

ORIGINAL PAPER

In search of the reliable repertory

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The development of homeopathic repertories is complex, reflecting history, the emergence of divergent views on homeopathic philosophy, and differences in opinion as to what constitutes reliable *materia medica*.

The purpose of this paper is to critically evaluate the content of repertories examining its reliability, the quality of source material, and the evidence that it forms a reliable bridge between case and *materia medica*. Reliability may be improved by demanding higher standards and consistency of evidence. However, it is necessary to understand what constitutes evidence, and the importance of taking into account the context in which practitioners use the repertory. This paper will suggest that rather than demanding certain 'standards', practitioners will be better served by a greater understanding of the sources of knowledge and by reflexivity of the key players in the construction of our repertories. 'The repertory' is considered generally here as the deconstruction of different repertories. The strengths and weaknesses in particular, whilst interesting, would be the topic of another paper in its own right. Where individual repertories are mentioned, they are referred to as examples only. *Homeopathy* (2009) 98, 60–64.

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Introduction

The reliability and validity of the homeopathic repertory has been questioned not least because of the apparent lack of reliability of its sources, namely 'provings' or homeopathic pathogenetic trials (HPTs) and clinical confirmation, and disagreements over what constitute valid criteria for additions.^{1–3} This paper will explore why the homeopathic repertory could be considered unreliable, and consider ways in which repertories could be made more reliable. It will be suggested that making repertories more reliable by agreed standards for incorporating additions, and confirmation, is itself problematic, as disagreements about standards may reflect underlying differences about what constitutes reliable evidence. This paper will suggest that the reliability of the homeopathic repertory cannot be considered without understanding the context in which it is used, or without taking into account the rich, diverse, and subjective nature of many of the sources of knowledge in homeopathy.

The reliability of the repertory has been questioned on numerous counts: confusing historical development, poor

referencing of sources, mistakes and omissions, inaccurate translation, misunderstanding of the context of symptoms, poor methodological quality of sources, inconsistency over standards for additions and gradings, etc.^{4–6}

Semantic problems

The breaking down of *materia medica* into specific rubrics is a complex task, in part because different homeopaths and authors conceive or understand differently the meanings and expressions of different symptoms, complaints, feelings and sensations.⁷

One of the problems with conversion of *materia medica* to the repertory is that additions are sometimes made without understanding context of the symptom from its original source.⁶ There are problems in language – both at the point of recording of symptoms, as well as in translation, exacerbated by changes in language usage and meaning over time. Sherr states that converting the information from HPTs into separate symptoms (rubrics) can be straightforward. However, sometimes the translation into rubrics is not possible; symptoms can be too complex, so that when broken down into parts, they no longer capture the meaning of the original symptom.⁸

Rubric meanings can also be ambiguous, abstract, or even misleading without reference to the original context.

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Dimitriadis, looking at the original meaning of Bönninghausen's Therapeutic Pocketbook rubrics, clarifies context, which could be confusing, e.g. "Walking in the open air" refers to prolonged walking in open air.⁶

There are other sources of confusion for rubrics, for example "Mistrust", which when Dimitriadis consulted the source literature, he found used in a broad sense, to describe more a doubt or uncertainty, of oneself (*Bar-c.*), or one's ability (*Anac.; Lyc.*), or of those around (*Anac. Lyc.*). Similarly, the rubric "Vexation" is often used as 'anger' (refer Kent's repertory) but the meaning in German *Ärger* is a disturbance or annoyance of any sort – perhaps by bad news, or by fright etc.⁶

Methodological problems

There are errors in the repertories, for example, in incorrect translation. Dimitriadis states that these are numerous, e.g. in *Cocculus* (MMP364) "Paralytic insensibility of the lower extremities" should read: "Paralytic immobility [Unbeweglichkeit] of the lower extremities".⁶ Winston gives an example where 'crawling' was been incorrectly translated as 'tingling'.³

There is disagreement in the relative value of information from HPTs and from clinical confirmation. Roger van Zandvoort argues that the gist of our information should come from clinical information, whilst the author of *Synthesis Repertory*, Schroyens, argues the opposite, that HPTs have always been the primary source of homeopathic information. He states that well-done HPTs are in fact scientific studies, with reliable results, provided they are well supervised.^{9,10}

For a full understanding of the validity and reliability of additions to the repertory, we need to understand the quality of HPTs, the foundation upon which the repertory is built. While a full critique of HPTs is beyond the scope of this study, doubt about the reliability of HPTs has implications for the reliability of the repertory.¹¹

Are compilers of repertories aware of the quality of HPTs; do they assess this before symptoms from a HPT are added to the repertory? The validity of symptoms does not just depend on the overall acceptability of the HPT, e.g. the controversial inclusion of 'meditative provings' in some repertories, but also the quality, e.g. the extent to which Hahnemann's guidelines are followed, the expertise and experience of the HPT co-ordinator, blinding, randomisation, selection criteria, quality of supervision etc.¹²

