State of Wisconsin
2019 - 2020 LEGISLATURE

LRB-5096/1
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2019 SENATE BILL 655

January 8, 2020 - Introduced by Senators SHILLING, L. TAYLOR and SCHACHTNER, cosponsored by Representatives DOYLE, ANDERSON, BILLINGS, CONSIDINE, EMERSON, OHNSTAD, POPE, SPREITZER, STUBBS, SUBECK, VRUWINK, ZAMARRIPA and BOWEN. Referred to Committee on Judiciary and Public Safety.

AN ACT ***to renumber and amend*** 154.03 (1) (d) and 155.10 (2) (d); ***to amend*** 154.02 (1), 154.03 (1) (intro.), 154.03 (2), 154.07 (1) (b) 1., 154.07 (1) (b) 2., 155.10 (title), 155.10 (1) (c), 155.10 (2) (intro.) and 155.30 (3); and ***to create*** 154.03 (1) (d) 4. and 155.10 (2) (d) 4. of the statutes; **relating to:** notarial officers taking acknowledgments of health care powers of attorney and declarations to physicians.

Analysis by the Legislative Reference Bureau

Under this bill, a power of attorney for health care instrument is validly executed if an individual who grants authority to a health care agent makes an acknowledgment of the instrument before an authorized notarial officer. Current law requires two witnesses in order to execute a health care power of attorney instrument. Additionally, the bill allows an authorized notarial officer who is employed by an individual's health care provider or inpatient health care facility to take an acknowledgement of the individual's health care power of attorney instrument if the notarial officer satisfies all of the following: 1) is not related by blood, marriage, adoption, or domestic partnership to the individual executing the instrument; 2) does not have knowledge of being entitled to a portion of the individual's estate; 3) is not directly financially responsible for the individual's health care; and 4) is not a finance or billing officer of the individual's inpatient health care facility. Under current law, a witness to a health care power of attorney

instrument must meet those requirements, and also may not be an employee, other than a chaplain or a social worker, of the individual's health care provider or inpatient health care facility. A health care power of attorney designates another person as an agent to make health care decisions on behalf of an individual who is incapable of making those decisions.

The bill also allows an individual to execute a declaration to physicians, also known as a living will, if the individual makes an acknowledgement of the declaration before an authorized notarial officer. Current law requires two witnesses in order to execute a declaration to physicians. The bill allows an authorized notarial officer who is employed by the individual's health care provider or inpatient health care facility to take an acknowledgement of the individual's declaration to physicians if the notarial officer satisfies all of the following: 1) is not related by blood, marriage, adoption, or domestic partnership to the individual executing the declaration; 2) does not have knowledge of being entitled to a portion of the individual's estate; 3) is not directly financially responsible for the individual's health care; and 4) is not a finance or billing officer of the individual's inpatient health care facility. Under current law, a witness to a declaration to physicians must meet those requirements, and also may not be an employee, other than a chaplain or a social worker, of the individual's health care provider or inpatient health care facility. If an individual has executed a declaration, and is certified to have a terminal condition or to be in a persistent vegetative state, in certain situations the declaration authorizes the withholding or withdrawal of life–sustaining procedures or of feeding tubes from the individual.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 154.02 (1) of the statutes is amended to read:

154.02 **(1)** "Declaration" means a written~~, witnessed~~ document voluntarily executed by the declarant and witnessed or acknowledged under s. 154.03 (1), but is not limited in form or substance to that provided in s. 154.03 (2).

