

TPWKY - Special Episode Alive by Gabriel Weston

EW: Hi, I am Erin Welsh and this is, this podcast Will Kill You. Welcome to another episode in the T-P-W-K-Y book Club series where I get to interview authors of popular science and medicine books. About their latest work. We have covered some fascinating topics so far this season from the history of the pelvic exam to the origin of language, the world of regenerative medicine, and how everything truly is tuberculosis. If you'd like to see the full list of books we've covered in this season and past season. Head over to our website. This podcast will kill you.com, where you'll find a link to our bookshop.org affiliate page. Under the extras tab. That page has lots of T-P-W-K-Y book lists, including one for the book club. I'm always updating these lists. So check in regularly to see what's new or upcoming. As always, we love hearing from you all, whether it's a book suggestion, episode suggestion, firsthand account, or anything else on your mind. So please feel free to reach out through our Contact us form on our website. Thank you to everyone who has sent in book suggestions. I truly appreciate it. Two last things before we dive into the episode, and that is to first rate, review and subscribe if you haven't already, it really does help us out. And second, we are now releasing full video versions of most of our episodes. Make sure you're subscribed to exactly right media's YouTube channel. So you never miss a new episode Drop.

EW: How does our heart pump blood? How does our gut digest food? How do our lungs draw in oxygen and exhale Carbon dioxide medical training focuses on the how and the why of our bodies, the anatomy and physiology of all the parts that keep us alive and healthy. What happens if they fail, and how to fix it. There are diagrams and charts and atlases that help instill specialized knowledge in medical trainees that they can use to heal, to relieve, and to repair. Sometimes over the course of a career, a doctor might find themselves forgetting that a kidney is not just a kidney, it's this person's kidney. A heart in need of surgery is more than Tuesday's operation. It's the beating muscle that has faithfully kept this mother, son, friend, spouse, alive for the past 15, 30, 60, 90 years. And it's not just medical professionals that may benefit from a moment of reflection on what it means to live in our bodies. When is the last time you thought about your skeleton, the bones inside you and how it supports us? When have you last looked over your skin, examined the scars and freckles and wrinkles, and appreciated how it protects us and holds us together in alive our bodies and the richness and brevity of existence. Award-winning writer and surgeon, Dr. Gabriel Weston transcends the usual boundary between doctor and patient to instill a sense of humanity in our bodies. Throughout each chapter,

she explores a different part of the body. Examining not just how it works, but what it has meant throughout history and how it has shaped the story of her life. The liver, with its incredible capacity for regeneration and transplantation, the brain unfathomably complex, and yet so vulnerable as Dr. Weston discovers with her son, the womb that nurtures and provides. And that has been used to control women for millennia. A profound blend of memoir science and meditation *Alive* is a beautiful absorbing book that honors what it means to be human with our incredible yet not infallible bodies. I really loved chatting with Dr. Weston. So we'll just take a quick break here before getting into the interview.

EW: Dr. Weston, thank you so much for joining me today.

GW: Thank you so much for having me. I'm absolutely thrilled to be part of this podcast.

EW: Oh, thank you. That means, it means the world. Well, in your latest, fantastic book *Alive*, you take readers on this really thoughtful and captivating tour. Through the human body, you weave together your personal experiences and reflections with the history and the science of the body parts that you explore. So tell me, how did this book take shape? I

GW: mean, I think first and foremost, it just came from this place of, and this is why I called it *alive*, this sort of sense that as doctors and medical students, that the anatomy that I was taught at medical school and as the basis for my surgical training had this kind of. Dead quality to it. So, you know, physiology always felt like it was a kind of experimental sort of specialty. And pathology of course had all the fantastic, wonderful illnesses that are so exciting. But there was something about anatomy, which I had expected. I would love, that just seemed really kind of inanimate and almost like the way it was taught was inanimate as well. And basically, I gotta this point, sort of 25 years into my surgical experience where I started realizing that actually the facts of anatomy are not as inert as we were led to believe. And also that many of those facts don't really apply to women or people of color. But then I think even more than that, I had this feeling as. A doctor who was herself getting older and going through lots of life's experiences that actually the way that we live in our bodies is so ever changing. And so kind of like not just a progress, you know, you have times in your life where you feel like you are going backwards and where everything has collapsed in on itself. And I just sort of thought it would be really interesting. To try and write a book that was almost like an alternative anatomy that would allow me to explore some of these kind of spaces that I didn't feel I saw anything of when I was learning myself.