In terms of methodology, it could be argued that HPTs are a form of qualitative research, whereby symptoms are analysed to understand their meanings (or their underlying meaning), patterns and themes are studied, and methodological quality is associated with engagement with the data, quality of observation (e.g. by provers and supervisors) and the credibility of interpretation of the narrated findings.^{13,15} This type of research method would normally require some kind of reflexivity from the researchers, e.g. understanding of one's biases, theoretical predispositions, preferences, etc. Should we demand the same of HPTs and clinical expertise before this information is included

in repertories?¹⁶ For example, in terms of reliability and validity, do we insist that HPTs are replicated before they are added to repertories? Should symptoms be seen in more than one prover, or more than one proving? Sherr states that the suggestion that a symptom needs to be experienced by more than one prover belongs to allopathic methodology, by definition, characteristic symptoms are those experienced by one or two provers only, and that eliminating all that is strange, rare and peculiar results in a flat, unusable remedy picture.¹⁷

Does this challenge our assumptions about reliability and validity of the repertory? Do we have different standards for what is a reliable symptom, as we are working in a different paradigm? There is even greater ambiguity about what counts as clinical confirmation. Where does this clinical confirmation come from? What are the standards or criteria for this? Clinical confirmation is seen as providing evidence, i.e. that a remedy contains, or is capable of curing, a certain symptom, but how reliable is this evidence?

Philosophical differences

Repertories reflect philosophical approaches to homeopathic methodology and case-taking. For example, Bönninghausen and Kent had different understandings of the totality of symptoms that are reflected in the different structures of their repertories. As Elizabeth Wright Hubbard warns us, they should not be mixed because the 'ideology is so disparate'.¹⁸

Philosophical differences also give rise to arguments around inclusion of primary materia medica. Given that all observation is theory laden, i.e. observations are coloured by background assumptions and beliefs, then symptoms produced from HPTs (and also clinical validation of symptoms in response to certain remedies) are consequently the product of interpretation, and affected by the underlying theoretical assumptions of HPT co-ordinators and repertory compilers.¹⁹

Hence the theoretical viewpoint of the person making additions to a repertory, making changes in gradings, and seeing 'clinical validation' of remedies for certain symptoms, are crucial. For example, some HPTs seem to vary according to the philosophical stance of the co-ordinator. Vithoulkas' proving of hydrogen resulted in a very different list of symptoms than Sherr's proving. Are we to include both? How do we decide which is the more accurate? And if we decide to use cases to confirm the symptoms, whose cases do we use? What is the standard for follow up and cure?

Potential solutions

There are a variety of ways in which the repertory could be 'reconstructed' to ensure greater validity and reliability. Some such ways would be to seek or achieve:

- Semantic difficulties could be overcome with an established link between the remedy addition and its original source either with a link to the source (in a computer

repertory), endnotes (in a book), or with complete reference details.

- Methodological improvements would require agreed standards for making additions to the repertory, from HPTs, from clinical experience and information, and from toxicological data.
- Agreed criteria for confirming a repertory addition as valid. Proposals for this have been made, for example see Vithoulkas' project "Confirmed Repertory" project.²⁰ This is an online database for clinical confirmation, which allows prescribers to assess the reliability of the sources of the information.
- Agreed standards for removing rubrics that are not confirmed in practice, or that have been over-represented in the repertory.

Limitations of this approach

Jones and Higgs define evidence as "knowledge derived from a variety of sources that has been subjected to testing and has been found to be credible".²¹ Rutten *et al.* argue that much of the repertory comes from 'expert opinion', which is often not valid because no clear and objective criteria for repertory entries exist.²² Research is used to guide decision-making so that decision-making is seen as rational and objective. Other forms of knowledge, such as clinical experience, can be viewed as biased and subjective. Relying on clinical experience is problematic, the argument goes, because practitioners may be misled by biased recollections of more dramatic incidents and statistically inadequate samples.²³ Scott-Findlay argues that the professionalisation of medicine and nursing is linked to making its knowledge base scientific. Homeopaths' desire for mainstream acceptance may result in a desire or need to follow this path. Yet, from the epistemological viewpoint, there are a variety of sources of knowledge in homeopathy. It could be argued that we should not diminish these sources of knowledge because they don't meet the strict criteria of 'evidence'.²³

Reflection on the above 'wish list' for reconstructing our repertories using better evidence raises the possibility that such standards are unattainable, as they simply reflect underlying disagreements about homeopathic philosophy, standards for HPTs, understanding of 'cure' in cases, and so on.

