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DEPARTMENT OF JUSTICE
GENERAL COUNSEL DIVISION

November 6, 1998

David S. Cook, Director
Department of Corrections
2575 Center Street NE
Salem, OR 97310

Re: Opinion Request OP-1998-6

Dear Mr. Cook:

You have asked several questions concerning a stay of execution received after commencement of the execution of a condemned inmate by lethal injection. Your questions and our brief answers are set out below, followed by a discussion.

1. What is the effect of a stay of execution that has been received by or communicated to the superintendent after the commencement, but before completion, of the injection of lethal chemical agents into the veins of the condemned inmate in accordance with proper execution procedures?

A stay of execution received by or communicated to the superintendent at any time before completion of the acts required by ORS 137.473(1) to carry out the execution, i.e., before completion of the injection of the three chemical agents, is valid. Upon receipt of such a stay order, the superintendent must instruct the person(s) responsible for injecting the lethal chemical agents to stop.

2. Is the superintendent required to have specially trained medical staff present in the execution room to intervene with lifesaving resuscitation efforts if a stay is received after the commencement of the execution but before completion of the acts required by ORS 137.473(1)? May such intervention occur only with the informed written consent of the condemned inmate?

The superintendent is not required to have specially trained medical staff or special medical equipment present, beyond that normally in the institution for the medical care of inmates, in anticipation of extraordinary lifesaving measure that may be needed to resuscitate an inmate for whom the sentence of execution has been commenced. If a stay were received after the commencement of the lethal injection, the superintendent must direct any medical staff present in the institution to attempt those resuscitation efforts that are appropriate in light of the inmate's medical condition and the available resources, including summoning an ambulance and transporting the inmate to an acute-care facility, unless the

inmate has completed an advance directive instructing that he does not want resuscitation or other life-sustaining procedures.

Discussion

1. Effect of Stay of Execution

ORS 137.473(1) provides, in relevant part:

The punishment of death shall be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and potassium chloride or other equally effective substances sufficient to cause death.

We understand from your staff, and conversations with an anesthesiologist arranged by your staff, that the three chemical agents to be used for the execution will be injected intravenously in sequence, as follows:

Agent #1 (sodium thiopental) will be injected using one syringe containing 2400 milligrams of this agent, which is approximately 4.5 to 6.8 times the normal dose for a 195-pound person.(1) Upon injection, this agent will attain full concentration in the brain in less than 30 seconds. When administered at the execution amount, this agent will rapidly cause unconsciousness, with a significant decrease in blood pressure and respiratory depression. Within a minute after injection of approximately half of the execution amount, the inmate's breathing will be transient and would likely stop for several minutes at a time.(2)

Agent #2 (pancuronium bromide) will be injected using two consecutive syringes containing a total of 100 milligrams of this agent, which is approximately eight times the normal dose for a 195-pound person.(3) This agent has an onset of action of approximately two minutes and over the next minute or so would cause paralysis of skeletal muscles, including the breathing muscles of the ribs and diaphragm.(4)

Agent #3 (potassium chloride) will be injected using three consecutive syringes containing a total of 100 millequivalents of this agent,(5) which is five times the recommended safe hourly concentration.(6) This lethal concentration will cause cardiac arrhythmias, heart block and cardiac arrest.(7)

After injection of each of the three chemical agents, a syringe of saline solution will be injected in order to avoid any mixing of the different agents, which could cause chemical interactions. Thus, a total of nine syringes must be injected before the acts required by ORS 137.473(1) will be complete. We understand that injection of all nine syringes will take six to eight minutes.

We are informed by prison staff that the superintendent will be standing within reach of a telephone through which a stay order could be communicated, that he will be within approximately five feet from the person(s) responsible for injecting the chemical agents, and that despite partitions that will block the superintendent's sight of such person(s), they will be able to hear any instructions given by the superintendent. Given the length of time needed to inject the three chemical agents, it is conceivable that a stay of execution could be received and acted upon before completion of all of the injections. It is also conceivable (though exceedingly unlikely) that a stay could be received and acted upon before anything more than a normal anesthetic dose of agent #1 has been injected.

An execution by lethal injection is no different than any other action that may be stayed by a court at any

time before its completion. Based on the above description of the method of execution, we cannot determine as a matter of law that it would be impossible for the superintendent to comply with a stay order received by or communicated to him before completion of the injections of the three chemical agents. Thus, we conclude that the superintendent must comply with any stay of execution received by him at any time before completion of the acts required by ORS 137.473(1) to carry out the execution, i.e., before completion of the injection of the three chemical agents. Upon receipt of such a stay order, the superintendent must instruct the person(s) responsible for injecting the lethal chemical agents to stop. A stay order received after completion of those injections would be ineffective because there would be no further action that could be stayed. Letter of Advice dated September 30, 1986, to Thomas Toombs, Administrator, Corrections Division (OP-6014) at 4.

2. Legal Obligations to Provide Medical Care and Treatment

Article I, section 16, of the Oregon Constitution[(8)] and the Eighth Amendment to the United States Constitution,[(9)] both of which proscribe cruel and unusual punishment, establish the government's obligation to provide medical care for persons being punished by incarceration. ***Billings v. Gates***, 323 Or 167, 916 P2d 291 (1996); ***Estelle v. Gamble***. 429 US 97, 103, 97 S Ct 285, 50 L Ed2d 251 (1976), *reh den* 429 US 1066 (1977).

The standard for evaluating claims that medical care was unlawfully denied to inmates is whether prison officials have exhibited "deliberate indifference" to an inmate's serious medical needs. ***Billings***, 323 Or at 180; ***Estelle***, 429 US at 104. A prison may exhibit deliberate indifference by failing to make available to inmates "a level of medical care which is reasonably designed to meet the routine and emergency health care needs of inmates." ***Ramos v. Lamm***, 639 F2d 559, 574 (10th Cir 1980), *cert denied* 450 US 1041 (1981). Absent additional statutory requirements, an institution's obligation to provide medical care and treatment to inmates is determined by this standard.

a. Availability of Specially Trained Medical Staff and Equipment

ORS 423.020(d) places on the department a general duty to provide medical care for persons confined in its institutions. ORS 179.360(1)(f) requires the superintendent of each institution to designate a licensed physician to serve as chief medical officer, "who will be directly responsible to the superintendent for administration of the medical treatment programs at the institution." In addition, ORS 179.479(1) authorizes the superintendent of an institution, "when authorized by regulation or direction of the Department of Corrections or division having jurisdiction over the institution, [to] convey an inmate to a physician, clinic or hospital * * * for medical * * * treatment when such treatment cannot satisfactorily be provided at the institution."

Based on the above constitutional and statutory provisions, we have previously concluded that the department must provide for the "day-to-day minimum necessary medical needs" of each person in its institutions through the staff of the institution to which the person is committed. 43 Op Atty Gen 192, 193 (1983). Necessary health care that is beyond the capacity of the institution staff, whether routine or emergency health care, may be provided in facilities outside the prison. *See* ORS 179.479(1) and OAR 291-124-020(2)(d) and 291-124-035(3). *See* ***Hoptowit v. Ray***, 682 F2d 1237, 1253-54 (9th Cir 1982) (prison's duty to provide system for responding to emergencies may be satisfied through institution's infirmary and use of outside facilities, provided such outside facilities are not too remote or inaccessible to handle emergencies promptly and adequately). Clearly, a prison is not an acute-care hospital and need not have on its premises either the facilities or the staff that are expected in such a hospital setting.

The prison must have available for an inmate sentenced to death the same medical services and facilities that it has for all other inmates who may have a medical emergency.(10) ORS 137.473(1) provides that the execution "shall take place within the enclosure of a Department of Corrections institution." The statute does not require the execution to occur within a hospital-type setting or require any type of medical equipment or preparations. Although the statute requires that the superintendent of the institution be present at the execution, it does not mandate the presence of medical staff, but merely requires the superintendent to "invite" the presence of one or more physicians.

Thus, we conclude that neither the department nor the superintendent are required to have particular medical staff or equipment present, beyond that normally in the institution for the medical care of inmates, in anticipation of extraordinary lifesaving measures that may be needed to resuscitate an inmate if a stay of execution were received after commencement of the lethal injections but before the death of the inmate. *Cf.* ***Billings***, 323 Or at 180 (rejecting "reasonably available" standard for inmate medical claims). The medical needs that might arise in that situation are not the day-to-day needs of inmates in the institution. To the contrary, the purpose of the execution room and, after commencement of the execution, the intent of the state is to put to death an inmate who has been sentenced to that punishment.

We do not believe that the failure to have specially trained medical staff present in the execution room or to have extraordinary lifesaving equipment (e.g., heart-lung machine or dialysis equipment) available in the prison,(11) in anticipation of a stay being received after the execution has commenced, is deliberate indifference to an inmate's medical needs. Deliberate indifference exists only when a prison official "knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists and he must also draw the inference." ***Farmer v. Brennan***. 511 US 825, 837, 114 S Ct 1970, 128 L Ed2d 811 (1994); ***Watson v. Caton***, 984 F2d 537, 540 (1st Cir 1993) (decisions to deny or delay care may constitute deliberate indifference if reckless in the "criminal law sense, requiring actual knowledge of impending harm, easily preventable"). The execution is a lawful act, the date and time of which is known to the superintendent; however, issuance of a stay after commencement of the execution is an unlikely event, the occurrence of which cannot be known until it happens, and, due to the nature and amounts of the chemical agents used for the lethal injections, the prevention of the inmate's death after those injections have begun would not be readily and easily achieved.(12) Therefore, we conclude that there is no deliberate indifference to an inmate's medical needs merely because arrangements are not made to have specially trained medical staff and equipment present to cover the remote possibility of receipt of a stay in the very short time period after commencement of the injection of the chemical agents but before death occurs.

b. Lifesaving Resuscitation Efforts

The conclusion that the superintendent is not required to have specially trained staff or special medical equipment present in the execution room does not resolve the question of the duty to intervene with lifesaving resuscitation efforts if a stay were received after commencement of the execution.

An inmate for whom a stay of execution has been granted is in no different position than any other inmate of the institution with respect to the institution's duty to provide medical care and treatment.(13) The fact that the event triggering an inmate's medical need for resuscitation is a lawful execution stayed before its completion, rather than, for example, a heart attack, does not affect the obligation of prison

officials to provide medical care to the inmate.[14] Unless the inmate has directed that he does not want resuscitation or other life-sustaining procedures, prison officials must attempt appropriate resuscitation efforts[15] if an inmate's sentence of execution has been stayed before completion of the acts required by ORS 137.473(1).[16]

c. Inmate's Medical Direction

In our earlier Letter of Advice OP-6014, we concluded that if the execution of an inmate were stayed before completion of the lethal injections, the inmate should be viewed as a patient in need of medical treatment. Relying on the doctrine of informed consent, we stated that the inmate should be asked to express in writing his or her wishes regarding potential resuscitation efforts, concluding that "as a general proposition, a mature, competent patient has self-determination rights in medical care decisions which will be honored absent overriding state interests in preservation of life." OP-6014 at 4-5.

Since that opinion was issued, the legislature enacted ORS 127.507, which provides that "[c]apable adults may make their own health care decisions."[17] A "capable" adult is one who does not lack the ability to make and communicate health care decisions to health care providers. ORS 127.505(13). "Health care decision" means consent or refusal of consent or the withholding or withdrawal of consent to "health care," including decisions relating to admission to or discharge from a hospital or other health care facility. ORS 127.505(8). "Health care" means the treatment or care of injury,[18] including the use, withdrawal or withholding of life-sustaining procedures. ORS 127.505(7). "Life-sustaining procedure" means any medical procedure, medical device or medical intervention that "maintains life by sustaining, restoring or supplanting a vital function." ORS 127.505(16). Thus, ORS 127.507 authorizes a capable or competent adult to make a decision for himself or herself to refuse consent for resuscitation efforts or other life-sustaining procedures.[19]

The Oregon statutes also authorize a capable adult to execute a written "health care instruction," which shall be effective when it is properly signed and witnessed. ORS 127.510(2). Such instructions must be in the form provided by Part C of the advance directive form set forth in ORS 127.531. ORS 127.515(3). Part C of this statutory advance directive form permits a capable adult to state in advance his or her instructions regarding life-sustaining procedures and tube feeding, if the person's doctor and another knowledgeable doctor confirm that the person is in one of the following medical conditions: (1) close to death, and life support would only postpone the moment of death; (2) unconscious and very unlikely to become conscious again; (3) in the advanced stage of a progressive illness that will be fatal and unable to communicate, swallow food and water safely, provide self-care, recognize family and others, and it is very unlikely for that condition to substantially improve; and (4) in a medical condition that will not be helped by life support, but life support would cause permanent and severe pain. ORS 127.531(2). Additionally, the person may provide in Part C a general instruction that he or she does not want life-sustaining procedures or tube feeding but to be allowed to die naturally if his or her doctor and another knowledgeable doctor confirm that the person is in one of the medical conditions listed in items (1) to (4) above. *Id.* Finally, the person may also use Part C to state additional conditions or instructions regarding his or her health care decisions. *Id.*

Because of the wording and structure of Part C of the form, it has been suggested that a capable person may not give an advance instruction refusing consent for life-sustaining procedures if he or she is not in one of the four listed conditions, as confirmed by the person's doctor and another knowledgeable doctor. We do not believe that is a proper interpretation of the statute.[20]

First, Part A of the advance directive form set forth in ORS 127.531(2) explains, in a section entitled *Facts About Completing This Form*, that: "You may cross out words that don't express your wishes or add words that better express your wishes." Thus, although ORS 127.531(1) requires that the "form" of an advance directive must be "the same as the form set forth in this section" in order to be valid, the terms of the form clearly provide that the person is not bound by the words on the form, but may modify the wording of the health care instructions provided on the form or add additional instructions.

