

ORIGINAL PAPER

Adjunctive homeopathic treatment in patients with severe sepsis: a randomized, double-blind, placebo-controlled trial in an intensive care unit[☆]

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Background: Mortality in patients with severe sepsis remains high despite the development of several therapeutic strategies. The aim of this randomized, double-blind, placebo-controlled trial was to evaluate whether homeopathy is able to influence long-term outcome in critically ill patients suffering from severe sepsis.

Methods: Seventy patients with severe sepsis received homeopathic treatment ($n=35$) or placebo ($n=35$). Five globules in a potency of 200c were given at 12 h interval during the stay at the intensive care unit. Survival after a 30 and 180 days was recorded.

Results: Three patients (2 homeopathy, 1 placebo) were excluded from the analyses because of incomplete data. All these patients survived. Baseline characteristics including age, sex, BMI, prior conditions, APACHE II score, signs of sepsis, number of organ failures, need for mechanical ventilation, need for vasopressors or veno-venous hemofiltration, and laboratory parameters were not significantly different between groups. On day 30, there was non-statistically significantly trend of survival in favour of homeopathy (verum 81.8%, placebo 67.7%, $P=0.19$). On day 180, survival was statistically significantly higher with verum homeopathy (75.8% vs 50.0%, $P=0.043$). No adverse effects were observed.

Conclusions: Our data suggest that homeopathic treatment may be an useful additional therapeutic measure with a long-term benefit for severely septic patients admitted to the intensive care unit. A constraint to wider application of this method is the limited number of trained homeopaths. *Homeopathy* (2011) 100, 95–100.

Keywords: APACHE II; homeopathy; critically ill patients; intensive care unit; sepsis; survival; double-blind; randomized prospective; placebo-controlled study

Introduction

The incidence of severe sepsis is 70,000 to 300,000 patients in the United States each year.¹ Septic shock is associated with mortality rates ranging from 40% to 90%.² Several new therapeutic approaches have failed during the last decades. Recent guidelines¹ recommend use of goal directed therapy, low-tidal ventilation, administration of recombinant Protein C (aPC), close monitoring of blood glucose with a target value of 80–100 mg/dl, and administration of hydrocortisone. Despite these therapeutic strategies, mortality has remained almost unchanged during the last few years.

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Homeopathic medicine has been used for about two centuries. Several studies describe its superiority above placebo.^{3–5} Experimental studies demonstrate the effect of high dilutions^{6,7} even beyond Avogadro's number.⁷ There are several case reports on the beneficial effect of homeopathy in critically ill patients.⁸ We initiated this study to investigate the effect of homeopathy on the outcome of critically ill patients. The aim of this prospective, randomized, double-blind, placebo-controlled trial was to evaluate at two time points (30 and 180 days) whether homeopathy can influence outcome in patients suffering from severe sepsis.

Materials and methods

Patients

The Ethical Committee of the University of Vienna approved the study. Seventy patients admitted to a Medical Intensive Care Unit (MICU) of the University of Vienna were assessed for eligibility, all were included in the study. All were randomized and treated, three had to be excluded because of incomplete data, all of the latter survived. Written informed consent was obtained from all participants or their authorized representatives. The criteria for severe sepsis of Bone *et al.* were used.⁹ Patients with a known or suspected infection on the basis of clinical data at the time of screening and three or more signs of systemic inflammation (temperature ≤ 36 or ≥ 38 °C, respiratory rate ≥ 20 /min, heart rate ≥ 90 /min, leukocytes ≤ 4 or ≥ 12 G/L) and sepsis-induced dysfunction of at least two organ systems that lasted no longer than 48 h were included. Treatment with homeopathy or placebo started within 48 h after the patients met the inclusion criteria (Fig. 1).

Randomization process

Within 24 h after meeting the criteria for sepsis, all eligible patients were sequentially randomized into two groups, receiving either the homeopathic medicine or placebo, according to a computer-generated code provided by a member of the Department of Medical Computer Sciences. An independent physician not involved into the study held the code. A person not involved in the decision and/or application process for the study prepared the medication for each patient.

Start of therapy and sublingual administration of the globules

Within 12 h after meeting the criteria for sepsis, homeopathic treatment started. A person not involved in the randomization process poured five globules into the lid of the tube containing the globules, then the globules were poured from the lid directly underneath the patient's tongue. In patients with endotracheal tubes, the globules were administered just aside the endotracheal tube. Globules were given twice daily at an interval of 12 h until sepsis was resolved or until death. Patients were treated for the duration of their stay in the intensive care unit. Treatment stopped on transfer to the general ward. Fifteen minutes before and after administration of the globules, no oral fluid or food intake or oral hygiene was allowed to avoid any potential interference with the globules. The homeopathic doctors were free to decide which homeopathic medicine should be applied. All medicines were prepared as a 200c (Rote Krebs Apotheke, Vienna, Austria).

