From Emergency Room to Entrepreneurship: One Doctor's Mission to Transform Palliative Care Transcript

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Episode Introduction and Guest Bio

Welcome to a special Heartline Echoes episode where we revisit some of the most impactful conversations from Heartline changemaking in healthcare. This rerun isn't just a replay.

It's an opportunity to reflect, reconnect, and reignite the ideas that continue to shape the future of healthcare. Whether you're hearing this for the first time or returning for some fresh insights, let's dive back into this powerful discussion.

Enjoy! Welcome to Heartline, conversations with healthcare changemakers following their heartline. I'm your host, Dr. Andrea Austin. I'm an emergency medicine physician, coach, and educator.

I believe that healthcare needs to improve the quality care that patients receive and that supporting the workers is at the heart of this transformation.

I'm really excited today to have my friend and colleague, Dr. Arya Nachat, on our podcast today. Her career is so multifaceted and fascinating. I will try to pick out a few highlights, but I will definitely be asking her a lot of questions during the next hour.

So she's an emergency medicine and palliative care physician and educator, and most importantly, a changemaker in healthcare. She's a regular speaker and contributor on emergency medicine, palliative care, traditional Chinese medicine, and pain management.

Most recently, she founded Pallity, a specialty-specific platform to access education, medical guidance, social support, as well as a marketplace for goods.

Their goal is to ensure that anyone with palliative needs has access, regardless of diagnosis and prognosis. She has been recognized for the past two years as a top doctor by her peers.

She founded Kaiser's first inpatient integrative symptoms management service in Northern California, served on the state of Oregon Opiate Prescribing Task Force and an exam item writer for the American Board of Internal Medicine.

I don't know how she does all of this. She currently practices emergency medicine and services clinical faculty at Naval Medical Center San Diego, the VA in San Diego, along with Scripps Memorial in San Diego.

So with a bio like that, I'm even more excited than when we set this up to talk about your many hats. Thanks for having me, Andrea. I'm super excited to chat with you and You know, a lot of the amazing things that have happened with my transition to San Diego, frankly, I owe you a huge gratitude for that because you made some connections happen that I did not previously have.

And it's just been a phenomenal move for us. I'm so happy to hear that. And that's what we're all about here at Revitalize is really operationalizing how we can all lift each other up.

And I was on a phone call with another woman physician today and we are sharing information about different opportunities. And it was so lovely because we weren't competing.

We were instead collaborating and figuring out how could we both move up and help each other. And it's such a refreshing transformation that I think we're going through.

I think that's something that healthcare has been severely lacking.

Healthcare Culture and Physician Support

And I think that some of what we get indoctrinated with during medical school, which is a very competitive, you know, you got to one up your classmates in order to get a competitive residency and residency, you want to make chief resident.

There are so many systemic conditioning events that happen during the course of someone's medical education that in many ways we've, we've, accustomed our medical physicians to really not support each other and lift each other up the way that you're speaking about it.

And instead it's a constant competition to see who can please the boss, so to speak, a little bit more. Well, hopefully both you and I and our friends and colleagues are starting to change that tide because I think we're seeing before our eyes the healthcare system, begin to crumble and it's already hard enough.

So I'm all about taking care of my fellow physicians on shift. Let's not throw any more necessary arrows because we're already taking in too many. Couldn't agree more.

I routinely will show up and give meals to my residents who work with me at one of my sites because they always forget to eat and they're so accustomed to running, running, running the entire, you know, eight, 10, 12 hour shift and not taking care of their own needs that they'll go the entire shift without eating.

And every time I show up and I just put a meal in front of them or put a, you know, a muffin or a drink or something, they're always so shocked. And so, oh my God, thank you so much.

And I'm thinking to myself, when did we stop being human? And how do we go back to being human first and physician second? I know that they're very intertwined and I would say for myself, my identity as a physician is a very potent part of who I am.

But I think that returning to the humanity of who we were prior to becoming physicians and taking care of ourselves is paramount to us fixing what's currently broken because the healthcare system isn't on the verge of collapse.

It is collapsing. It is crumbling. And bedside clinicians are leaving the workforce at rates that we've never seen before. Yeah, I've been thinking about this a lot because we essentially weren't taught how to take care of ourselves or how to have any boundaries.

And I really think to save healthcare, whether it's for our janitorial staff or for nurses or for physicians, we have to start putting the worker in the center and supporting them to do basic functions like take a break, eat food, not be sleep deprived.

I don't know why we do the 24 hour shifts anymore. I mean, you and I personally don't, but that our trainees are still enduring that. I think there's something to be said about being able to function sleep deprived, not because I think it's a good thing, but I do think that some of that rote muscle memory and having something so deeply ingrained that you can pull it out when you're under severe stress, I think is where it came from.

