

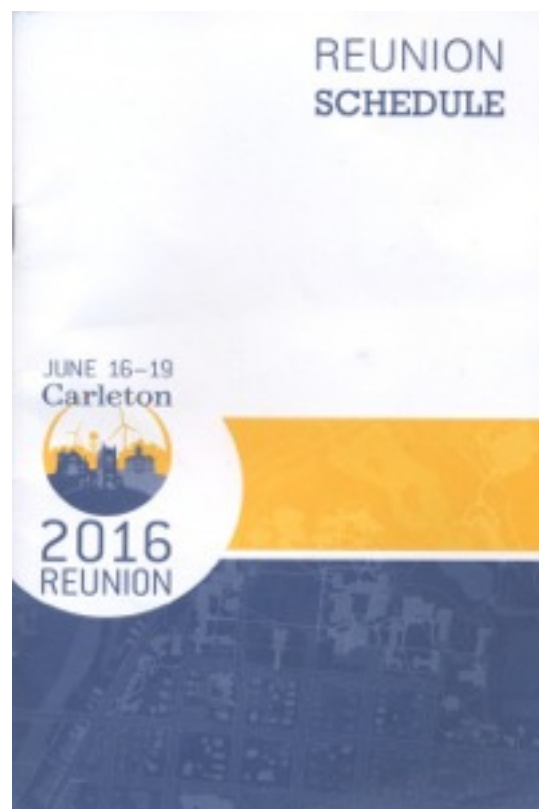
Carleton College 1966 Post 50th Reunion Newsletter

RATIONALE FOR FURTHER READING.

1. Catch-up on the Reunion and the Associated Programs in which classmates led and participated.
2. The 'Living Well, Dying Well' Program promised text, resources, and the part that Bruce Hanna was going to present.
3. Learn about the class gift.

In the very first issue of the Reunion Newsletter (January 2015), the aerial photograph of the campus in 1965 was featured (seen to the right; note the on-going construction of the soon to be women's gymnasium about one third of the way from the bottom left. At the very end, there will be an aerial of the campus today with notes about current and future construction.

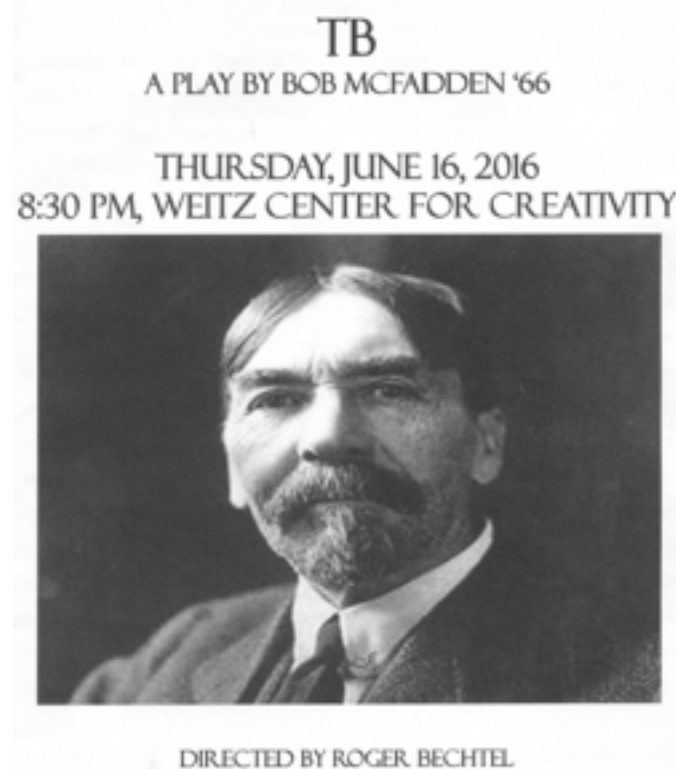




Reunion Update

137 members of the Class of 1966 and 69 spouses and partners attended the June 16 - 19 Reunion. Most stayed in Watson Hall and that was our headquarters for Thursday, Friday, Saturday, and Sunday. Several recent graduates and one rising senior were assigned to help us from dawn to dark. These students met every challenge and they, with senior staff, Mari Aylin, Jennifer Foth, **Catie Gardner**, and Mary Niebur, assured an incredible experience. Catie is highlighted because of her leadership role.

The schedule was full with a wide variety of meals, events, and programs. Weather was great. Classmates attended, organized and participated in many of these. Beginning Thursday at 1:00 pm, there was an open golf tournament; at 1:30, Dotty Broom led a '66 Courage and Renewal Workshop; at 6:30 President Poskanzer welcomed the class; at 8:30, there was the Thorstein Veblen reader's theater, based upon a play written by Bob McFadden—TB Veblen might be Carleton's most famous graduate, but, as effectively conveyed in the play, he had a difficult time finding focus, holding a job and keeping his



first wife and girl friends separated. Conveyed were his contributions to economic, sociological, and philosophical thinking; the interplay between his successes and failures, bitterness and humor, and tendency to push both academic and social boundaries, for which he paid dearly at times. See the composite figure on the right side of page 3.

