HOMŒOPATHIC PRINCIPLES

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One hundred and sixty-three years ago in Hufeland's journal, Samuel Hahnemann presented his first formulation of the philosophy and practice of Homœopathy—further expanded by him into a mature science during the next 19 years in his *Organon, Materia Medica Pura, Chronic Diseases* and in many individual articles. Save for an observation on certain characteristic therapeutic responses by one of his close associates, Constantin Hering, Hahnemann's writings contain those principles basic to the practice of homœopathic therapeutics. Since different interpreters of Homœopathy stress different principles, I have tried to include as many as are either stated or implied in Hahnemann's or Hering's writings.

From this extremely catholic viewpoint the basic homœopathic principles appear to number 10—six procedural and four philosophical.

The six procedural principles are:

1. Monopharmacy—the administration of one medicine at a time.
2. Dilution of the medicines in generally accepted ranges (molecular dilutions).
3. Dilution of the medicines beyond the generally accepted quantitative range of Avogadro, 6.12×10^{-23} (ultra-molecular dilutions).
4. Succession and/or trituration of the medicines at each stage of dilution.
5. Testing of all medicines on healthy humans before they are used therapeutically.
6. Use of experimental and control groups.

The four philosophical principles are:

1. Lawfulness—that therapeutic laws do exist.
2. Law of similars, based on the administration of that medicine to the patient which would produce his symptoms in the healthy.
3. Vitalism—that the patient's symptoms represent a natural attempt to restore health and should be reinforced rather than interfered with. Therefore, correct prescription is often followed by a brief aggravation of existing symptoms before they are ameliorated. From this it follows that a medicine which produces symptoms new to the patient has acted in a manner different from the self-healing of the patient.
4. Purposiveness—that the shifting symptoms of the patient follow a meaningful temporal pattern, and that a curative response is usually accompanied by a symptomatic shift from vital to less vital organs with the symptoms disappearing in the reverse order of their appearance, the newest first, the oldest last. As a corollary, it follows that a shift of symptoms in the opposite direction, from less to more vital

organs and from oldest to most recent symptom, indicates a repression of the patient's illness rather than a cure.

Ultra-molecular dilutions, were first introduced by Hahnemann but were, rather, re-statements of old, scattered observations both Occidental and Oriental, ancient and medieval, as pointed out by myself and others. In comparison to the medical practice of his day they were all unique, save the use of molecular dilutions, succession, and trituration and the concepts of lawfulness and individualization. In addition, the completed body of homœopathic investigation and practice which Hahnemann put together out of these disparate elements was then unique and remains so today. Hahnemann is probably the unrecognized founder of western clinical pharmacology.

Hahnemann, therefore, re-introduced his colleagues to 10 pharmacological principles: monopharmacy, ultra-molecular dilutions, testing of medicines on healthy humans, use of control groups, treatment by similars, vitalism, purposiveness, and an all-inclusive attitude toward the patient's symptoms of his response to therapy as well as the effects of medicines on healthy persons. The attitudes of his colleagues then, and since, both to these 10 principles and the 4 which they already accepted, provide a fascinating psychological and experimental study.

By one of those peculiar historical coincidences which have often characterized basic discoveries, in the very year in which Hahnemann's article was published in Hufeland's journal, Edward Jenner produced cow-pox in an eight year old boy by the implantation of cow-pox virus obtained from a milk-maid. Two months later the boy was shown to be immune to small-pox. However, Jenner did not publish this result for several years. Thus, almost as soon as it was formulated, Hahnemann's re-introduction of *treatment by similars* was substantiated by another, independent investigator.

Thirty-four years later Broussais, the physiologist, re-emphasized the importance of *including emotional and mental symptoms as well as* physical in the evaluation of the patient. Exactly 50 years after Jenner's work, Bucheim founded in Dorpat, Germany, the first European department of pharmacology based on the new anatomical and physiological principles of the followers of Harvey and Vesalius. In this manner he prepared the way for a laboratory study of the action of medicines and the re-institution of *mono-pharmacy*. Largely as a result of this attempt to include new disciplines, pharmacology shifted its orientation from the more or less empiric, traditional therapeutics it had maintained since the middle ages to one rational, laboratory-oriented system of therapy after another. Thus we can trace in the 19th century the growth of a physiological pharmacology, well expressed by Claude Bernard:

"In the empirical period of medicine, which must doubtless still be greatly prolonged, physiology and therapeutics could advance separately; for as neither of them was well established, they were not called upon mutually to support each other in medical practice. But this cannot be so when medicine becomes scientific: it must then be founded on physiology."

Next came the bacteriological pharmacology of Pasteur, followed by the pathological pharmacology of Koch who, in his classical work on tuberculosis, appears to have introduced the *use of controls* in experimental pharmacology. In the 20th century we see the radiological pharmacology of Roentgen, the bio-chemical pharmacology of Ehrlich, Best and others and, most recently, the isotopic pharmacology of Einstein. During the period of rapidly shifting viewpoints, the older concepts of *vitalism, individualization* and of *the lawfulness of therapy* were dropped, to be replaced by a pragmatic empiricism in which only those therapies were practiced which were in harmony with the particular laboratory discipline in vogue during any period.