I think where it's turned the tide and is no longer really helpful is when it's being used as a hazing technique. And I think a lot of our graduate medical education, it's almost a hazing experience.

I know I've used this analogy, you may or may not relate to it, but the people you go through residency with To me, they felt to me like my brothers and sisters in a foxhole, right?

We were all going to get through whatever this grueling three, four, five, seven year residency, whatever anyone is specializing in. And I really think it's important to learn from the things that are good about working in stressful conditions.

But I don't think that you need to make it a protracted experience that lasts the entire residency. I know that for myself, having something so rote, so ingrained that if you could wake me up at two o'clock in the morning on 15 minutes worth of sleep, I could still do the job correctly.

I think that's important for some of what we do, but certainly not for all of what we do. Yeah, I think that it comes back to what's the intent behind it and what's the support behind it.

I did an episode with Dr. Vinnie Aurora, who's an expert on sleep, or what I like to jokingly call lack of sleep, sleep among Chinese. And we have the data and the tools on how we could make calls safer, which involves napping.

It involves having appropriate sleeping areas post shift, but we still refuse to do it. And it wouldn't take that much of a capital investment for these, let's face it, the growing corporatization of healthcare, they could afford to put in private, comfortable sleeping conditions if they're going to require people to work 24 hours plus.

Absolutely. Look, The reality is, is with the corporatization of healthcare and when the push has become really about maximizing profits and no longer about delivering care.

And that's what we're really talking about, right? We're talking about caring for other human beings, whether it's our patients, their families, ourselves, our staff.

We do a horrible job of doing that. And they don't enable us to do it well either. I was reading a meme the other day and it made me laugh because it was so sad, but also so true.

And it was an example of someone who was going to be out of office in Europe. And it said something to the effect of, you know, European worker out of office alert.

I will be vacationing with my family and camping in the woods and I will be unavailable for the next two and a half months. I will return in September.

And then the American worker version was, I'm having my kidney transplant today. I should be available in approximately 12 hours to take your texts, phone calls and emails.

And that's kind of what's happened here. And we have forgotten to live. We are living to work and we should be working to live. And that was something that when I first moved out to California from the East coast, I really appreciated about the West coast mentality.

There was a lot more recognition. that our job is a job, but life is everything else we do. And while our jobs are meaningful and important and I really enjoy what I do, that can't be all of it.

You know, we have ourselves, our families, some of us who have children, you know, we have other things we're interested in. I wish I could answer the question of like, what are my hobbies?

Someone once asked me that recently. And it occurred to me that in the last 20 years, I haven't really developed a hobby per se because I was so busy practicing medicine.

Emergency Medicine, TCM, and Palliative Care Journey

Yeah. And that brings up a great point. And I was just at a conference that was sponsored by mission critical teams. And they really are thought leaders on how to take care of high-stress workers, whether it's doctors or firefighters, and they refer to this concept of having that third thing.

Most of us have work, maybe family, but what's your third thing? And they think that third thing should be an activity that you go to that nobody associates you being a doctor with.

So for example, we have a mutual friend that she's taken up outrigger paddling. And no, I mean, people do know

that she's a doctor at this point because it usually comes out in conversation, but her role paddling on that team has nothing to do with being a doctor.

I think that's fantastic. The closest I've come to that is, is going traveling with my children in our airstream and taking a break from the world and intentionally going to locations where I cannot be found on my cell phone and people cannot reach me.

you know, the exception of a couple of sparse moments where, where there's some wifi access, but I generally try to avoid doing things in places where people can find me so that I can spend that time in nature.

I can spend time with myself, with my thoughts. And I find for me personally, it's one of the most renewing periods of time where, where even though I'm not actively working, having the mental space to not do something and to just let the thoughts percolate in my brain.

And then I come back and I'm full of ideas and problems that beforehand I might have been struggling to figure out what a great solution would be for them.

They just sort of come organically by being away. Yeah, absolutely. So when I look at your bio, and I have the benefit of being friends with you, so I think I know more beyond the bio, the in-betweens, what stands out to me is, along with being emergency medicine trained, you have these other facets to your career of palliative care and pain.

And I was just going through the Rolodex of everybody that we've had on the show thus far. And we have yet to have a pure clinical physician, and I'm not opposed to having a peer clinical physician on the pod, but what came out of a conversation with Dr.

Shannon McNamara that I keep coming back to and I'm really thinking a lot about is in the current healthcare system, can anyone practice clinical medicine or emergency medicine full-time or is the path having a varied career and maybe to connect your journey, how you can explain that you've had these other facets and what drew you to them and at what point of your career you started to branch out beyond emergency medicine and why.

Well, I've always had a passion and a love for emergency medicine. partially paid my way through college by riding an ambulance. And so I got my EMT and I was working in the field and I got caught by the bug, so to speak, of emergency medicine.

