Dr. Don Nelson

Internal Medicine Doctor,
Pulmonologist, Triathlete

Chapter 1 – Introduction

Announcer: Dr. Don G. Nelson specialized in Internal Medicine and pulmonology for 60 years. He graduated from the University of Illinois College of Medicine in 1965. Don became affiliated in Oklahoma with multiple hospitals including Hillcrest Hospital South, St. Francis Hospital, and the Veteran Affairs Hospital in Muskogee.

He was born in Moline, Illinois, where he graduated Moline High School and then the University of Illinois.

In 1973 he moved to Tulsa, Oklahoma, and was first associated with Springer Clinic.

In addition to his medical career, Dr. Nelson became a triathlete and participated in three hundred Triathlons. His first triathlon was the first Hillcrest Ultimate Challenge. He was one of the pioneers of the sport in the Tulsa area and traveled to many countries while competing in World Championship events.

Listen to Dr. Don Nelson talk about his love for the medical profession, his triathlon experience, and his advice for everyone, regardless of their age, to exercise for good health on the oral history website and podcast VoicesOfOklahoma.com.

Chapter 2 – 11:00
Helping Dad

John Erling (JE): Today's date is November 1st, 2018. My name is John Erling. Don, would you state your full name, please?

Dr. Don Nelson (DN): Don Gaylord Nelson.

JE: And your date of birth?

DN: 11-16-1938.

JE: So that's November 16, 1938. You're about to celebrate a birthday.

DN: Just about.

JE: Because your present age is?

DN: 79.

JE: And you'll be 80 this month.

DN: Correct.

JE: We are recording this interview in the recording facilities here of VoicesOfOklahoma.com in Tulsa. I might mention at the outset how I met you, and that was when I was running and biking on Riverside Drive. We'd match up every once in a while. You were either running or biking, and we got conversing back and forth about that. And I was so taken with you and your great bikes that you had and all that.

And so one thing led to another, and then I thought, wait a minute, I need to interview him. I know he's got a great medical career, but his... level of activity at his age is remarkable. So that's how we came to sitting here today to do this interview. Where were you born?

DN: I was born in Moline, Illinois.

JE: Your mother's name?

DN: Mildred Nelson.

JE: And her maiden name?

DN: Olson, Mildred Olson.

JE: And where did she... where was she born?

DN: She was born in Moline.

JE: And she grew up there?

DN: And she grew up there. And Moline was very much an industrial town. John Deere's headquarters is there, and so lots of farm implements. And even a big arsenal that makes military weapons, and it was on an island in the river.

JE: What was her personality like?

DN: Well, she was a very pleasant but very relatively shy person, you know, competent in terms of her ability to manage a household and the kids. And later she had to work and take care of kids because of my father dying at a young age.

JE: And her name is Olson. Is she Scandinavian?

DN: She's Swedish. Her grandparents immigrated from Sweden. Her... Her grandparents immigrated from Sweden. Her mother... the story is that she was conceived in Sweden and born in Chicago, and so it was her grandparents that were the immigrants, the Swedish immigrants. And Moline was a very big Swedish town. Everybody came there to work at Deere's in the assembly lines.

JE: And then your father's name?

DN: My father was Einar Nils Nilsson, and he was born in Sweden, grew up there. And he... well, the way things work in Sweden, this... the oldest son gets the farm, so he basically was going to have to be a farmhand or a lumberjack. Which are things that he did and, you know, try and find him work.

And he decided he'd come to the United States rather than try and work in Sweden where there wasn't really any opportunities for advancement. And so he came when he was 25 years old.

JE: Remember what year that was?

DN: Be about 27, 1927. He initially went to... his sponsors were servants for the Studebaker people, the Studebaker car fortune. And he worked for several years as a butler and chauffeur for the Studebaker family.

JE: Did he tell you any stories about that?

DN: A little bit. But the interesting thing he did, he had no expenses living on the estate, so his salary, he invested in the stock market.

JE: Wow.

DN: Mr. Studebaker, senior Studebaker, advised him on where to invest. But my father said he did not want to be a servant type person. It just wasn't his personality. And he... and he moved to Moline because it was a very big Swedish community. And he was there about a year and took his money out of the stock market before the crash. And he and another gentleman formed a soft drink bottling company that sold all the different flavors.

It wasn't Coke or Pepsi or it was all the different flavors and that. So that he had a thriving business all through the depression. So that the immigrant, who'd been there just a few years, spoke very good English. I didn't really even pick an accent up on him. You know, had a thriving business all through the depression.

And after... and I can't... I forgot what year they got married to my mother. They went to this Swedish church, of course. It was originally called the Swedish Evangelical Covenant Church. And when my mother was growing up, the church actually had English services in the morning and Swedish services in the evening. And so she learned a little Swedish, not a lot, but enough, that they could speak Swedish to one another when they didn't want the kids to know what they were talking about.

So they waited, you know, until it looked like the defining 1938, why that's when I was born, of course. And then the war was coming. And so they got worried about what was going there. So they held off having any further

children towards... then towards the end of the war in 44 and 45, I had my brother and my sister were born.

JE: Did he join the military?

DN: He was... since he was born in like 1902, he was in Sweden during World War I. And in Sweden, he did... he was in the military in Sweden for two years, it was mandatory in Sweden. All the men had to serve, even though they were a neutral country. He was in his 40s during World War II.

And so he was way down the list. Plus he had a family and he had a business. And so he figured like, you know, I probably won't get drafted. But you know, they didn't know, of course, initially what was going to happen. But then by the time I was a... just turned 16 and I was junior in high school, my father had a heart attack and died. He was only 52.

And so my mother had three kids to raise and her skills were mainly secretarial and clerk type skills. So she wasn't going to get paid much. So you know, as a family, we struggled, end up living on the second floor of a house that people rented out to us. One bedroom, there's two beds in there completely filled the room. And the other bedroom where my sister and mother slept, well, it wasn't much bigger.

The kitchen, only one person could stand in the kitchen. It was such a small place. You know, and we basically struggled along. But you know, we really had a... We had a middle-class upbringing as it was. I mean, it wasn't like we felt that deprived, it was what it was, you know. So when I was in college, it was relatively inexpensive in those days.

JE: Let me stick with your father a minute. His personality for you, then, how would you describe him?

DN: Oh, he was very outgoing. In his business, his partner had no people skills. And so my father had all the people skills and he knew everybody in town. Yeah, he could talk to anybody, you know, and he just was very good.

And you know, he did physical work and he wasn't really particularly out of shape. But unfortunately, in those days, you know, he was very good. He

smoked, ate lots of fatty foods. And so, you know, all the things that can cause coronary disease came into play. Life growing up, my father was used to working hard. So when I was 12, he says, “okay, you know, you're not going to sit around and just play all summer. You're going to come to the factory or the plant, basically, and work.”

So I'd work pack, you know, bringing empty bottles to the washer and taking the full cases and stacking them of pop and would go out on runs and one of the most interesting part of my father is we come a weekend and there'd be a big fish fry or a church picnic or this kind of stuff and we'd provide the soda pop for it.

So the two of us, my father and I, we'd go to the plant and we'd load up the pickup truck with pop, throw these big coolers on top and drive out to wherever the golf course or the park somewhere, things like that, put these big coolers down and I'd load, take the pop out of the cases and load it in the coolers while my father went off to the ice plant to get ice.

And by the time he'd get back, well, I'd have these coolers filled. And we'd chip the ice on to the pop and, but then of course, come evening, we'd have to go back and load all the empty bottles into the cases again and put them in the truck and things and drive back to the plant. So you know, some really ended up working with my father a lot and every summer I worked in the bottling plant for him, you know, and so this is, you know, it's something that my brother and sister really never got that close with him because they never really worked with him like that.

Of course, I hated it as any kid would. All my friends were out there playing basketball and running around and doing things and I'm off going around. I'm going to work.

JE: So you got close to your father. So when he died, when you were 16, that had to be a huge shock.

DN: Oh, it was. Yes. Yeah. Yeah.

JE: Was he in the business? Did he still have that distributorship?

DN: He still had the business and my mother was able to sell it. That kind of independent business like that, though, was starting to get harder and harder to be profitable as the big Cokes, Pepsis and things got into doing flavors and holding the prices down.

And so nowadays it would sound ridiculous, but it was like 10 cents a bottle. Well, that was getting to be almost the cost of doing the business at 10 cents a bottle. And, you know, he was competing against the big companies. So we were able to sell it to people who had previously worked there. But after a few years, they went, you know, the business failed.

JE: You were living probably a good life economically then as a family.

DN: We were doing well. He had built in 1940, he built a new house and was driving an Oldsmobile, which in those days was the mid-level car, not the most expensive, but not the cheap ones either. So that, yeah, I mean, so we had a really very, very nice growing up in terms of the neighborhood.

JE: And so then when he dies, you're ending up finding yourself in this apartment upstairs and that had to be tough to come from this to that.

DN: Yeah. You know, just downsizing like that. Why they, you know, since I was a junior in high school when that happened, why, you know, by the time I went off, so I went off to college. So I was only, you know, I was only home in the summers.

JE: But you graduated from high school, what year?

DN: 1956.

JE: 1956. And that was in?

DN: Moline.

JE: Moline. And then you went on to the University of Illinois.

DN: Of Illinois.

Chapter 3 – 7:09
Med School

John Erling (JE): Were you, when you were in high school, were you active in athletics?

Dr. Don Nelson (DN): I was active in athletics. The thing is actually Illinois, particularly at that time, was a basketball state. Football was number two. So we played basketball every day almost, you know, I mean, not quite, but so even when football season, we'd play in football on the football team, you know, on the weekends, we'd play basketball.

In those days we'd, we'd walk home from grade school, we'd walk home for lunch. Yeah. And all of us would virtually run home, quick lunch, run back and either into schoolyard or in an alley where they had basketball, we'd play basketball for half an hour during the lunch hour. And then of course we'd play it afterwards.

And we literally, in the winter, would shovel off the snow off the basketball court so we could play basketball in the winter. So I was active doing athletic things always, even though I wasn't necessarily on a team.

JE: But did you play for the high school basketball team?

DN: I did not. I was, I didn't make the team, the, I always said that I was probably better than a couple of the guys that were, that were sitting on the bench, but the top, we had some really good athletes.

In fact, our, our team every year really at that time made it into the top 16, top eight basketball teams in the state of Illinois, which was, they had no divisions and you had, it was one division.

