Vaccination; a sacrament of modern medicine

by Richard Moskowitz

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I am honoured by your invitation to participate in this Conference, and deeply moved by the fraternal spirit, youthful vitality, and sincere dedication to homœopathy everywhere in evidence here. Homœopaths in all lands and of every stripe would do well to follow your example.

Andrew Tyler of the London *Evening Standard* recently told me that the National Health Service pays a substantial bonus to physicians with documented vaccination rates over 70%, and a still higher increment if the figure tops 90%.[1] His drift seemed to be that the overly civilized British need only informal pressures and inducements to obey authority, while the more rebellious, outspoken Americans have to be coerced with laws and penalties. If that is true, I can understand why you wanted to fetch somebody from America, and I shall try not to disappoint you.

My interest in vaccination arose out of a 'gut' feeling not to do it that I have devoted a considerable part of my career trying to clarify. In this as in so many other ways, the study of homœopathy has helped me to articulate what my heart and soul already seemed to know. To recognize the organism as a totality of symptoms already implies that any more narrowly defined standards of vaccine effectiveness cannot possibly be adequate. Other glaring inconsistencies include enforcing compulsory vaccination laws in the absence of any public health emergency, and waving the rules of scientific inquiry on their honour.

These special privileges give some measure of the reverence accorded to vaccines in what can only be called the 'religion' of modern medicine. [2] Its theology was admirably summarized by the French physiologist Claude Bernard well over a century ago:

> What we call the immediate cause of a phenomenon is nothing but the physical and material conditions in which it exists or appears. The objects of the experimental method and the limit of every scientific research is therefore the same for living as for inanimate bodies. It consists in finding the relations which connect every phenomenon with its immediate cause, or, putting it differently, defining the conditions necessary for its appearance. When the experimenter succeeds in learning the necessary causes of a phenomenon, he is in some sense its master. He can predict its course and appearance; he can promote or prevent it at will.

As a corollary to the above, neither physiologists nor physicians must imagine it their task to seek the cause of life or the essence of disease. That would be entirely wasting one's time in pursuing a phantom. The words 'life' and 'death', 'health' and 'disease', have no objective reality. Only the vital phenomenon exists, with its material conditions. That is the one thing that they can study and know.[3]

Precisely as Bernard foresaw, the search for identifiable components of human structure and function and for powerful technologies to control them has obscured the need for and even the possibility of any unifying concept of life or health against which to judge them. To be considered effective by present standards, vaccines need only satisfy two statistical criteria i.e. reducing the incidence of the corresponding acute diseases as low as possible, and demonstrating measurable titres of specific antibodies in the blood.

Vaccines have become sacraments of our faith in biotechnology in the sense that:

1. their efficacy and safety are widely seen as self-evident and needing no further proof;
2. they are given automatically to everyone, by force if necessary, but always in the name of the public good; and
3. they ritually initiate our loyal participation in the medical enterprise as a whole.

They celebrate our right and power as a civilization to manipulate biological processes *ad libitum* and for profit, without undue concern for or even any explicit concept of the total health of the populations about to be subjected to them.

I therefore want to re-examine and update the major concerns of my original article[4] from this theological standpoint. Now as then, I have mostly a lot of questions to offer, questions so thorny and difficult that decades of careful investigation will be needed to disentangle them. But they seem so basic and important that it would be reckless indeed to require vaccination of every newborn child without adequate measures being taken to address them. Until then, my position remains simply to make vaccines optional and freely available to all at the discretion of their parents, as is now the rule in the UK and other European countries.

A BRIEF HISTORY OF THE MEASLES VACCINE

I want to begin with a brief history of the measles vaccine, because its dramatic career highlights so many of these issues pertaining to the others as well.

In its natural state, the measles virus enters the body of a susceptible person through the nose and mouth and incubates silently for about 14 days in the lymphoid tissues of the nasopharynx, the regional lymph nodes, and finally in the liver, spleen, bone marrow, and the lymphocytes and macrophages of the peripheral blood. The illness known as the measles is the process by which the virus is expelled from the blood, through the same orifices that it came in, and involves a concerted and massive effort of the entire immune

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system. Once specific antibodies have succeeded in targeting the virus, the ability to synthesize them on short notice remains as a coded 'memory' of the whole experience, a virtual guarantee that people who have recovered from the measles will never get it again, no matter how many times they are re-exposed.

In addition to conferring this specific immunity, the process of recovering from the natural disease also 'primes' the organism non-specifically to respond promptly and efficiently to other micro-organisms in the future. A crucial step in the maturation of a healthy immune system, the ability to mount a vigorous, acute response to inflection unquestionably represents a major ingredient of optimum health and well-being in general.

