



Elder Law Newsletter

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Role of health care representative is increasingly important

By Brian Haggerty

As more Oregonians age and the likelihood increases that they will face a period when a medical condition renders them unable to direct their own medical care, the advance directive has become a standard estate-planning document. Although much of the public's attention is drawn to the effect of the advance directive on end-of-life decisions, the powers given to the health care representative (HCR) appointed in an advance directive are much broader.

Part B of the advance directive form established by statute (ORS 127.531) allows "a capable adult" to designate a health care representative and an alternate health care representative. The alternate may act whenever the original

designee is unavailable, unable, or unwilling to serve. ORS 127.510.

ORS 127.535 says that the health care representative has "all the authority over the principal's health care that the principal would have if not incapable," subject to limitations in the advance directive and two statutes. ORS 127.540 excludes mental health treatment, psychosurgery, sterilization, and abortion from the class of health care decisions that may be made by the health care representative. ORS 127.580 establishes a presumption that the inca-

pable patient wants artificially administered nutrition and hydration ("tube feeding").

These statutes set aside two special classes of decisions on which the health care representative's authority may be limited: withholding or withdrawing life-sustaining procedures, and withholding or withdrawing artificially administered nutrition and hydration. (See ORS 127.505 for definitions of these terms.) An appointed health care representative may make decisions regarding life-sustaining procedures ("life support") only if such authority is explicitly granted in the advance directive, or the incapable patient has been "medically confirmed" (by the attending physician and one other) to be in one of the four conditions set out in the advance directive, Part C.

The advance directive form itself says that if the space in Part B, paragraph 2, is not initiated by the principal, the health care representative may not decide about life support.

*Though wise men
at their end know
dark is right,*

*Because their
words had forked
no lightning they*

*Do not go gentle
into that good
night.*

—Dylan Thomas

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ORS 127.540, however, seems to indicate that the limitation on the health care representative's authority over life support is overcome when either the health care representative has been given such authority by the initialing of paragraph 2, or the principal is in one of the four end-of-life situations set out in the form.

Incapacity is turning point

The threshold determination is whether the patient is "incapable." This is defined in ORS 127.505 as lacking "the ability to make and communicate health care decisions to health care providers," and the statute says this determination may be made by a court in a proceeding to appoint or confirm the authority of a health care representative, or by the patient's attending physician.

Once a determination of incapacity has been made, the health care representative appointed by an advance directive takes over. The health care representative must act consistently with the principal's directions as stated in the advance directive "or as otherwise made known by the principal to the health care representative at any time." ORS 127.535(4).

The health care representative may be overruled by the principal with respect to tube feeding and life-sustaining procedures – if the (otherwise incapable) principal objects to a decision on these matters, he is treated as being capable in that respect. The health care representative specifically has the right to receive medical information and records and to consent to their disclosure, except as the right is limited by federal law ORS 127.535(3). This proviso may make it wise to include a HIPAA-type disclosure authority in the advance directive, or to have the principal execute a separate disclosure authorization while still capable.

HCR trumps guardian

The authority of an appointed health care representative supersedes the powers of a guardian appointed for the patient, and even the patient's spouse and family. However, if there is no advance directive appointing a health care representative, then ORS 127.635 designates who shall serve as such, with the authority going first to a guardian appointed for the patient, then to the patient's spouse,

then to others, even down to "any adult relative or adult friend." If no one else is available, then the attending physician may withhold or withdraw life-sustaining procedures, but apparently not make decisions regarding tube feeding. ORS 127.635(3).

Even when an attorney can sit with the statutes and review and consider them, the statutory structure is complex. The real-life situation faced by a health care representative will not be an academic exercise. It will be a stressful and immediate situation fraught with intense personal feelings and family pressures. Even though the health care representative's authority over medical decisions trumps that of a guardian or conservator or an attorney-in-fact with financial authority, the health care representative may have to deal with these other fiduciaries who still hold the purse strings and who may feel their input is important, regardless of statutory law. And of course, the health care representative will have to consider the beliefs and hopes of the patient's family, consistent with his or her duty to carry out the patient's wishes. Although the health care representative will have to make the decisions, involving as many family members as can be contacted in the decision-making process probably gives the best chance of avoiding discord later.

