Understanding and Planning with Advance Directives: Where the Legal Rubber Meets the Medical Road

Carter Brothers
Spilman Thomas & Battle, PLLC
Roanoke, Virginia
cbrothers@spilmanlaw.com

Nathan Kottkamp
Williams Mullen
Richmond, Virginia
nkottkamp@williamsmullen.com

November 19, 2024

Understanding and Planning with Advance Directives:
Where the Legal Rubber Meets the Medical Road

Carter Brothers has prepared estate plans for clients for 25 years, loving the relational aspect of this practice that invites the lawyer into the family to assist in all aspects of family decision-making. While law schools and tax degrees prepare estate planners for the complex economic and legal issues involved in the management and transfer of family assets in the most tax-efficient way, they have not adequately prepared us to assist with the increasing number of health care decisions that now must be made as part of the traditional estate plan.

In preparing these materials, Carter realized that while he has overseen hundreds, if not thousands, of estate plans and has routinely been asked to assist with the construction, implementation, or administration of wills, trusts, and durable powers of attorney, the same is not true for advance directives. He has yet to be involved in a dispute over an advance directive (whether interpreting, enforcing, or challenging them). After checking with the other estate planners in his firm and local bar, he found the same to be true for a vast majority of other lawyers. But the absence of known disputes to the estate planner does not mean there is an actual absence of disputes over these forms. That is where Nathan Kottkamp fits in.

After completing his undergraduate interdisciplinary ethics degree at William & Mary, Nathan anticipated a career in ethics, specifically serving as an in-house ethicist at a major medical center. In the course of earning his joint JD/MA in Bioethics from the University of Pittsburgh, Nathan shifted his focus to a broader healthcare practice, in which ethics remained a key component. Because of this unique skill set, Nathan has been involved in myriad healthcare matters, particularly those at the intersection of ethics and law. Beginning in his first year as a licensed attorney, he has been a member of several hospital ethics committees, where he participates on a pro bono basis. From his ethics committee experience, Nathan was inspired to found Virginia Advance Directives Day and then National Healthcare Decisions Day, which is in its 15th year (April 16, www.nhdd.org). These events highlight the importance of advance care planning for both professionals and the public. As a result of these experiences, Nathan was appointed to the Advance Directives Task Force Committee of the Supreme Court of Virginia Commission on Mental Health Law Reform, and he was one of the key drafters of the current version of the Virginia Health Care Decisions Act (§§ 54.1-2981 to 54.1-2993.1., the "Act").

I. It All Starts with a Form.

"§ 54.1-2984. Suggested form of written advance directives. An advance directive executed pursuant to [the Act] may, but need not, be in the following form:"

As with most states, Virginia has always had a template advance directive form in its statutes. The Act, which was adopted in 2009, is not different, and § 54.1-2984 sets out the suggested form, which we call the Statutory Template, a copy of which is Exhibit A. The Virginia

Hospital & Healthcare Association prepared another commonly used form for its members that closely follows the Statutory Template with a few changes and a more user-friendly format (the "VHHA Template"), a copy of which is Exhibit B. While the Statutory Template and the VHHA Template follow the Act, they have been criticized for being overly legalistic and written at a reading-level higher than what is needed for a universal document. And because use of the template language is not required, many organizations have developed their own versions of a Virginia advance directive form. The version that probably is the most widely accepted is the version prepared by a collaborative effort of Virginia healthcare attorneys, volunteering on behalf of the Virginia State Bar, and the Virginia Hospital and Healthcare Association. This collaborative effort created several versions with an emphasis on providing additional clarity, easier completion, and standardization of forms. Their most comprehensive version is Exhibit C (the "Collaborative Template").[1] Running down the left-hand side of each page of the Collaborative Template are helpful comments explaining the different provisions and options in completing the advance directive.

Built into the Act, therefore, is the option for individuals to prepare advance directives without assistance from legal counsel. The Act specifically provides that distributing written advance directives and providing technical advice, consultation, and assistance to persons regarding the completion and execution of such forms by health care providers, including their authorized agents or employees, or qualified advance directive facilitators do not constitute the unauthorized practice of law.[2] The Act further declares that ministerial assistance offered to make an advance directive does not constitute the unauthorized practice of law.[3] While ministerial assistance includes reading the form of an advance directive to a person, discussing the person's preferences regarding items in the form, recording the person's answers on the form, and helping the person sign the form and obtain any other necessary signatures on the form, it does not include expressing an opinion regarding the legal effects of any item in the form of an advance directive or offering legal advice to a person completing or executing such form.[4]

These materials will focus primarily on the Statutory Template, as that is the one most estate planners use to build their particular written advance directive. Where helpful, we will point

---

[1] These forms remain available on the Virginia State Bar website: https://www.vsb.org/site/public/healthcare-decisions-day/

[2] § 54.1-2988.1.A. Rules for advance directive facilitators are found in § 54.1-2993.1, which directs the Department of Health to approve a program for the training of qualified advance directive facilitators that includes (i) instruction on the meaning of provisions of the model form and (ii) requirements for demonstrating competence in assisting persons with completing and executing advance directives, including a written examination on information provided during the training program. Various organizations have been approved by VDH to provide training. See, for example, Honoring Choices Virginia at https://honoringchoices-va.org/

[3] § 54.1-2988.1.B.

[4] Id.

out differences in the VHHA Template and the Collaborative Template. We have also included as Exhibit D a form advance directive that attempts to synthesize the various templates into a workable form that can serve as a general form to be modified as required by your particular client's needs.

II. Advance Directive or Advance Medical Directive or Advance Health Care Directive—But (Please!) Not Advanced Directive.[5]

The first question drafters face preparing a new directive for a client is deciding what to call it. Note that right after the Statutory Template's introductory text, "[a]n advance directive…may…be in the following form," comes this text—"ADVANCE MEDICAL DIRECTIVE"—which appears to function as the title of the document. Yet aside from this apparent title, the only other place the statute refers to this instrument as an "advance medical directive" is § 54.1-2989.1, which provides a protective rule for agents in possession of "an advance medical directive" despite the failure of the person making the instrument to "deliver" it to the agent.

All other references in the Act to this instrument are to "advance directives." Even the header in § 54.1-2989.1 reads "Failure to deliver advance directive." When we discuss what should be done with these instruments, we will see that the statute creating an online registry for these instruments describes them as "advance health care directives."[6] To avoid confusion and to match the language of the Act, we will refer to these instruments as "advance directives" and the person making the advance directive as the "declarant."[7]

The Act permits two types of advance directives: written advance directives and oral advance directives. A written advance directive must be signed by the declarant in the presence of two subscribing witnesses.[8] An oral advance directive is authorized only for an individual diagnosed with a terminal condition (as defined in the Act) by the individual's attending physician and must be made in the presence of the attending physician and two witnesses.[9] Oral advance directives are extraordinarily rare, and intentionally so. The public policy principle here is that except in narrow situations, an individual's advance care planning choices should be put in writing, the requirements for which are easy to satisfy. Therefore, for the vast majority of decisions that

---

[5] Regardless of the term used, the key for these documents is that they provide guidance, in *advance*, for future events. With any luck, such guidance will be "advanced," but it still should not result in "advanced" being included in the document title.

[6] Nathan believes the inconsistency about the name was unintentional and merely not identified by legislative services upon publication of the Act.

[7] § 54.1-2982. Ultimately, because the use of any particular form is not required, the label given to any advance directive is legally irrelevant.

[8] § 54.1-2983 (first paragraph). We will revisit the execution requirements for advance directives in Section XXIII.

[9] § 54.1-2983 (second paragraph).

might be made in an oral advance directive, the Act effectively urges such choices to be memorialized in a written advance directive.

Our focus will be on the written option of an advance directive as these materials are primarily intended to assist with their drafting.

III. Begin at the Beginning, Part One.

"I, _____, willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision, as follows:

I understand that my advance directive may include the selection of an agent as well as set forth my choices regarding health care. The term "health care" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability, including but not limited to, medications; surgery; blood transfusions; chemotherapy; radiation therapy; admission to a hospital, nursing home, assisted living facility, or other health care facility; psychiatric or other mental health treatment; and life-prolonging procedures and palliative care.

The phrase "incapable of making an informed decision" means unable to understand the nature, extent and probable consequences of a proposed health care decision or unable to make a rational evaluation of the risks and benefits of a proposed health care decision as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way."

The Statutory Template begins with this introductory language that identifies the key function of the advance directive—to set out in advance the client's directives regarding health care to be followed by all parties if the client is incapable of making an informed decision. This language tracks the statutory authorization for advance directives found in § 54.1-2983, which permits any adult capable of making an informed decision to make "a written advance directive to address *any or all forms of health care* in the event the declarant is later determined to be incapable of making an informed decision." (emphasis added). The "any or all" represents a significant change from the original version of the Act, which limited written decisions to end-of-life care in the context of a terminal illness. The updated Act was specifically intended to allow for mental health and non-end-of-life decisions, such as the use of blood products. Both the term "health care" and the phrase "incapable of making an informed decision" are defined in the Act. The Statutory Template includes a verbatim definition of "health care" but has a slightly revised and truncated definition of "incapable of making an informed decision."

