

# MINERVA

A WOMEN OF BURGUNDY PUBLICATION / ISSUE EIGHT



HEALTHSPAN - LIFESPAN GAP

## TABLE OF CONTENTS



# WHAT'S INSIDE

## ISSUE / 08

### FROM THE EDITORS

#### EDITORS' LETTER

A letter from the minds behind *Minerva*.

P. 03

### FEATURE

#### THE NEW MAP OF LIFE

Acclaimed longevity expert Dr. Laura L. Carstensen on the exciting possibilities of getting older.

P. 05

### FEATURE

#### INSIDE THE HEALTH-CARE SYSTEM

Two of Canada's leading medical experts on the realities, challenges, and opportunities of navigating the system as we age.

P. 10

### FEATURE

#### FAMILY EXPERIENCE

Ruth Bastedo, Chair of the Board of Hospice Toronto, shares how to care for a loved one without losing yourself.

P. 15

### FINANCIAL PLANNING

#### LONGEVITY & LEGACY

How to plan for health, family, and wealth as you age.

P. 18

### LEGAL

#### EXPLAINING POWERS OF ATTORNEY

What goes into one of the most critical—yet overlooked—aspects of estate planning?

P. 22

### LONG-TERM CARE

#### THE ELEPHANT IN THE ROOM

Approaching the conversation about long-term care planning.

P. 26

### END-OF-LIFE CARE

#### HEART OF THE MATTER

Dr. Jean Marmoreo, pioneering MAiD expert, provides insight into end-of-life care and making informed health-care decisions.

P. 30

### PHILANTHROPY

#### CLOSING THE GAP

How giving—and community—can lead to meaningful change in health care.

P. 34

### MILESTONES

#### REMEMBERING DR. RUTH

Reflecting on the legacy of the iconic sex therapist.

P. 40

### WOMEN OF BURGUNDY WEBPAGE

P. 43

# MINERVA

ISSUE / 08—MARCH 2025

The Women of Burgundy was founded in April 2014. Our mission is to build a community that inspires women to make investing a priority. We will move forward together, fostering curiosity, confidence and continual growth as investors.

Named after the Roman goddess of wisdom and the sponsor of arts, trade and strategy, *Minerva* is a Women of Burgundy publication. An inspirational call to action, the goddess Minerva embodies the highest values of wisdom, knowledge and mastery.

# FROM *the* EDITORS

Since our beginning in 2014, Women of Burgundy has been guided by the fundamental belief that agency in managing our finances creates choice and freedom in all areas of our lives. This philosophy has shaped our work, our community, and our commitment to inspiring women to prioritize investing and take a leadership role in building and managing wealth.

In October 2024, we were proud to host our second Minerva Summit, with a focus on the healthspan-lifespan gap. Since the 1950s, the average global lifespan has increased from 47 years to 73 years, an extraordinary 26-year expansion in just seven decades. However, while we are living longer, the years spent in good health—our healthspan—are not increasing at the same rate. Currently, the average global healthspan is just 64 years, meaning many of us will spend the last decade or more of our lives in the “gap”—with age-associated chronic illness or disability.<sup>1</sup>

Addressing the healthspan-lifespan gap requires resources to extend our healthy years and expand access to necessary care—supporting our physical, mental, and social well-being throughout life.

## From Generational Wealth to Generational Well-Being

At our inaugural Minerva Summit in 2023, we established a vision of generational wealth that extends beyond financial assets to include purpose, values, and knowledge transfer between generations. This year, we expanded that vision to embrace generational well-being.

While the connection between wealth and health may not seem obvious, the guiding principles are the same. Just as wealth is about more than financial assets, aging goes beyond health-care management—it's about balancing immediate health needs with broader family well-being. With the right planning, every generation can thrive through proactive health and financial strategies that ensure aging isn't just about adding years, but living those years well. Intergenerational dialogue about finances, caregiving, and health priorities, coupled with shared knowledge of health-care and financial systems, creates lasting impact for future generations, regardless of means.

In this issue, we are delighted to share the discussions and learnings from the Minerva Summit. We feature Dr. Laura L. Carstensen, professor of psychology at Stanford University and founder of the Stanford Center on Longevity. She provides powerful insight into what it means to live in a society with unprecedented life expectancies and how we can reimagine aging for the better.



Anne Maggisano, Vice President and Founder, Women of Burgundy, and Rachel Davies, Vice President and Co-Head, Women of Burgundy.

Dr. Sharon Straus, Chief Medical Officer and geriatrician at Unity Health Toronto, and Dr. Ashley Verduyn, Chief of Providence healthcare, share an inside perspective on Canada's health-care system across the full spectrum of care—from acute to palliative—and what it means to serve aging and vulnerable populations.

In our interview with Ruth Bastedo, Vice President at William Thomas Digital and Chair of Hospice Toronto, Ruth shares personal insights from her experience as a caregiver and guides families in supporting their loved ones' wishes.

As longer lifespans reshape financial decisions, Julia Chung of Spring Planning examines the complexity of later-life planning, offering tools to align financial, legal, and family systems. Lucy Main of WeirFoulds LLP addresses critical estate planning elements, particularly power of attorneys, while Karen Henderson of the Long Term Care Planning Network guides us through preparing for long-term care—a reality that nearly half of Canadians will face after age 75.

In our interview with Dr. Jean Marmoreo, pioneering doctor in Medical Assistance in Dying, we address the final moments of our lives, underscoring the purpose, agency, and advocacy that is required when making informed decisions about end-of-life care.

Charitable organizations and philanthropists are also playing a crucial role in addressing the healthspan-lifespan gap, beyond what the public sector can do alone. We interview four remarkable

women who are driving meaningful change by leveraging their time, resources and networks to make lasting impact.

Finally, in our Milestones article, we celebrate Dr. Ruth Westheimer, whose groundbreaking work revolutionized conversations about women's health, breaking taboos and empowering generations through open dialogue and self-advocacy.

This issue of Minerva features original commissioned art by prominent Canadian artists Joanne Tod and Rachel Joanis, whose creative work brings the pages of our magazine to life.

We invite you to explore, engage with, and, above all, enjoy the eighth issue of Minerva. We believe it speaks to ideas that matter to you as informed and successful investors.

*Anne Maggisano Rachel Davies*

## ENDNOTES

- Garmany, A., Yamada, S. & Terzic, A. Longevity Leap: mind the healthspan gap. *npj Regen Med* 6, 57 (2021). <https://doi.org/10.1038/s41536-021-00169-5>



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Special thanks to Tiffany Huynh, Compliance Analyst on Burgundy's Legal and Compliance Team.

A portrait of Dr. Laura L. Carstensen, a woman with short brown hair, wearing green-rimmed glasses, a black blazer, and a colorful patterned scarf. She is smiling and has her arms crossed. The background is a blurred interior space with dark wooden railings.

# *The* NEW MAP OF LIFE

Longevity expert Dr. Laura L. Carstensen on the challenges—and exciting possibilities—of getting older.

Dr. Laura L. Carstensen is a professor of psychology at Stanford University and the founding director of the Stanford Center on Longevity ([longevity.stanford.edu](https://longevity.stanford.edu)). Her award-winning research on aging focuses on the motivational, cognitive, and emotional aspects of aging. During last fall's Minerva Summit, Dr. Carstensen delivered the keynote address, offering powerful insight into what it means to be living in a society with longer-than-ever human life expectancies, and how we can reimagine the future to make getting older even better. Below, find an edited version of her speech.

**L**iving longer is one of humankind's most remarkable achievements. It's also one of the greatest challenges of the 21st century. We're living longer today than my great-grandmother ever could have imagined. In fact, I wish I could tell her, "Grandma, the babies are surviving," because back in her day, many of them didn't. Just over 100 years ago, about 25 percent—one in four—of these little ones died before they reached age five, and many more died before 12. Back then, death was common at all ages; it wasn't strongly associated in people's minds with old age because people often died at any time. And then, in just one century, we added 30 years to the average human life expectancy.

Over the millennia, life expectancy inched up at a snail's pace. By the mid-1800s in Europe, it reached the mid-30s. In 1900 in the United States, it was 47. By the end of that century, it had climbed to 77. Today it's 79 in the U.S., and even longer in Canada. We added more years to life expectancy in the 20th century than we added across all prior millennia of human evolution combined. In the blink of an eye, historically speaking, we nearly doubled the length of our lives.

This, I argue every chance I get, is our challenge. We're still following social norms that tell us when to get an education, when to marry, when to have children, and when to retire—norms that worked when life expectancy was 50, but don't work when

it's approaching 100 for many people. We are also born into worlds that were literally designed by and for young people. When you're climbing a flight of stairs and your knees are hurting, it's not you—it's the stairs. The presumed users were very young. The same goes for the knowledge housed in our medical school libraries: We know a lot about acute diseases, but not much about chronic ones, creating this gap between lifespan and healthspan.

Some of you might feel uneasy about growing older, so let me tell you a story about Jeanne Louise Calment. She died in 1997 at the age of 122, holding the record for the oldest documented human ever. She lived in the French city of Arles, in her family home. She was remarkable. She rode a bicycle until she was 110 and made a rap album at 114. She even starred in the movie *Vincent and Me* because she had actually met Van Gogh, making her the oldest actress of all time. But my favourite story about her involves a property deal she made at age 90.

She was living in her family home, determined to stay there for the rest of her life, when a 47-year-old lawyer who desperately wanted to buy the house kept making her offers. She kept turning him down. Then one day, he showed up at her door and said, "I've got a proposition for you. I will pay you \$400 a month for the rest of your life if you will deed the house to me on your death."

She thought about it and agreed. They signed the contract. Over the next 30 years, he paid her more than three times the value of her home. And here's the kicker—she outlived him by two years. He died at 77, which was average life expectancy at the time. This is what 122 can look like.

People often ask me: "With everyone living so long, isn't overpopulation going to be a terrible problem?" But the answer, surprisingly, is no. During the same period that life expectancy increased, fertility rates fell by half in most developed countries.

In the United States in 1900, women had an average of 4.2 children. By century's end, that number had dropped to 2.1. In Canada today, the fertility rate is even lower at 1.2—well below the replacement rate. When each generation is smaller than the last, it doesn't take long for population numbers to decrease significantly. In fact, some government leaders and public figures are sounding alarm bells about this population decline.

This demographic shift has dramatically altered the shape of our population. Histor-

United States today, we have comparable numbers of five-year-olds and 65-year-olds. And perhaps this is the most exciting part of the story: We're experiencing a level of age diversity that's unprecedented in human history.

Just imagine what we can achieve when we combine the speed, ambition, and strength of young people with the emotional stability, experience, and social wisdom of older generations. We're standing at a unique moment in human history where, for the first time, four or even five generations are alive simultaneously.

So how do we make the most of this gift of time? That's our real challenge. Our ancestors handed us these 30 extra years of life for the average person, no strings attached. Now it's up to us to build a world where these added years can improve quality of life at all ages. Some of today's best news is that the potential of science and technology is simply breathtaking. We're learning how to keep people healthy, engaged, and functioning well despite vulnerabilities. And we're making incredible progress. Scientists in laboratories are studying senolytics and parabiosis—research that may help slow the aging processes that put us at risk for virtually all diseases.

Meanwhile, technology developers are creating ways to monitor nearly all our bodily systems, from glucose to blood pressure to respiration. These wearable devices that many of us have now, we'll look back at them like we do at mainframe computers—huge and clunky. Instead, we'll have tattoos on our skin monitoring our physiological processes, helping us stay healthier longer.

I have great confidence in science and technology. But what worries me more is the psychology of aging—the social norms that guide us. Sometimes I think our biggest problem is simply a lack of imagination. The stereotypes about aging aren't just often wrong—they're actually holding

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ically, populations looked like pyramids: many children at the bottom, gradually winnowing to a tiny peak of elderly survivors at the top. But now, as more babies survive to old age, that pyramid—which characterized every country on Earth as recently as 1950—is transforming into a rectangle.

While some countries are now top-heavy with older people, that's not quite the case in Canada and the U.S. What we're seeing instead is true age diversity. In the





Dr. Laura L. Carstensen on stage at Minerva Summit

us back. They're keeping us from chasing our dreams and planning vibrant, engaged futures. So much of what we believe about aging simply isn't true, yet these misconceptions keep getting reinforced.

We need to rethink our lives because older people today are fundamentally different from those of previous generations. Today's older adults are nothing like those of 1900, 1930 or even 1950. They're pursuing new passions, maintaining friendships that have lasted decades, and many aren't just staying in the workforce—they're running it, leading companies and contributing in all sorts of ways.

The data confirms this transformation. In a survey conducted by my colleagues a few years ago, they asked people aged 55 to over 85 a simple question: "Are you healthy enough to work?" While the percentage of people answering "yes" naturally decreased with age, more than half of those over 85 reported being healthy enough to work.

Many of these healthy older adults aren't working, perhaps because we haven't properly invited them to engage or offered flexible ways of working. You don't need to

commit to a 40-hour work week—maybe it's just 10 hours. There are many ways we could be inviting this new resource to engage with the world. As one of my colleagues puts it: "The only natural resource in the world that's actually growing is older people."

