Veronica E. Williams, Esq.
VIRGINIA LIFE CARE PLANNING
The Center for Elder Law & Estate Planning
A Professional Limited Company

PROACTIVE ADVOCACY IN THE CONTEXT OF ADVANCED DIRECTIVES

TABLE OF CONTENTS

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1. **Statutory Definition** – "Advance directive" means (i) a witnessed written document, voluntarily executed by the declarant in accordance with the requirements of § 54.1-2983 or (ii) a witnessed oral statement, made by the declarant subsequent to the time he is diagnosed as suffering from a terminal condition and in accordance with the provisions of § 54.1-2983.[1]

2. **The Principle of Patient Autonomy versus the frowned upon concept of paternalism**:

   a. **Patient autonomy in the context of the medical provider(s):** Patient autonomy is the right of patients to make decisions about their medical care without their health care provider trying to influence the decision. Patient autonomy does allow for health care providers to educate the patient but does not allow the health care provider to make the decision for the patient. (*Medline definition quoted in uploaded Harvard Health article).*

   b. **Patient autonomy in the context of the surrogate decision maker:** The principles of patient autonomy are equally applicable to decisions made by a surrogate decision maker, or medical agent, on behalf of a patient. Absent a thorough understanding of the principle of patient autonomy and the contrasting principle of paternalism, a surrogate decision maker is not properly equipped to serve or advocate against paternalism.

   c. **The import of the agent selection process**: The principal needs to have a thorough understanding of the concept of patient autonomy in order to effectively engage in the agent selection process (so that prospective agents who are likely unwilling to honor patient autonomy can be properly eliminated from consideration).

[1] Virginia Code §54.1-2982

3. **Drafting considerations:**
    a. Absent evidence that an agent is unsuitable, an advance medical directive provides the benefit of probate avoidance in the guardianship / conservatorship context when coupled with documents granting financial authority.

    b. Estate planning versus life care planning - A Last Will & Testament without an advance directive and a financial power of attorney is not comprehensive estate planning. It is limited to death planning only. Accordingly, it provides no authority, short of a guardianship petition, for trusted individuals, to act on the patient's behalf in a time of medical crisis.

    c. Properly drafted an advance medical directive can also provide proactive advocacy in the unenviable event of a conflict, between the patient's chosen surrogate decision makers and medical providers, regarding the patient's care and/or discharge planning.

    d. **The requisites of document execution**[2] - A written advance directive shall be signed by the declarant in the presence of two subscribing witnesses, and may:

        i. specify the health care the declarant does or does not authorize; and;
        ii. appoint an agent to make health care decisions for the declarant; and;
        iii. specify an anatomical gift, after the declarant's death, of all of the declarant's body or an organ, tissue or eye donation.

    e. In addition to the above, a written advance directive may specifically authorize agent to do anything to carry out the principal's decisions, including but not limited to the following:[3]

        i. Releasing medical records
        ii. Making decisions regarding who may visit[4]
        iii. Granting releases of liability

    f. **Oral advance directives**[5]
        i. Patient has been diagnosed as being terminal by attending physician, and;
        ii. Statement made in the presence of physician and two witnesses.

[2] Virginia Code §54.1-2983
[3] Virginia Code §54.1-2983
[4] Must be specified in medical power
[5] Virginia Code §54.1-2983

iii. Statement may appoint agent and/or specify medical care and treatment authorized or not authorized.

g. **Whose direction shall a physician follow in the case of <u>a patient who protests</u> a medical care or treatment decision made by his or her agent**?[6]

i. A patient's agent may make a health care decision over the protest of a patient who is incapable of making an informed decision if:

1. The patient's advance directive explicitly authorizes the patient's agent to make the health care decision at issue, even over the patient's later protest, and;

2. the patient's attending physician or licensed clinical psychologist attested in writing at the time the advance directive was made that the patient was capable of making an informed decision and understood the consequences of the provision;

3. The decision does not involve withholding or withdrawing life-prolonging procedures; and

4. The health care that is to be provided, continued, withheld or withdrawn is determined and documented by the patient's attending physician to be medically appropriate and is otherwise permitted by law.

ii. In cases in which a patient has not explicitly authorized his agent to make the health care decision at issue over the patient's later protest, a patient's agent or person authorized to make decisions **<u>pursuant to the default statute</u>** may make a decision over the protest of a patient who is incapable of making an informed decision **<u>only if</u>**:

1. he decision does not involve withholding or withdrawing life-prolonging procedures;

2. The decision does not involve (i) admission to a facility as defined in § 37.2-100 or (ii) treatment or care that is subject to regulations adopted pursuant to § 37.2-400;

[6] Virginia Code §54.1-2986.2

3. The health care decision is based, to the extent known, on the patient's religious beliefs and basic values and on any preferences previously expressed by the patient in an advance directive or otherwise regarding such health care or, if they are unknown, is in the patient's *best interests*;

4. The health care that is to be provided, continued, withheld, or withdrawn has been determined and documented by the patient's attending physician to be medically appropriate and is otherwise permitted by law; and;

5. The health care that is to be provided, continued, withheld, or withdrawn has been affirmed and documented as being ethically acceptable by the health care facility's patient care consulting committee, if one exists, or otherwise by two physicians not currently involved in the patient's care or in the determination of the patient's capacity to make health care decisions.

h. Legal terms of art:
   i. Mechanical life support[7]
   ii. Use of precatory language versus mandatory language to empower surrogate decision maker(s)

i. Triggering or springing language:
   i. To initiate surrogate decision maker's authority[8]
   ii. To require action on the part of a medical provider

j. Consider focusing upon ensuring the document provides a solid grant of authority to a trusted surrogate decision maker(s) instead of attempting to specify medical care and treatment preferences.

k. Counsel and equip your client regarding the agent selection process, and the importance of communicating with those agent(s) about their wishes.

l. Storage / Accessibility of the document(s):
   i. Virginia registry and/or National registry
   ii. Private registry (*See sample wallet medication card at* ***Enclosure 2*** *as an alternative to advertised benefit of private registry*)

[7] Virginia Code §54.1-2982
[8] Virginia Code §54.1-2983.2

iii. Wallet card identifying agent (*See sample wallet card at* ***Enclosure 1***)
iv. Recordation at Courthouse[9]

m. Revocation of an advance medical directive[10]
   i. by a signed, dated writing; or;[11]
   ii. by physical cancellation or destruction of the advance directive by the declarant or another in his presence and at his direction; or;
   iii. by oral expression of intent to revoke.

4. **Who is the surrogate decision maker in the absence of an advance directive?** In such a case, the state statute specifies the surrogate decision maker(s).[12] *(See Chart at* ***Enclosure 3****)*

   a. Best interest standard[13]
   b. Limited authority - Cannot prohibit visitation[14]

5. **What important question is often not asked of clients as they prepare advance directives?** In the event of a conflict between the medical care providers and the family, regarding the patient's care and treatment, whose decision would the patient want to control?

   a. It is commonly understood that patient autonomy, as opposed to paternalism, is the principle that is to be followed in terms of medical decision making. In the context of advanced directives, this speaks to the authority of a patient as expressed through the surrogate decision maker:

      i. Patient autonomy – freedom of choice, self-determination.

      ii. Client education is recommended in the context of the possibility that the surrogate decision maker may be asked to articulate the basis of decisions, on behalf of a patient, in a paternalistic setting[15]
      iii. Paternalism – An undesirable outcome, one individual assumes the right to make decisions for another.[16]

[9] Practice tip – execute multiple copies as Court house will only record an original.
[10] Virginia Code §54.1-2985
[11] If document has been submitted to registry, revocation must be notarized, but is valid without notarization.
[12] Virginia Code §54.1-2986.1
[13] Virginia Code §54.1-2986.1
[14] Virginia Code §54.1-2986.1
[15] Virginia Code §54.1-2986.1
[16] Wolters Kluwer, Health by Lippincott, Williams and Wilkins, Chapter 4, Ethical Issues

6. **Other forms of advance medical decision making**:
   Client education is important in terms of the various forms of other documents that may serve as advance medical directives, or override them, even if they do not meet the statutory definition of an advance directive. *(See chart at **Enclosure 4**)*

7. **DNR's:**
   a. DNR Fact Sheet *(See **Enclosure 5**)*

   b. Unethical use of DNR's[17]

   c. Distinguish between the Do Not Resuscitate Order (DNR) and the Durable Do Not Resuscitate Order (DDNR)[18]