The Act's definition of "incapable of making an informed decision" reads:

> "Incapable of making an informed decision" means the inability of an adult patient, because of mental illness, intellectual disability, or any other mental or physical disorder that precludes communication or impairs judgment, to make an informed decision about providing, continuing, withholding or withdrawing a specific health

care treatment or course of treatment because he is unable to understand the nature, extent or probable consequences of the proposed health care decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.[10]

The Statutory Template, however, reads:

The phrase "incapable of making an informed decision" means unable to understand the nature, extent and probable consequences of a proposed health care decision or unable to make a rational evaluation of the risks and benefits of a proposed health care decision as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way.

The Statutory Template follows the statute's "end result"—the inability to make or communicate an informed decision—while removing the statutory definition's causes of this inability—a mental illness, intellectual disability, or any other mental or physical disorder that precludes communication or impairs judgment. This omission can confuse clients for whom this omission impacts them, notably, clients who may have a particular "communication deficit" unrelated to mental acuity. Fortunately for those clients, § 54.1-2982 adds that persons who are deaf, dysphasic, or have other communication disorders, but are otherwise mentally competent and able to communicate by means other than speech, shall not be considered incapable of making an informed decision.

Drafting Note: Consider whether your form should remain silent as to the definition of incapacity that triggers the advance directive, since this definition is controlled by the statute. If you do include the Statutory Template's definition of "incapable of making an informed decision," consider including a provision excluding from the definition clients who are otherwise mentally competent and able to communicate by means other than speech. Both the most recent version of the VHHA Template and the Collaborative Template have eliminated this definition from their templates.

IV. Begin at the Beginning, Part Two.

"I, _____, willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision, as follows:

I understand that my advance directive may include the selection of an agent as well as set forth my choices regarding health care. The term "health care" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability, including but not limited to, medications; surgery; blood transfusions; chemotherapy; radiation therapy; admission to a hospital, nursing home, assisted

[10] § 54.1-2982.

living facility, or other health care facility; psychiatric or other mental health treatment; and life-prolonging procedures and palliative care.

The phrase "incapable of making an informed decision" means unable to understand the nature, extent and probable consequences of a proposed health care decision or unable to make a rational evaluation of the risks and benefits of a proposed health care decision as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way."

The second paragraph of the Statutory Template identifies another core function of an advance directive—naming an agent to make health care decisions when the principal is incapable of making an informed decision. Advance directives do not have to identify agents to be valid. But, it is important to note what happens for clients who have not established either a written or oral advance directive naming a health care agent. As with helping clients understand the importance of making a will (and revocable trust) by illustrating the effects of intestacy, clients can better understand the importance of making advance directives when they are told how the Act provides a default rule for health care decision-making.

The Act authorizes these individuals, in the specified order of priority, to make health care decisions when a patient (i) is incapable of making an informed decision, and either (ii) has not made a valid advance directive or (iii) has made a valid advance directive but has not indicated the patient's wishes regarding the health care at issue or did not appoint an agent:[11]

1. A guardian for the patient;

2. The patient's spouse except where a divorce action has been filed and the divorce is not final[12];

3. An adult child of the patient;

4. A parent of the patient;

5. An adult brother or sister of the patient;

6. Any other relative of the patient in the descending order of blood relationship;

7. Except in cases in which the proposed treatment recommendation involves the withholding or withdrawing of a life-prolonging procedure, any adult, except any director, employee, or agent of a health care provider currently involved in the care

[11] § 54.1-2986.A.

[12] Effective July 1, 2024, filing of an action for divorce or annulment of marriage revokes the authority of the spouse if named agent under an existing advance directive. § 54.1-2985.A1.

> of the patient, who (i) has exhibited special care and concern for the patient and (ii) is familiar with the patient's religious beliefs and basic values and any preferences previously expressed by the patient regarding health care, to the extent that they are known. A quorum of a patient care consulting committee as defined in § 54.1-2982 of the facility where the patient is receiving health care or, if such patient care consulting committee does not exist or if a quorum of such patient care consulting committee is not reasonably available, two physicians who (a) are not currently involved in the care of the patient, (b) are not employed by the facility where the patient is receiving health care, and (c) do not practice medicine in the same professional business entity as the attending physician shall determine whether a person meets these criteria and shall document the information relied upon in making such determination.

The individual or individuals so authorized are referred to in these materials as the "statutory decision-makers" to differentiate them from agents designated to make decisions under the advance directive.

The attending physician may provide or withhold health care for the incapacitated patient upon the authorization of any of the statutory decision-makers, including someone in a lower priority class, if the physician is not aware of any available, willing, and capable person in a higher priority class.[13] If the attending physician is informed by the then-applicable highest class of statutory decision-makers that there is disagreement over a particular health care decision, the attending physician may rely on the authorization of the majority of the reasonably available members of that class.[14]

Drafting Note. Prior to the Supreme Court's rulings in its United States v. Windsor[15] and Obergefell v. Hodges[16] opinions, it was especially important for same-sex couples to make advance directives to overcome a state's particular priority list of statutory decision-makers. For clients, however, who choose for their own particular reasons not to get married (or remarried in the case of some older couples), making an advance directive is the only way to guarantee their preferred decision-makers may act on their behalf.

V. Determining and Maintaining Incapacity of Making Informed Decisions.

"The determination that I am incapable of making an informed decision shall be made by my attending physician and a capacity reviewer, if certification by a capacity reviewer is required by law, after a personal examination of me and shall be certified in writing. Such certification

---

[13] Id.
[14] Id. (flush language).
[15] 570 U.S. 744 (2013).
[16] 576 U.S. 644 (2015)

shall be required before health care is provided, continued, withheld or withdrawn, before any named agent shall be granted authority to make health care decisions on my behalf, and before, or as soon as reasonably practicable after, health care is provided, continued, withheld or withdrawn and every 180 days thereafter while the need for health care continues."

The Statutory Template in this quoted paragraph restates in simpler language the statutory rules for how a determination of a client's incapacity of making informed medical decisions is determined and then maintained. The Act provides these separate rules related to the crucial incapacity determination triggering the advance directive:

1. Before providing any care pursuant to an agent's or statutory decision-maker's instructions for a patient or as soon as reasonably practicable after the start of care, the attending physician must certify in writing after personal examination that the patient incapable of making an informed decision regarding health care;[17]

2. A second written certification will be required from a capacity reviewer (defined in the Act as either a licensed physician or clinical psychologist who is qualified by training or experience to assess whether a person is capable or incapable of making an informed decision[18]) that, based on person examination, the declarant is incapable of making an informed decision unless at such time of the determination the declarant is unconscious or experiencing a profound impairment of consciousness due to trauma, stroke, or other acute physiological condition;[19]

3, If the certification of the capacity reviewer is required, the capacity reviewer shall not be otherwise currently involved in the treatment of the patient, unless an independent capacity reviewer is not reasonably available;[20]

4. The same certification or certifications must be renewed no less frequently than every 180 days while the need for health care continues (referred to in these materials as the "renewal period";[21] and

[17] § 54.1-2983.2.B. Separate rules apply, however, to determinations of incapacity that are required before an agent authorized in an advance directive to consent to the patient's admission to a mental health facility can exercise that authority. Once the required certification has been obtained to admit the patient under the agent's authority, separate certification under the standard rules discussed above must then be obtained before the agent can authorize specific health care for the patient. These rules are set out in § 54.1-2983.2.C.

[18] § 54.1-2982.

[19] § 54.1-2983.2.B.

[20] Id.

[21] Id.

5. Once the required certification or certifications have been obtained—and to serve as a failsafe for an erroneous determination—the patient is required to be informed of the determination, to the extent the patient is capable of receiving such notice;[22]

6. The cost of all required assessments (whether the initial determination or the renewal determination) shall be considered for all purposes a cost of the patient's health care.[23]

These rules ensure that before the health care providers take instructions from an agent under an advance directive or a statutory decision-maker, the patient is indeed incapable of making an informed decision regarding health care. And once that determination has been made, and physicians begin providing care consistent with the instructions of such agent or statutory decision-maker, the same certification requirement must be met at least every 180 days during which health care is being so provided.

Significantly, the Act expressly provides that only a single physician is required to make a determination that a patient has regained decision-making capacity (or, perhaps, never lost it in the first place). The rationale for not requiring a capacity reviewer is that the legal default is to assume capacity. When in doubt, deference to the patient prevails. Of course, this effectively sets up the need for a dispute to be decided by a court, but the notion is that the use of the courts would be appropriate in situations in which physicians disagree.

Drafting Note: Consider whether to include a provision setting out the procedure for an incapacity determination in your advance directive, since the statute provides the procedure by which the incapacity determination must be made and then maintained. What happens if client wants to create her own procedure for determining her incapacity? What happens if the statutory procedure changes, as it did with this most recent version of the Act? Both the VHHA Template and the Collaborative Template have omitted this procedural language. Among other things, any additional restrictions raise the practical question about whether it is possible or reasonable to limit the professional determination. Furthermore, it is unclear what remedy would exist for failure to follow the individual's determination restrictions if the healthcare professionals simply apply the statutory definition.

VI. Notice of Incapacity Determination.

"If, at any time, I am determined to be incapable of making an informed decision, I shall be notified, to the extent I am capable of receiving such notice, that such determination has been

---

[22] § 54.1-2983.2.D.

