Planning for end-of-life health care decisions is not just about old age. A medical crisis can happen at any age and can leave you or someone you care about too ill or unable to make his or her own health care decisions. Even if you're not sick now, making health care plans for the future is an important step towards making sure you get the medical care you want even when doctors and family members are deciding for you. It can be overwhelming to be asked to make some serious decisions for someone who's very ill or dying. It's even tougher for people who don't have written or even spoken guidance about what types of levels of treatment their loved ones wanted for themselves.

We are here today so that we can avoid those difficult situations. This afternoon, we have three distinguished panelists to speak on this important topic. And introducing them briefly starting to my left, Karen Griffith who is from Compassion and Choices of Washington, which provides support to clients and families facing difficult decisions; Carla Jolley who serves as a Palliative Care Advanced Nurse Practitioner at Whidbey General Hospital; and Grethe Cammermeyer who is a retired Army Nurse and owner of the Saratoga View Adult Home.

I will give each of our distinguished panelists an opportunity to make some opening comments about why Advanced Health Care Planning is so important and the experiences they have had with these matters. I will, then, each -- I will, then, ask each of the panelists some directions questions. Afterwards, we'll open the floor to questions from our audience here and those following this forum on Twitter. When the time comes for questions from the audience, I will ask audience members who have a question to raise their hand and we will come by with a microphone. So we're now ready for opening statements and I'll start with Karen Griffith.

Thank you. Thank you, Marshall. It's a pleasure to be here and to be in such distinguished company as Grethe and Carla. Uh, I've worked in Hospice for several years as a Director of Volunteer Services. I'm on the Board of the Hospice Foundation for Jefferson Healthcare and, as Marshall said, I'm a Client Support Volunteer for Compassion and Choices.

How many of you have heard of Compassion and Choices?

[Some raising hands.]

Oh, quite a few. Okay. I'm impressed. Our mission is to promote excellent end-of-life care and expand the choices you have of the end-of-life care. We advocate for you having a very peaceful
and humane death. Compassion and Choices of Washington is the organization that put together the Coalition that passed I-1000 back in November of 2008. How many of you remember voting on that in 2008? Okay. Interesting. What we've found in our organization is that many people voted on it one way or the other, and then kind of promptly forgot about it, and so I'm here to refresh your memory today about what it is you voted in or voted against.

We educate people about all kinds of options toward the end of life and what their choices are and help them through those issues. We have Client Support Volunteers all over the state that help people free. All our services are free. We provide information about Advanced Directives and, as many of you know, we have a wonderful couple of Advanced Directive Workshops here in this building tomorrow taught by Judy McCay, who's sitting in the back of the room. And the last but not least is we support and help people through the process called Death With Dignity. So when someone calls our office and said I've decided I want to leave this earth earlier than when the fates may take me, we send a volunteer, such as myself, to their home to talk them through the process, kind of literally and figuratively hold their hand through the process, and then we are even there on the day they choose to end their life.

The law passed was 60 percent of the voters in support of it. That meant 40 percent didn't support it so we know we have some people who are in opposition to this law but it is the law of the land and I want to share with you throughout the next hour and a half here and there about what this law is about. How many of you kind of remember this story? Brittany Maynard in the newspaper and on the local news and the national news last November?

[Some are raising hands.]

She was a young woman, 29 years old, with a glioblastoma brain tumor, and she was living with her family in California and they picked up and moved to Oregon, which also has the Death With Dignity law. She said I want to choose when and how I die and indeed, she did on November, uh, 1 and it was very, um, very sensitive and very sad but I'm glad that she had that choice.

There's lots of controversy around the law and so I want to clarify some of that. First of all, I want to tell you that doctors have been helping patients who are near the end of life to die ever since there have been doctors. It's been done very discreetly, um, not a lot of fuss about it, but it's been happening for literally centuries. I want to be very clear about terminology when we talk about Death With Dignity. We feel terminology is very, very important. This is not euthanasia, either voluntary or involuntary. Voluntary euthanasia is when a person asks a health professional to give them an injection of some sort, Dr. Kavorkian. Involuntary euthanasia is when we put down animals and capital punishment, where, of course, there is no consent. So in no way do we consider this euthanasia. Please don't refer to it as euthanasia. It is also not assisted suicide, which is a Class E felony in the state of Washington, and the reason it's not suicide is this. With suicide, a person often has some sort of a deep depression. They often take their life in a very violent way. They do it alone. They do it without warning their family or friends and it leaves horrible psychological after-effects. This is not that. This is now a quiet, peaceful death with family around. It is where a physician writes a prescription where the patient, himself or herself, takes the medication. So we're going to ask you please not to refer to this as suicide, which it's not. It is not also a choice between life and death because people who qualify for the law no longer have the luxury of choosing. They don't have an open-ended span ahead of them. They are facing a terminal illness. So if it isn't either -- any of those, we call it Aide in Dying or Physician Aide in Dying. Only mentally competent people can do it so that if you think about it being a slippery slope, well, first we're going to start taking the life of the mentally handicapped or the physically handicapped, et cetera, or people with Alzheimer's or grandma in the nursing
home who's using up my life savings, can't be done because it has to be done by a person who's mentally got all their marbles, has to be a legal resident of the state of Washington, age 18 or over, has to have the consent and the support of two different -- two different physicians. So it's not -- it's not done easily or without a great deal of thought.

Medical interventions are able to keep people alive long past the time where in the old days people would die of certain things like perhaps high blood pressure or hypothyroidism. Now, with medical treatment and drugs, people are living long, long lives and the downside to that is well, we may want our lives to be good as long as we can. We certainly don't want our death to linger, and most people don't want to suffer endlessly once the possibility of living a good life is gone. So at a certain point, our physical bodies give out and we're facing the inevitability of how we want to die. Hospice Palliative Care, very important component of Death With Dignity, and I'll be glad to give you lots of statistics about how, you know, who uses it, et cetera. But I will say this before I turn this over to Carla and that is it's not about escaping pain, interestingly enough. Only 15 percent of the people who use Death With Dignity say that pain is even an issue. Isn't that interesting? Only 15 percent. Pain can be well managed through great Hospice care and Palliative care but it is lots of psychic and emotional pain and there are other symptoms around the dying process that are not pretty to see or feel and so this is about people who come to the end of their life and say enough is enough. I will not let this take anymore away from me than it already has. So with that, I'd like to end and we'll talk more about it with your questions and give it to Carla.