So all the teams, you know, all the Chicago teams, all the downstate teams and everything all were competing. But we had, you know, some really good basketball players, probably, you know, all the, at least four of the top five all got college scholarships. So, I wasn't that caliber.

JE: But you still love the sport.

DN: Still love the sport. As you said, even in the wintertime. Oh yeah, we still play all the time.

JE: Even when it got down to 30, 40 degrees maybe.

DN: Um, 30, no, when it got down to 20 degrees.

JE: Oh really? That cold?

DN: When there was snow on the ground, sure.

JE: Yeah. You still play. Amazing. Yeah. All right. So you graduate from high school and you head off to the University of Illinois. What was your goal by going to the university? Now your parents never had college.

DN: No, no, they never had college.

JE: Was it instilled in you growing up that you were going to go to college?

DN: You know, it really wasn't so much, it wasn't really talked about. I think it was almost like expected, you know, I mean, it was like, I mean, not necessarily by then, but by me, I was expected I was going to go into college. I mean, it wasn't like, you know, gee, should I or shouldn't I? It was, well, I'm going.

When I went to college, I didn't know what I wanted to major in, so I actually went into electrical engineering. I was in electrical engineering major for two and a half years. And before I kind of, money got low and my interest in engineering wasn't there. So I took six months off and then went back to college in pre-med and had two years of pre-med.

JE: Let me come back to why did you choose electrical engineering?

DN: Well, if you know how counselors were in those days, I said, "I'm not sure what I want to do." And he says," well, what are your best subjects?" "Well,

math and science." "Oh, you must be wanting to be an engineer." Yeah.

Math and science are, you know, one of my strong points and English was not, I was not good at.

JE: Yeah. But then what was it that made you switch to pre-med? You could have switched to a lot of things. Why pre-med?

DN: You know, looking back, I kind of was saying, you know, gee, I kind of want to be in something that at the end of my life saying that I helped people, I did things and, and that's things like the ministry and dentistry and medicine.

And I didn't want to do ministry and I didn't want to do dentistry and that left medicine. So I think, you know, I thought, gee, you know, it's not going to be easy. It's something that, you know, I really think that fulfilling a life or life fulfilling, I guess is a better way to put it, profession to be in medicine.

So I, you know, I just, so I decided to give it a try.

JE: Did it feel good as you got into it?

DN: Oh yeah. No. Once, yeah, once I got into it, it was great.

JE: Were you able to transfer? You said you did math and science. Was that transferable?

DN: Oh, it was the math and science at the University of Illinois was, it was to get into the University of Illinois Medical School. Of course, they looked at two classes at the University of Illinois, your comparative anatomy and organic chemistry, and pretty much had to get an A in those two courses where you weren't going to get into medical school.

And so it was very competitive in the, there was enough Jewish people in the state of Illinois. Jewish people were very interested in having their family get into medicine. So we had a very competitive at the University of Illinois because of the strong Jewish influence. It's interesting how.

And even at, even once we got into medical school, had a very large Jewish component to the students in the school, but it was just their culture was such that, you know, law and medicine were, were something that, you know, they all wanted to get into.

JE: And very smart.

DN: And they were smart. And they were smart. Yeah.

JE: So you were competing against that.

DN: Was competing against that besides, of course, all of the rest of the state, because most of these, the Jewish people live in Chicago. They, there was. There are Jewish communities in other places, but so, yeah, it was interesting times.

JE: It had to be quite a thrill when you were then admitted.

DN: Admitted, yeah.

JE: Were you a straight A student in high school?

DN: This was an interesting thing I never quite figured out. I barely made the top third of my high school class. And I wasn't necessarily an outstanding student in college. I mean, I did very good well. In medical school, I ended up in the medical society, medical honorary fraternity as one of the top 5% students in medical school.

So I went from being a third, the class in high school to being the, an honor student in medical school.

JE: Okay. Could that be because you had a mission and a drive and you knew you where you wanted to go? Was that it? That drove you, you think? You kicked in?

DN: You know, I, I didn't think I worked any harder than anybody else, you know? We all worked hard. So it was just, I don't know if my brain matured during that time. I suppose that's the only real explanation is maturity.

JE: Well, you were probably only half working in high school and in college, but then you kicked in med school.

DN: Yeah. Something like that. Right.

Chapter 4 – 8:00
National Institute of Health

John Erling (JE): Didn't you meet your wife while you were at school?

Dr. Don Nelson (DN): It was in medical school and she was in Presbyterian St. Luke's nursing school, which was one of the hospitals in that area. The medical school was in what the medical campus area, a whole square mile of, and there was private hospital, university hospital, a VA hospital. There was three medical schools, two dental schools, three nursing schools, all there.

Plus, I forgot about Cook County Hospital, the county charity hospital was there and it was huge. And of course the training we got, particularly at Cook County and all that was, we were essentially as students and residents, we were the doctors. We took care of the patients.

JE: While you were attending med school?

DN: While we were attending med school, I mean, you know, as a, in my junior and senior year, if we had a rotation at Cook County, well rotations in the, not the private hospital, but either university or, we would draw the blood. We would do the blood counts, we would do the urinalysis, we couldn't do the chemistries, we had to ship those off, you know, so we'd do a lot of the laboratory work ourselves as students for the, on the patients, you know.

We learned to be basically, you know, we'd read the blood counts to see the white blood cell count and whether they have anemia, the whole thing, you know, that was, that was us.

JE: You were turned into, thrown into a great opportunity, weren't you?

DN: Oh, tremendous opportunity. And then of course that stretched on into internship and residency too, where you were.

JE: Did you have an internship there?

DN: Well, I actually, I had my senior year in medical school. My wife graduated from nursing school and she got a job as the assistant administrative admissions department. And so she was, she actually had a school car and traveled all over the Midwest promoting Presbyterian St. Luke's nursing program. But since we now had an income, we got, went ahead and got married. And so I stayed and did my internship at University of Illinois hospitals in the university hospital.

JE: Your wife's name?

DN: Nancy. Nancy Nelson.

JE: And did you have children from that marriage?

DN: Yes, we have three children.

JE: Did any of them go into the medical school?

DN: My youngest daughter did. She's a pediatrician and she's here at OU branch, Tulsa here. So the other two were, my daughter went into the business world and she got an MBA and, and that, and, and my son tried and was going to be a writer, but he's kind of stopped doing that and he's just working retail kind of thing now.

JE: An interesting thing I probably might be interested in particularly for students nowadays – when I was in college in the summers. The farming implement industry was booming and they had a second shift in the evening. And so they would hire college students to help make corn pickers. And so I was making.

JE: Excuse me, to make what?

DN: Corn. Pickers. Corn, the things you pick corn with.

JE: Okay.

DN: They, they paid a whole $2.10 an hour, which doesn't sound like much, except tuition at the University of Illinois it was $90 a semester. In the 10, 12 weeks that I would work on the assembly line, I could make my entire college tuition room and board in the summer time because it, you know, the – so that's one of the reasons I was able to continue going to college was with having no finances coming from my mother.

I was able to pay my own way. Then, of course I got farther along. I kept, you know, I had jobs that I would work doing things to help pay for things but – the so it was an interesting time where you could actually as a student you could just in your summers earnings earn enough money to pay for a whole year of college.

JE: Yeah, and then you had to want to work, too.You had that work ethic from your father and mother.

DN: Oh, yeah.

JE: Imagine yeah but after internship the was a Vietnam War era you have to go back because in medical school well the honors kind of things that I did get was I got picked by a researcher to help him doing research at the National Institutes of Health to NIH and in Bethesda, Maryland.

So between my sophomore and junior years was in Bethesda, Maryland doing research and I was able to go back to college. And I – we were researching a an organism called Leishmaniasis and it causes a parasitic disease in Central South America.

JE: What is that disease?

DN: Well it's – the main one is called Chagat's disease but we've never we don't see it in this country in the US. And so, you know, I had you know someone doing research at the NIH which you know was really fabulous

and that was during when Kennedy was president and the whole Washington area was full of colleagues and doctors and students doing internships and various things. It was an interesting time.

JE: Exciting time.

DN: Very exciting time. And they would put us on buses and haul us down into Washington from Bethesda and stand on the White House lawn while Kennedy spoke to us. And we were in an armory building and Lyndon Johnson spoke to us. And we had other people, different times, different events, you know, speaking to thousands of college students who were in Washington and various internship things.

JE: How fortunate he was.

DN: Yeah, it was really, really an interesting time.

JE: Kennedy was such a good public speaker. Oh, yeah. And it must have been energizing to a young student at that time.

DN: Oh, yeah, yeah. But they, so yeah, so that was a very interesting summer. But which gets me to, in order to get paid during that summer, I became inducted. I was inducted into the uniform, the public health service, which actually is for doctors and dentists and nurses. It's a uniform service.

It's considered similar to Army, you know, Coast Guard, Army, Navy, everything. So when I finished internship, I was, had, if I could get a position in the public health service, I wouldn't be drafted into the, who knows what service.

JE: Because Vietnam was on then.

DN: Vietnam was going on. Right. And so I ended up getting a kind of a plum position at a federal health clinic in Kansas City. It was a little bit different. Kansas City, Missouri. So, it's been, my military was in Kansas City, Missouri.

JE: Wow. So you did your, yes, you served your country in Kansas City, Missouri.

DN: Kansas City, Missouri. Yeah, that was my, but the more interesting position actually would have been Indian health. And I tried to get into, you know, be a physician at one of the Indian hospitals or reservations and, but they had all been sucked up ahead of time. You know, I didn't, wasn't able to get that.

JE: Why did you want that?

DN: Uh, just because it's more educational, and a sense of taking, you were going to do that you, You literally were in charge of the health care of these people, so it was being much more, you know, and they were sick people.

JE: Hands-on, more hands-on.

DN: Hands-on, yeah. You know, it would be just more training than that, so.

Chapter 5 – 8:25
Pulmonary Medicine

John Erling (JE): So what was your work in Kansas City?

Dr. Don Nelson (DN): It was just being a physician at a health clinic, and it was just employees, federal employees. It was a federal employees health clinic.

JE: And how many years did you do there?

DN: Well, it was two years, my two-year military obligation.

JE: So you came out of that what year?

DN: 67.

JE: So you finished?

DN: Medical school in 65. Well, then I had an internship in 66, so there were 68 when I came out of it.

JE: All right. So you finished that. Then what happens to you?

DN: Then I went into residency training and looked around. I ended up going to Cincinnati, University of Cincinnati Medical School residency program in internal medicine.