[23] § 54.1-2983.2.B. Separate rules apply, however, to determinations of incapacity that are required before an agent authorized in an advance directive to consent to the patient's admission to a mental health facility can exercise that authority. Once the required certification has been obtained to admit the patient under the agent's authority, separate certification under the standard rules discussed above must then be obtained before the agent can authorize specific health care for the patient. These rules are set out in § 54.1-2983.2.C.

made before health care is provided, continued, withheld, or withdrawn. Such notice shall also be provided, as soon as practical, to my named agent or person authorized by § 54.1-2986 to make health care decisions on my behalf. If I am later determined to be capable of making an informed decision by a physician, in writing, upon personal examination, any further health care decisions will require my informed consent."

The Statutory Template here restates the Act's notice requirement once an incapacity determination has been made, but in the first person to match the first person nature of the Statutory Template.[24] The final sentence, however, is added to give the patient control over the patient's health care decisions if the patient is later determined to be capable again of making an informed decision, thus negating the authority of the advance directive.

Drafting Note. Consider whether to include a notice provision, since it is simply restating the Act's statutory requirement. Similar concerns to the ones raised in the prior section apply here. The VHHA Template and the Collaborative Template both omit this notice provision from its form.

The Act provides two methods for turning off an advance directive once incapacity has been determined. First, the Act presumes every adult to be capable of making an informed decision unless such adult is "determined to be incapable of making an informed decision in accordance with [the Act]."[25] Therefore, if the statutorily required determination of a continuing incapacity (which might require a separate capacity reviewer, depending on the situation) cannot be provided within the renewal period, the agent's authority under the advance directive technically ends at the expiration of the renewal period. Second, the Act separately provides that a single physician may, at any time, upon personal evaluation, make a written determination that a patient previously determined to be incapable of making an informed decision is now capable of making an informed decision.[26]

Drafting Note. Given the competing provisions over regaining capacity, it should not be surprising to see that both the VHHA Template and the Collaborative Template omit this provision, although they both include a provision following the appointment provision in the particular Template that provides that "[m]y agent's authority is effective as long as I am incapable of making an informed decision."

VII. Selecting Agents.

[24] § 54.1-2983.2.D.
[25] § 54.1-2983.2.A.
[26] § 54.1-2983.2.E.

"OPTION I: APPOINTMENT OF AGENT (CROSS THROUGH OPTIONS I AND II BELOW IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

I hereby appoint _____ (primary agent), of _____ (address and telephone number), as my agent to make health care decisions on my behalf as authorized in this document. If _____ (primary agent) is not reasonably available or is unable or unwilling to act as my agent, then I appoint _____ (successor agent), of _____ (address and telephone number), to serve in that capacity."

We now reach one of the most difficult decisions facing both the drafting attorney and the client—how and whom to select as agents, especially when trying to choose among family members. Significantly, the Act does not prohibit the selection of multiple agents, which is inherently a logical approach. The problem with multiple agents is that experience shows that anticipated alignment does not exist when major medical decisions are at issue. We also see a potential drafting issue raised by the Statutory Template's use of options to be chosen by individuals who may be preparing their advance directives without counsel assistance. Specifically, the selection criteria that an individual may use on their own may be quite different from the criteria recommended by counsel. The Act, in the section identifying the statutory decision-makers, reveals its implied preference for avoiding co-agents. In that section, the attending physician is authorized to provide health care pursuant to the direction of any of the statutory decision-makers, in the specified order of priority, as long as the physician is unaware of (i) any available, willing, and person in a higher class, or (ii) disagreement within the class then having priority to make health care decisions for the patient.[27]

The Statutory Template implicitly adopts this preference by avoiding co-agents and instead designating a primary and successor agent, directing the medical providers to move on to the successor agent if the primary agent is not reasonably available or is unable or unwilling to act.

Drafting Note. To address the issues of availability, most advance directives will include contact information for the designated agents. The Statutory Template refers only to address and telephone number, although it may be advisable not only to provide and identify home and cell numbers but also email addresses and the preferred method of contact for each agent. The VHHA Template includes the option of adding email addresses and fax numbers. It may also be preferable to attach a separate schedule to the advance directive with this contact information and allow for it to be periodically updated by the client when agents' information changes. Significantly, the Act is silent about making ministerial changes to contact information, but, presumably, additional

[27] § 54.1-2986.A.

witnessing is not required, especially if the form itself provides the declarant with the authority to keep the contact information current.

The Act is also silent about how to define the concept of "availability." As a result, it is likely that different healthcare providers will take different approaches to their searches. Similarly, it is unclear what is necessary to conclude unavailability, but it is likely that reasonableness is the rule. For example, it should not be necessary to see a death certificate in order to remove someone from a potential agent list. A good faith statement by someone with a reason to know the status and/or availability of a potential agent ought to be sufficient.[28]

The Statutory Template also follows this implied preference for avoiding co-agents by naming a single primary agent and then a single successor agent. For many families, it may be too difficult because of family dynamics to create a hierarchy of decision-makers, especially when successor agents will be the client's grown children.[29] Reminding them that the default rule in the absence of picking a set order would permit any of the children to act if there was no known disagreement may help them see the need to identify the preferred order to avoid any conflicts when it is time to implement the advance directive.

Drafting Note. You may consider whether to include a consultation provision in your advance directive that attempts to involve, for example, all of the adult children in a decision to avoid hurt feelings. Care should be taken in the actual language of the provision to avoid providing an additional burden for hospitals and doctors to follow before taking the direction of the highest ranking agent. For example, clients may prefer language that names Child A as my primary agent but then reads "who may act after consulting with my other children." Has that language now created additional requirements that hospitals and doctors check first to see if such consultation did in fact happen? How would that be documented?

Drafting Note. It will normally be more common for clients to have more than one successor agents, especially if they avoid a majority-rule option for co-agents. The Statutory Template moves down the list of agents if a prior-named agent is "not reasonably available or is unable or unwilling to act as my agent." Consider including certification language similar to that often included with durable powers of attorney that will allow the health care providers to rely on a successor agent's certification under penalty of perjury as to the prior agent's unavailability or unwillingness to act. The practical timing issues related to successor agents are the same here, so be attentive to whether the language requires attaching the prior agent's statement of unavailability or unwillingness (or death certificate or incapacity letter, if applicable) to the certification or

[28] Of course, the same holds true of statutory decision-makers under § 54.1-2986.
[29] The definitions in the Act limit agents to "adults" (§ 54.1-2982), and adults are separately defined in § 1-203 as an individual age 18 years or older.

advance directive to be effective. This certification would prove especially useful where the continued use of the advance directive will be required for several months.

A final issue over the selection of agents is how to make both them and the medical providers aware of them. It is common for attorneys to provide clients with multiple copies of their advance directives that can be given to the clients' agents and medical providers. The Act places the responsibility of notifying medical providers that an advance medical directive has been made on the declarant.[30] A growing number of individuals are taking advantage of the Advance Health Care Planning Registry created under Article 9 (§ 54.1-2994 et seq.) of Title 54.1. and similar registry services. Only the individual making the advance directive, the individual's legal representative, or the individual's designee are authorized to submit an advance directive to be stored on the Virginia registry.[31] After uploading the advance directive, it remains the responsibility of the declarant to provide the attending physician with the information necessary to access the advance directive.[32] Any other person may notify the declarant's attending physician if the declarant is comatose, incapacitated, or otherwise mentally or physically incapable of communication.[33] Once notified, the attending physician must promptly make the advance directive or a copy of it a part of the declarant's medical records.[34]

Drafting Note. Consider adding language to your form alerting clients of the option to upload their advance directives to the Virginia registry and indicating that they have done so. Lawyers designated by the clients may also upload the forms to the registry, thus requiring a separate designation agreement between the lawyer and the clients. Suggested language: "Virginia created a free online advance directive registry at Connect Virginia (connectvirginia/org/adr) that allows Virginia residents to securely store important healthcare documents so that family members, medical providers, emergency personnel, or other persons you designate will know how to honor your wishes. Initial here _____ if you have uploaded your advance directive to the registry."

VIII. Guidelines for Agents.

"I hereby grant to my agent, named above, full power and authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision. My agent's authority hereunder is effective as long as I am incapable of making an informed decision.

---

[30] § 54.1-2983 (fourth paragraph).
[31] § 54.1-2995.A.
[32] § 54.1-2983 (fourth paragraph).
[33] Id.
[34] Id.

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 shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks, and side effects associated with treatment or nontreatment. My agent shall not make any decision regarding my health care which he knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent cannot determine what health care choice I would have made on my own behalf, then my agent shall make a choice for me based upon what he believes to be in my best interests."

Both the Statutory Template and the VHHA Template include these provisions immediately after the section naming the agents under the advance directive. Although most advance directives will include the naming of agents, advance directives under the Act need not appoint agents.[35] Once agents are appointed, however, certain duties are then placed on the agents.

The most obvious duty concerns the agent's authority to make health care decisions for the principal once the principal is determined to be incapable of making informed health care decisions. The Act provides, importantly, that not only does the agent now have the authority to make health care decisions as specified in the advance directive, but also has decision-making priority over the statutory decision-makers.[36] Under the Act, therefore, the agent's authority over health care decisions is limited to those decisions specified in the advance directive, which explains the statutory language in the first sentence above that limits to health care decisions "as described below."

Drafting Note. For those wishing to shorten their advance directive form, the entire first paragraph set out above can be eliminated by careful drafting of your appointment provision. For example, language that reads "I appoint _____ as my primary agent to make for me the health care decisions authorized in this advance directive if, and during such time(s) that, I am incapable of making an informed decision."

