BUILDING WEALTH IN CHANGING TIMES

The Solari Report

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Health Care Proxies

with Jo Kline Cebuhar

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C. AUSTIN FITTS: So with that, I'd like to introduce our very, very special guest tonight: Jo Kline Cebuhar. Jo is the author of a wonderful book on health care proxies and living wills. I've linked to it from the blog. She is an attorney and lives in Iowa. She also served as chairman of the largest hospice organization in Iowa, and hospices are just one – if you've ever been in a hospice, if you've ever had a family member need a hospice, you know what extraordinary institutions they are and what an extraordinary difference they make. We looked – I had my wonderful production assistant, Mike Linton, who's a professor, very brilliant, do a search, because it's extremely important on this topic that you have somebody very experienced and very clear-thinking.

Mike found Jo and her book, and I read her book. I have to tell you it's absolutely sensational. I've looked at a lot of materials that try and cover this subject. I can't recommend it enough. It's very detailed. It's very clear-thinking. This is somebody who knows a lot about this subject and has thought a lot about it and knows a lot of stories of what can go right and wrong. It's a reminder, you know, as those of you who know me know, I've known a lot of attorneys in my life, and there's nothing more dreadful than a bad attorney; and frankly, there's nothing more wonderful than a great attorney.

If you read Jo's book, you'll know she's a very wonderful and clear-thinking, trained attorney. So with that, it's my pleasure, Jo, to welcome you to the Solari Report. Thank you so much for being with us this evening.

JO KLINE CEBUHAR: Oh, thank you so much, Catherine. Great to be with you. Thank you for the invitation.

C. AUSTIN FITTS: Okay – so let's just start off. What is a healthcare proxy? What is a living will? What are they, and why do we care?

JO KLINE CEBUHAR: Well, they both come under the category of advance directives, healthcare directives. To be honest with you, there are 34 different terms that I've been able to find throughout the United States that describe these. But generally what they mean is – and they don't – let's talk for a second about what they aren't. They don't deal at all with assets. So this has nothing to do – there's always a lot of confusion about living wills and living trusts and – these advance directives have nothing to do with assets or distribution, holding anything and property. These are strictly concerned with healthcare planning.

So the two documents – and they can actually be a combination document, and many states provide for that – and I hope a little later we can talk about a form that I really recommend to people, and it's a combination form. But they're made up of two types: one is the power of attorney for healthcare. And the purpose for this is, Catherine, we all like to think we're in control of our healthcare, and we should be. There's no question. You have to be your own advocate, number one. But there are those occasions when we are not able to manage our healthcare.

A good example is even an outpatient surgery, if you are under anesthetic you can't make a decision. So if someone – the doctor comes out in the waiting room and says, "Gosh, we found something. We need to take step two, and we don't want to wake the patient up," you need somebody to make your decisions for you. So the healthcare proxy is the person that you're going to appoint in that power of attorney. So the first document is a power of attorney for healthcare. That's the appointment of a person.

That also includes – that document also includes you talking about the kind of care you want. So, "I want to have this done. I'm okay with a respirator if it's for a short term. I'm okay with a feeding tube" – you know, all that sort of thing. That's one type. So that's our power of attorney. The other document – the other advanced directive then is a living will, and a living will strictly focuses on end-of-life issues. Doesn't have an appointment in it.

It is all about how do you want to be treated at the end of your life? What do you consider quality versus quantity? How do you define when enough is enough? So two documents, really two purposes: one is to appoint and talk about healthcare; the other is end-of-life. But they can definitely be combined into one document. It can be a combination document that covers both. So why do we care? Well, I tell you what, we need to be our own self-managers on healthcare, and if you can't – and that is a small percentage – but, Catherine, we buy house insurance because our house might burn down.

We surely hope that it won't, and most do not, but that's why we have insurance. Well, think of it as the same way. It's that small percentage of us who won't be able to manage our own care, and what do we want? We want our ideas – our own ideas on healthcare to be carried out. And the only way to do that is to appoint someone to be your advocate.

"It's that small percentage of us who won't be able to manage our own care, and what do we want? We want our ideas – our own ideas on healthcare to be carried out."