[applause]

00:11:00 CARLA JOLLEY

Thank you, Karen. So I'm Carla Jolley. I'm a, uh, Palliative Care Advanced Practice Nurse and for those of you who are not familiar with Palliative Care. Palliative Care is actually when we look at a new health care specialty in the last decade or two, really focusing on what we look at as far as quality of life issues. And so the focus of care and the focus, what I call another layer of support for patients and their families because we know when someone has a serious illness, it is not just about the patient. It is about who supports them, their friends, their families, and sometimes it's about being in isolation if they don't have any support. So it becomes a bigger picture, a holistic approach.

So when we look at Palliative Care, it focuses on pain and relief of symptoms and, um, whatever the diagnosis. So a lot of times people associate just Palliative Care with, um, a cancer diagnosis but it also is for, um, end-stage lung disease and heart disease and Alzheimer's, um, because in that spectrum of disease trajectories, we do all leave the, um, world. Sometimes it is with advance stage and frailty but we do have a spectrum in that trajectory where, um, we may be getting treatment or curative treatment for a long period of time, then it may be just Palliative treatment. We're trying to treat symptoms and then it becomes advanced disease or providing support around end-of-life.

And so when people often associate Palliative Care with just Hospice care and my -- my feedback to that is all Hospice care is Palliative Care and that we are looking at relieving pain and suffering and supporting the patient and family. But not all Palliative Care is Hospice care because you can access that approach to care, that layer of support sooner in your, um, in your journey with chronic illness. So it specifically focuses on people who have serious illness, um, because we know that that can add a lot of stress and concern, um, around, um, how best am I going to manage in the next few weeks, few months, and sometimes few years when we think about
people who are living with end-stage dementia, which is a very, very difficult journey for families and their loved ones, much less for the patient, themself. So finding, you know, what we know in medical care is that sometimes, um, you know, those short five to eight minute appointments don’t always capture the ability to have what I call conversations, and so when we bring it back to Advanced Care Planning, which is when we're -- what we're here to learn a little bit about, is that Palliative Care really looks at that conversation around that. It really is not just filling out a form. It is really about having a conversation about what our values are, our beliefs are, what we want, what we don’t want. The question that I always start with patients and families with is what matters to you most. When you think about end-of-life care, what matters to you most? Is it being -- remaining independent? Does it mean being surrounded by your patient -- your families? Does it mean having a death at home? Does it mean feeling safe? What matters to you most and I can't answer that question for you but you can answer it for yourself. And even more important, if you have helping someone else in that decision making process, what is their answer or have you ever asked that question what does that mean to them? What matters to them most about where they want to be, what they might want to have happen? And what -- the other thing that we often need to consider in these conversations is the decision points because along the line that when we talk about Advanced Care Planning, it is important to get your information onto a form but it's more important to know that it is a process. And every time you have another trip to the emergency room or every time you have a stay in the hospital, if you are living with serious illness, it'll be another set of decisions to make. There'll be another person asking you what would your mother have said if she could speak for herself. Well, that's easy to -- for me to ask you but it's not always easy to answer if you haven't had conversation about that. And conversation is important about yes, do you want to resuscitated or not, but it's more important about what is their value around that. Is it quality of life? Is it quantity of life? Was your dad always a full-court press kind of guy and never give up or was it just like I'm an old lady now at 88 and I have -- lived a good life and don’t you dare take me to the emergency room and don’t you dare put a tube feeding down me and don’t you dare. Now, that's fine if you have a parent that is quite strong in letting their wishes be known. But what about the daughter who asks the question and the mom says that's very unpleasant. I don't want to talk about that. I mean what do you do then? Because I'll come to you, if I'm sitting at the bedside trying to help families make decisions, I'll come to you and I'll say what has your mom said. So maybe sometimes I can figure it out when they say I don’t want to be like Aunt Gertrude over there, no way, Jose, don’t ever do that to me, um, or they might say, you know, Uncle Joe had a great death. I want mine to be just like that. And so sometimes, teasing that out is hearing stories. You know, what stories, um, because stories is what informs us if we had a good experience with a loved one, then that's a great story as far as what we might want for ourselves. If we had a bad experience, then we know for sure what we don't want for sure as well. And so when we look at that spectrum of continuum, um, certainly sometimes we're allowed to make a decision and we have some control over it and sometimes, you know, health happens. Health crises happen and we don’t always get a lot of time or ability to think about that. So we need to have talked to our durable power of health attorney. If there is nothing else that you do when you walk out of here is that is the one form to have because that person's going to speak for you. We can write down our wishes and everything but that set of decisions is always complicated and so that person who's making those decisions for you really needs to understand what you would want or not have wanted.

One of the things that, um, I'd like to introduce and I put on your chairs is called the Conversation Starter Kit and the reason that I am such a pro advocate of this is that it's kind of that step before the Advanced Directive. It says, you know, really what are my values, what matters to me most, you know, how much do I want my loved ones in my business, you know, yes, no, um, or yes, I do want them but do they know what I want? Have I ever talked to them? Um, it talks about how much you want to be part of that decision making process as well. We, as a health care
community, as a medical health care community, we started out -- Dr. Goldberg -- way back when being very paternalistic and making all the decisions for patients, several decades ago. Then, we kind of swung the other way and we said okay, here's your information, make your decision. Well, I don’t know about you but a lot of us aren't sitting in this room with medical degrees and so, you know, it's just like well, you know, how am I supposed to know what I might want or not want with that. So really what we're looking at as a, hopefully, as we're growing as a community that's responding to people's concerns about having their choices honored is we want a shared decision making model, meaning that I give my best as I know expertise about what's happening with you, what kind of decisions you might need to make, and then you tell me what matters to you most, what do you value and what are you afraid of or afraid that might happen or what might not happen. So that becomes a very important conversation as well.

So I encourage you to take a look at that. If you're a social media buff, it is on the website, very interactive and has some lovely, um, some videos and she introduces this particularly, and this is what I would like to point out, when we look at, um, where people want to die, about 70 percent of them say I'd like to die at home. When we look at the kind of not so great statistic, about 70 percent of us will -- are still dying in hospitals, nursing homes, and facilities. So how do we make that different? Well, we make it different by being proactive. Um, just like the Berley movement. It didn't come from the medical community as far as fathers in the waiting room, having birth plans, all those things. It came from consumers and so your responsibility as consumers is to say I want my choices honored. Um, but I need to participate in that process too, which is putting a plan together, having a conversation with your loved ones about, um, if they have to speak for you or what you might want to have happen as best we know. And if we don’t know, at least they know what your values or beliefs are so if I ask them at the bedside what would your mother have wanted, what would she say to you right now if she could speak? Would this be acceptable to her or not? And you can say, you know, we had a conversation. Thank you.