Other duties also attach to the agents, both prescriptive and proscriptive. An agent (and also a statutory decision-maker) must (i) undertake a good faith effort to ascertain the risks and benefits of, and alternatives to any proposed health care for the declarant, (ii) make a good faith effort to ascertain the declarant's religious values, basic values, and previously expressed preferences, and (iii) to the extent possible, base the agent's decisions on the declarant's beliefs, values, and preferences, or if they are unknown, on the declarant's best interests.[37]

---

[35] § 54.1-2983.A.
[36] § 54.1-2986.1.A.
[37] § 54.1-2986.1.B.

Drafting Note. The Statutory Template's second paragraph quoted above attempts to capture these prescriptive duties and can be a good reminder for the agent later tasked with making health care decisions of what goes into the decision-making process. As is evident in this list of considerations, significant personal information of the declarant can and should be considered when making the decisions authorized in the advance directive. In other words, the advance directive often will not be the only source of this information, raising the importance of advising clients to make sure they communicate this information to their agents. The Collaborative Template includes a paragraph directing the agent to be guided not only by the advance directive but other information given to the agent "in other ways, such as conversation."

An agent under an advance directive may not refuse or fail to honor the declarant's wishes in relation to anatomical gifts, or organ, tissue, or eye donation.[38] Agents who otherwise do not wish to carry out the declarant's expressed wishes can simply resign or refuse to serve. The Act does specifically include provisions to address what happens with the declarant's physician refuses to comply with the advance directive or with an agent's authorized health care decision or any proposed health care treatment.[39]

Surprisingly, the Act does not require that the declarant deliver either the original or a copy of the advance directive to the agent. Neither the Statutory Template nor the NHHA form contain an acceptance or receipt acknowledgement for the designated agents. Instead, the Act presumes that an agent in possession of an otherwise valid advance directive is deemed to possess the powers and authority granted in the advance directive, notwithstanding any failure of delivery by the declarant.[40] Courts, however, may consider how the agent came into possession of the advance directive in a proceeding to remove the agent or revoke the advance directive.[41]

Drafting Note. To avoid any delays in, or confusion over, a client's health care, it is best to advise clients to make their agents aware of the advance directives by giving them copies for their records. Some lawyers will prepare separate acceptances and/or receipts for the agents to make sure there is no issue in providing the client's health care when the time comes to trigger the advance directive.

Agents who act in good faith in carrying out and making health care decisions for the declarant are protected from both criminal prosecution and civil liability for their actions and are

---

[38] § 54.1-2986.1.A. Note carefully that this section reads only the declarant's *wishes*, not the declarant's *wishes as expressed in the advance directive*. There is a more complete discussion of the anatomical gift rules in advance directives in Section XXI below.

[39] See § 54.1-2987, which requires the refusing physician to make reasonable efforts to transfer the declarant to another physician, and § 54.1-2990, which provides the procedures to be followed when physicians believe proposed health care is medically or ethically inappropriate.

[40] § 54.1-2989.1.

[41] Id.

protected against liability for the cost of the declarant's health care solely on the basis of having acted as agent under the advance directive.[42] These protections against liability do not apply if the preponderance of the evidence presented shows that the agent did not, in good faith, comply with the Act.[43]

While the declarant remains liable for the declarant's health care, these situations will by definition involve a declarant who is otherwise incapable of managing the declarant's financial affairs. Sometimes, the agent under the advance directive will also be the agent under the client's durable power of attorney for financial decisions or successor trustee of the client's revocable trust, thus providing the agent with the means to pay for care. Where these fiduciary positions are filled by different individuals, care should be taken in ensuring all parties understand their proper roles. Significantly, experience has demonstrated that healthcare providers routinely erroneously interpret financial power of attorney documents to constitute advance directives. Although the two legal mechanisms *could* be combined, financial power of attorney documents have different execution requirements.[44] Healthcare providers appear to confuse the formality of a notary and the significance of having two witnesses.

Drafting Note. The Statutory Template does include a reference to this protection of an agent from paying for health care of the declarant in the "Powers of My Agent" section by adding this sentence to the catch-all authorization in Paragraph L.—"Further, my agent shall not be liable for the costs of health care pursuant to [my agent's] authorization, based solely on that authorization." Both the VHHA Template and the Collaborative Template have removed this language from their form, as it is a statutory rule and therefore need not be included to be effective. It may, however, be wise to include in your form as it comforts the individual or individuals being asked to serve in this capacity.

IX. Introduction to Specified List of Powers of Agent, Part One.

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

The powers of my agent shall include the following:"

The Statutory Template's next section includes 13 paragraphs, each identifying a specified power granted to the agent under the advance directive. Before looking at each of the suggested powers, two issues should be addressed regarding the Statutory Template.

---

[42] § 54.1-2988 (second paragraph).
[43] § 54.1-2988 (fourth paragraph).
[44] See discussion in Section XXIII below.

To allow for individuals to make their own advance directive without an attorney's assistance, both the Statutory Template and the VHHA Template list the same specified powers and include the instruction that the individual should cross through any powers that the individual does not want to give to the individual's agent. And some of the listed powers include the option for individuals to authorize specific types of health care not otherwise included in the specified lists by including several lined blanks on which these additional directions could be written.

Drafting Note. For attorney-prepared advance directives, consider whether to remove the "pick and choose" nature of the Statutory Template to give you more control over the final document, especially if the original remains with the client. As addressed later in these materials, declarants retain the ability to protest certain authorizations in an advance directive and the ability to revoke it. Allowing for a post-execution crossing through of powers creates unnecessary certainty over the legitimacy of an advance directive. It also allows disgruntled family members or other interested persons an opportunity to delay, if not change, the declarant's expressed wishes regarding health care.

To protect against such willful actions by someone other than the declarant, the Act creates these separate offenses to punish interference with an advance directive:

> (1) Any person who willfully (i) conceals, cancels, defaces, obliterates, or damages the advance directive without the declarant's consent; (ii) falsifies or forges the advance directive of another; or (iii) falsifies or forges a revocation of the advance directive of another shall be guilty of a Class 1 misdemeanor, but if this proscribed action causes life-prolonging procedures to be utilized in contravention of the previously expressed intent of the declarant, the person committing such action shall be guilty of a Class 6 felony;[45] and
>
> (2) Any person who willfully (i) conceals, cancels, defaces, obliterates, or damages the advance directive of another without the declarant's consent, (ii) falsifies or forges the advance directive of another, (iii) falsifies or forges a revocation of the advance directive of another, or (iv) conceals or withholds personal knowledge of the revocation of an advance directive, with the intent to cause a withholding or withdrawal of life-prolonging procedures, contrary to the wishes of the declarant, and thereby, because of such act, directly causes life-prolonging procedures to be withheld or withdrawn and death to be hastened, shall be guilty of a Class 2 felony.[46]

Drafting Note. Although it may be very difficult to prove any of the acts above, one way to reduce the possibility of these falsification issues is to encourage clients to initial any

[45] § 54.1-2989.A. The statute also applies to the same actions with respect to a Durable Do Not Resuscitate Order.
[46] § 54.1-2989.B. The statute also applies to the same actions with respect to a Durable Do Not Resuscitate Order.

enumerated powers rather than merely to "check" them, if the form that is using has menu of options.

X. Introduction to Specified List of Powers of Agent, Part Two.

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

The powers of my agent shall include the following:"

Drafting Note. As noted, while declarants may make written advance directives to address "any and all forms of health care,"[47] the agents appointed under written advance directives only may make health care decisions for the declarant "as specified in the advance directive"[48] after the requisite incapacity determination. The Statutory Template's list of specified powers attempts to capture all potential health care decisions. Although it may be possible to add or subtract from this list, most practitioners may not feel competent to craft provisions dealing with health care decisions for their clients. The Virginia State Bar's Healthcare Decisions Day website[49] has additional forms to assist both practitioners and clients seeking to prepare more detailed or more individualized advance directives.

Drafting Note. It is, of course, possible for a declarant to craft an advance directive in such a way that the identified powers for the agent conflict with one another. Since the Act does not provide specific instructions for situations such as this, internally inconsistent advance directives should, to the degree possible, be interpreted as having named an agent but otherwise being silent on particular powers of the agency, which then defaults to plenary powers.

XI. Specified Powers over Health Care Decisions Unrelated to Mental Illnesses or Protest Provisions.

"The powers of my agent shall include the following:

A. To consent to or refuse or withdraw consent to any type of health 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 recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or of inadvertently hastening my death;

---

[47] § 54.1-2983 (first paragraph).
[48] § 54.1-2986.1.
[49] https://www.vsb.org/site/public/healthcare-decisions-day/

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 care providers;

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

The first four specified powers in the Statutory Template cover most decisions likely to be needed when providing for a declarant's health care. The VHHA Template includes these provisions without any significant changes, as do most online forms, although some of the VSB forms attempt to soften the legalese where appropriate.

Paragraph B. regarding a declarant's health information raises certain questions related to the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d to 1320d-9 ("HIPAA). Under HIPAA's applicable privacy rules and regulations, agents under an advance directive must *automatically* be treated as a personal representative of the declarant with respect to the declarant's protected health information, or informed decision-making by the agent would be impossible.[50] Hospitals and other medical professionals must therefore disclose protected health information to the agent, at least as needed to assist in making health care decisions for the declarant. There does not have to be a specific authorization in the advance directive regarding disclosure to the agent in that capacity.

