

Do the Miasms Have Their Origin in Social Changes?

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The emergence of a new disease cannot be understood fully without understanding its social dimensions.¹

If this statement is true for a new disease, how much more true it must be for the origin of disease - if there ever was such a point of origin. Certainly there have been changes in the scale and nature of diseases affecting people in the past, and that there are still such changes today. My basic premise in this article is that human beings are homeostatic organisms which evolved in the presence of disease agents, and therefore adapted to cope with them under normal circumstances, but were nonetheless vulnerable if environmental conditions changed beyond acceptable limits. I believe that the evidence shows that human social organisation needs to be included among these environmental conditions, and that changes in the social organisation of human beings in particular parts of the globe at particular times correlate with changes in disease tendencies.

In order to analyse and understand the significance of the available information, it is necessary to use a philosophical approach that can relate the social, psychological and physiological aspects of human beings, and for this reason I shall use a Marxist view of history.² Also, for the purpose of this article it should be understood that by 'diseases' I mean illnesses which are the organism's reaction to the physical invasion of the body by a disease agent, whether parasitic, bacterial or viral; and by 'miasms' I mean chronic conditions which result from suppression of a disease and which impair the organism's ability to respond to the environment, leading to an increased susceptibility to disease agents, and to disorders without any clear relationship to a disease agent. I shall focus on the miasms of psora (suppressed scabies)³, syphilis (suppressed syphilis)⁴, sycosis (suppressed gonorrhoea)⁵ and tuberculosis (suppressed tuberculosis).⁶ While I recognise that there is debate about the nature and number of miasms, I feel that it will become clear in the course of this article that the origins of these chronic conditions will demonstrate the relationship of diseases and miasms to historical circumstances.

Diseases

The earliest palaeopathological evidence of disease conditions is based on the analysis of bone formation and lesions, but osteoarchaeological conclusions are not beyond question, as similar effects may arise from various causes. Nonetheless the earliest such evidence relates to tuberculosis and suggests that Pott's tuberculous osteomyelitis of the spine existed as early as 3700 BC, while "undoubted evidence of tuberculosis has been found in a mummy of the XXI Dynasty (1070-946 BC)".⁷ This disease has two forms, the bovine and the human, and it is probable that humans acquired it after cattle domestication in the seventh and sixth millennia BC in the north-eastern basin of the Mediterranean, since an increased animal population density brought about by herding would favour the spread of infectious disease within herds.⁸ It has also been found to have infected neolithic peoples of the New World,⁹ while another species of the same genus causes leprosy, which is believed to have developed in China and India:

Andersen has proposed that leprosy was brought back from the Indo-Gangetic Basin by the returning armies of Alexander the Great in 327-326 BC. This is obviously a convenient and clear event, but may be simplistic, particularly since mercantile caravans may have been travelling the routes regularly and for some time previous. However, Dols states that "There is no persuasive evidence that true leprosy

occurred in ancient Egypt, Mesopotamia, or Persia before the time of Alexander the Great".¹⁰

Scabies and the itch, as *separate* illnesses, were known about in the seventh century BC, when they are both mentioned on some of the 800 clay medical tablets recovered from the great library of King Assurbanipal of Assyria (668-626 BC): "For diseases of the head the Sumerians used various ointments ... for lice and itch, sulphur and cedar oil; for scabies, millet seeds in dry dove's dung ...".¹¹ Furthermore, though some maintain that "historically and geographically considered, this parasite is coextensive with the human race itself",¹² others claim that "while the itch is quite general among the Karakas of the *Hawaiian Islands* it is the unanimous opinion of several French practitioners that it rarely occurs on the *Society Islands* (Tahiti) and according to Turner it is rare also in the *Samoa* group".¹³ Friedman also maintains that in Japan scabies "is said to have been unknown until about the beginning of the nineteenth century - where, according to Hakuji Hashimoto, it was introduced only after foreign ships began calling at the port of Nagasaki".¹⁴

