CONCLUSIONS OREGON
Prepare & Protect

Pro-Life ADVANCE DIRECTIVE

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PREPARING YOUR PRO-LIFE ADVANCE DIRECTIVE

Basic Definitions to Know

ADVANCE DIRECTIVE

By filling out your advance directive, you will create a legally operative document that preserves your end of life decisions. You will also appoint your health care representative. Your advance directive will be followed if you should no longer be able to speak for yourself.

HEALTH CARE REPRESENTATIVE

The person you appoint as your health care representative should understand your philosophy of life. They should also be someone you trust to advocate for your medical decisions in your advance directive. Your health care representative, armed with your advance directive, will have the legal power to make health care decisions for you should you no longer be able to communicate. It is also important that you appoint an alternative health care representative in case your primary representative is not available.

Why Fill Out a Pro-Life Advance Directive?

Enough legal protections have been removed from Oregon law to cause great concern that Oregonians' health care decisions and end-of-life wishes will not be fully protected.

This pro-life advance directive starts from the principle that the presumption should be for life. If you follow these instructions, you are giving directions to your health care representative to do his or her best to preserve your life until natural death.

It is important that you read through all the pages in this packet before you begin to fill out your pro-life advance directive. Even if you already have an advance directive it is wise to fill out this advance directive as it will replace your old one.

STEPS TO TAKE

STEP ONE
Put your name on the front of the folder.

STEP TWO
Read through the scenarios as they are designed to help you think about the kind of care you want in potential medical situations.

STEP THREE
Read the suggestions for filling out an advance directive.

STEP FOUR
Fill out your advance directive and have it witnessed by two individuals (or by a notary).

STEP FIVE
Destroy any and all copies of previous advance directives.

STEP SIX
Provide a copy to your doctor(s) and other medical professionals.

STEP SEVEN
Put your original copy in a location where you or your health care representative can easily access it should this become necessary.

Conclusions Oregon cannot provide you with legal advice. If you have questions when filling out an advance directive, please contact your attorney. If you need a pro-life attorney, please email us at ***help@conclusionsoregon.org*** *and we can refer you.*

MEDICAL SCENARIOS

Let's Sit Down and Talk

The purpose of this section is to assist you in exploring difficult situations with your loved ones. As you go through the following fictional scenarios, think about and discuss what you would want in each situation.

END OF LIFE CARE

Harry and Sally are in their early sixties and have been married for 44 years. They want to fill out an advance directive to preserve their medical decisions for the future. Both believe medical intervention and treatment is necessary if they were to need it. However, they are okay with only receiving comfort care should they be in their last few days of life and medical intervention would not prolong their lives or could accelerate death.

Comfort care focuses on relieving symptoms, not treatment, and can include the use of pain medication, oxygen, or food and water by mouth.

CARDIOPULMONARY RESUSCITATION (CPR)

Harry's family has a history of heart disease. This has caused some of his family members to have heart attacks in their late seventies. Harry wants emergency services to respond to a health crisis by giving him CPR and taking him to the nearest hospital so he can receive the necessary treatments. Sally agrees that she wants CPR in the same situation.

Sally works in a nursing home and knows that every patient will be given CPR unless they have a POLST that says otherwise. Sally and Harry have talked with their kids who know that when the time comes both Harry and Sally will move into a nursing home. Neither of them will fill out a POLST as they want CPR and to be taken to a hospital to be treated.

CPR is used to restart the heart when a person longer has a heartbeat.

NUTRITION THROUGH A TUBE

Years ago, Sally and Harry's granddaughter was in a severe car accident. She was in ICU for several weeks because she suffered brain damage. At first, she was in a coma on life support. She received water and other fluids (artificial hydration) through an IV. She also received artificial nutrition through a tube in her stomach. The doctors said she might stay in a coma for a while. They recommended the family consider terminating life support if there was no brain activity within the next few days. Thankfully, their granddaughter awoke from the coma.

Had she not received fluids and nutrition through a tube, she would have become dehydrated, causing her to die.

Sally and Harry decided that they want to have artificial hydration and nutrition if either of them gets in an accident or is diagnosed with a terminal illness. Because Sally works in a nursing home, she has seen how dehydration accelerates death. Sally and Harry do not want to die because of dehydration.