We can predict who's likely to stay healthy and capable of working as they age, and education emerges as the strongest predictor, closely tracking with income. Together, these factors—representing the resources to care for oneself and others—paint a revealing picture. Among those with some college education, over 80 percent remain functionally healthy into their mid-70s.

But for those who dropped out of high school, the story changes dramatically. Here we see the kind of linear decline that dominates headlines—health steadily worsening with age. This stark contrast illuminates both the possibilities and challenges of aging in modern society. Looking at U.S. data, as recently as 1970, about 40 percent of Americans had dropped out of high school, creating a very different popu-

lation of older adults than we see today. Now, older workers often have as much education—sometimes more, depending on the study—as young workers entering the job market.

This educational shift has far-reaching implications. We're finding that education appears to be reducing dementia rates. While the overall numbers of dementia cases will increase in older populations (since age remains the principal risk factor), the incidence—the rate within each generation or birth cohort—has been falling for about 50 years. It dropped 24 percent from 2000 to 2012, a remarkable decline that we see mirrored in other nations that implemented public education around the same time.

So, aging has changed. While it's clearly possible to stay healthy as we age, many people aren't achieving this potential. We have a lot of work to do to close this gap.

Perhaps the best news I can share about aging is that older people are happier than younger people. If you're having trouble believing this, you're not alone—nobody did at first. When my research group was



**Top to bottom:** Dr. Laura L. Carstensen; Burgundy Vice Chair and Co-Founder Richard Rooney; Rachel Davies at Minerva Summit.

studying this, it became the most scrutinized finding in social gerontology. But that intense scrutiny was great for science, because we've examined this phenomenon from every angle, and the results are clear: older people are more mentally stable,

slower to anger, more likely to appreciate life, and more likely to forgive. They're doing better emotionally than their younger and middle-aged counterparts.

A few years ago, the Center on Longevity collaborated with *Time* magazine to ask

people how they felt about the prospect of living to 100. The top two responses were telling: "I hope I don't have dementia" and "I hope I haven't run out of money." While these concerns resonate, we need to raise the bar. If we merely cope with aging—white-knuckled, hoping bad things don't happen—we'll miss this incredible opportunity. We can't achieve what we can't envision.

When life expectancy was about 50, there wasn't room for reinvention. The model was simple: get an education, find a mate, work like a dog, have a couple of kids for species survival, retire, and die a few years later. That's the life model we're still following, even though our circumstances have dramatically changed. It's time to rethink everything.

### The New Map of Life

In 2018, my colleagues and I at the Center on Longevity hosted what became the most fascinating meeting I've ever attended. The topic was drawing a new map of life. We gathered about 50 people—half were academics from diverse fields like medicine, sociology, psychology, business, and law. The other half came from industry: automotive, transportation, philanthropy, education and health care.

We gave these experts two challenges. First, we asked them to envision a thriving century-long life. "Think of yourself at your 100th birthday party," we said. "Who's there? What music is playing? What kind of cake are you having?" We wanted them to truly imagine what that milestone could look like.

That was the easy part. The second challenge was harder: How do we build a world that helps the majority of people reach that vibrant century mark? What needs to change? We spent years working on this topic, consulting experts and diving deep into current knowledge and future possibilities. The result was what we call the New Map of Life, which is available



on our website ([longevity.stanford.edu](http://longevity.stanford.edu)). From this intensive work, several key themes emerged.

**1) Make Use of Age Diversity.** What we're living through is not just aging societies—it's age-diverse societies. That's a fundamentally different reality. This story isn't about old age alone; it's about longevity—the full spectrum of life. Our focus needs to be on how we raise future centenarians. What do we want their lives to look like, and how do we start preparing them now?

**2) Learn throughout life.** We need to find ways that we can learn throughout our lives. It makes no sense in century-long lives to finish our education in our early 20s—especially if we're going to work until our 80s and 90s.

**3) Align health spans to life spans and build financial security from the start.** For me, the top two challenges are ensuring our healthspan matches our lifespan and building financial security. That financial piece is critical—we need to start thinking about it from the moment a child is born. Think about the transformative power of compound interest. The next time you set up a bank account for a grandchild—which I know many of you do—consider setting up one for a child who doesn't have those resources. That simple act of starting their financial pathway early could truly change the world.

**4) Work more years, with greater flexibility.** It doesn't make sense to live 100 years and only work for 65 of them. Individuals can't afford it. Societies and governments can't afford it. Even putting money aside, from a psychological perspective, going on vacation for 40 years isn't good for anyone. When I ask people, "If you had 30 extra years of life, where would you put them?" no one ever says, "I'd like to make old age longer." Here's the beautiful thing: We don't have to add those years at the end. We can distribute them anywhere we want throughout our lives.

**5) Support life transitions.** We need new infrastructure to support life transitions that earlier generations rarely faced. Surviving health challenges with decades of life ahead is now common, unlike when life expectancy was 50. Caregiving has also become a universal experience—most of us will both provide and receive care. Yet many of us navigate these transitions as if we are the first to experience them. We need infrastructure to support these new

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century  
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change?”

life patterns.

**6) Create longevity-ready communities.** We need to create physical environments that support long-term health. Consider this startling fact: The distance you live from an automobile overpass can actually predict your likelihood of developing asthma in midlife and dementia in later years. We've learned about many environmental factors that diminish our health and healthspan—from lead paint to air pollution. But there's also the positive

side: We need to design our surroundings with green spaces where people can walk and parks where they can connect with nature. Because we know that access to nature isn't just pleasant—it's fundamental to keeping us healthier longer.

**7) Harness scientific and technological breakthroughs to transform the future of aging.** Exciting technological breakthroughs are already reshaping how we age. A company in Menlo Park, Calif., for example, is developing sensors to help us stand up from those impossibly low couches we all hate. And that's just the beginning—imagine this kind of technology woven into our wardrobes, helping us stay healthy and active. These aren't just conveniences; they're innovations that could fundamentally change how we maintain our independence and vitality as we age.

**8) Ensure that advances are distributed to the entire population.** Perhaps the most crucial challenge is ensuring that longevity advances benefit everyone, not just the privileged few. Think about our past successes—we're living longer today because our ancestors made disease prevention available to all. They didn't reserve their discoveries about disease transmission for the wealthy 10 percent. Instead, they created community-wide programs so all children could be inoculated against diseases. When electricity brought refrigeration, every American and Canadian household got access, improving food safety for everyone.

Today, we are on a risky path where we are making advances in ways to keep people healthy that may be affordable for the top 10 percent and not for the other 90 percent. None of us want our grandchildren to inherit a world where 90 percent of the population struggles with aging while only a few thrive. The decisions we make today will shape century-long lives for generations to come. We must ensure these advances support everyone throughout their extended lifespans. **M**

# MINERVA SUMMIT

— A WOMEN OF BURGUNDY COMMUNITY —



## INSIDE THE HEALTH-CARE SYSTEM: REALITIES, CHALLENGES, & OPPORTUNITIES

— By: Rachel Davies —

Two of Canada's leading medical experts on navigating  
the system, especially as we age.

What does Canadian health care really look like from the inside out? Dr. Sharon Straus—geriatrician, clinical epidemiologist, University of Toronto professor, and Executive Vice President of Clinical Programs and Chief Medical Officer at Toronto-based health-care network Unity Health ([unityhealth.to](http://unityhealth.to))—and Dr. Ashley Verduyn—geriatric and medical rehabilitation specialist, assistant professor at the University of Toronto, Chief of

Providence Healthcare, and Unity Health's Vice President of Medical Affairs—join Burgundy Vice President Rachel Davies to offer a look inside the system. Together, they discuss Canada's health-care system across the full spectrum of care—from acute to palliative—respecting loved ones' wishes, supporting vulnerable populations, the challenges within, and how to access essential care resources.

**Rachel Davies:** *I want to begin by sincerely thanking you both for making time for this important conversation. Among our clients, there's a strong desire to better understand how the Canadian health-care system works, particularly as we age and require more care. To establish a common understanding, I'd like to start with a question for Dr. Straus: As a renowned geriatrician, could you help us understand the role your specialty plays in our health-care system?*

**Dr. Sharon Straus:** As a geriatrician, I specialize in caring for people aged 65 and older—with one important exception that I'll explain shortly. Our training path differs from primary-care physicians: After medical school, we complete specialty training in internal medicine, followed by two additional years of subspecialty training focusing on geriatric medicine. We primarily treat patients with complex medical conditions, such as dementia, working closely in partnership with primary-care colleagues. Currently in Canada, there is only half of a geriatrician available for every 10,000 people over 65. To put this shortage in perspective, the number of new geriatricians we train annually is just one-quarter of the number of people who enter cardiology. This creates a significant gap in caring for our aging population.

Geriatric medicine is also a holistic specialty. We address medical, social, and psychological aspects of care. This comprehensive approach is what draws me to the field. We treat the whole person while also involving family members and caregivers in the care plan.

As I mentioned earlier, there is one exception to our age requirement: For people with lived experience of homelessness, we begin care at age 50. This is because homelessness accelerates aging—a 50-year-old who has experienced homelessness is typically equivalent physiologically to someone 20 years older.

**RD:** *Could you explain the different pathways to accessing geriatric care?*

**SS:** Access is available through two main

pathways. First, primary-care clinicians can make direct referrals to a geriatrician. Second, we provide consultations within hospitals, which I do across several locations within Unity Health, including Providence and St. Michael's.

At St. Michael's, we've developed several programs. For example, our Acute Care for the Elderly Unit admits patients over 65 directly from emergency with acute medi-

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Family physicians  
and nurse  
practitioners  
are crucial for  
preventative  
screenings,  
managing chronic  
illness, connecting  
patients to  
community  
programs, and  
facilitating access  
to specialists, like  
geriatricians.  
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cal issues, focusing on those who can return home, with support, for independence. We've also pioneered an innovative trauma-care program where geriatrics automatically consults on every trauma patient aged 65 and older. This program, developed by Dr. Camilla Wong and Dr. Marissa Zorzitto, has significantly improved outcomes for older

adults with falls and injuries, and has been adopted by trauma centres across Canada.

**RD:** *Dr. Verduyn, perhaps like many Canadians, I had assumed our universal health-care system was designed to cover most medical needs, with private insurance mainly handling dental and pharmaceutical coverage. I was surprised to learn that when universal health care was introduced in the 1960s, its primary focus was on ensuring access to family doctors and hospital care. Long-term care wasn't prioritized because we were a younger nation—at the time, the average Canadian was 26 years old and life expectancy was around 70. Because we didn't fully understand the health-care needs of an aging population, services had to be added incrementally rather than through a comprehensive design for elder care. This helps to explain why navigating the system can be so challenging as we age. Dr. Verduyn, as Chief of Providence, you work at the intersection of hospitals, rehabilitation, and long-term care. Could you give us an overview of how these different levels of care work together?*

**Dr. Ashley Verduyn:** You're right, it's complex. While we're fortunate to have publicly funded health care, there are significant gaps.

Primary care is the foundation of our system, and it's currently in crisis. Over five million Canadians lack a primary-care team. Family physicians and nurse practitioners are crucial for preventative screenings, managing chronic illness, connecting patients to community programs, and facilitating access to specialists, like geriatricians.

Our hospitals remain vital for acute-care needs like illness, accidents, and trauma. However, they are increasingly serving as a broader safety net people experiencing social issues like homelessness and a lack of community supports. Rising living costs have led to housing insecurity, resulting in more people seeking hospital services even without acute medical needs.

Following hospitalization, rehabilitation is



essential for regaining function, particularly in older adults. Even brief hospital stays can cause muscle weakness that makes it difficult or impossible for patients to stand or walk independently. Fortunately, these vital services are available in hospitals and community settings. Evidence shows that geriatric rehabilitation helps patients regain function, prevent falls, reduce emergency room visits, and maintain independence at home.

Home- and community-care services help transition patients back home. While these services are part of our publicly funded health-care system, they are often quite limited. Support might consist of just one weekly visit from a personal support worker (PSW) for bathing assistance, or occasional nursing care for wound management. Most patients need additional support from personal care-

**RD: Dr. Straus, Dr. Verduyn touched on several resource limitations and care gaps. From your perspective, what do you see as the most critical gaps in our health-care system today?**

**SS:** There are two major gaps we need to address. First is the critical shortage in primary care and access to fully staffed family-health teams. The second is the challenge of navigating our health-care system. Whether you're a caregiver or an older adult without support, it's incredibly difficult to identify and access needed resources. This includes finding help with basic activities of daily living, such as bathing and dressing, as well as more complex tasks like managing finances and arranging transportation to medical appointments. The gap isn't just in accessing clinical care—it's in finding and coordinating all of these

increase waiting lists for care.

A particularly urgent issue that Ashley and I are passionate about is supporting less resourced populations, especially regarding housing stability. Women are disproportionately affected—they generally live longer, often need more financial support, and are increasingly at risk of becoming precariously housed. Imagine someone hospitalized for an acute illness who misses rent payments and faces eviction—this scenario creates a cascade of health and social challenges that our system struggles to address.

Finally, we need to encourage people to have clear discussions with their families about their wishes. This includes advanced-care planning and designating powers of attorney for both personal care and finances. As clinicians, we emphasize the importance

“Those of you who have been caregivers know that the stress of caregiving itself becomes a risk factor for health problems. Ensuring caregivers receive proper support and care is crucial, yet remains inadequate.”

givers to fill significant gaps in care.

