

Letter Opposing SB1003

Satyanarayana Chandragiri MD

Chandras Clinic, PC

PO 4060

1249 Fairview Ave SE

Salem, OR 97302

chandrasclinic@me.com

Tel: 503 269 9915

Fax: 503 371 2006

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**Respected Hon. Chair Jama, Vice Chair Bonham and members of the
Senate Committee on Rules**

I am writing to express my strong opposition to Senate Bill 1003 (SB1003). The amendment does not address the strong concerns that is the basis for this opposition.

I am a Board-certified Psychiatrist. I have served in three countries and now serving Oregon for nearly 25 years. I serve the 12 counties in Eastern Oregon, Eugene and all the way to Douglas County.

As a practicing psychiatrist and serving those with mental illness, developmental and cognitive disabilities, various chronic mental illnesses and dementia, brain injuries, compromised language and communication disabilities and often estranged from families or support system, they are some of the most vulnerable sections of our communities. Nearly all of them have lost the agency to speak or advocate for themselves and have struggles with access to care or they end up in the long-term care where I get to serve them. The people I serve have severe distrust, often end up being homeless, justice involved and have poor health in general.

Most lack the capacity to give informed consent even though they may express a choice. Ideally, they need a legal guardian but due to lack of resources, we are unable to get them a legal guardian in most cases. The combination of severe cognitive disabilities compromised medical and mental health, distrust and severe estrangement from the family or support system requires significant effort on our part to engage them in treatment and help them reconnect with their loved ones and eventually when they reach the terminal stage, we involve the hospice care to focus on ensuring they are free from pain and suffering.

My concern with this bill is as follows:

1. **Counseling referral.** If in the opinion of the attending practitioner or the consulting practitioner a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either practitioner shall refer to the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. **When I reviewed the OHA Death with Dignity Act data- in 2024 of the 135 physicians who wrote 607 prescriptions, only 3 patients were referred to psychological evaluation or psychiatric treatment. In 2023 out of 167 physicians, 560 prescriptions written, only 3 patients referred to psychological evaluation or psychiatric treatment, in 2022 out of the 146 physicians, 431 prescriptions written, only 3 referrals for psychological evaluation or psychiatric treatment, in 2021 out of the 133 physicians writing 383 prescriptions, only 2 referrals for psychological evaluation or psychiatric treatment were made.** One wonders if Capacity evaluation and understanding the complexities in decision making for physician assisted suicide in those at the end of life without ongoing therapeutic relationship, lack of training and experience in psychiatric evaluation or identifying psychological conditions can lead to false referral for these procedures. This is concerning as 30-70% of those with terminal cancers have depression. One wonders if we are missing large number of patients with depression and other psychological conditions contributing to impaired judgment.
2. Removing 15 day waiting period- There is often significant ambivalence at the end of life. Having a consulting practitioner and removing this waiting period will lead to false identification of those who may say 'yes but change their mind' if they were approached later.
3. **A health care facility, other than a hospice program as defined in ORS 443.850, shall have a process in place to, prior to or at the time of an individual's admission to the health care facility, disclose in writing to the individual the health care facility's current policy regarding the ability of admitted patients to participate in the Oregon Death With Dignity Act:** When hospitals, hospice and assisted care facilities, adult foster care, group homes for children, psychiatric residential treatment facilities for children, children or adults with developmental disabilities, forensic psychiatric residential facilities, extended care facilities are asked to disclose and post their policies openly, it will lead to further distrust, turn families and vulnerable elderly away thinking that they are sent there to be killed. In my experience there is already significant fear and misconception with regards to hospice. The patients and their family are often torn with guilt, stigma and struggle with inner conflict. Even mentioning the word hospice leads to reactions – **"you want to kill my mother"** or they delay even consenting to hospice or palliative care. Families and elderly patients struggle with anticipatory grief, having to sell their property, give up their homes and downsize to become eligible to move into assisted care, long term care or have benefits. While there is no other treatment procedures offered are listed upfront and they are discussed individually within the treatment relationship, having such an advertisement sends a wrong message that we are not going to try hard to help them or their loved ones.

I believe that this bill poses significant threats to vulnerable individuals, and I urge you to vote against it.

First and foremost, SB1003 undermines the principle of adequate informed consent and the importance of trusting therapeutic relationship and the physician's ethical duty – to '**do no harm**', which has long been a cornerstone of our health care system. This principle ensures that the sacred duty of physicians is to ensure they have the required training, skill and experience, practice in such a way that they will do no harm, the importance of therapeutic relationship, fiduciary duty and importance of informed consent.

SB1003 if passed **will cause more harm** by broadening the scope of practice by having one time consultant practitioner or even attending practitioners who often have minimal interaction with the patient make hasty decisions while leaving significant gaps in addressing historically very low identification and referral for counselling or psychiatric treatment before considering death with Dignity prescription or removing the waiting period which would have mitigated the ambivalence and advertisement upfront which would lead to vulnerable patients and distressed family members becoming alarmed and distrustful of the facility or the practice of hospice or even avoiding the needed care. In many rural and small towns, there is no choice for the patients and families, and they struggle with health care inequity due to the rural or frontier locations.

Furthermore, the provisions in SB1003 disproportionately affect vulnerable minorities including communities of color, immigrants and those who value the importance of taking care of their elderly vulnerable parents and loved ones till their natural end of life, thereby exacerbating existing inequalities. Many immigrant communities and Black communities have historic suspicion of the health care system. Any discussion of physician assisted suicide upfront or even advertised or posted online **will rekindle their historic trauma including the horrors of Tuskegee experiments** or similar traumatic experiences in Europe and elsewhere and lead to further health access inequity.

This bill fails to consider the nuanced realities faced by many different groups both in the urban and rural locations, and instead, it imposes blanket measures that could lead to more harm. It is imperative that we craft legislation that is equitable and just, rather than one that marginalizes vulnerable populations.

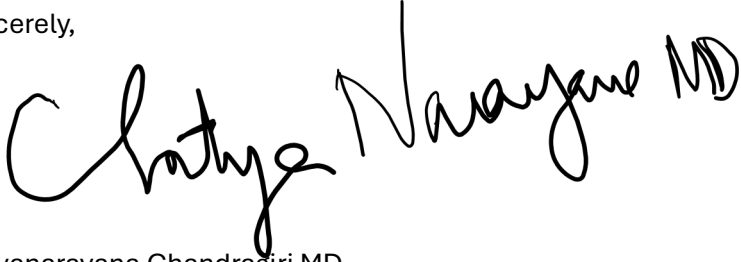
In addition, SB1003 lacks sufficient safeguards to prevent potential abuses. The broad and vague language of the bill leaves room for interpretation that could result in specific abuse or unintended consequences. We must ensure that any legislation passed is clear, precise, and includes robust mechanisms for accountability and oversight.

I strongly urge the Senate Rule Committee to reconsider SB1003 and its implications. Rather than moving forward with this bill, I encourage you to engage in meaningful dialogue with stakeholders

and experts to develop solutions that truly address the underlying issues without compromising our core values and principles.

Thank you for your time and consideration. I trust that you will make the right decision in opposing SB1003.

Sincerely,

A handwritten signature in black ink, reading "Satya Narayana MD". The signature is written in a cursive, flowing style. The first name "Satya" is written with a large, open 'S' and a trailing 'y'. The last name "Narayana" is written in a similar cursive style. The "MD" is written in a more formal, blocky font at the end of the signature.

Satyanarayana Chandragiri MD