[Season 2 Episode 5]

"Shifting the Orientations of the Heart": Conversation with Sarah deLeeuw, Part One

Sarah deLeeuw: If we want to make significant change in terms of the way marginalized and other geographies and communities are imagined, that's going to require seriously shifting the orientations of the heart. think stories do that. I think they do it powerfully.

Lisa Dickson: You're listening to W Y R D, The Wyrd House Radio. I'm Lisa Dickson and this is Wyrd Words, conversations about literature and learning in higher education. I am joined today by my Wyrd sister and Wyrd Words co-host Shannon Murray, Professor of English at the University of Prince Edward Island and, of particular relevance to today's episode, co-founder of the PEI History of Medicine Society.

Hello, Shannon!

Shannon Murray: Hi. Hello.

Lisa Dickson: Our guest today, Sara deLeeuw, seems to stand astride many borders and in many places. A human geographer by training, she works as a professor jointly with the University of British Columbia and the University of Northern British Columbia in the Northern Medical Program where she holds a Canada Research Chair in Humanities and Health Inequities. I like to say that she helps doctors in training keep the human in the human sciences. She's also an award-winning poet and essayist. Deeply rooted in the landscapes of British Columbia, Sarah's creative work has earned her among other things, the CBC Literary Award for Creative Non-Fiction, the Dorothy Livesay Prize for poetry and a spot as a finalist for the Governor General's Award for Literature.

So welcome. Hi Sarah. Thank you for joining us.

Sarah deLeeuw: Oh my goodness. It's such a pleasure. Hi, Lisa. Hi Shannon.

Lisa Dickson: Excellent. Good. We generally like to start these things by having a check-in, just to see how we are, particularly in our un- sub- and supernatural conditions as Tom Stoppard likes to say. So how are we, how are you doing Sarah? What's cooking?

Sarah deLeeuw: Oh, nothing is cooking. I'm not a bad cook, but I'm not cooking anything right now. And yeah. Thanks for the check-in. I think it's a really thoughtful way of, of beginning a conversation. Let's see, I'm sitting right now in my house in a sunbeam. My house right now is in Okanogan Center, which is on unceded Syilx territory in this sort of center of British Columbia. It's extraordinarily beautiful. I'm so thankful to be in British Columbia during these pandemic times. I also have a house up in Prince George on unceded Lheidli T'enneh territory, Lisa, a little closer to you. I was just out for a little bit of a run and a walk, and I tripped on a rock and my one-year-old puppy helped sort of propel me into motion and onto muddy trail. So how am I? I'm well-exercised, but I think I've got a new bruise on my right-hand hip, other than that, pretty good.

Lisa Dickson: Oh dear. Yes. I think poor Shannon can relate to that, having had a similar experience this week, how are you doing Shannon?

Shannon Murray: I'm doing fine. I'm doing fine. Yes. My, my very first sprained ankle of my 60 years this week. We're so close to getting rid of the ice and it just got me at the last minute.

Sarah, I'm so interested in your work, in your program. Can you tell us a bit more about the Northern Medical Program and what your role is there?

Sarah deLeeuw: Sure, thanks for asking. For folks that don't know UBC, which is one of Canada's largest universities and holds one of Canada's largest faculties of medicine, the faculty of medicine at UBC is what's considered a distributed faculty. So there's actually four campuses across the province. There's one in Vancouver. There's one in Victoria. There's one in Kelowna and there's one in Prince George. So our approximately 375 students for each year for first, second, third, and fourth year, sort of hive off after their first semester, their first four months through UBC Vancouver, and they're situated all across the province. The hope with that model, not unlike the school of medicine in Northern Ontario, NOSM, Northern Ontario School of Medicine, which is also distributed. The hope is that by training and educating future doctors in places where we really want them to practice, they'll stick around.

Now my particular role, I have to tell you, came about somewhat humorously. I was finishing off my PhD and I got a call in my little grad office. And I thought it was the wrong number because lots of people misspell and mispronounce my last name. And the person was like, is Sarah deLlala? It was like, Yes that's me. Anyway, it turned out that the Northern Medical Program in Prince George had just opened. There was really a push to try to educate future physicians in and for Northern and rural geographies. And somebody had heard that I was a critical humanities scholar that was quite interested in the health and wellbeing of people, particularly in Northern geographies. And they suggested that I might be interested in coming back and working for UBC's faculty of medicine through the distributed arm of the Northern Medical Program. I had no idea what it was to work in a faculty of medicine. Like, I just thought only doctors worked in faculties of medicine. So I agreed to this interview, not knowing at all what I was supposed to be doing.

