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STATE OF OREGON
Legislative Counsel Committee

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To: Senator Floyd Prozanski

From: Lori Anne Sills, Deputy Legislative Counsel

Subject: House Bill 4135—Fact Sheet

History

Oregon enacted the first advance directive in the nation in 1993, but the form has remained unchanged for the last 25 years. In 2015, a small group of stakeholders proposed Senate Bill 193 (2015), which removed the advance directive from statute and provided greater flexibility in what an advance directive could be. The measure was not enacted and a work group formed in the 2015-2016 interim. The work group had over 30 members and met extensively to develop a new strategy for the advance directive to balance the need for a strong legal document and a flexible instruction manual for end of life care. In 2016, the work group proposed Senate Bill 1552 (2016) through the Senate Judiciary Committee. The measure passed out of committee but did not come to the floor for a vote. In the 2016-2017 interim, the work group again met to revise the draft legislation and in 2017 proposed Senate Bill 494 (2017), which built on the feedback received from development of SB 1552 (2016). The Senate passed SB 494 (2017) but the measure did not make it to the House floor for a vote. The current House Bill 4135 is a redraft of B-engrossed Senate Bill 494 (2017) with a few minor technical fixes.

What is an advance directive?

The Oregon advance directive is a legal tool that can be used to appoint a person, called a health care representative, to make decisions for another, called the principal, when the principal is incapacitated and cannot communicate their desires. The advance directive also gives specific guidance on receiving or withholding tube feeding and life support. Currently, the form found in ORS 127.531 is the only form that is legally effective for Oregon residents. It has strict witnessing requirements and requires acceptance by the health care representative, traits not found in all advance directives. Throughout this document and in discussions, the advance directive is referred to in two parts: the appointment section and the instructions section. An advance directive may only be executed by a person when that person is competent and it only bestows decision making power on another when the principal becomes incapable.

What does HB 4135 do?

The goal of the work group was to provide a long-term path for developing an advance directive that reflects the values and wishes of the principal while maintaining legal integrity.

Acceptance of Appointment and Witnessing. Section 5.

First, HB 4135 updates the section of the advance directive form that appoints the health care representative. The measure attempts to make the language clearer and more user-friendly. The update allows acceptance of appointment by the health care representative in ways other than signature. For example, if a sister is appointed as health care representative to a brother, but the brother never sought her acceptance in person, the sister could verbally accept appointment via phone and begin making decisions on her brother's behalf immediately.

The measure also revises the requirements for witnessing the advance directive. Currently, two witnesses to an advance directive are needed. People prohibited from witnessing include relatives of the principal, the health care representative and any employee of a health care facility at which the principal is a patient or resident. House Bill 4135 brings the witnessing requirements in line with other estate planning documents and allows for either notarization in lieu of witnessing or for two witnesses, neither of whom may be the health care representative or attending health care provider.

Advance Directive Rules Adoption Committee. Sections 2 and 3.

Second, HB 4135 creates a 13-member advisory committee to propose and adopt changes to the current advance directive on a four-year cycle. The membership of the committee reflects the diversity of users of advance directives, including consumers, health care providers, attorneys, and ethicists.

The advisory committee may promulgate a new *instructions* section of the advance directive every four years, but may not make changes to the statute appointing a health care representative and specifying witness requirements. The instructions section developed by the group must always be married to the appointment section found in statute to complete the entire form. Once the advisory committee presents its proposal to the Legislative Assembly, the changes must be ratified by both the Legislative Assembly and the Governor before the proposed changes to the instructions section of the advance directive are effective.

Removing the instructions section of the advance directive from statute allows greater flexibility in modifications. Outside of the usual time constraints of a legislative session, the advisory committee will explore different models for learning about the values and beliefs of principals and provide an avenue for feedback on end of life care, beyond that which can be described by the series of check boxes found in the current form.

Temporary Form. Section 6.

The work group has indicated that a long, thoughtful approach is needed to make any significant changes to the instructions section of the advance directive. In the meantime, the group undertook a review of the current form and proposed changes that it felt made few substantive shifts while providing greater clarity for users.

A few additions were made to the temporary form, including adding a provision intended to express the principal's wishes on whether the instructions should be followed exactly or whether the instructions are guidance on care. The measure also adds a general statement rejecting life support and tube feeding.

