What the Hell Is Narrative Medicine? Listening as a Healing Art with Julia Schneider Transcript

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Introduction to narrative medicine

Pain is one of those things that you cannot measure. You cannot give, at least you from the outside perspective cannot, measure you can't give somebody a blood test and tell how much pain they're in, you cant put a thermometer in somebody and guess at their pain.

you have to elicit their story. There's virtually no training in pain care for how to listen to patient stories. Narrative medicine actually makes a pretty bold and controversial claim that story is a human field, it's not a medical field.

We should be able to relate to people as people in practice. And that's what we do. With the wisdom from holistic, alternative, and these conventional medicines, we are here to challenge the status quo.

We're curious about the connectivity and complexity between diverse fields of knowledge as a relief to consciousness, chronic illness, mental health, resilience, learning more about art and science of healing, or listening to stories of extraordinary healing.

You're in the right place. Let's dive in. Today, I'm so excited to begin our podcast where medicine is more than science, it's story, art, and connection.

And today I have a special guest, Julia Schneider, who I've known for many years at Columbia University where we both met studying narrative medicine and I could see the spark of passion and we worked together with her program, Narrative RX.

And Julia holds a master's degree in literature in University of Texas at Austin, also my alma mater. I actually did my undergraduate in chemical engineering in Austin.

She's a graduate of Columbia University narrative medicine and a founder of and director of narrative RX, a medical humanities initiative that brings together healthcare professionals, patients, educators and advocates through storytelling, reflection and dialogue.

As a writer, she works primarily in poetry, creative nonfiction, and lyric memoir. Writing under the name Jules Forchet, She explores themes of motherhood, ecology, southern folklore, And coastal landscapes of the deep south where she was raised.

Her work has appeared in Smokelong Quarterly, Simran Review, River Heron, Literary Mama, Emmy R, and other literary journals. She's also shortlisted for the Master's Review for Best Emerging Writers Prize in her poetry collection, Oranges in the Night of Plenty, And is the finalist in The Moon City Poetry Award.

Alongside her literary work, she brings two decades of experience as a massage and yoga therapist, specializing in persistent pain. she also has taught education courses in yoga, bodywork, pain management massage, facilitates narrative medicine workshops, retreats, courses and keynote presentations for interdisciplinary audiences around the world.

She's based in Austin, Texas, and she collaborates with healthcare organizations, universities, non-profit and community groups seeking to integrate the arts and humanities into clinical practice, education and professional wellbeing.

And if you want to learn more about Julia, she has a website, NarrativeRx. Thank you, Julia for being here. I'm so excited to have you today. at our podcast.

Our podcast is the alchemy of both narrative medicine, integrative medicine and psychedelic medicine. Particularly, I know we met many years ago at Columbia studying narrative and I would like to begin and have our audience understand kind of what narrative is and the definitions and meaning has so many meanings.

So I'm curious to hear your definition of what narrative medicine is and how you bring that into the work that you do. Thank you so much, Alia. It's such a joy to be here with you.

I think you and I were in the original cohort for the CPA program at Columbia. So it's so cool to feel this come full circle with your here. Yes. What the hell is narrative medicine?

It is a question I get all the time. Still don't know the answer to it. Hope I never know. The answer. To it, I have an inkling that it is less a thing than a mode, kind of a mood of paying attention, a listening practice.

more of a verb kind of thing, you know, something that you try to do. And of course that begs the question of how do you practice this indefinable thing?

And I think that really all narrative medicine is over and over again, trying to lean in and be curious. listening for the smallest details of tone and embodiment, all of the unspoken questions maybe that you see hovering around the borders of somebody as they speak, how to find everyone and everything interesting just by virtue of your curiosity.

Defining narrative medicine as listening

And that is something that takes diligent practice day in and day out. I find that narrative medicine is extraordinarily helpful, not just for people in healthcare, but also for writers, for our people interested in the arts.

For me personally, I come from a background in academia and I actually almost finished a PhD program in literature before I opened my wellness center.

And the kind of listening that I was taught to do in graduate school was a very critical kind listening. It was listening for gaps, it was learning for places to insert your own voice so that you could be a part of the scholarly conversation.

Narrative medicine is not that. And it is medicine to me to learn this new approach of thinking with other minds rather than against them. And that's helpful in countless different fields, right?

It's just helpful just in personal life, you know, to slow down, think with a speaker rather than waiting for our next turn to speak to truly try to understand.

