HOUSE COMMITTEE ON JUDICIARY SUBCOMMITTEE ON CIVIL LAW AND JUDICIAL ADMINISTRATION

June 1, 1993 Hearing Room 170 1:00 p.m. Tapes 125 - 126

MEMBERS PRESENT: Rep. Tom Brian, Chair Rep. Ken Baker Rep. Jim Edmunson Rep. Tom Mason

VISITING MEMBER: Rep. Cedric Hayden

STAFF PRESENT: Carole Souvenir, Committee Counsel Sarah May, Committee Clerk

MEASURES CONSIDERED: SB 286 - Establishes Oregon Health Care Act

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These minutes contain materials which paraphrase and/or summarize statements made during this session. Only text enclosed in quotation marks report a speaker's exact words. For complete contents of the proceedings, please refer to the tapes. [--- Unable To Translate Graphic ---]

TAPE 125, SIDE A

004 CHAIR BRIAN: Calls the meeting to order at 1:20 p.m.

WORK SESSION ON SB 286

Witnesses: Sen. Bob Shoemaker, District 3 Bob Castagna, Oregon Catholic Conference Tina Kitchin, Physician Miles Edwards, Physician Ted Falk, Attorney

009 CAROLE SOUVENIR, COMMITTEE COUNSEL: Discusses SB 286, and summarizes proposed amendments. On pg. 16, line 17 and line 19 cites changed

words. On pg. 16, after line 25 cites a new Subsection "i". On line 34

of same page, original language also needs to be restored.

027 REP. EDMUNSON: We are not leaving "only" in line 34?

028 REP. BAKER: No. This would be the original state that says a petition can be filed "by any of the following:"?

029 CHAIR BRIAN: Correct. Have we been reaching consensus on each of these amendments? 030 CAROLE SOUVENIR, COMMITTEE COUNSEL: There are several we haven't reached consensus on. On pg. 17, after line 23 there is a new

Subsection C relating to liability for a health care provider. Then on line 24, Subsection C would become Subsection D.

042 SEN. BOB SHOEMAKER, DISTRICT 3: Argues that we try to avoid the objective standard of "has reason to know", that might result in providers being unwilling to do the directive. Would like to leave that out.

053 CHAIR BRIAN: Where did that language come from?

054 CAROLE SOUVENIR, COMMITTEE COUNSEL: Sisters of Providence.

055 REP. EDMUNSON: "Knew" is a pre-common standard in civil cases. "Knew" may be a clause that is more objective than "knows".

067 SEN. SHOEMAKER: Looking at it from the decision making standpoint rather than from the court room standpoint. If at a decision making point and "knows" comes up, then you have reason to know that the decision that is being made by the health care representative is without flaw.

084 CHAIR BRIAN: Is there a consensus on whether "know" language should stay in? Then the addition of new Subsection C will stay in.

088 CAROLE SOUVENIR, COMMITTEE COUNSEL: On pg. 17, line 31 there is an "a" inserted and then on line 34 a "b" inserted.

096 REP. EDMUNSON: How does that relate to the new Subsection 5 on line 37?

099 CAROLE SOUVENIR, COMMITTEE COUNSEL: That deals with following the principal's direction, not the actual determination.

108 REP. BAKER: On pg. 17, lines 33-36, is that going to show up somewhere else?

116 CAROLE SOUVENIR, COMMITTEE COUNSEL: That is on pg. 20, lines 12-14, it is preserved.

121 REP. EDMUNSON: Referring to suspension, is that still on the table? In Subsection 5 on line 39, there is reference to suspension.

128 CAROLE SOUVENIR, COMMITTEE COUNSEL: On pg. 19, lines 7 and 11 deleting "actual". On pg. 20, lines 29-30 cited because committee has not come to consensus on whether it should be deleted. Then on line 30 "or" should be inserted and on line 31, reads what new Subsection C would say. Cite other words to be deleted.

153 REP. BAKER: Cites line 29 on pg. 19, what information do we have for people without a directive? Time is not an element. We could

strike

that language "as reasonably available".

164 CAROLE SOUVENIR, COMMITTEE COUNSEL: On line 18 of pg. 20, should insert "withheld or withdrawn", so that they may not receive life sustaining

procedures in the first place.