Finally, measles is about 20% fatal in populations exposed to it for the first time. It has taken us many centuries of adaptation and 'herd immunity' to convert it into an ordinary childhood disease, such that, when I first encountered it at the age of 6, non-specific mechanisms were already in place to help me deal with it effectively. In that historical sense, the permanent immunity acquired by recovery from the natural disease represents an absolute net gain for the total health of the race as well. However the vaccines act inside the human body, true natural immunity or any other qualitative benefit cannot be ascribed to them: their effectiveness is a mere statistic, and the resulting 'immunity' a narrowly defined technicality.

Thus, in contrast with the natural disease, the vaccine virus produces no local sensitization at the portal of entry, no incubation, no massive outpouring, and no acute disease of any kind. It can elicit long-term antibody production solely by surviving in latent form in the lymphocytes and macrophages of the blood. But then the vaccinated individual would have no way to get rid of it, and the technical feat of antibody synthesis could at most represent the memory of this chronic infection. Nobody would be foolish enough to argue that vaccines render us 'immune' to viruses if in fact they merely weakened our ability to expel them and forced us to harbour them permanently instead. On the contrary, such a carrier state would tend to compromise our ability to respond to other infections as well, and would have to be regarded as immunosuppressive in that sense.

Vaccination campaigns and their consequences

The laws mandating vaccination against the measles were enacted in the early 1960s, when the disease was limited almost entirely to children in elementary school, and both deaths and serious complications had already reached an all-time low. There was very little public debate, and the decision appears to have been made purely as a matter of policy, almost as soon as the vaccine became available. With very few people requesting exemptions, the compliance rate averaged well over 95%. From an average of over 400,000 cases annually in the pre-vaccine era, the incidence of measles in the United States dropped to less than 5000 in the early 1980s[5], and it looked as though the disease would soon be eliminated.

In the 1980s, however, this comforting mythology began to unravel, as measles began to reappear even in fully vaccinated populations, and public health authorities began to grapple with the mysterious phenomenon of 'vaccine failure'.

Thus in 1984, 27 cases of measles were reported at a high school in Waltham, Mass., where over 98% of the students had documentary proof of vaccination.[6] In 1985, 157 cases were reported over a three month period in Corpus Christi, Texas, and the surrounding Nueces County, despite a vaccination rate of over 99% and significant antibody levels in over 95%.[7] In 1989, an Illinois high school with vaccination records for 99.7% of the students reported 69 cases over a three week period.[8]

In all of these outbreaks, the authors concentrated on the documented vaccination rates of the target populations, and curiously neglected to mention the number of actual cases that had not been vaccinated. But they all implicitly refuted the hypothetical 'reservoir' of the disease in the unvaccinated, an argument still popular with health departments for frightening wavering parents into compliance.

As the dates from these various outbreaks were collected and analyzed, tentative generalizations were made and new strategies formulated. A survey of over 15,000 Canadian cases in 1985-86 indicated that 60% of the patients had documented vaccination records, with 28% 'unvaccinated', and the status of the other 12% 'unknown'.[9] Since the 'unvaccinated' group would also have been identifiable only by their own statements, the category 'unknown' presumably refers to those who claimed to have been vaccinated but could no longer prove it.

A comparable American survey[10] of 152 separate outbreaks comprising over 9000 cases in 1985-86 yielded similar results:

1. A large majority of cases (69%) were children of school age, i.e., five to nineteen years of age.
2. Of these, 60% had been 'appropriately vaccinated', i.e., at fifteen months or more (the schedule then currently in vogue), and another 20% 'inappropriately vaccinated' (at twelve-fouteen months, the schedule recommended before 1979), with the number of unvaccinated cases again omitted.
3. A significant minority of cases (26%) were children less than five years old, most of them unvaccinated and belonging to black, Hispanic, or other indigent minorities in urban ghettoes.

All of this data indicated a resurgence of the disease mainly in older children and adolescents of high-school and college age, groups with much higher rates of serious complications. The usual explanation was that vaccine-mediated immunity was time-limited, and 'wore off' with increasing age, presumably leaving the child otherwise unaffected and susceptible as before. This usually unstated assumption also formed the principal rationale for mandatory re-vaccination at a later date.

Refutations

Unfortunately, this assumption had already been disproved by an earlier study, which demonstrated that previously vaccinated children with declining antibody titres responded minimally and for an unacceptably short time to booster doses of the measles vaccine.[11]

Another refutation came from a sustained outbreak of 235 cases in Dane County, Wisconsin, over a nine month period in 1986, although the authors of the study declined to take it seriously. As in earlier studies, they found that the vast majority of the cases were in the school-age group (five to nineteen years), but that only 6% of these had not been vaccinated.[12] Their most unexpected finding was that 'mild measles', with typical rash but minimal fever, was much more likely in children who lacked vaccine-specific antibodies than in either the unvaccinated or those whose vaccinations had 'taken' properly. This apparent reversal suggested some kind

of unapparent or latent activity of the virus that had not been suspected before and did not show up on routine serological investigation.

