

# RIVERVIEW QUARTERLY INSIGHTS



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## THE HARD CALLS: MAKING FINAL DECISIONS

All financial and estate planning is first and foremost planning for the later stages and end of life.

Through planning, we turn negatives into positives: we are concerned for our spouses, so we buy insurance; we fear the uncertainties of old age, so we save for retirement; we worry about our kids' successful futures, so we save for college and create trusts to hold their inheritances when we are gone. Proper planning is the best way to protect our loved ones from the awful effects of our own mortality, and in doing so, gives us peace of mind.

So why is it that we spend so little time talking about and planning for end of life care, which is the one challenge that we all will face? This issue of our Quarterly Insights will be devoted entirely to this question. We will review the nature of the problems and the challenges to addressing them. We will explain the types of documents that can be used to plan for end-of-life decisions. Finally, we will discuss *Being Mortal*, one of the most thoughtful and important books to come out on the subject.

### THE SCOPE OF THE PROBLEM

We all know that medical science allows us to live longer. According to an article in the April 29 issue of *The Economist*, life expectancy globally was 32 years in 1900; it is now almost 72 years. Today a 50-year-old Englishman will live, on average, another 33 years, which is 20 years longer than he would have been expected to live at the beginning of the last century.

However, now that we are living longer, we are dying of chronic illnesses that last for years before the end of life. This is radically different from the past, when people often died quickly from infection or poor medical care. In

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Britain, for example, three fifths of deaths come after years of relapse and recovery. Because of this, the number of ultimately meaningless treatments at the end of life has increased greatly. An eighth of Americans with terminal cancer receive painful chemotherapy treatments in their last two weeks of life. A third of elderly Americans undergoes surgery in the last year of their lives; 8% in their last week.

People at the end of life aren't getting what they want from the health care system. The Kaiser Family Foundation and The Economist together conducted a poll of citizens in four countries about end of life care. In America, about 70% of respondents said they wanted to die at home, but only about 40% thought they'd be likely to do so. The health care system seems designed to keep terminally ill patients in hospitals until the end.

### THE CHALLENGES OF PLANNING

As difficult as these issues are, they aren't being addressed. According to the same Economist poll, over 70% of Americans had thought about the kind of treatment they'd want if they became seriously ill, and over 50% had discussed those wishes with a family member or loved one. However, less than 20% had discussed those wishes with their doctor, and less than 30% had their wishes memorialized in a written document.

We see three main reasons for such avoidance: misperceptions about what can happen, lack of knowledge about the process, and fear of the unknown. First, popular perception of the issue creates a lack of perspective. For many of us, end of life decisions are the result of situations faced by people like Terri Schiavo, whose terrible seven-year story achieved national attention. After suffering coronary arrest and resulting brain damage which left her comatose, Schiavo fell into an irreversible persistent vegetative state. Schiavo's husband and legal guardian argued that Schiavo would not have wanted prolonged artificial life

support without the prospect of recovery, and elected to remove her feeding tube. Schiavo's parents argued in favor of continuing artificial nutrition and hydration and challenged Schiavo's medical diagnosis. The Schiavo case involved 14 appeals in Florida courts; five federal district court suits; extensive political intervention (including from the President); and four denials of hearing from the U.S. Supreme Court. After hearing about this awful story, clients everywhere asked their estate planning attorneys about ways to avoid this problem, while others (certain that there were no such disagreements in their families) did nothing.

The typical case, however, is more mundane but in many ways just as challenging. For instance, what about comatose patients who aren't in a persistent vegetative state but who are on a feeding tube? Even if they have a terminal condition, leaving them on the feeding tube until they come out of the coma may allow them the dignity to die peacefully in their home. Or it may just prolong suffering.

Second, many people, including terminally ill patients, never discuss end of life care with their doctors, and so are unaware of the choices, and the process of end-of-life care. As discussed in the book review that follows, the one-third of patients in one study who were aware of the process and of their choices tended to not only end painful treatments sooner, but also lived longer. Doctors unwittingly promote this lack of clarity about the process. According to The Economist, a study of patients with congestive heart failure showed that doctors rarely followed up after a patient expressed a fear of death. Nearly three-fourths of nephrologists (those doctors dealing with illness of the kidneys) were never taught how to tell patients that they are dying. Early and regular communication reduces patient anxiety and tension with families, and creates opportunities to clarify and document the patient's plans, yet it happens only sporadically.