Long-term care homes are specifically designed for people requiring 24/7 care from nurses or personal support workers. About 80 percent of long-term care residents in Canada have cognitive impairment, such as dementia or physical disabilities that severely limit their ability to perform daily activities like moving, transferring, or using the wash-room independently. These homes also serve adults with complex mental health issues or severe intellectual disabilities requiring around-the-clock care.

Finally, palliative care is a vital part of this health-care continuum. It's not just a service, but a philosophy of care that can be provided in various settings—from dedicated palliative-care units and hospices to patients' own homes.

essential support services.

Another significant gap in our health-care system is support for caregivers. Those of you who have been caregivers know that the stress of caregiving itself becomes a risk factor for health problems. Ensuring caregivers receive proper support and care is crucial, yet remains inadequate.

This connects to our broader challenge of supporting those who cannot live independently. The COVID-19 pandemic exposed serious issues in long-term care facilities. While there's a natural desire to put the pandemic behind us, I'm concerned we're overlooking crucial lessons learned during that time. In Ontario, for example, several long-term care homes are now closing because they cannot implement recommended improvements, which will only

of having these crucial conversations early, before they become urgent. These discussions are far more effective when they happen during calmer times, allowing families to make thoughtful decisions about future care and support.

**RD: Dr. Verduyn, what key challenges do you encounter in rehabilitation and long-term care?**

**AV:** A major challenge many don't anticipate is the cost of medical equipment. Essential items like walkers and wheelchairs come with significant expenses, and this often triggers a cascade of housing modifications. A stair lift alone can cost \$15,000—beyond many patients' means. This financial burden becomes particularly challenging when combined with the rising cost of living. We need to plan how to adapt our environments

to accommodate potential future needs for mobility equipment.

Another major gap involves community support for those wanting to age at home. The waiting list for long-term care in Ontario currently stands at about 45,000 people. Supportive housing, where residents live in apartments with embedded PSW services, could help many age in place, but has an even longer waiting list. This gap in community support and affordable supportive housing is leading to increased homelessness among older adults, especially those without family support to help navigate the system.

**RD:** *We know that most people who have stable housing prefer to age in their homes. As family members, how can we assess whether a home environment will safely support our loved ones as they age? And what signs should we watch for that might indicate they need additional support or potentially a transition to more care, while still respecting their independence?*

**AV:** We always strive to honour our patients' wishes, and you're right, most people prefer aging at home. Occupational therapy is an invaluable resource in this process. These professionals, available through home- and community-care services, can visit homes and identify potential hazards that most people miss, from tripping hazards to areas needing safety features. Today's technology also offers more options than ever before, from fall alarms to video monitoring systems that help us check on loved ones, though cost can be a barrier. The greatest challenge typically arises when someone requires 24-hour care. Providing around-the-clock support in a home environment is extraordinarily expensive, making it financially unfeasible for many families.

**SS:** I'd add an important point about autonomy. As a caregiver for my elderly parents, I've learned that we sometimes need to accept choices we disagree with. When my mother chooses not to use her walker, I worry, but I've realized that respecting her right to make decisions—even ones I disagree with—is crucial to maintaining her dignity and independence.

**RD:** *You both mentioned challenges in long-term care that were exposed during COVID-19. As members of the COVID-19 task force, what key insights did you gain about long-term care, and what issues still need our attention?*

**SS:** This topic is near and dear to our hearts because it's fundamentally about providing the best possible home environment for older adults who need long-term care. We must remember this crucial point: These facilities aren't institutions, they're homes for people who require intensive, direct care.

Current funding doesn't align with the evidence-based recommendations for direct care hours these residents should receive. We're not asking for excessive care—just meeting proven, basic needs for our residents. Yet we continue to fall short of these fundamental standards. The staffing situation is equally concerning. Our workforce, predominantly racialized women older than the median Canadian worker, typically earns less than acute-care counterparts unless attached to organiza-



**Top to bottom:** Dr. Sharon Straus; Helen Burstyn, Host of the Minerva Summit; Rachel Davies, Dr. Ashley Verduyn and Dr. Sharon Straus in conversation at Minerva Summit.



tions like Unity Health. This wage disparity reflects a deeper issue: How we value both older adults and those who care for them.

We need strong advocacy to ensure these standards are delivered across Canada. This means pushing for accountability in federal transfer payments to provinces and territories, ensuring the funding directly improves care quality in long-term care homes.

**AV:** The waiting list situation illustrates these challenges. With a nine- to 10-year wait at our long-term care facility, the system can only accommodate crisis admissions based on scores that evaluate factors such as cognitive function and support needs. Early registration offers no advantage.

The pandemic highlighted these issues, particularly the need for full-time roles with proper compensation, but public attention has waned. These essential workers remain underpaid, undervalued, and under-resourced. We need continued advocacy to ensure we can provide the highest quality of care in long-term care homes.

**RD:** *As we wrap up, I'd like to focus on the positive changes ahead. What initiatives are you most excited about?*

**SS:** I'll share two initiatives that really excite me. First: Dr. Jennifer Watt is creating a rehabilitation pathway for people with dementia. Traditionally, these patients are often excluded from inpatient rehabilitation due to ageist assumptions about their ability to participate. However, our pilot study has shown promising results that they can improve and return home successfully. We've now secured funding for a larger-scale study that could transform care for this growing population. When someone with dementia is hospitalized for something like pneumonia, they risk deconditioning, which can severely impact their ability to function independently at home. Providing the benefits of rehabilitation for these patients could fundamentally change how we approach their care.

Our second initiative addresses homelessness among older adults. In Toronto,

3,500 people over 50 use shelters nightly, and 35,000 seniors await supportive housing. Through our shelter outreach program, we've discovered that about two-thirds of the older adults we assess have undiagnosed dementia. Imagine managing dementia while moving from shelter to shelter. What's particularly concerning is that while most of these individuals qualify for long-term care, less than 5 percent ever gain admis-

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sion. We've recently received funding to work directly with older adults experiencing homelessness and their caregivers to create a new model of long-term care. This will be the first initiative worldwide to support transitions from shelter to long-term care, and we're hopeful it will help address this critical gap in our system.

**AV:** One project I'm particularly excited about focuses on improving medical care in long-term care homes. Currently, residents

face significant challenges attending outside medical appointments, and many unfortunately end up in emergency rooms, which can be particularly frightening and unsafe for older adults living with dementia. The pandemic highlighted how disconnected long-term care homes have been from our broader healthcare system.

The project has gained government support and is expanding. We're now providing internal medicine consultations to long-term care homes and their primary-care providers, elevating on-site care capabilities including palliative and wound care. We've also implemented nurse-led outreach teams for on-site care to support medical care delivery within long term care homes. It's encouraging to see Ontario Health embrace this initiative and provide funding support, which is showing real promise in transforming how we deliver care.

**RD:** *Having supported so many people through these life transitions, what key advice would you offer to help families better prepare for aging?*

**AV:** Echoing Sharon's comments earlier, it's crucial to have those important conversations early—establish your power of attorney, clearly communicate your wishes to your family, and ensure they understand your values and goals regarding aging and future medical care.

Second, from my rehabilitation perspective: stay active and engaged with your community. Take advantage of local exercise classes and programs. Understanding what resources are available in your neighbourhood isn't just about staying physically healthy—it's about building connections and knowing where to turn for support as your needs change.

**SS:** I completely agree with Ashley's points. I'd also emphasize the critical importance of social connections. COVID-19 showed us how isolation affects older adults' wellbeing. Regular social engagement and community check-ins should be a priority for everyone. **M**



A portrait of Anne Maggisano, a woman with short brown hair, wearing black-rimmed glasses, a dark purple blazer, a pearl necklace, and gold hoop earrings. She is looking slightly to the right of the camera with a gentle expression. The background is a blurred mix of pink and blue lights.

# FAMILY EXPERIENCE

Navigating the personal and logistical issues of caring for a loved one.

By: Anne Maggisano

Ruth Bastedo is the Vice President, Senior Business Consultant at William Thomas Digital ([williamthomasdigital.com](http://williamthomasdigital.com)), an independent marketing agency purpose-built to deliver exceptional, tech-enabled customer experiences. A long-time volunteer on not-for-profit boards, Ruth is also the Chair of the Board of Hospice Toronto, an organization she became involved with after her father was diagnosed with a rare form of dementia.

A self-described member of the sandwich generation, Bastedo intimately understands the vital and difficult work of acting as a caregiver for a loved one. At the Minerva Summit, she sat down with Burgundy Vice President Anne Maggisano to share her experience of caring for her father during his progressive illness, building support networks, managing the cost of care and how to support a loved one without losing yourself in the process.

***Anne Maggisano: I'm going to start by asking you, Ruth, why did you say yes to speaking to our community today?***

**Ruth Bastedo:** I'm a big fan of Women in Burgundy. I think what you are doing here and what you have accomplished over the last 10-plus years is important—it's important that women have these conversations. My mother managed money professionally for 38 years. A lot of her clients were older women. So, I grew up seeing

her help women navigate all these various phases of their lives from a wealth-management lens.

I had a grandmother who passed away at 102 and a great-aunt who passed away at 103. So, while my father was ill, my mother was still managing the care of her great-aunt. This is the sandwich-generation model—I represent the Gen X version, but with these long lifespans, we could be caring for elders going into our 70s and



**Left to right:** Dr. Jean Marmoreo, Anne Maggisano and Ruth Bastedo at Minerva Summit

80s. This impacts your ability to manage your wealth and resources, but also your ability to manage your career, your kids, and the rest of it. That's why I'm here. We've got to talk about this stuff.

**AM:** *You come from a strong legacy of women, and you're a champion for women yourself. How do you think about women in caregiving in the context of our increased longevity and the widening gap between our healthspan and our lifespan?*

**RB:** Well, I think it's still women who, whether we like it or not, are managing a large part of care. I'm not saying that care these days doesn't include all different parts of the family. This is truly a multi-generational exercise when it works at its best, but it still has a very potent impact on women's lives. When I became involved in Hospice Toronto, one of the things I became much more aware of is the impact of caregiving on women's lives in all kinds of different contexts. It can impact your employment, it can impact your ability to look after your own kids, it can impact your relationships within your family.

**AM:** *Let's talk about where your conviction came from around women in caregiving—it really started with your experience with your dad's illness. Can you paint a picture of what happened?*

**RB:** My father was diagnosed with Primary Progressive Aphasia—[the type of dementia that] Bruce Willis has. The diagnosis came just before COVID-19, giving us a bit of

time to get a handle on what we faced. We were fortunate to get a geriatrician and build some support around the medical aspects of his illness. We were made to understand early on that it was a progressive illness—these illnesses only go one way. As a family, we had to prepare. You get the information as you need it. There were four years where we were all very actively involved in his illness. He passed away in February of 2023.

**AM:** *And what would you say united your family during this time?*

**RB:** My father was a lawyer, so we were fortunate that he had documented his wishes from a very early phase. I found André Picard's fabulous book, *Neglected No More*, at our cottage recently. My father had gone through and annotated it. He was educating himself as we were all learning what his diagnosis would mean for our family.

We focused on aligning what he wanted and needed, with what we could realistically do—sometimes those are two different things. We kept figuring out that balance. My mother is an extremely competent and capable woman, but it was her partner, so she needed help and support. We really rallied the troops across the family and got engaged in community organizations. The Aphasia Institute was important. The Alzheimer's Society and Hospice Toronto proved amazing for me—both helped us with learning about our options for caregiver supports and how to support someone to have a good life, even with this awful diagnosis.

My father loved life—he loved to travel; he loved to read. As a family, we tried to maintain the spirit of those things he enjoyed. We took a road trip to Northern Ontario—my mother, my aunt, and myself. We figured a three-to-one ratio was probably about right. When something like this happens, it forces everyone to slow down and prioritize human connection. I'm proud of our family and how we came together.

**AM:** *As you think back on that period, there must have been some areas that were unexpected.*

**RB:** André Picard said, "If there is no strong-willed dedicated family member to navigate the complicated bureaucracy, elders often end up in institutional care by default, and that is especially true of those who live alone." What struck me about that statement, which was part of my experience, is the amount of effort it takes. The project-management aspect, being assertive, being on top of where you get your resources, and how you are going to implement private care to supplement public care. My mother stick-handled a lot of it, but I think we were all a pretty good team.

You may have [developed a system] that's working well, but then the disease or illness goes into a different phase and you have to do something totally different. Being able to evolve and have conversations with your family takes a big piece out of your life.

That's what was most surprising. By the end, we were all a little burnt out. Other

things took a hit, whether it was work, careers, kids, or other priorities. This is a bit of a surprise for people who are used to working and living in a high-performance situation; having a loved one with dementia in your life is a totally different experience than the business world. You must shift, and that took a while to get used to.

**AM:** *How would you suggest a family start planning for these kinds of conversations?*

**RB:** First, at least in our situation, was getting a level set on the situation: What is the illness? What is the true situation you're dealing with? Whether you're an older person or an adult child, somebody has to start this difficult, uncomfortable conversation about what is really going on. It could be anything from, "Oh, mom seems a little forgetful lately," to some big inciting incident like a fall. You can then activate the medical component.

