Advance Directives

Living Will and Durable Power of Attorney for Health Care

St. Luke's and its physicians and staff believe in the basic principle of patient self-determination and the rights of competent adults to make their own medical treatment decisions and to execute Advance Directives.

Advance Directives are documents that allow individuals to make their wishes known in advance regarding end-of-life care and whom they want to make health care decisions for them if they should ever become unable to speak for themselves.

Advance Directives include the following properly-executed documents:

- Living Will
- Durable Power of Attorney for Health Care
- Written statements expressing a patient's wishes regarding treatment and/or end-of-life care
- Patient statements regarding treatment and/or end-of-life care documented in the medical record
- Physician Order for Scope of Treatment (POST)

In keeping with the values and mission of St. Luke's, and to the extent permitted or required by law, St. Luke's physicians and staff will honor and comply with the terms of a patient's Advance Directives in the inpatient and outpatient hospital setting, as long as the necessary physician orders are in place.

Note: Even if a patient has properly-executed Advance Directives, a current physician "Do Not Resuscitate" order (DNR) or Physician Order for Scope of Treatment (POST) is required in order to withhold resuscitative efforts. This order is written in the chart after the physician understands the patient's wishes.

If a patient's Advance Directives create medical, ethical, or professional dilemmas among physicians, family members, nurses, and/or other care providers, St. Luke's Medical Ethics Committee, or a comparable medical staff committee, is available for consultation.

St. Luke's will ask all patients who are 18 years of age or older and who are being admitted as inpatients to the Hospital, Hospice, or Home Care, whether or not they have Advance Directives and, if so, whether or not they wish to have a copy placed on their medical record.

Patients are not required to have Advance Directives, and St. Luke's does not condition the provision of care or otherwise discriminate on the basis of whether or not Advance Directives have been completed. If you don't have an Advance Directive on file, this information will be provided to you upon request. **Patients are encouraged to discuss their wishes with their family members and their physician, and to complete Advance Directives prior to their admission.**

For More Information

For additional information or assistance in completing Advance Directives, please visit the American Hospital Association website at putitinwriting.org (includes information in English and Spanish).

If additional Living Will and Durable Power of Attorney for Health Care forms are needed, download a printable form at stlukesonline.org/livingwill

Or call:

St. Luke's Boise and Meridian
208-381-2616

St. Luke's Magic Valley
208-814-0066

St. Luke's Wood River
208-727-8441

St. Luke's McCall Hospital
208-634-2221

or register your Advance Directive online with the State of Idaho:

sos.idaho.gov/general/hcdr.htm

Advance Directives - Important Definitions

Idaho Living Will: This document lets individuals state their wishes about medical care in the event they are terminally ill or in a persistent vegetative state and can no longer make their own decisions. *The Idaho Living Will becomes effective immediately and is implemented when two doctors acknowledge that a person is terminally ill and that death will occur with or without the use of life-sustaining procedures or that they are in a persistent vegetative state.*

Idaho Durable Power of Attorney for Health Care: This document lets individuals name someone to make decisions about their medical care – including decisions about life support – if they can no longer speak for themselves. This document is especially useful for individuals, because it appoints someone to speak for them any time that they are unable to make their own medical decisions, not only at the end of life.

Cardiopulmonary Resuscitation (CPR): A medical procedure, often involving external chest compression, administration of drugs, and electric shock, used to restore the heartbeat at the time of a cardiac arrest.

Note: At St. Luke's, as in many other hospitals, a current physician "Do Not Resuscitate" order (DNR) or Physician Order for Scope of Treatment (POST) is required in the chart in order to withhold resuscitative efforts. This order is written after the physician understands the patient's wishes.

Artificial Life-Sustaining Procedure: Any medical procedure or intervention that utilizes mechanical means to sustain or supplant a vital function which, when applied to a qualified patient, would serve only to artificially prolong life. It does not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

Artificial Nutrition and Hydration: Supplying food and water through a conduit, such as a tube or intravenous (IV) line, where the recipient is not required to chew or swallow voluntarily, but does not include assisted feeding, such as spoon feeding or bottle feeding.

Completing Advance Directives

Any competent person may complete a Living Will and Durable Power of Attorney for Health Care. A "competent person" is any person 18 years of age or older or any emancipated minor, as long as he or she is of sound mind. A person may cancel or revoke this document simply by issuing a new Living Will and Durable Power of Attorney for Health Care, or by writing or stating the wish that such document be cancelled or revoked.

The Idaho Living Will and Durable Power of Attorney for Health Care is easy to complete.

Individuals may complete the entire Living Will and Durable Power of Attorney for Health Care document, or they may just complete one part and leave the other part blank.

The Idaho Living Will and Durable Power of Attorney for Health Care does not have to be witnessed or notarized. It just needs to be signed by the person completing it.

Copies of the completed Living Will and Durable Power of Attorney for Health Care should be given to family members, physicians, hospitals, and others that may be involved in a person's medical decision-making. Individuals should keep the original or a copy in a secure but accessible place.

Physician Order for Scope of Treatment (POST)

In addition to a Living Will and Durable Power of Attorney for Health Care, patients may wish to request that their physician complete and sign a Physician Order for Scope of Treatment (POST) form.

The POST is a standardized form that allows a person to express his or her treatment wishes in advance of needing medical treatment. The POST is signed by your physician, and the orders on the POST will be followed by emergency medical personnel, medical care providers, and health institutions in the state of Idaho. Your physician may obtain a copy of the POST from the Idaho Secretary of State's website at sos.idaho.gov, by clicking on "Health Care Directive Registry."