Drafting Note. Some drafting attorneys revise Paragraph B. to tie it directly to HIPAA's rule for disclosure to personal representative, by revising it to read: "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, as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Regulations issued thereunder, and to consent to the disclosure of this information."

Drafting Note. The drafting attorney should remember that, as with all provisions in the advance directive, the rights under the advance directive only accrue to the agent after the declarant has been determined to be incapable of making an informed decision. A separate standalone HIPAA release, therefore, can provide greater control over a client's protected health information

[50] 45 C.F.R. § 164.502(g)(2). "If under applicable law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representative.

by the persons the client selects to make health decisions. The separate HIPAA release can also include authorization to hospitals and other medical professionals to release the client's protected health information to individuals other than the agent under the advance directive. For example, it may be necessary to provide this information to a trustee (or successor trustee) or an agent (or successor agent) under a financial power of attorney to trigger an incapacity provision. Also, clients may wish to make sure certain family members who may not be picked as the agent under the advance directive to have access to this information.

XII. Specified Powers Authorized Despite Declarant's Protest—the Ulysses Clause.

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

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

Despite the Act's grant of authority to an agent appointed by an advance directive to make health care decisions for the declarant after the declarant is incapable of making an informed decision, the Act (which is part of the licensure statutes ultimately regulating the healing arts) generally prohibits the declarant's attending physician from "providing, continuing, withholding or withdrawing health care if the [declarant's] attending physician knows that such action is protested by the [declarant]."[51] While it may seem odd to permit a patient who lacks the capacity to make informed decisions about health care to object to the decisions of the agent, public policy requires carefully balancing competing interests, especially when realizing these protest rules were developed first to address end-of-life decisions where allowing patients to "change one's mind" was a life or death matter.

Usually the protest may be a simple "no" from the patient, which is enough to trigger the protest rules. With the increase in awareness of mental health issues coupled with the rise of dementia in the population, allowing a simple "no" to prevent much-needed care for certain individuals has become more problematic, and so the Act introduced limited situations where care could be provided over the expression of protest by the patient with what are called "Ulysses Clauses," an idea taken from Homer's The Odyssey.

"Then, being much troubled in mind, I said to my men, 'My friends, it is not right that one or two of us alone should know the prophecies that Circe has made me, I will therefore tell

[51] § 54.1-2986.2.

you about them, so that whether we live or die we may do so with our eyes open. First she said we were to keep clear of the Sirens, who sit and sing most beautifully in a field of flowers; but she said I might hear them myself so long as no one else did. Therefore, take me and bind me to the crosspiece half way up the mast; bind me as I stand upright, with a bond so fast that I cannot possibly break away, and lash the rope's ends to the mast itself. If I beg and pray you to set me free, then bind me more tightly still.'"[52]

The act permits certain exceptions (fortunately, none involving being tied to a ship's mast), that if met grant agents continuing authority over health care decisions despite the protestations of their declarants. Some exceptions require express language in the advance directives, others apply generally to the health care being protested.

The first exception addresses the situation where the declarant, after the determination of incapacity has been made, later protests the agent's general authority to act on the declarant's behalf. If a declarant then protests the authority of the agent, the agent shall have no authority under the Act to make health care decisions on behalf of the declarant unless the declarant's advance directive explicitly confers continuing authority on the agent, even over protest.[53] Authority to make health care decisions is then determined by other provisions in advance directive, if applicable, or pursuant to § 54.1-2986, or other applicable law.

Protesting an agent's authority does not, importantly, somehow nullify the advance directive's grant of authority to an agent such that decision-making returns to the declarant. Instead, protest triggers the designation of a successor or alternate agent or the appointment of individuals in the absence of a successor or alternate agent. Furthermore, to avoid a potential conflict, the Act expressly provides that an individual who was named as an agent but is then removed by protest may not be included in the list of statutory decision-makers.[54]

Drafting Note. If the advance directive does not include specific authorization for the agent to continue to act as agent if the declarant protests the agent's authority, the agent's authority terminates. Given the issues with dementia and other similar illnesses, failure to include this particular Ulysses Clause may be detrimental to the care of the client. Both the VHHA Template and the Collaborative Template include this provision.

Failure to include a Ulysses Clause to address continuing authority over protest, however, does not always end the agent's authority. There is a second exception that permits an agent

---

[52] Homer, The Odyssey, Book XII (trans. Samuel Butler).

[53] § 54.1-2986.2.E. Protest of a particular individual serving as the statutory decision-maker (unless serving as guardian) also ends that individual's authority.

[54] Id. This section provides that protest of the named agent results in the protested individual having "no authority under this article," thus serving to remove that individual from the list of statutory decision-makers also.

acting under an advance directive to act over the declarant's protest and make a decision over the declarant's protest of such decision if these statements about the protested decision are true:

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

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

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

4. The health care that is to be provided, continued, withheld, or withdrawn by the decision has been determined and documented by the declarant'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 declarant's capacity to make health care decisions.[55]

In contrast to a Ulysses Clause, this protest exception effectively creates a rule that is common in parenting and managing those with cognitive impairments: "Your protest is noted, but it is rejected in your best interest." The result is to permit specific health care decisions to be made over the protest of the declarant regarding the particular health care decision (not just generally over the agent's authority) that are objectively the "right" thing to do. As a matter of public policy, this exception reduces the number of scenarios that would require a court to intervene to navigate a protest situation that is likely to be considered objectively unreasonable.

The last exception that overrides this protest deauthorization rule picks up two of the second exception's requirements about the decision being protested (that it cannot involve withholding or withdrawing life-prolonging procedures and that the effect of the decision has been determined and documented by the patient's attending physician to be medically appropriate and is otherwise permitted by law) and adds these two additional requirements:

1. The advance directive must explicitly authorize the declarant's agent to make the health care decision at issue, even over protest; and

[55] § 54.1-2986.2.C.

2. An attending licensed physician, a licensed clinical psychologist, a licensed physician assistant, a licensed nurse practitioner, a licensed professional counselor, or a licensed clinical social worker who is familiar with the declarant attested in writing at the time the advance directive was made that the declarant was capable of making an informed decision and understood the consequences of the provision.[56]

Although not clearly stated in the Act, the attestation by the authorized professional need not be included in the advance directive itself or be made at the same time the advance directive is made. It can be provided after signing the advance directive if the authorized professional attests that the declarant was capable of making an informed decision and understood the consequences of the Ulysses Clause at the time the advance directive was made.

Drafting Note. This version of the Ulysses Clause may be helpful when the client at the time of making the advance directive knows of specific health care decisions that may need to be made in the future, even over the client's protest, provided the decisions do not involve life-prolonging procedures. For clients who may already know they are at risk of recurring mental illness or dementia or other diagnosis that intermittently affects awareness, comprehension, or judgement, this provision allows the declarant to make binding decisions over care that may be crucial for later treatment, and which may otherwise only be provided following a time-consuming and expensive court order for treatment. The preparation of a client-tailored advance directive may require an interview process more detailed than normal in order to surface a client's medical history that should be addressed in the client's advance directive. While the Statutory Template includes this language, the standard VHHA Template does not (although there is a separate VHHA template that does).

Drafting Note. Once it has been decided to include this version of the Ulysses Clause, the next question concerns who will be providing the attestation as to capacity. The Statutory Template only lists physicians and licensed clinical psychologists, while the Collaborative Template has a check-the-box option for all possible authorized professionals.

Drafting Note. The Statutory Template has a place for the attesting party to sign, suggesting it must be signed at the same time the declarant makes the advance directive, which is not required under the Act; but the Statutory Template does not have a separate date option for the attesting party. The Collaborative Template has a separate signature box for the attesting party and includes the date the attestation was made. For clients seeking to include this version of the Ulysses Clause, they will need to get this required attestation after signing the advance directive and then provide a signed copy to the drafting attorney in order to know it has been completed. However, failure to get the authorized professional's signature is not fatal, as the attestation does

[56] § 54.1-2986.2.B.

not have to be included in the advance directive itself; it can be provided in a separate document if it meets the other requirements. Indeed, even if the Ulysses Clause attestation is included in the form but not obtained, the remaining provisions of the advance directive remain effective and the attestation can be provided at a later date.

Drafting Note. The Collaborative Template, which is designed to be the most expansive, includes this version of the Ulysses Clause with a check-the-box option permitting the agent "[t]o consent to other health care that is permitted by law, even if I object." It then states that this authority includes all health care except what the declarant in the advance directive has expressly declared may not be provided over protest. Given this rather expansive version of the Ulysses Clause and the option for the required attestation to be provided after the fact and in a separate document, drafting attorneys should consider whether to include both Ulysses Clauses in their standard document, when appropriate.

XIII. Specified Powers Related to Mental Illness Treatment.

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

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

Given the special nature of mental health care—as well as a long and horrific history of abuse of individuals who are affected by mental health issues—the rules governing an agent's authority to admit a declarant to a health care facility for the treatment of mental illness (referred to a mental health facility hereafter) and to make health-care decisions for the declarant after admission are governed by both the Act and the Emergency Custody and Voluntary and Involuntary Civil Admissions rules of Chapter 8 under Title 37.2. The rules governing admission to mental health facilities are found in § 37.2-805.1, although they are referenced in the Act's capacity determination provisions under § 54.1-1983.2.C.