Evaluation of patients

Patients were followed for 180 days after the start of treatment unless death occurred earlier. Base-line characteristics including demographic information and information on pre-existing conditions, organ function, markers of disease severity (APACHE II),¹⁰ and infection were assessed within the 24 h before starting treatment. Adverse effects were recorded during the treatment period.

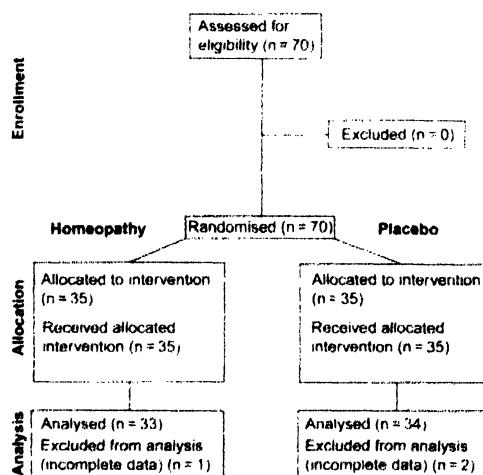


Figure 1 Flow of patients through the study.

Table 1 Baseline demographic characteristics

	Homeopathy <i>n</i> = 33	Placebo <i>n</i> = 34	<i>P</i>
Age	55.1±19.6	58.2±14.0	ns
Age			ns
≤60	15 (45.5%)	17 (50.0%)	
61–75	15 (45.5%)	14 (41.2%)	
>75	3 (9.1%)	3 (8.8%)	
Sex m:f	23:10	21:13	ns
Weight (kg)	79.3±11.9	76.9±11.1	ns
Height (cm)	174.7±8.9	172.0±10.0	ns
BMI	26.2±4.7	26.4±5.5	ns
Prior conditions			ns
Cancer	12 (36.4%)	13 (38.2%)	
Cardiovascular disease	5 (15.2%)	4 (11.8%)	
Recent trauma	5 (15.2%)	3 (8.8%)	
Infectious disease	3 (9.0%)	3 (8.8%)	
Intoxication	2 (6.1%)	4 (11.8%)	
Renal disease	3 (9.0%)	2 (5.9%)	
Liver disease	1 (3.0%)	2 (5.9%)	
Pneumonia	2 (6.1%)	3 (8.8%)	
Reason for admission			ns
Respiratory insufficiency	12	10	
Sepsis	19	21	
Other	2	3	

Statistical analysis

The evaluated end point was death within 180 days. Statistical analysis was done at the Department of Medical Computer Sciences, University of Vienna, using the SAS software package (Statistical Analysis System, SAS Institute Inc., Cary, NC). All statistical analyses were done before breaking the randomization code. Statistical analysis of the data was performed using Kruskal–Wallis Test for comparing the two groups.

Results

No adverse effects were observed in either group. Baseline demographic characteristics including age, sex, weight, height, and body mass index (BMI) as well as prior conditions were similar between the two groups (Table 1). Baseline clinical indices including APACHE II score and signs of inflammation, the number of organ failures, the need for mechanical ventilation, vasopressor support, veno-venous pump-driven haemofiltration and positive blood cultures were not significantly different between groups. Only heart rate exceeding 90 beats/min differed significantly, occurring more frequently in the placebo group ($P=0.033$; Table 2).

On day 30, survival showed a non-statistically significant trend in favour of homeopathy (verum 81.8%, placebo 67.7%, $P=0.19$; Table 3). On day 180, survival was statistically significantly higher in the verum group 1 (verum 75.8%, placebo 50.0%, $P=0.043$; Table 3). The most frequently prescribed homeopathic medicines were *Apis mellifica*, *Arsenicum album*, *Baptisia*, *Bryonia*, *Carbo vegetabilis*, *Crotalus horridus*, *Lachesis muta*, *Lycopodium clavatum*, *Phosphorus*, and *Pyrogenium* (Table 4).

Discussion

Our data suggest that adjunctive homeopathic treatment may be beneficial for the survival of critically ill patients. Short-time survival showed a non-statistically significant trend in favour of homeopathy; however, this may be due to the relatively small sample size. The lack of adverse effects is an important advantage of homeopathic treatment. As a further advantage, there is no interference with traditional treatment. Dosing via the oral route is easy and possible also in intubated patients orally and patients with oral or nasal feeding tubes. Furthermore, homeopathic medicines are low cost. One constraint is the small number of trained homeopathic doctors available in this setting.

Confounding factors include that placebo patients were more seriously affected in terms of heart rate and leukocyte count. However, there was no significant difference in the means of these variables. All patients received antibiotic therapy.

