

# **PRO-LIFE WISCONSIN ANSWERS YOUR QUESTIONS ABOUT THE PROTECTIVE POWER OF ATTORNEY FOR HEALTH CARE**

## **What is the Wisconsin Protective Power of Attorney for Health Care (PAHC)?**

This document is a **Protective** Power of Attorney for Health Care prepared by Pro-Life Wisconsin that enables you, a person who fully respects human life, to appoint someone you trust to make health care decisions for you, in accord with sound moral principles and your express wishes, in the event you become permanently or temporarily incapable of speaking for yourself.

## **Is the Wisconsin Protective PAHC preferable to a Living Will?**

Yes, definitely.

A Living Will is an advance directive in which the signer gives authority to an “attending physician” to withhold or withdraw “life-sustaining procedures” for some future illness or injury. The attending physician may be a stranger, unfamiliar with your moral principles and wishes, who may interpret your directive in ways you did not intend. The law does not require an attending physician, before stopping treatment, to consult with your family members and others who know you and care about you.

Signing a Wisconsin Protective PAHC will assure you that the person with authority to make health care decisions for you (your “agent”) is a carefully chosen family member or friend, familiar with your principles and wishes and capable of firmly protecting your best interests.

## **Why should I sign a Wisconsin Protective PAHC?**

1. By signing a Wisconsin Protective PAHC, you specifically reject euthanasia and assisted suicide. Unfortunately, many in our society no longer see the difference between allowing a person to die when no treatment or care can sustain his/her life and intentionally killing a person by an omission or an action. Euthanasia by omission is already commonly practiced, and there is a movement underway to add euthanasia by lethal injection and assisted suicide (already legal in three states) to end-of-life choices.

2. “Futile care” policies have been instituted by many hospitals. A “futile care” policy permits a physician or a hospital ethics committee to override a patient’s (or his/her family’s) wishes for treatment. The Wisconsin Protective PAHC states that “care or treatment which sustains life is not futile” and that “the meanings of the words used in this document are those which I have discussed with my agent.”

3. Every patient entering a health care facility is asked, “Have you signed a Living Will or Power of Attorney for Health Care?” This is because the federal Patient Self-Determination Act of 1990 forces hospitals and health care programs, under threat of losing Medicare and Medicaid funds, to give patients information about advance directives. Consequently, you will most likely be given a Living Will or Power of Attorney to sign at the time of admission – when

you are under stress and distracted by other paperwork. Be prepared. Always bring along your completed Wisconsin Protective PAHC.

### **Who should sign a Wisconsin Protective PAHC?**

Everyone who is 18 years old or older needs a Wisconsin Protective PAHC. Anyone of any age may suddenly become incapacitated due to illness or injury. Having a Wisconsin Protective PAHC could mean the difference between life and death.

### **Should I name more than one agent?**

It is not required, but it is advisable to name an alternate agent in case your primary agent is unavailable or becomes incapacitated. You should select your alternate agent as carefully as you select your primary agent.

### **What guidelines should I follow when choosing my agent(s)?**

Your agent(s) must be at least 18 years of age. Your agent(s) should share your values and be capable of firmly protecting your rights and best interests.

Wisconsin law does not permit the following persons to serve as your agent(s): your health care provider, an employee of your health care provider, an employee of a health care facility in which you are a patient, or the spouse of any of these persons. However, you may name an otherwise ineligible person as your agent if that person is related to you by blood, marriage or adoption.

### **Should I periodically renew and/or review my Wisconsin Protective PAHC?**

Your Wisconsin Protective PAHC is permanent, unless revoked by you. However, you should discuss your wishes in detail with your agent when you sign your Wisconsin Protective PAHC and periodically review your Wisconsin Protective PAHC with your agent.

### **To whom should I give originally signed copies of my Wisconsin Protective PAHC?**

You should give completed, witnessed, and originally signed documents to your agent(s) and to your primary care physician. Also, keep one for yourself in a readily accessible place, along with a record of each person to whom you have given your Wisconsin Protective PAHC. If you ever wish to change or revoke your Wisconsin Protective PAHC, this record will be helpful.

### **How do I revoke a previously signed advance directive?**

Simply by signing a Wisconsin Protective PAHC you revoke any Living Will or Power of Attorney for Health Care that you have executed previously. Nevertheless, it is wise to retrieve and destroy all copies of such documents.



# **PROTECTIVE POWER OF ATTORNEY FOR HEALTH CARE**

(Chapter 155 of the Wisconsin Statutes)

## **Pro-Life Wisconsin**

**WISCONSIN PROTECTIVE POWER OF ATTORNEY FOR HEALTH CARE**  
**NOTICE TO PERSON MAKING THIS DOCUMENT (Required by Wis. Stat. 155.30(1))**

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 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.