And it really is like catching a bug because when you realize that when other people are running away from the chaos and you're perfectly comfortable running towards the chaos, We have a unique personality.

Those of us who go into emergency medicine tend to not be as risk averse. We tend to be the ones who will charge into a situation and MacGyver it with duct tape and safety pins as we joke around a lot in emergency medicine.

I think personality wise, it was a really good fit for me. I grew up in a fairly chaotic environment. I grew up in a war zone for a while and it was my comfort zone.

And so that part came fairly naturally. I think that the detour I took, especially with the traditional Chinese medicine, which is an area that people tend to sort of be taken aback when I talk about doing both, is that what I found about traditional Chinese medicine that was so meaningful to me is actually what we've just been talking about.

It's this acknowledgement that we exist as part of a much bigger system. And how we do health-wise is impacted tremendously by our psychosocial environment, by the people in our lives, by our employment, by the change of seasons, by the foods we eat.

And it really appealed to me because as an ER doc, I'm sure you've had this experience where we have the revolving door of patients who come in who don't have a diagnosis, who don't have an answer.

And there's only so many blood tests and CAT scans and MRIs you can do on a person. And sometimes we don't have the answer. And what I really loved about traditional Chinese medicine was that it took a very different approach in assessing a patient's state of being.

And so that detour really led me to building what I built at Kaiser, which was the first inpatient integrative symptoms management service that really would address those patients who fell out of the bell curve.

So your typical 68% of the bell curve who are right in the middle were being managed beautifully by allopathic medicine. But then you had those two standard deviations who fell out and these patients were falling through the cracks.

People were starting to label them. They weren't doing well. And by approaching them differently and looking at them more holistically, We were actually able to move the needle on those cases.

I remember we looked at a specifically 23 high utilizers and we used them as their own control group. We looked at their usage in the year prior to our team's intervention and then in the year following our team's intervention.

And we were able to reduce 623 hospitalization days in 23 patients, which was incredible. And so, you know, my meandering path sort of all makes sense in my head, but it's a path that was atypical for sure.

And my passion for traditional Chinese medicine really came from during medical school when I did an elective in alternative medicine at the time is what they referred to traditional Chinese medicine in that bucket.

And I worked with an amazing acupuncturist. They partnered you up with one of the senior acupuncture students. And for those people listening who don't know, the master's program for traditional Chinese medicine is actually three and a half years long.

It's a master's program. And about a third of their education is in Western medicine. But they also learn about nutrition and pathophysiology and a traditional Chinese medicine version of pathophysiology and point prescriptions and herbal prescriptions.

and a fair amount of body work as well. So it's sort of on the DO side of things in terms of I find that many DOs get a lot of training on hands-on manipulation.

I know that I as an allopathic physician got none of that. And so it really appealed to me when I was in med school and then of course residency got in the way and I didn't go back to it until after I completed residency and I was already in attending because I had some more bandwidth again to be able to do that.

And the palliative piece really came into play naturally because in that bell curve and those two standard deviations who fell out that were referred to my service were a lot of oncology patients and a lot of patients who had a lot of severe symptoms.

And so about 60 to 70% of my patients were oncology patients. And so it made a lot of sense to just become boarded in hospice and palliative medicine because I was doing a lot of it anyway.

And then the pain piece of it, Again, really is an extension of that. In the ER, we treat pain all the time. And obviously, refractory cancer patients have a different threshold of pain management than what we normally do in the ED.

And so getting additional pain training made a lot of sense as well. I think for me personally, I don't know if I could have ever done a straight path where all I did was emergency medicine for my entire career.

I think emergency medicine has shifted so much from when I started and dating myself now I've been in practice for 21 years. It's not the emergency medicine we started out in and the corporatization of healthcare and profits over patients and focusing on efficiency rather than effectiveness really speaks to me deeply to my core.

I don't know how younger physicians coming out now feel about a career that they would spend entirely doing just one thing, but for me, it's been life preserving to be able to shift and pivot based on both my interests and making sure I followed something you speak about a lot in your podcasts and in your posts is being true to myself and my values.

And I didn't feel I could do that exclusively in just emergency medicine anymore. Yeah. So we're a little bit. different in our age, quite frankly. I graduated medical school in 2011, so you've been doing this for longer and you have more of that historical perspective.

For our younger doctors listening, they only know this way. They only know this phase of emergency medicine. When you look back from when you were training as a resident to now, what are some of the differences and some of the negative trends that you're seeing?

I think the biggest negative trend is how much time we're allowed to spend with patients and our staffing models that allow for that. I remember as an intern, one of my favorite attendings, who the first year I did not love him, I will be very honest about it, was because of how he taught.

He was very Socratic in his method and he would sit down with you and someone would come in and they'd have a very obvious femur fracture from a motorcycle accident.

