



# “Homoeopathy and Hospitals in History”, Stuttgart, July 2007

**ABSTRACT:** *It is interesting to see the evolution, rather devolution of Hospital practice in Homoeopathy. Therefore the whole report is given here for the pleasure of our readers with an addition at the end about Status of Hospital-care in India.*

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Conference of the International Network for the History of Homoeopathy (INHH)

The *Institut für Geschichte der Medizin* (IGM) of the Robert Bosch Foundation played host to the 7<sup>th</sup> International Conference of the European Association for the History of Medicine and Health's International Network for the History of Homoeopathy (INHH) from 4<sup>th</sup> to 6<sup>th</sup> July 2007. The theme was “Homoeopathy and Hospitals in History”, addressing the curious fact that, despite homoeopathy and “the clinic” emerging around the same time, the relationship between the two had so far not been seriously examined in any great detail. Proceedings were divided into four sections, “Europe I: North-West”, “Europe II: The Cradle of Homoeopathy”, “USA” and “Central and South America”.

In his opening words, **Martin Dinges (Stuttgart, Germany)** reflected on past INHH conferences that took place in disparate places as San Francisco, Budapest and Montevideo. The history of homoeopathy is a flourishing field, a fact to which the attendance of delegates from four continents bore testimony at this conference. The only note of regret was that, since the first conference, the history of homoeopathy was not completely fulfilling its potential as a strong field in its own right, with anthropological approaches to ‘alternative’ medicine still being more widespread.

In her inaugural lecture, “The last Frontier: Hos-

pitals, Homoeopathy and History”, **Naomi Rogers** (New Haven, USA) talked about the origins of the hospital as an institution and of the importance of the hospital for the flourishing of homoeopathic practice, through its role in demonstrating and explaining homoeopathy. Through hospitals, homoeopaths were healing the sick publicly. Controversially, Rogers argued that the hospital should not be seen as the pinnacle of medical practice; historians of homoeopathy should embrace the hospital as an institution with a contingent role in history. Discussion over the purity of homoeopathic hospital practice is futile, as hospitals were “messy” places by necessity. The changes and adaptations that occurred within the hospital should therefore be seen as necessary choices rather than a betrayal of principles.

The first section on North-West Europe, began from a Dutch perspective, with **Hein De Lange de Klerk's** (Groningen, Netherlands) paper “Homoeopathic hospitals in the Netherlands”. Homoeopathy only entered a Dutch hospital in 1907 and homoeopathic hospitals were constantly dogged by financial worries. Practitioners did work beyond homoeopathic institutions: unlike the rigid structure of other countries, homoeopathic doctors could be found in allopathic hospitals, treating patients by homoeopathic means. Faced with the *ziekenfondsbesluit's* requirement of insurance through large regional companies, an unwilling-

ness to unite spelt the end for the small homoeopathic insurers around 1950. Furthermore, a lack of recognition as a medical specialty meant homoeopathy was not covered by the National Health Service, resulting in the end of homoeopathic hospital in Utrecht in 1969. The discussion following this paper focused on issues of finance, the availability of insurance schemes and the presence of professional nurses in these hospitals, most of whom apparently were used to work "for love", resigned to insufficient remuneration.

Moving West across the English Channel, **Felix S von Rechwitz** (London, United Kingdom) presented "A case study of the London Homoeopathic Hospital". Its founder Dr Frederick Quin effectively utilized the existing orthodox medical professional structures as a blueprint for a professional homoeopathic association- The British Homoeopathic Society. This made the society and the hospital unassailable to the orthodox profession, while simultaneously ensuring a standard of training, perceived respectability and legitimacy for the hospital and its practitioners. An analysis of patient numbers and case types for the first decades, using published figures and returns from journals and annual reports, showed that the hospital successfully used the existing "specialist" hospital model, transcending it to become the first genuine Homoeopathic General Hospital in Britain.

Discussion centred around the current "black box" status of the hospital, as we do not know what really went on inside the wards beyond few published case studies, although all evidence suggests that they really did use homoeopathy to obtain their positive results. Furthermore, it was suggested that the role of managers and administrators in the homoeopathic hospital would be an interesting subject for further analysis.