As regards syphilis, there is evidence for it in the New World before Columbus arrived there in 1493, since traces of have been discovered "on several pre-Columbian bone specimens from Argentina, Peru, Mexico, Guatemala, the Antilles and various regions of the United States",¹⁵ whereas osteoarchaeological evidence for it in Europe is at best tenuous.¹⁶ The syphilis spirochaete, which is indistinguishable from that which produces yaws¹⁷ (or pinta¹⁸), appears to have been transmitted to Europe by the Spanish conquest of Hispaniola, with its first outbreak in Europe after the conquest of Naples by the French king Charles VIII in 1494, when it was described in the following terms:

"There appeared a new malady, spread by carnal contact, called the French sickness, and unknown to antiquity," wrote Alexander Benedictus in 1497. Juan de Vigo, for his part, wrote that "in the month of December, 1494, a malady of a hitherto unknown nature appeared in almost every part of Italy".¹⁹

While there is an opinion that gonorrhoea may have been known to the Greeks and Romans, the writers of that time neither referred to "the dysuria and inflammation often associated with the infection nor alluded to the concept of infectiousness or the development of complications such as urethral stricture",²⁰ and "although often stated that gonorrhoea has infected mankind since ancient times there is little objective evidence to support this".²¹ In addition the fact that "Man is the only natural host for *Neisseria gonorrhoeae*"²² means that the gonococcus developed in the human species after endemic health changes meant that an ecological niche was made available for it, as opposed to it being acquired by pressure of circumstances from another species.

Disease agents in general predate human beings, and there is evidence that "fossilized bacteria similar to our present micrococci can be found in geological formations that are 500,000,000 years old".²³ This means that human beings evolved in the presence of these disease agents, and so there must be some other factor or combination of factors involved for healthy people to become ill. Palaeopathological evidence indicates that one such factor could be the development of agriculture. "Perzigian and Widmer have noted, with regard to tuberculosis in prehistoric America, that the lesions are largely confined to sedentary agriculturally-based communities, rather than nomadic peoples."²⁴ Reasons put forward to explain the deleterious effect on health of the shift to agriculture include: an increase in proximity to animals;²⁵ other working conditions;²⁶ a reduction in the range of the diet;²⁷ lower hygiene standards;²⁸ and greater population densities,²⁹ though it is claimed that a low population density only limited acute diseases not chronic ones.³⁰

Colonisation

Whether or not primitive hunter-gatherer peoples were healthier than those relying on agriculture, they were certainly healthier than European colonisers. For example, in Australia

in 1788 the Aborigines “were physically, socially and emotionally healthier than most Europeans at that time.” Most of the infectious diseases which were responsible for the many deaths and much disability in Europeans including smallpox, measles, influenza, tuberculosis, syphilis and gonorrhoea at that time were unknown to Aboriginal Australians.³¹

Similarly,

Brough Smyth, the secretary of the Board for the Protection of Aborigines, later noted in his investigation into the health of Aborigines in 1878 that their recovery rate from wounds was much faster than that of Europeans. This suggests a strong immune system.³²

However, primitive, nomadic, hunter-gatherer peoples did suffer from illnesses, and these appear to have been of two sorts: on the one hand there were trauma and minor illnesses which were treated with medicines, such as herbs;³³ and on the other diseases regarded as having a social origin, which were treated using more socially oriented methods.³⁴ Against this background, the effect colonisation had on the health of the indigenous peoples is particularly significant, especially when compared with the effect on the Europeans, and it offers an opportunity for indentifying the process of disease development in the past.

It is readily understandable that the less healthy Europeans suffered a much more virulent form of syphilis than did the people of Hispaniola from whom it came:

[Gonzalo Fernandez de Oviedo y Valdes] expressed himself solemnly to the King of Spain as follows: “Your majesty may take it as certain that this malady (the bubas) comes from the Indes, where it is very common amongst the Indians, but not so dangerous in those lands as it is in our own”.³⁵