173 SEN. SHOEMAKER: In permanent unconsciousness, rarely are in a withhold situation, mostly a withdraw.

179 CHAIR BRIAN: On line 29-30 you would not object to deletion of words?

180 SEN. SHOEMAKER: It is in there for the rural hospitals, because it is such an expense to bring a doctor in, but that is what they have to do. There needs to be some limitation.

191 CHAIR BRIAN: If determining that someone is permanently unconscious for purposes of withdrawing life support, it is a critical decision.

194 REP. EDMUNSON: Section 21 is the procedure which applies when there is no advanced directive and there is no indication of person's wishes.

This section is where the bill departs from the advanced directive law?

204 CAROLE SOUVENIR, COMMITTEE COUNSEL: We are also dealing with that under ORS 127.580, the -8 amendments dealing with nutrition and hydration with no advanced directive.

207 REP. EDMUNSON: Considers the public policy questions where there is no advanced directive to be distinct from those where there is an advanced directive.

214 REP. BAKER: Need to delete line 29, on pg. 20.

223 REP. EDMUNSON: The existing language is still needed, but is there any alternative language to the bold faced language in the engrossed bill?

Is there a third option?

231 CAROLE SOUVENIR, COMMITTEE COUNSEL: No.

232 REP. EDMUNSON: Do we define "terminal condition"?

236 CAROLE SOUVENIR, COMMITTEE COUNSEL: Yes on pg. 3 lines 32-35. The committee has not reached a consensus on the definition of "permanently unconscious".

240 REP. EDMUNSON: In terminal condition, death is eminent regardless of treatment. Does "permanently unconscious" have language yet proposed?

249 CAROLE SOUVENIR, COMMITTEE COUNSEL: There have been two proposals for the definition.

255 BOB CASTAGNA, OREGON CATHOLIC CONFERENCE: In Subsection D of Section 20, lines 12-14 on pg. 20, there is the conscious clause issue. We

recommend that there should either be a deletion of lines 12-14, or

allowing a provider to discharge a patient, these two would be

consistent with the conscious clause language. (Pg. 17, line 33-36)

Our concern is that the health care provider should not be required to

transfer the health care provider objects, whether it is an oral

decision or a written instruction. Either the health care provider

should be able to discharge or that language should be deleted.

278 CHAIR BRIAN: Cites language on line 13, pg. 20 after "shall". The issue is that with certain health care facilities they may not want to

participate in transferring a patient to a facility where activity

occurs that they disagree with. This language would give that facility

the option of making arrangements for transfer or discharge. Cites

language.

299 SEN. SHOEMAKER: Would "either" work better?

306 REP. EDMUNSON: It makes it clear that there is no alternative third alternative.

309 REP. HAYDEN: A hospital or doctor cannot discharge a patient, you have to have some orderly way of releasing someone. Have to avoid the

prospect of being sued for abandonment. A facility should be able to

discharge a patient without the fear of being sued.

327 REP. EDMUNSON: Because of the immunity section, if this is an allowed procedure, it could be raised as a defense in a suit for abandonment.

What is the appropriate standard discharge? 343 REP. HAYDEN: The current standard is to notify the patient that you will no longer be responsible for their care, and give them 10 days to

seek alternative care. Then you are immune from abandonment charges.

346 REP. EDMUNSON: So they shall either notify of discharge, or a pending discharge within 10 days.

351 REP. BAKER: Is that by statute?

352 REP. HAYDEN: It is either legislative law or administrative rule.

360 SEN. SHOEMAKER: If it is a statute, Rep. Baker's approach is the correct one.

371 CHAIR BRIAN: Cites new wording of amendment, "The health care provider shall, without abandoning the patient, either discharged or make

reasonable effort, etc".

378 CASTAGNA: Cites example. Does that mean comply with the current practice?

393 REP. HAYDEN: In many cases the physician of the hospital would be able to effect the ordering transfer within twelve hours.

397 CASTAGNA: This is the problem when a principal has to be transferred and the health care provider isn't comfortable with it.

