Medical School, Part I

by Carl Nelson (April 2025)

The Medical Student's Dream (Charles Henry Miller, 1860s)

I never practiced medicine, but I did finish medical school so I can say something about that. This was fifty years ago, mind you, with all of the changes since not then encountered.

Oddly, medicine interests me more now than it did then. I entered medicine because I liked trying to understand people and talk to them. It was an impulse I would later pursue through the theater and playwriting as I took upon myself the goal of "writing a satisfactory conversation". What I found in

medicine was that my patients' most pressing need was not another friend—nor a "satisfactory conversation." Rather, they were sick and wanted to get well! It wasn't until retirement age, as well as the Covid pandemic, that I realized I couldn't blindly trust doctors to do what was best for me, and that I'd best use some of my training to read up and school myself so as to skirt many of my upcoming health problems. I didn't want to necessarily seek friendships with any doctors, either. I was on the age precipice of getting "sick and wanting to be well."

> *Suppose one endorses the view that westernized medicine, government-sponsored science, and the peer-reviewed literature have been co-opted by cooperation between big pharma, biotech, academia, and big government. In other words, the biopharmaceutical/government/academic, industrial complex. In that case, one is left with no alternative other than to explore other ideas, technologies, and solutions to optimize health. Sometimes this is referred to as integrative medicine when done in partnership with a medical practitioner, but when you are experimenting on yourself, this is bio-hacking. I suppose that when I treated myself with famotidine after I was infected with the original strain of SARS-CoV-2 in February 2020, I was essentially bio-hacking my COVID treatment to avoid going to the local hospital and being put on remdesivir and a ventilator*. —Robert Malone

When the lid came off the standard accepted medical protocols, and much of it was exposed for the lack of a scientific basis which had installed it, the new ideas and information percolating up from the substacks became quite fascinating. I had the background (and time) to dig in a bit, and so I did. The first thing I found out was that vaccinations were

anything but the single-sided medical sword for disease prevention that I had been sold in school; that they could actually limit one's natural immunity, and that their safety had been anything but proven.

Investigating further, I found that there is so much of curative value outlawed (lose your license, or worse) by the 'protocols' out there—for many reasons, and not the least of them monetary. Granted the internet is much like the Wild West, and caution is required. However, there are few advances without a few tactical retreats, and I have managed some successes among my retreats. One of the first things I learned is that, without much medical knowledge, you can still often eliminate some symptoms (many of which you didn't know you had) by scrutinizing the prescribed medicines you take. Their side effects might very well be the cause.

For example, my nephew had gotten so short of breath and weak that he could barely get out of bed to walk around. He's a middle-aged blue collar guy whose occupation requires some muscle and this was collapsing his life. His doctor had prescribed allergy treatments and given him a bagful of medicines including steroids. We found that substituting another drug for his lisinopril (a blood pressure medication), got him up and around. And his use of a C-pap machine and mask while sleeping resolved most the rest.

For myself, I found that I solved my urinary retention problems due to prostate enlargement by brushing the skin beside my urethral channel with a half-strength DMSO solution each day for a couple weeks. I now pee fine. And this allowed me to discontinue the Flomax prescribed by my urologist. Prior to doing this, there was an overall bodily weakness that badgered me which I had reluctantly accepted as one of the hallmarks of aging. But apparently it had been one of the side effects of taking the Flomax. By working through the remainder of my medications, (I kicked my Crestor to the curb, and reduced my blood pressure medication by a half to two thirds)

I've been able to wean myself to about half of them and currently I feel much better than before. Be careful of what problems you ascribe to 'growing old'!

An irony is that I am probably more interested in medical information now than I was when in medical school. The initial reason is that I am much more personally affected now by medical difficulties or their appearance on the horizon—that is, my blubber is meeting the road. But another aspect is that the medical profession's viewfinder is changing rapidly. The medicine I was trained in was very lockstep, very authoritative, and very much proscribed. One mustn't stray from the Accepted Standard of Care to stay within the good graces of the licensing boards and lurking legal suits. This has played very well into the hands of big Pharma, as we have witnessed during the Covid crisis.

This has stemmed in part from how the medical "science" has been arrived at. Reality is composed of a near infinite variety of variables. When testing for whether a proposed medicine will act on humans as you propose, it is near impossible to limit a study to the action/reaction of a single variable. What happens instead is that studies are done upon like populations which theoretically contain a like sorting of variables. Then doing nothing (the outcome of the 'control' group) is compared against the medicated (the outcome of the other group). If the trial is successful, the medicine or therapy is deemed useful for the entire population tested. The FDA passes accreditation based on this paradigm. This gives the therapy an enormous application. You may treat vast numbers of people with it. And pharmacologically, this means a vast market for the product. This also means a vast empowerment of the medical fraternity (vast populations may get this relief from us alone), and a vast moneymaker for the associated business interests. The result is that for powerful political, financial, and research reasons—the Accepted Standard of Medical Care based on this research becomes

cemented in. It is dangerous for any practitioner to practice outside of it—or even to speak such. If you stay within standard practices you may kill people without fear. Outside of them you may not even heal without fearing punishment.

