Complementary Medicine

# Imagine Homeopathy

## A Book of Experiments, Images, and Metaphors

Chris Kurz, Ph.D.

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I dedicate this book to Kathi and Alex.

They have shown me how much magic there is in imagination.

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# Foreword

I am honored to have been asked to write this introduction by the author. Although I have known Chris "on-line" for about ten years, I finally met him in person when I visited Slovenia in August 2004. I was not disappointed.

In the last 20 years there has been an amazing resurgence of homeopathy. Since 1990 there have been more books published about homeopathy than there were between 1875 and 1885—the "golden age of homeopathy." Publishing a book about homeopathy is not a money-making proposition. Most authors, now as then, write books either at the behest of their students or because they believe they have something valuable to say. It remains for the readers to sort the wheat from the chaff and it will be a task that will happen over time.

Many of the books written these days concern homeopathic methodology, the "how to do it." Many of them are based on the author's clinical experience. In this category we have the books by Rajan Sankaran that introduced us to the concepts of "kingdoms"—the need to assess patients in terms of their need of an animal, mineral, or plant remedy—and the books by Jan Scholten that take us through a fanciful exploration of the periodic table

where the series and stages can point us to unknown remedies that might be useful in a case. Many of the newer books are about the provings of new remedies: the numerous milks from both animals and humans, the feathers of birds, the blood of several species, and the assorted other elements—hydrogen, neon, plutonium—as well as a number of meditative provings of imponderables like *Luna* and *Sol*.

But among all these books there are few, if any, that get to the issues that are underneath it all; what *is* homeopathy and, moreover, how do we think about it? Those are the big questions the answers to which are found, one step removed, in all those other books.

The grand philosopher Bertrand Russell said: "Many people would sooner die than think. In fact they do."

What Chris is asking us to do is exactly that: to think about the "why" and not the "how" of it. It is a piece of homeopathy that is not often talked about as people rush into learning the method before asking the basic questions.

Says Chris: "Although this book will not by itself revolutionize educational practices in homeopathy, I conceived it with the teacher in mind. Hopefully, it will encourage more lecturers and educators to rethink their teaching style." And *that* is certainly needed. Good clinicians are not necessarily good teachers.

We see this rush into the method and inadequate teaching at many seminars. The speaker presents a case and asks, "What remedy did I give?" Often, no one can "guess" the remedy and the speaker then astounds the audience by discussing a new or

unknown remedy. This playing of "guess the remedy" is not a homeopathic way of doing it. We all learn, in § 84 of the *Organon*, to never ask closed questions. Is "What remedy did I give?" a closed question? It certainly is getting close!

The real questions to be asked are: In what ways can we look at this case? What is important in this case? What methodology would suit this case in this instance? Which symptoms are the most individualizing? To do this requires thinking about it at the level at which homeopathy truly exists, a multi-dimensional discipline where every piece has a direct bearing on every other piece. It is the "holographic entity of a well-planned curriculum" that Chris is talking about.

"Our goal," says Chris, "should therefore be—put a bit provocatively—to teach all of homeopathy in every lesson." It is these many parts and the way of drawing them together that Chris discusses in this book. He is not discussing the "how" but rather the "why." And *that* is what sets this book apart from all the other introductory books about homeopathy that we find on the market.

As Chris points out, many seem to hang their cases against homeopathy upon its non-intuitive reasoning that appears to be completely illogical: if someone suffers from a disease, he may be cured by a medicine which has the power to produce just such a disease in a healthy subject.

But keeping in mind the duality of homeopathy which is both a deductive philosophy and a practical methodology, we can again quote Bertrand Russell, who says: "the purpose of philo-

sophy is to begin with something so obvious as to not seem worth stating (i.e., the concept of the vital force) and to end up with something so paradoxical that no one will believe it" (like homeopathy!).

It is this very paradox that Chris so eloquently reviews in this book using the grand overview afforded by his images, metaphors, and experiments. It is an approach which, I hope, will open a lot of minds!

Julian Winston
Tawa, New Zealand
January 2005

# Acknowledgment

Before I started writing I had not realized how many people—knowingly or unknowingly—have actually contributed to this book.

For example, when writing the chapter about the individuality of a rose I was mentally transferred to the sunny room overlooking the Pacific Ocean in which I first discussed this idea with Vicky Menear. The idea of using a lemon to explain the law of similars came to fruition during a particularly fruitful discussion with Jo Daly at the sidelines of the 1997 IFH Conference in Seattle. The two cassettes that form the centerpiece of the chapter on homeopathy and its relation to science conjure up the memory of an argument with several fellow physicists who were unfortunate enough to challenge homeopathy one day in my lab at the university.

Then there are the members of the Lyghtforce mailing list. I received valuable feedback from them and would like to thank all of them collectively—and by no means less sincerely—for the bandwidth they shared with me. Among those, I want to mention David Little and Will Taylor in particular; their contributions, albeit via e-mail, are by no means confined to the virtual realm.

My thanks also to Misha Norland, with whom I remember a particularly invigorating walk through the Devon landscape during which we talked about several topics that found their way into this book in one way or another. I also would like to mention discussions with Peter König, Massimo Mangialavori, and Jeremy Sherr who focused my thinking and sharpened my understanding.

Many thanks also to Roland Schuller for providing some sorely needed images of excellent quality at short notice.

A project is only as good as its critics. Therefore I want to mention Julian Winston and Uta Santos-König who took it upon themselves to read the unfinished manuscript and shared their thoughts with me.

Last but not least, my sincere and heartfelt thanks go out to all those people dear to me, who endured me, made amends, and cut me sufficient slack that I could afford the luxury of taking so much time out to finish this book.

# Contents

# 1 Introduction

We live in an exciting time in which alternative therapies are beginning to reemerge from their long hibernation. Of those therapies, homeopathy is among the fastest growing and most widespread. On the one hand, this creates great opportunities to establish homeopathy as viable and often preferable to orthodox medicine. On the other hand, the explosive growth inherently comes with a challenge: the homeopathic community needs to find ways to meet the growing demand of capable practitioners.

In a historical context, homeopathy has already taken a wrong turn under similar circumstances. At the beginning of the twentieth century the popularity of homeopathy reached a peak in the United States, which led to a rise in the number of schools, practitioners, and homeopathic hospitals. Sadly, this rise was followed by a steep decline only a few decades thereafter, which almost led to its extinction. Dr. Daniel Cook, in a presentation at the 1995 Ohio Homeopathic Meeting, said, "If we don't identify what caused the problems and conditions that led to homeopathy's decline back then, we may overlook them if they happen in our time. And there are certainly a number of parallels between homeopathy at the end of this century and homeopathy at the

turn of the last century. So, it's more than just academic interest that should make us wonder about this question." [1]

There were several reasons for its near demise. The root of the problem, however, appears to me to have been the exchange of quality in favor of quantity. Never before had there been so many practicing homeopaths with so little grasp of the art and science they were practicing. Homeopathic schools and colleges failed to turn out competent and well-grounded homeopaths and graduated half-homeopaths in large numbers. The reputation of homeopathy was lost with this dilution of knowledge. By the 1940s, homeopathy had the status of an obscure and inconsequential treatment modality in America and most other parts of the world.

The credit for rekindling the fire and causing homeopathy to rise from its ashes goes in large part to a few charismatic and dedicated men and women who saw clearly what was needed. They recognized the need for high standards in training, modern teaching methods, and a firm grounding in the science and philosophy of homeopathy.

If we are to learn anything from history, it is that growth is impossible without proportional numbers of well-educated practitioners. This issue, to me, determines the lasting growth and recognition of homeopathy, and ultimately its success in lessening suffering in this world.

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[1] Quoted from J. Winston, *The Faces of Homœopathy*. Tawa, New Zealand: Great Auk Publishing; 1999:226

The term well-educated, in my opinion, encompasses all areas of knowledge: materia medica, history, philosophy, case taking, case analysis and case management, not forgetting the basics of medical science such as anatomy, physiology, and pathology. Yet someone who is knowledgeable in all of the above may still lack the necessary understanding to become a good homeopath. All truly exceptional homeopaths I know have one thing in common: they share a deep understanding of homeopathy that goes beyond their interaction with patients and gives them the ability to experience and discover homeopathy everywhere, in every facet of life. They have become skilled in the science as well as in the art of homeopathy. What the diligent but otherwise uninspired student of homeopathy is lacking turns out to be the same thing that, in a musical concert, transforms mechanical notes into an artistic performance. We refer to homeopathy as an "art and science," quietly admitting that the scientific part is amenable to being taught, studied, and learned. But what about the artistic part? Can it be taught too? Or does a person have to be genetically endowed with it?

As I see it, the art of homeopathy has something to do with allowing homeopathy to permeate one's view of life. It grows stronger as the distinction between homeopathy and all the rest diminishes. This is not a process of blurring and neglecting. On the contrary, it is all about sharpening one's perception to recognize the common foundation upon which health and disease, life and death, rest. One way to start this process is to internalize and become intimately familiar with all important concepts of

homeopathy. Not only on an intellectual but also on an intuitive and emotional level.

Practicing homeopathy requires a holistic and open-minded approach to all information pertaining to the patient's persona, disease, and homeopathic materia medica. If this is indeed the case, should homeopathy not be taught in the same way in which it is intended to be practiced afterward? The idea for this book emerged as a result of my lecturing and teaching engagements in study groups and at various seminars. It quickly became clear that students understand and retain conceptual homeopathic knowledge best if they become engaged in the material in a holistic way. It emerged that there are four key elements which, when emphasized in every learning experience, make it much more successful and even enjoyable: analogies are the main vehicle connecting different parts of knowledge; the emphasis is on insight rather than rote knowledge; personal experience irrigated with imagination yields the most fertile ground for insight; and true learning is always and solely trying to remind you of something you already know.

This book is written for people who want to take the time to understand things at a deeper level. People who like to draw parallels, think in analogies and have fun milking a metaphor for every bit of insight. And of course people who are looking for ways to explain the often difficult framework of homeopathic science to other inquiring minds. It is intended for those who have just started a course of study in homeopathy as well as for those who would enjoy a new perspective on things learned long ago.

And, not least, this book is for those in the homeopathic community who have taken it upon themselves to pass on the knowledge and teach.

To reach a profound level of understanding requires a good, solid foundation in basic homeopathic philosophy. Terms and concepts like totality, miasms, and constitution are, although ubiquitous and frequently used, in many cases poorly understood and not internalized. I am fully aware that there is no one correct interpretation of the concepts presented. Homeopathy is already too diverse a field for that. But just as I learned much from other people presenting their views to me, I hope you will find what I collected in this book useful for yourself.

In keeping with Hahnemann's warning that theoretical speculation and fruitless theory can never be the goal of a true healer, the new-found knowledge must have an impact on our prescribing to merit the effort. For myself I can say that whenever I was confronted with new insights on some basic aspect of homeopathy, my ability to help patients also took a step forward.

