

**Updated Testimony in opposition to OR SB 1003**  
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**Expertise: Pediatric Anesthesiology/Critical Care, Medical Ethics**  
**Senate Judiciary Committee**  
**March 3, 2025**

I am Dr. Sharon Quick, President of the Physicians for Compassionate Care Education Foundation (PCCF), an organization without religious or political affiliation. We advocate for the vulnerable terminally ill, opposing assisted suicide and euthanasia and promoting good palliative care. I have expertise in pediatric anesthesiology, critical care, and medical ethics. We oppose SB 1003. Please see the following reasons for our opposition.

**What SB 1003 does** and *problems with these changes*:

**1. Allows non-physicians, including Oregon-licensed nurse practitioners and physician assistants, to be prescribing or consulting “providers.” (p. 2, lines 37-42)**

- a. *There is no requirement that a physician be involved,<sup>1</sup> yet [Medicare requires that a physician](#), not other types of clinicians, certify that a patient is terminally ill for hospice admission. Physicians are fallible. Determining [how near someone is to death, for example, is difficult prognosis that specialists frequently get wrong; prognosis may be biased by age, disability, and race. Almost 20% of patients graduate from hospice](#) because they improve or do not decline quickly enough and no longer qualify (they still have a terminal illness, but are expected to live longer than 6 months). Vulnerable patients wanting to hasten death with lethal drugs risk their lives on the decisions made--they deserve the highest level of expertise from physicians. There is some [evidence that physicians are more accurate than nurses in prognoses](#).*
- b. *Given the change in 2 (below), only one clinician may be required to do a full evaluation, and no physician need be involved. It appears that, for example, one PA could evaluate the patient and then review a hospice program’s certification, making the hospice-certifying clinician the unwitting second opinion.*
- c. *Proponents state that this bill would allow patients in rural areas that lack physicians to obtain lethal drugs from non-physicians. However, both rural access to palliative care and the number of palliative care prescribers are estimated to be insufficient to meet Oregon’s needs according to [a 2024 Center to Advance Palliative Care \(CAPC\) report](#). Only 40% of rural and 32% of suburban areas have access to hospital-based palliative care—numbers which are below both the national and Pacific region averages. It is a disservice to patients to potentially make lethal drugs more accessible than palliative care.*
- d. *The training of physician assistants (PAs) does not include what this bill requires. Although PA education standards specify classroom instruction in “palliative and end-of-life care” and “death, dying, and loss,”<sup>2</sup> no instruction is required, nor covered on board exams, on evaluating a patient’s decision-making capacity, determining prognosis for terminal illness, or deciding that death is imminent. Most new PAs have no exposure to end-of-life issues beyond one classroom lecture. As of 2023 only 227 PAs (0.2%) in the nation had specialty training in hospice and palliative care.<sup>3</sup> This bill does not distinguish between PAs with experience/expertise and those without.*
- e. *PAs must have a collaborative agreement with physicians, at least until they have 2000 hours of post-graduate clinical experience.<sup>4</sup> There is no stipulation that a physician assistant not be under collaboration with a physician who acts as the other “provider.” Essentially one, not two opinions could be rendered in this case. PAs could be economically compelled to rubber-stamp decisions made outside their professional standards, outside of collaboration agreements, and for which they have not been trained.<sup>5</sup>*

**2. The consulting “provider” only confirms the patient’s diagnosis; the bill removes the requirement that the consulting “provider” confirm that the patient is “capable, acting voluntarily and has made an informed decision.” (p. 4, lines 34-43; p. 6, lines 11-13)**

- a. *This clause places undue trust in fallible clinicians, by removing a critical second opinion for some of the most important safeguards—ensuring patient capacity, absence of coercion, and a fully informed decision. It is unclear if the documentation of a physician certifying a patient for hospice can be the sole source of this “2<sup>nd</sup> opinion.” Hospice certification does not assess patient capacity or absence of coercion for the purpose of making life-ending decisions. This would make that hospice-certifying physician unknowingly complicit in the approval process for lethal drugs, which is never a component of hospice certification.*

- b. *Two physicians are required to sign a consent for a patient without capacity to undergo a lifesaving surgery, but this bill allows only one non-physician without any stated expertise to make some of the most difficult medical assessments, without a second opinion, and provide a patient with potentially immediate access to the means to end his/her life.*