Flying North once more, **Motzi Eklöf** (Linköping, Sweden) presented an intriguing alternative to hospital history from a Swedish perspective, namely the history of "The Homoeopathic Hospital that never was: Attempts in the Swedish Riksdag from 1835 to 1863 to obtain support of

government authorities for establishment of a homoeopathic hospital, and the issue of theory versus empiricism in medicine". Four separate attempts of obtaining government funds for its establishment were made between 1853 and 1862, yet all failed. Political arguments turned around the issue of demonstrated success abroad on one hand and accusations of unscientific quackery on the other. Eklöf argued that Swedish medicine's perception itself being more theoretical and having "a greater purpose than the treatment of patients" meant foreign examples never carried much weight in any debate. Furthermore, it was agreed that the State had no business in passing a bill that amounted to taking sides in an ongoing scientific dispute. Eklöf also argued that a political undercurrent was in opposition to homoeopathy, which represented to some a direct threat to the unity and power of the highest social and scientific spheres present in the Riksdag.

In the second European section, **Martin Dinges** (Stuttgart, Germany) presented a lecture on "Homoeopathic hospitals in Germany in the international context". This presented the situation of hospitals in Germany, the "cradle of homoeopathy", from the first Leipzig institution and misreported trials in Berlin's "Charité" to Robert Bosch's own efforts to secure hospital homoeopathy's future through his Stuttgart institution. While insurance companies became increasingly unwilling to pay for homoeopathic treatment once allopathic methods became more time-efficient, an emerging awareness of side-effects of the orthodox pharmacopoeia, as well as of chronic diseases during the 1980's provided a resurgence of homoeopathy. Beyond Germany, Dinges also provided insights into the situation in France, where the fortunes of homoeopathy were always closely linked with each hospital's chief medical officer's personal preferences and fluctuated accordingly. Dinges also pointed out the great importance of the availability of outpatient treatment as part of the services offered by the hospitals. Finally, an example of the modern economic argument for homoeopathy was given with Cuba,



where research is very active and even the emergency clinic at the capital's airport is led by a homoeopath. During the discussion, the question of eugenics was raised in conjunction with German homoeopathy. Dinges argued that, while undoubtedly eugenics was popular across Europe, in Germany this mostly affected those working in the psychiatric field. Reflecting attitudes prevalent in the larger medical community, some homoeopaths welcomed the National Socialist party's rise to power, whilst others deliberately distanced themselves.

THE SECOND DAY began with **Michael E. Dean's** (York, United Kingdom) lecture on "Evaluating homoeopathy in the hospital: the first 100 years". This provided an exhaustive review of 19<sup>th</sup> and 20<sup>th</sup> century homoeopathic clinical trials across the world. The study identified 44 clinical trials in countries ranging from Russia to the United Kingdom, Germany and USA, which were examined using the terms of reference of the day, avoiding anachronistic analysis. Tables of mortality were used, mirroring the most important factor to patients at the time: survival, not efficacy. The emerging picture granted a fascinating insight into the skewed perspective presented by orthodox commentators on the results of homoeopathic therapy. Possibly due to the fact that homoeopaths could often present more positive results than their allopathic colleagues, selective reporting was widespread. Positive results, such as efficacy against cholera, were suppressed, while studies such as that of Andral in 1830's France carried great weight and continues to do so to this day, despite serious flaws and Andral's own lack of skill and knowledge about homoeopathic methods, as described by his own assistants. According to Dean, the most important trials were conducted between 1844 and 1886, yet these are seldom remembered by history.