[applause]

00:21:11 GRETHE CAMMERMEYER

Well, you’ve been hearing the process. I'm a -- the pragmatist, uh, because, uh, you in most cases would not come to me. Uh, I have an adult family home. When I retired, I decided I needed to do something with 50 years of nursing and, um, my spouse, her mother lived with us for five years, uh, had progressive dementia and needed a caretaker, uh, someone, um, and I thought it was going to be me, uh, because I'm so good.

[laughter]

And, uh, and, uh, so, uh, I started doing her care and then realized that I was absolutely trapped. I could do nothing. I couldn't go see my kids or my grandkids or, uh, have -- have any sort of a life and realize that, uh, I was not alone in this, that there were other people who were going to be in the same situation. Uh, we've been talking about the process for us as individuals but many of you may have -- have, uh, family members who haven't had those discussions because they've been uncomfortable and you don't talk about it, uh, and, uh, some of you may have -- be familiar with this book called, uh, Can't We Talk About Something More Pleasant? It's a, uh, really a fascinating tragic story in a way. It's a cartoonist who tells the story of her elderly parents who don't want to talk about anything, don’t want to leave home, and the process of finally having enough bad things happen to them that they end up in a care facility because of they can't be taken care of at home and then, of course, as -- as children of aging parents, they also hook us.
You know, there's no way that even though we're 60 years old, that we are 60 years old to our parents because they can say something or do something and it just brings up that adolescent in us and time and again, and you, you know, my father's nostrils would wiggle before he was going to say something that was going to push my button. But the point is that we have an adult family home. Decisions to a point have already been made by the time you realize that you can't deal with the family member or you, yourself, don't want to live at home and take care of all of the issues and you know that you're going to die. Uh, you have just gotten a diagnosis of cancer and have less than six months to live and you want to be taken care of and just live your life without any burden at all and you may choose then to go to an adult family home rather than an assisted living facility of something like that, and then we contact Compassion and Choices and they come and work with -- with you as a member. In most cases, what happens is that someone who's already losing mental capacity, not only the physical capacity but also mental capacity and with that, you don't have the choice of how you choose to die and if you think about it, none of us know how we're -- well, it's rare that we would know how we're going to go and we would like, in those cases, for it to occur rather quickly. I've had a patient, a resident with me now for six years. She came with a broken neck, fractured femur, uh, couldn't speak, had had a concussion and, uh, we cured her. She was up walking around. The problem is that she had Alzheimer's so she has been with us for six years and we watch her just slowly lose capacity because that's the way the disease is. And there was a time when she said to me, uh, Grethe, you can help me. Uh, and I -- I said I don't know what you're talking about, um, but, of course, I did, uh, and she -- she just wanted it to end because she was feeling that she was losing control, um, but with Alzheimer's we don't do that, uh, and so we have to watch the process of somebody, uh, somebody dying.

Uh, the most difficult thing I think is for family -- family members to make a decision about what you do with mom, how do you -- or dad, how do you get the support that they need if they are living at home alone or are living with you? You know, you have to try to sort all of these things out because it can really, really expensive, uh, to have 24-hour daycare in your home at $20 an hour. That's more than $500 a day, uh, if -- if you need 24-hour care. So it's trying to, uh, just manipulate the resources that are available and look at what options might be. Most of the calls I get are not about placement or having someone in, uh, move into our home but rather, you know, where do I go and where can I get some help and how can I find somebody to help out, uh, and to try to advise people on what some of the options are. By the time they come to a facility, at least an adult family home or something, these, uh, POLST forms, uh, the physicians order for end-of-life or for life sustaining treatment are usually filled out, uh, and so that some decisions have been made by family members on behalf of their relative, uh, which really is essential and -- and I think to have really opened conversations about what is the cost, what is the risk of not having one of these forms. You end up on a ventilator and you die in the hospital and, uh, that -- that just really wipes out any resources that you might have. Uh, it wipes out the -- the sort of the dignity that you might have also. It is an essential piece of paper as well as for following after the Advanced Directive that you have written that -- that Carla talked about because otherwise, you really have no say in it and you have to have a little information about what's the benefit of CPR. What's the benefit of going on a ventilator? What's the benefit of having surgery when you are 95 years old looking at, you know, whether it's something acute or is it something that would prolong your life, and I think that we sometimes can get hoodwinked into thinking, you know, it's -- it's like putting a new model in a 60 year old car. You know, you've got a good motor but the rest of it just isn't working and no matter how much you try to repair the rusty holes, it ain't going to go back to where it was before, and -- and I mean the reality is that that's what our bodies are too. The minute you start cutting and pasting, it doesn't come together the same way and you have to take care of it early enough so that you don't have to cut and paste but then realize that, you know, it's the beginning of, you know, could be some real adverse effects in terms of your ability to care for yourself afterwards. I don't want you in my adult home and -- and I don't think
you want to be there. Actually, you might but, uh, but the point is that you would like to have more decisions about, uh, how your life progresses as -- as you get older.

So I don’t know that I have anything more profound in the process to say but thank you.

00:29:56 MODERATOR

Thank you.

[applause]

Well, I said we had a group of distinguished panelists. I'm more convinced than ever. Aren't you? Let's give them another round of applause.

[applause]

For this section, I had prepared, uh, some questions for them, kind of as filler because I -- what I want to know now is how many of you in the audience is prepared to ask a question?

[Some raising hands.]

Please raise your hand. See, I had a feeling -- I knew this was going to happen. That's great because it turns out, um, a lot of the questions I was going to ask or some of them were directly answered by this panel in their introductory remarks. But I do want to ask a couple maybe. Um, surveys show that only a small percentage of patients have used an Advanced Directive. In those with chronic illness, only one out of three surprisingly, and that only 18 to 30 percent of Americans have completed an Advanced Directive. Lack of awareness is cited as the most common reason for not having an Advanced Directive. Can you, and this is directed to all three, can you comment on the factors or barriers for not completing an Advanced Directive? We'll just go round robin.

00:31:13 CARLA JOLLEY

Oh, can I just say one thing? That my favorite phrase around that, it's all -- it's always too soon until it's too late.