For the 50 years after Koch's work there was a hiatus in respect to the acceptance of homœopathic principles until the 1930's when Flanders Dunbar re-emphasized the psycho-physical parallelism of Broussais and almost single-handedly brought into existence that detailed department of psychosomatic medicine we know today, with its emphasis on the *physical and emotional totality of the present and past symptoms of the patient.*

Next, in 1952, Delay, Denniker and Harl introduced the use of chlorpromazine into psychiatry and started the era of psycho-pharmaceuticals, many based on the *testing of medicines and the recording of their total physical, emotional and mental effects on both ill and healthy humans.* Next came Réné Dubos' stressing of the frequent *constitutional contribution of individual patients* to their contagious illnesses.

From our consideration of homœopathic principles so far, it is evident that Hahnemann's and Hering's discoveries have had a dual impact upon western medicine. First, like a single great explosion, came the appearance of a complex, virtually complete science of the evaluation and administration of medicines. This was accepted consciously, and in the majority of cases completely, by many of Hahnemann's contemporaries who became known as homœopathic physicians, their unconverted colleagues being called, variously, "regular," "orthodox," "non-homœopathic," or (a term coined by Hahnemann and with little meaning today) "allopathic" physicians. As a result, a schism appeared in the consciousness of western physicians which has not yet been healed. Although Hahnemann was a crusty, intransigent German, Sir William Osler did not equivocate as to where the blame for the split lay, when he said:

"It is not as if our homœopathic brothers are asleep: far from it, they are awake—many of them at any rate—to the importance of the scientific study of disease.... It is distressing to think that so many good men live isolated, in a measure, from the great body of the profession. The original grievous mistake was ours—to quarrel with our brothers over infinitesimals was a most unwise and stupid thing to do. That we quarrel with them now is solely on account of the old Shibboleth under which they practise.... The rent in the robe of Aesculapius, wider in this country than elsewhere, could be repaired by mutual concession...."

The second impact of Homœopathy was more like a small arms fusillade, consisting of the gradual, one-by-one acceptance by non-homœopathic physicians of the majority of the homœopathic premises, with little apparent consciousness of their origin. This second homœopathic impact has not been recognized to any degree either in homœopathic or non-homœopathic circles. As a result a split still exists at the consciousness level which has been largely healed in practice. Lest this seem too radical a statement, consider that any physican who has administered quinine for malaria, colchicine for grant' or X-ray for skin cancer (and what physician has not?) has treated on the law of similars and has, literally, practiced Homœopathy whether he was conscious of it or not. Von Behring, the discoverer of tetanus anti-toxin, recognised this when he said:

"In spite of all scientific speculations and experiments regarding small-pox vaccination, Jenner's discovery remained an erratic block in medicine, till the bio-chemically thinking Pasteur, devoid of all medical class-room knowledge, traced the origin of this therapeutic block to a principle which cannot better be characterized than by Hahnemann's word: Homœopathic. Indeed, what else causes the epidemiological immunity in sheep, vaccinated against anthrax, than the influence previously exerted by a virus, similar in character to that of the fatal anthrax virus? And by what technical term could we more appropriately speak of this influence, exerted by a SIMILAR virus, than by Hahnemann's word 'Homœopathy'? I am touching here upon a subject anathematized till very recently by medical pedantry; but if I am to present these problems in historical illumination, dogmatic imprecations must not deter me."

Without belaboring the point further, it should be evident that we have not been discussing 10 "homœopathic" principles but rather 10 pharmacological principles now largely adhered to in greater or lesser degree by all physicians, most of all by homœopathic physicians. Just four of the ten are actually only homœopathic at this moment, because they have not yet been accepted by other groups. These are the use of ultra-molecular dilutions, and a belief in therapeutic laws, vitalism and purposiveness.

The acceptance of these principles has been such an unconscious, gradual process that as yet neither the homœopathic or non-homœopathic physicians have appreciated its significance. The sooner they do so the sooner that "rent" (of which Osler spoke 50 years ago) can be mended. Each group—homœopathic and non-homœopathic—can help bring this about.

The homœopathic physicians can clarify their own speciality by using basic terms from the fundamental, non-medical sciences in place of more specialized terms understandable only to homœopathic physicians. For example, the use of the English "experiment" in place of "proving" (from the German PRUFUNG, meaning experiment), and of the simple term "medicine" instead of "potency" (after all many non-homœopathic medi-

cines are potent!), or, if more detail were needed about a medicine, one could speak of succussed or triturated dilutions. Equally, the vague terms "high" and "low" dilutions could be replaced by the objective terms "molecular" and "ultra-molecular" dilutions, defined by Avogadro's limit of 6.12×10^{-23}. The Latin names of many of the botanical and zoological medicines need to be brought up-to-date and many of the chemical names need to be anglicized for English publications, as is the present-day custom. A little thought will certainly provide other suggestions.

Non-homœopathic physicians need to focus on the facts of the case, rather than unsubstantiated, "authoritative" opinions, and test for themselves the validity of any of the homœopathic principles which are of interest. They can also be of great help by encouraging their homœopathic brethren to use those new applications of statistics to clinical pharmacology, such as the single-blind control introduced by Evans and Hoyle in 1933 and the double-blind controls of Gold et al. in 1937.

A new science of clinical pharmacology, incorporating the best of existing approaches to the subject, could bridge the gap in consciousness which still, unfortunately, exists between homœopathic and more traditional pharmacologists.

—Jourl. of the Am. Inst. of Homœopathy, Sept.-Oct., '60