8. **Potential Conflicts of Interest:**
   a. Facility staff:

      i. Chaplain/ethicists who are employed by the patient's treating medical facility[19]

      ii. Nurses are often placed in situations where they are expected to be agents for patients, physicians, and the organization simultaneously, all of which may have conflicting needs, wants, and goals.[20]

   b. Opportunity for client education in estate planning context

9. **Potential for Unanticipated Consequences:**
   a. Client education is important in terms of the danger of inadvertently undermining the authority of a surrogate decision maker.

   b. Voluntary Advance Care Planning in conjunction with the Annual Medicare Wellness Visit:

   c. Can occur outside of the context of a Medicare beneficiary[21]

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[17] American Medical Association (AMA) Code of Medical Ethics, Opinion 5.4. https://www.ama-assn.org/delivering-care/orders-not-attempt-resuscitation-dnar
[18] Virginia Code §54.1-2987.1
[19] American Medical Association (AMA) Code of Medical Ethics, Opinion 2.1.2 https://www.ama-assn.org/delivering-care/orders-not-attempt-resuscitation-dnar
[20] Wolters Kluwer, Health by Lippincott, Williams and Wilkins, Chapter 4, Ethical Issues

10. <u>Conflicts Regarding Care</u>:

a. The case when family members are not likely to be on one accord – The impetus for proactive preparation of advance directives.

b. The case when the family and the facility are not on one accord about care and/or discharge decisions – The case of unanticipated paternalism:

i. What can undermine a surrogate decision maker's authority?[22]

ii. Is there statutory provision that could conceivably permit a physician to withdraw a patient life support against the patient's wishes ?

iii. What procedures are legally required when a physician refuses to honor the wishes of patient or a patient's surrogate decision maker?[23]

[21] American Medical Association (AMA) Code of Medical Ethics, Opinion 5.1 https://www.ama-assn.org/delivering-care/advance-care-planning

[22] American Medical Association (AMA) Code of Medical Ethics, Opinion 2.1.2 https://www.ama-assn.org/delivering-care/orders-not-attempt-resuscitation-dnar

[23] Virginia Code §54.1-2987, Virginia Code §54.1-2990

Cut along dotted line and carry in your wallet

Notice to Health Care Providers:

I, _____, have executed an advance medical directive and have given a copy of such document to:

_____ ( ) _____

Name Phone

_____

Address

_____ ( ) _____

Name Phone

_____

Address

See other side for additional information

( )

Name Phone

Address

Signed

Date

Other Important Information: **What medications should I include?** Prescription medicines Over-The-Counter medicines Vitamins Herbal remedies Nutrition pills Respiratory therapy medicines (such as inhalers) Blood factors (such as Factor VIII) IV solutions IV nutrition	**Date of Most Recent Adult Immunizations:** Pneumonia: Tetanus: Hepatitis: Flu: **Allergies:**	**Doctors:** Name: Phone: Name: Phone: Name: Phone: **Pharmacies:** Name: Phone: Name: Phone:

Wallet Medication Card

Name:

Phone:

Emergency Contact Name:

Emergency Contact Phone:

----------Fold here first----------

----------Fold here first----------

Start date	**Drug Name & (Strength)**	**Dose** (pills, units, puffs, drops)	**When do you take it?** How many times a day? Morning & night? After meals?	**Reason** Why do you take it?	**Start date**	**Drug Name & (Strength)**	**Dose** (pills, units, puffs, drops)	**When do you take it?** How many times a day? Morning & night? After meals?	**Reason** Why do you take it?
1/1/06	Medicine (40 mg) **(Example)**	2 pills	Once a day with dinner	Heart					

HEALTH CARE DECISION MAKING ALTERNATIVES

STATUTORY DEFAULT - Va. Code § 54.1-2987

If (1) The patient is incapable of making an informed decision, and

(2) There is no advance medical directive, or

(3) *Has an advance directive that: (i) is silent on the health care at issue, and (ii) does not appoint an agent, then*:

The Virginia Code states that the attending physician provide, continue, withhold, or withdraw health care upon the authorization of the following persons, in order of priority:

1. A guardian (*medical facilities can't require appointment*); or
2. The patient's spouse (*except where divorce is pending*), or
3. An adult child of the patient, or
4. A parent of the patient, or
5. An adult brother or sister of the patient, or
6. Any other relative of the patient in the descending order of blood relationship, or
7. *Except in end-of-life cases, any adult, except health care providers currently involved in patient's care who (i) has exhibited special care/concern, and (ii) is familiar with the patient's religious beliefs, basic values, and preferences previously expressed by patient regarding health care to extent known. Facility patient care consulting committee quorum, or two disinterested physicians shall determine whether a person meets these criteria*.

