196: Resiliency Radio with Dr. Jill: The Sensitive Patient's Healing Guide with Dr. Neil Nathan

Dr. Jill 00:05

Hey, guys! I am so excited to announce that the movie that you've been waiting for, the documentary *Doctor/Patient*, is now available for rent or purchase at DoctorPatientMovie.com. Check out the trailer here:

00:18

Dr. Jill: When I really knew something was wrong was when I started having trouble walking up the stairs. I was supposed to be grateful and happy and healing and well and thriving, but I did not feel that way. I was so sick. Like always, I wanted to find an answer, and I had to figure it out. And I had to figure it out to save my own life. So I dove in.

00:43

James Maskell: Jill is the leading voice in biotoxin illness and chronic conditions that are driven by toxicity.

00:48

Bree Argetsinger: Oh my gosh, you're dealing with mold? You have to work with Dr. Jill Carnahan.

00:52

Patient 1: Dr. Jill is the first person that actually began to shed some light on the problem.

00:58

Dr. Jill: What I do is listen to the patient, and we together talk about what else is possible.

01:04

Patient 2: I don't know why I'm crying.

01:07

Patient 3: She saved my life.

01:11

Dr. Jill: The deepest lessons and most profound insights come in the suffering, come in the dark moments. Self-compassion is the healing transition that shifts something inside of us. It's actually the thing that we need most in order to heal.

01:31

Narrator: *Doctor/Patient*—available now at DoctorPatientMovie.com.

Dr. Jill 01:40

Welcome to *Resiliency Radio*, your go-to podcast for the most cutting-edge insights in functional and integrative medicine. I'm Dr. Jill, your host. With each episode, we delve deep into the heart of healing and personal transformation. Join us as we connect with renowned experts, thought leaders, and innovators who are at the forefront of medical research and practice, empowering you with knowledge and inspiration on your journey to optimal health.

Dr. Jill 02:05

Today, I have one of my favorite people in the world, Dr. Neil Nathan, a friend and colleague. We so often talk about how we think a little differently than a lot of our conventional colleagues. But one of the things we're going to talk about today is how to deal with a sensitive patient and how our intuition and the energetics of the healing process play into optimal outcomes. But before I do that, I want to introduce Dr. Neil Nathan.

Dr. Jill 02:31

He's been practicing medicine for 48 years and has been board-certified in family medicine and pain management. He's a Founding Diplomate of the American Board of Integrative Holistic Medicine and a Founding Diplomate of ISEAI, the Integrative Society for Environmentally Acquired Illness. He has written several books, including *Healing Is Possible*: *New Hope for Chronic Fatigue*, *Fibromyalgia*, *Persistent Pain and Other Chronic Illnesses* and *On Hope and Healing*: *For Those Who Have Fallen Through the Medical Cracks*. He's hosted an internationally syndicated radio program on Voice America called *The Cutting Edge of Health and Wellness Today*. He's been working to bring awareness that mold toxicity is a major contributing factor for patients with chronic illness, and he lectures around the world. He's also

written several books. And today we're going to talk about his very latest book, called... Is it "Healing the Sensitive Patient," Dr. Nathan?

Dr. Neil Nathan 03:20
The Sensitive Patient's Healing Guide.

Dr. Jill 03:22
Thank you.

Dr. Neil Nathan 03:24
There it is. It actually exists.

Dr. Jill 03:26
Yes.

Dr. Neil Nathan 03:27
The Sensitive Patient's Healing Guide. By the time this podcast airs, you should be able to order it on Amazon—in ebook or book form.

Dr. Jill 03:38
Perfect. And wherever you're listening, there will be links to where you can find this—to Dr. Neil Nathan's website and the Amazon links for the book. We're going to be talking about that today. But before we dive in, Dr. Nathan, you have an amazing history and have been a leader in our world of integrative and functional medicine, especially in my favorite topic, which is environmental toxicity and mold-related illness. Tell us a little bit about your journey into medicine and then into this more specific world of a holistic lens of medicine.

Dr. Neil Nathan 04:09
How much time do you have?

Dr. Jill 04:11
As much as you want. [laughs]

Dr. Neil Nathan 04:13

Okay. I'll give you the shorter version. When I went to medical school, I wanted to be a healer. I thought that's what I would learn about when I went to medical school. One of my greatest earliest disappointments was: No, that wasn't on the curriculum. I was going to learn how to be a medical technician. And that's fine. But that's not what I was looking for. So when I left medical school, that's when my real education began.

Dr. Neil Nathan 04:48
I began studying with anyone who had even an idea of what healing was about. I studied a wide array of healing arts, if you will. I was fortunate enough; I studied with some of the best in the world and had a phenomenal education. And I slowly evolved my own understanding of what healing was about.

