3. Medical Education and the Lasting Impact of its Trauma - with Dr. Kemia Sarraf (Part I)

FULL EPISODE TRANSCRIPT

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Arpita: Hi guys. Welcome back to Doctors Living Deliberately. I'm excited to have Dr. Kemia Sarraf with us here today. Dr. Sarraf is a board certified internal medicine physician and CEO and founder of Lodestar Consulting and Executive Coaching. She and her team help high achieving professionals overcome anger, disengagement, and compassion fatigue that afflicts their high stress lives through trauma responsive methods.

Welcome, Dr. Kimia. We're so excited to have you here today.

Kemia: Ah, thank you. I'm really excited to be with both of you. And your listeners don't know this, but we had a whole before the show, show going on talking about all the intersections of our lives. We always talk about how, what a small world medicine is, and it truly is just such a small, beautiful world.

Arpita: Totally is. Yes. I know. I had the pleasure of meeting you back in 2021 at the Institute of Physician Wellness Conference for coaches and that was where it sparked my interest to get to know you and I participated in your trauma mitigation course, and that was just mind blowing. Very, very impactful. So thank you again for coming on, and I think let's just dive right in and to have you tell us a little bit about yourself and your background and kind of what led you to where you are today.

Kemia: Yeah, well, I would say that one of the things that's missing in the bio is my background in public health. And it's an important missing piece only because that's really how I ended up getting where I am. I did a public health degree before I went to medical school, and what's so interesting about that, I've learned, I don't think I realized it at the time, but it informed not only the way that I learned, but the way that I practice medicine and sort of the worldview that I have. It was never the patient in front of me. It was always the patient in context and it's just a slightly different paradigm. It also led me to have very salutogenic world view. Rather than a pathogenic worldview. You know, in medicine, in the biomedical model, we really focus on what are the components that cause disease, right? And as internists, you know, and pediatricians also, we also try to think about, okay what helps keep people healthy? But really the biomedical model is focused on pathogenesis. Public health really is about what are the conditions that help people to thrive and how do we create and sustain those, right? Ideally. Now, I'm speaking in idealistic terms here because I'm a bit of an idealist. And so that is the salutogenic model, right? What are the conditions for wellbeing? For wellness?

And so when I finished up in St. Louis, down at Barnes and moved up here to Springfield, Illinois, which is where my husband and I live, we live on a little farm just outside of Springfield. One of the things that, at that time in my life I became very interested in was child health, community health and how we could, if we could create programming designed to support, sustain, flourishing. Right? And so I started a nonprofit called Gen H Kids; Generation Healthy Kids, and it was really focused on all of those things. Well our programming grew over the years, and here's where it gets interesting. As I was doing the research for, okay, what is underpinning the pathology here? What is underpinning the

3. Medical Education and the Lasting Impact of its Trauma - with Dr. Kemia Sarraf (Part I)

childhood obesity epidemic, the adult obesity epidemic? There are things beyond the obvious. What else is going on? I came across the ACEs study, Adverse Childhood Experiences study done in 19 98, 99 by Dr. Vincent Felitti and in partnership with the C D C. And that has informed everything that I have done since.

A couple years ago in, I, I wanna say 2015. There was a book that was published by Dr. Bessel Van Der Kolk, called The Body Keeps the Score. Which really looks at adverse experiences, it's severe adversity. Right? Those things that we would call traumas and how they impact health over a lifetime, sort of underlining what we found in this initial research, the ACEs study. Now the ACEs study has been replicated and validated many, many, many times. What's interesting about it is in children, it looks at what we might call the big 10, right? It does not go on, and nor should it have originally, it really was just very, very cutting edge thinking at the time. It did not go on to look at beyond the first Big 10. You know the impact of oppression, the impact of poverty, the impact of racism. It didn't go on to look at anything that might happen after your 18th birthday, right? When you begin occupying an adult body, but you're actually not an adult. I don't know when we actually become adults, but I'll let you know when I get there, because I think I get there before you two do, at least in terms of age. And so, it's, you know, it's an incomplete.

I began building all of our programs with that in mind, right? With that idea of what does it mean to be trauma informed, trauma responsive to the populations that we work with. And so this became over 12, 14 years as I was doing that work in particular, just became reflexive. Right? For me, there's a, I like to think about fluency, there's a fluency that develops when we work with a certain paradigm over time.