C. AUSTIN FITTS: Right – and it's so important to understand that if you have these in place then your wishes are respected as opposed to some machinery who doesn't even know you and may not care about you and are going to make it in very ways that from your point of view are completely arbitrary and in conflict with your wishes.

JO KLINE CEBUHAR: Well, and all of those things – and throw into the mix that many primary physicians really are pretty ignorant on end-of-life law. I mean, I can't believe the stories that I've been told over the years by folks in audiences who will come up to me afterwards and tell me things that doctors told them and nurses told them and they made life-and-death, literally, decisions for their family members based on that – you know, just a real blatant example that I like to refer to is that people need to understand they can always reverse a decision.

So you can say, "You know what? I want my loved one to have a respirator. Let's see how they do for a few days. If it looks like they're not

going to be able to breathe on their own, then we can take it off, but I don't want to not do that now in case they're going to be able to be independent." Or the same thing with a feeding tube – they need to have nutrition built up. Many times people are told by medical professionals, "Whatever we do here you've got to live with it. So make your decision now. We're either going to put in a respirator or we're not," and that's simply not true.

If you have the power to give it, you have the power to take it away. So that's an example and a good reason why you need to know your options because there's a fair to mid chance that the healthcare professionals may not know what the law is, and they may give you bad advice.

C. AUSTIN FITTS: Right – what happened to me when I was helping Georgie through the system is literally she became kidnapped by an institution. My interpretation of their behavior was they were basically just churning her for fees. And I felt like I was trying – you know, we were – she was incapacitated, and we were just trying to get her out of there to a place that was better for her and stop a whole bunch of treatment we thought was going to make things worse. And if we hadn't – if her niece hadn't had a durable healthcare proxy, we would not have been able to do that.

JO KLINE CEBUHAR: Right – and you know, it's – go ahead.

C. AUSTIN FITTS: And the other thing is we had a living will, so we could be very clear about what her wishes were. And even though in that instance it – you know, it wasn't always just a legal matter. It was because she had trained us. We knew what she wanted. We had very clear instructions. We knew we were authorized to deal on her behalf, and that gave us – you know, we were like two Foo dogs on either side of her. That gave us a power to act that was very powerful and very effective with some pretty aggressive and pushy healthcare providers in that instance.

JO KLINE CEBUHAR: Absolutely – and you know, you really hit the key to it, Catherine, which is communication. The piece of paper is great. Only about 20 percent of adults actually have completed advanced directives. The good news is once they learn about them – so hopefully that'll apply

to your subscribers here and your listener – then about half of the people who learn about them go ahead and do them. But that piece of paper is great, but that piece of paper isn't worth much if you haven't had the conversation.

So the first thing – I always say there's a one-two-three punch on this end-of-life plan: communication. Talk to your loved ones. Your friend, Georgie, talked to you, and she talked to her niece, and you knew what she wanted even if you hadn't had that piece of paper you could have carried out her wishes because you had the conversation. But when you have the piece of paper and you don't have the conversation, that's all you have. Then you become her decision-maker, and you know that's the way a lot of conflicts in families come up, not because you're carrying out the patient's wishes, but because you end up being a substitute decision-maker because they didn't, and that's not really what is meant to happen in advance directives.

And then you delegate those proxies, and you document under the law so that nobody can question your authority. But that first key was those conversations that Georgie had with you making sure – and you know, that wasn't just one conversation when you sat down and talked to her. That was your relationship. That was you knowing her well enough to really know what she considered the difference between quality and quantity of life and what was important in her life, how important independence was. Those are the sort of things you have to know in many conversations to really be able to step in for them.

You're just not going to cover every healthcare situation and every document or every conversation you have, so you kinda have to be prepared to know, "What would they do if they could still speak for themselves?"

C. AUSTIN FITTS: You know, I have to admit to you that I was really squeamish. I kept not wanting to do it because I kept saying, "Georgie, let's focus on keeping you alive," and I didn't understand the power of her – the power of doing this kind of planning and doing it among the people involved so that she could then turn and focus on being alive.

JO KLINE CEBUHAR: And you know, you might not agree. You might not agree with that person. You might not agree with what their idea is about when they want to say "enough." But if you know what it is with a clear conscience, you can help them carry out those wishes if they're not able to. And that's really respecting that patient and the autonomy of that patient.