Dr. Neil Nathan 05:19
I started out as a family physician, delivered babies, did some surgery, worked in the ER, and did the full gamut of what doctors do. But I was always drawn to those patients who my colleagues didn't know what to do with—the outliers. I love puzzles. I love working through complexity, which makes me probably a very strange man. I'll own that. I began to apply the new tools that I had to help these patients. I found that a lot of these tools were effective when conventional medicine didn't quite cut it.

Dr. Neil Nathan 05:59
That's not to say that conventional medicine isn't fabulous as far as it goes. But it is limited in its consciousness, amongst other things. It kind of encourages simplistic thinking, like one cause, one treatment. And we've learned over the last 25 years that bodies are really complicated. There is rarely one cause for why someone feels the way they do. So this was the beginning of understanding complexity.

Dr. Neil Nathan 06:32
In part of my travels, where I became a director of a regional pain clinic, I studied osteopathic manipulation and acupuncture. I studied a wide array of tools that would help people with pain. Then I began to see this weird condition called fibrositis, which we now call fibromyalgia, back in the mid-80s. It's this weird condition where people were systemically ill, but it didn't fit any models that we had. At that time, almost all those patients were being referred to psychiatrists for

therapy or drugs, and it didn't work. So slowly, we began to understand fibromyalgia and chronic fatigue as caused by a wide array of medical and nutritional imbalances in the body. As that evolved, we got into Lyme and mold. And here we are, you and me, both dealing with this kind of complexity.

Dr. Jill 07:40
Yes. I think we share that—the desire for mystery and the curiosity. And you're right; I always say we take the cases everybody else doesn't want to take. The conventional family practitioners are like, "I don't have time for that." And we're like: "Bring them on! I like the complexity." Patients will bring in inches of chartwork that they've had done. They always ask if I'm afraid that they brought too many medical records. I'm like, 'Nope!'—because we like that data.

Dr. Jill 08:04
Something that came to mind that I know you'll remember from medical school is Occam's razor. It was this idea that we have a single hypothesis that unifies the diagnosis: The most concise explanation is the right one. Maybe just talk a little about it because we're talking about blowing that apart and saying: No, it's actually multi-layered, multi-complexity. Maybe in that framework, let's talk a little about why that isn't the greatest model for this complex chronic disease that we see nowadays.

Dr. Neil Nathan 08:31
I think that's really important. The way medicine is taught in medical school and residency is to try to oversimplify things and pigeonhole symptoms into the first diagnosis you can come up with, to me, rather than ask the overriding question: Does that really explain this patient's illness? That's where I find my colleagues are often leading patients down the wrong road. I think of it as critical thinking skills. Let me put it this way, if you really look at it, "My patient is complaining of" this, this, this and this, the label that was given to him at some major medical center doesn't fit. That only explains 20% of their symptoms. Come on! If you really have a good diagnosis, it should explain everything. So that's where I think modern medicine is failing most people with chronic illness.

Dr. Jill 09:38
Yes. I just have to laugh at these terms we throw out, like 'idiopathic' (we don't really know what's going on) and NOS (not otherwise specified). We actually have

medical terms in the diagnostic criteria that explain this lack of curiosity, lack of in-depth... It's just like, "Oh, let's throw them in this garbage basket," right?

Dr. Neil Nathan 09:59
Yes. And I think that the majority of physicians want to do right by their patients. But the way the practice of medicine has evolved with HMOs and managed care, they don't have time. They're under tremendous pressure to cram through as many patients as possible in the shortest time possible. If you have someone with a chronic illness or any complexity at all, that's not going to cut it. It just can't. So, I know that you and I have evolved practices where we spend a lot more time with each patient visit because it's necessary. There's no other way to do this.

Dr. Jill 10:38
Yes. Let's talk about that because I feel like, as a clinician, you are one of the heroes and founders of so many of these principles. Part of it is because your approach to the patient has really worked and should also be an example for a lot of us who continue to try to go deep. Maybe talk a little bit about if a patient were to come to visit you or do a Zoom call. How would you approach this? I think that the approach is where it starts—with getting clarity.

Dr. Neil Nathan 11:05
I think it starts with just listening, meaning having enough time in your schedule so that a patient can tell their whole story. I can't count—I know you've had the same experience—[the number of] patients who've come to see me who have not felt heard or listened [to]. [Among] almost everyone that I work with, there are very few malingers and very few people who are making it up. It's not in their heads. They have a story to tell. The answer to what's wrong with them is almost always in that story if I can just be quiet enough, listen, and sit back.