00:31:19 MODERATOR

Oh, I love it. Good an --

00:31:23 KAREN GRIFFITH

Yeah, I think it's a real reluctance on the part of, uh, of all of us to really face the nitty gritty of I'm going to die and it's a -- it's real uncomfortable to actually stare at a piece of paper that it asking you to make black marks on it about what things you'd want done at the very moment of or weeks before you're going to die. So I think it's -- it's kind of natural thing for us to avoid the unpleasantness so I don't think there's any mystery about why, um, more people aren't doing it. Uh, there's a lot of things in life we would rather not do, you know, go to the dentist, et cetera, and yet we do because it's in the long run better for us. So I think it's just simply a reluctance to acknowledge our mortality and to get real as -- as Grethe was saying, very pragmatic about the
nuts of bolts of how I'm going to die. So this is our mission certainly in life. My sister in the back of the room who does the Advanced Directive Planning and myself were the death sisters --

[laughter]

-- and we just have a mission in life to get people to do this document and when people give us the excuse of well, you know, I'm not really that old yet. I say do you remember the names, Terry Schiavo, Nancy Cruzan, and Karen Ackland? Do you know those names? All three of those women were in their 20s and 30s and were ended up in vegetative states for like ten years because they were "too young to have thought about what they would do if that could occur.” So you never too young to be thinking about it.

00:33:11 **CARLA JOLLEY**

I just want to add, um, I think the other thing is that people often, um, think that it has to be done with a lawyer and it does not. It certainly, as you know, you have a couple classes coming up but it certainly can be done in a group setting or by yourself or there's lots of resources out there to download and fill out forms in Washington. If you download a form like it's a Five Wishes and it has a notary place, you need to have it notarized. But other than that, you don't have -- like I said, it doesn't take a lawyer to do it so it's finding a form or finding a format that makes sense to you.

00:33:52 **MODERATOR**

Thank you. Grethe?

00:33:53 **GRETHE CAMMERMEYER**

In -- in most facilities, you can't even get in the door without one, uh, and in the hospitals, uh, that you fill one out when you register to get in so if you don’t think about it in advance, the time you don’t want to have to deal with it is when you have to deal with it.

00:34:10 **CARLA JOLLEY**

Right. Yeah.

00:34:11 **KAREN GRIFFITH**

And may I just add one little thing about that? First of all, the state of Washington does not require living wills and Advanced Directives to be notarized. It's kind of interesting. Many places, uh, like Five Wishes, et cetera, have a place for notarization but it's not required. And secondly, if you have an Advanced Directive in place, you have -- excuse me -- you have it written and you have copies to your various medical providers and you enter the hospital and they give you another to sign, don’t do another one because then that supersedes and makes invalid the one that you probably gave a lot of thought to. So what you want to do when you enter a medical facility is to take with you your Advanced Directive that you've already created. So toward that end, my sister and I both have our copies literally by the front door behind a planter --

00:35:04 **CARLA JOLLEY**

So can I --
00:35:04  **KAREN GRIFFITH**

-- so that we can take it with us. It's a -- there's a copy in the glove box, et cetera. So, uh, just a couple little twists to that.

00:35:13  **CARLA JOLLEY**

So, um, if you go to Whidbey General Hospital's website, there -- on the Advanced Directive Planning site, there is a form that you can actually download and have your for -- send your Advanced Directives in ahead of time and so even if you don't get your care at Whidbey General Hospital, a lot of times if you access emergency services, then, um, you can, um, they will open a chart just for you to have that on record.

00:35:40  **MODERATOR**

Thank you. Well, since we talked about storage and you -- and, uh, copies of sandwich, I want you to know that I have mine right now.

00:35:47  **KAREN GRIFFITH**

Good.

00:35:47  **MODERATOR**

I never travel without it including becoming a moderator.

00:35:50  **KAREN GRIFFITH**

Good.

00:35:51  **MODERATOR**

So thank you. Um, I'd like to ask one more question and then I promise I'll turn it over to the audience, um, because I'm sure this has come up before. What happens when a patient's Advanced Directive runs counter to what the hospital or doctors want to do?

00:36:07  **KAREN GRIFFITH**

Well, I'll take one swipe at it and then I'll invite the two of you, and that is that I, if it was my mother, let's say, and I took her to a facility that did not want to, um, honor the Advanced Directive, I would find another hospital and, um, if it was myself, I would say could I go to another hospital. It's that important because there are things that you want to be able to say on your Advanced Directive about what care is done to you or not done onto you that in a hospital that won't honor it could be done to you or not done to you -- onto you, and that's very serious. So that would be my first bit of, um, advice.

00:36:56  **CARLA JOLLEY**

So, um, Advanced Directives, you never can put everything that ever will ever, ever, ever happen to you on it and the decisions that are going to be made, and I'd just like to give a quick example,
um, that, yes, it takes conversations with your family and your durable power of attorney but it also takes conversations with the person who's providing you, um, health care. My uncle who had, um, Parkinson's did a POLST and was pretty clear no tube feedings but he was a little stinker and was out there doing bark dust and fell over and broke his neck. So he is down at Harborview. My aunt is having a meltdown because he said no tube feedings but he is not end-of-life. It is not about this is a life prolonging measure. This is a temporary intervention so he had, uh, the tube feeding placed. He had a, uh, you know, removed after he didn't need it and he had healed and that is end-of-life event, which, you know, for end-stage Parkinson's, one of the decision points issue is about tube feedings. His wishes were honored so, again, Advanced Directives are guideposts and, um, our tools for, um, health care providers to have a starting point. But sometimes we have to go back and have conversations. You're right that it's important to honor them and if you're not feeling honored, there are definitely chains of command. Um, there's ethics committees and ensuring appropriate care. There's ways to, um, be able to be heard if you feel like that that is part of the conversation as well and all different kinds of health care settings. There are places to go with that as well.

00:38:35  GRETHE CAMMERMEYER

Well, I think this is one of the concerns that, uh, we who work in hospitals have had regarding affiliations, uh, that whether or not your, uh, end-of-life decisions and Advanced Directives would be followed if you were in a, uh, church affiliated facility, and as was mentioned, you know, don’t go there, uh, because you will -- you will end up being treated according to the religious doctrine of the facility rather than your own wishes. Whidbey General Hospital is not affiliated. It stands alone.

00:39:25  MODERATOR

On that --

00:39:25  GRETHE CAMMERMEYER

It's taking on the world.

00:39:26  KAREN GRIFFITH

Yes.

00:39:26  MODERATOR

On that note --

[laughter]

00:39:28  GRETHE CAMMERMEYER

Oh, that may be more real but --

[laughter]

00:39:33  MODERATOR
I thank you all for that. I’d like to now turn to audience questions but I do want to remind you of a few things. Uh, please stand when you ask your question and let us know which panelist your question is directed to. We would also appreciate it if you would identify which community you're from and if you represent a specific organization. If you have a comment to share first, that's fine. However, please limit it to a minute so that we can get the maximum audience participation possible. I do reserve the right as Moderator to move you along if you're taking too long to get to your question. That's why I signed up to do this in the first place.

