Statement on Senate Bill 1003, Relating to the Oregon Death with Dignity Act

Barbara Coombs Lee, President Emerita and Senior Advisor, Compassion & Choices and the Compassion & Choices Action Network

Senate Committee on Rules

Monday, June 2, 2025 | 1:00pm

My name is Barbara Coombs Lee. My credentials are nurse, physician assistant and retired attorney. In 1994 I was a co-author and one of three chief petitioners of Ballot Measure 16, the Oregon Death with Dignity Act. After its passage I was its advocate and spokesperson through assault in this legislature, a statewide repeal attempt, two federal court challenges, the US Department of Justice, and the US Congress. I'm currently President Emerita of Compassion & Choices and the Compassion & Choices Action Network, the nation's oldest and largest organization dedicated to improving end-of-life care, expanding options and empowering everyone to chart an end-of-life journey that reflects their values, priorities and beliefs.

Oregon's Leadership in End-of-Life Care

Oregon has been a national leader in expanding medical practice to include medical aid in dying and accumulating research data on its impact.

Now, with nearly three decades of experience, Oregon's approach has set the standard for all subsequent legislation. The evidence is clear: medical aid-in-dying laws provide a compassionate option for terminally ill individuals while maintaining strong safeguards for patients and providing legal protection for healthcare providers who choose to participate.

Today, I write in support of SB 1003, which seeks to modernize the Oregon Death with Dignity Act to improve patient access while preserving its essential safeguards. I also offer amendments to ensure these updates maintain the integrity and intent of the original law.

Key Improvements in SB 1003

<u>Expanding Access to Qualified Providers</u>

As originally introduced, SB 1003 would allow Physician Assistants (PAs) and Nurse Practitioners (NPs) to serve as attending and consulting providers. This is a necessary step, as these Advanced Practice Registered Nurses and PAs frequently provide ongoing care to terminally ill individuals. By broadening the pool of qualified providers, the bill helps address the disparity in access—particularly for patients in rural areas, with few, if any participating physicians.

I urge you to restore this provision. In order to ensure that more Oregonians have access to medical aid in dying if they receive care from a PA or NP. This is especially important in rural Oregon communities that are served primarily by non-physician healthcare providers.

Reducing Burdensome Waiting Periods

Currently, many terminally ill patients struggle to complete the multi-step process required under the Oregon Death with Dignity Act. Even without the mandated waiting period, it often takes weeks or months to navigate. Rather than serving as a safeguard, this waiting period has become an unnecessary barrier, forcing some individuals to suffer while they wait for access to medical aid in dying—if they survive long enough to complete the process at all.

As originally written, SB 1003 proposes reducing the waiting period between oral requests to 48 hours and adjusting the waiting period for written requests to 48 hours from the initial oral request. Nothing in the proposed bill would reduce the requirement that a patient is capable of making an informed decision. The updated version of the bill changed the waiting period between oral requests to seven days. While we would prefer the waiting period to be 48 hours, we are supportive of the reduction of the waiting period between oral requests to seven days.

Four other jurisdictions have already reduced waiting periods for medical aid in dying, recognizing the undue burden they place on patients. In 2021, New Mexico passed its medical aid-in-dying law with a 48-hour waiting period and a waiver for patients unlikely to survive even that long. Oregon should join New Mexico, California, Colorado, Washington, and Hawaii in modernizing its law to prevent needless suffering.

Concerns with Proposed Changes in SB 1003

While SB 1003 makes some necessary improvements, we strongly oppose one proposed change:

Altering the Definition of "Terminal Disease"

SB 1003 proposes removing the phrase "an incurable and irreversible disease" from the definition of "terminal disease" and changing the terminal condition from a "disease" to an "illness". I urge you *not* to change this definition. The original definition is crucial to retain a clear and objective qualifying criterion. A disease is objective and measurable. An illness is subjective and personal.The current definition excludes those with chronic diseases and life-preserving treatments and ensures medical aid in dying remains available only to individuals facing an illness that cannot be cured or reversed and that, within reasonable medical judgment, will result in death within six months.

The criterion of terminality should always relate to the natural progression of disease—not a patient's personal treatment decisions. This was the intent of the authors and more important, the clear understanding of Oregonians who voted for the law. By maintaining the explicit language of "incurable and irreversible," we preserve clarity in eligibility and prevent misinterpretation of the law. Perhaps more importantly, keeping the original language guards against creating a loophole that could distort the fundamental purpose of the law and essentially swallow long-established eligibility rules that have kept the practice safe for 28 years.