Yet, despite these warnings, none of these investigators dared consider the possibility that the 'immunity' conferred by the measles vaccine might not be genuine. Much as in the peak years of the Vietnam war, or the chemotherapy of advanced cancer patients after the initial round has failed, the purely quantitative redefinition of immunity cleared the way for the simple escalation of force as needed to approximate the desired goal.

In the last three years, the theologians of re-vaccination have generally carried the day in the face of all logical, scientific, and ethical considerations. Ironically, the major historical development in their favour has been the increasing progress of the disease among unvaccinated minority infants.

Thus over 500 cases were reported for Los Angeles County in 1988, over 17% of the total nationwide; and of these about 65% were under five years of age, 77% were Hispanic, and 38% were actually less than 16 months old, the age at which the vaccine is usually given![13] These data have been used effectively to browbeat state legislatures into allocating more funds and local officials into tighter enforcement of vaccination laws in minority districts.

As a result, lowering the vaccination age to nine months has been recommended for certain high-incidence areas, an idea which brings us back full circle to the pre-1979 era, when large numbers of kids were 'inappropriately vaccinated' according to similar guide-lines. These absurd vacillations have nevertheless caught millions of innocent children in their web, and even the most sanctimonious faith and piety will no longer suffice to excuse them.

Although only the measles vaccine has been implicated, the medical and public health authorities are currently advocating revaccination with the mumps and rubella vaccine as well, but cannot even agree on the proper age, while the various state legislatures are left to try to figure out which of them if any to pay attention to. Thus the American Academy of Family Practice currently advocates a second MMR booster at four to six years of age.[14] and a bill now before the Ohio legislature mandates documented proof of MMR re-vaccination before entering the seventh grade.[15] The general idea seems to be that the extra dose cannot possibly hurt, and therefore it makes sense to throw in the mumps and rubella vaccines as well.

New vaccines

This same generic faith continues to bless the pharmaceutical industry in its endless and immensely profitable quest for new vaccines, seemingly for no other reason than its technical capacity to make them.

In the late 1980s, a vaccine was introduced against haemophilus influenza type B, associated with scattered outbreaks of meningitis in crowded day-care facilities. At first purely optional for the pre-school age group (two to four years), it was eventually made compulsory for all infants, even those who never need day care, and is presently given at or before 18 months, in some cases before the first birthday.

Always primarily a disease of adult intravenous drug users, hepatitis B quickly found its way into blood banks and has become a more or less institutionalized risk of patients requiring transfusions and other blood products. As with chicken pox, the Hepatitis B vaccine was developed in the 1970s; it is now being marketed only because the medical authorities have never figured out how to approach or 'target' the drug subculture in a useful way. Once again, when all else fails, the favoured solution is simply to vaccinate everybody.

In the past few months, the CDC and the American Academy of Pediatrics have decided to mandate Hepatitis B vaccination for all newborn babies,[16] and are still trying to decide whether to give it at birth or with the DPT at two months of age. It remains to be seen whether the American public, already increasingly upset about the vaccination issue, will simply acquiesce in this latest baptism of its newly born, explicitly intended as their very first immunological experience.

Although still technically optional, comparable trans-substantiations are also available at the other end of life. Originally intended for the entire adult population, the influenza and pneumococcus vaccines have never been popular, and several studies have shown them to be ineffective as well.[17] [18] When the swine flu 'epidemic' of 1978 never materialized, and thousands of vaccinees developed crippling Guillain-Barre syndrome, the American public began to question the concept of vaccination openly for the first time. Yet the elderly and infirm continue to be pressured heavily to accept these 'rejects' on a yearly basis as a form of extreme unction against both diseases.

Seemingly without limit, the search goes on, now indissolubly linked to the technology of genetic engineering. Currently in the works are vaccines against the Group A streptococcus, the common cold, and bronchiolitis, all of which are being bred into the gene pool of mice, rats, baboons and other experimental animals without any discernible caution or restraint.[19] A fitting denouement not far off is the AIDS vaccine, monstrous even in principle, since those at risk are already seriously immunocompromised: a suppressive vaccine would not only increase their chances of getting it, but help to soften up the general population as well.

The DPT story

Next I want to reconsider the DPT story, presently the major battleground of the vaccine controversy in the United States, and the area in which most of my own experience with vaccine-related illness has been concentrated. Thanks to consumer organizations like Dissatisfied Parents Together (DPT), and books like Harris Coulter and Barbara Fisher's *A Shot In The Dark*,[20] the plight of vaccine-injured children is beginning to be recognized and taken seriously by the general public.

In 1986, despite intensive lobbying by the AMA and other vested interests, congress belatedly enacted the National Childhood Vaccine Injury Act, which requires the Public Health Service to investigate all reports of vaccine injury and formulate guide-lines for compensation.[21]. Unfortunately, the Public Health Service and its subsidiary agency, the Center for Disease Control (CDC), can usually be counted on to look the other way, since a large part of their budget is earmarked for advocating and enforcing the same compulsory vaccination programmes.

