

## 1 VIRGINIA ACTS OF ASSEMBLY — CHAPTER

2 *An Act to amend and reenact § 54.1-2984 of the Code of Virginia, relating to advance directives;*  
 3 *directions about life-prolonging procedures during pregnancy.*

[H 1657]

4 Approved

6 **Be it enacted by the General Assembly of Virginia:**7 **1. That § 54.1-2984 of the Code of Virginia is amended and reenacted as follows:**8 **§ 54.1-2984. Suggested form of written advance directives.**

9 An advance directive executed pursuant to this article may, but need not, be in the following form:

10 **ADVANCE MEDICAL DIRECTIVE**11 I, \_\_\_\_\_, willingly and voluntarily make known my wishes in the event that I am  
12 incapable of making an informed decision, as follows:13 I understand that my advance directive may include the selection of an agent as well as set forth my  
14 choices regarding health care. The term "health care" means the furnishing of services to any individual  
15 for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability,  
16 including but not limited to, medications; surgery; blood transfusions; chemotherapy; radiation therapy;  
17 admission to a hospital, nursing home, assisted living facility, or other health care facility; psychiatric or  
18 other mental health treatment; and life-prolonging procedures and palliative care.19 The phrase "incapable of making an informed decision" means unable to understand the nature,  
20 extent and probable consequences of a proposed health care decision or unable to make a rational  
21 evaluation of the risks and benefits of a proposed health care decision as compared with the risks and  
22 benefits of alternatives to that decision, or unable to communicate such understanding in any way.23 The determination that I am incapable of making an informed decision shall be made by my  
24 attending physician and a capacity reviewer, if certification by a capacity reviewer is required by law,  
25 after a personal examination of me and shall be certified in writing. Such certification shall be required  
26 before health care is provided, continued, withheld or withdrawn, before any named agent shall be  
27 granted authority to make health care decisions on my behalf, and before, or as soon as reasonably  
28 practicable after, health care is provided, continued, withheld or withdrawn and every 180 days  
29 thereafter while the need for health care continues.30 If, at any time, I am determined to be incapable of making an informed decision, I shall be notified,  
31 to the extent I am capable of receiving such notice, that such determination has been made before health  
32 care is provided, continued, withheld, or withdrawn. Such notice shall also be provided, as soon as  
33 practical, to my named agent or person authorized by § 54.1-2986 to make health care decisions on my  
34 behalf. If I am later determined to be capable of making an informed decision by a physician, in  
35 writing, upon personal examination, any further health care decisions will require my informed consent.

36 (SELECT ANY OR ALL OF THE OPTIONS BELOW.)

37 **OPTION I: APPOINTMENT OF AGENT (CROSS THROUGH OPTIONS I AND II BELOW IF**  
38 **YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR**  
39 **YOU.)**40 I hereby appoint \_\_\_\_\_ (primary agent), of \_\_\_\_\_ (address and telephone  
41 number), as my agent to make health care decisions on my behalf as authorized in this document. If  
42 \_\_\_\_\_ (primary agent) is not reasonably available or is unable or unwilling to act as my  
43 agent, then I appoint \_\_\_\_\_ (successor agent), of \_\_\_\_\_ (address and telephone  
44 number), to serve in that capacity.45 I hereby grant to my agent, named above, full power and authority to make health care decisions on  
46 my behalf as described below whenever I have been determined to be incapable of making an informed  
47 decision. My agent's authority hereunder is effective as long as I am incapable of making an informed  
48 decision.49 In exercising the power to make health care decisions on my behalf, my agent shall follow my  
50 desires and preferences as stated in this document or as otherwise known to my agent. My agent shall  
51 be guided by my medical diagnosis and prognosis and any information provided by my physicians as to  
52 the intrusiveness, pain, risks, and side effects associated with treatment or nontreatment. My agent shall  
53 not make any decision regarding my health care which he knows, or upon reasonable inquiry ought to  
54 know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If  
55 my agent cannot determine what health care choice I would have made on my own behalf, then my  
56 agent shall make a choice for me based upon what he believes to be in my best interests.

