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Comments

Physician-Assisted Death with Dignity: Expanding Palliative Care in Rhode Island

Camille Caron Capraro*

INTRODUCTION

Properly addressing palliative care and physician-assisted death (PAD) is a delicate, yet complicated, and even controversial, issue.¹ Some see PAD as a dignified choice, while others see it as encouraging suicide. States have begun to grapple with PAD in a multitude of ways, primarily through legislation.² American law accords the power to prevent or regulate PAD to the states, which also includes an individual's right to refuse to take necessary steps to preserve his or her life.³ When a state determines how

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1. The pro-PAD side of the debate has mostly done away with the term "physician-assisted suicide" and has instead used: "hastened death," "compassionate care," "end of life option," and "death with dignity." See Joseph B. Straton, *Physician Assistance with Dying: Reframing the Debate; Restricting Access*, 15 TEMP. POL. & C.R. L. REV. 475, 476 (2006). Eliminating the term "suicide" provides more appeal to the public when considering this issue. See *id.* For example, legislative proposals in Rhode Island have used "compassionate care" when referring to this topic. See H.B. 7297, 2018 Leg., Jan. Sess. (R.I. 2018).

2. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 292 (1990) (Scalia, J., concurring).

3. *Id.* (acknowledging that a medical patient has the right to refuse

best to address PAD versus continued life-saving treatment, it is necessary to balance the state's interest in maintaining and preserving life with the individual's interest in autonomy.⁴ In *Cruzan v. Director, Missouri Department of Health*, a landmark case regarding a patient's right to die and the right to refuse medical treatment, Chief Justice Rehnquist noted that the "interests at stake . . . are more substantial, both on an individual and societal level, than those involved in a run-of-the-mine civil dispute."⁵ States have a legitimate interest in protecting and preserving human life and preventing suicide, but, on the other side, an individual has a right to bodily autonomy, specifically, to have a choice to control the destiny of his or her own body.⁶ Indeed, in the case of a terminally ill patient, the state's interest in maintaining and preserving life directly conflicts with an individual's interest in autonomy—specifically, relieving oneself from undue pain and suffering.⁷

To understand the arguments and discussions surrounding PAD, one must first understand the distinction between certain commonly used terminology. This Comment will use the term "right to die" instead of "euthanasia." The term right to die in the PAD context refers to individuals rationally choosing to end their lives after careful deliberation.⁸ "Euthanasia," on the other hand, involves physician-made decisions that will ultimately shorten a patient's life based on the belief that death would be more beneficial to the patient rather than the patient continuing in his or her present state.⁹ Essentially, euthanasia connotes a focus on the physician and the physician's perspective, whereas right to die

unwanted medical treatment).

4. *Cruzan*, 497 U.S. at 271.

5. *Id.* at 283. This case primarily dealt with establishing an evidentiary standard. *Id.* A surrogate or guardian may make an end of life decision for another person under certain circumstances if there is "clear and convincing" evidence that the person wants this treatment. *Id.*

6. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 869 (1992); *Cruzan*, 497 U.S. at 271.

7. See Cass R. Sunstein, Essay, *The Right to Die*, 106 YALE L.J. 1123, 1128–29, 1131–33 (1997).

8. See Katherine A. Wingfield & Carl S. Hacker, *Physicians-Assisted Suicide: An Assessment and Comparison of the Statutory Approaches Among the States*, 32 SETON HALL LEGIS. J. 13, 16–17 (2007).

9. JOHN KEOWN, EUTHANASIA, ETHICS, AND PUBLIC POLICY: AN ARGUMENT AGAINST LEGALISATION 10 (Cambridge Univ. Press 2002).

shifts that focus to the individual's perspective and that person's individual right to make a choice regarding his or her body.¹⁰

This Comment argues that Rhode Island should enact legislation allowing PAD in very specific instances related to terminally ill patients.¹¹ As Part I shows, the United States Supreme Court has concluded that there is no constitutional right to PAD, but this leaves room for the states to enact PAD protections by statute.¹² Part II demonstrates that Rhode Island's current legal posture on the issue of PAD is antiquated and against individual interests, and thus, should be repealed and replaced.¹³ This Comment further argues that Rhode Island should adopt a law allowing PAD in specific circumstances for terminally ill patients because it is an effective way to balance the state's interest in protecting its citizens and preserving life against an individual's right to choose, and bodily autonomy.¹⁴ PAD comports with a physician's role as healer, posing no threat to the integrity of the medical community.¹⁵ Strict procedural safeguards within PAD legislation alleviate the possible risk of abuse or coercion, and data from Oregon, the first state to legalize PAD, clearly demonstrates the success of procedural safeguards in practice.¹⁶ Therefore, this Comment concludes that Rhode Island should pass legislation that is similar to the Lila Mansfield Sapinsley Compassionate Care Act (LMSCCA), which is a proposed legislation that is currently being considered by the Rhode Island legislature, and would give a terminally ill patient the right to opt for PAD if certain criteria were met.¹⁷

10. *See id.*
11. *See infra* Part II.
12. *See infra* Part I.A–B.
13. *See infra* Part II.A.
14. *See infra* Part II.B.1.
15. *See infra* Part II.B.2.
16. *See infra* Part II.B.3.
17. *See infra* Part II.C.

I. THE UNITED STATES SUPREME COURT HAS REJECTED A
CONSTITUTIONAL RIGHT TO PHYSICIAN-ASSISTED DEATH

*A. Right to Refuse Unwanted Medical Treatment Does Not
Extend to a Right to Hasten Death*

Many supporters for legalization of PAD contend that the right to die is protected by substantive due process and equal protection under the Fourteenth Amendment to the United States Constitution.¹⁸ Although PAD is not an enumerated right in the Constitution, the Due Process Clause is often the basis for protecting certain rights that are not specifically mentioned in the Constitution, but are “implicit in the concept of ordered liberty” or “deeply rooted in this Nation’s history and tradition.”¹⁹ While the United States Supreme Court recognizes a constitutionally protected right of a competent person to refuse unwanted medical treatment,²⁰ the Court refused to recognize a corresponding constitutional right of a terminally ill patient to choose to die with assistance from a physician.²¹ Nevertheless, the lack of a constitutionally protected right to PAD does not preclude the states from protecting that right on their own accord.²²

The question of whether the right to die and advance directives²³ are constitutionally protected was first addressed in *Cruzan*, where the Court held that “a competent person has a constitutionally protected liberty interest in refusing unwanted

18. See *Washington v. Glucksberg*, 521 U.S. 702, 723–24 (1997); *Vacco v. Quill*, 521 U.S. 793, 797–98 (1997).

19. *Glucksberg*, 521 U.S. at 720–21; *Palko v. Connecticut*, 302 U.S. 319, 324–25 (1937), *overruled by Benton v. Maryland*, 395 U.S. 784 (1969); *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934).

20. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278 (1990). The Supreme Court has found protected liberty interests in a number of personal decisions determined to be essential to an individual’s personal dignity and autonomy. See, e.g., *Roe v. Wade*, 410 U.S. 113, 152 (1973).

21. *Glucksberg*, 521 U.S. at 728; *Quill*, 521 U.S. at 807–09.