The medical field has always had a problem holding onto dogmatic traditions and attacking physician dissidents who risk their careers to point out why those practices are unsafe and ineffective. To address this, in the 1960s, physicians began pushing for medical practice to be dictated by scientific evidence rather than entrenched interests, and in 1991, "evidence-based medicine" was born.

This mindset quickly caught on and overturned many disastrous medical dogmas, but unfortunately, gradually succumbed to the same issues that had created it in the first place, with "evidence-based medicine" becoming its own dogma and the rest of the medical system (e.g., pharmaceutical dollars) restructuring itself to provide more and more fraudulent evidence to sustain the current dysfunctional medical dogma while simultaneously attacking any contrary view and "pseudoscience" "lacking evidence."

> *Note: much of this is a result of RCT [Randomized Controlled Trials] fundamentalism (a belief that only prohibitively expensive large RCT's can constitute "evidence" despite the fact those expensive trials are notorious for consistently finding results that favor their sponsors and a 2014 Cochrane review proving that smaller (affordable) observational trials will get the same results as larger RCTs. Likewise, there's a widely held belief that data is only valid if published in a major journal despite those journals having massive financial conflicts of interest, which cause them only to publish things that reinforce their existing narratives.* —A Midwestern Doctor

A problem with the preceding treatment model is that people are different in infinite and often unknowable ways– and this is easily seen just in terms of public health. No matter the flu, or cold passing around–not everyone suffers it. Some people eat all the pizza they want and don't get fat. There are any number of fairly rare diseases that just a very few of all of us will suffer from. And most of us will die for differing reasons. Likewise, some patients will suffer side effects to certain medications that others don't. Moreover, some medications will do little for some while of great benefit to others. Nevertheless, those medications seated firmly within the medical practitioner's Accepted Standard of Medical Care–are because they've been shown in large studies to be efficacious.

I had no idea in my medical school years, and have only realized lately, that this treatment paradigm obviated and/or punished a huge amount of medical practice that could be useful (and, incidentally, inexpensive!). For example, one criticism of spectacular treatment successes is that they are inconclusive on the account of not being corroborated by follow-up studies employing large numbers of randomly selected subjects. They are dismissed as "anecdotal evidence." But that is just the point isn't it? Where in medicine do we say that a disease doesn't exist because we can only find its occurrence in one in a thousand? No. We call it a rare disorder. Why then in turn can't we declare some of these unusual successes to be examples of rare–but real and life-saving–medical interventions? But we don't do that, do we? Though–as has been widely noted–the fact that a treatment only works in one out of ten patients takes on a very different cast–if that one out of ten is you!

With my growing awareness of the large body of work which has been done and successes achieved employing treatments outside of the Accepted Standards of Medical Care, a bit of mystery

and awe of the human condition and physique has returned. Medicine has become a bit more of an art, and the body a bit more a source of fascination than I witnessed during my term as a medical student, where treatment was more a matter of tracing flowcharts (currently algorithms). Currently, in fact, investigators are beginning to study the individual patient's response to various unusual therapies by analyzing a slew of bodily parameters and studying these much as if they were a randomized study of a large population, which indeed they are—a large population of cells—and making scientific deductions from this.

Another point I would make is that by investigating and taking charge of your health you return the agency to yourself. (I tell my worrisome wife that, "I would rather die by my own stupidity, than by some doctor's.")

Many of the medical specialties have what are their bread and butter services. These services are fed by patients referred through screening exams. The patients being 'screened' are usually asymptomatic. But through the screening of them, some are found whose test results fall within a value whose protocol calls for a referral and more tests. Often times at the referral a medicine is prescribed to manage the aberrant test value so that it will return within the norm. Both the prescription and the follow-up tests then place the (asymptomatic) patient permanently on the specialist's patient list. The specialist's bread has been buttered. And the payment is likely covered as it all falls within the Standard of Care Protocols. The patient disregards the fact that they felt fine and resigns themselves to continuing medication and continuing doctor appointments. All of the side-effects of these medications is just more frosting on the cake. (And you can take further medications to blunt those unpleasant side-effects.)

But what are termed medical "screening exams" are also referred to in business as, "marketing funnels" which allow

the specialist to expand their customer base. For example, high blood pressure was once defined as greater than 160 systolic over 100 diastolic. This is where a slowly rising graph of untoward incidents (strokes, heart attacks, etc.) begins to sharply rise. By lowering the criteria to 130/90 or shooting for a bp of 120/80 which is described as normal and healthy, medical practitioners vastly expanded their customer base. When it was noted that the elderly probably need higher blood pressures so as to eliminating fainting and improve cerebral blood flow, I got on board. By shooting for a blood pressure around 140/90-95 I was able to reduce my antihypertensives by over one half and eliminate the bothersome dry cough which is a side effect of the lisinopril. Also, I don't faint and fall. It's not good for the elderly to have a BP of 120/80, if they then faint and break their hip or crack their head.

Dermatologists have gone from one of the least remunerative specialties to one of the highest by teaching us to fear sunlight and the resultant skin cancer. (Lots of expensive bump removal there!) In truth the dangerous metastatic melanomas mostly occur in skin areas devoid of sun exposure. And people with lots of sunlight exposure are found to be healthier.