In this book, each chapter is devoted to one experiment, metaphor, or image which throws light on a particular area of homeopathy. It is by no means unintentional that some concepts are covered in more than one chapter. There are always different ways of looking at things and examining them in various contexts. Correspondingly, this book need not be read from cover to cover, page by page. You can pick and choose, jumping from one chapter to another; just follow your curiosity.

Toward the beginning of most chapters you will find instructions for a little experiment or meditation. I urge you to take the time and go through with this before reading on. You will benefit from it in several ways: setting aside the few minutes' time ensures that you are in a calm and receptive state of mind; performing a physical task opens up new neural pathways for learning and involves more of your brain in the act; looking at a three-dimensional object better focuses your attention; and it is simply more fun than dry mental exercises.

Make sure you have pen and paper handy before starting on an experiment. There will be many interesting thoughts crossing your mind which will be lost to you if you do not jot them down. Modern research tells us that if you skip this step you are depriving yourself of more than 40% of the learning effect.

As a book like this is never finished, I am, of course, keen to learn about your ideas and suggestions. What really interests me is how you "imagine" homeopathy. You can send me a note with your thoughts by email to the following address: ckurz7000@hotmail.com.

# 2 Note to Educators

Homeopathy is a holistic approach to healing which rightly puts the whole human being at the heart of its practice. Without acknowledging the indivisibility of body, mind, soul, and spirit, perceiving the totality of the individual disease will remain an elusive goal. We certainly expect every well-trained homeopath to practice with the individual patient at the center of his/her attention and with the patient's unique wholeness in mind.

If we expect graduates of any school to subscribe to this philosophy then the same standards should be set for the teachers—with one significant difference: as educators we have to realize that we are practicing homeopathy every time we are interacting with our students. Therefore our curriculum, our lessons, our teaching style, and our entire approach to teaching must be holistic. The message we convey in a course in homeopathy is very much affected by the way the course is taught, not just by what is said in each lecture. I will try to explain exactly what I mean by this in the following paragraphs.

A well-planned and effective curriculum is very much a holographic entity. The message we want to convey has to be present at each level of student interaction. Teaching is not about baffling

students with our knowledge but rather about surprising them with how much they themselves already know.

## A Shift in the Paradigm

The traditional teaching style has changed little over the past 150 years. We still meet the teacher preaching to the students in most instances. Yet our understanding of the learning process and how it can be facilitated has grown considerably in the past decades. It is high time, in my opinion, to let the stale air out of our courses in homeopathy and unleash the true potential of our students' minds.

I would like to touch briefly on several features which are the key to effective teaching. Let me start with an example. If you want to explain to somebody how to get to a certain place, you have two choices. You can either tell him where he is supposed to go or how he is supposed to get there. The former is a goal-oriented approach, the latter process-oriented.

Conventionally, when we teach a class, we have a goal in mind. We want to "get" there, "cover" the material. This attitude is not good homeopathy; we would not interact with a patient in this way, with the thought of getting the remedy first and foremost into our mind. Therefore, a goal-oriented attitude when teaching is counter to the message we want to send out. Just think of tourist guides. Their job is to show people around a certain place, make them familiar with it. Their primary job is not getting them from the entrance of the castle to its exit.

If I wanted to introduce the remedy *Sulphur*, I would not aim to teach *Sulphur* but rather teach homeopathy using *Sulphur* as an example. In practice this is a subtle difference in teaching style which nonetheless has a profound impact on the climate and success of a course.

## Integrative Teaching

It is a well-known fact that new material is better absorbed and retained if the way in which it relates to already familiar knowledge is apparent to the student from the beginning. This means that we have to make contact with the everyday world as much as possible and draw our examples and metaphors from there. But there is also a less obvious application of this principle. Let me explain.

Our goal, put in abstract terms, is to convey knowledge of a certain area up to a certain (minimum) depth. We can get there by two principally different routes. One is to go over small sections of the material in great detail, covering a different section in each lesson. When we piece together all the sections near the end of the course, we have reached our goal. Another approach is to cover large chunks of the material in each class period but go into proportionally less detail. In this manner we are covering a lot of ground each time but need to come back several times to reach the required depth of knowledge.

For many teachers the first approach is more familiar since it allows them to "check off" parts of the material as they are covered in class. The students are exposed to each topic in turn and to the required level of detail. However, they are thereby deprived of the big picture from the outset and only start to get a grasp of it towards the end of the course. By sacrificing depth for breadth, as the second approach suggests, they are able to see an outline of the whole from the very beginning. Every lecture then strives to add detail to the already existing picture. In this manner the students have a place to put the new knowledge and see it in context with what they already know. Our goal should therefore be—put a bit provocatively—to teach all of homeopathy in every lesson.

## Teachable Moments

There is a right time for everything in life. From our practices we know that there is a right time for healing, and any attempt to force a cure onto someone is bound to fail. Similarly, there is a time for the mind to learn. If the mind is not open, no amount of teaching skills will fill it with new knowledge. A teacher needs to be receptive for those magic moments when a mind asks for knowledge and be able to take advantage of them. It is not good enough to say: "Today we are going to learn about *Sulphur*," without first opening the minds for Sulphur. We have to create the need to know, make room for those teachable moments, before presenting the information.

In practice I have learned that the time spent preparing a lesson is more than half devoted to finding ways to open the students' minds. Filling them with the required information is comparatively easy. In this, a delicate balance is required between guiding the class and being guided by it. Those teachable moments are the "strange, rare, and peculiar" symptoms in our cases: we have to have an antenna out for them all the time, otherwise they slip by unnoticed.

## Hands-on Approach

Hands-on learning has become a buzz word in modern education; it is much talked about though seldom practiced. Everybody knows from experience that learning by doing is much more effective than learning by listening. I have never heard of a carpenter who has been taught the theory of carpentry for several years before actually using a hammer for the first time. If comparatively simple concepts are best taught hands-on then how much more must this be true for abstract and complicated ones?

The patient is at the center of homeopathic practice; the patient must likewise be at the center of our teaching. This means that we have to teach following a case-centered curriculum. There is very little in homeopathy that cannot be taught using a case. Studying materia medica is noting more than taking the case of Mr. Silica, Mrs. Lachesis, or what have you. Repertorization, analysis, first and second prescription are other examples.

History and philosophy are easily taught with a case-centered approach.

For these reasons we have to find ways that allow students to observe and interact with cases as early as possible. True to the integrative approach described earlier, exposure to cases is not something that comes at the end of the course but rather an element of the curriculum which the student meets early on and becomes increasingly acquainted with throughout the course.

Hands-on learning also requires that the teacher minimize the time spent addressing the class in a traditional lecture style. Different interaction styles, used judiciously and in a varied manner throughout each lesson, are necessary to capture the interest and creativity of the class. There are many good books available which are a helpful resource for the teacher on this topic.

## Lessons Versus Workshops

The paradigm shift in teaching, once instituted, will necessitate a gross shift in course and lesson planning. In practice, it is impossible to follow a hands-on, case-centered, holistic curriculum while maintaining a traditional 90-minutes-per-lesson format. In my experience, 2- to 3-day workshops are best suited to this way of teaching. Unless we make room for this amount of time, we will not be able to harness the power of group dynamics, allow an at-ease atmosphere to establish itself, or synchronize everyone's creativity in a constructive way.

Although this book will not by itself revolutionize educational practices in homeopathy, I conceived it with the teacher in mind. Hopefully, it will encourage more lecturers and educators to rethink their teaching style. To this end I offer the images, metaphors, and experiments presented here as starting points to develop your own. I would certainly appreciate feedback from you about any new ideas you might have which you would like to contribute to make a second edition of *Imagine Homeopathy* even more useful and thought provoking.

# 3 The Lemon and the Dolphin



Hahnemann was not exactly what you would call a diplomatic, round-about kind of person. He did not mince words and would get to the point right away. That is also why he devoted the beginning of the *Organon* to defining the centerpiece of homeopathy, which has since come to be known as the law of similars. "Let likes be cured by likes" is the English translation of what Hahnemann put in succinct Latin as "*simila similibus curentur.*"

Many have taken this statement on which to hang their cases against homeopathy, since what it says appears to be completely illogical: if someone suffers from a disease, he may be cured by a medicine which has the power to produce just such a disease in a healthy subject.

Should not the exact opposite be true? If you are too cold you do not need more of the same but rather the opposite, namely heat. If a piece is bent to the right you give it a good whack to the left. Banging it on the right some more is not going to straighten it. All this seems true enough and is in fact the basis of common medical practice. If your heart beats too fast you need something which has the primary effect of slowing it down. A person with a high fever requires a drug which has the power to reduce the body temperature. The underlying pattern seems to be that one should be looking for something opposite to the patient's symptom. This is the law of opposites, or "*contraria contrariis*" in Latin.

It is easy to see how, with the emergence of homeopathy, the stage was set for the conflict rattling at the basic tenets of medical thinking. It is either "*simila similibus curentur*" or "*contraria contrariis.*" There seems to be no middle ground between these two camps.

## The Meditation

I would now like to invite you into a little meditation. You will need a lemon for the full experience but in case you are reading

this book at an inconvenient time with no lemon at hand, take a look at the picture on page 14 and join in the meditation.

Take five to ten minutes to investigate the lemon inside out. Look at it, feel it, poke it. Cut it in half, taste it, smell it, study it in any way imaginable. I am sure there will not be too many surprises since this is only an ordinary lemon just like the ones you have squeezed the juice from or cut into slices many times before. But it is important that you refresh your memory and paint a vivid image of this lemon before your mental eye. Close your eyes and become a lemon.

Once you are satisfied, come back out of your peel and try to name as many properties as you can think of which make up the whole of the lemon. Jot them down on a piece of paper, one after the other. Do not be too analytical or too critical about this. You should have at least ten items on your list, the more the better. Your list may begin like this:

- roughly 5–10 cm in size
- yellow peel
- wrinkled peel
- citrus-like smell when scratching peel
- . . .

## The Totality

There are so many features that make up a lemon, for example, its size, weight, and color, the texture of the peel, the smell when

you scratch the peel. Then there is the color of the inside of the fruit, its taste, the shape of its pips, the amount of juice, etc. By the sum total of all of these you can recognize a lemon and tell it apart from other things.

You will probably agree with me that however long your list might be, it is by no means exhaustive. By using chemical analysis, for example, we could begin to include the amount of each and every chemical compound found in the object of our investigation. That would easily add many hundreds of items to the list. We might just as well decide to use a microscope and describe the cell structure in minute detail, which would contribute another big bunch of properties. And there is no end in sight.

Within the five letters of a lemon we have encountered what we call its "totality." On one level it is almost impossible to describe a lemon in minute detail, yet on another it is almost trivial. Otherwise we would all be completely lost on our next shopping trip. This is a common experience with all totalities. In fact, in everyday life we often tend to think in totalities. Pretty much every object that surrounds us is a totality. From lemons to carrots, from chairs to chandeliers, from you to me including everyone in between. Incidentally, other words for totality which you might encounter are gestalt, quality, or entity.

