

# The New York Times

## At the end of life, a turn to "slow medicine"

By [JANE GROSS](#), The New York Times, 5/6/08

HANOVER, N.H. — Edie Gieg, 85, strides ahead of people half her age and plays a fast-paced game of tennis. But when it comes to health care, she is a champion of **"slow medicine," an approach that encourages less aggressive — and less costly — care at the end of life.** Slow medicine encourages physicians to put on the brakes when considering **care that may have high risks and limited rewards for the elderly, and it educates patients and families how to push back against emergency-room trips and hospitalizations designed for those with treatable illnesses, not the inevitable erosion of advanced age.** Slow medicine, which shares with hospice care the goal of **comfort rather than cure**, is increasingly available in nursing homes, but for those living at home or in assisted living, a medical scare usually prompts a call to 911, with little opportunity to choose otherwise.

At the end of her husband's life, Gieg was spared these extreme options because she lives in Kendal at Hanover, a retirement community affiliated with Dartmouth Medical School that has become a laboratory for the slow-medicine movement. At Kendal, it is possible — even routine — for residents to say "No" to hospitalization, tests, surgery, medication or nutrition. Charley Gieg, 86 at the time, was suffering from a heart condition, an intestinal disorder and the early stages of Alzheimer's disease when doctors suspected he also had throat cancer. A specialist outlined what he was facing: biopsies, anesthesia, surgery, radiation or chemotherapy. Edie Gieg doubted he had the resilience to bounce back. She worried, instead, that such treatments would accelerate his downward trajectory, ushering in a prolonged period of decline and dependence. This is what the Giegs said **they feared even more than dying, what some call "death by intensive care."**

Many people in their 80s and 90s — and their boomer children — want to pull out all the stops to stay alive. **The costliest patients — the elderly with multiple chronic illnesses — are the only group with universal health coverage under Medicare,** leading to huge federal expenditures that experts agree are unsustainable as boomers age.

Dr. Tom Rosenthal, UCLA's chief medical officer, said aggressive treatment for the elderly at acute-care hospitals can be "inhumane," and that once a patient and family were drawn into that system, "it's really hard to pull back from it." "The culture has a built-in bias that everything that can be done will be done," Rosenthal said, adding that the pace of a hospital also discourages "real heart-to-heart discussions." Beginning that conversation earlier, he said, "sounds like fundamentally the right way to practice."

That means explaining that elderly people are rarely saved from cardiac arrest by CPR, or advising women with broken hips that they may never walk again, with or without surgery, unless they have the stamina for physical therapy. "It's almost an accident when someone gets what they want," said Dr. Mark McClellan, a former administrator of Medicare.

The term slow medicine was coined by Dr. Dennis McCullough, a Dartmouth geriatrician and author of "My Mother, Your Mother: Embracing Slow Medicine, the Compassionate Approach to Caring for Your Aging Loved One." Among the hard truths is that **nine of 10 people who live past 80 will wind up unable to take care of themselves, either because of frailty or dementia.** "Everyone thinks they'll be the lucky one, but we can't go along with that myth," McCullough said.