

Requested by SENATE COMMITTEE ON JUDICIARY

**PROPOSED AMENDMENTS TO
SENATE BILL 494**

1 On page 1 of the printed bill, line 14, delete “Rules”.

2 In line 16, delete “Rules”.

3 On page 2, delete lines 12 through 19 and insert:

4 “(I) One member from among members proposed by the Oregon State Bar
5 who has extensive experience in elder law and advising individuals on how
6 to execute an advance directive.

7 “(J) One member from among members proposed by the Oregon State Bar
8 who has extensive experience in estate planning and advising individuals on
9 how to make end-of-life decisions.

10 “(K) One member from among members proposed by the Oregon State Bar
11 who has extensive experience in health law.”.

12 In line 40, after “(1)” delete the rest of the line and insert “In accordance
13 with public notice and stakeholder participation requirements prescribed by
14 the Oregon Health Authority and”.

15 In line 41, delete “Rules”.

16 On page 3, line 7, delete “appointing” and insert “appointment of”.

17 After line 8, insert:

18 “(B) A statement about the priority of health care representative ap-
19 pointment in ORS 127.655 in the event the principal becomes incapable and
20 does not have a valid health care representative appointment.”.

21 In line 9, delete “(B)” and insert “(C)” and delete “expressing” and insert

1 “expression of”.

2 In line 11, delete “(C)” and insert “(D)” and delete “expressing” and insert
3 “expression of”.

4 Delete lines 13 and 14 and insert:

5 “(E) A statement that advises the principal that the advance directive
6 allows the principal to document the principal’s preferences, but is not a
7 POLST, as defined in ORS 127.663.”.

8 In line 45, delete “(4)” and insert “(4)(a)”.

9 On page 4, line 1, after “language” delete the period and insert: “, such
10 as ‘tube feeding’ and ‘life support.’

11 “(b) As used in this subsection:

12 “(A) ‘Life support’ means life-sustaining procedures.

13 “(B) ‘Tube feeding’ means artificially administered nutrition and hy-
14 dration.”.

15 In line 10, after “requirements” delete the rest of the line and insert
16 “prescribed by the Oregon Health Authority under section 3 (1) of this 2017
17 Act,”.

18 In line 11, delete “changing” and after “directive” insert “adopted or
19 changed”.

20 In line 15, delete “rule” and insert “form”.

21 In line 16, delete “Rules”.

22 In line 19, delete “rule” and insert “form” and delete “Rules”.

23 In line 25, delete “Rules”.

24 After line 27, insert:

25 **“SECTION 4a. The first form of an advance directive submitted by**
26 **the Advance Directive Adoption Committee pursuant to section 4 of**
27 **this 2017 Act following the effective date of this 2017 Act may not be-**
28 **come effective unless the form is ratified according to the constitu-**
29 **tional requirements for passage of a legislative measure.”.**

30 Delete lines 32 through 45 and delete pages 5 through 8 and insert:

1 **“SECTION 5. A form for appointing a health care representative**
2 **and an alternate health care representative must be written in sub-**
3 **stantially the following form:**

4 “ _____
5 **FORM FOR APPOINTING HEALTH CARE REPRESENTATIVE**
6 **AND ALTERNATE HEALTH CARE REPRESENTATIVE**

7
8 **This form may be used in Oregon to choose a person to make health**
9 **care decisions for you if you become too sick to speak for yourself.**
10 **The person is called a health care representative.**

11 • **If you have completed a form appointing a health care represen-**
12 **tative in the past, this new form will replace any older form.**

13 • **You must sign this form for it to be effective. You must also have**
14 **it witnessed by two witnesses or a notary. Your appointment of a**
15 **health care representative is not effective until the health care repre-**
16 **sentative accepts the appointment.**

17 • **If you become too sick to speak for yourself and do not have an**
18 **effective health care representative appointment, a health care repre-**
19 **sentative will be appointed for you in the order of priority set forth in**
20 **ORS 127.635 (2).**

