Date: April 5, 2019
Re: Testimony in Opposition to Senate Bill 579

Dear Chair Prozanski, 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. Part of my work I have been taking care of nearly 160 patients who have various psychiatric and neurological 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, those who struggle with thoughts of suicide and some end their life by suicide. My work involves saving life and not killing life!

I am opposed to Senate Bill 579 because of 4 reasons:

1. Diminished Capacity for informed consent: There is serious challenges in capacity evaluation and obtaining informed consent in the terminal phase of life. At this stage in life the people are confused, with fluctuating consciousness, many can not comprehend instructions or communicate due to language and speech limitation, have severe cognitive problems. They have a high likelihood of undiagnosed depression, dementia, 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. Capacity evaluation is not part of the training of all medical professionals. The capacity evaluation requires training and expertise by the evaluator. 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.
2. Turning Healers into Killers: It is inconsistent with my work as a psychiatrist where I have worked hard to prevent suicide. I help them remain safe. Sometimes I must consider involuntary hospitalizations and must override their autonomy and civil liberties when I admit them to the hospital, take away their means, prevent freedom. We know that once they get through the crisis, they can with the help of counseling, mental health treatment, 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 is 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. 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. 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. In 2016, the median duration of the **patient-physician relationship was 13 weeks (range 1- 1905 weeks)**! Reducing the time to determine capacity as SB 579 does, to hours or only a few days is also not enough time. If the steps to get the prescription are removed because a person is going to die before getting the prescription, there will be no time to address the grief and evaluate capacity for informed decision making by those asking for assisted suicide.

3. Price Gouging and exploitation: One worries if this bill will lead to preying on those near death by the industry and other interest groups as there is already price gauging by the manufacturers of death penalty and assisted suicide drugs. Some have increased the price as much as $25000 from the dying vulnerable people while only 0.6% of Oregon physicians prescribed it! I hope this does not lead to people profiting from those near death? Instead why not expand Hospice or palliative care to the terminally ill and reduce suffering?

4. Ethical Slippery slope: Oregon's Death with dignity act data shows some very disturbing trends that needs to be addressed before we hastily make amendments and fast track the process by removing the 15 days waiting time. How to account for the Botched procedure in 7 patients (0.6%)? One third of the patients who received prescription never took them and it supports the fact that many are ambivalent. When the waiting period is eliminated there is risk that we may end up killing those who would have changed their mind! I called the Legislative committee of Oregon Psychiatric Physician Association and we discussed this bill. It is clear it is an emotional and ethically controversial, the opinion is divided and in such a short time it is hard to come up with a clear position. Even Oregon Medical Association or any medical or health care association has been able to come up with a clear stand. Our committee wondered what is the real motive behind such a haste to pass this bill through and remove any safeguards? Oregon is a leader in many important landmark legislations. Let us not be in a haste to get such an important bill without thorough ethical or deeper scrutiny and in such a haste! There is no clarity as to who is the attending physician? The hospital admitting doctor who was on shift when the patient was admitted, the doctor covering

for the regular primary care physician, the emergency room doctor or the physician who has taken care of the person requesting the assisted suicide drugs for long term basis? The relationship between the treating doctor and the vulnerable end stage patient is asymmetric and there are no safeguards in ensuring no one is coerced into making such a hasty decision. Some need a guardian for decision making as they lack capacity. 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. Will this eventually end in a similar situation as the infamous Operation T4 when the Nazi Ideologues turned Healers into Killers when they came up with the mercy killing theories?

As a Physician I feel it is my ethical duty to oppose this and speak up. It is for these reasons I ask you to oppose SB 579.

Satya Chandragiri MD