Very true, yeah. I love how you say with the speaker, with person that you're in any form in medicine, in practice, and even in relationships. I'm also very curious about what made you move from literature, and I don't imagine you've separated that out yet because it's so entwined with narrative medicine, but you're an author, you are a writer, How do you bring that element into teaching that with other clinicians and other healers that you work with in your workshops and in the organizations and healthcare organizations?

How you really bring into an understanding that they can fully connect with? And I could, you know, imagine, and I'm speaking from my own personal experience with that is like poetry and medicine don't seem to be kind of connected, but so much of it is.

So how do you bring it together for people who are just new to this? Actually, I think my bigger hurdle as a teacher and a facilitator is working with people, who have a ton of experience in poetry, in the arts.

Those folks tend to the bigger challenges, that I put myself in that camp. You know when I came to, this I was in this camp as well and had a lot of challenges and hurdles.

And it's because of this way that we're taught in school to critique or to be the one who knows something about

something. And we bring our egos with us, especially if we are the only person with a degree in the arts in a room full of people in medicine, then we were talking about poetry and we want to the ones who know all about it, right?

And that's the personality that I have as well that actually, I think, requires the most kind of tenderness and humility and slowing down. Whereas I actually find that the people in medicine, the People who are practicing medicine all the time, they actually come to it like sponges.

They're hungry, for practice in the arts, because it is a kind a kind of therapy for them to not have to be the one who knows all the time and to being in this dabbling space where they can just sink in and wonder about a poem or wonder a painting.

And it's a study that I don't think get to do very often. So I guess to answer your question in a very roundabout way, how do I go about integrating these fields.

I think in medicine, it integrates very naturally because it's filling a gap that they didn't even know was there. And oftentimes after workshop or after study together, you know, there are folks in the medical arts are very much looking for next steps.

So why do stories matter? I often think about this as a clinician doctor and thinking about, well, you know, we only get 15 or 20 minutes per visit. There's a lot to be done and we have to think what medicine orders, labs, there's this constraint around time, but also all the other activities and all of the necessary things that have happened in that clinician, that visit, But I often feel like sometimes that can be ignored and you can really just try to be with a patient.

But why does it matter that the patient's story or the patients experience be in the forefront of that visit? How do you bring that into context for providers when they say they don't have enough time, they're not focused on that?

Why does it matter? So I should have these stats at the front of my brain. And of course, they've flown away. So we might need to fact check me in post.

Let's just assume I know what I'm talking about here. Can I ask you how long you think it takes for the average patient to be interrupted by their physician during an initial intake?

I would say I'd know the number. It varies from 12 to 15 or 17 seconds. Yes, I was going to say 11, but we were in the ballpark. Very short amount of time.

However, they've done other studies where they're actually tracking how long it takes to patients, for patients to get their whole story out without interruption.

Bringing poetry and the arts into clinical practice

And they consider the whole-story meaning either the patient has finished speaking and is now awaiting a reply, or the patients has said something like, okay, that's my story and asks a question of the physician.

How long do you think that takes on average for them to just spill it all out? I would say five minutes. Two. Is the average. And there are outliers, obviously.

There are people who can talk for a little bit longer, but it's a very small percentage. When I have people in class who are saying, God, if I ask them to tell me their story, they're going to me everything else but what I'm listening for.

I say, great, because you need to know all of those other things. What you're listening to isn't going tell you anything interesting. and it takes the average patient all of two minutes to get it all out.

If that's all I'm teaching people is to wait two minute before speaking, then I feel like I can tell myself job well done.

To answer your question though about the importance of story and putting story at the forefront of a visit, so Historically, I've worked mostly in pain care.

I have half of my professional life in academia, but the other half I worked as a massage and yoga therapist, and I owned a pain center here in Austin for many years before the pandemic.

And we focus primarily on persistent pain. And pain is one of those things that you cannot measure. You cannot give, at least you from the outside perspective cannot, measure you can't give somebody a blood test and tell how much pain they're in.

you Can't put a thermometer in somebody and guess at their pain. And yet there's virtually no training in pain care for how to listen to patient stories.

So primarily I would work with OTs, PTs people in the manual therapy field. And we are taught that story is not our purview. If someone comes in with a big long story that pertains to their pain, outsource them to somebody in psychology and somebody and psychiatry, that's not our field.