21 **1. ABOUT ME.**

22 **Name: _____ Date of Birth: _____**

23 **Telephone numbers: (Home)_____ (Work)_____ (Cell)_____**

24 **Address: _____**

25 **E-mail: _____**

26 **2. MY HEALTH CARE REPRESENTATIVE.**

27 **I choose the following person as my health care representative to**
28 **make health care decisions for me if I can't speak for myself.**

29 **Name: _____ Relationship: _____**

30 **Telephone numbers: (Home)_____ (Work)_____ (Cell)_____**

1 **Address:** _____

2 **E-mail:** _____

3 **I choose the following people to be my alternate health care repre-**
4 **sentatives if my first choice is not available to make health care de-**
5 **isions for me or if I cancel the first health care representative's**
6 **appointment.**

7 **First alternate health care representative:**

8 **Name:** _____ **Relationship:** _____

9 **Telephone numbers: (Home)**_____ **(Work)**_____ **(Cell)**_____

10 **Address:** _____

11 **E-mail:** _____

12 **Second alternate health care representative:**

13 **Name:** _____ **Relationship:** _____

14 **Telephone numbers: (Home)**_____ **(Work)**_____ **(Cell)**_____

15 **Address:** _____

16 **E-mail:** _____

17 **3. MY SIGNATURE.**

18 **My signature:** _____ **Date:** _____

19 **4. WITNESS.**

20 **COMPLETE A OR B WHEN YOU SIGN.**

21 **A. WITNESS DECLARATION:**

22 **The person completing this form is personally known to me or has**
23 **provided proof of identity, has signed or acknowledged the person's**
24 **signature on the document in my presence and appears to be not under**
25 **duress and to understand the purpose and effect of this form. In ad-**
26 **dition, I am not the person's health care representative or alternate**
27 **health care representative, and I am not the person's attending health**
28 **care provider.**

29 **Witness Name (print):** _____

30 **Signature:** _____

1 **Date:** _____
2 **Witness Name (print):** _____
3 **Signature:** _____
4 **Date:** _____
5 **B. NOTARY:**
6 **State of** _____
7 **County of** _____
8 **Signed or attested before me on** _____, 2____, **by**
9 _____
10 _____

11 **Notary Public - State of Oregon**

12 **5. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE.**

13 **I accept this appointment and agree to serve as health care repre-**
14 **sentative.**

15 **Health care representative:**

16 **Printed name:** _____

17 **Signature or other verification of acceptance:** _____

18 **Date** _____

19 **First alternate health care representative:**

20 **Printed name:** _____

21 **Signature or other verification of acceptance:** _____

22 **Date** _____

23 **Second alternate health care representative:**

24 **Printed name:** _____

25 **Signature or other verification of acceptance:** _____

26 **Date** _____

27 “ _____
28

29 **“(Temporary Form for Advance Directive)”**
30

1 **“SECTION 6. (1) In lieu of the form of an advance directive adopted**
2 **by the Advance Directive Adoption Committee under section 3 of this**
3 **2017 Act, on or before January 1, 2021, a principal may execute an ad-**
4 **vance directive that is in a form that is substantially the same as the**
5 **form of an advance directive set forth in this section.**

6 **“(2) Notwithstanding section 3 (2) of this 2017 Act, the form of an**
7 **advance directive set forth in this section is a valid form of an advance**
8 **directive in this state.**

9 **“(3) The form of an advance directive executed as described in**
10 **subsection (1) of this section is as follows:**

11 “
12 **ADVANCE DIRECTIVE**
13 **(STATE OF OREGON)**
14

15 **This form may be used in Oregon to choose a person to make health**
16 **care decisions for you if you become too sick to speak for yourself.**
17 **The person is called a health care representative. If you do not have**
18 **an effective health care representative appointment and become too**
19 **sick to speak for yourself, a health care representative will be ap-**
20 **pointed for you in the order of priority set forth in ORS 127.635 (2).**

21 **This form also allows you to express your values and beliefs with**
22 **respect to health care decisions and your preferences for health care.**

23 **• If you have completed an advance directive in the past, this new**
24 **advance directive will replace any older directive.**

25 **• You must sign this form for it to be effective. You must also have**
26 **it witnessed by two witnesses or a notary. Your appointment of a**
27 **health care representative is not effective until the health care repre-**
28 **sentative accepts the appointment.**

29 **• If your advance directive includes directions regarding the with-**
30 **drawal of life support or tube feeding, you may revoke your advance**

1 directive at any time and in any manner that expresses your desire to
2 revoke it.

