

Why can Doctors not diagnose Medical Injuries?

爲什麼醫生不能診斷醫療傷害？

A Midwestern Doctor

May 2

Years ago, I saw a comment on a forum that stated “Allopathic medicine gaslights you to death.” Since then, one of my missions has been to bring that meme to the public consciousness.

多年前，我在一個論壇上看到一條評論，上面寫著“對抗療法會讓你死去”。從那時起，我的任務之一就是將這個模因帶入公眾意識。

***Gaslighting** refers to the phenomena first described in a 1944 movie, of having an abusive partner who continually alters things in your environment, but then tells you (or says other people are saying) what you are observing is not happening, so you begin to doubt your whole reality. This is an effective method for making people go insane and I’ve seen multiple cases of essentially sociopathic romantic partners gaslight a friend or patient.*

Gaslighting 指的是在 1944 年的電影中首次描述的現象，即有一個虐待夥伴不斷改變你的環境中的事物，但隨後告訴你（或說其他人在說）你觀察到的事情沒有發生，所以你開始懷疑你的整個現實。這是一種讓人發瘋的有效方法，我見過多起本質上是反社會的浪漫伴侶的案例，讓朋友或病人感到憤怒。

The term has become well known in a relationship context that over the last few years and is now used frequently enough that I often see it flung around where I don't really feel it is merited (as certain people always like to pick the most offensive label and slap it onto everyone they don't like). However, medical gaslighting is still a relatively unknown, and in my opinion, just as important phenomenon.

這個詞在過去幾年的關係環境中已經廣為人知，現在使用得足夠頻繁，以至於我經常看到它在我認為不值得的地方到處亂扔（因為某些人總是喜歡選擇最令人反感的貼上標籤並將其打在他們不喜歡的每個人身上）。然而，醫療**煤氣燈效應**仍然是一個相對未知的，在我看來，同樣重要的現象。

Typically, when people have a disabling reaction to a pharmaceutical or a medical procedure (formally known as

iatrogenesis), they are either told the reaction is not occurring (ie. they don't have fatigue and they are just being lazy or trying to get disability), or that the injury was not due to the medication and rather due to psychiatric problems the person has.

通常，當人們對藥物或醫療程序（正式稱為醫源性）產生致殘反應時，他們要么被告知沒有發生反應（即他們沒有疲勞，他們只是懶惰或試圖獲得殘疾），或者受傷不是由於藥物，而是由於該人的精神問題。

Unless you or someone you are very close to has gone through this, it's nearly impossible to even begin to describe how miserable of an experience this is for the person who experiences it. Every single authority figure tells you to doubt your own reality and submit to other toxic pharmaceuticals, and most of your family members and friends side with the authority figure's interpretation of reality. At the same time, you are falling apart and are in the most vulnerable and confused state possible which makes it very difficult to maintain your own reality.

除非您或您非常親近的人經歷過這種情況，否則幾乎不可能開始描述這種經歷對經歷它的人來說是多麼悲慘。每一

個權威人物都告訴你懷疑自己的現實並屈服於其他有毒藥物，而你的大多數家人和朋友都支持權威人物對現實的解釋。與此同時，你正在分崩離析，處於最脆弱和最混亂的狀態，這使得你很難維持自己的現實。

When I review these cases, I find one of the greatest issues is neurologic damage that subsequently creates psychiatric symptoms is a very common side effect from the more toxic pharmaceuticals. This creates a cycle of circular logic where the neurologic damage is not recognized, and your psychiatric symptoms are cited as the cause of your entire illness (which is further worsened by the fact being gaslighted is a traumatic experience which will often make one appear “overly emotional”). The fact that neurologic damage can frequently cause psychiatric symptoms is fundamental to my medical practice but is not recognized by much of the medical fields, which views these two classifications as entirely separate entities.

當我回顧這些案例時，我發現最大的問題之一是神經系統損傷，隨後會產生精神症狀，這是毒性更大的藥物的一種非常常見的副作用。這會產生一個循環邏輯循環，其中神經系統損傷未被識別，並且您的精神症狀被認為是您整個疾病的原因（由於被煤氣燈效應點燃是一種創傷性經歷，這通常會使一個人顯得“過度情緒”）。神經損傷經常

導致精神症狀這一事實是我的醫療實踐的基礎，但許多醫學領域並未認識到這一點，他們將這兩個分類視為完全獨立的實體。

Medical gaslighting is not new either; people pushing poisons will always want to blame the victims so they can stay in business. The earliest example I have come across was in the [Age of Autism](#). Mercury was one of the most commonly used, and most toxic medications from the early centuries of allopathic medicine. A common side effect was severe neuropsychiatric disturbances, which disproportionately affected women.

醫用煤氣燈效應也不是什麼新鮮事。推毒的人總是想責怪受害者，這樣他們才能繼續做生意。我遇到的最早的例子是在自閉症時代。汞是對抗療法藥物早期幾個世紀中最常用和毒性最大的藥物之一。一個常見的副作用是嚴重的神經精神障礙，這對女性造成了不成比例的影響。

Because the medical profession did not want to give up mercury, they made excuse after excuse to keep it in use. Freud arrived on the scene and (poorly) argued the debilitating illnesses being observed were due to unresolved sexual issues the patients had (ie. a daughter's towards her father she was caring for). As this gave the mercury pushers a

get out of jail card, the medical field ate Freud's argument up and it became medical dogma.