EW: Yes, and I think that is what is one of the things that makes this book so valuable is being able to see the body parts and read about these body parts, not just in the way that you are exposed to it in a medical class or even in history class, but it's this bigger picture, this complete more beautiful picture. And each chapter kind of goes into. A different body part. You've got gut, lungs, kidney, genitals, heart, and so on, many more. And I'm curious how you decided on this organization, especially the order of the chapters.

GW: I mean, I was very keen that the book should start with a postmortem because I thought in a way like. The dead body and the first chapter of the book is called Dead. That in a way is my start point as as a surgeon, as a kind of medical student that once was, as I was saying before this kind of sense that the anatomy I was taught was dead. And I thought if I can begin the book, not just with a dead body, but actually with a kind of language that feels very cold and clinical, then that will be a kind of start point from which the rest of the book should be. Almost a coming alive of not just the body itself, but my way of kind of integrating my understanding of the body when it came to the actual like organs and which ones to go first and stuff. I mean, in a very sort of light way. I, I had all of the piles of organs on the floor at one point, and I remember kind of noticing that. A lot of the organs have got memories of my own body in them, and I sort of thought, I wonder if I could just very lightly arrange them in order of my age. So for example, you know, I think I remember a nasal fracture from when I'm a child in bone, which is the first organ. And then obviously womb is an organ I wanted to put later so that I could examine childbirth, menopause, all that kind of stuff in there. So there is some sense in which these organs are. Telling the story of my body, but you know, it's not super visible. So it was more like a kind of scaffolding for my sake, rather than the readers.

EW: Throughout your book, you share many personal stories with the readers. You give them this really intimate glimpse into some of the most challenging times of your life, and I was wondering whether that was difficult to be vulnerable in that way or to put so much of yourself out there. A.

GW: The truth of my experience of the body. I think my difficulty is, I think in medical literature, I don't mean like textbooks, but more kind of popular medical literature. There is a lot of sentimentality that attaches. To the way that people write about the body. You know, it's, I mean, it's a hard thing to describe without sounding slightly psychopathic, but I slightly feel particularly as women, that there's this sort of expectation that if we're writing, for example, about childbirth or motherhood, that there should be a kind of softness. To the, that we do that when in fact many of my experiences of certainly of motherhood have not been soft, fuzzy nurturing ones. They've been ones that have been kind

of full of confusion and sometimes rage and exasperation and even regret at times. And so I think. What I wrangled with was not the sense that there was anything that I didn't want the reader to get to see about me, but that I, I wasn't wanting to write in a sentimental way or in a way that I felt for me would not be true. And so it did mean kind of departing from. A lot of the sort of medical writing that I have read, particularly written by women, where I feel sometimes there's this expectation of, you know, what these feelings ought to be around death and birth and reproduction and love and all those stuff. So I think always kind of as a feminist writer, I'm very keen to. To have myself be an example maybe of a slightly like monstrous female who doesn't always feel all of these nurturing feelings that I think we're still, there's still such a great expectation that we should have.

EW: Let's take a quick break and when we get back, there's still so much to discuss.

EW: Welcome back everyone. I've been chatting with Dr. Gabriel Weston about her book *Alive, our Bodies, and the Richness and Brevity of Existence*. Let's get back into things. I'm sure that that also filters into not just your role as a writer, but also your role as a surgeon and how you are expected to be or think or feel about your patients or about your own self.