Friday morning began early with a bird walk organized by Abigail Nichols and Posie Lane Anderson. Eric Carlson and Professor Emeritus Robert Will '50 participated in the Alumni College program on 'The Golden Age of Entrepreneurship.' Early in the afternoon, almost two dozen classmates participated in the '66 oral history program group interview. Linda Nelson Blaisdell and Dotty Broom participated in the Alumni College program 'Religious and Spiritual Life at Carleton Through the Decades.' 'The Living Well, Dying Well' Program with Bruce Hanna, Arline Roller Hinckley, Judy Wickwire Nadal, and Stephen Smith, was hosted by '66. That evening there was a class of 1966 music recital with Mimi Garbisch Carlson, Marsha Garbisch Harbison '67, Grace Huenemann, Lise Olsen-Dufour '91, Jane Pughe Rogers, and Bonnie McNaughton Wheaton.

Saturday morning had a fun run/walk, a lecture by Pete Schultz entitled 'Chicken Little Was Right,' and the Parade of Classes and Reunion Convocation. Pete's lecture was crafted on humor, a well-spun story, and excellent science. Using a variety of proxies ranging from geological evidence to social media, Pete demonstrated the likelihood of an object hitting Earth and how its composition, size, and trajectory would or would not cause damage (and the nature of the damage). Pete's role as a scientist in unraveling the details of his presentation was very evident. At the Convocation, the Alumni Association awardees from the Reunion Classes as well as former faculty and administrators were recognized (Eric Carlson, Tom Merritt, and Mary Watson for 1966; Patricia Lamb, faculty, and Stephen Lewis, former President). At the Convocation, class contributions to the College were noted (see the next section, Gift Report, for the contributions from 1966).

There were two '66 class programs held during Saturday afternoon. Larry Soderholm organized 'The Times They Was A-Changin': A 50-year Assessment' with presentations by Jean Matteson Langdon, Jane



Pughe Rogers, Larry Soderholm, and Gelvin Stevenson. Later, Lawrie Cherniack's '66 Facing an Uncertain Future' with presentations by Mar-cie McGarraugh Andberg, Mike Gordy, Rick Heydinger, Tom Hinckley, Grace Huenemann, Chris Laing, Marilyn Arneson Moyle, and Bob White, was held. That evening's dinner in Great Hall enabled class-mates to sit with a number of present and emeritus faculty including Childs, Finholt, Iseminger, and Will. The Time Capsule from the 25th Reunion was unpacked and included a bottle of Alpine Vineyard wine (Dan and Christine Jepson), which was given to Dan, and predictions from 1991 were read. Dan shared the wine later in the evening.

Sunday morning was the '66 We Remember...memories of our absent classmates' was held in the Japanese Garden. Departures followed.

Gift Report: During Saturday's Convocation, we proudly announced our class gift to the College. See the middle of the photograph on the left side of the next page.

Thanks to the hard work of the 17 very dedicated members of the Gift Committee and the generosity of our classmates, we are delighted to report that:

1. We raised \$25,025,941,
2. 36% was cash and 54% was deferred,
3. \$9.6M of the \$25+M is endowment for scholarships, and
4. \$2M of the \$25+M is endowment for social entrepreneurship and civic engagement.
5. We achieved 76% participation, which broke our former record of 68%!
6. We doubled the number of Heywood society members in our class, with 73 Heywood members total.

Our \$25,025,941 gift is the third largest 50th reunion gift in Carleton's history!

Program Information



One request and associated promise were to provide the content given by Arline Roller Hinckley [ARH], Judy Wickwire Nadal [JWN] and Steve Smith [SS] as well as that not given (Bruce Hanna [BH], could not come as a result of a medical emergency).

Demographics (ARH)

People from 65 to 69 are the fastest growing age group in the US so we are going to have lots of company as baby boomers age.

In 2012, there were 43 million people over 65 in the US (13% of the total population). Estimates for 2016 are 48 million or 16% of total. There are 70,000 centenarians in the US. We have gained 28 years of life expectancy in the last century.

Social security began in the 1930s when the average age of death was 67. The system simply wasn't designed to support 48 million people! Older people are drawing money from public pension plans faster than young people are paying into them. Never have so many lived so long to be cared for by so few.

On the bright side, however, people 50 and over generate a whopping \$7 trillion in economic activity. We have enough discretionary income that more and more products and services are directed to us. As an age group, we vote more often than any other. We are a formidable group! Let's use that power as a force for good!

End of Life: Physicians and Hospice Care (SS)

Living Well (ARH)

In trying to decide what I wanted to say about living well and aging well, it occurred to me that we could call it the good, the bad, and the ugly. Well, I don't think any of us want to talk about the ugly – but let's talk about the bad and the good, in that order.

There is no denying it – our bodies wear out and break down. We have way out-lived our warranties!

Just think of all the changes – we are shrinking (between ages 30 and 70, men lose about 1 inch in height - that probably doesn't apply to Clay – and women lose up to 2 inches). Our hearing decreases, our skin thins and wrinkles, our bladders demand more attention when we're trying to sleep, falls become more frequent, our hair thins and turns gray, we sleep less deeply, our metabolism slows, we lose muscle

mass, our memories change as does our vision, we have decreased energy and resilience, half of us over 65 have some degree of arthritis.

A study of the health conditions feared by Americans over 60 found that 35% of us fear dementia, 23% fear cancer and 15% fear stroke. (Interestingly, there was a blissfully untroubled 20% who feared no health problem.) I think the fear of Alzheimer's and other dementias is understandable.

1/3 of seniors who die in any given year have been dx'd with dementia. It is the 5th leading cause of death for those over 65. The lifetime risk for a 75 year old with no dementia is 10% for men and 19% for women.