Less understandable, however, is the fact that European diseases devastated the indigenous populations. The “aboriginal New World peoples were without doubt exposed to a wide variety of zoonoses (diseases primarily affecting animals, with humans as secondary “accidental” hosts), environmental pathogens, such as soil fungi and endogenous staphylococcal and streptococcal bacteria”³⁶ and they were healthier than the Europeans. The orthodox medical explanation is that “the Aborigines who came into contact with the whites quickly caught European diseases, for which they had no natural immunity”³⁷, and that

The relatively small size of most pre-Columbian populations, with the exception of the largest urban concentrations in Mexico, did not provide the appropriate epidemiological setting for the appearance or maintenance of virulent acute infectious diseases, such as smallpox, to which Old World populations had become gradually adapted through centuries of repeated exposure.³⁸

A detailed analysis of what is meant by “gradually adapted”, and of the paradoxical relationship of health and immunity is unfortunately beyond the scope of this article, though the conclusions are interesting. Nonetheless the ‘immunity’ explanation is unsustainable for three reasons: firstly both the Europeans and the indigenous peoples suffered from these diseases, so neither group was immune; secondly immunity is acquired individually; and thirdly resistance to infection is linked to healthiness. Quite simply, the healthier indigenous populations should have suffered less than the Europeans, not more, so some other factor or combination of factors, must have affected their

response.

The most obvious factor is the significant and dramatic change in the social status of the indigenous people as a result of colonisation.³⁹ This took the form of loss of territory and the physical means of sustenance:

The spread of colonial rule and the taking of aboriginal land meant that by the start of the nineteenth century the Aborigines had three choices: they could resist white domination and risk being killed, move to an area uninhabited by whites but maybe occupied by rival tribes, or settle near one of the cities and survive off the European settlers' handouts. None of the options proved beneficial to their health.⁴⁰

There was also loss of their traditional way of life:

They changed their customary lifestyle and dietary habits and assumed their own version of the European: sugar, flour, tea, alcohol, tobacco, and gunpowder were adopted with gusto as John Lhotsky, the Polish traveller and naturalist, notes in 1834. To a large extent they abandoned the fish, kangaroo, possum, root vegetables and berries which had provided a balanced diet over the millennia. ... They deserted their river-bank campsites and became fringe-dwellers around the early settlements, homesteads and shepherds' huts.⁴¹

Lastly there was the loss of dignity and self-respect:

They were treated with indifference, mild curiosity or amusement and lived peacefully except when stirred to a frenzy by alcohol, resulting in injury and often death, usually to their own family members. Some European shepherds and stockmen cohabited with Aboriginal women resulting in half-caste children and the spread of venereal disease.⁴²

Even in the 1970s social degradation and exclusion continued to affect aboriginal health:

A study of Bourke statistics shows that if a child lives on the Reserve, he will be admitted to hospital five times before he reaches the age of three years, but only twice if he lives in the town. (The European child has a 1 in 250 chance of admission up to the age of three years.)⁴³

That the physical circumstances of social deprivation can be a major factor in producing illness is generally recognised,⁴⁴ but there is also evidence that hierarchies of personal status alone can be a major factor in producing illness. A long-term study of British civil servants revealed that:

There was an obvious *gradient* in mortality from top to bottom of the hierarchy. Mortality was significantly higher in the second rank, professional and executive personnel, than in the top, administrative, grades, and increased further as one went down the scale. But in none of these groups are people impoverished or deprived (at least according to the common understanding of those concepts). All are employed, most in office jobs with low risk from the physical environment (or at least no greater risk than those in the classes above them), and the professional and executive grades are relatively well paid compared with the general population.⁴⁵

Furthermore:

These observations suggest some underlying general causal process, correlated with hierarchy, which *expresses* itself through different diseases. But the particular diseases that carry people off may then simply be alternative pathways or mechanisms rather than "causes" of illness and death; the essential

factor is something else.⁴⁶

Another example of a social dimension to infection is revealed by a survey in the U.S.A. at the time of the First World War.⁴⁷ Figures showed that the higher incidence of scabies among black civilians (compared with white) contrasted with a dramatically lower incidence of the disease among black military personnel (compared with white). While the greater poverty of civilian black people appears to explain the former statistic, better hygiene could only explain an equalising of the incidence in military personnel. The most likely explanation for this reversal of the rates is the fact that joining up involved a significant improvement in status for black recruits, but not for white.