In the event of disagreement at the same level, the majority vote rules.

HEALTH CARE ADVANCE DIRECTIVES

LIVING WILL	MEDICAL POWER OF ATTORNEY (MPOA)	READILY AVAILABLE FORMS ADVANCE DIRECTIVE FORMS	PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POST)	MEDICARE SPONSORED ADVANCE CARE PLANNING
• Previously only terminal, futile care, end-of-life situations • Patient unable to make decisions • NO AGENT !!!	• Non-terminal treatment and/or end-of-life decisions • Patient unable to make decisions • Agent has authority	• "Best interests" language used as opposed to "substituted judgment" language. • Attempts to speculate regarding specified care	• Physician's order in medical record • Can be signed by surrogate decision maker, or agent, instead of patient.	• Part of initial Medicare annual wellness visit • Medical record annotation or physician's order • Possible unanticipated result - could undermine authority

OPPOSING VIEWS - DO NOT RESUSSITATE (DNR'S) ORDERS

The American Medical Association (AMA) states, as follows, in its Code of Medical Ethics Opinion about Order Not to Attempt Resuscitation (DNAR):

"Reinforce with the patient, loved ones, and the health care team that DNAR orders apply only to resuscitative interventions as they relate to the patient's goals for care. Other medically appropriate interventions, such as antibiotics, dialysis, or appropriate symptom management will be provided or withheld in accordance with the patient's wishes." American Medical Association Code of Medical Ethics Opinion 5.4

In the year 2012, the AMA code of ethics read as follows with regard to DNR Orders

The American Medical Association states in its code of ethics, E-2.22 DNR Orders:

"DNR orders and a patient's advance refusal of CPR preclude only resuscitative efforts after cardiopulmonary arrest and should not influence other medically appropriate interventions, such as pharmacologic circulatory support and antibiotics, unless they also are specifically refused…" American Medical Association Ethics rule 2.22

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1. Mary Catherine Beach, MD, Assistant Professor at the Bloomberg School of Public Health at John Hopkins University and Sean Morrison, MD, Hermann Merkin Professor of Palliative Care at Mount Sinai School of Medicine, wrote in their Dec. 2002 article, "The Effect of Do-Not-Ressucitate Orders on Physician Decision-Making," that appeared in the *Journal of the American Geriatrics Society*:

"Patients with DNR orders were significantly less likely to be transferred to an intensive care unit, to be intubated, or to receive CPR. In some scenarios, the presence of a DNR order was associated with a decreased willingness to draw blood cultures...central line placement...or blood transfusion... The presence of a DNR order may affect physicians' willingness to order a variety of treatments not related to CPR."

2. Hospice Patients Alliance President Ron Panzer wrote in his Jan. 30, 2006 article entitled "Dancing with Death" that appeared on the Hospice Patients Alliance website:

"Some people should be allowed to die when it truly is the end. But that 'logic' can be, and is, abused. People are labeled as 'DNR' inappropriately so that even minimal, ordinary treatments like providing food and water are denied them with the intent that they die sooner, ... much sooner. "

3. Wesley Smith, JD, Consultant to the International Anti-Euthanasia Task Force, wrote in his Nov. 23, 1998 article, "Futile Care: Who Decides?" that appeared in Canada's National Post:

"Imagine your husband is in a hospital, struggling against a debilitating or life-threatening disease. If something goes wrong, you tell the doctor to do what he can because your husband wants to live. But the doctor says no, he does not believe that the quality of your husband's life is worth doing as you ask. Indeed, he is so adamant, he puts a Do Not Resuscitate (DNR) order on your husband's medical chart over your objections, meaning that if he suffers a cardiac arrest or some other life-threatening event, he plans to stand by idly and watch your husband die. Frightening stuff. Unfortunately, it is also true."

