Wisconsin Right to Life
POWER OF ATTORNEY FOR HEALTH CARE

Informational Guide

The *State of Wisconsin Power of Attorney for Health Care Document* (DPH 00085, Rev. 06/11) is a form created by the State of Wisconsin which allows you to authorize another person (called your "health care agent") to make all health care decisions for you if you should become incapable of making these decisions on your own.

The *State of Wisconsin Power of Attorney for Health Care Document* only goes into effect when you can no longer speak for yourself. At that time, your health care agent and your physician will look to this document to determine the course of your health care.

The *State of Wisconsin Power of Attorney for Health Care Document* has serious pro-life ramifications. However, with the changes made by Wisconsin Right to Life, it can be used in a pro-life manner.

Pro-Life Concerns

The pro-life concerns regarding the *State of Wisconsin Power of Attorney for Health Care Document* are as follows:

1. It is totally silent regarding the health care you do want, whether it is routine health care or life-sustaining health care. Consequently, your health care agent is given unlimited authority to refuse life-sustaining health care, even if you do not have an incurable terminal illness and your death is not imminent. Your health care agent would even have authority to refuse medications for chronic conditions and simple antibiotics for an easily curable condition.

2. It permits your health care agent and your physician to cause your death by dehydration or starvation. There is no requirement that you have an incurable terminal illness or injury before a feeding tube can be withheld or withdrawn. If you are not in the final stage of dying, the withholding or withdrawal of a feeding tube will cause you to die of dehydration or starvation.

3. It provides no protection for your unborn child if you are a pregnant woman. Your agent would have authority to authorize an elective abortion for any reason.

Using the Wisconsin Right to Life POWER OF ATTORNEY FOR HEALTH CARE

These pro-life concerns can be addressed by using the attached Wisconsin Right to Life POWER OF ATTORNEY FOR HEALTH CARE, which is a modified version of the *State of Wisconsin Power of Attorney for Health Care Document*. The state form was modified by Wisconsin Right to Life with prolife changes and additions to protect your right to life.

The Wisconsin Right to Life POWER OF ATTORNEY FOR HEALTH CARE uses the familiar *State of Wisconsin Power of Attorney for Health Care Document* form as a basis so your physician can readily see the following pro-life additions in the "Statement of Desires, Special Provisions or Limitations" section of the state form:

Wisconsin Right to Life, Inc.
9730 W. Bluemound Rd., Suite 200, Milwaukee, WI 53226
Phone toll free (877) 855-5007 or (414) 778-5780 Fax (414) 778-5785
Online at www.wrtl.org

a) “MY HEALTH CARE PHILOSOPHY” was added to set forth a general rule that you want your health care decisions to be based on your belief in the inherent value of human life and that you want all reasonable efforts to be made to sustain your life and your health. You reject euthanasia and physician assisted suicide, even if you have a disability.

b) "MY HEALTH CARE DIRECTIVES” was added to give specific directions on the heath care you do want to receive. You want health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective. You clearly state that your health care agent has no authority to consent to any act or omission intended to cause your death. It contains positive directives, absent in the state form, for pain and comfort care.

c) “EXCEPTIONS TO MY HEALTH CARE DIRECTIVES” was added to permit your health care agent to refuse health care that would not be effective in terms of your survival. Your agent would be permitted, but not required, to discontinue life-sustaining health care in two clearly defined situations: when you are in the final stage of dying (within hours or a few days); and when you have a total, chronic and irreversible loss of consciousness. In both of these cases, your desire for pain, comfort care, and nutrition and hydration is indicated. Unless you are in the final stage of dying, you state that you still desire health care for easily treatable acute and chronic conditions.

d) “NUTRITION AND HYDRATION” was added to state your belief that nutrition and hydration are basic human needs which should be provided to you even if this requires medical assistance. It clearly states that a feeding tube can only be withheld or withdrawn from you when you are in the final stage of dying and the lack of nourishment will not cause you to die of malnutrition or dehydration. This provision permits the withholding of food or fluids where it would jeopardize your life or physical condition.

e) “IF I AM PREGNANT” was added for women of childbearing age to protect an unborn child. Your health care agent is given authority, absent in the state form, to make health care decisions on behalf of your unborn child as an individual patient. You direct that all reasonable efforts be made to sustain both your life and health and the life and health of your unborn child. No abortion is permitted unless it is directly and medically necessary to prevent your death.