And narrative medicine actually makes a pretty bold and controversial claim that story is a human field, it's a medical field we should be able to relate to people as people in practice.

And that's what we do. We give people that practice of relating. I'm particularly fascinated by what you just spoke about, which is pain and the element of pain, and this psychological component to pain.

How do you elicit that story now with your narrative training and narrative competency, I imagine? How do you elicit that story of pain in a patient? Because I find that that is a challenging diagnosis and there's so many layers to pain itself.

So it gets complicated very quickly and, there are all kinds of pains. And the history of the pain is there too for that patient. How you do elicited that?

How did you really get to that stories when it comes to the pains? I wish I had a good answer for you. I think the only answer I have is how not to. The default mode of asking someone about their pain right now is the scale, the 1 to 10, or even the little emojis that you have to choose between.

That's not it. I mean, that might be a place to start, you know, but I don't think you get anything interesting on a scale of one to 10 other than a starting place.

I think probably the best way to elicit a story in anyone is to ask an initial open-ended question and then shut up. And I, I Each case is different and each provider-patient relationship is difference.

Maybe somebody comes in already telling their story. practice keeping questions open-ended. I'm reading a great book right now by Elizabeth McCracken called The Long Game, and it's a craft book.

And in it, she says, there is no interesting binary question. Keep thinking about that. Go for the open ended questions and then just listen, see what happens.

See what other questions opened up for you. Yeah, I agree. I think keeping it open-ended, just starting with the initial question and then being very just quiet, as you said, and just listening because often there is the unraveling of that story as the patients kind of engage with their experience of it.

How does storytelling become a part of healing? What would you say? You know, you're a writer and also a poet and, also, somebody who, again, works very hands-on with patients.

What do you observe about storytelling as a form of from the perspective of somebody who works with manual therapy. So healing as it pertains to somebody is doing hands-on work with patients where there are issues in the

tissues, so to speak.

A lot of what we're learning about pain care is that there are very rarely issues that are only in the tissues or issues in tissues at all. In fact, a lot cutting-edge pain is looking at the nervous system and the system's role in healing.

So a a of pain, for example, In cases of persistent pain, you often get something called central sensitization, where the spinal cord actually starts to remember pathways of pain and it shunts it along those pain pathways, start becoming very effective.

It will signal pain even with something that would not normally trigger it, because now they're getting very good at delivering the pain signal. So it's like your monitors on your home, the sensors that turn the lights on when there's a squirrel passing by.

Maybe you have them set to something big normally, like somebody breaking into your house, but now it is going off at every little thing. That's the kind of work of central sensitization.

So when we're working with patients in manual therapy, we are not actually untying knots or melting fascia. Those things are metaphors. And metaphores can be very helpful for people psychologically, but what we're really doing is retraining nervous systems that they're safe.

We're giving the body an experience of being safe so that it can learn it doesn't have to exist in that fight or flight mode all the time. Various manual therapists do it in different ways.

You know, sometimes just a feeling of safety and relaxation can be enough for that. A lot of therapists in my camp, we actually work with a resist relax method where you kind of take people to the edge of a pain experience, let the body experience safety in the end of the pain experiences and then they can relax a little bit further into whatever posture that they're struggling with.

Why patient stories matter in limited visit time

So I think in one sense, story works as just the nervous system itself learning where it is right now versus where its been, right? So even without our input, the Nervous System is learning and changing story and rewriting story, and, you know, changing the tone of a story.

That's happening in practice already. And then there's the storytelling is healing where we're actually vocalizing our stories. And I actually don't work with patients on that side of things.

I work the providers on the side things and that's, I think, just as fascinating because these providers, man, they've got some things that that just the ambient trauma of working in pain, they have stories to tell too.

And being able to be in a group of other providers as they tell those stories can feel like such a safe space and can be very healing for providers, as well.

Yeah. Wow, I think that's fascinating. You know, when we do ketamine treatments and I have one particular patient who really speaks about his pain and now we're doing neurofeedback and we now do QEG and brain mapping.

So I was looking at his brain map and know the context of his story because he has so many injuries. physical injuries and then he's had surgeries and he has had trauma from the surgical complications and the fear around the recovery from that procedure and several procedures in addition to the trauma that he already experienced in the military, in combat.