3 • In all other cases, you may revoke your advance directive at any
4 time and in any manner as long as you are capable of making medical
5 decisions.

6 **1. ABOUT ME.**

7 **Name:** _____ **Date of Birth:** _____

8 **Telephone numbers: (Home)**_____ **(Work)**_____ **(Cell)**_____

9 **Address:** _____

10 **E-mail:** _____

11 **2. MY HEALTH CARE REPRESENTATIVE.**

12 I choose the following person as my health care representative to
13 make health care decisions for me if I can't speak for myself.

14 **Name:** _____ **Relationship:** _____

15 **Telephone numbers: (Home)**_____ **(Work)**_____ **(Cell)**_____

16 **Address:** _____

17 **E-mail:** _____

18 I choose the following people to be my alternate health care repre-
19 sentatives if my first choice is not available to make health care de-
20 cisions for me or if I cancel the first health care representative's
21 appointment.

22 **First alternate health care representative:**

23 **Name:** _____ **Relationship:** _____

24 **Telephone numbers: (Home)**_____ **(Work)**_____ **(Cell)**_____

25 **Address:** _____

26 **E-mail:** _____

27 **Second alternate health care representative:**

28 **Name:** _____ **Relationship:** _____

29 **Telephone numbers: (Home)**_____ **(Work)**_____ **(Cell)**_____

30 **Address:** _____

1 E-mail: _____

2 **3. INSTRUCTIONS TO MY HEALTH CARE REPRESENTATIVE.**

3 If you wish to give instructions to your health care representative
4 about your health care decisions, initial one of the following three
5 statements:

6 ___ To the extent appropriate, my health care representative must
7 follow my instructions.

8 ___ My instructions are guidelines for my health care representative
9 to consider when making decisions about my care.

10 ___ Other instructions: _____

11 **4. DIRECTIONS REGARDING MY END OF LIFE CARE.**

12 In filling out these directions, keep the following in mind:

13 • The term “as my health care provider recommends” means that
14 you want your health care provider to use life support if your health
15 care provider believes it could be helpful, and that you want your
16 health care provider to discontinue life support if your health care
17 provider believes it is not helping your health condition or symptoms.

18 • The term “life support” means any medical treatment that
19 maintains life by sustaining, restoring or replacing a vital function.

20 • The term “tube feeding” means artificially administered food and
21 water.

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

24 • You will receive care for your comfort and cleanliness no matter
25 what choices you make.

26 **A. Statement Regarding End of Life Care.** You may initial the
27 statement below if you agree with it. If you initial the statement you
28 may, but you do not have to, list one or more conditions for which you
29 do not want to receive life support.

30 ___ I do not want my life to be prolonged by life support. I also do

1 not want tube feeding as life support. I want my health care provider
2 to allow me to die naturally if my health care provider and another
3 knowledgeable health care provider confirm that I am in any of the
4 medical conditions listed below.

5 **B. Additional Directions Regarding End of Life Care.** Here are my
6 desires about my health care if my health care provider and another
7 knowledgeable health care provider confirm that I am in a medical
8 condition described below:

9 **a. Close to Death.** If I am close to death and life support would only
10 postpone the moment of my death:

11 **INITIAL ONE:**

12 I want to receive tube feeding.

13 I want tube feeding only as my health care provider recom-
14 mends.

15 I DO NOT WANT tube feeding.

16 **INITIAL ONE:**

17 I want any other life support that may apply.

18 I want life support only as my health care provider recom-
19 mends.

20 I DO NOT WANT life support.

21 **b. Permanently Unconscious.** If I am unconscious and it is very
22 unlikely that I will ever become conscious again:

23 **INITIAL ONE:**

24 I want to receive tube feeding.

25 I want tube feeding only as my health care provider recom-
26 mends.

27 I DO NOT WANT tube feeding.

28 **INITIAL ONE:**

29 I want any other life support that may apply.

30 I want life support only as my health care provider recom-

1 mends.