Can we separate the function of the repertory, from the process of repertorisation, in terms of its reconstruction? The function of the repertory is to form a bridge between a case and the materia medica. The process of using a repertory is not so straightforward. It only provides a reliable link between the case and the materia medica as long as the case has been understood, the analysis and synthesis of what needs to be cured is correct, and a meaningful totality of characteristic symptoms has been selected. Good use of the repertory requires a reliable selection of symptoms that reflect the inner *wesen* of the disturbed vital force. Use of the repertory that is just a collection of all the symptoms of a case will result in a meaningless repertorisation.

This paper suggests that the repertory cannot be considered out of the context of its use. Ignoring context results in a reductionist view of what constitutes evidence.²⁴ This view suggests that evidence has inherent value with the potential to provide factual or real justification for decisions.²⁵ Such is the approach taken by Rutten *et al.* in attempting to provide a likelihood ratio for a remedy's inclusion into a repertory, where remedy inclusion is based in statistical probability via observational research of the likelihood of that symptom occurring in any given population.²

This orientation focuses on the structural characteristics and properties of evidence (e.g. validity, reliability) in order to establish the appropriateness and credibility of specific types of evidentiary sources (e.g. HPTs) for supporting decisions (e.g. inclusion into a certain rubric). This is the current assumption of evidence-based practice; that the improved quality of evidence will result in higher quality decisions. Applied to the repertory, the improved quality of evidence supporting additions to the repertory will result in practitioners making more accurate prescriptions, and better decisions about the appropriate homeopathic treatment.

"If homeopathy is a science, and thus part of medicine, then basing homeopathic prescriptions on validated information should certainly help to improve results."¹

Thompson, for example, argues that homeopathic cases can be studied with increased rigour and sophistication in the form of "formal case studies", utilising features of qualitative research that ensure greater reliability such as triangulation, search for deviant cases, reflexivity, and so on. This allows the use of cases, e.g. for clinical confirmation, to be used to increase the evidence base in homeopathy in a systematic manner.²⁶

An alternative to this view is a more practical orientation to what constitutes evidence, with evidence defined with respect to a specific decision-making context.²⁴ This orientation suggests that the variation in context influences what constitutes evidence, and that evidence is subjective, with different perspectives producing different explanations for the same outcome.^{25,27}

Such a view may take into account the complexity of decision-making when it comes to deciding treatment approach and in finding the simillimum. In finding 'evidence' to support how homeopaths make decisions, it is necessary to take into account how a multitude of factors (for example, the understanding of the totality, the philosophical orientation of the practitioner, etc.) contribute to a decision outcome (remedy selection). Such factors will impact not only how the repertory is used as part of this process, but also which repertory is used, since different repertories having different philosophical underpinnings. In contrast then, this approach defines evidence less by its quality, and more by its relevance, applicability or generalisability to a specific context.²⁴

The complexity of homeopathic interventions is widely acknowledged and we cannot ignore this in understanding the interventions, or what constitutes reliable evidence for

making these interventions.^{26,28,29} In the same way in which evidence-based medicine could be criticised for failing to take context into account²⁴ it could be argued that it is up to the homeopath to determine whether a HPT of a substance, or clinical validation confirming a remedy in a certain symptom, is applicable to the patient sitting in front of him or her. Decision analysis demonstrates that decisions are made in the light of evidence, facts, values and preferences, giving rise in some practitioners to a preference for context sensitive medicine over evidence-based medicine.³⁰ Therefore to have a standard 'criteria' to determine inclusion of a remedy into a rubric fails to take into account the context in which this information may or may not apply to an individual case.

Conclusion

Barry *et al.* talk about reflexivity – acknowledging the importance of the researcher's presence in the research process.³¹ The process of building the repertory, as with conducting HPTs, is not so much one of research, but is conducted by those with homeopathic 'expertise' and understanding, and to ignore the role of the 'researcher', proving supervisor or repertory compiler is foolhardy.

Arguably, an overemphasis on validity and reliability belongs to the scientific paradigm. The key factors in explaining whether the repertory is useful to homeopaths might not be 'scientific rigour', as is suggested by some authors, but rather a quality of observation and perception, the objectivity of which is a myth.

An individual's perceptions cannot be independent of his or her beliefs and expectations.³² Consequently I suggest that there is a need to take into account that the repertory is a collection of subjective perceptions, mediated by the underlying beliefs and assumptions of the people who conduct the HPTs, make recommendations based upon clinical cases, and compile our repertories.

In this sense, the desire for a new repertory, constructed with agreed and rigorous standards for additions and grading, may be attempting to achieve the impossible. Rather, it may be important to further understand the knowledge-base in homeopathy, in particular the tacit knowing, which is part of the learned, transmitted, and unarticulated knowledge of practice, acquired through experience. Intuitive and informal, it is less susceptible to explicit analysis because of its subjectivity, but not necessarily any less valid to the homeopath because of that.³³

Conflict of interest

None declared.