Second, ORS 127.505 to 127.660 contain no explicit provision requiring medical confirmation of the four listed medical conditions for an advance instruction refusing consent to lifesaving procedures. Instead, the statutes state affirmatively that capable adults may make their own health care decisions, ORS 127.507, and that such persons may execute a health care instruction in advance to refuse consent or withhold consent to health care, including the withholding of life-sustaining procedures. ORS 127.505(7)-(8), (10) and 127.510(2). These rights would be severely limited if the instructions could only be followed when the person was in certain medical conditions that were confirmed by two physicians. Yet the statutes do not directly state that to be the case.

The only provisions explicitly requiring an individual to be medically confirmed to be in one of the four listed medical conditions are ORS 127.540(6)(b), 127.580 and 127.635(1). *See* ORS 127.640. None of these provisions are applicable to a capable adult who has executed an advance health care instruction to refuse or withhold consent to life-sustaining procedures. ORS 127.540(6)(b) limits the authority of a health care representative appointed by a capable adult to make health care decisions for him or her and requires medical confirmation of one of the four listed medical conditions only if the individual appointed as the representative has ***not*** been given authority to make decisions on withholding life-sustaining procedures. ORS 127.580 establishes a presumption that a person has consented to artificially administered nutrition and hydration unless the person, while a capable adult, clearly and specifically stated that he or she would have refused such nutrition or hydration, ***or*** the person is medically confirmed to be in one of the four listed conditions. ORS 127.580(2) necessarily implies that an advance directive stating a refusal to consent will also overcome the presumption irrespective of the person being in one of the four listed medical conditions. ORS 127.635(1) provides that life-sustaining procedures that otherwise would be applied to an incapable person "who does not have an * * * applicable valid advance directive" may be withheld in accordance with subsections (2) and (3) if the person is medically confirmed to be in one of the four conditions. Thus, the statutory provisions requiring medical confirmation that the person is in one of the four listed medical conditions actually demonstrate that the instructions of a capable adult contained in an advance directive are not conditioned on the person being medically confirmed to be in one of the four listed medical conditions if the directive does not so provide or states otherwise.

Third, the provisions relating to health care representatives do not require medical confirmation of one of the four listed conditions when the representative is authorized to make health care decisions for a capable adult. ORS 127.505 to 127.660 authorize a capable adult to appoint a health care representative to make health care decisions if he or she becomes incapable, although appointing such a health care representative is not a requirement for a valid advance health care instruction. *See* ORS 127.510(1), 127.515(2), 127.531, 127.535. A health care representative is ***not*** authorized to make a health care decision with respect to the withholding or withdrawing of a life-sustaining procedure ***unless*** the representative has been given authority to do so, ***or*** the person has been medically confirmed to be in one of the four medical conditions listed above. ORS 127.540(6). It would be a dubious legislative policy to

require an individual to be medically confirmed to be in one of the four listed medical conditions in order to independently direct his or her own future health care decisions, but not to require such medical confirmation if the individual authorized a health care representative to make such decisions.

Fourth, ORS 127.560(2) states that the provisions of ORS 127.505 to 127.660 "do not in themselves impose civil or criminal liability" on a health care provider who withholds life-sustaining procedures for an individual who is in a health condition other than the four listed conditions. Although this provision implies that liability might arise from a source outside of ORS 127.505 to 127.660,[(21)] it also clearly establishes that these statutes were not intended to change existing law with respect to informed consent. *See also* ORS 127.560(1)(g) and (j) (ORS 127.505 to 127.660 do not impair or supersede the laws of this state relating to right of persons to effect withholding of life-sustaining procedures in any lawful manner or to make their own health care decisions).

We have found no Oregon appellate court decisions addressing the right of competent adults to refuse life-sustaining medical treatment, either before or after the 1993 enactment of ORS 127.505 to 127.660.[(22)] In other jurisdictions, the courts have generally found that an individual has a right to refuse life-sustaining medical treatment, which is derived from either the common-law doctrine of informed consent or a constitutional right to privacy. 22A Am Jur *Death* §§ 579-587 (1988) and cases cited therein.[(23)] The Supreme Court has recognized such a right as a liberty interest derived from the Fourteenth Amendment to the United States Constitution. ***Cruzan v. Director, Mo. Health Dept.***, 497 US 261, 278-79, 110 S Ct 2841, 111 L Ed2d 224 (1990) (rejecting federal constitutional privacy interests in right to refuse treatment, but stating: "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions. * * * "[F]or purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.");[(24)] ***Vacco v. Quill***, __ US __, 117 S Ct 2293, 2301, 138 L Ed2d 834 (1997) (assumption of right to refuse treatment grounded on "well established, traditional rights to bodily integrity and freedom from unwanted touching").

The extent of an individual's right to refuse life-sustaining treatment must be determined by balancing the individual's interests against the following potentially countervailing state interests: the preservation of life, the prevention of suicide, the protection of innocent third parties and the maintenance of the ethical integrity of the medical profession. ***Superintendent of Belchertown v. Saikewicz***, 370 NE 2d 417, 425 (Mass 1977); 22A Am Jur *Death* §§ 579-587. *Cf.* ***Cruzan*** 497 US at 279. In the case of prison inmates, another governmental interest, the interest in upholding orderly prison administration, must also be balanced against an inmate's right to refuse medical treatment. ***Commissioner of Corrections v. Myers***, 399 NE 2d 452 (Mass 1979) (incarceration imposes limitations on inmate's constitutional rights in terms of state interests unique to prison context).[(25)]

We next consider whether any of these state interests might outweigh the decision to refuse life-sustaining procedures by an inmate whose execution is stayed after commencement of the lethal injections. The first is the state's interest in the preservation of human life. This interest has been found to include two aspects: preserving the life of the particular individual and preserving the sanctity of all life.[(26)] ***Matter of Conroy***, 486 A2d 1209, 1223 (NJ 1985). At least one court has stated that "[i]n cases that do not involve the protection of the actual or potential life of someone other than the decisionmaker, the state's indirect and abstract interest in preserving the life of the competent patient generally gives way

to the patient's much stronger personal interest in directing the course of his own life." *Id.* at 1223. Most other courts have concluded that the interests must be balanced against each other, with the state's interest weakening and the individual's interest growing as the degree of bodily invasion necessary for treatment increases and the prognosis of return to a cognitive, sapient life dims. ***Foody v. Manchester Memorial Hosp.***, 482 A2d 713, 718 (Conn 1984); ***Matter of Quackenbush***, 383 A2d 785, 789-90 (NJ 1978). This does not mean, however, that the right of a competent person to refuse life-sustaining procedures is limited to terminally ill persons. In ***Quackenbush***, a 72-year old man was diagnosed with gangrene in both legs due to arteriosclerosis, and his doctor concluded he would die within three weeks as a result of infection spreading throughout the body if both legs were not amputated above the knee. The court held that the extent of bodily invasion was sufficient to make the state's interest in the preservation of life give way to the individual's right to self-determination even though the probability of recovery was good and the risks of the procedure were limited. *See also* ***Thor v. Superior Court***, 855 P2d 375, 383 (Cal 1993) (in permitting refusal of tube feeding and medication by quadriplegic, court noted that state interest in preservation of life can only be asserted at "the expense of self-determination and bodily integrity, matters all the more intensely personal when * * * physical disability renders normal health and vitality impossible."); ***Matter of Farrell***, 529 A2d 404, 411 (NJ 1987) ("the value of life is desecrated not by a decision to refuse medical treatment but 'by the failure to allow a competent human being the right of choice'").

As discussed above, if a stay order were received after commencement of the lethal injections, the inmate's chance of resuscitation would be slim,(27) and even if successful, the inmate's risk of irreversible brain damage is high, if not certain. Consequently, the state's interest in the preservation of life would appear to be minimal, while the inmate's right to determine whether he wants resuscitation in the face of such risks must be overriding. We conclude, therefore, that the inmate's right to refuse life-sustaining procedures in this situation would outweigh the state's interest in the preservation of life.(28)

The second state interest, the prevention of suicide, is inapplicable in the case of a competent adult's refusal of life-sustaining medical treatment. *See* ORS 127.570 (the withholding of life-sustaining procedure in accordance with the provisions of ORS 127.505 to 127.660 does not constitute a suicide or assisting a suicide). The courts have also concluded that the decision to refuse life-sustaining treatment is not suicide for two reasons: (1) The individual may not have the specific intent to die, and (2) even if he or she did, the cause of death would be from the individual's underlying medical condition, not any act of self-destruction. ***Vacco v. Quill***, 117 S Ct at 2298-99 and cases cited therein; ***Farrell***, 529 A2d at 411 and cases cited therein; ***McKay v. Bergstedt***, 801 P2d 617, 627 (Nev 1990) (when life of a competent adult with irreversible condition whose life must be sustained artificially and under circumstances of total dependence, the adult's motive "may be presumed not to be suicidal"; there is substantial difference between a person desiring non-interference with natural consequences of his condition and a person who desires to terminate his life by some deadly means); ***Matter of Colyer***, 660 P2d 738, 743 (Wash 1983); ***Saikewicz***, 370 NE 2d at 426 n 11. *See also* ***Thor***, 855 P2d at 385 (because state interest in protecting people from direct, purposeful self-destruction is motivated by state interest in preserving life, "it is questionable whether it is a distinct state interest worthy of independent consideration"). For purposes of assessing the state's interest in preventing suicide, it is irrelevant that, in the case of an execution stayed after commencement of the lethal injections, the origin of the individual's medical condition is not due to disease or accidental injury. The state's interest in preventing irrational acts of self-destruction is not compromised by the decision to refuse life-sustaining procedures when made by an individual whose medical condition was not self-inflicted.

The third state interest, the protection of innocent third parties, is implicated when the individual is responsible for the support of minor children and the refusal of treatment would result in their "abandonment." 22A Am Jur *Death* § 583. Thus, one court ordered treatment over the refusal of the mother of a seven-month old child. ***Application of President & Directors of Georgetown Coll***, 331 F2d 1000, 1008 (DC Cir 1964). The courts have not found this state interest to be overriding when the individual had no minor children or had made provisions for them. *See* ***Matter of Melideo***, 390 NYS 2d 523, 524 (1976) (upholding refusal of treatment by patient who had no children and was not pregnant); ***St. Mary's Hospital v. Ramsey***, 465 So 2d 666, 668-69 (Fla 1985) (upholding refusal of blood transfusion in part because child resided with other parent and patient had made financial provisions for his child); ***In re Osborne***, 294 A2d 372, 374 (DC 1972) (upholding right to refuse treatment in part because patient had provided for future well-being of his children); ***Farrell***, 529 A2d at 413 (upholding right of competent patient to withdraw respirator when patient's decision took into consideration the extreme stress already put on her teenage children by her medical condition and other parent had capacity to care for children in her absence). This state interest may also be implicated when the refusal of medical treatment endangers public health. *Cf.* ***Jacobsen v. Massachusetts***, 197 US 11, 25 S Ct 358, 49 L Ed 643 (1905) (mandatory vaccination for small pox); *but see* 30 Op Atty Gen 58 (1960) (tuberculosis patient under care of state for isolation and quarantine may not be compelled to undergo surgery). Because the medical condition of an inmate whose execution is stayed after commencement of the lethal injections is likely to be such that he would be unable to support or provide care for any minor children, his refusal of resuscitation would not be a significant cause of their "abandonment" and thus the state interest in protecting third parties would be minimal at most.