And then there's this complex trauma that he holds in his body from abuse, from physical abuse early childhood. And you can see that the layering, this only layers to his pain, that when he does ketamine treatments, he gets a break from that.

all these kind of the element of where his pain exists and and where where he's daily focused on and just having that break and that safety as you described gives him a space to kind, of explore it in a very different way.

So when I was doing his brain map after several many treatments of ketamine treatments and his response he I said to him, I looked at his brain map, and I say, wow, you know, it seems like pain takes up a lot of real estate in your brain.

Like, there's a a of activity in that pain center. That seems to be, from my perception, just because of the activities. And he's not disabled. Mentally, encased in the experience of his pain, that separating it from the physical, the actual kind of psychological effect, is a real challenge.

And so I'm very curious about how the storytelling and one of the things that I was talking to him about, well, you know, while you do your session in ketamine, exploring your body and asking it and just using music and using the experience and the visualization.

of what you feel comes to you in your session, the supportive element of you're experiencing in that, and really bringing it into those places where that pain is felt for you.

And this is a person who isn't very creative. or feels very locked, I guess, held by creativity is really challenging. But when he comes out of his session, suddenly he sits up, he feels lifted, emotionally very relaxed, and then he can talk a little bit more about you know, his body in a very different way, in the way that says, hey, you look what else the body is doing, look at what I'm feeling.

And then kind of talking a little bit about the past experiences of his medical trauma. I see this as well, a lot of patients to have a long medical drama and so they hold their pain in terms of that trauma that they've experienced in their medical setting too.

So he's able to disengage in that. But I'm still working on ways of bringing in creativity or bringing the reflection of that experience. So the integrative experience is there for him to practice on between sessions.

I am just kind of exploring with you ideas on how that can be. What are your thoughts on? on bringing in something, an integrative practice like that or something creative using the tools of narrative medicine, especially for patients who hold different kinds of different layers of pain in their body.

I think the story that you've told is such a beautiful example of the difference between biomedical approaches and biopsychosocial approaches to pain.

In the biomedical approach, you would just look at the physical causes of pain in the body. You would be looking at his injuries and his surgeries. Something that you can actually take a picture of on some sort of a scan or measurements done during some analysis.

You know, something that is externally viewable by other people would be something biomedical. But what you're talking about, his childhood abuse, experience in the military, you know his feelings about his pain as they've snowballed over these years.

All of these are biopsychosocial. It doesn't mean that the biological influences are not there. it just means that they always come along with these inseparable other psychological and social influences.

And these influences, are going to impact an experience of pain to the point that, they may actually, make it worse. They make non-existent, depending on how you view it.

In the pain science community, We often call certain things SIMs or DIMMs. SIMS mean safety in me, and DEMs are things that cause a feeling of danger in my.

And a SIM or a DIN could be the same thing, just reframed.

Pain, trauma, and the biopsychosocial model

Like, for example, diagnosis. You get a diagnosis, you could look at the diagnosis and you can say, well, shit, my life is just one long, I'm just going downhill from here.

It could a be a dim. Or you could see it as a sim and say, hey, I know what I'm working with now. I have a plan. Let's do this. The same thing can be a dim or a SIM.

And I think with folks that are in this camp of persistent pain where it's been snowballing their whole lives and it has a lot of psychosocial dimensions, one thing that could be very helpful is to Get them to create a list of their Sims and Dems and help them lean into those Sims.

Help them identify the things that make them feel safe despite the pain and to lean in to those sims. I think also reframing pain itself. The more that we understand that pain is a protector and not the antagonist that think it is, the thing we should run away from.

Pain is protecting us. It is our body working at its absolute finest. And the more we can see pain as something to work with rather than against, the more safety, I think, we feel around it.

So yeah, it sounds like you're already doing very interesting work with him and not separating out the psychosocial dimensions of it, giving him space to explore those psychosocial dimension of and to talk about how they all interplay together.

Yeah. One of the techniques I use is called a feeling body map. And particularly I find it interesting as a clinician to do that because, you know, I tell them, hey, this is a filling body.

Everybody feels pain very differently. I don't understand your experience of pain and I can only just imagine it. So I'm going to give you this body, just a picture of a body and this isn't a study that was done that, the pain was described by different colors and different visuals on that feeling, body And so I try to bring that into, I guess, a sense of connection to the body because sometimes it's often there's this dissociation to their body, even though the pain is an alarm and signaling, hey, pay attention to me.