The temporary form retains the current rubric of four conditions and associated treatments. The four conditions are Close to Death, Permanently Unconscious, Advanced Progressive Illness

and Extraordinary Suffering. The three treatment options for each condition are receiving tube feeding and/or life support, receiving tube feeding and/or life support as recommended by the health care provider and not receiving tube feeding and/or life support. These options are currently found in ORS 127.531 and have been in use for 25 years.

Other updates. Sections 7-37.

Among updates recommended by the work group and incorporated into HB 4135 are definition changes and structural changes. The measure expands the field of medical professionals able to carry out the wishes of the principal or directions of the health care representative from only physicians to health care providers.

The measure removes what the work group determined are confusing terms, such as "power of attorney for health care" and "attorney in fact." The measure also allows a person to complete an older version of an advance directive, even if it is not the current version, and have the advance directive be effective.

What does HB 4135 not do?

Just as under the current advance directive, HB 4135 does not allow withholding of food or drink for incapacitated individuals. Current law and HB 4135 require that comfort care, including reasonable efforts to offer food and water orally, will always be offered. *See* ORS 127.642. Comfort measures cannot be removed by a health care provider or a health care representative. The advance directive also does not allow any unwanted measures or treatments to be provided to a competent person. The advance directive only comes into effect when the principal is unable to communicate. ORS 127.507 says that capable adults may make their own health care decisions. ORS 127.535 (1) specifically states that a health care representative may only make decisions for a principal when the principal is incapacitated. Furthermore, ORS 127.545 gives deference to objections or hints of revocation made by the principal, even when incapacitated. These provisions remain unchanged by HB 4135.

House Bill 4135 also does not change the order of surrogate decisions makers or the threshold for ending life-sustaining procedures in the event that a person does not have an advance directive or health care representative.

ORS 127.635 currently lists surrogate decision makers for withdrawing life-sustaining procedures when an incapacitated person:

- Has a terminal condition;
- Is permanently unconscious;
- Has a condition for which life-sustaining procedures would not benefit the person's condition and cause permanent and severe pain; or
- Has a fatal, advanced illness and the person is unable to communicate by any means, safely swallow food or water, care for self, recognize family or others, and is very unlikely to substantially improve.

If a person is in one of the above four conditions, and the person does not have an appointed health care representative or advance directive, the health care facility must try to locate, through reasonable efforts, the following persons to serve as the health care representative:

- A guardian authorized to make health care decisions for the person;
- The person's spouse;
- Another adult designated by the guardian, spouse, children, or parents, if there are no objections;
- The majority of the adult children who can be located;
- Either parent of the person;
- A majority of the adult siblings of the person who can be located; or
- Any adult relative or adult friend.

If none of these individuals can be found or none are willing to serve, then life-sustaining procedures may be withdrawn or withheld upon direction of the attending physician.

In any circumstance, if the person does not have an advance directive and no appointed health care representative, any person making the decision to withdraw life-sustaining procedures, including spouse, children or attending physician, must consult with concerned family and close friends, and if there is a case manager, with the case manager as well.

House Bill 4135 makes two changes to ORS 127.635. It clarifies that an advance directive must be valid and applicable and it adds attending health care providers, not just attending physicians. House Bill 4135 does not make any other changes this to this section.

House Bill 4135 does not affect the POLST. The POLST is another unique Oregon development. It stands for "Physician Orders for Life Sustaining Treatment." It is the physician's orders, developed by the patient and doctor, that give specific preferences on treatments in emergencies for persons with serious illnesses or near end of life. The POLST may be thought of as an immediate planning and preference document for persons facing serious illness, such as advanced cancer or heart disease, and how they would like emergency services to be provided. An advance directive is for any adult to use when contemplating future treatments that may be unexpected. The POLST may be an appropriate tool for an 80-year-old person facing risky heart surgery, while an advance directive may be completed by a healthy 30-year-old person. An individual may have both documents, or just one or the other. House Bill 4135 is not a POLST and does not infringe on existing or future POLSTs.

Conclusion

House Bill 4135 updates a health care planning tool that has been used in Oregon for 25 years. The measure retains the appointment of a health care representative in statute while allowing a committee made up of parties knowledgeable in the execution, implementation and effects of the advance directive form to explore modifications to the instructions section of the form on a limited basis. The measure requires legislative ratification of those changes prior to the changes taking effect. The measure modernizes the witnessing requirements and provides an updated temporary form while the committee begins its work.