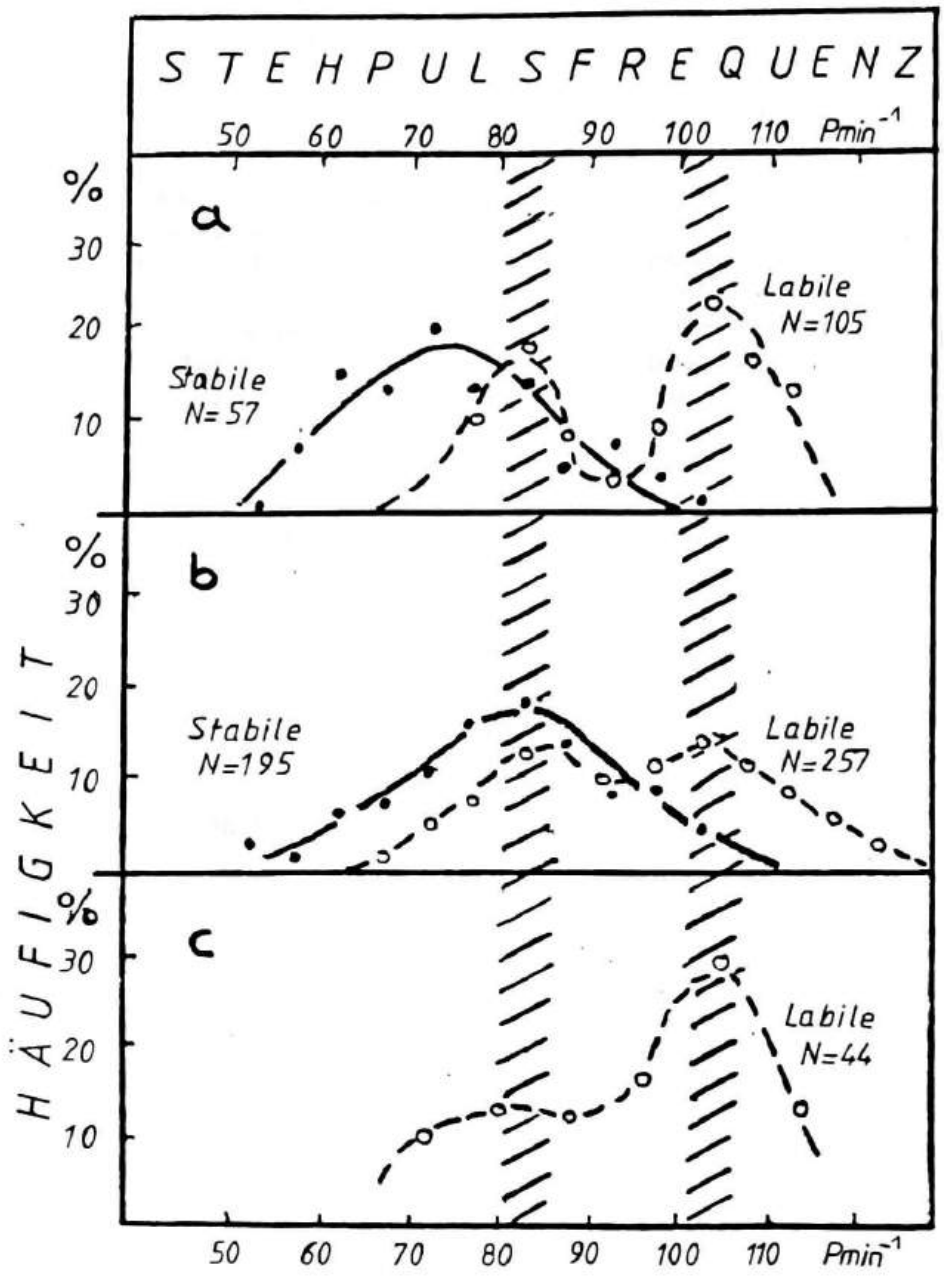

Fig.4
Frequency distribution in percent of pulse rates of orthostatically labile patients while standing (three random samples).
a) Weckenmann 1975,
b) Patients of the Carl-Unger-Klinik 1966—1975 (unpublished),
c) Weckenmann 1973.

she had also had a lymphoedema on her right leg, which had appeared without apparent cause. The patient had a tendency to chills and had cold extremities.

The x-rays showed a slight spondylosis in the lower and mid cervical vertebral column with irregular lordosis and leftsided scoliosis. The standing test presented the typical picture of a bradycardic orthostatic lability with an orthostasisquotient of 0,84 and a $Q^{P/R}$ of 6,7 standing.

Given the patient's age, the local finding on the cervical vertebral column seemed too small to be the cause of the headaches; and in connection with the lymphoedema and the bradycardic orthostatic lability, the picture pointed to a primary circulatory weakness. I began with alternating hot and cold showers. As fig. 7 shows, the respiratory rate at rest, which had originally been quite depressed, rose, but always went down again while standing. Thus, though the Q $^{P}/_{R}$ at rest did normalize towards 4, the Q $^{P}/_{R}$ standing remained unchanged. The orthostatic response of the systolic blood pressure became positive. The diastolic blood pressure had been normal from the beginning. After this I decided to give Cardiodoron in addition, 30 drops in the morning. Just before the next standing check she had an acute gastroenteritis, which brought about a striking acceleration of the resting respiratory rate with normalization of the Q $^{P}/_{R}$ but also a strong pathological orthostatic response with a drop in respiratory rate. It was not until the last test that the pulse rate at rest and standing was normal, and the respiratory rate for the first time showed a positive orthostatic response in the form of a slight tendency towards normalization with a strongly positive orthostatic response of the systolic blood pressure. The Q $^{P}/_{R}$ remained uninfluenced. The headaches improved under the therapy, occuring less often and requiring only 1 tablet of an Aspirin like analgetic (Thomapyrin) instead of three as before.

Then, instead of Cardiodoron, I prescribed Ferrum/Quarz, 1 capsule mornings, whereupon the headaches became still shorter and milder.

The acute process of the gastroenteritis clearly set off an "ergotropic" stimulus. This, however, did not compensate for trophotropia with a stabilisation in standing. A proper mediating process had not occurred. Though Cardiodoron did not improve the effects of the hydrotherapy in a dramatic fashion, it did bring about a better respiratory regulation.

To the four trophotropic cases I would like to add three with an ergotropic autonomic quality.

[8] A 39-year-old female patient (Pat. no. 8) had been feeling very tired for two years. She felt a need to breathe deeply. This would become worse after 10 a. m. and before changes of weather. In general her condition was worse in summer than in winter. She felt palpitations, especially walking uphill and before speaking to other people. She complained of abdominal cramping during bowel-movements and of chills. She had an exited-depressed air.

Examination of the leptosome, well-groomed, suntanned patient revealed no pathological findings. Average values in standing were: 95 P min^{-1}, Q $^{P}/_{R}$ 7 and blood pressure 119/95 mm Hg.

In this case I felt quite sure that Cardiodoron would be efficacious. The patient lost all her symptoms within two months. Later, the reactive depressive problem recurred but without the accompanying circulatory problems. What was noteworthy here was the typical aggravation during summer and warm front phases, which always favour hypotonic circulatory disturbances. Nevertheless Cadiodoron improved the situation during the summer months from June till August, though the patient had no holidays.

[9] The next patient a woman of 30 (Pat. no. 9), had already had a tachycardic orthostatic lability which had reacted to Cardiodoron. Now she came again at the age of 35, this time complaining less of orthostatic symptoms than of inner vibration and the need to breathe deeply. She did not feel the tachycardia very strongly at all. It was striking in this patient's case that several unsuccessful attempts at therapy preceded Cardiodoron, under which there was a rapid improvement. No relapse came until three years later, although the patient took no medicine in the meantime.