JE: So you did that for how many years?

DN: Well, I was there. It was two years of general internal medicine, and then it was two years of pulmonary subspecialty. And then I was asked to be chief medical resident, which I had accepted, saying, well, I'm going to practice medicine the rest of my life, you know, being chief resident for one year, that sounds like it'd be interesting to do.

So I was chief resident in medicine, and we spent six months at the Cincinnati General Hospital, six months at the Cincinnati VA Hospital as chief resident.

JE: You were an instructor, were you?

DN: We actually, yeah, we got in a position as instructor in the university. So we were on faculty, too, as well.

JE: Did you think that you could stay there the rest of your life or would want to?

DN: The – you know what, I got spoiled by Kansas City. The sun shined, the weather was nicer. Cincinnati, the gray days, the gray days, the gray days, the gray days. You know, it just, I swear the sun never shone.

JE: Yeah.

DN: It obviously did, but so I wasn't happy with the climate. And there really wasn't much. And the way of positions for pulmonary specialist in Cincinnati at the time anyway, if I hadn't taken the internship, I mean, the chief residency, I probably would have been ended up in Kansas City because there were several positions open that year.

But the next year when I came out and was looking, why, those positions were all filled in Kansas City, but there was a position here in Tulsa.

JE: How did you drift into the pulmonary area of the medical profession?

DN: My interests at that time kind of were between cardiology, heart, and pulmonary. And the chairman of the pulmonary department at that time was, you know, just a very, very good guy and really liked him. So, you know, it sort of, you know, it's hard to say that why did I pick it? Well, yeah, it looked good. You know, at the time, it really seemed to be a good way to go.

You know, some of the other subspecialties, I remember this is back, medicine was still somewhat frontier medicine. We didn't have all the things we have now.

JE: Yeah. Talking about in the 60s.

DN: In the 60s. Right. So that, you know, so, you know, like cardiology, well, you took care of patients with heart attacks. You didn't put catheters in them and inject dye or put stents in their coronary arteries or, you know, replace heart valves or do things. You kind of gave them medications and treated them and put them in bed rest and things of that nature for, you know, took care of their blood pressure.

So it was, you know, cardiology wasn't much different than just being an internal medicine doctor. You know, it was a little bit different than, you know, a medical medicine doctor and pulmonary and similar, we didn't really, we did have ventilators, but they were really rudimentary ventilators. So there was a little bit of technology in pulmonary.

And it was, of course, before they had fiber optic instruments, that gastroenterologists used to look into the colons and stomachs. And so, you know, there you just, you know, again, you were giving medications for people with ulcer symptoms and trying to treat diarrhea and, and, but you had no, no way to really diagnose what was really going on, except, well, you'd had x-rays, of course.

So, you know, it was a different time in terms of, nowadays you look and you look at all the things that the very subspecialties do, you make a different decision, you know, because of what's going on. But, you know, pulmonary looked good. And I did have asthma as a kid, although I was not bad asthma, I just had attacks occasionally. So I had a little bit of interest in lung disease from that point of view.

JE: You had a couple of papers published in the American Review of Respiratory Diseases.

DN: Yes.

JE: And tell us about them.

DN: Well, they were, this was my second year in pulmonary fellowship and they're really case reviews. They're unusual cases. One was a brand new medication was out for treating tuberculosis called rifampin. And we had some patients who had died of other reasons who had taken the rifampin and we were able to look at the pathology in their lungs to see, you know, what was going on. And we found actually live organisms still in the lungs, even though they had taken the full course of their tuberculosis medicine.

JE: And what was the medicine again?

DN: Rifampin, it's called.

JE: Okay.

DN: So it was, you know, we needed, so we needed to publish and show that, well, maybe rifampin really isn't that good a medication. Well, it turned out that was, these were probably anomalies because in the long run, it turned out to be a very, very good medication for curing tuberculosis.

So, and the other one was really on some unusual presentations of a disease. It's called sarcoidosis, which.

JE: What is that?

DN: It's an interesting disease in which you get what we call granulomas in various organs of the body, the lung mainly, but can be in the liver and skin and other tissues. And it, we had, we still have no idea what caused it. It still occurs, but it was a, this seemed to be some kind of autoimmune disease. And it was just some unusual presentations of that disease that had never been reported before.

JE: So you did a ton of research on this, obviously.

DN: Yeah, yeah.

JE: And your papers had to be very beneficial to the community.

DN: The, we hope. Always an interesting thing. I always think it's like, at that time, the chairman of the pulmonary department had changed. And he was actually Scottish and was trained in Scotland and that, and immigrated to the United States and worked into the university systems and that. But he was an editor, a reviewer of medical articles. To see, you know, how good they were and, and how well written and everything. Well, he knew the King's English precisely.

So one of the things, when I finished writing most of the paper and presented it to him, I sat back saying, how many red marks am I going to have telling me, you know, well, no, this isn't, you know, this isn't correct English. You know, he had all these red marks off of the paper correcting my English.

I was more afraid of, oh. Yeah. How bad my English would be compared to, you know, the quantity, the quality of the paper.

JE: But you were lucky he was there, weren't you?

DN: He was there. Yeah. Yeah. Because he would make sure that the paper was done properly.

Chapter 6 – 4:35
Tuberculosis

John Erling (JE): A little personal experience, you talk about tuberculosis. My mother had tuberculosis in 1930. She went into a TB sanatorium, was there for a little over a year. Then she comes out and gets married, and I'm born, my brother's born. But then she had a relapse in May of 1958 and was in a sanatorium for a year, then up in North Dakota where I lived. So when you say tuberculosis, I have close association.

Dr. Don Nelson (DN): Close association with that, yeah.

JE: And she was only 24 years old when she went into that TB sanatorium because she'd been taking care of her father who had tuberculosis. She contracted it from him.

DN: Yeah, well that's the thing with tuberculosis. You often had it when you were young and would get over it, but you'd carry the organism, the organism, in a dormant state for the rest of your life. So any time in the rest of your life, it could reactivate.

JE: So you had many cases of relapse?

DN: Oh, most of the cases are relapse. They were all, they'd been exposed in childhood and early adulthood, and then when they relapsed, we would get them as adults. Tuberculosis did kill young people. Yeah. Yeah. Most, much of the time, they would recover from it, but carry the organism.

JE: And they would stay in these sanatoriums, and they weren't taking medicine back then in the 30s.

DN: They may have had, given them some medicine, but it wasn't effective.

JE: Wasn't it just being in the sunshine or whatever?

DN: Probably the biggest advantage of putting the tuberculosis in the sanatorium was taking them out of normal civilization so that they

wouldn't spread it. But as far as what it did to get them better, we're not sure it did much.

JE: Well, then why did it eventually go away if they weren't doing much for it? How did they get over it?

DN: The natural body's defenses. Oh, their immune system began to work. Their immune system were able to control it, yeah. And if it didn't, you died, of course. But the immune system would work to control it. And we, you know, a lot of times when people got sick for a variety of other reasons or took medicines or something, the tuberculosis would reactivate.

But now by her second, when she reactivated, why, I think isoniazid, INH, was available at that time and was a good tuberculosis drug. So there was a drug available, I think, in the late 40s.

JE: Well, when then... It relapsed and we all had to be tested because we were in the home. And of course, fortunately, the rest of us had tuberculosis. But we were exposed to it.

DN: Yeah, yeah.

JE: It's been virtually eliminated, but in the world, it still is quite a...

DN: It's still almost the number one infectious disease in the world. And it would probably could have eliminated in the United States except for the AIDS, HIV, and the HIV-infected people get tuberculosis because their immune system is so bad. They, you give them the drugs to control the disease.

And because their immune systems were no good, the drugs, the tuberculosis organism would become resistant to all the drugs because you didn't have any help from the immune system. And so then we've got all these drug-resistant tuberculosis floating around that's created a problem. And then people coming from, you know, Southeast Asia, you know, most of the people who immigrated from Southeast Asia were carriers of tuberculosis.

We try and treat them all prophylactically to try and prevent the disease from flaring up, but they'd still have some flare-up. So we still have, you know, some tuberculosis in the United States, but it's... It's bad. It's pretty rare now.

JE: Right. I have here about 80% of people in many Asian and African countries test positive. Well, 5 to 10% of people in the United States test positive.

DN: Yeah. Yeah.

Chapter 7 – 12:23
Moved to Tulsa

John Erling (JE): So somewhere in here, you decide to come to Tulsa, Oklahoma

Dr. Don Nelson (DN): Correct.

JE: And how did that come about?

DN: Well, the chairman of my department had worked with Dr. Lawson, who was at Springer Clinic. And he had been in Tulsa. My chairman had been in Tulsa and said, Oh, you need to go look. There was advertising. Springer Clinic was advertising for specialists, pulmonary disease specialists.

And so he said, Well, you should go look. It's really a nice town. We came and looked. Yeah. We kind of thought it was a great town, great city.

JE: Had the sunshine that you wanted.

DN: We had the sunshine. Now, we... It had snowed the day before we arrived in April. And the day we arrived in April, it had already all melted. It was gone.

JE: Right.

DN: But it snowed the previous day.

JE: All right. And we love that. And what year was that?

DN: 1973. 1973.

JE: Okay. And so Springer Clinic, of course, from across the street from St. Francis Hospital. So what are you doing on staff when you come to Springer Clinic?

DN: Well, basically, it's patient care. You're doing patient care. And we did a lot of internal medicine besides pulmonary specialty. And even did... We're doing a lot of employee executive physicals. So a lot of the employees of the Williams Companies and other businesses would be our patients coming for executive physicals.

And that... But the... And then in the hospital, of course, all we had hospitalized patients. The... As a pulmonologist, why I was, of course, the person who knew how to take care of people on ventilators who were in respiratory failure and had to be, you know, on ventilator assist for their breathing while they... Until they recovered. Consulting on all of those patients that... They're part of the Springer Clinics.

JE: What brought these patients to that position of respiratory failure?

DN: Respiratory problems and having difficulty breathing. All kinds of things. Post-surgical complications, pneumonias, lots of, of course, emphysema patients.

JE: Smoking patients.

DN: Smoking patients who had emphysema. And even, you know, patients who had had part of their lung removed for... And they had poor lung function because they had had part of them removed for cancer or tuberculosis. In those days... Well, prior to then, but they were still taking out badly diseased lung... Badly tuberculosis diseased lungs.