People with dementia have 3x the hospital admissions as other older people, 25% of which are for falls. Medicare and Medicaid are expected to pay \$150 BILLION for health care, long term care, and hospice for dementia patients. In 2013, Americans provided 177 BILLION hours of unpaid care for dementia patients. That number is shocking enough but consider the physical and emotional toll on the care-givers. (Women shoulder the greatest burden of caregiving and are impacted the most.)

There is a condition called mild cognitive impairment or MCI – this is impairment which is noticeable but does not interfere with everyday activities. It can be predictive of Alzheimer's but is not always. It is important to note that this condition can be caused by side effects or interactions of the many medications some seniors take. If medications are ruled out as a cause of MCI, this may be the optimal time to start rx since the brain changes of dementia can begin as early as 10 to 20 years before outward symptoms appear.

Let's look at some risk factors for Alzheimer's and other dementias. Age is, of course, the greatest risk factor. Others are a family history of dementia in a 1st degree relative (parent or sibling), a certain form of the E(APOE) gene which is implicated in early onset Alzheimer's, cardiovascular disease, and a lack of social and cognitive engagement. Fewer years of formal education or a lower "cognitive reserve" is also a risk factor as is traumatic brain injury or TBI. Moderate TBI – that is, amnesia for more than 30 minutes or loss of consciousness - results in double the risk for dementia.

Briefly, some other potential risk factors for dementia are being revealed by research. Those who take anti-cholinergic drugs (those for allergy, nausea and over-active bladder and the tri-cyclic anti-

depressants) are 4x as likely to develop MCI. This is a correlation but not a causation. A lack of vitamin D (less than 20 ng/ml) has demonstrable effects on brain function. Heartburn meds (proton pump inhibitors) are correlated with dementia but not proven to be causative.

Intriguingly, research is giving new life to an old theory about Alzheimer's - the pathogen hypothesis or the idea that common microbes can infect an aging brain and cause the debilitating damage of the disease.

OK, I think that's plenty about the "bad." Let's talk about the good aspects of aging.

In terms of emotional health, the best years of life come late. People over 65 have the most stable and optimistic outlook of all adults. We have the positive emotions more common to those 20 to 39 years old.

With age come lowered depression, anxiety, and substance abuse. We have fewer negative emotions and we don't dwell on those we do have. We have a greater life perspective – we focus more on depth of experience, closeness to others. We evaluate what is worth our time and attention and recognize that bad times will pass. We are more satisfied with our social relationships. Our brains may be changing but we have better visual/spatial function, organization, working memory, tracking, and abstract reasoning than we had in earlier years.

More good news – DNA is not destiny. We may have a genetic predisposition for things like diabetes, CVD or some kinds of Ca but that does not mean a prediction. A very small number of factors make a big difference in longevity: no smoking, no ETOH abuse, regular exercise and weight control, a stable marriage, education and good coping mechanisms. After age 70, only 4 factors are paramount – not smoking, regular exercise, moderate ETOH and a Mediterranean diet (This does NOT mean a constant presence at Olive Garden.).

Let's look at some strategies for thriving as we age –

1. Challenge your mind – book clubs, learning a new skill, tutoring (especially a high school student). A Johns Hopkins study showed tutoring can delay and even reverse declining brain function. Is anyone familiar with the Osher Lifelong Learning Institute? This program has often been called the "fitness club for the mind" – it is present in all 50 states on 119 college campuses and offers short classes taught by current or retired faculty..

2. Exercise, especially that done outdoors, causes an immediate release of neuro-transmitters and an elevation of mood. The longer and more regularly you exercise, the more your chance of suffering cognitive decline decreases).
3. Volunteer- Most of us have been extraordinarily lucky in life and have considerable social and intellectual capital to share. Now is the prime time for us to give – and, lo and behold! – the benefits are even greater for us than for those we serve. People who volunteer regularly report higher levels of happiness, life satisfaction, self-esteem, control over their lives, higher functional ability and less depression. Numerous studies show volunteers have better biomarkers and even volunteers with chronic or serious illnesses receive benefits beyond what can be achieved by medical care (lower intensity of pain, sense of purpose).
4. Humor – is not only fun, it elicits laughter which is a physiological response which stimulates respiration, O₂ exchange, and BP, all of which rise dramatically and immediately fall to below pre-laughter levels. It also promotes coordination between the two hemispheres of the brain leading to a unique level of consciousness, brain processing, increased immune functioning and lower stress hormones.
5. Pets – Do you who have children remember the aquariums in the waiting rooms of your pediatricians? Do you remember how quickly an anxious child could be calmed by watching the fish? Petting a dog or cat is also calming and they are good listeners. Just a few minutes of petting leads to lowered stress hormones (cortisol) and increased serotonin, lower BP and lower risk of dying from CVD. Caring for a pet (feeding, grooming, playing, exercising) takes your focus off yourself and makes you responsible for another living being. Dogs are better for maintaining physical fitness since they let you know in no uncertain terms when it is time for a walk. Dog owners have better cardiovascular & bone health. And since dogs have been described as “a conversation waiting to happen,” they promote social interaction and alleviate isolation. (Dogs have also been called “chick magnets.”)
6. Expressing gratitude towards people or being aware of the good in the world is good for mental, physical, and cognitive health. They lower stress and depression. Many people keep a gratitude journal.

