PAAM Medical Letter, Vol. 2, Issue 4, August 24, 2015

Dear PAAM Members!

Welcome to another edition of the PAAM Medical Newsletter. Thank you to all for being members of PAAM! We hope that belonging to PAAM is worthwhile to you. Your membership certainly makes PAAM stronger and helps support the anthroposophical medical movement in the US and North America. Thank you. We appreciate your involvement.

Please note: This Letter is for your thoughtful consideration and personal research and is not to be taken as something dogmatic to believe in nor promote as something official from PAAM or the international anthroposophic medical movement.

This medical newsletter is part 2 on the complex topic of homeopathy, current debates and anthroposophic medicine's relationship to it. As we did in the last issue and is now our custom, I want to introduce again the meditative saying that Rudolf Steiner gave to the members of the General Anthroposophical Society as a motto for how to orient oneself and work in the world:

Seek the truly practical life,
But seek it in such a way that you do not become blind
To the spirit working in it.

Seek the spirit,
But do not seek it out of spiritual greed,
But rather seek it
Because you wish to selflessly apply it
In the practical life in the material world.

Apply the ancient principle:
Spirit is never without matter,
Matter never without spirit
In such a way that you say:
We wish to work in all that is material in the light of the spirit,
And we wish to seek the light of the spirit,
That it may develop warmth for our practical work.

Rudolf Steiner
9/24/1924

May the above saying be a continual, unfailing guide in our work as AM practitioners!

Attached Literature

Attachment #1 and Attachment #2. These two published papers from Iris Bell and colleagues give a good modern view of homeopathy, using the language of science and its research results as well as providing a scientific model from which to understand homeopathic remedy effects (their potential, non-pharmacologic mechanisms). While Bell et al., lay heavy emphasis on the documented presence of nanoparticles in homeopathic remedies, there is also certainly some evidence of epitaxis, i.e., changes in the structure of the solvent after serial potentizations that allows for a kind of "memory" of the

solvent (water, alcohol or lactose powder). Iris Bell is an important academic researcher of homeopathy; her published work is something to follow. These two papers are dense, with a lot of information and references to support her views. One important observation that Bell honestly points out is the lack of reliability and consistency of the clinical effects of homeopathic remedies. She thinks that the variability of the amount of nanoparticles present may be part of the problem. We will come back to this point.

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Attachment #3. This is a recently published debate in the BMJ between a researcher who believes the clinical research is supportive of clinical homeopathic remedy effects and a long-term critic of homeopathy who scornfully dismisses the positive research as biased and insists on the implausibility of homeopathic remedies having any significant active substance at all. Each side has some good points and evidence with references to support them. However, an impartial observer can't help but notice that the positive clinical evidence for homeopathy is modest or weak (OR 1.53-1.98), depending on your point of view. A lot of studies have been done (most with poor methodological quality) but only a few are suitable to analyze and they show a weak, statistically positive, clinical effect (OR 1.98). The critics of homeopathy, who are often rabid scientific materialists and atomists, always go around in the same circles with their arguments and seem to be unaware of the modern research on the plausibility of nanoparticles being generated by potentization and their possible effects (not to mention the ability to detect subtle, epitatic effects). The critics point to biases and methodological errors in positive studies, the presence of negative RCTs and meta-analytic reviews, and believe the weak, positive results are from biases (one critic called it "trickery") and/or placebo effects. They also rightly point to the inconsistency of the clinical findings and study results, but don't seem to appreciate the heterogeneity of the studies and the importance of individualized homeopathic treatment. In addition, the weak or modest effects of homeopathic remedies is about on par for other pharmaceuticals, like NSAIDs.

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Attachment #4. From our anthroposophic friends at the Lily Kolisko Institute comes their 2014 monograph on the Kolisko Validation Method (a standardized, biological test looking at the germination and growth of wheat seeds under various potentized substances) that they have studied, and now use in making their single, potentized, homeopathic remedies. They have carried further the early work of Lily Kolisko, who was a collaborator with Rudolf Steiner. The institute directly addresses the questions of what potency to use and the reliability and quality of the homeopathic remedy and its clinical effects. Using a more standardized, reproducible and statistically analyzable approach, they have been able to verify Lily Kolisko's earlier results and also Steiner's indications to graph the results and see patterns in the curves produced, as well as the null points (see Steiner's comments below). This work of the Lily Kolisko Institute is one important and anthroposophical way to the solve the reliability problem in homeopathy (noted by Bell, Steiner, and others). True Botanica offers may validated potencies of homeopathic remedies.