So they had poor respiratory function. So they'd get pneumonia, get

infection, and they... And they were unable to maintain the normal oxygenation and that of their blood. And then we had to support their breathing until the infection was cleared.

JE: So you were across the street at St. Francis, too, then?

DN: Oh, yeah. Back and forth? Oh, yeah. Back and forth every day. Twice a day.

JE: I should know this. Was Springer Clinic... Was that owned by... That wasn't owned by St. Francis?

DN: No. Springer Clinic was owned by the doctors.

JE: Okay. All right.

DN: And then, you know, I did other things. I was... Anyway, I was a pulmonary function department doing all the pulmonary function testing at the hospital. I was in the respiratory therapy department. I was the doctor chairman of the respiratory therapy department at the hospital for many years. And when I came to St. Francis, the fiber optic bronchoscope was just out. It had been out about a year.

And so, you know, I got a fiber optic bronchoscope and really was the first one to do that kind of bronchoscopy at St. Francis, which is where you look down into the lungs with a scope. The old way of doing it was a rigid pipe. You'd have to... Straighten out their throats and all that and put this pipe down there to look down there.

JE: And you're looking into their...

DN: Bronchial tubes and all the way down to see... Look for cancers or, you know, other kinds of problems. Main things for cancers, of course.

JE: A tube made of what?

DN: A fiber optic.

JE: No. The original, when you went down there...

DN: The original ones? Right. Oh, the original ones were just metal pipes. Yeah. I mean, they were designed... They were, you know, curved at the ends and they were, you know, and you had... But, yeah, it was... Primitive. It was brutal. You really didn't want to do it on anybody.

And with the fiber optic thing... And, of course, you know, then the fiber optics came in for gastroenterologists and, you know, so it became standard procedures. But then I was... You know, I did the first ones that were done at St. Francis.

JE: Well, that had to be... Interesting that you came to be the first one to do that. Tell us, the fiber optic...

DN: Oncoscopy.

JE: Are you then looking, able to look at a screen? Is that what...

DN: No, no. You look... It's, you know, the fiberglass transmits the image. So you have a bundle of fiberglass raw tubes there and they... And you actually just look at the end. The end of it, of course, has lenses. And you just look. You're looking through the scope. But it bends and twists because the light is carried through the flexible fiber bundle.

And you had a light on the end of it and you had a hole in it that you could run instruments down there and take little bites or scrapings and things of things that you'd see.

JE: Well, how exciting then for you to do the very first one. And did you... You must have done some training on that before you did it?

DN: Well, that's right. It came out just before I left... I finished training in Cincinnati. So we'd had a little bit of training in Cincinnati before I came. But it was so new that I had done only a few up to that point. But they were... It was relatively easy to do. You know, it wasn't like, you know, a complex surgical procedure.

You slip it through the nose and down out there and... Of course, you know,

we learned we have to numb up the throat and we give him some medicine to make him sleepy. And even just the same way they do now, use the same medication they do now. Yeah. So that was, you know, one of the things that we introduced at the hospital.

JE: So how long then are you at Springer Clinic?

DN: Well, I was... I was... Probably got there when I was about 35 and left when I was 65. So that's 30 years. In the early days, we also had medical residents that were... That we were... Was seeing our patients in the hospital when we were teaching and was involved. And so we were... You know, I was actually on faculty at the University of Oklahoma Medical School.

JE: You were an instructor there, yes.

DN: Yeah. Well, actually the assistant professor, I guess. And anyway, the... And then we did some, you know, classroom teaching too. But after, oh, I don't know how many years, why, the University of Oklahoma pretty much pulled most all of its programs out of St. Francis and put it all in St. John's.

And a lot of that was because they had more and more full-time faculty members and they are... And they practiced at St. John's as opposed to practicing at St. Francis. So the... So eventually we didn't have any students to... Or residents, actually, to teach anymore at St. Francis.

JE: Is there something overriding here? Doctors didn't want to be at St. Francis? Was there an issue there?

DN: You know, the... I was never privy to the back room reasons for all this going on. So I don't know. Really can't blame Mr. Warren, of course, who built St. Francis Hospital. He actually paid for a physician to teach full-time at St. Francis. And he would actually pay the university and the university pays the doctor's salary. So he supported a teacher at St. Francis for, I don't know, many, many years.

So it wasn't like he was not working with the university at all. So I don't know. Now, of course, Oral Roberts came in. And his medical school, he wanted to kind of take in and do it his way at St. Francis. And Mr. Warren

said, no. We're doing it my way at St. Francis. If you want to have your students over here, fine, but we'll do it my way. So the... So when Oral Roberts University started its medical school, we didn't get any residents from there either. No.

JE: But Dr. C.T. Thompson, who was then at St. Francis...

DN: Yeah.

JE: ...was one of the vocal opponents, probably representing Mr. Warren...

DN: Oh, yes, undoubtedly.

JE: ...of Oral Roberts to build his hospital.

DN: Oh, yes. Yeah. No, we didn't mean that was... You know, most of his physicians didn't feel like they could make a go of it. But do we know how big that community is out there of people? Of people who would believe in Oral Roberts and would show up? We didn't know, but we kind of believed it wouldn't make it.

JE: And it turned out it didn't.

DN: No.

JE: We do have a building out there.

DN: Yes.

JE: And that's left. That's it. And that was turned into housing other...There are doctors. Including doctors.

DN: The one... The hospital building is a hospital now. Yeah. The... The... What was to be the office building, the... Of course, never... They never filled it with doctors. And now, of course, eventually it's now businesses and then the big office part.

JE: Yeah. It's interesting. The state granted Oral Roberts the license or whatever to build...

DN: To build, yeah.

JE: ...and probably should have said no to him, but at any rate...

DN: Well, I'm sure he had plenty of political clout with... He did seem to have a fair amount of money.

JE: Yes. And I've interviewed Oral Roberts. I've interviewed him for this website, and you can find his interview elsewhere. And talking about this, I kind of asked him, well, what was the outcome of all that? And he believed that coming out of it, he believed in his faith, adding his Christian faith to the application of the medical application.

So combining faith and medicine together... He felt maybe he was a forerunner of that.

DN: Yeah.

JE: And he had to draw something out of it. And he did it there. But Catholic hospitals had done that for years.

DN: Correct, yes. Before him, he saw it differently. And that's, of course, probably the big reason why they... St. Francis being a Catholic hospital and was going to come in with evangelical type of Christian teachings that didn't go over well.

JE: No. Did you see W.K. Warren around much? Did you have any interaction?

DN: No, I really didn't have any interaction with him. I'd see him around now and then, but not really.

JE: And that's a remarkable story, too. And Bill Warren, his son, has told the story here on VoicesOfOklahoma.com. And how this young man came as a 16-year-old to Tulsa, Oklahoma. And that's an amazing story. And people should listen to it.

Chapter 8 – 9:13
Medical Changes

John Erling (JE): But you were the... You became the part-time medical director of St. Francis Hospital Respiratory Department and Pulmonary Function Lab

Dr. Don Nelson (DN): Right.

JE: And that's for a couple of years?

DN: Oh, you know, I lost track. Probably at least 10, maybe 15. Yeah.

JE: So you enjoyed a good time for your profession at St. Francis and Springer Clinic.

DN: Yeah. Oh, yeah. Yeah, it was good. In those days, why... You know, medicine was... We concentrated on the patients. And then the medical record was an afterthought. We write down the important things, and that's about it. And then the insurance companies and Medicare got into saying, Well, you got to prove you spent some time with the patients.

So we had to start doing increasing documentation of every visit. More writing and more writing and less time available. And, of course, then, as of nowadays, of course, now the electronic medical record is fine. The doctors are spending so much time on the medical record, they hardly have time to talk to the patient.

JE: Yeah.

DN: The, you know, it's medicine... The payment side of medicine became... The medical record became the billing record. You billed off of that. The medical record. Not over what you did. If you didn't write it down, you didn't do it. So you couldn't bill for it. So the medical record... So now, you know, so all the doctors have to enter in the medical record, the computerized medical records in order to get paid. Because if it's not there, you don't get paid.

JE: Right. So is that good or bad?

DN: The medical records are good to have it. But doctors being data entry people is bad. The doctor shouldn't have to be a data entry person. He needs to concentrate on the patient, what's going on. And that's the bad part.

JE: And so have we built in assistance to do that for a doctor?

DN: The medical records systems have gotten more sophisticated and are making it easier for the doctor. But a lot of doctors now are actually hiring scribes. Someone who comes into the room with them and writes everything down. And the doctor doesn't write it down. And it may come to that everybody will do that. So it's the only way to get all the information into the medical record and still have time to talk to the patient and examine the patient.

JE: You've witnessed some dramatic changes in the practice of medicine in your career. When you enter the profession, talk about hospitals and how many patient beds would be in rooms and all.

DN: Well, the hospitals generally were, particularly the big charity hospitals, would be 80 beds, 70, 60 beds in a room, single room.

JE: In a ward, I guess.

DN: In a ward. And you might have curtains that you could, you know, when you examine the patient, you could pull around. And that was the privacy you would have. In the summertime, the air conditioning was open windows with screens to keep the flies out. So if it was 80, 90, 95 degrees out, why, it was 95 degrees in the room. And, you know, it wasn't very conducive to patients getting well to be, you know, in that heat. But the student at Cook County Hospital.

JE: That's in Chicago.

DN: That was in Chicago. And it had, at the time, 2,500 beds. The, these big wards. And, you know, somebody came in the emergency room when they were sick. They sent them to the ward to be taken care of. They didn't do anything in the emergency room. They didn't take care of them. If you came in with laceration, they'd sew it up. But if you need surgery, you know, the surgeons would have to take care of them.

And so that we'd have to do everything on the patient. In, on the ward, because the emergency room was just more as a triage rather than a true emergency room, where you would get everything started and get the patient under treatment and all those things, and then put them on the floor.

So, you know, there was nothing done. There was no blood work done. There was no nothing. You were starting from scratch on these patients up on the wards, you know, 24 hours a day. And the x-ray department would only do, you know, say, 10 kidney x-rays a day. And so the residents would go down and a week ahead of time or two weeks ahead of time, they'd write out a fictitious patient's name to get a kidney x-ray.

And then when they came, you know, came along and they had to have one of their patients needed a kidney x-ray, they'd go down at night and erase that patient's name and put the real patient's name in so they'd get the kidney x-ray. And, you know, he had, so he had all these, you really had to play the game. He had this game of trying to get decent patient care. And it was, it was quite a deal.