But the amazing thing that I learned through the interview process, and then when I was offered the job is that medicine, as you probably know, medicine of course has always translated into the art of healing. So medicine is really an art and a science. And I think increasingly faculties of medicine are starting to realize that placing an overemphasis on the science and the sort of biopharmaceutical kind of lenses of cure are increasingly alienating people from a sense of care. So I like to say, say that I'm the art of medicine at UBC. There aren't very many of us in Canada, who are fully tenured professor faculties in medicine, who are entirely critical humanities and social science research. But that's what I am. I'm interested in adding to medical training a lens of critical humanities and social science research. So that's what I do in the Northern Medical Program.

Shannon Murray: What a great title. You are the art of medicine. That's wonderful. I want to come back to that in a bit, but I'm also really interested in that distributed function of the medical school and the sense of place that comes from that. So you've said in an interview that you feel there's "a naive and reductive sense of hinterland places." How much does it matter to you that, that this is a distributed degree, that this happens in a variety of different places and up North as well and remote places. What does that mean to you?

Sarah deLeeuw: It means the world to me. That's no exaggeration. Not even the slightest hyperbole is embedded into that sentence. And I say that because I've almost died in remote geographies and I've almost died because there are no medical professionals. So I grew up on Haida Gwaii in Port Clements, population of about 200 and Queen Charlotte City, population of about 580.

When my appendix ruptured in grade seven, there are no surgical capacities in the hospital in Queen Charlotte City. There's no capacity to recruit and retain specialists in the land of pediatric surgery. So I needed to be flown out about 1500 to 2000 kilometers South in a night when we couldn't get the ferries operating because the storms were so bad. We couldn't fly the Learjet out of Haida Gwaii, out of the Queen Charlotte Islands, because of the gale force winds. And what that means is my appendix ruptured somewhere about a thousand kilometers north of Vancouver. By the time they landed that Learjet in Vancouver, I was almost dead. I was almost dead at the age of 12. The reason for that is purely because the North has such challenges, recruiting and retaining medical professionals.

Fundamentally, we have an extremely difficult time recruiting and retaining family physicians. Family physicians in my estimation are really the heart of the healthcare system in this country. Without family physicians, you cannot get referrals to specialists. Many people are orphaned patients across Canada and certainly across British Columbia, but we see the numbers of orphaned patients-- I. E. People who don't have primary care providers, don't have family physicians-- increase exponentially as we move into marginalized tantra land geographies. That directly translates into health outcomes for people in rural, remote and Northern populations.

A really significant reason, and lots of evidence points to this, that people don't want to be in rural and Northern geographies is because they think that these are kind of wastelands. They're places where they couldn't possibly lead a fulfilled creative well-educated life. They hear things about sort of redneck, outcast, minor places. And to be honest, I think that that's an outcome of kind of a discursive landscape, if you will, of a certain kind of plac- ism that really places emphasis on large urban metropolitan areas. All areas, I might add, within 150-kilometer radius of the US-Canadian border. And it privileges those places, those metropols, as places where life really happens. And you kind of, onc--this is a very idiosyncratically British Columbia reference--but once you're beyond Hope--and Hope is about 110 kilometers North of the US-Canadian border in British Columbia--you are figuratively and literally, beyond hope. There's no hope for you if you are in these remote Northern geographies. And to be frank, I think that imaginary is worth pushing against. And I deeply believe if we can convince people from Northern geographies to come back and retrain in these places and fall in love in these places and get mortgages, enjoy art galleries and see that there's neat people doing writing and, you know, there's universities and colleges, and there's incredible opportunities in these places--and not stepping stone kind of opportunities like, Oh, I'll put my two years in here and then I'll go back down, you know--where there's a really hope and there's really life, I think that if we can disrupt those kinds of imaginaries we will be actually, radically equalizing landscapes of healthcare and of wellbeing in this country.

So what does the Northern medical program mean to me, to bring it back full circle? It literally means the world to me. Had these places been injecting through distributed models of medical education physicians, and healthcare professionals into the geographies that I grew

up in, the likelihood of me coming so close to death at such an early age would have been mitigated.

Shannon Murray: Well, you've just demonstrated something so valuable. So, you've told us all kinds of wonderful, important, clear, persuasive things, but you started with a story. You started with a story of how you almost died and, you know what? Three days from now, when I forgotten a lot of what happened to me today, I'm going to remember that story. And that strikes me as so central to what you're doing too. I had a great time today looking through all of your worksheets on your webpage, the worksheets of words and art, and it kept coming back to this idea of telling stories and, from what you were just saying, telling different stories, right? Telling new stories, telling different stories, telling stories of the North that haven't been told before. Can you talk a bit more about the importance of storytelling as connected to health and wellness and medicine? Why does that matter?