[laughter]

For those who join us by Twitter, please tweet your questions and comments as you have them and we will ask them at the appropriate time. So now we turn to audience questions. We have two, uh, roving microphones. Do we have a Deb -- Debbie, I believe? Is that --

00:40:28    KATE

Kate.

00:40:29    MODERATOR

Kate? And I'm -- I'm sorry. And Becky. Becky? Okay. Go ahead.

00:40:37    BECKY

Yes. All right. So I -- I guess probably Carla, you might be the better answerer of this. Um, as far as how many copies of a single Directive does a person -- should a person have around and where should they be stored?

00:41:04    CARLA JOLLEY

So definitely not in the bank deposit --

00:41:09    KAREN GRIFFITH

Safe deposit box.

00:41:09    CARLA JOLLEY

-- safe deposit box, yes. So, like I said, get a copy to your, um, providers. If you have specialists, get a copy to your specialist. So I mean part of it helps them to understand what your values are, um, to whoever you said was your durable power of health attorney, to whoever might get called as a, um, a person who's on your, um, emergency contact list, in your glove compartment, like Karen said, and then also, um, one in your purse. Uh, you can never have enough, uh, you can have -- never have enough copies. Um, but the pieces if you change them, you want to make sure you've kept, uh, track of where you've put copies out because that's important if you've updated them as well.

00:41:57    MODERATOR

Okay. Next person.
00:42:00  **FEMALE**

I heard recently that, uh, if you have a Directive and you say on there do not resuscitate and then if you are unconscious and someone else calls, uh, 911 and paramedics come, that they are required to resuscitate you. Can anyone tell me if this is true?

00:42:21  **CARLA JOLLEY**

Yeah. It -- it is true unless you have taken that Advanced Directive and you, um, and turned it into a POLST. So, um, unless -- because EMS has a, uh, responsibility to respond to an emergency if someone's called 911, um, and if you -- someone does call 911, the only way they can kind of break that is to, um, certainly if someone's there with you that knows your wishes, they can certainly talk to the, um, physician that's overseeing that, um, code. Um, but really what you want is a POLST and that is a physician orders and it is signed by your provider that says to the EMS do not resuscitate me. That's the first question it says and that gives them legal -- legal right not to, um, start CPR. Okay.

00:43:13  **MODERATOR**

Good question. Very good question. Next person? Uh, hand over there, behind you.

00:44:09  **CARLA JOLLEY**

So, um, so, again, Advanced Directives, um, in and of themselves, are, you know, guideposts. They give us the medical community as best we know, and if you're telling me you want a trial of tube feedings, um, what does that mean? Well, it might mean something different in different scenarios but it gives me a sense that you would like to kind of say if there's something reversible, maybe I'd like it reversed but at some point, you know, I want you to give up. Um, or we may be forced to give up. There's the other piece of that. Um, the durable power of health attorney, that
person -- that's why I'm saying, that person is so key in the equation because they can, again, you've given them the, um, responsibility to speak for you and to be your voice and, um, if -- if they've been assigned that, then the assumption is they're going to speak what your wishes are and like I said, we can't always know, um, as far as what may or may not, um, happen to people and there are nuances in medical decisions that need to be made and so, um, in -- what we do default to is the, um, medical power of health attorney and if it -- if it is in conflict, um, then that's a problem and that's why I would say that, um, it's import -- Advanced Directives are important because they communicate to the medical community. They communicate through durable power of health attorney. But more important is that you're having a conversation and you get a sense of whether your loved one or who you have assigned is going to speak your voice, and, um, because they will be speaking for you.

00:45:54    MODERATOR

Okay. Thank you.

00:45:56    FEMALE

Um, my question is directed to, uh, I think both Grethe and Karen. Uh, you mentioned, Grethe, that you have a, um, client who has Alzheimer's and has been there for six years and I guess my question to you is if in her Directive, she specifically said, uh, she did not want to be around when her mind wasn't working right, what happens then? Can you get the -- the, uh, assisted?

00:46:23    KAREN GRIFFITH

Unfortunately, the law is read -- the law is written so that the person applying to use the Advan -- excuse me -- the Death With Dignity has to be mentally sound so by the time someone with Alzheimer's or dementia is terminally ill, which is another requirement of using the law, they no longer are able to make that kind of a determination, even though they said it a long time ago. That's unfortunate. Um, now Compassion and Choices of Washington does have an Advanced Directive for people with Alzheimer's but it is meant to be filled out by people who are in the early stages or fear that they are getting Alzheimer's and it takes care of all kinds of things about your care when you are no longer able to make those kinds of decisions. But unfortunately, because of the protections and the safeguards that were built into the law to preclude abuse of the law, it was necessary to say you must be able to make a sound decision. Therefore, what are the choices left for someone with Alzheimer's and sadly, there are not many, and Grethe can speak more to those, um, after I say the following. And that is we know of people in the early to mid-stages of Alzheimer's and that's difficult to even determine because it's such a long -- long, um, slide, that have chosen to do what we call voluntarily stopping eating and drinking. So that they had still enough decision making capacity, not allowed to use Death With Dignity, but have said I'm through taking in any liquid or food and that's a choice that is still up to them. And then, down the road would be on the part of the caregiver who, shall we say, chooses not to treat something, for example, a UTI, a urinary tract infection or an pneumonia toward the end of life with an Alzheimer's person is -- and -- and not treat it is often a quiet nice way out if the symptoms are treated. Grethe, you could probably add to that.

00:48:59    GRETHE CAMMERMEYER

Well, it's -- it's, uh, the -- it's the conversation that you have with family. Uh, the family determines the powers of attorney, determines when they no longer want, uh, a family member treated and sometimes we have, you know, the problem is that we get so good in treat and
prevention that they don’t have the treatable illnesses or complications to allow them to pass, and so that becomes a problem on the one hand, uh, and a good thing on the other. But, you know, we all -- we -- we don't die of Alzheimer's. We die of a complication, uh, an pneumonia, urinary tract infection. You have somebody that takes a fall and then they break their, uh, them and they end up in the hospital and -- and then, it just deteriorates from there. So it is one of those long progressive, uh, problems where you can't do anything specific but you can just withhold treatment for something that is acute.

00:50:14 MODERATOR

Thank you very much. Uh, we're getting more questions now. Uh, forgive me if I don't pick you in the order in which you arose your hand. This gentleman, I remember. Go ahead, sir.

