

It's not about dying it's about living.

Welcome to SBH Bronx Health Talk, produced by SBH Health System and broadcast from the beautiful studios at St. Barnabas Hospital in the Bronx. I'm Steven Clark.

Palliative care is defined by the World Health Organization as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification, an impeccable assessment and treatment of pain and other problems – physical, psychosocial and spiritual. With us today to discuss palliative care is Dr. Steven Reichert, director of palliative care at SBH Health System. Welcome Dr. Reichert.

Does that sound like a good definition?

*It actually is. It's a hard thing sometimes when I tell people what I do for a living and I tell people I'm a comfort care doctor and my job is to try and improve your life. My friends and family sometimes jokingly call me Dr. Death, but I do like to talk about living and we all face challenges. When I walk into your room you've had a bad day and you're facing serious mental illness, this is some physical illness and either you or your family is having a hard time and I'm there to help try to make things better now.*

Hospice care is palliative care, but palliative care is not necessarily hospice care, right?

*Absolutely. Hospice care is a very specific discipline doctors and nurses and social workers that are trained in managing patients who are truly at the end of life, but also in those situations patients have already made a decision or their families. They've decided to forego aggressive life-sustaining care. These are patients that have given up on chemotherapy or their oncologists has said "I'm sorry there's nothing we can do" These are patients who have decided not to pursue artificial life support so the hospice population is various. In palliative care I deal with a much broader range of patients, patients who face certainly very serious illness and life-threatening but patients who may have months or even years to live but face serious challenges either because of emotional issues or social issues or physical issues or also just helping them with medical decision-making, understanding some of the really complex choices that are available to them and what might fit their own personality, their own lifestyle best as they move forward.*

Do you think patients understand the difference?

*No, absolutely not. Even hospice care itself has an understandably negative connotation, but many people when they think of hospice care they think "Oh a hospice as a place you go to die. They send you somewhere and you go there to die." and hospice care is also that living it's about helping you live as best you can for the remaining time of your life. By estimation, most hospice patients have less than six months to live many are only in hospice care for a few weeks but some hospice patients*

*can live for much longer than six months. Palliative care is even broader and more diffuse and that's why when I introduce myself I now say "I'm a comfort care doctor I'm here to try and make things better" in a very broad sense.*

When we talk about comfort care, which I think is a good way of putting it, what services are we talking about specifically?

*Well, it's multidisciplinary, so I might be addressing physical symptoms of illness – pain or nausea, vomiting, loss of appetite, and I work not just with the patient, but often times with families, managing family's expectations, helping them understand what's going on with their loved one because it's very confusing sometimes to watch your loved one as they get sicker and a common symptom would be loss of appetite. "Well, my mom isn't eating" and one option is to put a tube in them and help them eat but you're not really forcing them to eat they're getting calories. A big portion that might be just working with the patient and the family understanding that's a portion of their life process. Along with physical there might be social issues they might need; helping them appoint a health care proxy, a guardian, helping them improve their living situation or perhaps finding a different situation because their health has now impacted their ability to live independently in the community and they might need to go either get a home health aide or move into a nursing home environment.*

So again, in addition to cancer patients, and I guess patients with dementia, what other patients do you typically see?

*Any patient who has a disease where the physician or the care provider wouldn't be surprised if you died within a year is someone who's appropriate for me. So heart failure patients, patients with liver disease, bad lung disease, kidney, problems, certainly cancer, dementia it's a very broad range and I like to look at it just if you think somebody's suffering and they're having a hard time that's a good time to get a palliative care physician to come in and help out in any of the different disciplines.*

Now I guess there are new palliative care services coming down the pike on an ongoing basis. As we become perhaps more holistic.

*It's an evolving discipline so the discipline itself is probably reasonably only about 20 years old and has really seen a big growth in the past 10 to 15 years. It's mostly a hospital-based discipline, but in the future the growth would be into the outpatient arena trying to get people and working with them before they get sick. Almost all my patients that I see I see in the hospital setting, but ideally I'd love to see somebody and do the things that I do with them before they're even facing their life-threatening or more serious illness and there is a bit of an expansion in the outpatient area. It's slow, it's hampered by lack of resources. There aren't that many people who do what I do and also let's face it, it also comes down to money and the reimbursement for outpatient facilities and outpatient palliative care is slow to change. It's coming, but it's slow.*

I remember during the physician award ceremony in the spring and I know you and Dr. Perlstein, as president/CEO of the hospital, both grew up in Cincinnati area and I guess you go pretty far back and he mentioned that he could never do what you do in dealing with seriously ill patients. How did you get involved in that?

*You know I'd like to tell you it was intelligent design, that it was a thought-out concept, but it wasn't. When I started working at Mount Sinai in 1995, one of my co-attendings I was partnered with, somebody for a month, he was a palliative care doctor. It was a brand new discipline and I had no idea what he was doing. I knew what palliative care was because I had experience in Mount Sinai and I moved around in my career when I was working at Queens about ten years ago. I saw an institution that badly needed palliative care I knew enough about what it was and I kind of went on a bit of a pilgrimage or a bit of a mission to get palliative care at this hospital I finally did. I convinced the administration to hire somebody who I had known from Mount Sinai. She was really brilliant and a nurse who works with her and then somewhere along the way I found out that I could become trained in palliative care myself. I did the training under her tutelage and then as fate would have it as that job at Queens disappeared the door opened for me here at St. Barnabas and I've been here for six years now. So it hasn't been by intelligent design, but I think it's been a little bit by fate.*

Yeah, I would imagine there are days that are very tough. I mean it's I mean let's face it, it could be sort of a downer even though I know palliative care is for the living not just for the dying but still it's got to be tough, right?