It is fortunate that our thinking is well adapted to working with totalities. If I just say "fruit, yellow, tart, juicy" I bet you will discover pretty quickly that I was thinking of a lemon. We do not need complete information to identify a totality. Our mind works well with incomplete information and, by filling in the blanks,

conjures up a rich, detailed, and life-like image which we recognize immediately.

In order to relate the lemon to homeopathy let me turn to § 6 of the *Organon*:

> *The unprejudiced observer, even the most sharp-witted one—knowing the nullity of supersensible speculations which are not born out in experience—perceives nothing in each single case of disease other than the alterations in the condition of the body and soul, disease signs, befallments, symptoms, which are outwardly discernable through the senses. That is, the unprejudiced observer only perceives the deviations from the former healthy state of the now sick patient, which are felt by the patient himself, perceived by those around him, and observed by the physician.*
>
> *All these perceptible signs represent the disease in its entire extent, that is, together they form the true and only conceivable gestalt of the disease.*

As instructed by Hahnemann, the physician needs to make a list of all observable symptoms just as you compiled the list of all lemon symptoms, so to speak. But it is not any individual symptom that is important to us; it is the entity which gives rise to all our observations in total that we seek to recognize. This is what Hahnemann calls the gestalt or totality of the disease. As such it is an elusive concept since we cannot nail it down on paper or teach it to a computer. If, however, we use our brain's capability to think in entire images, we can accept the notion of a totality as the complete and entire image which is hinted at by an incom-

plete list of individually observable properties. Suppose you wanted to teach someone what a lemon was. Would you give him your list from before or would you rather just hand him a lemon? I bet that showing him a lemon has a much better chance of success.

In the previous experiment you actually went through the very process of a homeopathic patient interview (just allow me to neglect the fact that your patient was a lemon). During such an interview we see the gestalt of the disease sitting right in front of us and we cut it up into little bits and pieces which we write

**Fig. 1** With just the right set of identifying features, our brain is able to recognize the underlying totality and fill in the blanks. Despite its lack of details, you will probably agree that this sketch shows a lemon.

down on paper; these are called symptoms. If we are not careful we might end up with useless bits and pieces and no chance to recognize the totality, which expressed them, ever again. In order to make us see the whole we have to be careful what we write down. Let me give you an example.

Suppose you were allowed three statements to characterize a lemon and you chose the following:

- fruit
- edible
- has seeds

What are the chances of someone recognizing these as symptoms of a lemon totality? If, on the other hand, you put down:

- sour
- yellow
- juicy

the likelihood of guessing right is much higher, simply because these three properties are more characteristic of a lemon than the previous three.

It requires some experience and practice to take a good case which retains the characteristics of the disease totality. To help you focus on what is important, try asking yourself this question: "What makes this person unique?"

Have you ever been to one of those tourist places where street artists offer to draw a quick sketch of your likeness? The artist is trained to zoom in only on those features that are characteristic of you and distinguish you from everybody else. Anybody

who knows you would recognize the totality which sat model for the drawing. And that is exactly what a good homeopathic interview should be like: the totality of the disease is expressed by the symptoms you notice and choose to include in your transcript.

There has been much misunderstanding about what exactly the expression "totality of symptoms" means. Some interpret it as being all symptoms, an exhaustive list of all observable changes caused by the disease. In the light of the previous discussion it is clear that no list of symptoms can ever be equivalent to the thing itself. The emphasis is not on the quantity of symptoms but on choosing those among all possible ones that make the underlying totality become apparent. These are the ones that enter in further case analysis such as repertorization and study of materia medica. These symptoms, which are particular characteristics of a disease totality, are often referred to as "strange, rare, and peculiar" symptoms. They are the ones that strike us as odd or out of the norm. A coldness in an extremity which is relieved by cold applications, for example. Nobody would find it the slightest bit odd if the same coldness were ameliorated by warmth. But it is strange, rare, and peculiar if cold should be what the patient craves in that particular case. Hahnemann points us in this very same direction in § 153 of the *Organon*:

> *In the search for a homeopathically specific remedy . . . the more striking, exceptional, unusual, and odd (characteristic) signs and symptoms of the disease case are to be especially and almost solely kept in view. . . . The more common and indeterminate symptoms (lack of appetite, headache, lassitude, rest-*

*less sleep, discomfort, etc.) are to be seen with almost every disease and medicine and thus deserve little attention unless they are more closely characterized.*

## The Law of Similars

Let us do another thought experiment. First, clear your mind for a minute and then recall the image of the lemon from the beginning of this chapter. Starting from there, try to name the one thing most similar to a lemon. What comes closest to it? If you are like most people who have gone through this exercise, you probably thought of a lime. In most people's understanding a lime comes closest to a lemon.

Now I want you to think of the opposite of a lemon. What is the most dissimilar entity to a lemon imaginable? This is where it starts to become interesting. Whereas most people have no problem settling for the lime in the first part, I have gotten wildly different answers to the second question. One particularly creative

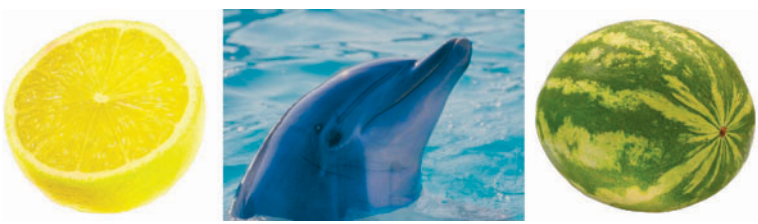


**Fig. 2** What is the opposite of a lemon? A melon? A dolphin?

person insisted that a dolphin was the opposite of a lemon. He argued thus: The lemon is a fruit, the dolphin is not; the lemon is colorful, whereas the dolphin is a drab gray; the lemon has an uneven peel compared to the dolphin's smooth skin. But what about the tartness of the lemon or the citric smell? Someone else identified a melon as being farthest from a lemon. The melon's smooth exterior and its comparatively large size and sweet taste were her arguments.

I hope you begin to see the conclusion: there is no opposite of a lemon. Actually, we have just hit upon the much more general discovery that there is no opposite to any totality. Going back to your list of properties from the initial exercise you might be able to find opposing matches to each single line, just as the person did when he suggested the dolphin. He was looking down his list, picking out a few items: fruit, colorful, uneven peel; then he chose something that has opposing qualities to those. And it turned out to be a dolphin. The other person selected other items from her list and decided on a melon based on the opposites to those.

What conclusions are we going to draw from this experiment? First, whereas it is easy to find a similar totality to any given one, it is impossible to define an opposite. In fact, the only possible relationship between any two totalities is their degree of similarity. The significance of this insight becomes clear if we remind ourselves that a disease is, in fact, a totality. Therefore we are left to conclude that the degree of similarity is the only possible relationship between a patient's disease and anything else. If there is a law of healing then it can only be based on similarity.

Hence, the law of similars is the only possible law of cure. It is important to point out that the application of this law is not necessarily limited to homeopathy. Any holistic therapeutic modality that uses the overall condition of the patient as its basis for treatment is built upon this law. Homeopathy, however, is the one where it is clearly stated as a principle and therefore most easily recognized as a basic tenant of its philosophy. But homeopathy by no means "invented" the law of similars, nor was it the first therapy to make use of it.

The logical chain of reasoning contained in the previous paragraphs is based on one assumption: that a disease is indeed an indivisible totality. If you agree with this, you cannot escape the law of similars. You may, of course, disagree with the notion of disease being a totality. Let us see where that leads us.

Suppose you do not think of disease as a single state, a totality. Then the list of symptoms you write down during a patient interview is just that: a list of disjointed observations with no underlying entity. In that case you can pick out any group from your list of symptoms and find an opposite to it. Since you do not believe that they are part of an indivisible whole, who is going to stop you from picking and choosing? As we have seen from the second exercise, the one with the dolphin and the melon, you can find opposites to an arbitrary group of symptoms. If a person with high blood pressure, fever, and depression consults you, he or she will likely be prescribed three different remedies: an antihypertensive drug against the high blood pressure, an antipyretic for the fever, and antidepressants to treat his or her emotional

state. Three "anti"-drugs, signifying that we are dealing with opposites.

The "anti"-approach is, in fact, the one applied in conventional medicine. This method of treatment is only possible because conventional medicine does not view a patient's diseased state as a single, indivisible, and unique entity. Using several drugs, each one opposing a certain subset of disease symptoms, is the strategy. This clearly is not an example of the law of similars but rather of the law of opposites, "*contraria contrariis.*" It is important to realize that the law of opposites is not amenable to a holistic approach since, by its very nature, it is not applicable to whole entities.

## The Scope of the Law of Similars

The law of similars is intimately intertwined and inexorably linked with homeopathy. So much so that many people think of the two as defining one another. The name homeopathy (this is the American spelling, the British spell it homoeopathy) itself derives from two Greek words meaning similar (*homoion*) and suffering (*pathein*). Hahnemann apparently coined this name with the sole purpose of establishing the law of similars as the most important principle governing this particular art of healing we know as homeopathy.

The question that I want to ask is this: Is the scope and applicability of the law of similars limited to homeopathy? Or, alterna-

tively, is homeopathy merely one among many forms in which we meet the law of similars?

Let me approach this topic from a historical angle, for the law of similars does have a history that predates Hahnemann by many centuries. The famous Greek philosopher and physician Hippocrates, who lived 400 B.C., had this to say: "Diseases are brought forth by the similar and also cured by its application." Twelve centuries later, Hahnemann hit upon it as he was translating a medical text. Its author claimed that the extract of the bark of the Cinchona tree (which contains quinine) can heal malarial fever because it strengthens the digestive system. To Hahnemann this explanation seemed questionable and he proceeded to perform an experiment on himself. He prepared the bark extract and, for several consecutive days, ingested some of it. Each time, shortly after taking the dose, he noticed on himself bouts of fever accompanied by a peculiar weakness, headache, and perspiration. As a doctor, he knew these symptoms well: they were typical of malarial fever. The attacks would come on each time he ingested the bark extract and last for several hours. Afterwards he felt perfectly well and healthy again.

Hahnemann's observation was that Cinchona bark extract had the ability to stimulate symptoms very much like the real malaria disease in a healthy person. He also knew from long experience that this very substance was at the same time effective in curing this disease in people afflicted by it. Putting these two observations together, Hahnemann rediscovered the law of similars in the year 1790. Six years later, he published his findings

and proposed a new general principle for healing. His first edition of the *Organon*, in 1810, contained 42 examples of practical applications of the law of similars. These examples were not taken from homeopathy but mostly from folk medicine. He argued, for example, that the application of frozen sauerkraut to frost bites (a common folk remedy in rural Germany at this time) constitutes an application of this law. Thus we now know that the law of similars had been around long before the advent of homeopathy as a general and independent principle of cure. Many people before Hahnemann knew of it but nobody besides Hahnemann has built an entirely independent therapy around it.