00:50:25 MALE

Hi. Just a couple of short questions. Carla, and I'm confused about this, can you get a -- does the hospital take an Advanced, uh, health care power of attorney?

00:50:35 CARLA JOLLEY

Yes. Yes, you can, um, any of your forms can be put, um, into a medical record whether you've received care there or not. You just, um, get -- go down to medical records and they'll open up a chart.

00:50:46 MALE

Okay. And also, that green form, I'm not sure I understand what that is and where I -- where you can get that.

00:50:51 GRETHE CAMMERMEYER

From your doctor.

00:50:52 CARLA JOLLEY

So this is, um, this is a -- a form that for people who, um, have a serious illness or chronic illness or have a reason to think that they're getting towards those last few years of life and are very strongly want to make sure that absolutely nothing happens, um, that they don’t want to have happen, um, and that is -- has to be signed by your provider. Um, so they have them in all the providers' offices and it's a conversation to have with them and fill out with them. You can -- I'll be happy to give you one but, uh, to make it --

00:51:26 MALE

Apparently, I don’t need it.

00:51:27 KAREN GRIFFITH

No, they don’t, not yet.

00:51:29 CARLA JOLLEY
But, um, but, um, but to have it valid, it does have to be signed by your provider and also, um, by the patient or their durable power of health attorney.

00:51:38       **MALE**

And finally, can the person that has the durable power of attorney for your health care, can they override or can you make it that they can override whatever is written? For example, if you want to say you want to have a DNR if you're, uh, I mean if something happened to me and I had a heart attack, --

00:51:54       **CARLA JOLLEY**

Right.

00:51:54       **MALE**

-- of course, I want to be resuscitated if my heart stops because I have some expected life ahead of me.

00:51:59       **CARLA JOLLEY**

Right, right.

00:52:00       **MALE**

But there's a difference between a DNR when you don't have any expectation of life --

00:52:03       **CARLA JOLLEY**

Right.

00:52:04       **MALE**

-- and when you do and so I'm concerned how that works.

00:52:07       **CARLA JOLLEY**

Again, um, that durable power of health attorney, making sure they just understand what your wishes would be or not be, um, so that when they come to that point to make the, um, make those decisions, they know what you would want under what circumstances and what you would not want on other circumstances. And that's why I'm saying that Advanced Care, um, Planning is a process, you know, as we age every year. I had one lady who, um, bless their little family, that was a conversation of the Thanksgiving dinner, they -- everybody had to show up with their Advanced Directives and update them depending on what happened the year before --

00:52:42       **KAREN GRIFFITH**

Or else they didn't get food, huh?

00:52:43       **CARLA JOLLEY**
-- or they didn't get their dinner.

[laughter]

So I think that actually is a really great idea, that, you know, because we do -- health care -- health changes, our attitudes change, our, you know, what's happening to mom or dad changes so it's important to keep, um, the process going, not just do it and put it away and don’t think about it again.

00:53:06 GRETHE CAMMERMEYER

And -- and if you do have a POLST, make sure that it's available.

00:53:10 CARLA JOLLEY

Yeah.

00:53:10 KAREN GRIFFITH

On your fridge.

00:53:11 GRETHE CAMMERMEYER

Uh, usually on the refrigerator or at least in the -- the door of the nightstand or something like that. When -- when my spouse's mother died, uh, she -- she never moves fast for anything but on -- my -- my spouse but on this particular time, she called to let 911 know that she had died. They got there so quickly that, you know, she was barely cold and, uh, we couldn't find the POLST and so, you know, in this 95 year old emaciated dead woman, they were going to start CPR because they had to because that's what their job is. They are the first responders and I, uh, I, with my military background, I would have said to -- either drop on her body so they couldn't touch her or go --

[laughter]

-- or go and get my gun.

[laughter]

-- to protect her body. Uh, but we eventually found this, uh, and the sheriff came and -- and, you know, so protected the EMS people but --

[laughter]

-- but -- but you want to make it so that this is available if it's needed because unless you're in -- in a facility. For example, in our facility, if someone dies and they have a POLST, I can pronounce them because I'm a registered nurse but if it's anywhere else, you have to have somebody, uh, that is -- I won't say qualified, but is allowed to -- to pronounce someone, uh, and so the EMS people are the first -- first ones that show up, uh, and so just have it, make it available, have them see it and, uh, then make sure it takes over in a much more calm way.
MODERATOR

Thank you. I want to turn to my right. This is the neglected part of the room. So does anyone over here want to ask a question? See, they're engaged. They're really engaged. Okay. I -- I can't tell who was what, when they were. I remember this hand. I'm sorry. I apologize if I overlooked you.

FEMALE

Well, my question is a follow up on the last comments. Marshall has his durable power of attorney with him. Yours is behind the potted plant. People I know who have POLST have them on the refrigerator. How in situations where you're not at home do you make your wishes known?

GRETHE CAMMERMEYER

That's where you have --

KAREN GRIFFITH

Well, it's either in my glove compartment in my car or it's in my suitcase so I've got a pretty good chance that if I'm not at home --

FEMALE

What happens when you go for a hike?

KAREN GRIFFITH

Yeah, well, then you're going to be at the mercy of -- of who is --

GRETHE CAMMERMEYER

Well, then in your --

KAREN GRIFFITH

-- your companion who can speak for you.

FEMALE

Okay. So there's nothing like a sticker you can put on your driver's license?

KAREN GRIFFITH

No.

GRETHE CAMMERMEYER

So you end up in the hospital, uh, assuming that you make it there and your next of kin or whomever is contacted and they, then, will have to make a decision depending on how aggressive
the hospital has gotten prior to someone in the family being notified, uh, which is the advantage of having something with you, uh, or at least in your records or something like that so that you're not on a ventilator before somebody comes and says they didn't want that. Um, and so it's, you know, I -- I'd like to tattoo on my chest, you know, DNR, uh, but, uh, you know, it's -- these are the things that one has to think about, uh, in -- in making decisions about what you take with you and the paperwork that you have already done that's at home.

00:56:48 MODERATOR

Thank you very much. Um, I'm not the technical person but, uh, I presume a digitalized form would work if you load it up into your computer or your smart phone and then had to produce it at an emergency room or somewhere, would that work? It doesn't have to be the original document or does it?

00:57:05 CARLA JOLLEY

Well, I mean we're -- we're entering a new stage for sure, yeah. Um, you -- if -- what they need to know are your wishes and if that form tells us what your wishes are, then that informs them as far as that decision making. Um, is that a guarantee? No, but it will help. Yeah.