And then, I mean, even, you know, there's blood gases to measure the oxygen level and carbon dioxide levels. When I was in Cincinnati, as a resident, I'd have to draw the blood and I'd go over to the lab and I'd turn on the machine, calibrate the machine, and do my patients' tests. Myself, because there wasn't anybody at night doing that kind of thing. So, and we did, like I said earlier, we didn't have any of these tools we have now.

There were no intensive care units. And, you know, so you didn't have these monitors monitoring patients' hearts and that kind of thing. Of course, a lot of that monitoring stuff and all that was developed by NASA for astronauts to keep track of what was going on with them. And the, the

stress of space flight. But, you know, it filtered down into medicine from there. By the time I got towards later on in my residency, by that time, we had, we were getting, we had intensive care units.

They started doing heart catheterizations. We had, we were getting good ventilators, ventilators that were really, could really tell what was going on and do things with it well. And, and the medications changed dramatically. We had, you know, if someone was in heart failure, full of fluid, we didn't really have anything good to get the fluid off. We gave medicines that we had. But the, by the time I left residency, we had a couple of medicines that were very powerful. Diuretics to get rid of extra fluid.

We had new antibiotics, whole new classes of antibiotics. Some of the old ones that were toxic. We didn't have to use anymore. The, and it really changed dramatically during my training. From the time I was a student until I finished residency, we had dramatic change. We really moved into the modern medicine from, you know, 1940s, 1930s medicine. That, when I first started in, in 61. So it was, it was quite, quite an interesting time.

JE: So again, in the 60s, it was beginning to...

DN: In the 60s, all this stuff was coming online. It was coming on.

JE: It must have been exciting to see all this coming on. And as you look back in your career to have been there in that time.

DN: Yeah, when you look back, of course, you say, oh yeah. Of course, everything was incremental. I mean, you know, you'd get something new here, you know, and then, you know, a few months later, it'd be something here. Or you, you could, they'd come out with. And, you know, so it was, it was just a little piecemeal thing. It wasn't like who.

JE: Yeah. You couldn't feel it.

DN: You just couldn't feel it, you know, in the sense that it was a sudden change. I mean, if you, you know, I mean, if now I feel like I go third world country where they don't have much compared to what we have here. You could see that huge dramatic difference. But, you know, here it was just

very, very piecemeal, very little bit of a time. And, but when looking back, you say, wow. Yeah. It's changed.

JE: So, the antibiotics ramped up too.

DN: You hit a few. Antibiotics, blood pressure medicines, diuretics. Right. Cancer chemotherapy drugs, you know, so on the, they were really, I mean, the drug companies are really cranking out medicine. And, and the prices were, you know, not really a concern in those days, in the sixties.

Chapter 9 – 13:27
Opioids

John Erling (JE): But pain medicine, too, would be, would that come along as being a major transformation?

Dr. Don Nelson (DN): Not really. We had morphine and codeine and...

JE: Oxycontin?

DN: We didn't have Oxycontin. We had, you know, just quick-release medications. Oxycontin, of course, is a slow-release opiate. The, supposedly, you know, so it's not as, you don't get the rush or the high from it. I mean, the way the drug addicts use Oxycontin, they break the pill up and dissolve it so that they can get the full amount all at one time.

The newer medicines that are slow-release supposedly have ingredients in there that just won't let you do that, but break up the pill. But the original... You know, slow-release pills, why, the drug addicts would turn them into quick-release.

JE: And where would they get the pills?

DN: There are prescriptions, you know, and the, you know, chronic pain patients. And there was people who would go doctor shopping and get pain pills from several doctors. And there was no, you know, we didn't have

any way of knowing. I mean, now you would get a patient and you'd, you know, you'd get the feeling that, oh, no, this guy's doctor shopping, you know.

JE: Oh.

DN: But, you know, but these, these would be, you know, people really addicted who, you know, look like they were addicted. So those you get to know. But if you, you know, you dress nice and came in and you're clean-shaven, it's saying, oh, okay. Or female.

JE: So you would be writing those prescriptions yourself.

DN: Yeah, yeah. You know, the, and, you know, the... The vast, vast majority of patients who are prescribed narcotic medications never abuse them. It never happens. It was actually, it's a small portion that's a problem. The, you know, I can't remember. I had two patients who were definitely addicted to narcotics that came into my practice because of their insurance. You know, they got their company's insurance.

But other than that, I don't remember anybody. My patient of mine ever become an addicted to narcotics the, through my prescription, my prescribing, you know. So I don't, you know, I didn't see it as a problem in my day.

JE: Yeah. But now here we are in 2018 and opiates is a major problem and people are...

DN: Yeah.

JE: ...addicted to them. And is it fair to say that for a while the doctors prescribed too many or they'd send home patients after surgery with many more than they needed or...

DN: That's, yeah, that's correct. They would, that's, it was fairly common. You know, because you didn't really look at it as being something that they would get addicted to. Now they might, you know, if you wanted a second prescription, they might start, you know, balking at that. But the first one...

Yeah. I mean, I had, my wife and I have had some surgeries and the, we'd get 30, 40 pills and... Yeah. ...you know, we'd use four of them and throw the others away because we never, we didn't need that many.

We needed maybe, you know, 10 for whatever the procedure. So, you know, I mean, we made sure that we didn't try and go out and sell them on the market.

JE: No.

DN: Which you could have probably gotten five, $10 a pill, but... So the mentality of doctors then, were drug companies feeding this? You know, the drug companies, they always make a big deal if the drug companies fall for defeating it. And the thing is that they, you know, they told us about, you know, slow release medication and all that. I don't remember the drug companies ever telling me, oh, nobody's going to get addicted, you can take this and do this.

And I don't recall ever being pushed. The, by drug companies to prescribe more narcotics. We did have a, right around 2000, that here and there, there was a big thing in medical literature and discussions and things going on that we were under treating patients' pain. That we, we just, we're not doing a good job at taking care of patients' pain like we should.

So there was a big push. To be more aware of patients' pain. And, and take care of patients' pain better. And I think that probably was, you know, made very well, and this was in the medical literature on the drug company. May have actually contributed to the fact that, you know, doctors became much more liberal with, with pain medications.

Because the, we were being told, we're not giving enough. We're not taking care of patients properly. You know, now we're, you know, it's said, oh, okay. So it's like a pendulum. It's swung from being, you need to give more, because we're not taking care of patients' pain. To now, you know, oh, you need to give less. You know, you need to cut back on your prescriptions. And I guess there's, so it was, so it was a little bit of a pendulum kind of effect there.

JE: And I suppose that, let's just say, the body of doctors in the United States couldn't understand that, or see that people would get, become addicted to them.

DN: You know, for the average doctor, we didn't see it. We didn't, we didn't have patients. So it was, you know, you know, and all these patients supposedly addicted, the, you know, I don't know where they came from. They, because it, like I say, you know, you know, other internists and stuff, maybe we were in the wrong specialty. They, they, you know. And so, you know, the surgeons, the orthopedic doctors, the back pain doctors, the things where they'd have, be more likely to treat chronic pain conditions would be the ones where they were seeing this.

JE: Yeah. Well, those who will be listening to this 20, 30 years from now will know that it's a major problem today in the United States.

DN: Yeah.

JE: And, but it is being addressed.

DN: Well, of course, the, the problem comes when. When they can't get the prescription medication. And they go out and get the street drugs. Heroin, I mean, to buy, to get an Oxycontin might cost you, you know, 10, 20, 30 dollars a pill. And to buy some heroin, you can get a heroin dose for five bucks, three bucks.

So heroin is cheap compared to prescription opiates. And, and one of the things that the drug dealers are doing is they're putting another drug in fentanyl. They're mixing it in with the heroin because it gives a much bigger high, but it's tiny amounts of it are, are lethal. And so they, they just mix it in. They don't know.

And so we get this lethal combination of. Fentanyl and heroin. And so the, the patient who's been addicted to prescription drugs, when he can't get them, goes to heroin. And the heroin's laced with fentanyl and it kills him. And so the, much of the deaths aren't due to the prescription. It's due to the substitute for the prescription. The illegal drugs.

JE: What a slide to have that pain, have medication to that pain, and then they can't get it as much as they wanted because they are, they get hooked on it. And they're afraid that pain's coming back. I mean, to be real simple about it. So then they have to go to the street. Okay. We can add another things to this because in Oklahoma, we passed medical marijuana. And at this point, the state is having a difficult time sorting this out and how we're going to do it. But it was by the vote of the people that we voted for medical marijuana.

How important is that in treating pain?

DN: The, it's, it seems to be fairly unique drug in that actually the cannabinoids, which are what the active ingredient in marijuana. There's multiple types of cannabinoids. And there's the type that gives you the, the high, the, that you get from smoking marijuana. But there's other cannabinoids which seem to be able to treat pain. They definitely seem to be able to treat seizure disorders without any of the high ingredient.

So that there's, there's more to it. The obviously – the receptors in the brain were there before marijuana was found to trigger these receptors. And so these receptors in the brain for the drug, why you can give different types of cannabinoids to get different effects. So that, you know, all this research was on, on medical marijuana was totally stifled and not done because the federal laws against it.

And universities wouldn't ever allow its researchers to abuse it because they might lose their federal funding. And so we're really in the infancy of understanding the medical aspects of medical marijuana. I'd taken courses at TU and just that and got to meet some of the students. And one of the students I met there in Afghanistan, and he was having PTSD problems.

And he says, when is PTSD? He'd smoke some marijuana, call him Donnie. It worked great. It was the best thing. He says, the prescription drugs that the doctors gave him didn't, they didn't really work very well. But marijuana was the best drug he could take to control his PTSD. So, and, you know, again, but it's individual.

You take other individuals, it doesn't do anything. So, you know, it's, it's, it's going to be a number of years where you sort out. Really what's going on. And we don't really probably for a lot of these things don't have to smoke marijuana and be able to take the type of cannabinoid that works for that particular problem.

But, you know, we've stifled the research with, so for so long that it's just starting to come online.

JE: So maybe there should have been a whole lot more research.

DN: Before now.

JE: Yeah. Before a state, and we're not the only ones. Yeah. Before we said, okay, we want to sell it.

DN: Well, I think the medical marijuana thing, there's enough patients out there around the country that it's pretty helped. That makes sense. Now, whether you want to make it a recreational drug, it's, I guess we'll find out. The states that have allowed it as a recreational drug and now Canada, we'll find out what kind of problems there are with it.