The mortality of severe sepsis, defined as sepsis with at least one organ failure, and septic shock, defined as hypotension not reversible by fluid resuscitation and associated with organ dysfunction or hypoperfusion abnormalities, remains very high despite increased efforts in intensive care medicine.^{11,12}

Table 2 Baseline clinical indices

	Homeopathy <i>n</i> = 33	Placebo <i>n</i> = 34	<i>P</i> *
APACHE II score	24.7±3.2	24.0±4.4	ns
APACHE II score ≥25	18 (54.5%)	16 (47.1%)	ns
Temperature at entry (°C)	37.9±1.34	37.8±1.1	ns
Respiratory rate at entry (min)	21.6±4.6	19.7±5.3	ns
Heart rate at entry (min)	102.7±23.5	112.9±22.2	ns
Leukocytes at entry G/L	13.7±9.4	14.4±10.0	ns
Temperature ≤36 or ≥38 °C	22 (66.6%)	19 (55.9%)	ns
Respiratory rate ≥20 (min)	26 (81.3%)	22 (64.7%)	ns
Heart rate ≥90 (min)	22 (66.7%)	30 (90.9%)	0.033
Leukocytes ≤4≥12 G/L	21 (63.6%)	29 (85.3%)	ns
Number of organ failures			ns
2	2 (6.1%)	5 (14.7%)	
3	16 (48.5%)	14 (41.2%)	
4	12 (36.4%)	13 (38.2%)	
5	3 (9.0%)	2 (5.9%)	
Mechanical ventilation	29 (87.9%)	30 (90.9%)	ns
FiO ₂ %	58.6±19.2	65.0±20.9	ns
Vasopressors	26 (78.8%)	30 (88.2%)	ns
Veno-venous hemofiltration	14 (42.4%)	12 (35.3%)	ns
Central venous pressure mmHg	8.7±3.8	9.7±4.7	ns
Blood cultures positive			
Gram negative	7 (21.2%)	4 (11.8%)	ns
Gram positive	4 (12.1%)	6 (17.6%)	ns
Fungi	3 (9.1%)	3 (8.8%)	ns
Mean blood pressure (mmHg)	80.6±16.6	78.2±20.9	ns
Platelet count	158.1±108.0	172.7±136.6	ns
Blood sugar (mmol/l)	8.9±4.3	7.8±2.8	ns
Serum creatinine (μmol/l)	194.5±185.7	185.7±176.8	ns
Blood urea nitrogen (mmol/l)	5.9±4.5	6.0±4.1	ns
Total protein (g/l)	57±8	60±13	ns
Bilirubine (μmol/l)	0.9±0.8	1.1±1.1	ns
Potassium (mmol/l)	4.1±0.7	4.1±0.8	ns
Sodium (mmol/l)	141.9±6.2	142.4±8.7	ns

* Kruskal–Wallis.

Guidelines have been developed in an endeavour to improve outcome.¹ Resuscitation of a patient in severe sepsis or sepsis-induced tissue hypoperfusion should begin as soon as the syndrome is recognized and should not be delayed pending ICU admission. During the first 6 h, the goals should include all of the following: central venous pressure 8–12 mmHg; mean arterial pressure >65 mmHg; urine output >0.5 ml/kg/h; and central venous or mixed venous oxygen saturation >70%. Early therapy directed towards these goals improves survival.¹³

Appropriate cultures should always be obtained before antimicrobial therapy is initiated¹⁴ and tests should be done as soon as possible to determine the source of the infection and the causative organism. Imaging studies such as ultrasound and/or bedside computer tomography should be performed. Sources of infection requiring drainage should be identified promptly. Intravenous antibiotic therapy should be started within the first hour of recognition of severe sepsis, after appropriate cultures have been obtained.

Establishing vascular access and initiating aggressive fluid resuscitation is the first priority when managing patients with severe sepsis or septic shock. The antimicrobial regimen should always be reassessed after 48–72 h on the basis of microbiological and clinical data with the aim of using a narrow-spectrum antibiotic to prevent the development of resistance, to reduce toxicity, and to reduce costs. Fluid challenge in patients with suspected hypovolemia (suspected inadequate arterial circulation) may be given over 30 min and repeated based on response (increase in blood pressure and urine output) and tolerance (evidence of intravascular volume overload). If appropriate fluid challenge fails to restore adequate blood pressure and organ perfusion, administration with vasopressor agents should be started.

Table 3 Survival

	Homeopathy <i>n</i> = 33	Placebo <i>n</i> = 34	<i>P</i> *
Survival 30 days	27 (81.8%)	23 (67.7%)	0.19
Survival 180 days	25 (75.8%)	17 (50.0%)	0.043

* Kruskal–Wallis.

