Vaccines, Drugs, and Other Causes: A Homeopath Looks at the Medical System Part 2

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Abstract: Allopathic medicine utilizes a model of causality based on superior physicochemical force, which relies on the effect of external agents, and puts patients at risk by seeking to override their individual predispositions. Thus, adverse effects of vaccines tend to be overlooked, because they entail pre-existing tendencies that are characteristic of the patient, and could conceivably occur even if the vaccine were not given. My cases are exaggerated versions of what is already there, run the whole gamut of pediatric diseases, and can best be understood as non-specific reactions to vaccination *per se*, rather than to any specific vaccine.

The pharmaceutical industry seeks drugs with the power to control single biochemical reactions in almost everyone who takes them, while adverse reactions represent a diverse array of individual "side effects," each far less common and buried in the fine print. But when added up together, the risk of *something* bad is very significant indeed.

Consequently, spontaneous cures requiring no further treatment are dismissed as "placebo," while drugs are deemed effective only if they can overpower the physiology of as many patients for as long a time as possible. A new research model is proposed in which the placebo effect is maximized, nobody is blinded, and the comparative effectiveness of homeopathic and allopathic treatments are measured on the basis of the totality of symptoms and followed over extended periods of time.

Keywords: allopathic vs. homeopathic medicine, their divergent views of disease and healing; vaccine reactions, allopathy's limited recognition of; vaccine reactions, homeopathic treatment of; individual predispositions to disease; conventional medicine as a causation of disease; causes of disease, Bernard's perspective; side effects; placebo effects; spontaneous cures

2. Hidden in Plain Sight: Adverse Reactions to Vaccines

I will start with the example of vaccines, a subject which I have thought about for most of my career, not least because the United States requires them of all children to an extent that is unparalleled in the developed world, a circumstance that dramatizes and gives real immediacy to the same problem I have been speaking of. The vague uneasе I have always felt about mandating them began to make more sense when I became interested in homeopathic medicine, which reminded me of the obvious but unremembered truth that medicines have the power to elicit a totality or *array* of symptoms, not just the one we happen to be interested in at the moment. In contrast, vaccines need achieve just two limited and predefined goals to be deemed effective, namely,

1) a significant reduction in the incidence of the corresponding natural disease, and
2) a measurable titer of specific antibodies in the blood.

But *how* they achieve these results - their actual mechanism of action - and whatever *else* they do along the way, are not thought to be interesting questions, or in any case are rarely talked about.

How much this simple schema leaves out is evident in the tale of a 10-year-old boy who developed the nephrotic syndrome soon after his MMR vaccination. One of the clearest and most obvious examples of an adverse reaction that I am personally acquainted with, it was nevertheless adamantly denied to be so by every one of the doubtless sincere and well-meaning physicians who cared for him. Although he lived nearly a thousand miles away, and I know of him solely from his mother's letter, her words were so heartfelt and so congruent with the rest of my experience that I cannot imagine them to be anything but the honest truth:

> "My son Adam was healthy until his first MMR at 15 months. Within 2 weeks he had flu and cold symptoms, which persisted for 6 weeks, at which point his eyes became puffy, he was hospitalized with nephrotic syndrome, and a renal biopsy showed "focal sclerosing glomerulonephritis." When it didn't respond to steroids, I asked if it could be related to the vaccine, but they told

me it couldn't, and we accepted that. Over the next 4 years he was hospitalized repeatedly, and missed many months of school, but finally went into total remission, seeming normal and healthy and staying off all medications for about 5 years.

"When he turned 10, his pediatrician recommended a booster, saying that a rise in measles cases made it dangerous for him not to be protected. Checking the PDR and other sources, I found no contraindication for kidney disease and no listing of nephrosis as a possible adverse reaction, so I agreed to it. In less than 2 weeks he relapsed, with 4+ protein in his urine, swelling, and weight gain, signs that we recognized immediately. He got worse even on Prednisone, and was admitted in hypertensive crisis, with blood in his urine, fluid in his lungs, and massive edema. On Cytoxan, high doses of Prednisone, and three other drugs, he slowly improved, but missed another 7 months of school.

"It's been 2 years since that horrible episode, and he still needs Captopril daily for high blood pressure and spills 4+ protein every day. The doctor says that he sustained major kidney damage, will always need medication to control his blood pressure, and will worsen as he grows older, necessitating a transplant eventually. This time I was sure that his condition was related to the vaccine, but still the doctors didn't take me seriously, and told me it was a coincidence.

"I began searching for information, and even contacted the manufacturer of the vaccine. Finally they sent me two almost identical case reports of nephrotic syndrome following the MMR vaccine. It's difficult for laypeople to get information or even ask questions, since we don't use correct medical terms and are made to feel stupid. Please tell me if my ideas are reasonable.

"I don't think my son could tolerate another episode, and I think he'd have normal blood pressure and kidney function today if not for that second vaccination. I also have a great concern for other children who develop nephrotic syndrome some weeks after receiving the MMR and whose doctors never make the connection. They could all be at great risk if revaccinated. I realize that this letter has taken up a great deal of your time, and I'd appreciate any help you can give me. If we were closer, I'd make an appointment to see you in person, so please feel free to charge me. Thank you."[7]

This woman no longer doubted that her son's life had been ruined and cut short by the vaccine, yet had no thought of suing the drug company that made it, the doctor who prescribed it, or the Federal Vaccine Injury Compensation Program (VICP), as she was legally entitled to do, a lack of ulterior motive that only lends further credence to her story. She wrote solely for independent validation of what she had witnessed first-hand on two separate occasions and had been forced to endure the consequences of ever since, a causal link that would be obvious to any eighth-grader of average intelligence. Yet even when the vaccine manufacturer belatedly provided two almost identical cases of their own, each of the boy's physicians independently and without hesitation continued to dismiss his misfortune as a coincidence. Today, almost twenty years later, renal failure has still not been recognized as an adverse effect of the MMR vaccine, an omission that would also have assured the boy's defeat in court, had his mother chosen that route. This glaring discrepancy between the boy's catastrophic illness and the ease with which the doctors and vaccine manufacturers escaped having to take any responsibility for it will serve to introduce the profound mystery that inspires my talk today.

According to the official guidelines, damages from a vaccine merit compensation if they can be shown to be a necessary and predictable effect of that particular agent. With one or two exceptions, all of the listed complications are sudden, acute, and catastrophic *events* that appear full-blown within hours or at most a few days after the vaccine and result in death or permanent injury. The classic example is anaphylaxis, which oddly enough can occur after *any* vaccine, and thus has no specificity whatsoever.

Reportable Events Following Vaccination[8]

As for *chronic* conditions, only two have ever occurred with sufficient frequency to be considered seriously for inclusion, namely, "DPT encephalopathy" and "autism," both of which tend to appear somewhat more gradually, with a time lag of days or weeks after the vaccine, and to follow a chronic course, like ongoing, self-sustaining *illnesses*. In both cases, physicians advocating compulsory vaccination, many with financial and other ties to the industry, have succeeded in keeping them off the list, or at least tightening the eligibility rules so drastically that almost all damage claims against them are defeated, however catastrophic the outcome.