Right now, it's the Oklahoma probably could use recreational marijuana to improve its financial state because Colorado is bringing in millions and millions of dollars into the state coffers through licensing and taxes. And so it's a good source of state funding.

JE: But I don't know if they've had it long enough to do a study to. And then to know how many people then became addicted and can people then go on to harder drugs as the old argument, if they use marijuana. I don't know if that study has been made.

DN: Oh, they've been, yeah, they've done a lot of those studies and it's actually very uncommon.

JE: To be?

DN: Yeah. Addicted.

JE: Addicted.

DN: I mean to go to other drugs.

JE: To go to other drugs. Yeah. But you could become addicted to marijuana.

DN: Yeah. In that sense.

JE: Okay.

DN: But just as we now, of course, have alcohol. Right. The addiction, alcohol addiction is a major problem in, in society. So.

JE: It is indeed.

Chapter 10 – 7:55
Muskogee Veterans Administration

John Erling (JE): After Springer Clinic, did we establish, and when did you leave Springer Clinic? In '65?

Dr. Don Nelson (DN): When I was age 65.

JE: When you were age 65 and that would have been in...

DN: Well, that's 10 years ago now. So you left Springer Clinic in 2008.

DN: 2008. Yeah.

JE: And then you were in the Muskogee Veterans Administration.

DN: Worked for the Veterans Administration, yeah.

JE: And how did that come about?

DN: Well, for one, I wasn't really ready to quit practicing medicine, but I was really getting tired of being on call the long weekends, being hospital rounding for six, eight hours on Saturday and Sunday and, and the nights and the, and a number of internists from St. Francis had gone to the VA and had talked to them and they said, it's great, you know, I can practice medicine and go home at night.

So it sounded kind of intriguing to, to get away from, from this intensity of private practice and the intensity of being a pulmonary specialist, which means you had a lot of patients in intensive care all the time, which means you rounded on them at least twice a day. So you do your office and you'd still have to go back in the evening. So I went, you know, so I put private practice and went and applied and got a position at the VA as a primary care doctor.

And I called that being semi-retired, I was only working a 40 hour week. Monday through Friday.

JE: Monday through Friday. Eight to five.

DN: Eight, yeah. Eight to five. Basically. Yeah. And I had nights free, weekends free, you know, it was, it was really, really nice.

JE: Did you live here in Tulsa and drive there?

DN: Oh yeah. You drove down there. Yeah, it was about an hour down there. And that was kind of pain. They have the VA clinic here in Tulsa. The Tulsa doctors that were working down in Muskogee, you know, all wanted to come to the clinic here in Tulsa. So it was like the long, you moved up as doctors, as a doctor would get to Tulsa, then you'd move up on the waiting list.

So you know, eventually if I stay. I would have been, I would have been able to come to the, to the Tulsa clinic. So the Tulsa clinic is where all the Tulsa doctors would want to go. Now, some of the doctors that were down there were actually lived in Broken Arrow area. And you know, it wasn't much farther to drive down there if you're South Broken Arrow and to drive to St. Francis.

JE: You must have met some interesting people there at the Veterans Clinic. And people who served their country and military type.

DN: Oh yeah. Yeah. Oh yeah. Lots of them. There was, you had really, you had two kinds of patients really at the VA. You had those who the VA was providing all their care and you had patients who couldn't afford their medications. This was before Medicare Part D medications. So all these older people, particularly older veterans. Would come and would come to the, would have private doctors in their home town and would come to the VA to be seen and all that to get their medicines.

And so we had lots of, of patients doing that. Would be using the VA to get their medications. And you know, with diabetics and hypertension, you know, sometimes, you know, a patient could be on six, seven drugs and you could see where, you know, this got very expensive for retired, retired retirees.

But then you had those vets who, you know, who got all their care at the VA and they were, you know, young vets and middle-aged and everything. But so you had kind of the retirees who were coming for medicines and the, and the younger vets who were.

JE: From various wars.

DN: From various wars. And there were some of those patients who were definitely addicted to narcotics. And that was tough because I mean, they had quotes, they had reasons for chronic pain. You know, they'd been in the war, they'd been injured, this kind of thing. And they would have a, a definite chronic pain thing, but they would be, they really were addicted in the, in making the decision as to whether, you know, you should try and wean them off was always hard because they, they had a reason.

JE: Did you have to have that tough conversation with some of your patients?

DN: Not very, actually not very often because he kind of accepted. A lot of them, he just accepted the fact that they weren't going to get off their medication. They just went with it. We did have clinics where they could,

you know, in, at the VA that they could go to, to get off. So there was, it was available and we could refer them there.

So it wasn't, it wasn't our job to get them off medication. We could refer them to. That's interesting at the VA while I was there, they, they were talking about even closing the Muskogee Veterans Hospital at the time, but then all these veterans coming back from Iraq and, and Afghanistan and that, all the problems they were having and PTSD and, and they decided we need a rehab hospital. We need a psychiatric hospital.

And so two floors of the Muskogee VA, one floor became rehab and another floor became psychiatric. And so they didn't need to close the hospital. Cause it was now fully utilizing the building.

JE: I'm interested in the psychiatric part of this. We should have been addressing that way back when, maybe. I mean, it wasn't just the soldiers of today, but a World War I, a World War II were suffering some of these post-traumatic syndrome and that you talk about and we didn't spot it back then.

DN: You know, shell shocked, things like that.

JE: Yeah. That's what we always heard, shell shocked, right.

DN: Yeah. Well, if you want to hear an interesting story, you may want to erase this, but leave it in. When we were in Australia, we were down in Melbourne and we took a little van tour of the great river, great ocean road. Well, the great ocean road was built in, a lot of it's built on sides of cliffs along the ocean back after World War I.

Of course, Australia had soldiers in World War I for four years because, you know, we were only there two years in World War I before it was over. So they had all these patients with basically PTSD, shell shocked. They took them and they put them to work building this road by hand. They carved this road out of cliff sides.

And they didn't want to use heavy machinery because this was, you know, machines and tanks and things they, you know, the PTSD people would

bother them and they didn't want to use dynamite because they didn't want to have, so they did it by hand. So they carved this 30 mile road, part, like I say, maybe a third of it on cliff side by hand as treatment for their PTSD.

JE: Wow.

DN: So we, um, veterans.

JE: That's bizarre. Isn't that interesting? Yes. Wow. Well, they got a road out of it, right?

DN: They got a road out of it. Yeah.

Chapter 11 – 4:40
Proud of Profession

John Erling (JE): I must think, as you look back on the medical career, should feel good about all the peace and people you treated, made well. Doesn't that bring you satisfaction even today?

Dr. Don Nelson (DN): Oh yeah. Oh sure. Sure, yeah, it was a good career. The, you know, leaving Springer Clinic, leaving private practice, the hardest part of all was leaving my patients because they were like my friends. I had known them for years.

And to all of a sudden cut off, you know, all this interaction with all these people I had known for years, I really kind of had a little depression after leaving private practice, even though I was busy at the VA seeing patients, new patients. It just was kind of like, you know, like you lost a friend or something, you know.

JE: Yeah.

DN: Just lost all these friends and things. It really was, you know, it was, and yeah, it was a very good career. You know, and as much as everybody

complains about all the problems in medicine, I would recommend medical career to anybody. The, because of the satisfaction, the financing of this, all the various problems. Yeah, but taking care of patients and the satisfaction of doing that. Yeah, so you're not going to get rich or you're, you know, you're going to work hard. The, yeah, but you know, it's still a great career.

JE: You say we're not going to get rich. People always think a doctor is wealthy, don't we?

DN: Yeah, they, doctors do well. I mean, they are paid well. You know, some of the specialties get paid very, very, very well, you know, but still, yeah, it's, you get paid a decent wage compared to, you know, the rest of them. But then again, when you think about it, you know, I was, I was, because of basically five years of college, four years medical school, the internship, four years residency, two years military, I was 35 before I started getting paid.

JE: So how many years is that total about?

DN: Well, it's five, 10, 14, 16 years.

JE: Of education and practice.

DN: Education and all that before I was actually in practice. Yeah. So, you know, the, you know, it was a long time to get to that point.

JE: Well, sometimes there is an argument about, oh, those doctors get rich. Yeah. And I've never felt that way. If they're saving lives or making lives better, I don't care how much you get rich. I don't care how much money you make.

DN: And doctors in general work hard. I mean, they really, it's really not. And you think about, you know, it's the decisions you're making. You know, not all doctors, maybe a dermatologist isn't life and death, but the, most doctors, it's, it's, you know, you're making extremely important decisions in other people's lives, you know, that, that affect their health, their welfare, all kinds of things that's in.

So, I mean, you're, you really are a tremendous responsibility. You kind of grow into it and you don't think of it in those terms, but there is a tremendous responsibility to do the right things for your patients.

JE: Yeah. And you were right at the heart of. And, uh. You were dealing with the heart. You were at the heart of the matter.

DN: You know, and like I say, the education involved. And now, of course, nowadays, the kids come out with huge debts. You know, they come out with $100,000. I think my daughter married a pediatrician, so there's two pediatricians in the family. And they, I don't know, they're almost 50 now. And they, they're still, I think, haven't quite paid off their debt for medical school, college.

Although, like, well, they didn't have, they didn't have, well, they may have. I don't think they had any college debt, but they had medical school stuff. My daughter didn't have very much because I paid for a good deal of it. But then she wanted to be independent. So, you know, I'll borrow. You don't have to pay for it all, Dad.

JE: It's nice to know that. But when you were working summers to get yourself through and you were able to help them, that makes you feel good.

DN: Oh, sure. Right. Yeah.

Chapter 12 – 13:36
Triathlons

John Erling (JE): Well, while you've had such a career in medicine, you've had another career going. And right now you're very active in triathlons. Take us back to when did this passion for running, biking, swimming set in? Was it in high school or where? Tell us about that.

Dr. Don Nelson (DN): Well, really, I always felt better when I was physically active. So in college, we'd always go to the gym, play basketball. And I know sometimes I'd run between classes and things like that just to run,

just to be active physically. So it was always the mental side of being physically active was there. I always felt better when I was physically active. So, you know, when we got to medical school, not much of any physical activity at all.

There just wasn't any way to do that, any place, any time. And so we went on into the first year of internship, first year postgraduate in an internship. You know, so when I ended up in Kansas City working in that federal health clinic, I all of a sudden had time again, had time. So the thing, I went over to the local YMCA. And got on their indoor track.