Table 4 Most often used homeopathic medicines and indications

	Homeopathy number of prescriptions	Placebo number of prescriptions	P
<i>Apis mellifica</i>	4	3	ns
Oedema			
Extreme dyspnoea			
<i>Arsenicum album</i>	6	8	ns
Weakness, exhaustion			
Cardiovascular compromise			
Anxiety, restlessness			
Cachectic appearance			
<i>Baptisia</i>	5	7	ns
ARDS			
Sepsis			
Hot skin			
<i>Belladonna</i>	6	7	ns
High temperature with sweat			
Red discolouration, face			
<i>Bryonia</i>	4	3	ns
Pneumonia, esp. right lung			
Stitching pain in chest			
<i>Carbo vegetabilis</i>	6	7	ns
Respiratory insufficiency			
ARDS			
<i>Crotalus horridus</i>	7	8	ns
Purpura haemorrhagica			
Haemorrhages			
<i>Lachesis muta</i>	15	20	ns
Septic shock			
Haemorrhage			
High temperature			
Embolism			
Discolouration blue, purple			
<i>Lycopodium clavatum</i>	2	4	ns
Fever, afternoon			
Distension, abdominal			
<i>Phosphorus</i>	12	14	ns
Pneumonia, esp. right lower lobe			
Haemorrhage			
Purpura haemorrhagica			
<i>Pyrogenium</i>	5	6	ns
Septic fever			
Offensive odour			

Intravenous corticosteroids are recommended in patients with septic shock who, despite adequate fluid replacement, require vasopressor therapy to maintain adequate blood pressure.^{15–17} Recombinant activated protein C (rhAPC) is recommended in patients at high risk of death (APACHE II >25, sepsis-induced multiple organ failure, septic shock, or sepsis-induced ARDS) and no absolute contraindication that outweighs the potential benefit of rhAPC. The inflammatory response in sepsis is pro-coagulant in the early stages. rhAPC, an endogenous anti-coagulant with anti-inflammatory properties, has been shown, to improve survival in patients with sepsis-induced organ dysfunction.¹⁸

Mechanical ventilation in sepsis-induced acute lung injury (ALI)/acute respiratory distress syndrome (ARDS) should be adjusted to a “low” tidal in conjunction with the goal of maintaining end-inspiratory plateau pressures less than 30 cmH₂O.^{19–22} Daily spontaneous breathing trials reduce the duration of mechanical ventilation.^{23–25} Mechanically ventilated patients receiving continuous sedation may have a significantly longer duration of mechanical ventilation, ICU and hospital length of stay.²⁶ Daily interruption or lightening of sedation may reduce the duration of mechanical ventilation and ICU stay.²⁷ Following initial stabilization, blood glucose should be kept below 8.3 mmol/l using continuous infusion insulin if necessary.²⁸

Conclusion

Our data suggest that homeopathic treatment has a beneficial effect on the long-term survival of patients with severe sepsis, further research is required before making firm recommendations. The lack of trained homeopaths available to advise on treatment on ICUs is an important constraint to further research and implementation.

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SOCIAL AND HISTORICAL

20 years ago: *The British Homoeopathic Journal*, January 1991

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Metamorphosis

In this first issue of Volume 80, the editorial is entitled “A metamorphosis on our 80th birthday”.¹ Peter Fisher spoke of the illustrious ancestry of the Journal in the plethora of journals published by the British Homoeopathic Society (which became the Faculty in 1950) in the 19th and early 20th century. He named them, from the *British Journal of Homoeopathy*, published from 1843 to 1885, until the Journal’s immediate forbear, the *Journal of the British Homoeopathic Society* (1893–1910), originally edited by Richard Hughes. Fisher stated: “The large quantity which these journals published, in an age when the total volume of medical publishing was an order of magnitude less than it is today, reflects the strength of the homoeopathic movement compared to our own time”. The very first volume of the present journal is reviewed in this issue.

The metamorphosis referred to for the current issue had three aspects. A new cover carried the new Faculty logo, and had a cleaner and more modern layout. A far more important innovation was the introduction of the new supplement, *Simile*; the title a revival of the Faculty newsletter of the 1970s. This was in response to increasing demand for news, views and debate. An important aspect was the documentation of single case studies, in an attempt to counterbalance important elements of homeopathy which could be eliminated by increasing use of Information Technology (IT). In due course, these reports would be stored by the HOMINFORM Scientific Information Service of the Glasgow Homoeopathic Library, allowing on-line searching of the case report database. The third aspect is the acknowledgement of the importance of IT for homeopathy: “A technical revolution analogous to the discovery of printing”. The issue is devoted to this subject.