The fourth state interest is in maintaining the integrity of the medical profession. In ***Farrell***, the court found "unanimous support" in the medical authorities for the right of a competent and informed terminally ill patient to decline medical treatment, concluding that:

Health care standards are not undermined by the medical authorities that support the right to self-determination that we recognize today. Even as patients enjoy control over their medical treatment, health-care professionals remain bound to act in consonance with specific ethical criteria. We realize that these criteria may conflict with some concepts of self-determination. In the case of such a conflict, a patient has no right to compel a health-care provider to violate generally accepted professional standards.

529 A2d at 412. Often, such a conflict is resolved because "prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances," ***Satz v. Perlmutter***, 362 So 2d 160, 163 (Fla 1978), and the patient has found a physician who does not oppose the patient's choice. *See, e.g.*, ***Saikewicz***, 370 NE 2d at 426-27. Other courts have found the patient's right to self-determination to be paramount, particularly when the patient's condition is terminal or the patient's condition is painful. *See* ***Bouvia v. Superior Court (Glenchur)***, 179 Cal App 3d 1127, 225 Cal Rptr 297, 305 (1986) (decision to have nasogastric tube withdrawn "is not a medical decision for [patient's] physicians to make. * * * It is a moral and philosophical decision that, being a competent adult, is [the patient's] alone."); ***Bartling v. Superior Court***, 209 Cal Rptr 220, 225 (1984) (if right of patient to medical self-determination "is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors"). Yet other courts have found a patient's right of self-determination to include the right to determine when his or her life no longer has value, irrespective of the judgment of the medical profession. In ***Thor***, the court stated that the standards of medical ethics

cannot exist in a social and moral vacuum, thereby encouraging a form of medical paternalism under

which the physician's determination of what is "best," i.e., medically desirable, controls over patient autonomy. Doctors have the responsibility to advise patients fully of those matters relevant and necessary to making a voluntary and intelligent choice. Once that obligation is fulfilled, "[i]f the patient rejected the doctor's advice, the onus of that decision would rest on the patient, not the doctor. Indeed, if the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole."

855 P2d at 386 (citations omitted). *See also* ***McKay v. Bergstedt***, 801 P2d at 627-28 (decision by competent adult "to reject continuation of respirator-dependency that has proven too burdensome to endure" does not present ethical threat to medical profession).

We need not enter this debate because we believe that ORS 127.625 resolves this issue for persons who have completed an advance directive refusing life-sustaining procedures. ORS 127.625 states that a health care provider shall not be under any duty to participate in the withholding of life-sustaining procedures, but shall authorize the transfer of that patient to another provider. We understand that prison medical staff have agreed to abide by any decision of the inmate to refuse resuscitation.

Lastly, we consider the state's penological interest in managing inmates in the prison setting. An adult prisoner retains only "those rights not fundamentally inconsistent with imprisonment itself or incompatible with the objectives of incarceration." ***Hudson v. Palmer***, 468 US 517, 523, 104 S Ct 3194, 82 L Ed2d 393 (1984) (inmate has no reasonable expectation of privacy enabling him to invoke Fourth Amendment protections against searches). Although the Supreme Court concluded that prisoners possess a significant liberty interest in avoiding the forced administration of antipsychotic drugs, the Court also found that the state may compel the administration of such drugs over the inmate's refusal if the inmate is dangerous to himself or others and the treatment is in his medical interest. ***Washington v. Harper***, 494 US 210, 221-22, 110 S Ct 1028, 108 L Ed2d 178 (1990). Nevertheless, the courts have routinely concluded that an inmate may not manipulate his medical circumstances to the detriment of the state's interest in penal order, security and discipline. In ***Myers***, the court found that the governmental interests in the preservation of internal order and discipline of the prison facility, the maintenance of institutional security, and the rehabilitation of prisoners were paramount over the rights of the inmate to refuse hemodialysis treatment and supportive medication when the inmate's refusal was an attempt to manipulate the prison system. 399 NE 2d 452. *See also* ***Scheutzle v. Vogel***, 537 NW 2d 358 (ND 1995) (prison could require inmate to submit to diabetes monitoring and, if ordered by a physician, forced administration of food, insulin or other medications when inmate's refusal had little to do with his disease); ***Turner v. Safley***, 482 US 78, 89-90, 107 S Ct 2254, 96 L Ed2d 64 (1987) (factors relevant in determining reasonableness of a prison regulation). These cases suggest that the right of an inmate to refuse lifesaving medical treatment may be outweighed by the interests of the prison officials in maintaining discipline and security in the prison.

Nevertheless in ***Thor***, the court upheld the right of a quadriplegic prisoner to refuse tube feeding and medication, finding that prison officials had offered no evidence that allowing him to do so undermined prison integrity or endangered the public. 855 P2d at 387-89. The court noted the unique susceptibility of a prison to the "catalytic effect of disruptive conduct" and stated that in another case, or if circumstances changed in the case before it, the court would not preclude prison officials from establishing the need to override an inmate's choice to decline medical intervention. *Id.* at 388. The court also held that the inmate's refusal of treatment negates a violation of the Eighth Amendment's "deliberate indifference" standard. *Id.* at 389.

In the present case, we have no reason to believe that a refusal by the inmate to consent to resuscitation if a stay were received after commencement of the lethal injections would be motivated by a desire to disrupt the orderly administration of the prison system. Moreover, we have not been informed by prison officials that such refusal would pose a risk to prison security or discipline. Accordingly, we conclude that the inmate's right to refuse resuscitation or other life-sustaining procedures if a stay were received after commencement of the lethal injections would not be outweighed by the state's penological interests.

4. Recommended Procedures

Having concluded that the inmate's right to refuse life-sustaining treatment would outweigh any countervailing state interests,(29) we recommend that prison officials discuss with the inmate the possibility of a stay being received after commencement of the execution and ask him whether he would like to complete an advance directive stating his instructions regarding life-sustaining procedures in that event.(30) If the inmate chooses to complete an advance directive,(31) the Department of Corrections should:

1. Confirm that the inmate is a "capable" adult, i.e., able to understand and communicate his decision regarding health care;(32)

2. Inform the inmate about the prognosis of resuscitation after commencement of the injection of the lethal chemical agents, the range of procedures that could be undertaken, depending upon the type and amount of the chemicals that had been injected at various points in time, and the risks involved in such resuscitation efforts;(33) and

3. Assist the inmate in completing an advance directive in the form required by ORS 127.531 that properly and fully articulates the inmate's health care instructions.(34)

An advance directive must be executed and witnessed as required by ORS 127.515.(35) We suggest you seek the advice of this office in complying with that procedure.

If the inmate provides an advance directive refusing resuscitation efforts or other lifesaving procedures, the superintendent should ensure that any medical personnel who will be present during the execution will voluntarily abide by that directive.(36) *See* ORS 127.625(1) ("No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the * * * withholding of life sustaining procedures[.]"). Judicial approval of an advance directive refusing consent to life-sustaining procedures is unnecessary. ORS 127.510(2), 127.550(1). *See also* ***Farrell***, 529 A2d at 415 (judicial intervention "could infringe the very rights [of patient self-determination] that we want to protect").

If the inmate states in an advance directive that he wishes resuscitation, the superintendent should ensure that any medical personnel present in the institution during the execution will take appropriate steps to comply with that directive. An inmate's completion of an advance directive containing such an instruction does not alter our above conclusion that prison officials have no duty to bring into the institution, or have present in the execution room, special medical personnel or equipment beyond that normally in the institution for the medical care of inmates.

If the inmate chooses not to provide an advance directive, in the event of a stay of execution after commencement of the lethal injections, the superintendent should direct medical personnel present in the

institution to attempt appropriate resuscitation efforts. See note 14, above. In OP-6014, we stated that prison officials should designate a physician to be at the execution site as the inmate's physician should resuscitation efforts be needed. *Id.* at 5. In light of our above analysis and conclusions, we now reverse that portion of the opinion.

Sincerely,

Donald C. Arnold
Chief Counsel
General Counsel Division

AVL/llm/JGG0E526

November 6, 1998

David S. Cook, Director
Department of Corrections
2575 Center Street NE
Salem, OR 97310

Re: Opinion Request OP-1998-6

Dear Mr. Cook:

You have asked several questions concerning a stay of execution received after commencement of the execution of a condemned inmate by lethal injection. Your questions and our brief answers are set out below, followed by a discussion.

1. What is the effect of a stay of execution that has been received by or communicated to the superintendent after the commencement, but before completion, of the injection of lethal chemical agents into the veins of the condemned inmate in accordance with proper execution procedures?

A stay of execution received by or communicated to the superintendent at any time before completion of the acts required by ORS 137.473(1) to carry out the execution, i.e., before completion of the injection of the three chemical agents, is valid. Upon receipt of such a stay order, the superintendent must instruct the person(s) responsible for injecting the lethal chemical agents to stop.

2. Is the superintendent required to have specially trained medical staff present in the execution room to intervene with lifesaving resuscitation efforts if a stay is received after the commencement of the execution but before completion of the acts required by ORS 137.473(1)? May such intervention occur only with the informed written consent of the condemned inmate?

The superintendent is not required to have specially trained medical staff or special medical equipment present, beyond that normally in the institution for the medical care of inmates, in anticipation of extraordinary lifesaving measure that may be needed to resuscitate an inmate for whom the sentence of execution has been commenced. If a stay were received after the commencement of the lethal injection, the superintendent must direct any medical staff present in the institution to attempt those resuscitation efforts that are appropriate in light of the inmate's medical condition and the available resources, including summoning an ambulance and transporting the inmate to an acute-care facility, unless the

inmate has completed an advance directive instructing that he does not want resuscitation or other life-sustaining procedures.

Discussion

1. Effect of Stay of Execution

ORS 137.473(1) provides, in relevant part:

The punishment of death shall be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and potassium chloride or other equally effective substances sufficient to cause death.

We understand from your staff, and conversations with an anesthesiologist arranged by your staff, that the three chemical agents to be used for the execution will be injected intravenously in sequence, as follows:

Agent #1 (sodium thiopental) will be injected using one syringe containing 2400 milligrams of this agent, which is approximately 4.5 to 6.8 times the normal dose for a 195-pound person.(37) Upon injection, this agent will attain full concentration in the brain in less than 30 seconds. When administered at the execution amount, this agent will rapidly cause unconsciousness, with a significant decrease in blood pressure and respiratory depression. Within a minute after injection of approximately half of the execution amount, the inmate's breathing will be transient and would likely stop for several minutes at a time.(38)

Agent #2 (pancuronium bromide) will be injected using two consecutive syringes containing a total of 100 milligrams of this agent, which is approximately eight times the normal dose for a 195-pound person.(39) This agent has an onset of action of approximately two minutes and over the next minute or so would cause paralysis of skeletal muscles, including the breathing muscles of the ribs and diaphragm.(40)

Agent #3 (potassium chloride) will be injected using three consecutive syringes containing a total of 100 millequivalents of this agent,(41) which is five times the recommended safe hourly concentration.(42) This lethal concentration will cause cardiac arrhythmias, heart block and cardiac arrest.(43)

After injection of each of the three chemical agents, a syringe of saline solution will be injected in order to avoid any mixing of the different agents, which could cause chemical interactions. Thus, a total of nine syringes must be injected before the acts required by ORS 137.473(1) will be complete. We understand that injection of all nine syringes will take six to eight minutes.

We are informed by prison staff that the superintendent will be standing within reach of a telephone through which a stay order could be communicated, that he will be within approximately five feet from the person(s) responsible for injecting the chemical agents, and that despite partitions that will block the superintendent's sight of such person(s), they will be able to hear any instructions given by the superintendent. Given the length of time needed to inject the three chemical agents, it is conceivable that a stay of execution could be received and acted upon before completion of all of the injections. It is also conceivable (though exceedingly unlikely) that a stay could be received and acted upon before anything more than a normal anesthetic dose of agent #1 has been injected.

