SB 193-2
(LC 1103)
4/3/15 (MBM/ps)

PROPOSED AMENDMENTS TO SENATE BILL 193

1 On page 1 of the printed bill, line 2, delete "and".
2 In line 3, before the period insert "; and repealing ORS 127.531.".
3 After line 24, insert:
4 "(c) An attorney-in-fact for health care designated under paragraph (a)
5 of this subsection and an alternative attorney-in-fact for health care desig-
6 nated under paragraph (b) of this subsection may not be one of the following
7 at the time of the designation:
8 "(A) The principal's attending physician or health care provider; or
9 "(B) A paid employee or volunteer of a health care facility or long term
10 care facility where the principal resides.".
11 In line 25, delete "(c)" and insert "(d)".
12 On page 2, line 37, after "physician" insert "or health care provider".
13 On page 3, line 14, delete "may" and insert "shall".
14 In line 15, after "with" insert "evidence-based best practices,".
15 In line 16, before the period insert "and any available input from inter-
16 ested parties".
17 Delete lines 19 through 45 and delete pages 4 through 8.
18 On page 9, delete lines 1 through 22.
19 In line 26, delete "6" and insert "5".
20 On page 10, after line 16, insert:
21
22 "**ADVANCE DIRECTIVE**

1 **"SECTION 6. Section 7 of this 2015 Act is added to and made a part**
2 **of ORS 127.505 to 127.660.**
3 **"SECTION 7. (1) Subject to subsection (2) of this section, the**
4 **Oregon Health Authority shall adopt by rule model forms for advance**
5 **directives and, subject to ORS 127.505 to 127.660, the manner in which**
6 **a resident of this state may execute an advance directive. Rules**
7 **adopted under this section must:**
8 **"(a) Include the adoption of advance directive forms that account**
9 **for a principal's values and that allow a principal to provide informa-**
10 **tion about the basis for the principal's health care choices;**
11 **"(b) Provide for the availability of at least two nationally recognized**
12 **advance directive forms that easily can be made available to a princi-**
13 **pal by the authority or a health care provider;**
14 **"(c) Allow an advance directive to be included as part of a**
15 **principal's medical record; and**
16 **"(d) Establish minimum specifications for any advance directive**
17 **executed in this state, including but not limited to the designation of**
18 **an attorney-in-fact for health care and the designation of an alterna-**
19 **tive attorney-in-fact for health care.**
20 **"(2) For the purpose of adopting, amending or repealing rules under**
21 **this section, the authority shall convene a rules advisory committee**
22 **as described in ORS 183.333. The rules advisory committee convened**
23 **pursuant to this subsection must include, if available and willing to**
24 **participate, the following members:**
25 **"(a) A representative of a medical specialty society located in this**
26 **state that provides support to family physicians;**
27 **"(b) A representative of the Oregon Medical Association;**
28 **"(c) A representative of the Oregon Association of Hospitals and**
29 **Health Systems;**
30 **"(d) An expert in power of attorney law recommended by the**

Oregon Bar Association;

"(e) Two medical ethicists affiliated with hospitals located in this state;

"(f) An individual who represents persons with a disability;

"(g) An individual who represents persons who are elderly; and

"(h) Up to three experts in end-of-life health care as deemed appropriate by the authority.

"**SECTION 8.** ORS 127.531 is amended to read:

"127.531. (1) **Except as provided in section 7 of this 2015 Act,** the form of an advance directive executed by [*an Oregon*] **a** resident **of this state** must be the same as the form set forth in this section to be valid. In any place in the form that requires the initials of the principal, any mark by the principal is effective to indicate the principal's intent.

"(2) An advance directive shall be in the following form:

" ____

ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts About Part B

(Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your "health care representative." You can do this by using Part B of this form. Your representative must accept on Part E of this form.

You can write in this document any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your

desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About Part C

(Giving Health Care Instructions)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using Part C of this form.

Facts About Completing This Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this advance directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTHDATE AND ADDRESS here:

____

(Name)

____

(Birthdate)

____

____

(Address)

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE:

__ My entire life

__ Other period (__ Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint ________________ as my health care representative. My representative's address is __________ and telephone number is __________.

I appoint ________________ as my alternate health care representative. My alternate's address is __________ and telephone number is __________.

I authorize my representative (or alternate) to direct my health care when I can't do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption or that person was appointed before your admission into the health care facility.

