Senate Bill 494 (hereinafter “SB 494”) proposes numerous changes to the current advance directive and health care representative scene:

1. SB 494 proposes to establish an Advance Directive Rules Adoption Committee (the “Committee”). The Committee will be tasked with adopting the sole form of an advance directive to be used in the State of Oregon, and the form must be reviewed by the Committee once every four years for the purpose of adopting “necessary” changes. With the creation of the Committee, legal practitioners can expect periodic changes to the required form of an advance directive, meaning that what is currently valid, may not be valid four years from now, and meaning that practitioners will have to keep track of every iteration of the advance directive form just in case they have to prove the validity of an advance directive drafted using a previously valid form (assuming advance directives created using previously valid forms continue to be valid). In the same vein, the Committee’s periodic "updates" to the advance directive form will force health care providers to likewise periodically update their procedures with respect to handling advance directives, and will, to some degree, force principals and health care representatives to be masters of the law of advance directives (since they must be able to show why their particular advance directive is valid).

2. SB 494 provides for the creation of a brand-new document in the world of advance directives and health care representatives: The Appointment of Health Care Representative and Alternate Health Care Representative (the “Appointment”). While the Appointment provides an easy way for a person (called a “principal”) to appoint a health care representative, it is not without its drawbacks. The Appointment provides no opportunity for the principal to instruct his or her health care representative(s) as to the principal’s wishes with respect to his or her desired health care when the principal us unable to express those wishes him- or herself, and unless a health care representative receives separate oral or written instructions from the principal as to the principal's wishes, the health care representative merely has a duty to act in a manner that the health care representative "in good faith" believes to be in the best interests of the principal, and what the health care representative believes to be in the best interest of the principal may not be what the principal considers to be in his or her best interests.

3. With respect to the advance directive, SB 494 proposes a number of changes. First, with respect to the principal’s wishes regarding his or her health care, SB 494 proposes to change the language of the principal’s wishes in the statute and advance directive from "desires" to "preferences." This change, coupled with SB 494’s omitting from the advance directive (and Appointment) the health care representative's acceptance that he or she must act consistently with the desires of the principal, seemingly lessen the effect of what the principal actually wants with respect to his or her health care. If the advance directive is to continue functioning as it has, as the mechanism by which one's specific health care wants are met when he or she cannot express those wants him- or herself, lessening the effect of what the principal actually wants by using the term "preferences" and omitting other certain language from the advance directive is not the way to accomplish that. Second, SB 494 proposes to remove the definitions of "life support" and "tube feeding" from the statute; this is particularly problematic. Unless the principal (in the absence of a court decision otherwise defining the aforementioned terms) expressly defines "life support" and "tube feeding," and makes those definitions known to his or her health care representative(s), in many circumstances, the health care representative will not know what medical procedures, medication, or otherwise he or she is authorized to allow or withhold under the principal's advance directive or Appointment. Moreover, removal of the above definitions will increase litigation with respect to end of life decisions (as the courts will be forced to define "life support" and "tube feeding"), and such litigation will be time consuming and expensive for both principals and health care representatives, a result that the advance directive has traditionally been designed to avoid.

For a more comprehensive analysis, including recommendations, please read my post titled “Advance Directives & Health Care Representatives: Oregon Senate Bill 494” at www.portlandadvocate.com/blog/.