ORS 127.550 provides for a petition for judicial review by a circuit court for a wide variety of purposes relating to advance directives, including a determination that a principal is incapable, whether an advance directive is valid, and whether acts taken or proposed by a health care representative are valid and consistent with the principal's wishes. Despite this provision, this author found no reported cases on advance directives.

The role of the attorney

Whether helping a client fill out an advance directive or advising an appointed health care representative, an attorney should carefully review the form to make sure that the choices made by the principal are consistent. The attorney should also counsel the principal to discuss the choices made in the form with family members, and especially with the health care representative and alternate. The appointed representatives should review the form carefully to make sure that the choices marked are consistent with the representative's understanding of the principal's beliefs, and should discuss the document with the principal. The attorney should assure the people chosen as HCR and alternate are not the principal's attending physician (or his or her employee) and are not an owner or employee of a health care facility where the principal is a patient or resident. ORS 127.520. This review must be done while the principal is still capable of correcting any deficiencies.

The attorney should also ensure that the document is correctly executed. The principal's signature (or acknowledgment of his or her signature) must be witnessed by two adults, one of whom must not be a relative, must not be entitled to any portion of the principal's estate, and must not be an owner or employee of the health care facility where the principal is a patient or resident. However, if the principal is in a long term care facility at the time of executing the document, one of the witnesses must be a person designated by the facility. ORS 127.515.

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Role of the health care representative *Continued from page 2*

It is important to discuss carefully the advance directive and health care decisions with clients who are filling out the form, and to encourage clients to discuss their choices with family members. The attorney must then be prepared to counsel the family and the health care representative (keeping in mind at all times who is the client) on how decisions are to be made when the advance directive must be put in play.

The role of the HCR

As noted above, the health care representative must follow the principal's wishes to the extent that the principal's desires are known, as set out in the advance directive or "as otherwise made known." The health care representative "has a duty to act consistently with the desires of the principal." ORS 127.535(4). This seems to be intuitively comfortable for most clients, who tend to refer to "what Mom wants." Unfortunately, the health care representative may be called on to make many decisions which are not set out within the four corners of the advance directive. If the desires of the principal are not known, the statute says the health care representative must make the decision he or she in good faith believes is in the best interests of the principal.

The health care representative has no civil or criminal liability for any decision made in good faith—ORS 127.555(2)— and is not personally liable for costs of the principal's care solely because of making health care decisions. ORS 127.535(2).

Conflicts may arise

There may be family discord over decisions made. There may be disagreement in the family about "what Mom wants" as well as disagreement over what is in her best interest. As noted in the Oregon State Bar's CLE program "Elder Law," Section 2.24 (2000), formal or informal mediation may help improve communication among family members and help the fiduciary to decide. If time is short, an attorney representing a fiduciary may have to become an informal mediator in the hospital corridors.

The attending physician has the legal power to declare a principal "incapable," thus invoking the authority of the health care representative. ORS 127.505(13). However, the principal and/or other family

members may not accept this determination. Family members may deny the authority of the health care representative to act at all (without being willing or able to take the matter to court as provided by ORS 127.550).

To further complicate matters, it may be that a principal, although having been declared "incapable" by the attending physician, may continue to speak to one or more family members about his or her health care preferences. These preferences, even if expressed by a person who is confused or demented, may have weight in family discussions disproportionate to their objective validity. Family members may become strident in declaring that the principal's expressed desires must guide the health care representative, who may feel that the principal is in fact incapable and is not understanding the decisions that must be made.

The statute makes the principal's expressed desires paramount with respect to tube feeding and life support. ORS 127.535(5). However, the incapable principal's expressed desires on other matters may make life difficult for a health care representative who is trying to make a good-faith determination of what is best, in the absence of the principal's desires expressed when clearly capable.

It appears from the statutes that a guardian who is authorized to make health care decisions or another person who steps in under the statutory provisions becomes the "health care representative" and would be bound by the same decision-making criteria. ORS 127.635(2). This applies only in the case of a principal who has been medically confirmed to be in one of the four end-of-life situations outlined in the statute. ORS 125.315(1)(c) also makes a guardian's powers to consent or withhold consent to health care subject to those provisions of Chapter 127 relating to advance directives. Where there is no written advance directive, it may be much more difficult to establish what the principal's desires are, as recently seen in the Florida case which garnered so much attention.