And he'd say, what is the reason they have a femur fracture? And you're like, duh, the motorcycle accident. And he would just sit there and go, no. And he'd have you guess, essentially, All of the reasons someone might wind up with a femur fracture that had nothing to do with this exact patient.

Why Pallity Was Created

But as an intern, he could spend an hour teaching, at the time felt like torturing me, to kind of go through that thought process and think through all of the different options.

He was also very insistent that every patient was fully disrobed and in a gown. He was very old school and he was triple boarded. He was internal medicine, emergency medicine and critical care trained, but we could take the time to do that.

I don't think any residency training program nowadays would allow an attending to spend an hour discussing a case with a patient, you know, with a resident about a patient.

I think the push to churn through the charts, move the meat, you know, all of the terms we know has changed that. And, The whole point of teaching is to be able to take the time to sit down and really talk about a case and formulate those thoughts.

And it's funny because while that first year it felt like torture, now I'm so appreciative of it. And it's funny because I take some of the same teachings that he shared with me back then, and I share those with my residents now.

One of my pet peeves is patients who aren't put in a gown. There's so much you can miss when the patient is 95% clothed and the art of touching patients, physically laying hands on a patient for more than three seconds with a stethoscope or now with point of care ultrasound, actually touching and feeling what hurts and assessing for symmetry, asymmetry, all the things that you can't get without doing a good physical exam, I think are the biggest differences.

And again, it's in the name of efficiency. Right. Yeah, 100%. I mean, I remember, I'm sure all of us have had the doctor in our lives that has told us that, you know, that physical exam, yes, it's really important for diagnostics and not to miss something, but the exam itself can be healing.

And I don't think that's a message taught much in allopathic medicine. It's so like, it's just a necessary thing you do. It's an interaction. that you have with a patient versus, you know, probably what you learned in Chinese medicine

that part of it was the laying on the hands and the assessing and that's healing in and of itself.

And I think we're losing that at a really alarming rate right now. Couldn't agree with you more. And I think that's part of what appealed to me about traditional Chinese medicine is the fact that it really is about the laying of hands, whether it's twina, which is a form of osteopathic manipulation or acupuncture where you're actually putting in needles, but you're palpating the points and you're picking your point prescriptions partially based on how you're palpating and what you sense when you're palpating and feeling the pulse.

The pulse in Chinese medicine taking is very different than in Western medicine. there are 27 different pulse positions in one wrist depending on which philosophy of traditional Chinese medicine you're trained in and three different depths and the subtlety and the real nuance of feeling a pulse and understanding that there are three layers to the pulse and that each one of those three layers has their own three layers of the pulse and getting that mastery of really subtle messaging from a body is so important We don't do that in Western medicine anymore.

All of our workups are heavily laboratory and imaging based and some of that is med legal, right? Let's, let's be honest. I don't know that some of us do all the things that we do because we really think we need it for the information, but we feel we need it to protect ourselves from a liability standpoint.

There used to be. A respect for physicians and an understanding that we aren't omnipotent, but we are in fact fairly knowledgeable, but we're not perfect.

And we've lost a lot of the respect in general. I feel physicians have been thrown under the bus horribly by lots of different players and stakeholders in the healthcare system.

And so there's this distrust there to begin with now that's really problematic. The patients at the end of the day, you know, they want to be heard. And I think we've had our handcuffed in that sense as well.

Now we don't have the time to sit and talk and listen and feel and be present in a way that we used to. And so our liability also goes up because patients feel that we didn't pick up on the subtle things that they were saying or they didn't have the opportunity to share the things that would have helped make the diagnosis.

And then we're responsible for it on the other end of it. I don't think there's a single physician out there who's happy with a 15 minute visit with primary care, and I don't know a single primary care physician who feels they can do an adequate history and physical and exam and really address a patient's concerns in 15 minutes.

But someone, being counter wise, sat down on a spreadsheet and said, that's how many patients you need to see a day and this is how much time you get.

Well, a lot of people are pushing back on that now. Yeah, and I think this is a good time to pivot to a discussion about what you're doing with Palady.

So tell us what is Palady and your why behind it. So Palady came about during the pandemic. I initially had to take a step back from some clinical work because my kids were out of school and I couldn't single parent them, homeschool them and also work and pay the mortgage.

So I took a step back and initially thought, OK, I should just do concierge medicine. I'll just do concierge palliative medicine. I worked in an area where my my expertise level was far and few between.

And I figured, OK, people could just come see me privately. And what really bothered me about that was the lack of access, because the people who could find me and pay for me privately probably had access to reasonable palliative care resources within their health care systems.

And it really spoke to me deeply about the inequity about access to palliative care and end of life care for patients throughout the country. And so I pivoted from that and started thinking bigger, which may or may not be my downfall ultimately, is I have very big vision and I decided I wanted to try and fix this on a national level.

