Testimony on Oregon Bill SB 1003

Dear Esteemed Members of the Oregon Senate Rules Committee:

I wish to make my objections to SB 1003 as clear as possible in the next few paragraphs.

First, be advised that in my remarks, I will use the term **assisted suicide** to describe the practice which was legalized by the so-called Death With Dignity Act in 1994. I am convinced that we must call things by their proper names, in order that we might come together to understand solve the problems that face us in our current political situation.

Now, to the issues raised by the bill:

Pages 1-2, Sections 1 and 2 discuss hospice care, requiring hospice facilities to disclose their stance on assisted suicide to the public. This has the detrimental effect of creating an association between hospice care and assisted suicide, by causing potential clients to ask the question, “Can a patient die by lethal poison here, or not?” The proper answer to this question, in every single case, ought to be No – for one simple reason: <u>Assisted suicide is not and never has been part of the philosophy of hospice care.</u> In fact, assisted suicide does not belong at all in the field of palliative care. <u>It is the exact opposite of, the complete rejection of, palliative care</u>. I know that Oregon has folded and stuffed assisted suicide requests into its palliative care statistics; this has been wrong-headed from the start, though it is not addressed in this bill.

Page 2, line 42: “(12) “**Practitioner** means a <u>physician</u> licensed under ORS 677.100 to 677.228.” (emphasis mine). If a person licensed by the state as an **MD or DO** is what is designated by the word **practitioner,** what is the point of 11 pages’ worth of changing the word *physician* to *practitioner*? This is confusing because in common health care usage, the word *practitioner* has a wider meaning than this artificial definition gives to it; specifically, the word includes other categories of providers, such as physicians’ assistants (PAs) and nurse practitioners (NPs). The only reason I can see for such an unnecessary, confusing change is that assisted-suicide advocates intend later to broaden the types and numbers of health care providers allowed to 1) make diagnoses of terminal conditions, 2) determine whether patients suffer from any psychological conditions, and 3) prescribe presumably lethal cocktails of controlled substances… and at that later time, they can do it by simply obliterating this one line.

Physicians undergo 8-12 years of graduate-level education (including residencies and practicums) to obtain their credentials. PAs and NPs, however, can be licensed in their fields after only 6 years of graduate study. PAs and NPs make great contributions to the health and wellbeing of their patients, but <u>they do not have the training and experience necessary</u> to make these complex diagnoses or decisions. A recent study published in the British Medical Journal proves that even physicians are unable to reliably predict whether a terminally-ill patient will live for 6 months or less. Its title: <u>The inherently uncertain trajectories of terminal illnesses pose challenges for clinicians</u>. https://www.bmj.com/content/388/bmj.r490 Their conclusion: "Prognostic eligibility criteria are limited by the fact that prognosis is inherently uncertain and **there are no valid tools, tests, or clinical examinations that can reliably and safely identify that a person is expected to die within six months**." This and other studies of the accuracy of 6-month terminal prognoses show physicians are proven wrong 37-40% of the time. If this is the best that MDs and Dos can do, PAs and NPs will surely not be better at it.

Page 5, Sections 11 and 13 revise the timeline for DWDA requests to be processed, shortening the waiting time between requests and prescription-writing to 7 days (from 15 days). PAS advocates often downplay the presence of depression or other mental conditions that could compromise the informed consent of a terminally-ill patient; they have tried in the past to do away with the suggestion of psychological evaluation altogether. However, you should know that the psychiatric protocol for the diagnosis of depression <u>takes at least two weeks</u>, and handling suicidal ideation is often a part of it. That is, a 'durable' bout of depression is one that lasts for two weeks or more; episodes can pass more quickly. The reduction of the wanting period to 7 days puts people with a passing episode of depression at great risk.

Lastly, on Page 6, Section 16, lines 39-40 read: "Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing…" This sentence remains unchanged from the previous version of the law, but I wish to point out that it is still, not to put too fine a point on it, BS. (Or 'Newspeak', if you prefer.) Ending one's own life by one's own efforts is, in fact, suicide. Giving help to someone intending to end their life, in "a humane and dignified manner" or any other sort of manner, is assisting a suicide. You absolutely must face the reality of what is happening here. Removing the word 'suicide' from the debate will not change the fact that socially, psychologically, and physically, these acts are **suicides** - and they will have the family, local, and statewide repercussions that suicides have.

Please, do not do further damage to our social fabric by passing this bill.

Respectfully submitted,

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