Development of IT in homeopathy

Most of this issue contains reports of papers presented at a meeting organized by the Faculty’s Data Collection

Project. “The methodology of computerized medical case study”² by Jeremy Swayne is a personalized methodology by the author; an early attempt to develop a practical system. “The global knowledge revolution and medicine”³ by RD Brittain is a 6-page summary of the then current state of hardware and software systems available to acquire, store, retrieve and process information. “The Read clinical classification (Read codes)”⁴ by James Read is a general 6-page description of the system. “Minimal effective data sets (MEDS)”⁵ by Roderick Neame presents the case for vastly increased investment in order that a ‘universal’ might be developed. “Computer-aided case-following and diagnosis”⁶ by Andrew Wright is a 7-page account of some trial heuristic systems, with much speculation on problems and solutions for both diagnosis and prognosis. “Computer-aided homoeopathy”⁷ by J Fichet suggests that any knowledge-based system should have a multidisciplinary design if it is to work efficiently. “Data collection at the Royal London Homoeopathic Hospital”⁸ by Peter Fisher is a description of the system then being used to compare rheumatoid arthritis outcomes at the Royal London Homoeopathic Hospital (RLHH), St Bartholomew’s and Homerton Hospital. “Data-matrix requirements for inductive analysis”⁹ by Robbert A van Haselen is a simple worked theoretical example of a database which can be worked using Statistical Analytical System (SAS) software.

Asking the right questions

In the midst of all the contributions to the conference on so many aspects of computer technology, this paper by Peter RT Davies sounded a cautionary note. He said there were two important objectives for the use of computers: the first, which he considered to be ideal, was to bring its wealth of information to bear on improving the way patients’ medical notes were stored and structured, and to give global statistics; but the second, to use this structure to conduct research, had many pitfalls. For research, any series of observations needed to be put into the right methodological framework. He warned of the need to define methods of dealing with manual pilot-scale data before larger-scale data collection, because many data

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collection/accumulation systems did not include appropriate data analysis methods. There is often the assumption that a computer will be needed, with the very real danger of collecting large amounts of data on the assumption that this will be a necessary part of any research. "The key is in formulating the right question: the computer should simply allow one to get to the result faster". The author considered it no good to be collecting data if it was not known how to interpret it; and quoted the adage 'garbage in equals garbage out'. He gave four examples of the kinds of studies which should be tackled; illustrated by four figures.¹⁰

The repertory and IT

This short paper "Hidden paradigms in homeopathy"¹¹ by Lex Rutten, points out another danger; one which is involved with the development of new systems from the material in the repertory. This author's concern was the bias inherent in the repertory if its structure was not uniform in every respect. He spoke of the difference between the experienced and inexperienced use of the repertory, stating: "If we want to make a better instrument than the repertory, we have to analyse carefully these differences and the shortcomings of the repertory". He cited several figures to show the variability in the size of rubrics and occurrences of medicines in Kent's *Repertory*. He suggested three paradigms necessary for developing an appropriate information retrieval system.

Review of the first volume

"Eighty years ago: The British Homoeopathic Journal, Volume 1, 1911"¹² was reviewed by Noel J Pratt, the author of the 'Twenty years ago' column at the time. It contained some interesting items for the ninety's readers. It was first published monthly, with the subtitle 'A monthly record of scientific therapeutics, general medicine, and surgery'. The editors Drs Goldsborough and Stonham, achieved a good balance of homeopathic articles and news, and extracts from the general medical news. The February issue had an article on General Practice by an AE Hardy, who had become a member of the Society in about 1861. Pratt commented: "Some of his experiences make strange reading — general practice has changed a great deal since then". A paper on ions related various experiences of electrolysis used for healing, including the healing of two long sinuses in a leg amputation stump by electrolysis in saline using metal probes. 'Some clinical cases' is an account of eight patients exhibited before the Society by Margaret Tyler. The author thought it was nice to know that they had demonstrations as well as the reading of papers. It is noteworthy that the paper 'Exophthalmic goitre and a proving of Belladonna' by HP Bellows of Boston, which had appeared in the *Journal of the American Institute of Homoeopathy*, referred to the use of 53 proverbs. At a meeting of the Society in June there was a discussion of the Government Invalidity Insurance Bill, and the possible effects of it on the practice of homeopathy as well as on the profession as a whole. This was a step towards National

Health as we know it today. Contemporary medical literature was reviewed in most issues, usually two books concerned with conventional medicine or surgery. Each month there were acknowledgements of other journals received — as many as 27 — and of occasional books for the Society's Library. In July, the extension of the Hospital, the Sir Henry Tyler Wing, was opened by Princess Louise, Duchess of Argyll; and in May the laying of the foundation stone of the new Nurses' Home was performed by the Duchess of Hamilton and Brandon.

Book review

Insights into Homoeopathy by Frank Bodman
Edited by Anita Davies and R Pinsent

The reviewer considered it evident from this book that Frank Bodman was a man of remarkable vision and personality; who took infinite care and patience over everything he did. There is a very wide variety of helpful clinical observations and findings; particularly those dealing with psychiatric and psychosomatic disorders. The author, with his psychiatric training, was a pioneer in this field. The last chapter includes a discussion on homeopathy and research, much of which was as relevant as when it was written. The wide extent of his knowledge and inquiry reflects an experience and wisdom rarely found in one individual. This book encapsulates the life work of a most erudite, meticulous, remarkable and far-seeing physician.¹³

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We were saddened to hear of the death of Sylvia Land, the author of the Journal's regular feature '20 years ago' on the 17th November 2010, shortly after completing this article. A tribute is published in this issue.