Thus the new DPT compensation guide-lines rule out every condition other than the few already identified (collapse anaphylaxis, and brain damage), and everything chronic unless it appears less than seven days after the vaccination.[22] Even these massive exclusions are insufficient for many vaccine proponents, who still deny the encephalopathy charge as well.[23] [24]

So the battle continues, with no end in sight: the unit

cost of the DPT vaccine has sky rocketed, as have the number and size of personal injury awards against manufacturers, and many pediatricians are privately willing to give the DT alone if the parents insist. Meanwhile, pertussis has made a slight come back in the years 1986-88, when the CDC reported a 3-year total of roughly 10,500 cases.[25]

As in the case of the measles, the bureaucratic language effectively conceals the true demographics. Thus, of those cases with 'known vaccination status,' 63% had been 'inappropriately immunized', and 34% had not been vaccinated at all. We are meant to infer that the vaccine is nearly 100% effective, with very few cases in the vaccinated group. Only by reading the fine print do we learn that those whose vaccination status was 'unknown' (7700 cases) actually comprise more than 70% of the total. Since even its chief proponents concede the DPT to be the least effective of all the vaccines, my bet once again is that most or all the 'unknown' 70% were simply vaccinees without documentation acceptable to the Inquisitorial authorities.

Indeed, after reporting several cases in infants less than two months old, a Philadelphia pediatrician recently advocated that the DPT be given even earlier, ideally 'as early in life as possible'.[26] The sacramental status of vaccines is widely interpreted by public health officials as prior authorisation for vaccinating almost anyone against anything at any time.

My own patients

With that history as background, I want to speak about some of my own patients' illness related to the DPT vaccine, the one I am most familiar with. Because these cases can be very difficult to trace, I am reasonably sure that the other vaccines will prove just as important clinically when we know better how to recognize and look for them.

By no means the least of what homœopathy has to teach is its re-affirmation of the individual patient as the presiding genius of what the healer needs to know. Whereas modern medicine seeks to define itself quantitatively, as a set of technologies to identify and control the key numbers (antibodies etc), the vision of homœopathy is essentially qualitative, matching the unique energy of each patient with the singular totality of the remedy. If the following cases are acceptable evidence for my theories and speculations, they are the ultimate source of them as well.

While the DPT vaccine is specifically implicated in brain damage and a variety of other neurological syndromes, and many of these cases are amenable to homœopathic treatment, I want to concentrate today on cases that are far less serious but also more common, easier to understand, and more representative of the problem as a whole.

Both high fevers of unknown origin that were treated successfully with the corresponding nosode, my very first DPT cases illustrate the thought process by which specific symptoms may be added to the remedy picture of any given vaccine. While the history must ultimately show that the child has 'never been well' or quite the same since one or more DPT injections, this connection may not be obvious or even suspected unless specific questions are asked to elicit it.

In some cases, an abnormal white count and differential may give independent pathological confirmation: other examples include tender posterior cervical or retro-auricular nodes for rubella, parotid swellings for mumps, and the like. Naturally, symptoms like high fever that seem aberrant or unusual to the parent are more suspicious and therefore easier to trace. But only a curative response to the DPT nosode really suffices to prove that the illness in question was specifically related to the vaccine.

Case 1

A baby girl of eight months had had three episodes of high fever, typically 105°F or more, but lasting 48 hours at most. During the second episode, she was hospitalized for tests, but her paediatrician found nothing. Each time she felt quite well afterwards, and appeared to be growing and developing normally. The only other information I could elicit from the mother was that the episodes had occurred exactly one month apart, and that the first episode had come just one month after the last of her DPT shots, which likewise had been given at one-monthly intervals. With the help of these revelations, the mother was able to recall that similar fever episodes has also occurred after each injection, but her paediatrician had advised her to ignore them, since fever is perhaps the commonest reaction to the vaccine. I therefore give a single dose of *DPT* 10M, and the child never had another episode.

Case 2

A nine-month-old girl was brought in with a fever of 105°F and very few other symptoms. Two previous episodes had occurred at irregular intervals, and the parents, who felt ambivalent about vaccinations in general, had given her only one DPT shot, particularly since the first fever had come less than two weeks afterwards. After 48 hours of high fever unresponsive to acute remedies, a CBC showed a white count of 32,000, with 43% lymphs, 11% monos, 25% polys (mainly with toxic granulations), and 20% bands. With only the blood picture to go on, a paediatrician friend at once suggested pertussis. After *DPT* 10M, the fever came down in two hours, and the child has been well since.

