State of Wisconsin
1997 - 1998 LEGISLATURE

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1997 ASSEMBLY BILL 582

October 29, 1997 – Introduced by Representatives WASSERMAN, HUBER, UNDERHEIM, KREUSER, WALKER, STASKUNAS, BAUMGART, BOCK, BRANDEMUEHL, GOETSCH, GRONEMUS, KRUG, LADWIG, MURAT, NOTESTEIN, PORTER and R. YOUNG, cosponsored by Senators ROSENZWEIG, RISSER, ROESSLER, GROBSCHMIDT and HUELSMAN. Referred to Committee on Judiciary.

AN ACT ***to amend*** 155.30 (1) and 155.30 (3); and ***to create*** 157.06 (2) (f) 1m., 157.06 (2) (f) 6. and 157.06 (3) (a) 7. of the statutes; **relating to:** allowing a power of attorney for health care instrument to be used to make or refuse to make an anatomical gift and allowing a health care agent to make an anatomical gift.

Analysis by the Legislative Reference Bureau

Under current law, an individual may, in a power of attorney for health care instrument, designate another individual (health care agent) to make health care decisions for him or her if he or she is incapable of doing so. Also under current law, by following certain procedures an individual may make an anatomical gift, which is effective after the individual's death.

Under this bill, an individual may, in a power of attorney for health care instrument, specify that he or she wishes to make or refuses to make an anatomical gift. The bill also includes a health care agent in the list of person who may make an anatomical gift of all or part of a decendent's body in the absence of an unrevoked refusal to make that anatomical gift.

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

SECTION 1. 155.30 (1) of the statutes is amended to read:

155.30 **(1)** A printed form of a power of attorney for health care instrument that is sold or otherwise distributed for use by an individual in this state who does not have the advice of legal counsel shall provide no authority other than the authority to make health care decisions on behalf of the principal and shall contain the following statement in not less than 10–point boldface type:

"NOTICE TO PERSON

MAKING THIS DOCUMENT

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG–TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN

THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR DOCUMENT OF GIFT THAT YOU MAY HAVE MADE. YOU MAKE REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE

BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.".

SECTION 2. 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 a valid instrument, a statement explaining that valid witnesses 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 ~~or~~ nor my alternate health care agent whom I have designated is my health care provider, an employe of my health care provider, an employe 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 the mentally retarded, 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 ~~only~~ 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, ~~verbal~~ 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 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 employe of the health care provider, other than a chaplain or a social worker, or an employe, other than a chaplain or a social worker, of an inpatient health care facility in which the declarant 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....

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.

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....

SECTION 3. 157.06 (2) (f) 1m. of the statutes is created to read:

157.06 **(2)** (f) 1m. Signing a new document of gift. Signing a new document of gift revokes any previously signed document of gift.

SECTION 4. 157.06 (2) (f) 6. of the statutes is created to read:

157.06 **(2)** (f) 6. Revoking the provision of a power of attorney for health care instrument that makes an anatomical gift or revoking that power of attorney for health care instrument.

SECTION 5. 157.06 (3) (a) 7. of the statutes is created to read:

157.06 **(3)** (a) 7. A health care agent, as defined in s. 155.01 (4), for the decedent at the time of death.

(END)