GW: I think so, and I think, I mean, in a way, one of the things I find most beautiful about the body as a writer. But also just as a human walking around as a woman is, you know, if you have a thought, it is very likely that most other people are having that thought to, like, you're gonna have thoughts and you're gonna think you're the only person in the world that is having those thoughts or desires, or you're gonna think that you've just thought something that is the most shocking thing that you could even imagine. Someone thinking it highly to be that. The way that we experience kind of life's big changes and events through our bodies. It's like if the body is kind of telling you, I feel disgust, or I feel desire, or I feel fear, or I feel longing, it's okay. And sometimes we might have those feelings in odd circumstances and I. Doctoring and writing that is about telling people what they're experiencing in that moment. So yeah, that's a big thing for me.

EW: Your background is not necessarily, you didn't start out your, your career, your adulthood, uh, with designs on becoming a doctor. Can you tell me a little bit about your atypical journey?

GW: Yeah, yeah. So I mean, in the UK we have this crazy system where when you're about 16, you have to choose three subjects. That become the only three

subjects you're gonna study at school, and then usually you choose one of them to go on and do at university. And I gave science up when I was 13, as soon as I possibly could. So I had to keep one science for what we call GCSE, which is a kind of 15, 16-year-old style exam. And then after that science disappeared from my life. That was a great relief to me and I had a year out. Then I went off to do English and philosophy. You know, English was always the thing that I was good at. So it seemed like the obvious choice of thing to read at university. And then when I was at uni, I just started kind of discovering that whenever someone was sick or someone like fell off a ladder or broken arm, or it was around the time that ER was on TV for the first time, that's how old I am now that it came. It came on around that time that I was doing my English degree, and I noticed that I was much more than usually interested in all of this stuff and not from the point of view of. I did not have an overarching desire to help people. That was not the impulse. The impulse was just pure untrammelled fascination, like kind of not okay style fascination. And then completely by happenstance, one of my friends who was a math student. His dad came to visit us up in Edinburgh and his dad was a surgeon, and this was back in the day where, you know, there were no mobile phones or anything like that. And he had these old school photo albums in his car filled with photographs that he or his scrub nurse had taken when he was operating. And I remember everyone else went out clubbing and drinking. He and I stayed in alone. And at the end of that evening, he said, next time you're in London, give me a call. You can come to my operating theater. So I did that. I was about 21 back in the day where you could just rock up to someone's operating theater with no credentials. And I just literally walked into this room and it was like I was having some kind of religious conversion. I mean, I was just. Beside myself with excitement and I went a couple more times after that. And then I kind of thought, I don't really see how I'm gonna make, be able to make surgery a hobby. I don't think that's gonna be a kind of socially acceptable thing for me to be doing in my spare time.

GW: So after a little kind of while of arming and aing, I just thought, I think I'm gonna have to go and be a doctor. So I had to go back because I had English, French, and Latin A levels. I had to basically do all the science A levels that would get me a place at medical school and then into medical school. I went and the crazy thing was that apart from that early year where I had to do all the science and it was so difficult for me, really, the rest of it. Was kind of fine. It's like I loved it and I had this amazing feeling that most of the other medical students didn't have of like a kind of glorious sense of the glamor of being a medical student who would come from a background where it didn't seem like that would ever be possible. And so I never quite lost my sense of. The kind of in loveness with the persona of this new person that I was. And in a way I think I still have that now. It's like when I go into the operating theater now to do, you

know, very small surgery with, you know, very low risk and kind of nothing to write home. When I put my scrubs on, I just still feel that's very cool. You know, I've never lost that sense. And so I, I think there's a lot to be said for that, you know, for kind of whatever it is that makes you keep loving it. And I, and I really do, I mean, even despite our NHS being in the most kind of powerful state, the actual business of being a doctor who gets to handle people's bodies. It's just a joy, isn't it? It's just, it's like intimacy of the most extraordinary, beautiful kind that life has on offer.

EW: You write about the human body with such care and with such lyricism, it shines through along with your endless curiosity about the human body and about your own ability to express your stories. And I, I. Wanted to kind of get into a few specific parts of the body that you covered in your book, starting With Bone. So in your chapter on Bone, you talk about the common misconception that bones are these static, unchanging things when really they're very dynamic. Can you talk about how our use of the skeleton as the symbol of death really contradicts the true vitality of bones?