2 ___ I DO NOT WANT life support.

3 c. Advanced Progressive Illness. If I have a progressive illness that
4 will be fatal and is in an advanced stage, and I am consistently and
5 permanently unable to communicate by any means, swallow food and
6 water safely, care for myself and recognize my family and other peo-
7 ple, and it is very unlikely that my condition will substantially im-
8 prove:

9 INITIAL ONE:

10 ___ I want to receive tube feeding.

11 ___ I want tube feeding only as my health care provider recom-
12 mends.

13 ___ I DO NOT WANT tube feeding.

14 INITIAL ONE:

15 ___ I want any other life support that may apply.

16 ___ I want life support only as my health care provider recom-
17 mends.

18 ___ I DO NOT WANT life support.

19 d. Extraordinary Suffering. If life support would not help my med-
20 ical condition and would make me suffer permanent and severe pain:

21 INITIAL ONE:

22 ___ I want to receive tube feeding.

23 ___ I want tube feeding only as my health care provider recom-
24 mends.

25 ___ I DO NOT WANT tube feeding.

26 INITIAL ONE:

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

28 ___ I want life support only as my health care provider recom-
29 mends.

30 ___ I DO NOT WANT life support.

1 **C. Additional Instruction.** You may attach to this document any
2 writing or recording of your values and beliefs related to health care
3 decisions. These attachments will serve as guidelines for health care
4 providers. Attachments may include a description of what you would
5 like to happen if you are close to death, if you are permanently un-
6 conscious, if you have an advanced progressive illness or if you are
7 suffering permanent and severe pain.

8 **5. MY SIGNATURE.**

9 My signature: _____ Date: _____

10 **6. WITNESS.**

11 **COMPLETE A OR B WHEN YOU SIGN.**

12 **A. WITNESS DECLARATION:**

13 The person completing this form is personally known to me or has
14 provided proof of identity, has signed or acknowledged the person's
15 signature on the document in my presence and appears to be not under
16 duress and to understand the purpose and effect of this form. In ad-
17 dition, I am not the person's health care representative or alternate
18 health care representative, and I am not the person's attending health
19 care provider.

20 **Witness Name (print):** _____

21 **Signature:** _____

22 **Date:** _____

23 **Witness Name (print):** _____

24 **Signature:** _____

25 **Date:** _____

26 **B. NOTARY:**

27 **State of** _____

28 **County of** _____

29 **Signed or attested before me on** _____, **2**____, **by**

30 _____.

1 _____

2 **Notary Public - State of Oregon**

3 **7. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE.**

4 **I accept this appointment and agree to serve as health care repre-**
5 **sentative.**

6 **Health care representative:**

7 **Printed name:** _____

8 **Signature or other verification of acceptance:** _____

9 **Date** _____

10 **First alternate health care representative:**

11 **Printed name:** _____

12 **Signature or other verification of acceptance:** _____

13 **Date** _____

14 **Second alternate health care representative:**

15 **Printed name:** _____

16 **Signature or other verification of acceptance:** _____

17 **Date** _____

18 “ _____ ”.

19 On page 9, delete lines 1 through 41.

20 On page 10, line 14, after “use” delete the rest of the line and insert “an
21 advance directive or the”.

22 In line 19, after “use” delete the rest of the line and insert “an advance
23 directive or the form”.

24 On page 12, line 8, delete “validated” and insert “valid”.

25 Delete lines 36 and 37 and insert:

26 “(2)(a) ‘Advance directive’ means a document executed by a principal that
27 contains:

28 “(A) A form appointing a health care representative; and

29 “(B) Instructions to the health care representative.

30 “(b) ‘Advanced directive’ includes any supplementary document or writing

1 attached by the principal to the document described in paragraph (a) of this
2 subsection.”.

3 On page 28, line 1, delete “RULES”.

4 In line 4, delete “Rules”.

5 On page 29, line 25, delete “Rules”.

6 _____