"DPT encephalopathy" achieved considerable notoriety in the 1980's, when thousands of brain-damaged children won large court awards or settlements against the manufacturers, and this broad, nondescript entity was reluctantly accepted as a *bona fide* complication of the triple vaccine, particularly its whole-cell pertussis component. Here is a typical case, sent to me by the lawyer who represented him, involving a 3-year-old boy who reacted badly to his first DPT shot and suffered permanent brain damage after the second:

"Our firm represents a child who was born normal and healthy in every way. After his first DPT at 6 weeks, he began falling off growth charts, exhibited multiple developmental delays, and was diagnosed as "failure to thrive," but then slowly began to recover. At 5 months he received a second DPT, and his delays became much more extreme. He has never recovered. He is now 3 years old, with the mental capacity of an infant of a year-and-a-half. I am convinced that his problems came about as a result of the DPT. In view of what happened after the first shot, he should not have had the second, or at

least the pertussis component of it."[9]

While the information provided was very limited, the boy's serious and prolonged reaction to his first DPT, from which he eventually recovered, should have warned and indeed *did* warn his pediatrician against giving him the second, but it was merely postponed for a few months. This tragic pattern of a warning ignored - a lesser version of the same illness with eventual recovery, followed by death or irreversible brain damage after a subsequent vaccination - helped fuel a major public uproar, in response to which Congress passed the Vaccine Injury Compensation Act of 1986, which created a Federal reporting system and no-fault hearings for *all* vaccine injuries, and authorized compensation for damages at taxpayers' expense when vaccines were shown to have been at fault. In reality, however, the effect was just the opposite - a precipitous decline in the number and size of awards, a further tightening of the guidelines, and a vigorous counterattack by physicians of the vaccine establishment like this one, who rejected even the *concept* of DPT encephalopathy as essentially a coincidence:

> "Dr. [Edward] Mortimer's article is the third controlled study in recent months to examine the risk of seizures and other acute neurological illnesses after the DPT. In these studies, involving 230,000 children and 713,000 vaccinations, no evidence of a causal relationship was found between the vaccine and permanent neurological illness. *It is clear from these recent studies that the major problem has been the failure to separate sequences from consequences.* Now is the last decade of the 20th Century, and it's time for the myth of 'DPT encephalopathy' to end." [Italics mine: R. M.][10]

By 1996, with the scandal largely contained, the Center for Disease Control (CDC) and its Advisory Committee on Immunization Practices (ACIP), led by the same coterie of physician-advocates, published its official Report on DPT Encephalopathy. Rather more judicious in tone, this policy document briefly acknowledged the fact of ruined lives, but then blithely concocted three distinct levels of possible causal influence, concluded that it was impossible to tell them apart, and jumbled them all together into a tangle of obfuscations, equivocations, and government bureaucratese:

> "Rare but serious neurological illnesses, including encephalitis, encephalopathy, and prolonged convulsions, have been anecdotally reported following the whole-cell DPT. *Whether the vaccine causes such illnesses or is only coincidentally related to them has been difficult to determine precisely."*

The National Childhood Encephalopathy Study and others have provided evidence that the DPT can cause encephalopathy. This occurs rarely, but children who had a serious neurological event after DPT were significantly more likely than their controls to have chronic CNS dysfunction 10 years later and to have been given the DPT within 7 days of its onset.

The Committee proposed three possible explanations for this association:

1) the illness and dysfunction could have been *caused* by DPT;
2) the DPT could *trigger* these events in children with brain or metabolic abnormalities who might also experience them if other stimuli such as fever or infection are present; and
3) the DPT might cause the acute event in children with underlying abnormalities that would inevitably have led to the chronic dysfunction even without it.

> *"The data do not support any one explanation over the others. The balance of evidence was consistent with a causal relationship between the DPT and CNS diseases in children who developed acute neurological illness after the vaccine, but insufficient to determine whether it increases the overall risk of them 10 years later.* SIDS is listed on death certificates as cause of death for 5000-6000 infants each year in the United States. Because the peak incidence is at 2-4 months of age, many instances of a close temporal relationship between the DPT and SIDS are to be expected by simple chance." [Italics mine: R.M.][11]

The ACIP Report gives lip service to the *possibility* of a chronic reaction, but only if the vaccine *forces* it to occur: the only type of "cause" that it allows is one powerful enough to compel the desired effect to occur in a preponderance of cases, using the same standard that Claude Bernard had proposed so long ago. According to the Report, DPT encephalopathy falls well short of it, because the authors claimed they could not distinguish between patients victimized or passively acted upon and those with pre-existing tendencies to react in the same way, either to a *precipitating* cause in those already mildly or potentially ill, or merely to one *incidental* cause among many other possibilities in those predestined to get sick.

In other words, to be recognized and compensated as such, victims must prove the absence of any pre-existing tendency to react in such ways, in spite of the fact that

1) it is famously difficult to prove a negative, and in clinical practice it is almost impossible to imagine a situation where we could know that someone is *fated* or predestined to become ill in the future;

2) almost every illness in every patient requires both external morbid influences and individuals sensitized or at least receptive to them; and

3) even the experts insist that they can't tell the difference.

Simply by *postulating* an ambiguity to dismiss the concept of "DPT encephalopathy," the ACIP Report also comes perilously close to disqualifying every other such claimant, both now and in the future, implying that *there are no other adverse reactions out there*, and that *there can't be any*, by quietly relying on the same truism that their strict notion

of mechanical causality had previously been invoked to rule out, that such individualizing tendencies are invariably present after all.

The Report is equally inconsistent for a second reason, that almost all of the adverse reactions that the ACIP and the courts *do* allow are acute *events*, which are extremely rare, and clearly involve a very high degree of predisposition, as we saw. On both counts, it defies ordinary experience, simple logic, and common sense to try to restrict the term "cause" to a fixed quantum of force achieving the same effect in most of the people subjected to it, when the only situations in which that standard seems usefully applicable are emergencies, like surgery, car accidents, gunshot wounds, and other traumatic injuries, or anatomic dissection of dead bodies, since they at least are no longer susceptible.

But its most important flaw is at the other end, in its *conclusion*, since even an innate or pre-existing tendency to react in a certain way by no means absolves vaccines of *some* level of causal role in the outcome. In any of its three hypothetical scenarios, even the one that it is virtually impossible to imagine or accept, a significant misfortune has befallen a patient as a result of being vaccinated that very probably would not have occurred if he or she had not been. By trying to disprove too much, the advocates of mandatory vaccination thus end up proving *nothing;* for whatever the extent to which a vaccine may contribute to a patient's illness, it is decidedly more than a *coincidence*.

In any case, exactly as one would expect, the same fallacy is regularly invoked to close off the debate surrounding autism, the other serious contender for inclusion in the official guidelines, an equally broad, generic, and far more prevalent form of serious brain damage in children. So named and first described by the psychiatrist Leo Kanner in 1943, curiously enough just one year after the DPT vaccine was introduced, since the 1990's it has been diagnosed with ever-increasing frequency, to the point that today, less than two decades later, it has been shown to affect tens of millions of young people at a rate that even the CDC calculates at roughly one percent of eight-year-olds,[12] making it by far the leading cause of brain damage in American children.

Here again, the public clamor and outrage have so far been contained and to some extent dissipated by numerous studies purporting to show no causal connection with the MMR or any other specific vaccine, in the face of voluminous anecdotal evidence and well-designed experimental research to the contrary, and marshalling the very same arguments against them. As with the cases of DPT encephalopathy, these are not empirical judgments, based on actual histories of victims, but purely statistical analyses based on the policy of vaccinating *everybody,* which relegates even these millions of damaged lives to the waste-basket category of predisposed and thus already tainted individuals, whose misfortune cannot be simply imputed to any one vaccine, a conclusion that for once I actually agree with.