So, flash forward to 20 13 and my eldest son Joseph, who was 13 at the time, is racing through my house on a Monday morning, you know, half naked as my 13 year olds always seem to be anyway, and I noticed that one half of his body is just absolutely black and blue, top to bottom. And I called him over and I took a good look at it and you know, he had a great excuse for it. He's like, oh mom, I was wrestling with Tommy on the bus and Tommy was his best friend and three times his size, three times my size at the time. And he said, I just, you know, we just were wrestling. And I thought that's not what I'm seeing here. And in fact, I knew, you know, the kind of, the way that medical mamas, medical daddies sometimes know that what they're looking at ain't good. I knew what I was looking at was leukemia. And so as we moved through that day the call to his pediatrician, the trip to his pediatrician, that looks that you exchange with your pediatrician across the exam table as he palpates liver and spleen, and goes, well, it could be, and you're like, yeah, we both know. I mean, we were in the I C U by two o'clock that afternoon with a white count of 130,000. One lonely platelet. That's how I like to phrase it. One lonely, platelet doing its job, doing its damnedest.

And, you know, ultimately a diagnosis that meant three and a half years of daily chemotherapy. A, a really, really intense first year. So I, of course was able to step away. That was the privilege of my life

at the time. Really step away from the work that I was doing, the leadership in this nonprofit just to take care of my son and I did. And I, I really, for any listener who's out there, I really do wanna acknowledge the fact that that was an immense privilege not available to most people, right? I had the privilege of my education that I knew what to do to take care of him. I also had the privilege of our financial situation, which meant that, you know, we weren't dependent on me for insurance.

So about a year and a half later, one of my best friends came and scooped me up. She's also a doctor. She said, you know, you haven't left this damn house, barely. You haven't, certainly haven't left this town in the last 18 months, and we're gonna go do some CME. You need to think about something other than cancer. And I said, you're gonna take me away for the first time for Continuing Medical Education, what the hell kind of friend are you? And she said, well, I gotta go, so you gotta go with me. I cleared it with the husband, blah, blah, blah. I said, well, where are we going? This is January, she says, we're going to Baltimore.

Arpita: Oh geez.

Kemia: February? Are you... she looked at me, she said, there will be room service. It was the room service that got me to go, if I'm completely honest. So I went with her and as it turns out dirty dog friend that she is, it wasn't CME at all. It was a coach training intensive. And what she knew about me was that I was arrogant and snotty enough at that moment in time that had, she told me that's what we were gonna go do, I would've rolled my eyes so hard they would've popped out of my head and like skidded across the floor. And that the only way to get me there was to lie to me. Thank you, Wendy.

Arpita: I love her.

Kemia: And so, yeah. And so we went through this training intensive and what brilliant and beautiful and fascinating to me was, holy hell there's this entire skillset and way of being in healing spaces with people that I not only knew nothing about, but had no skill in yet. Right? And so I began practicing. You know, I began really doing the work of learning this other set of professional skills. And the thing that I loved so much about it is that they were, those skills were so congruent with who I was sort of at my core. That was number one, but also so freeing. I did not need to have the answer for any longer. Right? And for someone who, and I imagine this might resonate with the two of you, when you spend your entire life being responsible for having the answer for, and then being responsible for the outcomes of that answer, to begin to understand that we also, not in place of, but also can practice the skill of holding space long enough for people to surface their own answers and experiment with what does and doesn't move them towards that. This concept of growth towards abnormal stages of adult development, of a lot of things that started really surfacing for me as a result, was just beautiful.

3. Medical Education and the Lasting Impact of its Trauma - with Dr. Kemia Sarraf (Part I)

And so when I began working and I wanted to come back and work with physicians because one thing I had noticed in, you know, those years with Joseph was how brittle and burned out, those were their words, so many of our colleagues were feeling, and this is 20 15, 20 16, right? And I thought, well, you know, let's coach around this. Let's do this. So that's where I began. What very quickly became apparent to me you know, in those first few years was that what I was seeing was something more than burnout, something beyond burnout. And also that the way that I coached, and I didn't realize this immediately, but that the way that I coached was very much from a trauma informed paradigm. Because that to me was like breathing, right? It's no longer a hat. The fluency was there already. It wasn't a hat that I took off and on.

And so about 2018 I was approached about actually getting detailed in how this paradigm worked and in beginning to teach other physicians, physician coaches in particular how to do it. And so I began developing that training program, that sort of advanced coach training program, in partnership with Dr. Ann Deaton, who's a clinical psychologist, been in the field of coaching for, oh God, 35, maybe 40 years now. Sorry Ann, if I'm dating you. And Antoinette Ayers who trained me originally and had been in the field of healthcare coaching her entire career, from a more from a corporate perspective. And, you know, we launched this, initially as in-person training. What was fascinating was not only how quickly it began to resonate with folks, you know, because there's so much power in giving things an accurate name. And how well it worked. Not as a replacement for, right. I mean, these aren't coaching skills that are replacement for any paradigm that we've already learned for coaching or any platform from which we coach. These are additive. It's a bit like a fellowship maybe. To sort of borrow from that.