I'm trying to help you here. So I find that that's one. Are you familiar with? kind of using visuals or things that bring in that connection to their body that helps them kind-of reframe their pain?

Well, I don't actually work a lot with the patients, so I used to. I did a massage and yoga therapy for almost 20 years. What I did was less verbal than felt.

If there were any images that we were working with, they were images provided to me by the patient themselves, and we could talk about those in session.

But usually, it was very hands-on. I could give you some silly kind of woo examples, but I worked with breath work a lot, often. If people would say that they have a persistent ache or tension in a certain area, you know, I would just provide pressure to a point of tolerable comfort and just have them breathe into that area in which with each breath in I will resist and with breath out I go to the next available barrier and that way just kind of work with that feeling of tension until slowly we could totally release the tension together.

So what the kind of imagery that I was working with was more embodied and felt. But now what I work, when I worked with physicians, the visual imagery we work is visual art.

You know, we do a lot of exploration of paintings together and close reading the details and visuals there, but no, I've not done any actual, you know.

So that re-experiencing is kind of what you're describing. Breathwork is a very deep and very necessary part of, again, ketamine treatments. We do bring that in, and I know breathwork very supportive of aligning the sympathetic

and parasympathetic system as well and expanding and releasing that tension as you describe breath work.

Thank you. You know, these are some of the things that I think it sounds like from your experience in massage and yoga therapy. and pain, recognizing that the body's connection to pain and reconfiguring or reconnecting to it in a different way in very supportive ways.

Reconnecting it to in different ways is such a great way to phrase that. I, as a massage and yoga therapist, a lot of people come with the idea that pain care is something that is done to you, on you.

Like someone is going to give you a message and you're, you know, it's just gonna melt away. And maybe that happens, but maybe, that's the experience of it.

But I think really what actually happens is that you do it to yourself from the inside out. You practice letting go of tension, you practice breathing into stuck areas.

And it's this active relationship, and it can be subtle action. It doesn't have to be somebody who's doing a full yoga practice in an extremely physical way.

It can be very subtle, but we're retraining our nervous system from the inside out to feel safer. And that's the whole goal is as a body worker, my goal was to be a facilitator and not somebody who is doing the work for them because that is not the works that works.

Yeah, I want to switch topics to narrative competency, because I think Rita Sherron talks a lot about narrative competence, and this is a very important term, for anybody who's doing healing.

Tell us about the narrative competencies and how does it work in everyday clinical practice, how do they show up? Well, I guess I consider narrative competency just the ability to hear narrative, to your stories.

So when we're working with narrative competence with physicians, usually there's a lot of hubris involved. Of course I listen to a patient tell their story.

I take the appropriate notes. And I think that the challenge really is introducing the idea that you will never be completely competent. that narrative competence is a goal, but it is never an achievable one.

And the moment you think you got it, that's the moments you need to slow down and be humble and more curious. So your question was, how do we integrate it into daily practice?

How do you teach that to clinicians that you do workshops with? Yeah, practice. Yeah. So we use artwork as a kind of test site so that we can slow down and be with something in the still present.

You know, when we're working with patients, everything is so fast. And we are getting a lot of facts all at once, not just spoken, but embodied, you know.

Working with the text, we get the kind luxury, the pleasure to be this at least somewhat still thing. and to sink in through each of those layers and really practice leaning in.

Also, when we do this in a group setting, which we always do at Narrative Medicine in the group settings, we have the benefit and the privilege of hearing other perspectives on that same still inert piece of artwork and then it comes alive because we realize Everyone has a different way to read this.

And as long as we're grounding our observations in the details of the text itself, there's a lot of room for different interpretations to coexist in this same piece.

As people start realizing the wealth of information and observation and perception of their colleagues, they start to become more open-minded just in life in general and to start listening for other voices because they realize

everybody has the secret wisdom they bring with them.

Yeah, I love that it's a shared space to kind of explore different perspectives. I think it is true in medicine. We think there's only the danger of the single story, they say, right?

You know, there is never a single stories. There's always many angles to that story. What do you think poetry and literature can teach doctors or providers something that textbooks cannot?

I don't think that poetry or literature, They may teach us certain things, you know, certain perspectives, but really, if anything, I think all they give us is a mode of listening, a mood of paying attention.

So I guess what I'm saying is I don't think they teach content, they just teach form. They teach the way we go about. They give us space to practice being humble and not having to know everything in one fell swoop, but also the space just to be curious.