Dr. Neil Nathan 11:46
I think it's estimated that in the average patient encounter, and this has been studied, patients have about 14 seconds before they're interrupted by their physician to move them along and get them going—14 seconds! You can barely give me your name in 14 seconds. I think the key is listening. I would say listening not just to the words or content but [also to] how the patient tells their story—their body movements, their language, where they pause, where they reflect. They're constantly radiating information to me while we're talking together. If I can just be

receptive, then I can take that information and begin to get a feel for: What is the primary issue that they're wrestling with? I think that has always been the basic tenet of medical practice, but we just don't do it anymore.

Dr. Neil Nathan 12:58
My second pet peeve is that I can't count the number of patients who've been to me, who've been to specialists—you name it—and when I would examine them and do an actual physical exam, they would say: "You're the first person who's touched me—ever!" And you're going: "What? That's basic medical practice." "No, no, no. My cardiologist never even listened to my heart. He's just looking at the echocardiogram and the CT and coming up with a diagnosis with that." We're not doing what medicine has always evolved to do: Listen, touch, connect. I think that's where we begin the process of helping figure out what's really wrong with them.

Dr. Jill 13:50
I could not agree more. And I love how eloquently you said that. We know that from birth, the infant's connection to the mother [is so important]—the eye connection, being seen, being held. We know that the infants who weren't held at all have way worse outcomes, probably more than food, drink, or anything. It's this human connection that's the start of healing. So you spoke about that very well.

Dr. Jill 14:14
We talked earlier about the intuitive piece that we bring as clinicians. I think—at least [from] my experience in medical school—it had no value. It's all science and an analytical mind. Tell us a little bit about why you believe—and I believe as well—this is not true. Maybe some of our most powerful insights come from that intuitive, energetic sense.

Dr. Neil Nathan 14:37
As you know, I taught at the University of Minnesota at the medical school for 11 years. I also trained family practice residents. I would watch how they would come to a conclusion about what was wrong with a patient and how they interacted. It was part of my job to teach them how to do that. I would watch them make an intuitive leap throughout their interactions. But when I would ask them, "How did you decide that?" nobody would own, "That was an intuitive leap." It was like: "Oh, no. That would be unscientific. I wouldn't be a good person if I did that." So I

watched people minimize their intuition and thereby lose a huge piece of what was going on.

Dr. Neil Nathan 15:25
When I was in medical school, I had an experience that I'll share with you. I was learning the art—from ENT physicians—of looking in an ear. It's pretty straightforward. You just put in an otoscope and look inside and you see something. But I began to get the sense that we're all looking in these otoscopes, but we're not all seeing the same thing. It's the same experience we have when people sit at a beautiful scenic overlook. They've got a camera, and they're all taking different pictures. They're not all seeing the same thing in the same way. And how that informed diagnosis would be [was that] I would look in an ear and then I would ask my residents and attending physicians to draw what they saw—not tell me about it, draw it. They all drew different pictures.

Dr. Neil Nathan 16:28
Let's say there's a child and we're thinking that maybe they have otitis media, which is very common. When you look in an ear with otitis, the eardrum is red, it's bulging, or it's retracted. It has a certain appearance. I would watch two residents and an attending [physician] look in an ear and all draw something different. It occurred to me that they were being affected by their intuition to draw what they thought the patient needed so that they could justify it by their drawing. If a physician thought that this was simply a retracted ear and not infected, they would not put the patient on an antibiotic. But if they thought that the ear was red, they would put the patient on the antibiotic and feel justified by it.

Dr. Neil Nathan 17:18
Even at that stage, I became fascinated by human perception and how we shape it to do what we think is right. I'm not saying that those physicians did anything wrong whatsoever, but they didn't own or understand their own process for how they worked. To me, that's a major topic in medicine that we should be talking about. How do we decide if "you have this" or "you have that"? Yes, we put our well-developed right brains into action by putting data, information, and lab tests together. But especially with chronic patients, they're so complicated. There's so much data. How do you tease it apart to come up with: "What should I do first?" Not, "Can I list the 23 things that are wrong with you?" which in medicine we call

differential diagnosis. But what do we—you and I as a patient—need to work on first? That's the priority; that's the starting point. That's where I think if you don't use intuition, you have no way to figure this out, because intuition can cut through that process in a way that merely listing all these things doesn't do.

Dr. Jill 18:47
That is such a profound and important thought. You're right. Science would say there are these three things, and it doesn't matter how you order them. But you and I know that it does. It makes me think of mold-related illness. We both deal with a lot of patients with mold-related illness. My thought on that is that years ago, when I had mold exposure myself and got very ill from mold, I could have a line in the sand. Before that, I never thought about that in my differential because I didn't realize how many people were affected by it and how much it affected autoimmunity, brain function, skin, histamine, mast cells—you name it.