22. See *infra* Part II.B.; *Glucksberg*, 521 U.S. at 737 (O’Connor, J., concurring) (“States are presently undertaking extensive and serious evaluation of physician-assisted suicide In such circumstances, the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the laboratory of the States.” (internal quotations omitted)).

23. “Advance directive” is defined as “[a] written declaration of health care decisions made in advance of incapacity.” *Living Will (Advance directive)*, THE WOLTERS KLUWER BOUVIER LAW DICTIONARY (Desk ed. 2012).

medical treatment,” even if such treatment is lifesaving; this liberty interest can outweigh the legitimate state interest in preservation of life.²⁴ The facts in the case presented an issue because a serious car accident left the patient on life-support, and thus, deemed incompetent to make medical decisions; her parents sought a court order to remove the life-support.²⁵ The Court explained that an individual has a constitutionally protected liberty interest in deciding to end her own life support, but when a patient is incompetent, the state’s interests at stake are more compelling.²⁶ There, the removal of life-sustaining treatment by third parties justified the imposition of heightened evidentiary requirements, which further supports the position that the patient could have made this decision if he or she was medically competent to do so.²⁷ While the *Cruzan* holding appears to allow for a broad categorization of the liberty interest involved—that being the right to die in general—the Court subsequently clarified that the right in *Cruzan* is narrowly defined as the “constitutionally protected right to refuse lifesaving hydration and nutrition.”²⁸

In *Washington v. Glucksberg*, plaintiffs challenged a Washington statute prohibiting PAD under the Due Process

24. *Cruzan*, 497 U.S. at 278–79 (holding that due process does not require the state to repose judgment on matters concerning the right to refuse treatment with anyone but the patient herself). In *Cruzan*, Justice Scalia noted the “difficult, indeed agonizing, questions that are presented by the constantly increasing power of science to keep the human body alive for longer than any reasonable person would want to inhabit it.” *Id.* at 292 (Scalia, J., concurring).

25. *Id.* at 265 (majority opinion).

26. *Id.* at 281–84.

27. *Id.* at 281. The Court imposed a “clear and convincing” evidentiary standard when a surrogate or third party makes an end of life decision for an incompetent patient. *Id.* at 284. *Cruzan* remained in a vegetative state on life-support for almost eight years before her parents came up with sufficient additional evidence to halt artificial nutrition and hydration. D. KELLY WEISBERG & SUSAN FRELICH APPLETON, MODERN FAMILY LAW: CASES AND MATERIALS 94, 99 (6th ed. 2016). She died twelve days after the feeding tube was removed. *Id.* The hospital staff who had cared for her for seven years were deeply troubled by this outcome because they believed it would have been easier to cope had she been allowed to die quickly by lethal injection. *Id.*

28. *Cruzan*, 497 U.S. at 284; see *Washington v. Glucksberg*, 521 U.S. 702, 722–23 (1997); *Vacco v. Quill*, 521 U.S. 793, 807–09 (1997).

Clause on the grounds that it violated the protected interest of individual autonomy and, like the plaintiffs in *Cruzan*, the right to hasten one's death.²⁹ The *Glucksberg* opinion emphasized that the holding in *Cruzan* was not solely deduced from concepts of bodily autonomy, but rather—as all due process cases demand—an examination into “our [n]ation's history, legal traditions, and practices.”³⁰ Justice Rehnquist defined the liberty interest narrowly, explaining that the right to assistance for suicide is not a value that is deeply rooted in the nation's history.³¹ He noted that history actually points the opposite way: “for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide.”³² Moreover, the Court rejected the plaintiff's reliance on *Cruzan*, and stated that there is an important distinction between withdrawing life support (as was the case in *Cruzan*), and opting to take medication to end one's own life, which ultimately becomes the proximate cause of death.³³ PAD involves doctors giving drugs to end a life, whereas *Cruzan* involved taking away a life-giving mechanism, which resulted in the patient's death.³⁴ The law regards forcing medical treatment as the equivalent of battery, while assisting suicide has never received the same treatment.³⁵

In the companion case to *Glucksberg*, *Vacco v. Quill*, plaintiffs challenged a New York statute prohibiting PAD under the Equal Protection Clause.³⁶ The contention was that it is unfair for family members to be permitted to take an individual off life support, but that an individual cannot make that decision for his

29. *Glucksberg*, 521 U.S. at 708.

30. *Id.* at 710.

31. *Id.* at 710–11.

32. *Id.* “The earliest American statute explicitly to outlaw assisting suicide was enacted in New York in 1828.” *Id.* at 715.

33. *Id.* at 725–26. “The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection.” *Id.* at 725.

34. *Id.* at 725; see *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278–79 (1990).

35. *Glucksberg*, 521 U.S. at 725.

36. *Vacco v. Quill*, 521 U.S. 793, 796–97 (1997). *Quill* was argued and decided on the same days as *Glucksberg*. See *Quill*, 521 U.S. at 808–09.

or herself with PAD.³⁷ The Court found this argument no more convincing than the one in *Glucksberg*, and upheld New York's statute, concluding that banning PAD while allowing refusal of life-sustaining treatment did not treat patients differently from one another or "draw any distinctions between persons."³⁸ The Court stated, "[e]veryone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide."³⁹

Ultimately, the Court refused to recognize a constitutionally protected fundamental right to determine the time and manner of one's own death under either the Due Process Clause or the Equal Protection Clause.⁴⁰ Since the liberty interest of PAD is not considered a fundamental right, the Constitution only requires that a ban on PAD be rationally related to legitimate government interests, such as preserving life.⁴¹

B. States May Recognize a Right to Physician-Assisted Death

Justice Brandeis famously stated, "[i]t is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."⁴² Accordingly, the United States Supreme Court defers to the states to legalize or regulate PAD, and some states have begun to legally permit PAD.⁴³ Although *Glucksberg* and *Quill* were decided without any dissenting opinions, the majority opinions in both cases leave open the option of legal protection for PAD at the state level, arising either under state constitutions or state legislative authorization; many states are taking the avenue

37. *Id.* at 800.

38. *Id.*

39. *Id.*

40. *Glucksberg*, 521 U.S. at 728; *Quill*, 521 U.S. at 800.

41. *Glucksberg*, 521 U.S. at 728. In *Glucksberg*, the government's interest included protecting medical ethics and vulnerable groups, such as the disabled and elderly; the court concluded that this was sufficient justification to pass a rational basis test. *Id.* at 731–32, 735.