THE THIRD SECTION of the conference moved proceedings across the Atlantic to the United States of America. Beginning on the West coast, **Nadav Davidovitch** (Beer Sheva, Israel) presented "The Homoeopathic University Hospital – Massachu-

setts Homoeopathic Hospital in Context", an institution portrayed as uniquely forward-facing and situated in a location where homoeopaths were exceptionally well integrated in the medical community. With the emergence of germ theory, practitioners at the MHH blazed a trail for vaccination and serum treatment as an integral part of practice at a time when other homoeopaths were still debating the issue. Teaching and dissemination of findings were also major parts of the hospital's role and results could be published in journals, both orthodox and homoeopathic. Discussion following the paper suggested that the unique ease with which MHH practitioners could publish in orthodox journals was possibly due to their having shared a Harvard education with those in charge of the publications, thus sidestepping any possible opposition by ways of an "old boys network". A further interesting point made was that, unlike most homoeopathic hospitals, the MHH retained a lot of patient records, not dissimilar to 'standard' hospital records, providing valuable insights into its workings. Finally, unlike hospitals who struggled to get paying patients, 50% of MHH was allocated to private beds.

Flying East once more, **Melanie J Grimes** (Seattle, USA) provided an East-coast perspective through her "History of Homoeopathy in hospitals in Washington – from Gold Rush territory to Grace Hospital". Besides highlighting the debate between high and low potency advocates and discussions over acute versus constitutional homoeopathic treatment, Grimes evocatively argued that the early success of homoeopathy in Washington was helped by the predominance of a "frontier spirit", which encouraged free thinking that continues to the present day. In addition, the presence of the charismatic figures of Dr Charles Bryant and Dr John Bastyr, who could trace their medical lineage back to Hahnemann himself in only four and five steps (respectively), ensured the survival and revival of homoeopathy as part of a newly energised naturopathic movement. In the discussion it was suggested that other cultural or political elements might be considered besides the mythical "fron-

tier spirit" that may not have been as dominant or benign as believed. As for patient records, these had been neglected for decades and possibly partly destroyed, but boxes of interesting data still exist and are being examined.

Moving South from Washington State, **Josef M Schmidt** (Munich, Germany) completed the North-American picture with his "History of the Homoeopathic College and Hahnemann Hospital at San Francisco", representing research conducted through the examination of hospital records, telephone directories and registers of medical practitioners. This retraced the emergence of homoeopathic hospitals in the American west, from Hiller's Nevada City Hospital in 1854 to the Hahnemann Hospital of San Francisco and its subsequent merging with the University medical school. Schmidt argued that the American west was not affected by the sectarian problems of eastern centres. Rather than strict adherence to Hahnemannian principles at the expense of medical innovation, extensive scientific research was conducted to prove homoeopathy's claims and attempts were made to integrate it into the standard medical curriculum. These efforts did not, however, save west-coast homoeopathy from the decline; its east-coast counterpart and by 1958 the last chair of Homoeopathy at the university of California was abolished. The subsequent discussion raised questions as to the influence of German developments over a possible American homoeopathic identity at the time, as well as how homoeopathy defined itself against "Germanism", with physicians extracting nuggets of innovation from publications of a country with which they were at war.

**THE FOURTH AND FINAL SESSION** turned to Central and South America, with **Paulo Rosenbaum** (Sao Paulo, Brazil) talking about the "Brazilian experiences in hospitals from the 19<sup>th</sup> to the 21<sup>st</sup> centuries". Rosenbaum presented a fascinating account of homoeopathy's progress through Brazil, from its initial period, with Duque Estrada, the first Brazilian medical practitioner to use homoeopathy and the foundation of the Homoeopathy School

of Rio de Janeiro in 1844, through periods of expansion, resistance and rebirth, to the "golden period" of the foundation of the Hahnemannian Hospital of Brazil in 1916, the subsequent decline of homoeopathy and its revival from the 1970s. Rosenbaum also summarised recent developments and the current situation of homoeopathic institutions in Brazil, where progress is illustrated by the University of Sao Paulo's receptiveness to the inclusion of homoeopathy on the curriculum. He concluded with an optimistic prognostic on Brazilian homoeopathy's future, where, in the mid term at least, integrative medicine and non-exclusive homoeopathic Hospitals must be created, to maximise the chance of homoeopathy being included on a large scale as part of the national *Sistema Único de Saúde*.