Dr. Jill 19:24
In that period prior to my own exposure, I would have probably missed a lot of diagnoses that, at their root, had mold. Then, of course, I'd go through it. My lens all of a sudden is shifted because then I see what it did to my body. I understand it at a deep, deep level. I understand what it took to heal. I understand the complexities of how weirdly it changes your mind, your perception, your extraversion versus interversion, and your limbic system. And we can talk about some of this. But all that to say, after that, I remember thinking: "Oh my gosh, this is crazy! There are so many people affected by mold."

Dr. Jill 19:54
I held myself back a little because I wanted to make sure that I wasn't seeing everything as mold because I knew I had a new lens. But what happened was that I would hold back and say, "This can't be mold again." And guess what? At the root, it ended up [being mold]. So it shifted my perception. And as you and I know, it's probably one of the reasons why we are good mold-related illness clinicians because we have a lens that understands this crazy disease. Talk a little about that, because what you're saying is that the lens that we bring as clinicians affects everything, right?

Dr. Neil Nathan 20:25
It is now estimated that there are 10 million Americans suffering from mold toxicity. I would say a fraction know it because their physicians have never heard of it. One of my favorite comments from physicians is: "If this was a real thing, they would have taught it to me in medical school." I'm thinking: "Gosh, I went to medical school 50 years ago. This wasn't a known illness back then. If I'm stuck with what I learned in medical school as all-I-have tools I have to work with, there's nothing we've learned in the last 50 years? Really? For me, that's a non-sequitur. It's a silly statement. But I get it a lot. I get the sense [that they feel], "Somebody should have taught this to me if it's a real thing to look at."

Dr. Neil Nathan 21:18
There's also the phenomenon of what I call 'water seeking its own level.' I don't know how people find me. You and I are fairly well known now in our field, so people seek us because we're known. But before we were known, people still sought us [out]. What was that energetic resonance that would get someone to hear about me from a friend and go, "I think that he might be the person who would help me"? We all attract the kinds of people who need us for some reason. And no one's studying that. I think that's a really important thing to study.

Dr. Jill 22:01
Wow, I could not agree more. Again, you're saying the things that are unspoken so eloquently.

Let's shift a little bit to your new book about the sensitive patient. At the core of so many people you and I tend to attract are sensitive patients. I think you and I had a conversation about this before—that part of our view of the world, our curiosity, and our love for this complexity is the fact that we like details. We like to see these things. So we are probably those same sensitive people, right? Talk a little about the sensitive patient, how we approach them, and why it's different from the classical way that we might get success in medicine.

Dr. Neil Nathan 22:39
I think you're touching on two things: One is being an empath—which, of course, we know you are, and I am to some degree—which allows a human being to actually feel what someone else is describing. Not just hear it, not just resonate to it, but

actually feel it. It's a very common human capacity that people don't own the way they need to, because it allows us to connect to people on a very deep level without words being exchanged. The person who you are being empathic to can feel it also. Medically, it's an extremely helpful thing to do as long as you don't get sucked up in the other person's feeling, which is also a liability to that process and very important. That's a piece of what you were saying.

Dr. Neil Nathan 23:42
Again, I'll come back in time. Twenty-five years ago, I'm not sure I was seeing patients [who were] as sensitive as I see them now. Over the past 25 years, I think, due to the increasing toxicity of the world we live in, patients have been increasingly getting more and more sensitive. By sensitive, I mean sensitive to all of the stimuli—light, sound, touch, smell, EMF, food. All of those things are true sensitivities. And unfortunately, those sensitive people have generally not been believed by the people in their lives—their spouses, their family, their friends, and certainly not their physicians.

Dr. Neil Nathan 24:33
When someone would say, "I'm becoming so light sensitive that I have to wear sunglasses indoors," "I can barely be around certain sounds because it grates on my nervous system," or "I can't be around certain smells because I get sick immediately," the general response of most people in the medical community has been: "You're weird. You're a nutcase. It's in your head. Nobody's that sensitive." And the truth is, yes, people are that sensitive. There are now many, many, many more of them than we realized.

Dr. Neil Nathan 25:11
A recent study in England, reported on by Claudia Miller, found that 1% of the English population was so sensitive that they were legally disabled. Up to 35% of the English population was sensitive enough that it affected their lives. We're not talking about something super rare or unheard of. It's way more common, but no one really wants to talk about it. "Hmm, we've already had that conversation."

