

Testimony in opposition to OR SB 1003-A Engrossed
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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, promoting good palliative care. I have expertise in pediatric anesthesiology, critical care, and medical ethics. We oppose SB 1003-A Engrossed. Please see the following reasons for our opposition.

1. **Reducing the waiting period to 7 days from 15 days (p. 5, lines 27-31, 40-43) does not allow adequate time to fully assess a patient who may be suffering from complex emotional/mental health/existential problems that can worsen physical pain.** Mental health problems and deficits in decision-making capacity are common in the terminally ill but often missed by physicians. **This bill devalues vulnerable patients suffering from disabilities—such as mental health problems, lack of capacity, psychological distress over loss of function—that will not be uncovered due to inadequate time for assessment.** Nor is there time for patients to change their minds, which they often do.
 - a. 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. 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.
 - b. 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.
2. **There are good medical reasons to DISALLOW lethal drugs the closer a patient gets to death, but this bill authorizes the opposite (waiving the waiting period for patients close to death)—and allows this difficult determination by one clinician, without any defined expertise, and without a second opinion.** (p. 5, lines 44-45 to p. 6, lines 1-4) **PATIENTS WITHIN A WEEK OF DEATH USUALLY HAVE COMPROMISED MENTAL CAPACITY AND INABILITY TO INGEST LIQUIDS, MAKING CONSENT UNLIKELY AND INGESTION DANGEROUS.**
3. **Shortening and/or eliminating the waiting period provide a mechanism for anyone, whether terminally ill or not, to access lethal drugs through voluntarily stopping eating and drinking (VSED). This is happening in OR, but physicians have not been sanctioned for this abuse.**
 - a. Voluntarily stopping eating and drinking (VSED) has been used as a “bridge” to prescription of lethal drugs in Oregon. In 2023, Oregon resident Cody Sontag, decided to commit suicide via VSED to prevent her dementia from advancing. On her fifth day of VSED, a physician assessed Cody as “terminally ill” due to dehydration, and a consulting physician concurred through telehealth. The physician determined that Cody would die within 15 days and waived her waiting period; she died by lethal drug ingestion 2 days later. This action is in clear violation of Oregon’s law which defines terminal illness as an “incurable and irreversible disease.” Dehydration is neither incurable nor irreversible, nor is it a “disease.” Additionally, dehydration reduces cognition, and this is worsened by a baseline of dementia; it is unlikely that Cody had sufficient decision-making capacity to make her consent valid. VSED could potentially be used in this way for any adult for any reason. In 2024, 179 patients (29% of those who received lethal drug prescriptions) had their waiting periods waived. How many of these patients had an induced “bridge” to lethal prescriptions like Cody? No one, including physicians, should be granted god-like powers to decide which disabilities make life worthless and to assist with termination of those so judged.
4. **The bill removes the requirement for the second opinion to include evaluating patient capacity, absence of coercion, and a fully informed decision.** (p. 3, lines 42-43; p. 4, lines 35-40) These are potentially more difficult assessments than determining the presence of a terminal disease, and a second opinion should be mandatory for those assessments.

5. **Requiring health care facilities and hospice programs to publicly disclose their positions on participation in assisted suicide may be a conscience violation.** Assisted suicide is not considered a medical procedure but unethical patient abandonment by most physicians and health care practitioners in the world. Requiring health care facilities or programs to make statements about their degree of involvement with it has the effect of making those facilities appear to agree that assisted suicide is a medical practice, even when they do not agree that it is. This is a conscience violation.
6. **Changing the word “physician” to “practitioner” is confusing and unnecessary if only physicians are allowed to prescribe lethal drugs. The obvious reason for this word change is to set the stage to allow non-physicians, such as nurse practitioners or physician assistants to prescribe lethal drugs by a simple definition change of “practitioner” in line 42 on page 2 (p. 2, Sec. 3, lines 8-9, 15-17, 42). 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. Reasons to not open the door to non-physicians:**
 - a. Proponents have stated that rural areas lack physicians willing to prescribe lethal drugs, and advocate allowing non-physicians to participate to expand access in these areas. However, both rural access to palliative care and the number of palliative care prescribers are estimated to be insufficient to meet Oregon’s needs.¹ **It is a disservice to patients to potentially make lethal drugs more accessible than palliative care.**
 - b. [Medicare requires that a physician](#), not other types of clinicians, certify that a patient is terminally ill for hospice admission.
 - i. Although physicians are frequently wrong about a 6-months prognosis, there is [evidence that physicians are more accurate than nurses in prognoses](#).
 - ii. Physicians often miss depression² and deficits in decision-making capacity³; those with lesser qualifications should not make such judgments.
 - iii. **The training of physician assistants (PAs) is insufficient** in end-of-life care, evaluating a patient’s decision-making capacity, determining prognosis for terminal illness, or deciding that death is imminent.⁴
7. Given the current abuse of Oregon’s law, allowing it to function as a mechanism for termination of people who may not be terminally ill or may be under coercion, please oppose SB 1003, which drops further safeguards. Instead, perhaps further safeguards and better oversight need to be put in place.
 - a. VSED, as described in #3 above, is being used as a way for non-terminally ill patients to obtain lethal drug prescriptions.
 - b. In Oregon, patients are getting lethal prescriptions for diagnoses of anorexia, hernia, and arthritis ([Oregon 2021 Data Summary](#), p. 14, footnote 3)—diagnoses that are not terminal by themselves—but there is no process for challenging physician actions. [Oregon, California, and Colorado have unethically provided lethal drugs to patients with eating disorders](#).
 - c. [Thomas Middleton, a terminally ill Oregon resident, moved in with the trustee of his estate and then died by physician-assisted suicide in 2008](#). The trustee sold his house and deposited the money in her account; she was arrested on theft and criminal mistreatment charges, but whether physicians had inappropriately prescribed lethal drugs (by not properly investigating coercion) was never investigated.

NOTES

1. 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. <https://scorecard.capc.org/wp-content/uploads/2020/02/State-Report-2024-Oregon.pdf>
2. Oregon patients with depression have died from lethal prescriptions. Ganzini, L., E. R. Goy, and S. K. Dobscha. "Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying: Cross Sectional Survey." *Bmj* 337 (2008): a1682.
3. 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. Kolva, E., B. Rosenfeld, and R. Saracino. "Assessing the Decision-Making Capacity of Terminally Ill Patients with Cancer." *Am J Geriatr Psychiatry* 26, no. 5 (May 2018): 523-531. <https://www.ncbi.nlm.nih.gov/pubmed/29398351>.
4. As of 2023 only 227 PAs (0.2%) in the nation had specialty training in hospice and palliative care. This bill does not distinguish between PAs with experience/expertise and those without. <https://www.nccpa.net/wp-content/uploads/2024/07/2023-Statistical-Profile-of-Board-Certified-PAs-by-Specialty-Annual-Report.pdf>, p. 6