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AN INTRODUCTION TO

OREGON'S ADVANCE DIRECTIVE FOR HEALTH CARE

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An Introduction to Oregon's Advance Directive For Health Care

Federal and state laws require health care organizations, such as hospitals and nursing homes, to provide information on the rights of an individual to make health care decisions. These decisions include the right to accept or refuse medical or surgical treatment and the right to execute advance directives for health care.

The state of Oregon provides an advance directive for an individual to indicate intentions regarding health care. The 1993 Oregon Legislative Assembly passed legislation, the Oregon Health Care Decisions Act, unifying the previously used power of attorney for health care and directive to physicians. The unified form is called an advance directive.

The advance directive is a legal document enabling an individual (the "principal") to name a surrogate decision-maker (the "health care representative") to make health care decisions for the individual if the individual becomes incapable of making health care decisions for himself or herself. The health care representative is prohibited by law to consent to any of the following on behalf of the principal: (1) admission to or retention in a health care facility for care or treatment of mental illness; (2) convulsive treatment; (3) psychosurgery; (4) sterilization; and (5) abortion. The advance directive is good for your entire life or for a period of years which you determine, for example 7 or 10 years, or until you revoke it.

The advance directive also enables an individual to give health care instructions and to direct physicians to administer, withhold or withdraw life-sustaining procedures.

If you are an adult capable of making your own decisions, you may choose to sign an advance directive for health care. If you do not want to, you do not have to fill out and sign the advance directive for health care. Health care representatives and health care providers generally are protected from liability when acting to implement an advance directive for health care. A capable principal can revoke an advance directive at any time and in any manner.

In order to place the advance directive in the context of your faith and your journey through life, a pastoral letter and statement on euthanasia have been provided in this folder for your review and reflection. Included in this "Introduction to Oregon's Advance Directive for Health Care" is a suggested "Catholic Addendum to the Advance Directive for Health Care." The addendum is intended to place that particular legal document in the context of your faith. If you choose to use the addendum, you can write in Part B's Special Conditions or Instructions and in Part C's Additional Conditions or Instructions: "See attached Catholic Addendum to the Advance Directive for Health Care."

This "Introduction to Oregon's Advance Directive for Health Care" is intended to serve as an orientation to some of the most important questions, issues and decisions which each of us will be called upon to make in our lifetime. Discussion about these questions, issues and decisions with our families, loved ones, spiritual advisor or pastor, physician and attorney is healthy and can be helpful to all involved when a health care decision must be made.

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 do not 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 cannot 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 do not 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 do not 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. **Close to Death.** 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.

   _____ I want **NO** life support.

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

   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.

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

   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.

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:

1. Is personally known to us or has provided proof of identity;
2. Signed or acknowledged that person's signature on this advance directive in our presence;
3. Appears to be of sound mind and not under duress, fraud or undue influence;
4. Has not appointed either of us as health care representative or alternative representative; and
5. 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 desire of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desire 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 of Health Care Representative)

____

(Signature of Alternate Health Care Representative/Date)

____

(Printed Name of Alternate Health Care Representative)

Catholic Addendum to the Advance Directive for Health Care

I am a Roman Catholic. It is my wish that my health care representative make health care decisions for me which are consistent with the authentic teaching of the Catholic Church and based upon my profound respect for life and my belief in eternal life.

Consistent with Church teaching, I reject measures which would constitute euthanasia[1] as defined by the Church. However, I also accept, as the Catholic Church teaches, that death need not be resisted by any and every possible means under every circumstance. I have the right to refuse those medical treatments that are useless or excessively burdensome and that would only prolong my own dying, thus delaying my return to God in Whom "there will be no more death, no more grief, or crying out in pain" and Who "makes all things new" (Rev. 21:3).

Instruction

It is my intention that as a patient, I receive medical treatment and care including:

1. standard comfort care appropriate for any patient suffering from illness, injury or disease;
2. food and water when they are capable of sustaining life;
3. appropriate pain-alleviating medication; and
4. life-sustaining procedures unless they are useless or excessively burdensome as determined by my health care representative.

With respect to the use of artificially administered nutrition and hydration, if I am permanently unconscious, I wish to further specify my intentions:

Initial One

________(A) I view artificially administered nutrition and hydration to be a medical procedure. It is my intention to accept this procedure in the case of transitory need; but not in the case of my being permanently unconscious if the burdens outweigh the benefits as determined by my health care representative.

Or

________(B) It is my intention to establish a presumption in favor of artificially administered nutrition and hydration for the purpose of sustaining life if I am permanently unconscious, provided such administration is medically possible, unless: (i) artificially administered nutrition and hydration would itself cause severe, intractable, and long-lasting pain, or (ii) I am in the final stage of a terminal condition, my death is imminent, and the withholding of artificially

administered nutrition and hydration will not cause death from dehydration or starvation rather than from some underlying terminal illness or injury.

The authority of my health care representative is subject to the above instruction and limitations.

____
(Date)

____
(Signature)

Witnessed By:

____
Signature of Witness/Date)

____
(Printed Name of Witness)

____
Signature of Witness/Date)

____
(Printed Name of Witness)