C. AUSTIN FITTS: One of the stories that I thought was really effective in your book is the story of Edna and her proxy in her pocket.

JO KLINE CEBUHAR: Yes, yes.

C. AUSTIN FITTS: Could you just tell that?

JO KLINE CEBUHAR: Sure. Well, Edna was 87 years old, and she had witnessed, obviously, a lot of people passing in her life, and she knew for sure that she did not want to see what had happened to many of her friends, which is that lingering and, "Oh, my gosh, let's keep them alive at any cost," and so she made sure she executed the proper documents, and she carried with her all the time. Sure enough, Edna's out in the flower bed, and she keels over, and the EMTs find her proxy at the hospital in the ER, just like they're supposed to, and they called the person in it, which was her nephew, and he came running in and says, "You know, gosh, I had no idea that she named me as proxy."

And the doctor goes, "Well, we have to make a decision. She is not going to survive unless we put her on a respirator, and the nephew says, "Oh, well, she's such a fighter, I know she'd want – put her on the respirator." And you know she stayed on the respirator for years before she finally passed away.

C. AUSTIN FITTS: I think the book said six years.

JO KLINE CEBUHAR: Yes – she named him as her proxy, but she forgot to ever talk to him about it. So that – there's that communication part again. You've got to ask that proxy. And you know, they might say "no," and you need to be prepared for that. Sometimes people are not

comfortable with it for one reason other. You just have to respect that and go on to the next person. But it doesn't really do any good.

It's a burden – an unfair burden on that person – that person that you say you love and trust – to name them and not tell them that you've done that. So we're back again to the communication issues.

C. AUSTIN FITTS: Right. Well, how do you determine who would be a good proxy?

JO KLINE CEBUHAR: You know, I think it – first of all, you don't always go to the same obvious choices that you do for a lot of things. I have people tell me when I do presentations, "Well, we're going to name our daughter because she's really the alpha daughter in the family, and I know she expects us to name her, and she lives out in California," and as you said, I'm in Iowa, and I point out to them, "You know, there's a lot of qualities that we want to see an in effective proxy. We want to – number one, their job is to see that your wishes are carried out, so you really have to know that they're willing to do that and trust them to do that."

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I've had people even say to me, "You know, my husband told me he doesn't ever want to be on a respirator, but I'm telling you right now if it's up to me he's going to be on one." Well, that's awful. I mean, there is somebody who's not respecting the patient's wishes. So you want to make sure they're trustworthy, that they're a strong advocate, as you pointed out, Catherine; sometimes you've got medical people right in your face, and you really have to be able to be strong and know where you stand on the options. But the most important thing as it is – you know, I think Woody Allen said, "80 percent of success is showing up," availability.

It really has to be someone who is going to be available to make those decisions. We can do a lot with emails, and we kind of get into the

mindset that we don't have to see people face-to-face anymore. We've got such great electronic communication. But you know, if you have a loved one in a medical facility, you need to be there at 6:30 a.m. when the doctors make the rounds, and you need to find out what's going on, because you can't – who you going to get it from? You can't go back to the nurse later and say, "What'd the doctor say this morning?"

That's not really effective advocacy. So availability, trustworthiness and most importantly are they willing to carry out your wishes? Are they committed to that?

C. AUSTIN FITTS: Right. Now, a lot of the exact kind of proxy and living will you write or just healthcare directives are overseen – or it's the jurisdiction of state law. So it's on the state – how do I find out what my options are within that state law?

JO KLINE CEBUHAR: Well, you know, it's a lot less complicated than it used to be, and that's the good news. When I wrote this book, I actually have in the print copy a chart of every single state – 51 jurisdictions, including D.C. – talking about each one of them, the major – the really important aspects of their laws. You know, what do they call their advance directives? Who is your advance directive proxy if you don't name one? How does the law look at that? How does the law look at guardians versus proxies? That sort of thing – and there really hasn't been much change in the law.

But when I did the Kindle version, and I just updated that recently, I thought, "You know what? That doesn't translate well to Kindle," number one. But now we have so many great resources on the web to pop right on there. You can go to all the law sites, but the best thing I think, Catherine, is I have a resource of a form that is accepted in 42 states. It's in 26 languages. It's a not-for-profit organization known as AgingWithDignity.org is their website. You can go on there and order their form, which is "Five Wishes," and I'm sure many of your listeners are familiar with that.