57 OPTION II: POWERS OF MY AGENT (CROSS THROUGH ANY LANGUAGE YOU DO NOT  
58 WANT AND ADD ANY LANGUAGE YOU DO WANT.)

59 The powers of my agent shall include the following:

60 A. To consent to or refuse or withdraw consent to any type of health care, treatment, surgical  
61 procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect  
62 any bodily function, including, but not limited to, artificial respiration, artificially administered nutrition  
63 and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to  
64 consent to the administration of dosages of pain-relieving medication in excess of recommended dosages  
65 in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or of  
66 inadvertently hastening my death;

67 B. To request, receive, and review any information, verbal or written, regarding my physical or  
68 mental health, including but not limited to, medical and hospital records, and to consent to the  
69 disclosure of this information;

70 C. To employ and discharge my health care providers;

71 D. To authorize my admission to or discharge (including transfer to another facility) from any  
72 hospital, hospice, nursing home, assisted living facility or other medical care facility. If I have  
73 authorized admission to a health care facility for treatment of mental illness, that authority is stated  
74 elsewhere in this advance directive;

75 E. To authorize my admission to a health care facility for the treatment of mental illness for no more  
76 than 10 calendar days provided I do not protest the admission and a physician on the staff of or  
77 designated by the proposed admitting facility examines me and states in writing that I have a mental  
78 illness and I am incapable of making an informed decision about my admission, and that I need  
79 treatment in the facility; and to authorize my discharge (including transfer to another facility) from the  
80 facility;

81 F. To authorize my admission to a health care facility for the treatment of mental illness for no more  
82 than 10 calendar days, even over my protest, if a physician on the staff of or designated by the  
83 proposed admitting facility examines me and states in writing that I have a mental illness and I am  
84 incapable of making an informed decision about my admission, and that I need treatment in the facility;  
85 and to authorize my discharge (including transfer to another facility) from the facility. [My physician or  
86 licensed clinical psychologist hereby attests that I am capable of making an informed decision and that I  
87 understand the consequences of this provision of my advance directive:  
88 \_\_\_\_\_];

89 G. To authorize the specific types of health care identified in this advance directive [specify  
90 cross-reference to other sections of directive] even over my protest. [My physician or licensed clinical  
91 psychologist hereby attests that I am capable of making an informed decision and that I understand the  
92 consequences of this provision of my advance directive: \_\_\_\_\_  
93 ];

94 H. To continue to serve as my agent even in the event that I protest the agent's authority after I have  
95 been determined to be incapable of making an informed decision;

96 I. To authorize my participation in any health care study approved by an institutional review board or  
97 research review committee according to applicable federal or state law that offers the prospect of direct  
98 therapeutic benefit to me;

99 J. To authorize my participation in any health care study approved by an institutional review board  
100 or research review committee pursuant to applicable federal or state law that aims to increase scientific  
101 understanding of any condition that I may have or otherwise to promote human well-being, even though  
102 it offers no prospect of direct benefit to me;

103 K. To make decisions regarding visitation during any time that I am admitted to any health care  
104 facility, consistent with the following directions: \_\_\_\_\_; and

105 L. To take any lawful actions that may be necessary to carry out these decisions, including the  
106 granting of releases of liability to medical providers. Further, my agent shall not be liable for the costs  
107 of health care pursuant to his authorization, based solely on that authorization.

108 OPTION III: HEALTH CARE INSTRUCTIONS

109 (CROSS THROUGH PARAGRAPHS A AND/OR B IF YOU DO NOT WANT TO GIVE  
110 ADDITIONAL SPECIFIC INSTRUCTIONS ABOUT YOUR HEALTH CARE.)

111 A. I specifically direct that I receive the following health care if it is medically appropriate under the  
112 circumstances as determined by my attending physician: \_\_\_\_\_.

113 B. I specifically direct that the following health care not be provided to me under the following  
114 circumstances (you may specify that certain health care not be provided under any circumstances):  
115 \_\_\_\_\_.