[10] The third patient (Pat. no. 10) was 45-years-old when she came to me. She complained of migraine with nausea and vomiting, aggravated before menses and from over-

Sample	17.8.8....		19.8.8....	12.9.8....
Symptoms:	2 yrs. ⟹	Emptiness in head + yawning	—	|
		Dizziness	—	>
		Palp. of hrt. < eves. in bed	—	|
		swelling of eyelids and backs of hands	< mornings	|
		ache, back of neck < mornings	—	|
		anxiety when swimming w. air hunger...		?
		chills		|
		stool hard, every 2nd-3rd day	—	|
Findings:		leptosome, thin, brunette		
		acne scars		
		thick white coating on tongue		>
		struma nodosa , w/out signs of overfunctioning		—
		atrophic mammae		
		pulmo — no finding, cor — no finding, abd. — no finding		
Laboratory:		standing test: trophotrophia w/out orthostat. lability		
Therapy:			Cardiodoron, 3 × 20 drops	

Fig. 5
Sample Outpatient Record.
Symbols: ? can't judge; — unchanged; > improved; \| disappeared; < aggravated; → Year duration of symptoms.

work, of upset stomach, flatulence, outbreaks of perspiration, rotary vertigo on standing up, difficulty waking up in the morning, exhaustion and cold hands.

The slim, dark-blond patient spoke in a strikingly clipped and fast manner; her throat and nape muscles were sensitive to pressure and hardened. There was an osteochondrosis $C_{3\text{-}6}$, the standing test gave a pulse rate of 91 min^{-1} with Q P/R of 6.0 and BP at 115/84 mmHg. — i. e. an orthostatic lability with an orthostasis quotient 0,82 on the border between tachycardia and bradycardia. Despite the pathologic-anatomical alterations, this seemed such a typical case for Cardiodoron that I prescribed it.

After two months the perspiration outbreaks had disappeared. The improvement of flatulance symptoms was striking, although the therapy consisted only of a "circulatory remedy". Here we touch on the question of the so called secondary symptoms — say so called, because there really is no such thing. A symptom can be less prominent or troublesome, but it is just as characteristic. The remarkable thing is how such symptoms can also disappear under Cardiodoron if the total picture is correct.

Another example of this was given to me by a woman who came to me at the age of 40 (Pat. no. 11) with a 10-year history of unclassifiable pain in the joints. A treatment with vegetarian diet, Folia Betulae, mustard plasters, abdominal compress, Equisetum D15 / Formica D10, Betonica D3 / Rosmary D3 brought good improvement.

Then, however, the patient suddenly complained of nausea while swallowing. I found no objective alterations: the symptom was a riddle at first. I tried to find a greater context

in which to see it, and discovered traits in the patient that seemed to point to Cardiodoron therapy. Hence I interpreted the throat symptom as local "nervous weakness" with insufficient metabolic supply, and gave Cardiodoron — with prompt success.

This can perhaps show how a mysterious symptom will find its place when the general concept is recognized, how this concept may arise more intuitively than logically orationally, and how the correctness of a certain procedure can be confirmed through the therapeutic steps. I believe that this is a legitimate procedure, though often an unconcious one. However, it can only be valid for regulatory therapy methods, and needs "exact imagination" in Goethe's sense. Those who think differently may pass this of as a placebo effect.

Discussion of the results

How did my expectations of Cardiodoron fit the patients with successful therapy? "Nervous weakness", i. e. the inability to tolerate nervously charged moments, is what I saw in the excitability, the expectation anxiety, and sometimes also to an extent in the headaches. The tendency towards slow respiration was experienced as dyspnea in the trophotropic patients (very typical!) and this was felt especially on the day following emotional stress and improved with physical stress (Case no. 6 and case no. 7). Since the respiratory stimulus is very dependent on the waking CNS (Comroe 1968), one can speak of a "falling asleep" of the respiration, from which trophotropic patients suffer particularly. In most cases the pulse rate showed a relative or absolute elevation with indications of circulatory depression while standing. This leads to "sedimentation" — an indication that the circulation is insufficiently vitalized when under difficult circumstances, e. g. on standing and in warm weather (Pat. no. 8). In theses cases we can see a correspondence between expectation, interpretation of the symptoms and action of the therapy. There were also indications of the need to differentiate. The effect of Cardiodoron applies largely to primary functional disturbances and not to secondary ones caused by anatomical deformations (Case no. 1). Therefore, prescription of Cardiodoron in advanced age should be carfully considered. However, premature aging in relatively young adults does not seem to be a contra indication (Case no. 6).

It can be seen that hypertension becoming stable and incipient signs of bradycardic rhythmic disturbances with retardation of the spread of the action potential, even when this leads secondarily to tachycardia, cannot be brought to a long-term cure with a sulphur therapy such as Cardiodoron (Case no. 2). On the other hand cases of rigid regulatory patterns with hypotonia but without orthostatic lability are clearly still treatable with it. This finding, however, should be subject to further testing (Case no. 4).

The frequency of the leptosome build among our Cardiodoron patients is striking. This is explained by the observation that leptosomes tend more often to heightened pulse-respiration-quotient than do pyknotics. (Weckenmann and Schreiber, publication in preparation). If a raised $Q^{P/R}$ ratio proves to be an indication for Cardiodoron, then it would be sensible to associate the leptosome body type with this indication.

Disconnected symptoms which are at first hard to classify can disappear with Cardiodoron if the patient's functional system and constitution speak in favour of a Cardiodoron therapy (Case no. 11).

Relapses years later will respond again to Cardiodoron when the symptoms indicate it (Case no. 9).

Experiments have shown that a single daily dose of Cardiodoron can be efficacious.

The preponderance of the female sex found here, however, does not seem a probable indication to me, since though women also predominate in larger groups of orthostatically labile patients, they are also more often ill than men. Thus the ratio of women to men

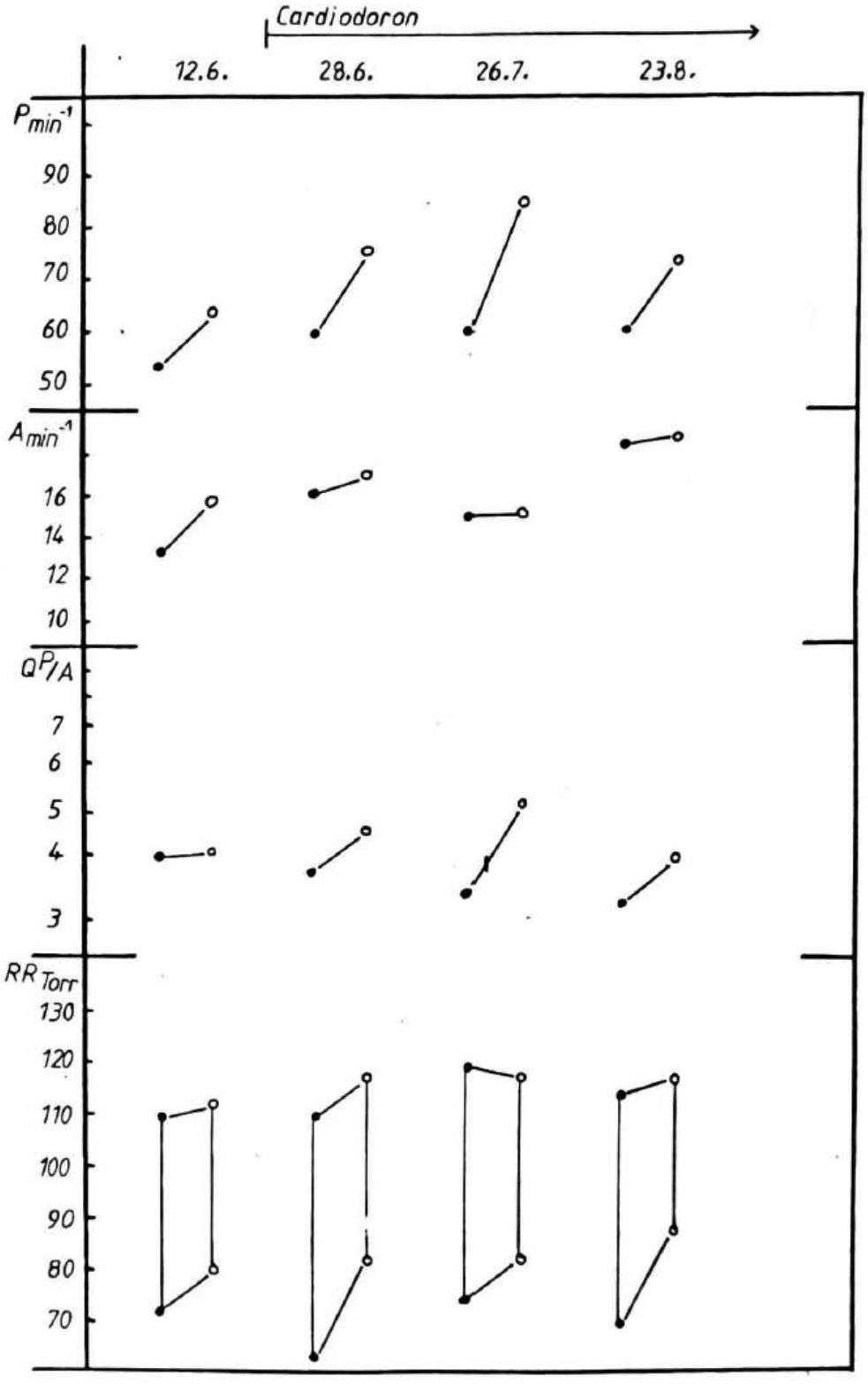

Fig. 6
Behaviour of average values of pulse and respiratory rate, $Q^{P/R}$ and blood pressure lying ● and standing ○ for patient no. (4) before and (after) during Cardiodoron.