Next is getting a handle as early as possible on what your loved one wants. How do they want to live out this phase of their life? Do they want to stay in their home? Are they open to some kind of hybrid situation? What are their end-of-life wishes? My father documented this in a living will, and that document was honestly invaluable. It outlined different things that provided guidance on that last part of his life. My mother has one now too. We are working on similar documents in my family.

Then you need a plan, and a community and resources to support that plan. I was part of the Women in Philanthropy for Providence for 10 years before caring for my father. I learn by getting engaged in things, which is why I got involved with Hospice Toronto. There are lots of different resources and options out there. Educating yourself before there is a crisis is key. You do not want to have a crisis and be doing that groundwork while you are making big serious decisions.

**AM:** *You're talking about having the tough conversations, and one topic that must come up has to do with money.*

**RB:** Money, yes. Getting old and being ill is expensive, particularly with illnesses like dementia, where you need a lot of care. We knew my father wanted to stay home as long as possible. He did until we just couldn't continue because there were medical issues we couldn't manage. What we ended up doing was going into a home-like retirement home. Temmy Latner, who does in-home hospice care, came in to support us for those last few weeks. It was a very peaceful experience, and we had our own private nursing and PSW support.

But putting all of that together and doing

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it over a long period of time is jaw droppingly expensive. It could easily be tens of thousands of dollars a month, particularly when you're in some of the private retirement homes in midtown Toronto. There are wonderful private resources in Toronto. We had excellent care. But you still have to manage it—it doesn't manage itself.

**AM:** *So, Ruth, what do you think gets in the way of planning?*

**RB:** These are not topics we like to talk about. Every family has their issues and blockages—whatever family dynamics you have in your family will be the same family dynamics you have during this crisis. That's

just how it is, right? The best you can do as a family is decide, "Okay, we're going to pretend to be functional, and we're going to put a stake in the ground. What would we do if we were a functional family to handle this crisis?" That is your guiding light.

We pulled it off, with my aunts and friends. I would be setting up Zoom calls with my dad's old friends from university. My brother, who's an artist, did beautiful paintings and photography sessions with him. He did the 24-hour acute care sessions. My other brother hung out with him. Everybody did their part. My husband and kids were great. But the lion's share of it, of course, fell to my mother.

**AM:** *In the desire to control and take care of everything, how can we keep in mind what matters most?*

**RB:** It's looking after yourself in all of this. If you burn out, are not able to function, and you're the one providing the support, then the whole thing falls apart. That one thing is, in many ways, one of the hardest things to do. Know when you need to take a time out; know when you need a break.

One of the things our geriatrician told me when my father was near the end was: "Watch out for your mom." What often happens is the spouse, in particular—but it could be another person—is so burnt out that they get sick afterwards. It is about finding that balance of having the right supports in place and taking care of your own mental health—and the mental health of those around you. Ask, "Do you need a break?" or "Is this good for you?" and being very conscientious about it.

A person who is gravely ill is a vortex. Everything is around that person, and it could go on for years. The needs of other people and yourself can get deprioritized. I'm just now starting to feel like my old self—a different version of my old self, but it has been a five-year chunk of time. It takes a while to come out of these experiences. But I feel we put everything out on the table for my dad, and I am very much at peace. **M**





# LONGEVITY & LEGACY

Financial planning for health, family, and wealth.

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By: Jessie Bobinski and Julia Chung

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With longer lifespans and evolving health-care needs reshaping personal financial decisions, it's essential to plan ahead. Burgundy's vice-president Jessie Bobinski sits down with financial-planning expert Julia Chung—co-founder of advice firm Spring Planning ([springplans.ca](https://springplans.ca)), and a specialist in personal finance, multi-generational wealth, and legacy planning—to discuss how to navigate these changes. Together, they cover essential topics, such as managing generational wealth, addressing caregiving expenses for both children and parents, optimizing tax strategies, and preparing for the unexpected—all while maintaining a comfortable present and a secure future.

***Jessie:** We know the world around us is changing. Today, we have up to five generations that can be alive at the same time. But I'm wondering if you can expand on some of the financial issues that you're most concerned with here as we go through our extending lifespans?*

**Julia Chung:** I think some of it is partly just not recognizing that the change is happening. We've got this massive change around personal financial and savings structures. For instance, when we go back to the late 1970s, early '80s, around 70 percent of working men generally had defined-benefit pension

plans in Canada; 30 to 35 percent of working women had them. Now everybody's sort of in the 30 percent to 35 percent range, meaning most of us are required to manage our own personal finances for the long term without the guarantees of employment pension plans. And we're now looking at much, much longer

lifespans to support. All of these things make the world very complex.

**JB:** *Roughly 22 percent of working-age adults are aged 55 to 64, which is a record high. And the 65-plus age group is now growing six times faster than children aged zero to 14. Why is this important?*

**JC:** Well, one of the things that we're thinking about here is how a lot of our financial structures were built. And a fair number of them, especially when we're looking at public services that support all of us in a variety of ways, were counting on having this larger group of working-age people paying taxes and supporting these systems, and this much smaller group of older people. And we've seen that flip the other way, where the younger working-age group is smaller than those who are nearing retirement age. The Canada Pension Plan and Old Age Security programs were built around expectations of retirement as early as age 60, with a normal retirement age expected to be 65 and then an expectation that a person would likely die by age 70. Everything was built for this old world, and we're in this new place.

**JB:** *While we are on this subject of the Canada Pension Plan and Old Age Security—how much, a ballpark figure, are we entitled to?*

**JC:** Currently, the maximum Canada Pension Plan at age 65 is about \$1,300 a month. The average person is getting between \$700 and \$800 a month. These payments, guaranteed for your lifetime, are impactful to your planning. Old Age Security is \$727 a month if you start at age 65, and is clawed back based on your income. Canada Pension Plan payments can be split for tax purposes with your spouse. It also has a disability component and great survivor benefits.

**JB:** *How do we even begin to start to plan for living longer and our futures when there is so much to plan for over the next handful of years?*

**JC:** It's really hard, because there are all these things we don't know. I remember at the start of the pandemic, journalists would

call me and they would say, "Okay, how are you doing this now that we don't know what the future holds?" And I said, "We do it the same way we always did, because I never knew."

But what we're working with is different. And what we're working with is more complex. We have so many different systems we're working with, including medical and family dynamics. It's very, very difficult.

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So, when we're thinking about the complex systems that we live in, the first place we've got to go to is the big picture. What are we trying to achieve? And all of our systems, are they working together? Are they integrated?

When we're under stress, and we're feeling panicked and anxious about things we don't know, we race towards action. Taking action feels better than slowing down, digging in, and saying, "I'm not taking action until I've created some plans." We need to focus on the process, not the outcome, because we've

never known what the future holds.

The personal relationships piece is very important—all the people who support you, whether they're in your family, whether it's your investment counsellor, your accountant, your lawyer, those relationships are meaningful. This is no longer a transactional world. Those are the people that we're going to rely on in our community as our systems change. And it's so important that we find a way to remain open and curious.

**JB:** *As investment professionals, we often have the clients we care for come to us with the hard numbers, and that's where we tend to focus our efforts on in terms of planning. But we are also recognizing and integrating more and more of those tough, vulnerable conversations around, "What about you? What about what you want in life?"*

**JC:** This is the deepest part of the conversations I have with most of my clients. A lot of people will come to me, and say, "I'm going to retire at age 65. I need X number of dollars per month. And I think I'm going to live exactly to the age of life expectancy, and I will have no problems between now and then. Could you just do the math?" And I can do the math, and it will be fundamentally wrong and not useful for you. The most important thing that we can start with is figuring out what's important to you. So, I say to people, "What kind of life do you want to have? What's going to be meaningful to you?"

What I want you to think about when you're designing your best life is to start by identifying who are the people in your life? What kinds of things are you doing? What makes you have a good life? What is joy for you? When you're having a good day, what does that look like? And I'm talking about the minutes of the hours of that day. What's bringing you joy? What does that look like now? What might that look like in the future? And for a lot of people, it's hard to think about all of this past next week, let alone five, 10 years from now. How about

## FINANCIAL PLANNING

40 years from now? It's really important to try to create those visions at those different points. I ask people to get really specific, because this helps with your finances.

**JB:** *How can I think about what the next 40 years look like? I can't get past thinking past tomorrow half the time.*

**JC:** If it's too hard to come up with the vision, then I flip it the other way and say, "Okay, so what are you scared about? What are the things that are freaking you out right now? Who do you worry about the most?" For lots of women, we have this thing that I like to call "bag lady syndrome." A lot of us, regardless of the amount of money and resources that might be available to us, are pretty confident that, someday, we will be financially insecure. We should probably talk about that. Generally, my experience

okay to have a vision that changes, because the world is changing around you. You don't have to be the one thing that's stuck. Do away with perfection and just keep trying to pay attention, keep reflecting, like, "This felt good for three years, and now I hate it." Or, "This felt great, it still feels great and I'm going to keep building on that." Plan to do things. Plan to try things out.

**JB:** *Where's a great place to start when we are ready to get into the nuts and bolts of the numbers?*

**JC:** I am lucky enough to work with lots of wonderful people who say, "Oh yeah, I'm fine financially now, what I really want to do is help my kids buy houses and send my grandchildren to post-secondary school. I want to give stuff away to people who I care about and causes that are meaningful

"Oh, but it costs so much more than just paying for it out of pocket would." But in 10, 20, 30 years from now, your health care will be a lot more expensive, and nobody will want to cover you. You are the youngest and healthiest you are ever going to be right now. So, please, if you can get insurance for anything, get it.

**JB:** *And that would include taking a look at critical illness, long-term, extended health care while you're your youngest, healthiest self?*

**JC:** Yes, even if it seems like it is not a good use of your money right now, the person you are when you're much older will be happy you did so.

Another point: Often, when it comes to the specifics of financial planning, and we're thinking about retirement income, there are

“When we are taking care of ourselves first, we want to make sure that the potential cost of elder care - even if we are not 100 percent sure - is something we're planning around.”

with women is that they're worried about everybody. So, who are we worried about specifically? And what sorts of things do we need to consider? And if you, or someone you love, experience incapacity, disability, or illness, who's going to make the decisions? Who's going to be there for you? Who are you going to be there for?

Remember, too, that your best life is iterative. Visions change with experience and time. For instance, you might say, "You know what? I always thought that I really liked camping. But I sure don't—that stuff's terrible."

**JB:** *After you bought all the gear.*

**JC:** Yeah, you're like, "Oh, my God, you mean I'm doing dishes in the woods? Why is this a good thing?" So, you find out what you don't like by trying it out, and you find out what you do like by trying it out. And it's

to me." I see this with lots of people, but I especially see this with women who tend to be very community-oriented. But before you do that, please, please take care of yourself first. I know that might seem counterintuitive to anything you've ever been taught in your life—you might think of yourself as someone who always helps and takes care of other people. But you cannot pour from an empty cup. You cannot help other people if you haven't helped yourself first.

After that, remember that, when you're younger, health-care costs are generally lower. I see a lot of people who are in their early 50s who might have some wonderful extended health-care plans. Then they get a few years older and maybe retire, and I say, "Hey, you had that extended health-care plan. Could you roll that over into an individual plan now that you're retired?" And lots of people say,

a lot of people who have planned retirement income around a two-person household, because, in Canada, we can often split our income when we're over 65 between two people. This is a wonderful tool. But the thing that most people forget is that not many spouses die at exactly the same time. For a lot of women, we are going to have a period of time that I like to call our "Golden Girls era," and hopefully we will have as good a time as the ladies in the *Golden Girls* show. But that may mean we're not sharing our tax return with someone. And if our entire retirement income plan is based on the idea that we will split income with someone, when that spouse dies—and I've seen this a lot—the surviving spouse, usually the woman, now has to take out much more money out of her portfolio to maintain their lifestyle because there's only one tax return.





### Top to bottom:

Kate Mostowyk and  
Mirjana Vladusic,  
Mathew Harrison,  
Jessie Bobinski  
and Julia Chung at  
Minerva Summit



**JB:** *And that too, just to digress a little bit, comes down to when and how much you take out of your RRIF, your RRSP and when you convert that over to drawing retirement income. Is it better to do so when you have somebody in the home you can income-split with versus leaving it to blossom and grow when you draw later in life and end up paying more tax as a single person?*

**JC:** As we know, elder care is very expensive and harder and harder to come by. It is getting costly, it is really hard to plan for, and it is tough to think about. So, when we are taking care of ourselves first, we want to make sure that the potential cost of elder care—even if we’re not 100 percent sure—is something we’re planning around. It’s really important to tackle that, not only from a purely financial planning, “how much money do I need” perspective, but also to understand who is going to be there for you. Imagine it’s like Murphy’s Law—if you put a lot of time, energy, and money into it, maybe nothing will happen; maybe the worst thing that will happen is that you’ll die with a bunch of money.