THE OPPOSING VIEW

4. David Muller, MD, Chair of Medical Education at Mount Sinai School of Medicine, wrote in his Sep.-Oct. 2005 article, "Do NOT Resuscitate," that appeared in *Health Affairs*:

"Preparing for death has its own ritual. It requires many family meetings, innumerable phone calls, lots of reassurance, and a great deal of reinforcement. It is critical that the family and patient have easy and immediate access to a nurse and doctor, as well as proper documentation at home on the patient's wishes about resuscitation, including--and this is essential--an out-of-hospital DNR form...

New York is one of the more than twenty states that has an out-of-hospital DNR law intended to ensure that emergency medical services (EMS) personnel do not resuscitate terminally ill people at home against their wishes...

The option to refuse cardiopulmonary resuscitation (CPR) exists because of resuscitation's dismal success rate: only 1-2 percent for out-of-hospital sudden cardiac death. And that's for a typically healthy businessman who collapses on the subway platform from a heart attack, not for someone dying of a terminal illness."

5. Mark Hilberman, MD, Anesthesiologist at Delano Regional Medical Center, wrote in his Dec. 1997 article entitled "Marginally Effective Medical Care: Ethical Analysis of Issues in Cardiopulmonary Resuscitation (CPR)," that appeared in the *Journal of Medical Ethics*:

"Cardiopulmonary resuscitation is a rough, some would say abusive, intervention. When life is snatched from death, this is inconsequential. However, cardiac arrest normally precedes death and providers are appropriately disturbed when they perform CPR on people afflicted by advanced illness, the debilities of old age, or dementia…

Since the decision not to perform CPR is irreversible, it is appropriate for there to be a bias toward its initiation. However, the extensive outcomes literature and ethical analysis justify a more limited application of CPR than do present DNR policies."

DURABLE MEDICAL POWER OF ATTORNEY

I, _____, of _____, appoint my _____, _____, as my primary agent to make health care decisions on my behalf as authorized in this document. In the event that my _____, _____, is not available, I appoint my _____, _____, to serve as my successor agent to make decisions on my behalf.

All references herein to my "agent" shall also refer to my "successor agent." *This document revokes all previous advance medical directives*.

I have specifically chosen not to execute a Living Will Advance Medical Directive, pursuant to Virginia's Health Care Decisions Act as it is my desire that my agent(s), if the need arises, have the sole authority to make decisions based upon the facts and circumstances that may exist at that time. My agent(s) shall not have the authority to execute a POST form or a POLST document. *My agent shall have the authority to delegate tasks set forth within this advance medical directive to other individuals.*

It is important to note that I do not consider artificial nutrition and hydration to be mechanical life support. To the contrary, I consider them to be food and water. My agent is well aware of my wishes, philosophy, and probable decision-making process as it relates to issues such as changing my code status and/or the withdrawal of life support. Please know that it is extremely important to me that my agent, under this medical power of attorney, have sole authority to speak on my behalf regarding health care decisions (to include end-of-life type decisions). Therefore, under no circumstances shall an outside party (including but not limited to an ethics counselor or committee, patient care consulting committee, etc.) override my agent's decision-making process or authority. I direct that medical professionals educate my agent on the objective medical facts regarding my condition and then allow my agent to apply my wishes, philosophy, and probable decision-making process to those facts.

Additionally, I direct that my agent is not required to articulate my wishes, philosophy, and probable decision-making process to any third party or medical professional (including but not limited to ethics counselors and committees and patient care consulting committees). I direct that my agent's only duty, in the event that he or she is asked to consider changing my code status and/or withdraw life support, is to state his or her final decision on my behalf; more specifically, my agent shall not be required to justify or explain the underlying basis for his or her final decision other than to state that he or she believes it reflects what I would want, and that his or her opinion regarding what I would want is based upon our emotionally intimate relationship.

Under no circumstances, shall a physician's order or notes written by a medical professional, medical team, etc…, in my medical records or otherwise, override or take precedence over the expression of patient autonomy, on my behalf, by my family and/or health care agent. I sincerely believe that the emotionally intimate nature of my relationship with my family and/or health care agent affords a more current and/or in-depth insight into my probable health care decision making processes as well as the decisions I would ultimately make than would an order or notes written in my medical records by a medical professional. As a result, after careful consideration, I have executed this document to expressly prohibit any action that would result in the decisions of my family and/or health care agent being overridden by a medical professional(s), ethics committee, patient care consulting committee, or other similar entity.