42. *New State Ice Co. v. Liebermann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

43. *Glucksberg*, 521 U.S. at 737; see Wingfield & Hacker, *supra* note 8, at 23–44.

of legislative reform.⁴⁴ Thus, states retain the power to regulate PAD, but must ensure that any new legislation is consistent with United States Supreme Court rulings.⁴⁵

Beginning in 1994, five states and the District of Columbia have exercised their right to regulate and legalize PAD through legislation, and one state has exercised this right by means of a court ruling.⁴⁶ The increasing number of states that have expressly legalized the right to choose to die by enacting PAD statutes demonstrates a national shift in public opinion towards acceptance of this right.⁴⁷

In November 1994, Oregon became the first state to legalize PAD when voters passed the Oregon Death with Dignity Act (DWDA) by a narrow margin of fifty-one percent to forty-nine percent.⁴⁸ The modern idea of DWDA was initially met with public resistance, particularly in the form of a legal injunction that stemmed from a constitutional challenge under the Fourteenth Amendment, in addition to a referendum effort to force repeal.⁴⁹ Yet, in November 1997, Oregon voters confirmed their support by voting in favor of the Act a second time by a margin of sixty percent to forty percent, an even larger majority

44. *Glucksberg*, 521 U.S. at 737 (O'Connor, J., concurring); Erwin Chemerinsky, *Privacy and the Alaska Constitution: Failing to Fulfill the Promise*, 20 ALASKA L. REV. 29, 36 (2003); see Kathryn L. Tucker, *The Death with Dignity Movement: Protecting Rights and Expanding Options After Glucksberg and Quill*, 82 MINN. L. REV. 923, 926 (1998) [hereinafter Tucker, *The Death with Dignity Movement*].

45. *Gonzales v. Oregon*, 546 U.S. 243 (2006). *Gonzalez* is the most recent Supreme Court decision to affirm the states' authority to legalize and regulate PAD. *Id.* at 274–75.

46. *Baxter v. State*, 224 P.3d 1211, 1213 (Mont. 2009); Wingfield & Hacker, *supra* note 8, at 23–44. States that legally permit PAD include Oregon, Washington, Montana, Vermont, California, Colorado, and the District of Columbia. See *infra* notes 49–54 and accompanying text.

47. See Wingfield & Hacker, *supra* note 8, at 23–44. “Expressly” legalizing PAD, as it is used in this Comment, refers to a state affirmatively allowing for PAD whether it be through common law or statute.

48. Eli Stutsman, *Twenty Years of Living with the Oregon Death with Dignity Act*, 30 GPSOLO 49, 50 (2013) (describing the ballot measure that created the Oregon Death with Dignity Act).

49. *Id.* Implementation of the DWDA was delayed by injunction until 1997. See *Lee v. Oregon*, 107 F.3d 1382, 1386 (9th Cir. 1997), *vacating* 869 F. Supp. 1491 (D. Or. 1994). The Ninth Circuit found federal courts did not have jurisdiction over the plaintiff's claims and vacated the injunction. See *id.*

than the initial ballot.⁵⁰

Oregon's DWDA became the catalyst for other states to invoke their right to legalize and regulate PAD. Washington voters approved an almost identical initiative in 2008;⁵¹ Montana permitted PAD by court ruling in 2009;⁵² Vermont passed the End of Life Choices Act in 2013; California passed the End of Life Option Act in 2015; and both Colorado and the District of Columbia passed legislation permitting PAD in 2016.⁵³

II. RHODE ISLAND SHOULD LEGALIZE PHYSICIAN-ASSISTED DEATH

A. *Rhode Island's Current Legal Posture on PAD is Outdated and Does Not Adequately Protect an Individual's Interests*

Rhode Island's common law and statutes pertaining to the issue of PAD should be repealed and replaced because they are inadequate in a crucial way—they are antiquated and contrary to the public interest.⁵⁴ Current state law expressly prohibits a patient's right to choose PAD.⁵⁵ In 1996, Rhode Island adopted a statute specifically prohibiting physician-assisted suicide.⁵⁶ The Rhode Island General Assembly promulgated legislative findings that the welfare of Rhode Island citizens requires, "vulnerable persons be protected from suicide and that the cost to the taxpayers of enforcing laws preventing assisted suicides will be reduced by promoting civil enforcement of such laws."⁵⁷ These

50. See Lindsay N. McAneeley, Comment, *Physician Assisted Suicide: Expanding the Laboratory to the State of Hawai'i*, 29 U. HAW. L. REV. 269, 275–76 (2006).

51. Christina White, Comment, *Physician Aid-In-Dying*, 53 Hous. L. REV. 595, 610, 610 & n.126 (2015).

52. See *Baxter v. State*, 224 P.3d 1211, 1213, 1215 (Mont. 2009) (affirming the lower court's decision to permit physician-assisted suicide but rejecting the constitutional analysis and relying on the consent statute as a defense to a charge of homicide).

53. PROCON, *State-by-State Guide to Physician-Assisted Suicide*, <https://euthanasia.procon.org/view.resource.php?resourceID=000132> (last visited Mar. 14, 2018).

54. In fact, Rhode Island currently considers suicide a felony and the Rhode Island Supreme Court has expressly deemed it as such. *Clift v. Narragansett Television L.P.*, 688 A.2d 805 (R.I. 1996) (citing *In re Marlene B.*, 540 A.2d 1028, 1029 (R.I. 1988)).

55. See, e.g., 11 R.I. GEN. LAWS § 11-60-3 (2002).

56. See *id.*

57. § 11-60-1; see H.B. 8244, 1996 Leg., Jan. Sess. (R.I. 1996); S.B. 2558,

legislative findings led to the enactment of the Prevention of Assisted Suicide Act, which, in effect, made PAD illegal in Rhode Island.⁵⁸

A physician violates this statute if he or she “*knowingly* . . . [p]rovides the physical means by which another person commits or attempts to commit suicide; or . . . [p]articipates in a physical act by which another person commits or attempts to commit suicide”⁵⁹ Notably, in order to commit the foregoing, the physician must do so “with the *purpose* of assisting another person to commit suicide”⁶⁰ While on its face this legislation appears to prohibit licensed healthcare practitioners from providing another person with the physical means to commit suicide, a closer reading reveals that there is a requisite *mens rea* for the commission of this crime: that the physician acts “knowingly” and with “purpose.”⁶¹ While the *mens rea* requirement may insulate doctors from liability because the state bears the burden of proving state of mind, this element still poses the risk of deterring doctors from implementing vigorous medical treatment in fear that their intentions will be misunderstood.⁶² The prosecution must prove a physician’s intent to cause death and not just his intent to act; yet, if a doctor’s actions result in death, that intent is left to the subjectivity of jurors to decide.⁶³ While this is only a possible risk, it certainly is not in a patient’s best interest for doctors to be hesitant in making medical decisions.⁶⁴

Moreover, the ban on assisted suicide does not apply to a licensed physician who “administers, prescribes, or dispenses medications or procedures to relieve another person’s pain or discomfort, even if the medication or procedure may hasten or increase the risk of death,” so long as the measures taken were not intended to cause death.⁶⁵ This permits physicians to give

1996 Leg., Jan. Sess. (R.I. 1996).

58. § 11-60-3 (statutorily stating physicians assisted death is illegal).

59. *Id.* (emphasis added).

60. *Id.* (emphasis added).