If hierarchies and status changes can cause such effects, then the process of dramatically changing a whole population's social standing in relation to other people is quite sufficient to explain an increase in susceptibility to disease. In addition, if an individual's tendency to become ill can be affected by their social circumstances in this way, then it is reasonable to expect that such a major social upheaval as the first appearance of class society would have significant health implications, and the evidence suggests that this could have been the case.

Class Society

Hunter-gatherer (or forager) societies were the only form of human social organisation until the last 10,000 years of the 100,000 years or so of human existence. Archaeological evidence and anthropological studies of hunter-gatherer societies reveal that they were based on sharing and equality between members,⁴⁸ and the division of labour was such that:

At every point, the premium was on co-operation and collective values. Without them, no band of foragers could have survived for more than a few days.⁴⁹

This is important for any consideration of human health, since a change to the way of life within which human beings had evolved represents a distortion of the 'natural' environment, as much as a major change in diet or climate. Indeed, to homoeopaths, who recognise that symptoms affecting the mind are some of the deepest indicators of a patient's state of health, such a change would be of more profound importance.

Egalitarianism continued during the first agricultural revolution, which began around 8000 BC, and into the 'urban revolution' of 4000 - 3000 BC in the Nile Valley and the Middle East, but by 3000 BC civilisations based on class-divisions between rulers and ruled had emerged in the Mesopotamian states and the Egyptian 'Old Kingdom'. This new pattern of social organisation spread to the Indus Valley (2500 - 2000 BC) and to China (2000 - 1600 BC). It also developed independently in the Meso-American and Andean regions of the New World around 1000 BC.⁵⁰ Each of these class-based civilisations arose as a result of changes in the material circumstances of human agricultural societies, but not without problems or opposition.⁵¹ Indeed, at various times they all collapsed under the strain of the contradictory interests of different sections of society.⁵² They were characterised not only by increasing social differences of power, wealth, status and sex,⁵³ but by concomitant differences in the standard of living in respect of work, housing, food, and so forth.⁵⁴

The apparent geographical origins of the various miasmatic chronic diseases can now be seen to have an interesting relationship to social changes. Both scabies and tuberculosis have their earliest recorded occurrences in the Africa-Middle East axis of the first civilisations based on class society. Leprosy, a different species of *Mycobacterium*, appears to have arisen in China or India,

which were centres of class-based civilisation that developed later and, especially in the case of China, with little contact with Africa and the Middle East. Syphilis arose in the Americas, where class-based civilisations appeared among the Incas and Aztecs completely separately from those of the Old World. On the other hand, no miasmatic chronic diseases developed in the continent of Australia, and neither did a civilisation based on class society. In short, the origins of miasmatic chronic diseases appear to correlate closely with the establishment of endemic conditions of social deprivation of one section of society in relation to another.

Miasms

Up to this point I have used orthodox medical research, oriented around the activity of disease agents, to investigate the origins of those chronic diseases that Hahnemann and other homoeopaths have designated as ‘miasmatic’, and to relate them to the appearance of class societies. Miasms are not diseases, though, but arise from the suppression of diseases,⁵⁵ and miasmatic conditions are considered to be coextensive with the life of the patient,⁵⁶ transferable,⁵⁷ inheritable,⁵⁸ and to develop wide-ranging but characteristic symptoms.⁵⁹ Homoeopaths have subsequently confirmed that the process of suppression includes eradication of the disease agent of a chronic disease,⁶⁰ eradication of the primary manifestation of the disease,⁶¹ and eradication of the potential risk of catching a disease (vaccination).⁶² The ensuing chronic illness is not the same as that of the disease process, but is a related process with its own characteristics.⁶³ Observation of a such shift from diseases to other chronic illnesses is not confined to homoeopaths:

We may have won the struggle against a large number of diseases, especially the infectious ones, but instead we are facing other health problems, especially degenerative diseases, malignant diseases, and the so-called psychosomatic disorders, which are much more difficult to treat and at present impossible to prevent.⁶⁴