OBITUARY

Llewelyn Ralph Twentyman: 6 June 1914–29 April 2010



“Spirit is never without Matter, Matter never without Spirit.”

Ralph Twentyman passed away peacefully at home shortly before his 96th birthday.

He was born on 6th June 1914 into a wealthy family living in the Wolverhampton area. Despite the First World War and the difficult economic times that followed, he had an idyllic childhood growing up in the country with loving parents and even a jolly butler. He was rather a shy boy who disliked parties and occasionally needed to withdraw – he was often found hiding in the bushes. His father, a successful businessman, had a reputation for being a great teaser. His mother was both artistic and musical and in addition a great teller of imaginative stories to her children.

He was a senior member of the medical staff of the Royal London Homoeopathic Hospital (RLHH) for over 30 years until his retirement in 1979. For those who in later years knew him as a physician, teacher, mentor, boss and colleague, these influences in his early childhood, as well as those of his formative years, will come as no great surprise. We will never forget the booming laughter emanating from his consulting room audible all over the basement outpatient department, his challenging teaching sessions and his immense contributions, both clinical and non-clinical, to the development and survival of the RLHH before and after the Trident air disaster at Staines in 1972.

Ralph was privately tutored until the age of nine when he went to a preparatory school in Liphook. At the age of fourteen he went to public school at Shrewsbury. He gained a scholarship to Cambridge to read medicine. However, once there he became so dissatisfied with the lack of a human aspect to medicine and research that he interrupted his studies and went to London to become a follower of Dimitrije

Mitrinović who became his spiritual mentor. Mitrinović was secretary of the New Europe Group and later started the New Atlantis Foundation. This group of young intellectuals was particularly interested in literature; mythology; social questions and the psychological approaches of Freud, Adler and Jung. It was Mitrinović who introduced Ralph to Anthroposophy, he remained a fatherly friend until his death in 1953. Ralph returned to Cambridge to complete his medical degree. He then worked at University College Hospital, London as a House Physician and then as Casualty Medical Officer and later Medical Registrar.

Mitrinović introduced Ralph to Karl König, the founder of the Camphill Schools which led to a fruitful working relationship and friendship. Ralph was trustee and Vice President of the Camphill movement until his death. König in turn introduced him to Dr Rita Leroi and Dr Kaelin who pioneered the use of mistletoe in the treatment for cancer (as proposed by Rudolph Steiner) in Arlesheim, Switzerland. For Ralph this opened up a whole new world of understanding about the human being. Having struggled greatly with the reductionist approach of modern medicine, he now found ways of answering questions regarding psychosomatic phenomena, and gained an approach to the Anthroposophical contribution to medicine.

In 1939 he married Jean Rutherford, the sister of a school friend, they had three children – Alex, Elizabeth and Philip. During the Second World War he joined the RAF Medical Service as was posted first as Physician to the RAF Hospital in Cairo and subsequently as Medical Specialist to the RAF Hospital in Habbaniyah, in Iraq. After returning in 1947, his marriage broke down and he was left with the care of his three young children. His close friends gave much needed support. It was probably his all-prevailing humour, so much part of his personality, which helped him to tackle life again. He would later use this humour, together with his empathy and deep interest in his fellow human beings, as a therapeutic tool to help his patients. His second marriage in 1949 was to Jean Grizzy, an ophthalmologist, they had a son, Orion. Grizzy, as she was generally known, lovingly brought up all four children.

Ralph took a course in homeopathy at the RLHH and was appointed Assistant Physician in 1948. In due course he was appointed Consultant Physician, a position which held until his retirement in 1979. In 1958 he was appointed editor of the British Homeopathic Journal which he then carried for 21 years until his retirement. He served as President of the Faculty of Homoeopathy from 1961–1964.

In 1956 he met Dr John Raeside, a colleague at RLHH. They became great friends and together, despite some

internal opposition from more 'classically-orientated' homoeopaths, introduced an Anthroposophical approach and related remedies to the hospital

Ralph and Grizzy narrowly escaped death in 1972. They were due to attend the LMHI Congress in Brussels with John Raeside and a number of senior homoeopaths and colleagues from the RLHH. However Grizzy decided at the last minute that she wanted to go to Bruges with Ralph for a short holiday before the conference, so they rebooked their flight. When they arrived at the conference, they found that John, their friends, colleagues had all died in the Trident air disaster at Staines. There were no survivors. Ralph gave a moving address in memory of those who were killed (which is reprinted in this issue of the Journal) but this tragedy affected him deeply. Indeed, this event is still remembered by many today. Three years later Grizzy died.