00:57:24 MODERATOR

Okay.

00:57:24 CARLA JOLLEY

Yeah.

00:57:24 MODERATOR

Thank you. Let's do someone in the back this time. That lady over in the back. Now, come in towards the middle. This is where I'm going to move.

00:57:32 SANDY MULKEY

My name is Sandy Mulkey and I'm with Regency on Whidbey in Oak Harbor and this is really directed to caregivers in the room. Uh, if you are a caregiver and your spouse or sibling or whomever you're caring for is at home and you have run to 7-11 to pick up a jug of milk, God forbid you're in an accident, no one knows that the person you're caring for is now alone. My suggestion is to wear like a Net-E alert bracelet that says I am the caregiver for -- which would prevent some, uh, disastrous situations. Just a suggestion.

00:58:15 CARLA JOLLEY

Excellent. Good.

00:58:16 MODERATOR

Thank you very much for that.

[applause]
00:58:17   **KAREN GRIFFITH**

Yep, I like that suggestion.

00:58:18   **MODERATOR**

Okay. I promise we're moving -- this lady over here. Please.

00:58:26   **FEMALE**

This is more a comment than a question. I -- I don't fear death. I fear living with dementia or Alzheimer's. I'd like to see the Death With Dignity or the Compassion and Choices of Washington work on that. In what way? I have no clue but I would like not to fear living with that disease forever.

00:58:53   **CARLA JOLLEY**

I know. I know. Thank you.

00:58:55   **MODERATOR**

Okay.

00:58:56   **FEMALE**

I'm still confused. I've got, uh, a health care directive, which I filled out and left with a friend and my daughter, and I never heard of that green form before and somebody's going to have to spell it because I didn't hear. I can't tell what it is if I'm going to ask from my doctor and I've got two of those little pill bottles that I picked up from the hospital with information filled out in them that's a little bit different. Now, I'm willing to, you know, condense one of these into the pill bottles and carry them but which one should it be? I still don't get the difference between the green thing and the health care directive. So could you speak to that?

00:59:41   **CARLA JOLLEY**

So the POLST, P-O-L-S-T.

00:59:45   **GRETHE CAMMERMEYER**

It's an acronym.

00:59:45   **CARLA JOLLEY**

It's an acronym, stands for Physician Orders for Life Sustaining Treatment. It is -- the intention of it is for people who have serious illness or chronic illness or advanced age or, um, have some reason to think that they, um, have a shortened life expectancy in the next few years, and your physician or your provider may be able to say this is appropriate or not appropriate, um, for you because they are the ones that have to sign off on that.

01:00:18   **MODERATOR**
Okay. Thank you. Uh, let's see. Let's go to this lady right here.

01:00:26  FEMALE

I'm from Oak Harbor and if anyone has difficulty hearing, this library loop is wonderful. And also every time Grethe said POLST, I thought she was saying pulse, if they have a pulse.

01:00:42  MALE

Pulse, yes.

[laughter]

01:00:45  GRETHE CAMMERMEYER

That's important too.

01:00:45  KAREN GRIFFITH

Well, that sort of goes along with it.

01:00:46  FEMALE

Yes, it is indeed.

01:00:47  GRETHE CAMMERMEYER

Pretty vital.

01:00:50  FEMALE

So when I came to Washington about ten years ago, I did go to an attorney and I had the Advanced Directive and, uh, the power of attorney but does that -- I have a feeling the POLST is more comprehensive than what I filled out at that time. Does -- does one need to return to that and make sure that that's up to date, and I am going to do the POLST form absolutely. But one thing I really -- I've learned a lot today, very grateful to hear about keeping it in the car, uh, because that's where you very easily could have an accident or so that's great. I've learned a lot from attending classes that Sandy gives or is part of for caregivers. So, um, my question would be do I need -- I know about the attorney and have -- that it has to be given to the ambulance drive -- to the medics when they arrive and but I don't have enough copies and so I -- I've learned and will behave myself in the future. Thank you very much.

01:02:08  MODERATOR

Thank you.

01:02:08  KAREN GRIFFITH

The POLST form does get periodically updated and it was updated in I believe March or April of last year so if you've got one, first of all, I don't know why you would have had one ten years
ago. You're way to spry and spritely to have had one but it does get updated. Um, there's a -- there's a committee in the state that works on it and it was recently updated. What does that say, Grethe? Because ours I think --

01:02:34 GRETHE CAMMERMEYER

Well, March of 2014.

01:02:36 CARLA JOLLEY

Well, this one said 2011. There is the organization.

01:02:39 KAREN GRIFFITH

No, 2014. I think Judy the latest one? Yeah. So the latest ones are fresh off the press, um, and again, I want to reiterate what Grethe and Carla both said about that POLST is as I kind of just look at you, most of you probably wouldn't need one yet because it really is for, as Carla said two or three times, for the frail, for the people who are really on that proverbial banana peel, shall we say, and are pretty homebound and you don’t need multiple copies of it. You can have but you just need the one kind of on your refrigerator because that's where an EMT is trained to look for it. So you wouldn't need one from ten years ago updated because you probably didn't have one that was up to date but there is one that's fairly off the press within the last six months to, um, and your -- your doctors have them. Your doctors have them. Ask your doctor do I need a POLST or not, and your doctor will say no, I don’t think it's time yet or the doctor may say yeah, it's time and that's kind of scary. It's time.

[laughter]

01:03:55 MODERATOR

Thank you. I think what we'll do we're -- I'd like to take one more question from the audience but let you know that after we conclude our program formally, then we will have about a half hour informally to mingle with our panelists and amongst each other to talk about some of these issues further. So I'll take one more question. I saw a hand go up. You, sir.

01:04:17 MALE

I'm going to retract my question because I have --

01:04:21 MODERATOR

You have to -- would you speak in the microphone please?

01:04:22 MALE

Yeah. I'm going to retract my question because I would rather direct this question to either of -- of you panelists or specialists, um, because as an atheist, I have very specific concerns about when and where the POLST will be, uh, accepted or rejected. Specifically, I want to know about, uh, Island Hospital. So I'm not going to put you to the test here.

01:04:58 MODERATOR
Does anyone attempt to take that?

01:04:59  **GRETHE CAMMERMEYER**

I don’t know if Island is affiliated or not.

01:05:01  **MODERATOR**

No, Island Hospital, I can say on a quick --

01:05:03  **GRETHE CAMMERMEYER**

Oh, oh, did you say Highland?