因為醫學界不想放棄汞，他們找了一個又一個藉口繼續使用它。弗洛伊德（Freud）到達現場並（可憐地）辯稱，觀察到的使人衰弱的疾病是由於患者未解決的性問題（即女兒對她正在照顧的父親的態度）造成的。由於這給了水銀推動者一張出獄卡，醫學界將弗洛伊德的論點吃掉了，它變成了醫學教條。

Since this strategy is effective, there are many other historical examples. The movie [Radium Girls](#) focuses on [women](#) working at a factory who painted radioactive paint onto watches and were instructed to repeatedly lick the brushes. This created numerous issues in the mouth, cancers and ultimately the deaths of many worker. The company responded by insisting the paint was safe and having a company doctor diagnose each injured worker with [syphilis](#). This effectively silenced these women since promiscuity was viewed in a very negative light by the culture of the time, leading the workers to hesitate to discuss their new illness.

由於這種策略是有效的，因此還有許多其他的歷史例子。電影《鐳女孩》聚焦在一家工廠工作的女性，她們將放射性塗料塗在手錶上，並被指示反復舔刷子。這造成了許多

口腔問題、癌症，並最終導致許多工人死亡。該公司的回應是堅稱油漆是安全的，並讓公司醫生為每位受傷的工人診斷出梅毒。這有效地使這些女性保持沉默，因為當時的文化以非常消極的方式看待濫交，導致工人們對討論她們的新疾病猶豫不決。

Similarly, after hundreds of thousands of servicemen became severely injured by the anthrax vaccine, the military took the strategy of blaming all illness on “stress” from the Gulf War. The military funded large number of studies to provide this correlation, pressured the VA to only focus on PTSD as a potential cause and relentlessly pushed this message to the media. This explanation was recognized by many to be absurd since many of the Gulf War Syndrome veterans had previously been in much worse wars with no issues (the Gulf War was a quick massacre of the Iraqis primarily done from afar), and many individuals with Gulf War Syndrome never even deployed to the Middle East.

同樣，在數十萬軍人因炭疽疫苗而嚴重受傷後，軍方採取了將所有疾病歸咎於海灣戰爭的“壓力”的策略。軍方資助了大量研究來提供這種相關性，迫使 VA 只關注 PTSD 作為潛在原因，並無情地將這一信息推送給媒體。這種解釋被許多人認為是荒謬的，因為許多海灣戰爭綜合症退伍軍人以前曾參加過更糟糕的戰爭而沒有任何問題（海灣戰

爭是對伊拉克人的快速屠殺，主要是從遠處完成），並且許多海灣戰爭的人綜合症甚至從未部署到中東。

This form of gaslighting has proven itself in the public relations field and is hence pushed by the manufacturers of many of the more toxic pharmaceutical drugs on the market. Pharmaceutical victims in turn periodically forward me literature they uncover of (industry funded) medical journals discussing psychiatric explanations for iatrogenic injuries.

這種形式的煤氣燈效應已在公共關係領域證明了自己，因此受到市場上許多毒性更大的藥物製造商的推動。藥物受害者反過來定期向我轉發他們發現的（由行業資助的）醫學期刊討論醫源性損傷的精神病學解釋的文獻。

Prior to the COVID-19 vaccines, while this issue was common enough that I frequently found myself shouting into the wind about it, it was rare enough that it could be easily swept under the rug and ignored. Since the COVID-19 vaccines have entered the market, it has become so common that on a daily basis I now hear stories (including from my readers) of significant iatrogenic complication from this vaccination followed by widespread gaslighting by friends, family and health care workers.

在 COVID-19 疫苗出現之前，雖然這個問題很常見，以至於我經常發現自己對它大喊大叫，但它很罕見，很容易被掃到地毯下並被忽視。自從 COVID-19 疫苗進入市場以來，它變得如此普遍，以至於我現在每天都聽到關於這種疫苗接種導致嚴重醫源性並發症的故事（包括我的讀者的故事），隨後朋友、家人和醫療保健工作者廣泛使用煤氣燈效應。

These stories are typically greeted with the shock and awe that something like this could possibly be happening in America. This I argue, is because until recently, the experiences of patients with iatrogenic injuries were relatively unknown and has only entered popular knowledge because it's become so common media censorship can't hide it anymore (normally pharmaceutical companies never allow stories critical of their products to make it to air).

這些故事通常會讓人感到震驚和敬畏，因為這樣的事情可能會在美國發生。我認為這是因為直到最近，醫源性損傷患者的經歷還相對不為人知，只是因為它變得如此普遍，媒體審查無法再隱藏它（通常製藥公司從不允許批評他們的產品的故事）讓它流通）。

My sincere hope is that this newfound public awareness of medical gaslighting will also bring awareness to the dozens of

other medications that frequently injure patients who made the mistake of trusting the doctors who prescribed it to them (due to reduced time constraints for doctors, many medical visits just result in the prescribing of a medication to a patient).

我真誠的希望是，這種新發現的公眾對醫療煤氣燈效應的認識也能引起人們對其他數十種藥物的認識，這些藥物經常傷害那些錯誤地相信給他們開藥的醫生的病人（由於減少了醫生的時間限制，許多醫療訪問只會導致給患者開藥）。

Why do Doctors Gaslight?