402 REP. HAYDEN: That is the reason for discharging someone from a practice, because you don't want to be responsible.

411 CASTAGNA: The physician would neither have to perform the procedure or transfer a patient.

412 CHAIR BRIAN: In these cases, we are always talking about withdrawal rather than a provision.

417 REP. EDMUNSON: There may be procedures that some physicians may not feel comfortable performing.

422 CHAIR BRIAN: We have consensus on line 29-30 to remove "if a specialist is reasonably available".

427 CAROLE SOUVENIR, COMMITTEE COUNSEL: On line 41 of pg. 21, there is a conceptual amendment to make it clear that the first person located in

that order shall have the ability to make life support withdrawal

decision.

434 SEN. SHOEMAKER: Suggests language to make above language stated by Counsel clearer. Reads suggested language for lines 35-41.

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012 REP. EDMUNSON: If the individual at the beginning of list still exercises independent judgement and does not need approval of others,

there must be an attempt of a discussion.

019 REP. MASON: How does this relate to the presumption?

020 CAROLE SOUVENIR, COMMITTEE COUNSEL: The presumption goes to artificially administered nutrition and hydration, and Section 21 goes

to life sustaining procedures, not including artificially administered nutrition and hydration.

022 REP. MASON: What is the current law on this?

023 CAROLE SOUVENIR, COMMITTEE COUNSEL: Under the current law for artificially administered nutrition and hydration it is set out in ORS 127.580, which is being amended. And under ORS 127.635, life sustaining procedures as defined does not include artificial nutrition and hydration.

038 REP. MASON: We haven't defined "permanently unconscious" yet? Need to do that.

047 CAROLE SOUVENIR, COMMITTEE COUNSEL: Other changes in Section 21 would be making spouse second in line in order of priority, on pg. 21, line 2 which would be moved to line 45, Subsection B. Cites changes on line 7, pg. 21. Regarding the case manager, if available they should be consulted. Adds words on line 41, pg. 20.

061 CHAIR BRIAN: What is a case manager?

064 TINA KITCHIN, PHYSICIAN WITH DEVELOPMENTAL DISABILITIES SERVICES: A case manager is a person who is either a state employee or a county employee using state funds, who acts as that person's advocate in arranging services and making sure that their rights are protected.

089 REP. HAYDEN: Is a case manager a patient's advocate in that they are ombudsman for the patient and strive to preserve the patients rights?

092 KITCHIN: An ombudsman in the Senior system is a separate entity from a case manager. Their function is the same in that they are to advocate for a principal and protect their rights.

096 REP. HAYDEN: Why wouldn't we define a "court appointed ombudsman", rather than going to a state employee?

099 KITCHIN: A court appointed ombudsmen would require that these decisions would be made after you have taken them to court. A case manager is someone who is available and active in their life. We shouldn't put the decision making process on the case manager, this is an extra safeguard that gives the case manager a chance to get into court and advocate for the principal.

109 CHAIR BRIAN: You would want this person consulted with, on the

same basis as on line 41 of pg. 20, along with concerned family and friends?

111 KITCHIN: Would prefer "who have consulted with concerned family and friends and notified a case manager if available".

115 CHAIR BRIAN: We don't know if they have physician assistance tracking down people.

117 KITCHIN: These are difficult decisions that are life and death and it is a vulnerable population. 121 CHAIR BRIAN: The case manager should be able to make themselves known to the physician. 124 KITCHIN: Some of these decisions happen quickly and sometimes the case manager is not notified. Would prefer that "if known" is not included.

129 CHAIR BRIAN: Discusses different situations and what the possibilities are concerning consulting family, friends, and case managers. Where do

they all fit in?

139 KITCHIN: With the people just mentioned, it is faster to notify a case manager than next of kin who are not actively involved.

141 CHAIR BRIAN: But this says "and", so they all have to be notified anyway.

142 KITCHIN: The list of priorities are family and friends already.

144 CAROLE SOUVENIR, COMMITTEE COUNSEL: How would the physician find out who this case manager was?

146 KITCHIN: In most of the counties there is an emergency Department of Human Services telephone number that would tell them who the case

manager is.

151 CHAIR BRIAN: Would be convenient for the case manager to have the patient fill out an advanced directive.

153 KITCHIN: With someone who mentally retarded they are not considered capable.

161 CHAIR BRIAN: We were going to insert this subject into lines 41 of pg. 20.

163 REP. HAYDEN: Dealing with the principal's case manager?

165 CHAIR BRIAN: Section H would be deleted and would be added to line 41 of pg. 20.

172 KITCHIN: This circumstance is only for withholding or withdrawn life support which is never a middle of the night decision, so there should

be enough time to contact someone.