A lot of church groups, civic organizations have stepped up and

distributed those to their members, and it's great because it is accepted in so many places, and it's a wonderful crucial conversation outline. So you can – not only are you getting the legality covered and you know that it's going to be accepted, and in the eight states that it is not accepted then you can go and you can say, "What do I need to do in my state if I'm one of those eight?" Your Bar Association will probably have information for you, Medical Association – you know.

The answer to the question of, "Do you need an attorney?" I think the attorneys have answered that question themselves because many states offer these forms on their Bar Association sites. So that tells you that they're saying to the consumer, "You don't really need us to do this." Well, this *Five Wishes* form goes above and beyond, and that's really why I like it, because it's not just the advance directive. It does that, but it also talks about what kind of medical treatment do you want, and it talks in very simple, common, everyday terms, and it covers a lot of situations. You know, it'll say right in there, "Okay, you need help breathing, but your doctor says it's possible that you'll recover. Do you want to have a respirator?"

Well, there's a real situation that you can really sit down and talk to your loved ones about and make a really informed decision. It talks about how you want to be treated – I mean, the things like do you want hospice care? Do you want to die at home? Would you prefer to die at home?

Seventy percent of people would prefer to die at home. Only 25 percent of them get to because they ask about hospice too late, their doctor doesn't want to bring up the subject, nobody understands it.

The average stay in hospice is three days. Well, that's way too late. That's way too late. And I know you have a story –

C. AUSTIN FITTS: Oh, and I will tell you as somebody who's been through this, if you need a hospice it's the most wonderful thing in the world to have one.

JO KLINE CEBUHAR: Absolutely! Absolutely – and people – if they don't understand what hospice is, it is an approach to care which is not treating the underlying disease. At that point, we have said, "This person is terminal or has an irreversible condition. They're headed towards the end of life. Medicare defines it as six months or less remaining," and that's a judgment call, obviously; if it goes past six months the doctor re-certifies it. But Medicare will pay for that. That's the other misnomer. People think they have to pay for that expensive care.

Obviously, many people don't have those means. That's not true. Medicare will pay for hospice care. And if you require nursing care, they'll actually pay for you to be in a facility. So those are the questions you need to ask up front, and that's what I love about Five Wishes, so you can use that form. It's $5 to order this form, and if you get 24 friends to order it with you it's $1 a piece. So you know, you get together your church group or your book club or whomever – your office and you order those forms, and it walks you right through it.

And as I say, the only ones who really need to worry about it are the eight states where it doesn't apply, and they could easily get information from their Bar Association or their Medical Association.

C. AUSTIN FITTS: Right – I'm assuming even if it doesn't apply if you're in one of those eight states, it's still a great planning device.

JO KLINE CEBUHAR: Yes.

C. AUSTIN FITTS: It can help walk you through the conversation.

JO KLINE CEBUHAR: Absolutely – and you can use it in conjunction with the state form.

C. AUSTIN FITTS: Right. I want to talk about a couple things that are in your book. One is – you know, because we're talking as though this is sort of an age thing, and in fact many, many people at very young ages become incapacitated. And one thing you cover in your book, which is very interesting, is some of the more famous cases where you get into these

real food fights between the doctors, different members of the family, and the whole shebang ends up in court in a huge mess.

JO KLINE CEBUHAR: Yes, it's interesting that we do kind of think of this as an issue for the aging or in a final chapter of our journey in life, but in reality the famous cases – the Nancy Cruzan and Karen Ann Quinlan and Theresa Schiavo – were all young women – very young women who happened to have these awful, debilitating accidents or diseases – some sort of a health issue that resulted in them being in vegetative states, all three of them. That's why you'll find that most state laws will talk about terminal illnesses, but they'll also talk about irreversible conditions, which simply means it's not terminal.

"You'll find that most state laws will talk about terminal illnesses, but they'll also talk about irreversible conditions, which simply means it's not terminal."

You're not going to die from being in a vegetative state, but you won't ever wake up from it, chances are, and so at some point someone will have the legal authority to make the decision to remove feeding tube, respirator if there is one, and you will be allowed to pass away. That is not euthanasia, of course. That is simply withdrawing life support. It's interesting, Catherine, I was just finishing the book at the time of the Theresa Schiavo public tragedy, and actually as awful as that appeared to all of us, the system actually did work.