爲什麼醫生要煤氣燈效應？

I will admit there are some bad and some truly evil doctors out there (Fauci is not unique). However, while I frequently read or hear of them, unlike many of my colleagues, I've never crossed paths with these people (which is likely due to the fact I've stayed in rural areas and avoided the urban centers of power that trend to attract those types). All the doctors I trained under and have practiced with wanted the best for

their patients and made a sincere effort to follow medical ethics.

我承認那裡有一些壞的和一些真正邪惡的醫生（福奇並不是唯一的）。然而，雖然我經常閱讀或聽到他們，但與我的許多同事不同，我從未與這些人有過接觸（這可能是因為我一直住在農村地區並避開了這種趨勢的城市權力中心吸引這些類型）。我培訓過的所有醫生都希望為他們的病人提供最好的服務，並真誠地努力遵守醫療道德。

This then raises the question: Why is medical gaslighting so common? From my own experience, I would say there are three primary reasons and two secondary reasons. Henceforth for simplicity's sake, I will discuss "doctors" but these concepts also apply to other healthcare workers.

這就提出了一個問題：為什麼醫療煤氣燈效應如此普遍？根據我自己的經驗，我想說有三個主要原因和兩個次要原因。此後，為簡單起見，我將討論“醫生”，但這些概念也適用於其他醫護人員。

The primary reasons are as follows:

- Doctors lack the training or ability to recognize iatrogenic injuries.

• *Doctors who detect iatrogenic injuries will refuse to acknowledge them because it is psychologically challenging to do so.*

• *Many of the drugs and procedures used in Allopathic medicine are intrinsically harmful, so unless there are systemic biases against the existence of Iatrogenesis, the entire system cannot work. In the early 1900s when Carnegie and Rockefeller bought out the medical system, this was a serious concern for Allopathic medicine, and with the trends of that time, this toxic and ineffective system of medicine would have likely been discarded for a competing model had the market not been monopolized by those robber barons.*

主要原因如下：

- 醫生缺乏識別醫源性損傷的培訓或能力。
- 發現醫源性損傷的醫生會拒絕承認，因為這樣做在心理上具有挑戰性。
- 對抗療法中使用的許多藥物和程序本質上是有害的，因此除非存在針對醫源性存在的系統性偏見，否則整個系統將無法工作。在 1900 年代初期，當卡內基和洛克菲勒收購醫療系統時，這是對抗療法藥物的一個嚴重問題，隨著當時的趨勢，這種有毒且無效的藥物系統很可

能會被市場拋棄而成為競爭模式 沒有被那些強盜貴族壟斷。

The secondary reasons are as follows:

- Sometimes very complex diseases emerge (such as those having spiritual origins) that are completely beyond the scope of most doctors to understand. Since Allopathic medicine is a faith based on being all-knowing and the best form of medicine, when diseases that challenge its supremacy emerge, many doctors will deny the disease exists rather than admit they don't understand what is happening. I grew up playing puzzle games, so I seek these puzzling cases out, but I'm a bit of an anomaly.*

- There are a significant number of patients who do have psychiatric issues they choose not to address that create their illness, and there are many patients with psychiatric issues or external motivations that lead to them fabricate false symptoms or histories of their disease. Because every doctor encounters these patients, and much of medicine is pattern matching, they will juxtapose these patients onto the current patient in front of them who has a legitimate (and often neurologic) iatrogenic injury. I personally find this scenario*

quite challenging, as while I am strongly opposed to gaslighting patients, I also recognize it is extremely important for a patient's wellbeing to not validate false delusions. It is hence understandable why doctors without my bias to avoid gaslighting are prone to label many things their patients report as delusions.

次要原因如下：

- 有時會出現非常複雜的疾病（例如那些具有精神起源的疾病），這些疾病完全超出了大多數醫生的理解範圍。由於對抗療法是一種基於無所不知和最佳醫學形式的信仰，當出現挑戰其至高無上的疾病時，許多醫生會否認疾病的存在，而不是承認他們不了解正在發生的事情。我是玩益智遊戲長大的，所以我尋找這些令人費解的案例，但我有點反常。

- 有相當多的患者確實有他們選擇不解決的精神問題，這導致了他們的疾病，還有許多有精神問題或外部動機導致他們編造虛假症狀或疾病史的患者。因為每個醫生都會遇到這些患者，而且大部分醫學都是模式匹配，所以他們會將這些患者與他們面前的當前患者並列，這些患者有合法的（通常是神經系統的）醫源性損傷。我個人覺得這種情況非常具有挑戰性，因為雖然我強烈反對給病人用煤氣燈效應，但我也認識到不驗證錯誤的妄想對病人的健康非常

重要。因此，可以理解為什麼沒有我偏向於避免煤氣燈效應的醫生傾向於將他們的患者報告的許多事情標記為妄想。

For simplicities sake though, for the remainder of this series, I will focus on the first two reasons and why doctors gaslight patients: they cannot see or will not see iatrogenic injuries.

為簡單起見，在本系列的其餘部分中，我將重點介紹前兩個原因以及為什麼醫生會為患者提供煤氣燈效應：他們看不到或不會看到醫源性損傷。

The Complexity of Nature

自然的複雜性

Some people thrive in chaos and hate continual repetition. Typically though, people crave a solid box they can work within where everything is predefined, understandable and safe. When you take a more meta-approach within that dichotomy, you can argue most things can actually be either order or chaos depending on the manner in which you choose to observe the phenomena.