GW: Yeah, I mean, skeleton's so interesting, isn't it? Because it's like. Lay people. You don't have to be a doctor. Like we all know what skeletons look like. Kids know what they look like. They wear Halloween costumes with skeletons on the front of them, and you can go for a walk in the woods and like see a bird skeleton. And most of us have touched bones. You know, whether we're eating a chicken wing or what, whatever. We have a very kind of established sense of what bones are, and yet when you see bones. Inside a body that is alive. They're not like that at all. So for this book I went to, there's an amazing orthopedic hospital just outside of London called the Royal National, and I went there and saw an amazing surgery where a guy was basically. Removing a tumor from a woman's thigh bone, and he had to kind of take an enormous length of her thigh out in order to take this tumor out. And when they were sawing through the femur, I was just so struck by the cross section of this. Biggest bone in the body that it was filled with marrow and it was filled with blood vessels and it had this kind of live yellowy looking periosteum. And it just, I looked at it and I thought, it's just not at all the way you would think bones are. And then of course when you look at the physiology of bone. You realize that bone is kind of changing itself all the time. So the bone, you know, the bones that you have today, you wouldn't have had 10 years ago. Every year, 10% of our bones are being remodeled by a process of, you know, osteoclasts removing old bits and osteoblasts, putting in new bits. So I think even this kind of symbol of death, when you look closely at it inside the living body, which obviously most people don't get to do. You just see that it's alive in a way that's really counterintuitive and, and really beautiful.

EW: It's like instead of the ship of these, we have the skeleton of these. You know, the bones that we have now are not the bones that we started out with. They've just been continuously remodeled throughout our entire lives and. In your chapter on the womb, you take readers on journeys through the inner workings of this amazing organ. You know, the ways that it's been used to dismiss or harm women, as well as your own experiences in childbirth, both, you know, as the one giving birth and as the one observing childbirth. Did any part of this chapter feel especially meaningful or challenging to write?

GW: Yeah, I mean, like you say, it's such an incredibly sort of dynamic organ in the womb when you think it sort of begins as something the size of a small pair, and then if you are pregnant, you know, it occupies your entire abdomen. It's, so, it kind of, it, it presents itself as something to write about, almost like the most beautiful kind of metaphor for Changeling. And that really appealed to me and kind. You know, it kind of intersected with really, in a way, the main drive behind this book is this kind of philosophical desire that I have all the time with the body to somehow occupy that space between being in a body and observing a body. You know, like. Where That's the mystery, isn't it? Is like when you're a surgeon, you're standing at the operating table, you have your hands inside someone's body, but your own heart is beating, your lungs are working, your hands are warm because of blood running through them. I'm so struck always by that kind of like a desire to be and know at the same time, which never feels possible. It's always like a hologram. You have flip from another. When I had my, so my first two children, I had vaginally the second two at the same time by C-section because they were twins, which was also kind of cool because I thought, I get to kind of experience all the ways that the womb can give birth to children, and I just thought it would be really interesting to. Get in touch with the obstetrician who delivered my babies by C-section, which I did about six months after they were born. I mean, I think she probably thought I was crazy, but she was very accommodating and I just sort of said to her like, I really, I want to see what you did to me. I want to kind of be on the other side of the line, like.

GW: And you pulling my twins out, I wanna stand there next to you with my scrubs on seeing you do that to someone else. And so in the womb chapter, I'm really exploring that kind of very female. Again, I think it's a very existentially deep part of being a female this way, that our bodies are the thing that life is enacted on. But it is also self. It's like if we are to express agency, it's through our bodies, and yet the second you hit puberty as a girl, you are suddenly aware that the world is objectifying you. And so. I felt like the womb was a really, really exciting organ to look at some of those things through. And, um, and then just as the icing on the cake, um, I also for the BEC went to Sweden to see a womb transplant being, being performed. That was just kind of mind boggling

in a wonderful way as well to see like, uh, in adjoining operating theaters, you know, a mother's womb. Being carried down a corridor in a dish to be put inside the pelvis of the daughter who had been gestated in that womb herself. Just so cool. You know, just like those moments again, where I'm kind of maybe thinking to myself in this moment, I should be having a sentimental reaction, but actually I'm just blown away by how exciting it's. Existentially It is. And you know, so that, that was really like a terrific experience as well.