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Third, people fear death. As a result, their thoughts are not always clear about it, and even when they are, they are subject to change. The Economist poll ranked priorities of those facing the end of life. Among Americans, the biggest priority (from almost 90% of respondents) was not burdening their family financially, followed closely by having wishes for care followed (about 85%), having loved ones around (about 80%) and being comfortable and without pain (almost 80%). On the other hand, living as long as possible was a priority for less than 50% of American respondents.

Despite these poll results, many people change their mind when faced with an imminent death. In one study, just 43% of people who had written “living wills” that spelled out desired courses of treatment agreed with those decisions two years later. People who agree in the abstract with the idea that they do not want extraordinary measures taken to prolong life may change their minds if it means living to see a marriage or the birth of a grandchild. This type of vacillation about critical care issues leaves some doctors skeptical of planning efforts.

## CONCLUSIONS

Even though the medical profession has a long way to go in dealing with the process of final illness, and even though planning for such illnesses requires answering the most difficult questions, there are some signposts that can help guide us. First, we all need the courage to face such issues head-on. Particularly as we age and we slow down, we need to be very clear with ourselves what a meaningful life and a meaningful death look like. Second, we need to communicate these thoughts with all the stakeholders in our lives: our spouses and families (of course), but also our caregivers, physicians, friends. It is important that these people hear from us directly what we want. And third, as we discuss in more detail in the next article, document these wishes in the form of both legally binding and merely advisory documents. Taking these three steps puts us ahead of the curve, and makes a very difficult process just a little easier, and perhaps more meaningful.

## SPOTLIGHT ON PLANNING

### PLANNING FOR MEDICAL DECISIONS

As we discussed in the previous article, communicating, especially in writing, about last wishes and treatment decisions can go a long way to making the end of life meaningful, dignified and a little less painful. However, there are a lot of different kinds of forms that deal with different aspects of the medical process, and especially in the area of final illnesses. Not all of these documents are right for all people, all the time. This article will address the major types of documents, how they are used and when a person might need one.

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## THE ADVANCE DIRECTIVE (OR HEALTH CARE POWER OF ATTORNEY)

### What is it?

This document (known in Oregon as the Advance Directive for Health Care Decisions, and in Washington as the Durable Power of Attorney for Health Care) allows a person (the “principal”) to appoint another person as his or her agent to make medical decisions when the principal can’t do so. In Oregon, this document can also specify the types of treatment the principal desires if the principal is in a persistent vegetative state, or if treatment would only prolong the moment of death. In Washington, a second document is also needed, known as the “advance directive.” The distinction is confusing, since in Oregon the entire document is known as the advance directive.

### Who should have it?

Everyone over the age of 30 or so should consider it, if they have someone they trust to act as their agent. Anyone going in for surgery should definitely have one, as should anyone over the age of 60 or who has a terminal or very serious illness, or a history of such illness (e.g., stroke or heart attacks).

## THE LIVING WILL

### What is it?

Not a will at all, the “living will” is a statement of intention about the kinds of health care a person would like to receive in certain circumstances. It can also include things like funeral or burial preferences. Again, the terminology can be confusing, because in Washington the term “living will” is another name for the “advance directive,” which is a binding document, not merely a statement of intention.

Because this document is nonbinding, it is probably best to discuss it with loved ones and possibly with physicians and maybe even clergy, so that there are no misunderstandings and anything controversial can be discussed openly.

### Who should have it?

As with the advance directive, anyone going in for surgery, as well as anyone over the age of 60 and anyone with a terminal or very serious illness should have one. Additionally, a person of any age with very specific faith-based intentions, particularly when they are different from family traditions, should seriously consider having a living will and discussing it with family ahead of time.

## PHYSICIAN’S ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

### What is it?

A POLST is a form that must be signed by a physician that sets out the level of care to be provided by hospital caregivers or EMTs in emergency situations. It deals mainly with resuscitation following a life-threatening event. Most people don’t need them, because they want all treatment applied to resuscitate them (for instance, if a young person has a heart attack or stroke). People with life-threatening or terminal illnesses, however, may not want full treatment.