In 1979, with his retirement, a new phase of life began; Ralph and Annelie Raeside, John's widow, married and moved to Forest Row. For 15 years Ralph gave weekly medical lectures at Tobias School of Art and other UK Anthroposophical Institutions and also lectured in South Africa, Australia, New Zealand, U.S.A., Hawaii, Japan, Denmark and Ireland. He was always accompanied by Annelie who gave workshops at the same events.

During these years he also wrote two books. "*The Science and Art of Healing*", was a compilation of previously published papers with some fresh contributions, published in 1989. His second book, "*Medicine, Mythology and Spirituality*", published in 2004 when he was 90 years old, deals with disease as a human phenomenon rather than a chemical or physical error.

Ralph was very well read and had a tremendous library. His lecturing style was unscripted, spontaneous and packed with colourful imagery and classical allusions and at times flights of fancy. Even when one did not agree with him, one had to admire his style and eloquence and he made a lasting impression on all those who heard him speak. Ralph was a very clear, sharp thinker and Rudolph Steiner's maxim: "*Spirit is never without Matter, Matter never without Spirit*" makes a most appropriate motto for his lifelong striving for knowledge and deeper understanding.

Until his very last days Ralph Twentyman remained sharp-witted in discussions and deep conversations. On the day he passed away (29th April 2010), at around lunch-time, he said farewell to his wife in a clear but non-verbal way. He wanted to die alone. When she came back into the room he had already crossed the threshold.

He will be remembered as a striving but humorous Anthroposophist and homeopath as well as an outstanding physician who adeptly appealed to both the light and serious sides of people and a great human being to have known.

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In his own words . . .

Below is Ralph Twentyman's short auto-obituary

I studied medicine at Cambridge and University College Hospital (UCH). After qualifying M.B. B.Chir I was

appointed House Physician, Casualty Medical Officer and Medical Registrar, I was then in R.A.F. medical service and was posted as Physician to RAF Hospital in Cairo and then as Medical Specialist in RAF Hospital in Habbaniyah, Iraq. After demobilisation I took the course in Homeopathic Medicine at the RLHH and was appointment Assistant Physician in 1948. In due course I was appointed Consultant Physician. My interest in Homeopathy had been aroused before the war when he was lucky and privileged to meet a number of Homeopathic doctors and also Psychiatric specialists from Europe, in the New Europe Group.

For me, homeopathy represented an early attempt to overcome the abyss between Soul and Body which was opened by the advance of so-called Natural Science. Its founder Samuel Hahnemann, a contemporary of Goethe worked with a method similar to Goethe's in Science, qualitative, not exclusively quantitative. He however could not reach a concept of Man. In U.S.A. where there was a strong and influential Swedenborgian movement homeopathy became united with Swedenborgism and provided a wide scientific and philosophical basis for understanding Man which could include the approaches of men of the calibre of Goethe and Hahnemann. For Swedenborg the body was the Kingdom of the Soul. For Science the Soul had been reduced, as Eddington and Heisenberg showed, to a mere observer, a one-eyed colour blind observer of measurements.

I felt these psychosomatic problems acutely. I met Karl König, the founder of the Camphill Schools for handicapped children and through him was introduced to Dr Leroi and Dr Kaelin who were pioneering the Mistletoe treatment of Cancer, proposed and indicated by Rudolph Steiner. This helped me to gain an approach to the Anthroposophical contribution to Medicine. Foremost in these contributions was the relating of the soul functions, thinking, feeling and willing to the nerve sense processes, the rhythmic processes and the metabolic-limb processes, respectively.

I was asked to lecture in many different places; lecture tour followed in South Africa, Australia, New Zealand, U.S.A. and Hawaii and Japan and courses in Denmark and Eire, and compiled a book from various papers already published together with fresh contributions. The book "*The Science and Art of Healing*" was published in 1989.

I wrote a further book dealing with disease as a human phenomenon rather than a genocidal elimination of diseases, as a main motif. I called it *Medicine, Mythology and Spirituality*, it was published in 2004 when I was 90 years old.

Ralph Twentyman

Ralph Twentyman: a tribute

In the 1970s and 1980s Ralph Twentyman's booming laugh was a familiar sound to everyone working at the RLHH, as it then was. It could be heard echoing through the dungeons of the basement consulting rooms during the day, and long after that in the upper reaches of the hospital, because Ralph often used to stay in the wards long

into the evening. His first wife had died not long before and he probably disliked the prospect of returning to an empty house. After his happy second marriage to Annelie these long hours reduced to more normal proportions.