EW: I don't have the words. It is the coolest thing. Yeah. And it is also, you know, earlier you mentioned, and I wanted to, to circle back to this earlier you talked about how it wasn't like you went into medicine because you wanted to help people or because you had this like altruistic, this is what I was put on this earth for. You love the, and I feel like that is the expectation, to feel that way, to feel like I went into medicine because I want to save the world and make the world a better place. And I feel like it is. It is challenging then, or is maybe viewed as sometimes not acceptable to say, I really just thought this was fascinating. Yeah, and I wanted to do this.

GW: I mean, I definitely feel sometimes when I was a junior surgeon that I would be so excited in an operation. I'd kind of think, I'm glad I've got a mask on because then they, you know, they, they're not gonna see how excited I'm, I mean, obviously there is a limit to how much a patient wants to see that on a person's face. But we would prefer all of us, I think, to have our doctors really into what they do. And, um, and I, and I definitely think for writing about the body, like. There are lots and lots of places to get facts about the body, and I think it's, I still feel that it's very political writing the truth about the experience of being inside one. I still feel that that is something women can keep writing truthfully about their experiences of being inside their bodies till the cows come home and it'll not be enough, you know? Mm-hmm. The deficit.

EW: Let's take a quick break here. We'll be back before you know it.

EW: Welcome back everyone. I'm here chatting with the wonderful Gabriel Weston about her book *Alive*. Let's get into some more questions. So skin is an incredible organ. I mean, again, like they all are, I'll say this about all the organs, but I really appreciated how your chapter encouraged readers to see skin, not just as the thing that holds us together, not as a barrier to the outside world. And you talked about some of the things that skin can show, what it can reveal as well as what it can hide. Mm-hmm. And I was hoping you could just elaborate a little bit more on that.

GW: Yeah, I just, I, so I think, again, like with all of these organs, I'm always sort of after something literal, you know, what does the skin do? What is its function as our biggest organ? Um, and I guess its main function is letting sunlight in and heat out in the most basic way. But it's kind of, it is a barrier and a protective barrier, but it's also like a filter because your skin doesn't work well. And if it's completely impermeable, it wouldn't be doing the things it has to do. I got, of course, thinking about skin more symbolically as the thing that marks out where I end and the world begins, which is again, kind of going back to the more philosophical sense of like, what is a self, where are we inside ourselves, and where do we touch the outside world? It was a chapter that I felt was kind of a really interesting chapter to examine themes of time through. So one of the things I did in this chapter was kind of take a bit of a, like a spread of members of my family from, at the time, my twins were like toddlers right up to my parents in their eighties and have these kind of moments where I'm stopping my usual. Into the skin to just look at the skin of these loved one. You know, of my little kids and my teenage kids and my middle aged husband and my elderly parents. And then I also had this amazing opportunity to. Visit one of the immigration removal centers near one of our airports in London. So these are kind of like hidden places with no signposts and basically it's where tens of thousands of people who don't have their asylum papers are left often for years while those papers are processed.

GW: And I managed to get access with a GP who goes in there to kind of assess some of these asylum seekers claims for asylum. I managed to go in with her and had this fascinating day where I realized that this particular young man who we was seeing. His job and the job of the GP who'd come to visit him was to document all of the scars on his skin, which were his evidence that he had come from a place where he had been traumatized and tortured. And so this really fascinating like turning on its head of. I want our skin to be, particularly, again, women aging. We want our skin to be sort of perfect, like the perfect flawless canvas. And yet here was this young man at pains to show all these kind of traumatic blemishes because he knew that if. We could document enough of them and if he could get them to match the story that he was telling us, that that might be the ticket for him to be able to stay in the uk. So that was the kind of way of acknowledging the complexity of skin as a political organ without like treading on ground that didn't feel like my ground to tread on.