### Who should have it?

Because it is often associated with “do not resuscitate” orders, the POLST ordinarily should be used primarily with those patients whose condition is such that treatment would only prolong their suffering.

### SERIOUS ILLNESS CONVERSATION GUIDE

A newer, lesser known document for talking about and planning for a serious or final illness is the “Serious Illness Conversation Guide,” created by Dr. Atul Gawande at Ariadne Labs (<https://www.ariadnelabs.org/wp-content/uploads/sites/2/2015/08/Serious-Illness-Conversation-Guide-5.22.15.pdf>). Although this is a guide for doctors to use when talking with patients, it is a useful tool for patients to print out and take to their doctors, if the doctor does not raise it himself or herself.

### CONCLUSIONS







Communicating about final wishes is a difficult but necessary process. Any adult can benefit from having a health care power of attorney or advance directive. In addition, people with serious (and especially terminal) illnesses should consider talking to their doctors about POLSTs, and perhaps reviewing the Serious Illness Conversation Guide.



# ECONOMIC SNAPSHOT

## MARKET SUMMARY – SECOND QUARTER 2017 INDEX RETURNS

Although equity returns in first quarter were stronger, the broader equity and fixed income markets were all up in the second quarter, led by international developed and emerging market equities.

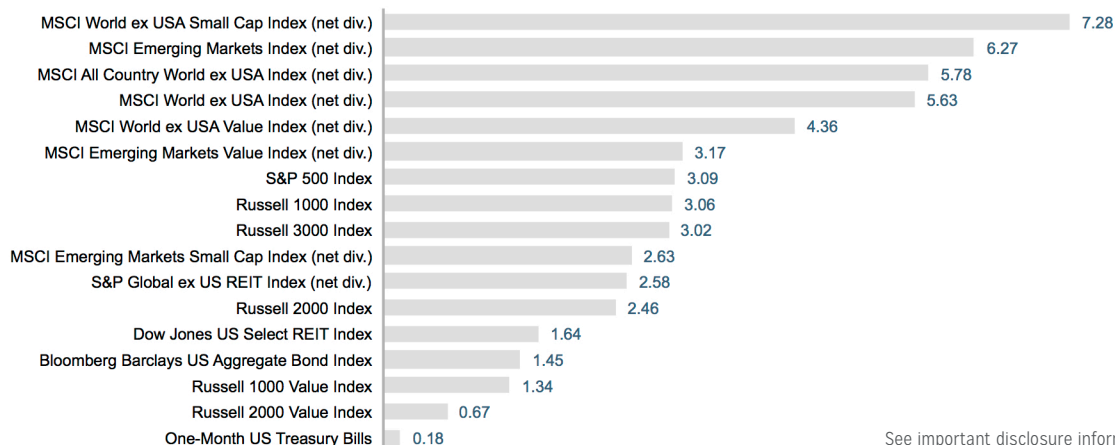
	US Stock Market	International Developed Stocks	Emerging Markets Stocks	Global Real Estate		US Bond Market	Global Bond Market ex US
Q2 2017	STOCKS					BONDS	
	3.02%	5.63%	6.27%	1.67%		1.45%	0.60%
							

Since Jan. 2001							
Avg. Quarterly Return	1.9%	1.5%	3.1%	2.7%		1.2%	1.1%
Best Quarter	16.8% Q2 2009	25.9% Q2 2009	34.7% Q2 2009	32.3% Q3 2009		4.6% Q3 2001	5.5% Q4 2008
Worst Quarter	-22.8% Q4 2008	-21.2% Q4 2008	-27.6% Q4 2008	-36.1% Q4 2008		-3.0% Q4 2016	-3.2% Q2 2015

See important disclosure information

## WORLD ASSET CLASSES – SECOND QUARTER 2017 INDEX RETURNS (%)

Looking at broad market indices, non-US developed markets and emerging markets recorded similar returns, outperforming the US during the quarter. Small caps outperformed large caps in non-US developed markets but underperformed in the US and emerging markets.



