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EDITORIAL •

CAUSAL MEDICINE AND HOMŒOPATHY

Since the beginning of the nineteenth century when the European Medicine decided to become a science it tacitly assimilated the philosophical doctrine of determination and the principle of the uniformity of Nature, i.e. the belief that every event must have a cause and that under similar conditions, the same cause produces the same effect. Since medical theory, and partly also medical practice, stand or fall with the principle of causation we may rightly label the modern 'so-called' scientific medicine as causal medicine.

According to this system of medicine three things have been pointed out as causal factors of diseases e.g., pathological structure, pathological function and indirectly pathogenic bacteria capable of producing pathological structure and function. It will be our endeavour here, to scrutinise whether the structure, function and bacteria do possess the properties of cause, strictly according to the canons of logic and philosophy.

Scientifically, the cause is the invariable, unconditional, and immediate antecedent of the effect or the sum total of conditions, positive and negative, taken together which are sufficient to produce the effect without the presence of any other antecedent. As Bain puts it: "In scientific investi-

gations, the cause must be regarded as the entire aggregate of conditions or circumstances requisite to the effect." Thus the properties of cause are as follows: (a) when the cause appears the effect must always follow it; (b) when the cause disappears the effect must always disappear; (c) when the cause varies the effect must always vary accordingly; and (d) the cause precedes the effect. The law of causation then may thus be summarised: same cause—same effect. It is clear that a factor is a cause only if it is followed by another factor an effect, or if there were no effect it would be impossible to know whether there had been a cause. In other words, a factor acquires the status of "cause" if it manifests itself by an effect.

The followers of the dominant system of medicine look first of all for the cause of clinical syndromes constituting diseases *i.e.*, they make their diagnosis and having found a cause in the shape of pathological structure, function or pathogenetic bacteria, they automatically think of removing the respective causative factor, paying no heed to the consequence dispensing with experimental verification and often barring the way to a different form of treatment. At first sight their procedure seems to be quite rational and therefore their practice should be labelled as perfectly scientific. But what comes out if they seem to beg the very question they are out to solve?

Let us assess the causal properties of structure, function and bacteria relating to diseased conditions from the standpoints of clinical evidence and experimental biological evidence.

Let us take the essential causal properties one by one from the clinical standpoint:

(a) If a factor is a cause it must be the cause of a certain clinical syndrome. This being so, it must necessarily on every occasion give rise to this syndrome and no other. The descriptions of the clinical manifestations of diseases which can be found in every text-book of medicine prove, however, that this is not the case, for a disease, *i.e.*, a cause

may sometimes manifest itself by one syndrome and sometimes by another, while on some occasions it does not manifest itself at all. Moreover, differential diagnosis, which theoretically teaches us the degree of probability with which various diseases can be recognised from the clinical syndrome, indicates that each clinical syndrome may be produced by several causes. Let us take the example of Gastric ulcer: it is a *pathological structure*, and must therefore be the cause of clinical manifestations, which as stated in the text-books, take the form of epigastric pain, vomiting, heartburn etc. But there are cases where gastric ulcer manifests itself only by water brash or hæmatemesis; and there are even cases of this disease which do not present any clinical manifestations whatsoever or where the condition is detected for the first time by profuse hæmatemesis which may lead to collapse and death. On the other hand, this syndrome *viz.*, epigastric pain of the same character, vomiting, heartburn etc., may be produced by gastritis or other lesions or by no lesions at all. Taking a *functional example*, low calcium content of the blood is supposed to be the cause of tetany. But it is found that low calcium content of the blood may sometimes be accompanied by tetany and sometimes not. Taking a bacteriological example: all pathogenic bacteria are supposed to give rise to lesions. But it is known, however, that this is not so, as pathogenic bacteria may be found in so-called carriers, *i.e.*, in people who do not present any lesions or even clinical manifestations.

Thus the factors said to be causal do not fulfil the first attribute of cause.

(b) Clinical experience teaches that the disappearance of a certain structure, function or micro-organism need not necessarily be followed by the disappearance of the clinical syndrome that was considered to be its effect. As for example: the removal of the gastric ulcer is not necessarily followed by the disappearance of gastric pain, vomiting, heartburn etc.; the restoration of blood-calcium to its

"normal" level is not necessarily followed by the disappearance of tetany; and the disappearance of diphtheritic bacilli is not necessarily followed by the disappearance of the membranes from the throat.

Thus the factors said to be causal do not fulfil the second attribute of cause.

(c) Though the factors said to be causal may vary in their magnitude, these variations are not necessarily followed by appropriate variations in the clinical manifestations. As for example, variations in the size of the gastric ulcer are seldom accompanied by corresponding variations in the degree of clinical manifestations, which may begin prior to the occurrence of the ulcer and may not alter after it has occurred; variations in the percentage of blood-calcium are not necessarily reflected by corresponding variations in the clinical picture; and variations in the number of pathogenic bacteria are seldom accompanied by corresponding variations in lesions.

Thus the third attribute of causal factors is not satisfied.

(d) It is often impossible to say whether or not the "causal" factors occurred before the clinical manifestations. Since usually they are diagnosed from the fully developed clinical picture, it is merely assumed that they occurred prior to the clinical manifestations, on the ground that the cause must have preceded the effect. It is seldom possible to prove whether it actually did so or not, and on the other hand, it is known that those factors may occur after the clinical manifestations have appeared. As for example, gastric ulcer may persist after the clinical syndrome has disappeared; low calcium content of blood may appear, not at the beginning but in the course of tetany; and if a case of diphtheria is diagnosed, it is assumed that the micro-organisms have been present in the patient's throat before the appearance of clinical manifestations.

Consequently clinical evidence proves there is no causal relationship between clinical manifestations and the allegedly causal factors, such as structure, function and

bacteria. In our next issue, we will examine the experimental evidence furnished by the biological sciences in order to discover whether here the attributes of cause can be established.

B. K. S.

THE TEACHING OF HOMŒOPATHY

By T. DOUGLAS ROSS, M.B., Ch.B. (Glas.).

We assert that an understanding of the principles and practice of homœopathy would greatly increase the healing powers of doctors who acquired it. If all practising doctors could use it, the general health standard of the population would be raised; children would benefit during the susceptible growing period, healthier adults would result, and their senescence would be delayed and lightened.

There is an enormous amount of ill-health, unhappiness, and time lost from work, because of chronic diseases, which are little improved by the measures now generally used for their cure. I need instance only rheumatism, tuberculosis, peptic ulceration, and skin diseases. In spite of the brilliant discoveries of the antibiotics, which homœopathic physicians are also glad to use, the recovery of patients from acute disease is quicker, and more satisfactory when the homœopathic remedy is given; its scope in chronic disease is little affected by these modern advances.

As I see it, the object of the Faculty of Homœopathy is to preserve the principles of our specialty and to improve and propagate the art of its practice in the cure of disease, until it is properly taught in all medical schools, or until it is superseded by something better. Therefore, it is our moral duty to teach homœopathy to a far larger number of doctors.