*Personally it's been a humbling and life-affirming experience as a physician being present, being witnessed to see so many people with so many terrible situations, not just a physical illness but their spiritual loss of faith, their abandonment by family, their difficult social situations. To be honest, selfishly I think there but the grace of God goes I, so it's very life-affirming for me. It also is very humbling because it makes you realize and look at your own mortality. I see people all the time younger than me who won't live to be as old as I am. So it is very positive in some respects. Depressing at times. There's a lot of sadness, but what's very interesting is that I can often times take situations where people are really suffering in multiple ways and I can make things better even if that better might be death. One of the most rewarding experiences I get from my job, and it happens a lot, is the unexpected unsolicited phone call from a family member who I might have only worked with once or twice, calling me after the loved one's dying and thanking me, thanking me for helping their loved one have a peaceful end. So, sad that they died, but we're all going to die someday, but I can do a lot to help make sure they have a peaceful end and that's in some ways uplifting.*

I can understand that. I sort of piggybacking off that answer of yours I know you are the ethics columnist for our physician magazine and I would think as far as the family is concerned there are some issues they have to grapple with and come to terms with as well, right?

*Many. To begin with just the shock and the process of dealing with bad news and I break a lot of bad news, so family is working with denial or anger or bargaining as they work through the process before they can accept what's going on. For many in this community especially their strong spirituality and religious beliefs become very challenged and tested when they're in an ICU environment and their belief and faith that God will heal and restore sometimes can become very much challenged as their loved ones get sicker and suffer. So then you also have the families that unfortunately are in disagreement or sometimes even fight with each other. I ask very hard questions and we spend a lot of time talking about life support machines and whether to stop them or not and sadly sometimes there's disagreement amongst families and I have to kind of allow them to go through their process as they each come to their own accord.*

What have you learned from your patients and your patients' families?

*I've learned to be humble. I've learned to remove myself from the decision-making. I don't push my families or my patients in a direction, nor do I lead them. I try and stay beside them. I try and be witnessed to what they're going through and instead of doing what I know is best, something I might have done 10 years ago, telling them what to do and no you don't understand this is the best choice, I now try and stay beside them and whatever decisions they make, which are very personal, I respect them. I spent a lot of my time in the ICU with life support machines and I see a lot of families making decisions that I personally wouldn't make if it was myself or my loved ones; keeping patients who were comatose and will be so for the rest of their lives on life support machines. Ten years ago, before I started doing this work, I would have tried to push them or lead them in the direction that I felt they should go and then when they didn't I would get frustrated and kind of step away. Now, I stay with them, I'm present beside them and respect the decisions they make and help them come through the process that meets them best and that's humbling. We're not used to that as physicians. We're used to giving orders and having a plan and then they don't do what we want to do it gets frustrating as doctors. Not anymore for me because it's not my loved one and it's not my decision to make.*

I would think that the advent of euthanasia now being legal in certain states and including New Jersey, I think just passed it this month, does that impact on you?

*It's not euthanasia. That's an important distinction. New Jersey just passed a law consistent with some other states in the United States which allows for physician-assisted suicide – California, Oregon, Vermont, I think Alaska, Colorado and now New Jersey maybe one or two other states that have the bill passed allows for a patient to solicit from their physician a prescription for a lethal dose of medication which the patient self-administers. It's not legal in New York. I have only once or twice in my career had a patient ask me or a family ask me to do something I can do to speed this along because it isn't legal. I wasn't able to do that. Whether that law comes into effect in New York or not we'll see and it certainly would change my practice to a degree. I have my own concerns about that particular law because I sometimes worry that a patient's decision to end their life is based upon the failure of them seeing a*

*palliative care doctor in and that there are things that we can do to improve your life before you die of your natural course. Now there are some patients that say, "Look I just don't choose to live the way I live moving forward I'd like to end my life," and I respect that and I think in the right situation I probably would prescribe if I were in a state where it was legal.*

I read somewhere, I think it's the New England Journal of Medicine, that 60 percent of patients who would benefit from palliative care don't receive those services. Do you see that as well?

*Not at St. Barnabas. I've been here for six years and my initial worry was that I wouldn't be used as often as I thought I needed to, or I would walk into situations and say what have you been waiting for? Why have you taken so long to call me? I think I've worked up a strong enough relationship with our community and our doctors that at least at the extreme measures I don't walk into situations and shake my head and and feel like I have not got my message out. There are certainly a lot more patients that I could see, but at least at Barnabas I feel like those that really need my services are getting them and it's rare that I run across a situation where they haven't.*

I know I often see you in the cafeteria with a lot of the residents. Is that a rotation palliative care?

*Yeah at our institution every resident during their second year spends two weeks with me, in internal medicine. Other residents have the choice to. I'm actually working with a doctor from emergency medicine now and I think as my message becomes spread through the hospital and the residents know what I do, more and more of them who don't have a mandatory rotations are seeking out time to work with me. That's not the way it is around the country. Our residency has a mandated rotation but the vast majority don't. It's an elective for others.*

How do these young doctors respond to this rotation?

*Most of them, their eyes are pretty wide open and the response that I get is "wow I never knew how to talk to a person...I never know to communicate with somebody." Many of them are really kind of stunned when they have spent all their career learning to do things one way and then they spend their time with me and I would say I had the same epiphany because when I did my training in palliative care I had been a doctor for 20 years and I thought well I know what I'm doing with 20 years experience. I was remarkably humbled when I learned the more effective way to really communicate and to evaluate a person as a whole, not just by their disease.*

OK, Dr. Reichert, thank you for a few minutes today on SPH Bronx Health Talk. For more information on services available at SBH Health System visit [www.sbhny.org](http://www.sbhny.org) and thank you for joining us today.