Artificial hydration is when a needle or tube placed in a person's veins to provide fluid. Without fluids, a person could die within 3 -14 days.

Artificial nutrition is when a tube is put in the nose, mouth or stomach to provide food when a person is unable to eat normally.

ALZHEIMER'S OR DEMENTIA

Sally's family has a history of Alzheimer's disease. Harry and Sally are both aware that should Sally be diagnosed with Alzheimer's Harry will not be able to care for her properly. Both want to be sure that if Sally is unable to feed herself she has someone who can help her eat. Harry and Sally do not want food to be taken away from her if the disease cripples her. Harry and Sally both agree they want assistance with food if either of them is diagnosed with a terminal illness.

BREATHING WITH A MACHINE

When Harry and Sally's granddaughter was in the coma she was on a ventilator. The ventilator enabled their granddaughter to have oxygen flowing through her lungs and to her brain. Without the ventilator, Harry and Sally's granddaughter would have sustained more brain damage and never woken from the coma.

Harry and Sally both agree they want a ventilator if they are in an accident or diagnosed with a terminal illness. They feel a ventilator could improve conditions and may save their lives one day. They are willing to be on a ventilator for as long as medically possible.

MANAGING PAIN

Harry's sister was diagnosed with brain cancer and passed away three years ago. During her last days, Harry's sister was given pain medication to make her comfortable. Her family all agreed that having her comfortable and not in pain was the best decision while she was dying under hospice care. Harry and Sally have thought a lot about pain management. They are very aware that pain medication could have the effect of hastening their deaths or other secondary effects.

They have also talked it over with their children who expressed that they did not want to see their parents in pain. Harry and Sally's children remember how peacefully and painlessly their aunt died. Harry and Sally agree with their children. They would opt for pain medication if they are in their last days of dying.

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PLEASE SEE NEXT PAGE FOR INSTRUCTIONS TO COMPLETE YOUR PRO-LIFE ADVANCE DIRECTIVE.

COMPLETING YOUR PRO-LIFE ADVANCE DIRECTIVE

You are not required to fill out any part of this advance directive or any other document such as a POLST. No one may compel you to sign this document or any other of its kind.

STEP ONE

Initial the 3rd option entitled "Other instructions:" in Section 3 of this Advance Directive.

STEP TWO

It is strongly recommended that you DO NOT complete Section 4 of this Advance Directive entitled "DIRECTIONS REGARDING MY END OF LIFE CARE." Oregon law requires Section 4 to be included in this document, but you do not have to fill it out. If you initial the wrong choice in Section 4, it will conflict with the pro-life language in Section 3.

Some people may wish to continue certain types of medical treatment when they are terminally ill and in the final stages of life. Others may not.

STEP THREE

If you wish to refuse some specific medical treatment, this document provides space to do so. You may make special conditions for your treatment when your death is imminent, meaning you will live no more than a week even if given all available medical treatment; or when you are incurably terminally ill, meaning you will live no more than three months even if given all available medical treatment.

STEP FOUR

It is VERY important if you choose to identify treatments you wish to refuse at the end of your life that you are very specific in listing what treatments you do not want. Do not simply say you don't want "extraordinary treatment" or that you don't want a treatment that is an "excessive burden." There is a danger that a vague description of what you do not want will be misunderstood or distorted so as to deny you treatment that you do want.

Here are some examples of treatments you might—or might not—want to refuse at the end of your life: (see page 3 for medical scenarios)

- Cardiopulmonary resuscitation (CPR) if the cardiopulmonary arrest has been caused by my terminal illness or a complication of it.

- Surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain.

- A treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me.

STEP FIVE

You do not have to refuse any treatments if you do not wish to. If you leave these sections blank, this pro-life advance directive will still be valid.

YOUR PRO-LIFE ADVANCE DIRECTIVE IS ON THE NEXT PAGE

ADVANCE DIRECTIVE (STATE OF OREGON)

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

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

- If you have completed an advance directive in the past, this new advance directive will replace any older directive.
- You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.
- If your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expresses your desire to revoke it.
- In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

1. ABOUT ME.

Name:_____ Date of Birth: _____

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

Address:_____

Email: _____

2. MY HEALTH CARE REPRESENTATIVE.

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

Name: _____ Relationship: _____

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

Address: _____

Email: _____

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me or if I cancel the first health care representative's appointment.