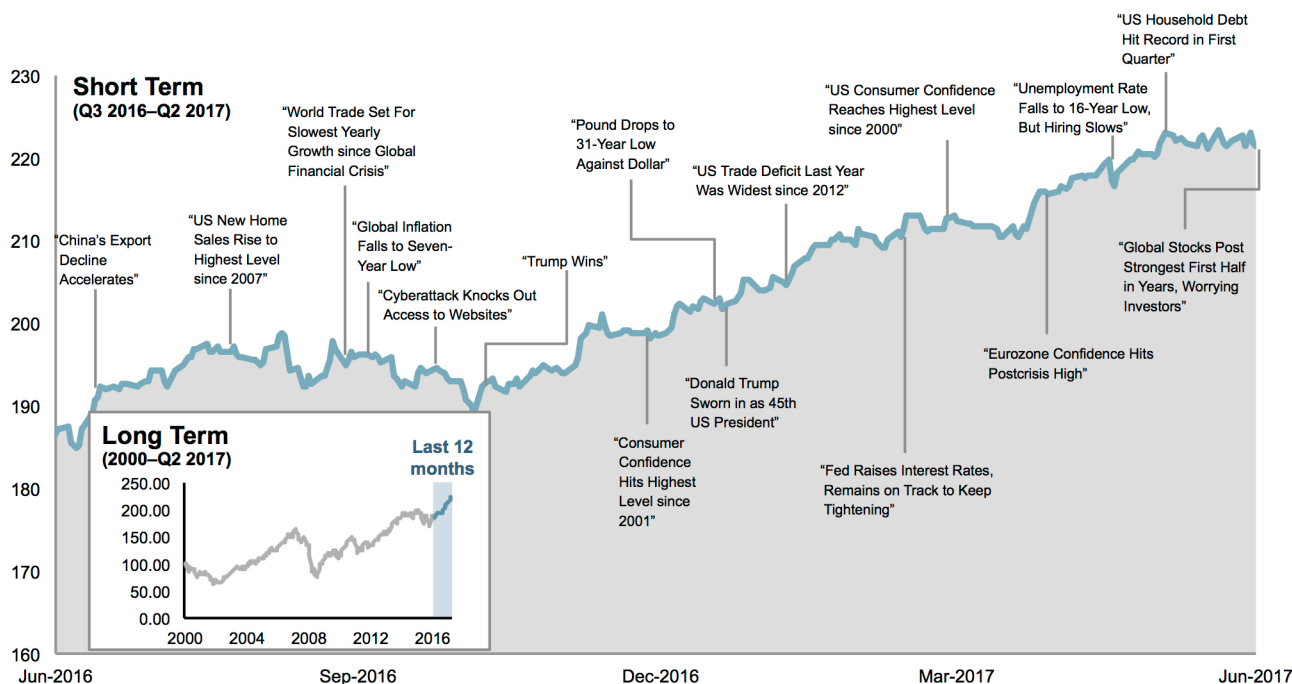
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## WORLD STOCK MARKET PERFORMANCE

### MSCI All Country World Index with selected headlines from past 12 months.

These headlines are not offered to explain market returns. Instead, they serve as a reminder that investors should view daily events from a long-term perspective and avoid making investment decisions based solely on the news.



Graph Source: MSCI ACWI Index [net div.]. MSCI data© MSCI 2017, all rights reserved.  
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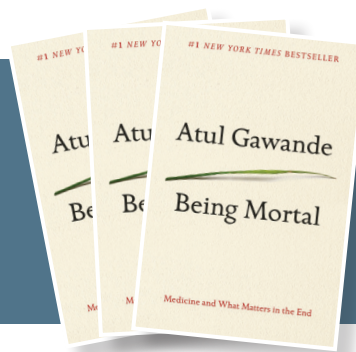
## BOOK REVIEW

### BEING MORTAL By Atul Gawande

"Medicine has triumphed in modern times, transforming the dangers of childbirth, injury and disease from harrowing to manageable. But when it comes to the inescapable realities of aging and death, what medicine can do often runs counter to what it should." This quote from the cover flap of Atul Gawande's *Being Mortal* summarizes a concern that most people feel but many

do not express. In particular, the role of medicine in estate and financial planning lurks in the background, quietly informing the process in ways that people don't always talk about.

Through stories from his patients and his own father, Gawande explains how the human desire for meaning in life can clash with the medical community's desire to keep people alive, sometimes at all costs. The chapter headings themselves explain the meaning: The Independent Self, Things Fall Apart, Dependence, Assistance, A Better Life,







Letting Go, Hard Conversations and Courage. These are the most important factors in the last stage of life, but are often not part of the dialog with medical professionals.