176 REP. HAYDEN: The case manager in this concept is someone who is a consultant and a resource for information before going to the list

of

people who are going to make a decision for the principal?

180 KITCHIN: A case manager is someone who can say something when they don't think that the principals best interests are being met and can

take it to court.

183 CAROLE SOUVENIR, COMMITTEE COUNSEL: The person in that list of priorities would have to consult with the case manager if we insert this language?

185 KITCHIN: Correct. Would use "notification" of decision.

190 REP. MASON: These decisions are usually made on the phone?

192 KITCHIN: I have seen cases that because of the lack of statutes, the physician goes through the next of kin list and finds who ever is first available.

210 CAROLE SOUVENIR, COMMITTEE COUNSEL: On pg. 21, lines 12-13, discusses use of ethics committee, patient advocate, or ethics consultant.

217 REP. BAKER: Do we have a definition of "ethics committee"?

218 CHAIR BRIAN: Or "patient advocate" or "ethics consultant"?

220 REP. BAKER: Do we have hospital requirement for ethics committee in licensed hospitals in Oregon?

224 REP. MASON: These ethics committees as well as patient advocates mean nothing. If you can't find any of these people should not do anything.

236 REP. EDMUNSON: This Subsection 3 is only going to work if a person has been abandoned by everyone.

245 SEN. SHOEMAKER: This makes it explicit that this is what shall happen.

250 REP. EDMUNSON: A physician shouldn't have to face a situation at a facility following a procedure backed only by a statute. 253 CHAIR BRIAN: A physician can consult with whom ever they want.

258 REP. HAYDEN: A patient advocate as an ombudsmen may be like a case manager. Ethics committees are representative of the institution of

which they exist. Most times they have a conflict of interest that may

not be in the patients best interest. Cites different types of ethics

committee's. In these instances an ombudsman who has a duty to protect

that patients best interest would work the best.

286 CHAIR BRIAN: We should end line 12 after "physician"?

294 MILES EDWARDS, PHYSICIAN: Any ethics committee or consultant that would be a hospital representative would be unethical.

308 CHAIR BRIAN: Is there a disadvantage if we end line 12, (reads language)? They are only consulting, they will still make their own

decision.

315 EDWARDS: The final decision should be the physician's, but the ethics committee's proper role would be to see to it that the right people are talked to. The ethics committee's job isn't to make the decision but to get the right people to make the decision.

321 REP. MASON: Anyone who has a interest in the hospital shouldn't be involved, but the physician doesn't have an interest?

328 EDWARDS: It would be highly unethical if the physician and the ethics committee let economic factors dictate their decision.

333 REP. MASON: How do we get a neutral decision maker?

340 REP. MASON: If you are looking for neutral decision maker, it has to be someone outside of the situation.

353 SEN. SHOEMAKER: The economic interest of the physician or the ethics committee is to keep the patient alive and money coming in. This is the decision by the physician or the hospital to withhold or withdraw who

will suffer financially from the decision. I don't think physicians

make decisions based on financial situations.

367 CHAIR BRIAN: Gives an example of a lawyer giving objective advice, like a doctor who is a case manager should do.

375 SEN. SHOEMAKER: The health care profession is different. You do trust the physician to make the decision.

380 REP. MASON: The people that have no friends and no family are the ones that have no financial funds behind them.

389 SEN. SHOEMAKER: The chances are that they are on Medicare or Medicaid.

390 REP. MASON: This could be someone who is in an accident on the street, and they may have no financial backing.

396 EDWARDS: I have worked on a ethics board, and they are not in the mind set of being hospital representatives or thinking in economical terms.

406 CHAIR BRIAN: How often would an attending physician consult with an ethics committee in these circumstances?

409 EDWARDS: It would be very common in nearly all cases in major hospitals.

418 CHAIR BRIAN: Why do we require it by law?

419 EDWARDS: I don't know that you need to, it is and usually should be done.

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006 CHAIR BRIAN: If there is a consensus to add a ".", then that enables the physician to consult with whomever they wish.

008 REP. MASON: Uncomfortable with giving the authority to the physician.

009 CHAIR BRIAN: Can't avoid it if no one else is around. When there is no one else around, the physician has to make the decision.