Also powerful is expressing gratitude to another, either in person or by letter.

Aging in Place: 90% of Americans want to remain in their own homes as long as possible. Using the philosophy that “it takes a village to raise a centenarian”, there is a non-profit membership organization which helps communities develop aging -in-place villages. There are 190 of these villages throughout the country and 150 in development. Because they are formed and governed locally, they differ somewhat but all are designed to give seniors a sense of security, independence, and belonging. Volunteering is encouraged and subsidies are available for the low annual memberships. A good example is NEST, or Northeast Seattle Together. Volunteers in this group – or service providers who offer reduced rates – help with home maintenance and modification, house-keeping, grocery delivery, cooking, laundry service, tech training, dog walking, social events, all with the goal of allowing seniors to remain in their own homes.

Now, I would like to mention someone who has gracefully shown us that old age can be the most defining time of one’s life. This person has had a 69-year marriage and has a deep commitment to their faith. This person finished their last book at age 91. This person has actively worked – and continues to work -for the last 30 years for the eradication of the guinea worm in Africa and for Habitat for Humanity. They have worked tirelessly in international diplomacy. In August, this person was diagnosed with skin cancer with metastases to the brain. They described being “surprisingly at ease with the diagnosis” but were successfully treated with targeted immunotherapy and are now back to a very busy life. This person, of course, is Jimmy Carter.

Now, I would like to ask you some questions. How many of you plan to live to 100? I’m sorry to tell you that only one in 10,000 Americans live that long. 98% of us will die within 3 years of our 85th birthdays. How many of you plan to live a rich, full life, then after a good day doing what you like, go to bed and not wake up? Only 26% of us will be that lucky. The majority of us will experience a period of vulnerability, of frailty. How many of you want to spend the last part of your life at home, surrounded by family? 75% of us will spend those last days in a hospital or other care facility.

Probably the most powerful thing we can do to age well is to ensure that our care when we become seriously ill is the kind of care we want. The best way to do this is to express our wishes in Advance Directives (AD). I decided long ago that I do not want to die the way someone else thinks I should die. My AD gives me the chance to make that very clear.

Now, I'm not going to embarrass you by asking how many of you have completed your directives. This is a difficult task because it forces us to step into places that frighten us, to think about what our own dying means. We have difficulty envisioning ourselves as terminally ill. Procrastination is normal! 2/3rds of people who know about ADs do not fill them out. Unfortunately, many if not most discussions about end of life care are delayed until the person is critically ill, often in the ICU. Good decisions and consensus cannot be arrived at in such crisis situations.

Understand that laws concerning ADs vary by state. You can find the details about your state's regulations at www.compassionandchoices.org.

There are 3 documents used for advance planning of future medical care:

1. A Health Care Directive (aka Living Will, Directive to Physicians) allows you to state your care preferences should you become seriously or terminally ill and are unable to speak for yourself. You should be very specific about life sustaining treatments you do or do not want (CPR, feeding tubes, respirator) and under what circumstances. You may state what conditions you consider worse than death (advanced dementia, catastrophic irreversible stroke, persistent vegetative state for example). These are difficult decisions. On the class website is a values worksheet to help you think through what is really important to you. You can also go to www.endoflifewa.org to take a look at a more detailed AD which may serve as a good starting point for thought and discussion. And you can always attach a personal statement to your directive explaining your choices. This is often very meaningful for loved ones.
2. The second planning document is the DPOA, the person and alternate you chose to make decisions for you when you cannot make them yourself. It is important that this person is willing to make decisions for you as put forth in your Directive, not "in the patient's

best interest" which may conflict with your wishes. Be sure the person you choose is readily available, that he/she is willing to serve in this capacity and clearly understands your wishes. Your agent should be able to work well in a crisis and be a strong advocate. Let your loved ones know who will be your legal spokesperson in order to avoid surprises at a time of serious illness.

When you have completed these two documents, make sure a copy is in your medical records. Discuss your directive with your care providers and ask if they will honor it. (If the answer is no or an equivocation, you may want to consider finding another provider.) And be sure to talk with your loved ones, preferably face-to-face so you can explain your choices and they can ask questions.

3. The 3rd planning document is called by various names – WA's is the POLST or Physician's Orders for Life Sustaining Treatment. It may also be called the MOLST or something similar. 38 states have these forms. They are on very bright paper and are posted in your home or care facility for quick access. They are designed primarily for people with terminal or life-limiting illnesses and are essentially replacements for out-of-hospital DNR forms. Both you and your MD sign this form so it carries the weight of doctor's orders and gives EMS the legal right not to resuscitate.

I want to briefly mention 2 other ADs. Many states have Mental Health Directives which allow people with mental illness to indicate, at a time when their illness is stable, how they wish to be treated when they are in crisis and their thinking is disordered.

In WA state, we also have an Alzheimer's/Dementia AD designed for those with a strong family history of Alzheimer's or those who are in the early stages of dementia and can still make some basic choices. This AD is endorsed and used by the WA state's Alzheimer's Assn. You can find it at www.endoflifewa.org.

Two notes of caution about ADs. One very commonly used form is called "Five Wishes." It is a good form as long as you are aware that it contains one statement in wish #2 which could be problematic. "I do not want anything done or omitted ...with the intention of taking my life." This could preclude the withdrawal of a ventilator or the cessation of artificial nutrition and hydration. If you use "Five Wishes" and are concerned about this statement, you should draw a line through it.