And then the pandemic hit. Right? And now I was pulled into a lot of public health work almost immediately for about the first six months. And as I was able to begin drawing back from that and really step back into coaching and at that point I was doing a lot of leadership work as well. What I was seeing was that the stress had for all of us morphed into something more, but also that there was some significant opportunity in this. Because what happens is leadership is often buffered for an extended period of time from the acuity of the pain that is happening to those they lead. That is not to diminish the stress and pain of leadership in any way. Right? I do think we need to begin seeing each other differently from that perspective. It is to say that when you are the tip of the sphere, you are typically better resourced and you are in choice most of the time, much more so than those you lead. And what we know when we start talking about trauma is that all trauma involves a real or perceived loss of control. All trauma involves a sense of ongoing threat. So activation, continuous activation of that threat detection system. And a sense of being under-resourced. Well, I mean, amongst other things, right? But these are the things that hit leadership hard. So that is what pandemic brought to the fore, right? Absolute loss of control, absolute ongoing threat and significant under resourcing from every level, internal resources as well as external resources.

3. Medical Education and the Lasting Impact of its Trauma - with Dr. Kemia Sarraf (Part I)

And as we often talk about, we all learned our first day of medical school, the dose makes the poison. So when we begin looking at stress, toxic stress and trauma and the continuum that exists, there's an expansion of the paradigm around what is it that contributes to stress becoming embedded, embodied in us as trauma? And that continuous activation, that continual priming of our threat detection systems was showing up in that way in so many places with so many people. And so that leadership paradigm, how do we, you know, we talk about BRAVE coaching, that's our acronym to help people sort of think about what are the skills that go into trauma-informed, trauma responsive coaching. Also a brave leadership paradigm. How do we begin to lead in a trauma responsive way so that we can build trauma responsive culture?

Flash forward to October, actually, of this year, and you may have seen that the Surgeon General released what is, I'm referring to it as the five essentials for rebuilding America's workforce. And it really is looking at, you know, the harm that's been done and what do we need to create corporate and governmental and hospital cultures across the board from A to Z, cultures that support and sustain and are salutogenic, right? That allow for people to step into work and not be harmed by the place they're working. And it was fascinating to me because when the report dropped and I, I read it, I read it as a tweet first, five steps of a tweet, which there's so many things wrong with that sentence, um, that I, as I'm reading, I'm thinking, well, number one, exactly right. Yes, yes, yes. And number two, all of these, all of these have their roots, their tap root in trauma responsive culture building, every last one. Right? And so what has been laid out is here's the destination, here's where we want to be. And the question then becomes, what's the path? What's the path from where we are to that place?

And that's what, in addition to sort of the one-on-one coaching and the coach training, that's really been the primary focus of my work for the last, our work really for the last two years at Lodestar, which is helping organizations and leadership to recognize and name what's going on. It is fascinating to me, despite the fact that my news feeds will continually feed to me stuff about recognition and understanding of trauma in society writ large, in corporate culture, in hospital culture, there really still is a lag in leadership understanding. They know something's wrong, and they're not sure what the diagnosis is, right? Even if they have a sense of what the diagnosis is, what does it look like to begin to heal?

And so this is what I like to refer to as the hope in broken things. Right? There is hope in this brokenness because we get to look at all these pieces on the ground and say, oh, these are the pieces we're gonna pick up, to build something new or better, or restorative and some of this shit. Sorry, can I say that? We're just gonna leave on the ground. Should have never been part of it to begin with. We're going to leave it there for the earth to reclaim. See what happens when you ask me one question. I'm going to drink my coffee and shut

Michael: I was just about to say, I'm so glad you talked about the fact that like, this is what is coming up in your newsfeed. But there are so many physicians and leaders out there that have never thought

about trauma before. And I know for me it was never, it was never on my radar prior to finding physician coaching. And so there may be physicians out there that are hearing this for the first time and are, number one, this could just be a mic drop moment where all of a sudden kind of the clouds part and they are seeing this for the first time and others that may not see how trauma affects them day in and day out. And so my question for you is, what do you say to those physicians that are just kind of maybe seeing this for the first time?