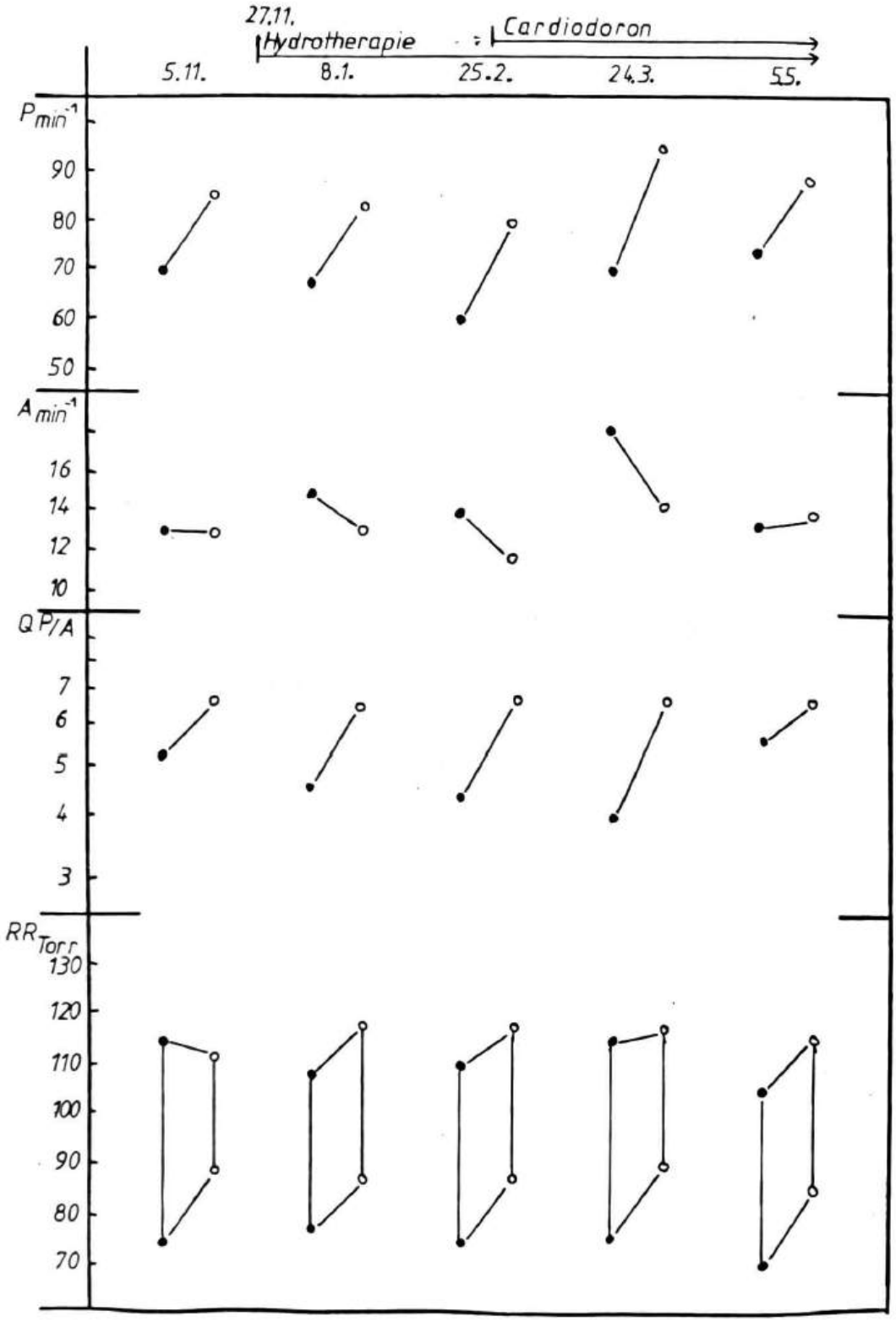

Fig. 7
Behaviour of the average values of pulse and respiratory rate lying ● and standing ○ for patient no. (7) before and during hydrotherapy and Cardiodoron.

in our clinic was 1,8/1,0 and that of the surrounding population 1,1/1,0 (Statistisches Landesuntersuchungsamt Stuttgart).

Is my concept of Cardiodoron and of the patient for whom it is indicated correct? — It seemed surprising how few patient are necessary to obtain indications when one observes exactly, makes exact documentation and prescribes only a single remedy. In this way guide lines arise for new therapeutic approaches and contra-indications. To be sure, we are dealing more or less with therapeutic attempts; but the mistakes appear early on and can be corrected. This manner of finding indications is not statistical but individual.

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THE LILIACEAE

Sulphureous succulence, congestion and rocketing growth

by the later Wilhelm Pelikan

Translation from the German of the twentieth chapter of the author's *Heilpflanzenkunde* (botany of medicinal plants). Vol. 1: published with the kind permission of the author and of the publishers. Philosophisch Anthroposophischer Verlag am Goetheanum/Dornach. Switzerland, whose permission should be sought for reproduction. Translator: A. R. Meuss, FIL. Member of the Translators' Guild.

In the Liliaceae, the class of monocotyledons reach their highest development, the pinnacle of flowering form. The lily family offers quite a variety of forms, yet basically it has a very simple, easily discernible pattern of growth. One feature shown by the family type is etheric congestion*), watery, mucilaginous swelling. Bulbs, corms and rhizomes are characteristically formed, so that this plastic swelling and congestive growth takes place beneath the surface of the soil; it frequently extends also to the leaf process, holding it back close to the sphere of subterranean organs, where rosettes may form. Bulb formation – sometimes below ground, sometimes half in the earth and half above it – does of course represent a leaf principle held back in a closed-up, swollen bud, around a shoot pushed down and compressed to the nth degree? Actual root development is poor and rather primitive, as in many of the monocotyledons. This indicates that the Liliaceae arose during an early period of earth development and plant evolution, a time when growth took place not in the solid, mineral earth of today, but in a softer, more plastic, fluid soil. The plants belonging to this familiy do give the impression of something childlike, soft, primitive, indeed embryonic. What they desire, first and foremost, is to become a living drop, a watery sphere.

*) Readers who are not familiar with the terminology used here may find it helpful to read the first three chapters of the book. These were published in translation in *The British Homoeopathic Journal*, 59, 164-173 and 224-234 (available as reprints in part 1 of *Healing Plants*, Rudolf Steiner Press, London).

A tremendous effort is required to move out of such watery succulence, and advance to a flowering process of great intensity in scent, colour, and form. A long period during which the plant rests within the rounded sphere is followed by vehement release from tension, arrow-straight upward-rocketing growth, with the plant giving itself up entirely to the upper elements of light, air and warmth, and the worlds of colour. The watery, mercurial principle gives way to a tremendous sulphur process that needs the assistance of the element sulphur itself to come about, especially in the subgroup of the Allioideae. Sulphur substance enters into the fluid proteinic plasticity, releases from it the sulphur-containing essential oil that is found in all the onion family, and channels it up into the volatile sphere of floral scents. Thus the lily plant ascends from the fluid sphere to the region of airy elements. Even the most lovely perfumes of this family, like those of the lily-of-the-valley and the hyacinth, always have a hint of something sharp and inflammatory, onion-sulphureous, lingering in the background. It is because their protein processes are "sulphur-treated" like this that members of the Liliaceae, watery and succulent as they are, nevertheless are also strongly permeated with light and warmth.

Liliaceae existence therefore swings to and fro between mercury and sulphur principles. Salt, the earth processes, have little part in it. Mineralization, lignification, tree growth, is unusual in the familiy. The assimilative process does not condense as far as starch formation; it suffices for it to have concentrated as far as a slimy, sugary stage that holds on to the watery principle with great tenacity, preventing it from evaporating into the air.

