



If It Bleeds or Oozes...



By John Ostrich, MD

"Many Americans Mistrust So-called Western Medicine" - Headline, Portland Oregonian, June 6, 2005

"Most medical schools are adjusting their curricula to adapt to widespread public mistrust of conventional medicine." - Article, NY Times, Sept. 12, 2008

"A Comparison of the Effects of Black Cohosh and Valerian Extracts in Menopausal Women." - Lead article and editorial, NEJM, Jan. 17, 2022

LADIES AND GENTLEMEN...We are pleased to have with us today the dean of the Central California Medical College, Dr. Merkel Motley. Dr. Motley has agreed to take some questions from our panel and, time permitting, from the audience.

Now for our first question, from me. Can you tell us how your medical school came to be?

Dr. M: Of course. As you all may recall, the California Senate and Assembly endorsed, and the people overwhelmingly passed, Proposition 84 in 2014. It authorized the creation of, for lack of a better term, a non-traditional medical school at which alternative, or non-traditional treatments of human disease would be studied and applied to clients. We were, of course, concerned that we would be consigned to a campus far off the beaten track, so we are thankful for our central location here in Sacramento on the site of what were the State Fairgrounds.

Q: Yes, it is a beautiful campus, and we all understand that it is very busy, indeed. But I also understand that you have no inpatient facility.

Dr. M: That is correct. We on the faculty feel that, no matter what the problem, it can be adequately and successfully treated in an outpatient setting.

Q: Well, what if someone arrives at your door-step bleeding and in shock as a result of some sort of trauma?

Dr. M: That simply never happens, because the emergency response teams have been instructed never to bring such cases in here. In fact, if it bleeds or oozes it goes to the University Hospital or an emergency facility.

Q: But you just said...let me look at my notes... Here...you said, more or less, that no matter what the problem, it can be treated in the outpatient setting. That is what you said, right ?

Dr. M: That is right, and of course there are instances where emergent care is necessary, but that is not our mission. Let us consider spontaneous severe bleeding of a non-traumatic nature for a moment. We see these cases and successfully treat them every day.

The major bleeding sites, nasal, gastrointestinal, and gynecological, are all due to problems that can be reversed and cured by lifestyle and dietary adjustments, or by the application of nutraceuticals or probiotic products. Even CNS bleeding, except perhaps

for those cases due to genetically-based anatomic defects, is due to disease that is preventable by proper diet and lifestyle changes. If a worker falls from a height, or two Segways collide, the resultant bleeding, broken bones and lacerations will be taken care of at the University Medical Center. When the victims are discharged from there, we handle all of the post-hospital care.

Q: So aren't there two different populations of physicians being trained? There are the people at the acute care hospitals. They set the bones, remove the shattered spleens, sew up the wounds and generally clean up the messes, and the only patients your students see are pristine and ambulatory, it seems.

Dr. M: I guess that's one way to put it, but your question is slanted, in my opinion. You are suggesting, I think, that the students in my school are somehow inferior to their colleagues at the University campus because they are not involved in trauma medicine and surgery, am I not right?

Q: Well, it seems odd to me, and I will bet to a lot of Californians, that MD degrees are being granted to large numbers of medical students who have never been inside an emergency department or an operating room except perhaps as patients themselves!

Dr. M: I do not believe that having never experienced ER or OR activities translates to inferior training. After all, what can the ED physician offer the 35-year-old man who comes in with his umpteenth episode of abdominal pain and constipation? The usual tests are done and he's sent home to resume the same faulty diet and lifestyle that will inevitably bring him back with a true surgical problem such as a diverticular abscess. What is the surgeon going to do with the 28-year-old lady who arrives with right lower quadrant pain, chronic dyspareunia, insomnia, headache and low back pain after he rules her out for surgical disease?

I'll tell you what he does. He sends her to us. Most medicine is practiced in a very unglamorous outpatient setting. We believe, that if we get the first crack at these clients, we can keep them out of those emergency venues, and save the clients and society at large a lot of time, money and stress.

Q: I see by your curricular outline that your students do not participate in human dissection or in traditional physical examination techniques.

Dr. M: That is true. We do not believe that experience of that sort is time well spent. As an example, a study done at UCLA in 2009 looked at 1,000 consecutive outpatient clinic cases, all ages, both sexes, etcetera, in three major categories. One was chronic cough, cough for more than six months. The next was chronic - again more than six months - abdominal pain, and the third was anterior chest pain recurrent over six months.

In only 2 percent of those 3,000 people were serious or potentially life-threatening etiologies identified. The rest, that is about 2,940 people, were adequately cared for by the use and application of products and techniques approved by the California Health Care Commission in 2008. No so-called allopathic products or invasive techniques were used, and cures, as measured by follow-up interviews and questionnaires, were around 80 percent.

Myself and my faculty see no reason why we should waste our students' time with dissecting dead bodies, palpating abdomens, and learning to do pelvic or rectal exams. If we determine that a man has an elevated PSA, he is referred to a competent urologist. If he is found not to have cancer, he is back in our care and he learns preventive prostate health care. Rectal bleeding cases all get virtual endoscopy and suspicious masses are referred appropriately. We are fully equipped with the latest non-invasive laboratory and radiological equipment. All our clients have total body radiological and laboratory screens every 10 years from age 40 to 80.

Q: How are your clinics organized?

Dr. M: All our faculty and students see one client every hour. We have weekend appointments and some evening clinics. All our record keeping is electronic. We encourage all our clients to bring family members and significant others with them. Almost all follow up is in large group settings.

We have diabetic groups as large as 300 strong, and our irritable bowel groups are often even larger. We use multi-media presentations, and individuals can be seen after the presentations briefly by a health practitioner. We are always available to answer individual questions.

Q: You never mention any post-graduate programs.

Dr. M: We have none. Our students stay as long as they feel they need to, and when they are comfortable with their knowledge, they let us know and that triggers the granting of their degrees. We believe that our graduates give the finest care in the world, and numerous studies have confirmed the efficacy of our methods.

Seeing no more hands up, I hereby call an end to this delightful session and invite all of you to the faculty lounge for herbal tea and cookies.

Thank you.

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