The individual patterns of weakness of each miasm are of particular interest when considered in connection with the transition to agricultural, urban, and politically unstable class-based societies. For example, the symptoms of the syphilitic and tubercular miasms reveal a pattern of disturbance on a psychological level consistent with social friction tending towards destruction, anger and despair.⁶⁵ Rajan Sankaran describes someone with the tubercular miasm as having “the feeling of being oppressed, of suffering injustice and labouring under a burden difficult to endure”,⁶⁶ while someone with the syphilitic miasm “feels viciously attacked from all sides - a desperate situation which requires him to do desperate things to come out of it”,⁶⁷ and in the leprosy miasm “there is intense oppression (lepers are treated worse than animals; often the objects of loathing) and an intense hopelessness, with an intense desire for change”.⁶⁸

Symptoms of dissatisfaction also appear in the psoric miasm, but the pattern reflects more anxiety and disorientation than destructiveness.⁶⁹ There is also the specific dissatisfaction with “the existing state of things” and personal wealth, and Agrawal remarks that “the mind of the psoric is not exactly deformed but is tied down or say inhibited; that is why a psoric is timid, taciturn, weak and seeks protection”.⁷⁰ Sankaran also notes that in the psoric miasm:

We find that there is a struggle with “ego” and “money”. The feeling is that he is losing [sic] something and must struggle to get it back. There is a feeling that things may go wrong at any time though they are fine at the moment. Therefore to keep things as they are he must struggle.⁷¹

Other more indirect evidence of the nature of the psoric miasm is seen in the provings of sulphur, the “great antipsoric remedy”.⁷² These indications suggest that psora also has a relationship with

class society, but that it is more consistent with an earlier stage, since “while pure psora does not produce any structural changes, psora does produce functional changes”,⁷³ and in the development of chronic illness, functional changes necessarily precede structural ones.

The archaeological evidence of the Assyrian tablets mentioned above reveals that the Sumerians used sulphur for the itch (a homoeopathic treatment for the miasmatic condition) rather than for scabies (the orthodox treatment for the parasitic condition), and that they already had medications for a number of chronic conditions other than minor illnesses. It is clear that at this time the psoric miasm at least was already in existence, but what of tuberculosis? The disease has a long history, but while tuberculosis is now a frequently observed miasm, Hahnemann did not identify it, and the first proposal of a tubercular miasm was not made until the end of the nineteenth century, when Allen called it ‘pseudo-psora’ and claimed it was a fusion of psora with syphilis.⁷⁴ Within orthodox medicine Bristowe “and like-minded clinicians at the century’s end, *managed* tuberculosis”,⁷⁵ and this suggests an answer to the question. While the disease was old, it was only at this time that medical practice became able to suppress it and cause the miasm. Furthermore, because the social conditions that permitted the disease to enter humans resembled those for syphilis, there were similarities to this miasm, whilst the long period of interaction with psora meant that it also substantially shared those characteristics.

Conclusion

It is all too easy to assume that the world we live in is the same as people have always lived in, with the same patterns of social organisation and the same patterns of disease. We forget that new diseases have appeared in our own lifetimes, and that society has changed throughout history and continues to change before our eyes. There is incontrovertible evidence that in late prehistoric times human beings changed their way of life in certain areas of the world, becoming dependent on agriculture instead of hunting and gathering. Archaeological evidence and modern medical studies show that the change to an agricultural way of life substantially increased the risk of illness and may possibly have led to an increase in the incidence of illness, and by historical times there is evidence that miasmatic diseases had come into existence. Somewhere in this interval there was a significant change in the health status of people living in the newly-emerged civilisations.

Evidence is abundant that overcrowding, poor nutrition, inadequate housing and lack of hygiene predispose people to illness, so it is reasonable to conclude that the process of increasing urbanisation that accompanied the rise of civilisation was the also the cause of a decline in people’s health. However, while such a conclusion may explain the change in health in those societies at that time, it is not able to explain the impact of these civilisations on hunter-gatherer societies encountered at a later date. These encounters led to disproportionate levels of sickness and mortality among the *healthier* colonised indigenous people without any prior shift to an agricultural or urban way of life. Attempts to explain this circumstance rely primarily on the claim that the indigenous people had no acquired immunity to European diseases, but this explanation is at best paradoxical, since a healthier person should be less likely to get ill.