Despite the simplicity of its basic theme, the family type is capable of producing much variety, and has given rise to approximately 2600 species. The individual species are distributed over the whole of the earth; the far north and alpine regions with their crystalline rock-forces, the "salt" pole of the earth, have to do without them, however, whilst they love the sulphureous climates of the tropics and subtropics. There are no aquatic or swamp plants among them, for water on the outside would only interfere with formative forces closing themselves up within their own fluid sphere. A drop form, waiting for the light to come and fill it with colour, waiting to arise itself as a form of colour, would be threatened in its existence as an individual drop by large expanses of water, in danger of dissolving into them. The cold of polar regions on the other hand would cause this fluid entity to freeze and become an ice crystal.

Protein, the "water of life", always needs sulphur, as we have stated in an earlier chapter, the substance "the spirit uses to moisten its fingers" before it moulds the stuff of life. In the Liliaceae, sulphur assists mercury to make the transition into the flowering process.

With this transition into the flowering region, the lily process explodes into another principle of form—the six-pointed star that is characteristic of all the monocotyledons. What a transition this is, from a drop form to a hexagon. The hexagon is of course inherent in the circle, with the radius equal to the length of one side of the inscribed hexagon; in geometrical terms, circle and hexagon show the most intimate relationship one can think of. If we consider a drop of water, from its origin, the precipitation of a rain drop, making it subject to the earth, and then rising in the opposite direction, upwards into the heights that are part of the cosmos... up there it may have been an ice or snow crystal, until winter brought it floating down to earth. Water has a drop form on the one hand, and the hexagonal shape of a snow crystal on the other. In the lily, this inner nature of water is expressed as a living form, rounded and drop-like in the lower, and radiantly hexagonal in the upper organs. The image could be expressed like this: the lily archetype streams down from above as a six-pointed star, in cosmic purity and coolness, and melts into a watery drop as it touches the surface of the earth.

The type outlined above is shown most clearly by the Liliaceae growing in the temperate regions, particularly around the Mediterranean. In early spring they produce a head of leaves, keeping it close to the congested subterranean organ, be it a root stock, corm or bulb. Often enough, this looks like an onion opening out half way. In the summer-flowering species, a leaf element is taken upwards, spiralling, with the flowering shoot, or may gather itself again, rosette-like, in a leafy head at the top. The calyx with its three sepals loses its greenness, assuming the same colour as the three-petalled corolla. This gives a six-petalled appearance to the flower.

Snowdrops* see the winter out, squill, bog asphodel, grape hyacinth, daffodils, narcissi and tulips bring beauty to spring; lilies and crown imperial are part of summer, and the meadow saffron concludes the procession. This is how the family type spreads itself across the growing season in our latitudes. In warmer climates, the brief spring of deserts and steppes is made manifest by Liliaceae. For one wondrous week, their life, carefully protected below ground in corms and bulbs, floods the desolate earth with the colour and scent of millions of blooms. Bulb formation may be pushed up above ground level to some distance, on a short, stout stem, with thick, fleshy green leaves, pointed and prickly, the whole structure opening out half-way or completely; after many years, often, of vegetative stasis in this type of succulent structure, an impressive inflorescence suddenly shoots upwards, like a candle or a rocket, and in this the plant often exhales its life. The aloes and dragon-trees of Africa, yucca and nolina in the desert steppes of Mexico, Texas and California, the bowstring hemps (Sanseviera species) of India and Africa, and the Australian "grass-tree" are of this nature.

In the 100 asparagus species, the bulb has become a much branched system of underground shoots; the leaves of these tall and slender climbing shrubs have sacrificed their existence to stem formation, dissolving into bushy branches of airy greenery. In the asparagus species, lily nature has transcended itself and entered into the sphere of the air, has developed "in the air and for the air", whilst onions and leeks, for instance, incorporate air elements in their hollow fleshy leaves.

Tropical forests provide the habitat for spider plants and Smilax species (prickly ivy, sarsaparilla); these climb up into the trees, twining or holding on with tendrils that are lateral leaf organs, with backward curving spines or similar structures on their stems; or they are hanging plants, nesting in the branches, sending down long aerial roots. One might say they are living one floor higher up than our own Liliaceae, in a region full of upward proliferating earth forces, where they tend to get somewhat out of hand. The flowers with their beautiful perfume on the other hand become insignificant. In many of these species, saponins may be found in the bulbous root stock.

Medicinal plants among the Liliaceae

The medicinal plants of this family show onesided development, in one direction or another, of the basic type. As they are strongly flowering plants, the action is on metabolic processes, chiefly in the lower organization, and largely follows the paths taken by sulphur in the body. Digestive activity is stimulated, the liquefied food is made more accessible to the etheric body and taken over into anabolic processes, handed over to the part of the astral body that is active in metabolism, and left to be breathed through, permeated, with the airy organization. The fluid organization is filled with light and warmth where it is caught up in morbid congestion, and excess fluid is eliminated. Inflammatory swellings

*) Botanically, snowdrops, daffodils and narcissi belong to a closely related family, the Amaryllidaceae; their growth pattern is the same, however, as the lily process presented here, so that they may be included in the description.

and watery from exudation in the region of the head and neck have their plant counterprocess and polar opposite in the bulb process, a process situated between root and leaf. For details of this, see the descriptions of individual plants.

Allium sativum, garlic

Congestive growth occurs at first, in the small centre bulb which has multiplied vegetatively, producing daughter bulbs of equal size all around itself (the cloves). In spring, the plant shoots upwards, producing a stem about 75 cm in height, accompanied by four or five grass-like carinate leaves. The shoot rapidly develops a loose umbel of flowers. Emerging from an enveloping leaf that is broad at the base and terminates in a point, this opens out in summer, with two dozen bulbils revealing the earthy bulb-forming principle untransformed and unchanged, and between them a few long-stemmed flowers, white and six-pointed. Garlic thus presents an interesting variation on the Liliaceae theme. The whole plant is filled with the persistent, fiery, sulphureous leek smell (allyl propyl disulphide). It grows wild in the hot, dry regions of the Mediterranean and Asia Minor.

This plant, which pushes bulb formation right up into the flower, helps the upper organization to find the right way of acting on the lower organization, especially the digestive process. With its assistance, the ego and astral body will break down the food energetically and completely in the gastrointestinal region, and, owing to the sulphur processes, the degraded food is well prepared when it is handed over to the etheric body to be imbued with life. Alien astrality, parasitic elements, are thus deprived of a substrate, and the intestinal flora kept within normal range. Freed from all foreign elements, the food will not give rise to allergic reactions and rheumatic processes in the body. The result is a general improvement in resistance. Correct dosage is however important with this powerful medicinal herb. It also relieves intestinal spasms and has a soothing effect, liberating the astral body when it has become caught up in spasms in the intestinal region.

With the lower processes "put to rights", the upper organization is relieved of pathological metabolic processes; the fact that this medicinal plant lives so strongly in bulb formation immediately gives a dynamic relationship with the region of the head and chest. Chronic bronchial catarrh, asthma, bronchiectasis, pulmonary emphysema, and even gangrene of the lung have been treated with garlic; in this sphere, too, which as part of the respiratory organization belongs particularly to the astral body, the effect is to establish proper astral activity in coordination with the processes of the fluid, etheric principle. The hypotensive, antisclerotic action of the plant may be seen in conjunction with this; the intensely "sulphurized" process between root and leaf (bulb information) counteracts excessive "salt" processes, tendencies to mineralize and form deposits. The beneficial action on vascular damage due to nicotine or vitamin D poisoning may also be ascribed to this.

Allium ursinum, ramsons, broad-leaved garlic

This ist a real forest leek. From an elongated bulb grow glossy, green, broadly elliptical basal leaves and a slender stalk bearing the handsome umbel of white star-shaped flowers; these develop into trilocular capsules with black seeds that are carried off by ants. Growing in large colonies, ramsons fill the forest air with "sulphur". One the flowering is over, the plant soon dies.

This plant, too, has digestive and anthelminthinc properties; it prevents metabolic processes from erupting upwards into the sphere of the nerves and senses. On the other hand it also has an action on the "upper" organization, benefiting more the lung region, if there are catarrhal conditions, as one would expect with a well-developed leaf process.