Brian Haggerty has focused on estate planning since 1998, and more recently has added elder law as an area of concentration. Prior to earning his J.D. from Northwestern School of Law of Lewis and Clark University, Brian was a tax consultant for 12 years. His practice is in Newport, Oregon.

Family discussion as important as documents

By Richard Warren, APRN, BC



Rick Warren earned his bachelor's and master's degrees in nursing from the University of Portland. He is a certified hospice nurse and a certified adult nurse practitioner with twenty years of experience in hospice and palliative care. Rick is a manager in end-of-life care with Providence Home and Community Services.

I was called to a home, as I am several times each week, to help a family better understand the options for their mother's care. Mrs. Schneider was a pleasant woman in her eighties with several chronic illnesses. Two of her three daughters were present that day, as was her son-in-law. Another daughter lived out of state and wasn't much involved in her mother's care. They asked many of the questions I have come to expect: How will we care for mom as her needs increase? Can we keep her at home? What if we need additional help? How will we find a placement if needed? And who pays for all this?

We discussed Mrs. Schneider's preferences, her care needs, costs, community resources, and family resources. After answering their questions I asked about advance directives. The room grew quiet and all eyes turned to Mrs. Schneider. She didn't respond.

Wanting to be certain she understood my question I produced our advance directive packet. "Do you have one of these?" I asked.

"Oh yes," she replied. "I have three or four copies. They give me one each time I go to the hospital."

"And have you filled it out?" I ventured.

"No," she said softly.

"May I ask why not?" I continued.

"They all know what I want," she said, glancing at her children. "They'll do the right thing if the time comes."

Although we talked for another twenty minutes I didn't learn much more about her wishes that day. Unfortunately our discussion was ultimately too little, too late. Later that month Mrs. Schneider became more short of breath. She was taken to the emergency room and subsequently admitted to the hospital with pneumonia. Despite aggressive treatment she grew weaker and eventually unresponsive. Her daughter from Washington arrived. As Mrs. Schneider's life hung in the balance, her daughters hurriedly tried to understand the treatment options and make the right decision without any input from their mother. The youngest daughter was distraught and unable to participate. The eldest was in favor of aggressive treatment up to, but not including, resuscitation and mechanical ventilation. The middle daughter from Washington was by far the

most vocal. She felt that her mother would want any and all treatment. The primary care physician, who had known Mrs. Schneider for more than twenty years, did not believe that resuscitation or ventilation would be in her best interest. He expressed his opinion and allowed the family to decide. Mrs. Schneider was placed on mechanical ventilation and died within days of respiratory and renal failure.

I'll never know how this family dealt with the loss of their mother and all the conflict that arose. I will remember the discussion we had in her living room. At the time completing the POLST seemed prudent but not pressing. Unfortunately this family will never know if they "did the right thing."

Expressing our wishes for care at the end of life remains problematic. Virtually all of us have preferences and yet most never complete the necessary documents or discuss these issues with our loved ones and physicians.

Mrs. Schneider's responses are not uncommon. Many of us believe that our families inherently know what we want and will "do the right thing." We assume our family members will agree with each other and with our physicians—a risky assumption.

As people age and/or their health deteriorates, completing an advance directive makes sense.

However, the advance directive should be in addition to, not instead of, naming a surrogate decision-maker. I recommend that everyone over the age of 18 designate a surrogate, confirm that the surrogate understands this responsibility, and agrees to participate. I encourage patients to choose someone who knows them well and who is assertive. In a crisis, if there is any ambiguity, the most assertive or persuasive party may prevail.

Most people are surprised to learn that choosing "no life support" on the advance directive is not the same as having a POLST (physician's orders for life sustaining treatment) with a DNR (do not resuscitate). Paramedics can't honor the advance directive because it is not a signed order from a physician or nurse practitioner.