Dr. Neil Nathan 25:46
I've sort of become the Lorax. "I speak for the trees," in Dr. Seuss talk, realizing that nobody was making up what they were telling me when they described this kind of

sensitivity as real. I didn't know what to do with it 25 years ago. I didn't have any grasp of what was physiologically happening to them or their biochemistry. I knew that I didn't know how to help them, which was very frustrating. But I didn't doubt what they were feeling. Over the last 25 years, and this is the whole purpose of my new book, we have learned a great deal about what sensitivity means neurologically and biochemically inside the body. Meaning we now know what is happening to us that's creating the sensitivity. And by knowing that, we now know how to treat it.

Dr. Neil Nathan 26:46
So the beauty of it and the reason I wrote this book is that I really wanted all those sensitive folks out there to understand: It's not in my head. This is totally real. This is a neurological-biochemical shift in me. And we know what is triggering it or causing it. Great! Now we know how to treat it. So it's a whole new field. And I know you work with these patients the way I do.

Dr. Jill 27:11
Yes. And I want to dive into that and talk about: How do we approach it as clinicians? And how do the patients deal with these sensitivities? So, some real practical things. You did a really good job at some of the common things. I recently posted a little post on a highly sensitive person. Elaine Aaron wrote about emotionally sensitive people and light and sound and stuff. But what I found is that it overlaps into those who are chemically sensitive and sensitive to drugs. So it's kind of a whole spectrum—emotionally, physically, spiritually, and energetically. You name it. Would you say that's true—that when someone's extra sensitive, they're usually extra sensitive in multiple layers and areas, and they might also be more prone to environmental toxicity? Is that true?

Dr. Neil Nathan 27:55
Yes, on all counts. Once you understand what the nervous system is doing, it begins to make sense because what controls sensitivity is the limbic system of our brain. Depending on your innate biochemistry and genetics, we could all be exposed to a particular stimulus and respond in different ways. Once the limbic system begins to be dysfunctional, it starts with one thing, and then it spreads. You might start with being a little bit chemically sensitive. Then you become sensitive to light and then you become more sensitive to EMF. Those get worse as time goes on.

Dr. Neil Nathan 28:40
If you don't figure out what's triggering that sensitivity in the first place, it will get worse because the limbic system's job is to protect you by scrutinizing the stimuli that you're being exposed to for safety. It's all about safety. It's not trying to make you sick, but it's trying to go: Is that sound safe for me? Is that smell safe for me? And if it doesn't think you're safe, it's going to shut you down by giving you symptoms—not to make you miserable, but to warn you: There's something out there that you need to get away from in order for you to be healthy and safe. And that just gets worse with time. So that's the start of it.

Dr. Neil Nathan 29:32
To complete the beginning of that subject, another part of the brain, which we call the vagal nerve system, does the same thing differently. The vagus nerve controls intestinal motility and has branches that go to the heart and lungs. It controls what we call our autonomic nervous system—our breathing, our pulse, and our ability to regulate temperature. That system is also looking at those stimuli. The two systems talk to each other constantly. They're different parts of the brain, but they're talking to each other regularly about: Is that safe? Is that safe? Do you think that's safe? And they shut us down.

Dr. Neil Nathan 30:15
What we've learned—this is the wonderful part of it, and I want listeners to know this—[is that] everything I'm talking about is treatable. We now understand it. We have methods for quieting the limbic system and methods to bring the vagus nerve back online properly. The trifecta in this that makes us sensitive is the mast cell activation process. That's not neurological; it's cellular. Mast cells are in the family of white blood cells. They're a bridge between the immune system and the nervous system—a direct bridge. So we have these three systems that are constantly talking to each other. When one system tends to get out of whack, the others will come along as well. So in the sensitive patients—I call it 'the trifecta of sensitivity'—we have limbic, vagal, and mast cell issues, all of which are treatable. So that's the start of it.

Dr. Jill 31:18
Ah, that makes so much sense. I know a lot of our listeners are going: "Yes, that's me. Tell us more. Dr. Nathan!" This is a great framework because you and I both

have been out there talking to their doctors and saying we have to start with the limbic system and the vagal system. With these patients—maybe you can tell us why—if you just throw a drug or even supplements in the beginning, if you don't go to the beginning points of this, you're not going to get a great response. Tell us a little bit about the order of operations and why understanding this is a key to the start of healing.