61. *Id.*

62. Editorial, *Stay Out*, PROVIDENCE J., July 25, 1996, at B-06.

63. *See id.*

64. *See id.*

65. § 11-60-4.

medication to patients with terminal conditions when the primary purpose of giving that medication is to alleviate pain, notwithstanding whether or not the medication is so powerful as to hasten death.⁶⁶ Notably, the American Medical Association endorses administering pain-killing medication to terminally ill patients to prevent excruciating pain, even when it is known that this act will advance the time of death.⁶⁷ The ability to deny the requisite intent to commit this crime creates readily available defenses and mitigating arguments for a physician to refute a possible charge.⁶⁸

The problem with this law is that the difference between “intending” to alleviate pain while also “knowing” it may cause death, as opposed to “knowingly” treating a patient for the “purpose” of causing death, may be unclear.⁶⁹ Doctors are committed to their patients and may want to respect their decision to die with dignity, even though they may not do so under Rhode Island law.⁷⁰ Physicians in Rhode Island now have the ability to engage in PAD under the guise that the purpose for the fatal dose of medication was merely to alleviate pain.⁷¹ Thus, some doctors may get away with violating the law by saying that they did not intend to cause death, even though they knew death could be a result.⁷² On the other hand, this provision may result in physicians withholding heavy doses of pain-relieving morphine—which can hasten a terminally ill person’s death—in fear that their actions will be interpreted as illegally helping patients end their lives, when the true intent was to relieve burdensome pain.⁷³ With punishment of up to ten-years in prison looming over their heads, it seems unlikely that physicians would jeopardize their careers and freedom on the subjective analyses of witnesses, prosecutors, and jurors.⁷⁴ Thus, doctors may avoid

66. *See id.*

67. *Washington v. Glucksberg*, 521 U.S. 702, 750–51 (1997).

68. *See id.*

69. *See* § 11-60-4.

70. *See id.* § 11-60-4; *see also* Felice J. Freyer, *Doctors confront assisted suicide: The Rhode Island Medical Society will decide next week whether to support physician-assisted suicide*, PROVIDENCE J., May 9, 1996, at A-1.

71. *See* § 11-60-4.

72. *See id.*

73. *Stay Out*, *supra* note 62.

74. *See id.*

alleviating pain altogether because they fear that they could be prosecuted or convicted.⁷⁵ It is overtly against the public interest to have doctors who are overly-paranoid in performing their duties.⁷⁶ Either way, the subjective standard is problematic because in medical practice, as opposed to law books, the difference between the two mental states is nearly impossible to distinguish.⁷⁷

Accordingly, passing laws that prohibit PAD in Rhode Island did not come without substantial pushback from the public—including doctors, patients, lawyers, and politicians.⁷⁸ Doctors are bound by the Hippocratic Oath to “do no harm,” yet, many patients and doctors in Rhode Island believe that allowing a patient to suffer the indignities of the final stages of a terminal illness is doing just that: doing harm.⁷⁹ Around the time these laws came into effect, a Brown University bioethicist stated “[p]eople want to know this assistance will be available, . . . even though the vast majority will never come to want it.”⁸⁰ PAD imposes no obligation on patients or doctors to hasten death; to take that opportunity and choice away does not respect an individual’s interests, beliefs, or wishes.⁸¹

75. *See id.*

76. *See id.*

77. *See* *Washington v. Glucksberg*, 521 U.S. 702, 750–51 (1997).

A doctor who fails to administer medical treatment to one who is dying from a disease could be doing so with an intent to harm or kill that patient. Conversely, a doctor who prescribes lethal medication does not necessarily intend the patient’s death—rather that doctor may seek simply to ease the patient’s suffering and to comply with her wishes. The illusory character of any differences in intent or causation is confirmed by the fact that the American Medical Association unequivocally endorses the practice of terminal sedation—the administration of sufficient dosages of pain-killing medication to terminally ill patients to protect them from excruciating pain even when it is clear that the time of death will be advanced.

Id.

78. *See* Freyer, *supra* note 70.

79. *Id.*

80. *Id.* “Bioethics” is defined as “the discipline dealing with the ethical implications of biological research and applications especially in medicine.” *Bioethics*, MERRIAM-WEBSTER DICTIONARY, <https://www.merriam-webster.com/dictionary/bioethics> (last visited Mar. 14, 2018).

81. *See* Freyer, *supra* note 70.

Those provisions of the Rhode Island General Laws relating to PAD that were enacted over twenty years ago no longer comport with individual interests or the nation's emerging trends on PAD.⁸² It would be more effective to adopt carefully-constructed legislation that allow for PAD in very limited circumstances, which would accomplish the dual purpose of protecting an individual's interest in making choices about his or her body, while also balancing the state's interest in preserving life and protecting vulnerable groups.⁸³

B. Rhode Island Should Enact a Statute That Protects an Individual's Interest in Autonomy While Establishing Procedural Safeguards Against Abuse

The most effective means by which to effectuate PAD is through the legislative process because this allows for more extensive fact-finding, continual development of proposed provisions, concentrated refinement throughout the drafting process, and an opportunity for meaningful commentary from interest groups and litigators.⁸⁴ Passing a statute would provide a more flexible procedure, as opposed to the restrictions incorporated with ballot-initiative measures or court orders, where any fine-tuning would then come on an *ad hoc* basis.⁸⁵

Strong autonomy interests and maintaining control over the destiny of one's body weigh in favor of the right to PAD as an option.⁸⁶ Indeed, many terminally-ill patients view the "death

82. See *supra* Part I.B.

83. See *infra* Part II.B.1.

84. Tucker, *The Death with Dignity Movement*, *supra* note 44, at 931.

85. *Id.*

86. Sunstein, *supra* note 7, at 1126. Religious arguments are beyond the scope of this Comment. However, it is worth noting that the Catholic Church is one of the greatest opponents against the recent "aid in dying" legislation and has contributed a great deal of financial resources to support its stance in an effort to defeat bills of this kind. See Kathryn L. Tucker, *When Dying Takes Too Long: Activism for Social Change to Protect and Expand Choice at the End of Life*, 33 WHITTIER L. REV. 109, 123 (2011) [hereinafter Tucker, *When Dying Takes Too Long*]. Recent data also found that as of 2015, forty-four percent of the Rhode Island population identified as Catholic, which was the second highest percentage in the United States; thus, Catholic resistance to PAD legislation will likely hinder progress in Rhode Island. See Ana Swanson, *Chart: The United States of Catholics and Protestant*, THE WASHINGTON POST (Mar. 4, 2015), <https://www.washingtonpost.com/news/>

with dignity” movement to be about control.⁸⁷ Furthermore, while opponents of PAD have concerns that families may coerce or put undue pressure on a terminally ill family member to opt for PAD, social interests actually support the right to PAD, particularly because there is no substantive evidence to support a finding that coercion is an issue in practice.⁸⁸ The risks of PAD legislation that concern opponents of the right can be effectively addressed through procedural safeguards written into carefully composed legislation.⁸⁹ A blanket prohibition against PAD actively obstructs the autonomy interest in providing an option for those who seek a compassionate death.