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Attachment #5. These are all the statements I could collect that Steiner made about homeopathy in his first medical course to physicians and medical students. He gave a total of 20 lectures from 3/21/1920 to 4/9/1920 in Dornach, Switzerland. These lectures are published as Spiritual Science and Medicine and as Introducing Anthroposophical Medicine (CW/GA 312). There only a few paragraphs where Steiner mentions homeopathy. In reading them, it becomes clear that Steiner doesn't talk about homeopathy in the abstract, but always relates it to nature, her processes and the anthroposophical view of the human being. Through these brief indications one can surmise that the anthroposophical approach to homeopathic remedies is seated in nature, in substances and their processes, and in the

physiology of the human being. Steiner is also clearly aware of the unreliability of results in homeopathic medicine.

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I also included the last few paragraphs of his 20th lecture where he tries to summarize his approach and purpose of these lectures, warns of the need to cure the materialism in medicine, tries to engender a scientific approach in his listeners, and finally, provides the moving admission of the difficulty he had in knowing where to best begin and the more painful difficulty he had in concluding “this introduction”, knowing he couldn’t tell all he had to say!

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How can we briefly summarize the differences between anthroposophic medicine and homeopathy? The points noted below can be a help. Anthroposophic medicine:

a. Recognizes other principles of healing besides the similimum concept (the law of similars or “like cures like”), including allopathic, naturopathic ones, and uniquely anthroposophic ones. The threefold, polar view of the human being means that true health requires a balance between the upper cephalic pole and lower metabolic pole that can be mediated by the middle rhythmic system. The two functional/organic poles may be relatively weak or strong and can be found to work inappropriately in a wrong sphere of the body, causing a sclerotic tendency in the metabolic-limb system (ex. cancer) or an inflammatory tendency in the nerve-sense system (ex. migraine headache). Anthroposophic remedies and treatment are designed to separate these two spheres into their functional/organic poles and thereby restore health.

b. Employs combinations or complexes of remedies to achieve a unique and harmonious effect, balancing the three functional and organic systems (Nerve-Sense System, Rhythmic System, Metabolic-Limb System). Classical homeopathy uses only a single remedy at a time, although it certainly can use more than one in a sequence of treatment.

c. Employs processes of preparation that mimic nature’s processes and have several complex pharmaceutical steps (“modern alchemy”). The 7 pharmaceutical processes are: maceration/cold extraction, digestion or incubation, infusion, decoction, distillation, carbonization and ash formation. There are also processes that expose the remedy preparation to light and dark periods in rhythmical ways. Most of these processes are not done in homeopathy.

d. Rarely uses homeopathic potencies above 30X or 60X. Remember Peter Hinderberger’s contribution in the last medical newsletter where he pointed out how Steiner used tinctures and low potencies between D4 and D6 most often. Homeopathy will use extremely high dilutions 1 M (a million dilutions) and above (all achieved by mechanization). Anthroposophic medicine will also use herbal teas, tincture and capsules, either alone or in combination with other remedies, as well as injections. Homeopathy uses almost exclusively oral remedies. He even suggests some nutritional and herbal supplements to build up general health.

e. Uses largely human, and carefully thought-out rhythmical methods of mixing of the substances (vortex or lemniscate mixing). Homeopathic companies, on the other hand, use machines and mechanical means for the mixing and potentization. The only exception to this is True Botanica’s use of a shaker/agitation machine to create a vortex and precise, identical agitations between dilutions (avoiding human fatigue).

f. Employs the fourfold (physical body, etheric body, astral body and "I") and the threefold (Nerve-Sense System, Rhythmic System and Metabolic-Limb System) polar views of the human being for diagnosis and treatment and to understand the pathophysiology of the illness. Homeopathy can be a confusing catalogue of symptoms produced by hundreds of remedies that one tries to match up with the patient's total symptoms and complaints; this can be time-consuming and overwhelming.

e. Employs polar views of illnesses (e.g. inflammation vs. sclerosis; hysteria vs. neurasthenia) in a developmental time framework of the human being's biography and threefold and fourfold anthroposophical physiology. While this is admittedly complex (because the human being and nature are complex), the point is to try to make the practice of medicine more rational and in accord with the dynamic processes in nature and in the human being. Anthroposophic medicine tries to train our thinking and subtle observations so that we can have insight into the illness of the patient and provide an anthroposophically rational treatment approach. This is clearly a non-homeopathic way to approach diagnosis and treatment.