EW: It sort of is runs parallel in some ways to some of the challenges that people face and the, the range of challenges that people face when seeking healthcare in general. Yeah. And one of those being communication and being able to. Adequately receive care and attention and explanations from their physician. And this is something that you touch on in your chapter on the kidney. Yeah. Some of the ways that doctors just aren't always the best

communicators. Yeah. Why do you think communication still poses such a challenge and there's still so much room for improvement?

GW: So I think in the UK the primary difficulty is one of the resource of time. So in our NHS, which is, you know, free at the point of access and kind of on its knees now as a system which is just totally overrun with need and insufficient resources to meet needs. I genuinely think that if. Hospitals and medical schools could take whatever paltry funding they have that they're diverting into communication skills courses, and just somehow enable that to manifest itself as a couple more minutes per consultation for each doctor. A lot of the communication problems would disappear. So I think, you know, if you can imagine, like if you were trying to. Talk to your partner about being unhappy in the relationship or you know, talk to one of your kids about their drug problem or whatever. If someone said, you've got 10 minutes to do that, yeah, it would be absolutely impossible. And yet that's what doctors and nurses are expected to do with highly complex patients who they've never met before. You know, it's just totally extraordinary. So I think time is one thing. I think the other thing is. We have such an embedded kind of distance in the way that we're taught as doctors, the kind of ancient ways of treating patients from on the other side of a desk from above. You know, if you've got through medical school, you're someone who's really good at learning facts, you are probably someone who's come from a pretty advantage background with all the assumptions that go with that. And I just think there's still such a distance. Between doctor and patients so much of the time, and you know, that's a really complex thing to fix. But I think certainly in my own experience, I think having become a patient and perhaps more importantly, the mother of a patient I, I have just really experienced now. How awful it feels to be in a doctor's room or in a hospital where you are terrified. You feel like no one is listening to the thing that you need them to know, and this kind of awful sense that you somehow have to kind of behave yourself in order not to irritate the people who need after lots. Quite British problems and quite entrenched in the fact that our healthcare system doesn't involve any exchange of money in, in the way that it does in other places. So it's almost as if any motivation for a doctor to be nice to a patient that might have anything to do with patronage or reputation. That doesn't exist here. And so in a way, all you are left with is these very overworked, exhausted healthcare providers who are just gonna get paid what they're gonna get paid regardless. And I, yeah, I just, I think the, the dual problem of this kind of culture of superiority combined with real time deprivation is the problem of communication between doctors and patients.

EW: And I think it's also not helped by some of the, as you kind of touched on this, this entrenched way that physicians see patients where we've incorporated. More quantitative tools to assess a patient's condition or, you know, we used to

have these scans. We have, uh, blood tests, we have all of these, these ways to look at the individual parts of a patient that can sometimes then make a doctor lose sight of the person as a whole, not just as a patient or as a patient's body part. What role do you think that plays and how can we maybe strike a better balance between using these quantitative tools, not just as something that's shaping the entire narrative.

GW: Yeah, it's really tricky, isn't it? I mean, in, in an area like for example, psychiatry versus neurology, I mean, that's quite interesting. Those two specialties were the same specialty until the late 19th century, early 20th century. And then as neurology became. I guess a more sort of objectifiable form of medicine. It kind of split off. I mean, interestingly, Freud I think was a neurologist to begin with and then became a psychiatrist, and once he started, you know, developing ideas of a kind of psychological and psychiatric self, those two things split. And now we're in a situation where, as you say, the quantitative tools that have gone so far with neurology. Have given people with neurological conditions a kind of status in a way that is very, very different from the continuing stigmatized low status of psychiatric patients. And I think it is really interesting that, you know, if you think the brain is the site where. Schizophrenia, bipolar, depression, you know, all that stuff is coming from that and the brain tumors and all the neurological stuff. And yet I know from my own experience, one of my, my son had a brain tumor. You know, it was an awful time, but you couldn't imagine a situation where people would be nicer than a children's hospital with a brain tumor. But by comparison, I have a very close family member who's been very acutely psychiatrically unwell for a long time, and have, I've walked through that path with that family member and all that is his stigma and low status. You know, it's, and, and that is because I think because there isn't a. And also I think when we can't find it, it's the same with all these conditions where there's a little controversy over whether the condition is a so-called functional condition or an organic condition. There's something that kind of brings out the kind of nasty playground. Thing in us that is to do with kind of this idea of a person faking something or like why are they saying they have these symptoms when there's nothing to correlate them with? And so I think there is that problem in psychiatry that because it's all in someone's head, so to speak, we can't, we can't kind of corroborate it in the ways that we seem to need to.