Secondly, in many states, WA included, many small public hospitals, clinics and hospices are being swallowed up by religiously owned health care systems, mostly those operated by the Catholic Church. In no way do I want to denigrate the Church and all the good it does but you need to be aware that these facilities must abide by the Ethical and Religious Directives of the Catholic Conference of Bishops which may be in direct opposition to the choices you have outlined in your AD. It is important that you educate yourself about the ownership and policies of any care facility you are considering. A corollary to this is that the NEJM reports that 40 million Americans receive care from MDs who do not believe they are obligated to disclose information regarding medically available treatments which they personally consider morally objectionable.

One more thing about ADs. - Remember that the 3 most contentious right-to-die cases in the U.S. – Karen Quinlan, Nancy Cruzan and Terry Schiavo – were all healthy young women with NO ADs. Their families went through hell to get for their daughters the right not to exist forever in vegetative states. Please encourage the young people in your lives to complete their ADs.

Dying Well (ARH)

Buddhists have a saying about death – “we are alive, therefore we will die.” There is no denying that our bodies age and eventually break down. Death is, after all, inevitable.

I believe we all have a vision of how we want to die. Some of us will want all possible treatment, some will choose to endure suffering finding it redemptive, some will choose to forgo aggressive treatment and let nature take its course and some of us will want to control the time and manner of our deaths. ALL of these choices should be honored.

Death used to come quickly, chiefly from infections, war, & accidents. But we now have the ability to cure or reduce the suffering of people afflicted by once painful or fatal disease. Combine this with the fact that many, if not most, doctors see aging and death as enemies to be defeated rather than a natural part of life. Quoting Atul Gwande: “Our medical system is excellent at staving off death with \$8000 a month chemo, \$3000 a day ICUs, and \$5000 an hour surgeries...no one is very good at knowing when to stop.”

People at end of life who are treated aggressively have a much worse quality of life and 6 months after the death, caregivers and loved ones are 3 times as likely to suffer major depression. Aggressive rx at the end of life may well worsen things or even shorten the time we have left.

If you receive a terminal diagnosis, there are questions you need to ask yourself. How do you want to spend the time you have left?

What trade-offs are acceptable? Are you willing to forgo quality of life for a shot at a longer life? (Keep in mind that more than 40% of oncologists offer treatments they believe unlikely to help, MDs’ estimates of life expectancy are OVER estimated 63% of the time, and 2/3rds of terminally ill patients are willing to undergo treatment they don’t want if their loved ones want them to.) When do you stop fighting in order to experience more of what is really important to you?

When time is short and the end is in sight, you do have choices about how you want to approach your death. Currently, 5 states have laws which allow aid-in-dying (often known as Death with Dignity laws) – WA, OR, MT, VT and CA which just took effect a few days ago. More about these laws later. If you live elsewhere, you can still have some control over the course of your illness and your death:

1. You can refuse treatment
2. You can terminate treatment – this can include chemo, radiation, dialysis, ventilators, artificial hydration and nutrition, antibiotics, transfusions, drugs and devices which control heart function.

If you choose to do this it is important to talk with your MD and get his/her commitment to aggressively treat any symptoms of discomfort and to refer you to hospice.

This can be difficult, especially if you have had a long-term relationship with your doctor. (My patient, Joan, was a single mother with a daughter in college and a high functioning autistic son in high school. She had never smoked but got an aggressive form of lung cancer. She fought that cancer hard for 3 years with multiple rounds of brutal chemo, radiation, surgeries and the support of her MD. Her goal had always been to get her son into college – when he successfully completed his first year at Vassar, she was exhausted and ready to let go with the knowledge that her son would be OK but it was very hard for her to say this to the MD who had worked along side her to get her to that point.)

3. Another choice you have is to voluntarily stop eating and drinking (VSED). Done with support, this can be a gentle means to a peaceful death. A person choosing this needs cooperative round-the-clock caregivers and an MD who will refer to hospice. It takes a disciplined person with strong determination although symptoms of thirst and hunger are easily treated and abate after the first few days. Death usually occurs within 14 days, often much sooner, depending on the underlying condition of the person. Although many who choose this route lapse into a coma, the people I have worked with have been awake and conversant until the end. The one I will never forget was a tiny 88 year old woman. This was just before a national election when the Democrats hoped to take back the Senate. Two days before she died, she was on the phone telling her friends how to vote. She told me if the Democrats won, we would know she had sold her soul to the devil.

VSED has been used for hundreds of years, not only by those nearing death but also by those with conditions with a very slow downhill course but not terminal. It is also used by terminally ill people in DwD states who, for various reasons, cannot use the DwD laws.

I think VSED is often hardest on families. We, like most cultures, nurture each other through food. I worked with an MD dying from melanoma. His wife always had a beautiful dinner for him when he returned after a long day – this was one of her favorite ways to nurture him. When he stopped eating and drinking, she grieved the loss of that ritual but she was able to find other ways to care for him.

It helps to remember that a dying body does not need food and hydration in the same way that our healthy bodies do. The smell of food often nauseates dying people and can cause gastric discomfort. Encouraging fluids can cause edema, congestion and secretions that the person cannot clear, necessitating unpleasant suctioning. Also, remember that many religious communities have fasting as part of their rituals and those who fast often report a feeling of euphoria, something I have also observed in people I have worked with.