1. Individual Interests and State Interests Are Adequately Served by Procedures and Safeguards That Ensure Vulnerable Groups Are Protected from Coercion and Undue Pressure When Opting for PAD

Rhode Island should adopt a tightly crafted PAD statute containing strict procedural safeguards because it would be an effective method to balance an individual’s interest in personal autonomy and compassionate care against the state’s interest in protecting vulnerable groups and preserving life. PAD should be allowed for terminally ill patients who are deemed capable and competent, whose condition has a confirmed prognosis of resulting in death within six months or less, and who have participated in multiple evaluations by at least two treating physicians.⁹⁰ Further, the patient should be required to make two oral requests for PAD separated by a period of at least fifteen days and should make a subsequent written request in the presence of two

wonk/wp/2015/03/04/chart-the-united-states-of-catholics-and-protestants/?utm_term=.c1c1dfd2dad4.

87. See White, *supra* note 51, at 596 & n.8.

88. See *Oregon Death with Dignity Act 2017 Data Summary*, OR. HEALTH AUTH., PUB. HEALTH DIV. 10, 11 (Feb. 9, 2018), <http://www.oregon.gov/oha/PH/providerpartnerresources/evaluationresearch/deathwithdignityact/Pages/ar-index.aspx>. Coercion is a serious concern from a public policy standpoint, however, data suggests that procedural safeguards effectively combat the risk of coercion; notably, there is a lack of substantive evidence showing otherwise. See *infra* Part II.B.3.

89. McAneeley, Comment, *supra* note 50, at 270.

90. See, e.g., OR. REV. STAT. ANN. §§ 127.800–.995 (West, Westlaw through Jan. 1, 2018).

witnesses to ensure competency and absence of coercion.⁹¹ Physicians should be required to inform the patient of feasible alternatives, and request that the patient notify his or her next of kin.⁹² This proposal properly serves the patient's autonomy interests while preventing abuse.⁹³

The state has a legitimate interest in protecting the elderly, as a vulnerable group, from abuse, neglect, coercion and mistake.⁹⁴ A concern is that PAD will create a risk of undue influence in end-of-life choices, specifically that individuals whose well-being and autonomy are already weakened by advanced age might opt for PAD to spare their families of the financial burdens involved with health-care and the emotional trauma of watching their loved one die.⁹⁵ This state interest is especially relevant in Rhode Island because it has a substantial aging population which continues to grow.⁹⁶ A recent Rhode Island Department of Human Services report ranked Rhode Island fourth in the nation in the per capita elderly population.⁹⁷ As people age, they become more susceptible to disease and disability; thus, a rise in the elderly population in Rhode Island will likely result in a dramatic increase in terminally ill patients.⁹⁸ Elderly patients have a personal interest in choosing PAD because it allows them the opportunity to exercise self-determination and offers a "more humane option to those seeking a compassionate death."⁹⁹

91. *See id.*

92. *See id.*

93. *See* Emily P. Hughes, Note, *The Oregon Death with Dignity Act: Relief of Suffering at the End of Medicine's Ability to Heal*, 95 GEO. L.J. 207, 209 (2006).

94. *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

95. *Id.* at 732.

96. Maureen Maignet, *Aging in Community: Executive Summary Report June 2016*, SUBCOMM. OF THE LONG TERM CARE COORDINATING COUNCIL 2 (June 2016), <http://www.rilin.state.ri.us/Reports/AginginComm%20Exec%20SummaryFinal.pdf>.

97. *Rhode Island's Senior Population . . . By the Numbers*, R.I. DIV. OF ELDERLY AFF. (2006), <http://www.dea.ri.gov/stats/> (finding Rhode Island had 117,391 residents aged seventy and older, and 82,292 residents aged seventy-five and older).

98. *Research Involving Elderly Or Terminally Ill Subjects*, VA. POLYTECH. INST. INSTITUTIONAL REV. BD., <http://www.irb.vt.edu/pages/elderly.htm> (last visited Mar. 26, 2017).

99. Katherine A. Chamberlain, Note, *Looking for a "Good Death": The Elderly Terminally Ill's Right to Die by Physician-Assisted Suicide*, 17 ELDER

Although the state's asserted interest in prohibiting PAD is to protect vulnerable groups from coercion and abuse, these interests may not be as significant in every context or set of circumstances.¹⁰⁰ While Rhode Island common law states that preventing suicide because of depression and coercion is a legitimate state interest,¹⁰¹ terminally ill patients who are deemed competent and are seeking PAD on a voluntary basis may pose only a modicum of risk of coercion.¹⁰² The state interest in preventing abuse of vulnerable groups is satisfied if the patient requesting PAD is not a victim of abuse or suffering from mental illness.¹⁰³ Justice Stevens in his *Glucksberg* concurrence acknowledged that in these instances, "the State's legitimate interest in preventing abuse does not apply to an individual who is not victimized by abuse, who is not suffering from depression, and who makes a rational and voluntary decision to seek assistance in dying."¹⁰⁴ Beyond this, to support and comply with the state's interest in protecting vulnerable groups, a PAD statute in Rhode Island should be tightly drafted with language providing for multiple professional checks as to the competency of a patient to reduce the risk of depression-triggered PAD.¹⁰⁵ Diagnosing depression and recognizing a coerced patient is not an easy task, but hospitals' staff include mental health workers and other professionals whose primary purpose is to work with terminally ill patients to help them cope with physical and emotional pain, and assess all of their treatment options.¹⁰⁶ These checks for competency and voluntariness allow for a patient to exercise autonomy over his or her body, while still protecting the state's interest in safeguarding against coercion.¹⁰⁷

L.J. 61, 80 (2009) (quoting Glen R. McMurry, Comment, *An Unconstitutional Death: The Oregon Death with Dignity Act's Prohibition Against Self-Administered Lethal Injection*, 32 DAYTON L. REV. 441, 456 (2007)).

100. R.I. GEN. LAWS § 11-60-1 (2002).

101. *Laurie v. Senecal*, 666 A.2d 806, 808 (R.I. 1995). The Rhode Island Supreme Court emphasized that it "generally accept[s] that the state has an interest in preserving life and preventing suicide." *Id.* (citations omitted).

102. *See* *Washington v. Glucksberg*, 521 U.S. 702, 747 (1997).

103. *See* *Vacco v. Quill*, 521 U.S. 793, 809 (1997) (Stevens, J., concurring).

104. *Id.* at 747 (Stevens, J., concurring).

105. McAneeley, Comment, *supra* note 50, at 275–80.

106. *Quill*, 521 U.S. at 809 (Stevens, J., concurring).

107. *See* McAneeley, Comment, *supra* note 50, at 275–80.