And I can tell you, I guess in defense of content, and I was too quick to sideline content.

Using metaphor, imagery, and body awareness in healing

In defense content I think I have learned more things obliquely through poetry, through the saying of something sideways than I ever would have learnt from hearing a fact about the thing itself.

Hope is the thing with feathers, right? Like, how do you put that into a factual term that you can feel and understand? And you know what? Patients speak in poetry all the damn time.

They don't even know it. I had so many patients who would come with names for their pain that I often would just kind of laugh at but not make note of.

And the more that I could actually use the terminology that they had given me, that more I can participate in their metaphors, the I think it built trust between us and actually gave us useful gauges for progress.

Yeah, it's so true. You mentioned metaphor as a way of visualizing, as way anchoring, metaphores are sideways. Some people want direct information and sometimes it is not clear until patients tell you kind of things in their own language.

And I find that as a clinician, you have to be observant of that, that listening into kind the exact why this word and why not the other. A patient said to me one day that she gets this kaleidoscope experience of seeing things when she came out of her session.

She said, I get this, and I said wow, what a beautiful word you chose, kaleidoscope. Why kaleidoscope? So it's interesting that people have this natural way of communicating that I think in the medical setting we're kind of blind to because we want it to, we wanna ask the patient, well, give us the time, frequency, quality of your pain.

describe it to us so that I can document it this way instead of like when they start becoming poetic about it. Well, that's not going to fit my documentation.

Right. Even the patients themselves will be like, well, I don't know why I chose that word. It's important. But in narrative medicine, we operate under a kind of psychoanalytic framework that it's all important and it is all coming from a place in our unconscious that it does need to be heard, does have stories to tell.

And I find, so there's always a point in a narrative medicine workshop where we write ourselves and then we share our writing with the group. I found that when people reflect my words back to me, or they'll hang on a particular phrase that I hadn't even thought was important, and they reflect it back me.

Those are where the real insights come for me to understand what I didn't know I'd already written, to know what i

didn' even know i already knew. And I think that's the work that we can do with patients by highlighting not just their words, but their tones, how they say things, what they're not saying, you know, to reflect that back to them helps them kind of maybe not, it doesn't help them tell their story.

It just helps him hear their stories in a different way to see their own wisdom in it. Yeah. You work with other providers, physicians, nurses, therapists, educators.

What have you noticed about how they share their stories in healthcare? Well, I guess it depends on the person, and it definitely depends in the group.

Every group is its own animal. I've worked a lot with palliative care here in Austin with the Seton team. And I worked with chaplaincy departments. And they each come with their own kind of sets of concerns and questions.

So it would be a wildly different answer for each one. I do try to, before I get a group together, I try kind to get the preoccupations of the group before we get in so that I can choose the right artwork for us to discuss.

I don't do much planning other than that because the artwork will lead us. You know, so I will ask whoever is setting this up for the group, what are some of the struggles that they're going through right now?

Some of goals for group right. And then I'll choose an artwork that might help thicken conversation around those things so that we can dive in as a group and then different things come up.

It's an example of some other the works that you bring into your workshops. Well, just then, I was thinking of one of the very first big groups I worked with, and it was the chaplaincy department.

And I had done a retreat for them out of my home. So I the whole hospital chaplaincy group there. It was such an honor. I taught college classes before, but not this level of professional before.

I had all of these texts and I have all these questions, close reading questions and all the ideas for how we were going to spend our time. And you know what, we got to one text and one question because this group, they had much to discuss and it was such a gift to just allow them after we read the work together to each reflect to the whole group their feelings on it.

And it was a large group. I should never have done that. You know, as a facilitator, now I look back and I cringe that I allowed the entire group to share because it's so big, but it is so wonderful for them at this time.

In that case, the text that we were looking at was William Carlos Williams' Use of Force. and it was asked this, it asked lots of great questions of the group I think, but the most compelling for a chaplaincy group was when does medical advice become coercion.

So that was absolutely a wonderful discussion. And then let's see, I try to use a lot of authors and artists who come from marginalized backgrounds. I tried not to do a Lot of The Dead White Guy approach, sometimes it happens anyway, just to give you know, providers alternate experiences and perspectives.

Yeah. I mean, I think probably my favorite, just because it's my home base, my favourite genre to work with is poetry, but that's purely my own bias. Just because I love poetry so much and I find that anything you're passionate about, you can kind of that passion can become contagious for your group.