有些人在混亂中茁壯成長，討厭不斷重複。但通常情況下，人們渴望一個可以在其中工作的堅固盒子，其中所有內容都是預定義的、可理解的和安全的。當您在這種二分法中採用更元的方法時，您可以爭辯說大多數事物實際上可能是有序的或混亂的，具體取決於您選擇觀察現象的方式。

The human body, mind and spirit is very similar. On some levels, people are all the same and they follow the same predictable repeating patterns. On other levels, the body, the mind, and the spirit are an incredibly chaotic dynamic living unit. When interacting with others, it thus becomes a question of which lens you want to see people through; homogeneity or diversity.

人的身體、思想和精神非常相似。在某些層面上，人們都是一樣的，他們遵循相同的可預測的重複模式。在其他層面上，身體、思想和精神是一個非常混亂的動態生命單元。因此，在與他人互動時，您想通過哪個鏡頭來看待人們，這就變成了一個問題；同質性或多樣性。

My own opinion is that each lens makes sense in certain circumstances and certain patients or diseases but not in others. However, in real life, people tend to default to using the same lens over and over, and strongly resist changing it.

I've also found that most people who vocalize the importance of "diversity" tend to be the ones who are the most focused in seeing the homogeneity in everything they encounter.

我自己的觀點是，每個鏡頭在某些情況下和某些患者或疾病中都有意義，但在其他情況下則不然。然而，在現實生活中，人們傾向於一遍又一遍地使用同一個鏡頭，並且強烈反對更換它。我還發現，大多數強調“多樣性”重要性的人往往是最專注於看到他們遇到的一切事物的同質性的人。

Nature in general is incredibly complex and the amount of data present within it is overwhelming. One of the largest stressors for the human mind is excessive data, and the typical response to excessive data is for the mind to contract and try to simplify reality into something the mind can comfortably contain (alternative responses do exist but they typically require spiritual training). In recent years, it seems the world has started to go insane, and a few of the wisest people I know attribute this to the internet making more data available than what much of the population can process.

一般來說，自然界非常複雜，其中存在的數據量是壓倒性的。人類大腦最大的壓力源之一是過多的數據，對過多數據的典型反應是讓大腦收縮並嘗試將現實簡化為大腦可以

舒適地容納的東西（確實存在替代反應，但它們通常需要精神訓練）。近年來，世界似乎開始變得瘋狂，我認識的一些最聰明的人將此歸因於互聯網提供的可用數據超出了大多數人的處理能力。

In certain meditation traditions, this process is often referred to as “mental laziness.” When something is hard for the mind to contain (which frequently comes up in meditation), mentally lazy individuals will shy away from it, while non-mentally lazy individuals will not. A key point is that smart people are not immune to mental laziness.

在某些冥想傳統中，這個過程通常被稱為“精神懶惰”。當某些事情難以讓頭腦控制時（這經常出現在冥想中），精神上懶惰的人會迴避它，而非精神上懶惰的人則不會。一個關鍵點是，聰明的人不能免於精神上的懶惰。

Modern education is based on creating a very specific pattern of thought, which has the side effect of creating mental laziness to forms of thought outside that pattern. This form of mental laziness is often very difficult to recognize since the taught pattern of thought for the educated class on the surface represent a high degree of intelligence. It is only once you probe deeper or question parts of one’s belief structure that the mental laziness and avoidance of thoughts “outside their box”

makes itself evident (which many of you have observed in recent times as you questioned professionals espousing the COVID paradigm).

現代教育的基礎是創造一種非常具體的思維模式，這種模式的副作用是對這種模式之外的思維形式產生心理惰性。這種形式的精神懶惰通常很難識別，因為表面上受過教育的階級所教授的思維模式代表了高度的智力。只有當你更深入地探索或質疑一個人的信仰結構的某些部分時，精神上的懶惰和迴避“在他們的盒子之外”的想法才會變得明顯（你們中的許多人最近在質疑支持 COVID 範式的專業人士時觀察到了這一點）。

While mental laziness in the professional “expert” class is a significant societal problem, I believe the most problematic form of mental laziness relates to ones existential purpose. Most human beings cannot exist without some type of purpose to support and orient their minds, to the point they will adopt a bad one rather than choose to be without one. Exploitation of the existential laziness within the population has been used by countless despicable institutions to recruit lifelong adherents and within medicine, I frequently find one of the reasons why doctors will not challenge medical dogma is because so much of their existential worth (that they did not create prior to medical school) is tied to their identity as a physician.

雖然專業“專家”階層的精神懶惰是一個重大的社會問題，但我認為最成問題的精神懶惰形式與存在目的有關。如果沒有某種目的來支持和引導他們的思想，大多數人就無法生存，以至於他們會採用一個壞的，而不是選擇沒有一個。無數卑鄙的機構利用人口中存在的懶惰來招募終身信徒，在醫學界，我經常發現醫生不會挑戰醫學教條的原因之一是因為他們的存在價值太多（他們沒有在醫學院之前創建）與他們作為醫生的身份有關。

In summary, to address this innate human need for simplicity, science always seeks to create models to simplify complex natural phenomena. While these models are often exceedingly useful, they always have short comings that arise from the section of reality they exclude. Most of the incredible (and often forgotten) medical or scientific discoveries I've come across for example, came from the minority who embraced complexity.