**JB:** *A few guiding principles thus far: Start to plan early—the younger you are, obviously, you have the compounding of wealth over time, but the insurance factor comes into play. Take care of yourself first. Be mindful of tax implications when you’re doing your planning today. And, of course, remember that the process of creating your best life is iterative, and it will change over time. Now what about when you’re planning for others?*

**JC:** It’s a good question. You’ll want to think about each group of people—and each individual—that you want to care for, and think about what that bare minimum looks like. So, you might say, “At bare minimum, I want to make sure that Johnny goes to college, or that Sally gets to travel around Europe, and we think it’s going to cost a certain amount.” Or, “I definitely want to make sure that I’m giving \$10,000 to my community foundation.” After we’ve done the planning for you, we can start thinking about what you can reasonably afford in the balance of your plan.

But before we do that, there’s an important question we need to ask: “Do they even want that?” This is a problem that I see fairly often, which is, “I know my family. I know my people. It’s fine. Sally’s going to want the business and Johnny’s going to want the house.” And then somebody dies, or the gift is made, and everybody gets mad, the whole family blows up, and this is not what anybody imagined. And it’s not because someone is greedy, but because we didn’t ask people what they wanted and what was meaningful to them. I’m a big proponent of family meetings, which is a place where you can talk about fun things, like where you’re going to spend your holidays, and not-so-fun things, like, “Hey, guys, if I can’t think for myself, here are the things I want you to do.” It’s amazing how often people are surprised by all those conversations. If you build a forum into your family system where, at least once a year, there’s just a conversation about things that are important—no matter how big your family is, no matter how old your kids are—then you can create a system of communication that lasts for generations. **M**

# EXPLAINING POWERS *of* ATTORNEY

Exploring what you need to know about one of the most critical—yet often overlooked—aspects of estate planning.



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First, a disclaimer: substitute decision-making and powers of attorney (POA) are governed by the provinces. As an Ontario-qualified lawyer, the text below is from the Ontario perspective. While these concepts share similarities across Canada, it is important to note that the laws and procedures governing POAs differ by province and territory. The intention is not to provide specific legal advice but rather to encourage thoughtful consideration of POAs and to prompt informed discussions with your legal counsel.

In Ontario, POAs are structured as two separate documents, each addressing a specific area of decision-making. Historically, a single document could encompass both property and personal care, but this is no longer the case. We will begin by discussing POAs for property before addressing POAs for personal care.

## POWERS OF ATTORNEY FOR PROPERTY

The power of attorney (POA) for property grants the designated “attorney” authority to manage your financial affairs, including bank accounts, real estate, securities, and shares in private companies. The attorney can act on your behalf in all matters related to your assets, except for altering your will. (In this context, “attorney” does not mean lawyer; it refers to the individual you appoint to act on your behalf.) While you can place restrictions on the POA, it provides full authority by default unless otherwise specified.

Everyone over the age of 18 should have a POA for property. If you have financial assets—such as a bank account, real estate, or investments—and become incapacitated due to a coma, cognitive decline, or a brain injury, someone does not automatically

have the authority to make financial decisions on your behalf. This means a parent is not automatically able to make financial decisions for an adult child who has had a brain injury, nor are spouses able to automatically make such decisions for one another if and when one has dementia, for example. In such cases, someone would need to seek a court-appointed guardian to manage your affairs, which is a costly process that is time-consuming and lacks privacy.

### When Powers of Attorney for Property Take Effect

A POA for property can be “springing” or “non-springing.” A non-springing POA becomes active as soon as it is signed, even if it is not immediately used. In contrast, a springing POA activates only at a specified time or upon the occurrence of a specific event, typically when the grantor loses capacity. Most people prefer non-springing POAs, as they remain technically active in the background without requiring additional steps when really needed. Springing POAs, on the other hand, often use incapacity as a trigger and require some sort of a test to be met to confirm that the grantor lacks capacity, which can introduce complications during an already stressful time.

Determining capacity is not always straightforward. Many POAs require the attorney for property to first obtain two doctors' letters, but many doctors are not specifically trained to assess capacity to manage financial affairs, and their evaluations can be inconsistent or subjective. Increasingly, doctors are reluctant to provide such letters, further complicating the process.

### What the POA for Property Document Covers

POAs can be simple and grant the attorney the authority to handle all financial matters. Or they can be detailed and set out what the attorney can and cannot do. A detailed POA allows you to specify the extent of your attorney's powers. For instance, should they be allowed to engage in last-minute probate fee and/or income tax planning, or make gifts or loans on your behalf to family, friends, or charities? Are there restrictions you would like to impose? Should they have the ability to delegate their responsibilities?

If you own or manage a business, additional considerations arise. Do you want your attorney to have the authority to appoint themselves as a director of your company, or would that create a conflict of interest? Alternatively, would it be better to appoint a separate attorney to handle specific assets, such as a private business?

A detailed POA offers several advantages. It provides clarity to the grantor regarding the powers being assigned, ensures financial institutions can verify the attorney's authority more easily, and minimizes the potential for future disputes among family members or other interested parties.

Additionally, if you have assets outside Ontario—such as property in Florida or Quebec—you may require separate POAs that comply with the laws of those jurisdictions. Without proper planning, managing assets across regions can become complex, challenging, and costly.

### Choosing your Attorney for Property

When selecting an attorney for property, you can choose one or more individuals, such as family members, friends, trusted advisors, or professionals. You may also appoint an entity, like a trust company. If you select multiple individuals, you can structure the



## LEGAL



**Right:** Lucy Main, at Minerva Summit.

**Top to bottom:** Meghan Moore and Lucy Main; Sarah MacNicol; Burgundy Chief Investment Officer Anne-Mette de Place Filippini and Yeugenia Kazantseva at Minerva Summit



arrangement in different ways:

- **Joint appointment:** Attorneys must act together and agree on all decisions.
- **Joint and several appointment:** Attorneys can act independently of one another.

If you do not specify, decisions will automatically require unanimous agreement.

Choosing an attorney for property is much like hiring for a job—it depends on the individual's skills, experience, and their ability to handle the specific “job” of managing your assets. One of the most critical qualities is their ability to collaborate with professionals. Can they effectively communicate with your accountant, financial advisor, or lawyer? If so, they are likely equipped for the role.

How many attorneys should you appoint? If, for example, you have three children, should you name all of them? While this may seem fair and equitable, the individuals must be able to cooperate effectively. Factors like family dynamics, the complexity of your financial affairs, differing opinions, and logistical challenges (such as locations or time zones) can create complications. Appointing multiple attorneys can lead to conflict if they are unable to work together.

It is important to remember that while being chosen as an attorney is an honor, it can also be a demanding and time-intensive role that carries significant responsibility. For this reason, prioritize selecting the right person(s) based on their capabilities and suitability for the role, rather than out of concern for hurt feelings.

### POWERS OF ATTORNEY FOR PERSONAL CARE

The POA for personal care differs from the POA for property in two



significant ways. First, it has no connection to financial matters; instead, it governs decisions related to health care, welfare, medical treatment, and end-of-life treatment. Second, it only takes effect when you are no longer capable of making such decisions for yourself.

In Ontario, the absence of a POA for personal care is handled differently from the absence of a POA for property. Provincial legislation provides a default hierarchy of individuals who can make decisions in your best interests. While this backup system ensures someone will step in if needed, most people prefer to retain control by choosing who will act on their behalf. Having a POA for personal care also allows you to provide clear instructions and guidance on your specific wishes, ensuring your preferences are respected.

### Determining Capacity for Personal Care POA

The POA for personal care takes effect only when you are no longer able to make personal health-care decisions for yourself. This involves a legal test to determine incapacity, which often requires input from doctors. A doctor may need to make a statement,

such as, “I can no longer take instructions from your mother because she does not understand the nature of the question or its implications.”

### Selecting Attorneys for Personal Care

Your attorneys for personal care can be the same or different from those appointed for property, and it is not uncommon for people to choose different individuals for each role, given that they cover distinct areas of responsibility and require different skills. For example, you might select a financially savvy, type-A personality for the POA for property, and someone more empathetic and patient for the POA for personal care.

When choosing an attorney for personal care, it is essential that they share your values and approach to decision-making. Consider potential differences in perspectives, including religious beliefs, personal biases, or life experiences, that could impact how they interpret and apply your wishes.

If you appoint different individuals for the two roles, it is also important to think about how they will interact and work together. Your attorney for property, who manages your finances, must respect the financial needs communicated by your attorney for personal care. The latter will be acting in alignment with your wishes, which could involve significant financial costs, and it is crucial that both attorneys cooperate to ensure your desires are honored.

### Wishes

You may be familiar with letters of wishes or advance care directives. While these instructions can sometimes be communicated verbally, best practice is to provide a formal letter or document. This letter can be separate from your POA for personal care or included within it—both options work.

These wishes and directives may include preferences such as staying at home for as long as possible, even if it involves additional costs; requesting no artificial life support if there is no hope of recovery; or maintaining

specific grooming standards, such as routine haircuts, manicures, and dental cleanings, all tailored to your personal preferences.

### BEST PRACTICES WHEN ACTING AS AN ATTORNEY

As you can imagine, serving as an attorney for property or personal care is a significant responsibility and it also carries substantial risks. Best practices for fulfilling this role include meticulous record-keeping (particularly for the POA for property), seeking guidance from professional advisors, and consulting with a lawyer if you have any concerns or questions about your responsibilities or the best course of action.

If you accept the role, it is important to be well-prepared, comfortable, and fully informed about the grantor's circumstances and wishes. Unfortunately, conflicts can arise within families, particularly when it comes to how an attorney manages the grantor's finances. This can become especially contentious when the estate is settled, and estate beneficiaries are disappointed with how the deceased's finances were handled in the years leading up to their death. To protect yourself and minimize potential disputes, it is essential to document every decision and seek professional assistance when needed.

In conclusion, establishing a POA for both property and personal care is crucial for ensuring your wishes are respected and your affairs are managed appropriately if you become incapacitated. While the laws vary by province, understanding the roles, responsibilities, and potential complications associated with POAs is essential for effective planning. Whether you are the grantor or the attorney, being well-informed, selecting the right individuals for the role, and seeking professional guidance can help mitigate risks and conflicts down the road. Ultimately, thoughtful consideration and proper documentation can provide peace of mind for both you and your loved ones. **M**





# THE ELEPHANT *in the* ROOM

Long-term care planning makes for a difficult—yet essential—conversation. Expert Karen Henderson offers advice on how to approach the issue.

Nearly half of Canadians will require some form of long-term care after age 75, making it an issue that deserves our attention. During her workshop at last fall's Minerva Summit, long-term-care expert Karen Henderson—founder of the Long Term Care Planning Network ([ltcplanningnetwork.com](http://ltcplanningnetwork.com)) and a respected speaker, educator, and consultant with over 25 years of experience—provided insight into the planning process, from asking the right questions to finding the best resources. Kate Mostowyk, Vice President, Investment Counsellor for Burgundy's Private Client Team, recaps Henderson's must-know advice.



As we age, many of us tell ourselves we won't need long-term care. What we're really saying is that we don't know enough about it or can't imagine ourselves needing such support. The truth is, long-term care isn't just about nursing homes—it's about the entire journey we take through the health-care system as we age and need more support. Ahead, we'll explore the full spectrum of care options available to us, from aging at home to end-of-life care. We'll look at the costs involved, what government support you can expect, and the critical factors that influence our care decisions.

### The Long-Term Care Continuum

Long-term care encompasses the essential support services that help maintain our quality of life when dealing with chronic

facilities. These privately owned establishments can offer a luxurious lifestyle with readily available access to support services. However, the initial monthly rent—ranging from \$4,000 to over \$12,000—typically includes minimal care. Additional care packages come at extra cost, and unlike some other health-care services, retirement homes typically receive no government subsidies. The entire cost comes from the resident's own resources.

The next stage in the journey is long-term care, a nursing home, or memory care. While ownership varies between for-profit companies, non-profits, and municipalities, all must provide 24/7 care under provincial legislation. The financial structure here differs: the government covers food and care costs, while residents pay only for accom-

those who do manage to spend their final days at home, only about 15 percent have access to fully integrated palliative-care services, though these are typically covered by provincial funding.

### Government Support and Limitations

Understanding government support for aging and health care can be confusing, but it's crucial for planning purposes. The *Canada Health Act* mandates certain coverage, while other support varies significantly across provinces.

The foundation of our health-care system rests on the *Canada Health Act*, which requires provinces to subsidize medically necessary physician care, hospital care, and diagnostics. Beyond these basics, governments provide:

“The truth is, long-term care isn't just about nursing homes—it's about the entire journey we take through the health-care system as we age and need more support.”

illness, disability, or cognitive impairments. This includes help with daily activities like bathing, eating, dressing, and moving around. While it doesn't cure conditions, it helps us live as well as possible until the end of our days.

Our journey typically begins at home, where most of us want to stay. It's familiar, it's safe, and it's where we feel most comfortable. However, the reality of aging at home often comes with a stark financial revelation: provincial governments provide limited subsidized care, forcing many to pay for private alternatives. Home-care costs range from \$30 to \$80 per hour, adding up to about \$35,000 annually for just a few extra hours of private pay daily support. Full-time care can exceed \$100,000 per year.

