

**Attached you will find a copy of the Virginia Advance Medical Directive, along with an information sheet about Advance Directives entitled “Your Right to Decide.”**

**If you should have questions about Advance Medical Directives or would like help in completing an Advance Directive, please tell your nurse.**

## Your Right To Decide—Communicating Your Health Care Choices

In 1990, Congress passed the Patient Self-Determination Act. It requires health care institutions to tell patients and the people in their communities about their rights under Virginia law to make decisions about their medical care. These rights include the right to accept or refuse care and the right to make advance directives about their care.

### **How Do I Exercise My Health Care Rights?**

Under Virginia law, “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.” Doctors help their patients to exercise about medical treatment they are recommending. When you then agree to the recommended treatment, you have given your **informed consent**. You also have the right to refuse the recommended treatment.

### **What Happens If I Cannot Give My Consent?**

Many people worry about what would happen if, due to mental, physical or emotional problems, they are unable to tell their doctor whether they want or don’t want recommended medical treatment. Under a Virginia law called the Health Care Decisions Act, if you are an adult you may sign a document that makes your choices about treatment known to your doctor and family in advance. In that document, you also can name someone you trust to make these decisions for you if you become unable to express your wishes yourself. This document is known as an **“advance directive”**.

The Health Care Decisions Act became law in 1992, but most of the decision-making rights contained in it have existed in Virginia for several years under other laws. The Health Care Decisions Act combines these laws to bring them together in one place and to be sure that they do not disagree with each other. Any advance directive made under the old laws is still valid.

This brochure describes advance directives and answers some questions about them. If you have questions about advance directives that it does not answer, you may ask those in charge of your health care or call your local hospital for more information. You also may wish to talk about advance directives with your family, your doctor, or a lawyer.

### **How Do I Make My Choices About Life-Prolonging Treatment Known?**

The Virginia Health Care Decisions Act allows you to make two types of decisions about your health care in an advance directive. The first type of decision you can make tells people how to care for you if you ever have a **terminal condition** and you are unable to make decisions for yourself. This document is often called a **“living will”**. A **terminal condition** is an incurable condition in which death is imminent. It also means a **persistent vegetative** state, which some people call a permanent coma, even when death is not imminent. In either case, a doctor has determined that there is no medically reasonable hope for recovery.

Signing this type of advance directive permits you to decide in advance whether you want doctors to give you what the law calls **“life-prolonging procedures”**.

### **What are “Life-Prolonging Procedures?”**

These are treatments that aren’t expected to cure a terminal condition or make you better and that only prolong dying. They include hydration (giving water) and nutrition (giving food) by tube, machines that breathe for you, and other kinds of medical and surgical treatment. Life-prolonging procedures do not include treatments needed to make you comfortable or to ease pain. Your doctor will give you treatment or drugs to ease pain and make you comfortable unless you say in your advance directive that you do not want them. You can also say in this type of advance directive that you want to have particular life-prolonging procedures given to you. For example, if you want to have all life-prolonging procedures except tube feeding withdrawn, you may say that in your advance directive.

### **Will an Advance Directive Help Me if I Do Not Have a Terminal Condition?**

Yes, The Health Care Decisions Act permits you to make a second kind of decision in an advance directive. You may name someone to make treatment decisions – to accept or refuse medical care – for you if at some point you cannot make them yourself. This type of advance directive is often called a **“medical power of attorney”** a **“durable power of attorney for health care”** or a **“health care proxy”**. The person named in this type of advance directive can make all health care decisions for you that you could have made for yourself if you were able, whether or not you are terminally ill. Or you may direct instead that he or she make only those decisions you list. The law says that the person you choose cannot make decisions that he or she knows go against your religious beliefs, basic values and stated preferences. You also may name a person who will see that your organs or your body are donated, as you wish, after your death.

## **How Do These Two Types of Advance Directives Differ?**

The first type of advance directive – known as the living will – is only followed when you have a terminal condition and only deals with life-prolonging procedures.

The second type of advance directive – often called a durable power of attorney for health care – covers those cases and also covers situations where you can't make treatment decisions for yourself but do not have a terminal condition, such as when you have an accident or take a drug that leaves you unconscious. It also covers more than decisions about life-prolonging procedures. It will cover any decisions you want it to cover. If you wish, the person to whom you give a durable power of attorney for health care could make any decisions about your health care that you could have made yourself.