The agent's authorization to consent to admission to a mental health facility on behalf of the declarant must be expressly stated in the advance directive, as it does not fall under a general

authority consenting to admission to health care facilities.[57] Additionally, the agent's authority is limited to admission for no more than 10 calendar days.[58] This admission statute separately provides that anyone admitted pursuant to these rules must be discharged no later than 10 calendar days after admission unless within that time that individual's continued admission if authorized under other applicable laws.[59] If the declarant protests admission, then the Act's protest rules under § 54.1-2986.2 apply and must be followed in the advance directive (thus creating a third type of Ulysses Clause, subject to the same rules discussed in the previous section).

Additional determinations also apply before the agent can admit the declarant to a mental health facility. The Act's normal incapacity determination rules must be followed before the agent's general authority to act under the advance directive is triggered, but the Act includes a separate incapacity determination before the agent's authority granted in the advance directive to consent to admission of the declarant to a mental health facility:

> If a person has executed an advance directive granting an agent the authority to consent to the person's admission to a facility as defined in § 37.2-100 for mental health treatment and if the advance directive so authorizes, the person's agent may exercise such authority after a determination that the person is incapable of making an informed decision regarding such admission has been made by (i) the attending physician, (ii) a psychiatrist or licensed clinical psychologist, (iii) a licensed nurse practitioner, (iv) a licensed physician assistant, (v) a licensed clinical social worker, or (vi) a designee of the local community services board as defined in § 37.2-809. Such determination shall be made in writing following an in-person examination of the person and certified by the physician, psychiatrist, licensed clinical psychologist, licensed nurse practitioner, licensed physician assistant, licensed clinical social worker, or designee of the local community services board who performed the examination prior to admission or as soon as reasonably practicable thereafter. [60]

The Act connects back to the Emergency Custody and Voluntary and Involuntary Civil Admissions rules by adding that admission to a mental health facility upon the authorization of the person's agent shall be subject to the requirements of § 37.2-805.1.[61] Under those rules, a physician on the staff of, or designated by, the proposed admitting facility must also, prior to admission, examine the declarant and state in writing that the declarant has a mental illness, is incapable of

---

[57] § 37.2-805.1.A.
[58] Id.
[59] § 37.2-805.1.C.
[60] § 54.1-2983.2.C.
[61] Id.

making an informed decision about admission, and needs treatment in the facility.[62] Effectively, this requirement creates a best interest backstop for the protection of (potentially) vulnerable patients.

Drafting Note. Failure to include authority over admissions to mental health facilities means an agent will not have such authority under the advance directive. Whether to include this authority in an advance directive should be discussed with each client, whether or not admission over protest is desired. Not all practitioners include either option in their standard form. Also, given the interwoven nature of the rules between different sections of the Act and other parts of the Code setting out the different requirements, consider whether the Statutory Template's language attempting to capture some of the procedural rules would be better left unwritten. For example, consider this language for admission without protest: "[t]o authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days provided I do not protest the admission, assuming all other requirements under law for such admission are met, and to authorize my discharge (including transfer to another facility) from the facility."

Drafting Note. In light of the prior discussion of the timing and placement of the attestation required to trigger Ulysses Clauses related to particular health care decisions, it may be appropriate to consider eliminating the distinction between admissions without protest and admissions over protest, such as this language found in the VHHA Template: "[t]o authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If I have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document.)" The Collaborate Template includes this check-the-box option under its section titled What My Agent Can Do Over My Objection: "[t]o consent to my admission to a mental health care facility as permitted by law, even if I object."[63]

XIV. Authorization to Participate in Health Care Studies.

"I. 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 offers the prospect of direct therapeutic benefit to me;

J. To authorize my participation in any health care study approved by an institutional review board or research review committee pursuant to applicable federal or state law that aims

---

[62] § 37.2-805.1.A. Similar rules permit guardians appointed under Chapter 20 (§ 64.2-2000 et seq.) to consent to admission to a mental health facility, but none of the other statutory decision-makers under § 54.1-2986 have this authority.

[63] The Collaborative Template also includes the general authorization to consent to admission to a mental health facility in its specified powers section "What My Agent Can Do On My Behalf."

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;"

The Act permits a declarant to authorize an agent to consent to participation in both a health care study that offers the prospect of direct therapeutic benefit to the declarant and a health care study that aims to increase scientific understanding of any condition the declarant may have or otherwise to promote human well-being, even through there is no prospect of direct benefit to the declarant.[64] In either case, the health care study must be approved by an institutional review board pursuant to applicable federal regulations or by a research review committee pursuant to Chapter 5.1 (§ 32.1-162.16 et seq.) of Title 32.1.[65] This provision was among the major changes to the Act that were made in 2009 to expand the range of decisions that may be authorized in an advance directive, particularly because informed consent restrictions for human research otherwise prohibit obtaining consent for participation in research without written authority. Consistent with this intent, the authority of a statutory decision-maker does not include research participation.[66]

Drafting Note. As with all specified powers in the Statutory Template, failure to include either authorization results in the agent being denied the power to make these decisions for the declarant.

XV. Authority over Visitation Rights.

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

Reflective of a public policy position that patients should enjoy the broadest array of potential visitors unless they expressly indicate otherwise, control over visitation rights is granted only to agents acting under an advance directive that expressly includes provisions regarding visitation rights; none of the statutory decision-makers (including guardians) has the authority to restrict visitation of the patient.[67] Any such visitation decision by the agent remains subject to physician orders and policies of the institution to which the declarant has been admitted.[68]

Drafting Note. As with all specified powers in the Statutory Template, failure to include authority over visitation rights results in the agent being denied the power to make these decisions for the declarant. A blanket authorization, however, may also present problems, which is why the Statutory Template includes the option to insert specific directions regarding visitation. The

---

[64] § 54.1-2983.1.
[65] Id.
[66] Id.
[67] § 54.1-2986.1.A.
[68] Id.

blended family creates specific problems over visitation that should be discussed with clients, especially when the agent under the advance directive may feel alienated from or even hostile toward the "other" side of the family. Guidance over who can and cannot be denied visitation rights may be necessary.

XVI. A Catch-All Provision?

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

At a cursory glance, this final authorization may be understood as a catch-all provision authorizing any and all possible health care decisions. Agents under an advance directive, however, have only the authority to make the health care decisions "as specified in the advance directive."[69] This provision, therefore, authorizes only such other lawful actions needed to carry out the specified decisions and suggests, for example, that an agent may have to provide releases of liability to medical providers to facilitate the acceptance of the agent's authority. This language is taken from the Act's provision authorizing advance directives, under which it provides that an advance directive may "authorize an agent to take any lawful actions necessary to carry out the declarant's decisions, including, but not limited to, granting releases of liability to medical providers, releasing medical records, and making decisions regarding who may visit the patient.

The drafters of the Act included this provision to recognize how the Statutory Template has to allow for real life situations that are either impossible to address in a "one-size, fits-most" statutory form or are simply unforeseen for any number of reasons, including most significantly, the evolution of medicine.

Drafting Note. Both the VHHA Template and the Collaborative Template include the catch-all authorization but neither includes the sentence about agents not being liable for the declarant's health care costs.

XVII. Other Possible Authorizations—Durable Do Not Resuscitate Orders.

Given the rule that an agent has only the authority to take the health care decisions specified in the advance directive, additional authorizations may be added to a particular client's advance directive as the Statutory Template does not (nor was intended to) include an exclusive (or

[69] § 54.1-2986.1.A.

exhaustive) list. Some authorizations may be client-specific while others might be suitable to include in your general form.

Many clients who include the standard end-of-life provisions discussed below will also want a do not resuscitate instruction in their advance directive. Care should be taken to explain what can and cannot be included in a client's advance directive and the additional rules in the Act authorizing Durable Do Not Resuscitate Orders.

Most often, when clients say they want a do not resuscitate direction as part of their end-of-life planning, they mean a Durable Do No Resuscitate Order (DDNR), which is defined in the Act as a written physician's order issued pursuant to § 54.1-2987.1 to withhold cardiopulmonary resuscitation from a particular patient in the event of cardiac or respiratory arrest.[70] DDNRs cannot be built into advance directives because these orders must be prepared by a physician having a bona fide physician/patient relationship with the client as defined in the guidelines of the Board of Medicine.[71] At most, an advance directive can express the wish for a physician to issue a DDNR when it is medically-appropriate.

But a DDNR must also be prepared with the consent of the patient, so here is where the lawyer drafting an advance directive should pay attention. The Act provides that for patients otherwise incapable of making an informed decision regarding consent for a DDNR, the physician may prepare the DDNR upon the consent of and with the consent of the person authorized to consent on the patient's behalf.[72] The Act then defines "person authorized to consent on the patient's behalf" in the context of written advance directives as any person authorized by law to consent on behalf of the patient incapable of making an informed decision.[73] Therefore, an agent under the advance directive would appear to have this authority, even without a specific authorization in the advance directive.

Remember the general rule discussed in these materials that an advance directive must specify the health care decisions authorized by the agent. The Statutory Template includes as its first specified power a broad power over "any type of medical care, treatment, surgical procedure, diagnostic procedure, medication," but it is unclear whether that would authorize DDNRs.