Sarah deLeeuw: I've had the very good fortune of working with a very well-respected Indigenous scholar for about 25 years. I think one of the most valuable things that working with my friend and scholar and working with many, many Indigenous communities and Indigenous organizations across the country is the piece of learning that goes like this:

If you want to affect real and meaningful change, you have to change people's heads and their hearts. And I'm pretty convinced that the best way to transform hearts is through stories and other modalities. Of creative and artful method. You know, I think stories of course can transform the brain and can transform the head. But if we move the heart through creative practices and creative expressions, the likelihood that the mind is going to follow, I think, is fairly high. I think if we focus purely on the head all the time and tha-- it's possibly a little sort of overly Descartian dualistic in nature because I think the head and the heart of course are tethered and the body and the brain and all of that and emotion and intent-- but just for the sake of discussion, I think that a great deal of health and medical education places, an overemphasis on the intellect at the expense of emotion and affect. And I think that if we begin to elevate emotion and affect, those realms of the heart, if you will, I think that it is in fact story that is going to embed itself in our heart and that, fundamentally, is the remarkable importance of story. As, as we alluded to, if we want to make significant change in terms of the way marginalized and other geographies and communities are positioned and imagined, that's going to require seriously shifting the orientations of the heart. And I think stories do that. I think they do it powerfully

Shannon Murray: Do your students buy this? Do you have any difficulty convincing medical students that, not only do they need to listen to stories, but they need to tell better and different stories themselves?

Sarah deLeeuw: You know it's a complicated question that you've just asked. And it's a complicated question because I can't homogenize medical students. Medical students, of course, like any other big body of students, are remarkably heterogeneous and they're complex and they're messy and they're different. And they shift throughout the various components and areas of their career.

What I can say is. First, I think there is a very significant percentage of medical students who are absolutely, desperately craving engagement with the heart, and they don't find it in medicine, and they are shattered and sad that they are asked to shelve that aspect of their

personality and their orientation to the world in order to focus on, dare I say it, more mechanistic, reductive kind of modalities of thought. So I think there are these students who want desperately to, to have that engagement and don't find it. I think that there are lots of my students who think I'm a complete and utter flake and they are mostly interested in clinical nuggets and scientific validation. I think the challenge is that, in today's very complex and very rapidly shifting socio-cultural conversation about the role of medicine in this society, we actually are going to have to reach the students who think I'm a flake and who really just want to think about medicine as a reductive cure-based science that looks at diagnosis and is uninterested in kind of a holistic, whole person orientation to questions of health. And I think some of the challenges that I face is that I don't necessarily reach those folks.

My plate is overflowing with residents and practicing docs and healthcare students who want to write poetry and are interested in theater and love visual arts. There are so many of those folks that I've got a full-time job until I retire. The challenge is trying to access the folks who are genuinely uninterested in that mode of thinking and interacting with the world. The challenge is, I think, accessing the minds of those folks, because, in my experience, the people who are quite interested in the affective, emotive, embodied, complex questions of medicine are also big supporters of science, but the same can't necessarily be said for folks who are very, very focused on purely clinical bio scientific modalities of medicine.

I think there will be large paradigm shifts as we reckon with issues of transphobia, fatphobia, places heteronormativity, anti-Indigenous racism, pervasive sexism, and we realize that those health inequities are not going to be solved by bio scientific intervention. We can't solve racism through you know, what we develop in a lab.

So since the discipline of medicine is increasingly being called to account for more cultural issues, I think we are going to, as a discipline, have to elevate and have to surface fewer bio-scientific solutions, because they're just not going to solve the very significant issues that are the driving forces behind the greatest inequities in health care and wellbeing in this country.

Shannon Murray: So if you had $12 million, how would you fix that?

Sarah deLeeuw: I would ensure that all 17 faculties of medicine had mandatory curriculum that included radical, critical humanities at all aspects of medical education.

Shannon Murray: That sounds good.

Lisa Dickson: I just want to interject: the only keynote talk that I have ever bawled my eyes out at was at STLHE, which is the Society for Teaching and Learning in Higher Education, a medical doctor who talked about an exercise she does with her students where she gets them to write down on five cards, five things that mean the most to them in the world. And then as she's giving her lecture about anatomy or whatever it is, she goes around the room and she starts to take them away and dropping them in a garbage can. And by the end of the class, the students are lying on top of their desks, trying to keep her from taking these things away. And it was this exercise in understanding what a patient feels like when you tell them things about their medical world, that this is not about your pancreas; this is about your family.

