

Date: March 18, 2019
Re: Testimony in Opposition to House Bill 2217
House Health Care Committee

Dear Chair Salinas, Vice Chair Nosse, Vice Chair Hayden and members of the committee,

I am a Board-Certified psychiatrist and have been practicing in Oregon for over 18 years and have thirty years of experience in the field of psychiatry altogether and this is the third country where I have practiced psychiatry. Currently my psychiatric practice extends from Harney County to Douglas County and part of my work I have been taking care of nearly 160 patients who have various neuropsychiatric conditions, and many are elderly, those with various forms of brain injuries and residing in care homes and we provide the end of life care for many of them in these homes.

As a psychiatrist I have spent my career in serving those with various mental illnesses, helping those who suffer immensely due to many different mental health conditions, hopelessness or struggle with thoughts of suicide and many have ended their life due to suicide. My work involves saving life and not killing life!

Sadly, Oregon has a very high suicide rate and poor mental health system.

I am opposed to House Bill 2217 for two reasons: First, HB 2217 is inconsistent with the work I do as a psychiatrist, and secondly, capacity evaluations for persons requesting the prescription are not thorough enough.

As a psychiatrist, this is a slippery ethical slope as my job involves working hard to prevent suicide and help those who are at high suicide risk, help them remain safe and often with involuntary hospitalizations and have to override their autonomy and civil liberties when we admit them to the hospital, take away their means, prevent freedom as we know that once they get through the crisis, they can with the help of counseling, mental health treatment, they will regain hope and lead a fruitful life. Even in the face of terminal illness, I have found the prediction of the days they are expected to live is false and the days in their life can be spent in helping them take care of their unfinished business, make amends, help say good bye with their loved ones and transition smoothly. All that requires availability of quality psychiatric and psychological care at last stage in their life, reaching out to the family and the loved ones, help them prepare for the transition, help address their anticipatory grief. Unfortunately, in Oregon the death with dignity Act report shows only 1.8% of those who requested were referred for psychiatric consultation. In 2016, the average duration of the patient-physician contact was just 13 weeks! This is clearly not enough time to address the grief, evaluate capacity for informed decision making by those asking for assisted suicide.

- HB 2217 is also inconsistent not only with my work to prevent suicide, but also with all the efforts around the state to prevent suicide. Oregon is in the middle of a mental health and suicide crisis. On average, two Oregonians die a day by suicide.
- Suicide is the ninth leading cause of death in Oregon.
- Our state is ranked in the top 10 among states for suicide incidence.
- Seventy percent of people who died by suicide had a diagnosed mental disorder or depression at the time of death.

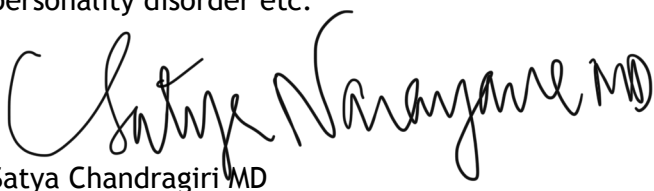
Legislation has been proposed to prevent suicide for youth and adults (at least ten bills to prevent suicide have been proposed in the 2019 session) while simultaneously expanding access to assisted suicide.

It seems to me that HB 2217 which is expanding the ways a person can medically kill themselves is sending extremely mixed messages to our youth, the disabled, and terminally ill.

ie- It is not okay for someone to commit suicide under these conditions and we will offer you as many resources and help as possible, yet under these conditions it is okay for a person to commit suicide and here are the various ways you can end your life. We can do better than permit and promote suicide on one hand and prevent it on the other. This is one of the main reasons I oppose HB 2217.

Additionally, I oppose HB 2217 because capacity evaluation for those requesting assisted suicide is a complex task. Leaving it to the attending physician and with low psychiatric consultation request (1.8%) or even not seeking a second opinion is a matter of grave concern. The relationship between terminally ill patient and the physician is asymmetric, with safety, information and power on the side of the physician. If assisted suicide is a legal option, the physician may feel obliged to list it as an option and the patient may feel obliged to consider it. The patient may feel he has to make the decision under duress, or fear of losing his quality of life, dignity, becoming a burden on family and other stated reasons. If the physician does not discuss this as an option, it poses additional ethical dilemma by withholding an option.

Capacity evaluation is very complex task and not part of the training of all medical professionals. In terminally ill patient they have a high likelihood of neuropsychiatric conditions, depression, other undiagnosed psychological conditions, dementia and cognitive problems, fear, pain, fatigue, worry. In addition, without a detailed psychological evaluation it is hard to evaluate if there have been any personality traits that predispose the person to suicide risk. The capacity evaluation requires training and expertise by the evaluator, the capacity evaluation is function based and assess capacity specific ability. Most evaluations are commonly referred to as "Applebaum's criteria". However it depends on the fidelity to the set of questions, the patient's ability to comprehend language and express, context based and there is significant variation between examiners. Just because the patient makes a stable choice and repeats within two weeks is not by itself an indication of capacity to give informed consent. Those in terminal stage of their illness often have significant brain changes. It impacts their language expression and comprehension. The brain function can fluctuate. Many of those I serve have brain damage, dementia, delirium, and multiple health concerns such as cancers, renal, liver or lung disease etc. which impact brain function. Some need a guardian for decision making as they lack capacity but cannot afford to have a legal guardian as it is financially unaffordable. If the patient can't decide, will the legal guardian be required to make the decision? Will this open the door for euthanasia for - minors, those in jails and prisons, if they cannot afford housing or medical care, those who have no insurance and cannot afford health care, swallow, those with mental illness or addiction or personality disorder etc.


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