



Testimony Opposing Rhode Island “Compassionate Care Act” Bill H 7100

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I am a two-time cancer survivor who depends on full-time breathing support. This testimony is filed on behalf of Not Dead Yet, a national disability organization headquartered in New York with members in Rhode Island. Not Dead Yet is among 17 major national [disability organizations](#) that oppose assisted suicide laws. Not Dead Yet is also a plaintiff in a [major lawsuit](#) filed under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act and the U.S. Constitution to challenge the California assisted suicide law as discriminatory based on disability.

One of the most frequently repeated claims by proponents of assisted suicide laws is that there has not been “a single documented case of abuse or misuse.” To the contrary, I refer you to two resources describing problem cases. The first is from the Disability Rights Education and Defense Fund, [Oregon and Washington State Abuses and Complications](#). The second is a journal article by two New York medical doctors, Drs. Herbert Hendin and Kathleen Foley, [Physician-Assisted Suicide in Oregon: A Medical Perspective](#) (2008).

[Data](#) from states where assisted suicide is legal show that all people who request assisted suicide have disabilities, even if some don’t think of their impairments that way, and that unmet disability related needs are their reasons for wanting to die. The [top five reasons](#) Oregon doctors give for their patients’ assisted suicide requests over all reported years are not pain or fear of future pain, but psycho-social issues that pertain to disability. Three of these (losing autonomy, losing dignity, burden on family) could be addressed by consumer-directed in-home personal care services, but the law operates as though the person’s reasons don’t matter, and nothing needs to be done to address them.

Moreover, eligibility is far broader than most people imagine. Oregon reports that the types of non-cancer conditions found eligible for assisted suicide have grown over the years, to include: neurological disease, respiratory disease, heart/circulatory disease, infectious disease, gastrointestinal disease, endocrine/ metabolic disease (e.g. diabetes)

and, in the category labeled “other”, arthritis, arteritis, sclerosis, stenosis, kidney failure, musculoskeletal systems disorders and, most recently, **anorexia** (reported for 2021).

Doctors are also supposed to detect coercion, but how could they do so when, for example, [Oregon’s state reports](#) say that the median duration of the prescribing physician patient relationship was only 5 weeks in 2021 and 2022. The Rhode Island bill authorizes the doctor to communicate with the patient “through persons familiar with the patient's manner of communicating,” risking inaccuracy in translation or worse.

Over all the years, a supposed lack of coercion is not usually determined by a physician with a longstanding relationship with the patient. This is significant in light of well-documented elder abuse-identification and reporting problems among professionals in a society where an estimated one in ten elders is abused, mostly by family and caregivers. (Lachs, et al., New England Journal of Medicine, [Elder Abuse](#).)

In about half the reported Oregon cases, there is also no independent witness to consent or self-administration at the time of ingestion of the lethal drugs. If the drugs were, in some cases, administered by others without consent, no one would know.

Research on healthcare disparities has also shown that medical providers are not immune to prevailing social biases. Making assisted suicide part of “end-of-life care” and designating doctors as its gatekeepers and administrators could only further undermine patient safety, particularly for older adults, disabled people, Black, indigenous, communities of color and other multiply marginalized people who already experience life threatening healthcare discrimination.

Legislators should also be concerned about the pressures toward expansion in the broader euthanasia movement. Expansions already adopted by a few states allow non-physician prescribers of lethal drugs and allow waiting periods to be waived.

To further consider the risks of expansion, it would be appropriate to look at Canada. Only five years after Canada passed its national law for people with terminal illnesses, Bill C-7 was passed making assisted suicide and active euthanasia available to healthy people with disabilities. Canadian press has since reported on disabled individuals getting euthanasia by lethal injection when they want to die because they can’t get housing or otherwise can’t afford to live on government payments. Canada’s bill also allows eligibility for people whose sole illness is psychiatric but implementation has been delayed. See Coelho R, Maher J, Gaiind KS, Lemmens T (2023). The realities of Medical Assistance in Dying in Canada. *Palliative and Supportive Care*.

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It's not compassion, it's discrimination. Equal rights include equal suicide prevention, not suicide agreement and assistance for people who are too often devalued. Rhode Island should firmly reject the dangerous discrimination of assisted suicide.