But visual art is a great entry point. In fact, recently I started working a lot with children's drawings or people who have a kind naive art style. And that's actually been, I always kind worried that people are going to think you know, that this isn't real art, but man, some of the most profound discussions have come out of those.

So just arrange. What an array of things. I think, yeah, it's so true. And it is very, I guess in groups, you can be so prepared and yet you also can just come up so naturally.

You know, you need sometimes that whole array. You can just really have the single things that definitely bring out so much more conversation than one can imagine, that it's only unique based on the group that you're working with.

I want to speak a little bit about what clinicians and the space that in healthcare, burnout is real. Healthcare is not in a good space right now. In my own experience and how I came to narrative medicine really was you I came to Neriman, I thought it was going to be writing, how to write.

And that's really what I though it would be. The first course I did, they're not teaching me how write, just talking about stories and art. But it opened up a part of me I didn't even know existed and it allowed me to kind of grieve my own experience in healthcare.

From training to the stories that I held in my experience that never had a place to talk about.

Narrative competence, burnout, and grief in healthcare

as a provider and taking care of really complex cases and children and families and seeing death and never had a place to really explore, talk about those experiences because we were told, well, move on to the next patient.

And so in a way I was grieving. processing my own experience in medicine. That's really what I was able to really appreciate about narrative medicine and having a space for that.

I feel it's very important. What do you feel is missing in healthcare? And especially when it comes to trauma, how does narrative medical help kind of reconstruct or support that experience and trauma from your experience within training and the work that you do?

So you just said so much that I want to unpack there. So at first we were talking about burnout in medicine, and then you mentioned your own kind of experience of burnout and how when you came to narrative medicine there was a kind grieving process you had to go through.

And I identify with that so, much and it's a story that i've heard from so many of our colleagues and our students that there is along with the kind medicinal quality of getting to share stories with other people.

There's also a grieving process built into that too, a release that everybody comes to it differently. But I feel like most people have that. Most people experience that grief.

And as you were talking, it made me wonder if a lot of burnout isn't just itself, a kind of grief over what you thought this profession was about, over you what thought your role was in it, and maybe grieving the ideal of what it should or could have been.

So just as you're talking, I made that connection between grief and burnout that I think is very important. But then to your question of, what is missing from healthcare right now that narrative medicine may be able to provide, especially narrative I think the risk of belaboring the point of narrative medicine as a listening practice, I would hope that any study of the arts might actually help people listen in a way that's beneficial, not just for their patients, but for themselves.

So that as providers, we don't become automatons and we experience that level of burnout. Because when we allow ourselves to really relate to people as people, which is what's missing in healthcare today, is relating to them as authentic conversations with them about mortality, about the struggle of pain and not knowing if you'll ever get your life back and having these deeper conversations, of course, with the caveat that we know when to refer out when it's needed.

But being able to just listen to these stories, this can actually, I think, restore our humanity. rather than it becoming too much of a burden and too taxing, I think it'll actually helps us fight burnout because it restores that kind of heart to the medical practice.

And one of my favorite ways to begin a workshop or any sort of retreat with a group is to ask everybody who's there to write down on a piece of paper why they became whatever it is they are.

If I'm working with chaplains, why they became a chaplain, write down a word or a phrase and to tuck that piece of paper away. And my hope is that by the end of our time together, that the reason why somehow more front and center for them than it was before that they came in.

Usually it's something like connection, relationship, I want to help somebody, or maybe they have a personal story about their brother who had X, Y, and Z issues and now they want help other people like their brothers.

And it really, for most people, what they write down on that little square of paper is some synonym for connection. And when they get to experience connection in the group setting and they help other people tell their stories and connect with them on that level, I think it can be extraordinarily relieving and help prevent their own burnout as time goes on.

Thank you. it all together. Because as I was speaking, I actually used the word grief, which kind of surprised me when I saying the words grief because that's exactly what was happening.

I kind was grieving my experience in medicine and the loss of that. that ideal. And I think a lot of us are grieving essentially when we're talking about burnout.

So burnout is not just, I mean, definitely it's fatigue and all the other things, but it is also grieving kind of the imagined hope that it was, that is isn't and can be.