An execution by lethal injection is no different than any other action that may be stayed by a court at any time before its completion. Based on the above description of the method of execution, we cannot determine as a matter of law that it would be impossible for the superintendent to comply with a stay order received by or communicated to him before completion of the injections of the three chemical agents. Thus, we conclude that the superintendent must comply with any stay of execution received by him at any time before completion of the acts required by ORS 137.473(1) to carry out the execution, i.e., before completion of the injection of the three chemical agents. Upon receipt of such a stay order, the superintendent must instruct the person(s) responsible for injecting the lethal chemical agents to stop. A stay order received after completion of those injections would be ineffective because there would be no further action that could be stayed. Letter of Advice dated September 30, 1986, to Thomas Toombs, Administrator, Corrections Division (OP-6014) at 4.

2. Legal Obligations to Provide Medical Care and Treatment

Article I, section 16, of the Oregon Constitution(44) and the Eighth Amendment to the United States Constitution,(45) both of which proscribe cruel and unusual punishment, establish the government's obligation to provide medical care for persons being punished by incarceration. ***Billings v. Gates***, 323 Or 167, 916 P2d 291 (1996); ***Estelle v. Gamble***. 429 US 97, 103, 97 S Ct 285, 50 L Ed2d 251 (1976), *reh den* 429 US 1066 (1977).

The standard for evaluating claims that medical care was unlawfully denied to inmates is whether prison officials have exhibited "deliberate indifference" to an inmate's serious medical needs. ***Billings***, 323 Or at 180; ***Estelle***, 429 US at 104. A prison may exhibit deliberate indifference by failing to make available to inmates "a level of medical care which is reasonably designed to meet the routine and emergency health care needs of inmates." ***Ramos v. Lamm***, 639 F2d 559, 574 (10th Cir 1980), *cert denied* 450 US 1041 (1981). Absent additional statutory requirements, an institution's obligation to provide medical care and treatment to inmates is determined by this standard.

a. Availability of Specially Trained Medical Staff and Equipment

ORS 423.020(d) places on the department a general duty to provide medical care for persons confined in its institutions. ORS 179.360(1)(f) requires the superintendent of each institution to designate a licensed physician to serve as chief medical officer, "who will be directly responsible to the superintendent for administration of the medical treatment programs at the institution." In addition, ORS 179.479(1) authorizes the superintendent of an institution, "when authorized by regulation or direction of the Department of Corrections or division having jurisdiction over the institution, [to] convey an inmate to a physician, clinic or hospital * * * for medical * * * treatment when such treatment cannot satisfactorily be provided at the institution."

Based on the above constitutional and statutory provisions, we have previously concluded that the department must provide for the "day-to-day minimum necessary medical needs" of each person in its institutions through the staff of the institution to which the person is committed. 43 Op Atty Gen 192, 193 (1983). Necessary health care that is beyond the capacity of the institution staff, whether routine or emergency health care, may be provided in facilities outside the prison. *See* ORS 179.479(1) and OAR 291-124-020(2)(d) and 291-124-035(3). *See* ***Hoptowit v. Ray***, 682 F2d 1237, 1253-54 (9th Cir 1982) (prison's duty to provide system for responding to emergencies may be satisfied through institution's infirmary and use of outside facilities, provided such outside facilities are not too remote or inaccessible to handle emergencies promptly and adequately). Clearly, a prison is not an acute-care hospital and need

not have on its premises either the facilities or the staff that are expected in such a hospital setting.

The prison must have available for an inmate sentenced to death the same medical services and facilities that it has for all other inmates who may have a medical emergency.(46) ORS 137.473(1) provides that the execution "shall take place within the enclosure of a Department of Corrections institution." The statute does not require the execution to occur within a hospital-type setting or require any type of medical equipment or preparations. Although the statute requires that the superintendent of the institution be present at the execution, it does not mandate the presence of medical staff, but merely requires the superintendent to "invite" the presence of one or more physicians.

Thus, we conclude that neither the department nor the superintendent are required to have particular medical staff or equipment present, beyond that normally in the institution for the medical care of inmates, in anticipation of extraordinary lifesaving measures that may be needed to resuscitate an inmate if a stay of execution were received after commencement of the lethal injections but before the death of the inmate. *Cf.* ***Billings***, 323 Or at 180 (rejecting "reasonably available" standard for inmate medical claims). The medical needs that might arise in that situation are not the day-to-day needs of inmates in the institution. To the contrary, the purpose of the execution room and, after commencement of the execution, the intent of the state is to put to death an inmate who has been sentenced to that punishment.

We do not believe that the failure to have specially trained medical staff present in the execution room or to have extraordinary lifesaving equipment (e.g., heart-lung machine or dialysis equipment) available in the prison,(47) in anticipation of a stay being received after the execution has commenced, is deliberate indifference to an inmate's medical needs. Deliberate indifference exists only when a prison official "knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists and he must also draw the inference." ***Farmer v. Brennan***. 511 US 825, 837, 114 S Ct 1970, 128 L Ed2d 811 (1994); ***Watson v. Caton***, 984 F2d 537, 540 (1st Cir 1993) (decisions to deny or delay care may constitute deliberate indifference if reckless in the "criminal law sense, requiring actual knowledge of impending harm, easily preventable"). The execution is a lawful act, the date and time of which is known to the superintendent; however, issuance of a stay after commencement of the execution is an unlikely event, the occurrence of which cannot be known until it happens, and, due to the nature and amounts of the chemical agents used for the lethal injections, the prevention of the inmate's death after those injections have begun would not be readily and easily achieved.(48) Therefore, we conclude that there is no deliberate indifference to an inmate's medical needs merely because arrangements are not made to have specially trained medical staff and equipment present to cover the remote possibility of receipt of a stay in the very short time period after commencement of the injection of the chemical agents but before death occurs.

b. Lifesaving Resuscitation Efforts

The conclusion that the superintendent is not required to have specially trained staff or special medical equipment present in the execution room does not resolve the question of the duty to intervene with lifesaving resuscitation efforts if a stay were received after commencement of the execution.

An inmate for whom a stay of execution has been granted is in no different position than any other inmate of the institution with respect to the institution's duty to provide medical care and treatment.(49) The fact that the event triggering an inmate's medical need for resuscitation is a lawful execution stayed

before its completion, rather than, for example, a heart attack, does not affect the obligation of prison officials to provide medical care to the inmate.(50) Unless the inmate has directed that he does not want resuscitation or other life-sustaining procedures, prison officials must attempt appropriate resuscitation efforts(51) if an inmate's sentence of execution has been stayed before completion of the acts required by ORS 137.473(1).(52)

c. Inmate's Medical Direction

In our earlier Letter of Advice OP-6014, we concluded that if the execution of an inmate were stayed before completion of the lethal injections, the inmate should be viewed as a patient in need of medical treatment. Relying on the doctrine of informed consent, we stated that the inmate should be asked to express in writing his or her wishes regarding potential resuscitation efforts, concluding that "as a general proposition, a mature, competent patient has self-determination rights in medical care decisions which will be honored absent overriding state interests in preservation of life." OP-6014 at 4-5.

Since that opinion was issued, the legislature enacted ORS 127.507, which provides that "[c]apable adults may make their own health care decisions."(53) A "capable" adult is one who does not lack the ability to make and communicate health care decisions to health care providers. ORS 127.505(13). "Health care decision" means consent or refusal of consent or the withholding or withdrawal of consent to "health care," including decisions relating to admission to or discharge from a hospital or other health care facility. ORS 127.505(8). "Health care" means the treatment or care of injury,(54) including the use, withdrawal or withholding of life-sustaining procedures. ORS 127.505(7). "Life-sustaining procedure" means any medical procedure, medical device or medical intervention that "maintains life by sustaining, restoring or supplanting a vital function." ORS 127.505(16). Thus, ORS 127.507 authorizes a capable or competent adult to make a decision for himself or herself to refuse consent for resuscitation efforts or other life-sustaining procedures.(55)

The Oregon statutes also authorize a capable adult to execute a written "health care instruction," which shall be effective when it is properly signed and witnessed. ORS 127.510(2). Such instructions must be in the form provided by Part C of the advance directive form set forth in ORS 127.531. ORS 127.515(3). Part C of this statutory advance directive form permits a capable adult to state in advance his or her instructions regarding life-sustaining procedures and tube feeding, if the person's doctor and another knowledgeable doctor confirm that the person is in one of the following medical conditions: (1) close to death, and life support would only postpone the moment of death; (2) unconscious and very unlikely to become conscious again; (3) in the advanced stage of a progressive illness that will be fatal and unable to communicate, swallow food and water safely, provide self-care, recognize family and others, and it is very unlikely for that condition to substantially improve; and (4) in a medical condition that will not be helped by life support, but life support would cause permanent and severe pain. ORS 127.531(2). Additionally, the person may provide in Part C a general instruction that he or she does not want life-sustaining procedures or tube feeding but to be allowed to die naturally if his or her doctor and another knowledgeable doctor confirm that the person is in one of the medical conditions listed in items (1) to (4) above. *Id.* Finally, the person may also use Part C to state additional conditions or instructions regarding his or her health care decisions. *Id.* (56)

First, Part A of the advance directive form set forth in ORS 127.531(2) explains, in a section entitled *Facts About Completing This Form*, that: "You may cross out words that don't express your wishes or add words that better express your wishes." Thus, although ORS 127.531(1) requires that the "form" of

an advance directive must be "the same as the form set forth in this section" in order to be valid, the terms of the form clearly provide that the person is not bound by the words on the form, but may modify the wording of the health care instructions provided on the form or add additional instructions.

Second, ORS 127.505 to 127.660 contain no explicit provision requiring medical confirmation of the four listed medical conditions for an advance instruction refusing consent to lifesaving procedures. Instead, the statutes state affirmatively that capable adults may make their own health care decisions, ORS 127.507, and that such persons may execute a health care instruction in advance to refuse consent or withhold consent to health care, including the withholding of life-sustaining procedures. ORS 127.505(7)-(8), (10) and 127.510(2). These rights would be severely limited if the instructions could only be followed when the person was in certain medical conditions that were confirmed by two physicians. Yet the statutes do not directly state that to be the case.

The only provisions explicitly requiring an individual to be medically confirmed to be in one of the four listed medical conditions are ORS 127.540(6)(b), 127.580 and 127.635(1). *See* ORS 127.640. None of these provisions are applicable to a capable adult who has executed an advance health care instruction to refuse or withhold consent to life-sustaining procedures. ORS 127.540(6)(b) limits the authority of a health care representative appointed by a capable adult to make health care decisions for him or her and requires medical confirmation of one of the four listed medical conditions only if the individual appointed as the representative has ***not*** been given authority to make decisions on withholding life-sustaining procedures. ORS 127.580 establishes a presumption that a person has consented to artificially administered nutrition and hydration unless the person, while a capable adult, clearly and specifically stated that he or she would have refused such nutrition or hydration, ***or*** the person is medically confirmed to be in one of the four listed conditions. ORS 127.580(2) necessarily implies that an advance directive stating a refusal to consent will also overcome the presumption irrespective of the person being in one of the four listed medical conditions. ORS 127.635(1) provides that life-sustaining procedures that otherwise would be applied to an incapable person "who does not have an * * * applicable valid advance directive" may be withheld in accordance with subsections (2) and (3) if the person is medically confirmed to be in one of the four conditions. Thus, the statutory provisions requiring medical confirmation that the person is in one of the four listed medical conditions actually demonstrate that the instructions of a capable adult contained in an advance directive are not conditioned on the person being medically confirmed to be in one of the four listed medical conditions if the directive does not so provide or states otherwise.

Third, the provisions relating to health care representatives do not require medical confirmation of one of the four listed conditions when the representative is authorized to make health care decisions for a capable adult. ORS 127.505 to 127.660 authorize a capable adult to appoint a health care representative to make health care decisions if he or she becomes incapable, although appointing such a health care representative is not a requirement for a valid advance health care instruction. *See* ORS 127.510(1), 127.515(2), 127.531, 127.535. A health care representative is ***not*** authorized to make a health care decision with respect to the withholding or withdrawing of a life-sustaining procedure ***unless*** the representative has been given authority to do so, ***or*** the person has been medically confirmed to be in one of the four medical conditions listed above. ORS 127.540(6). It would be a dubious legislative policy to require an individual to be medically confirmed to be in one of the four listed medical conditions in order to independently direct his or her own future health care decisions, but not to require such medical confirmation if the individual authorized a health care representative to make such decisions.