**3. Reduces the waiting period to 48 hours from 15 days. (p. 5, lines 19-23)**

- a. *Reducing the waiting period does not allow adequate time to fully assess a patient who is suffering; sometimes it is emotional/psychological/existential problems that can worsen physical pain. Mental health problems are common in the terminally ill (estimates range from 20-60%), but physicians often miss depression in these patients. Anti-depressants take a minimum of 2 weeks to become effective; 48 hours is too short to see results. Studies have also shown that decision-making capacity fluctuates and declines as a patient nears death. One study found that about 90% of cancer patients had deficits on some subscale of decision-making capacity, but the majority of physicians missed these deficits.<sup>6</sup> Psychiatrists doubt that decision-making capacity of terminally ill patients can be assessed in one visit. Studies also show that physicians view people with disabilities as having a lower quality of life than the people do themselves. This bill sets up death by ablism, devaluing vulnerable patients who are suffering from disabilities (e.g., mental health problems, lack of capacity, psychological distress over loss of function due to new onset disabilities associated with their decline) that will not be uncovered due to lack of time for proper assessment.*
- b. *It is unclear why there is a need to reduce the waiting period. **No dying patient should have unbearable pain.** Such a complaint indicates the clinician lacks knowledge about the management of complex pain—an unawareness that is far too common. Besides opioids, other types of medications, nerve blocks, long-term epidurals, and other procedures as indicated by pain management specialists, may be used. Dame Cicely Saunders, UK hospice movement founder, states: “...there is no such thing as ‘intractable pain,’” although she admitted there were “intractable doctors.”<sup>7</sup> Even a physician who is a public supporter of prescribing lethal drugs states that [hospice care can manage symptoms, and no patient should take lethal drugs because they have inadequate symptom management](#) (p. 22). Lethal drugs are a poor solution for lack of education of clinicians. Furthermore, patients in significant pain have compromised capacity to choose, invalidating consent for lethal drugs. [Lethal drugs do not guarantee a peaceful death](#); there are many contraindications and side effects to these mouth-burning, experimental concoctions. Palliative care can ensure a peaceful death to a far greater degree than lethal drugs.*

**4. Eliminates the waiting period if the “prescribing provider” believes the patient will die within 48 hours. (p. 5, lines 24-28, lines 41-45 and p. 6, line 1)**

- a. *This difficult determination can be made by one clinician, who may be a non-physician, without any defined expertise, and without a second opinion.*
- b. *Patients close to death usually have compromised mental capacity and inability to ingest liquids (about 90% of cancer patients have these losses within 3 days of death), making consent unlikely and ingestion dangerous. There are good medical reasons to DISALLOW lethal drugs the closer a patient gets to death, but this bill authorizes the opposite.*

**5. Removes the requirement that a psychiatrist or psychologist assessing a patient’s capacity and mental health be “state licensed.” Instead, it allows a “psychiatrist or licensed psychologist.”**

- a. *This change implies that mental health assessment could be done, perhaps remotely, by psychiatrists or psychologists who reside out of state, and only the psychologist needs to be licensed. (p. 2, lines 13-15) Psychiatrists who have had their licenses revoked in Oregon or other states would be eligible to do these assessments. Out-of-state remote evaluations may miss crucial elements of assessing a patient's capacity, mental health status, and coercion.*

**NOTES**

1. There is a contradiction on p. 4, lines 13-17, where the “prescribing provider” must be “registered as a dispensing physician.” So it is ambiguous as to whether the prescriber can be other than a physician.
2. <https://www.arc-pa.org/wp-content/uploads/2024/07/Standards-5th-Ed-July-2024.pdf>, p. 14
3. <https://www.nccpa.net/wp-content/uploads/2024/07/2023-Statistical-Profile-of-Board-Certified-PAs-by-Specialty-Annual-Report.pdf>, p. 6
4. <https://www.oregon.gov/omb/Topics-of-Interest/Documents/HB%203036%20FAQ.pdf>

5. Adapted from testimony in opposition to WA SB 5179 by Jonathan Clemens, PA-C, Feb. 2, 2023
6. Kolva E, Rosenfeld B, Saracino R. Assessing the Decision-Making Capacity of Terminally Ill Patients with Cancer. *Am J Geriatr Psychiatry* 2018; **26**(5): 523-31.
7. Cicely Saunders, cited in Kerr, Christopher and Carine M. Mardorossian. *Death Is but a Dream: Finding Hope and Meaning at Life's End*. New York: Avery, an imprint of Penguin Random House LLC, 2020.