These cases are noteworthy for two reasons; first, because they exhibited a characteristic symptom or 'keynote' (high fever) of the DPT vaccine; and second, because their responses to it were strong and healthy, such that their illnesses, although recurrent, soon resolved each time without chronic sequelae. But, like the brain-damaged cases, they are also the exception rather than the rule, instructive mainly in contrast with others less specific and therefore more difficult to trace.

In the following case, the vaccine appeared to act non-specifically, whether by exacerbating a pre-existing chronic condition or simply by casting a shadow over the background of a chronic condition that did not materialize until some time later. Because excellent results were obtained with the usual constitutional or miasmatic remedies, and the specific nosode often was not needed, the vaccine connection could not always be proved. In other instances, the nosode was used later to remove a quasi-miasmatic 'block', when seemingly well-indicated remedies no longer worked or failed to hold or act deeply.

In general, these cases are reminiscent of the way that grief, physical injury, or some other stress often simply exacerbates the pre-existing miasmatic or chronic disease structure, rather than substituting the specific picture of *Ignatia*, *Arnica*, or the usual 'never well since' remedies. In another large subgroup, the symptoms specific to the vaccine and those already latent or pre-existing in the patient are all mixed up together, and begin to disentangle only as the treatment progresses.

Far from being restricted to any particular category, vaccine-related illness similarly encompasses the full range of chronic diseases in children, from asthma, eczema, and

allergies to otitis media, far and away the commonest in my practice, as well as learning disabilities and emotional and behaviour problems.

CASE 3

A girl of six was brought in for being 'sick all the time', especially with ear infections, which she had had repeatedly since the age of five months, when she was given antibiotics for four months without interruption. Especially vulnerable in the fall and with abrupt changes in the weather, she would often become 'grumpy' when ill and lost her appetite, but rarely had fever or earache. Although showing no obvious reaction to her regular DPT shots at two, four, six and eighteen months, she had another ear infection for four months soon after her last shot, just before entering first grade. Over the next eighteen months, she did beautifully on *Sulphur*, *Pulsatilla* and *Mercurius* constitutionally: she began to have acute illnesses from time to time, but responded well to the usual remedies, never needed antibiotics, and seemed perfectly well in between. Three years later, after a long hiatus, her mother reported that she had not missed a single day of school and required no further treatment.

CASE 4

A five-year-old girl was brought in for treatment of seasonal asthma, which had begun the previous spring, did not respond very well to the usual drugs, and worried both parents in view of their own allergic histories. When she was weaned at thirteen months, her health problems began with protracted ear infections, often associated with teething, and requiring frequent antibiotics. While her first set of vaccinations were tolerated without any obvious reaction, she had recently developed pneumonia and high fever two weeks after her five year DPT booster, followed by the return of her asthma for the first time in the dead of winter. After two years of treatment, mostly with *Arsenicum album*, *Phosphorus* and *Lachesis*, her health slowly improved to the point that she no longer needed drugs or remedies, even during allergy season, and the nosode was never given.

CASE 5

A two-year-old boy was brought in for treatment of recurrent ear infections that tended to drag on for months and responded only temporarily to antibiotics. His first ear infection followed an upper respiratory tract infection at six months of age, and was picked up on a routine medical check up with no symptoms whatsoever, although at other times he often complained of earache. But his worst illnesses had been acute episodes of high fever and prolonged screaming at the time of his first two DPT shots, after which he was given the DT only with no obvious reaction. While his ear infections quickly subsided with the aid of *Calcarea sulphurica* and *Tuberculinum*, he developed jealousy and tantrum behaviour around the birth of a baby sister a year later, and was eventually given *DPT* 10M when the seemingly indicated remedies failed to help. Now four years old, he is healthy, free of ear infections and continuing to grow and develop normally.

CASE 6

A baby girl of ten months was brought in with acute otitis (high fever, earache, screaming), her fourth such attack since the age of two months, each one beginning soon after stopping the antibiotics from the one before. Weaned at two months when her mother returned to work, she could not tolerate lactose formulas but did well on soy milk. When her first DPT shot was followed by a week of cranky behaviour, she was given only the DT thereafter and did not seem to react to it. Her ear infections stopped readily enough after *Chamomilla* and *Calcarea carbonica*, but recurred eight months later, when her parents separated and the MMR was given while she was visiting her father. Again she did beautifully on remedies, mainly *Lycopodium* and *Sulphur*, despite occasional relapses, including another following a DPT booster that the father engineered, which ended only after the DPT nosode was given. Over the last four years, I have continued to see her after occasional acute illnesses which her father again 'took care of' with conventional treatment, with progressively longer intervals of good health between them.