A specific causal link to a particular vaccine remains the "smoking gun" that both sides of the debate are looking for, whether because or in spite of the fact that the only methodology currently available all but guarantees the impossibility of ever finding it. Like the Holy Grail, the quest for specific effects of particular vaccines is a mirage, a figment of the imagination that our limited notion of cause and effect conjures up and dangles irresistibly before our eyes. Although they all occur with some frequency, even the adverse reactions that have been proposed by the anti-vaccination movement - DPT encephalopathy, DPT and SIDS, MMR and autism, Hepatitis B and auto-immune disease - are all broad, generic pathological categories that are poorly defined and have been documented to follow other vaccines as well. "Autism," for example, is essentially another name for brain damage or "encephalopathy," and has also been diagnosed in DPT cases,[13] while SIDS has been reported after the Hep B,[14] and may have more to do with the special vulnerability of early infancy than the particular vaccines that happen to be administered at that time. As for Hepatitis B and the ever-increasing roster of autoimmune diseases that have so far been linked to it, my own experience leads to the conclusion that autoimmune phenomena are an essential component of how *all* vaccines work, and tend to turn up wherever we look for them, as if indicative of chronicity itself.

This brings me to the adverse reactions that I have seen in my own practice, which are common enough to be the rule rather than the exception, involve conditions that may be latent or already manifest *before* the child is vaccinated, and are likely to be precipitated, activated, intensified, and made more chronic in the same way by *any* vaccine, often by two or more different ones in the same child. For all of these reasons, I regard them as essentially non-specific reactions to the vaccination process itself, rather than to any one vaccine. Without exception, they involve a definite susceptibility or pre-existing tendency of these individuals to react in a way that becomes characteristic of *them*, therefore do not qualify for compensation, and are often invisible to doctors and parents alike until the child recovers for an extended period of time, and then relapses promptly after another vaccine or combination is given.

Encompassing the full spectrum of illnesses and diseases that pediatricians and family physicians habitually deal with, and all degrees of severity, they include asthma, eczema, otitis media, sinusitis, allergies, ADD, autism, and learning and behavioral problems, as well as a variety of less common diagnoses, and even more idiosyncratic reactions that have no name at all. Like any primary immune response, they often take fourteen days or more to develop, and thus fall into the category of chronic illnesses, rather than acute events, and easily fly under the radar, as we saw, but are by no means necessarily minor or trivial.

Here are a few typical cases. I'll begin with one of the simplest to recognize and easiest to understand, an eighteen-year-old girl whose childhood patterns of OCD and enuresis were abruptly reactivated after years of good health by an MMR booster newly required for attending college:

A patient of mine since early childhood, this eighteen-

year-old girl was preparing to leave for college. In primary school, she had been plagued by enuresis and a variety of obsessive-compulsive symptoms, which she had overcome completely with the help of *Arsenicum album* in various potencies, remaining more or less symptom-free for over ten years without ever having to repeat it. Within a week after the required MMR booster, her old pattern of bedwetting and OCD behavior returned in full force, and she came seeking treatment on her own for the first time. One dose of *Arsenicum album 1M* was rapidly effective, and she completed her first two years at a top liberal arts college with a brilliant academic record, repeating the remedy at rare intervals. She has since graduated with honors, served challenging internships in rural Latin America without major difficulty, and has not needed further treatment.[15]

Another common pattern is exemplified by this fifteen-month-old baby girl, who had already endured eleven ear infections and eleven rounds of antibiotics by the time I saw her:

Otherwise in good health, a chubby girl of fifteen months was brought in for repeated ear infections, which had never cleared up despite eleven rounds of antibiotics. After a good pregnancy and easy labor, her mother chose not to nurse, and the child developed her first ear infection with a fever of 103° at two months of age, soon after her first DPT, HiB, and polio combination. All later episodes were afebrile, most with fretting, screaming, and pulling at the ear, and were relieved by being carried about; but twice she had no symptoms whatever, was treated because the pediatrician found some fluid on otoscopic exam, and developed persistent diarrhea both times.

I asked the parents to stop vaccinating her for a while, and gave her a dose of *Calcarea carbonica* 200 preventively and *Pulsatilla* 30X to take as needed in the event of a flare-up. Two weeks later, she came down with a replica of her first episode, a high fever with intense screaming, which cleared up with *Pulsatilla* in a day or two. By her next visit, three months later, she had recovered completely and was thriving in every way. That was more than three years ago, an interval during which she has had no ear infections, no antibiotics, and no more shots.[16]

As often happens, the vaccine connection seemed rather tenuous at first, the only clear indication being her first episode at two months, after her first DPT, HiB, and polio series, after which her condition became chronic and the later shots made no further difference. What was striking about it was that the episode after homeopathic treatment was just like her first one, with fever and violent earache, and resulted in complete recovery. Hers and other such cases have taught me to regard acute illnesses with fever as a favorable sign of strong vitality and a healthy immune system that can mount a vigorous response to infection, as it seems innately programmed to do.

Another infant exhibited her own distinctive pattern of recurrent ear infections in response to two different vaccine combinations, beginning with the DPT, HiB, and polio, then even more intensely after the MMR:

A baby girl of ten months was brought in for otitis media, with high fever, intense earache, and loud screaming, her fifth such episode since two months of age, each one beginning soon after finishing the antibiotic from the previous one. Even before that, she grew fussy when her mother weaned her to go back to work, and developed a florid rash from her milk-based formula. All of these symptoms intensified soon after her first DPT, HiB, and polio vaccinations, reaching their climax two weeks later in her first ear infection, with high fever and violent earache. Thereafter she got only the DT, which she didn't react to at all, but the ear infections continued unabated.

With homeopathic treatment, they stopped soon enough, but six months later her parents separated, and her father took her for the MMR. Three typical ear infections and three rounds of antibiotics followed in rapid succession. Again she was brought in by her mother, responded well to homeopathy, and remained in very good health overall, despite a tendency to relapse when she visited her father, who indulged her with dairy products and took her to the pediatrician for her full quota of vaccines and antibiotics. I have continued to see her at rare intervals, most recently as a college student of eighteen. Her ear infections are long gone, and when she does get sick, her robust immune system helps her to respond acutely and vigorously, and she recovers promptly each time.[17]

Already seriously compromised at birth, a fourth child developed persistent croup, signs of mental retardation, and other chronic complaints shortly after his first DPT and HiB vaccines, which led his mother to postpone the second round for many months, but the long wait failed to prevent a dramatic relapse as soon as he received it:

A fifteen-month-old boy was brought in for croup, recurrent colds, swollen glands, and developmental issues. Born to a diabetic mother, he weighed eight pounds at birth, and spent many weeks in the Newborn ICU because of "undeveloped lungs," with cyanosis and unstable blood sugars. In the first three months he was also quite colicky, with a nasty diarrhea that stopped when his mother eliminated wheat from her diet. At three months of age, soon after his first DPT, HiB, and polio combination, he became very restless, with swollen glands and a sickly pallor that lasted for months and culminated in a prolonged episode of croup, high fever, and sunken chest, for which he was hospitalized and given intravenous corticosteroids. But the cough persisted for so long that the mother decided to postpone his second round of vaccinations until he recovered. At twelve months of age, she finally gave in, but the croupy cough and swollen glands reappeared within a few days, with almost exactly the same symptoms as before.