In the Renaissance, there's this idea of Penance, and, in medieval drama, she has a spear or a lance and she comes up to you and she stabs you with this lance. And it's this moment when you recognize your place in the world and the results of your actions. That story that she told

to the students was like the lance, it was just like a stab in the heart, but that was paradigm shifting, you know, because it put those people in a position that they couldn't objectify from.

I was thinking about that when you were talking about the way that these shifts happen not in the lab, but in the stories we tell about what's going on in those spaces. It was such an interesting connection between, medieval fiction and teaching and learning and medicine, and these students who were kind of jolted out of one way of thinking into another way of thinking which I'm sure was quite traumatic for them also.

Sarah deLeeuw: I mean, I think Lisa, one of the things that you're touching on so beautifully is medicine is such a process of enculturation. It's a process of enculturation, like no other process that I've seen. It's a fascinating thing as a critical human, historical geographer, who happens to be a poet and an essayist, to be in a very, very detailed professionalizing program. You know, students come in and they leave as doctors. That's the way that works. And there isn't much room for meandering and self-reflectivity. And I think one of the things that enculturation does by its very nature, it becomes invisibilized the deeper that you are sort of thrown in and interpolated into this culture that sort of sucks you in and then pumps you out as a certain kind of profession at the other end.

And in that process of invisiblizing itself, it of course becomes this remarkable power. And one of the things I think that can be revolutionary for learners in this process is to show them how that process of interpolation of enculturation is working. And I really believe, not dissimilarly to the example that you just gave that, for instance, if you hand them a poem that they don't understand and they feel awkward and they're not an expert, and it destabilizes them and you sort of push them in the kind of lands of expert language that a poet might have, you know? So can you talk to me about the enjambment in the fifth stanza here? I don't. What do you mean by enjambment? Ah, well, what do you think a patient feels like when they don't understand a single one of the extraordinarily specialized pieces of language that you're hurling across to them in usually a time of high trauma? Okay. Let's talk about that disruption that you're feeling when you're being asked to parse apart the iambic pentameter rhythm and the enjambment on the ninth stanza. They start to get really shaky, like, what, who talks like this? That's a way that the arts can be very gently disruptive to medical learners.

My partner's a printmaker, which is this totally nerdy, specialized, weird language that I don't know anything about. If you put medical students in a printmaking lab where they're forced to suddenly be immersed in a totally separate language, I think it really illuminates for them that they too are becoming enculturated in this remarkably specific set of languages and knowledges that medical school doesn't disclose to them. Medical school appears to be this remarkable, neutral, professionalizing ground. And they're also told that they are *Ia creme de la creme.* At the end of the day, they are not encouraged to feel humble and at home with a sense of failure. And I truly believe, not unlike the pedagogical strategy that you just pointed out or, the lance, that that is what the arts can offer: this remarkably safe--like nobody's going to die--moment of reflection about the sort of incredible level of power and specialization that that process of enculturation is. Forcing itself upon these students. So anyway, that was that was me saying yes, Lisa, yes.

Lisa Dickson: So, I'm going to maybe transition us a little bit. That's a good moment to kind of do a bit of a crossing into some of the creative work.

So I have a particular interest in embodiment. And so I'm always very interested in your work because the bodies are really present in the language. And so, for example, I was reading some of the *Geographies of a Lover*, which maps a love affair onto , the landscape, and so I was wondering as a way of maybe drawing a line between the work with the medical program and your own creative work, which I know you probably can't even really prise apart in that way, but to think about what bodies mean, because the body is such a weird, universal, problematic thing, right, that exists in medical science and in all kinds of different discourses. And I'm just wondering if you could talk a little bit about how you think about the body, or bodies, in the context of telling stories, whether that story is in a medical program where we might be talking about an abstracted body relative to, you know, your 12-year-old body in Haida Gwaii, you know, or even in the stories that you tell about the landscape and the situatedness of that.

Sarah deLeeuw: I appreciate your sort of final invitation in the, in the latter part of the question to draw a line. So I think that that's exactly what I'm going to focus on in an attempt to answer that question, Lisa, I'm going to draw some lines in part via a few stories about my own curiousness and my own focus on bodies and bodies in relation to other bodies and in relation to place. And then maybe bodies across disciplinary concerns. And I'll try to kind of weave those meditations into an answer.