026 REP. BAKER: On pg. 21, lines 19-20, did we take the issue of no insurance to be impaired or invalidated? Is that still preserved

somewhere?

040 CAROLE SOUVENIR, COMMITTEE COUNSEL: That is on pg. 18, line 27.

041 CHAIR BRIAN: On pg. 3, lines 13-14, the definition of "permanently unconscious" is of concern.

046 REP. EDMUNSON: We don't deal with anoxic episode, but that was a real key with determining how extensive the brain damage was.

059 EDWARDS: Refers to EXHIBIT B, and cites examples.

086 REP. HAYDEN: Aren't some patients induced into this state by drugs?

088 EDWARDS: Yes, that needs to be dealt with separately. Continues with EXHIBIT B.

100 REP. EDMUNSON: In order for there to be a persistent vegetative state (PVS) must there be anoxia?

102 EDWARDS: We usually deal with anoxia insult either as a trauma situation, or a heart attack. Continues summary of EXHIBIT B.

116 REP. MASON: If column 1 is confusing to physicians, that doesn't argue very well for this bill.

123 EDWARDS: A neurological specialist understands the conditions very well. A specialist can define what they are dealing with, and they are

not confused by this. We don't want the average doctor making the

determination.

137 REP. MASON: Refers to and reads from EXHIBIT B.

147 EDWARDS: Go on into the next paragraph. Continues explanation of EXHIBIT B.

156 CHAIR BRIAN: You are saying "persistent", and we are trying to define "permanent", there is a difference.

157 REP. MASON: Cites EXHIBIT B. Some of the factors seem to be non factors. How can the presence of a sleep and wake cycle argue for a

persistent vegetative state?

168 EDWARDS: It does, it separates it from other entities that we might be considering. This is clearly understood by the neurological

specialists.

179 CHAIR BRIAN: How do we move into a definition?

183 REP. HAYDEN: Persistent vegetative state is not necessarily permanent. It could become permanent, but we need to define permanent

unconsciousness.

191 EDWARDS: There are no single tests which would clearly identify a persistent vegetative state. If the 8 criteria that are cited on pg. 387 of EXHIBIT B are met, the criteria, the neurological specialist will say that there is no reversibility.

209 REP. HAYDEN: How do we define "permanently unconscious"?

215 EDWARDS: I can't say that a coma is irreversible. If a neurological specialist were to say that a coma was irreversible, I would be

reassured by that.

233 REP. EDMUNSON: Is it medically correct to say that a PVS may be the cause of a coma?

237 EDWARDS: No, they are different things. Comatose people don't have sleep wake cycles.

240 SEN. SHOEMAKER: Discusses what the Senate has done in the last few sessions, and the definition that they came up with.

256 CHAIR BRIAN: Can you conclude that the condition would be only caused by anoxic event?

261 EDWARDS: The anoxic event that persists long enough, meets the criteria that a neurological specialist would be qualified to declare. PVS is

the brain being killed totally with no chance for it to come back.

267 CHAIR BRIAN: Are there other ways to get to the same point that Sen. Shoemaker just described? 269 EDWARDS: Permanent unconsciousness could occur for other reasons. If a qualified neurologist said that there was no hope of recovery, I would

agree with that.

279 REP. EDMUNSON: We may agree with the first part of the definition of "permanent unconsciousness". Could we insert "neurologically

determined" into that definition so there is a higher standard of

medicine?

296 SEN. SHOEMAKER: In order for withholding or withdrawing to occur under an advanced directive or a Section 21 situation, you do need medical

confirmation. The difference is that an advanced directive medical

confirmation is by a second physician who has examined the patient and

has clinical expertise. (line 10-12 is the definition of "medically

confirmed") Dealing with permanently unconscious, might want to call

for a neurological examination.

311 CHAIR BRIAN: Then use "medically confirmed" in "permanently unconscious" definition?

312 SEN. SHOEMAKER: No, because you can't act upon permanent unconsciousness without medical confirmation.

316 REP. HAYDEN: What are some of the conditions that a layman would refer to as "unconscious" in addition to "coma" and "PVS"?