Fourth, ORS 127.560(2) states that the provisions of ORS 127.505 to 127.660 "do not in themselves impose civil or criminal liability" on a health care provider who withholds life-sustaining procedures for an individual who is in a health condition other than the four listed conditions. Although this provision implies that liability might arise from a source outside of ORS 127.505 to 127.660,[57] it also clearly establishes that these statutes were not intended to change existing law with respect to informed consent. *See also* ORS 127.560(1)(g) and (j) (ORS 127.505 to 127.660 do not impair or supersede the laws of this state relating to right of persons to effect withholding of life-sustaining procedures in any lawful manner or to make their own health care decisions).

We have found no Oregon appellate court decisions addressing the right of competent adults to refuse life-sustaining medical treatment, either before or after the 1993 enactment of ORS 127.505 to 127.660.[58] In other jurisdictions, the courts have generally found that an individual has a right to refuse life-sustaining medical treatment, which is derived from either the common-law doctrine of informed consent or a constitutional right to privacy. 22A Am Jur *Death* §§ 579-587 (1988) and cases cited therein.[59] The Supreme Court has recognized such a right as a liberty interest derived from the Fourteenth Amendment to the United States Constitution. ***Cruzan v. Director, Mo. Health Dept.***, 497 US 261, 278-79, 110 S Ct 2841, 111 L Ed2d 224 (1990) (rejecting federal constitutional privacy interests in right to refuse treatment, but stating: "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions. * * * "[F]or purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.");[60] ***Vacco v. Quill***, __ US __, 117 S Ct 2293, 2301, 138 L Ed2d 834 (1997) (assumption of right to refuse treatment grounded on "well established, traditional rights to bodily integrity and freedom from unwanted touching").

The extent of an individual's right to refuse life-sustaining treatment must be determined by balancing the individual's interests against the following potentially countervailing state interests: the preservation of life, the prevention of suicide, the protection of innocent third parties and the maintenance of the ethical integrity of the medical profession. ***Superintendent of Belchertown v. Saikewicz***, 370 NE 2d 417, 425 (Mass 1977); 22A Am Jur *Death* §§ 579-587. *Cf.* ***Cruzan*** 497 US at 279. In the case of prison inmates, another governmental interest, the interest in upholding orderly prison administration, must also be balanced against an inmate's right to refuse medical treatment. ***Commissioner of Corrections v. Myers***, 399 NE 2d 452 (Mass 1979) (incarceration imposes limitations on inmate's constitutional rights in terms of state interests unique to prison context).[61]

We next consider whether any of these state interests might outweigh the decision to refuse life-sustaining procedures by an inmate whose execution is stayed after commencement of the lethal injections. The first is the state's interest in the preservation of human life. This interest has been found to include two aspects: preserving the life of the particular individual and preserving the sanctity of all life.[62] ***Matter of Conroy***, 486 A2d 1209, 1223 (NJ 1985). At least one court has stated that "[i]n cases that do not involve the protection of the actual or potential life of someone other than the decisionmaker, the state's indirect and abstract interest in preserving the life of the competent patient generally gives way to the patient's much stronger personal interest in directing the course of his own life." *Id.* at 1223. Most other courts have concluded that the interests must be balanced against each other, with the state's interest weakening and the individual's interest growing as the degree of bodily invasion necessary for treatment increases and the prognosis of return to a cognitive, sapient life dims. ***Foody v. Manchester***

Memorial Hosp., 482 A2d 713, 718 (Conn 1984); ***Matter of Quackenbush***, 383 A2d 785, 789-90 (NJ 1978). This does not mean, however, that the right of a competent person to refuse life-sustaining procedures is limited to terminally ill persons. In ***Quackenbush***, a 72-year old man was diagnosed with gangrene in both legs due to arteriosclerosis, and his doctor concluded he would die within three weeks as a result of infection spreading throughout the body if both legs were not amputated above the knee. The court held that the extent of bodily invasion was sufficient to make the state's interest in the preservation of life give way to the individual's right to self-determination even though the probability of recovery was good and the risks of the procedure were limited. *See also* ***Thor v. Superior Court***, 855 P2d 375, 383 (Cal 1993) (in permitting refusal of tube feeding and medication by quadriplegic, court noted that state interest in preservation of life can only be asserted at "the expense of self-determination and bodily integrity, matters all the more intensely personal when * * * physical disability renders normal health and vitality impossible."); ***Matter of Farrell***, 529 A2d 404, 411 (NJ 1987) ("the value of life is desecrated not by a decision to refuse medical treatment but 'by the failure to allow a competent human being the right of choice'").

As discussed above, if a stay order were received after commencement of the lethal injections, the inmate's chance of resuscitation would be slim,(63) and even if successful, the inmate's risk of irreversible brain damage is high, if not certain. Consequently, the state's interest in the preservation of life would appear to be minimal, while the inmate's right to determine whether he wants resuscitation in the face of such risks must be overriding. We conclude, therefore, that the inmate's right to refuse life-sustaining procedures in this situation would outweigh the state's interest in the preservation of life.(64)

The second state interest, the prevention of suicide, is inapplicable in the case of a competent adult's refusal of life-sustaining medical treatment. *See* ORS 127.570 (the withholding of life-sustaining procedure in accordance with the provisions of ORS 127.505 to 127.660 does not constitute a suicide or assisting a suicide). The courts have also concluded that the decision to refuse life-sustaining treatment is not suicide for two reasons: (1) The individual may not have the specific intent to die, and (2) even if he or she did, the cause of death would be from the individual's underlying medical condition, not any act of self-destruction. ***Vacco v. Quill***, 117 S Ct at 2298-99 and cases cited therein; ***Farrell***, 529 A2d at 411 and cases cited therein; ***McKay v. Bergstedt***, 801 P2d 617, 627 (Nev 1990) (when life of a competent adult with irreversible condition whose life must be sustained artificially and under circumstances of total dependence, the adult's motive "may be presumed not to be suicidal"; there is substantial difference between a person desiring non-interference with natural consequences of his condition and a person who desires to terminate his life by some deadly means); ***Matter of Colyer***, 660 P2d 738, 743 (Wash 1983); ***Saikewicz***, 370 NE 2d at 426 n 11. *See also* ***Thor***, 855 P2d at 385 (because state interest in protecting people from direct, purposeful self-destruction is motivated by state interest in preserving life, "it is questionable whether it is a distinct state interest worthy of independent consideration"). For purposes of assessing the state's interest in preventing suicide, it is irrelevant that, in the case of an execution stayed after commencement of the lethal injections, the origin of the individual's medical condition is not due to disease or accidental injury. The state's interest in preventing irrational acts of self-destruction is not compromised by the decision to refuse life-sustaining procedures when made by an individual whose medical condition was not self-inflicted.

The third state interest, the protection of innocent third parties, is implicated when the individual is responsible for the support of minor children and the refusal of treatment would result in their "abandonment." 22A Am Jur *Death* § 583. Thus, one court ordered treatment over the refusal of the

mother of a seven-month old child. ***Application of President & Directors of Georgetown Coll***, 331 F2d 1000, 1008 (DC Cir 1964). The courts have not found this state interest to be overriding when the individual had no minor children or had made provisions for them. *See* ***Matter of Melideo***, 390 NYS 2d 523, 524 (1976) (upholding refusal of treatment by patient who had no children and was not pregnant); ***St. Mary's Hospital v. Ramsey***, 465 So 2d 666, 668-69 (Fla 1985) (upholding refusal of blood transfusion in part because child resided with other parent and patient had made financial provisions for his child); ***In re Osborne***, 294 A2d 372, 374 (DC 1972) (upholding right to refuse treatment in part because patient had provided for future well-being of his children); ***Farrell***, 529 A2d at 413 (upholding right of competent patient to withdraw respirator when patient's decision took into consideration the extreme stress already put on her teenage children by her medical condition and other parent had capacity to care for children in her absence). This state interest may also be implicated when the refusal of medical treatment endangers public health. *Cf.* ***Jacobsen v. Massachusetts***, 197 US 11, 25 S Ct 358, 49 L Ed 643 (1905) (mandatory vaccination for small pox); *but see* 30 Op Atty Gen 58 (1960) (tuberculosis patient under care of state for isolation and quarantine may not be compelled to undergo surgery). Because the medical condition of an inmate whose execution is stayed after commencement of the lethal injections is likely to be such that he would be unable to support or provide care for any minor children, his refusal of resuscitation would not be a significant cause of their "abandonment" and thus the state interest in protecting third parties would be minimal at most.

The fourth state interest is in maintaining the integrity of the medical profession. In ***Farrell***, the court found "unanimous support" in the medical authorities for the right of a competent and informed terminally ill patient to decline medical treatment, concluding that:

Health care standards are not undermined by the medical authorities that support the right to self-determination that we recognize today. Even as patients enjoy control over their medical treatment, health-care professionals remain bound to act in consonance with specific ethical criteria. We realize that these criteria may conflict with some concepts of self-determination. In the case of such a conflict, a patient has no right to compel a health-care provider to violate generally accepted professional standards.

529 A2d at 412. Often, such a conflict is resolved because "prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances," ***Satz v. Perlmutter***, 362 So 2d 160, 163 (Fla 1978), and the patient has found a physician who does not oppose the patient's choice. *See, e.g.,* ***Saikewicz***, 370 NE 2d at 426-27. Other courts have found the patient's right to self-determination to be paramount, particularly when the patient's condition is terminal or the patient's condition is painful. *See* ***Bouvia v. Superior Court (Glenchur)***, 179 Cal App 3d 1127, 225 Cal Rptr 297, 305 (1986) (decision to have nasogastric tube withdrawn "is not a medical decision for [patient's] physicians to make. * * * It is a moral and philosophical decision that, being a competent adult, is [the patient's] alone."); ***Bartling v. Superior Court***, 209 Cal Rptr 220, 225 (1984) (if right of patient to medical self-determination "is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors"). Yet other courts have found a patient's right of self-determination to include the right to determine when his or her life no longer has value, irrespective of the judgment of the medical profession. In ***Thor***, the court stated that the standards of medical ethics

cannot exist in a social and moral vacuum, thereby encouraging a form of medical paternalism under which the physician's determination of what is "best," i.e., medically desirable, controls over patient autonomy. Doctors have the responsibility to advise patients fully of those matters relevant and necessary to making a voluntary and intelligent choice. Once that obligation is fulfilled, "[i]f the patient rejected the

doctor's advice, the onus of that decision would rest on the patient, not the doctor. Indeed, if the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole."

855 P2d at 386 (citations omitted). *See also* ***McKay v. Bergstedt***, 801 P2d at 627-28 (decision by competent adult "to reject continuation of respirator-dependency that has proven too burdensome to endure" does not present ethical threat to medical profession).

We need not enter this debate because we believe that ORS 127.625 resolves this issue for persons who have completed an advance directive refusing life-sustaining procedures. ORS 127.625 states that a health care provider shall not be under any duty to participate in the withholding of life-sustaining procedures, but shall authorize the transfer of that patient to another provider. We understand that prison medical staff have agreed to abide by any decision of the inmate to refuse resuscitation.

Lastly, we consider the state's penological interest in managing inmates in the prison setting. An adult prisoner retains only "those rights not fundamentally inconsistent with imprisonment itself or incompatible with the objectives of incarceration." ***Hudson v. Palmer***, 468 US 517, 523, 104 S Ct 3194, 82 L Ed2d 393 (1984) (inmate has no reasonable expectation of privacy enabling him to invoke Fourth Amendment protections against searches). Although the Supreme Court concluded that prisoners possess a significant liberty interest in avoiding the forced administration of antipsychotic drugs, the Court also found that the state may compel the administration of such drugs over the inmate's refusal if the inmate is dangerous to himself or others and the treatment is in his medical interest. ***Washington v. Harper***, 494 US 210, 221-22, 110 S Ct 1028, 108 L Ed2d 178 (1990). Nevertheless, the courts have routinely concluded that an inmate may not manipulate his medical circumstances to the detriment of the state's interest in penal order, security and discipline. In ***Myers***, the court found that the governmental interests in the preservation of internal order and discipline of the prison facility, the maintenance of institutional security, and the rehabilitation of prisoners were paramount over the rights of the inmate to refuse hemodialysis treatment and supportive medication when the inmate's refusal was an attempt to manipulate the prison system. 399 NE 2d 452. *See also* ***Scheutzle v. Vogel***, 537 NW 2d 358 (ND 1995) (prison could require inmate to submit to diabetes monitoring and, if ordered by a physician, forced administration of food, insulin or other medications when inmate's refusal had little to do with his disease); ***Turner v. Safley***, 482 US 78, 89-90, 107 S Ct 2254, 96 L Ed2d 64 (1987) (factors relevant in determining reasonableness of a prison regulation). These cases suggest that the right of an inmate to refuse lifesaving medical treatment may be outweighed by the interests of the prison officials in maintaining discipline and security in the prison.