It took a very long time for the system to work, but all states have provisions that if you don't have advance directives, then the state mandated lists of people who could make decisions for you, much like people who are intestate. If you don't have a will, then the state says, "Okay, then your spouse gets this much, your kids get this much." It's very similar to that. The state steps in – the government steps in where we abdicate our self-determination. And in this case, they will typically start with the spouse.

The spouse will be the decision-maker. If there's no spouse, then we're talking adult children, and then we go on to adult siblings, but that

might leave it up to people that maybe you don't want to be your decision makers or who also may not be in capacity and able to make that decision. Those cases – every one of them was – the beginning cases – the oldest cases – Cruzan and Karen Ann Quinlan were really when we were really creating the laws. These were the cases of first impression for our courts. They had never dealt with this before.

We had never been able to keep people alive like that before, but now we have the high, high –

C. AUSTIN FITTS: Right – so part of it is the technology is really requiring –

JO KLINE CEBUHAR: Absolutely – yes – yes, we didn't have any issues of life support because life support didn't exist. When people couldn't eat anymore, they died because they simply couldn't take in nutrition anymore. So once we developed those medical means, then the law had to play catch-up. The Theresa Schiavo case really was a case of an argument over whether or not she was truly in a vegetative state.

She did not have an advance directive, but her husband, Michael, under Florida law, was the decision-maker, and had her parents not argued that they did not believe that she was actually irreversibly in a vegetative state he would have made the decision, and we would have never known about it. It happens every day in this country. People make those – they're terrible decisions, but people make them, and they have to make them, and they have the legal right to make them. But that's really why it became a big public fight.

And you know, it took years, but eventually he was able to carry out his wife's wishes, which was that she not live that way. So the system did work. Sometimes those legal wheels grind slowly, but it did work, and the legal history of life-prolonging measures in this country is interesting. I think it's a continuing debate. The law has decided where it stands, but I'm not sure people have decided where they stand.

C. AUSTIN FITTS: Okay – now you're going to laugh at me about this, but I have the most wonderful clients, and I'm always encouraging them to go

through this planning process, which is why I'm so delighted to learn about your book and now the Aging with Dignity form. But I know all of these – these are wonderful families. They're busy. They're creative. They're intelligent.

I can see them getting the book and getting the form and one of them is pushing this trying to get everybody to say, "Look, we want to sit down and talk about this," and everybody saying, "Oh, Mom, you know, this is too gruesome. This is too hard. No, no, no, no, no!" How do you get a group of people – what – how do you get the conversation going in a way where you can really dig into all the different kinds of things?

I'm not saying turn this into a potluck dinner, but how do we get the conversation flowing so that people really understand the power of – because I've seen these things keep people alive because you had people who were trained, because they had the power and the authority, they could rock and roll for you, made a huge difference and it stopped a whole lot of really dangerous and stupid things, and you could navigate a system and get the machine working for you as opposed to something arbitrary happening.

So I've personally felt the power of that, but how do you get a whole bunch of real busy people to take the time to – and how do you get them to feel the power of that?

JO KLINE CEBUHAR: And you know, it's interesting, because you said it – you're very accurate in the way you said it: it is the children. Nine times out of ten, people – the older – the parents will tell me, "It's my kids who don't want to talk about it. I'm more than willing to talk about it. It's the kids who don't want to talk about it." I think, number one, you make it a part of your life. And I love the couple of phrases that you used earlier when you were speaking about this topic, that death and you have become friends. I do think that our relationship with death is not very healthy in this country.

C. AUSTIN FITTS: Oh, it's terrible!

JO KLINE CEBUHAR: And the more we're willing to talk about it – I'm sorry?

C. AUSTIN FITTS: I'll tell you, one of the thing – it's very interesting because I remember in 1997, I joined a church. I'd been raised a Quaker and in Quaker meeting you're silent. There's no preacher. So in '97, I joined a church, and one of the things I realized was, "Oh, my God, they're talking about death!" Well, I had lived between Wall Street and Washington. I'd lived in a bubble where death was not part of socially acceptable conversation.