Showing a marked fear of strangers, the boy came into my office appearing subnormal, drooling profusely, with his mouth hanging open, and hiding behind his mother. After a few remedies failed to act, a single dose of *Ba-*

ryta carbonica 200 wrought such a change that the entire illness cleared up in a few days, and never returned. At follow-up a month later, his mother was ecstatic. For the first time, even in the dead of winter, there was no croup or swollen glands, he was sleeping well, and seemed much more alert, interested in his surroundings, and less fearful around strangers. That was six years ago, and I've not seen him since, but the experience convinced his mother not to vaccinate him again, and she recently called to tell me that he continues to thrive and develop normally, "like other children his age."[18]

My final case is that of a four-year-old boy with severe allergic asthma since the age of two, and on medicines all year round, who began a splendid recovery on remedies, even during his peak allergy season, until a DPT booster brought on an immediate and profound relapse:

Asthmatic since the age of two, and testing positive for a broad spectrum of allergens, a four-year-old boy was brought in for homeopathic treatment, because even a strict regimen of bronchodilators and inhaled corticosteroids had failed to prevent frequent major attacks the previous fall and winter, several of them requiring prednisone and antibiotics as well. Six weeks later, after two doses of *Kali iodatum* 200, he had cut his medicines by half, maintained higher peak flows of 150 or more, and made it through a cold for the first time without asthma or drugs of any kind. Emotionally, too, he was calmer and less wild, even expressing remorse after a fit of rage, which he had never done before.

Early the next fall, during the peak of his allergy season, he was still doing well on half-doses of Beclovent, and had been energetic and in good health all spring and summer, with peak flows at record levels of 150-175. Almost immediately after his pre-kindergarten DPT booster, he came down with bronchitis, for which the pediatrician gave antibiotics, and his asthma and allergies returned in full force. Once again, he responded beautifully to *Kali iodatum* 200, and has continued to improve over the past two years, to the point that he hasn't needed to come back or take it again.[19]

The adverse reactions that I witness on a routine basis are no mere *aberrations*, but predictable complications of the vaccination process itself, and therefore provide valuable clues to how vaccines actually *work*. The stated purpose of all vaccines is to stimulate continuous antibody synthesis on a chronic basis, and for long periods of time, ideally for years or decades. *Chronicity* is likewise the chief feature of all my cases, and in fact the only thing they have in common, representing chronic or relapsing versions of the same broad range of diseases and illnesses seen by every pediatrician. For example, the baby girl with recurrent ear infections who responded to constitutional treatment with an *acute* episode just like her first one, followed by a complete and long-lasting cure, embodies two simple but important lessons:

1) that the immune system is "hard-wired" to mount acute and vigorous responses to infection, and

2) that the effect of vaccination is to reprogram the host cells to respond *chronically*, not only to the vaccine organism, but also non-specifically to other antigens as well.

Precisely how vaccines bring this about is not entirely clear to me, even after decades of trying to figure it out. What I do know is that forcing cells of the immune system to harbor foreign antigens inside them for long periods of time will most likely result in autoimmune phenomena once their neighbors recognize them as "foreign," and eventually in various forms of chronic disease, depending on which cells, tissues, and organs are sensitized and targeted.

To appreciate what this means, compare vaccination with the process of coming down with and recovering from the corresponding acute disease, such as the measles. For measles to evolve from a scourge that kills twenty percent of a population exposed to it for the first time into a normal disease of childhood required centuries of adaptation, such that when I contracted it at the age of six, non-specific mechanisms were already in place that helped me and almost all of my schoolmates to recover from it with no complications or *sequelæ*. The natural immunity that resulted was permanent and multi-layered: partly specific, which prevented us from ever getting it again, no matter how many times we were re-exposed to it, but also *non-specific*, involving a massive, coordinated mobilization of every component of the immune mechanism as a whole, almost like a graduation ceremony, certifying that our systems were primed and ready to respond acutely and vigorously to whatever other infections we might encounter in the future. On both counts, the ability to fall ill with and recover from acute diseases thus confers enormous benefits for the health of every individual, and of the nation and the race as a whole.

In contrast, the cases I have presented demonstrate that the artificial immunity obtained by vaccination is *counterfeit* in both respects:

1) because the specific antibody response is only partial and temporary, and leads to no general outpouring, and

2) because to produce those precious antibodies, we must necessarily substitute chronic responses and autoimmune phenomena for the acute programming we were born with.

In other words, if children vaccinated against a particular acute disease fail to come down with it, it is because we have given them the chronic version instead, so that they are *incapable* of responding acutely, not only to it, but also non-specifically to other infections and antigenic challenges as well.

In much the same fashion, our unquestioning readiness to pile on as many different vaccines as we like rests on the unspoken assumption that each one acts separately on the immune system, more or less independently of the others, as the leading vaccine advocates have always contended. But the generalized, across-the-board reactions that I have been describing suggest a very different story, namely,

1) that *all* vaccines, precisely by doing what they are intended to do, promote a wide variety of autoimmune phe-

nomena and a major escalation in the incidence and severity of the chronic diseases that correspond to them; and

2) that that effect is in some measure proportional to the total number of vaccines administered to a given individual, and the total vaccine *load* borne by the population as a whole.

The ACIP's official vaccination schedule for 2004 lists a total of twenty-two separate vaccination events between birth and two years of age, many of them with several different components:[20]

One flu shot yearly, beginning at six months;
Three Hep B shots in the first twenty-four months, beginning at birth;
Three DPT shots at two, four, and six months, and a fourth at twenty-four months;
Three HiB shots at two, four, and six months, and a fourth at twelve to eighteen months;
Three pneumo shots at two, four, and six months, and a fourth at twelve to eighteen months;
Two IPV polio shots at two and four months, and a third at six to twenty-four months;
One MMR shot at twelve to eighteen months; and
One chickenpox shot at twelve to twenty-four months.

The same source lists twenty-five more separate vaccination events that are recommended or required for children between two and eighteen years of age:[21]

Sixteen flu shots, one per year from two to eighteen years of age;
Three or four Hep A shots, from two to eighteen years of age (suggested);
One DPT booster at four to six years;
One DT booster at eleven to twelve years;
One IPV booster at four to six years;
One MMR booster at four to six years; and
One chickenpox booster at four to six years (very likely).

That adds up to forty-seven separate vaccination events that every child is expected to receive before the age of eighteen, with plenty more still to come. Since 2004, several have already been added or proposed: HPV for adolescent girls, meningococcus and rotavirus for all children of both sexes. Many vaccines on the list have also been or soon will be recommended for young adults and the middle-aged and elderly, while Group A Strep, AIDS, and others are already in the pipeline, or are planned or projected for the future, often for no more pressing reason than our technical capacity to make them.