Dr. Neil Nathan 31:50
If a body doesn't feel safe, it can't accept or respond to supplements or medications, even if it needs them, because it's in survival mode. It's basically going: "Yep, thanks for that. But what am I going to do with that? I'm on survival mode. I can't do anything until I feel safer." Not everyone that we treat is in this state, of course. Some of our patients with mold toxicity can easily take the binders, anti-inflammatories, [and/or] anti-fungal materials that they need to get well. And that's great. But you and I are often seeing the patients who have become sensitive. Those materials given by other physicians at normal doses have thrown those patients under the bus. Didn't mean to. They just can't do it.

Dr. Neil Nathan 32:46
So for most of our patients, for me, the order is limbic and vagal first as a duality. You have to work on them together. If the limbic and vagal systems are both hypervigilant and you quiet the limbic system and don't work on the vagal system, [you are] not going anywhere—vice versa. So you have to work on the limbic and vagal systems together, then mast cell activation. It depends on the patient. If a patient can take the supplements for mast cell activation from the get-go, [that is] fabulous. But our most sensitive patients often can't. They'll take normal doses of the materials we use for mast cell activation and under the bus they go. So my order is limbic, vagal. When they're ready, mast cell. When they're ready, then we treat mold, Lyme, Bartonella, or whatever we think the primary issue is that's triggering all of this.

Dr. Jill 33:47
Yes, I could not agree more. So let's go to limbic and vagal. I agree with you there. What are some practical ways that someone, maybe at home or without even a physician involved at this point, could start to work on these things? And I'm sure

it's all in your book. I want to be sure to call out to get the book so you have a guide. But in addition to the book, where else can they start?

Dr. Neil Nathan 34:09
By the way, in my book, I have 20 guest authors. They're all top in their field in that subject. For example, on the limbic system, chapters are written by Annie Hopper and Ashok Gupta. On the vagal nerve, I wrote the chapter with Steve Porges. These are all the major people in the field [who are] doing this work. I didn't want this book to be my book. I wanted it to be our book of a whole bunch of experts, people who all work, telling you: Yes, what you have is valid and we know how to fix it. So to answer your question, there are three main systems I like to work with for the limbic system: Annie Hopper's Dynamic Neural Retraining Program, Ashok Gupta's Amygdala Retraining Program, and a newer one that I like a lot is Primal Trust by Cathleen King.

Dr. Jill 35:07
I couldn't agree more!—all three.

Dr. Neil Nathan 35:09
Those are my favorites. There are others out there. As people have recognized how important limbic retraining is, more and more people are getting on the bandwagon. But Annie and Ashok have been in the field the longest. You can go online, Google their names and their program, and you can get their program and work with it. They're excellent. I've had over a thousand people do Annie's program and a thousand people do Gupta's program. And increasingly, my patients are liking the Primal Trust program as well. So in that category, that's where you want to start.

Dr. Neil Nathan 35:51
In the vagal world, I'll give you what I call a smorgasbord of vagal treatments, because there's a bunch. One of the things I like a lot are some new devices that are called vagal nerve stimulators. There's a bunch on the market. I list them in my book. But the main thing I want to tell you all about vagal nerve stimulators is: Do not use them the way the instructions from the company come. For example, one of my favorites is called Apollo Neuro. It's a band that you can wear on your wrist. You can set it at varying levels. The company says [to] start by wearing this for five to

eight hours a day. Please don't do that if you're a sensitive patient. Your body will not thank you. You can overstimulate a vagus nerve as well as reboot it. I tell my sensitive patients to start wearing it for three minutes once a day. Then slowly increase to five minutes, ten minutes once a day, and ten minutes twice a day. If you can do more comfortably, fine. But do not start the way any of the devices tell you to start. Start low; work up from it.

Dr. Neil Nathan 37:06
I love osteopathic cranial work as a method for treating the vagus and the autonomic nervous system. I love frequency-specific microcurrent as a method for treating this. There's a device that I like a lot—BrainTap, by Patrick Porter. But it uses light and sound to reboot those systems. For those people who are light or sound sensitive, that will set you back. For those folks, if that's the issue, that wouldn't be the first thing that I would do.

Dr. Neil Nathan 37:44
There's more, but those would be my favorite vagal strategies. My advice to patients is that you must do limbic and vagal work concurrently. The more of these things you can do, the more effectively and quickly you will begin the process of feeling safer. Then you will be able to respond better to all the treatments that you need to do to get well.

Dr. Jill 38:12
Yes. Boy, amen! That's a really, really great list there because it's very practical. I've bought a couple of vagal nerve stimulators. One thing: Some of these will attach to your earlobe, the tragus, which is a common pathway for the vagal nerve. I think the problem is that some of those can burn your skin. It's a little device. I found that if I wear it too much, I get an irritated sore there, which is not healthy.