Right. Absolutely. Yeah. But is a powerful thing. I don't think that it's like other emotions that can inspire and impel you to action. For me, grief is the feeling that gets its fingers pruney in itself in the best way and allows you a true depth of feeling, that I think a lot of that we're just not allowed to have in professional society or in society at large.

And grief allows for that depth a feeling that well of feeling to rise up. And to have a place to express that through art, that can be an extraordinary thing.

But I think also, I'm sure you've heard of this as a common saying, grief is just love with no place go. I love that too. There are always other emotions kind of simmering underneath grief.

A lot of times there's love there. To be able to connect with that love, again, in a new way and find new directions for it to go by connecting with others is often a kind of medicine.

Well, this is Two Curious MDs, and we always try to really bring in the idea of curiosity through a question. And what would be a questions that incites your curiosity that you'd like to ask the audience or for our next podcast or the work that What question would I like to ask the group?

Whatever your role is, whatever you do professionally or personally, what was the original reason you decided to do it? What is your why? Write it down, put it on a piece of paper, and put in your back pocket.

Keep it close. Yeah, keep it closed. Thank you. Now I'm just going to do some rapid fire questions. How do you feel about doing some Rapid Fire questions?

Let's do it. Okay. Coffee, tea, or a quiet walk before writing? Tea and quiet walks before… Coffee makes me squirrely. Pen and paper or laptop? I know.

I wish I could make it work just by hand, but I need a laptop to think. Morning writer or midnight writer? Morning, definitely. One word that describes healing for you?

Connection. one word you hope describes medicine in the next 20 years? connected. What's a poem every clinician should read? that every clinician should read.

Instead of poems themselves, I'm going to give poets. It's too big of a question for a single one. I'd say Mary Oliver simply for the fact that it has nothing to do with medicine, at least in the formal sense.

And I think most physicians could use a little bit of nature in their lives. I would say Tony Hoagland, his deathbed book, Priest Turned Therapist Treats Fear of God, I think is just a wonderful experience of dying that I believe every physician should tune into.

Gosh, let's see. I could keep going. I feel like this is a flash question round, so I should probably stop, right? No, keep going. Yeah. Okay. Karen Olds, her sonnets, absolutely fantastic.

What else? Oh, anything by Louise Glick. Again, nature writer, but lots of conversations with God going on in the background. I'm glad we're recording this because I am definitely going to be pulling those out.

Emily Dickinson or Mary Oliver, I think you already answered that. Yeah, well, yeah, I gotta go Mary Oliver.

Rapid-fire reflections on writing, poetry, and curiosity

I mean, that's a hard call, but I got to go. Listening or speaking, which is harder? Listening. Yeah. And where do you feel most creative? Where? In my car, parked in front of the coffee shop that I never actually go into, with the AC off, totally melting, so that, a deadline for finishing writing because I am so hot that I can go in and get my cup of tea.

Most creative under duress, for sure. Wow. Yeah. Well, thank you. Is there any question you would want to ask me or any kind of closing question that you have for me?

So much. Yeah. So I guess my closing question for you would be, what is your hope for this particular podcast? Who do you want it to reach? What message do hope that it gives to this audience?

I always have grand ideas on this. I want this to be for patients, for people who are doing some hard work, even for doctors, and even providers. It's for that relationship between the patient and the doctor and provider healer.

all kinds of relationships. And I hope that it keeps that humanism, that connection as you described that alive, because I can see that, it can quickly dissipate.

I find the patients use AI for therapy and they look up AI medical diagnoses and, they may get the right answer and then we get thing that they need, but that we're going to lose that contact, that communication, and that humanistic approach to healing.

And so my hope that this podcast really allows for kind of an exploration and keeping that alive, between the experience of an illness and the healer's side of that, what can emerge from that and keeping the healing ongoing.

No one is ever going to be cured of any illness, I think. Although people talk about cures, there's no illness that can be cured. It can only be supported and healed.

nurtured and something else can emerge from that. So that's what I think about how medicine is. And that why I like to do this podcast because I thinking people can hear all kinds of, and they can, like you said, they learn something different that probably I didn't even know that we were talking about from what they hear and what the observe from this, this podcasts.

Beautifully said. Thank you so much, Alia. It was a delight to be part of it. Thank you. Thanks for joining us on the Two Curious MD podcast. We hope today's episode inspired you to ask new questions and explore fresh perspectives.

post or comment with a question or curious inquiry that you have and seek to explore or learn with us. Stay curious and we'll see you next time.