In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent may consider the medical diagnosis and prognosis and any information provided by my physicians as to intrusiveness, pain, risks, and side effects associated with treatment or non-treatment. If my agent cannot determine what treatment choice I would have made on my own behalf, then my agent shall make a choice for me based upon what my agent, in his or her sole and un-reviewable discretion, believes I would have wanted.

TO WIT: The powers of my agent shall include the following:

A. To consent to or refuse or withdraw consent to any type of medical care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or

other procedures that affect any bodily function, including, but not limited to, artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to the administration of dosages of pain-relieving medication in excess of standard dosages in an amount sufficient to relieve pain, even if such medication carried the risk of addiction or inadvertently hastens my death;

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

C. To employ and discharge my health providers, and to authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, adult home or other medical care facility; and;

D. To restrict or eliminate the hospital visitation rights of individuals;

E. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medial providers.

F. To act as my authorized agent in order to access any protected health care information ("PHI") under the Health Insurance Portability and Accountability Act (known as "HIPAA").

Further, my agent shall not be liable for the costs of treatment pursuant to my agent's authorization, based solely on that authorization.

This durable power of attorney advance directive for making health care decisions shall not terminate in the event of my disability.

If any Court determines that it is necessary to appoint someone to serve as guardian of my personal affairs, including responsibility for making decisions regarding my support, care, health, safety, habitation, education, therapeutic treatment, and residence, I request the court to give primary consideration to the person serving as my agent hereunder.

By willfully and voluntarily signing, the following page, on this _____day of _____, 201__, I indicate that I am emotionally and mentally competent to make this durable medical power of attorney and that I understand the purpose and effect of this document.

_____
Declarant

This power of attorney was signed by the declarant in my presence.

_____
Witness

_____
Witness

STATE OF _____:

CITY OF _____:

The foregoing durable medical power of attorney was personally signed and acknowledged before me on this _____ day of _____, 201____ by the above named declarant and witnesses.

_____
Notary Public

My commission expires _____.

DOCUMENTATION OF
ORAL ADVANCED DIRECTIVE
EXECUTED
IN ACCORDANCE WITH
§ 54.1-2983 OF THE CODE OF VIRGINIA

The Code of Virginia, in § 54.1-2983, provides as follows with regard to the execution of Oral Advance Directives:

> "…Further, any adult capable of making an informed decision who has been diagnosed by his attending physician as being in a terminal condition may make an oral advance directive (i) directing the specific health care the declarant does or does not authorize in the event the declarant is incapable of making an informed decision, and (ii) appointing an agent to make health care decisions for the declarant under the circumstances stated in the advance directive if the declarant should be determined to be incapable of making an informed decision. An oral advance directive shall be made in the presence of the attending physician and two witnesses."

Accordingly, _____, of _____, Virginia 23123, meets the criteria, according to § 54.1-2983 of the Code of Virginia, as cited above, for being able to execute an oral advance directive based upon the following facts:

1. He has not been adjudicated incapable of making an informed decision, and;
2. He has been diagnosed, by his neurologist, as having Amyotrophic Lateral Sclerosis (ALS), also commonly known as Lou Gehrig's disease and commonly understood to be a terminal diagnosis.
3. He appointed _____, his brother to serve as his agent to make health care decisions for him and to exercise substituted judgement on his behalf in the event that he is ever determined to be incapable of making an informed decision.
4. He communicated his appointment through a combination of verbal and non-verbal communications, such as pointing and lifting his arms and making oral utterances.
5. He communicated his appointment in the presence of the attending physician and two witnesses as set forth on the following page.

I attended the patient, _____, on the _____ day of _____, 20__, in my role as a physician with Visiting Physician's Association. The patient, _____, appointed Mr. _____, to serve as his agent for medical decision making in the event that he should become incapable of making an informed decision. The patient, _____, communicated his decision that Mr. _____ be appointed to serve as his medical agent, in my presence, and in the presence of two witnesses, through a combination of verbal and non-verbal communications such as pointing his finger, lifting his arms, and making oral utterances.

_____
Physician's printed name

_____
Physician's signature

This oral advance medical directive was executed by the bed bound patient, _____, in my presence, and in the presence of the attending physician on the _____ day of _____, 20__. The patient, _____, communicated his appointment of Mr. _____, to serve as his medical agent through a combination of verbal and non-verbal communications such as the pointing of his finger, the lifting of his arms, and oral utterances.