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SOCIAL AND HISTORICAL

20 years ago: *The British Homoeopathic Journal*, January 1989

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Myalgic encephalomyelitis

In "Thoughts on the management of myalgic encephalomyelitis: *The problem of 'ME'*" Michael Jenkins dealt comprehensively with this rather indeterminate condition, first observed in the Royal Free outbreak in the 1950s, and described by AM Ramsey in his monograph *Post-viral Fatigue Syndrome: The saga of Royal Free Disease* in 1986. Jenkins was not convinced that it is a single disease entity and felt that trying to make it so could cause confusion. He was convinced that most cases have an organic basis to their illness. He thought that, provisionally, it was perhaps better to consider it a syndrome with many possible causes. There seem to be considerable overlaps between the manifestations of 'Classical ME' as described by Ramsey (extreme muscle fatiguability, cerebral dysfunction and autonomic/vasomotor disorders); and post-viral fatigue syndrome, intestinal candidiasis, hyperventilation, hypoglycaemia, hysteria, depression and multiple allergies.

The author dealt briefly with each of these conditions; noted that physical signs are usually unremarkable, and dealt at length with the range of investigations available. The treatment, for the present, needs to be holistic and multidisciplinary. It covers regimen (rest and careful 'pacing'), diet and dietary supplements, drugs (antifungals – he noted that caprylic acid was used by some in place of Nystatin, and is non-prescription), desensitization treatments, homeopathic medicines and acupuncture for some (suggested points are Stomach 36 and Liver 3). An extensive Appendix outlines some of the homeopathic medicines the author has tried in patients, and two tables present repertory analyses of common ME features using CARA: one shows several polychrests; the second iteration deliberately excludes them, bringing up several other notable medicines.¹

Two provings

This issue included two provings: the first "A study of *Iris versicolor* 3c"² is by AE Vakil, AS Nanabhai & YE Vakil. It was an attempt to confirm the effectiveness of *Iris v.* in the treatment of pancreatitis, as suggested by Kent and Boericke, and cited in Boericke's *Therapeutic Index* as the medicine of choice for the condition. The 24 day single blind trial had 16 provers and 10 controls. As a rise in serum amylase and lipase is diagnostic during an attack, blood was collected before and after the trials. The results for these were negative. The findings and numbers of provers and controls are recorded briefly under systems of the body. The findings are similar to previous *Iris v.* provings, but in this case are remarkably similar to the controls. One exception is pain in the right trapezius, eased by shrugging of the shoulders, which was noted also in Allen's *Encyclopedia of Pure Materia Medica*. Apart from this symptom, the authors found no definite relationship between *Iris v.* and pancreatitis, but advised a further study, preferably double blind, with a larger sample and for longer.

The second proving "*Tarantula hispanica*"³ is by VM Nagpaul, IM Dhawan, AK Vichitra & DP Rastogi. This was undertaken because of uncertainty and confusion in much of the previous proving work for this substance. The trial lasted from December 1985 to February 1987. It was double blind, based at two different centres more than 1,000 kilometres apart. Eight of the 28 volunteers functioned as controls. Trials consisted of four legs; placebo for all, four times a day for a fortnight, followed by 'wash-out' for seven days; then similarly the second, third and fourth legs consisted of 200c, 30c and 6c, respectively. "At the end of the trial, data were sifted, analysed and compiled, eliminating symptoms generated by placebo". There follow four pages of pathogenesis evoked, again under systems (with potency and number of provers reporting, in most cases only one per symptom). They report similar patterns from the two centres; confirmed many of the findings in earlier provings; and provided many new symptoms which, if confirmed clinically, would be of value.

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The polio saga of 1958

"In the light of experience: *The polio saga of 1958*" was a lecture given by Dr RAF Jack at the Advanced Course of the Faculty at Warwick University. He was reminded of his part in the dilemma by a recent query about a Dutch homeopathic oral vaccine for yellow fever; to which he advised caution. The first two pages of the report describe the chequered history of poliomyelitis vaccination in this country, from 1955 until 1957, with the debate about the Salk vaccine after its disastrous effect in the US, and the delay in production of an adequate British version. Public demand for vaccination was growing, but with little awareness of the Salk failures in the US. Eventually many of Jack's patients shared his unease about the Salk vaccine, and requested a homeopathic alternative. The remaining four pages describe his personal involvement with the issue.