Allium cepa, onion

In this member of the lily family, too, growth is congestive in the first year, with bulb formation at root level, and the air-filled, hollow leaves kept close to the ground. The following year, the inflorescence shoots upwards, a spherical umbel removing itself as far from the ground as possible. Allium cepa also originated in the Orient. It has aromatic sulphureous elements in all its parts, a wide variety of "sulphureous" substances. Other constituents derive from a vitality held down in the plastic, fluid element: mucilage, inulin, sugars, elements governing the sugar process (glycokinins), biocatalysts, vitamin C (see also under Cruciferae). Reduced to a pulp, onions give off rays that will greatly stimulate cell division (Gurwitsch radiation). Flavone glycosides and substances that strengthen cardiac activity have also been found in the onion.

The digestive, metabolism-accelerating "sulphureous" action is again greatly emphasized. The flow of bile is stimulated. In addition, the whole of the fluid organization is brought more strongly under the influence of the astral body; diuresis is greatly encouraged, watery congestion, oedemata, exudation into the tissues, are overcome and removed. The plant, with its bulb formation, also acts on the head and chest region, reducing inflammatory processes and stimulating the secretion of mucus. Used externally, as a poultice, onions will reduce inflammatory swelling (insect bites, paronychia), and on the other hand act as a derivative skin irritant. These polar spheres of action are a reflection, in the human organism, of the dynamics of the onion plant—on the one hand congested in the root region, on the other energetically exploding into the flowering process.

Urginea maritima (U. scilla, Scilla maritima), squill

A native of Mediterranean shores, this plant with its large bulb manages to live in a salty habitat, in an abundance of light and intense heat. The perennial bulb, its outer scales a reddish brown, may reach a diameter of 30 cm. The greater part of it stands out above the soil. In spring, this enormous, swollen structure sends forth a slender stem about a metre high and with a gentle S-curve to it, that terminates in a close spike of numerous white flowers with crimson stripes; these emerge laterally. When the flowering is over, the bulb produces a head of leaves the length of a span.

The plant was well known for its medicinal virtues to the ancient Egyptians. It was given the name "eye of Typhon" in antiquity. The onion-type action is greatly enhanced in the squill, with digitalis-like steroid glycosides (scillarin A and scillarin B) produced in addition to the volatile sulphureous compounds common to these plants. Medicinal preparations made from the fleshy inner scales have a powerful action on the fluid organism, where they bring about the energetic elimination of pathological cumulations of fluid, when the fluid has withdrwan from the sphere of action of the etheric organization to become "dead water". The astral body will come in strongly, squeezing out the fluid, as it were (action in cases of dropsy, ascites, anasarca, and also the watery inflammatory effusions of pleurisy). Inflammatory processes in the region of the bladder and kidneys respond well to the drug. On the other hand there is also an action on the region of the head and chest in cases of chronic bronchitis and of asthma in the elderly. Plants showing this kind of tension between etheric and astral processes always have an action on the rhythmic system, for a rhythmic equilibrium is constantly re-established between these processes. These plants act on the heart and on respiration. In the squill, the rapid transition from congested etheric processes to the unleashing of flowering processes governed by astral principles occurs in spring, the season of rhythm. It is only after the upward elimination of its flowering nature that the plant enters into proper leaf formation (always kept close to the bulb).

The crushed leaves have been used externally to treat wounds, burns, and suppurative inflammatory processes (boils, paronychia), in the same way as with other members of the lily family that we have described.

Colchicum autumnale, meadow saffron, autuum crocus, naked ladies

Having made ourselves familiar with the life and growth patterns of the familiy type and a number of Liliaceae, we find, as we come to consider Colchicum, that this plant shows distinctive anti-tendencies. As it comes into flower, the vital powers of the year are declining, with plant life withdrawing into root and seed. The meadow saffron flower thus stays at the level of the corm; the flowering process is pushed right down into the subterranean sphere, the upper forced down upon the under, without the mediating rhythmical middle, the leaf principle. The life rhythm of this plant resists the normal rhythm of life. The "rocketing growth" of Liliaceae coming into flower, leaving behind and beneath all that is leaf and root, free to rise into the upper regions, here remains caught up in the congestive sphere of the corm. After pollination, the microspores germinating on the stigma take many weeks to reach the ovules in the ovary situated on the corm below; "fertilization" occurs only at around Christmas; the seeds are formed in the sphere not of summery but of wintry forces. In spring, when all "normal" plant life goes into flowering, the infructescence arises, with its dark seed capsule, and it is at that time, too, that the leaves finally appear, to produce the new corm which will bear flowers in the autumn. During the summer, the plant stays quiescent beneath the ground. Spring and autumn, summer and winter have changed places for the meadow saffron.

It is not surprising that a plant like this is highly poisonous. The "anti tendencies" of the meadow saffron produce the poison. It is evident to the eye that the astral is coming in much too strongly. Colchicine, the alkaloid found in every part of the plant and most of all in the seed, is the most powerful mitotic poison known to man. It inhibits the stages preceding cell division and multiplication. Seeds treated with colchicine get completely out of hand etherically, with their formative forces cut off, in a sense, from the spiritual form principle; erratic mutations occur, of a type seen normally only as the result of an extreme provocation such as X-ray or radium treatment.

The medicinal actions of Colchicum do follow the lily theme, but in greatly metamorphosed form. Vomiting and diarrhoea, dropsy, scarlatinal nephritis and uric acid diathesis are treated with Colchicum. The astral body is encouraged to act more strongly on the lower organization, and particularly its eliminatory processes. On the other hand, a powerful action is to be expected in the region between head and chest, in line with the development of a corm in the plant. This action can be utilized particularly if there are "anti-tendencies" to normal form processes in the upper organization, a tendency to form deposits, to harden or form tumours in that region, and especially a tendency to hyperplasia of the thyroid. Rudolf Steiner suggested the use of preparations made from the flowering corm for the treatment of goitre, describing how this condition is due to "atony of the astral body", causing the ego organization to be pushed back by the physical and etheric bodies. Cochicum acts as a powerful stimulant for the part of the astral body which is active in the region of the larynx. Thyroid activity, of great importance in many metabolic processes (as may be seen from its effect on basal metabolism), is spurred on by increased activity of the astral body. (Bearing its flowering process within itself, the meadow saffron corm is particularly well suited to the task of stimulating thryoid activity and guiding it towards metabolism.) Rudolf Steiner has also recommended the use of Colchicum roots as a remedy for inflammatory and proliferative processes affecting the meninges.

The action of Colchicum preparations on gouty and rheumatic conditions, particularly in the joints, also relates clearly to what has been said above. The reader is advised to compare the description given above with that of Mandragora.[1])

DR. KARL ERNST SCHÄFER
(1912—1981)

On the evening of December 26th, after spending a happy Christmas with his wife, children and grandchildren, our friend and colleague, Dr. Karl Ernst Schäfer, died of a heart attack at his home in Old Lyme, Connecticut. Though the attack itself was sudden, Dr. Schäfer had known of late that his health was precarious and that his heart was under strain. But, in his characteristic way, he chose to remain active rather than to slow down and rest. At the time of his death, he was engaged in many projects and in helping many people with their own projects. It is particularly telling just how many of the people who gathered for memorial services — or just spoke to each other on the phone — after his death had spoken to him about some project or work just in the few days before he died.

In recent years, especially following his retirement from the Naval Submarine Medical Research Laboratory in Groton and from his work as Visiting Professor of Environmental Medicine at Brown University, Dr. Schäfer had spent an increasing amount of time working with anthroposophical-oriented medical students and young physicians. Even before his retirement, though, he had begun to help organize conferences on anthroposophical medicine: the annual week-long conferences in Wilton, the more frequent weekend conferences, and, in September 1973, a symposium held at the community hospital in Herdecke, West Germany. *A New Image of Man In Medicine,* the four-volume work which Dr. Schäfer edited, brought together the contributions made at the Herdecke conference by the many participants, some anthroposophical-oriented and some not, in many different fields. The form of these books, and of the conference, reflected the goals, skills and

[1]) Pelikan W. The Solanaceae. Br. Hom. J. 1975: 254 59.

vision of Dr. Schäfer: his vision was of a science of medicine that would incorporate without prejudice the observations from both spiritual science and contemporary natural science, with the understanding that these cannot be mutually incompatible. His great gift was the ability to bring together people with very different orientations, in the hope that something truly new would be synthesized from their interaction. He wanted to keep anthroposophical medicine from becoming insular or dogmatic, believing that it must be practised in a way that is simultaneously rigorous and imaginative. The attempt to fuse the imaginative and the rigorous in medicine was for Dr. Schäfer a lifelong struggle.