_____ _____
Witness' printed name Witness' printed name

_____ _____
Witness' signature Witness' signature

STATE OF _____:
CITY/COUNTY OF _____:

The foregoing Oral Advance Medical Directive was executed in accordance with § 54.1-2983 of the Code of Virginia. Specifically, _____ executed the Oral Advance Medical Directive in the presence of the attending physician and two witnesses as indicated above, and before me on the _____ day of _____, 20___.

_____
Notary Public

My commission expires: _____.

Code of Virginia
Title 54.1. Professions and Occupations
Subtitle III. Professions and Occupations Regulated by Boards within the Department of Health Professions
Chapter 29. Medicine and Other Healing Arts
Article 8. Health Care Decisions Act

§ 54.1-2990. Medically unnecessary health care not required; procedure when physician refuses to comply with an advance directive or a designated person's health care decision; mercy killing or euthanasia prohibited

A. As used in this section:

"Health care provider" has the same meaning as in § 8.01-581.1.

"Life-sustaining treatment" means any ongoing health care that utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function, including hydration, nutrition, maintenance medication, and cardiopulmonary resuscitation.

B. Nothing in this article shall be construed to require a physician to prescribe or render health care to a patient that the physician determines to be medically or ethically inappropriate. A determination of the medical or ethical inappropriateness of proposed health care shall be based solely on the patient's medical condition and not on the patient's age or other demographic status, disability, or diagnosis of persistent vegetative state.

In cases in which a physician's determination that proposed health care, including life-sustaining treatment, is medically or ethically inappropriate is contrary to the request of the patient, the terms of a patient's advance directive, the decision of an agent or person authorized to make decisions pursuant to § 54.1-2986, or a Durable Do Not Resuscitate Order, the physician or his designee shall document the physician's determination in the patient's medical record, make a reasonable effort to inform the patient or the patient's agent or person with decision-making authority pursuant to § 54.1-2986 of such determination and the reasons therefor in writing, and provide a copy of the hospital's written policies regarding review of decisions regarding the medical or ethical appropriateness of proposed health care established pursuant to subdivision B 21 of § 32.1-127.

If the conflict remains unresolved, the physician shall make a reasonable effort to transfer the patient to another physician or facility that is willing to comply with the request of the patient, the terms of the advance directive, the decision of an agent or person authorized to make decisions pursuant to § 54.1-2986, or a Durable Do Not Resuscitate Order and shall cooperate in transferring the patient to the physician or facility identified. The physician shall provide the patient or his agent or person with decision-making authority pursuant to § 54.1-2986 a reasonable time of not less than 14 days after the date on which the decision regarding the medical or ethical inappropriateness of the proposed treatment is documented in the patient's medical record in accordance with the hospital's written policy developed pursuant to subdivision B 21 of § 32.1-127 to effect such transfer. During this period, (i) the physician shall continue to provide any life-sustaining treatment to the patient that is reasonably available to such physician, as requested by the patient or his agent or person with decision-making authority pursuant to § 54.1-2986, and (ii) the hospital in which the patient is receiving life-

sustaining treatment shall facilitate prompt access to the patient's medical record pursuant to § 32.1-127.1:03.

If, at the end of the 14-day period, the conflict remains unresolved despite compliance with the hospital's written policy established pursuant to subdivision B 21 of § 32.1-127 and the physician has been unable to identify another physician or facility willing to provide the care requested by the patient, the terms of the advance directive, or the decision of the agent or person authorized to make decisions pursuant to § 54.1-2986 to which to transfer the patient despite reasonable efforts, the physician may cease to provide the treatment that the physician has determined to be medically or ethically inappropriate subject to the right of court review by any party. However, artificial nutrition and hydration may be withdrawn or withheld only if, on the basis of physician's reasonable medical judgment, providing such artificial nutrition and hydration would (a) hasten the patient's death, (b) be medically ineffective in prolonging life, or (c) be contrary to the clearly documented wishes of the patient, the terms of the patient's advance directive, or the decision of an agent or person authorized to make decisions pursuant to § 54.1-2986 regarding the withholding of artificial nutrition or hydration. In all cases, care directed toward the patient's pain and comfort shall be provided.

C. Nothing in this section shall require the provision of health care that the physician is physically or legally unable to provide or health care that the physician is physically or legally unable to provide without thereby denying the same health care to another patient.