Through DW Everitt of Nelson & Co, the author eventually procured a potentized sample of the South African vaccine (the Mahoney strain replaced by the modified Brunhilde one). By mid-May 1958, he had prescribed this to about 100 patients – when the storm broke. The Midland television news warned the public against certain pills prescribed by a doctor in Worcestershire. There was much press coverage about these "useless pills" and much difficulty for 'the doctor' in dealing with reporters; quite apart from worry about his legal status. However, within a month or two the storm blew itself out, and there were several positive effects. The *Birmingham Post* (13 May) gave the fullest and most balanced account. The *Sunday Despatch* subsequently reported an interview with Everitt and quoted a Ministry of Health spokesman: "There is nothing to stop doctors prescribing anti-polio pills, though the main body of medical opinion is against them. They won't protect people from polio". Everitt wrote to the press, taking up the issue of their published statements, and started a positive correspondence with Pickup, the Medical Officer of Health, much of which is quoted. Encouragement for Jack came from the Secretary of the British Homeopathic Association: "We have been enjoying some reactions here from your polio effort, and several of the newspapers have been inquiring for a story. However, knowing that you were anxious for no publicity, I gave them a brief explanation of homeopathic nosodes, and referred them to Nelsons for technical data". The interesting thing was that the *Yorkshire Post* had telephoned the Ministry of Health, and been told that the pills were probably homeopathic, and in that case were being prescribed by a qualified doctor, and if that were so, and they were prepared by a reputable firm of pharmacists, then the Ministry had no objections.

On the 14th October, the *Telegraph* published a long letter from AL Wagland, Chairman of the British Homeopathic Association, defending homeopathic vaccines and citing their success, both in the 1957 Asian influenza epidemic, and in a poliomyelitis epidemic in four localities in the Belgian Congo. There was further publicity in

1964, when Everitt replied to a letter in the *BMJ* (20 June) about the death of a child who had received homeopathic vaccination. The Editor published his reply, which gave descriptions of nosodes and their uses. Jack commented, "History repeats itself. Only recently we have gone through the whooping cough saga, which attracted far greater opposition and raised far more bitterness than did the polio saga, and if we are not careful we could be courting another saga – the AIDS saga"⁴

Historical column 2

Bernard Leary cited three reports in this his second historical column. They are quite shocking in their tone, certainly compared with the gentler interaction with the establishment a century later, as described by Jack in the previous article. The first report, from 1846, was "Resolutions of the Provincial Medical and Surgical Association: *Report on irregular practice*". The following extracts give a flavour of the sentiments of the committee: "That it is the opinion of this Association, that Homeopathy... is so utterly opposed to science and common sense... That it ought to be in no way or degree practised or countenanced by any regularly educated Medical practitioner"; "That Homeopathic practitioners, through the press, the platform, and the pulpit, have endeavoured to heap contempt upon the practice of medicine and surgery as followed by members of the Association and by the profession at large"; "That for these reasons it is derogatory to the honour of members of the Association to hold any kind of professional intercourse with homeopathy practitioners". They expressed thanks to those who resolved to refuse diplomas to practitioners of Homeopathy, and felt "imperatively called on to express its disapproval of any school of medicine which retains among its teachers any one who holds Homeopathic opinions". The Committee were anxious to state that "they are actuated by a strong sense of the importance of the subject in its relation to both humanity and morals. They most conscientiously believe that the countenance afforded to the form of charlatany herein alluded to is detrimental to the true interests of the public, as it is subversive of that integrity which ought to characterize practitioners of medicine".

The author commented that despite its strong language this document resulted in no important action and homeopaths continued to practice without interference. However, nearly forty years later attempts were made, once more, to prevent homeopathic doctors from joining the Association. The second report, a leading article in the *Lancet* (19 August 1882) was couched in similar terms. The third, Report of Council, June 10, 1882, adopted two bye laws: one required candidates for admission to state in writing that they neither were, or intended to become practitioners of homeopathy; the other that any member convicted of practicing homeopathy or of holding professional intercourse with such should have their name erased at one from the roll of members. In conclusion, the author stated: "So far as is known, these bye laws have not been rescinded. Perhaps it is better to let sleeping dogs lie"⁵

Hahnemann – the final decade

This short article "The final decade of Dr Hahnemann's glories in life and death" is an enthusiastic appraisal by SR Wadia of his marriage to his second wife: "a new and glorious chapter opened in Hahnemann's life when he married a young French lady, Mademoiselle Marie Melanie d'Her-villy". It is a very sympathetic account of their relationship, with quotations of their own words which express their intimacy. She was shocked by his death and reacted strangely: sleeping for 10 days beside his embalmed body; then hurriedly burying it in an unmarked grave in Montmartre graveyard, with only a few others present. The exact place was a mystery, actively sought for the next 50 years by French, German and American homeopaths. Finally located by a group of American homeopaths, the grave was opened, with an International committee of 35 persons present. The coffins of Hahnemann and his widow were formally transferred to Père Lachaise cemetery, in the midst of France's famous dead. Two years later, a fitting monument was erected there; while "the largest and most impressive Hahnemann monument which the world possesses" was erected in the centre of a large public place in Washington DC, next to that of General Winfield S Scott. "This was clear proof that Hahnemann and his discovery did not belong to Germany alone, but to the whole world."⁶