For those who are very elderly and/or ill,

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Making changes to the advance directive form

By Phil Hingson

Recent discussions on the elder law Internet discussion list raised the question of whether or not the form of the advance directive can be changed. The statutory language in ORS 127.531 is at the heart of this issue. Paragraph (1) of that section states in part that “[t]he form of an advance directive executed by an Oregon resident must be the same as the form set forth in this section to be valid.” Paragraph (2) states that “[a]n advance directive shall be in the following form,” and then proceeds to give the actual advance directive form. However, in the statutory form itself, in the last paragraph of instructions located just before the blanks for filling in name, birth date, and address, the language states that “[y]ou may cross out words that don’t express your wishes or add words that better express your wishes.” At first blush, these statutory provisions seem contradictory.

When interpreting statutory language, ORS 174.010 requires that “where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all.” The simplest interpretation that will give effect to all of the above advance directive provisions is that the advance directive must be given to an individual in its statutory form, but the individual filling it out can modify the form.

Assuming the above interpretation, it should be very clear that the person who fills out the advance directive can cross out words in the statutory form, or add words to the statutory form, to better express his or her wishes. For example, the last choice of paragraph (7) in *Part C* states that “I DO NOT have a health care power of attorney.” However, given the definition of a “health care power of attorney” at the beginning of paragraph (7), *Part B* constitutes a health care power of attorney. Thus, if a client fills out *Part B* and then fills out *Part C* and indicates in paragraph (7) that she does not have a health care power of attorney, she may arguably have just revoked *Part B*. While such an argument defies common sense, this is exactly the position the Veterans Administration recently took in refusing to honor the appointment of health care representatives

under *Part B* of an advance directive. To avoid this result, some attorneys have clients write in the language “other than *Part B*” after initialing “I DO NOT have a health care power of attorney,” and then have the client initial the change. Other attorneys avoid this particular issue by instructing their clients not to initial any of the choices under paragraph (7) of *Part C*.

If you are having your clients repeatedly make the same changes, the issue arises as to whether you, as their attorney, can modify the advance directive form on your computer. Since your clients can personally modify the statutory form, they individually should be able to direct you to do so on their behalf. The fact that the change is made on the computer instead of manually should not invalidate the advance directive. However, if you present all of your clients with the same pre-modified version of the form, the risk of invalidating the advance directive increases, because the form you are initially presenting to them is not the statutory form. In either case, showing the changes to the form on your computerized version may reduce the risk of invalidation. This could be done by using strike-through fonts and/or by typing language above or below the existing statutory language. Such obvious changes would then be visible to the person signing the advance directive as well as to his or her physicians. If the form presented shows the original statutory language as well as the change, and if the client acquiesces by initialing such change, it should be difficult for anyone to invalidate that advance directive. Also, keep in mind that minor changes made for clarification purposes, as illustrated in the above paragraph, are much less likely to be attacked than substantive changes to the scope or intent of the statutory form.

Changing the statutory form differs from adding an addendum to the form. The advance directive form clearly allows individuals to write in additional conditions or instructions, and if such instructions surpass the three blank lines provided in *Part B* or *Part C*, there is nothing in the statutes to



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Family discussion

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a POLST clearly expresses his or her wishes on resuscitation, life sustaining measures, artificial nutrition, and antibiotics. This document is signed by a physician or nurse practitioner and will be honored by care facilities, paramedics, and other health care providers. Advance directives do not serve this function.

Some people dutifully complete advance directives and lock them away for safekeeping, never to be seen again. They find discussing their wishes for care at the end of life more difficult than completing the forms. However, without this dialogue the forms are much less useful. I try to normalize this conversation and bring it up with all my patients. I often tell them it is one of the nicest gifts they can give their families. It isn't a matter of if but when. After all, the death rate in this country really hasn't changed. It's still one per person.

Changes to advance directive form

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prohibit referencing an attached addendum. However, care should be exercised to ensure that the addendum adds clarity instead of further confusion. To avoid any argument that you have modified the statutory form, the safest practice is to incorporate the addendum by reference in the statutory blank lines in *Part B* and/or *Part C*, then attach the addendum to the advance directive, rather than placing the addendum language directly in *Part B* or *Part C*. The addendum must be filled out prior to having the advance directive witnessed.

To summarize, individuals can change their own advance directives and can add an addendum. They should also be able to direct their attorneys to make such changes or to add the requested addendum to the computerized form. However, attorneys who present their clients with advance directive forms that the attorneys have modified without individual direction from their clients run the risk of violating the provisions in ORS 127.531 that require the advance directive to be the same as the form set forth in that section. Such attorneys should try to minimize that risk by showing the statutory language along with the changes thereto, and by making the changes reasonably obvious.