D. Nothing in this article shall be construed to condone, authorize, or approve mercy killing or euthanasia or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

E. Compliance with the requirements of this section shall not be admissible to prove a violation of or compliance with the standard of care as set forth in § 8.01-581.20.

1983, c. 532, § 54-325.8:10; 1988, c. 765; 1992, cc. 748, 772; 1999, c. 814;2000, cc. 590, 598;2009, cc. 211, 268;2018, cc. 368, 565.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

HARVARD HEALTH BLOG

Take control of your health care (exert your patient autonomy)

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Autonomy means being in control of your own decisions without outside influence — in other words, that you are in charge of yourself. It is considered an essential development step toward maturity. We all make decisions about how to live our lives, although sometimes we have less choice than we might like.

When it comes to your health care, how much autonomy is the right

amount?

There's lots of interest in what the term means. Here's a definition from MedicineNet:

> Patient autonomy: The right of patients to make decisions about their medical care without their health care provider trying to influence the decision. Patient autonomy does allow for health care providers to educate the patient but does not allow the health care provider to make the decision for the patient.

This can be a hard line to navigate. In the past, physicians made all the decisions for their patients. They would plan the care, prescribe the treatment, and the patient would either comply or not. The word "comply" is itself pejorative. We have moved into a much more enlightened era of care, and many physicians seek to involve patients, to help them understand treatment options, and to work collaboratively to achieve goals of wellness.

When you and your doctor don't see eye to eye on the best health care for you

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c continues to rage in parts of the world, it is slowly retreating in the
-authorized vaccines, including one for children as young as 12. The
arly as effective in the real world as they were in clinical trials. The
ition measures, particularly for people who are fully vaccinated, and
ile, scientists continue to explore treatments and to keep an eye on

But what if you and your physician don't agree on the best course of care for you? What if your doctor insists that she knows best, and that your health will be at risk if you don't follow her advice? Maybe your physician has discouraged you from researching your medical condition yourself. From the physician's angle, most of us want our patients to understand their illness, be educated on goals of wellness, and be active participants in their own healthcare. But here's where it gets tricky: physicians study for years to become doctors and bring their scientific knowledge and clinical acumen to the office and the bedside. Patients may not have those skills, but they know their own bodies, tolerance for treatment, and the manner in which they are comfortable receiving care.

Finding the right doctor

It's sometimes hard to find a doctor you're comfortable with, whether it's for you or your child. Making a list of what's important to you — whether you have a physician you like now, are uncomfortable in your current treating situation, or are in the process of looking for a new provider — can really help. Ask yourself these questions:

What is my style about health care? Do I want my doctor to tell me what to do, list the options but give me the final choice, or let me describe the medication and plan that I have researched first?

Would I like someone who is more relational or more boundaried? Do I want a physician who has the style of sharing his own life with me, asks about my life and tries to incorporate who I am as a person as well as a patient, or would I prefer a more businesslike approach? Do I want my physician to tell me if she has the same illness I do, and what it's like for her, or would I prefer my doctor keep this to herself?

How much do I want my doctor to know about me as a person? Is that important in the way I want to receive my health care?

What might happen if I disagree with my doctor? Would that end the treating relationship right there, or could we work through a difference?

The right doctor will naturally support your patient autonomy

Figuring out how you want your physician to work with you lets you maintain your patient autonomy, whatever that autonomy might be. Receiving the kind of care that is comfortable for you is exercising your autonomy. There will always be blips along the way. One woman told me

about a primary care doctor she had worked with for years who became enraged with her at a visit, seemingly out of the blue. She felt he was attacking her health care behavior without asking appropriate questions. She offered him several opportunities during the visit to re-evaluate his comments. When he couldn't do so, she used her autonomy to fire him. Another patient described being told that if he did not take a specific medication, the outcome could be devastating for his health. This may have been true, but perhaps a more collaborative discussion would have allowed this patient to feel less bullied into a treatment. Feeling comfortable with your right to get the answers you need to understand your treatment reflects your patient autonomy. Make sure your doctor's style matches your own. How the **treating** *relationship* works is an essential part of the treatment. If it works, everything is enhanced. If your autonomy is not respected, your health care will suffer.

Comments

Hornibrooks Tools & Fasteners

May 09, 2018

We agree with you. Our body is the only fundamental home we have now, that's why we need to control it! Great blog!

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