Dr. Schäfer was a catalyst, using the energy of his heart, always generously, to bring together people who might otherwise remain separate or uninvolved. Not infrequently, these interactions resulted in controversy or explosions; this, however, did not trouble him. In fact, he liked controversy and occasionally provoked it intentionally if he thought it would be constructive in the long run. He was not afraid to criticize, but his criticism was never of the rancorous or *ad hominem* variety; it, too, was constructive, and it was based on the assumption that he and others were working toward the attainment of shared goals, and he wanted to hasten the process.

Dr. Schäfer's help and advice were often provocative as he "lit a fire" under a hapless advisee. There are few anthroposophical-oriented young doctors or medical students in America who did not, at one time or another, have the experience of being confronted point blank by one of his *strong* suggestions. He would lean forward, talking persuasively, until one felt positively surrounded. There was always a way out, though, if one only had the presence of mind to think of it, because he never minded being talked back to, and inevitably something concrete would result from these conversations.

Dr. Schäfer was a native of Bad Nauheim, Germany. He received his medical degree from the University of Kiel in 1936 and subsequently became a research assistant at the Physiological Institute of Heidelberg. He was drafted into the German Navy in World War II and, after the War ended, returned to teach at the University of Heidelberg. He first came to the United States in 1949 in order to complete some studies in physiology, he went back briefly to Germany and then returned to the United States in 1950 at the request of the United States Navy. He served as head of the Physiology Laboratory at the Naval Laboratory in Groton from 1951 until 1970 and of the Department of Biomedical Science there from 1972 until 1978. The author of 150 scientific articles and the author or editor of many books on the subjects of respiratory physiology and environmental medicine, he was also a founding editor of the *Journal of Anthroposophical Medicine.*

Dr. Schäfer never confined himself to his research in physiology at Groton; instead, he alternated his research, writing and editing with practical work in the community — or perhaps one should say "communities," because Dr. Schäfer took an active part in the life and work of so many different communities. While working at the Naval Laboratory, he did a great deal of environmental work to help protect the Lower Connecticut Valley. And as soon as he arrived in the United States, he began to be active in the Waldorf School movement, frequently traveling to different schools in order to speak to teachers about the physiology of breathing and the importance of rhythm in the organism or to discuss Rudolf Steiner's *Study of Man.*

Dr. Schäfer's recent work with young doctors and medical students did not consist only of organizing conferences, giving lectures and editing books. Perhaps even more important than these was the extraordinary amount of time and energy — again, given from the heart — that he gave to anyone who came to him for advice or help or information. He was a great resource, knowing many people and keeping abreast of developments in all kinds of medicine all over the world, and he never failed to share what he knew.

Dr. Schäfer will be sorely missed by all those who have known and worked with him. In fact, I suspect that in the next year or two, it will only slowly dawn on many of us just how much Dr. Schäfer was doing for all of us, because he will no longer be here to do it.

Lisa Davisson

INTERVIEW, THERAPY COLLOQUIUM, NOTES AND REPORTS

Notes from a City Practice — Two Cardiodoron Case Histories. When does medicine become anthroposophically extended?

Much of the time I do nothing more than what any decent, concerned physician would do — particularly if the patient has not sought me out for my philosophy which is, after all, a personal matter, and if I know that a "regular" prescription will work. I do not necessarily consider it appropriate to try and persuade an unsuspecting patient to an unorthodox approach if the orthodox approach will get him out of his present difficulty without too much ado. Some people are made uncomfortable by the suggestion of something out of the ordinary.

Quite different, however, are those situations when in all honesty one may say: Orthodox medicine has no answer here, — but there are possibilities based on a different view of the world. Suddenly you need courage — you are out there pretty much on your own. Can we trust each other, the patient and I? Strangely, at this moment, we are both vulnerable. Anyway, we risk it. At least, that is what happens most of the time. And when it then works — or after it has worked, or at least begun to work —, that is when you are ready for your prayer of thanks. Healing happens by Grace. And it is when a situation that would have had to be left alone otherwise is solved with the help of the extended knowledge of the world and man which Anthroposophy can give, that one experiences that Anthroposophical Medicine is not merely an alternative to the medicine taught at universities but extends beyond it.

Two case histories may illustrate this.

Case 1. A 34 y. old woman, a freelance film editor, presented with a two months history of extreme fatigue (: "like my body is walking two feet behind me"), and episodes of faintness with nausea ("not stomach nausea"). She had given birth to her only child one year previously and had continued to breastfeed until the baby had weaned himself, i. e. had started to refuse the breast two months earlier and had stopped nursing about the time the patient saw me. Since delivery she had continued to lose weight until now she was nine lb. below her previous weight although she was eating with good appetite and sleeping soundly. She had also developed occasional episodes of headache, the last one one month earlier had been quite severe and lasted two days; formerly she had not been subject to headaches.

Her past medical history included a skull fracture with concussion at age 24 or 25, sustained in a fall from her bike, after which she had had to learn to walk again and was back to normal in six months, further the removal of one ovary because of a huge ovarian cyst and a coincidental appendectomy at age 30. Since the operation she had been taking Proloid gr. 1 ½ daily, prescribed for symptoms similar to the ones she presented with, although thyroid function tests had not shown an abnormality. This had had little effect, and she had felt no different recently when she had temporarily omitted this medication for six weeks and then resumed it. She had been on oral contraception for altogether eight years.

She was a tall, slender woman of predominantly Scandinavian extraction, ht. 67 in., wt. 123 lb., with brown hair and brown eyes. BP was 118/76, P. 60. Hands and feet were cool with reddened skin despite comfortable outside and room temperatures. Physical examination was unremarkable otherwise. So were urinanalysis, CBC, and chemistry profile including T4.

She was advised to omit the Proloid, and to take Cardiodoron B, 12 drops three times daily. After four weeks of this she reported having felt very much better within a few days of starting the medication, except for one day when she had forgotten to take it while helping a friend move house, and the dizziness had returned just

slightly. T4, T3 resin uptake, calculated free T4, and TSH were all well within the normal range off Proloid. The dose of Cardiodoron was decreased to twice daily, to be taken for another two weeks. One month later she phoned to say that her symptoms had recurred immediately after discontinuing Cardiodoron, and thus she had resumed it. When she stopped it again after four more weeks, she "felt absolutely no change in how I felt from the last day I took it to the first day I didn't take it". One year later her symptoms had not recurred.

For those who read German I wish to add that the prescription of Cardiodoron for this patient had been inspired by the case histories in the article by Dr. Weckenmann on "Cardiodoron und seine Wirkung auf die rhythmische Ordnung des Menschen" in Weleda Korrespondenzblätter für Ärzte, No. 98, 1980.

Case 2. A 25. y. old man, a postgraduate student of mathematics, presented with a one month history of increasingly frequent and severe episodes of vertigo, without obvious precipitating factors. I first met him at a Student Health Service, and ordinarily would have had to refer him out for a neurological evaluation. However, I had recently had a similar case in my practice, — another young man, member of one of the learned professions —, in whom careful neurological and medical investigation in the hospital had not yielded an explanation of the symptoms. I had learned something there. Besides, this patient volunteered that anxiety he was experiencing over being able to solve the problem posed to him for his doctoral thesis by a certain deadline might be a factor in the generation of his symptoms. Thus I felt it was safe to suggest to him that he come to my private office for an examination and treatment rather than go through a workup elsewhere which almost certainly would be negative. By the time I saw him in my office he had had another attack which he described as follows: He had been on his way bicycling home when, after stopping and parking his bike to look at a shop window, he felt "like he had been on a merry-go-round" and also very weak, so that he crouched down and then lay down on the side walk, very pale according to a bystander, and in a cold sweat. He remained entirely conscious, — "observing so he could tell me what happend" —, and after a while went home by subway. The day before, immediately on awakening, "before I had moved yet", he had felt everything turning, and in the evening he had had another episode while sitting and reading a book. He stated that altogether he felt very weak, "like after an illness with high fever". He denied palpitations, nausea, or tinnitus associated with these episodes. He occasionally had a sensation of pressure in the heart region, not asociated with attacks of vertigo. He did not smoke, drink coffee, tea, or coke, and used no drugs. He had fainted a few times as a child. The remainder of the medical history was non-contributory. But he spoke about a girl having been raped and killed in his building by a couple of teenagers recently.