Important elder law numbers as of July 1, 2005

SSI Benefit Standards	Eligible individual \$579/month Eligible couple \$869/month
Medicaid (Oregon)	Long term care income cap. \$1,737/month Community spouse minimum resource standard. \$19,020 Community spouse maximum resource standard \$95,100 Community Spouse Minimum and Maximum Monthly Allowance Standards. \$1,604/month; \$2,377/month Excess shelter allowance Amount above \$481/month Food stamp utility allowance used to figure excess shelter allowance. \$287/month Personal needs allowance in nursing home. \$30/month Personal needs allowance in community-based care \$122/month Room & board rate for community-based care facilities. \$458.70/month OSIP maintenance standard for person receiving in-home services \$580.70 Average private pay rate for calculating ineligibility for applications made on or after October 1, 2004 \$4,700/month
Medicare	Part B premium \$78.20/month Part B deductible \$110/year Part A hospital deductible per illness spell \$912 Skilled nursing facility co-insurance for days 21-100. \$114/day

Resource Corner

An interview with Dr. Susan Tolle

By Alexis Packer, Attorney at Law, Ashland

I asked Dr. Tolle, "As an involved physician, what advice do you have for lawyers helping clients fill out advance directives?" She had two specific suggestions:

1. Encourage your clients to discuss their wishes with their health care representatives. Because "a patient's wishes will be honored almost all of the time," it is helpful for physicians charged with implementing an advance directive if, in addition to filling out the form, the patient and her or his health care representative (HCR) and alternate HCR have discussed the patient's wishes. Dr. Tolle encourages a family meeting and conversation while copies of a completed advance directive are passed out. "This is truly ideal because what you meant can be expounded upon in a way that family members in a time of crisis can hear your voice saying, I want, I don't want," and can add nuances to assist the HCR in understanding what the patient would want in a particular situation. In addition, Dr. Tolle notes that formal studies about stress levels on family members who were the decision makers who decided about whether to withdraw life-sustaining treatment show that "The more they knew, the less they woke up at 2:00 a.m. wondering if they did the right thing."
2. Advise clients to distribute their completed advance directives widely. Sometimes patients who have completed their forms with a lawyer "seem to think of them like they think of their will and lock them up with the other legal papers given to them by the lawyer. First and foremost a copy should be given to the physician and, of course, to those persons appointed." Dr. Tolle also encourages giving a copy to "those who might think they should have been appointed to let them know they are not appointed." Doing so "will allow a chance for conversation to take place that needs to take place and, later on, will make it much easier on the people that have been appointed." This can help avoid the often difficult situation physicians see when children who have had an

ambivalent relationship with their now-ill parent and who have just flown in from another state learn for the first time upon arrival at the hospital that they are not the HCR. Notification to children not appointed, "as unpleasant as it may seem at the moment, is about the biggest kindness you can give to those appointed" because it will help avoid a conflict when the time arrives for implementation of the advance directive.

According to Dr. Tolle, anyone older than 18 with concerns about his or her end-of-life medical treatment should complete an advance directive. A POLST (physician orders for life-sustaining treatment), which must be completed by a physician or nurse practitioner, is typically offered to persons "approaching the end of their lives, but not necessarily actively dying." POLST candidates are usually persons with advanced frailty, who want some types of end-of-life care but not others. For example, a person might not want to be placed in an intensive-care unit but want to go the hospital for other end-of-life care.

I asked Dr. Tolle how she interprets the situation in which a person appoints an HCR in *Part B* of an advance directive and in *Part C* paragraph 7 of the same form initials the box "I DO NOT have a health care power of attorney." Specifically, I asked her if she thinks that paragraph 7 refers to another document and whether it should be read as negating the appointment made in *Part B*. Dr. Tolle agrees that this is a confusing part of the form, but thinks it refers to another document and should not negate the appointment. As a physician she has no problem if patients want to clarify their wishes by adding language after the words in *Part C* paragraph 7, "I DO NOT have a health care power of attorney," such as "except for the appointment I have made in *Part B* of this form."