Obituary: Rita Leroi

Rita Leroi was born in Germany in 1913 and attended the Stuttgart Waldorf School. During her medical career, she became a Clinical Assistant at the Ita Wegman Clinic in Arlesheim, during which time she was able to "establish firmly and inwardly her relationship to the anthroposophical medical impulse and work. She developed a deep and continuing interest in cancer and the Iscador treatment of this disease". In 1954 she married Alexandre Leroi, leader of the Society for Cancer Research and Director of the Hiscia Research Institute in Arlesheim, where Iscador was produced and researched. In October 1963 the Lukas Klinik for cancer opened in Arlesheim, and Rita Leroi became its Director. In 1968, on the death of her husband, she also took on directorship of his institute and in 1978 was elected President of the International Anthroposophical

Association. She had outstanding personal qualities: "Everything around her became warmed through and made personally human. She had the capacity to look into every detail of the ever enlarging activities in which she played so leading a role, but in such a way that she lifted them up from mere fact and detail into human significance, a truly artistic achievement". The extension of the Iscador treatment of cancer all over the world is due very largely to the work of Alexandre and Rita Leroi.⁷

The end, or just the beginning

Peter Fisher's editorial, with this title, was a postscript to the Benveniste affair. He briefly described the salient points of the debacle and its unfortunate effects for all concerned. The *New Scientist* was most uncomplimentary of *Nature's* stance and there were unfavourable comments from a number of other journals. On the other hand, the publicity was highly damaging to Benveniste personally; and efforts to develop scientific research in homeopathy had been harmed by the mistrust and ill-will generated. The prestige of science itself cannot have been enhanced. However, Fisher felt that this episode might yet be turned to profit if lessons were learnt for the design and conduct of homeopathic research; keeping it as immune from criticism as is humanly possible. He ended on a very positive note: "One thing, however, is certain: history will record this chapter, not as the end of scientific research in homeopathy, but as the beginning."⁸

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BOOK REVIEWS

Homoeopathy: the Science and Art of Dynamic Healing

Shaik Rahmathullah

Publisher: Shaik Rahmathullah.; UK, 2006

Price: £29.95, ISBN: 978-0953076536

This book gives a basic but sound introduction to homeopathic philosophy. It does not add significant new material to the homeopathic literature on philosophy or principles and practice but it does effectively draw out the thinking of 'the old masters' of homeopathy, quoting widely. It could act as a primer for those who wish to know the historic background of the philosophy of homeopathy, without reading the original texts.

For someone, like myself, who learnt their philosophy the hard way, by reading the *Organon*, *Chronic Diseases* and Kent's lectures, this book would present a much more straightforward and integrated presentation of the key philosophical principles. Many students would welcome this. Although it would probably have meant I would not have pondered so hard on what was intended in the original texts. As is permissible for an author and compiler of such a book, there are a number of personal asides. On the one hand this contributes towards a thread running through the book and a sense of relationship with the author; on the other hand they are sometimes distracting. In some areas the book ranges outside of classical homeopathy, e.g. presentation of celestial and astrological types.

There are sections on fundamental philosophy and on homeopathic pharmacology and patient management. These include chapters on case taking, different methodologies, remedy reactions and supportive therapies (Bach, drainage, Schüssler, bowel nosodes, etc.). In some areas Rahmathullah's views are at odds with traditional thinking, for the experienced homeopath these are likely to be the most interesting. Unfortunately he gives little explanation or background as to why he holds a divergent view. This book, like others on philosophy, principles and practice faces the dual challenge of honouring the past masters of homeopathy and trying to move the debate on, reflecting the strength of homeopathic roots with the frustrations and difficulty of progressing the science and art of homeopathy in a coherent way.

The book is easy to read and will make a useful foundation text for students of homeopathy. But the more serious student will require reference back to and sometimes extensive reading around subjects in the original texts.

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Homeopathic prescribing pocket companion

Steven B. Kayne and Lee R. Kayne

Pharmaceutical Press: London, July 2007

Price: £21.95, ISBN: 978-0-85369-697-1

When one first studies homeopathic prescribing the process can feel like a minefield and can be bewildering: Selecting a specific remedy from over 3000 possible homeopathic medicines; matching the patient's symptoms using individualisation, totality of symptoms, keynote and modalities requires training and skill. In this pocket companion the Kaynes have done an excellent job of summarising the process and making acute prescribing of homeopathy easier and more practical. This book is an excellent introduction for students of homeopathy, pharmacists and other healthcare professionals interested in prescribing homeopathic medicines.

The authors use a novel and user-friendly approach to facilitate homeopathic prescribing. The bulk of the book comprises of 56 commonly encountered minor ailments with a simplified, easy to follow flow chart, for each ailment, guiding the reader to a possible indicated remedy. The use of such flow diagrams may seem over-simplified and controversial to trained homeopaths and traditionalists who are well versed on using repertories and materia medicas, however, in my opinion as time and generations evolve homeopathy and its presentation also needs to evolve. This book has presented a model to make homeopathic prescribing simple, easy, practical and accessible, particularly for busy community pharmacists and students of homeopathy. Perhaps, the title of the book should read "Acute Homeopathic Prescribing" rather than "Homeopathic Prescribing" to avoid ambiguity. The authors comment on this unique presentation in the preface, highlighting the origins and reasons for its adoption and mention that this way of presenting homeopathy may be met with resistance by traditionalists.