When we open our eyes, we can observe the law of similars in action outside the bounds of homeopathy. There are many examples, even in the realm of established orthodox medicine. Anti-cancer drugs, for example, which suppress cell growth (so-called cytostatic drugs) are themselves carcinogenic as a side effect (e. g., cisplatin). In some forms of psychoanalysis the patient is treated by being confronted with the traumatic experience once again in a therapeutic setting, thereby reliving it in his or her memory on a conscious level.

Moving farther afield from medicine, even art exerts its influence on the audience through a mechanism akin to the law of similars. The emotions evoked by a theater performance confront and remind each person of similar situations in life and thereby exert a positive influence. In fact, the classical Greek form of tragic theater had exactly this in mind and strived to bring about a cleansing effect in the psychology of each individuum—the so-

called catharsis. And can the same not be said for all other art forms as well? Rajan Sankaran, a contemporary Indian homeopath, has taken the step and performed a homeopathic proving of certain forms of Indian music, with interesting and promising results.

In natural science we encounter the law of similars in the form of the resonance phenomenon. When we strike a tuning fork so that it gives off a sound of a particular pitch, another tuning fork of sufficiently similar pitch in its vicinity will start to sound all by itself. The degree of similarity is the pitch, that is, the frequency of the note.

Philosophers through all times have discovered the law of similars as well. Parmenides stated around 400 B.C.:

*The similar is everywhere only recognized by the similar.*

And Goethe put it thus:

*Were the eye not of the sun,*
*How could we behold the light?*
*If God's might and ours were not as one,*
*How could His work enchant our sight?*

With this in mind, we realize that similarity is the foundation upon which all insight builds. Two entities which have nothing at all in common have no way to interact and exchange information. The transfer of information is contingent on similarity. It is tempting to take this statement to its seemingly logical extreme and substitute "identity" for "similarity." But in doing so, we lose the most important ingredient: new insight. Two identical entities have nothing new to offer each other. Learning requires both:

a certain degree of similarity and at the same time the presentation of something new, something as yet still foreign.

Viewed in this light, we can define disease as lack of information. Only by application of the appropriate similar entity can the missing piece of information be transferred to the diseased organism. The law of similars is therefore the principle governing all acts of learning, and disease is a state of being requiring learning to enable transformation into health.

# 4 Cutting the Wire

The homeopathic approach to healing vs. the allopathic model

Suppression of symptoms

Defining principles of homeopathy

Winston Churchill once said "The British and Americans are two people divided by a common language." This phrase, which Churchill coined for two nations, seems to be equally true when applied to homeopathy and conventional medicine (what Hahnemann called "allopathy"). They share many terms and expressions, tricking the unsuspecting into assuming that they must naturally carry the same meaning in both fields. Take, for example, the terms disease and cure. Those should be easy ones, but not so! Let us look at disease. Diseases manifest themselves through symptoms. This is a statement with which both conventional physicians and homeopaths would still agree. The difference, however, first shows when we take note of which symptoms physicians and homeopaths use to arrive at their corresponding treatment.

Many patients who come to see me think that I am going to ask them the same things that conventional medical doctors wanted to know of them. At this point it is worth stopping for a minute to tell them about the basic premise of homeopathy and about the meaning of disease and how its meaning differs in homeopathy from the conventional interpretation. As an intro-

duction to homeopathy for any patient I can recommend a good, concise book by Timothy R Dooley entitled *Beyond Flat Earth Medicine* (Dooley 2002).

## The Two Meanings of Disease

Suppose a patient suffering from asthma visits the doctor and complains of shortness of breath and wheezing. The doctor examines the patient and notes an abnormal breathing test, prior asthma attacks, and a history of allergies. At this point asthma is diagnosed and a treatment plan drawn up. This plan will virtually always be the same for all asthmatic patients.

In contrast, the signs and symptoms upon which conventional medicine bases its diagnosis are of little or no importance in homeopathy. The homeopath is interested in how this one patient differs from all the other asthma patients rather than what is common to all asthmatics. Disease is a state of being which expresses itself through the whole person. Every asthma patient has a wealth of other symptoms which would never come up in the course of a conventional medical examination simply because conventional medicine has no use for them.

A dialog not uncommon to a doctor's visiting room might go something like this (quoted from *Beyond Flat Earth Medicine*, Dooley 2002):

> *"I am sorry, Mrs Jones, but all my tests indicate you are in perfect health."*

*"But, Dr Smith, I feel terrible much of the time. Isn't there anything you can do?"*

*"Well, sometimes a trial course of antidepressants is helpful."*

Conventional medicine can only treat what it can diagnose. Every disease treatable by conventional medicine has a name. Unfortunately, many people have symptoms for which there is no medical diagnosis and, consequently, no treatment. Most people who develop a serious condition have suffered from unspecific symptoms some time before, maybe even for years. But the rule 'no diagnosis, no treatment' has nothing to offer them. A homeopath does not require a medical diagnosis to prescribe a remedy. This allows intervention at a point well before unspecific symptoms develop into a serious chronic disease. The main difference is that the homeopathic view of disease is based on a broader concept. The state of being of the patient as a whole is viewed as an expression of the disease rather than some predefined subset of common symptoms required for a diagnosis.

This is probably a good point at which to underline my recognition of the merits of conventional medicine. A serious surgical condition such as an acutely inflamed appendix that needs to be removed, a broken leg that needs to be set and immobilized, a deep wound that requires suturing, and many other life-threatening conditions demand allopathic treatment. We would be equally foolhardy, however, if we disregarded the limitations of conventional medicine. As homeopathic practitioners we must not repeat the mistake of so many of our allopathic colleagues and be unaware of our own philosophical foundations, weak-

nesses, and strengths while at the same time wallowing in ignorance about neighboring therapeutic fields.

After this brief sidebar I want to return to more pragmatic grounds. Disease is an observable phenomenon and not a theoretical concept. This is why Hahnemann wrote in § 8 of the *Organon*:

> *It is not conceivable, nor can it be proved by any experience in the world, that, after removal of all the symptoms of the disease and of the entire collection of the perceptible phenomena, there should or could remain anything else besides health, or that the morbid alteration in the interior could remain uneradicated.*

Symptoms and disease are one and the same. Similarly, neither are disease and patient two separate entities. By focusing on the totality of symptoms, homeopathy, therefore, treats the whole patient.

A good example of this was when a female patient consulted me for mastitis, an acute inflammation of the breast which may occur when breast-feeding an infant. She told me of her complaint and I examined her breast during the interview. My prescription was *Belladonna* 30 C, which she took once, that evening. The next day she called to tell me that her breast was already a lot better. I was relieved and asked her to check back with me in two days if everything continued to improve. She never called back, and the first time I heard from her was about six months later when she came in with her baby. Asked about how she was doing, she said, "I have been feeling great! The breast inflamma-

tion was gone by the second day and my migraine, which I have had for years, has vanished with it."

Now, you have to realize that the migraine never came up in the initial interview; the patient never mentioned it. The only complaint I was aware of was the mastitis. Yet, *Belladonna* cured her of the mastitis as well as the migraine. Since *Belladonna* was the fitting remedy for her entire state it also corresponded to the migraine and consequently helped her in this area also. This experience is by no means an isolated occurrence and is well known to every homeopathic practitioner. It is these experiences that, to me, confirm the validity of homeopathy and keep me going on the path of becoming a better homeopath.

## The Metaphor

Since health and disease are central concepts to any therapeutic modality, how we understand them will have a large influence on how and what we practice. Two short pieces of wire will show you what I mean. Take two straight pieces of single-strand wire, about 20 cm (8 in) long. Now make a bend in the middle of one of them so that it looks something like the one at the top of Figure **3**.

In this metaphor, a healthy person corresponds to the straight wire and a sick individual is symbolized by the bent piece. With the two pieces in front of you, ask yourself how to separate the bend from the wire. It cannot be done, of course! A bend needs some kind of medium through which it can express itself. I have

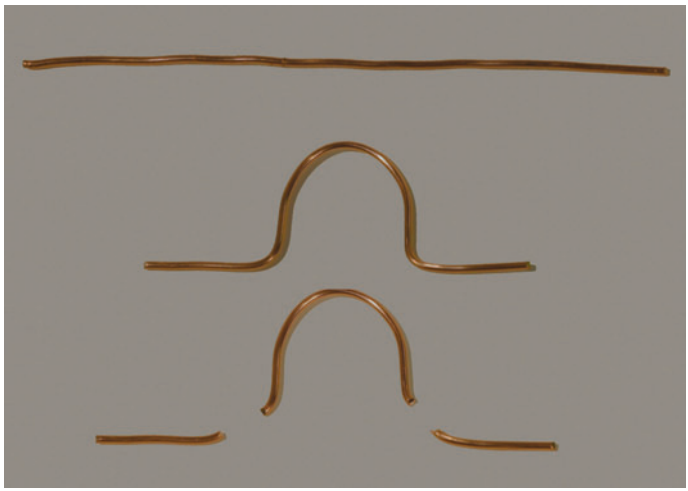


**Fig. 3** A healthy individual is symbolized by the straight piece of wire. The bent wire in the middle corresponds to a sick person. One way to remove the bend is to cut the wire and thereby destroy its integrity (shown at the bottom).

never seen a naked bend without something that was bent. The wire and the dent in it are one. The wire *is* bent, it is an expression of the bent state. Similarly, disease and patient are one, the patient is an expression of the disease. They cannot be separated. The concept of a disease without a patient is meaningless. To discuss the treatment of, for example, jaundice, is impossible in homeopathy. Homeopaths can only discuss the treatment of a particular case of jaundice as expressed by a certain individual. When you ask a homeopath how he treats influenza, he will answer: "Which influenza? The one Mrs Smith has or the one

Mr Jones has?" On the other hand, conventional doctors meet at congresses devoted solely to a particular disease.

There is one aspect which the wire metaphor does not capture well: the dynamic nature of disease. Disease is not static but a subtle equilibrium of forces which adapts immediately when one of the forces involves changes. This notion will be the focus of our attention in the chapter The Sunflower.

Remaining with our wire metaphor just a little longer, let us see how we can restore our patient to health. This would be akin to removing the dent from the wire. Why not go ahead and do just that? Take the bent piece of wire and remove the dent. If you are anything like me you probably tried to bend the wire back into its original straight shape. Congratulations, this is the thinking of a real homeopath. The alternative is to take a pair of pliers and cut out the dent as depicted at the bottom of Figure **3**.