SECTION 2. 154.03 (1) (intro.) of the statutes is amended to read:

154.03 **(1)** (intro.) Any person of sound mind and 18 years of age or older may at any time voluntarily execute a declaration, which shall take effect on the date of execution, authorizing the withholding or withdrawal of life–sustaining procedures or of feeding tubes when the person is in a terminal condition or is in a persistent

vegetative state. A declarant may not authorize the withholding or withdrawal of any medication, life–sustaining procedure or feeding tube if the declarant's attending physician advises that, in his or her professional judgment, the withholding or withdrawal will cause the declarant pain or reduce the declarant's comfort and the pain or discomfort cannot be alleviated through pain relief measures. A declarant may not authorize the withholding or withdrawal of nutrition or hydration that is administered or otherwise received by the declarant through means other than a feeding tube unless the declarant's attending physician advises that, in his or her professional judgment, the administration is medically contraindicated. A declaration must be signed by the declarant in the presence of 2 witnesses or the declarant must make an acknowledgment of the declaration before a notarial officer authorized under s. 706.07 to take acknowledgments. If the declarant is physically unable to sign a declaration, the declaration must be signed in the declarant's name by one ~~of the witnesses~~ witness or some other person at the declarant's express direction and in his or her presence; such a proxy signing shall either take place or be acknowledged by the declarant in the presence of 2 witnesses or be acknowledged by the declarant before a notarial officer authorized under s. 706.07 to take acknowledgments. The declarant is responsible for notifying his or her attending physician of the existence of the declaration. An attending physician who is so notified shall make the declaration a part of the declarant's medical records. No witness to the execution of the declaration or notarial officer who takes an acknowledgment of the declaration may, at the time of the execution, be any of the following:

SECTION 3. 154.03 (1) (d) of the statutes is renumbered 154.03 (1) (d) (intro.) and amended to read:

154.03 **(1)** (d) (intro.) An individual who is ~~a~~ any of the following:

1. A health care provider, as defined in s. 155.01 (7), who is serving the declarant at the time of execution~~, an~~.

2. An employee, other than an employee authorized as a notarial officer under s. 706.07, a chaplain, or a social worker, of ~~the~~ a health care provider ~~or an~~ who is serving the declarant at the time of execution.

3. An employee, other than an employee authorized as a notarial officer under s. 706.07, a chaplain, or a social worker, of an inpatient health care facility in which the declarant is a patient.

SECTION 4. 154.03 (1) (d) 4. of the statutes is created to read:

154.03 **(1)** (d) 4. A finance or billing officer of an inpatient health care facility in which the declarant is a patient.

SECTION 5. 154.03 (2) of the statutes is amended to read:

154.03 **(2)** The department shall prepare and provide copies of the declaration and accompanying information for distribution in quantities to health care professionals, hospitals, nursing homes, county clerks and local bar associations and individually to private persons. The department shall include, in information accompanying the declaration, at least the statutory definitions of terms used in the declaration, statutory restrictions on who may be ~~witnesses~~ a witness to or be a notarial officer that takes an acknowledgment of a valid declaration, a statement explaining that valid witnesses or notarial officers acting in good faith are statutorily immune from civil or criminal liability, an instruction to potential declarants to read and understand the information before completing the declaration and a statement explaining that an instrument may, but need not be, filed with the register in probate of the declarant's county of residence. The department may charge a reasonable fee

for the cost of preparation and distribution. The declaration distributed by the department of health services shall be easy to read, the type size may be no smaller than 10 point, and the declaration shall be in the following form, setting forth on the first page the wording before the ATTENTION statement and setting forth on the 2nd page the ATTENTION statement and remaining wording:

DECLARATION TO PHYSICIANS

(WISCONSIN LIVING WILL)

I,...., being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life–sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment.

1. If I have a TERMINAL CONDITION, as determined by 2 physicians who have personally examined me, I do not want my dying to be artificially prolonged and I do not want life–sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes:

.... YES, I want feeding tubes used if I have a terminal condition.

.... NO, I do not want feeding tubes used if I have a terminal condition.

If you have not checked either box, feeding tubes will be used.

2. If I am in a PERSISTENT VEGETATIVE STATE, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of life–sustaining procedures:

.... YES, I want life–sustaining procedures used if I am in a persistent vegetative state.

.... NO, I do not want life–sustaining procedures used if I am in a persistent vegetative state.

If you have not checked either box, life–sustaining procedures will be used.

3. If I am in a PERSISTENT VEGETATIVE STATE, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of feeding tubes:

.... YES, I want feeding tubes used if I am in a persistent vegetative state.