In addition to the Wisconsin Right to Life POWER OF ATTORNEY FOR HEALTH CARE, the instruction letter furnished by the Wisconsin Division of Public Health (DPH) is attached. The DPH instruction letter gives you all the technical information you need regarding how a power of attorney for health care document is to be signed.

If you have previously signed a *State of Wisconsin Power of Attorney for Health Care Document* or another power of attorney for health care document, it can be revoked (cancelled) and replaced with the Wisconsin Right to Life POWER OF ATTORNEY FOR HEALTH CARE. Revocation instructions are included in the DPH instruction letter.

Extra copies of the Wisconsin Right to Life POWER OF ATTORNEY FOR HEALTH CARE are available free of charge from Wisconsin Right to Life by calling toll free (877) 855-5007 or by downloading and printing a copy from the Wisconsin Right to Life website at http://www.wrtl.org/poa.

Revised April 2014

This is a modified version of the State of Wisconsin's Power of Attorney for Health Care Document (DPH F-00085, Rev. 06/11, prepared by the DEPARTMENT OF HEALTH SERVICES, Division of Public Health, pursuant to s. 155.30)**. The State's document was modified by Wisconsin Right to Life with pro-life changes and additions to protect your right to life.**

This guide has been prepared for information purposes only and is not intended to be legal advice.
Please consult with your attorney or another trained expert for further assistance.

WISCONSIN RIGHT TO LIFE
POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT

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 or your domestic partner and your marriage is annulled or you are divorced or your domestic partnership is terminated 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 MAY 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.

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 mental retardation, 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.

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, and is subject to the special provisions or limitations that I specify. The following are the specific desires, provisions or limitations that I wish to state:

MY HEALTH CARE PHILOSOPHY

My philosophy regarding the health care decisions I would make, if I were able, is based on my belief in the inherent value of human life. I do not want my life intentionally ended by lethal injection, assistance with an overdose of drugs, or by starvation or dehydration, even if I have a disability.

It is my desire that all reasonable efforts be made to sustain my life and my health.

MY HEALTH CARE DIRECTIVES

1. "Health Care" means any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.
2. I direct my health care agent to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.
3. My health care agent has no authority to consent to any act or omission intended to cause my death.
4. I instruct my health care agent to ensure that my attending physician and other health care professionals provide my health care based on my health care philosophy and my health care directives.

EXCEPTIONS TO MY HEALTH CARE DIRECTIVES

1. My health care agent may refuse consent to health care that would not be effective in terms of my survival.
2. If I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, my health care agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or to make me comfortable.
3. If I have a total, chronic and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care agent **may** consent to the withholding or withdrawal of life-sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or to make me comfortable.
4. I desire that nutrition and hydration be continued in all the above circumstances unless one of the conditions in the next section applies.

NUTRITION AND HYDRATION (FOOD AND FLUIDS)

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical assistance.
2. A feeding tube can **only** be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying and it is medically certain that my death will occur within hours or a few days, **and**
   b. The withholding or withdrawal of the feeding tube would **not** cause me to die of malnutrition or dehydration, or complications of malnutrition or dehydration.
3. Nutrition or hydration (given orally or through a feeding tube) may be withheld or withdrawn from me if, and only so long as, the provision of either would jeopardize my life or physical condition.

IF I AM PREGNANT

1. My health care agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.
2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.
3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.
4. Even if I have an incurable terminal illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care. “Brain dead” means a condition where I have sustained irreversible cessation of all functions of my entire brain, including my brain stem.
5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

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 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, domestic partnership under Wisconsin Statutes chapter 770, 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 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 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 Number 1

(Print) Name _____ Date _____

Address _____

Signature _____

Witness Number 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, where I have sustained irreversible cessation of all functions of my entire brain, including my brain stem:

____ 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 _____

This document was modified by Wisconsin Right to Life in the following manner: the title was changed; the original state form sections on "Provision of Feeding Tube" and "Health Care Decisions for Pregnant Women" were deleted; and specific pro-life statements were inserted in the "Statement of Desires, Special Provisions or Limitations" and "Anatomical Gifts" sections.

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