Nevertheless in ***Thor***, the court upheld the right of a quadriplegic prisoner to refuse tube feeding and medication, finding that prison officials had offered no evidence that allowing him to do so undermined prison integrity or endangered the public. 855 P2d at 387-89. The court noted the unique susceptibility of a prison to the "catalytic effect of disruptive conduct" and stated that in another case, or if circumstances changed in the case before it, the court would not preclude prison officials from establishing the need to override an inmate's choice to decline medical intervention. *Id.* at 388. The court also held that the inmate's refusal of treatment negates a violation of the Eighth Amendment's "deliberate indifference" standard. *Id.* at 389.

In the present case, we have no reason to believe that a refusal by the inmate to consent to resuscitation if a stay were received after commencement of the lethal injections would be motivated by a desire to

disrupt the orderly administration of the prison system. Moreover, we have not been informed by prison officials that such refusal would pose a risk to prison security or discipline. Accordingly, we conclude that the inmate's right to refuse resuscitation or other life-sustaining procedures if a stay were received after commencement of the lethal injections would not be outweighed by the state's penological interests.

4. Recommended Procedures

Having concluded that the inmate's right to refuse life-sustaining treatment would outweigh any countervailing state interests,(65) we recommend that prison officials discuss with the inmate the possibility of a stay being received after commencement of the execution and ask him whether he would like to complete an advance directive stating his instructions regarding life-sustaining procedures in that event.(66) If the inmate chooses to complete an advance directive,(67) the Department of Corrections should:

1. Confirm that the inmate is a "capable" adult, i.e., able to understand and communicate his decision regarding health care;(68)

2. Inform the inmate about the prognosis of resuscitation after commencement of the injection of the lethal chemical agents, the range of procedures that could be undertaken, depending upon the type and amount of the chemicals that had been injected at various points in time, and the risks involved in such resuscitation efforts;(69) and

3. Assist the inmate in completing an advance directive in the form required by ORS 127.531 that properly and fully articulates the inmate's health care instructions.(70)

An advance directive must be executed and witnessed as required by ORS 127.515.(71) We suggest you seek the advice of this office in complying with that procedure.

If the inmate provides an advance directive refusing resuscitation efforts or other lifesaving procedures, the superintendent should ensure that any medical personnel who will be present during the execution will voluntarily abide by that directive.(72) *See* ORS 127.625(1) ("No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the * * * withholding of life sustaining procedures[.]"). Judicial approval of an advance directive refusing consent to life-sustaining procedures is unnecessary. ORS 127.510(2), 127.550(1). *See also* ***Farrell***, 529 A2d at 415 (judicial intervention "could infringe the very rights [of patient self-determination] that we want to protect").

If the inmate states in an advance directive that he wishes resuscitation, the superintendent should ensure that any medical personnel present in the institution during the execution will take appropriate steps to comply with that directive. An inmate's completion of an advance directive containing such an instruction does not alter our above conclusion that prison officials have no duty to bring into the institution, or have present in the execution room, special medical personnel or equipment beyond that normally in the institution for the medical care of inmates.

If the inmate chooses not to provide an advance directive, in the event of a stay of execution after commencement of the lethal injections, the superintendent should direct medical personnel present in the institution to attempt appropriate resuscitation efforts. See note 14, above. In OP-6014, we stated that prison officials should designate a physician to be at the execution site as the inmate's physician should

resuscitation efforts be needed. *Id.* at 5. In light of our above analysis and conclusions, we now reverse that portion of the opinion.

Sincerely,

Donald C. Arnold
Chief Counsel
General Counsel Division

AVL/llm/JGG0E526

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1. Sodium thiopental is an ultra-short-acting barbiturate which is administered intravenously to induce surgical anesthesia. *See* The Pharmacological Basis of Therapeutics, *Hypnotics and Sedatives*, ch 9 (5th ed). According to the anesthesiologist, a normal dose for such purposes would be four to six milligrams per kilogram of body weight.

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2. According to the anesthesiologist, because of the decrease in blood pressure and depressed respiration, brain damage is likely to occur as soon as three minutes after commencement of the injection of this agent due to the substantially reduced perfusion of blood containing oxygen in the brain. Prior to this time, there is a possibility of irreversible brain damage, the exact point of which would be difficult to predict. After injection of the full execution amount of this first agent, resuscitation is conceivable, but the chances of success are slim. Even if resuscitation was successful, if brain damage had occurred, the situation would be irreversible.

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3. Pancuronium bromide is a neuromuscular blocking agent which is administered intravenously as an adjunct to a general surgical anesthesia to obtain relaxation of skeletal muscle. *See* The Pharmacological Basis of Therapeutics, *Neuromuscular Blocking Agents*, ch 28 (5th ed); American Hospital Formulatory Service, Drug Information 96, at 928-31, 940-41. According to the anesthesiologist, a normal dose for such purposes would be 0.1 milligram per kilogram of body weight.

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4. Following injection of the first agent, the injection of this second agent would insure that the inmate would not resume breathing. Although this second agent causes an increase in heart rate, that effect would be overwhelmed by the massive amount of the first agent. After injection of the full execution amount of this second agent, resuscitation is still conceivable, but the chances would be slim; the likelihood of irreversible brain damage would now be substantially greater because of the additional length of time that the brain was not perfused with blood containing oxygen.

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5. A milliequivalent is a measure of potassium based on the number of available potassium ions.

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6. Potassium chloride is an important activator in many enzymatic reactions in the human body and, at the correct concentration, is essential for the transmission of nerve impulses, contraction of cardiac, smooth and skeletal muscle and renal function. The usual safe dosage for intravenous injection is 20 millequivalents per hour. *See* American Hospital Formulatory Service, Drug Information 96, at 1871-73.

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7. The injection of the execution amount of this third agent will cause the heart to be unable to sustain a beat, particularly in the face of the decrease in blood pressure caused by the first agent. After injection of the execution amount of this third agent, the chance of resuscitation is almost nil because the heart would not be able to respond to any attempt to restart a beat. Without the brain being perfused with blood containing oxygen, brain death will occur.

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8. Article I, section 16, of the Oregon Constitution provides in part:

Cruel and unusual punishments shall not be inflicted[.]

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9. The Eighth Amendment to the United States Constitution provides:

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

The Eighth Amendment is made applicable to the states by the Fourteenth Amendment. ***Robinson v. California***, 370 US 660, 82 S Ct 1417, 8 L Ed2d 758 (1962).

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10. Courts have found that a prison's denial of medical treatment on non-medical grounds may violate the Eight Amendment. ***Watson v. Caton***, 984 F2d 537, 540 (1st Cir 1993) (refusal to provide medical treatment for injuries caused by events that occurred before incarceration); ***Gill v. Mooney***, 824 F2d 192, 196 (2nd Cir 1987) (refusal to provide medical attention as a form of punishment for misconduct unrelated to medical condition or treatment).

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11. We understand from your staff that the execution room will contain only such medical equipment and supplies necessary to facilitate the execution, and that a medical person will be present to confirm the death of the inmate. We further understand that the infirmary used to provide routine and emergency medical care for inmates in the Intensive Management Unit (IMU) of the penitentiary is located approximately 40 feet from the execution room and that two registered nurses will be on stand-by in the IMU during the execution in the event that any of the witnesses to the execution need medical attention.

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12. The judiciary is fully aware of the difficulties created by last-minute stays of execution. *Cf.* Judge Stephen Reinhardt, *The Supreme Court, The Death Penalty, and The Harris Case,* 102 Yale LJ 205 (1992) (describing "nightmare" resulting from last-minute stays in this death penalty case). Accordingly, we have every reason to believe that if a court were to issue a last-minute stay, it would nevertheless do so sufficiently in advance of the time for the execution that the difficult issues addressed in this opinion would not become germane.

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13. See note 10, above.

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14. The United States Supreme Court has articulated a standard of deference to prison officials when a prison regulation impinges on inmates' constitutional rights, stating:

the regulation is valid if it is reasonably related to legitimate penological interests. In our view, such a standard is necessary if "prison administrators . . . , and not the courts, [are] to make the difficult judgments concerning institutional operations."

Turner v. Safley, 482 US 78, 89, 107 S Ct 2254, 96 L Ed2d 64 (1987). The Court then outlined the factors that are relevant in determining the reasonableness of a prison regulation. *Id*. at 89-90. Absent issues of prison security or "a significant 'ripple effect' on fellow inmates or on prison staff," *id.* at 90, nothing in the Supreme Court decision suggests that prison officials may refuse to provide the only medical treatment that will successfully treat a prisoner's medical problem. *Cf.* ***Lawson v. Dallas County, TX***, No. CA-3-95-CV-2614-R, 1998 WL 246642 (ND Tex Mar 24, 1998) (continuous and consistent disregard for medical needs of paraplegic inmate).

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15. The nature and extent of appropriate resuscitation efforts, if any, would depend upon the medical state of the inmate at the time the execution were stayed. According to the anesthesiologist, there are no specific antidotes or reversal agents for these chemicals. Given the massive amounts of the agents used for the execution, initial attempt at resuscitation would require intense measures including the infusion of several liters of fluids, injection of epinephrine, cardiopulmonary resuscitation and maintenance of artificial respiration. Complete circulatory support, ventilation support and intensive care unit management would be required, perhaps for days or weeks, along with hemodialysis.

If a stay were received after the inmate was determined by medical personnel to be dead, whether or not all of the acts required by ORS 137.473(1) to complete the execution had occurred, attempts at resuscitation would be futile and need not be attempted. *Cf.* ***Barber v. Superior Court of State of Cal***, 195 Cal Rptr 484, 491 (Cal App 2 Dist 1983) ("Although there may be a duty to provide life-sustaining

machinery in the ***immediate*** aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel."). Medical personnel may also reasonably conclude, based upon the lethal nature and amounts of the chemicals already injected into the inmate, and the speed at which those chemicals act on the human body, that resuscitation would be futile and need not be attempted. This is essentially a medical determination to be made at that time on the basis of the inmate's medical condition and in light of the generally acceptable standards of medical practice in the community for determining when there is a duty to provide medical treatment. *Id.* at 491-92.

A reasonable decision by medical personnel that resuscitation would be futile is not deliberate indifference to the inmate's medical needs, even if there might be a legitimate difference in professional medical judgment. *See* ***Billings***, 323 Or at 181; ***Sanchez v. Vild***, 891 F2d 240, 242 (9th Cir 1989) (honest difference of medical judgment as to diagnosis or treatment does not amount to deliberate indifference); ***Jackson v. McIntosh***, 90 F3d 330, 332 (9th Cir 1996) (denial of opportunity for kidney transplant would be deliberate indifference if medically unacceptable under the circumstances and in conscious disregard of excessive risk to inmate's health); *but see* ***Delker v. Maass***, 843 F Supp 1390, 1398 (D Or 1994) (court need not blindly defer to prison doctors in determining whether there had been deliberate indifference). Whether a decision by medical personnel not to attempt resuscitation would constitute negligence would depend on whether the medical personnel present had a duty of care toward the inmate under the department's rules by virtue of their employment with the department or otherwise, the type of medicine those personnel were authorized to practice and whether they exercised the degree of care, skill and diligence used by ordinary careful practitioners in that field or discipline in the same or similar community under the same or similar circumstances. ***Creasey v. Hogan***, 292 Or 154, 163-64, 637 P2d 114 (1981).

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16. A stay received after completion of the acts required by ORS 137.473(1) to carry out the execution would be ineffective to stop the execution and imposes no duty on prison officials to attempt resuscitation. At that point in time, the state has lawfully carried out the sentence of execution pursuant to the laws of this state. To the extent that our earlier opinion concerning the department's rules regarding execution by lethal injection suggests that the department may have a duty to attempt resuscitation in this situation or face a

considerable risk of liability for failure to do so, Letter of Advice dated September 30, 1986, to Thomas Toombs, Administrator, Corrections Division (OP-6014) at 4, we hereby reverse that opinion.

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17. ORS 127.507 was enacted in 1993 as part of the Oregon Health Care Decisions Act, ORS 127.505 to 127.660 and 127.995. Or Laws 1993, ch 767, § 2.

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18. The lethal injections required by ORS 137.473(1) constitute an intentional "injury."