### **Will My Advance Directive be Followed in an Emergency If I Cannot Make My Wishes Known?**

Usually emergency medical personnel, such as rescue squads or ambulance teams, cannot follow your wishes in an advance directive if they are called to help you in an emergency. Also, hospital emergency providers may not know your wishes in an emergency. But if you have a terminal or serious condition, under certain circumstances you can make decisions in advance about refusing one type of emergency medical care – resuscitation if your heart stops beating or you stop breathing. You do this by having your doctor complete a “**Do Not Resuscitate Order**” (often called a “DNR order”) for you on a form approved by the state. Your doctor also may write a DNR order to be followed in a hospital or nursing home. This order is valid unless you revoke it – that is, you change your mind and tell your doctor that you do want to be resuscitated.

### **If I Die Because I Refused Life-Prolonging Treatment Under the Health Care Decisions Act, Will My Death Be Considered Suicide?**

No. The Health Care Decisions Act specifically says that, if it is followed and the patient dies, the death are not suicide. Following the Act will not void a life insurance policy even if the policy says otherwise.

### **Must an Advance Directive be in Writing?**

No. The Health Care Decisions Act allows people who have a terminal condition and who never sign an advance directive to make an oral advance directive. They may say what they want, or name a person to make decisions for them, in front of witnesses.

### **Must I Have an Advance Directive?**

No. An advance directive is just one way of being sure your doctors and your loved ones know what health care you want when you can't tell them yourself. You may have only one or both of the two types of advance directives. The law requires that health care providers not discriminate against people based on whether they have or do not have an advance directive.

### **What Happens If I Can't Make Decisions and I Have No Advance Directive?**

Virginia law lists persons such as guardians or family members who may make decisions about your medical care even if you have no advance directive. If no listed person is available to decide for you, a judge can decide what treatment is best.

### **Do I Need a Lawyer to Help Me Make an Advance Directive?**

A lawyer is helpful, but you don't have to have a lawyer prepare either type of advance directive. In fact, the Health Care Decisions Act gives a suggested form that you may use.

### **What If I Change My Mind After I Sign an Advance Directive?**

You can revoke it. If you want to, you can make a new one. If you are a patient or resident in a health care facility, tell your doctor or nurse that you want to revoke or change your advance directive. It is best to destroy all copies of the old one.

### **How Will My Doctor Know I Have an Advance Directive?**

Hospitals and other health care facilities must ask patients or residents if they have an advance directive and, if so, must see that a patient's or resident's medical record shows that they have one. In any case, you should give copies of your advance directive to your family and to your doctor, and to anyone else you think needs to know what medical treatment you do or don't want.

### **Where Can I Go For More Information About Advance Directives?**

There are many sources of additional information on advance directives, including your local hospital. You also may wish to talk this over with your physician and lawyer.

You may also contact Mary Washington Hospital's Patient and Guest Relations at 540-741-1442.

**PLEASE  
REMEMBER TO  
BRING YOUR FAMILY  
MEMBER'S  
ADVANCE DIRECTIVE  
TO THE HOSPITAL.  
THANKS!**

## HOW TO COMPLETE THE BASIC MARY WASHINGTON HEALTH CARE ADVANCE DIRECTIVE

The Advance Medical Directive allows you to provide direction for your health care if you become temporarily or permanently unable to express your wishes. This is a short form of the Advance Directive language recommended in Virginia law. There is a longer document that includes direction about mental health care and about what to do if you protest the decisions of my Power of Attorney after you lose capacity. You can choose to complete that form instead of this one, or you can use another form or even write out your wishes yourself. It is a legally valid Advance Directive as long as it is signed, dated, and witnessed by 2 people.

### A. Identifying Information

Write your name on the first line as the person who is completing the Advance Directive.

B. This section enables you to name the person you would want to make health care decisions for you if you are temporarily or permanently unable to speak for yourself. This person can be a relative, but does not need to be related to you. It is important that you select someone who will know your wishes, and who will be able to understand and make decisions about your health care.

1. Fill in the name, address, and telephone number of the person you would like to make health care decisions for you if you cannot speak for yourself and of an alternate if the primary agent is unavailable or unable to serve. Your agent is directed to make decisions based on your desires and preferences, your medical condition, and your beliefs and values.
2. The next section provides a list of powers you can grant to your agent. Mark through any you do not want.
3. If you would like to allow your Medical Power of Attorney/Agent to control your visitors, fill in directions under #9.
4. At the bottom of the page you can give additional directions or powers to your health care agent.