And it was like 16 loops to a mile or something, you know. And I could run one loop and I have to walk. And the, and so I started running a little more, a little more. And about that time, a book written by an Air Force physician, Dr. Cooper, wrote about, a book called Aerobics. In this book, he talked all about, you know, exercise. Exercise and all that. And he gave points for each physical activity.

And so he got like 40 points a week where I was good. So I started wanting to get points. So I started running more and I played basketball at noon. Along with some, with kids that were just college basketball players who were just post-college. Things like that, running. I started running outdoors. Well, I was the only one anywhere running outdoors. And, and, you know, anybody who would, who knew me drove by, they'd want to stop, pick me up, take me home.

Figured there was something wrong, you know, that I was out running around. And, and in those days, dogs weren't, the dogs just ran free and they all chased you. And, and the kids would point at you and say, what's that funny man running around in his underwear, you know? And so I started running then.

JE: Okay, this is in the 70s?

DN: This is in the 60s.

JE: 60s. Okay.

DN: So, and then. I'd do some lap swimming in the apartment complex pool and that kind of thing. So I was getting, I was starting to get some exercise and it felt a lot better. I really hadn't gained weight particularly, maybe a few extra pounds. I hadn't gotten fat or heavy or one, you know, that kind of thing. But when I got to residency, well, you know, we started off, first couple of years was, you know, 36 hours on and 12 off, you know. Well, and 12 off, I wasn't getting any running.

So again, I had another couple of years where I didn't get really hardly any exercise. And then as we got farther along in residency, you didn't have to, you weren't, your call schedule was such that you weren't on call that much and, and you were in specialties where you didn't take call. And so I got back to running in my neighborhood and, and swimming in the, the local tennis club pool and got to playing a lot of tennis.

And then we came to Tulsa. And the main thing I was doing was playing tennis and I started running around the block in the neighborhood. And after a couple of years, well, I had met some friends. People who were part of the running community at that time. And they said, well, you come run races, you can run. I said, oh, okay. So I started running some races, you know.

I don't know, you probably, I remember Larry Adottle and, and Bailey, I forget Bailey's first name. And there were some other guys, I can't think of their name right now, were part of this. And so a couple of years of running races, I said, well, I'm going to do the Tulsa Marathon.

JE: Did you run the Tulsa Run at the beginning?

DN: Yeah. But this, this was before Tulsa Run. Okay. Or still before Tulsa Run.

JE: All right.

DN: So I decided to run the Tulsa Marathon. And what it was, we ran four loops around out at Mohawk Park. So I do the Tulsa, I do the marathon and I finished the marathon in four hours and 10 minutes, which most people say, oh, that's good. Yeah, I had a pretty good time. They had already taken down the finish line, packed it up, given out the awards. Almost everybody

had left. There was one guy with a stopwatch. He gave me my time and a cup of water.

Nobody ran that slow. And that running community, they didn't run four, they ran three hours. They ran three hours, 10. And so the running community at that time was such that, you know, four hour marathon, well, you know, we don't even wait for him. And then a couple of years later, Tulsa Run came.

JE: So now we're into the 70s now.

DN: Now we're into the 70s because it's the 41st run this year. So if you go back, why?

JE: You came to town in 73. So that's when you were into this. Yeah. And running. And you were a slow runner, according to them.

DN: According to them.

JE: Right. Right. So then you saw that. But then you also participated in the Hillcrest Ultimate Challenge.

DN: Yeah, well, then a few years after Tulsa Run started, and that went on a couple of years. In fact, probably it's about four or five years after Tulsa Run started, they just had the first triathlon. Yeah. And at the time, I was blogging at Hillcrest Tennis Club, and they had a nice pool, and in the summer, I'd swim laps. And so, plus playing a lot of tennis and then running, the triathlon came along.

Well, I just got to buy a bike, and I went out and spent a whole hundred dollars on a bike. Got a bike and did the first triathlon and kind of got into it. I've been doing them ever since.

JE: Just to clarify, did you run in the first Tulsa Run?

DN: I did, yeah.

JE: And how many years did you run?

DN: I've done, well, counting this year, I've done 37 Tulsa Runs.

JE: So out of 41, you've done how many? You've done 37.

DN: 37 Tulsa Runs. Now, I did actually two 5Ks, which didn't count, of course, because towards doing the full Tulsa Run, 15Ks. There's one I missed way back in the beginning, and I had plantar fasciitis, and my foot was painful, and I decided not to run it. But then, you know, who knew, you know, it was going to be something that went on forever like that.

JE: And now, is it down to 10 or 11 of them who have run all of them?

DN: Yeah. Right. Well, there's only, they listed now, went down in several years in terms of number of years run, and there's like only 26 people who have run more Tulsa Runs than I have. It's down to that. Interesting thing is that they're all men. There's no women.

JE: And that continues, because back when you were running, it was a male sport.

DN: It was a male sport. There weren't that many women.

JE: And today, it's very much a female sport.

DN: Yeah. Generally, there's almost, for runs under a half marathon and even half marathons, there's more women running than men in races, 5Ks and 10Ks. Right.

JE: And these half marathons, women are really into as well. But we should also point out, when you were running, and the running community then kind of left you behind, the running craze had not started with the general population.

DN: No. Not at all.

JE: Because then, when they did, you got lots of company.

DN: Once Tulsa Run came and the running.

JE: Right.

DN: And everybody got into it. And everybody got into it. And then the running was all over the place.

JE: And so now we respected everybody who runs, no matter what their time, is the fact that they do it.

DN: Right, right. Oh, yeah. Now, you run five, six hour marathon. Oh, okay. Yeah, you did a marathon.

JE: Right. Right. And so, but this, as you noticed, there's stress that comes from your medical profession. And this helped alleviate the stress. You didn't have to do drugs. No. You did the drug of running.

DN: No. Well, in fact, I always, when the weather was nice, I'd run in the morning early, you know, before I'd go to the hospital. And I'd say, well, when I'd finish my run, I'd say, playtime is over. Now I got to go to work. I never looked at going out for a run as being work. I looked at it as play.

JE: Yeah. Oh, yeah. Clear the brain.

DN: Clear the brain. Feel good, yeah.

JE: You can, your brain can be all muddled with all that. And you know, within an hour, it's going to be cleaned out.

DN: Yeah, yeah.

JE: That's what's so great about it. And you're not fighting the residue of drugs. So how many races do you think you've participated in?

DN: Running races, I have no idea.

JE: 300 or more probably.

DN: Oh, no, I've done 300 triathlons.

JE: Okay.

DN: Running races, I may have done thousands. You know, because you do, you know, you do running five, six, eight. Runs, maybe 10 runs a year.

JE: Yeah. Right. You've qualified for the USA Triathlon Age Group Team, competed in I don't know how many World Championship events.

DN: Yeah, I'm up to about 22 World Championship events.

JE: You've finished as high as sixth place several times.

DN: Yeah. In the long course triathlon, yeah. Now lately, in other kinds of multi-sport events, you know, in what they call the Aquathon, where you just swim and run, you know, bike. I've been second and third and twice been third place in that and second in the world. Well, in fact, in Australia this year, I was fifth in the triathlon, the regular Olympic district triathlon.

JE: So you've traveled to many cities to do this.

DN: I've traveled basically, you know, most of the world, yeah. I've been to Australia twice, to Zealand twice. I've been to Sweden because I've got relatives in Sweden. I've been to Sweden and done, you know, three races in Sweden. And two in Denmark. Of course, I've been to Hamburg and Budapest and Nice, France and Rotterdam. But each, you know, we would make vacation out of it, too.

You know, you'd go do the race and then you'd spend a week in Europe, you know, if it was Europe.

JE: And you recently went to Denmark and Sweden. So that's just the recent events.

DN: Yeah, this summer I did the two races in Denmark and partly going to Sweden because I have relatives there. First time I went, I went with my wife and did a race. Second time I went, my brother and sister and I went.

We visited all the Swedish relatives. Third time I went, which was actually the World Swimming Championships, took my three kids, they were not kids, they were, you know, adults, to Sweden to visit relatives.

And now when we did this trip to Denmark, Sweden and all that, this summer, why, we took the grandkids.

JE: Isn't that great?

DN: So they've all been to Sweden now and visited all the relatives. Yeah. The Swedish relatives.

JE: Yeah. Well, I'm Norwegian, as you know, and I've done Norway, but not as many times as you've done Sweden. And Norwegians and Swedes can get along as we have here today.

DN: Yeah, yeah.

JE: We should track this age thing, though, because when you went into the now known as the Tulsa Triathlon, how old were you then when you started that?

DN: Well, it would be 36 years ago, 36 from 79.

JE: Let's call it 80 because you'll be 80. You're 44.

DN: Okay, 44.

JE: So you're 44, 45 years old when you start triathlons.

DN: Yeah.

JE: And you've continued that for all these years. All these years. And when you were 65, when you were 70, when you were 75, 79, soon to be 80, and the example that you have set for lots of people who are older or younger than you is absolutely, well, you know you've set examples. You've set examples for all these people.

DN: I hope so. Yeah. It can be done.

Chapter 13 – 10:09
Training

John Erling (JE): But then we just kind of say, well, you went here and you did that, and the training for triathlons. How much time in a day, in a week?

Dr. Don Nelson (DN): Well, this was always the problem because you'd really have to fit it in. Because I think I've always said one of the reasons why I'm still able to do it is I had so many rest days, days where I'd be on call and so I couldn't go out for an evening run or anything. Or evening swim or evening bike.

So that was every third night I couldn't do those things. Weekends, every third weekend I could maybe get a run in early before I started hospital around, but that'd be about it. So lots of guys got into triathlon and just trained and trained and trained. They were training out there every day and hard. And I couldn't do it. I mean, I didn't have the time. And then you also had kids' events and you had PTA and you had...

And you had meetings at the clinic and meetings at the hospital. And so I could go for several days at a time without doing anything just because I couldn't fit it in. So I would try and fit it in wherever I could. And weekends, when I wasn't on call, I'd do long runs and long bike rides and stuff to try and... And during the week, I'd join the Masters swim team. Once I started doing triathlons, just to get more swimming done and have a place to swim, you'd go do a Masters swim team workout, which is... And so I actually got into Masters swimming, so I do the Masters swimming events as well.

JE: Now?

DN: Now, yeah.

JE: And what is a Masters swimming? What events? How far?

DN: Well, it's like a regular swim meet where you have 50s and 100 meters, 50 or 100s, 200s, 400s. And then you do back breast, fly. Freestyle. And I do breaststroke and freestyle, and that was my two events.