And now I live in a world where we talk about it all the time. If you live on a farm and you're dealing with livestock and – you know, it's just in the rural town, death is with you, and you have an intimate relationship with it, because it's a very concrete world. But I had lived in the bubble. So too many of us, I know, still live in that bubble, and we haven't – there's no sort of intimacy – we haven't made friends with death. We need to because it's one thing we all share.

JO KLINE CEBUHAR: Exactly! And you know, I have – the very closing line of my book is, "What's the death rate around here? One per person." I mean, it – there's only one way out of here, and that's it.

C. AUSTIN FITTS: Right!

JO KLINE CEBUHAR: And you know, one of the wonderful parts of what happened to Theresa Schiavo was there was a huge flood of awareness of this subject. There was, unfortunately, a lot of misinformation flying around in the media, but AgingWithDignity.org and sites such as that who have addressed this were flooded with requests. People really – that started the conversation, so that's where I would start. I would say anytime you have the opportunity – if you see a movie, if you read a story – talk to your loved ones about this.

Bring it into your lives. Make it part of your lives. And you know, we can laugh about the potluck idea, but whatever works is what you should do. And I do not think it's inappropriate for the parents of a family – and if the parental units may be in their 40s and they may be in their

80s, to say to their loves ones, "You know what's the greatest Christmas gift you could give me" – or Mother's Day gift or birthday gift – fill in the blank – "When we're all together, I'd like to take a half-hour of your time.

"I've talked to two of the kids. I've named them as my proxy and my alternate. I want to go through the form with all of you. Then we're done with it." And as you put it so well, Catherine, "Then I have permission to live. I've handled that part. We all go with the peace of knowing that you know what I want, and this is all I'm asking of you, is to carry out my wishes. We're not going to sit around and talk about me dying. I don't plan on going anywhere in the near future. But if you'll all do this for me, that would be a wonderful gift for me.

"We're not going to sit around and talk about me dying. I don't plan on going anywhere in the near future. But if you'll all do this for me, that would be a wonderful gift for me."

I think we do have to – it's that first conversation. It's that first word that's so tough. But the more – now, I know for a fact without even asking you that your experience with your friend, Georgie, changed your attitude about dying and death for the rest of your life.

C. AUSTIN FITTS: Oh, tremendously.

JO KLINE CEBUHAR: That experience – that privilege – privilege of sharing her final trip of her journey with her. It is a huge privilege. Not everyone will get that privilege. Not everyone wants to experience that. But it is a reality, and you know, end-of-life can break up families. They can be the last memory you have of someone, and that's not necessarily good if it's a source of conflict and discord in a family and watching your loved one suffer. Here's a statistic for you.

We're spending almost a third of our Medicare budget in the final year of the recipient's life for aggressive treatments that they don't want, they don't need and do not add to the quality of their life. You have to talk

about these things. This is a reality.

C. AUSTIN FITTS: I use the metaphor of the Pillsbury Dough Boy a lot where you squeeze down on one place and it jumps out in another. A lot of times we go along in our day-to-day life and we don't realize the impact that this macroeconomic event is going to have on our day-to-day life and vice versa.

We don't see the connections. But you do a wonderful job of describing the demographics of the baby boomers both in terms of need for services and then the cutback of revenues and support for services and how we literally – that's going to create a gauntlet where it makes it much trickier to get quality care.

And maybe if we could just go through that big picture and what it looks like and what it means to us and why it's so important that we – when we go into the system we know how to navigate it and use the machinery to serve us and we don't get eaten up by it.

JO KLINE CEBUHAR: Yes, I always refer to the baby boomer, and I'd be one, that we're the people who are knocking at the door. And every time our culture comes to the door and opens the door, they go, "Oh, my gosh! Where did you come from?" This is the same thing they said when we went to kindergarten, you know, "Oh, my gosh! Where'd all these kindergarteners come from?" Well, those were the babies that were born five to ten years ago. "Oh, my gosh! Where'd these high schoolers come from?" Then we got to college and on and on and look at the housing boom and –

C. AUSTIN FITTS: "Where'd these hippies come from?"

JO KLINE CEBUHAR: Yes, "Where did these hippies come from? Why do we have the birth control pill? Why do we have the hula-hoop?" We have defined the culture at every stage of our lives, and this is going to be no different. This is going to be no different, and I think it is going to be interesting to see how baby boomers approach end-of-life. I'm not very heartened about how they're doing it so far. But –

C. AUSTIN FITTS: Well, but we're willing for them to become the wise elders. We're willing.

JO KLINE CEBUHAR: Wouldn't that be great to have 78 million of those in this country?!