### C. Health Care Instructions

1. #1 gives direction regarding the care you would want provided or withheld if you are determined to be very close to death and medical treatment would not help you recover. Choose the box that represents the kind of care you would want in that situation, or write in your own instructions about what you would or would not want.
2. #2 gives you the opportunity to indicate what kind of care you would want if your condition makes you unaware of yourself or your surroundings, and it is reasonable certain that you will never recover this awareness even with medical treatment. Choose the box that represents the kind of care you would want in that situation, or write in your own instructions about what you would or would not want.
3. This section gives you an opportunity to indicate treatments you do or do not want under certain circumstances, even if you are not terminally ill or permanently unresponsive. Write in any directions you would like here.

### D. Affirmation and Right to Revoke

1. Date and sign the document.
2. Two adult witnesses should sign and print their names. They must be 18 or over, but can be a spouse, blood relative, or member of your health care team. You do NOT need a notary or attorney to help complete this form.
3. Once you have completed your Advance Directive, give copies to your Health Care Agent, family members, and doctor. Bring a copy when you come to the hospital.
4. Finally, take this opportunity to talk to your family, physician, and Health Care Agent about your health care choices and values, so that they can best honor your wishes.

If you wish to make provisions for mental health care patients, use the Alternate Form for Virginia Advance Medical Directive.  
I, \_\_\_\_\_, willingly and voluntarily make known my wishes in the event that I am incapable  
Printed Name of Individual Making This Advance Directive for Health Care (Declarant)

making an informed decision about my health care, as follows:

(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I AND II BELOW.)

## SECTION I: APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION I IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

### A. Appointment of My Agent

I hereby appoint \_\_\_\_\_

Name of Primary Agent

E-mail Address

Home Address

Telephone Number

as my agent to make health care decisions on my behalf as authorized in this document. If the primary agent named above is not reasonably available or is unable to act as my agent, then I appoint as successor agent to serve in this capacity:

Name of Successor Agent

E-mail Address

Home Address

Telephone Number

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision. In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests.

### B. Powers of My Agent

(IF YOU APPOINT AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. YOU MAY CROSS THROUGH ANY POWERS LISTED BELOW THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.)

The powers of my agent shall include the following:

- To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain. This applies even if this medication carries the risk of additional or of inadvertently hastening my death.
- To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive.
- To employ and discharge my health care providers.
- To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.
- To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
- To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.
- To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.
- To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following direction:  
\_\_\_\_\_  
\_\_\_\_\_
- To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.
- To donate all or part of my body for transplantation, therapy, research or education.

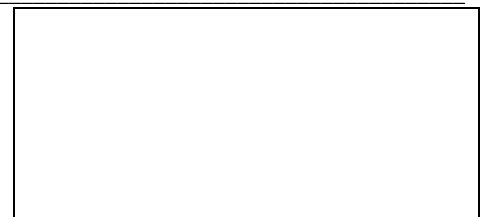
ADDITIONAL POWERS, IF ANY: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Mary Washington Healthcare

Virginia Advance Directive for Health Care – Basic Form



**SECTION II: MY HEALTH CARE INSTRUCTIONS**

*(YOU MAY USE ANY OR ALL OF PARTS 1, 2, OR 3 IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT WISH TO HAVE AN AGENT. IF YOU CHOOSE NOT TO PROVIDE WRITTEN INSTRUCTIONS, DECISIONS WILL BE BASED ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS.)*

1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover: *[CHECK ONLY 1 BOX IN THIS PART 1.]*

- I do not want any treatment to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/ respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable.
- I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)
- [YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO NOT WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover awareness or ability even with medical treatment: *[CHECK ONLY 1 BOX IN THIS PART 2.]*

- I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/ respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable.
- I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest \_\_\_\_\_ as the time after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)
- [YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO NOT WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

3. I provide the following other instructions concerning my health care:

*[YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO NOT WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

**AFFIRMATION AND RIGHT TO REVOKE:** By signing below, I indicate that I understand this document and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

Date \_\_\_\_\_ Signature of Declarant \_\_\_\_\_

The declarant signed the foregoing advance directive in my presence. *[TWO ADULT WITNESSES NEEDED]*

Witness Signature \_\_\_\_\_ Witness Printed \_\_\_\_\_

Witness Signature \_\_\_\_\_ Witness Printed \_\_\_\_\_

*This form satisfies the requirements of Virginia's Health Care Decisions Act. If you have legal questions about this form or would like to develop a different form to meet your particular needs, you should talk to an attorney. It is your responsibility to provide a copy of your advance medical directive to your treating physician. You also should provide copies to your agent,, close relatives and/or friends. This form is provided by the Virginia Hospital & Healthcare Association as a service to its members and the public. (March 2010, [www.vhha.com](http://www.vhha.com))*



**Mary Washington Healthcare**

**Virginia Advance Directive for Health Care – Basic Form**