Altering Duties of the Consulting Provider

A consulting provider must confirm that a patient is qualified for medical aid in dying. This includes "verification that the patient is capable, acting voluntarily and making an informed decision." We recommend not removing this requirement from Section 7.

Recommendations for Additional Changes in SB 1003

We are excited about the improvements proposed by SB 1003 and also think the following changes would increase access to medical aid in dying in Oregon and make the law less vulnerable to litigation.

Addition of definition of self-administration

The Oregon Death with Dignity Act requires self-administration and prohibits injections, but these stipulations should be made clearer by adding a definition of "self-administration." A thorough and concise definition would prevent varying interpretations of the term, strengthen the principle of self-determination, and ensure that the patient remains in control. The self-administration requirement is a core patient safeguard to prevent coercion and distinguish the practice from euthanasia. The jurisdictions where medical aid in dying is currently authorized all require that medication be self-ingested. The definition of self-administration must specify that the medication be ingested by the qualified patient, and does not include injection or infusion. Our proposed amendment also reinforces current law: medication cannot be administered, even by the patient themselves, via injection, infusion, or any other parenteral route. Parenteral route means administration outside of the digestive tract including intravenous, intramuscular and subcutaneous administration.[1]

We recommend adding the following definition to Section 3:

> (14) "Self-administer" means a qualified individual performs an affirmative, conscious, voluntary act to ingest medication prescribed pursuant to this Act to bring about the individual's peaceful death. Self-administration does not include administration by any parenteral route, injection or infusion.

As the first law to authorize medical aid in dying, Oregon is looked to as a model for future bills. Being explicit about self-administration will clarify and reinforce the original legislative intent and safe practice standards.

Clarify "Capable" Definition

In order to qualify for medical aid in dying, an attending and consulting physician must confirm a patient's ability to make an informed healthcare decision. The current and proposed definition of "capable" should be modified to make this requirement clear.

We recommend the following changes to the definition of "Capable":

(3) "Capable" means that ~~in the opinion of a court or~~ in the opinion of the patient's [attending physician] attending practitioner and consulting practitioner [or consulting physician], psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication

---

[1] Cambridge University Press, "Medication Safety: An Essential Guide, Chapter 7: Parenteral Administration." January 22, 2011. Available at: https://www.cambridge.org/core/books/abs/medication-safety/parenteral-drug-administration/B00E3CE7C00873D4114AA08E8B92DD86.

through persons familiar with the patient's manner of communicating if those persons are available.

Edit the immunity provisions in the law to minimize litigation risk

In December 2022, a physician and Christian Medical and Dental Associations sued the State of New Mexico challenging, among other points, the constitutionality of the law's language that required a professional organization or association to "not subject a person to censure, discipline, suspension, loss or denial of license, credential, privileges or membership or other penalty for participating, or refusing to participate, in the provision of medical aid in dying in good faith compliance with the provisions of the End of-Life Options Act."

The State of New Mexico settled the lawsuit quickly and removed this requirement from the End of Life Options Act via legislative amendment. Going forward, C&C recommends that the "professional organization and association" language not be included in any medical aid in dying law as CMDA may sue asserting that the State should not restrict how an association determines its membership in this way.

The inclusion of private organizations or associations in the immunities section of the Oregon Death with Dignity Act is likely to increase the risk of litigation on the grounds that the state cannot dictate membership rules to private entities.

We recommend the following edit:

A ~~professional organization or association or a health care provider~~ health facility or licensing board shall not subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for refusing to participate in this act or for participating in good-faith compliance with this act.

Conclusion

With the recommended amendments, SB 1003 will strike the right balance—preserving strong safeguards while ensuring that eligible individuals can access medical aid in dying without unnecessary barriers. These updates will honor the original intent of the Oregon Death with Dignity Act and ensure it continues to serve Oregonians with compassion and integrity.

We appreciate your leadership in advancing thoughtful policy improvements and welcome the opportunity to collaborate further. Thank you for your time and consideration.

The Compassion & Choices family comprises two organizations: Compassion & Choices (the 501(c)(3)), whose focus is expanding access, public education and litigation; and Compassion & Choices Action Network (the 501(c)(4)), whose focus is legislative work at the federal and state levels.

Paid for by Compassion & Choices Action Network