She did, however, draw a distinction between this type of clarifying language and language that attempts to "micro manage" the person's medical treatment by, for



Dr. Susan Tolle, Professor of Medicine and Clinical Professor at OHSU Schools of Nursing and Dentistry, holds the Cornelia Hayes Stevens Endowed Chair in Health Care Ethics and is a practicing internist in the Division of General Medicine and Geriatrics. Dr. Tolle founded and has directed the OHSU Center for Ethics in Health Care since 1989 and has shepherded its growth into an internationally recognized ethics center with programs such as the Physicians Orders for Life-Sustaining Treatment (POLST) program. Dr. Tolle presented "Advance Directives and the POLST Form: Understanding and Planning for End-of-life Decisions" at the 1998 OSB CLE seminar Counseling Elderly Clients, co-sponsored by the Elder Law Section.

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Physician Orders for Life Sustaining Treatment (POLST): an Oregon innovation

By Leslie Harris, Dorothy Kliks Fones Professor, University of Oregon School of Law

Even though a person has an advance directive to explain his or her preferences for health care at the end of life, it may be unavailable at a critical time. Furthermore, in some circumstances first responders such as emergency medical technicians (EMTs) may be unable to follow the directions to withhold life-sustaining care. The *Physician Orders for Life Sustaining Treatment* (POLST) converts these directions into a physician-signed order directed to EMTs and other first responders, who must “respect the patient’s wishes including life-sustaining treatments. Physician supervised First Responders and EMTs shall request and honor life-sustaining treatment orders executed by a physician or a nurse practitioner, if available.” OAR 847-0035-0030(6).

The POLST form uses very clear, even

blunt, language to prescribe whether and the extent to which four kinds of life-sustaining care are to be given: cardiopulmonary resuscitation, antibiotics, artificially administered nutrition, and other medical interventions (including IV fluids, oxygen, intubation, etc.). It is, in effect, a more thorough and standardized form of a *Do Not Resuscitate* (DNR) order. While the POLST is usually described as a means of implementing a patient’s desire that certain types of treatment not be provided, the form offers a range of choices for each type, up to and including full-blown use of the treatment. The form requires that comfort care always be provided. Because the form addresses only life-sustaining care, it is ordinarily used only for patients who are terminally ill.

A task force of the Center for Ethics in Health Care at Oregon Health & Science University chaired by Dr. Patrick Dunn developed the POLST during the early 1990s. It is a standardized, easily recognized form that can be used and honored by all health care providers and in all health care facilities. A physician or other health care professional is supposed to complete the hot-pink, two-sided form,

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Recommended Resources

Statutes relating to advance directives are contained in ORS 127.505-127.660. The actual statutory form of advance directive appears in ORS 127.53 and can be reproduced free of charge.

Making Health Care Decisions is a booklet available for purchase from Oregon Health Decisions, 7451 SW Coho Ct., Suite 101, Tualatin, OR 97062; Phone: 503.692.0894 or 800.422.4805. It is designed for use by lay people and, in addition to the advance directive form itself, has a summary of Oregon’s advance directive law and instructions for filling out the form. Price varies by quantity purchased.

For further information on POLST forms, see www.polst.org.

Interview with Dr. Tolle

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example, inserting into the form how many days the person wants certain treatment. Stating the number of days you want certain treatment can be very confusing because the language implies that you want this treatment for that number of days “in all circumstances,” even though Dr. Tolle doubts this is what the patient meant.

Do physicians see a conflict when *Part B* of a completed advance directive says the HCR can decide about tube feeding and life support and *Part C* says the person doesn’t want either? Dr. Tolle sees these provisions as complementary. “We read that as, this document philosophically is talking to the person they appointed and helping support their action. I’ve never seen that as a problem.” She added, however, that in all situations where the patient deeply trusts her loved ones, it would be useful for the patient to write into the form words such as “I have had many conversations with my HCR and if a situation arises that is not specifically addressed in the form, I deeply trust the surrogate to make a decision that is in my best interest.”

How are conflicts about the interpretation and application of advance directives resolved? “All hospitals have extensive resources to assist in conflict resolution including ethics consultants/committees, patient advocate offices, chaplains, social workers.” The nature of the conflict dictates who will be involved. “If it’s a faith-related issue, the chaplain might get involved first. If it’s a resource problem, it might be the social worker first. If it’s a clearly a values conflict, it’s the patient advocate.”