4. Using the principle of double effect (first described by Thomas Aquinas in the 13th century) is another method that has been used for years to bring about death for those experiencing intractable suffering. When symptom relief requires ever increasing medication, it is permitted by our courts and the medical community to give enough

medication to treat the symptoms, as long as the INTENT is to relieve the suffering and even if it may hasten death. (Interestingly Pope Pius the 12th also gave the Catholic Church's approval in 1951.)

Using the principle of double effect is akin to palliative sedation, a rarely used treatment initiated by hospice and/or an MD. When all other palliative interventions have failed to relieve intractable suffering, sedation is used to maintain the sufferer in a coma. Respiration will not be stopped but the coma will continue.

5. Unfortunately, a small number of desperate terminally ill people feel their only recourse is to resort to violence. There was a particularly tragic situation in WA state where a dying man begged his hospice providers for information so he could access the DwD law. Because it was a religiously owned hospice, the staff were forbidden to give him that information. He got his gun, got in the bathtub and shot himself in the head.
6. Death with Dignity Laws – This is a difficult subject. There are strong feelings on both sides of the issue and I want to be very clear that there is room for all of those feelings. My bias will become clear – if it hasn't already – but I fully realize this is not a choice for everyone. Because our time is limited, I am not going to discuss the arguments for and against these laws but I would be glad to discuss this with anyone later.

Support for DwD is high in the U.S., hovering between 60 and 70%. Again, there are 5 states in the US which allow DwD. With the exception of MT, the laws are very similar, allowing terminally ill adult state residents with very specific guidelines and safeguards, to ask for and receive medication which they can self-administer at a time and place of their choosing to end their lives in a peaceful and humane manner. The laws have very strict guidelines and a rigorous qualification process. The request to use the law cannot be made by a DPOA or family member nor can it be made through an AD. The person must be competent and able to express their wishes at the time of request and the time of ingestion. Most importantly, the person must be able to self-ingest the medication – this is what ensures that the act is voluntary. In Washington, the DOH issues an annual report detailing such things as the number of people prescribed medication, the number actually taking it, the number of participating MDs, illnesses involved,

reasons for requesting to use the law, etc. (Talk with me later if you are interested in more detail.)

For those of you interested in Death with Dignity but living in a state without such a law, there are two organizations which offer counseling about ways in which you can take control of your own dying – Compassion and Choices and Final Exit Network or FEN. Those groups are listed with other resources on the class website.

A word about language – you will notice that I very purposely do not use the word “suicide”, which, in our culture, has a pejorative connotation. We think of terrorists, those with clinical depression, even teenagers whose lives have gone awry. “Suicide” is a decision made and carried out alone; it is often violent and is an action by a person who no longer wants to live. Using the Death with Dignity law is a rational, well thought out decision made in consultation with loved ones, medical providers and clergy and the death is peaceful. It is a decision made by a person who would rather live but is no longer able to. Calling this “suicide” is deeply hurtful to those using the law and their survivors. Multiple professional organizations agree that “suicide” is not an appropriate word in this context and, in fact, use of the word is specifically prohibited in most DwD laws. So, please consider using the terms aid-in-dying, planned death, assisted death or death with dignity.

Data show that the law is working as expected. It is rarely and cautiously used. In fact, of all the deaths in the state, only .2% took advantage of the law.

I remember how many of you said you hope to die in your sleep. DwD laws make this a reality for our patients. After taking the final medication, they are asleep within 10 minutes – usually much sooner. Their sleep is very deep; they do not wake. Their respiration decreases and, within an hour on average, they pass peacefully.

Although the numbers are small, we know that the existence of the option of aid-in-dying gives MANY more terminally ill people great comfort and reassurance that, should their suffering become intolerable, they can control their own dying process. (About 1/3 of those who have access to the medication do not use it.) Giving terminally ill people the ability to plan their deaths gives them the opportunity to complete important tasks without worrying about how the end will come. Our patients put that time to good use – tying up loose ends, reviewing their lives, forgiving and asking to be forgiven.

I would like to tell you about one of my early DwD patients – a young man who affected me deeply and convinced me that dying people must have choices –Tim’s Story (here Arline related how a person, located in a relatively remote part of Washington State and in the end stages of ALS, took advantage of Washington’s DwD Law.

I want to say again – this is a difficult subject. There are many ways to die with dignity. It helps to remember that this is not a choice between life and death for these people. It is a choice between one kind of death and another kind of death. I firmly believe that having options is, in itself, palliative.

Achieving a Quality Death (JWN)

From Thornton Wilder’s Bridge of San Luis Rey: “There is a land of the living and a land of the dead and the bridge between them is love, the only survival, the only meaning.”

As illustrated above and as one approaches the end of life, the role of



palliative care should be to increase the quality of life for the person and family; increase the ability to cope; and decrease suffering. The balance between life-prolonging therapy and palliative care should seek meaning and personal growth.

Beginner’s Guide to Dying Well (BH)

If I had made it to the reunion, for my part in the “Living Well, Dying Well” session, I’d have focused on: 1. bad deaths, good deaths; 2. the

players — not just the one who dies, but the connected several; 3. accepting death

1. **Bad Deaths:** In 2002, after my wife of 30 years died, hospice orgs in Santa Barbara encouraged me to attend a grief group. I attended twice and stopped. Most participants had been there for years, telling their story and getting support— they'd experienced "bad deaths" of partners. The worst were suicides (which included elements of guilt) and quick deaths. My brother's 7 yr. old died of Reye's syndrome: sudden high temperature and gone. My sister's 18 yr. old died after three months in a comatose state following a car accident: they drove 90 miles a day to be at his bedside, but he could not respond.