Dr. Jill 38:34
The other thing I thought was very interesting: I did a retreat in Mexico not too long ago and I was probably in a very low sympathetic tone/state. They did some testing. I'm not sure what the machine was—it was from Germany—that showed my sympathetic, parasympathetic tone. I was in the realm of 'master meditator.' It was because my parasympathetic [level] was so high and my sympathetic [level] was so low. That week, when I was so relaxed and in a low tone, I was like, "I feel like I'm

going to die if I don't move." I was literally so still that I was like, "I'm going to die." I obviously wasn't in a depressed state or anything. It was just my limbic system. That was so low on the other end that I needed to move to activate. That just brings up a thought because sometimes I tell people to walk because that motion is so healing. Any sense of those who might be stuck in a free state and how they could do some things to get out of that free state?

Dr. Neil Nathan 39:30
It's all about balance. But I suspect, if I'm going to go out on a limb, that you've been running on a sympathetic drive for so long that when you went into the parasympathetic state, your body went: What is this? How am I supposed to deal with this? It can be a shock to the body if you jump, shift, or quantum leap from being in a hyper-sympathetic state to a hyper-parasympathetic state. I'm guessing that that might have played a role for you.

Dr. Jill 40:08
It was interesting, though, because I'm hearing you talk about using all these vagal nerve simulators. And at that moment, I was like, "I think I need to walk," like move. So I love that you said that because we're back to our personalized and intuitive medicine. I intuitively knew what my body needed and I got out of it. It was no big deal. I never in a million years thought that I would be registering such a high parasympathetic tone. But again, I was in a different state—relaxed.

Dr. Jill 40:30
I think all of us have the ability to access these if we just learn. I'm sure what you do is teach patients to really trust their own intuition. Maybe talk about that a little bit because I think it's underrated—empowering the patient to really trust what the signals in their body are telling them.

Dr. Neil Nathan 40:48
We're all taught from an early age that there are experts who know more about us than we do: Our parents, our religious leaders, our teachers. We're vulnerable when we're little to their information. Whatever it is they tell us, which is: "You have no artistic ability," "You have no musical voice; please don't sing in public," or whatever you're taught. We're little and we can't objectively look at that information. So we were filled with what I call other people's programs, other people's ideas of who we are that may have nothing to do with who we are now as a human being. So we have

to rewrite those programs when we get older. We have to really look at: What were we taught? Is that true? Maybe it was well-intentioned as a statement to us, but it's simply not true. So our job as we get to be adults is to rediscover who we are and own it. Because that's what we're supposed to be doing here on this planet—to be the best version of ourselves.

Dr. Jill 42:01
Yes. And going back to medical school, at least for me as an empath, I was trained to live from the neck up. Everything was a brain-derived analytical assessment of the situation. As I've grown in my own healing and in the healing of patients, I've learned to go down and actually feel because the sensations in our bodies clue us into what's happening. I think a lot of women and men get disconnected from that. As a sensitive patient, part of the healing is really reconnecting: What is healing? What feels good to me? What do I need to do next?

Dr. Jill 42:31
And [it's about] us as clinicians encouraging the patient to trust that. Sadly, what's happened to a lot of patients is that they go to their doctor, like: "Doctor. I don't feel well. Something's wrong." They don't really know what's wrong, but the doctor looks at the labs and says, "Well, everything looks fine." So then, just like you said, we outsource our trust to that expert. And we think, "I must be fine because he says I'm fine" or "she says I'm fine." So I love that you're encouraging reconnecting to our body systems because our body gives us all the information we need if we just listen.

Dr. Neil Nathan 43:03
Yes. I got through medical school primarily because of three things I did that most of my colleagues did not. When I started medical school, I went to the University of Chicago. I know you're in Chicago as well. That was maybe a connection we have there. I went to the University of Chicago. It's filled with really bright people. I saw, when I started, really intelligent, bright, creative people become increasingly shut down as human beings. By the time they graduated, they were a shadow of who they had been when they started medical school. I just couldn't let that happen. My spirit wouldn't allow it. I don't know if it's intelligence or intuition, but my spirit was dying doing that.

Dr. Neil Nathan 43:59
One of my loves in life has been playing basketball, so I was on every intramural team that I could be on at the University of Chicago. I loved theater, so I acted in every play possible. And I loved art, so I used to go to the Art Institute, which in those days was open in the evenings until nine o'clock. If you went in the evening, you could have some of the museum to yourself. I remember sitting for hours in the Monet room, just looking at that incredible artwork and taking it in. That's how I got through medical school. I just wouldn't let my spirit not be me. I couldn't be taken over by becoming an automon, like what happened to so many of my colleagues. For whatever reason, I didn't let medical school kick that out of me. I think the world might regret that, but there we are.

