3] *Medical Aid-in-Dying Utilization Report, 2026.* Compassion & Choices. Available from: https://compassionandchoices.org/wp-content/uploads/2024/02/final_utilization-report-3.31.26.pdf
[4] *A Therapeutic Death: A Look at Oregon's Law.* Psychology, Public Policy, and Law, K. Cerminara & A. Perez, (2000) Available from: https://www.ncbi.nlm.nih.gov/pubmed/12661538
[5] *A History of the Law of Assisted Dying in the United States.* SMU Law Review, A. Meisel, (2019) Available from: https://scholar.smu.edu/cgi/viewcontent.cgi?article=4837&context=smulr

or life-extending interventions, or to forgo treatments and opt for palliative care, hospice care or medical aid in dying.

Decisions about death belong to the dying, and good public policy enables them to engage in open conversations with their healthcare providers, their loved ones, and their faith or spiritual leaders about their physical and spiritual needs at the end of life. This legislation gives terminally ill people peace of mind to focus on the time that they have left. Terminally ill individuals don't have the luxury of endless deliberations; they need the relief that this law affords them right now.

You will hear and receive testimony from patients and surviving family members about the importance of ensuring access to the full breadth of legal end-of-life options including the right to choose curative or life-extending interventions, or to forgo treatments and opt for palliative care, hospice care or medical aid in dying. I urge you to act now.

Medical aid in dying authorization, Rhode Island effectively denies many terminally ill individuals meaningful access to this option, leaving them to endure suffering they may find unacceptable or to seek care far from home. You have the opportunity to address this inequity by adopting thoughtful, evidence-based legislation that ensures people can receive comprehensive end-of-life care within their own communities, supported by the clinicians and loved ones they trust.

Thank you,
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