Ralph had an impish sense of humour. He liked to tell the story of the homeopath who had cured a patient with *Bufo* because the man looked like a toad. And he said that, when giving lectures to doctors unfamiliar with homeopathy, he introduced the subject by saying: "*Here's how we treat in-growing toenails. We take a bar magnet and use the south pole to stir some sugar of milk, which we then give to the patient.*"

He was our link to an earlier generation of homeopaths, because he had joined the staff shortly after the Second World War, when many of them were still about. He spoke amusingly, and not always with unqualified admiration, about some of them. But his loyalty to the hospital was unquestionable. When one of the consultants resigned unexpectedly to go abroad, Ralph was furious. At the time I was doing some research on *Arnica* which involved dropping a weight on the arms of volunteers to cause a bruise; the departing consultant was one of them. "*Drop it hard on Dr X.*" Ralph advised sourly.

Ralph loved to teach, and he held regular tutorials for the hospital staff. These were very wide-ranging and drew on Ralph's extensive reading in all sorts of subjects. He saw medicine as embedded in the larger frame of Western history and culture and as having much to learn from earlier ways of thinking. The philosophy of Rudolf Steiner was a principal influence here, and he often cited Steiner's ideas. At the same time, he was firmly grounded in orthodox clinical medicine and often came up with an astute diagnosis in a difficult case.

I am sure that the audience at these tutorials learned a lot from them. In my case, his remark that Kent had

incorporated a lot of Emanuel Swedenborg's ideas in his teaching was revelatory, and caused me to embark on a historical survey of nineteenth-century homeopathy that transformed my understanding of the subject.

As well as giving us the benefit of his own wisdom and experience, Ralph knew a remarkably wide range of people and he used to arrange for visiting lecturers from all kinds of backgrounds to address us on subjects that were only loosely, if at all, related to medicine.

The use of complementary methods in cancer was one of Ralph's main clinical interests, for which his intuition and compassion made him eminently suited, and he introduced the use of *Iscador*, an Anthroposophical medicine derived from mistletoe, for the purpose. Other consultants at the hospital followed his lead in this. He was also concerned with caring for patients with other forms of chronic disease as well as cancer. In the 1970s the hospital had a lot of inpatients, many of whom were under Ralph's care — sometimes for long periods, because at that time it was possible to accommodate patients literally for years. He was keen to do this, because he saw — rightly at the time — that maintaining bed occupancy was crucial to the hospital's survival. He continually exhorted us to admit as many patients as possible.

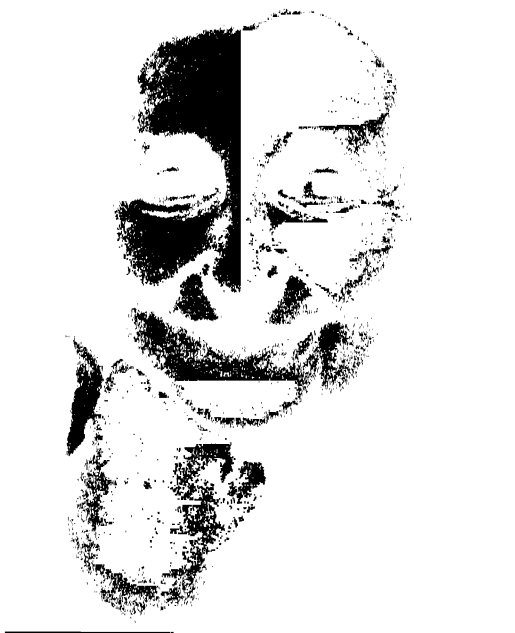
The disappearance of inpatients is just one of the ways in which the RLHH has altered very considerably from how it was in Ralph's day. Another, of course, is the recent change of name, which he didn't live to see. Would he have approved? I think he probably would, for his instinct was always to expand the thinking of those of us who worked with him.

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OBITUARY

**Sylvia Teresa Land, *nee* Ballard:
14 July 1935–17 November 2010**

Sylvia Land graduated in medicine at Aberdeen in 1959, and after registration began work in microbiology. On moving to Cambridge her work included research into build-up of resistant *Staphylococcus pyogenes* in

Addenbrookes hospital using phage typing and antibiotic sensitivity. Her research highlighted small outbreaks caused by transference from other hospitals on bedclothes and that neither cubicles nor nasal cream effectively prevented colonization.

Sylvia moved to Norwich and whilst raising a family she studied homeopathy, applying it widely amongst family and friends. Sylvia became a Member of the Faculty in 1972 and was an active member of the East Anglian Group of medical homeopaths.

Sylvia took over from Dr Noel Pratt in July 1996 compiling and writing the regular article "Twenty years ago" featured in this *Journal*. She was a pleasure to work with always positive; paying attention to accuracy and detail. I never met Sylvia, despite working with her since 1998, but my conversations with her over the years were always full, varied and filled with humour.

Sylvia was laid to rest at the Church only minutes from her Norfolk home on a snowy, but sunny November morning with over 200 people attending. We at the Faculty would like to express our condolences to the Land family: Sylvia and her husband Derek had only recently celebrated their 50th Wedding Anniversary.

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