總而言之，為了解決人類天生對簡單的需求，科學總是尋求創建模型來簡化複雜的自然現象。雖然這些模型通常非常有用，但它們總是存在由它們排除的現實部分引起的缺點。例如，我遇到的大多數令人難以置信的（而且經常被遺忘的）醫學或科學發現都來自接受複雜性的少數人。

Complexity in Medicine

醫學的複雜性

When you as a doctor are with another living human being, there is an immense amount of data present. I am fortunate to have an aptitude for appreciating subtle details that often go unnoticed by other clinicians. Despite this, each day in clinical practice, I notice countless things I never spotted before, and to this day, I still feel I am only scratching the surface of what's really there during each patient encounter.

當您作為醫生與另一個活生生的人在一起時，會出現大量數據。我很幸運能夠欣賞其他臨床醫生經常忽視的微妙細節。儘管如此，在臨床實踐中的每一天，我都會注意到無數以前從未發現過的東西，直到今天，我仍然覺得在每次遇到患者時，我都只是觸及了真實情況的皮毛。

Embracing this complexity is one of the things that makes medicine a lifelong passion for me. However, for people who have resistance within their minds to their reality expanding, they reject that process and instead seek out models to simplify things.

擁抱這種複雜性是讓醫學成為我畢生熱情的原因之一。然而，對於那些內心對現實擴展有抵抗力的人，他們拒絕這個過程，而是尋找模型來簡化事情。

The capacity to expand your awareness is directly linked to the health and current level of stress in the nervous system (a key part of my own self-care regimen focuses on my nervous system). When someone is tired, sick, fatigued, burned out or has a subtle (or overt) injury to their nervous system, this resistance to expansion always increases. Medical education and medical practice are both structured in a manner that regularly creates those states, and thereby radically decreases the number of doctors who have minds comfortable with following the path of complexity.

擴大意識的能力與神經系統的健康和當前壓力水平直接相關（我自己的自我保健方案的一個關鍵部分集中在我的神經系統上）。當某人疲倦、生病、疲倦、精疲力竭或神經系統受到輕微（或明顯）傷害時，這種對擴張的抵抗力總是會增加。醫學教育和醫學實踐的結構都定期創建這些狀態，從而從根本上減少了能夠適應複雜路徑的醫生的數量。

For those who resist complexity, the practice of medicine is largely a process of learning models to describe individuals or

diseases and then applying the applicable model to each patient they see. Most of the medical education process is designed to support this method: we are taught model after model to apply, list after list to memorize and as physicians in training, we are graded on how accurately we replicate them.

對於那些抵制複雜性的人來說，醫學實踐在很大程度上是一個學習模型來描述個體或疾病的過程，然後將適用的模型應用於他們看到的每個患者。大多數醫學教育過程旨在支持這種方法：我們被教導一個又一個模型來應用，一個又一個列表來記憶，作為接受培訓的醫生，我們根據我們複製它們的準確程度來評分。

Many of the therapies we use are designed to fit within that paradigm. Pharmaceuticals for example, are typically prescribed on the basis of a matching symptom or diagnosis being present, a parameter it lowers being too high, or a parameter it raises being too low. I have some sympathy with this approach being chosen, as it is both the way most people are conditioned to think by the American educational system, and when training medical students, it is much easier to standardize and teach. The problem is that it is in direct opposition to producing critical thinkers who can solve complex problems; a role society expects of doctors this is

simultaneously opposed by many stakeholders in the healthcare industry.

我們使用的許多療法旨在適應該範式。例如，藥物通常根據存在的匹配症狀或診斷、降低的參數太高或升高的參數太低來開具處方。我對選擇這種方法有一些同情，因為它既是大多數人習慣於美國教育體系的思維方式，而且在培訓醫學生時，標準化和教學要容易得多。問題在於它與培養能夠解決複雜問題的批判性思想家直接相反。社會對醫生的期望，這同時遭到醫療保健行業的許多利益相關者的反對。

To a large extent, this all mirrors the debate within science of reductionism vs. holism, where the dominant narrative seeks to break everything into individual variables to understand nature while the holistic camp argues necessary qualities only emerge when you move beyond the reductionist level. I side with the holists and argue that much of the practice of medicine, especially the interesting parts, is missed by taking the reductionist approach.

在很大程度上，這一切都反映了科學內部關於還原論與整體論的爭論，其中占主導地位的敘述試圖將一切分解成個體變量以理解自然，而整體陣營則認為只有當你超越還原論水平時才會出現必要的品質。我站在整體論者一邊，認

為許多醫學實踐，尤其是有趣的部分，都被還原論的方法所遺漏。

Treatment Algorithms

治療算法

Sadly, as time moves forward, it always seem more and more lists or models are developed, and algorithms, believed to “optimize” medicine dominate a larger and larger portion of clinical practice. The main exception to this rule is psychiatry, where a large portion of the field is beginning to embrace the holistic biopsychosocial model since classical reductionist models often don’t hold up once the human mind is involved.

可悲的是，隨著時間的推移，似乎總是有越來越多的列表或模型被開發出來，並且被認為可以“優化”醫學的算法在臨床實踐中佔據越來越大的份額。這條規則的主要例外是精神病學，該領域的很大一部分開始接受整體的生物心理社會模型，因為一旦涉及人類思維，經典的還原論模型通常就站不住腳了。

One of the most frequent complaints from doctors (and their patients) is electronic medical records turning the practice of medicine into an exercise of asking questions to input enough data into an EMR to be able to bill insurance. As you would imagine, beyond this form of medical care making it challenging to develop a doctor patient relationship, or figure out the root cause of disease, it also makes it impossible for the physician to observe subtle details or the complexity of the patient in front of them.