Finally, ever since the Clinton years, vaccines have been touted as the most economical, efficient, and strategic use of our health-care resources, based on what looks like a simple cost-benefit analysis; i.e., the ratio between the cost of the vaccination and the cost of caring for the additional cases of the acute disease that would be expected had the vaccine *not* been given. But once we factor in their share of the increased incidence and severity of childhood asthma, otitis media, sinusitis, ADD, autism, and all the rest, and calculate their share of the cost of caring for the tens of millions so afflicted, that same cost-benefit equation will look vastly different. Far from being inexpensive, let alone an unmixed blessing for the public health, vaccination represents an enormous hidden cost and risk factor to the medical system as a whole, a hugely expensive and dangerous experiment that has already overburdened and sickened the population, and will undoubtedly continue to do so. Only our blind, quasi-religious faith in it, unique in all the world, will suffice to explain the scandal that the United States spends so exorbitantly on medical care, yet lags so far behind all other developed countries in every standard health measure.

3. Different Look, Same Problem: The Causal Power of Pharmaceutical Drugs

Although vaccines highlight the limits and inconsistencies in our medical notions of causality, the same basic dilemma haunts the pharmaceutical industry as a whole, where its consequences are equally elusive, similarly hidden from view, and if anything even more pervasive and injurious.

While it played a leading role in the chemical revolution that gave the world qualitative and quantitative analysis, and much of organic and inorganic chemistry as we know them, the drug industry still clings religiously to the same experimental methodology that it developed in the post-Civil War era. In its first phase, crude botanical drugs such as opium, belladonna, digitalis, ergot, and coca were refined by extracting individual alkaloids with greater specificity of action - morphine, codeine, papaverine, atropine, scopolamine, digoxin, digitoxin, ouabain, cocaine, and the like. In the Twentieth Century, the same analytic trend yielded semi-synthetic derivatives - dilaudid, heroin, ergotrate, and many others - and eventually wholly synthetic analogues, like meperidine, amphetamines, xylocaine, propanolol, omeprazole, alendronate, etc., each targeted to specific biochemical receptors, in order to minimize the risk of adverse or unwanted reactions - even pleasant ones, like the wondrous euphoria of cocaine and heroin, the inexhaustible craving and demand for which upstaged and ultimately ruined their splendid contributions to medicine.

In this way, each new drug is developed for use against a particular disease, ideally a single enzyme or chemical reaction, just as diseases came to be defined more rigorously and linked to objective abnormalities of specific biochemical pathways, which it became the goal of drug treatment to inhibit or stimulate or otherwise regulate, again precisely as Claude Bernard had foreseen. As more such pathways were discovered, more and more metabolites were shown to play into them, and an ever-growing array of synthetic drugs, almost all petrochemicals, were developed to manipulate them, Bernard's ideal of "immediate" causes that followed natural physiological pathways, and could be relied upon to produce the desired effect in almost every case, quickly receded from view; even biologically active hormones were

eventually replaced for the most part by a variety of synthetic analogues, derivatives, and antagonists.

Under these circumstances, the closest approximation to Bernard's *necessary* cause is in most cases merely a *sufficient* one - a drug with sufficient chemical power at a maximum dose to impose the effect by force on a statistical preponderance of cases, whatever their mechanism of action, and regardless of how an individual patient might respond to them in other ways. A well-known example from Hahnemann's time that continued throughout the Nineteenth Century, calomel and other mercurial drugs were widely used against syphilis in increasing doses until the patients salivated, then the accepted limit of tolerance. Even today, especially in the chemotherapy of cancer and other serious or life-threatening diseases, the *maximum* dose, the largest quantity that the patient can tolerate without unpalatable or toxic side effects, remains a standard therapeutic goal, as in the case of a dear friend with ovarian cancer, who lived through her first six months of intensive, punishing chemotherapy with so few signs of toxicity that her genuinely devoted oncologist offered her a second round as a special favor.

Once the causal power of drugs could be quantified as the fraction of patients exhibiting the desired effect, it became possible and desirable to refine that measurement by comparing it to the percentage who recovered without it. Experimental tests of drug efficacy thus involved dividing subjects into two or three groups, those given the newer drug in question, and control groups, matched as closely as possible demographically and in other ways, who were treated with a more established drug or not treated at all. Just as with vaccines, to qualify as a sufficient cause of the effect in question, drugs must be shown to produce it in a majority or at least a large preponderance of patients taking it, over and above the record of their controls.

In the aftermath of World War II, this statistical exercise achieved its ultimate technical sophistication in the Random Controlled Trial, or RCT, now generally accepted as the "Gold Standard" of drug effectiveness, in which the causal power of any drug or combination against a particular disease or abnormality is measured by randomizing the subjects into two groups, one receiving the drug, and the other only an inert imitation, with both patients and doctors kept "blinded" as to who gets which. A drug's potency is thus reduced to a definite, measurable quantity, the extent to which patients taking it outperform their placebo controls, while the level of effect should itself be controllable to an extent, by titrating the dose to any desired level. In this fashion, rather than an optimal *qualitative* fit with the unique features and needs of a particular patient, as homeopaths aspire to, the best drugs and the ones most diligently sought after became simply the most *potent* ones, those with the most chemical power to compel the organism to behave in whatever ways the profession determines that they should.

Almost by definition, this force will tend to be exerted in a direction that the organism shows very little natural or spontaneous inclination to go, because the "placebo effect" that they must outdo is precisely the sum of those individual tendencies and predispositions that are too subjective to define or measure, too unpredictable to control, and too idiosyncratic to merit systematic study. In other words, what we call the "placebo effect" is essentially the starved and tattered remnant of the innate self-healing capacity, the ancient *vis medicatrix naturæ*, or what little is left of it when the patient becomes an experimental subject and conditioned to expect no help at all unless graced with the tablets or capsules in question.

In the same way, modern doctors are equipped with the latest and most advanced chemical weapons to attack a vast array of diseases and abnormalities as if they were enemies on a battlefield: antibiotics to kill bacteria, anticonvulsants to control seizure activity, antihypertensives to force down the blood pressure, antimetabolites to seek out and destroy cancer cells, antihistamines to inhibit the allergic response, antithyroid drugs to suppress hormone secretion, bronchodilators to open constricted air passages, diuretics to compel the kidneys to excrete more urine, corticosteroids to block inflammation, insulin to substitute for a diabetic pancreas, and so forth. In advanced cases, such drugs may indeed give miraculous relief, buy valuable time, or at least do the best that can be done under adverse or extreme circumstances. Leaving aside the ultimate question, whether most patients taking the drug will in fact *feel* better, live longer, and suffer fewer complications as a result of their treatment than without it, I will simply stipulate what is not always true in practice, that many of the drugs in common use do indeed have the power to accomplish at least some of what we ask and expect of them, to correct the abnormality in question, or at least to fight the disease process at some strategic juncture, in hopes that these more subjective, personal goals will eventually follow. But just beneath the surface of that success, as with those precious antibodies for the sake of which we vaccinate, lurks a huge built-in complication at the very heart of the system, and two other threats of equal magnitude and importance that follow directly from it.

First, when drugs really *work*, when they effectively suppress or counteract the target symptom or abnormality, the problem is likely to reappear with equal or greater intensity when the drug wears off. Using a chemical to force the issue, rather than assist whatever self-healing processes are already available, thus poses the serious risk of needing to *continue* using it for long periods of time, and always with the expectation that the original complaint or worse will reappear as soon as it is discontinued. In this fashion, what often began as an idiomatic episode in the patient's life routinely and insidiously develops into a less and less curable *chronic* illness or disease element, now *chemically* programmed, in exchange for partial and temporary relief of symptoms and the technical correction of abnormalities. Apart from acute ailments ending in death or recovery, such long-term perpetuation of the original energy disturbance also feeds into and even helps carry out the self-fulfilling prophecy that chronic diseases are by definition incurable anyway,

and must therefore be controlled with drugs throughout life, removed surgically, or simply borne in silence.