## Suppression of Symptoms

Cutting out the bent section is a perfectly logical solution if you believe in the bend as an independently viable entity. Alas, by getting rid of it you destroy the integrity of the wire. The allopathic disease model tends to do just that. Take, for example, a child with recurrent inflammation of the tonsils. Most conventional physicians would recommend a surgical removal of the tonsils, believing that by doing this they remove the root of the problem. This is true only in the sense that the site of inflamma-

tion has been removed, not, however, the child's apparently weakened ability to fight infections. Robbed of the tonsils as a comparatively harmless and superficial location for it, the underlying weakness will often find another vent. The result is many times an apparently unrelated problem. This could be the growth of nasal polyps or frequent bouts of bronchitis, for example. It really depends on the particular constitution of the patient, the surrounding circumstances and stress situations. In any case, however, according to the homeopathic interpretation of disease, the body is further weakened by taking out the tonsils. Sooner or later, maybe in a particularly stressful life situation, the still unresolved issues of the underlying disease will rear their ugly head.

"But," you may say, "did you not argue that the removal of symptoms is equivalent to the removal of the disease? And haven't you removed the symptoms of tonsillitis by removing the tonsils?" Here we encounter again the difference between allopathic and homeopathic diseases.

Let me be specific and refer to the case of a six-year-old girl. The child suffered from frequent inflammations of her tonsils and had them removed at age five. But there were many other symptoms at the time that were still present when her mother brought her to see me. Reading through my notes I discovered that she appeared to have been a cheerful and healthy child before an episode of scarlet fever at age three. Afterwards she had trouble sleeping at night, her mood became much more fearful, and she developed recurrent tonsillitis a year later. The most striking other symptom, however, was the cracked skin on both her

palms; something I had not seen in a child before. Her mother said that the skin symptoms first showed up after removal of the tonsils. The dermatologist diagnosed an atopic contact dermatitis and prescribed a cortisone ointment. The mother, worried that continued application of cortisone might not be in the best interest of her child, finally sought homeopathic help. After several doses of *Mercurius iodatus ruber* she started to turn into her old self, the nights became calm again, and the cracked skin disappeared completely. At this point she was in every respect a perfectly normal and healthy child with no observable disease symptoms.

This case is a good example of how conventional medicine compartmentalizes a person. The tonsils were treated by an ENT specialist, the skin by a dermatologist. By no means was the child any healthier in a homeopathic sense after the surgery. There were plenty of symptoms beside those connected directly to her tonsils. Note how the skin symptoms are the organism's way of expressing the still uncured disease at a new location after removal of the tonsils. The homeopath recognizes the individual's indivisibility and treats the person in a context where all problems fit into one picture and are cured by one remedy. Had the mother consulted a homeopath even before the tonsils became a problem, I am certain that all the other problems could have been avoided.

Have you ever had to tackle a leaky hose spewing water from several gaping holes? If so, you probably know what I am talking about. Take a look at Figure **4**: plugging the biggest hole with your

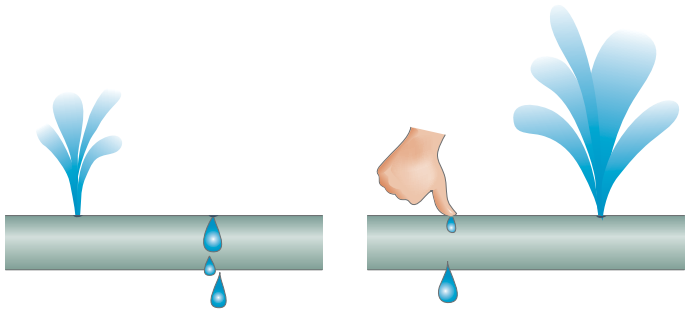


**Fig. 4** Plugging one hole in a leaky water hose will spring another one and generally soak you faster.

thumb only makes the other leaks worse. The only sensible way to fix the hose is to turn off the water and mend all the holes.

As sick individuals we behave just like a leaky water hose. You suppress one symptom and the result is that in some other place a new symptom comes up. If you never look beyond the spot where your thumb is, you will never realize that you have not solved the problem by plugging one hole. Suppression does not make the disease go away, it only makes matters worse. We now recognize that removing the tonsils in the previous case was a prime example of suppression. By plugging this one hole, the pressure in the metaphorical hose built up to the point where a new symptom occurred: the cracked skin.

Suppressing a symptom is not confined to conventional medicine. It can also arise in homeopathy in situations where practitioners lose sight of the whole person and suffer from tunnel vision. They concentrate their attention on only a few symptoms

and do not prescribe for the entire disease. Situations where you have to be particularly careful about this are patients with a low vitality and a weakened constitution. Their proverbial hose has already become brittle and will easily spring many new leaks at only the slightest buildup of pressure.

Although the concept of suppression is easy enough to understand, it is quite a different beast to recognize it in time should it happen in one of your patients. On the path to health, patients will sometimes develop new symptoms for a brief time as their state of health changes for the better. You need to be able to distinguish those transitory new symptoms, which herald changes for the better, from the worrisome signs of suppression. As a guide, however, you can use the patient's general state of health. If, as a whole, the patient is better, any locally appearing new symptoms will be transitory in nature and are signs of recovery. On the other hand, if a symptom disappears and the patient as a whole does not appear to be better, you have probably suppressed it and will have to correct your mistake.

## Definition of Homeopathy

It might seem strange to bury the definition of homeopathy inside a chapter on disease. Should this headline not feature prominently and lead the line up of topics? Well, I chose to bring it up here because I would like to show you a new view on how to define homeopathy which, I think, goes well with the topic of

homeopathic disease. Most people who studied homeopathy a bit feel that they know what homeopathy is. Therefore, a discussion devoted solely to its definition might seem like preaching to the church choir, superfluous. On closer examination, though, I found out that most people do not have a clear idea of what it is they are practicing. Homeopathy, since its inception, has always been grappling with several avant-garde groups which challenge the classical core. The spectrum ranges from the Hahnemannian fundamentalists to the modern classical homeopaths to practitioners who, for example, use electro stimulation instead of potentized remedies or who give several remedies as one medicine. Some amount of tension between the core and the fringe is the sign of a healthy and evolving science. It can drive evolution and get us to explore new territory as long as it does not turn into a fighting match of who is right and who is wrong. Only when we, as the homeopathic community, have a clear sense of identity can we effectively represent ourselves and what we stand for. It is under this heading that we must develop a clear definition of what we call homeopathy and what lies beyond. I do not call a table a horse just because they share the same number of legs. Doing so will only lead to confusion. The debate is a purely semantic one and has nothing to say about the therapeutic value or validity of a particular way of practice.

During seminars I have, at this point, asked students to write down not more than five points which they believe are at the core of homeopathy. I was looking for the shortest and most concise list which encompasses homeopathy. The answers were wide and

varied. I would like to invite you to do the same now. Lest you think it is not worth the effort to get a pen and some paper, it makes a difference whether you put your thoughts down on a page in concrete writing or just keep them vaguely floating around in your mind.

Some time ago I asked a few people how they would define homeopathy. I also posted the question to a homeopathic mailing list on the internet with approximately one thousand members. This was not an exercise in market research, just something to satisfy my curiosity. Depending on whom I asked I got different definitions. Lay people tend to associate homeopathy with the little white pellets. To them, it is homeopathy when they take tiny, sweet-tasting globules. Critics commonly use the high dilution of our remedies as defining principle. They call it homeopathy when there is nothing in it anymore. What, however, is the definition given by homeopaths? Surprisingly, there does not seem to be one agreed-upon definition of our art and science! Different people emphasize different aspects and what emerges is a somewhat fuzzy collection of principles that more or less captures the spirit of homeopathy. I am not happy with this because it leaves room for misunderstandings, which ultimately will damage the reputation of homeopathy. Take, for example, a bottle of "homeopathic" cough drops available at many health food stores. It may contain upward of five different drugs mixed together in varying potencies and has little to do with homeopathy besides the advertorial claim. Yet, people will believe that they are using homeopathy when they buy these drops. They will form an opinion with

accompanying prejudices about homeopathy based on their experience with this kind of preparation. Many outspoken critics confuse the likes of health-food-store drops with the kind of treatment available from a well-trained classical homeopath, and this tends to reinforce their negative attitude. Therefore it is very much in the interest of the homeopathic community to state clear defining boundaries of their field of knowledge. Let me reemphasize that this does not imply that other therapies are less efficient or should be abandoned in favor of homeopathy. They should be practiced under their own name and be judged on their own merits.

Now, let me step off my soap box and I will show you the combined answers I got from my poll of homeopathic practitioners:

1. The leader of the pack was the law of similars.
2. The single remedy (only one remedy and potency given at one time) came in second.
3. The minimum dose was mentioned by almost as many. This is the principle that the smallest active dose (i. e., number of pellets) of a remedy should be given.
4. Hering's law was in a tie with the minimum dose. In case you are unfamiliar with it, it is an observation which says that as health increases during a cure, symptoms move and disappear first from inside to outside, from top to bottom, and in the reverse order of their onset.
5. The use of potentized substances as remedies was mostly added as an afterthought.

Let us see what past great homeopaths had to say on this topic. Browsing the literature, I found an article by Jost Künzli von Fimmelsberg entitled *The pillars of homeopathy* (Künzli 1982). In it, he refers to work published by Constantine Hering in *Stapf's Archiv* and summarizes the principles of homeopathy thus:

- the recognition of the power of medicines to make people ill. All that has the power to cure has the power to bring disease as well
- the necessity to prove substances on healthy individuals
- application of medicines according to the law of similars
- attention to minute detail when recording symptoms during the patient interview

Elisabeth Wright-Hubbard, an eminent British homeopath, condenses four principles from Hahnemann's *Organon* (Wright-Hubbard 1977):

- the proving of substances on the healthy to be used as medicines
- the selection and administration of so proved medicines according to the law of similars
- the single remedy
- the minimum dose

However, some of those alleged principles, when examined critically, are not part of the definition of homeopathy at all. The principle of the minimum dose states that a homeopath should give the smallest amount of medicine to the patient which still has the

desired therapeutic effect. While uncontested as a general principle, this demand is certainly not specific to homeopathy. It is only prudent to use the smallest dose, and what Hahnemann required of every homeopath is a guideline for every therapy: use the least amount of intervention necessary to achieve the desired effect. The principle of the minimum dose is therefore not specific to homeopathy and cannot, therefore, be counted among its tenets.

Another item that is not part of the definition is Hering's law. In it, Constantine Hering expressed the observation that on the path to health, as the hold of the disease on the patient weakens, symptoms may vanish in a particular order. This is a result of the changing equilibrium of forces between the increasingly stronger vital force and the disease. As such, it is not specific to homeopathy since the same observation holds true for other therapies acting primarily on the vital plane (e. g., acupuncture). Although it was a homeopath who first made this observation, Hering's law is not specific to homeopathy.

My own starting point for a definition is a different one. I would start at the heart of homeopathy: the patient. Our understanding of what disease in the homeopathic context really is must be the starting place for a definition of how homeopathy treats it. We view disease as an indivisible state of being which affects the individual as a whole and manifests itself through the totality of observable symptoms. Disease is an expression of the vital force and hence inseparable from the patient.