醫生（及其患者）最常抱怨的問題之一是電子病歷，這將醫學實踐變成了提問的練習，以便將足夠的數據輸入 EMR，以便能夠為保險計費。正如你想像的那樣，除了這種形式的醫療服務使建立醫患關係或找出疾病的根本原因變得困難之外，它還使醫生無法觀察到細微的細節或面前患者的其中複雜性。

Years ago, I was told by someone well connected to Congress that existing evidence showed EMRs worsened quality of care. However, since EMRs were also known to slow physicians down (hence making them less able to bill for medical procedures) they saved the government money, and thus they would never be abandoned. Medicare for example, has instituted a strong push towards EMRs and now pays

significantly less for patient visits done by paper charts rather than EMRs (which is backbreaking for many medical facilities that operate on low profit margins).

多年前，一位與國會關係密切的人告訴我，現有證據表明電子病歷惡化了護理質量。然而，由於眾所周知 EMR 會減慢醫生的速度（因此使他們無法為醫療程序開具賬單），因此它們為政府節省了資金，因此它們永遠不會被拋棄。例如，醫療保險大力推動電子病歷，現在為通過紙質圖表而不是電子病歷進行的患者就診支付的費用要少得多（這對許多以低利潤率運營的醫療機構來說是一項艱鉅的任務）。

In addition to the cost argument, I believe the health care industry has a vested interest in taking doctors out of the medical decision-making equation. While many doctors will follow the prevailing narratives of the medical field without question, the independent clinical judgement of physician is an ever-present challenge to these vested interests. There have hence been many converging trends that seek to prevent physician “non-compliance.”

除了成本論點之外，我認為醫療保健行業有既得利益將醫生排除在醫療決策等式之外。雖然許多醫生會毫無疑問地遵循醫學領域的流行說法，但醫生的獨立臨床判斷是對這

些既得利益的永恆挑戰。因此，出現了許多趨同的趨勢，旨在防止醫生“違規”。

The first has been the gradual shift from private medical practice to corporate medical jobs. When physicians work for a corporate entity, they have significantly less freedom to practice medicine as they would like to and cannot advocate for basic labor rights. There has been a gradual top-down push in this direction for decades (for example regulatory requirements are put into place most independent practices cannot sustain) and I have seen numerous cases of excellent well liked and well regarded general practitioners having to close shop because they can't compete with the primary care providers at the local corporate medical system who provide significantly worse care.

首先是從私人醫療實踐逐漸轉向企業醫療工作。當醫生為公司實體工作時，他們可以按照自己的意願行醫的自由明顯減少，並且不能倡導基本的勞工權利。幾十年來一直在這個方向上逐漸自上而下地推動（例如，大多數獨立實踐無法維持的監管要求已經到位），我看到許多優秀的廣受好評的全科醫生不得不關閉商店，因為他們無法與當地企業醫療系統的初級保健提供者一起提供明顯更差的護理。

Many of my colleagues believe our profession screwed up big

time by surrendering our power to the corporate health care systems, and we sometimes discuss the creative way each of us has found to get out of this dilemma. However, we are few and far between; most doctors are forced into compliance by these systems.

我的許多同事認為，通過將我們的權力交給企業醫療保健系統，我們的職業搞砸了很多時間，我們有時會討論我們每個人發現擺脫這種困境的創造性方法。然而，我們卻寥寥無幾；大多數醫生被迫遵守這些系統。

The recent [lawsuits](#) by hospital physicians against their hospitals to prescribe ivermectin to patients who would otherwise die is one such example. Similarly, many doctors cannot speak out against the vaccine in any context or they risk losing their employment, and I have seen dozens of cases of doctors fired for doing so.

最近醫院醫生針對他們的醫院提起的訴訟，要求將伊維菌素開給可能會死亡的患者，這就是一個例子。同樣，許多醫生在任何情況下都不能公開反對疫苗，否則他們就有失去工作的風險，我已經看到幾十個醫生因此而被解僱的案例。

The second has been a shift to standardized medical practices, where (predominantly industry funded) research is assessed by committees (largely composed of physicians with pharmaceutical conflicts of interest) to produce medical guidelines or treatment algorithms physicians are “suggested” to follow. One of the most recent examples of this was [Fauci personally nominating the NIH committee](#) who decided the appropriate medical care for COVID-19, and for some reason primarily nominated individuals who had financial conflicts of interest with manufacturer of remdesivir. Not surprisingly, that committee mandated remdesivir and refused to approve safer and off-patent treatments with significantly greater evidence of efficacy.

第二個是向標準化醫療實踐的轉變，其中（主要由行業資助的）研究由委員會（主要由有藥物利益衝突的醫生組成）評估，以製定醫療指南或“建議”醫生遵循的治療算法。這方面的最新例子之一是福奇親自提名了 NIH 委員會，該委員會決定了 COVID-19 的適當醫療護理，並且出於某種原因主要提名了與瑞德西韋製造商有經濟利益衝突的個人。毫不奇怪，該委員會強制要求使用瑞德西韋，並拒絕批准更安全和非專利的治療方法，這些治療方法的療效證據明顯更大。

Despite the “voluntary” nature of these guidelines (the only federal lawsuit I have [seen](#) on this subject declared they are suggestions and not law), they are treated as law by each other branch of the medical system. Insurance either requires or incentivizes you to follow these guidelines, hospitals require you to follow them, and legally, you are significantly more vulnerable to either being sued or losing your license if you fail to follow these guidelines.