JE: I didn't ask you about your parents. Were either one of them athletic?

DN: No.

JE: So this comes out of nowhere.

DN: This comes out of nowhere, yeah. And my brother and sister aren't either.

JE: You know, your forced days off actually played into the thought of running because there was a time people thought you had to run every day. And maybe take one day off. And now we're not thinking that so much.

DN: Right.

JE: You're right. At least take one day or two days off in a week maybe. And so you were ahead of...

DN: I was having to do that by virtue of my profession and family. And it turned out to be the right thing. In terms of, yeah, my joints are still going strong.

JE: What do you say to some people that say that to me? Oh, that running is going to wear out your knees or your hips and so forth. Have you had any problems?

DN: I did have a torn meniscus a few years ago. And they took out a torn piece because it would occasionally lock. And so that knee is... You've got to be a little bit careful in terms of what you do.

JE: But that was after years of running?

DN: Oh, yeah. That was after years. Yeah, I was in... I don't know if I was... At least late 60s.

JE: Yeah. But as you enter these events, you've gotten older, maybe there is... You're the only one in your age group.

DN: Well, locally, that's pretty true now. Not quite. There's a gentleman who's a very, very good triathlete. He was All-American many, many years. He shows up now and then. He still rides his bike on, you know, the ride across Oklahoma and the ride across to Iowa. And he lives in an apartment building that has a swimming pool in the basement.

I forget what it's called. So he swims there. And he's always been one of the best runners in Tulsa. So he shows up every now and then. And then there's a guy from Claremore who is always one of the best runners around. And he's not a very good swimmer, but he's very good. He rode his bike to work. He worked as a dentist in Claremore.

He had been a Navy dentist for many years, retired from there and was working in, I think, the VA. Claremore, he'd ride his bike to work year round.

JE: Wow.

DN: So his cycling skills were good because he was riding his bike. And he's always a great runner. The bad thing is, is that in national championships this summer, why, he died in the water during the swim. They pulled him out of the water and resuscitated him and didn't bring him back.

JE: And how old would he have been?

DN: He'd been 76, 77.

JE: Yeah, but, you know, as we say, what a way to go, huh?

DN: Yeah. I mean, he, yeah, in fact, he had, he won, he won nationals in his age group in the duathlon swimming, or running and biking. So, you know, he was a great runner. He was in great physical shape. And he was a small, skinny guy, you know, short, probably weighed 140 pounds, you know. You know, here's a guy who shouldn't ever get heart disease.

JE: Right.

DN: But you know, you know. Right.

JE: You know, you were used to swimming and running, but then you took on biking. And then you would bike. You'd go on bikes 50 miles, 100 miles. Was that difficult to get adjusted to biking or did you, was that an easy?

DN: Well, you know, riding a bike is riding a bike. And, you know, getting stronger and climbing hills and things like that. Yeah, it was hard. It's still hard. I never consider myself very strong. I have endurance, but not strength. So, you know, going out for long bike rides where you climb a lot of hills, that was hard. Because it just, it takes strength. If it's nice and flat, I love it then. Because I can go forever.

JE: Did you do weight training?

DN: I would do weight training in the winter. Because I would have more, you know. Well, you'd be inside more because of the bad weather outside. So, you know, you wouldn't be out there riding the bike. So, I'd be doing weight. So, I'd do maybe four or five months of weight training every year.

JE: And you're still doing that?

DN: Still doing that, yeah. So, I haven't done any since last, you know, March or something.

JE: But you've been so active. Is there something you're getting ready for now?

DN: Yeah, I've got a race next weekend down in Florida.

JE: What is that?

DN: And we've got two races. On Saturday is what they call the Aquathon. That'll be a 1,000-meter swim and a 5K run. And then Sunday, they're having a half-Ironman triathlon. But I'm just doing the swimming and biking part. They call it the Aqua Bike. So, it's, you know, a 1.2-mile swim and a 56-mile bike. And, of course, I'm in for triathloning. They use the

international rules for age.

And they use the AGR at the end of the year. So, since I turn 80 in a couple weeks, I've been 80 all year in triathloning. So, I'll be racing in the 80-84 age group.

JE: And the chances are great you win your age group because you're the only one in it.

DN: Well, I'm not the only one in the Aqua Bike. And there is one guy in the Aquathon, but he's not very – he's much slower than I am, I know of. But this summer in the Olympic distance triathlon, I won my age group. So, I'm the age group champion at the Olympic distance.

JE: And you had others in that with you.

DN: Oh, yeah, there was others in there. But the swimming is where I excel. And in this case, I was 11 minutes ahead of the second-place guy after the swim, the mile swim, 1500-meter. So, you know, he couldn't catch me on the other parts.

JE: So, you were the best running and then biking?

DN: Used to be, but now it's swimming, biking, and running. The running has deteriorated the most. And I'm really down to run walking. I can't run continuously anymore.

JE: And that too has been promoted by running experts, run-walk. So, that's – a lot of people are into that now. And tell us, you told me when you were – was it Sweden or Denmark recently – how cold it was?

DN: Oh, the racing. We did a race called, again, the aqua bike race. I didn't prepare for cold temperatures and cold north wind. So, I was just in my swim gear. I didn't have a jacket or a hat or, you know, a helmet, of course, but didn't have anything on. And that wind, you know, it was in the 50s. And the wind blowing and just – I got so chilled.

My teeth were chattering. And my hands were numb. I couldn't feel it. I

couldn't – I had to look to shifting levers to shift them because I couldn't feel anything. And that race, I actually abandoned it. It was a 75-mile bike, and I abandoned about 50 miles.

JE: But even that – even that was amazing.

DN: Yeah.

JE: It's hard for me to believe – you're an 80-year-old man. You'll be 80 in a couple of weeks – that I'm talking to somebody who's talking about such an active life at 80.

Chapter 14 – 6:45
Exercise Advice

John Erling (JE): What is your message to older listeners about living an active life?

Dr. Don Nelson (DN): You know, Nike's got the right thing. Just do it. You know, get out and walk. If nothing else, just walk. You know, the get outside and walk. Get outside and walk. You know, all these people say, oh, it gets too cold in the wind. It's too hot. You know, go out early in the morning and walk. It's never too cold to put on clothes and walk in the winter.

You know, you can do that. I mean, obviously, it does get too cold sometimes. So, you know, most of my patients, I would say, you know, don't – don't try and – I don't want you to think, well, gee, here's – I can't do what he does, so therefore I'm not going to do anything. You know, it's just – you know, walking is the place to start. No, you get going and you say, well, I want to do a little more, and you start – and you run a little bit, and so you're running a little more, and maybe you get into the running and that.

You know, like if you were – enjoy swimming, just, you know, go to the pool and swim. You know, several health clubs and – and – Well, Chang's High School, they have adult swim for laps and stuff going on. And down there,

there's lap swimming for adults. And you – so, you know, you can swim, run, or just walk. And nowadays, with spin classes being so good, you don't need – my – my wife doesn't want to get on a bike, but she does spin classes.

And, you know, it's a nice, controlled environment. It's – it's not – you're not out in the cold. You don't get run over by a car. You just – Yeah. You don't – you don't get biking. So it's just – it's just do it. You have to do something. Just do something. Right. Yeah. And, you know, it's – but you don't – you know, you don't have to be going to running triathlon or going – doing a marathon or, you know. Just get on a walk. Start there.

JE: You also are exercising your mind because you're auditing courses at the University of Tulsa?

DN: Correct. Yeah. Yeah, I started doing that when I retired. And I'd take one or two courses that I would just audit. I didn't have to take the tests or write the papers. But just sitting in and the lectures and reading the books is, you know, one of the things as a doctor I studied all my life. One thing, medicine. And in college, what were the courses I took? Well, you know, basically all science courses.

I had one literature class, I think, and no history classes and no political science and no, you know, all that. So going to TU, so what do I take? You know, I take political science courses. I take a religion course. I take an art history course. You know, American Indian history course. History of modern China, you know, modern, you know. They started 3,000 years ago and they call it modern China.

But anyway, you know, so things that I never had time for before, never had done, I really enjoy it. You know, so it's, you know, that way I would say I, you know, spend half a day in my body and half a day in my mind. Here we go.

JE: And you know, don't they say as we get older and to fight maybe dementia and Alzheimer's, keeping that mind active, being curious is supposed to ward off or help our fight against it?

DN: Yeah, yeah. It's the evidence that exercise seems to help ward it off is pretty good. So that actually, you know, you can help your mind. Stay healthy by exercising your body. The evidence that doing a lot of mental things helps ward it off is a little less secure in terms of, you know, there's studies that say yes.

Studies that say, well, maybe not so much. I think a lot of these studies, the amount of exercise or the amount of mental exercise that they're doing isn't very much. It isn't very. So that. So doing a little bit, which is what kind of these studies end up showing is that a little bit doesn't help that much. You really need to be really active, much more active than.

JE: Just physically active.

DN: Physically and. Socially.

JE: And socially.

DN: And actually socially does seem to help too. I mean, having good social network seems to help the brain stay more.

JE: Well, my love of running has given me wonderful joy and I feel sorry for people who don't enjoy running. You're swimming and biking, but running was my thing. But I only bring it up because it was a way for me to meet you.

DN: Yeah.

JE: And often you were getting your bike out and I was getting ready to run. And so we met on our running path. And so that's why we're here. Because of my running and your love for exercise.

DN: Right.

JE: How would you like to be remembered as a good doctor or a good triathlete or how would you like to be remembered?

DN: Oh, gosh. The really both those things, I think, you know, really one was my career as a doctor. And of course, one of the problems you have in terms of being remembered as a good doctor is that your patients have all died by that before you do. You outlive them.

And hopefully I'm probably will hopefully live long past my triathlete. Triathlete career. So, you know, whether I'll be remembered for that or not, I don't know. That's one of the, I don't know what you call it, aspects of living a long life is that all the people that knew you are gone.

JE: Yeah. But you will be remembered for your medical career.

DN: Yeah.

JE: And here you're at 80 years old and you're still participating in events. You'll be long remembered for all of that. Well, Dr. Don, thank you. Thank you. For this time.

DN: Okay.

JE: And, you know, we've reached two hours and 26 minutes. And when you came in, you didn't know if you could talk for an hour. So it's been very enjoyable. And thank you for sharing your story.

DN: Oh, very good. Thank you.

JE: You're welcome.