The flow charts presented can be used as a first reference point to find the appropriate remedy for a particular condition before referring to more detailed texts like materia medica and repertories. Additionally, for homeopaths and people interested in looking for chronic, constitutional remedies the flow charts may provide a pointer in the right direction for remedy selection or perhaps help in confirming a constitutional remedy.

In addition to the flow charts there is a brief summary of each remedy included for the particular condition in a comparative table format including modalities and keynotes to help the prescriber to distinguish between remedies and find the right one. The flow charts have been constructed

using various *materia medicas* which are referenced. The Kaynes' personal experiences of prescribing homeopathy Over The Counter (OTC) in a community pharmacy setting have also been included in the flow charts, adding useful information which cannot be obtained elsewhere.

The first section of the book gives a good overview on the background of homeopathy including: definition and principles of homeopathy, history of homeopathy, preparation and manufacture of homeopathic medicines, dispensing and labelling, legal classification and evidence base of homeopathy. This part of the book will be very useful to anyone new to homeopathy. It also explains the different terminologies used in homeopathy. The authors attempt to define and explain various words and phrases used in the world of homeopathy. They also mention alternative words or phrases used when more than one term is used to describe a particular process. For example, they mention when describing, potentisation that it is also referred to as dynamisation or attenuation.

The preparation of homeopathic medicines is very well covered and illustrated. Information on dispensing and endorsing prescriptions is useful for all pharmacists preparing homeopathic remedies. Other forms of medicine related to homeopathy, including flower essences, anthroposophical medicine and complex remedies, homotoxicology and biochemical tissue salts are described, highlighting any similarities and differences; this information is very relevant.

I found some limitations in Part One. For instance in the chapter entitled "Types of homeopathic medicines, practitioners and practices". The authors discuss classical and constitutional medicines. I found this a little confusing: it would make more sense if this section was described as methodologies of homeopathic prescribing. The information on types of practitioners is also limited and by no means complete. Under the description of types of homeopathic medicines there is a good explanation of allergodes, sarcodes and nosodes but no mention of the commonly used miasmatic nosodes.

A step by step approach on when to treat, when to refer, how to decide on a remedy is described. An attempt has been made to tackle the issue of potency selection and frequency of the prescribed remedy. This is a complex area, and in this book the discussion is rather general and does not highlight limitations. There is no mention, for instance, of using high potencies in acute situations or for more mental or emotional situations and lower potencies for chronic, long standing illnesses or weaker constitutions.

In summary, this is an excellent book, a quick reference guide for acute homeopathic prescribing and as the name suggests a great pocket companion!

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LETTERS TO THE EDITOR

Are media attacks justified? A response to Vithoukas

Dear Sir,

I have studied Vithoukas' work and benefited from his knowledge, including experiencing a week at his teaching centre on Alonissos. I also trained with and later taught for the excellent HPTG – an organisation that was greatly influenced by him. Hence it was with a sense of sadness and *deja-vu* that I read the article from Vithoukas in the April issue of *Homeopathy*.¹ I remember how in a similar way he criticised his fellow leaders in the homeopathic world in 1999 in *Homeopathic Links*.² Homeopathy has moved on enormously in the last nine years, but it would appear Vithoukas has not.

Firstly his article is illogical. The anti-homeopathic tirades in the UK are nothing to do with the teachings of Sherr, Scholten or Sankaran. I doubt our detractors have heard of them. It is the whole subject of homeopathy that incenses them for other reasons, primarily because like curing like, and potentisation are beyond their experience and conception.

Secondly to not acknowledge the enormous contribution that these teachers have contributed displays ignorance. I can speak with experience having studied extensively with them and their colleagues, and use their methods daily. The contribution to us all of Jeremy Sherr's provings is obvious. The philosophy and case management he teaches are invaluable for those who complete his *Dynamis* course. The case taking and analysis techniques of Sankaran and Scholten have revolutionised homeopathy. They have enabled more accurate prescriptions to be made from a vastly increased number of remedies to the advantage of our patients and the joy of ourselves.

To not acknowledge and applaud some of the greatest contributors to our science in its history is at best hiding one's head in the sand. At worst it smacks of sour grapes.

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Response to Geoff Johnson

Dear Sir,

I usually reply with facts and to the point.¹

The three persons mentioned were really my students – not one week followers, they attended a lot of my teaching before they became well-known.²

I think I have the right to criticise their public statements and ideas concerning a, which that according in my opinion has been badly distorted in recent years.

If some of their "followers" do not like this criticism or are shaken by this it is not my problem. A science that does not receive criticism from the inside either will disappear or will end up as a caricature.

