

# **SUGGESTIONS FOR PREPARING WILL TO LIVE DURABLE POWER OF ATTORNEY**

*(Please read the document itself before reading this.  
It will help you better understand the suggestions.)*

**YOU ARE NOT REQUIRED TO FILL OUT ANY PART OF THIS "WILL TO LIVE" OR ANY OTHER DOCUMENT SUCH AS A LIVING WILL OR DURABLE POWER OF ATTORNEY FOR HEALTH CARE. NO ONE MAY FORCE YOU TO SIGN THIS DOCUMENT OR ANY OTHER OF ITS KIND.**

The Will to Live form starts from the principle that the presumption should be for life. If you sign it without writing any "SPECIAL CONDITIONS," you are giving directions to your health care provider(s) and health care agent<sup>1</sup> to do their best to preserve your life.

Some people may wish to continue certain types of medical treatment when they are terminally ill and in the final stages of life. Others may not.

If you wish to refuse some specific medical treatment, the Will to Live form provides space to do so ("SPECIAL CONDITIONS"). You may make special conditions for your treatment when your death is imminent, meaning you will live no more than a week even if given all available medical treatment; or when you are incurably terminally ill, meaning you will live no more than three months even if given all available medical treatment. There is also space for you to write down special conditions for circumstances you describe yourself.

The important thing for you to remember if you choose to fill out any part of the "SPECIAL CONDITIONS" sections of the Will to Live is that you must be very specific in listing what treatments you do not want. Some examples of how to be specific will be given shortly, or you may ask your physician what types of treatment might be expected in your specific case.

Why is it important to be specific? Because, given the pro-euthanasia views widespread in society and particularly among many (not all) health care providers, there is great danger that a vague description of what you do not want will be misunderstood or distorted so as to deny you treatment that you do want.

Many in the medical profession as well as in the courts are now so committed to the

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<sup>1</sup> Some states use the terms "attorney in fact," "surrogate," "designee," and "representative" instead of "agent." They are synonymous for purposes of these suggestions.

quality of life ethic that they take as a given that patients with severe disabilities are better off dead and would prefer not to receive either life-saving measures or nutrition and hydration. So pervasive is this "consensus" that it is accurate to say that in practice it is no longer true that the "presumption is for life" but rather for death. In other words, instead of assuming that a now incompetent patient would want to receive treatment and care in the absence of clear evidence to the contrary, the assumption has virtually become that since any "reasonable" person would want to exercise a "right to die," treatment and care should be withheld or withdrawn unless there is evidence to the contrary. The Will to Live is intended to maximize the chance of providing that evidence.

It is important to remember that you are writing a legal document, not holding a conversation, and not writing a moral textbook. The language you or a religious or moral leader might use in discussing what is and is not moral to refuse is, from a legal standpoint, often much too vague. Therefore, it is subject to misunderstanding or deliberate abuse.

The person you appoint as your health care agent may understand general terms in the same way you do. But remember that the person you appoint may die, or become incapacitated, or simply be unavailable when decisions must be made about your health care. If any of these happens, a court might appoint someone else you don't know in that person's place. Also remember that since the agent has to follow the instructions you write in this form, a health care provider could try to persuade a court that the agent isn't really following your wishes. A court could overrule your agent's insistence on treatment in cases in which the court interprets any vague language you put in your "Will to Live" less protectively than you meant it.

So, for example, do not simply say you don't want "extraordinary treatment." Whatever the value of that language in moral discussions, there is so much debate over what it means legally that it could be interpreted very broadly by a doctor or a court. For instance, it might be interpreted to require starving you to death when you have a disability, even if you are in no danger of death if you are fed.

For the same reason, do not use language rejecting treatment which has a phrase like "excessive pain, expense or other excessive burden." Doctors and courts may have a very different definition of what is "excessive" or a "burden" than you do. Do not use language that rejects treatment that "does not offer a reasonable hope of benefit." "Benefit" is a legally vague term. If you had a significant disability, a health care provider or court might think you would want no medical treatment at all, since many doctors and judges unfortunately believe there is no "benefit" to life with a severe disability.

What sort of language is specific enough if you wish to write exclusions? Here are some examples of things you might--or might not--want to list under one or more of the "Special Conditions" described on the form. Remember that any of these will prevent treatment ONLY under the circumstances--such as when death is imminent--described in the "Special Condition" you list it under. (The examples are not meant to be all inclusive--just samples of the type of thing you might want to write.)