## **GENERAL STATEMENT OF AUTHORITY GRANTED**

Subject to the directions, special provisions, and limitations in this document, I hereby grant my agent full authority to make health care decisions for me if 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. I expect to be fully informed about and allowed to participate in any health care decisions for me to the extent that I am able.

**Nothing in this document shall authorize anyone to approve or commit any action or omission which will cause my death. While certain forms of care and treatment may be futile in curing a disease or injury, care or treatment which sustains life is not futile. I reject both euthanasia and assisted suicide, which are contrary to my belief that human bodily life is inherently good and not merely instrumental to other goods.**

## **DIRECTIONS, SPECIAL PROVISIONS, AND LIMITATIONS**

I have carefully discussed my beliefs, principles, and health care preferences with my agent. I trust my agent to make health care decisions for me based on my desires as stated in this document or which I have otherwise expressed to my agent.

1. The meanings of the words used in this document are those which I have discussed with my agent and my agent's interpretation of them is controlling. "Benefit" refers to my physical health, comfort, and longevity and shall not be determined by a quality of life standard. I oppose suicide and euthanasia and direct that nothing in this document be interpreted to request or authorize providing or withholding treatment or support for the purpose of causing my death.
2. My agent has the authority to request, review, and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records, and to consent to the disclosure of this information.
3. I direct that nutrition and hydration, whether orally ingested or administered through a tube, be provided to me unless death is inevitable and imminent from a cause independent of nutrition and hydration so that the effort to sustain my life is futile or unless I am unable to assimilate food and fluids.
4. I direct my agent to request, require, and consent to care, treatment, and procedures which are appropriate to my condition and offer a reasonable hope of benefit.
5. I direct my agent to withhold or withdraw consent to care, treatment, and procedures which are not appropriate to my condition and do not offer a reasonable hope of benefit.

6. I authorize my agent to determine whether or not a Do Not Resuscitate (DNR) order is appropriate for me.
7. I authorize my agent to admit me to or discharge me from a nursing home or community-based residential facility under the conditions I have expressed to my agent.
8. If I am pregnant, I direct that every effort be made to save the life of my child.
9. My agent shall not be held personally liable for any medical goods or services purchased or contracted for in compliance with my wishes regarding medical care and treatment, except as required by law.
10. I direct my agent to firmly protect my rights and best interests, taking legal action if necessary.
11. It is my express wish that no one petition the court to remove or replace my agent unless it can be clearly shown that my agent has failed or refused to act in accord with these directions, special provisions, and limitations.

**These instructions are always a part of my Protective Power of Attorney for Health Care document and are binding on my agent and all of my health care providers. Only this document which bears my original signature shall be deemed legally valid.**

### **IMMUNITIES**

My health care agent may not be held criminally or civilly liable for making a decision in accord with this document. No health care facility or provider may be held criminally or civilly liable for following the directions of my health care agent acting in accord with this document.

### **REVOCATION, AMENDMENTS, AND ADDENDUMS**

By signing this power of attorney for health care, I revoke any prior health care directive that I have made. This power of attorney shall remain in force and effect until revoked by me in the presence of two witnesses. Amendments and addendums to this document shall be made in writing by me personally (and not by my agent or a health care provider) and they shall be attached to the original of this document. My subsequent physical or mental disability, incapacity, or incompetency shall not affect this durable power of attorney nor diminish the authority of my agent.

### **GUARDIAN**

If it becomes necessary to appoint a guardian for me, I nominate, in the same order of preference, my agent and alternate agent. I direct that this document be treated as my “written instrument” under Sec. 880.09(7), Wisconsin Statutes, authorizing such nomination.

**SIGNATURE OF PRINCIPAL**

I, being of sound mind, intend this document to create a power of attorney for health care. I am executing this document voluntarily.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**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 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. I signed this statement in the conscious presence of the principal and saw the principal sign this document.

**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 the principal (signer of this power of attorney for health care), \_\_\_\_\_, has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to lack the capacity to make health care decisions for himself or herself. I further understand that my authority to make such decisions is only operative for the duration of the principal’s incapacity. The principal has discussed his or her desires regarding health care decisions with me.

**Agent’s signature** \_\_\_\_\_

Address \_\_\_\_\_

**Alternate agent’s signature** \_\_\_\_\_

Address \_\_\_\_\_



**Pro-Life Wisconsin Education Task Force, Inc.**

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**PROTECTIVE POWER OF ATTORNEY FOR HEALTH CARE  
ADDENDUM**

I, \_\_\_\_\_, refuse to make an anatomical gift of any vascularized organ (vital organ). I do not want any vascularized organ (vital organ) taken for transplantation or for any other purpose. My agent, appointed in my Power of Attorney for Health Care, may make all other decisions regarding anatomical gifts after my agent is certain that I am dead.

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