Follow-up on measles and vaccinations

Citation: Science 8 May 2015: Vol. 348 no. 6235 pp. 694-699DOI:10.1126/science.aaa3662, entitled, Long-term measles-induced immunomodulation increases overall childhood infectious disease mortality. I am unable to distribute this article via the medical newsletter, hence the citation and title of the research paper in Science. This is a typical Science research paper with technical jargon and dense content with sophisticated statistical transformation (gamma transformation) of measles incidence data and infectious disease mortality data in England, Wales, USA and Denmark, where adequate population statistics are available. The authors provide strong evidence that is consistent with other recent research that has shown that natural measles infection causes a profound immune suppression that lasts 26-30 months (maybe more). The paper provides a review of the modern scientific data showing the long-term immunomodulation by the measles virus. It appears that measles-specific T and B lymphocytes wipe out non-measles antigen specific memory cells and these memory cells take a long time and re-stimulation to eventually recover. Their data correlation and statistical gamma transformation clearly show that the immunosuppression by measles correlates with higher childhood ID mortality from non-measles infections. Measles vaccination prevents this measles-induced long-term immunomodulation/suppression and also appears to protect against the higher incidence of non-measles childhood infectious disease mortality. Hence, this research adds further support for conventional medicine's goal of global measles vaccination to protect against not only measles morbidity and mortality, but also from other ID mortality in childhood. We need to know about this. This is new information that needs to be incorporated into our thinking and treatment approach. Perhaps an anthroposophical approach to treatment and good nutrition can mitigate the long-term immunomodulation (no data/evidence to date). Perhaps anthroposophic medical treatment needs to evolve to specifically treat the immune system and help it more rapidly recover from the measles-induced immunosuppression. It would be interesting to see if there is this long-term measles-induced immunomodulation also in anthroposophical communities such as in two areas in Sweden where natural measles still occurs and is treated anthroposophically.

Attachment #6. This is another recent paper, from 8/2015, using mathematical modeling based on recent data on measles, varicella and rubella outbreaks in subpopulations of developed countries, purporting to show the risk of vaccine refusal. Empirical data has shown that in the modern era with high vaccination rates, but not necessarily high enough in subpopulation to have herd immunity, the unvaccinated tend to get measles, varicella and rubella at older ages and have more severe disease. In

the pre-vaccine ear the typical age for getting these childhood illnesses was between 4-11; now in the post-vaccination era the average time to get these illnesses is late adolescence and young adulthood, with more severe disease (morbidity and mortality). Therefore, vaccine refusal near the threshold for herd immunity, will decrease herd immunity, allow for limited transmission of disease, and increases the risk of older-age of onset of these infectious diseases in subpopulations and also more severe disease. Herd immunity is difficult to approach with especially measles. Modern estimates suggest at least 95% to >97% vaccination rates to attain herd immunity, i.e., sufficient vaccine immunization-protection, because not all vaccinations lead to immunization. What doesn't seem to be sufficiently emphasized is that the MMR and HZV vaccines are relatively weakly immunogenic, largely provide only humoral immunity, and therefore require at least two separate doses. This requires that nearly everyone needs to be vaccinated to have sufficient immunization and herd immunity/protection. No option is provided to make the vaccines more truly immunogenic or requiring more necessary doses to provide adequate protection in those who want to be vaccinated. See Paul EM Fine's Herd Immunity 1993 for more background information on the conventional view of herd immunity. He has other, briefer, and more recent papers as well.

Addendum: After further study, reflection and discussion with another person familiar with statistics and scientific methodology, here are some further thoughts. This study appears to be well done with the limited data available. However the study does some statistical massaging by gamma transformation that only shows a correlation between incidence of measles and subsequent non-measles infectious disease mortality. First, any time series data like these are approached, it is always fraught with difficulty in making a strong and valid inference; there are too many potentially confounding variables that are also correlated with measles infection, not just higher non-measles ID mortality incidence. Hence, there is only a correlation shown, even if it is a strong correlation with $R^2= 0.92$. Second, the actual number of data points for the USA and England and Wales (the best data) is only about 100. The statistics are clear but may be difficult to understand. Each "data point" is the coupled relationship between the number of measles cases and the number of non-measles ID mortality cases during an interval of time and a structured time lag (in England & Wales and in the USA, this interval of time is 3 months or 1 quarter of the year; in Denmark the time interval was 1 year). The data in the graphs after the gamma transformation is not based on individual cases, but on the coupled relationship just mentioned. With 4 quarter time intervals in a year and about 25 years of data, there are then only 100 data points, which is a limited number of data to support any strong inference. One last point, the authors did not appear to eliminate the immediate post-measles ID mortality from their study which could have been due to the well-known suppurative complications (OM, pneumonia and meningitis) from measles. It would be nice to know what the correlation would be without including the immediate post-measles ID mortality data.

Statistics aside, we still have to reckon with the animal data showing measles infection's long-term immunomodulation and the reported epidemiological data showing improvement of non-measles ID mortality after measles virus vaccination. As indicated above, optimal nutrition, use of anthroposophic remedies, judicious use of antibiotics, avoidance of fever suppression, and perhaps some further treatment of immunosuppression are all likely to be helpful.

These last two papers provide modern, more sophisticated arguments and data modeling to bolster arguments in favor of vaccinations and help round out the measles and vaccination issue of the PAAM Medical Newsletter, Vol 2, issue 2.

Contributions and Questions and Answers

There are some contributions from PAAM members to share. However, this issue is substantially lengthy and so we will look forward to sharing these contributions in the next issue.

For the PAAM Board,
Ricardo Bartelme, M.D.