For more information about the POST, please visit the Idaho Health and Welfare – Emergency Medical Services web page.

You may also have your POST placed in the State Health Care Directives Registry by following the instructions at the Idaho Secretary of State's website at sos.idaho.gov, and clicking on "Health Care Directive Registry."

LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Date of Directive: ____

Name of person executing Directive: ______________________________________

Address of person executing Directive: ____________________________________

____

A Living Will
A Directive to Withhold or to Provide Treatment

1. I willfully and voluntarily make known my desire that my life shall not be prolonged artificially under the circumstances set forth below. This Directive shall be effective only if I am unable to communicate my instructions and:

   a. I have an incurable or irreversible injury, disease, illness or condition, and a medical doctor who has examined me has certified:

      1. That such injury, disease, illness or condition is terminal; and
      2. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
      3. That my death is imminent, whether or not artificial life-sustaining procedures are utilized.

   OR

   b. I have been diagnosed as being in a persistent vegetative state.

In such event, I direct that the following marked expression of my intent be followed and that I receive any medical treatment or care that may be required to keep me free of pain or distress.

Check one box and initial the line after such box:

☐ ___________ I direct that all medical treatment, care, and procedures necessary to restore my health and sustain my life be provided to me. Nutrition and hydration, whether artificial or non-artificial, shall not be withheld or withdrawn from me if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.

OR

☐ ___________ I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial shall not be withheld or withdrawn from me if, as a result, I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition, as follows:

(If none of the following boxes are checked and initialed, then both nutrition and hydration, of any nature, whether artificial or non-artificial, shall be administered.)

Check one box and initial the line after such box:

☐ __________ A. Only hydration of any nature, whether artificial or non-artificial, shall be administered.

☐ __________ B. Only nutrition, of any nature, whether artificial or non-artificial, shall be administered.

☐ __________ C. Both nutrition and hydration, of any nature, whether artificial or non-artificial shall be administered.

OR

☐ ___________ I direct that all medical treatment, care and procedures be withheld or withdrawn, including withdrawal of the administration of artificial nutrition and hydration.

2. If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy.

3. I understand the full importance of this Directive and am mentally competent to make this Directive. No participant in the making of this Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

4. Check one box and initial the line after such box:

☐ ___________ I have discussed these decisions with my physician and have also completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Directive. I hereby approve of those orders and incorporate them herein as if fully set forth.

OR

☐ ___________ I have not completed a Physician Orders for Scope of Treatment (POST) form. If a POST form is later signed by my physician, then this living will shall be deemed modified to be compatible with the terms of the POST form.

A Durable Power of Attorney for Health Care

1. DESIGNATION OF HEALTH CARE AGENT

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.

If the agent or an alternate agent designated in this Directive is my spouse, and our marriage is thereafter dissolved, such designation shall be thereupon revoked.

I do hereby designate and appoint the following individual as my attorney in fact (agent) to make health care decisions for me as authorized in this Directive.
(Insert name, address and telephone number of one individual only as your agent to make health care decisions for you.)

Name of Health Care Agent: ____

Address of Health Care Agent: ____

Telephone Number of Health Care Agent: ______________________________________

For the purposes of this Directive, "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 portion of this Directive, I create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity. This power shall be effective only when I am unable to communicate rationally.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

I hereby grant to 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 Directive or otherwise made known to my agent including, but not limited to, my desires concerning obtaining or refusing or withdrawing artificial life-sustaining care, treatment, services and procedures, including such desires set forth in a living will, Physician Orders for Scope of Treatment (POST) form, or similar document executed by me, if any.

(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 artificial life-sustaining care, treatment, services and procedures. You can also include a statement of your desires concerning other matters relating to your health care, including a list of one or more persons whom you designate to be able to receive medical information about you and/or to be allowed to visit you in a medical institution. 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 Directive, 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 and is subject to the special provisions and limitations stated in my Physician Orders for Scope of Treatment (POST) form, a living will, or similar document executed by me, if any. Additional statement of desires, special provisions, and limitations:

(You may attach additional pages or documents if you need more space to complete your statement.)

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

A. General Grant of Power and Authority

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

1. Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records;
2. Execute on my behalf any releases or other documents that may be required in order to obtain this information;
3. Consent to the disclosure of this information; and
4. 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.)

B. HIPAA Release Authority
My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES

Where necessary to implement the health care decisions that my agent is authorized by this Directive 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/or a "Leaving Hospital Against Medical Advice"; and
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 agent is unable or ineligible to act as your agent. If an alternate agent you

designate is your spouse, he or she becomes ineligible to act as your agent if your marriage is thereafter dissolved.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity 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 Directive, such persons to serve in the order listed below:

A. First Alternate Agent

Name: ______________________________

Address: ______________________________

____

Telephone Number: ______________________________

B. Second Alternate Agent

Name: ______________________________

Address: ______________________________

____

Telephone Number: ______________________________

C. Third Alternate Agent

Name: ______________________________

Address: ______________________________

____

Telephone Number: ______________________________

8. PRIOR DESIGNATIONS REVOKED

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

DATE AND SIGNATURE OF PRINCIPAL

(You must date and sign this Living Will and Durable Power of Attorney for Health Care.)

I sign my name to this Statutory Form Living Will and Durable Power of Attorney for Health Care on the date set forth at the beginning of this Form at:

____

(Signature) (City, State)