

Submitter: David Richter
On Behalf Of:
Committee: Senate Committee On Rules
Measure, Appointment or Topic: SB1003
Honorable Members of the Committee:

I write in strong opposition to the proposed modifications to the Oregon Death with Dignity Act that would shorten or eliminate the current safeguards, including the waiting period. These changes are not only ethically indefensible—they are medically and physiologically incoherent. The foundation of Oregon’s physician-assisted death statute rests on informed, voluntary consent and the patient’s ability to self-administer the prescribed medication. The proposed revisions effectively discard both.

Informed consent is not optional; it is the ethical and legal foundation of all medical decision-making. The clinical literature is clear and consistent: at a Palliative Performance Scale score of 10% or below—typically reached within the final weeks of life [1]—patients are almost universally incapable of sufficiently participating in the consent process [2]. Such patients experience profound cognitive impairment, confusion, fatigue, and in many cases, delirium. Many are sedated. Under these conditions, they cannot process complex information, weigh alternatives, or appreciate the finality of the act they are being offered. To pretend such vulnerable patients can engage in meaningful decision-making is not just false—it’s a dangerous misrepresentation of the facts.

Even if consent is obtained, many could not act. The law requires that patients self-administer the lethal medication. Yet at this stage, most cannot swallow, sit upright, or even hold a cup. These are not abstract issues—they are fundamental physiological facts. This sets up a cruel and confusing scenario in which patients are told they qualify for something they physically cannot complete, leaving caregivers and clinicians in an ethically untenable position.

This is not a hypothetical concern. If these changes pass, the reality will be patients unable to comprehend their choice, unable to complete the act themselves, and yet still funneled through a process that ends in death—without the capacity or agency to fully understand or participate in that outcome. Oregon’s original law, while controversial to some, was at least grounded in careful procedural safeguards. These changes would obliterate such safeguards, resulting in the most vulnerable patients being pushed toward death not because they truly chose it, but because they were suffering, disoriented, and could not adequately evaluate their choices.

This is not “death with dignity”; it is systematic abandonment of patients who are at the most vulnerable moments of their lives. I urge you in the strongest possible

terms—do not mistake acceleration for compassion. Vote no on these unethical and untenable modifications.

1. Goswami R, Moore J, Bruera E, Hui D. Assessment of the Decision-Making Capacity for Clinical Research Participation in Patients With Advanced Cancer in the Last Weeks of Life. *J Pain Symptom Manage*. 2020 Aug;60(2):400-406. doi: 10.1016/j.jpainsymman.2020.02.014.
2. Lau F, Maida V, Downing M, Lesperance M, Karlson N, Kuziemy C. Use of the Palliative Performance Scale (PPS) for end-of-life prognostication in a palliative medicine consultation service. *J Pain Symptom Manage*. 2009 Jun;37(6):965-72. doi: 10.1016/j.jpainsymman.2008.08.003.