CASE 7

After five episodes of otitis media treated with antibiotics, a 16-month-old boy was referred to me for constitutional treatment. Colicky for the first three months of life, he developed acute otitis with fever at about six months, but all subsequent episodes were afebrile. He likewise reacted violently to his first DPT shot, with vomiting and 'hard crying', somewhat less so to the second (with 'sad' crying and general malaise), and not at all to the third or the MMR, which had just been given a week before I saw him. Less than three days after a dose of *Sulphur 10M*, he developed a high fever and diarrhoea, from which he soon recovered. Next he was given *Calcarea carbonica* 10M, and *Calcarea sulphurica* 12 to be used as needed at the threat of a cold, and there were no more ear infections or remedies for well over a year. After another round of *Sulphur*, he has been well for the past three years, and the nosode was never needed.

CASE 8

A boy of three had never reacted to any vaccination, and had appeared to be in good health until eight months prior to seeing me, when he came down with a flu-like illness, followed by otitis media, and antibiotics were prescribed. According to the mother, he seemed lethargic while taking them, and generally 'not himself', with outbursts of stuttering and a foul diarrhoea from which Giardia lamblia was isolated. At this point he was found to have no gamma-globulins in his serum, and had to be given transfusions on a regular basis. Over the next six months, he was treated successfully with *Influenzinum*, *Stramonium* and *Cuprum*, followed by *Sulphur* the following year. Within a few weeks his serum proteins rose dramatically, the stuttering subsided, and he continued to improve steadily after that. The transfusions were discontinued after a year, and he has remained well since. No nosode was needed, and no one vaccine could be implicated. Yet total unresponsiveness to vaccines and total immune collapse are two similar ways in which any vaccine could act non-specifically to weaken the immune system of a sensitive individual.

CASE 9

A girl of fifteen months was brought in for repeated ear infections and antibiotics since her first round at four months of age. Associated with typical upper respiratory tract infection symptoms, ear involvement was often signaled by pain, but she had never had a fever in her life. An hour after her first DPT shot, she woke up from a nap screaming, and soon developed her first cold. Another followed her second dose, with earache two days later, around the time when her mother weaned her to go back to work and put her on milk-based formula. Yet another followed the third dose, the

eardrums failed to improve on antibiotics, and the mother decided to try homœopathy eight months later, when myringotomy was proposed. Responding miraculously to *Calcarea carbonica.*, her ears cleared up, and she cut three teeth in less than two weeks, but then developed persistent diarrhoea after a bottle of cows milk. Less than an hour after the nosode was given, she came down with a high fever, the diarrhoea was gone by the next day, and her health has improved steadily ever since, with no ear infections reported or new remedies needed in the past five years.

Analysis

As documented in many of these cases, the evolution of otitis media in recent years exactly parallels the theoretical concerns outlined above. In the early 1960s, as a medical student, I saw acute ear infections daily in the emergency room, with high fever and violent earache. Almost always, they would respond dramatically to penicillin at levels of 100,000 units daily or less. If the eardrum had already burst, as often happened, the child would recover promptly and completely without any treatment at all.

Today, although such cases are still seen occasionally, otitis media is predominantly a chronic or relapsing illness, with significantly less fever and pain than in the past. In a surprising number of cases, there are no symptoms whatsoever, and the diagnosis is made solely on morphological grounds at the time of a routine examination. For presumably the same reasons, it is much likely to heal spontaneously or to respond favourably to antibiotics, has a much greater tendency to relapse soon after the drugs are stopped, and is more often associated with chronic or residual symptoms such as behaviour problems, learning disabilities, swollen tonsils, and hearing loss. Recent studies further indicate that tubes inserted to facilitate drainage, the most advanced technology presently available, are themselves an important cause of permanent hearing loss, the spectre always used to justify them.

To be sure, many immunosuppressive factors other than vaccines also have to be considered, such as the widespread use of antibiotics, the development of resistant organisms, urban and industrial pollution, and doubtless many more.

But my fear is that any other chronic disease would tell the same tale. In addition to their specific effects, only a few of which have yet been identified, each vaccine probably has immunosuppressive or non-specific effects that would look quite different for each patient, promoting chronic at the expense of acute responses, i.e., having to do with 'style' rather than content. In the case of the DPT vaccine, and probably for the rest as well, the net will have to be widened to include enuresis, eczema, asthma, allergies, nervous and mental diseases auto-immune phenomena, cancer and indeed the whole spectrum of pediatric and adult medicine.

Research and political will

I now want to address the most important and difficult problems of all: the research that will have to be done in the future, and the political will that will be needed to carry it out. Both questions are inseparably connected, and both will need radically new models to succeed.

Because current studies ignore and indeed preclude any concept of the total health picture over time, they cannot provide unambiguous information about how vaccines act. At the same time, controlled scientific investigations based on the totality of symptoms will require a large population of unvaccinated kids, just what the existing laws are designed to prevent. To those parents who decide not to vaccinate we therefore owe a considerable debt of gratitude.

Similarly, the accusation that unvaccinated children help propagate the various diseases and thus threaten the rest of the population cuts both ways. For the extent to which this argument is true also admirably quantifies the ineffectiveness of the vaccines: if the 'immunity' they conferred were genuine and lasting, the unvaccinated kids would pose a threat only to themselves.