One wholly predictable consequence of targeting drug treatment to specific pathological conditions is *polypharmacy,* the reliable expectation that without a unifying principle, like the "vital force" that Claude Bernard was so eager to do away with, more and more drugs will be needed to keep at bay all other identifiable diseases and abnormalities. The other is that drugs potent enough to do the things we expect them to do also have the power to act coercively on other aspects of our patients' functioning, even though these unwanted and usually undesirable "side effects" will vary quite a lot, according to the unique features and predispositions of the patient.

This is precisely where we left off with vaccines: an array of individualized responses, each indicating some degree of predisposition, which may be difficult to recognize and accept as belonging to the vaccine for that reason. In the same way, the unwanted or extra symptoms that drugs elicit or provoke are simply written off as side effects and relegated to the fine print, because each one affects a much smaller number, and may thus be regarded as an idiosyncrasy of the victim, rather than a consequence of drug action, an easy sleight-of-hand that similarly helps defeat malpractice suits against physicians and manufacturers for bad outcomes, unless specific acts of negligence can be traced to them.

But even though each particular side effect of a drug may seem relatively uncommon, the aggregate total of all of them combined may tell a very different story. Just as an exercise, and more or less at random, I picked out the brand-name drug *Savella,* or milnacipran hydrochloride, which was originally developed as an SNRI (serotonin-norepinephrine reuptake inhibitor) antidepressant, but is now marketed and used mainly for the treatment of fibromyalgia, in expensive advertisements that include the following warnings about serious side effects and possible interactions with other drugs or ailments:

1) Savella is an SNRI, similar to drugs used for depression and other psychiatric disorders. *Antidepressants increased the risk of suicidal thinking and behavior in children, adolescents, and young adults. Patients of all ages should be monitored closely for suicidality or unusual changes in behavior.*
2) *Savella is contraindicated in patients taking MAO inhibitors concomitantly. There have been reports of serious or fatal reactions* in patients started on MAOI's who were also receiving or had recently discontinued an SSRI or SNRI.
3) *Savella is contraindicated in patients with uncontrolled narrow-angle glaucoma and should be used cautiously in patients with controlled narrow-angle glaucoma.*
4) *Development of a potentially life-threatening syndrome may occur with SRI agents, including Savella,* particularly with concomitant use of serotonergic drugs, and those that impair serotonin metabolism, such as MAOI's.
5) *SNRI's, including Savella, have been associated with cardiovascular effects, including high blood pressure, requiring immediate treatment.* Among patients who were not hypertensive before, roughly twice as many receiving Savella became hypertensive as those receiving placebo. *It should be used cautiously in patients with significant hypertension or cardiac disease.*
6) *Savella should be used with caution in patients with a history of mania or seizure disorder.*
7) *Savella has been associated with mild elevations of liver enzymes (up to three times the upper limit of normal). Rarely, serious liver injury and fulminant hepatitis have been reported.* It should not be prescribed to alcoholic patients or those with chronic liver disease.
8) *Hyponatremia may occur as a result of treatment with SSRI's and SNRI's, including Savella.* Elderly patients may be at greater risk.
9) *SSRI's and SNRI's, including Savella, may increase the risk of bleeding events.* Patients should be cautioned about concomitant use with NSAID's, aspirin, warfarin, and other drugs that affect coagulation.
10) *Savella can affect urethral resistance and micturition.* Caution is advised in patients with dysuria, especially in males with obstructive uropathies, who may experience higher rates of adverse events.
11) *There are no adequate, well-controlled studies in pregnant women,* for whom it should be used only if the potential benefit outweighs the potential risk to the fetus.[22]

Needless to say, these are merely the most visible, aboveground portion of a much larger iceberg. In clinical trials, the most common adverse reactions listed were as follows:[23]

	Savella (%)	Placebo (%)
Nausea	37	20
Headache	18	14
Constipation	16	4
Dizziness	10	6
Insomnia	12	10
Hot flashes	12	2
Hyperhidrosis	9	2
Vomiting	7	2
Palpitations	7	2
Hypertension	7	2
URI	7	6
Tachycardia	6	1
Migraine	6	3
Dry mouth	5	2
Anxiety	5	4
Abdominal pain	3	2
Chest pain	3	2
Dyspnea	2	1
Tremor	2	1
Paresthesias	2	2
Loss of appetite	1	0
Blurred vision	1	1

Other less common reactions included the following:

Premarketing:[24]

Metabolic: weight loss, weight gain, hypercholesterolemia
Male: dysuria, incomplete ejaculation, erectile dysfunction, decreased libido, prostatitis, scrotal pain, testicular pain
GI: dyspepsia, GERD, diarrhea, flatulence, distention
General: fatigue, edema, irritability, fever
Infections: UTI, cystitis
Injuries: falls, contusions
Nervous system: somnolence
Psychiatric: stress, depression

Postmarketing:[25]

Blood: leukopenia, neutropenia, thrombocytopenia
Cardiac: supraventricular tachycardia
Endocrine: hyperprolactinemia
Hepatobiliary: hepatitis
Metabolic: anorexia, hyponatremia
Musculoskeletal: rhabdomyolysis
Nervous system: convulsions, Parkinsonism
Psychiatric: delirium, hallucinations
GU: acute renal failure, urinary retention
Breast: galactorrhea
Skin: *erythema multiforme,* Stevens-Johnson syndrome
Vascular: hypertensive crisis

Remember that for any side effect to make it onto this list, reluctantly compiled by the drug companies themselves, it must meet the strict standard of "cause" already alluded to; i.e., either a sudden, acute event, appearing almost immediately out of nowhere, or more chronically, in patients not obviously predisposed to it. Although individually many of them are more or less infrequent, the arithmetic sum of all of them together, and thus the risk of at least one of them occurring in any given patient, are substantial enough, when added to the various warnings, contraindications, and cross-reactions with other drugs, to make it seem like Russian roulette for *anyone* to take their chances with this still very popular drug.

Moreover, the track record of the industry virtually guarantees that when claims of actual adverse reactions mount up to the point that a drug is taken off the market, a process that consumes at least five years on average, the manufacturer will already have cashed out a huge profit and moved on to a whole new generation of synthetic chemicals to send up through the same process. Nor is this line-up in any way unusual: almost any brand-name drug listed in the PDR (*Physician's Desk Reference*) can boast of a similar profile.