When home care becomes insufficient, many consider retirement or assisted-living

modation (\$2,000 to \$3,000+ monthly in 2024 depending on the province). However, accessing these facilities can be a significant challenge. Every province maintains a waiting list, with Ontario facing the most severe shortage of space—approximately 40,000 people currently await placement. Many could remain in their homes if sufficient provincially subsidized home care was available. Instead, they find themselves forced onto waiting lists for institutional care they'd prefer to avoid.

The final stage is palliative or end-of-life care. At its best, this integrated approach provides comprehensive support for both the dying person and their family, managing pain and symptoms while providing emotional support. While many express a preference to die at home, the reality is that most deaths occur in hospitals. Of

- Food and care costs in long-term care homes
- Limited home-care hours
- Some physiotherapy services
- Comprehensive long-term care for veterans through federal programs
- A new national dental-care program for those under 18 and over 65, though with strict criteria and limited participating dentists
- The emerging National PharmaCare program, currently covering diabetes and contraception drugs

### What's Partially Covered or Missing:

Long-term care itself falls outside the *Canada Health Act*, which explains several significant gaps in coverage:

- Retirement living receives almost no government support, with British

## LONG-TERM CARE

Columbia being the only province offering limited aid for assisted living

- Prescription drug coverage varies by province, with each maintaining its own formulary of subsidized medications. Many expensive drugs remain uncovered
- Optometry services face continued provincial cutbacks
- Caregiver support is minimal; only Nova Scotia offers direct compensation for those who leave work to care for family members
- Home-care hours are limited, forcing many to pay privately for additional support

### Critical Factors in Long-Term Care Planning

While most of us hope to age in our own homes and communities, successful planning requires honest assessment of whether our homes are truly suitable for aging. Two critical factors often force unexpected changes in our aging journey: falls and social isolation.

Falls, a leading cause of hospitalization and transition to long-term care, represent one of the most underestimated risks of aging at home. They happen in an instant, yet can permanently alter our lives. One in three people over 65 will experience a fall, though many keep it to themselves—a dangerous choice that prevents them from accessing vital fall-prevention programs. By age 90, falls become nearly universal, costing our health-care system over \$15 million daily. Despite these sobering statistics, many dismiss the risk with thoughts like, “It won’t happen to me,” or “I’ll just pick myself up and keep going.”

Equally concerning is the impact of loneliness and social isolation. Research has shown that lonely seniors face a 59 percent higher risk of physical decline and a 64 percent increased risk of developing dementia. The evidence is clear: Social connection isn’t just about quality of life,

it’s a fundamental health concern.

The time to start planning is now, before health issues arise. For families discussing parents’ care needs, consider the 40/70 rule: When children are around 40 and parents around 70, it’s time to start the conver-

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**The most important question remains personal: Can you afford the lifestyle that will make you happiest as you age?**

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sation. While these discussions may take months or even years, it’s never too late to begin planning.

Several factors can indicate a future need for long-term care. Age is the most obvious, with women facing higher risk due to longer life expectancy. Other risk factors include existing disabilities, single status, lifestyle choices, current health conditions, family

health history, and mobility issues. Even couples who currently support each other must consider that the surviving spouse may eventually need additional care.

When evaluating whether to remain in your home, ask yourself some crucial questions: Do you have adequate support systems in place? Can your home be adapted with a main-floor bedroom, bathroom, and laundry room to minimize stair use? Are you located near essential services, like transportation, medical care, and pharmacies? Can you maintain social connections? And, perhaps most importantly, can you afford the home care you’ll likely need?

### Additional Considerations for Long-Term Care Planning

While many people, particularly those in their 50s who are healthy and active, believe they can postpone planning for long-term care, two critical factors make early planning essential.

First is the rising prevalence of Alzheimer’s disease. Currently, over 700,000 Canadians live with some form of dementia, with more than 350 new diagnoses daily. Women represent 60 percent of cases, largely due to their longer life expectancy. While Alzheimer’s typically affects those over 65, early -onset cases can occur in people as young as their 30s. Though there’s no known cure, research published in *The Lancet* suggests that nearly half of all dementia cases could be prevented or delayed by addressing modifiable risk factors. These include hearing loss, social isolation, and various lifestyle factors. Simple interventions, from wearing hearing aids to maintaining social connections and pursuing lifelong education to build cognitive reserve, can significantly impact risk reduction.

The second consideration is end-of-life planning, including the possibility of medical assistance in dying (MAiD). Since its legalization in 2016, over 31,600 Canadians have accessed MAiD, with the average age being 76. Eligibility criteria include being

## LONG-TERM CARE



seriously ill, suffering significantly, and making the decision voluntarily after receiving comprehensive information about treatment options, including palliative care. The most common conditions leading to MAiD requests are cancer, neurodegenerative diseases like ALS, and severe lung diseases. Recent changes in Quebec now allow advance requests for MAiD through power of attorney documentation, a significant development that may influence policies across Canada.

These complex considerations underscore why early planning is crucial. Working with health-care and legal professionals can help navigate these decisions, but the most important question remains personal: Can you afford the lifestyle that will make you happiest as you age? After all, maintaining quality of life throughout our final years is the ultimate goal of all this planning.

### Taking Control of Your Future

While there's no one-size-fits-all approach to long-term care planning, taking action now can help ensure a better future. Start by understanding how the continuum of care works in your province. Exercise, eat well—stay as healthy as possible to avoid hospitalizations, which pose particular risks for older adults.

Being proactive means more than just maintaining health. Keep your home safe, understand potential health challenges you may face, and, most importantly, communicate your wishes clearly to family, professional advisors, and medical teams. No one should have to guess what you want as you age. Organize your legal documents and important information in one accessible location, and don't delay making decisions about future accommodation.

Resources are available to help you navigate this journey. The Alzheimer's Society of Canada offers comprehensive information, including the LANDMARK Study (as written here: <https://alzheimer.ca/en/research/reports-dementia/landmark-study-report-1-path-forward>) and brain health assessments. For understanding care options, particularly around dementia, the Advanced Directive for Dementia provides valuable educational guidance. Review the resources that are available through your provincial healthcare system and local hospitals.

Remember, the key to aging well isn't just about having a plan—it's about taking action while you still can. Start today, keep moving, and take control of your future care journey. **M**



**Top:** Karen Henderson

**Bottom:** Kate Mostowyk and Karen Henderson at Minerva Summit





# HEART OF THE MATTER

How do you see the last days of your life?  
Leading end-of-life care expert Dr. Jean Marmoreo on the purpose and  
advocacy that goes into making truly informed decisions.

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By: Jacoline Loewen

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Dr. Jean Marmoreo is a pioneering doctor in Medical Assistance in Dying (MAiD) whose work also spans mid-life and end-of-life medicine ([dr-jean.com](http://dr-jean.com)). She co-authored the book, *The Last Doctor: Lessons in Living from the Front Lines of Medical Assistance in Dying*. In conversation with Jacoline Loewen, Burgundy's Director of High Net-Worth Relationships, she delves into Canada's world-leading efforts in MAiD, how end-of-life care differs for men and women, what women need to know to make informed decisions about their health care, and how they and their loved ones can advocate for their needs.

**Jacoline Loewen:** *You are one of the first doctors in Canada to practice MAiD. Tell us about where we are with it in Canada.*

**Dr. Jean Marmoreo:** Canada has set the model for the world on how to do MAiD well—not because we invented it, but because we’ve followed the lead of countries that came before us and adapted the program for a nation of over 40 million people. We have a bigger population, more diversity. We are spread out with more remote areas, and we have complex issues regarding accessibility and service in Canada. Despite these challenges, we’ve managed to put together a model of care at the end of life that gives people a choice in how they end their life. This is a model we can be truly proud of.

Only 5 percent of the population, at best, will ever opt for MAiD. It relates to hope, values, and how people pursue their lives and goals. The other 95 percent of the population will need end-of-life planning, including identifying available resources, determining what to access, making financial plans, and communicating your wishes to your family, friends, or community.

**JL:** *Dr. Peter Attia, the Canadian doctor who co-wrote the book *Outlive*, has research that shows 90 percent of people want to die at home, but 80 percent die in a hospital, hospice, or care home. What’s more, 80 percent of men die married or with a caregiver/spouse, while 80 percent of women die alone. We need to pay attention to this as women and think about financial considerations and providing for ourselves. Do you find a difference regarding MAiD for men vs. women, and the decision-making around it?*

**JM:** Two-thirds of people choose MAiD because of cancer, which falls under Track One: your death is foreseeable. In that Track One population, progression typically goes from cancer diagnosis to cardiovascular diagnosis, followed by respiratory, kidney, and, lastly, neurological deficits. Currently, the average age for Track One patients is about 77 years.

However, the older you get, the more likely you will encounter women who are 94 or older. Their request for assisted death comes from a range of deficits and decline in managing their activities of daily living. They have more comorbidities, conditions that affect us all as we age. So heart, kidney and lung conditions, along with arthritis and chronic pain. For many of these women, it is more the loss of independence in their

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Despite these challenges, we’ve managed to put together a model of care at the end of life that gives people a choice.”

daily life, the quality of life they are living. They have lost friends and family; they are more isolated.

COVID-19 underscored that isolation for people living alone or in long-term care homes. The forced isolation devastated elders in terms of what makes their life worth living. They lost engagement, being able to eat meals together. What happened in long-term care homes underscored the value of having a community, whether it’s a community in your home, a community of your friends, or a community of people who are just around you. This is what gives

value to living. People do not do well living in isolation.

When you look at a 94-year-old and she says, “I’m done. I want to go. I’ve had a good life. I’ve had a rich life. I’m alone now. My family’s dispersed all over the world. I don’t have the purpose I had before and I’m tired”—tired becomes a big part of it. It’s not cancer, it’s not heart failure. They are tired of living because they have lost quality in terms of what their past was and what they’ve valued. They haven’t got the energy to push anymore. That’s what you see in older women that you may not see in older men, because older men often don’t reach this stage.

**JL:** *Let’s talk about developing your own unique playbook. The number one thing is to start by having a plan.*

**JM:** It’s challenging to persuade somebody who’s anchored in their family home to think about moving into assisted living or a different community of care. We’re starting to rethink what housing for a community of aged people should look like—today, for many, the only options are retirement homes and long-term care nursing homes.

Long-term care homes received a bad rap during COVID because 95 percent of the deaths in the first months happened there. What didn’t get talked about is that the publicly funded long-term care homes performed better than the private homes in early COVID. The reason they did better was because they had a stable care-provider population. They didn’t have workers going to three or four different homes, being paid minimum wage, and lacking a good pension plan.

When the provincial government did their study and said, “This is dreadful. We need to make sure that everybody in a long-term care home gets 3.5 hours of personal care per day as a standard,” the publicly funded long-term care homes were already doing 3.8 hours. They were already ahead of the mark in what personal-care service should be. What does that mean? It means some-

## END-OF-LIFE CARE

body helps you get dressed. Somebody makes sure you've got lunch in front of you, and if you need your food cut up, it will be done. They make sure you've got a spoon when you can't handle a fork. They make sure your glass won't tip over and spill water on you. These are activities of daily living and personal support work that nobody talks about.

**JL:** *A necessary part of planning is choosing the right advocate. My mother would like to have MAiD, and I told her, "I cannot help you here. You need to get someone else to advocate for you." You must be honest about these things. Now one of my sons has been assigned her power of attorney for care. I feel the advocate should not be a family member*

bility to be approved. This process requires two clinicians who are not related in any way to each other in a reporting capacity, and they cannot benefit from your estate. You cannot have any financial arrangement. It requires only one witness, and there is no waiting period for a Track One patient to have an assisted death. But it does require, in terms of my assessment, that I do not sense coercion. If I sense there is any pressure on you to proceed with this because the family is going to suffer—for example, if you continue costing them a quarter of a million dollars a year in your care—you will not be eligible.

**JL:** *Let's discuss the hospital readiness kit. You have that big red envelope, and it's got your power of attorney for care,*

People do not have a choice at this point. The person receiving you at the hospital has a duty of care to resuscitate. And they will do that unless someone in the family arrives to say, "Wait a minute, hold it. Dad doesn't want resuscitation. I am the daughter, and I have the power of attorney of care for my father." But if you say, "I'm the friend next door," you will not have that choice.

So, it becomes important for people to say, "I am 92 and I do not want to be resuscitated." Today, when you tell your family doctor or nurse provider, "I want a DNR put in place for me," it is a processed document and sent to the fire chief and emergency medical services; it's now an online document. When they get a call for help, they can pull the record up and

“It's me who has to be willing to say, “I need to talk about this, and I'd like to talk about it with the whole family so that we're all on the same page about my wishes.”

*who is going to benefit from your wealth. There's a conflict there.*

**JM:** With MAiD, you can't just dial a death. You must meet eligibility criteria: You must have a serious disease, illness, or disability; it must be causing grievous and irremediable suffering; you must have discussed options available to help ameliorate or ease you through the pain; and you must decline those options, saying, "That is not acceptable to me."

I can't put a suffering monitor on you and say, "You don't meet the criteria because you're only at 65 percent of suffering." If it's grievous and irremediable to you, it's grievous and irremediable. Nobody questions that. The coroner doesn't question that. I don't question that as a doctor. It's you who is suffering, not me.