Research into the health of people from different positions in society has shown that social stratification alone has an impact on human health, and so it is highly significant that the civilisations that emerged between the first agricultural revolution and the beginning of recorded history also developed social structures of inequality that had never existed before. In addition, the appearance of the diseases of tuberculosis, leprosy and syphilis seems to be historically and geographically related to the emergence of separate class-based civilisations. In particular the biologically related diseases of tuberculosis and leprosy come from geographically distant but

related areas of the Africa-Middle East axis and Northern China or the Indus Valley, whereas the biologically different syphilis comes from an area geographically isolated from these: Meso-America and the Andean region. Australia, which never developed class society has no history of originating a severe chronic disease.

In terms of the miasms themselves, there is evidence from the beginning of recorded history not only for scabies, but for psora too, tending to confirm Hahnemann's conclusion that the multitude of conditions that can appear on suppressing the primary itching symptom was indicative of the age of the miasm. Psora's tendency to functional effects and its characteristic mental symptoms make it unlike the other chronic miasmatic diseases. These points tend to the conclusion that Hahnemann was right to believe that psora was the primary human miasm, and that the endemic potential for other major chronic diseases followed from its establishment. Finally, orthodox medical research has even noted that the tendency to primary scabies infection may be related to social status and not just to the physical conditions relating to such status.

There is no direct evidence (and may never be) of the specific origins of the psoric miasm, but the actual and circumstantial evidence all point to the same conclusion. It would appear not only that psora was the first miasm to arise, but that it emerged in its miasmatic form with class society, and as a direct consequence of that social change acting as a maintaining cause of illness. If this is the case, then implicit in such a conclusion is a further one, that a permanent cure for the miasms depends not only on the curing of the miasmatic conditions, but on the eradication of their maintaining cause, that is, the transformation of the social conditions of inequality to conditions of equality and free collective and self-expression.

Bibliography

- Agrawal, Dr. Y. R. (1995) *A Comparative Study of Chronic Miasms* 3rd revised edition, Delhi, Vijay Publications.
- Ackerknecht M.D., Erwin H. (1982) *A Short History of Medicine*, Baltimore, The John Hopkins University Press.
- Allen, J. Henry (1998) *The Chronic Miasms: Psora and Pseudo-psora* reprint edition (volumes I and II combined), New Delhi, B. Jain Publishers Ltd.
- Bagley, Caroline (2004) *Race Relations: The Impact of Western Colonisation on the Health and Welfare of Australian Aborigines with particular reference to Coranderrk Aboriginal reserve*, Victoria, [London], [The author].
- Berkow, Robert M.D. (Editor in Chief) (1997) *Merck Manual of Medical Information; home edition*, New York, Simon and Schuster Inc.
- Boericke, William (1990) *Pocket Manual of Homoeopathic Materia Medica and Repertory*, Delhi, B. Jain Publishers.
- Burnett, J. Compton (2001) *Vaccinosis and Its Cure by Thuja* reprint edition, New Delhi, B. Jain Publishers Pvt. Ltd.
- Bynum, W. F. (1994) *Science and the Practice of Medicine in the Nineteenth Century*, Cambridge, Cambridge University Press.
- Cawte, John (1966) *Healers of Arnhem Land*, Sydney, University of New South Wales Press.
- Choudhury, Dr. Harimohon (2003) *Indications of Miasm*, New Delhi, B. Jain Publishers (P) Ltd.
- Close, Stuart (1995) *The Genius of Homoeopathy* reprint edition, Delhi, B. Jain Publishers Ltd.
- Coolican, Ralph Edward (1973) *Australian Rural Practice*, Glebe, Australasian Medical Publishing Co.
- Evans, Robert G., Baer, Morris L., and Marmor, Theodore R. (Eds.) (1994) *Why Are Some People Healthy and Others Not?: The Determinants of Health of Populations*, New York, Aldine de

Gruyter.