116 OPTION IV: END OF LIFE INSTRUCTIONS

117 (CROSS THROUGH THIS OPTION IF YOU DO NOT WANT TO GIVE INSTRUCTIONS

118 ABOUT YOUR HEALTH CARE IF YOU HAVE A TERMINAL CONDITION.)

119 If at any time my attending physician should determine that I have a terminal condition where the  
120 application of life-prolonging procedures - including artificial respiration, cardiopulmonary resuscitation,  
121 artificially administered nutrition, and artificially administered hydration - would serve only to artificially  
122 prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be  
123 permitted to die naturally with only the administration of medication or the performance of any medical  
124 procedure deemed necessary to provide me with comfort care or to alleviate pain.

125 *OPTION: LIFE-PROLONGING PROCEDURES DURING PREGNANCY. (If you wish to provide*  
126 *additional instructions or modifications to instructions you have already given regarding life-prolonging*  
127 *procedures that will apply if you are pregnant at the time your attending physician determines that you*  
128 *have a terminal condition, you may do so here.)*

129 *If I am pregnant when my attending physician determines that I have a terminal condition, my*  
130 *decision concerning life-prolonging procedures shall be modified as follows:*

131 \_\_\_\_\_  
132 \_\_\_\_\_  
133 \_\_\_\_\_  
134 \_\_\_\_\_;

135 *OPTION: OTHER DIRECTIONS ABOUT LIFE-PROLONGING PROCEDURES. (If you wish to*  
136 *provide your own directions, or if you wish to add to the directions you have given above, you may do*  
137 *so here. If you wish to give specific instructions regarding certain life-prolonging procedures, such as*  
138 *artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition, and artificially*  
139 *administered hydration, this is where you should write them.) I direct that:*

140 \_\_\_\_\_  
141 \_\_\_\_\_  
142 \_\_\_\_\_  
143 \_\_\_\_\_;

144 *OPTION: My other instructions regarding my care if I have a terminal condition are as follows:*

145 \_\_\_\_\_  
146 \_\_\_\_\_  
147 \_\_\_\_\_  
148 \_\_\_\_\_;

149 In the absence of my ability to give directions regarding the use of such life-prolonging procedures,  
150 it is my intention that this advance directive shall be honored by my family and physician as the final  
151 expression of my legal right to refuse health care and acceptance of the consequences of such refusal.

152 *OPTION V: APPOINTMENT OF AN AGENT TO MAKE AN ANATOMICAL GIFT OR ORGAN,*  
153 *TISSUE OR EYE DONATION (CROSS THROUGH IF YOU DO NOT WANT TO APPOINT AN*  
154 *AGENT TO MAKE AN ANATOMICAL GIFT OR ANY ORGAN, TISSUE OR EYE DONATION*  
155 *FOR YOU.)*

156 Upon my death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye  
157 donations may be made pursuant to Article 2 (§ 32.1-289.2 et seq.) of Chapter 8 of Title 32.1 and in  
158 accordance with my directions, if any. I hereby appoint \_\_\_\_\_ as my agent, of  
159 \_\_\_\_\_ (address and telephone number), to make any such anatomical gift or organ, tissue or  
160 eye donation following my death. I further direct that: \_\_\_\_\_ (declarant's directions  
161 concerning anatomical gift or organ, tissue or eye donation).

162 This advance directive shall not terminate in the event of my disability.

163 *AFFIRMATION AND RIGHT TO REVOKE: By signing below, I indicate that I am emotionally*  
164 *and mentally capable of making this advance directive and that I understand the purpose and effect of*  
165 *this document. I understand I may revoke all or any part of this document at any time (i) with a signed,*  
166 *dated writing; (ii) by physical cancellation or destruction of this advance directive by myself or by*  
167 *directing someone else to destroy it in my presence; or (iii) by my oral expression of intent to revoke.*

168 \_\_\_\_\_  
169 \_\_\_\_\_

170 \_\_\_\_\_  
171 (Date) \_\_\_\_\_ (Signature of Declarant)

172 The declarant signed the foregoing advance directive in my presence.

173 (Witness) \_\_\_\_\_

174 (Witness) \_\_\_\_\_