PAD legislation, if properly drafted, will advance an individual's interest while still appreciating the state's interest. Studies from the states where PAD is legally permitted show that proper legislation will safeguard vulnerable groups from coercion.¹⁰⁸ For example, Oregon requires a patient to be suffering from terminal illness, deemed competent, and voluntarily express an informed desire to end his or her life on multiple occasions with timing requirements in order to qualify for PAD.¹⁰⁹ Importantly, the aforementioned elements must be confirmed by a second physician, and multiple requests strengthen the physicians' surety of voluntary desire for PAD all the more, thus, further safeguarding patients from coercion into choosing PAD.¹¹⁰ The elderly's personal interest in exercising a right to PAD is compatible with the state's interests in preserving life and preventing suicide because legislation would contain safeguards to properly regulate PAD, without undermining the state's interest.¹¹¹

Ultimately, an individual's right to personal autonomy and dignity justifies legalizing PAD, but the state's interests in protecting its citizens and preserving life consistently serves as a roadblock.¹¹² Passing a carefully constructed PAD statute is a valid way to balance these interests because it recognizes the state's interest through procedural safeguards, but also takes into consideration dire cases of terminally ill patients and allows them to opt for PAD.¹¹³ The state's interest is neither implicated nor furthered by a blanket prohibition on PAD when valid eligibility and procedural requirements, such as those mentioned above, are

108. Chamberlain, *supra* note 99, at 84. See OR. REV. STAT. ANN. § 127.805 (West, Westlaw through Jan. 1, 2018).

109. Chamberlain, *supra* note 99, at 86.

110. *Id.*

111. *Id.* at 84; see Lisa R. Hasday, *The Hippocratic Oath as Literary Text: A Dialogue Between Law and Medicine*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 299, 302 (2002); see also *Compassion in Dying v. Washington*, 79 F.3d 790, 793–94 (9th Cir. 1996) (holding the integrity of the medical field is not compromised by doctors having a right to assist terminally ill patients in opting to die when appropriate), *overruled by Washington v. Glucksberg*, 521 U.S. 702 (1997).

112. McAneeley, Comment, *supra* note 50, at 293–95.

113. *Id.*

in place.¹¹⁴ PAD would merely afford an available option to those seeking to end their suffering with compassionate death.¹¹⁵

2. *Legalizing PAD in Rhode Island is Consistent with a Physician's Role as a Healer and Does Not Undermine the Medical Profession*

The medical industry in Rhode Island will be able to adapt to the legalization of PAD without losing its integrity. United States Supreme Court doctrine maintains that a person has a right to autonomy, bodily integrity, and control of his own body; specifically, this principle has been extended to include autonomy in medical decision making.¹¹⁶ The law—as well as medicine—is constantly changing and evolving, and “experience shows that most doctors can readily adapt to a changing legal climate.”¹¹⁷ It is assumed that medical professionals will engage in these permitted practices only when deemed appropriate in their medical opinion, and that the integrity of the medical profession will be maintained.¹¹⁸ Accordingly, allowing PAD in Rhode Island would likely bring about a similar result: doctors could perform PAD in compliance with procedural requirements when appropriate, and the integrity of the medical profession would be unharmed.¹¹⁹

Rhode Island should adopt a law allowing a terminally ill patient to opt for PAD because incorporating deference to patient autonomy reflects a nuanced perception of the goals of medicine and the Hippocratic Oath.¹²⁰ The goals of medicine are predicated

114. See McMurry, Comment, *supra* note 99, at 456.

115. *Id.*

116. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990); see also *Roe v. Wade*, 410 U.S. 113 (1973).

117. *Compassion in Dying v. Washington*, 79 F.3d 790, 829–30 (9th Cir. 1996). For example, following *Roe v. Wade's* holding that a woman has a constitutional right to an abortion, the nation saw the medical profession quickly adapt and begin performing abortions with the ethical integrity of the profession remaining intact. *Id.* (citing *Roe v. Wade*, 410 U.S. 113 (1973)).

118. See *id.* at 830. The court granted doctors the right to PAD on the ground that “doctors would engage in the permitted practice when appropriate, and that the integrity of the medical profession would survive without blemish.” *Id.* (dismissing the Oath's implicit prohibition on physician-assisted suicide).

119. See *id.*

120. Hughes, Note, *supra* note 93, at 209.

on the Hippocratic Oath—the famous maxim “do no harm”—and a doctor’s role as a healer.¹²¹ A terminally ill patient is almost intuitively in discord with a doctor’s role as healer because he or she, by definition, cannot be healed.¹²² At the end of medicine’s ability to heal, PAD provides an option that would relieve a patient’s suffering when that is his or her ultimate wish.¹²³ When there is no other alternative to relieve that pain, PAD is a legitimate way to further the medical goal of relieving patients from suffering and undue pain, so long as it is autonomously requested.¹²⁴ PAD is consistent with the maxim “do no harm” because the patient knows his or her own limits, and it allows willing physicians to relieve suffering while respecting their patient’s autonomy.¹²⁵ The patient is the only one physically feeling pain—not the physician, and especially not policy-makers.¹²⁶ Thus, when a patient is diagnosed with a terminal disease that will inevitably result in death, the law ought to allow a physician to respect and defer to the patient’s autonomous choice about his or her own dying process.¹²⁷

Furthermore, PAD legislation merely provides an option for physicians willing to perform the procedure; legalizing PAD in Rhode Island would impose no legal obligation or duty on the physician to engage in such practice.¹²⁸ Therefore, no medical professional would be required to act in disagreement with his or her own moral beliefs or his best medical opinion.¹²⁹ Similarly, the physicians who do consider PAD to be consistent with their ethical beliefs and role as healer would be allowed to engage in such assistance.¹³⁰ PAD allows individuals to exercise their

121. *Id.* at 209 & n.5, 225. Medical professionals take the Hippocratic Oath, swearing to “keep [the sick] from harm and *injustice*’ and promise that they themselves will ‘remain. . . free of all intentional *injustice*.’” Hasday, *supra* note 111, at 302 (alterations in original).

122. *Terminally ill*, MERRIAM-WEBSTER DICTIONARY, <https://www.merriam-webster.com/dictionary/terminally%20ill> (last visited May 6, 2018); *see* Hughes, Note, *supra* note 93, at 225.

123. McAneeley, Comment, *supra* note 50, at 270.

124. *Id.*

125. *See* Hughes, Note, *supra* note 93, at 235.

126. *See id.*

127. *Id.*

128. *See id.* at 210.

129. *See id.*

130. *See id.*

autonomy and doctors to exercise their medical opinions without placing any obligations or imposing any moral judgments on others. Since the legalization of PAD allows terminally ill individuals to make autonomous decisions about their life that comply with their own morals and beliefs, and the prohibition of PAD restricts the rights of individuals by disallowing patients and doctors to exercise their own morals and ethics and imposing the beliefs of others upon them, legalization of PAD ought to prevail.¹³¹

Thus, Rhode Island should legalize PAD because it is not only consistent with the sentiment of the Hippocratic Oath and the purpose of medicine, but safeguards in the statute also respect and defer to a physician's moral and ethical beliefs by making PAD an option, not an obligation.

3. Tightly Crafted Legislation Can Appropriately and Successfully Safeguard Against Perceived Risks and Feared Abuses of PAD

Nineteen years of data collected and analyzed by the Oregon Health Authority's Public Health Division (Public Health Division) supports the contention that carefully drafted legislation containing adequate procedural safeguards can serve to prevent, or at least substantially mitigate, the risk of abuse or coercion with respect to PAD.¹³² While opponents of PAD charge that it will be forced upon vulnerable patients (e.g., poor, uninsured, uneducated, elderly), data suggests the contrary.¹³³ PAD in Oregon is used primarily by individuals with a baccalaureate education or higher.¹³⁴ Notably, higher levels of education positively correlate to a higher percent of people who invoke PAD, with individuals who have a bachelor's or higher who opt for PAD being forty percent more than those without a high school diploma.¹³⁵ Further, since the DWDA's enactment in 1997, over

131. *Id.* at 210, 235; McAneeley, Comment, *supra* note 50, at 283.