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19. Throughout this opinion, we use the term "life-sustaining procedures" as it is defined in ORS 127.505(16). That term includes not only life-sustaining therapies such as hydration, nutrition and hemodialysis, but also lifesaving procedures that restore or supplant a vital function, such as cardiopulmonary resuscitation, cardioversion or mechanical ventilation.

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20. In interpreting ORS 127.505 to 127.660, we must discern the intent of the legislature. ORS 174.020; ***PGE v. Bureau of Labor and Industries (PGE)***, 317 Or 606, 610-611, 859 P2d 1143 (1993) (establishing template for construing statutes and affirming agency's interpretation of statute). Our analysis begins with the text and context of ORS 127.505 to 127.660 and other related statutes, including statutory and case law rules of construction that bear directly on the interpretation of the text and context of this statute. We may consider legislative history to ascertain intent only if the legislative intent is not clear from the text or context of the statutes. *Id*. at 611. Finally, if the meaning of a statute remains unclear after the foregoing steps, we may resort to general maxims of statutory construction to aid in resolving any remaining uncertainty. *Id.* at 612. One such maxim is to "construe the statute so as to satisfy the constitution." ***Westwood Homeowners Assn., Inc. v. Lane County***, 318 Or 146, 160, 864 P2d 350 (1993) (interpreting statute, in part, to avoid infringement of constitutional rights).

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21. Such an implication of liability for withholding life-sustaining procedures in reliance on an advance directive refusing consent for such procedures is questionable in light of ORS 127.555(3). This provision states that a health care provider acting or declining to act in reliance on a health care instruction in an advance directive is not subject to criminal prosecution, civil liability or professional disciplinary action on the grounds that the decision is unauthorized unless the provider failed to satisfy a duty imposed by ORS 127.505 to 127.660, acted without medical confirmation "as required" under those statutes, knows or has reason to know that the requirements of those statutes have not been satisfied, or acts after receiving notice that the authority relied upon is not valid.

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22. The only Oregon case that we have found discussing informed consent is a medical malpractice case predicated on the lack of informed consent to a surgical procedure. In this case, the Oregon Court of Appeals noted that a "competent adult is free to refuse treatment which the average reasonable person would be highly likely to undergo and which other competent adults might consider it imprudent to forego." ***Arena v. Gingrich***, 84 Or App 25, 30, 733 P2d 75 (1987).

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23. Courts in other jurisdictions have upheld the right of a competent adult to refuse such lifesaving medical treatments as a respirator, ***Satz v. Perlmutter***, 362 So 2d 160, 162 (Fla 1978); nasogastric tube for forced feeding, ***Bouvia v. Superior Court (Glenchur)***, 179 Cal App 3d 1127, 225 Cal Rptr 297 (Cal App 2 Dist 1986); amputation of legs for gangrene, ***Matter of Quackenbush***, 383 A2d 785, 789-90 (NJ 1978); ***Lane v. Candura***, 376 NE2d 1232, 1233 (Mass 1978); and blood transfusions, ***Erickson v. Dilgard***, 252 NYS2d 705 (1962); ***St. Mary's Hospital v. Ramsey***, 465 So 2d 666, 668 (Fla 1985).

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24. The issue before the court in ***Cruzan*** was whether Missouri could constitutionally require clear and convincing evidence of a comatose

patient's previously stated wish not to be kept alive by artificially administered nutrition and hydration. In order to reach this issue, it was necessary for the Court to first recognize the right of a competent patient to make the decision to refuse life-sustaining medical treatment.

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25. In ***Commissioner of Corrections v. Myers***, 399 NE 2d 452 (Mass 1979), prison officials obtained a court order compelling a competent adult inmate to submit to hemodialysis treatment and administration of supportive medication despite his refusal to consent. Finding that the inmate's refusal was an attempt to manipulate the prison system, the court concluded that the governmental interests in the preservation of internal order and discipline of the prison facility, the maintenance of institutional security and the rehabilitation of prisoners were paramount.

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26. *But see Developments in the Law -- Medical Technology and the Law, VI The Right to Refuse Medical Treatment*, 103 Harv. L. Rev 1643, 1675 (1990) ("the state interest is not in the preservation of life per se, but, as the New York Court of Appeals recognized in *O'Connor* [*v. Hall*, 513 NE2d 607, 613 (1988)], in guaranteeing that a severely medically disabled patient is not denied his constitutional right to life").

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27. In his dissenting opinion in ***Cruzan***, Justice Brennan acknowledged, "[t]he possibility of a medical miracle [may] indeed [be] part of the calculus, but it is a part of the *patient's* calculus." 497 US at 321 (emphasis in original).

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28. In reaching the conclusion that in this situation the state's interest must give way to the inmate's right of self-determination, we also note that the state has not embraced an absolute policy of preserving life at the expense of self-determination. The Oregon Health Care Decisions Act, ORS 127.505 to 127.660, clearly embodies a policy of permitting an individual or designated health care representative to refuse life-sustaining procedures. We believe that

this legislative policy evidences a recognition that fostering self-determination in such matters enhances rather than deprecates the value of life. *See also* The Oregon Death with Dignity Act, ORS 127.800 to 127.897 (1995 Ballot Measure 16).

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29. Our weighing of the inmate's interests in the right of self-determination against the countervailing state interests is predicated on the facts discussed in this opinion. If those facts were to differ, e.g., because of changes in the means of execution or advances in medicine affecting the prognosis or risks of resuscitation, a different balance might be struck.

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30. Such an advance directive may include not only instructions regarding resuscitation but also instructions regarding admission to a hospital or other heath care facility. *See* ORS 127.505(8).

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31. Prison officials must ensure that the choice to complete an advance directive in this situation is made voluntarily and without coercion, and that the substance of any health care instructions is also the inmate's voluntary decision.

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32. *See* ORS 127.505(13); *see also* ***Farrell***, 529 A2d at 413 n 7 ("A competent patient has a clear understanding of the nature of his or her illness and prognosis, and the risks and benefits of the proposed treatment, and has the capacity to reason and make judgments about that information."). We do not believe that any additional procedures are necessary to determine the competence of the inmate or the voluntariness of his decision. *See* ***Thor v. Superior Court***, 855 P2d 375, 390 (Cal 1993) ("[W]e have no basis for assuming [the prison environment] inherently jeopardizes the voluntariness of [medical decision-making].").

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33. *Cf.* ORS 677.097 (procedure to obtain informed consent of patient).

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34. There is no legal requirement that a physician be present when an inmate completes an advance directive, nor that someone not employed by the department be present. In the context of an inmate facing execution, however, we recommend that a physician or other individual be available who can explain to the inmate the medical consequences of the three lethal chemicals and the likely efficacy of any resuscitation attempt after commencement of the injections. We also recommend that someone not employed by the department actually advise the inmate regarding his options in completing an advance directive in light of arguments that might be raised that an element of coercion is present when an inmate facing an execution is being asked for his or her health care instructions if a stay is received after commencement of the lethal injections.

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35. ORS 127.515(4) provides:

(4) An advance directive must reflect the date of the principal's signature. To be valid, an advance directive must be witnessed by at least two adults as follows:

(a) Each witness shall witness either the signing of the instrument by the principal or the principal's acknowledgement of the signature of the principal.

(b) Each witness shall make the written declaration as set forth in the form provided in ORS 127.531.

(c) One of the witnesses shall be a person who is not:

(A) A relative of the principal by blood, marriage or adoption;

(B) A person who at the time the advance directive is signed would be entitled to any portion of the estate of the principal upon death under any will or by operation of law; or

(C) An owner, operator or employee of a health care facility where the principal is a patient or resident.

(d) The attorney-in-fact for health care or alternative attorney-in-fact may not be a witness. The principal's attending physician at the time the advance directive is signed may not be a

witness.

(e) If the principal is a patient in a long term care facility at the time the advance directive is executed, one of the witnesses must be an individual designated by the facility and having any qualifications that may be specified by the Department of Human Resources by rule.

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36. Although there are no Oregon cases on liability for resuscitation of a patient against his wishes, at least one jurisdiction has found that a patient may recover damages based upon the torts of negligence or battery when medical treatment is provided to a patient who has expressly refused treatment. *See* ***Anderson v. St. Francis-St. George Hosp.***, 671 NE2d 225 (Ohio 1996).

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37. Sodium thiopental is an ultra-short-acting barbiturate which is administered intravenously to induce surgical anesthesia. *See* The Pharmacological Basis of Therapeutics, *Hypnotics and Sedatives*, ch 9 (5th ed). According to the anesthesiologist, a normal dose for such purposes would be four to six milligrams per kilogram of body weight.

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38. According to the anesthesiologist, because of the decrease in blood pressure and depressed respiration, brain damage is likely to occur as soon as three minutes after commencement of the injection of this agent due to the substantially reduced perfusion of blood containing oxygen in the brain. Prior to this time, there is a possibility of irreversible brain damage, the exact point of which would be difficult to predict. After injection of the full execution amount of this first agent, resuscitation is conceivable, but the chances of success are slim. Even if resuscitation was successful, if brain damage had occurred, the situation would be irreversible.

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39. Pancuronium bromide is a neuromuscular blocking agent which is administered intravenously as an adjunct to a general surgical anesthesia to obtain relaxation of skeletal muscle. *See* The Pharmacological Basis of Therapeutics, *Neuromuscular Blocking Agents*,

ch 28 (5th ed); American Hospital Formulatory Service, Drug Information 96, at 928-31, 940-41. According to the anesthesiologist, a normal dose for such purposes would be 0.1 milligram per kilogram of body weight.

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40. Following injection of the first agent, the injection of this second agent would insure that the inmate would not resume breathing. Although this second agent causes an increase in heart rate, that effect would be overwhelmed by the massive amount of the first agent. After injection of the full execution amount of this second agent, resuscitation is still conceivable, but the chances would be slim; the likelihood of irreversible brain damage would now be substantially greater because of the additional length of time that the brain was not perfused with blood containing oxygen.

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41. A milliequivalent is a measure of potassium based on the number of available potassium ions.

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42. Potassium chloride is an important activator in many enzymatic reactions in the human body and, at the correct concentration, is essential for the transmission of nerve impulses, contraction of cardiac, smooth and skeletal muscle and renal function. The usual safe dosage for intravenous injection is 20 millequivalents per hour. *See* American Hospital Formulatory Service, Drug Information 96, at 1871-73.

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43. The injection of the execution amount of this third agent will cause the heart to be unable to sustain a beat, particularly in the face of the decrease in blood pressure caused by the first agent. After injection of the execution amount of this third agent, the chance of resuscitation is almost nil because the heart would not be able to respond to any attempt to restart a beat. Without the brain being perfused with blood containing oxygen, brain death will occur.

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44. Article I, section 16, of the Oregon Constitution provides in part:

Cruel and unusual punishments shall not be inflicted[.]

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45. The Eighth Amendment to the United States Constitution provides:

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

The Eighth Amendment is made applicable to the states by the Fourteenth Amendment. ***Robinson v. California***, 370 US 660, 82 S Ct 1417, 8 L Ed2d 758 (1962).

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46. Courts have found that a prison's denial of medical treatment on non-medical grounds may violate the Eight Amendment. ***Watson v. Caton***, 984 F2d 537, 540 (1st Cir 1993) (refusal to provide medical treatment for injuries caused by events that occurred before incarceration); ***Gill v. Mooney***, 824 F2d 192, 196 (2nd Cir 1987) (refusal to provide medical attention as a form of punishment for misconduct unrelated to medical condition or treatment).

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47. We understand from your staff that the execution room will contain only such medical equipment and supplies necessary to facilitate the execution, and that a medical person will be present to confirm the death of the inmate. We further understand that the infirmary used to provide routine and emergency medical care for inmates in the Intensive Management Unit (IMU) of the penitentiary is located approximately 40 feet from the execution room and that two registered nurses will be on stand-by in the IMU during the execution in the event that any of the witnesses to the execution need medical attention.

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48. The judiciary is fully aware of the difficulties created by last-minute stays of execution. *Cf.* Judge Stephen Reinhardt, *The*

Supreme Court, The Death Penalty, and The Harris Case, 102 Yale LJ 205 (1992) (describing "nightmare" resulting from last-minute stays in this death penalty case). Accordingly, we have every reason to believe that if a court were to issue a last-minute stay, it would nevertheless do so sufficiently in advance of the time for the execution that the difficult issues addressed in this opinion would not become germane.

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49. See note 10, above.

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50. The United States Supreme Court has articulated a standard of deference to prison officials when a prison regulation impinges on inmates' constitutional rights, stating:

the regulation is valid if it is reasonably related to legitimate penological interests. In our view, such a standard is necessary if "prison administrators . . . , and not the courts, [are] to make the difficult judgments concerning institutional operations."