C. AUSTIN FITTS: Yes!

JO KLINE CEBUHAR: 75 percent of the people who die every year in this country – and that's 2.4 million people die every year in America – 75 percent are over 65. Now, yes, that makes sense. That absolutely makes sense because older people die, and the causes of death when you get over 65 are the types of death that are going to be more likely to be long, lingering deaths. In other words, we've gotten past our accident-prone stage in life, and the crime – the chances of being a victim of crime.

We're going to die of strokes, heart disease. Those are the issues that are really going to bring this to the forefront. We only have 2 geriatricians – doctors who specialize in elder care – for every 10,000 Americans over 65 years of age. They can't fill these positions in the medical schools and the residencies. These young people don't want to be geriatricians. That's going to be a problem for us. We are going to have a nursing shortage. We're going to have a shortage of everything that older people need.

But the biggest things we're going to have a shortage of is an understanding of what is so, so different about that last chapter in life from the rest of it. It is a time of self-reflection. As you – it is just – I love your phrase, Catherine, "Permission to live." Once you've accepted the fact that this train ride is going to end, you can really get busy on what you need to get done. If you think it's going to last forever, there's no deadline.

And I think getting older is really going to make a huge difference in a lot of people's lives as they accept it and their parents die – for many people, many baby boomers, that's their first experience with close death is their parents, and it's shocking to them to know that people actually

die and they're gone. And I don't say that flippantly. I mean that really is the first time they've experienced it. Then their friends start passing away. Then they start getting it.

They start getting that there's mortality here, that we have a limited amount of time to do what we intend to be known for on this earth. So I think those resources – that's going to be one issue, but I think the cultural psychology of death is probably going to be our larger issue than even the medical resources.

C. AUSTIN FITTS: Right – although I will say this, and this is because I fret about this on behalf of subscribers and clients. My family's always been very involved in health. My father was Chief of Surgery at a big teaching hospital. I have another uncle who was a surgeon. I have cousins who are nurses and doctors, and my grandfather was a doctor. I feel like I've been surrounded by health issues all my life, and what I've seen in the last ten years is the same thing I see in the financial area, which is the pressure is on to generate profit, you know, and it's a drumbeat, and it makes the model crazy.

So you get – I get a lot of reports from different colleagues and subscribers and investors and clients about stories where they just go into the health machinery and just crazy things go on because this whole machinery is on a tempo to make money and get things done, and it really has become the gauntlet. I don't know if you've ever seen the film from the *I Love Lucy Show*, "Lucy and the Chocolate Factory"?

JO KLINE CEBUHAR: Oh, yes! Oh, yes!

C. AUSTIN FITTS: But our medical system –

JO KLINE CEBUHAR: With the conveyor belt – oh, yes!

C. AUSTIN FITTS: Our medical system has become like Lucy, and the chocolate – and you're on the conveyor belt, and these are life-and-death issues. And so to me as I read the part in your book about the – just the demographics of both the resources and the people who are going to put

pressure on the system, I realize, "Oh, my goodness! The conveyor belt on the chocolate factory is speeding up, and we just do not want to go –

JO KLINE CEBUHAR: Yes, that's the way it's going to be.

C. AUSTIN FITTS: Yes, we don't want to go into that machinery –

JO KLINE CEBUHAR: It's so much more important –

C. AUSTIN FITTS: – unless we're unbelievably prepared.

JO KLINE CEBUHAR: That's right – for you to understand what the options are for you, Catherine, for everyone who's listening and anyone that they can influence, do they really know what a DNR is? Do they really know what it means to have a "do not resuscitate"? I have to tell you this quick story because this is – it's funny, but it's kind of sad. This is the tattooed lady story.

"Catherine, for everyone who's listening and anyone that they can influence, do they really know what a DNR is? Do they really know what it means to have a "do not resuscitate"?"