First alternate health care representative:

Name: _____ Relationship: _____

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

Address: _____

Email: _____

Second alternate health care representative:

Name: _____ Relationship: _____

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

Address: _____

Email: _____

3. INSTRUCTIONS TO MY HEALTH CARE REPRESENTATIVE.

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

_____ To the extent appropriate, my health care representative must follow my instructions.

_____ My instructions are guidelines for my health care representative to consider when making decisions about my care

_____ Other instructions: _____

GENERAL PRESUMPTION FOR LIFE

In exercising the power to make health care decisions on my behalf, my health care representative must follow my instructions.

I direct my health care representative to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

I consider food (nutrition) and water (hydration), even when provided by artificial means, always to be ordinary means of preserving life, not medical treatment. I direct my health care representative to provide me with food and fluids, orally, intravenously, by tube, or by other means, including without limitation artificially administered nutrition and hydration as that term is defined in ORS 127.505, to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided as long as the medication is not used in order to cause my death.

I direct that I be provided basic nursing care and procedures to provide comfort care.

I reject in any situation any treatment that directly uses an unborn or newborn child, or any tissue or organ of an unborn or newborn child who has been subject to an induced abortion.

I reject any treatments that use an organ or tissue of another person obtained in a manner that directly causes, contributes to, or hastens that person's death.

The instructions in this document are intended to be followed even if it is alleged that I have attempted suicide at some point after it is signed.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age, physical or mental disability, or the actual or anticipated "quality" of my life.

I direct that my life not be ended by assisted suicide or euthanasia, the latter meaning an action or omission that would directly and intentionally cause my death.

I direct that the following be provided:

- The administration of medication;
- Cardiopulmonary resuscitation (CPR); and
- The performance of all other medical procedures, techniques, and technologies, including surgery,

-all to the full extent necessary to correct, reverse, or alleviate life threatening or health impairing conditions or complications arising from those conditions.

WHEN MY DEATH IS IMMINENT

If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me the following may be withheld or withdrawn:

_____

_____

_____

WHEN I AM TERMINALLY ILL

If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

_____

_____

_____

IF I AM PREGNANT

If I am pregnant, I direct my health care provider(s) and health care representative to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

_____
Signature of Principal

4. DIRECTIONS REGARDING MY END OF LIFE CARE.

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

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

- The term "life support" means any medical treatment that maintains life by sustaining, restoring or replacing a vital function.

- The term "tube feeding" means artificially administered food and water.

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

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

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

_____ 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 health care provider to allow me to die naturally if my health care provider and another knowledgeable health care provider confirm that I am in any of the medical conditions listed below.

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

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

INITIAL ONE:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my health care provider recommends.

_____ I DO NOT WANT tube feeding.

INITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my health care provider recommends.

_____ I DO NOT WANT life support.

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

INITIAL ONE:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my health care provider recommends.

_____ I DO NOT WANT tube feeding.

INITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my health care provider recommends.

_____ I DO NOT WANT life support.

c. 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:

INITIAL ONE:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my health care provider recommends.

_____ I DO NOT WANT tube feeding.

INITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my health care provider recommends.

_____ I DO NOT WANT life support.

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

INITIAL ONE:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my health care provider recommends.

_____ I DO NOT WANT tube feeding.

INITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my health care provider recommends.

_____ I DO NOT WANT life support.

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

5. MY SIGNATURE.

My signature: _____ Date: _____

6. WITNESS.

COMPLETE EITHER A OR B WHEN YOU SIGN.

A. NOTARY:

State of _____

County of _____

Signed or attested before me on _____, 2_____, by _____.

_____
Notary Public – State of Oregon

B. WITNESS DECLARATION

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

Witness Name (print): _____

Signature: _____ Date: _____

Witness Name (print): _____

Signature: _____ Date: _____

7. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative.

Health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____

First alternate health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____

Second alternate health care representative:

Printed name:_____

Signature or other verification of acceptance: _____

Date: _____