In addition, instead of the usual strategy of downplaying such side effects, several more forward-looking manufacturers have recently begun to see the advantage of *emphasizing* them, as further proof of the drug's power to do *something.* A splendid example is the recent television ad for *Cialis,* a long-acting drug for impotence, impressively renamed "Erectile Dysfunction" to sound like a genuine disease, in

Which Drugs May Trigger Diabetes?[26]

l-Asparaginase (Elspar)	Occurs in 3-17% of recipients
Chenodeoxycholic acid (bile salt)	
Chlorpromazine (Thorazine)	Inhibits insulin secretion
Cimetidine (Tagamet)	Impaired glucose tolerance, retarded absorption
Clofibrate (Atromid)	Arginine-stimulated insulin secretion 60% lower
Contraceptives, oral	Disputed
Danazol (Danocrine)	Impaired glucose tolerance
Diazoxide (Hyperstat IV)	Hyperglycemia usual, direct effect on ß-cells
Diuretics	Hyperglycemia
Estrogens	Reduced glucose tolerance
Glucocorticosteroids	Hyperglycemia (in high doses)
Vitamin A	Hyperglycemia (in high doses)

Drug-Induced Thromboctyopenia[27]

Acetaminophen	Thrombocytopenic purpura
Acetazoleamide (Diamox)	Thrombocytopenic purpura
Aspirin	Thrombocytopenia, with or without purpura
Tricyclic antidepressants	
Antineoplastic agents	Direct bone marrow toxicity, pancytopenia
Benzodiazepines	Single cases, several such drugs implicated
Cephalosporins	Allergic type, infrequent
Chloramphenicol	Associated with fatal blood dyscrasias
Chloroquine phosphate or HCl	Associated with pancytopenia
Diazoxide (Hyperstat IV)	Associated with neutropenia
Digitoxin	Specific antibodies detected
Estrogens (synthetic)	
Ethchlorvynol (Placidyl)	Recurrent episodes, ending in death (1 case)
Furosemide (Lasix)	Uncommon
Gentamicin sulfate	Rare
Gold salts	Incidence as high as 40%
Heparin	Mild decrease common, but all degrees reported
Immune sera	Toxic reactions 1 week after injection
Inandione anticoagulants	Associated with hypersensitivity reactions
Indomethacin (Indocin)	Rare form of toxicity
Insulin	Has been reported
IV Fat Emulsions	Reported in infants on long-term therapy
Iopanoic acid (Telepaque)	Allergic reactions
l-Dopa	Long-term use
Methyldopa (Aldomet)	Uncommon
NSAID's	Possibly allergic, several drugs implicated
Oxybutazone, Phenylbutazone	Associated with severe anemia
Penicillamine	Fatal TTP
Penicillin	Allergic reactions
Quinidine	Rare
Quinine	Allergic reactions
Rifampin	Allergic reaction, with severe endothelial damage
Rubella Vaccine	Thrombocytopenic purpura
Rubeola Vaccine	Thrombocytopenic purpura
Sulfonamides	Acute reactions (rare)

which viewers are piously warned to beware of and seek immediate medical help for erections lasting more than four hours, a complication which to potential customers sounds a lot like hitting the jackpot.

Another way to appreciate the impact of adverse drug reactions on the general public is to highlight a particularly common or serious complication by listing the drugs known to cause it, as was done in a series of articles from the 1980s entitled "Drug Actions and Interactions," which appeared in the free tabloid *Modern Medicine.* A few examples are shown in the tables at right.

Additional side effects from the same series include impotence (11 drugs and drug classes), infertility (15), hallucinations (38), and several others. Illustrating the perils of polypharmacy, the series also featured drug interactions, such as the following, among many others:

Oral Anticoagulants: Caution with Concurrent Drugs [28]

Anabolic steroids	Hemorrhages dues to lowered clotting factors
Antidiabetic agents	Effects on protein binding and metabolism
Barbiturates	Decreased response to anticoagulants
Cholestyramine (Questran)	Decreased absorption of anticoagulants, Vitamin K
	Clofibrate (Atromid) Increased anticoagulation effect
Dextrothyroxine (Choloxin)	Lowered prothrombin levels
Disulfiram (Antabuse)	Inhibits anticoagulant metabolism
Glutethimide (Doriden)	Increases anticoagulant metabolism
Oxybutazone, Phenylbutazone	Inhibit anticoagulant metabolism, GI bleeding
Phenytoin (Dilantin)	Unpredictable: several interacting mechanisms
Rifampin	Stimulates liver to metabolize anticoagulants
Salicylates	Impair platelet function, lower prothrombin
Thyroid hormones	Reduce clotting factors

The point of all this is very simple. Involving so many different classes and types, the principal risk of excessive drug use is not *malpractice,* which involves fault or negligence on the part of an individual physician, but quite the opposite and immensely greater threat, an iatrogenic illness caused by medicines that are *inherently* dangerous, even when prescribed according to current standards, with appropriate levels of skill and genuinely informed consent. This was the shocking conclusion of a landmark study involving 815 consecutive admissions to an eighty-bed medical service at a university hospital over a five-month period.[29] Of those admitted to the unit within that time, the authors found"

1) that 36% suffered at least one iatrogenic complication during their stay;
2) that 9% developed complications that were seriously disabling, potentially fatal, or both; and
3) that 2% actually died as a result of such complications while still in the unit.[30]

They further stipulated that these disturbingly high figures would actually have been even higher, had they included:

4) iatrogenic events suffered by the same population over the same interval, but before their admission or transfer into the unit, or after their discharge or transfer out of it, and
5) other episodes not attributable to any specific drug or procedure, such as seizures or falls in heavily medicated patients, which were written off as "incident reports," even though their medications clearly made such events more likely.[31]

In the latter part of the study, the authors tried to find out which drugs or procedures posed the greatest risk of serious and fatal complications, and were even more surprised to learn that it didn't make a lot of difference, that the risk depended much less on which tests were ordered, which drugs prescribed, and which surgical procedures performed, than simply on *how many;* i.e., the total number of transactions with the medical system, regardless of their specific content.[32] The obvious implication of their data is that patients are harmed much less by malpractice or how *badly* medicine is practiced, than simply by *how much* it is practiced, an admonition to which both advocates and opponents of health care reform would do well to pay heed.

4. Some Systemic Implications for Medicine as a Whole

The ubiquity of adverse reactions to vaccines and drugs and their relative invisibility to those who manufacture and prescribe them make it easy to understand why homeopathy and other alternative approaches have become so popular with patients on the fringes of the medical system, and so easily dismissed by that establishment as ineffective, impossible, or unworthy of serious study. In pointed contrast to allopathic drugs and vaccines, which are chosen and developed for their power to *force* the organism to do what it has no natural inclination to do, homeopathy and holistic medicine in general seek to enhance the innate capacity for self-healing that is synonymous with life, perpetually at work in every patient, and encompasses those same individualizing tendencies, predispositions, and sensitivities which as physicians we were taught to ignore in our diagnoses, outperform in our research, and override in our treatment.

One important consequence of reducing patients to specimens of abstract disease categories existing in a sense apart from them has been to redefine these "entities" as simple *automatisms,* concatenated sequences of mechanisms that are pre-programmed to *worsen,* while the substantial and all-important capacity to *recover* remains vested in the individual patient, that least scientific of constructs, and thus quietly drops out of sight, rarely to be seen again.

Even when homeopathic remedies act curatively, the re-

sults are routinely dismissed or written off as isolated cases, possibly even miraculous at times, but nevertheless "anecdotal evidence" without scientific import, and therefore always located on the placebo side of the ledger, because medical science restricts "cause" to those interventions that force things to happen, and measures that power against the idiomatic tendency of patients to recover without it. Even in the case of well-designed RCT's that demonstrate a statistically significant benefit from homeopathic treatment, the result still "feels" unscientific and unpersuasive to most people, simply because no chemical force was exerted and no resistance overcome, just as to trained scientists its looser interpretation of causality and its reliance upon idiosyncratic elements similarly disqualify it from serious consideration as a force potent, measurable, and consistent enough to count as "hard science."