Accepting disease as a totality, gestalt, quality of its own right (see also the chapter The Lemon and the Dolphin for an explanation

of totality) we can only relate it to another quality—the totality of the drug—via their mutual degree of similarity. Therefore the law of similars is already an implicit part of homeopathy once we agree on how to interpret disease. There simply is no other way to relate two totalities. The single remedy proposition is yet another consequence of the homeopathic disease concept. Since any individual can only be in one single state at any given time there can only be one corresponding most similar drug totality. Someone who prescribes two different homeopathic remedies to be taken together is at odds with the homeopathic understanding of disease.

Let us be absolutely clear about this: by accepting the holistic concepts of a disease and a drug state, the law of similars and the administration of a single remedy are merely consequences thereof.

The core defining elements of homeopathy are therefore:

- the concept of a holistic and indivisible disease state which becomes observable through symptoms expressed by the sick individual
- the correspondence of each homeopathic remedy to a holistic and indivisible state, exactly like a disease. These states are made observable through homeopathic drug provings on healthy individuals

Strictly speaking, nothing more needs to be added, everything else is a logical consequence of these two statements. Still, it does not hurt to state some consequences explicitly. For this reason I would add the following statement:

- the explicit application of the law of similars to find that particular drug whose state most closely matches the disease state of the patient

Should we also require that homeopathy make use of potentized substances only? Hahnemann, in the beginning, was practicing homeopathy with crude, unpotentized substances. Some homeopaths already employ remedies which do not lend themselves well to potentization. One such example is Indian raga music which has been proved by Rajan Sankaran. Another example are remedies prepared by special machines which do not succuss the medium (e. g., radionically prepared remedies). To me, people using remedies prepared in another way than that laid out by Hahnemann in the *Organon* are still practicing homeopathy if they adhere to the first three principles. To distinguish them from those who follow Hahnemann more literally I propose a fourth principle which defines "classical homeopathy" and sets it apart from a more liberal interpretation of homeopathy:

- the use of remedies prepared by serial dilution and succussion as described by Samuel Hahnemann

What about practitioners who do not perform a patient interview to elicit all the information required to get an understanding of the disease state? What if someone uses a pendulum or some other kind of divining instrument to arrive at the disease state? Since remedy provings are our basis of getting at the drug state, you cannot match it to a disease state which was "measured" by

some completely different set of tools. Someone using a pendulum to get information about the disease state cannot apply the law of similars. Our materia medica was not compiled with a pendulum in mind and therefore does not contain the information required to match it with shapes traced out by a pendulum. It may well be that someone using a pendulum to prescribe homeopathic remedies is a great healer helping a great many patients, but he is not doing homeopathy and should not call himself a homeopath. How about "homeopathic divination" as an alternative? A practitioner prescribing more than one remedy to be taken together is also not a homeopath in the above-described meaning of the word.

What about someone who prescribes remedies which have not been proved yet, based on information available through other sources? I know practitioners who have a wealth of knowledge about the natural properties of substances and use this information to form an image about the drug state. They do not rely on the information of a Hahnemannian remedy proving for the drug state, yet fall within the definition of a classical homeopath in every other respect. This is a borderline case. We know now that the clarity of a remedy state arrived at by a Hahnemannian proving can gain much by incorporating all kinds of other information about the substance gathered from other areas such as biology, history, or mythology (you can read more about this particular topic in the section on the doctrine of signatures in the chapter Solving the Puzzle). There needs to be a balance, however, between those sources of information. I would be hesi-

tant to call someone a classical homeopath who relies primarily on information outside of remedy provings in his or her practice.

As you can see, the field of homeopathy is anything but homogeneous. It helps to have some guiding principles to know where you are standing and why. Above all, I would urge you to keep an open mind and practice tolerance. Infighting has in the past led homeopathy to the verge of extinction; we do not want to commit the same mistake again. A healthy amount of self-awareness tempered by an open mind is the best way to keep our art and science alive and well.

# 5 The Individuality of a Rose

## The unbiased observer

## Case taking

When your photographs appear blurry and out of focus, first check that your lens is clean before you toss the camera. Not even the most expensive camera can give you crisp and sharp photos with a smudged lens. What sounds almost embarrassingly trivial

**Fig. 5** The blurry picture is like a badly taken case. No matter what kind of analysis you apply afterward, it is mere luck if you can identify the simillimum. A well-taken case corresponds to a crisp image. Even if you cannot identify the flowering plant yourself, there is enough information for someone more knowledgeable to identify it; in this case *Hypericum perfoliatum*.

becomes less obvious when we turn to homeopathy. The first step to a good prescription is a clear taken case. In other words, without a well-taken case not even the most internationally renowned homeopathic guru will have a chance of finding the simillimum.

Anyone researching the history of homeopathy will discover the 1990s as a time marked by a resurgence of interest to perceive deeply into the core of the patient in order to understand the roadmap by which the individual navigates through life. However, homeopaths had already recognized much earlier the necessity of looking upon the world through the eyes of the patient. Kent intended to describe the process of perception involved in this when he said:

> *You must see and feel the internal nature of your patient as the artist sees and feels the picture he is painting. He feels it. Study to feel the economy, the life, the soul.*

One of the most important things to acknowledge in our work with patients is that the mental state of the practitioner—how we influence the interaction in terms of our intentions and expectations—determines the quality of our perceptions and, hence, has an important influence on the case's evolving history. Hahnemann demanded of homeopaths to be unbiased observers during the patient interview. The question is: who is ever unbiased?

## The Meditation

With these introductory paragraphs let us now turn to the meditation which was originally inspired by Vicky Menear, a contemporary American homeopath. You will need to find yourself a rose. When I do this meditation experiment during a seminar, each student receives a flower and I always use a rose of the long-stem, dark-red variety. Call me sentimental but I find it works best for me. Besides the rose you will need a pen and three sheets of paper. First, write the following headline on the top of a blank page: "I am looking at it." Now take about three to five minutes to look at the flower while constantly retaining the thought "I am

looking at it" in your mind. When you are done, write down what kind of experience or reaction you had. What crossed your mind? What did you notice? How did you feel? Copy down your impressions beneath the headline.

Now start over with a blank piece of paper. Take a few deep breaths to clear your mind from the previous exercise and then look at the flower while eliminating any thoughts from your mind. Try to make your mind go blank while you watch the rose. Again, continue with this exercise for about three to five minutes and then make a note of your experience on the page.

For the third part take the third page and write the heading "The flower is revealing itself to me" at the top of the page. After a couple of cleansing breaths, take a couple of minutes to look at the flower while sustaining this thought. At the end, put down your impressions under the heading.

## The Unbiased Observer

When you think about it, being an unbiased observer, which Hahnemann demands we should be when interviewing a patient, is an almost impossible goal to reach. During the patient interview we try on the one hand to get all the information we need while on the other hand leaving the patient room to take the initiative. We are supposed to categorize yet at the same time refrain from interpretation. We strive to be unbiased and simultaneously attempt to see the world through the eyes of the patient.

We all have a certain preconceived notion of how a well-taken case should be, and subconsciously we more or less strive to make each interview turn out this way. Depending on each individual's inclination, therefore, the focus may be on detail, trying to chisel out each symptom, or on the gestalt, the encompassing bigger picture, with an accompanying free-flowing style.

The first meditation exercise was governed by the motto "I am looking at it." This sentence connotes an active participation of the observer. Whenever I have done this exercise with a group of students, the general feeling that came across from their combined notes could be characterized as an intention to extract some information from the flower, to "do something." Usually, there is some form of objective information about the flower which the students feel obliged to collect: the serrated edge of the leaves, the exact shade of the petals, or a remark about some blemish on the flower. Frequently I hear comments that the need to "do something" expands into a demand on oneself to "do it right," finally leading to a certain amount of self-consciousness. This is like watching and judging oneself doing the exercise—we are more concerned with our own performance and tend to forget about the flower.

| **Structure**<br>**Practitioner dominated** | **Gestalt**<br>**Patient dominated** |
|---|---|
| • Attention to detail<br>• Completing symptoms<br>• Categorizing the information | • Focusing on the bigger picture<br>• Letting the patient lead<br>• Giving the patient room to develop his/her story |

In the second part of the exercise you tried to banish all thoughts from your mind while looking at the rose. The resulting experience usually bears a close resemblance to a Zen meditation. If there was a certain amount of self-induced stress or performance anxiety in the first round, this time most people report calmness and summarize it as a pleasant and relaxed exercise. You might have felt a sense of becoming one with the flower, of merging with the object of your observation. The pressure felt during the first part is almost never present in the course of the second exercise. Most descriptions mention a certain loss of clear distinction between the "I" and the flower and consequently a loss of purpose and intention. The ability of the observer to be a witness is lost by the self dissolving into the object of observation.

During the discussion following the third part of the meditation, where you were retaining the thought "It is revealing itself to me," students report a different experience. They usually speak of a sense of relief and do not feel under pressure like in the first part. Often, students summarize their feelings as becoming aware of the individuality of the flower for the first time. I have observed that students who were examining the rose at close range during the first exercise frequently held the flower at a greater distance this time around. Someone even put it in a glass of water, got up and walked around it, regarding it from all angles while taking in its surroundings.

It now becomes clear how these results relate to the case-taking process.

| “I am looking at it” | “It is revealing itself to me” | “—” |
|---|---|---|
| Practitioner dominated | | Patient dominated |
| Structure | | Gestalt |

The mental attitude of the first exercise, catalyzed by the sentence “I am looking at it,” corresponds to the practitioner-dominated approach in which the patient is the subject under active interrogation and investigation. The practitioner focuses less on the patient and more on him- or herself. Questions often seem to serve the purpose of filling out some mental questionnaire which the homeopath carries in his or her mind. Leading questions—the kind which require only a “yes” or “no” reply—are not uncommon.

Jumping from one end of the spectrum to the other, we arrive at the Zen meditation on the rose where I asked you to clear your mind of active thoughts. The corresponding interview style is one where the homeopath is full of empathy with the patient and seems to relive the patient’s life, feeling the patient’s pains and experiencing the patient’s emotions. There seems to be little separation between the patient and the practitioner. Although patients usually prefer this kind of atmosphere and often subconsciously try to maneuver the practitioner into this role, it is not a good foundation for finding the simillimum.

Apparently the best place to be is at neither of the two extremes but rather somewhere in the middle. The third part of the meditation, the one with the theme of “it is revealing itself to

me," gave you a glimpse of what this might feel like. A well-taken case needs to be dominated by the patient while at the same time have a certain structure that puts the information in context and completes it where necessary.