Elder Law Newsletter to be published online only

By Leslie Harris, Chair, Newsletter Subcommittee

The Executive Committee of the Elder Law Section decided in May that future issues of the Section newsletter will be available in electronic format only, beginning with the fall 2005 issue. The newsletter will no longer be printed and mailed.

The Executive Committee decided to go to all-electronic distribution of the newsletter for several reasons. Most critically, the elimination of printing and postage costs saves the Section a significant amount of money and allows us to continue to produce four issues per year without limiting the number of articles in each issue. The change will also save environmental resources and time.

How it will work

Section members will receive an e-mail message that includes a link to each new newsletter as it becomes available. You can click on this link or paste the URL into your Web browser to go directly to the newsletter, which will be posted in portable document format (pdf). You will also be able to print out a hard copy of each issue and to save issues electronically for future reference.

The distribution list for the newsletter will be separate from the elder law discussion list (listserv); so even if you have opted out of the discussion list, you can receive notice of the newsletter publication.

Make sure the Bar has your e-mail address

Please make sure that the Bar has your current e-mail address so that you'll get these messages, because current issues of the newsletter will *not* be available from the Section's Web site. Only those who receive the e-mail message will be able to get access to the new issue.

There are several ways to add or change your e-mail address:

- Send an e-mail to addresschanges@osbar.or.
- Log in to the Bar's member site at www.osbar.org/secured/login.asp? and select *change your address* from the right-hand yellow menu.
- Print out the form found at www.osbar.org/_docs/forms/addrchg.pdf, write in your changes, and mail the form to the Bar.

The Section will continue to make the archive of past issues of newsletters available from links on the Section Web site. The URL for the archives page is www.osbar.org/sections/elder/newsletters.html.

Process to be tested this summer

To test the new process, this issue of the newsletter will be posted electronically. By August 15, you will receive a message from the Bar telling you how to find the newsletter online. If you do not receive the message even though the Bar has your correct e-mail address, or if you have difficulties gaining access to the electronic version of the newsletter, please contact Anna Zanolli, Design Center Supervisor, Oregon State Bar, at 503.431.6414 or 800.452.8260, ext. 414, or azanolli@osbar.org.

POLST *Continued from page 8*

based on discussions with the patient. The patient's doctor must sign the form, which should be kept near the patient, where it can easily be seen by caregivers and first responders. A common practice is to post it on the refrigerator door.

Anecdotal evidence indicates that some health care organizations have misused the POLST form by, for example, telling patients that they must complete the form or just handing the form to the patient to fill out for him or herself. Just as an advance directive is voluntary, so is use of the POLST form. Problems of this sort should be brought to the attention of the patient's doctor.

The POLST has proven so successful in Oregon that the form or

variations of it are used in all or parts of Georgia, Kentucky, Michigan, Nebraska, Nevada, New Hampshire, New Mexico, New York, Pennsylvania, Tennessee, Utah, Washington, West Virginia, and Wisconsin.

A free video and free PowerPoint presentation about the POLST for use with clients are available at www.ohsu.edu/ethics/polst/edmat.shtml. A brochure in pdf format is available at www.ohsu.edu/ethics/polst/docs/brochure.pdf.

unCLE program again a winner

By Brian Thompson, Attorney at law, Eugene

One of the challenges elder law practitioners face is the relative absence of case law to draw upon. To help fill this gap, the Elder Law Section sponsored its third "unCLE" program on May 6, 2005. The event functions as a brainstorming session where elder law attorneys meet and discuss the issues that arise in practice. In addition, five CLE credits were approved by the Oregon State Bar.

The unCLE is an unstructured educational experience. There is no formal lecture. There is no written outline. Instead we assign a moderator and a subject to each of three small conference rooms. The moderator is simply available to guide the discussion and to make sure that all parties are given an opportunity to ask questions and share their views. There are four sessions, and three subjects in each session, which offers participants twelve options to choose from.

This year, about 40 participants shared their thoughts, experiences, and insights into the often murky worlds of Medicaid application strategies, spousal elective shares, administration of guardianships and conservatorships, long term care insurance, Oregon and Washington Medicaid differences, advance directives, estate recovery, dueling fiduciaries, spousal transfers, and capacity issues. Another session discussed bright ideas in office technology. Some subjects, such as trips and traps involving the advance directive, were held twice to accommodate the demand.