1. Limits. Special Conditions or Instructions:

____

____

____

INITIAL IF THIS APPLIES:

__ I have executed a Health Care Instruction or Directive to Physicians.

My representative is to honor it.

2. Life Support. "Life support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:

___ My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding. One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:

___ My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

____

(Date)

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

____

(Signature of person making appointment)

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

- The term "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.

- "Life support" and "tube feeding" are defined in Part B above.

- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.

- You will get care for your comfort and cleanliness, no matter what choices you make.

- You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. <u>Close to Death</u>. If I am close to death and life support would only postpone the moment of my death:

A. INITIAL ONE:

__ I want to receive tube feeding.

__ I want tube feeding only as my physician recommends.

__ I DO NOT WANT tube feeding.

B. INITIAL ONE:

__ I want any other life support that may apply.

__ I want life support only as my physician recommends.

1 __ I want NO life support.

2 2. Permanently Unconscious. If I am unconscious and it is very unlikely
3 that I will ever become conscious again:

4

5 A. INITIAL ONE:

6 __ I want to receive tube feeding.

7 __ I want tube feeding only as my physician recommends.

8 __ I DO NOT WANT tube feeding.

9

10 B. INITIAL ONE:

11 __ I want any other life support that may apply.

12 __ I want life support only as my physician recommends.

13 __ I want NO life support.

14

15 3. Advanced Progressive Illness. If I have a progressive illness that will
16 be fatal and is in an advanced stage, and I am consistently and permanently
17 unable to communicate by any means, swallow food and water safely, care
18 for myself and recognize my family and other people, and it is very unlikely
19 that my condition will substantially improve:

20

21 A. INITIAL ONE:

22 __ I want to receive tube feeding.

23 __ I want tube feeding only as my physician recommends.

24 __ I DO NOT WANT tube feeding.

25

26 B. INITIAL ONE:

27 __ I want any other life support that may apply.

28 __ I want life support only as my physician recommends.

29 __ I want NO life support.

30

4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

A. INITIAL ONE:

__ I want to receive tube feeding.

__ I want tube feeding only as my physician recommends.

__ I DO NOT WANT tube feeding.

B. INITIAL ONE:

__ I want any other life support that may apply.

__ I want life support only as my physician recommends.

__ I want NO life support.

5. General Instruction.

INITIAL IF THIS APPLIES:

__ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. Additional Conditions or Instructions.

____

____

____

(Insert description of what you want done.)

7. Other Documents. A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:

__ I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.

__ I have a health care power of attorney, and I REVOKE IT.

__ I DO NOT have a health care power of attorney.

____

(Date)

SIGN HERE TO GIVE INSTRUCTIONS

____

(Signature)

PART D: DECLARATION OF WITNESSES

We declare that the person signing this advance directive:

(a) Is personally known to us or has provided proof of identity;

(b) Signed or acknowledged that person's signature on this advance directive in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Has not appointed either of us as health care representative or alternative representative; and

(e) Is not a patient for whom either of us is attending physician.

Witnessed By:

______________	______________
(Signature of Witness/Date)	(Printed Name of Witness)

(Signature of Witness/Date) (Printed Name of Witness)

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me.

____

(Signature of Health Care Representative/Date)

____

(Printed name)

____

(Signature of Alternate Health Care Representative/Date)

____

(Printed name)

" ____ ".

In line 20, delete "7" and insert "9".

On page 12, line 8, delete "8" and insert "10".

In line 42, delete "9" and insert "11".

On page 13, line 11, delete "described in ORS 127.531".

After line 24, insert:

"**REPEAL**

"**OPERATIVE JANUARY 1, 2018**

"**SECTION 12. ORS 127.531 is repealed.**

"**SECTION 13. The repeal of ORS 127.531 by section 12 of this 2015 Act becomes operative on January 1, 2018.**".

In line 28, delete "10" and insert "14".

In line 30, delete "11" and insert "15".

Delete lines 32 and 33.

In line 34, delete "13" and insert "16".

In line 35, delete "6" and insert "5".

After line 36, insert:

"**SECTION 17. The Oregon Health Authority shall first convene a rules advisory committee as required by section 7 of this 2015 Act no later than January 1, 2017, and shall first adopt rules establishing forms for advance directives no later than July 1, 2017.**

"**SECTION 18. The repeal of ORS 127.531 by section 12 of this 2015 Act does not invalidate any advance directive executed before the effective date of this Act.**".

In line 40, delete "14" and insert "19".