Drafting Note. To avoid any confusion over an agent's authority to consent to a DDNR, it is best to include specific authorizing language in the form if the client wants to make sure the

---

[70] § 54.1-2982, which further provides that cardiopulmonary resuscitation includes cardiac compression, endotracheal intubation, and other advanced airway management, artificial ventilation, and defibrillation and related procedures.
[71] § 54.1-2987.1.B. Copies of DDNRO forms along with instructions for purchasing DDNRO bracelets and necklaces may be downloaded at the Office of Emergency Medical Services website: https://www.vdh.virginia.gov/emergency-medical-services/other-ems-programs-and-links/durable-do-not-resuscitate-program/
[72] Id.
[73] Id.

agent can request, and consent to, a DDNR, such as "To direct that my attending physician issue a Durable Do Not Resuscitate Order to be entered in my medical records (or other similar order preventing resuscitation) and to consent to such order(s) on my behalf." There is no specific mention of DDNRs in the VHHA Template or the Collaborative Template.

How a DDNR can be revoked should be explained to clients as the Act distinguishes between DDNRs entered with the consent of the client/patient and DDNRs entered with the consent of an agent under an advance directive. Only the client/patient can revoke a DDNR executed upon the request of and with the consent of the client/patient.[74] In other words, even if authorized under an advance directive, the agent cannot revoke a DDRN that was issued with the consent of the client/patient, although the agent can revoke a DDNR issued with the agent's consent.[75] Additional rules regarding DDNRs and the current forms for DDNRs can be found in Exhibit E to these materials.

XVIII. Additional Possible Specific Authorizations—Two H's (Hospice and Health Insurance)

As was mentioned when discussing the Statutory Template's catch-all provision, it can be difficult to prepare a form to address all health care decisions involved in a patient's care, especially given the rapid pace at which medicine is evolving. Frequent additional authorizations that appear in advance directives give the agent authority over hospice care and health insurance, including long-term care, disability, and state and federal programs.[76]

XIX. Additional Optional Health Care Instructions.

"OPTION III: HEALTH CARE INSTRUCTIONS

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

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

B. I specifically direct that the following health care not be provided to me under the following circumstances (you may specify that certain health care not be provided under any circumstances): _____."

---

[74] § 54.1-2987.1.D. (first paragraph).
[75] § 54.1-2987.1.D. (second paragraph).
[76] Dealing with insurance providers may also require the assistance of the declarant's agent under a financial power of attorney.

For clients who know of particular health care decisions or procedures that they either want to ensure are provided to them or want to make sure they are not provided can add specified instructions under the Statutory Template. For example, a particular client might have been living with a particular diagnosis for which certain treatments or procedures may likely be required. Similar concerns will come up with end-of-life instructions, which will be discussed in the next section. Importantly, this provision does not enable individuals to order care for themselves that is otherwise considered to be inappropriate care.

Drafting Note. The Collaborative Template includes even more client-tailored options regarding care and related issues, including lists for medications, treatments, and health care providers. Directions regarding tasks that need to be addressed while hospitalized (such as care for pets or scheduling for school-aged children) can also be included in this section. The drafting attorney needs to consider how detailed a standard form should be and how reasonable (and cost-effective) it may be to include many of these additional provisions.

Drafting Note. As is discussed in the End-of-Life materials, many research societies associated with a particular illness provide helpful guides for preparing advance directives for their patients. In working with a client with Lou Gehrig's Disease—that is, Amyotrophic lateral sclerosis (ALS)—these additional directions and authorizations were included in the advance directive:

"Should I be incapable of making and/or communicating an informed decision resulting from my ALS diagnosis, I specifically authorize my agent to take these options on my behalf in the latter phases of ALS:

1. To decline artificial respiration, especially if it entails a tracheostomy and a ventilator. This option will not necessarily exclude the use of a positive pressure device to assist with respiration.

2. To withhold nutrition and hydration given by mouth or via gastric tube, including the authority to direct the removal of any gastric tube.

3. To decline cardio-pulmonary resuscitation, including the authority to enter a DNR on my behalf. This listing of options is not intended to limit my agent's authority and is intended to make my wishes better known."

XX. End-of-Life Instructions.

"OPTION IV: END OF LIFE INSTRUCTIONS

(CROSS THROUGH THIS OPTION IF YOU DO NOT WANT TO GIVE INSTRUCTIONS ABOUT YOUR HEALTH CARE IF YOU HAVE A TERMINAL CONDITION.)

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

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

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

_____

_____

_____

_____*:*

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

_____

_____

_____

_____*;*

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

_____

_____

_____

_____*;*

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

When most clients are asked about advance directives, they typically immediately think of these end-of-life provisions in the Statutory Template and then make some comment about the wisdom or follow of giving a particular family member the power to "pull the plug." Care should be taken to explain the difference between these end-of-life instructions (what is still occasionally called a client's "Living Will") and the discussed agent authorizations that apply after the client is incapable of making an informed decision. The end-of-life provisions, which direct specific actions or inactions by the declarant's physicians, are authorized by the Act's general authorization provision that permits written advance directives to specify the health care that the declarant does or does not authorize.[77]

There is no separate authorization in the Act specifically over end-of-life provisions, which may be surprising to read. There is, however, an implicit authorization of end-of-life provisions in advance directives when the Act declares that the "withholding or withdrawal of life-prolonging measures in accordance with the provisions of this [Act] shall not, for any purpose, constitute a suicide.[78]

Many of the terms commonly used in advance directive forms come solely from the Definitions provisions of the Act and the Statutory Template itself, thus suggesting drafting attorneys have more flexibility in how to craft these provisions than may be commonly thought. For example, the terms "life-prolonging measures," "persistent vegetative state," and "terminal condition" are all defined in § 54.1-2982.

Drafting Note. For drafting attorneys who follow the End-of-Life Instructions from the Statutory Template, it may be advisable to connect those terms directly with the statutory definitions, if you have not separately defined them in your form. While the Statutory Template includes provisions that we have described as extraneous and can be eliminated, the template here allows for uncertainty over the meaning of these terms by failing to define them or connect back to the Act's definitions. The VHHA Template and the Collaborative Template have largely rewritten the end-of-life provisions in its forms. The "terminal condition" provision is instead triggered when "my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover." They also provide a separate trigger for when "my condition makes me unaware of myself or my surrounding or unable to interact with others, and it is reasonably certain that I will never recover awareness or ability even with medical treatment;" this language replaces the Act's definition of "persistent vegetative state" with broader language

[77] § 54.1-2983.A.
[78] § 54.1-2991 (first paragraph).

that no longer requires a loss of consciousness, with no behavioral evidence of self-awareness or awareness of surroundings in a learned manner.

Drafting Note. For clients with particular diagnoses, it may be needed to alter the life-prolonging measures definition under the Act. For example, clients with Lou Gehrig's Disease—that is, Amyotrophic lateral sclerosis (ALS)—will often require limited respiratory assistance as the disease progresses. The Statutory Template's inclusion of artificial respiration in the list of prohibited life-prolonging measures may need to be modified to permit this type of limited respiratory assistance typically provided by a positive pressure device over the mouth and/or nose.[79] Additionally, an ALS patient may consider a specific direction that no tracheostomy be performed to assist with respiration once the ALS diagnosis can be considered a terminal condition.

Drafting Note. Many of the research societies associated with particular diseases publish helpful guides to assist those with the particular disease in thinking through end-of-life decisions and in preparing advance directives. For example, the Huntingdon's Disease Society for America publishes a HDSA Family Guide Series on Advance Directives for Huntington's Disease, which includes the difficult conversation over gastrostomy feeding tubes and intubation.[80]

XXI. Anatomical Gifts and Organ Donation.

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

Upon my death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye donations may be made pursuant to Article 2 (§ 32.1-291.1 et seq.) of Chapter 8 of Title 32.1 and in accordance with my directions, if any. I hereby appoint _____ as my agent, of _____ (address and telephone number), to make any such anatomical gift or organ, tissue or eye donation following my death. I further direct that: _____ (declarant's directions concerning anatomical gift or organ, tissue or eye donation)."

The final option in the Statutory Template concerns anatomical gifts and organ donations. The Act's statute authorizing advance directives allows the specification of an anatomical gift, after the declarant's death, of the declarant's body or an organ, tissue, or eye donation pursuant to Virginia's Revised Uniform Anatomical Gift Act (§§ 32.1-291. Through 32.1-291.25).[81] Unlike the discussed authorizations that must be included in an advance directive to be effective, agents under an advance directive automatically have the authority to make anatomical gifts and

[79] For more on clients with ALS, see https://www.als.org/navigating-als/resources/fyi-advance-directives
[80] See https://hdsa.org/product/hdsa-family-guide-series-advanced-directives-for-huntingtons-disease/
[81] § 54.1-2983 (first paragraph).

donations of the declarant's organs both during the life of the declarant and after death unless the advance directive or other record prohibits the act taking such actions.[82]

Drafting Note. A client who does not want an agent (or anyone else) making anatomical gifts must expressly prohibit donation in the advance directive, not just authority over donation. The VHHA Template and the Collaborative Template both include instructions that the agent will have this authority unless specifically prohibited in the advance directive (by adding language such as "I do not want to be an organ donor") or other document.