A key element common to these deaths is no opportunity to mutually share the dying process with one's life partners, to say goodbye to each other. Other factors could lead to bad deaths: intense prolonged pain, profound mental dementia, or medical procedures that prolong life but at a painful or dreadful cost.

Getting familiar with the necessary forms for clear, binding communication with health professionals is a key factor. I did not comment on this here because my other panelists did.

A Good Death: My late wife was ~55 when we learned she had a likely terminal disease: metastatic melanoma had escaped from a mole excised six years earlier. Though at the time we were ignorant about melanoma, we both had liberal arts and science educations and biology teaching/research careers. We developed two strategies to cope: a. partitioning our lives, b. engaging our children and close friends.

By partitioning we kept sanity: one life arena was our mad dash to find a cure and pursue aggressive treatment protocols; the other arena was pursuit of our usual life, just as if nothing life-threatening had happened. [It worked well — days after she died, I noticed in my web browser history I had been searching new melanoma treatments

online the day before she died. I also gave a reflection on "Spirituality" in my Unitarian church service the day she died.]

Because she had been so healthy and strong all her life, we knew we had to find a way to get our two early 20s "kids" and my two early 30s "kids" from another marriage involved — or they would not believe she was dying until it happened. So, I started writing poems and short notes every few days to chronicle our experiences, and most important, our feelings.

Her dying process lasted about 18 months — the most touching, intimate, caring part of our 30 years together.

Of interest, given the popularity of the "Bucket List" concept, we had no desire to take a special trip and special action. We just wanted to continue being together in love, sharing mundane daily activities, stories, and heartbeats. She was in the hospital for six rounds of intense chemo-immuno therapy 24 hours for 6 days — then two weeks off to recover. Every day I showed up with the morning paper about the time she woke, had breakfast with her, went to work, and came back in the evening with dinner for another few hours together. Although we could not stop the cancer, it did not rule our lives either.

We did experience a "roller coaster" of overreacting emotionally to good news and bad news. I suspect everyone does — so we just felt it and rode it. I wrote poems about it — and denial and other feelings. We experienced and I wrote about feeling the classic stages of grief: denial, anger, bargaining, depression, and acceptance.

Arline and Steve covered the benefits of Living Well even with our diminished physical capacity as we enter the last chapter of our life. We experienced the paradox of clarity and increased appreciation of life and love even as we witnessed and lived the last months of her life and our time together— time slipping away.

We were very fortunate NOT to deal with severe pain, dementia, profound anxiety, or other conditions — and we were relatively young, "healthy", financially secure, and had great insurance — 18 months of intense care cost us very little. "Your mileage may vary."

A few months before she died our whole family was together for the Xmas/New Year holidays, knowing it was probably our last time together. It was our best family gathering, full of dancing, laughing, life stories, group cooking, visits to beautiful natural settings.

A week before she died our younger kids flew in to say goodbye. We made a happy, comfortable space to be together. We focused on gratitude for our lives together and our love. She was magnificent in her practical clarity and tenderness, setting them free to live and love without any strings of guilt or promises. She even told them (unknown to me) that I was a lover and would find a new partner, and she wanted them to know I had her full blessings.

The weekend she died, we, along with her only sister, all celebrated our lives together and love — reading love poems, listening to favorite music, sitting by the fire, eating ice cream, telling stories, holding each other. Celebrating a full life was so comforting, I felt willing to change places with her and be the one to die that weekend surrounded by love.

The hour she died, she emerged somehow from her dying coma to tell me she loved me and we embraced for the last time. I called our kids. The next morning, my daughter attended her college English class and wrote a beautiful paper about how she would “see” her mother in dreams and visions from now on... when she burped or picked up a sharp knife to slice tomatoes...[A few days after she died, after talking with a hospice staffer, I made an unedited 90-minute video to share this experience. I also have many poems and emails from that time. Let me know if you want a copy.]

Good Deaths: As social animals, we build trusting relationships with our closest life partners, family members, and special friends. Within our ever-changing trust groups, we connect to share joys, seek comfort, express concern and surprise, get support, and gain understanding of a world whose dimensions expand beyond the ones we were born into.

Dying confronts the unknown dimension of death: a point in time, after which little is known. Our culture is both fascinated and in

denial about it. As individuals who will die, “we need to talk” — within our trust groups — about our feelings.

2. The Players: Cultural focus is on the one who dies. But the supporting cast is as important to die well. And if you’re not in a partnership or marriage, someone from a wider circle will need to be your health care advocate.

When death nears, one common concern is making sure it’s OK for us to leave, because our work taking care of others is done. Arline, Judy, and Steve talked about important healthcare paperwork. Also wills and trusts to protect and convey property are advisable.

My emphasis is to celebrate a life well lived, affirm life, provide a legacy of love and gratitude for those we leave behind. Death is the end of in-person communication. Many sources report on what matters to people at the end — they seem to be variations on:

- I Love You to those closest
- Thanks for sharing your life with me
- I Forgive You for lingering things you did or didn’t
- I Apologize for “my bads”



Above: Sunday morning in the Japanese garden. A remembrance.