And to that end, I built Pallity, which is a comprehensive platform where we are trying to make access to both patients, caregivers, families, clinicians, healthcare systems, payors, accessible regardless of their diagnosis or their prognosis.

So it's a combination of both resources and education. The first pillar is really based on the education foundation. The second is telehealth and actual delivery of palliative care expert services by board certified palliative care physicians and teams.

And that will evolve into machine learning and AI. So we can start identifying patients at risk before they get into trouble and wind up in the ER or the ICU, et cetera.

And then the third is a marketplace because many services that patients and families need access to is just not available to them through the traditional healthcare system.

It's not covered and people are paying for things out of pocket. And I've seen enough people being sold snake oil. And I wanted to make sure that they had access to a marketplace where things were evidence-based, where they could access resources to any kind of goods that they could possibly need as a seriously ill patient or family member supporting that patient.

And so after two and a half years now almost of COVID and watching people dying really horribly on iPads across the country and people not talking about death and dying, I felt that there's finally a little bit of wiggle room in there where people are acknowledging their own mortality and realizing how important it is to talk about what they do and don't want and what defines living for them.

And I feel that pallity is coming at the right time in the right place because suddenly talking about goals of care and talking about what medical interventions you feel are appropriate and aligned with your values is something people are willing to at least, you know, put their toe in the water and talk about more freely now.

Wow. This is so exciting. I'm just so happy for you and proud of you. And this is such a needed, just a huge void. And you're right, depending on what hospital or community you're in, palliative care is either viewed as a necessity or an extra and just not something we have at our hospital.

And it's so, there's so many inequities going on in society, both at the beginning of life, I mean, really all throughout, but the indignity to see that at the end when people are so vulnerable and it's a universal experience, right?

Nobody escapes it to the best of my knowledge.

Advance Care Planning and Patient Agency

None of us are coming out of this alive. We all get a one-way ticket. And you're right. I think what was abhorrent to me and the part that sort of got the hairs on the back of my neck standing up really was the fact that these are some of the most vulnerable patients out there.

They are not in a position to advocate for themselves as well as they might have under other circumstances. And it's just flat out overwhelming. You know, when you get a cancer diagnosis or you get a major illness diagnosis involving a major organ system.

The analogy I use with a lot of people is, and this is dating myself now. So for the younger folks listening to this and have never seen a VHS tape, this may not be relevant.

But if you take a VHS tape, which has a whole bunch of ribbon inside of it, and you just pull the ribbon out and you put it on the table and go, hi, I'm really sorry to tell you, but you have this new diagnosis.

The patient's sitting there with that VHS tape worth of ribbon going, now what? And I really, really believe strongly in allowing patients to not only have agency and their voice back, but really empowering them to be able to make

decisions that are based on their personal understanding of the risks, benefits, and alternatives specific to them.

The least appropriate informed consent conversations I see are around CPR. We do so much informed consent around simple things, a laceration repair, an IND, you know, obviously any major types of things that were cost of me tubes, et cetera.

But the one thing that we do that is by far the most aggressive, most invasive, most physically traumatic procedure we do to a patient is performing a resuscitation.

And our version of informed consent and the conversations we have about it are minimalistic at best. I can't tell you how many conversations I've overheard where someone walks in the room and says, well, if your heart stops while you're in the hospital, would you like me to try and restart it as if it's a light switch?

Many of us who've been in EM long enough understand that that is not how that works. And so I try to inject a fair amount of humor into my conversations because people are very overwhelmed and scared.

And I tell them all, I don't have a shiv and I don't have a black cloak. I'm not the angel of death. People confuse me with hospice and I try to explain to them that that's not what palliative medicine is.

And for those people listening who may not be familiar with palliative medicine, palliative medicine is a specialty that has come about because we've actually gotten really good at keeping people alive for really extended periods of time with serious illness, diseases that may have killed them 30, 40 years ago, they can now live with sometimes for decades.

And so palliative medicine helps patients and their families to really go through their serious illness with support, with an interdisciplinary team that involves usually a physician, a nurse, a chaplain, a social worker, case manager.

And it's an entire team who comes to bear to support a patient going through a difficult time. You become hospice eligible when one of two things happens.

Either one, we've run out of things to offer. So there are no more breaks to put on the train tracks on that train and that illness is going to do what that illness is going to do.

There's nothing we have available to offer. or a patient says, I'm not interested in what you've got to offer because let's be honest, a lot of the interventions we make at end of life, sometimes they're completely not medically appropriate and they may not help the patient and may harm the patient.

And so patients sometimes will opt out and enroll in hospice for that reason. So, you know, It's a hard conversation to have with people, but it's such a necessary conversation.

And as I say to them regularly, talking to me isn't about talking about dying. It's actually talking about how you want to live because your values and what brings meaning to you and how you define those things determines how you're going to live.

You know, all of us don't know when our numbers going to be up. It's rare. And so making conscious choices about, I want to do this intervention or not that intervention.