EW: You mentioned this really terrifying medical ordeal with your son and you begin that chapter on the brain by asking, you know, did I think being a doctor would protect me?

GW: Yeah.

EW: And you discuss some of the, your roles as mother, as surgeon, as patient yourself. Um, how did those roles intersect during that time?

GW: Yeah, I mean, it's so interesting. I. I tried very hard because a friend of mine who first came to see us in the emergency department, when we first realized that my son, he'd had headaches and then they did a scan and they discovered he had a Mac, quite a large mass in his brain. So in that awful early stage of realizing something was wrong, a friend of mine who was an ED doctor said to me, just be a mother here. Like, that's my one piece of advice to you. Don't be a. I also feel, in all honesty, that there were certain moments in that journey where the fact that I was a surgeon helped me advocate for him in a way that I think actually did make a difference. I mean, I'll never be able to say whether it was a life or death difference, but there were definitely a couple of junctures where I was able to say to a system that was not acknowledging. How serious something was. You know that I'm saying this to you as a mother, as a surgeon, and with this other surgeon friend of mine who's my kind of backup plan guy. So there was a weird braiding of mother with surgeon in that time. And um, I think if the healthcare system had been perfect, I would not have needed to be a surgeon at all. And I certainly. I was astonished by my lack of curiosity, like about the actual surgery my son had and about the particular he ended up, when they finally found out what it was. 'cause they thought he had something called a medulloblastoma to begin with, but he actually had a cavan, which is a, an abnormal cluster of blood vessels in his brain.

GW: Once we knew what it was and that he was gonna have surgery, I amazed myself with how, like I did no research. I didn't go on Google, I didn't look anything up. I said to my family and friends, I don't want anyone telling me anything outside of what the surgeon looking after him tells me like he is my source of information and that's all I want. So I really did the opposite. What I do as a writer and a doctor in other circumstances, which is to cast my net as wide as I can, you know? But it was a very, I mean, we were very lucky because he came outta that surgery. He's recovered, he's fine. I, it's given me a lasting feeling for any patient who is in a situation where. They are completely terrified and I don't think I'd realized before that happened to me. You're not in your right mind when you know, I mean, nevermind that you're not sleeping. You are like you're in an altered state. And the way that I am with patients now, when they're in the early stages of discovering something very shocking is completely different than it was before in view of that. So, you know, I'm grateful to have learned that and I sometimes feel. I feel a little bit ashamed of the young doctor. I was, I don't think I was harsh, but I think I was very disconnected almost as if by being a doctor I was, I don't know. I, I had some kind of, I mean, I can't ever have actually been that stupid as to think that that was gonna protect me, but in a weird way, I think I did think it was protecting me.

EW: Throughout your book, you also discuss, you, you interspersed correspondence with some of your physicians and recollections about your own heart condition, and you end the book with a chapter on the heart. Would you mind sharing a bit about sort of the, the journey, sort of how you decided to intersperse those and then why you decided to end with the heart?