320 SEN. SHOEMAKER: Under Section 11, which is being deleted, we provided check points that you had to go through before making one of these

decisions. If permanent unconsciousness was the condition that you were going to act upon, that confirmation had to be by a neurological

specialist. If we take out Section 11, we need to put it in somewhere

else.

335 REP. EDMUNSON: On pg. 13, lines 38-40, I like your definition of permanently unconscious. Does that neurological specialist need to have a hands on examination of the patient or are the medical records and

test sufficient?

357 EDWARDS: A neurologist should see the patient personally.

364 SEN. SHOEMAKER: "Medically confirmed" means confirmed by a second physician who has examined the patient.

368 REP. EDMUNSON: Is a neurological specialist reasonably available in Oregon?

370 EDWARDS: Yes, the major cities in Oregon have them.

380 KITCHIN: For the small towns, there is usually a neurological specialist not too far away, could possibly be just across the border.

385 REP. EDMUNSON: In order to satisfy the proposed definitions the patient or the physician would be transported?

389 KITCHIN: Most times the patients are transported. It is not reasonable to require that these specialists be in all of the little towns.

403 REP. EDMUNSON: That pertains directly to whether the specialist should be reasonably available, but for the people in far away areas, that may mean being airlifted to somewhere else.

410 REP. MASON: Someone needs to speak on behalf of the neurological specialist. Refers to EXHIBIT B.

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008 EDWARDS: Neurologists are highly trained physicians in the area of diseases of the brain and nervous system, and they are very qualified to make decisions about what we are talking about. I would be uneasy about other doctors making life and death determinations without them being

specialists.

020 REP. HAYDEN: In your testimony a few weeks ago you said it would take a minimum of six months to determine a condition which would allow plenty of time to transport a patient to see a neurological specialist. Could

you define a few more terms that a layman might be able to determine as unconscious other than a coma and PVS?

028 EDWARDS: There really isn't anything else. Cites EXHIBIT B. The main thing we deal with is PVS.

038 CAROLE SOUVENIR, COMMITTEE COUNSEL: On pg. 3, lines 13-14 defines "permanently unconscious".

044 REP. HAYDEN: Do you want to lock in a time limit on how long this state can be allowed to let go?

047 REP. BAKER: That is a specialist's prerogative.

048 CHAIR BRIAN: It is defined tightly enough that I feel comfortable. Are you asking for a minimum amount of time to be set before that check is

made?

054 REP. HAYDEN: Some people will wake up after five years, so we should set the outside time limit for five or ten years.

057 CHAIR BRIAN: We are trying to write the definition for permanently unconscious tight enough where there is a complete lacking of awareness, and it has been confirmed by a specialist who is

an expert in

unresponsive individuals.

063 REP. MASON: You've asked a neurologist to make a professional judgement about something that they are uncomfortable with.

066 REP. EDMUNSON: The article says that a doctor has to make a case by case analysis.

071 REP. MASON: If a neurologist makes this determination, what standards are they working off of?

075 REP. EDMUNSON: The same standards that determined their expertise. 079 REP. HAYDEN: Cites the time parameters in EXHIBIT B. Are we presuming that any neurologist would take that time frame into consideration when making a decision?

085 EDWARDS: Yes.

086 REP. EDMUNSON: You will either have a neurologist who will use the best science possible to make a decision, or you won't. Nothing we write in

this statute will protect us from people who fail to meet the standard

of care and professionaliSM that we have established. We cannot

legislate that in this bill.

095 REP. MASON: You are asking people to make a professional decision, you have no standard of care in this definition.

102 REP. EDMUNSON: A neurologist practicing professionally and competently will rely upon all of the scientific standards, durations, etc., that go into establishing an expertise. If they fail to measure up to that

standard, then their liability will be the same as if they are treating someone in a car wreck or a newborn infant. It would be a mistake to

change the standard of care in this bill for people in an unconscious

condition.

113 REP. MASON: But we are adopting a definition that according to EXHIBIT B, the people have rejected.

123 CAROLE SOUVENIR, COMMITTEE COUNSEL: In Section 22, pg. 21, lines 23-27, discusses insertions and language for adding the presumption back into

the bill.

147 REP. MASON: This is for both the people with and without a directive?

148 CAROLE SOUVENIR, COMMITTEE COUNSEL: Yes, under ORS 127.580 the -8 amendments deal with both situations of artificially administered

nutrition and hydration.