I want to be able to go on a cruise with my family before I can't go on a cruise with my family. I actually get to have really wonderful conversations with patients and their families and help them figure out how to do those things that they care about, which is really pretty fantastic job to have.

I get to be Julie, the cruise, cruise director, so to speak of, of their life. Wow. What a, what an honor. What a beautiful. of your career and so meaningful.

So at this point, is Pallity up and running? Can anybody reach out for services or education? So the Pallity website

is up. People can go to www.pallity.com.

We have a subscribe button there. Right now we're in beta testing phase. We have entered into an agreement with a platform that curates clinical trials for advanced cancer.

And we're going to be taking on several hundreds to a thousand of their patients onto the platform to test it out while it's in the beta phase. And what we're hoping is to open this up more broadly in probably mid 2023 to the general public.

And really we want to be a resource for anyone in the palliative space. And that applies to the physicians as well. If you're a primary care clinician in a rural part of the country that has no palliative care support and you need palliative care backup, you can reach out to us as well.

If you're a caregiver and you're trying to support your family and your family member who's going through a serious illness, we want you to be able to reach out to us as well.

So it really is meant to be a comprehensive, accessible platform, as well as to systems who may not have palliative care at all. Only 17% of rural hospitals have access to palliative care.

And that's a ridiculously low number considering A lot of the country lives in rural America. Yeah. I mean, that's just underlining what an inequity, again, that urban-rural divide.

And, you know, everyone, I mean, just like we want everybody to have a great experience with their birth and having beautiful birthing centers, that's great.

But we also need to support people through the dying experience. And it shouldn't matter what town you live in, especially in a country that's as wealthy as the United States.

It's just really heartbreaking that we're still dealing with this level of inequity. And it's sad enough when the person's dying or your family or friend is dying and then to feel helpless.

So I'm glad there'll be an educational component that people can reach out. Are there tools that a family member can download to maybe help drive a conversation with?

Absolutely. There are two organizations that I like to refer folks to right now. They're both nonprofits. I have no financial ties to either of them. And one of them is Pulse.org, P-O-L-S-T.org.

It's a national website that allows you to download a form that is specific for end of life care. It needs to be signed by a physician in the state that you're in, and the form has to be specific to your state.

But prior to completing a PULST form, which really should only be completed if you don't want everything done. We don't want people filling out a PULST form just for the sake of having one.

It's really intended for people who want to put some brakes on what they do and don't want. The presumption is everyone is full code, full interventions otherwise.

But the other form, which I think is even more important than that form is an advanced directive form. And people can get those from their lawyer's office, but I really dislike those because they're written in legalese.

They're not specific to the patient. Your lawyer doesn't really have the background to help you complete that form so that it is appropriate for where you are in your medical journey.

And so there's a company called prepare for your care, which is another nonprofit, and you can download the form. And I think it's an 12 different languages and it's state specific as well.

And that one's more of a narrative form. It's about 14 pages, whereas the traditional one is like six or seven and it has lots of pictures and explanations and it's written in large print so that for older patients who might have a hard time reading.

And it really explores the what is important to you part in a way that is really meaningful. My personal favorite page is page 12 where it's mostly a blank page and it just says, tell us what you think your medical team should know about you.

That's important to you.

Motherhood, Burnout, and Finding Support

And I tell people, write me a sonnet, put a haiku in there, draw me a picture, whatever it is that makes your heart sing that when you're unable to communicate and all we see in front of us is this frail and ill patient that reminds us of who you are.

I love it when families bring in pictures from a patient's life outside of the hospital and put them in their room. And so that way, you know, nurses and doctors and, you know, the cleaning services and the food services folks, they can actually see that person as a person and not just as a patient.

I want to move to your role as a mom and your experience during, well, I'm going to say, I mean, it's still ongoing through this pandemic and through I mean, quite frankly, the social upheaval that we're seeing.

You're very outspoken on Twitter and I love following your tweets. What advice do you have for moms out there? Our audience is mainly physician moms that maybe have left the workforce, maybe they're planning to leave, maybe they don't even know what they're going to do tomorrow.

They just feel so tapped out. And I've seen you on your not great days and after working 12 plus hours, how do you find that fire to keep going back in and working and raising children and some modicum of hope?

Well, there certainly have been days where that hope feels, you know, I, as you mentioned, I tend to be fairly outspoken on Twitter and that is both a good thing and a bad thing depending on whose perspective you're looking at.

But I care very passionately about all of us and I want all of us to be okay. So whether it's related to gun violence that now has impacted us by having a shooting of our own because a patient felt that their symptoms weren't adequately managed or a school full of children getting shot up, I feel very deeply that we all need to use our voices, whatever that voice is and whatever that is that is important and meaningful and speaks to you.