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Homeopathy: the clinical picture is no clearer

Dear Sir,

Relton and colleagues¹ attempt to bring clarity to the debate on homeopathy, yet fail to do so for reasons which are themselves clear. They quite rightly show that terminology may be variably used, and seem to imply that this is particularly a problem with homeopathy. The fact is that the same occurs throughout medicine. The very word 'medicine' can mean a course of education, a practice, or a treatment. 'Pharmacy' similarly can mean a place where drugs are dispensed, a university course, or a functional area within a research project. The reality is that terms are in part defined by their context, and few of us have difficulty with this. However in the present debate it is what homeopaths themselves say that matters. Whatever terms are being used, what are homeopaths claiming? Are they claiming that ultra-dilute preparations of certain substances have

specific therapeutic effects? If they are, then this is readily testable and indeed has been tested repeatedly. If they are not, then what are they claiming?

The authors approach the truth in their consideration of 'efficacy' *versus* 'effectiveness', but they miss the point. Surely there is huge danger in accepting the latter while ignoring the need for the former? Effectiveness is a measure of the generalisability of a finding of efficacy. This is an important distinction when considering the role of the National Institute for Clinical Excellence (NICE). The paper alludes to the steadfast refusal of the government to refer any complementary or alternative medicine (CAM) to NICE, a fact which has previously been documented.² But to be fair to NICE, cost-effectiveness can only be calculated when a measure of effectiveness is available, and the prerequisite for that is a positive finding of efficacy. For orthodox medicines, NICE will not carry out any appraisals unless Randomised Controlled Trials (RCTs) show efficacy. Why should CAM be different?

I am particularly concerned at the authors' treatment of the term 'evidence'. I agree that the contextual effects of a homeopathic consultation might be beneficial, but I have to return to the question of what homeopaths are claiming. If they are claiming that the consultation alone does the job, then fine, but they are claiming more than that. What they are doing to my mind is to make it impossible to identify what really is happening, by refusing to allow the separation of treatment from consultation. This only happens in CAM, and in no other area of medicine or indeed of science. I do not dismiss the value of observational evidence. However it ranks poorly in the hierarchy of evidence,³ and it is hardly reasonable to accept it in the absence of RCT evidence. Relton *et al.* follow the time-honoured tradition of homeopaths by citing a colourful anecdote as if this were evidence for anything.

It is the mission of science, and of scientists, to bring clarity to that which was unclear. Refusing to allow the analysis of homeopathy as a practice, however one wants to define it, serves only to raise the turbidity of already muddy waters (even though the water in question really contains nothing). Yet Relton *et al.* do an about face at the end, with a remarkably reductionist set of recommendations. Will homeopaths take any notice? I suspect that herding cats will be easier to achieve. It is hard to see how this paper has added to our knowledge, and whether its recommendations have any value in the context of the barren evidential landscape that is homeopathy. It is noteworthy that funding by the Department of Health is acknowledged. This presumably is the sort of work that the government refers to when it claims to be supporting research into CAM.

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Response to Leslie Rose

Dear Sir,

We thank Rose for his interest in our paper and agree with him that it is the 'mission of science and of scientists to bring clarity to that which was unclear'.¹ However, Rose is mistaken in stating that we are 'refusing to allow the analysis of homeopathy as a practice'. There are different ways of delivering homeopathy – homeopathic medicine alone or treatment by a homeopath and distinction must be made between these in research to reflect practice.

An additional point is that there are universally applicable measures of effectiveness (e.g. EQ 5D²) that are recognised by the National Institute for Clinical Excellence (NICE) and the international research community that can (and have been) successfully applied to trials of the practice of homeopathy – treatment by a homeopath.³

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**Re: Land S. Social and Historical.
20 years ago: *The British
Homoeopathic Journal*, April 1988.
Homeopathy 2008;97:108–110**

Dear Sir,

It is good to review past editions of our Faculty Journal and especially the April 1988 edition when Bowel Nosodes

were discussed – an area that should attract more research in the light of recent advances and current laboratory techniques. However, I write to correct inaccuracies in the report of the obituary of Dr RJFH Pinsent. Robin Pinsent was very meticulous and was insistent that he was Chairman of the Midlands – later The British – Homeopathy Research Group. His association with the Blackie Foundation Trust as Chairman of their Scientific Committee (not Community) and later Medical Advisor was inspirational and he had much to share when he gave the first Blackie Memorial Lecture.¹ His lecture is available online at www.blackieft.org by clicking on News and then lectures.

The Blackie Foundation remains committed to supporting research into the principles and practice of Homeopathy and

invites those interested in pursuing such research to contact the Trust Administrator (+44 (0) 20 7935 0856).

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1 Communications No. 11, February 1984:1–16.

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^aCompeting interest: Trustee of Blackie Foundation Trust.