Obstetricians perform periodic 'wellness exams' in which fetal imaging is performed which has been shown to negatively affect fetal development (more business).

But I had intended to talk about medical school. Perhaps I include this preface so as to describe the current fluctuating reality of medical therapies versus the near biblical presentation of facts and treatments which we received in medical school. And it was presented in such a overwhelming stream, that one hadn't the time to consider much reasonable doubt (even if there were conflicting literature and studies readily available). It's hard to contest where you're going when you are struggling just to keep up!

My first thought when I was introduced to the other medical students was that I liked this group of people more than any I'd previously known. (My second thought was to rocket my self-esteem as I went from anybody—to somebody, with acquaintances and women, following medical school admission.) My colleagues were smart, alert, inquisitive and generally friendly. And medicine came with a very strong ethos. You were expected to be someone of character who will work hard and as long as needed, in order to place the needs of your patient first. This meant that you had a duty to study and learn as much as possible so that you were the best physician you could be. People were depending upon you. Failure would involve more than yourself. Ethics and patient consent were a parcel of every treatment. This created a strangely marbled psyche when mixed with the hippie lifestyle of the era which included "finding your bliss." At the time, finding my bliss was caging a full night's sleep when on duty as an extern.

Where the rubber meets the road, it's fairly common for the practitioners of a profession to resent their audience, and understandably. The practitioner does all the work and takes all the risk, whereas the audience must bring nothing to the plate but their dismissal or support. Truman Capote was taken aback by how derisively the Rolling Stones spoke of their fans. Teachers and nurses resent their wards. Sales people gripe about their customers. And all of it, is due partly to the troublesome nature of human beings, and partly due to the difficulties in realizing any sort of goal for those human beings.

Medical professionals weren't immune to this downside of their benevolence and righting the emotional balance seemed to involve attaching descriptive epithets to the various stock characters and situations of the medical profession. There were the "gomers" (doctor jargon) who were "a troublesome patient, especially an elderly or homeless one." And there were elderly patients for whom no definitive diagnosis could

seemingly be reached, but that they had “the dwindles.” Let’s face it, reality is vexing! One reason for the strong medical ethos was to keep the despair and vexation inherent in trying to triage humanity in check.

Our first year of medical studies was mostly lecture and lab work, but there was also an effort to get us out into the clinics for patient encounters and to practice our initial patient exam. I remember one student (with a fairly poor social filter) exiting from the lecture auditorium one afternoon and declaring loudly while in conversation with another about his clinic experience that, “I just realized that I don’t like sick people!”

No one responded to that, but walked on quietly as if they had just encountered a baboon heading their way down the pathway but had skirted it.

One of the bothersome aspects of medicine I found was that people with their problems are like deep wells. One can get lost in speculation. Or realize, like Narcissus, that one is staring at oneself … or at best, reveling in one’s curative powers.

I didn’t get a chance to revel much. Oddly—or perhaps naturally, the most effective advice I offered happened outside of the school and its wards. The most immediate was a neighbor who brought her kitten over because of his sudden inability to breathe. I took a look down his throat. He had gotten a loop of scotch tape stuck to his tongue. After that was removed, he perked right up! Another was a hippie couple who lived in a handmade boathouse (of sorts, on a tiny barge) who had a baby whose rash wasn’t responding to any treatment that the doctor offered. I asked if he had been taking any antibiotics. He had, and I suggested that it was likely a yeast overgrowth due to the antibiotics. They discontinued the antibiotics and he got better. The last was a sculptor friend whose back gave out. He was considering surgery. I suggested

he try letting rest and time cure it. He did. Forty years later he is still doing well, as far as I know. Then there is our son. We solved his diarrhea when I remembered that Thailand was a region of the world where the people are largely lactose intolerant. So they don't drink milk. His eczema improved rapidly when he began taking Vitamin D supplements.

These small acts were very rewarding, and I can fully understand how a doctor could become addicted to their practice of them. A problem though was that the chance to revel seldom occurred. On the wards it was a crowd of patients, a quick examination or history, recording the notes and then off to the next in order to finish before rounds. Few were quick cures, and most were ameliorations of a recurrent condition. There were flocks of symptoms and crowds of possible causes and a short period of time to recollect and suggest possibilities. My mind didn't work like that at all. It resented the lack of opportunity to speculate and muse. I was amazed by those students who could grasp the bull by the horns and literally stalk the wards making quick observations and suggested treatments, and handling the medical narratives of a bevy of patients with nary a missed beat, then stopping by the critical care unit to analyze a few of the newest EKGs. I remember sharing a night on with a red-haired extern like this. When she sat her knee was characteristically bouncing up and down, and aptly, she was a fourth year extern doing the job of a grizzled intern. "You're an odd duck, aren't you?" She assessed me as we sat on our bunks in the intern nap room.

'Well, I'm a fish out of water,' I would later surmise.

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Carl Nelson's latest book of poetry titled, *Strays, Misfits,*

Renegades, and Maverick Poems (with additional Verses on Monetizations), has just been published. To have a look at this and more of his work please visit Magic Bean Books.

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