The rose meditations show how our own attitude can subtly change the kind and flavor of information we receive. They also describe how our perception is expanded by having our attention on another with a clear intention to be available to whatever information emerges. When students of homeopathy encounter their first patient and are expected to present a well-taken case for analysis afterward, this almost always produces tenseness and anxiety. They are under the impression that they have to somehow con the patient into giving them the right kind of information needed to make a good prescription. However, there is no need to do anything but be alertly present. Drawing again on the rose meditation, there is absolutely nothing we can possibly do to make the flower express more of its nature. It is the same with patients. Patients have no choice but to be themselves. We sometimes operate under the impression that patients hide behind a mask and thereby prevent us from seeing their nature. This is not so. What we see is the patient at every and all times. When we think we might be seeing a "mask" we forget that this mask itself is part of the patient. It is true that frequently the essence of a case eludes us. In such a case it is tempting to project some of our own frustration back onto patients and indirectly blame them for not showing us their "true" self.

## Some Notes on Case Taking

When I said that the middle ground between a practitioner-dominated and patient-dominated interaction is the best place to be, I did not intend to turn this statement into a dogma. What is more important is that you become able to move fluidly and consciously through the spectrum, always aware of your current place and continuously adapting to the demands of the moment. For example, when I want to get a clear picture of a particular physical symptom, I revert to a more practitioner-dominated technique and ask those questions which give me the information I need directly. There are other times during the 60 to 90 minutes of an initial interview where the patient takes the reins and I follow, wanting to see where he or she takes me. During these moments I consciously try to get "in tune" with the person vis-à-vis.

Through the meditation exercise you have experienced how your own mental attitude sets the stage for the entire session and determines to a large degree what kind of symptoms you receive. We can use this knowledge constructively by realizing that our mental and emotional states during the interaction with the patient are also determined by our vis-à-vis. Our reactions to the patient, therefore, are a mirror of the patient's state.

I experienced this for the first time during a seminar with Rajan Sankaran. Before showing a patient video he asked us not to focus on the patient but to observe our own reactions. We were to write down any changes we observed in ourselves as we were

watching the taped interview. I remember vividly the collective mood this video presentation evoked in the audience. The patient, an elderly Indian man, was talking at breakneck speed while gesticulating agitatedly. He conveyed a strong aura of immediate danger and behaved as if he were trying to warn everybody of some imminent threat. The literal meaning of what he was saying, however, was in stark contrast to the emotions that he expressed nonverbally. After some time of this, my head started to spin and I began to detach myself mentally from the video. I even felt some stitching pain in my left shoulder and became quite anxious, feeling hemmed in from all sides. The video presentation lasted for about 15 minutes, after which Rajan asked us to relate what we had recorded and to pool our collective experience. He then invited us to treat this collection as a single case and find a remedy for it. This experience turned out to be very easy; everything pointed to *Argentum nitricum*. Surprisingly, the remedy which the patient needed was also *Argentum nitricum*. The patient's case and the audience's case (after having been exposed to the patient) required the same remedy.

I did not realize the full importance of this until weeks after the seminar. What I had been part of was a proving; a patient proving, not a remedy proving. Whenever we interact with a patient we immerse ourselves in the aura this individual exudes. Since the patient is in a disease state corresponding to a particular remedy we are subject to the aura of that remedy as expressed by this patient. Our reactions to that patient therefore bear the footprint of the simillimum and may be used as a pointer to it. For

this reason I am jotting down any strong reactions of myself during the interview in parenthesis. A male patient with incapacitating year-round allergies had me almost reach out and hug him. As he was telling his story, I wanted to put down my pen, sit back and just talk with him, feeling totally sympathetic. He was freed of his allergies by a dose of *Phosphorus*. Of course, the prescription of *Phosphorus* was not made solely on my emotions. There were other symptoms pointing to it. In the final analysis, however, it was my strong sympathetic reaction toward him that made me choose *Phosphorus*.

It is common knowledge that 80% of what we communicate is through nonverbal channels, and only the remaining meager 20% is carried by what we say. What we wear, how we look, our body language is four times more important in terms of the overall communicative experience than the semantic meaning of our language. Should we not, therefore, devote our attention correspondingly to that 80%? Although, like most people, I was intellectually aware of this 80/20 split, I had been relying solely on the 20% until this one day when our study group met. I had prepared a video case that I wanted to share and discuss. The TV set was already hooked up to the camcorder and, after some fiddling, I got the picture on the screen. However, no matter how much I tried, I could not get the sound working. Not wanting to overtax the patience of the group, I resigned to show the case without sound and intended to fill in the story afterward from my notes. After about five minutes of soundless observation I turned the TV off and asked everybody what they thought of the case so far. The

ensuing statements were amazingly accurate, cutting right to the heart of the case: the patient's insecurity for which she compensated by a show of grandeur. I had selected this particular case to share with the group because it had taken me several attempts to find a good remedy. Only after I was able to perceive the insecurity and put it in perspective to the patient's outwardly projected behavior was I able to prescribe *Palladium*. I was surprised how obvious the core elements of the case became once the patient's words no longer distracted me. Showing a video case with the volume turned down has since become a favorite exercise of mine. Only after I have gotten an initial "silent movie" impression will I turn up the volume. I would like to encourage you to go ahead and turn down the volume during the next movie you watch. Observe each character and you will be amazed how much you pick up about the character's mood and intentions. This works, of course, only if the character is played by a reasonably good actor.

In fact, we can tap into the silent movie channel during a patient interview as well. This works best for me when I think of "the patient is revealing himself to me." I habitually make a note of this kind of observation in the margin of my notes. Our repertory is rich with observations of this kind, so most of the time they are easy to translate into "repertorese," the language of the repertory. Examples are rubrics like "timidity," "loquacity," "making gestures."

It is impossible to write an authoritative guide to case taking. This is simply because the way someone takes a case is a direct reflection of how he or she understands and interprets homeopa-

thy. The style will change over time as his or her understanding evolves. This, however, is only one of the many factors influencing the style of case taking. There is, of course, the patient who brings as much to the interview as the homeopath. Another determining factor is the kind of pathology with which we have to deal. An acute case, for example, asks for a different approach in case taking than a chronic one. Among a wealth of other factors we cannot neglect the influence of the setting in which the interview takes place. Rather than dropping the discussion of case taking altogether at this point, I think it might be helpful to mention a few techniques that I have adopted over time.

I usually start with the formal things like obtaining the patient's personal data. Even though I often already have this information, it eases the patient and me into a conversation from a safe starting point. It also gives me an opportunity to write down my impressions of the first couple of seconds after I meet the patient (important nonverbal information most of the time). Frequently this is only one word, for example, timid, nosy, obnoxious, or sometimes the name of a person that the patient reminds me of. Sometimes you will notice a peculiar quality to the handshake or the way the patient approaches you. Whatever it is, these first few seconds hold information that I have found valuable many times. Do not deprive yourself of it. Once seated and past the formalities, I want to know if the patient has any idea what to expect of the next 90 minutes and I describe in a couple of sentences that there are several thousand homeopathic remedies, of which only very few have the power to help the patient in

a profound way. Therefore, a lot of information is required to find the proverbial needle in the haystack, and everything is pertinent and may be decisive in finding a helpful remedy.

The question, "How can I help you?" or some corollary thereof, is a good point to jump into the case. Most of the time the patient will answer by describing the chief complaint, which almost always is something physical. This is usually a good time to get a clear symptom picture of the complaint, therefore I stay with it and ask clarifying questions if necessary. Remembering what we said earlier, at this point in the interview I am slightly on the practitioner-dominated side of the spectrum simply because I find that this is what most patients expect. From there, I want to find out how the complaint is linked to the patient's life. To do so, I shift the focus and move deeper into the case usually by asking a question like, "How long have you had this?" or "When did this start?" Then I want to know a bit about what went on in the life of the patient at this time. Sometimes the question "Do you have any idea why you suffer from this?" can yield astonishing information. If nothing is forthcoming, I ask about the situations in which the complaint bothers the patient most.

My goal now is not to record the "Complete Memoirs" of the patient's life. What I am after is the sore spot, the metaphorical blister where the shoe has been chafing too long. I ask myself: "On what does the patient expend a disproportionate amount of energy?" or "What is limiting the patient?" Sometimes the answer is the physical complaint given at the beginning. More often, however, it is something else.

In some recalcitrant cases where none of these nudging questions yield any results, I ask the patient to describe a typical day to me, starting from the time he or she woke up in the morning. This takes the interview through many of the interesting topics such as living conditions, family, job, points of daily irritations, sleeping habits, dreams, etc., which we can now choose to explore further.

A well-taken case should give the homeopath enough information to picture the patient against his or her cultural background. It should provide a sort of framework putting the patient into perspective with respect to living conditions, family and job situations, cultural background, and so on.

I remember a particular instance in which I had the chance to work on the case of a native American Indian living on a reservation. Already very early on I was amazed by the wealth of psychological symptoms and apparent delusions he related. He talked about a "skinwalker" stalking him and described the kind of visions he had at night. In the end I wound up with about ten pages of written notes chock full of detailed descriptions of these vivid delusions. Luckily, when I spoke to someone knowledgeable in the traditional Indian belief system, he told me that these images are part of the religion and are common to all American Indians of the Navajo tribe. The only remarkable symptoms I had recorded were how this particular patient dealt with this situation: he was checking the trailer he lived in from end to end repetitively and almost constantly. This was really the only symptom out of the ordinary considering the patient's cultural back-

ground. On the basis of it he received *Arsenicum* which cured him of his ailments. The lesson contained in this is that we have to take the particular cultural, social, and religious background into consideration when we record and analyze the case.

Once I have the patient's story down, I go back over it trying to complete and clarify it until I am satisfied that I understand everything. Remember never to take anything for granted. In the case of a patient who told me that she had a fear of flying I had the lucky impulse to ask her what in particular scared her most. "Oh," she said, "it's when the plane accelerates on the runway. I can't stand going that fast. Not even in a car." This valuable piece of information changed my take on the case and hence my prescription—*Borax* was her remedy.

As the final part of the interview I go through a head-to-toe routine where I ask the patient about all major anatomical systems and some general preferences (food, temperature, etc.). There is one last question which has opened up many cases for me, and without which I would probably have missed a lot of information: "Is there anything else you feel is important?" It is not uncommon that a rather bland and featureless interview with little to go on takes on an exciting turn when the patient replies, "Well, there is this one thing that I haven't mentioned to anybody yet . . ."

## Dimensions of a Symptom

A common mistake in the beginning is to record lots of symptoms enthusiastically which, in the end, turn out to be virtually useless. What distinguishes the useful ones from the chaff is their accompanying information, their completeness. Clemens von Bönninghausen, a German contemporary and close friend of Hahnemann, formulated a useful scheme. According to him, a symptom has four dimensions: localization, sensation, modality, and concomitants. There are other more elaborate schemes on the completeness of symptoms but, in my opinion, Bönninghausen's scheme provides a perfect starting place. Let us look at an example: a bursting headache in the forehead during menses which is worse from stooping.