132. See *Oregon Death with Dignity Act Data summary 2016*, OR. HEALTH AUTH., PUB. HEALTH DIV. 4, 7 (Feb. 10, 2017), <http://www.oregon.gov/oha/PH/providerpartnerresources/evaluationresearch/deathwithdignityact/Documents/year19.pdf> [hereinafter Nineteenth Annual Report].

133. *Id.* at 8–9; see McAneeley, Comment, *supra* note 50, at 280–81.

134. Nineteenth Annual Report, *supra* note 132, at 8.

135. *Id.* at 8, tbl. 1 (showing that after DWDA's enactment in 1997, 46%

ninety percent of patients using PAD were enrolled in hospice care and over ninety-eight percent of those patients had healthcare insurance.¹³⁶ A patient with health insurance is less likely to be subjected to coercion because their continued treatment is not costly to the family.

While there is a gradually increasing trend of patients who opt for PAD each year, the number of patients exercising this option remains minimal; in 2016, there were only 204 DWDA prescription recipients in all of Oregon.¹³⁷ This does not mean that all the prescription recipients ingested the drugs; in fact, the Public Health Division reported only 133 people who passed away due to ingesting the prescribed medications.¹³⁸ Additionally, DWDA requires at least fifteen days to elapse between the patient's initial request and the writing of the prescription for the medication, and the median reported time between the initial request and actual death was fifty-six days in 2016.¹³⁹ Allowing a patient time to understand his or her options and confirm his or her decision without rushing the patient is general practice as a procedural safeguard in PAD statutes, and the prolonged time frame demonstrates that patients truly contemplated the decision.¹⁴⁰

The Oregon reports also show that terminally ill patients typically experience many end-of-life concerns, the most prominent being loss of autonomy, decreased ability to engage in enjoyable activities, and loss of dignity.¹⁴¹ With an integral part of autonomy and dignity being the ability to make one's own

of those who opted for PAD had a bachelor's degree or higher; 27% had some college-level education; 22% graduated from high school; and only 6% had less than a high school degree).

136. *Id.* (showing that 54% of patients had private healthcare coverage, and 44.6% had Medicare, Medicaid or other governmental insurance).

137. *Id.* at 4.

138. *Id.* at 5.

139. OR. REV. STAT. ANN. § 127.850 (West, Westlaw through Jan. 1, 2018); Nineteenth Annual Report, *supra* note 132, at 11.

140. Peter G. Daniels, *An Illinois Physician-Assisted Suicide Act: A Merciful End to a Terminally Ill Criminal Tradition*, 28 LOY. U. CHI. L.J. 763, 779–80 (1997).

141. Nineteenth Annual Report, *supra* note 132, at 10 (according to cited patient responses from 1997 to 2016: 91.4% feared loss of autonomy; 89.7% feared decreased ability to engage in activities; and 77% feared loss of dignity).

personal decisions, the ability of a patient to be a part of his own end-of-life choices and decide when “enough is enough” demonstrates value in that patient’s autonomy.¹⁴² Therefore, the DWDA serves to alleviate some of a terminally ill patient’s concerns by incorporating respect for his or her autonomy and giving it deference.

In addition, Vermont recently assigned a legislative commission to review Oregon’s experience since passing the DWDA.¹⁴³ The resulting report concluded, “it is quite apparent from credible sources in and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-life care and in all probability has enhanced the other options.”¹⁴⁴ The Vermont study made no mention of abuse, coercion, or misuse of the policy.¹⁴⁵ Notably, during 2016, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.¹⁴⁶

Oregon’s successful experience with PAD legislation does not necessarily translate to Rhode Island having an equivalent experience if it were to adopt a similar death with dignity law. However, stringent procedural safeguards within the PAD legislation would adequately serve to alleviate coercion in Rhode Island.¹⁴⁷ In addition to imposing specific restrictions on the requesting patient, PAD legislation would require the physician to comply with a number of procedures as well, mainly pertaining to documentation and diagnoses.¹⁴⁸

142. McAneeley, Comment, *supra* note 50, at 290, 292.

143. See Robin Lunge et al., *Death with Dignity Law and Euthanasia in the Netherlands: Factual Disputes*, VT. LEGISLATIVE COUNCIL 2–3 (2004), available at http://www.leg.state.vt.us/reports/04Death/Death_With_Dignity_Report.htm.

144. See *id.* at 24.

145. See *id.*

146. Nineteenth Annual Report, *supra* note 132, at 8. These requirements include two oral requests separated by fifteen days, a written request in the presence of two witnesses, confirmation of the diagnosis and prognosis, determination that patient is capable and competent, informing the patient of feasible alternatives, and requesting the patient notify his or her next of kin. OR. REV. STAT. ANN. §§ 127.810, .815, .820, .840 (West, Westlaw through Jan. 1, 2018).

147. See Lunge et al., *supra* note 143.

148. H.R. 7297, 2018 Leg., Jan. Sess. (R.I. 2018).

C. A Proposed Bill in Rhode Island Possesses Adequate Procedural Safeguards Against Coercion and Effectively Balances an Individual's Interest in Autonomy with the State's Interest in Preserving Life

While Rhode Island law explicitly prohibits PAD, the state has previously proposed legislation that would allow for certain medical patients to choose to end their life, stemming from the mid-to-late nineties through 2018.¹⁴⁹ For example, in 1998, a bill was introduced that called to repeal laws prohibiting PAD and, instead, would authorize and regulate it.¹⁵⁰

The Lila Mansfield Sapinsley Compassionate Care Act (LMSCCA), introduced to the Rhode Island General Assembly on January 25, 2018, is an example of well-crafted legislation that Rhode Island should pass.¹⁵¹ This initiative demonstrates that carefully drafted legislation could appropriately safeguard against perceived risks and feared abuses of PAD.¹⁵² The LMSCCA reflects changes in public perceptions over the last two decades by replacing “suicide” with the term “compassionate care.”¹⁵³ This law would provide a legal mechanism whereby a terminally ill patient may choose to end his or her life using drugs prescribed by a physician.¹⁵⁴ Under the proposed legislation, doctors who engage in PAD and prescribe lethal prescriptions to terminally ill

149. See, e.g., H.R. 7918, 1996 Leg., Jan. Sess. (R.I. 1996); H.R. 7918, 1998 Leg., Jan. Sess. (R.I. 1998); H.R. 5507, 2015 Leg., Jan. Sess. (R.I. 2015).

150. H.R. 7918 (1998) §§ 11-60-3, -4; *Id.* § 23-71-1.

151. H.R. 7297, 2018 Leg., Jan. Sess. (R.I. 2018). The bill is named the “Lila Mansfield Sapinsley Compassionate Care Act” in honor of the former state senator who died in 2014. She was working to craft the legislation when she died. Jennifer Bogdan, *Bill in R.I. General Assembly would let terminally ill control death*, PROVIDENCE J. (Apr. 8, 2015 11:15, PM), <http://www.providencejournal.com/article/20150408/NEWS/150409326>.