儘管這些指南具有“自願”性質（我所見過的關於該主題的唯一聯邦訴訟宣稱它們是建議而非法律），但它們被醫療系統的其他分支視為法律。保險要求或激勵您遵循這些準則，醫院要求您遵循它們，從法律上講，如果您不遵循這些準則，您將更容易被起訴或失去執照。

EMRs are an excellent tool for enforcing this form of medicine. When charting, you often have to document the treatment algorithm, and since you have limited time to practice medicine, you are hence encouraged to follow each step of the treatment algorithm during your patient visit rather than having a complex human interaction.

電子病歷是執行這種醫學形式的絕佳工具。繪製圖表時，您通常必須記錄治療算法，並且由於您練習醫學的時間有限，因此鼓勵您在就診期間遵循治療算法的每個步驟，而

不是進行複雜的人際互動。

*The EMRs will also often suggest prescription options based on what you have entered into the EMR (which doctors, to save time, often follow) further establishing the practice of algorithmic medicine. The best example I know of for this phenomenon occurring was when Practice Fusion (a free EMR service many doctors use because EMRs are expensive) **was fined 175 million dollars**. This was because they took a million dollar bribe from an opioid manufacturer in return for having the EMR suggest their opioid for a variety of cases where the opioid was not appropriate. This lawsuit arose because stopping the creation of lifelong opioid addictions has recently become a priority for the government due to the horrific societal damage they cause, and this algorithm change resulted in a significant number of unnecessary addicts.*

電子病歷通常還會根據您在電子病歷中輸入的內容（醫生為了節省時間，通常會遵循）建議處方選項，從而進一步建立算法醫學的實踐。我所知道的這種現象發生的最好例子是 Practice Fusion（許多醫生使用的免費 EMR 服務，因為 EMR 價格昂貴）被罰款 1.75 億美元。這是因為他們從阿片類藥物製造商那裡收受了 100 萬美元的賄賂，以換取 EMR 建議他們在阿片類藥物不適合的各種情況下使用他們的阿片類藥物。之所以提起這起訴訟，是因為製止造成終

生阿片類藥物成癮最近已成為政府的首要任務，因為它們造成了可怕的社會損害，而這種算法變化導致了大量不必要的成癮者。

Silicon Valley's vision for the future is to transform society into a pool of algorithmically managed data where AI can perform many of the jobs previously done by human beings, and the creativity and spontaneity of each living human being is replaced by a soulless collective algorithmic homogeneity. Beyond this fulfilling many of the longstanding goals of the ruling elite (complete control of the populace with minimal difficulty) there is also a religious zeal behind it, and I've spoken with numerous people who work in or are tied to Silicon Valley who believe this ascension into algorithmic AI represents the destined evolution of our species. I personally believe that shift is the single greatest mistake the human race could make.

矽谷對未來的願景是將社會轉變為算法管理的數據池，人工智能可以在其中執行許多以前由人類完成的工作，並且每個活人的創造力和自發性被沒有靈魂的集體算法同質性所取代。除了實現統治精英的許多長期目標（以最小的難度完全控制民眾）之外，它背後還有一種宗教熱情，我曾與許多在矽谷工作或與硅谷有聯繫的人交談過，他們相信這種向算法人工智能的提升代表了我們物種注定的進化。

我個人認為，這種轉變是人類可能犯的最大錯誤。

During Clinton's presidency, a groundswell of hatred against the pharmaceutical industry emerged and many felt it was likely the industry would go into major decline. As best as I can tell, the industry at this time began to focus on prioritizing the mass administration of psychiatric medications, which tend to make populations more compliant both in general and towards pharmaceuticals (George Bush for example was a board member for Eli Lilly, the maker of Prozac). This trend has continually accelerated and has been enabled by the wide range of pharmaceuticals which create neurologic damage resulting in psychiatric symptoms requiring lifelong pharmaceutical management.

在克林頓擔任總統期間，對製藥業的仇恨情緒高漲，許多人認為該行業很可能會陷入嚴重衰退。據我所知，該行業此時開始專注於優先考慮大規模使用精神科藥物，這往往會使人們在一般情況和藥物方面更加順從（例如，喬治·布什是禮來公司的董事會成員，百憂解的製造商）。這種趨勢不斷加速，並且已經被廣泛的藥物所支持，這些藥物會造成神經系統損傷，導致需要終生藥物管理的精神症狀。

During Obama's presidency, a merger occurred between big tech and big pharma and these industries became the primary donors of the Democratic Party. This resulted in many changes to the Democratic party at odds with its traditional populist positions in support of the working class and a gradually increasing support of the transhumanist agenda worshipped by the previously mentioned sects within Silicon Valley. This merger is also why I believe big tech has so been so aggressive in censoring anything that challenges the COVID-19 narrative.

在奧巴馬任總統期間，大型科技公司和大型製藥公司發生了合併，這些行業成為民主黨的主要捐助者。這導致民主黨發生了許多變化，與其支持工人階級的傳統民粹主義立場背道而馳，並且逐漸增加了對矽谷內部上述教派所崇拜的超人類主義議程的支持。這次合併也是為什麼我認為大型科技公司如此積極地審查任何挑戰 COVID-19 敘事的事物。

*EMRs have the potential to radically improve the practice of medicine. For example, I have worked with individuals who **on their own** were able to produce AI systems that could comb through data collected by EMRs and identify proof of iatrogenic injuries or compare outcomes of different pharmaceuticals to determine ideal treatment algorithms.*

These are very simple to do (hence why small teams can pull them off), and yet despite a fanatical need to “acquire more data” are never done.

