Dear Chair and Honorable members of the Senate Judiciary committee:

I am a Board-Certified psychiatrist and have been practicing in Oregon for nearly 23 years and have thirty-five 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 Eastern Oregon 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.

I am opposed to Senate Bill 891 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 cannot 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, Physician Assistant or Nurse Practitioners. 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 48 hours is not by itself an indication of capacity to give informed consent.
2. Waiting Period: The reduction of the waiting period to 48 hours is a concern as patients can be in a state of delirium or confusion state and not much can change except fluctuation of the cognitive status while making the request. It is unclear why there is a hurry to write the prescription if the natural death is likely to occur sooner than 48 hours waiting time.
3. Residency Requirement removal: This is a concern as it should not lead to families moving frail, potentially cognitively impaired persons across the state line and have someone testify they know the person and obtain prescriptions to die or hasten death. Having a witness testify is not a substitute to having good therapeutic relationship with the patient and the attending physician do a detailed capacity evaluation to ensure there is no misuse of this law especially if family members start to bring persons to our state only to use the death with dignity law and lead to death tourism in Oregon.
4. 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)**! Now someone can write the prescription even after only one visit and without any therapeutic relationship with the patient!

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 891.

Satya Chandragiri MD