**Fernando François Flores** (Mexico City, Mexico)'s paper on "The National Homoeopathic Hospital in Mexico City" concluded the session, providing an insight into Mexican homoeopathy. The National Homoeopathic Hospital, founded in 1893, is the largest of its kind in Mexico, and remains operational to the present day. Initially located in a disused arsenal, it developed and evolved continually, even throughout the period of the Mexican revolution. By 1900, its significant contribution to the advancement of Mexican homoeopathy already numbered around 20,000 consultations, with a total of 400 inpatients. By 1943, the number of beds had risen to 150 and X-ray diagnostics were introduced. State-led attempts of structural alterations and rebuilding of the hospital since the 1970s, partly motivated by a desire to remove homoeopathy from within the institution, were successfully averted, not least thanks to a groundswell of popular support displayed through demonstrations on the city's streets. The discussion that followed focused on specific framework conditions for homoeopathic hospitals in Mexico. **Robert Jütte** (Stuttgart, Germany) concluded the conference proceedings with his closing remarks on the "Specificities of the homoeopathic hospital". Despite the diversity a few general features can be singled out. The motives in founding



homoeopathic hospitals were of four kinds:

- 1) To gain public recognition by proving the efficacy of the new art of healing
- 2) To ensure scientific progress in theory and practice.
- 3) To provide training for future homoeopaths.
- 4) To offer patients better treatment.
- 5) To compete with allopaths and to gain prestige in the scientific community.
- 6) To prove that homoeopathy is the cheaper and better treatment.

There are also common denominators to be observed as far as the closing down of homoeopathic hospitals is concerned: Among the general problems were, the lack of funds, the internal strife, and lack of space. But also the trend of time played a role, eg structural changes in the health system or progress in biomedicine. And there were, last but not least, intrinsic problems, eg the failure to provide scientific evidence and the lack of research. More research is needed on open questions such as the everyday life in a homoeopathic hospital or the specific treatment provided by these institutions.

**EDITOR: AN ADDITION**

*Strictly speaking, this last part is not part of the report of the seminar, but an addition by NJH about Indian Homoeopathic Hospitals as of today.*

There are Hospitals attached to every Teaching Institution in India. There is also some major work being done by Dr MLD Trust which runs a PG institute without an undergraduate college.

The **Dr M L Dhawale Memorial Trust** is making a valiant effort to establish the concept of Homoeopathic hospital-care in the community. It has so far established six Homoeopathic hospitals in Maharashtra and Gujarat States of India. The experiences acquired indicate that Homoeopathy can successfully manage acute conditions in the field of General Medicine, Paediatrics, Psychiatry, Rheumatology, Diabetes, Chest Medicine etc. Homoeopathy has also got a significant role in Gynaecology and Obstetrics and in pre and post-operative management of Surgical, Orthopaedic, Ophthalmic and Dental conditions. The rural Homoeopathic Hospital at Palghar is doing pioneering work in the field of Homoeopathic management of emergencies and is now embarking on management of neonates in NICU.

The work done in hospitals indicate that a Homoeopath desirous of managing IPD cases needs to be specially trained at the level of knowledge, attitude and skills in addition to his studies in Homoeopathic Philosophy, Materia Medica and repertory. He should acquire sufficient clinical judgement through 24/7 work at the bedside and be in a position to use necessary diagnostic and ancillary measures. He must learn to develop rapport with allopathic specialists in assessing the scope and limitations of Homoeopathy (or Homoeopath) in complicated situations. The patient care should be his primary concern. Personal concerns or ego should not be an issue in clinical decision making.

- **Dr ANAND KAPSE**



*Three friends from the local congregation were asked, "When you're in your casket, and friends and congregation members are mourning over you, what would you like them to say?"*

*Artie said: "I would like them to say I was a wonderful husband, a fine spiritual leader, and a great family man."*

*Eugene commented: "I would like them to say I was a wonderful teacher and servant of God who made a huge difference in people's lives."*

*Al said: "I'd like them to say, "Look, he's moving!"*