And I think that being a mom is super hard and being a mom physician is super hard in different ways. I think you've heard me say this probably more times than I care to count that I feel like I'm failing at something at all times because you can't be in every place at every time.

And so the pandemic has been really difficult. I mean, I left a full-time position because they couldn't accommodate my need to be able to be there for my kids.

And they were super young. They were five and seven when the pandemic started and I'm single parenting them. And so I think the plus or silver lining of what has come out of COVID is the fact that we have an opportunity to take stock and really take inventory of what What is okay with us?

What's not okay with us? And I would encourage anyone listening who's been struggling with that to realize that you can pivot. You absolutely can pivot.

You don't have to stay stuck in a situation that isn't working for you and isn't working for your family. And even wearing my entrepreneurial hat, you know, I had one early team member who was frustrated by the pace at which

things were moving.

And I get it because I would love to do nothing but work on Pallity full-time, but I also need to pay the mortgage and my kid's tuition and the nanny.

And I can't do that based on a hope and a dream. I can do that when we're fully invested as a company, but we're still fundraising. So I still have to work.

And I still have to pay those bills. And so being able to, as you were mentioning, put boundaries up and say, here is my line. Here's what I can and cannot do.

Here's what I'm willing and not willing to do. And that's harder when you have kids because you have other responsibilities and people you're beholden to.

It's not just your employment. You have to think about the impact to the whole family. And so I would say, find your passion, figure out what your voice is, figure out what you want to lend that voice to.

And it doesn't have to be clinical medicine. There are many companies out there that are looking for physician voices on their boards, on their teams.

They want to innovate in this space. You know, there's biopharma and frankly, even just pivoting completely away from medicine. I know some folks who have walked away completely and have like opened up bakeries and they're thrilled and their quality of life is better than they felt it was before.

So I would say if you're concerned, reach out, you know, not to be an advertisement for you, but join the revitalized circle and talk to other physician.

women who are trying to figure this out. We are better together. We can support each other to make change happen. And I don't think that sitting at home and living a fearful life where you are not living what you want your life to look like is living.

That's my personal sense on it. I realized that asking people to make a big shift is hard and it's scary. I know it was for me and I had a lot of support systems in place to make me feel brave enough to do that.

Some of which was having people like you say to me, you can walk away from what you're doing. You can find other opportunities. Here are some opportunities I know about that might be up your alley.

I don't know if I would have been that brave to do it without having people in my corner. But I think physicians as a group and women physicians as a group and physician moms as a group, we tend to be pretty big on supporting each other.

There are multiple Facebook groups that are physician mom based that have all sorts of niches, you know, physician moms who RV, physician moms who airstream at national parks.

There's a group for you somewhere. Just find your people. Yeah, I think that's really key. And one of our core tenants of Revitalize is you've got to have your tribe.

You have to have a core group of people that you can be vulnerable about because our jobs are hard. I mean, we knew that when we signed up, maybe we didn't know how hard, but we had an inkling.

But I think life has gotten harder and more complex, certainly COVID alone. So having those people that you can lean on, You know, one of the things that get me the most emotional, I've teared up a couple of times already during this podcast, but physician suicide just cuts me to my core.

I don't want anyone to kill themselves. And I belong to two communities that are extremely good at killing

themselves, veterans and physicians. So I've always wondered, what is my risk if you over-reliant those two?

I've never seen that study published. But it's so disturbing to me, the rate of physician suicide. And if you're a non-physician or even physician listening, physicians are the top occupation.

We kill ourselves more than any other occupational group. And if that's not a red flag, I don't know what is. Yeah. I think that I would echo that that is definitely a major issue that we need to tackle.

And I think the first step in tackling it is for people to find their own tribes. I think that helps eliminate that sense of isolation that happens. And really, doctors in particular are not great about seeking help, let's be honest.

Starting out with our conversation, we aren't good at taking care of ourselves. Many of us went into the healthcare and healing professions because we're really good at taking care of others.

And so I think the first step is having that accountability, buddy, having that circle of people who, when you're not doing okay, you feel okay saying, I'm not okay.

And being able to reach out, which is something that's hard for us to do. We're used to being in charge and in control and. Knowing what the right answer is, you know, we're the ones who got the A on the test in high school.

We're not good with uncertainty. At least most of the physicians I know, we're not great with uncertainty and we're not great with having to ask for help.

And so I know for me, the last two and a half years have had moments that have been very hard and, and very dark. And I've reached out to my people. And my people have helped buoy me up and keep me going and, you know, made sure that I was still okay when things weren't going fantastically.

I don't know too many physicians who haven't had fleeting thoughts of, God, things would be easier if I just ended this, whether it be their career or what they're doing or, or sadly their lives.

And. The only way out is through, you know, going back to that that book that my children read over and over and over again. We're going on a bear hunt.