You must go through the criteria of eligi-

*your medical history. What else do you think should be in there? And where should people keep it?*

**JM:** People who end up in hospital don't have instructions strapped to them that say, "Don't resuscitate me." People say to me, "I've named a power of attorney for care, and they know that I do not want to be intubated." I say, "That's fine, except when first responders arrive at two in the morning."

The duty of care is profound. First responders do not make these decisions. They must take you to a hospital. At the hospital the first thing they do is ask, "Who's their power of attorney? Where do we find that? Is it in their wallet?" They have been brought in at two in the morning, they're unresponsive and in their pajamas. Often, it's not clear who has the power of attorney, or if they have a health card with them.

say, "There's a DNR here." Then the first responders coming through the door know that Joe or Mary has, in fact, effectively documented a DNR order.

**JL:** *The next step in the playbook is communication. You always talk about having that family dinner conversation.*

**JM:** It's always a wonderful opener: "Hello, let's talk about dying." It isn't an easy conversation and there's never a right moment.

What I do is remind myself that it is about me. This means it's me who needs to initiate the conversation. I'm the one who has to tell the kids, "Look, we need to talk about this because it matters to me. Maybe you don't want to hear it, but I have to take this opportunity." In the end, it's me who has to be willing to say, "I need to talk about this, and I'd like to talk about it



with the whole family so that we're all on the same page about my wishes. Because what you think is best for me might not be the same as what I want for me."

**JL:** *Let's consider the final moments: the last day, the last words, the last doctor. I'd like to end the conversation in a positive way: You have a knapsack story that's a useful way to think about how to make that last day beautiful.*

**JM:** I had gone deep into MAiD, taking on incredibly difficult scenarios and cases. I was recognizing too late that to take a life is to increase your own moral burden. No matter what you do, if you take a life, there is a cost to the person doing it. The clinicians and nurse practitioners across Canada who take on this work do it with tremendous dedication and pride, and tremendous expectation of the highest quality of service you can give.

I was at a MAiD conference, and we were presented with the question: "What does it cost to do this?" The speaker used a knapsack, and I rolled my eyes like, "Oh no, here we go again with this knapsack story about all the little things in your knapsack that you need to pull out to help you." She started with a broken shell from her son. Then she said, "I'm just going to keep throwing these grenades at you about what it costs you to do this work." Every time she threw out another grenade, I gulped. At the end, when I went up to talk to her, I could not speak. I ran out.

I got home and realized after a few weeks that I had started to withdraw. I wasn't answering the phone so quickly or engaging much. And then it dawned on me—I was the queen of backpacks. I had hiked 1,000 miles of the Appalachian Trail. I knew about backpacks. I knew about carrying your whole house on your back. I knew what it was to carry a burden and be supported.

A knapsack is your resource, it's your kit, it's what gives you comfort, what provides affirmation and power, and what lets you sink back into your values. I began to create my own knapsack of what I needed for my soul, what I needed to keep me going.

I'm a woodworker, and I will spend hours trying to create a perfect bowl with a perfect lid. If it doesn't work, I keep working at it. So I have this lovely imperfect half bowl that I carry with me.

I've been in a psychedelic psychotherapy course where a participant, a social worker, said, "I carry crystals in my pocket because crystals remind me of the joy and value and meaning of life." All of these physical things that you pull together affirm your value and what matters to you. Knowing what that is and carrying that with you—that is the backpack story. We all can utilize a self-mastered backpack—for comfort, for affirmation, for reassurance about values, purpose and commitment. **M**



**Top to bottom:** Jacoline Loewen & Dr. Jean Marmoreo; Dr. Jean Marmoreo; Lisa Ritchie, Vice President Emeritus and past Co-Head, Women of Burgundy, at Minerva Summit.



# CLOSING THE GAP *with* PHILANTHROPY

By: Angela Bhutani

How giving—and community—can lead to meaningful change in health care.

In this inspiring conversation, Angela Bhutani, Vice President, Investment Counsellor for Burgundy's Private Client Team, sits down with remarkable women from key Canadian organizations focused on mental health and social services, and the philanthropists who have partnered with them to support their missions. Deborah Gillis, President and CEO

of the CAMH Foundation ([camh.ca](http://camh.ca)), Teresa Vasilopoulos, Executive Director of the WoodGreen Foundation ([woodgreen.org](http://woodgreen.org)), and philanthropists Juliana Sprott and Sandi Treliving share moving and empowering examples of how to drive meaningful change by leveraging time, resources, and networks, ultimately revealing how each of us can make a lasting impact.



**Angela Bhutani:** *Charitable organizations and philanthropists are playing a crucial role in addressing the healthspan-lifespan gap. They step in when government alone cannot bridge these gaps. Teresa, please describe WoodGreen and its work.*

**Teresa Vasilopoulos:** WoodGreen is the largest social service agency in Toronto, serving the community for 87 years. We support people who find themselves unhoused, unsupported, or unfed. In terms of senior care, WoodGreen Community Services has been front and centre. We help when you are in the hospital as an elderly person and have to be discharged home but might have more complex needs than when you entered. We send in Personal Support Workers (PSWs) and provide that home care.

**AB:** *Deborah, please tell us about CAMH.*

**Deborah Gillis:** CAMH, the Centre for Addiction and Mental Health, is the largest mental health care hospital in Canada, and has a mandate and focus on education, research, and advocacy. The hospital sees over 40,000 patients a year. Our emergency department, one of the only 24/7/365 emergency departments for mental health in the country, sees about 16,000 patients a year. The hospital also provides treatment and conducts research for patients ranging from young people to older adults experiencing mental health challenges.

**AB:** *Sandi, the strongest partnerships between donors and organizations they support normally stem from a personal story. What initiated your involvement and support of CAMH?*

**Sandi Treliving:** My brother, 10 years older than I, developed psychosis and schizophrenia. His whole life was about managing his wellness as best he could in the '70's, when there was no support for persons with lived experience and certainly nothing for the family. We have come a long, long way. But my heart is in the

cause of mental health.

**AB:** *And it is a family affair. Both you and your husband, Jim, support CAMH, but at a certain point in 2020, your personal involvement really deepened through your help in launching an initiative called womenmind™. Describe*

“  
Being open,  
putting  
your name  
on things,  
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about your  
support  
has an  
incredible  
impact on  
people's  
lives.”

*what that initiative is about.*

**ST:** womenmind™ came about for a couple of reasons. I was doing extra work with the board because I am also co-chairing the current \$500 million campaign, No One Left Behind, which will be build-

ing the new Temerty Discovery Centre [research tower] on the CAMH campus—an incredible, game-changing advancement for mental health. Deborah pulled me aside with some other board members. She has had a career in gender equality work, and asked the VP of research to get some data about how many research studies are focused specifically on women's mental health, and how we're supporting careers for women in research. Even though 40 percent of our scientists are women, we learned that they are not getting the funding, mentorship, or leadership they need to advance their work and careers.

After we had this conversation, I kept it in the back of my head. I was also thinking, “It's time for us to do another gift.” However, the first gift felt too much about me, about my husband, and it wasn't inclusive of family and our values regarding how we view the importance of money, causes, and bonding together. I pitched my husband on an idea: “What if it's not actually a gift from you and me, but rather a gift from the Treliving women, and we give to women's mental health?” He responded, “Oh, love it, love it. Go back, talk to the girls. If we get buy-in, let's do it.” And that's how it started.

womenmind™ is a community. We weren't sure what that was going to look like, so that took the collaboration of the CAMH Foundation, the hospital, and the researchers coming together and saying, “Okay, what does success look like?”

We decided we were going to create a giving circle. We wanted to include more families, individuals, women, and men who were interested in supporting the cause. And we distribute funds through leadership programs, seed grants, post-docs, and mentoring programs—all to bolster our women working in science on women's mental health. That's not being done anywhere else but here.

**AB:** *Why is this so important?*

**ST:** We don't know enough. We've lived



## PHILANTHROPY

in a world that was created for male-dominated health care. Only 3 percent of all research dollars go to women's health, and one half of 1 percent goes to women's mental health.

Women experience depression, anxiety, and trauma more than men. Women are given antidepressants that were never tested on women—only on men. We're so far behind. Women are an underrepresented, underserved, and undervalued population. And we're the caregivers of the world.

**AB:** *You described this, at first, as a "giving circle." And so, it serves to magnify reach and impact for further involvement.*

**ST:** A lot of people don't know where to get started, so here it is. It's been absolutely amazing how these women have rallied. They're not just giving their funding—they're giving their time, their resources, their networks. They're bringing friends into the community.

**DG:** It's one of the things we didn't anticipate or plan for. We've got over 100 members in this giving circle now, and we host events that are both awareness-raising and knowledge-sharing—researchers talking about the work and the issues, ranging from young people dealing with eating disorders, to perinatal mental health and menopause, to Alzheimer's and dementia.

We've seen women share their stories, often for the first time, and the reaction of other women in the room, often strangers, is to walk up to them, put an arm around them, and embrace them. There's that piece of knowing you're not alone in this and there's hope. What's really been exciting is seeing women go from surprise and anger when they hear the statistics that Sandi just shared, to hope and optimism from the research that's being done, the community that's being built, and the support that people are offering each other.

**AB:** *Let's change the spotlight to Juliana and the Sprott Foundation. What*

*is the Sprott Foundation's mandate, and where does it come from?*

**Juliana Sprott:** The Sprott Foundation focuses on urgent human need, homelessness, and hunger. My mom was born in a refugee camp during the Second World War and grew up in a very poor environment. She lived in Timmins, Ont., and it was a difficult upbringing. When my parents came to a point financially where they thought, "We can actually give back," the thinking was to focus on the basics: hunger and homelessness.

**AB:** *You became involved with WoodGreen through your funding of an incredible project: 60 Bowden Street. Describe to us what 60 Bowden Street is about.*

**JS:** Sixty Bowden Street is 50 units—and I would actually prefer to say 50 homes—within a single building that will provide

holistic services such as meals, PSWs, and social workers for single seniors aged 59-plus. The senior population is so underserved that when this donation request crossed our board desk, it was unanimously agreed upon very quickly.

**AB:** *It matches all of the key areas that WoodGreen is doing well in providing health and wellness in one's home and meeting the increasing number of seniors who are otherwise relying on Toronto community housing. This is an incredible project. It was also a fairly large investment, wasn't it, at the time?*

**TV:** It was the largest single investment in WoodGreen in its 87-year history. It's something that speaks to what we're all talking about today, and that is the senior population that is having that lifespan, wealth, and health gap. This is a unique affordable housing project—it is an old





church that will be demolished and redesigned, maintaining a historical element, to create a spectacular senior centre with strong community connections. It will even include a food bank to support the community at large.

**AB:** *What I take away from knowing you, Sandi, and Juliana, is that your giving and contributions have taken different forms than what might be considered traditional gifts or forms of support. Are you finding that you are giving, acting, and thinking differently about support compared to your parents?*

**JS:** When my parents started the foundation, they preferred to give anonymously. At the time, they didn't want to draw attention to themselves—they just wanted to do the work in the background. However, when I took over the foundation in 2005, I really tried to impart to them that putting our name out there accomplishes several things. First, it encourages other donors to give and think: "Okay, this family's doing this, and we have an interest as well. Let's get on board with this project." Second is that there's this bizarre misconception that the government is this beautiful, benevolent being that takes care of everybody. This perception is wrong. Private family



**Left:** Angela Bhutani, Juliana Sprott, Teresa Vasilopoulos, Sandi Treliving, and Deborah Gillis on stage at Minerva Summit.



**Top to bottom:** Deborah Gillis; Della Langley; and Burgundy Chair and Co-Founder Tony Arrell, all at Minerva Summit.





## PHILANTHROPY

philanthropy, corporate philanthropy, and individual philanthropy make up a huge chunk of the funds these charities operate with. So, I said, “No way, we are not letting the government take credit for our investment in our own community. Forget it.”

**TV:** Additionally, it lends a real stamp of credibility and trust to an organization when a family puts their name on something, since often it will be people who are philanthropic leaders or well-recognized business leaders. The ability to say, “Oh, if they’ve invested in this organization, they’ve done their homework. This must be a good organization that’s managing their funds well.” This gives [other donors] a bit of trust.

**AB:** *Let’s stay on the subject of anonymity. CAMH recently experienced the disclosure of an anonymous donor who had gifted \$203 million, given over time. Deborah, can you talk about the impact that revealing the donor’s identity had for the organization?*

**DG:** There was a time when no one wanted to publicly attach their name to the cause of mental health because of the stigma associated with mental illness and addictions. Therefore, it took some very public champions in the early days to initiate change and shift the dynamic.

Subsequently, there’s been a huge change as awareness and understanding have grown and people have been willing to be associated with the cause of mental illness. The “anonymous donor” who was unveiled first came to CAMH in 2017, sending an email to [info@camhfoundation.ca](mailto:info@camhfoundation.ca). This is a true story. That email stated: “I’m interested in making a donation. Can I speak to someone?” They were connected with a foundation team member, who invited them to tour our facilities, learn about our research, what was happening, and the plans and vision for the hospital.