GW: Yes. So all the way, as you say, all the way in between the organs. Clinical evidence in a way from my own heart condition. I've got mitral valve regurgitation, so one of my heart valves doesn't work properly and it's getting worse, and at some point I'll need to have open heart surgery for that. So that was all kind of happening while I was writing this book. And really what I wanted to convey by interspersing these little kind of emails from doctors or. Little kind of moments of almost like clinical text is present to the reader. This very profound textual difference between what happens when we tell a story and everything is perfect and has jeopardy and it has a kind of narrative arc and it goes up to a crisis and then it kind of falls away and wraps itself up. And on the other hand, the totally. Unshaped. Disorientating experience of being a patient in the middle of a clinical story whose end you cannot predict. So someone who reviewed my book said something like, they felt that these fragments in between were kind of a bit of a letdown because they didn't rise to a sufficient conclusion. And I thought to myself, well, no, like that's. They're not meant to, like what I'm, what I'm trying to do in a way is almost destabilize my own narrative by saying, okay, I've just written this chapter on the breast or the skin or the liver, and when you get to the last sentence, you'll feel a sense of satisfaction that I have closed that chapter. But here's the reality of me being in this body where there's just. These few facts and there's all this space and all these questions that are not answered, and it doesn't go anywhere. It's like it doesn't end with me telling you what happens because here I'm, I don't know what's gonna happen. Like my valve is still flapping around there with blood going in the wrong direction. And I don't know, I don't know what the end of the story is, and that's my experience of being in a body. The way that I chose to tell it. So of course at the end I then thought I need a hot chapter as well to talk about some of the issues around really interesting new stuff to do with how kind of. Stress and emotion actually manifests itself in the tissues of our body or the really shocking statistics around women and heart health and how badly served we're currently in terms of our cardiology. Um, so I, I thought at the end of the day, I better provide that chapter because there is all this really interesting stuff. And if I just leave these fragments, it's like too big an organ to ignore. So I guess at the end it was like starting with a dead body and hopefully ending with this kind of integrated sense of an organ that is a pump, but also the feeling center of ourselves.

EW: It touches on, again, this theme of honesty of this is the reality. You know, sort of this how you said there is no narrative arc to this, to your story. There is no narrative arc to any of our stories. If there is one, we've constructed it artificially. Yeah. And that's some, that's fine. But that's not necessarily the reality. And I'm, I'm curious how you feel this honesty. Is or is not being accurately portrayed or acknowledged in science communication these days, or how we can all do better about incorporating honesty into science communication.

GW: I mean, that's such a big question, isn't it? And I guess it just. Really depends on sort of what area we're talking about. I mean, I think the introduction of AI and machine learning has been really, really interesting in this regard because now that AI is doing such a good job of data gathering and. Kind of synthesizing data in a way that, you know, we used to have to do for ourselves just a few years ago. I think the lovely thing about that is it kind of puts more of an onus on each of us to actually, when we are communicating about science, to be doing it in a way that is not a way a machine could do, you know, in an authentic way, in a disruptive way, in a way that doesn't feel nice or comfortable because the machine can do that stuff. So. I prefer the messy truth, and I prefer it in, I prefer it in lectures. I prefer it in books. I prefer it in movies. I prefer it in people. I, I'm not interested in the airbrushed version, but I'm not like, I don't think I'm in the main stream there. I think most people do prefer the polished version, so I don't know what we do with that.

EW: Well, I'm excited to see what you do next. And Dr. Weston, I just wanna thank you for taking the time to chat with me today. This was so fantastic.

GW: Honestly, it was an absolute thrill for me.

EW: A big thank you again to Dr. Gabriel Weston for taking the time to chat with me. If you enjoyed today's episode and would like to learn more, check out our website. This podcast will kill you.com, where I'll post a link to where you can find alive. Our bodies and the richness and brevity of existence, as well as a link to Dr. Weston's website where you can find her other incredible work. And don't forget, you can check out our website for all sorts of other cool things, including but not limited to transcripts, quarantining, and placebo reader recipes, show notes and references for all of our episodes. Links to merch. Our bookshop.org affiliate account, our Good reads list, a firsthand account form, and music by Blood mobile. Speaking of which, thank you to Blood Mobile for providing the music for this episode and all of our episodes. Thank you to Liana Sachi and Tom Bre Fogle for our audio mixing. And thanks to you listeners for listening. I hope you liked this episode and are loving being part of the T-P-W-

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