Dr. Jill 45:01
Oh, no, I love it! And I love, love, love what you bring to medicine, to the world, to myself, and to all of our colleagues. That unique perspective is so important. I think we do need to keep it. It's like the right brain, left brain, science, faith—all these pieces of ourselves. We separate them, and we draw these things that are not true. And [yet], it's all connected.

Dr. Neil Nathan 45:26
I would not study before exams. I would play basketball so that I would come into my exams relaxed. In a relaxed state, you can access information incredibly better than being uptight, like: "What was that thought? What was that fact? What page was that on?" You just come into it in a more [relaxed way]: "Okay, I trust my memory. I studied hard. I'm going to trust my memory to spit back whatever information you all want."

Dr. Neil Nathan 45:57
The way we are taught, the way education is done… I'll take this back a step. The world that little children are being born into right now is so stressful that everyone should be taught to meditate in school at the earliest of ages so that we can begin the process of quieting our limbic and vagal systems down at an early age, not to the point that by the time we're a teenager, we're frazzled already. "Are we getting into the right college? Did I do all the right things?" Like, "uhhh…" As opposed to: "No, I worked hard, and I studied." I think there's something really wrong with the way we're preparing children to enter the world that we're creating for them.

Dr. Jill 46:50
Oh, I couldn't agree more. Even eight hours in a chair is not the right thing for [inaudible]—young men or women. Oh goodness.

In our last few minutes, first of all, if you are listening and want *The Sensitive Patient's Healing Guide* by Dr. Neil Nathan, it will be out when this podcast is live, so you can get your own copy. I highly recommend it. I think you're going to want to read and reread it. The nice thing, Dr. Nathan, is that we're empowering people. It's great if they can see you, me, or another colleague of ours. But many of these people either won't have the resources, the location, or a place where they can see someone like us. And the great thing is that they can do a lot on their own with your resource, the book.

For that person who's sitting there listening and who has been told they're crazy by the doctors—they have symptoms, they are incredibly sensitive to this world and they're feeling hopeless—what would you say to that person?

Dr. Neil Nathan 47:44
Find someone who understands what you're saying, and don't take no for an answer. But you probably need to look in the right place for it in functional or integrative medicine. It's unlikely that someone in conventional medicine will have those answers. It's much more likely that someone who has been studying integrative medicine for a while will be knowledgeable enough that they will understand what you're saying. Most physicians in that field don't work in an HMO and don't limit your visit to seven minutes before "We're done with you." So you're more likely to be heard. Whoever is talking to you—I don't care what their credentials are—it could be me, if you don't feel heard [by them], leave. Leave that area. Don't take it to heart that it's you. Find someone who can listen to you, understand you, and then begin the process of leading you back on the road to recovery.

Dr. Jill 48:55
Brilliantly said and so true. There is always hope. What are the next steps for Dr. Neil Nathan? Are you working on anything else? Is there anything to expect in the next year or two from you besides this new book?

Dr. Neil Nathan 49:08
You're not going to be surprised at the answer. My publisher has asked me to put out an updated second edition for *Toxic*, and I'm working on that right now. And I have started a new book, which is basically about how inflammation is the central role of almost all chronic illnesses and how to understand inflammation at a deeper level and know how to work with it. I've written the first few chapters of that. I'm writing it with another person who is even more knowledgeable about the immune system than I am. So I've got those things cooking.

Dr. Neil Nathan 49:54
I do consult with physicians about their most difficult patients. That's available. And I do have a mentorship program that I do with Jill Crista on these chronic inflammatory conditions. We have almost 200 physicians in our mentorship group. For any physicians out there listening to this or anyone with prescriptive authority—naturopaths, PAs, nurse practitioners—you're very welcome to join our group. And if you want to learn how to do this in more detail and better, Jill and I want to impart what we know to those of you who want to hear it.

Dr. Jill 50:41
Two of my favorite people in the world are you and Jill Crista, so I couldn't endorse that more. Where can people find you, Dr. Nathan?

Dr. Neil Nathan 50:49
I live on the south coast of Oregon. I know you didn't mean it that way, [laughter] but that's my sense of humor. My website is very simple: NeilNathanMD.com. You can get access to the mentorship program, my books, lectures, and workshops. I teach a great deal. I appreciate very much, Jill, the opportunity to hang out with you for a while and share what we've learned with your audience.

Dr. Jill 51:20
Thank you. Thank you, as always, for the wealth of knowledge, heart, compassion, and sensitivity that you bring to the world of medicine. You are so appreciated!