Kemia: Yeah, yeah. Well, I, the first thing I would say is of course. This isn't part of our training. You know, the ACEs study has been around for 30 years. Let's just back up. It's been around for almost 30, well, no, 25 years now. Right? I am outside of the field of pediatrics, very, very, very few physicians are familiar, they're just not familiar with it. So, you know, it isn't, it's still to this day is not part of our training, the idea that trauma has a lasting impact on health in any way, shape or form. Okay. So that's just like at the foundation. And I wanna acknowledge, you know, Bessel Van Der Kolk had been doing that work since the late seventies. Right? He became interested in this when he was a resident himself in psychiatry in VA hospitals and was seeing all sorts of symptoms, you know complaints, physiological complaints in his patients that he couldn't find a physiological root cause for, an underpinning. So he's been at this a long time. Let's go back even further to Dr. Maria Yellow Horse Brave Heart, who is a psychologist and member of the Lakota Nation who has been doing work in historical trauma and healing of historical and intergenerational trauma in indigenous peoples since the 1960s. And what is fascinating to me is that her original work is now, even though she isn't getting credit, is now what we are seeing over and over and over again, people talk about when they talk about how we heal and move forward, right? The return to the sacred path, which is her terminology for how one moves from pain and trauma into transcendence of that trauma has been around since the 1960s.

So, you know the thinking has been around for a few decades and we also know that that's a pretty short period of time overall. One of the reasons I think this hasn't been prominent or at front of mind for our colleagues, for doctors in particular. I think there are a couple of reasons. I think that prior to, I know that prior to this there has been a lot of worry, concern, both real and imagined about what it means to seek help. Right? Real licensure risk. In some states, it's state dependent, so some real licensure risk around that. Perceived licensure risk, even if it's not real. Horror stories that exist out there around physicians who have sought, and I'm putting big air quotes here, mental health assistance. Right? I think, again, coming back to errors in the biomedical model, this idea that we have separated mental health from physical health is one of the most damaging paradigms in Western medicine. Big fan of western medicine, have a degree in it, practiced it, saved my son's life. Right? And that is a particularly damaging paradigm. We are a system. Right. And separating mental health from physical health has allowed us to stigmatize one, elevate, focus on the other, diminish research in one side. And it is just profoundly harmful. If I am emotionally, psychologically, mentally unwell, my body will suffer. And the repercussions of that may not show up for several decades and it will show up. Likewise, when I am physically sick, it is going to impact my cognitive, emotional,

behavioral state. We should stop separating those two. Okay. I'll step off of that particular soapbox because I could stand there forever.

But physicians don't seek help for that reason, number one, reputational risk also kind of lands in there. Number two, I think there is a sense that I'm going to, I just was talking about this two days ago, there's a sense that I'm going to dissolve from structure to soup, you know, like I'm gonna step into talking about the pain, the anguish, the trauma, the however they make the approach to begin with. And if I do that, if I pull away one tiny layer of the armor that I've built so carefully, I will dissolve into a puddle of goo on the floor. It's going to require, you know, a decade on a therapist's couch. It's going to, and that sounded diminishing and it's not. A decade on a therapist couch is probably something every single one of us needs let me be clear. And there is a sort of unspoken belief that it is going to mean that everything has to come apart.

What I notice, what the experience has been with clients and with organizations because organizational trauma is every bit as real and harmful as individual trauma, right? Organizations are made of organisms. When the organisms in the organization are traumatized, they harm the organization and vice versa. When the organization has been harmed, they harm those who work there and around and around we go in this feedback loop that never ends. There's a belief that the path forward, that restoration, that repair, that healing is an undoable thing that it is going to take something profound. What it takes is willingness to step into. It is slow work. Yes. We talk about it sometimes as slower, closer work, and it isn't as all or none. There isn't further damage done in the work because it isn't about digging down, right. Being trauma responsive, that's a therapeutic model that is for the experts, right? Those are places that trained therapists, who have the skills and the tools to do that safely and well. That's their realm. And I'm very, very, very respectful of that, right? Learning to be trauma responsive is a different skillset and path, right?

First we become informed, we know that it exists, we begin to notice all the contributors. What are all the things that go into one's trauma or an organization's trauma? What are the things that cause the harm? Then we start to become sensitive and aware of it. What does it look like when someone's threat detection system is activated? Right? How is that showing up? How's that showing up in me? And then we can begin to get to this place where people name, oh, you know what this has been trauma. And trauma is very subjective. What traumatizes or what has landed at some point as trauma for me may not for you, Michael, and vice versa, depending on a lot of different things.

How well resourced I am, how well connected I am, what I've experienced previously in my life, what I know to do, what internal resources I have to bring to it. So trauma's, not trauma's, not trauma. Yeah. But our paradigm historically has been that trauma is a singular event, and that paradigm is limited and limiting when we begin to think of it as a continuum, what we begin to notice is that in that continuum, which many of us have been sort of swamped in, right? In that continuum, there are

also places to disrupt. Yeah. Right? So if we know the things that move us along that continuum, we also know how to engage with each other in ways that disrupt us from going further.