Turner v. Safley, 482 US 78, 89, 107 S Ct 2254, 96 L Ed2d 64 (1987). The Court then outlined the factors that are relevant in determining the reasonableness of a prison regulation. *Id*. at 89-90. Absent issues of prison security or "a significant 'ripple effect' on fellow inmates or on prison staff," *id.* at 90, nothing in the Supreme Court decision suggests that prison officials may refuse to provide the only medical treatment that will successfully treat a prisoner's medical problem. *Cf.* ***Lawson v. Dallas County, TX***, No. CA-3-95-CV-2614-R, 1998 WL 246642 (ND Tex Mar 24, 1998) (continuous and consistent disregard for medical needs of paraplegic inmate).

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51. The nature and extent of appropriate resuscitation efforts, if any, would depend upon the medical state of the inmate at the time the execution were stayed. According to the anesthesiologist, there are no specific antidotes or reversal agents for these chemicals. Given the massive amounts of the agents used for the execution, initial attempt at resuscitation would require intense measures including the infusion of several liters of fluids, injection of epinephrine, cardiopulmonary resuscitation and maintenance of artificial respiration. Complete

circulatory support, ventilation support and intensive care unit management would be required, perhaps for days or weeks, along with hemodialysis.

If a stay were received after the inmate was determined by medical personnel to be dead, whether or not all of the acts required by ORS 137.473(1) to complete the execution had occurred, attempts at resuscitation would be futile and need not be attempted. *Cf.* ***Barber v. Superior Court of State of Cal***, 195 Cal Rptr 484, 491 (Cal App 2 Dist 1983) ("Although there may be a duty to provide life-sustaining machinery in the ***immediate*** aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel."). Medical personnel may also reasonably conclude, based upon the lethal nature and amounts of the chemicals already injected into the inmate, and the speed at which those chemicals act on the human body, that resuscitation would be futile and need not be attempted. This is essentially a medical determination to be made at that time on the basis of the inmate's medical condition and in light of the generally acceptable standards of medical practice in the community for determining when there is a duty to provide medical treatment. *Id.* at 491-92.

A reasonable decision by medical personnel that resuscitation would be futile is not deliberate indifference to the inmate's medical needs, even if there might be a legitimate difference in professional medical judgment. *See* ***Billings***, 323 Or at 181; ***Sanchez v. Vild***, 891 F2d 240, 242 (9th Cir 1989) (honest difference of medical judgment as to diagnosis or treatment does not amount to deliberate indifference); ***Jackson v. McIntosh***, 90 F3d 330, 332 (9th Cir 1996) (denial of opportunity for kidney transplant would be deliberate indifference if medically unacceptable under the circumstances and in conscious disregard of excessive risk to inmate's health); *but see* ***Delker v. Maass***, 843 F Supp 1390, 1398 (D Or 1994) (court need not blindly defer to prison doctors in determining whether there had been deliberate indifference). Whether a decision by medical personnel not to attempt resuscitation would constitute negligence would depend on whether the medical personnel present had a duty of care toward the inmate under the department's rules by virtue of their employment with the department or otherwise, the type of medicine those personnel were authorized to practice and whether they exercised the degree of care, skill and diligence used by ordinary careful practitioners in that field or discipline in the same or similar community under the same or similar circumstances. ***Creasey v. Hogan***, 292 Or 154, 163-64, 637 P2d 114 (1981).

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52. A stay received after completion of the acts required by ORS 137.473(1) to carry out the execution would be ineffective to stop the execution and imposes no duty on prison officials to attempt resuscitation. At that point in time, the state has lawfully carried out the sentence of execution pursuant to the laws of this state. To the extent that our earlier opinion concerning the department's rules regarding execution by lethal injection suggests that the department may have a duty to attempt resuscitation in this situation or face a considerable risk of liability for failure to do so, Letter of Advice dated September 30, 1986, to Thomas Toombs, Administrator, Corrections Division (OP-6014) at 4, we hereby reverse that opinion.

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53. ORS 127.507 was enacted in 1993 as part of the Oregon Health Care Decisions Act, ORS 127.505 to 127.660 and 127.995. Or Laws 1993, ch 767, § 2.

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54. The lethal injections required by ORS 137.473(1) constitute an intentional "injury."

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55. Throughout this opinion, we use the term "life-sustaining procedures" as it is defined in ORS 127.505(16). That term includes not only life-sustaining therapies such as hydration, nutrition and hemodialysis, but also lifesaving procedures that restore or supplant a vital function, such as cardiopulmonary resuscitation, cardioversion or mechanical ventilation.

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56. In interpreting ORS 127.505 to 127.660, we must discern the intent of the legislature. ORS 174.020; ***PGE v. Bureau of Labor and Industries (PGE)***, 317 Or 606, 610-611, 859 P2d 1143 (1993) (establishing template for construing statutes and affirming agency's interpretation of statute). Our analysis begins with the text and context of ORS 127.505 to 127.660 and other related statutes, including statutory and case law rules of construction that bear directly on the interpretation of the text and context of this statute. We may consider legislative

history to ascertain intent only if the legislative intent is not clear from the text or context of the statutes. *Id*. at 611. Finally, if the meaning of a statute remains unclear after the foregoing steps, we may resort to general maxims of statutory construction to aid in resolving any remaining uncertainty. *Id.* at 612. One such maxim is to "construe the statute so as to satisfy the constitution." ***Westwood Homeowners Assn., Inc. v. Lane County***, 318 Or 146, 160, 864 P2d 350 (1993) (interpreting statute, in part, to avoid infringement of constitutional rights).

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57. Such an implication of liability for withholding life-sustaining procedures in reliance on an advance directive refusing consent for such procedures is questionable in light of ORS 127.555(3). This provision states that a health care provider acting or declining to act in reliance on a health care instruction in an advance directive is not subject to criminal prosecution, civil liability or professional disciplinary action on the grounds that the decision is unauthorized unless the provider failed to satisfy a duty imposed by ORS 127.505 to 127.660, acted without medical confirmation "as required" under those statutes, knows or has reason to know that the requirements of those statutes have not been satisfied, or acts after receiving notice that the authority relied upon is not valid.

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58. The only Oregon case that we have found discussing informed consent is a medical malpractice case predicated on the lack of informed consent to a surgical procedure. In this case, the Oregon Court of Appeals noted that a "competent adult is free to refuse treatment which the average reasonable person would be highly likely to undergo and which other competent adults might consider it imprudent to forego." ***Arena v. Gingrich***, 84 Or App 25, 30, 733 P2d 75 (1987).

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59. Courts in other jurisdictions have upheld the right of a competent adult to refuse such lifesaving medical treatments as a respirator, ***Satz v. Perlmutter***, 362 So 2d 160, 162 (Fla 1978); nasogastric tube for forced feeding, ***Bouvia v. Superior Court (Glenchur)***, 179 Cal App 3d 1127, 225 Cal Rptr 297 (Cal App 2 Dist 1986); amputation of legs for gangrene, ***Matter of Quackenbush***, 383 A2d 785, 789-90 (NJ 1978);

Lane v. Candura, 376 NE2d 1232, 1233 (Mass 1978); and blood transfusions, ***Erickson v. Dilgard***, 252 NYS2d 705 (1962); ***St. Mary's Hospital v. Ramsey***, 465 So 2d 666, 668 (Fla 1985).

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60. The issue before the court in ***Cruzan*** was whether Missouri could constitutionally require clear and convincing evidence of a comatose patient's previously stated wish not to be kept alive by artificially administered nutrition and hydration. In order to reach this issue, it was necessary for the Court to first recognize the right of a competent patient to make the decision to refuse life-sustaining medical treatment.

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61. In ***Commissioner of Corrections v. Myers***, 399 NE 2d 452 (Mass 1979), prison officials obtained a court order compelling a competent adult inmate to submit to hemodialysis treatment and administration of supportive medication despite his refusal to consent. Finding that the inmate's refusal was an attempt to manipulate the prison system, the court concluded that the governmental interests in the preservation of internal order and discipline of the prison facility, the maintenance of institutional security and the rehabilitation of prisoners were paramount.

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62. *But see Developments in the Law -- Medical Technology and the Law, VI The Right to Refuse Medical Treatment*, 103 Harv. L. Rev 1643, 1675 (1990) ("the state interest is not in the preservation of life per se, but, as the New York Court of Appeals recognized in *O'Connor* [*v. Hall*, 513 NE2d 607, 613 (1988)], in guaranteeing that a severely medically disabled patient is not denied his constitutional right to life").

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63. In his dissenting opinion in ***Cruzan***, Justice Brennan acknowledged, "[t]he possibility of a medical miracle [may] indeed [be] part of the calculus, but it is a part of the *patient's* calculus." 497 US at 321 (emphasis in original).

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64. In reaching the conclusion that in this situation the state's interest must give way to the inmate's right of self-determination, we also note that the state has not embraced an absolute policy of preserving life at the expense of self-determination. The Oregon Health Care Decisions Act, ORS 127.505 to 127.660, clearly embodies a policy of permitting an individual or designated health care representative to refuse life-sustaining procedures. We believe that this legislative policy evidences a recognition that fostering self-determination in such matters enhances rather than deprecates the value of life. *See also* The Oregon Death with Dignity Act, ORS 127.800 to 127.897 (1995 Ballot Measure 16).

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65. Our weighing of the inmate's interests in the right of self-determination against the countervailing state interests is predicated on the facts discussed in this opinion. If those facts were to differ, e.g., because of changes in the means of execution or advances in medicine affecting the prognosis or risks of resuscitation, a different balance might be struck.

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66. Such an advance directive may include not only instructions regarding resuscitation but also instructions regarding admission to a hospital or other heath care facility. *See* ORS 127.505(8).

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67. Prison officials must ensure that the choice to complete an advance directive in this situation is made voluntarily and without coercion, and that the substance of any health care instructions is also the inmate's voluntary decision.

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68. *See* ORS 127.505(13); *see also* ***Farrell***, 529 A2d at 413 n 7 ("A competent patient has a clear understanding of the nature of his or her illness and prognosis, and the risks and benefits of the proposed treatment, and has the capacity to reason and make judgments about that information."). We do not believe that any additional procedures are necessary to determine the competence of the inmate or the

voluntariness of his decision. *See* ***Thor v. Superior Court***, 855 P2d 375, 390 (Cal 1993) ("[W]e have no basis for assuming [the prison environment] inherently jeopardizes the voluntariness of [medical decision-making].").

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69. *Cf.* ORS 677.097 (procedure to obtain informed consent of patient).

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70. There is no legal requirement that a physician be present when an inmate completes an advance directive, nor that someone not employed by the department be present. In the context of an inmate facing execution, however, we recommend that a physician or other individual be available who can explain to the inmate the medical consequences of the three lethal chemicals and the likely efficacy of any resuscitation attempt after commencement of the injections. We also recommend that someone not employed by the department actually advise the inmate regarding his options in completing an advance directive in light of arguments that might be raised that an element of coercion is present when an inmate facing an execution is being asked for his or her health care instructions if a stay is received after commencement of the lethal injections.

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71. ORS 127.515(4) provides:

(4) An advance directive must reflect the date of the principal's signature. To be valid, an advance directive must be witnessed by at least two adults as follows:

(a) Each witness shall witness either the signing of the instrument by the principal or the principal's acknowledgement of the signature of the principal.

(b) Each witness shall make the written declaration as set forth in the form provided in ORS 127.531.

(c) One of the witnesses shall be a person who is not:

(A) A relative of the principal by blood, marriage or adoption;

(B) A person who at the time the advance directive is signed would be entitled to any portion of the estate of the principal upon death

under any will or by operation of law; or

(C) An owner, operator or employee of a health care facility where the principal is a patient or resident.

(d) The attorney-in-fact for health care or alternative attorney-in-fact may not be a witness. The principal's attending physician at the time the advance directive is signed may not be a witness.

(e) If the principal is a patient in a long term care facility at the time the advance directive is executed, one of the witnesses must be an individual designated by the facility and having any qualifications that may be specified by the Department of Human Resources by rule.

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72. Although there are no Oregon cases on liability for resuscitation of a patient against his wishes, at least one jurisdiction has found that a patient may recover damages based upon the torts of negligence or battery when medical treatment is provided to a patient who has expressly refused treatment. *See* ***Anderson v. St. Francis-St. George Hosp.***, 671 NE2d 225 (Ohio 1996).

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