- Friedman, Reuben (1947) *The Story of Scabies* volume 1, New York, Froben Press.
- Hahnemann, Samuel (translated by William Boericke) (1996) *Organon of Medicine* reprint of 6th edition, Delhi, B. Jain Publishers Ltd.
- Hahnemann, Samuel (translated by Prof. Louis H. Tafel) (1995) *The Chronic Diseases, Their Peculiar Nature and Their Homoeopathic Cure* reprint edition, Delhi, B. Jain Publishers.
- Harman, Chris (1999) *A People's History of the World*, London, Bookmarks.
- Karlen, Arno (2001) *Plague's Progress; a social history of man and disease* paperback edition, London, Phoenix (an imprint of Orion Books).
- Kent, James Tyler (1993) *Lectures on Homoeopathic Philosophy* reprint edition, New Delhi, B. Jain Publishers Pvt. Ltd.
- Lewis, Thomas H. (1990) *The Medicine Men; Oglala Sioux Ceremony and Healing*, Lincoln, University of Nebraska Press.
- McNeill, William H. (1979) *Plagues and Peoples* reprint edition, Harmondsworth, Penguin Books.
- Manchester, Keith (1991) Tuberculosis and Leprosy in Antiquity: An Interpretation, in *Medical History; a quarterly journal devoted to the history of medicine and related sciences* volume 28, London, The Wellcome Institute for the History of Medicine.
- Marx, K. (1981) *Economic and Philosophical Manuscripts of 1844* reprint edition, Moscow, Progress Publishers.
- Proust, A.J. (Editor) (1994) *History of Medicine in Canberra and Queanbeyan and their hospitals*, Gundaroo, Brogla Press.
- Proust, A. J. (2003) *A Companion of the History of Medicine in Australia 1788-1939*, Forrest, [The Author].
- Quétel, Claude (translated by Judith Braddock and Brian Pike) (1992) *The History of Syphilis*, London, Polity Press.
- Roberts, Herbert A. (1995) *The Principles and Art of Cure by Homoeopathy* reprint edition, B. Jain Publishers Ltd, Delhi.
- Ross, J.D.C. (1996) *Gonorrhoea: past and present*, in *Proceedings of the Royal College of Physicians in Edinburgh* volume 26, Edinburgh, Royal College of Physicians in Edinburgh.
- Sankaran, Rajan (1999) *The Substance of Homoeopathy* 4th edition, Mumbai, Homoeopathic Medical Publishers.
- Speight, Phyllis ([no date]) *A Comparison of the Chronic Miasms (Psora, Pseudo-psora, Syphilis, Sycosis)*, [no publisher].
- Verano, John W., and Ubelaker, Douglas H., (Editors) (c1992) *Disease and demography in the Americas*, Washington, Smithsonian Institution Press.
- Wilson, Mary E., Levins, Richard, and Spielman, Andrew (Editors) (1994) *Disease in Evolution; Global changes and emergence of infectious diseases*, *Annals of the New York Academy of Sciences* vol. 740, New York, The New York Academy of Sciences.
- Wulff, Henrik R., Pedersen, Stig Andur, & Rosenberg, Raben (1986) *Philosophy of medicine; an introduction* 2nd edition, Oxford, Blackwell Scientific Publications.

¹ Wilson 1994 p. 275.

² See Marx 1981 pp. 61-74.

³ Hahnemann 1995 pp. 9 and 87ff.

⁴ Hahnemann 1995 pp. 9 and 83ff.

⁵ Hahnemann 1995 p. 7; Hahnemann 1996 §§80f. pp. 167-70.

⁶ Allen 1998 p. 69; Close 1995 (pp. 103-4) considered tuberculosis to be psora and to have much in common with leprosy, which Hahnemann considered to be psora (Hahnemann 1995 p. 10).

⁷ Manchester 1991 pp. 163-4.

⁸ Manchester 1991 p. 164.