Here in Iowa in an Iowa town a couple of years ago, front page in the *Des Moines Register*, this elderly – quite elderly lady had had DNR, do not resuscitate, spelled out tattooed on her chest, and she was so proud of this because she had had so many friends that she felt had been resuscitated when they didn't want to be against their wishes and had been kept alive when they didn't want to be. She wanted to make no question when those EMTs, she falls down, she wants them to see that tattoo, and they're not to do anything.

And everybody thought this was a great idea, and they were amused, but they also thought, "Well, how smart is she?" Well, not that smart because a DNR is meaningless. That EMT comes across you and you've collapsed, he's required by law to try to revive you unless you have an out-of-hospital do-not-resuscitate order issued by a doctor. So you can't say, "I don't want to be resuscitated." Only your doctor can say you

don't want to be resuscitated. How many people understand that?

Until you really grasp what your options are, and you understand – and these are pretty general across the country. There's no states that don't comply with this, so this is something that really is universal no matter where you go. You've got to know what those options are. You've got to understand when hospice applies. You've got to understand what is life support.

C. AUSTIN FITTS: In true confession, I was halfway through your book, and I realized, yes, I have a healthcare proxy, and yes, I have a living will, and now I realize they're totally inadequate, so I've got to go back and do them again.

JO KLINE CEBUHAR: And I told you – I'm going to send you a copy of *Five Wishes*, and you'll love this form because it's very friendly and it really makes you think about these things.

C. AUSTIN FITTS: I may get my Solari Circle and see if they'll do it with me so that we can all talk about it together.

JO KLINE CEBUHAR: Oh, yes!

C. AUSTIN FITTS: Actually, you know, I have a little investment club called The First Ever Solari Circle, but our topics range far and wide, and they're just – you know, and we do it by phone, so we could even get the Solari Circle doing this by phone. I'll ask them to do it with me, because I think you just – I find in something like that you need other people to kind of think it out and help you deep-breathe your way through it. Well, Jo, this is –

JO KLINE CEBUHAR: Well, you know, if you do it as family. You know, if you did it the day after Thanksgiving – I mean, the young people – anybody who has children – and I – 20-something or an 80-something – they all need to be doing it. They're doing this for the sake of those that are going to have to make the decisions.

C. AUSTIN FITTS: Okay – so tell us one more time how do we find your book? How do we find the guide? And how do we keep up on your work?

JO KLINE CEBUHAR: Well, stop by my website, which is SoGrowsTheTree.com, and that name comes from my most recent books, which are on ethical wills, not a legal document, but I think they tie in great with healthcare directives and then, of course, the other legal documentation, "Last Wills and Testaments," because an ethical will is an ancient tradition of writing what you stand for.

And I think part of the great part of this process of going through these healthcare directives is for our self-reflection, for the person who's doing it to stop and think, "Gee, when do I consider enough is enough? When am I ready to say, 'Guys, it's time for me to sign out'?" So really thinking about what you stand for, that's an ethical will. So that's where the name SoGrowsTheTree.com comes from. My books are available there. They're available on amazon.com.

I've got Kindle versions of my books that are available as well which is – you know, and they're very inexpensive. So you know, you can download a Kindle version of *Last Things First, Just in Case* for $2.99, and it's going to tell you everything you need to know.

C. AUSTIN FITTS: It's beautiful. I've read it. It's beautifully, beautifully written. It's very clear.

JO KLINE CEBUHAR: Well, thank you. Thank you. You know, I love stories. I always thought I was going to be a fiction writer. I always wanted to be a fiction writer. It's not in me! I'm a nonfiction writer, so I always try to spice things up with stories because it makes everything more enjoyable, and examples are always great. So then go to my website and find that – my – all my email contact stuff is there, my calendar, and I do lots of workshops on ethical wills and end-of-life issues, and I'd love to talk to your listeners.

So yes, watch that because I have a blog every day. I give little tips about

how to use your value system to develop these legal documents. I think the first step to estate planning, healthcare planning, giving planning, philanthropy planning should all be, "What do I stand for?" You've got to figure out those core values first before you do any of those legal documents.

C. AUSTIN FITTS: I agree. I agree. That's great. Okay, well, Jo, again thank you so much for joining us on the Solari Report. You have a great evening.

JO KLINE CEBUHAR: Oh, thank you, Catherine. Bye-bye.