01:05:04  **KAREN GRIFFITH**

Or Island.

01:05:05  **MODERATOR**

Island.

01:05:05  **GRETHE CAMMERMEYER**

Island.

01:05:06  **MODERATOR**

Island. Island Hospital is not affiliated.

01:05:07  **GRETHE CAMMERMEYER**

No, not affiliated.

01:05:09  **KAREN GRIFFITH**

You're safe.

01:05:09  **MODERATOR**

Okay. Island Hospital, last I've heard, was the only hospital in the state of Washington that actually provided for Death With Dignity on its staff, through its staff members, the only one. But yes, there's two? I'm sorry. I'm correct --

01:05:25  **FEMALE**

There's two hospitals.

01:05:26  **MODERATOR**
I understand that. Yes. He asked about --

01:05:28  **FEMALE**

He'd just like to know.

01:05:29  **MODERATOR**

Yeah, yeah. Yeah, he was speaking -- we're speaking to Island Hospital in Anacortes, not Whidbey General. I think with -- can we go from that? We have these -- these looks. I'm looking at these looks here. Okay. What I'd like to do now, I thank you for your questions. Uh, we're at the close of our program this afternoon and before we conclude, I'd like to ask each of our panelists, uh, to answer this final question. It's a trick question. If the -- if the audience members were to take home just one message today, what should it be? In any order that you want to respond to. Just one message.

01:06:08  **KAREN GRIFFITH**

Oh, well, okay. I'll start then. Um, the one message I would like you to take home is that you have a wonderful organization in this state, Compassion and Choices of Washington, who stands ready to help you if and when you get to that point when you want to use the Death With Dignity. Um, short of that, Compassion and Choices stands ready to help you with preparation of Advanced Directives. We have developed with the -- with the help of a senior, uh, elder law attorney at the University of Washington, an Advanced Directive that combines both a living will and a durable power of attorney into one document. It has been vetted and tested and molded and loved and it is a wonderful document and it even has some aspects about it that really delve into sort of the possibilities of Alzheimer's affecting some of your care, et cetera. So I would urge you to attend the workshops tomorrow or on March 23rd. If you're unable to do either of those, I would urge you to get onto our website, Compassionwa.org and download the Advanced Directive that we have there and the Alzheimer's Advanced Directive is also on our website. So that's what I want to leave with you is an awareness of this organization filled with compassionate people who stand in awe of the death process who consider it a privilege to hold the hands of our clients when they actually make that step and to know that you can indeed have a good death. That's what I want you to know.

01:08:04  **MODERATOR**

Thank you. Carla?

01:08:09  **CARLA JOLLEY**

So, um, around Advanced Care Planning, if you didn't hear me before, the most important thing is that person who's going to speak for you when you can't and that they understand your voice and what that might be and what matters to you most around that. Um, I would use the tool, the conversation starter kit, for those who have people who are difficult to engage in those conversations. They even have icebreakers in there. Um, so and also, um, to, um, look at the spectrum of choices that are available for you at end of life. Um, when you're living with a serious illness, certainly we look at, um, hospice when, um, there's no longer a cure but we're look, you know, focusing on comfort. It is about living until you die and allowing that natural death and supporting that through that interdisciplinary team. If you're in the process of still getting Palliative treatment for their, um, live, you know, looking at what else is out there
available for you as a supportive -- a supportive layer, there are -- it's an amazing community for such a small community. We have some great resources and, um, look at what those might be to support you and your family in this journey. Thanks.

01:09:26 MODERATOR

Thank you.

01:09:27 GRETHE CAMMERMEYER

There is another really quite exceptional book called Being Mortal that has just recently come out. It's a physician who, uh, sort of has an epiphany in terms of -- and they do occasionally, don't they?

[laughter]

Uh, but that -- that, um, sort of takes you through, uh, how we ended up having nursing homes and, uh, assisted living facilities and that sort of thing, and then vignettes on, uh, sort of the process of dying, um, depending on what the illness was of the particular patients that he's talking about, and then his own journey to understand hospice, to understand the importance of, uh, having those conversations early with significant others, whether they be family members, uh, direct family members or parents or children so that everyone hears the same message and that that's done while you can still make the decisions rather than leave those decisions for somebody after you are in the hospital or when they have to make tough decisions about whether or not to take you off the ventilator. Uh, you don’t want to leave those decisions for someone who hasn't - - who doesn't know what your journey is, uh, and, uh, it -- I think it really reflects well what happens if you don’t -- if you don’t do the work when you can. Um, my kids have known for a long time, you know, do not resuscitate, um, but that's my choice and my values. I'm too bull-headed for anything else but so were these parents, uh, of this particular, uh, writer and, uh, so there's some humor in both of them but there's also the seriousness to give you some ideas, uh, if you -- if it's such an uncomfortable subject or you haven't been around people as they take the journey to that next phase.

01:11:45 FEMALE

Who's the author?

01:11:47 GRETHE CAMMERMEYER

Uh, the last name is G-A-W-A-N-D-E. That's why I didn't say it.

01:11:53 MODERATOR

It's Atul --

[laughter]

Yeah, I believe it's Gawande.

01:11:57 KAREN GRIFFITH
Atul Gawande.

01:11:57 MODERATOR

Atul Gawande.

01:11:59 CARLA JOLLEY

Yeah, lovely book.

01:12:00 MODERATOR

Well, thank you very much, Grethe. We've come to the end of our allotted time. If you've not already done so, please complete your evaluation of our program and discussion. Sno-Isle Libraries would appreciate any suggestions on how to improve Issues That Matter Forums or ideas you may have for future topics. At this point, I'd like to recognize our panel. Please help me with a round of applause.

[applause]

I also would like to thank you, our attentive audience, for your thoughtful questions and comments. Please give yourselves a round of applause.

[applause]

And last but not -- and last but not least, I would like to thank Sno-Isle Libraries and the Sno-Isle Library's Foundation for making this forum possible. More applause please.

[applause]

If this afternoon's discussion has made you even more curious about this topic, you can explore the many information resources available through your community library or on the Sno-Isle Library's website. You may also wish to attend the next classes on writing an Advanced Directive scheduled for March 23. The classes tomorrow, by the way, are full. The classes on March 23 will be taught by Karen Griffith and Judy McCay of Compassion and Choices and will be held here at the Library at 9:00 a.m. and 1:30 p.m. Spaces are limited to 35 per class and pre-registration is required. After we adjourn, please feel free to stay for the next half hour or so and chat with each other and our panelists. Thank you again for coming.

[Music and Credits] to end

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