⁹ Manchester 1991 pp. 164-6.

¹⁰ Manchester 1991 p. 168.

¹¹ Quoted in Friedman 1947 p. 377.

- ¹² Quoted in Friedman 1947 p. 377.
¹³ Quoted in Friedman 1947 p. 377.
¹⁴ Friedman 1947 p. 52.
¹⁵ Quézel 1992 p. 41.
¹⁶ Quézel 1992 p. 40-2.
¹⁷ McNeill 1979 p. 166.
¹⁸ Berkow 1997 p. 878.
¹⁹ Quézel 1992 p. 34.
²⁰ Ross 1996 p. 240.
²¹ Ross 1996 p. 240.
²² Ross 1996 p. 240.
²³ Ackerknecht pp. 3-4.
²⁴ Manchester 1991 pp. 164-5.
²⁵ Manchester 1991 p. 164.
²⁶ Karlen 2001 p. 42.
²⁷ Karlen 2001 p. 35.
²⁸ Friedman 1947 p. 377.
²⁹ Verano c.1992 p. 41.
³⁰ Karlen 2001 p. 43.
³¹ Proust 1994 p. 1.
³² Bagley 2004 pp. 15-16.
³³ Proust 1994 p. 1; Proust 2003 p. 1; Ackerknecht p. 11.
³⁴ Ackerknecht p. 11; Proust 2003 pp. 1-2; Bagley 2004 p. 15; see also Lewis 1990 and Cawte 1966.
³⁵ Quézel 1992 p. 35.
³⁶ Verano c.1992 p. 41.
³⁷ Bagley 2004 p. 16.
³⁸ Verano c.1992 p. 41.
³⁹ Lewis 1990 pp. 1-2.
⁴⁰ Bagley 2004 p. 18.
⁴¹ Proust 1994 pp. 1-2.
⁴² Proust 1994 p. 2. Note that they 'cohabited' as opposed to 'married'.
⁴³ Coolican 1973 p. 73.
⁴⁴ Bynum 1994 p. 75; Friedman 1947 p. 11.
⁴⁵ Evans 1994 p. 5 (author's emphasis).
⁴⁶ Evans 1994 p. 7 (author's emphasis).
⁴⁷ Friedman 1947 chapter VI.
⁴⁸ Harman 1999 p. 3.
⁴⁹ Harman 1999 p. 8.
⁵⁰ Harman 1999 p. 2.
⁵¹ Harman 1999 pp. 24f.
⁵² Harman 1999 pp. 33f.
⁵³ Harman 1999 p. 29-31.
⁵⁴ Harman 1999 p. 23.
⁵⁵ Hahnemann 1995 p. 7.
⁵⁶ Hahnemann 1996 §78 p. 166.
⁵⁷ Kent 1993 p. 146.
⁵⁸ Kent 1993 pp. 136, 140 & 150.
⁵⁹ Hahnemann 1995 pp. 8ff.
⁶⁰ Roberts 1995 pp. 281-2; Creasey, 10/11/2002, lecture at the London School of Classical Homoeopathy.
⁶¹ Kent 1993 pp. 140-151.
⁶² Burnett 2001 passim.
⁶³ Hahnemann 1995 pp. 7-141.
⁶⁴ Wulff 1986 p. 10.
⁶⁵ Agrawal 1995 pp. 32 & 40; Choudhury 2003 pp. 50 & 98; Speight pp. 2-9.
⁶⁶ Sankaran 1999 p. 70.
⁶⁷ Sankaran 1999 pp. 27-8.
⁶⁸ Sankaran 1999 p. 70.
⁶⁹ Agrawal 1995 p. 11-12; Choudhury pp. 18 & 31; Speight pp. 2-9.

⁷⁰ Agrawal 1995 p. 12.

⁷¹ Sankaran 1999 pp. 26-7.

⁷² Boericke 2000 p. 620.

⁷³ Roberts 1995 p. 191.

⁷⁴ Allen 1998 pt. 1 pp. 9-73.

⁷⁵ Bynum 1994 p. 226 (author's emphasis).