He was a tall, slender German, blond, with light blues eyes, ht. 68 ½ in., wt. 130 ½ lb. He looked pale and was slightly diaphoretic, although the room was not over hot. BP was 130/70, and P 80 with marked respiratory arrhythmia. Reflexes were hyperactive. Otherwise, physical examination was unremarkable. Blood count, urinanalysis, and chemistry profile were well within the normal range.

The prescription was for Cardiodoron B, 15 drops three times daily, and Aurum met. praep D 12, 5 drops three times daily. He began to feel better after three to four days and continued to improve steadily. After 12 days the dose of Cardiodoron was decreased to 10 drops. After altogether two to three weeks he began to feel well and thus occasionally forgot to take his medication. He had another slight attack of dizziness after someone upset him. Thereafter he went back to taking the medication regularly. After altogether four weeks there had been no more symptoms, and he stated that "the medicine has not been unnecessary". He looked better and was no longer clammy, although the respiratory arrhythmia was unchanged. I had him continue for another three weeks. He cancelled the follow-up appointment as there had been no more attacks, and he "had no money"!

To clarify the indications as I perceived them: the Cardiodoron to stabilize him physiologically, and the Aurum to help him get a hold of himself psychologically.

This is not alternative medicine. Let me show you. Alternatives are like the George Washington Bridge. For those who do not know it: it has an upper and a lower level, both carrying two-way traffic. On the access road from Manhattan there is a sign which reads: "Alternate to Palisades", meaning that whether you take the upper or the lower level, either will get you over to the Palisades Parkway in Jersey. You may prefer

one or the other, but essentially, there is no difference. You have not entered another element. Compared to this, anthroposophically extended medicine would be like, shall we say, a pier with a boat? An active pier with lots of boats? Even big liners, maybe? Work it out yourself — and: Let's not miss the boat!

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MEDICINES COMMITTEE OF THE ANTHROPOSOPHICAL MEDICAL ASSOCIATION IN GREAT BRITAIN

Two reports from Talander Journal & Newsletter, Oct. 1981

The Medicines Committee has continued its work which is aimed at establishing Anthroposophical Medicine as a recognised, responsible, self-governing school of medical thought and practice, with its own Medicines Commission within the Medicines Division of the Department of Health and Social Security. This aim emerged early in its work because the criteria being developed by the Medicines Division of the D.H.S.S. for judging the safety and efficiency of medicines were grossly inappropriate for anthroposophical medicines. The only way to meet the spirit of the Medicines Act 1968 would be to establish the right of the different schools of medicine, such as Anthroposophical Medicine, Homoeopathy or Medical Herbalism, to draw up their own, appropriate, criteria for judging the safety and efficacy of their own medicines, within the provisions of the Medicines Act. In other words, decisions about medicines used in Anthroposophical Medicine can only be made by those doctors with theoretical knowledge of and practical experience in the use of such medicines. If other doctors, having only knowledge of allopathic medicine, are in a position to pass legally binding judgements on anthroposophical medicines then that amounts to the majority school of medicine suppressing a minority school of medicine; and in the end it means a denial of the right of patients to the medicine of their choice.

In the course of the past year the work of the Medicines Committee proceeded gradually. In response to a request from the Weleda (U. K.) Ltd., discussions on the appropriate route of sale for the various anthroposophical medicines continued amongst the members of the A. M. A., eventually leading to a consensus of opinion. The recommendations were drafted in January 1981 and sent to colleagues on the Continent for comment. Apart from the direct effect of regularizing the route of sale for the various categories of anthroposophical medicines, the process of discussion, consultation and decision making is the fabric of the exercise of professional responsibility and provides the basis for any future claim by the anthroposophical medical movement for the right to govern its own affairs under the provisions of the Medicines Act.

In March 1981 the third international meeting concerned with the problems of medicines legislation in G. B. took place at the Weleda in Ilkeston. Those attending included Dietrich Spitta (lawyer to the German Weleda), Rainer Burkhardt (medical statistician and author from the Herdecke Community Hospital in W. Germany), six anthroposophical doctors from Britain, a few supporting members of the Medical Group of the Anthroposophical Society and members of staff of Weleda (U. K.) Ltd. Rainer Burkhardt reported on three papers by the Herdecke team published in English language scientific journals, which dealt with the very severe ethical problems of controlled clinical trials of medicines, showing that many trials involve procedures which can be regarded as criminal and are therefore illegal. These papers, which question the rationale of controlled clinical trials and show them to be unsuitable as a legally sanctioned method of establishing the efficacy of medicines, have touched off a heated international debate. The meeting also reviewed the previous year's work of the Medicines Committee and it became clear that although useful work had been done we still appear to be a long way from achieving our own Commission for Anthroposophical Medicine.

Following this meeting arrangements were made to discuss the position of anthroposophical medicine with Tom Ellis M. P., who has been championing the cause of Homoeopathy in Parliament. More recently the Medicines Committee have invited senior civil servants from the Medicines Division of the D.H.S.S. to a half day meeting at which is planned to present Anthroposophical Medicine as a world wide movement. The meeting will be attended by Drs. Douch, Dyson and Evans, who make up the Medicines Committee, Dr. Schürholz, who is a member of the "C" Commission for Anthroposophical Medicine of the German Federal

Health Department, Martin Viner and Hella Levi from Weleda (U.K.) Ltd., Maurice Hanssen, who is a consultant to Weleda on medicine legislation problems, and John Davy, who is principal of Emerson College and member of the Executive of the A.S. in G.B. It is hoped that this meeting will provide a basis for fruitful further discussions and negotiations with the D.H.S.S. Some very useful preparation for this meeting was done in the form of researching and preparing a detailed reply, on behalf of the A.M.A. and the Medicines Committee, to the "Threshold Survey of Complementary Medicine" being conducted by the British Association for Natural Therapies. This included documenting the extent of the practice of anthroposophical medicine by determining the number of doctors practising and patients treated, by describing the various centres, the professional organisations, the training centres, the therapists' organisations, the various publications, the research institutes and projects, etc. It was a reminder to us, who are only too aware of our movements limitations, just how much has been achieved, especially on the Continent.

In June '81, the usefulness of Iscador as a cancer treatment was unjustly discredited in a brief article in the British Medical Journal. The Medicines Committee prepared a reply which was submitted as a letter to the editor, but so far this has not been published.

As part of our attempt to work together with our colleagues abroad a report on the work in England was given to the International Association of Anthroposophical Physicians (I.A.V.) at their annual meeting. At this meeting a dramatic report on the situation as it is developing in Germany was given by Dr. Gerhard Kienle. Dr. Kienle had spearheaded the successful campaign in West Germany to have the various schools of medicine legally recognized and to be represented by their own government commissions for judging the safety and efficacy of their medicines. However, having won the legal battle, at least for the time being, the "complementary" schools of medicine are now under threat at a financial level. As a result of attempts to curb the escalating costs of medical services, lists are being prepared of "medicines for minor illnesses" which will not be paid for by the state controlled medical insurance companies. It is feared that many, or even most, non-allopathic medicines will be added to such lists. Similarly there are plans being prepared which would systematise and regulate every aspect of clinical work in hospitals so that only predetermined actions, investigations and types of treatment would be deemed essential and therefore paid for by the insurance companies. This represents a blatant attempt to remove human decision making responsibility from the practice of medicine and to reduce the practitioners to technicians operating a system for which they cannot be responsible.

In reflecting on this development in Germany it is apparent that the reccently won battle for legal recognition and the protection of the right of the individual to the medicine of his choice may prove practically meaningless because the **financing** of medicine itself does not rely on the individual but is vested in state controlled insurance companies. It is a reminder of the importance of such initiatives as Talander Trust which place the responsibility for the financing of medicine on the free decisions of individuals rather than on organs of the State or commercial enterprise which have a responsibility to no-one in particular but only to the anonymous and ficticious "average citizen".

The direct expenses of the Medicines Committee for the year 1st January to 31st December 1981 have so far been covered by its float and direct contributions, but the personal expenses of the members of the Committee relative to the time spent on the project are being provisionally covered by Park Attwood. After the end of the year a detailed account will be drawn up and submitted to Talander Trust. It is estimated that this will be in the region of £ 2 000 for the year.