Drafting Note. The VHHA Template and the Collaborative Template also both include language that reduces the potential for a conflict between the terms of the advance directive and the organ donor designation: "I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes or tissues for donation." Among other things, this language may be important in responding to concerns by third parties about the use of "life support" measures to sustain the viability of organs for donation despite stated wishes against the therapeutic use of such measures in an advance directive.

Drafting Note. A client who wishes to allow anatomical gifts and certain organ, tissue, or eye donations should make sure the advance directive language is consistent with any other method of making anatomical gifts during life under the Revised Uniform Anatomical Gift Act, such as statements on a driver's license, in a will, or donor card.[83]

Separate rules apply regarding the actual disposition of an individual's remains. A person may designate an individual to be responsible the arranging and disposing of the individual's remains if (i) such designation is in a signed and notarized writing, and (ii) the designated individual has accepted in writing this responsibility.[84] If a copy of the designation is provided to the funeral service and to the cemetery, if applicable, no later than 48 hours after receiving the remains, the designated individual has priority over a statutory list of authorized individuals who would otherwise have authority over arrangements for and disposition of the remains.[85] In the absence of making this designation, the individual's next of kin have authority but if there is disagreement among the next of kin, any of the next of kin may petition the circuit court where the decedent resided to determine who shall have this authority.

Drafting Note. As will be discussed in the final section of these materials, an advance directive does not have to be notarized although many attorneys will include notarization in their form. If the client wishes to include this authority over the disposition of the client's remains, not only must the advance directive be notarized but the person so designated must accept in writing

---

[82] See § 32.1-291.4 (during life) and § 32.1-291.9 (after death). Such gifts are authorized for the purpose of transplantation, therapy, research, or education.

[83] The alternate methods are specified in § 32.1-291.5, including the Virginia online donor registry at www.DonateLifeVirginia.org.

[84] § 54.1-2825.A.

[85] Id.

this authority. The person designated to control the disposition of the remains does not have to be an agent under the advance directive, which may create confusion.

XXII. Durability and Revocation.

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

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

The express purpose of the advance directive is to be "durable"—that is to say, its function is to be effective after the declarant's disability. The Act never explicitly discusses the durability of advance directives other than the general rules governing capacity at the time of execution, at the time when the agent can act, and for revocation.

Drafting Note. Neither the VHHA Template or the Collaborative Template include the statement of durability if disability occurs.

The Act permits three methods for revoking an advance directive: (i) by a signed, dated writing; (ii) by physical cancellation or destruction of the advance directive by a declarant or by someone in the presence, and at the direction of, the declarant; or (iii) by oral expression of intent to revoke.[86] For each method, the Act requires that at the time of the revocation, the declarant could understand the nature and consequences of the revocation.[87] This additional capacity requirement is necessary for clients who, similar to the reasons for including Ulysses Clauses, might express a desire to revoke the advance directive while not being capable of understanding the consequences of that action.

Drafting Note. The Statutory Template includes the three permitted methods of revocation but does not mention the capacity requirement. To avoid confusion of later revocations while lacking the requisite capacity, it may be better to revise the revocation language. The VHHA Template reads "I also understand that I may revoke all or any part of [this advance directive] at any time as provided by law." The Collaborative Template reads "**Right to Revoke**. I understand that I may cancel all or part of my AD at any time that I am able to understand the consequences of doing so."

---

[86] § 54.1-2985.A.
[87] Id.

When an advance directive has been submitted to the Advance Health Care Planning Registry, there is a separate procedure for removing the revoked advance directive from the online registry that creates an additional requirement for the revocation document. The document revoking the advance directive must be submitted to the Department of Health for removal, but before submission, that document must be notarized.[88] Fortunately, failure to notify the Department of Health of revocation filed with the online registry does not affect the validity of the revocation, so long as the revocation met the statutory requirements for revocation

Drafting Note. As discussed in Section XXIII, advance directives do not have to notarized to be effective. If a new advance directive serves to revoke a prior advance directive that has been filed with the online registry, the new advance directive under the removal procedure must be notarized prior to submission to the online registry.

XXIII. Signature Requirements for Advance Directives, Litigation, and Reciprocity.

"_____ _____
(Date) (Signature of Declarant)

The declarant signed the foregoing advance directive in my presence.

(Witness) _____ (Witness) _____"

An issue that often presents itself to hospitals and care providers concerns the confusion over advance directives and durable powers of attorney. Durable Powers of Attorney designed to address financial decisions for a particular individual occasionally contain provisions regarding medical care for the individual. Confusion is understandable as a core function of an advance directive is to name an agent for making health care decisions for the principal, similar to how that same principal can name an agent for making financial decisions for the principal. Provisions authorizing agents under the durable power of attorney to pay for medical care and health care expenses are appropriate for the form, but what about provisions that give the agent authority over actual health care decisions?

Unfortunately, the requirements for making an advance directive under the Act are more restrictive than making a financial power of attorney. Under Virginia's Uniform Power of Attorney Act (§ 64.2-1600, *et seq.*), a power of attorney must be in writing or other record and be signed by the principal or in the principal's conscious presence by another individual directed by the principal to sign the principal's name on the power of attorney.[89] A notary acknowledgement

[88] § 54.1-2985.B.
[89] § 64.2-1603.

is not required unless it is to be recorded, although the principal's signature will be presumed to be genuine if acknowledged before a notary.[90]

Besides a signature of the principal (here, the declarant), the Act further requires not only that the declarant sign the advance directive, but the declarant must also do so in the presence of two subscribing witnesses.[91] The Act broadened the pool of permissible witnesses to an advance directive, defining the term to mean any person over the age of 18, and expressly including in this definition a spouse or blood relative of the declarant. Adult employees of health care facilities and physician's offices are also expressly permitted to serve as witnesses if they are acting in good faith.

Drafting Note. While estate planning attorneys may prefer to control the execution of their documents by holding signings at their office, the health care protections implemented over COVID-19 forced many planners to adopt new signing procedures. For those who still believed the rules required disinterested witnesses, it may have been difficult to arrange for witnesses. Given the Act's presumption of validity, it is hoped that allowing spouses and family members to serve as witnesses will make it easier to facilitate signings for clients unable to travel.

Drafting Note. Pay attention to the attestation clause used in your form immediately before the signature of the witnesses. Several older advance directives include attestations that the declarant is known to the witnesses, is of sound mind, and is not a blood relative or spouse of the witnesses. None of these three attestations are required under the current authorizing statute, although a recitation that the declarant is capable of making an informed decision may be helpful to remind everyone of that requirement.

No notary acknowledgment is required, similar to the financial power of attorney. But unlike a financial power of attorney, adding the notary acknowledgment does not create a presumption of genuineness—the Act presumes that the advance directive made under the Act's requirements has been made voluntarily and in good faith by an adult capable of making an informed decision.[92]

It is perhaps the Act's presumption of validity that explains the apparent lack of litigation over advance directives. The Act does provide a right of any person to petition the circuit court of the city or county in which a patient resides or is located to challenge an action regarding the patient's health care that will be or is currently bring provided, continued, withheld, or withdrawn pursuant to the Act.[93] The court may then enjoin the challenged action upon finding by a

[90] Id.
[91] § 54.1-2983 (first paragraph).
[92] § 54.1-2988 (fifth paragraph).
[93] § 54.1-2985.1.A.

preponderance of the evidence that the action is not lawfully authorized by the Act or by other state or federal law.[94] The Act does expressly provide that nothing in the Act shall limit the ability of a person to petition and obtain a court order for health care of a patient pursuant to other existing laws of Virginia.[95]

While all states have statutes authorizing advance directives, there is little uniformity among the states. To date, only seven states have adopted the Uniform Health-Care Decisions Act,[96] leaving the rest to have developed their own versions. When this lack of uniformity is coupled with the increasingly mobile nature of society, questions over enforceability are natural and frequent. The Act, therefore, deems an advance directive executed in another state that was either executed in compliance with the Act or executed in compliance with the laws of the state where executed to be validly executed for the purposes of the Act.[97] Those advance directives will, however, be construed under Virginia laws.[98]

Drafting Note. Although all states have reciprocity provisions in their advance directive laws, practitioners who serve clients that are likely to travel to other states should consider building in elements to meet the requirements of the relevant other state. For example, despite provisions to accept non-notarized advance directives, experience has proven that providers in states with notary requirements often do not honor documents that have not been notarized.

Drafting Note. As discussed, it is the client's responsibility under the Act to provide a copy of the advance directive to the client's health care providers, even if the client uploads a copy to the online registry. Consider adding language reminding clients of this responsibility so they understand what still needs to be done once the advance directive has been signed. The Collaborative Template includes this sentence after the signature blocks: "It is your responsibility to provide a copy of your advance directive to your health care providers. You should also provide copies to your agent, close relatives, and/or friends."

> *<u>Please note</u>: This presentation contains general, condensed summaries of actual legal matters, statutes and opinions for information purposes. It is not meant to be and should not be construed as legal advice. Individuals with particular needs on specific issues should retain the services of competent counsel.*

---

[94] Id.
[95] § 54.1-2985.1.B.
[96] Maine, Delaware, Mississippi, New Mexico, Utah, Alaska, and Hawaii. Significantly, the Uniform Law Commission is in the midst of drafting an updated "Uniform Health-Care Decisions Act." Adoption of the updated uniform act is anticipated at some point in 2023. Nathan has been involved in the drafting process as an "American Bar Association Advisor."
[97] § 54.1-2993.
[98] Id.