Submitter:	Morgan Mohalla
On Behalf Of:	
Committee:	Senate Committee On Rules
Measure, Appointment or Topic:	SB1003

As a concerned citizen and advocate for ethical medical practice, I argue that this legislation undermines the core values of medicine, introduces dangerous conflicts of interest, and risks coercive pressures on vulnerable patients. Instead of endorsing policies that facilitate death, we must prioritize strengthening hospice and palliative care to ensure compassionate, dignified end-of-life care for all.

The practice of medicine is rooted in the principle of preserving life and alleviating suffering, as enshrined in the Hippocratic Oath's commitment to "do no harm." Physician-assisted suicide, as facilitated by SB 1003, fundamentally contradicts this ethos by involving physicians in actively hastening death. The American Medical Association (AMA) has consistently stated that physician-assisted suicide is "incompatible with the physician's role as a healer." By enabling doctors to prescribe lethal medications, SB 1003 erodes the trust patients place in healthcare providers, transforming the physician from a caregiver to a potential agent of death. This shift risks undermining the integrity of the medical profession and the patient-physician relationship. Medicine should focus on healing and comfort, not on expediting death, which is more akin to euthanasia than a dignified end-of-life process.

SB 1003 introduces troubling conflicts of interest that prioritize cost and convenience over patient welfare. Healthcare systems, particularly in an era of managed care and cost containment, face financial pressures to reduce expenses. Assisting in a patient's death is often cheaper than providing comprehensive, ongoing care for complex, chronic conditions. This creates a perverse incentive for insurers, healthcare organizations, or even overburdened families to favor assisted suicide over resource-intensive treatments like hospice care. Patients may feel indirect pressure to "choose" death to alleviate perceived burdens on their families or society, especially when high medical costs are a concern. Some patient cases in Oregon showed that patients cite financial strain as a factor in considering assisted suicide, raising questions about whether these decisions are truly autonomous or influenced by external economic pressures. Such conflicts of interest compromise the principle that medical decisions should prioritize the patient's best interests, not the bottom line of healthcare systems.

Recommending physician-assisted suicide presents patients with a coercive false choice: death or prolonged suffering. This framing is misleading and fails to acknowledge the transformative potential of high-quality hospice and palliative care. Patients facing terminal illness often fear unbearable pain, loss of autonomy, or becoming a burden, but these concerns can be addressed through comprehensive

end-of-life care that prioritizes symptom management, emotional support, and spiritual care. By expanding access to assisted suicide, you risk normalizing death as a solution, subtly pressuring vulnerable patients, particularly those with disabilities, low socioeconomic status, or untreated mental health conditions, to view it as their only viable option. The absence of robust safeguards to detect coercion, especially in the 60% of Oregon cases where no healthcare provider is present when lethal medication is taken, heightens the risk of abuse. True patient autonomy requires informed choices supported by access to all alternatives, not a system that implicitly endorses death over life.

Thank you for your time and consideration in this matter.

Morgan Mohalla