You can't go over it. You can't go under it. You got to go through it. And I think going through it together, holding arms, holding hands, having someone with their hands on your back to to quote one of my favorite Peloton instructors.

It makes a huge difference. I don't think it's the only answer, but I think it's part of the answer. Yeah. And I just want to send the message to anybody listening that if you need to take time off from work, take time off.

You know, I was on a call with another doc today that says they're losing a doc in their group and they're all being asked to pick up more hours. And it is okay to say, I can't pick up anymore.

I simply cannot, it's not possible because at some point the system's going to have to change. And this is where I think we need to take a nod from the nurses because they've unionized, they've banded together, they have set extremely firm boundaries about work hours and what they will and will not do.

And I think physicians are just starting to finally get the message that we're going to have to do some serious boundary work to ultimately protect our patients.

Totally. And if anyone listening is feeling distressed, please do reach out. Reach out to your friends. Reach out to your colleagues. Reach out to your employee assistance program.

Most hospitals have one. It's confidential. Reach out to the national hotlines. We want people to be OK. And we understand that a lot of people right now are not OK.

And we're here. And there are a lot of docs out there who want to help other docs who are struggling right now. Absolutely. And I promise you that after the struggle, and we don't want you to just be stuck in struggle.

It's everything when you get to those doors of your hospital and you're like, OK, one more day. I'll probably make it through this day. And that's not a way to live either.

Couldn't agree more. I think that we've spent way too many years becoming the physicians that we are to not find joy in what we do. And sometimes it's just a matter of switching work environments.

You know, some places are just not the right fit. Some places are just not the right culture. And it's okay to acknowledge that and move on. And I get that that's hard.

And especially as, as a mom, I know it's hard, especially if you have a family and you're situated in a specific place and the schools and the, you know, your spouse's employment and things like that.

I get that that's really hard to do. But one nice thing about being a doc is we are very employable. You know, we, we have skills, we have assets both clinically and nonclinically.

that we can bring to bear. And so I think we've been indoctrinated into believing that the only way is the system we're potentially already in. So, you know, a lot of my friends who are in academics, oh, I can only do academics.

Like, actually, no, you can step out of the ivory tower. You can actually go do something else. We have a lot of choices. I think we've been trained to believe we don't.

They can't run a hospital without physicians. They cannot run healthcare without physicians. They sure as heck are trying, but they cannot really run it without physicians.

And we as a group need to start setting those boundaries like Andrea was talking about and say, I'm willing to work under these circumstances.

Closing Thoughts and Contact Information

I'm not willing to work under these other circumstances. And the more people who say, no, that's not okay. They're not gonna be as able to do what they've been doing, which is really exploiting our nature, which is to always offer more and always say, Oh, sure.

I'll pick up that extra shift or sure. I'll help out. I know we're short staffed or sure. I'll take on this new committee or administrative task that you're not compensating me for, but that's eating away at my time with my family or my kids or my hobbies.

Oh, so much work to do, but I'm energized that there's doctors like you and all of the women that we've had on the season of the podcast so far. such an inspiring group that I am, while I'm incredibly worried about the future of healthcare, I'm also cautiously optimistic that we have enough people that are going to be the trailblazers and the transformers.

I mean, a company like Pallity that can really push the needle and bring things directly to patients is so exciting. Well, thanks, Andrew. I really appreciate you having me on to chat.

And I really do agree with you that we as a group have so much power to make change happen. And I think that if we all find that voice and that thing we're passionate about and we speak up and we, we make change happen in our own, you know, small microcosms that, that will coalesce into a very large movement of change.

And I do feel that that revolution is coming. And we're going to be sisters right on the front lines, making it happen. So where can our audience connect with you?

Can you mention Palade's website and your social media handles? Sure. So you can find me on Twitter under my name, ariannachat. You can find me on LinkedIn under my name, ariannachatmd.

You can find us at palade.com. I have a, I'm trying to think of what other social media handles I have. I think I have Instagram and a few others, but I frankly don't use them as much.

So LinkedIn and Twitter are probably the easiest places to find me professionally and then at pallity.com. And if people. I would go on over there and just subscribe.

I promise you're not going to get spammed, but you will get an announcement when we do open for the general public to be able to engage with us. And in the meantime, there are some videos and educational tutorials and blogs that will be posted.

It's free. It's accessible to anyone. And it'll just keep you on our list of people that when we do open the doors for everybody to come on in. people can start joining.

I'm so excited and thank you so much for everything that you're doing as a physician, as a mom, as an advocate, as a change maker. I honestly don't know where you find the time or the energy, but it is amazing to have you in my life.

I feel the same way about you, Andrea. Thanks for listening to Heartline, conversations with healthcare changemakers following their heartlines. I'd so appreciate it if you could take a quick moment and hit the like button and also the subscribe button that you'll find within your podcast app or platform that you're listening on.

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