Furthermore, it will not be possible to study each vaccine independently unless we legally authorize parents to choose some vaccines but not others. At present, even the most liberal states allow parents to refuse all vaccinations across the board, on religious or philosophical grounds, but not to make informed medical decisions for their children. Once the vaccines are made totally optional, as in the UK, the experimental and control groups can become purely self-selecting for each vaccine, with those receiving it matched as closely as possible to those exempted.

Once these groups are in place, it will be necessary to follow them prospectively for at least a generation, if not a lifetime. For the present, pilot studies could also be done retrospectively, using other kids with known vaccination histories.

But by far the most difficult and important questions are the inextricably connected theoretical one of what to measure and the technical one of how to measure it. As homœopathic clinicians, we already have a reasonably good sense of how to ascertain a working totality of symptoms tailored to our individual patients and how to follow them over time.

In studying large populations, we will eventually need to select a few key variables sufficiently broad and inclusive to reflect the most fundamental aspects of human functioning, yet also flexible enough to accommodate the infinite richness and diversity of real people. Which ones we choose will then further determine and be determined by the techniques with the requisite detail and precision for measuring them.

Probably this means that we will not really know what we need to measure until we have followed a much smaller pilot group more extensively for a shorter period of time, perhaps four or five years, and just see what happens. In any case, the homœopathic agenda - the total health picture over time - remains the best available methodology for such an investigation; and any progress we can make towards it will automatically contribute to research design in biomedicine generally.

How, then, is one to investigate the total health picture of large populations over time? Clearly, we need to look at the elements of the standard medical history, and to follow the incidence and severity of the usual acute and chronic diseases. Regular physical and laboratory examinations might also suggest persistent or subclinical changes of a more constitutional or chronic type, such as swollen nodes for rubella, abnormal white cell and differential counts for pertussis, and non-specific developmental criteria (height and weight, dentition, gross and fine motor co-ordination, vision, hearing etc) for all the vaccines.

Other important variables lying outside the medical history per se would include intelligence, language, socialization in family and school settings, and other demographic, socio-economic, and psychological factors (poverty, race, learning disabilities, behaviour and emotional problems, school attendance and performance).

On the other hand, pilot studies of the pneumococcus

and influenza vaccines might need only a few simple variables, because they are given primarily to elderly people at high risk or in nursing homes, when their chronic disease structure is already more or less firmly established. Under these circumstances, a reasonable first approximation of how these vaccines act might be simply to measure their effect on the life span, the sheer ability to survive, compared to that of their unvaccinated friends and neighbours.

A NOTE OF OPTIMISM

Finally, I want to explain why, in spite of the very considerable dangers I have been talking about (and innumerable others we all could mention), I remain strangely optimistic about the future of the healing arts. The principal reason has to do with the growing awareness of ordinary people taking more responsibility for their own health and more control over their transactions with the medical system as a whole.

In the United States, the movement for free choice in health care now includes not only such groups as DPT, but also the supporters of midwifery, home birth, homœopathy and other forms of alternative or complementary medicine, and even of the right to die. Within the last twenty years, all of these groups have already achieved major changes in the conventional doctor-patient relationship. Now that the American economy is manifestly unable to afford the present health care system, no matter how it is organized, it is virtually certain that these changes will continue to accelerate, and that organized medicine will face further repudiation until it accepts them.

In the meantime, lest you suppose that I am opposed to religious concepts in medicine entirely, I will cite three aphorisms of Paracelsus, which offer a practical and ecumenical theology of healing that virtually all of us whatever discipline can accept and live by, without having to ram them down anybody's throat:

§ The art of healing comes from Nature, not the physician ...
§ Every illness has its own remedy within itself ...
§ A man could not be born alive and healthy were there not already a physician hidden in him.[27]

Taken together, these sayings amount to a summary of everything that the present medical system has left out:

HEALING IMPLIES WHOLENESS

Etymologically, the verb 'to heal' comes from the same Anglo-Saxon root as 'whole'. 'Healing' means simply to make whole again, is a basic attribute of all living systems, and is evident in spontaneous recovery from illness and in effective medical and surgical treatment as well. Because it represents a concerted response of the entire organism, it implies a totality, a purely qualitative integration on a deeper level that can be defined by any assemblage of parts or approximated by any quantitative measurement.

ALL HEALING IS SELF HEALING

As a fundamental property of all living systems, healing is going on all the time, and thus tends to complete itself spontaneously, with or without external assistance. This means that all healing is ultimately self-healing, and that the role of physicians and other professional or designated 'healers' is essentially to assist and enhance the natural process that is already under way. The mechanical correction of abnormalities might be perfectly legitimate in some instances, but primarily in relation to the more fundamental standard.