The event was supported in part by Wells Fargo Private Client Group, Long Term Care Associates, and Sacred Heart Hospital Center for Senior Health. These event sponsors paid a fee to set up information tables at the event. We are very grateful to them for their financial support. In addition, sponsor representatives proved to be valuable resources who willingly shared their experience and knowledge with us. They even sat in on some of the sessions.

Overall, the event proved extremely valuable to those in attendance. The opportunity simply to pose a question that has been bugging you or to discuss the practicalities of an issue with other attorneys has proved extremely valuable, year in, year out.

The unCLE program is held every year at the Valley River Inn in Eugene, usually on the first Friday in May. We hope to see you there next year!



Scenes from the 2005 unCLE event in Eugene



Resources for elder law attorneys

EVENTS

The Basics of Elder Law

August 19 to 21, 2005

Nashville, Tennessee

Presented by TennBarU, the Tennessee Bar Association Elder Law Section, and the National Academy of Elder Law Attorneys

This program covers the breadth of elder law. The faculty for this program includes past NAELA presidents and authors of several national treatises on elder law. Level of instruction is basic and intermediate. A unique aspect of this program is its focus on a case study, in which participants will develop a long term care plan under the tutelage of experienced elder law attorneys. 15.75 hours of general and one hour dual CLE credit.

www.tba.org/onsiteinfo/elderlaw_2005.html

2005 NAELA Advanced Elder Law Institute

September 29 to October 2, 2005

New Orleans, LA

A joint meeting with the National Association of Professional Geriatric Care Managers

www.naela.org

Joint Conference of The National Council on the Aging (NCOA) and the American Society on Aging (ASA)

March 16 to 19, 2006

Anaheim, California

www.agingconference.org

2006 NAELA Symposium

April 19 to 23, 2006

Washington, DC

www.naela.org

PUBLICATIONS

Lawyer's Tool Kit for Health Care Advance Planning

ABA Commission on Law and Aging

A series of ten "tools" that you can give your clients. Each tool contains self-help work sheets, suggestions, and resources to help focus the discussion and help your client work through the issues that present themselves in this important process. Included with the booklet is a companion diskette containing each of the tools in a Microsoft Word format.

18 pp. plus diskette (2000); \$29. Order from the Commission or pay with a credit card by calling the ABA Service Center at 800.285.2221.

Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers

American Bar Association Commission on Law and Aging and American Psychological Association

This handbook offers ideas for effective practices and makes suggestions for attorneys who wish to balance the competing goals of auton-

omy and protection as they confront the difficult challenges of working with older adults with diminished capacity.

80 pp. 2005; \$25. Order from the Commission or pay with a credit card by calling the ABA Service Center at 800.285.2221

ELDER LAW SECTION ELECTRONIC DISCUSSION LIST (LISTSERV)

Everyone in the Elder Law Section is automatically signed up on the list, but your participation is not mandatory. If you want out, simply unsubscribe.

How to use the discussion list

Send a message to all members of the Elder Law Section distribution list by addressing it to: eldlaw@lists.osbar.org.

Replies are directed (by default) to the sender of the message ONLY. If you wish to send a reply to the entire list, you must change the address to: eldlaw@lists.osbar.org, or you can press "Reply to all."

Legislature clarifies role of HCR

The Oregon legislature has approved House Bill 2442, which amends ORS 127.535 to add a subsection that states:

- (7) A health care representative is a personal representative for the purposes of ORS 192.518 to 192.524 and the federal Health Insurance Portability and Accountability Act privacy regulations, 45 C.F.R. parts 160 and 164.

MEMO



From: The editor
To: Elder Law Section members
Subject: Changes in Section newsletter

Beginning with the fall 2005 issue, the *Elder Law Newsletter* will be published electronically. It will no longer be printed and mailed.

To receive the newsletter, you must have Internet access and an e-mail address.

When a new issue of the newsletter is available, Section members will receive an e-mail notice. In that notice will be a link to a special Web page from which the newsletter can be downloaded in pdf format and printed.

Further details are on page 9.

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Newsletter Board

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