151 REP. MASON: That doesn't relate back to the people we were just talking about?

152 CAROLE SOUVENIR, COMMITTEE COUNSEL: It does relate back to ORS 127 .635 which is Section 21. On pg. 22, lines 23-25 refer to "organization"

that is used throughout the bill. Cites insertion on line 26 of same

page. On line 35, of same page, cites disclaimer and insertion. 180 CASTAGNA: We asked for an amendment to the Oregon Self-Determination Act, so that if these are amended, might be considered in an objectional manner. So that those health care providers would not be obligated to

distribute those forms.

191 CHAIR BRIAN: These are the advanced directive forms?

193 CAROLE SOUVENIR, COMMITTEE COUNSEL: Yes, but there is also information about policies. They are required to distribute information on the

rights of the individual to make health care decisions including the

right or refuse medical or surgical treatment.

199 CASTAGNA: Might be able to attach this amendment to the hand engrossed amendment, to add a conscious law for the organization. 205 CHAIR BRIAN: The only form being provided would be the advanced directive? How would that change this?

212 CASTAGNA: Discusses the possibility of the Hemlock society's filing an initiative to allow for assisted suicide.

215 CHAIR BRIAN: How would this change this advanced directive form?

216 CASTAGNA: Their initiative could amend the advanced directive created by SB 286.

218 REP. EDMUNSON: You could also repeal any conscious clause.

220 CHAIR BRIAN: By changing this line, it would substantially change the bill.

223 CASTAGNA: But you will still have the organizations under a statuted mandate that will be handing out these forms. We suggested that the

Oregon Self-Determination Act be extended for two years, and have the

1995 Session reexamine it.

233 REP. HAYDEN: It would be easy to insert a few words to comply with the american public's conscientious objections.

239 REP. BAKER: We are trying to guess something that may or may not happen. It is inappropriate at this time to put that language

in there.

241 REP. HAYDEN: But some people might object to distributing this form as it stands.

245 REP. MASON: What is the hospital's position on distributing this?

247 CHAIR BRIAN: They don't want to distribute this every time someone walks in the door which is what this amendment does.

250 SEN. SHOEMAKER: When the Sisters of Providence favor the bill, you know that they are comfortable enough distributing the forms.

254 REP. HAYDEN: Describes what the hospitals initially wanted to do with signing the forms.

264 CHAIR BRIAN: That is the potential abuse. Are they not handing these out for consciousness reasons, or because they are a bother?

271 REP. HAYDEN: I was thinking of individual practices that might not want to participate in the program.

279 REP. MASON: Conceptually proposes Rep. Hayden's amendment.

282 CHAIR BRIAN: If it is written so that it is on a conscientious objection, then that will work.

287 REP. EDMUNSON: If there is going to be a disclaimer, then it will require notification that there are other legal responsibilities, which they may need to consult individually. 299 REP. HAYDEN: The federal standard is that it is permissive, it is the state law that makes it mandatory.

309 REP. MASON: Proposes an amendment.

319 REP. EDMUNSON: There must also be a notice to the patient that there are certain forms not being distributed.

326 CHAIR BRIAN: Reviews conceptual amendments.

333 CAROLE SOUVENIR, COMMITTEE COUNSEL: On pg. 23, delete lines 33-35 which has to do with the notification on the driver's license.

337 REP. EDMUNSON: Gives example of how a physician would know that it was on a driver's license.

346 SEN. SHOEMAKER: We just thought it would be helpful to have an advanced directive stated on a public document.

352 TED FALK, ATTORNEY: It is already in the law. There is already a conscious clause in the laws that state references about the

distribution.

411 CHAIR BRIAN: Adjourns the meeting at 3:11 p.m.

Submitted by: Reviewed by:

Sarah May Anne May Committee Clerk
Committee Coordinator

EXHIBIT LOG:

A - Hand Engrossed Amendments to SB 286 - Committee Counsel - 23 pages
B - Testimony on SB 286 - Dr. Miles Edwards - 5 pages C - Proposed Amendments to SB 286 - Committee Counsel - 3 pages D - Proposed Amendments to SB 286 - Rep. Mason - 1 page E - Proposed Amendments to SB 286 - Rep. Mason - 1 page