Unlike most cases, where we typically know who a donor is and know something

about their philanthropic background or interests, we knew virtually nothing about the prospective donor. The tour happened, and in the elevator on the way back to the office, the foundation team member asked, “So what were you thinking?” Their response was, “\$50 million?” As you can imagine that person almost fell over in the elevator. As they tell the story, so too did

“  
We really  
believe in  
the charities  
with whom  
we are  
allies, and  
trust-based  
philanthropy  
is now at  
the core.  
”

all the other people in the elevator who overheard that conversation.

That \$50 million first indicated in February 2017 turned into an announcement in January 2018 for \$100 million. The donor wished to remain anonymous—not because of the stigma issue, but more like Juliana’s parents—feeling like “It’s not about me. It’s about the institution. I don’t

want the attention, and I don’t need to be recognized for what I’m doing.” The \$100 million turned into \$200 million, with a \$100 million investment in our current campaign supporting our campus redevelopment. Additionally, they made another \$3 million gift to endow a chair in forensic psychiatry, one of only four in the world.

Eventually, they decided to put their name on our forensic mental health building—this is incredibly important because there’s probably no population of clients the hospital serves who is more deeply stigmatized than those in the forensic system. They’re also often the sickest patients we are dealing with, often with very serious mental illness. Therefore, the donor’s choice to put their name on that building was really amazing. However, it’s named not for their name, but for the address of the home where they lived in Ottawa: Waverley Street. They described their home as a place where people felt welcome, and they opened it up to people who came to Canada from other countries—there was always an open door, food to share, and a sense of inclusion. It seems perfect that this will become the name of this building. It also means that every building on the CAMH campus will carry a donor name, marking an incredible change over 25 years.

What was surprising to me was the reaction of the staff. The announcement was made on a Thursday, and on the Friday morning, we conducted huddles with the hospital staff in the forensic program. As I was wrapping up and leaving with one of the team leaders, he got very choked up. He turned to me and said, “I was really considering quitting until this announcement—it told me that my work is valued. The patients I work so hard to treat and serve are seen, cared for, and valued as well.”

So being open, putting your name on things, being public about your support has an incredible impact on people’s lives—you’re standing with them, saying they matter, and saying you care.



## PHILANTHROPY

**AB:** *You've all gone through a learning journey and really changed your approach to your relationship with organizations. In the last number of years, we've seen more focus on "trust-based" philanthropy. Juliana, what do you think these words mean, and how do they drive that relationship you have?*

**JS:** I think it was through our work with Indigenous groups that we started to shift towards trust-based philanthropy and essentially tried to get out of the way. [It was like saying:] "We trust you. We believe that you know what you're doing. We're not there every day. It's not our place to tell you what you're doing right or wrong." We really believe in the charities with whom we are allies, and trust-based philanthropy is now at the core, as well as really shifting toward unrestricted funding. These concepts go together.

As a result, we have excellent relationships with our grantees. They really can text me, call me, whatever, anytime. We have a beautiful holistic relationship. The trust-based philanthropy and the unrestricted funding really help that.

**TV:** Yeah, absolutely. While you'll have many things like PSWs and different components of a WoodGreen organization that are supported by the government, there are service gaps where we can only help people through philanthropy. A great example of unrestricted funds in action was during COVID-19. Suddenly, we had these vulnerable seniors across the city who were not able to reach the grocery stores and were experiencing food insecurity. We established a food bank with unrestricted funds within WoodGreen, and we delivered those groceries weekly to these vulnerable residents. If we didn't have the unrestricted funding, we wouldn't have been able to respond in that situation.

**DG:** I think part of this is on the charitable sector and the language that we use. When I say, "unrestricted funds," what does that make you think? I think we need to be better at explaining that these funds go directly to the highest priority and often urgent needs of the organizations they support. These funds give the leadership of those organizations the flexibility to say, "This is a priority. This changed and we need to be able to act quickly and move funds to those priorities as they emerge." **M**



**Top to bottom:** Sandi Treliving; Lauren Davis Landau (left); Burgundy Chief Executive Officer Rob Sankey (right); Deborah Gillis, Teresa Vasilopoulos, Angela Bhutani, Sandi Treliving, and Julianna Sprott.



Dr. Ruth Westheimer; original portrait by Rachel Joanis

## *Remembering* **DR. RUTH**

The iconic sex therapist who believed that no topic was off-limits.

By: Elizabeth Andrews \_\_\_\_\_

At our recent Minerva Summit, we gathered to address many challenging topics on the gap between the onset of declining health and the end of life. We believe that providing a space for these conversations truly makes all the difference, and through open discussions, we explored issues around long-term care, financial and philanthropic planning, and the importance of maintaining strong personal relationships. Throughout the day, we made room for these essential yet often uncomfortable conversations. In this spirit, we honour Dr. Ruth Westheimer, the iconic sex therapist who challenged the status quo. She firmly believed that, when approached properly and with grace, no topic is off-limits. In her 50s, when many women were expected to fade into the background, Westheimer stepped directly into the spotlight. For decades, she made her voice heard—through her groundbreaking radio and TV shows, countless television appearances, and the many books she authored.

In 1980, sex talk went mainstream in the United States thanks to a little-known, 52-year-old sex therapist with a blonde bouffant, a warm smile, and a diminutive 4'7" frame. That year, Ruth Westheimer launched her radio call-in show *Sexually Speaking* on WNBC in New York. What began as a 15-minute segment airing at midnight on Sundays became a sensation that captivated its audience for an entire decade.<sup>1</sup>

Listeners tuned in as Dr. Ruth gave candid, no-holds-barred advice on sex. Her approach-



able demeanour allowed her to discuss topics in a way that others could not—or dared not. Her casual discussions about sex and contraception were rare for the time, as these topics were seldom broached in public, let alone broadcast on the radio. With an affable delivery and German-accented voice—likened by one journalist as “a cross between Henry Kissinger and Minnie Mouse”—she kept her audience captivated. She continued to gain popularity in the ’80s, becoming a mononymous cultural icon.

### Shattering the Status Quo

Westheimer’s career was groundbreaking, particularly in how it challenged the prevailing norms of her time. In the late ’70s and early ’80s, female sexuality—especially for older women—was largely absent from the public discourse. Desirability was often linked to youthfulness, conformity, and physical perfection filtered through the male gaze. In her 1972 essay, “The Double Standard of Aging,” Susan Sontag paints a bleak picture of such limitations, writing that “women’s sexual validity depends, up to a certain point, on how well they conform to the youthful ideal.”<sup>2</sup> In mainstream media, sexuality was synonymous with young bombshells. In 1976, Farrah Fawcett may have been the epitome of beauty standards. With her red swimsuit poster—one of the best-selling of all time—plastered on walls across the United States and beyond, Fawcett embodied the “all-American” beauty ideals of the era: a woman in her 20s with big blonde hair, broad white teeth, and a slim figure.<sup>3</sup>

Meanwhile, women like Westheimer—mothers, women in their 50s and beyond—were rarely depicted as sexual beings. They were often desexualized and relegated to the roles of mother or grandmother, where their sexuality was either ignored, played up for laughs, or portrayed as predatory. (Think of *The Graduate*: “Mrs. Robinson, you’re trying to seduce me. Aren’t you?”).

By openly discussing sexuality for women of all ages and challenging the outdated and restrictive idea that sexual vitality disappears with age, Westheimer fought convention, bringing a radical and refreshing perspective.

### “Everything can be talked about”

After her radio success, exciting new opportunities came Westheimer’s way, from the Tri-State airwaves to a much broader audience. In 1983, she applied her no-nonsense approach and playful humour to *Ruth’s Guide to Good Sex*, the first of dozens of books she would go on to write. She also became a staple on the late-night talk show circuit. During her first appearance on *The Tonight Show Starring Johnny Carson*, after a few uncomfortable snickers from the audience, she leaned toward Carson and said: “If you do it in good taste and you do it properly, everything can be talked about. Everything.” With her candour came even greater visibility. She would go on to host her own TV show, *The Dr. Ruth Show*, which began airing in 1984. Dr. Ruth Westheimer’s openness was matched by her ability to connect and converse with anyone—from Joan Rivers and Burt Reynolds to Gene Simmons and Howard Stern. In a pre-sitcom-fame conversation with comedian Jerry Seinfeld, he told her, “You have changed sex in America.”<sup>4</sup>

Perhaps the most remarkable thing about Westheimer was her ability to overcome the unimaginable circumstances of her childhood. In 1939, at just 10 years old, she was sent from Germany to a children’s home in Switzerland to flee the war. She never saw her family again. Still, in a 2012 interview with *The Guardian*, she recalled the care and adoration she received in her early childhood: “I was in a household with two loving parents and an adoring grandmother who spoiled me.”<sup>5</sup> It seems that the seeds of her future career as a radio host were also planted during this time.

“My mother was a very quiet woman and people say that she didn’t get much of a chance to talk because my grandmother and I talked so much.”

In the same interview, Westheimer shared the tragic experience of not knowing her parents’ fate as their letters stopped coming. She reflected on the strength she drew from being an orphan of the Holocaust: “I was left with a feeling that because I was not killed by the Nazis—because I survived—I had an obligation to make a dent in the world. What I didn’t know was that that dent would end up being me talking about sex from morning to night.”<sup>6</sup>

After escaping the Holocaust and earning a master’s in sociology and a degree in psychology, she took a research position at Planned Parenthood in 1960s Harlem. This experience would inspire her to study sexuality, using the data on the women she worked with for her doctorate dissertation.<sup>7</sup>

### Lifelong Advocacy

An advocate for safe sex and sexual health, Westheimer’s rise to stardom in the ’80s coincided with the early days of the AIDS epidemic, a time when many suffering from the complications of the illness were treated as social pariahs. Against this backdrop, the stakes for frank sexual discourse were raised tremendously. With government inaction, misinformation, and discrimination running rampant, her empathetic approach, rooted in practicality, education, and human decency was sorely needed. In the 2019 documentary *Ask Dr. Ruth*, she attributed her lineage and personal history to her need to speak out: “I took that very seriously because of my background as a German Jewish refugee. I certainly had sensitivity for the people who were really regarded as subhuman.” The director of the film, Ryan White, highlighted that Westheimer didn’t merely attach herself to causes once they became popular. Rather, because of her background, empathetic



“Westheimer was a pop culture icon who thrived in the world of taboos that shouldn’t be taboos, from speaking openly about women’s pleasure to debunking myths about sexuality to dismantling stereotypes about what it means to get older.”

nature, and education she was always an ardent supporter of the LGBTQ and a pro-choice advocate. As White put it, “She was at the forefront of both of those things throughout her entire life,” adding that meeting her friends from the orphanage confirmed her lifelong acceptance of the gay community: “She was always accepting of those people and always saying that people should be treated with respect.”<sup>8</sup>

### Living Many Lives

Westheimer was a pop culture icon who thrived in the world of taboos that shouldn’t be taboos, from speaking openly about women’s pleasure to debunking myths about sexuality to dismantling stereotypes about what it means to get older. And though she was passionate about destigmatizing sex between consenting adults, regardless of the gender of the partners, sex was not her only cause.

In a conversation with the *New York Times* in 2023, the then 95-year-old said that, though she was still willing to talk about sex and sexual dysfunction, she had done all that: “So, now I am going to say, let’s go and see how we can help people who don’t have a sexual problem,” adding, “I don’t want to be known only as a sex therapist. I want to be known as a therapist.”<sup>9</sup> In her twilight years, she sought to address the messy complications of loneliness, which

had escalated dramatically following the pandemic, when social isolation reached a fever pitch. As *Times* writer Allison Gilbert wrote, “[Westheimer] understood loneliness not just through the prisms of COVID-19 and adolescence.”<sup>10</sup> After being America’s most famous sex therapist for decades—and a widow for over 25 years—Dr. Ruth Westheimer took it upon herself to become New York State’s first “Ambassador to Loneliness,” a wish granted by New York Governor Kathy Hochul.<sup>11</sup> At the heart of her work, we find a deep desire to speak openly, address intimacy, and foster connection through empathy and without judgment. Westheimer’s influence endures even after her passing. Her final book, *The Joy of Connections: 100 Ways to Beat Loneliness and Live a Happier and More Meaningful Life*, was published on September 3, 2024, less than two months after her death at age 96. She was the embodiment of living many lives in one.

No matter how uncomfortable the subject, whether sex, loneliness, death, or finances, not talking about these things leads to far more discomfort down the road. It’s essential that we talk about the hard things and listen to the hard things that others tell us—ideally, with the same empathic approach that Westheimer championed for so many decades. This is how we take care of ourselves and those around us. **M**

## ENDNOTES

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INTRODUCING THE NEW

# WOMEN OF BURGUNDY WEBPAGE



Since 2014, Women of Burgundy has focused on empowering women to take charge of their financial futures—fostering curiosity, connection, and confidence in investing. Now, we're thrilled to introduce our newly launched webpage, a central hub to showcase our mission, impact, and resources.

Through our publication, Minerva Magazine, and events like Minerva Summit, we've connected with over 1,300 women and men, sparking important conversations around investor education, generational wealth, philanthropy, and more.

After years of growth and impact, Women of Burgundy deserves its own dedicated space. This new webpage reflects our ongoing commitment to education, inspiration, and community, ensuring that the conversation around women and wealth continues to evolve and expand.

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