"Cardiopulmonary resuscitation (CPR)." (If you would like CPR in some but not all circumstances when you are terminally ill, you should try to be still more specific: for example, you might write "CPR if cardiopulmonary arrest has been caused by my terminal illness or a complication of it." This would mean that you would still get CPR if, for example, you were the victim of smoke inhalation in a fire.) "Organ transplants." (Again, you could be still more specific, rejecting, for example, just a "heart transplant.")

"Surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain, but would only keep me alive longer."

"A treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me."

### **Pain Relief**

Under the "General Presumption for Life," of your Will to Live, you will be given medication necessary to control any pain you may have "as long as the medication is not used in order to cause my death." This means that you may be given pain medication that has the secondary, but unintended, effect of shortening your life. If this is not your wish, you may want to write something like one of the following under the third set of "Special Conditions" (the section for conditions you describe yourself):

"I would like medication to relieve my pain but only to the extent the medication would not seriously threaten to shorten my life." OR

"I would like medication to relieve my pain but only to the extent it is known, to a reasonable medical certainty, that it will not shorten my life."

Think carefully about any special conditions you decide to write in your "Will to Live." You may want to show them to your intended agent and a couple of other people to see if they find them clear and if they mean the same thing to them as they mean to you. Remember that how carefully you write may literally be a matter of life or death--your own.

**AFTER WRITING DOWN YOUR SPECIAL CONDITIONS, IF ANY, YOU SHOULD MARK OUT THE REST OF THE BLANK LINES LEFT ON THE FORM FOR THEM (JUST AS YOU DO AFTER WRITING OUT THE AMOUNT ON A CHECK) TO PREVENT ANY DANGER THAT SOMEBODY OTHER THAN YOU COULD WRITE IN SOMETHING ELSE.**

**IT IS WISE TO REVIEW YOUR WILL TO LIVE PERIODICALLY TO ENSURE THAT IT STILL GIVES THE DIRECTIONS YOU WANT FOLLOWED.**

Robert Powell Center for Medical Ethics  
National Right to Life  
[www.nrlc.org](http://www.nrlc.org) ~ (202) 378-8862

## **How to use the Idaho Will to Live Form SUGGESTIONS AND REQUIREMENTS**

1. You must be a competent adult (18 years of age) to make this declaration. You cannot make the declaration orally; it must be in writing and must bear your signature. Two adult (age 18 or older) witnesses must also sign the document, or else you may have it notarized, for it to have legal effect. If witnesses do sign the document, they must meet the requirements listed in the document, and at least one of them must make the additional declaration included on the form.
2. You should tell your doctor about this declaration. You should also ask your doctor to keep a copy of this declaration as a part of your medical health record. Should you decide to change doctors, you should tell your new doctor about this declaration and give him or her a copy to place in your medical health record.
3. The establishment of this declaration has been authorized by § 39-4501 through § 39-4509 of the Idaho Durable Power of Attorney for Health Care statute (part of the Idaho Natural Death Act) in recognition of your right as a competent adult to make a declaration stating your desires on the use of health care procedures.
4. It is the assumed responsibility of your agent to act in accordance with your wishes to act in your best interest. What you tell a doctor will continue to take precedence over your declaration as long as you are capable of making and communicating your health care decisions.  
Note: You have the right to appoint substitute health care agents, in the event that the first agent is unwilling or unable to serve.
5. A properly signed and witnessed declaration will remain in effect until you revoke (cancel) it. You may revoke your declaration by any of the following means: cancelling the written text or physically destroying the document yourself, or directing someone else to do so in your presence; writing and signing a document expressing your intent to revoke the declaration or orally telling people you want to revoke it.
6. You should give a copy of this document to family members or others who someday might have to make medical decisions for you. In particular, give copies to your designated health care agent(s). You should keep your own declaration at home in a safe, but easily accessible place. Notify someone where you are storing it.
7. You should periodically review your document to be sure it complies with your wishes. Before making changes, be aware that it is possible that the statutes controlling this document have changed since this form was prepared. Contact the Will to Live Project by visiting [www.nrlc.org](http://www.nrlc.org) (Click on “Will to Live”) or an attorney to determine if this form can still be used.