Dr. Michael R. Evans

TRAINING PROJECT

During this past summer, Dr. Anthony Degenaar accepted an invitation to become resident at Park Attwood. Dr. Degenaar retired from general practice in Holland in the early 1970's, and since then has been very active in anthroposophical medical teaching, both in this country and abroad. Through his involvement both as a medical advisser and as a teacher it is now possible to begin planning a more intensive training activity at Park Attwood.

The introductory conferences for medical students and young doctors which have been

regular bi-annual events since Easter 1974 have been successful in reaching a wide circle of interested medical students and in offering a living introduction to anthroposophical medicine. It is hoped that what may develop at Park Attwood will complement these conferences and provide those doctors, medical students, nurses and therapists who want to deepen their relationship to anthroposophical medicine with opportunities for further study in the context of a practical anthroposophical medical initiative.

A first step towards this has been taken in June with a small seminar, led by Dr. Degenaar, for members of the Anthroposophical Society directly connected to the work at Park Attwood, entitled: "Man's Five-Fold Connection to the Earth". The next seminar, planned for the last weekend in November, will be open to members of the Anthroposophical Society who are actively involved in medical and therapeutic work and who wish to deepen their relationship to anthroposophical medicine. Dr. Jürgen Schürholz, a leading consultant at the Filderklinik in Stuttgart, West Germany, who plans to be in England at that time, has agreed to extend his visit to be the guest lecturer. The seminar will address the theme: "The Spectrum of Treatment — from surgery to psychotherapy".

In addition to weekend seminars, Dr. Degenaar is also involved in a number of specialized study activities at Park Attwood.

In order that this new training venture can develop its own identity within Park Attwood and stand objectively for what it is, it is being constituted as an independent project, associatively financed via the Talander Trust. Drs. Degenaar, Dyson and Evans are jointly responsible for the project and will be guiding its development as members of the Medical Section of the School of Spiritual Science. Initially Park Attwood will provide its facilities free of charge except for such things as catering and travel expenses.

The costs for the first seminar were approximately £ 70,00 but a higher figure is estimated for the next seminar. The first Voucher/Statement will be submitted to Talander after the November seminar. Reports on the progress of this new project will appear as seems appropriate.

Dr. James A. Dyson

REPORT ON ANTHROPOSOPHICAL MEDICAL ACTIVITIES IN THE USA, 1981

by the late

Karl E. Schaefer, M. D.

The Association for the Healing Arts in Harlemville, N. Y. sponsored a weekend meeting with Dr. Mueller-Wiedemann April 3-5, 1981 which focused on the functions of the Waldorf School physician. Dr. Mueller-Wiedemann's book *Mitte der Kindheit* served as a reference. Case presentations of school children with discussions of both teachers and physicians broadened the scope of the meeting, which was attended by over 20 physicians and 30 teachers and therapists.

"Organ Functions and Psychopathology of Heart and Lung" was the theme of the 5th annual summer conference on Anthroposophical Medicine held at High Mowing School, Wilton, N. H., June 28-July 5, 1981. Twenty-three doctors and two medical students participated, and they were joined by twenty-eight therapists, eurythmists and teachers who listened to the morning lectures of Dr. Otto Wolff, Switzerland. By a fortunate coincidence this year's annual Waldorf School teachers' conference was also held at High Mowing School during the preceeding week.

The teachers had selected a theme: "The rhythmic system, a key to Waldorf education" in an effort to continue with the theme at the May members' meeting of the Anthroposophical Society with the Vorstand. Dr. Otto Wolff was also the guest speaker at the teachers' conference and quite a number of teachers decided to stay on for the subsequent medical conference to hear Dr. Wolff's morning lectures on „Heart and Lung Functions" which represented, so to speak, a third variation of the theme started in May. During this week teachers and doctors found a wonderful and rare opportunity to exchange ideas and discuss problems of mutual concern.

In addition to the morning lectures Dr. Wolff gave therapeutic seminars in which the treatment of heart and lung diseases was discussed. His great experience in the therapeutic field proved to be invaluable for so many young doctors entering the field of anthroposophical medicine.

Dr. von Zabern gave two case presentations one evening, Dr. Fill presented a lecture on "Experiences with Anthroposophical Medical Seminars", and Dr. Schaefer reported on

"Subtle Effects of the Technological Environment. Disruption of the Rhythmical Functional Order in Man. The Need for Active Preventive Measures of the Individual". Danilla Rettig led the group every morning in eurthmy and Thorn Zay in the afternoon with modelling clay and getting a feeling for organs such as the heart. Both activities provided the participants with the right balance and were greatly enjoyed. A nature walk and plant observations with Dr. Wolff led us this year to a very interesting bog exhibiting a variety of insect-eating plants. One evening was devoted to a presentation on the Weleda by Finbar Murphy and the showing of a film, "Weleda II".

Another meeting of anthroposophical physicians is planned for Nov. 6-8, 1981 in Harlemville, N. Y., which deals with the inner path of the physicians.

Activities in Anthroposophical Medicine in 1982:
In March, 1982 Dr. Wolff will give seminars in San Francisco, Vancouver, Ann Arbor and Harlemville. The 6th annual summer conference on anthroposophical medicine will deal with "Nutrition" and will again be held at High Mowing School in Wilton, N. H. from June 20-27, 1982 with Dr. Otto Wolff. All these activities are sponsored by the International Research Institute for Man-Centered Environmental Sciences and Medicine and the International Physicians Association for Anthroposophically Expanded Medicine — North American working group in connection with the Medical Section of the Goetheanum.

Iscador

There is a major effort under way to get Iscador off the list of unproven remedies of the Food and Drug Administration in the U. S. At the request of Dr. R. Leroi, Mr. Weinberger has taken all the possible legal steps. Moreover, scientific studies have been carried out to elucidate the effects of Iscador on tumors. They are described in the following:

Scientific studies on Iscador

Dr. T. A. Khwaja, University of California Cancer Center and Department of Pathology in Los Angeles, Cal., presented a paper, ,,Studies of cytotoxic and immunological effects of Viscum album (mistletoe) at a meeting of the Amer. Assn. for Cancer Research (AACR) of which a printed abstract has appeared. In the introduction the authors made reference to the successful treatment of cancer with Iscador in Europe. They analyzed the chemical components of mistletoe and studied the cytotoxic and immunostimulatory effects in vitro and in vivo.

The cytotoxic activity of mistletoe could be fractioned into a chloroformsoluble alkaloid fractions. In cell culture studies, the most active fractions inhibited the growth of mouse leukemia L 1210 and humalan Leukemia. Intraperitoneal injections of alkal. fractions caused a 77 percent increase in the life span of BDF mice bearing implants of leukemia P 388.

Prof. Maria Linder, Dept. of Chemistry, University of California in Fullerton, Calif., has begun a collaboration with Dr. Khwaja. Prof. Linder is an anthroposophist and the daughter of one of the pioneer anthroposophical physicians in the USA, the late Dr. Christoph Linder, New York. Her previous work on copper and iron metabolism in tumors has demonstrated among others that cancer patients exhibit elevation in serum copper concentrations and this is mainly due to the increase in ceruloplasmin, the copper-containing oxidase responsible for 90 procent of the copper in plasma and serum. Ceruloplasmin was greatly increased in lung cancer patients and the degree of elevation was related to the stage of cancer.

Dr. Linder has recently completed 2 experiments with Iscador. Iscador was given daily by injection to 4 groups of rats, those with and without a fast-growing transplantable tumor and those with and without Iscador injections (5-fold different doses were used). In rats which received Iscador and who carried a tumor, the growth of the tumor was significantly reduced and the rise in ceruloplasmin was significantly less. Moreover, the rats receiving Iscador were able to maintain a normal hematocrit.

In a second study Iscador was fractionated by gel filtration and it was found to contain 3 copper-containing components with molecular weights of 20000, 15000 and 3 — 6000. All these fractions are capable of binding additional copper. Dr. Linder is now carrying out studies in collaboration with Dr. Khwaja to test the individual components of Iscador for cytotoxic and immunostimulatory effects.

Use of Unapproved Drugs

In connection with the use of unapproved drugs by physicians, the May 21 New England Journal of Medicine (1981) published two surveys confirming the widespread prescription of a drug (cimetidine) for unapproved uses. The article makes the point that doctors prescribing a drug for an unapproved use are doing *nothing illegal.* (my italics!)