.... NO, I do not want feeding tubes used if I am in a persistent vegetative state.

If you have not checked either box, feeding tubes will be used.

If you are interested in more information about the significant terms used in this document, see section 154.01 of the Wisconsin Statutes or the information accompanying this document.

ATTENTION: You and ~~the~~ 2 witnesses or a notarial officer must sign the document at the same time.

Signed .... Date ....

Address .... Date of birth ....

I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness signature .... Date signed ....

Print name ....

Witness signature .... Date signed ....

Print name ....

Notarial officer:

(print) Name....

State of ....

County of ....

This document was acknowledged before me on .... (date), by .... (name of principal).

(Seal, if any)

Signature of notary ....

My commission expires: ....

DIRECTIVES TO ATTENDING PHYSICIAN

1. This document authorizes the withholding or withdrawal of life–sustaining procedures or of feeding tubes when 2 physicians, one of whom is the attending physician, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.

2. The choices in this document were made by a competent adult. Under the law, the patient's stated desires must be followed unless you believe that withholding or withdrawing life–sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life–sustaining procedures or feeding tubes be used, this directive must be followed.

3. If you feel that you cannot comply with this document, you must make a good faith attempt to transfer the patient to another physician who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.

4. If you know that the patient is pregnant, this document has no effect during her pregnancy.

* * * * *

The person making this living will may use the following space to record the names of those individuals and health care providers to whom he or she has given copies of this document:

.....

.....

.....

SECTION 6. 154.07 (1) (b) 1. of the statutes is amended to read:

154.07 **(1)** (b) 1. No person who acts in good faith as a witness to a declaration or takes an acknowledgment of a declaration under this subchapter may be held civilly or criminally liable for participating in the withholding or withdrawal of life–sustaining procedures or feeding tubes under this subchapter.

SECTION 7. 154.07 (1) (b) 2. of the statutes is amended to read:

154.07 **(1)** (b) 2. Subdivision 1. does not apply to a person who acts as a witness or takes an acknowledgment in violation of s. 154.03 (1).

SECTION 8. 155.10 (title) of the statutes is amended to read:

155.10 (title) **Power of attorney for health care instrument; execution; witnesses and notarial officers.**

SECTION 9. 155.10 (1) (c) of the statutes is amended to read:

155.10 **(1)** (c) Signed in the presence of 2 witnesses who meet the requirements of sub. (2) or the principal makes an acknowledgment of the instrument before a notarial officer authorized under s. 706.07 to take acknowledgments who meets the requirements of sub. (2).

SECTION 10. 155.10 (2) (intro.) of the statutes is amended to read:

155.10 **(2)** (intro.) A witness to the execution of a valid power of attorney for health care instrument shall be an individual who has attained age 18. No witness to the execution or notarial officer who takes an acknowledgment of the power of attorney for health care instrument may, at the time of the execution, be any of the following:

SECTION 11. 155.10 (2) (d) of the statutes is renumbered 155.10 (2) (d) (intro.) and amended to read:

155.10 **(2)** (d) (intro.) An individual who is ~~a~~ any of the following:

1. A health care provider who is serving the principal at the time of execution~~,~~ ~~an~~.

2. An employee, other than an employee authorized as a notarial officer under s. 706.07, a chaplain, or a social worker, of ~~the~~ a health care provider ~~or an~~ who is serving the principal at the time of execution.

3. An employee, other than an employee authorized as a notarial officer under s. 706.07, a chaplain, or a social worker, of an inpatient health care facility in which the principal is a patient.

SECTION 12. 155.10 (2) (d) 4. of the statutes is created to read:

155.10 **(2)** (d) 4. A finance or billing officer of an inpatient health care facility in which the principal is a patient.