8. If you have any questions about this document, or want assistance in filling it out, please consult an attorney.

For additional copies of the Will to Live, please visit [www.nrlc.org](http://www.nrlc.org)

**Idaho Durable Power of Attorney for Health Care  
Will to Live Form**

**1. DESIGNATION OF HEALTH CARE AGENT**

I, (your name) \_\_\_\_\_  
(your address) \_\_\_\_\_  
\_\_\_\_\_  
(your phone number) \_\_\_\_\_

do hereby designate and appoint:

(Name of agent) \_\_\_\_\_  
(address of agent) \_\_\_\_\_  
(phone number(s) of agent) \_\_\_\_\_

*(insert name, address and telephone number(s) of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider; (2) a non-relative employee of your treating health care provider; (3) an operator of a community care facility; or (4) a non-relative employee of an operator of a community care facility.)*

as my attorney-in-fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical condition.

**2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

By this document I intend to create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity.

**3. GENERAL STATEMENT OF AUTHORITY GRANTED**

Subject to any limitations in this document, I hereby grant my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures. (If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4, "Statement of Desires, Special Provisions, and Limitations,") below. You can indicate your desires by including a statement of your desires in the same paragraph.

#### **4. STATEMENT OF DESIRES, SPECIAL PROVISIONS AND LIMITATIONS**

*(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)*

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below.

#### **GENERAL PRESUMPTION FOR LIFE**

I direct my health care provider(s) and health care attorney in fact(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care attorney in fact to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

—all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and health care attorney in fact to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my attorney in fact, as named above, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

**WHEN MY DEATH IS IMMINENT**

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:  
**(Be as specific as possible; SEE SUGGESTIONS.):**

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(Cross off any remaining blank lines.)

**WHEN I AM TERMINALLY ILL**

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:  
**(Be as specific as possible; SEE SUGGESTIONS.):**

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(Cross off any remaining blank lines.)



**C. OTHER SPECIAL CONDITIONS:**  
**(Be as specific as possible; SEE SUGGESTIONS.):**

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(Cross off any remaining blank lines.)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**IF I AM PREGNANT**

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care attorney in fact(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

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

**5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH**

Subject to any limitations in this document, my agent has the power and authority to do all of the following:

- (a) request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records;
- (b) execute on my behalf any releases or other documents that may be required in order to obtain this information;
- (c) consent to the disclosure of this information;
- (d) consent to the donation of any of my organs for medical purposes. (If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 (“Statement of Desires, Special Provisions, and Limitations”) above.

**6. SIGNING DOCUMENTS, WAIVERS AND RELEASES**

Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

- (a) Documents titled or purporting to be a “Refusal to Permit Treatment” and “Leaving Hospital Against Medical Advice.”
- (b) Any necessary waiver or release from liability required by a hospital or physician.

**7. DESIGNATION OF ALTERNATE AGENTS**

*(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, above, in the event that the agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if the marriage is dissolved.)*

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make health care decisions for me, or if I revoke that person’s appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

**A. First Successor Agent**

(successor agent’s name) \_\_\_\_\_

(successor agent’s address) \_\_\_\_\_

\_\_\_\_\_  
(successor agent’s phone number) \_\_\_\_\_

**B. Second Successor Agent**

(second successor agent’s name) \_\_\_\_\_

(second successor agent’s address) \_\_\_\_\_

\_\_\_\_\_  
(second successor agent’s phone number) \_\_\_\_\_

**8. PRIOR DESIGNATIONS REVOKED**

I revoke any prior durable power of attorney for health care.

**DATE AND SIGNATURE OF PRINCIPAL**

*(You must sign and date this power of attorney)*

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,

in the city of \_\_\_\_\_, state of \_\_\_\_\_.

(Signature)\_\_\_\_\_

**SIGNATURE OF WITNESSES**

*(This power of attorney will not be valid unless it is signed by two qualified witnesses who are present when you sign or acknowledge your signature. If you have attached any additional pages to this form, you must date and sign each of the additional pages at the same time you date and sign this power of attorney.)*

This document must be witnessed by two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as your agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.

I declare under penalty of perjury under the laws of Idaho that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document; and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

First Witness Signature:\_\_\_\_\_

Residence Address:\_\_\_\_\_

Second Witness Signature:\_\_\_\_\_

Residence Address:\_\_\_\_\_

**TO BE SIGNED BY ONE OF THE WITNESSES:**

I further declare under penalty of perjury under the laws of Idaho that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing by operation of law.

Witness Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

**NOTARY PUBLIC**

*(The signer of this instrument may either have it witnessed as above or have his/her signature notarized as below, to legalize this instrument.*

State of Idaho

County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,

before me, (name of notary public)\_\_\_\_\_

personally appeared, \_\_\_\_\_  
to me known (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Notary Seal

Signature of Notary Public \_\_\_\_\_

My commission expires \_\_\_\_\_

Form prepared 2001  
\*clerical changes made 08/10