152. H.R. 7297.

153. *Id.*; see H.R. 7927. Rhode Island has rebranded “suicide” and the “death with dignity” and “end of life option” terminology used in other states’ legislation with the term “compassionate care.” *Id.*; see, e.g., OR. REV. STAT. ANN. §§ 127.800–.890 (West, Westlaw through Jan. 1, 2018). The term “suicide” is often associated with one who is suffering from despair and irrationally takes one’s own life. See also Straton, *supra* note 1, at 476. A terminally ill patient is looking towards imminent and unavoidable death, so, removing the term “suicide” from the current legislation creates a more accurate dialogue on the issue. *Id.*

154. H.R. 7297.

patients would be immune from civil or criminal liability, as well as professional disciplinary action, as long as all procedural safeguards stated in the statute are precisely followed.¹⁵⁵ Physicians, however, could not be forced to prescribe lethal medication to terminally ill patients under the law; physicians are under no duty of law to participate in PAD.¹⁵⁶ Further, health care facilities would also have the right to prohibit physicians from prescribing lethal drugs to patients under their care.¹⁵⁷ These provisions defer to hospitals and physicians who may not want to partake in PAD by imposing no obligation, but rather, allowing the option.¹⁵⁸

Furthermore, the LMSCCA sets strict guidelines for when a patient can request PAD.¹⁵⁹ It requires the patient to have a prognosis of a “terminal condition,” meaning an “incurable and irreversible disease which would, within reasonable medical judgment, result in death within six months or less”;¹⁶⁰ this prognosis must be confirmed by a second doctor.¹⁶¹ Other bills have allowed for patients with particularly burdensome pain to fall within the PAD statute’s bounds, but the LMSCCA avoids scenarios where a prognosis may ultimately be too hard to consistently measure, such as chronic illnesses where the life-expectancy varies.¹⁶² Employing a strict requisite standard for a prognosis of terminally ill with six months to live may seem stringent, but it is easy to measure with a higher degree of certainty. Also, a physician must determine that the patient is capable of making an informed decision, the decision is voluntary, and the patient intends to take medication for the purpose of hastening death.¹⁶³

The LMSCCA also incorporates mechanisms that greatly reduce the chance of coercion, as its opponents charge.¹⁶⁴ The

155. *Id.* § 23-4.13-3(a).

156. *Id.* § 23-4.13-5(a).

157. *Id.* § 23-4.13-6.

158. *Id.*

159. *Id.* § 23-4.13.

160. *Id.* § 23-4.13-2(8), (10).

161. *Id.* § 23-4.13-3(a)(7).

162. H.R. 7918, Leg., Jan. Sess. (R.I. 1998).

163. H.R. 7297 § 23-4.13-3(a)(5).

164. Steve Ahlquist, *Talking about end-of-life options in Rhode Island*, RI FUTURE (Feb. 15, 2016), <http://www.rifuture.org/end-of-life-options-ri/>.

LMSCCA is virtually identical to the Oregon Death with Dignity Act insofar as which patients qualify to choose PAD and the procedural restraints imposed on the patient and physician.¹⁶⁵ The most significant difference in the two acts is that Oregon's Act does not require the patient to self-administer the drugs, whereas the LMSCCA explicitly requires self-administration.¹⁶⁶ The added requirement that a terminally ill patient administer the medication themselves provides an additional procedural safeguard, allowing further surety that the patient willfully and intentionally ended his or her life.¹⁶⁷

The LMSCCA requires the terminally ill patient to verbally request to be prescribed medication that can be self-administered for the purpose of hastening his or her death in the physical presence of a physician.¹⁶⁸ After the initial request, a patient must make a second request in the physical presence of the same physician no fewer than fifteen days after the first oral request.¹⁶⁹ At the time of the second request, the physician must offer the patient the opportunity to rescind the request.¹⁷⁰ The fifteen-day waiting period and additional inquiry by the physician act as procedural safeguards to ensure competency and sureness of the patient.¹⁷¹ In addition to the oral requests, the patient must make a third, written and signed request to be prescribed the medication to self-administer for the purpose of hastening death.¹⁷² In order to significantly reduce the risk of coercion, this written confirmation requires two witnesses, and at least one of those witnesses must be a disinterested party.¹⁷³

165. H.R. 7297. See OR. REV. STAT. ANN. §§ 127.800–.995 (West, Westlaw through Jan. 1, 2018).

166. *Id.*; see also White, *supra* note 51, at 610 n.126.

167. H.R. 7297.

168. *Id.* § 23-4.13-3(a)(1).

169. *Id.* § 23-4.13-3(a)(2).

170. *Id.* § 23-4.13-3(a)(3).

171. Daniels, *supra* note 140, at 779 (acknowledging the general practice in aid in dying statutes of prescribing a minimum amount of time a patient must wait between his first and second requests).

172. H.R. 7297 § 23-4.13-3(a)(4).

173. See *id.*; see also § 23-4.13-2 (defining an interested person as the patient's physician, a person who is a relative of the patient by blood or by law, a person who knows that they would be entitled, upon the patient's death, to any portion of the estate or assets, or an owner, operator, or employee of the health care facility where the patient is being treated).

While the LMSCCA prescribes numerous procedural safeguards and eligibility requirements for the patient and physician to comply with if both parties decide PAD is an option, it imposes no obligation on a patient to opt for PAD and no legal duty on a health-care facility or individual physician to perform PAD.¹⁷⁴ Accordingly, neither the patient or physician would be bound to act contrary to their morals and beliefs.¹⁷⁵

The proposed legislation should be passed because it contains adequate procedural safeguards that provide an effective way to balance state interests with individual rights, is consistent with United States Supreme Court decisions, and is supported by sound policy justifications. The LMSCCA has been referred to the House Health, Education & Welfare Committee.¹⁷⁶

CONCLUSION

Rhode Island should allow for PAD in very specific instances related to terminally ill patients. The United States Supreme Court permits the states to be the laboratories of PAD legislation and many states have begun to do so, evidencing a change in public sentiment regarding PAD on a national level. Rhode Island's current legal posture on the issue is outdated and operates against an individual's best interests; PAD legislation in Rhode Island would be an effective way to balance the state's interest in preserving life and preventing suicide with an individual's right to autonomy and relief from undue pain and suffering. PAD comports with a physician's role as healer and poses no threat to the integrity of the medical community. Also, data suggests that adequate procedural safeguards are successful in preventing coercion in practice. The recent sustained activity in the Rhode Island General Assembly demonstrates that there is momentum and enthusiasm in addressing this issue. The LMSCCA is a great example of legislation that contains adequate procedural safeguards; it places no obligation on the patient or the physician to engage in practices that do not comport with his or

174. H.R. 7297 § 23-4.13-5(a)-(c).

175. *See id.*

176. H.B. 7297. The bill's primary sponsor is Edith Ajello, Representative for District 1 of Providence, Rhode Island. Representatives Ajello, O'Grady, Knight, Carson, and Donovan introduced the bill on January 25, 2018. *See id.*

her own ethical beliefs, but leaves the option available for an individual to make an autonomous decision that complies with his or her own morals and beliefs.