The first thing that I should say is I, I think I knew myself as a feminist from the moment that I started to sort of think of myself as me. And I suspect that that's coming from a fairly long line of left-leaning women. Feminism has always been very key to my orientation to the world, and a fairly critical feminism I might add, because I think feminism has done a shit-poor job of addressing issues of indigenous women, black women, BIPOC women. It's been historically quite a movement of cis-gendered, white, straight gals who are interested in ourselves. But I think the premises of feminism have always emboldened my own relationship with the world. And I'm unable to think of a more profoundly foundational component of what the politics of feminism involve than the body: autonomy over body, politics of body movement, and transformation of body.

My orientation as a feminist to the body has led me to direct political action around the body. So, for instance, I, work with rape relief shelters, work in the Kingston prison for women. I was a counselor for Planned Parenthood. I've been an activist for women's right to termination. I accompanied women to exercise their legal rights over our bodies. And I think, I think that the politic of the body and particularly bodies that aren't marked and constructed by society as cis-gender, sort of heterosexual, white, socioeconomically privileged men have, fascinated me for as long as I can remember as a sort of political way of orienting to the world.

So with that in mind, I then approach bodies as nested within larger geographies. So in some ways I'm pretty preoccupied with the idea of this configuration of human body as sort of a weird, leaky appendage that has a strong relationship to other scales of geographies around us, just as we are in some ways multi-scalular ourselves, especially women, given that we can carry other humans around and we can attach small humans to various components of our body. But I think our bodies are always an inextricably nested inside larger scales that of course include the physical geographies that we exist in. So when you see something like G*eographies of a Lover*, you see my efforts to embolden the sexual rights of, in the case of

the narrator, in G*eographies of a Lover*, a cisgendered heterosexual woman, but to embolden those through multi-scalular relationships with physical environments around her.

And I think that as somebody, again, to harken back to what we were talking about the Northern Medical program and Relationship with place, I'm very interested in how that body interacts with already marginalized geographies. So there's sort of a multi-scalular plurality of relationships between bodies.

Finally, how does that kind of cross disciplines from places like geography, where I'm interested in the geographies of small children and relationship to racist Imperial processes of subjugation, through to the geographies of women? How does that translate into a faculty of medicine?

When I brought out geographies of a lover, which, for listeners who don't know, I am not allowed to read G*eographies of a Lover* on CBC. When I publish excerpts of G*eographies of a Lover*, I have to excise massive, massive pieces of it because it's considered too explicit. It's considered pornographic. So when I went forward to publish *Geographies of a Lover*, I was in my early stages of my career, and I thought, "Oh my gosh, what's my head of department going to say? Am I going to be reprimanded for bringing out a book of pretty hardcore pornographic, feminist poetry?" And so I went to my head of department and I said that I'm going to bring out this book and, but I don't want to be fired about it. He said, "Oh, well, can you. Give me a copy of the manuscript. I'd like to look over it." I swallowed my pride and said, okay, I'll send it to you over email. And six days later in the hallway, Dave took me aside and said, "I read your book geographies. It's a great book of poetry, just terrific." He said, "Listen, you're in the faculty of medicine. We've seen all these dirty bits before."

And I was so, so, so humbled in a way, because I think I had an idea that medicine would be a remarkably staid and resisting discipline to explore poetically and pornographically, from that hardcore feminist perspective, the body. What I realized was that my colleagues were completely happy about me publishing a pornographic book on the body from a feminist perspective. And in fact, it was literary landscapes and environments that were resistant to publishing this book because it was obscene, because it was overly pornographic. So I think there are disruptions that happened for me through thinking about the body across different disciplines.

Lisa Dickson: It also makes your point for you, in a weird kind of way, which is trying to make a space for a story that is an invisible story, which is, you know, women's access to their own bodies, which--

Sarah deLeeuw: And our sexuality. Yeah.

Lisa Dickson: Yeah, which then, you know, gets edited out of the spaces that are supposedly made for that space, and sort of the kinds of limits on literary language and so I'm so happy to hear the story about, you know, the medical faculty that's just like, well, yeah, we've seen them before.

Sarah deLeeuw: It was so, I mean, even thinking about it, it kind of tears me up, also because, I have to say, I find it very exciting when my own limited kind of stereotypes of the world are upended.

Lisa Dickson: This brings us to the end of part one of our conversation with Sarah deLeeuw. Join us for part two, in which we travel with Sarah through her creative work and explore the ideas of hope and empathy and the importance of telling the particular stories of the absent and the overlooked.

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