For example, Gawande tells the story of a low income apartment complex that operated much like an assisted living facility, with the goal of allowing its residents to live like they would live in their neighborhood, to the extent possible, trying to make lives in old age meaningful. This is contrary to the traditional philosophy of nursing homes, the primary goal of which is to keep residents safe, even if it means limiting their lives in ways that reduce meaning (and in many cases, life expectancy). The book sets out the ways in which operations like this constantly have to improvise in the face of poor funding, government bureaucracy and even objections from physicians.

At some point, a person's health diminishes to the point that making life more meaningful is less important. Instead, the focus shifts to having a meaningful death. In the chapter on "Letting Go," Gawande observes a simple, powerful insight: "as people's capacities wane, whether through age or ill health, making their lives better often requires curbing our purely medical imperatives-- resisting the urge to fiddle and fix and control." For example, when do you stop the painful regimen of chemotherapy on patients with advanced and incurable cancer? Is it right to attach such patients to machines in the ICU, leaving them with the knowledge that they will never leave that place, and depriving them of the ability to say goodbye or I love you to the important people in their lives? These are incredibly difficult questions that have only gained prominence as medical treatments have advanced. Until the late twentieth century, people with such diseases tended to die quickly and at home. Neither the patient nor the doctor had to face such questions.

Yet despite this painful dilemma, two-thirds of terminal cancer patients in a recent study reported having no discussion with their doctors on end-of-life care. The third who did have this discussion were far less likely to choose ventilators or ICU stays, and instead most

enrolled in hospice. The result was that they suffered less, were physically more capable and were able to interact with others for longer. A further study showed that stage four lung cancer patients who received palliative care (designed to prevent and relieve suffering, not prolong life) stopped chemotherapy sooner, enrolled in hospice sooner, experienced less suffering and (most shockingly) "lived 25 percent longer."

In other words, a "monumental transformation" is happening, in which alternatives to ending life in sterile nursing homes and hospitals are emerging. But this emergence is unsettling, as it disrupts the traditional understanding that "you agree to become a patient, and I, the clinician, agree to try to fix you, whatever the improbability, the misery, the damage, or the cost." The new model involves sitting down, patient and doctor, to work together to determine how to face down mortality while preserving as meaningful a life as possible. And neither doctor, patient nor estate planning advisor is typically trained and ready for this discussion.

Gawande notes that "the betrayals of body and mind that threaten to erase our character and memory remain among our most awful tortures," and that the "battle of being mortal is the battle to maintain the integrity of one's life -- to avoid becoming so diminished or dissipated or subjugated that who you are becomes disconnected from who you were or who you want to be." Medical and lifestyle choices should help in that effort, not hinder. One way to achieve clarity is to plan out and discuss candidly the choices that may need to be made with all the people who need to know: not just the patient and the physician, but also spouses and family, friends and advisors (see the section on planning, above, for a more detailed discussion).

In the end, according to Gawande, two kinds of courage are required in aging and sickness. First, the courage to face mortality, to face the truth of what really is to be feared and what to be hoped. The second, even more challenging type, is the courage to act on the truth we find. This means deciding which is more important: acting on fear or hope. This is perhaps the greatest challenge of all.



## IMPORTANT DISCLOSURE INFORMATION

INVESTMENT AND INSURANCE PRODUCTS ARE: NOT FDIC Insured | NOT Bank Guaranteed | MAY Lose Value.

Past performance is not a guarantee of future results. Asset allocation does not guarantee better performance and cannot eliminate the risk of investment losses. Indices are not available for direct investment. Index performance does not reflect the expenses associated with the management of an actual portfolio.

Market segment (index representation) as follows: US Stock Market (Russell 3000 Index), International Developed Stocks (MSCI World ex USA Index [net div.]), Emerging Markets (MSCI Emerging Markets Index [net div.]), Global Real Estate (S&P Global REIT Index [net div.]), US Bond Market (Bloomberg Barclays US Aggregate Bond Index), and Global Bond ex US Market (Citi WGBI ex USA 1-30 Years [Hedged to USD]).

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