SECTION 13. 155.30 (3) of the statutes is amended to read:

155.30 **(3)** The department shall prepare and provide copies of a power of attorney for health care instrument and accompanying information for distribution in quantities to health care professionals, hospitals, nursing homes, multipurpose senior centers, county clerks, and local bar associations and individually to private persons. The department shall include, in information accompanying the copy of the

instrument, at least the statutory definitions of terms used in the instrument, statutory restrictions on who may be witnesses to or be a notarial officer that takes an acknowledgment of a valid instrument, a statement explaining that valid witnesses or notarial officers acting in good faith are statutorily immune from civil or criminal liability and a statement explaining that an instrument may, but need not, be filed with the register in probate of the principal's county of residence. The department may charge a reasonable fee for the cost of preparation and distribution. The power of attorney for health care instrument distributed by the department shall include the notice specified in sub. (1) and shall be in the following form:

POWER OF ATTORNEY FOR HEALTH CARE

Document made this.... day of.... (month),.... (year).

CREATION OF POWER OF ATTORNEY

FOR HEALTH CARE

I,.... (print name, address and date of birth), being of sound mind, intend by this document to create a power of attorney for health care. My executing this power of attorney for health care is voluntary. Despite the creation of this power of attorney for health care, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

DESIGNATION OF HEALTH CARE AGENT

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate.... (print name, address and telephone number) to be my health care agent for the purpose of making health care decisions on my behalf. If he or she is ever unable or unwilling to do so, I hereby designate.... (print name, address and telephone number) to be my alternate health care agent for the purpose of making health care decisions on my behalf. Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if 2 physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. A copy of that statement must be attached to this document.

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but my health care

agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for persons with an intellectual disability, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES OR
COMMUNITY–BASED RESIDENTIAL FACILITIES

My health care agent may admit me to a nursing home or community–based residential facility for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

1. A nursing home — Yes.... No....

2. A community–based residential facility — Yes.... No....

If I have not checked either "Yes" or "No" immediately above, my health care agent may admit me only for short–term stays for recuperative care or respite care.

PROVISION OF A FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube — Yes.... No....

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withdrawn from me.

HEALTH CARE DECISIONS FOR

PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant — Yes.... No....

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

STATEMENT OF DESIRES,

SPECIAL PROVISIONS OR LIMITATIONS

In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are specific desires, provisions or limitations that I wish to state (add more items if needed):

1) –

2) –

3) –

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

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

(a) Request, review and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records.

(b) Execute on my behalf any documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(The principal and the witnesses all must sign the document at the same time.)

SIGNATURE OF PRINCIPAL

(person creating the power of attorney for health care)

Signature.... Date....

(The signing of this document by the principal revokes all previous powers of attorney for health care documents.)

STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this power of attorney for health care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, or adoption, am not the domestic partner under ch. 770 of the principal, and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employee of the health care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the ~~declarant~~ principal is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness No. 1:

(print) Name.... Date....

Address....

Signature....

Witness No. 2:

(print) Name.... Date....

Address....

Signature....

ACKNOWLEDGMENT OF NOTARIAL OFFICER

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I am at least 18 years of age, am not related to the principal by blood, marriage, or adoption, am not the domestic partner under ch. 770 of the principal, and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time. I am not

a finance or billing officer of an inpatient health care facility in which the principal is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

(print) Name....

State of ....

County of ....

This document was acknowledged before me on .... (date), by .... (name of principal).

(Seal, if any)

Signature of notary ....

My commission expires: ....

STATEMENT OF HEALTH CARE AGENT AND

ALTERNATE HEALTH CARE AGENT

I understand that.... (name of principal) has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself. .... (name of principal) has discussed his or her desires regarding health care decisions with me.

Agent's signature....

Address....

Alternate's signature....

Address....

Failure to execute a power of attorney for health care document under chapter 155 of the Wisconsin Statutes creates no presumption about the intent of any individual with regard to his or her health care decisions.

This power of attorney for health care is executed as provided in chapter 155 of the Wisconsin Statutes.

ANATOMICAL GIFTS (optional)

Upon my death:

.... I wish to donate only the following organs or parts: .... (specify the organs or parts).

.... I wish to donate any needed organ or part.

.... I wish to donate my body for anatomical study if needed.

.... I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failing to check any of the lines immediately above creates no presumption about my desire to make or refuse to make an anatomical gift.

Signature.... Date....

(END)