But the standard argument that homeopathic remedies are merely placebos cuts both ways. In the first place, it's simply *wrong*, since they have an equally impressive track record in the treatment of animals, newborn babies, and comatose patients, for whom the influence of suggestion is generally agreed to be negligible. Secondly, if giving placebo or natural remedies or nothing at all can achieve results equal to or better than those obtainable with suppressive drugs or crippling surgery, but without the mutilation, chronic dependence, polypharmacy, and toxicity that regularly accompany them, then it is at least an open question which method actually works better, and who of sound mind would not prefer the cheaper, gentler, and safer alternative to start with. And finally, when homeopathic remedies do act curatively, our patients rightly feel that they have healed themselves, and sometimes wonder if they might have done so without our help. But that "delicious quandary" is hardly cause for complaint, since I can imagine no higher compliment to be paid to a medicine than that its action cannot be distinguished from a gentle, spontaneous, long-lasting cure requiring no further treatment.

On the contrary, the irony lies wholly on the other side, that this optimal response is relegated to the placebo side of the equation, while pharmaceutical drugs are valued and considered effective only to the extent that they can overpower the physiology of as many patients for as long a time as possible. It is absurd and contemptible to boast of standards that prize brute force over elegance of fit, and subordinate healing the sick to manipulating their life functions artificially, whether for the sake of "science," ambition, or some equally abstract, hypothetical good that we are supposed to take on faith.

That is why, for the present at least, I am glad that our cures remain snugly ensconced on the placebo side of things, because until we develop a kinder, more accurate and inclusive notion of causality, that is precisely where they belong. What the nuclear physicist J. Robert Oppenheimer once told a group of psychologists seems even more apposite for the medical community as a whole:

> "We inherited at the beginning of the Twentieth century a notion of the physical world as a causal one, in which every event could be accounted for if we were ingenious, a world characterized by *number*, where everything interesting could be measured, and anything that went on could be broken down and analyzed. This extremely rigid picture left out a great deal of common sense which we can now understand with a complete lack of ambiguity and phenomenal technical success. One is that the world is not completely determinate. There are predictions you can make about it, but they are purely statistical. Every event has in it the nature of a surprise, a *miracle*, or something you could not figure out. Every pair of observations taking the form 'we know this and can predict that' is global and cannot be broken down. Every atomic event is individual: it is not in its essentials reproducible."[33]

This passage reminds me of a woman patient from my early years in Boston, a 34-year-old registered nurse with a history of endometriosis since her teens, who consulted me to re-establish her menstrual cycle. After two courses of male hormones to suppress it, and four surgeries to remove large blood-filled cysts from her bladder and ovaries, her periods had become scanty, dark-brown, and "dead," as had any hopes of childbearing. After two or three remedies, her menses were richer and fuller, and within six months she was pregnant. When I next saw her for a different ailment eight years later, she had given birth to two healthy children after normal pregnancies and uncomplicated vaginal births, and had remained in good health ever since.[34] While it would be absurd to attribute such an outcome to a homeopathic remedy or any other agency in precise, linear fashion, my patient has never stopped thanking me for it, which is reason enough to honor and be grateful for a process by its very nature catalytic and persuasive rather than forcible and compulsory.

For all of these reasons, instead of *competing* with the placebo effect in order to defeat it, I submit that the highest goal of medicinal treatment, whether homeopathic or otherwise, is precisely to *maximize* it, by doing everything possible to promote *healing*, rather than merely correct abnormalities, and cultivate a more intimate knowledge of our patients, rather than ignore, circumvent, or override what they have to teach us. Although certainly admiring the ingenuity and dedication of my colleagues who conduct RCT's to prove the effectiveness of homeopathic treatment to the scientific world, I propose a different model for clinical research, based on *self-healing*, one that I believe is more suitable for allopathic medicine as well:

1) *Nobody is blinded:* all subjects know whether they are receiving homeopathic or allopathic treatment, having chosen it beforehand precisely because of their interest and faith in it.
2) *Nobody gets placebo:* everyone gets the treatment they selected, and the physicians who administer it are matched to them by *their* beliefs, and encouraged to use prayer, suggestion, exhortation, shamanic incan-

tation, faith healing, laying on of hands, or whatever they or their subjects believe will most effectively assist their healing path. In other words, *each group will serve as the control of the other.*

3) *Using the totality of symptoms over time,* including subjective and objective criteria, as well as reports of family, friends, teachers, employers, etc., both *homeopathic and allopathic subjects will be followed and evaluated for a period of months or years* as to how well or badly they are measuring up in their own lives, according to their own standards and those of their community, in addition to clinical and pathological criteria, and extending beyond the acute phase to include the chronic dimension.
4) Qualified judges not doctrinally committed to either point of view will then ascertain which form of treatment comes out ahead, in which respects, and publish the results in a friendly, fair, and unbiased journal of good repute to be agreed upon in advance.[35]

A self-healing orientation in medicine will help to create the conditions under which homeopathic and allopathic points of view can collaborate and flourish in relative harmony, for both are valuable and useful, and neither by itself can accomplish everything that needs to be done. Without the scientific revolution, we would not have modern surgery, the leading edge of medical progress and quintessence of the allopathic point of view. Yet the surgical ideal also rests on a paradox that cannot be ignored or set aside. As a method of assisting normal healing, whether by repairing the body when it is broken, or removing a part that is already dead, surgery unquestionably ranks among the supreme technical achievements in human history. But as the preferred method of curing *illness,* and thus the paradigm for the medical enterprise as a whole, it is a cruel travesty, a quasi-military decision to cut and burn in lieu of gentler, safer, and more authentic methods of healing the organism as a living system and the patient as a human being.

That is why, for myself, I prefer these aphorisms of Paracelsus, the great Renaissance physician and alchemist:

> 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.[36]

I interpret them roughly as follows:

Healing implies wholeness

Derived from the same root as "whole," the English verb "to heal" literally means to make whole [again], and suggests a basic property of all living systems, a concerted effort of the entire organism that cannot be accomplished by any part in isolation.

All healing is self-healing.

As an inherent function of the organism, the process of healing goes on automatically and continuously throughout life, and tends to complete itself spontaneously, with or without outside help. In other words, all healing is self-healing, and the proper role of medicines, surgery, physicians, and professional or designated "healers" of any kind is simply to facilitate the natural process which is already under way, not to alter, interfere with, or substitute for it.

Healing pertains solely to individuals

Healing is always *possible,* but also problematic and even risky, and can always *fail* to occur. That is because it pertains solely to individuals in concrete, here-and-now situations, rather than to abstract diseases or principles. In other words, it is inescapably an *art,* and can never and should never be reduced to any technique or formula, however scientific its foundation.[37]

To conclude, I offer this little homily from Lao-Tse, as an appropriate bottom-line criterion:

> A leader is best when people hardly know he exists,
> Not so good when they 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."[38]

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35. *Ibid.,* p. 342.
36. *Selected Writings of Paracelsus,* trans. N. Guterman, Bollingen Series, Pantheon, New York, 1958, pp. 50, 76, *passim.*
37. Moskowitz, *Resonance,* pp. 21-22.
38. Lao Tzu, *The Way of Life,* trans. W. Bynner, Putnam, New York, 1944, pp. 34-35.

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