HEALING APPLIES ONLY TO INDIVIDUALS

Always possible but also problematic, even risky, healing applies only to individuals in unique here and now situations, rather than to abstract 'diseases', principles or categories. In other words, it is inescapably an art, and can never be (and should never be) reduced to a technique or procedure, however scientific its foundation.

I should like to add a fourth principle governing the doctor-patient relationship, which is not exactly theological, but may have to be affirmed as a fundamental political and legal right, as in the *Magna Carta* or the American *Bill of Rights*:

> Health, illness, birth and death are inalienable life experiences belonging wholly to the people undergoing them. Nobody else has the right to manipulate or control them, or any part of the body involved in them, without their explicit request or that of somebody authorized by them to act on their behalf.

My concluding principle was contributed by Lao Tzu, and supplies an appropriate 'bottom-line' criterion:

> A leader is best when people barely know he exists,
> Not so good when people obey and acclaim him,
> Worst when they despise him.
> Of a good leader, when his work is done and his aim fulfilled,
> The people will say, "We did this ourselves".[28]

APPENDIX: SOME RELEVANT RUBRICS

Mind; ANXIETY; vaccination, after: Thuj.
Mind; DISCONTENTED, displeased, dissatisfied; inflammation of eyes, in chronic, with otorrhoea, after vaccination: Thuj.[2]
Mind, IMBECILITY; vaccination, after: Thuj.[2]
Mind; IRRITABILITY; abscess, in, after vaccination: Apis[2]

Head Pain; GENERAL; vaccination: Thuj.[8]

Eye; INFLAMMATION; vaccination, after: Thuj.

Stomach; NAUSEA; vaccination, after: Sil.
Stomach; PAIN; General; vaccination, after: Thuj.

Rectum; DIARRHOEA; vaccination, after: Ant-t., Sil., Thuj.

Respiration; ASTHMATIC; children; vaccination, after: Thuj.
Respiration; ASTHMATIC; vaccination, after: Thuj.

Cough; VACCINATION, after: Thuj.

Extremities; EMACIATION; Upper Limbs; vaccination, after: Maland., Thuj.
Extremities; ERUPTION; Leg; pustules; vaccination, after: Sulph.
Extremities; FELON; run-around; vaccination, after: Thuj.
Extremities; PARALYSIS; Lower Limbs; vaccination, after: Thuj.
Extremities; SUPPURATION; Fingers; nails; vaccination, after: Thuj.
Extremities; SWELLING; Shoulder; vaccination, after: Apis, Thuj.
Extremities; SWELLING; Upper Arm; vaccination: Sil., Sulph., Thuj.

Sleep; RESTLESS; vaccination, after: Thuj.[2]
Sleep; SLEEPLESSNESS; vaccination, after: Mez.[3], Thuj.[3]

Skin; ERUPTIONS; vaccination, after: Crot-h.[8], Mez.[12], Sars.[34], Skook.[12]
Skin; ERUPTIONS; eczema; vaccination; agg.: Mez.[8]
Skin; ERUPTIONS; eczema; vaccination; after: Maland.[8], Skook.[12]
Skin; VACCINIA: Acon.[8], Ant-t.[8], Apis[8], Bell[8], Merc.[8], Phos.[8], Sil.[8], Sulph.[8], Thuj.[8], Vac.[8]

Generalities; CONVULSIONS; vaccination after: Sil., Thuj.[8]
Generalities; VACCINATION, after: Acon.[8], Ant-t.[5], Apis[1], Ars., Bell.[6], Bufo[7], Carc.[535], Crot-h.[8], Echi., Graph.[12], Gunp.[129], Hep., Kali-chl., Kali-m.[2], Lac-v.[12], Maland., Merc.[5], Merc-sul.[8], Mez.[7], Nat-bic.[535], Ped.[7], Phos.[12], Psor.[7], Rhus-t.[5], Sabin.[2], Sarr.[535], Sars.[7], Sep.[8], SIL.[7], Skook.[12], SULPH.[7], Syc-co.[114], THUJ.[7], Tub.[2], Vac.[6], Vario.[5]
Generalities; VACCINATION, after; prophylactic: Sulph.[5], Thuj.[5], Vario.[5]
Generalities; WHOOPING; ailments after: Carb-v.[535], Carc.[535], Per.[535], Sang.[8]

Note that many of these rubrics refer to vaccination against smallpox. It appears that *Sulphur* may be third in importance to *Thuja* and *Silica* in these rubrics. These rubrics are taken from the *Complete Repertory* compiled by Roger van Zandvoort for MacRepertory™. Adding them to this article by Richard Moskowitz was suggested by Caroline Schuck, and edited by Francis Treuherz.

ADDITIONS CODE

No reference number Kent *Repertory*
1 Kent other sources
2 Knerr
3 Boenninghausen
6 Stauffer
7 Schmidt
8 Boericke
12 Clarke
34 Hering
114 Paterson
129 Anshutz
535 Kokelenberg & Dockx

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