3. Accept Dying — A classic plot of fables and stories is the taming of the feared monster by inviting it to the table, getting to know it. Arline nicely covered the reality that despite our fantasies of living to 100 and dying in our sleep (after making passionate love if you are a guy)... at our ages, “98 percent of us will die within three years of our 85th birthdays,” 10-15 years from now. And as some of us know from personal experience, death can come suddenly at any moment.

Need I say, that quantity of time passes very quickly?

At our reunion, we just finished telling stories that felt fresh — from 50 years ago. So don’t wait till next year to engage your precious people, your trust groups. Pick up the phone, write that email or letter, arrange a specific time to get together.

Sharing what you care about most may seem hard. In many of our life roles, task focus takes precedence over the deeply personal. But this is the task for the end of your life: closure with your closest family and friends.

Any variation of the big four is a good place to start: love, thanks, forgiveness, apologies. Many other stories and precious memories will follow. Enjoy your one-on-one reunions. Tell the stories: laugh, cry, play, be real with each other.

Ask yourself: is there anything more important in your lives at this time. Maybe you’ll identify a bucket list item or two. But making regular times to share the rest of your life with your loved ones is right up there.

Have a good life and a good death! Bruce Hanna

Resources for Living Well, Dying Well

Publications:

- Gawande, Atul, *Being Mortal*
- Chast, Roz, *Can’t We Talk About Something More Pleasant?*
- Didion, Joan, *The Year of Magical Thinking*
- Cousins, Norman, *Anatomy of an Illness as Perceived by the Patient*
- Humphrey, Derek, *Final Exit*

- Buchwald, Art, *Too Soon to Say Goodbye*
- Buettner, Dan, *Blue Zones: Lessons for Living Long from the People Who Have Lived the Longest*
- *End of Life: Helping with Comfort and Care* – a 68 page guide available at www.nia.nih.gov

Audio-Visual:

- “How to Die in Oregon” (movie, available from Netflix)
- “Not Here By Choice” (TED talk about voluntarily stopping eating and drinking available at: www.tedxbellingham.com/phyllis-shacter)

Websites:

- Osher Lifelong Learning Institute - college level classes offered at low cost to people over 50 at 100 different colleges and universities
- Encore.org - Second Acts for the Greater Good
- Village to Village – www.vtvnetwork.org - helping people age in their own homes by forming a support network
- AARP Experience Corps – volunteer tutoring and mentoring – www.aarp.org/experiencecorps/
- National Council on Aging (Aging Mastery Program) at <https://www.ncoa.org/healthy-aging/aging-mastery-program/>
- State by state listings of resources for elder care – www.eldercare.gov
- A wealth of information on health conditions, living alternatives for elders, caregiving – www.caring.com
- Finding respite care for caregivers – www.archrespice.org
- National Hospice and Palliative Care Organization – www.nhpco.org

Resources on Death with Dignity

- End of Life Washington – www.endoflifewa.org - documents re end of life, Advance Directive, Alzheimer’s Advance Directive, end of life counseling, etc.
- Compassion and Choices – end of life counseling for anyone in the U.S. (patient information at 1-800-993-4548), Advances Directives

for each state – information about CA. End of Life Option Act - www.compassionandchoices.org.

- End of Life Choices, New York – Judy Schwarz, PhD. – end of life counseling – judy@endoflifechoicesny.org or 212 252 2015; advocating for a Death with Dignity Law in NY- www.endoflifechoicesny.org
- Final Exit Network –counseling on end-of-life options for anyone in the U.S. – www.finalexitnetwork.org -1-866-654-9156
- DDNC – leader in working for Death with Dignity laws throughout the U.S. – www.DeathwithDignity.org

Next Post- Reunion Newsletter: Will have some further content from the various programs held during the June 16 - 19 period; included will be Mike Gordy's piece for program on "Dealing with an Uncertain Future."



Loss of snow and ice, longer, warmer summers, more frequent and hotter fires as a result of climate change were discussed in the session on 'Dealing with an Uncertain Future,' which, as Mike Gordy clearly pointed out, has always existed. The picture above illustrates three aspects of the future as portrayed by a relatively non-anthropogenic system, the legacy of the past in the form of the charred and uncharred stems of the former forest, live trees that survived the fire, and the beauty of the present in the form of incredible floral displays, in this case subalpine lupine and Indian paintbrush (the site is at 7350 feet on Rock Mountain in the eastern Cascades; the fire was the 2006 Tripod Fire that burned 175,000 acres of forested landscapes). The process of recovery of this system demonstrates resiliency and continuity.



Although this aerial photograph is from a different angle, there are several landmarks that one can use to help orient oneself. Lyman Lakes, the Women's Gymnasium next to Evans (note the tower dorm, Watson, just next to the Women's Gymnasium (the Japanese Garden is between Watson and Evan's Field), and the track and stadium. Above the water tower is the baseball field; between the water tower and Goodhue is the Recreation Center. Near the bottom center is the Weitz Center for Creativity (was the old high school and then middle school). Already there are some major projects on campus, the remodeling of Scoville (built in 1896 and last remodeled in 1954) and

the construction of the second phase of the Weitz Center, a new music and performance commons. Those of us on campus for Reunion saw clear evidence of that activity. In the very near future, Mudd Hall will be torn down and a new science building with a focus on bringing the interdisciplinary/integrated learning and research potential of having biology, chemistry, computer science, geology, physics, and psychology housed together.