電子病歷具有從根本上改善醫學實踐的潛力。例如，我曾與能夠自行開發 AI 系統的個人合作，這些系統可以梳理 EMR 收集的數據並識別醫源性損傷的證據或比較不同藥物的結果以確定理想的治療算法。這些很容易做到（因此為什麼小團隊可以完成），但儘管“獲取更多數據”的狂熱需求從未完成。

That said, I know of two cases where an AI system was made to analyze EMR data, found strong evidence of vaccine injury, and then was discarded. For example to quote the Real Anthony Fauci: ”In 2010, the federal Agency for Health Care Research Quality (AHRQ) designed and field-tested a state-of-the-art machine-counting (AI) system as an efficient alternative to VAERS. By testing the system for several years on the Harvard Pilgrim HMO, AHRQ proved that it could capture most vaccine injuries. AHRQ initially planned to roll out the system to all remaining HMOs, but after seeing the AHRQ’s frightening results—vaccines were causing serious injuries in 1 of every 40 recipients—CDC killed the project and stowed the new system on a dusty shelf.”

也就是說，我知道有兩個案例是用人工智能系統分析 EMR 數據，發現疫苗損傷的有力證據，然後被丟棄。例如，引用 Real Anthony Fauci 的話：“2010 年，聯邦衛生保健研究質量局 (AHRQ) 設計並現場測試了最先進的機器計數 (AI) 系統，作為 VAERS 的有效替代方案。通過在哈佛朝聖者 HMO 上對該系統進行了幾年的測試，AHRQ 證明它可以捕獲大多數疫苗傷害。AHRQ 最初計劃將該系統推廣到所有剩餘的 HMO，但在看到 AHRQ 的可怕結果後——疫苗導致每 40 名接受者中有 1 名受重傷——CDC 終止了該項目並將新系統存放在塵土飛揚的架子上。”

All of this has lead me to believe the purpose of collecting all this data no one is analyzing has nothing to do with improving medical care of medical outcomes. Rather, the focus on data and algorithm driven medicine is to train the AI systems that will eventually replace doctors. There are a many preliminary signs this is happening, and I suspect it is unlikely doctors will oppose it until it is too late for them to do anything about it. The transition to AI doctors represents a holy grail for those seeking to control society and it is my hope this article provides a credible basis for that argument.

所有這一切讓我相信，收集所有這些沒有人分析的數據的目的與改善醫療結果的醫療護理無關。相反，數據和算法驅動醫學的重點是訓練最終將取代醫生的人工智能系統。

有許多初步跡象表明這種情況正在發生，我懷疑醫生不太可能反對它，直到他們對此採取任何行動都為時已晚。對於那些試圖控制社會的人來說，向人工智能醫生的過渡是一個聖杯，我希望這篇文章為這一論點提供一個可靠的基礎。

As most of you have now realized, there are many shortfalls in medical care that lead a large number of patients to seek care in the wild west outside the medical system. In my medical community, we treat many of those patients with complex medical issues. We have discussed this topic at length and while some aspects of medicine can be performed algorithmically, we do not believe it will ever be possible for an AI system to replicate many of the necessary therapeutic approaches we utilize. It will be very interesting to see exactly where medicine ends up 50 years from now.

正如你們大多數人現在已經意識到的那樣，醫療服務存在許多不足，導致大量患者在醫療系統之外的狂野西部尋求醫療服務。在我的醫學界，我們治療許多有復雜醫療問題的患者。我們已經詳細討論了這個話題，雖然醫學的某些方面可以通過算法進行，但我們認為人工智能系統永遠不可能複製我們使用的許多必要的治療方法。看看 50 年後醫學的確切結局將是非常有趣的。

Conclusion

結論

Yesterday, Steve Kirsch [posted](#) an interview with a midwestern rheumatologist who has been one of the first to go on record with the large number of adverse responses to vaccinations he has observed throughout his clinical practice ([click on the image to view](#))

昨天，Steve Kirsch 發布了對一位中西部風濕病學家的採訪，他是第一個記錄在案的人之一，他在整個臨床實踐中觀察到了對疫苗接種的大量不良反應（點擊圖片查看）

Rheumatologist Robert Jackson: 40% vaccine injured; 0.33% dead



stkirsch · Published April 30, 2022 · 1,562 Views

UNSUBSCRIBE

SHARE



One of the first questions this interview raises is “why is this doctor seeing so many more reactions than many of his peers?” There is a remarkably simple explanation that goes well beyond the fact patients with autoimmune conditions are at an elevated risk for adverse reactions to the COVID-19 vaccination. It will be discussed in [part two](#) of this article, where we will begin to explore the specific reasons why (otherwise well intentioned) doctors cannot and will not see iatrogenic reactions, which frequently leads to some truly horrific gaslighting of patients.

這次採訪提出的第一個問題是“為什麼這位醫生看到的反應比他的許多同齡人多？”有一個非常簡單的解釋，遠遠超出了患有自身免疫性疾病的患者對 COVID-19 疫苗接種不良反應的風險升高的事實。這將在本文的第二部分進行討論，我們將開始探討為什麼（否則出於善意）醫生不能也不會看到醫源性反應的具體原因，這經常導致患者出現一些真正可怕的煤氣燈效應。