The more complete a symptom is, the more reliably it can be used in our analysis. Just as a stool needs at least three legs to stand on, a good symptom should have three out of the four dimensions. It pays to go over all symptoms mentioned in the interview and ask clarifying questions aimed at completing the symptoms. In my experience, this is best done at or near the end of the session. We need, however, to adopt a style of questioning which does not project our expectations into the mouth of the

| | Question | Example |
|---|---|---|
| Localization | Where? | Headache in forehead |
| Sensation | How? | Bursting |
| Modality | Modified by what? | Stooping |
| Concomitant | Accompanied by what? | Menses |

patient. For this reason we need to stay clear of leading questions, i. e., questions which can be answered by a simple "yes" or "no." It is best to phrase our inquiries in a way that leaves the field of possible answers wide open. If you want to know if there is anything noteworthy about the menstrual period you could ask directly, "Is there anything special about your period?" Most likely you would get a "no" for an answer. If, however, you were to ask "What changes do you notice during your period?" you would get a much richer answer with correspondingly more chance of containing valuable information.

Let me warn you of one trap that I have fallen into myself: keep the task of case taking separate from the job of analyzing it. In other words, do not try to think of a particular remedy during the interview. If you do, you will lose the broad perspective and start to filter the information prematurely. James T. Kent must have had this in mind when he said:

> *It is a fatal error for the physician to go to the bedside of a patient with the feeling in his mind that he has had cases similar to this one, and thinking thus: In the last case I had I gave so and so, therefore I will give it to this one. The physician must get such things entirely out of his mind.*

There was a period in my homeopathic career when I was most susceptible to this kind of error. It was the time when I felt that I had a good number of drug pictures memorized so that I should be able to recognize the remedy quickly. It is embarrassing now when I look back and realize how little I really knew. Patient interviews at this time frequently turned into something like this:

Patient: "I feel a pain in the small of my back."

Practitioner (thinking of *Rhus toxicodendron*): "Are you restless?"

Patient: "Not really, just when I feel the pain worst."

Practitioner: "Aha! So you can't sit down and have to move around a lot?"

Patient: "I guess, but there is this other strange thing . . ."

Practitioner: "Hold on! So you are saying that you can't keep still?"

Patient: "Yeah, but . . ."

Practitioner: "Don't you like milk a lot?"

Patient: "I usually take my coffee with milk."

At which point the prescription of *Rhus toxicodendron* is made. It took me a while to realize that I had been forcing the poor patient into a remedy cubby hole with my questioning style. Of course there are moments when you will be absolutely convinced that you have already discovered the right remedy. When this happens, just make a note of the remedy in the margin of your notes so that you will not forget your idea. Then put the thought aside and carry on. Case analysis is best done on the next day, if you can allow yourself the luxury.

I hope you agree with me now that the initial patient interview is the foundation for any further progress to be made toward a homeopathic cure. Any subsequent analysis, prescription, or case management draws on the information learned during case taking. There are a few hints that will help you become proficient in this skill which I would like to share with you.

1. To take good cases you need to develop your overall understanding of homeopathy, including its philosophical and theoretical foundation. So keep studying and reading.
2. Try to find an experienced homeopath who will supervise you during case taking.
3. Take any opportunity you get to observe different experienced homeopaths when they take a case.
4. Team up with other students and form a study group where you observe each other during case taking and discuss the experiences afterward.
5. Tape your patient sessions and listen to them again afterward.

When you observe other homeopaths taking cases you will undoubtedly notice that each has their own style. I know homeopaths who use the help of a questionnaire filled out by the patient. They use the items on the form in the actual interview as a guide through the process and record their notes in the margin. Other practitioners, and I include myself in this group, prefer to interview the patient without the rigidity imposed by a printed form and rely on the dynamics of the interaction to guide them to the important topics. Gradually you will find certain elements that work well for you and a structure will emerge. Over time, this will develop into your own style and technique. If I were to give you a warning on the way, it would be to not accept any pattern prematurely and keep experimenting constantly.

# 6 A Game of Golf

Simillimum and simile

Case taking

Second prescription

Have you ever played golf? It seems that some people are more susceptible to this game than others. But who has not been on a golf course or at least watched a tournament on TV? The goal is pretty simple: get the ball from your present position into the next hole using the least number of strokes. To make the game more interesting, golf is played in surroundings with obstacles and treacherous pitfalls that make it difficult or impossible to take the direct path.

## The Meditation

Ideally, you would be out on a real golf course now, turning the meditation into an experiment. If you do not play the game yourself it is almost as instructive (homeopathically speaking, of course) to tag along with a friend who does. When you return from the day out, with the impressions still freshly embedded in your mind, go ahead and relive the experience before reading on. If you do not live near a course and do not know anybody who

**Fig. 6** A golf course poses a geometrical challenge: how to get the ball from the present position into the hole with the fewest possible strokes. The direct way is often not the shortest.

would take you along, the next best thing is to watch a tournament on the TV sports channel.

In any case, after your exposure to the real thing, you need to sit down in a quiet spot and go through the experience again. The picture on the previous page might help you to get in the mood. However, since you have already had some exposure to golf from the human perspective, this time I want you to squeeze your imagination into a golf ball and view everything from that perspective instead.

You are now a golf ball resting in the fresh cut lawn right at the point from where the above picture was taken. In the far background you can see the flag marking the hole: your destination. Now examine the terrain. Notice the slight downward slope initially, then the slope down to the right. Following that you get to a low point just before the sand pits on the right of the direct path, with accompanying slope. Continue like this until you have reached the hole. While you are on the way, do not forget to take note of the length of the grass, the direction and speed of the wind, patches of moisture on the ground, or anything else that may affect your trajectory. It is pretty far to the hole. Can you make it with one stroke? If you get hit up high there is the danger of gusty wind pushing you to one side. If you stay too low you will not get very far.

There are many different approaches you can potentially take to reach the hole. You could play it safe, stay to the left to avoid the pits and try for an intermediary stop before conquering the flag. In this case you would leave the ground only for a short hop,

rolling through the grass for most of the time. Maybe, however, you feel confident about your estimation of the wind, wait for a quiet moment, and then go high and far. Your perspective as a golf ball would be an entirely different one, viewing everything from high up instead of rushing through the blades of grass.

I invite you to use all your senses and imagine what it would feel like to follow one particular trajectory. Be creative and do not hold back. There is no wrong answer to this as long as you make this a rich experience for yourself. Go ahead, feel the rush of initial speed and the thump as you kiss the ground and keep rolling, slowing down gradually until a small bump in the ground finally stops your progress and you come to rest.

From your new location everything looks quite different. The surrounding terrain is different, the relative bearings to obstacles and the hole will have changed, and, hopefully, the distance to the hole will be smaller now. A second pitch will be necessary, this one getting you still closer to the flag, maybe even into the hole itself. Depending on the golf course and the skills of the person wielding the club you will eventually end up on the green, sufficiently close to the hole so that now everything comes down to putting.

Let us leave the golf course for now and keep the experience stashed away in the back of our minds. We will return to it shortly.

## Short Pitches and a Long Shot

A patient goes to see a homeopath; the homeopath prescribes a remedy and the patient is cured—case closed. Cures that follow this pattern are by no means infrequent but it would be misleading not to mention the other variety of case histories where the practitioner prescribes several remedies—one after the other—until the patient is relieved. Mind you, I am not talking about prescriptions which are wrong right off the bat and where it takes several attempts to finally hit upon the simillimum. What I mean are situations where the initial remedy helps the patient some and then a second prescriptions further moves the case in the right direction. This is followed by yet another remedy . . . and so on until the patient is cured.

Here is a great example, furnished by James Compton Burnett, a British homeopath of great renown who lived during the second half of the nineteenth century (Burnett 2003).

C A married lady of 54 came on August 8th, 1883 to consult me about a lump in her throat. In the left side of the top of the neck there was a hard body about the size of a hen's egg, but flatter. The tumor had been there for a very long time and with it she had much throat irritation. It was situated to the left and behind the larynx, but whether actually connected with the esophagus or larynx, I could never quite satisfy myself. It moved up and down with the act of deglutition.
Rx *Sulphur iodatum* 3x, Ziv., three times a day six grains.

August 22nd. No change.

Rx *Psorinum* C30.

October 5th. The throat (i. e., the fullness, uneasiness, pain, and distress in the throat) is very much better, and the tumor has sensibly diminished in size.

Rx *Thuja* C30.

November 1st. The tumor is about half gone.

Rx *Psorinum* C30.

November 29th. The tumor about two-thirds gone; general health good.

Rx *Thuja* C30.

December 21st. There is some tickling in the throat. The tumor is larger again, and the patient feels choky.

Rx *Psorinum* C30.

January 14th, 1884. The tumor has again sensibly diminished in size.

Rx *Psorinum* C100.

February 8th. Tumor still swollen.

Rx *Mercurius* C5.

March 3rd. "I feel the lump much less, about half its original size," said the lady. She has much rheumatism in ankles and knees.

Rx *Silicea* C6, in frequently repeated doses.

March 31st. Has been visiting a friend suffering from consumption and since then has spit a little blood-streaked phlegm; has a good deal of tickling in the throat.

Rx *Psorinum* C30.

April 16th. No colored expectoration for a week, and then very trifling; the tickling in the throat is better, but the throat feels very rough. The tumor is rather smaller.

Rx *Sulphur iodatum* 3x, six grains three times a day.

April 30th. No colored expectoration for the past week; the tickling in the throat is very much better but talking brings it on. The tumor has lately not altered sensibly in size but it is more self-contained and one can now demonstrate that it is not connected with the larynx, being in the areolar tissue, behind and to its left. Has a good deal of rheumatism.

Rx *Cundurango* C1, Ziv. Five drops in water three times a day.

May 21st. Thinks it is not so well; tickling sensation in the throat is worse. Feels the spring. The throat is worse in the morning and when tired.

JRx *Thuja* C30.

June 10th. Throat rather better; has only had the colored expectoration once but the voice is hoarse and she feels her throat weak. Has rheumatism in ankles and knees, worse after motion. The tumor is a trifle smaller.

Rx *Urea* C6.

June 11th. More blood-colored expectoration. Has had all the symptoms of a cold; aching all over with tingling and feeling giddy and ill; aphonia; much tenderness in the neck; rheumatism better; urine thick (unusual); violent tickling in the throat with scraping and dryness; the tumor is nearly gone.

The throat symptoms are worse night and morning, and when she is tired.

Rx *Phytolacca* C1, Ziv., nights and mornings five drops.

August 6th. Better in every way; the tumor is barely to be found.

Rx Repetition of remedy.

September 3rd. Feels practically well. I can find the small remains of the tumor only with great difficulty.

Rx Repetition (at night only).

November 13th. Still a little uneasiness in the throat.

Rx *Sulphur iodatum* 3x.

November 28th. Nearly well.

Rx Repetition.

December 31st. The tumor cannot be found, but she still complains of a husky voice.

Rx *Kalium bromatum* C4.

I did not see the patient again for some months as the tumor had quite disappeared and she herself felt quite well, but she came to me again on April 10th, 1885, complaining of tickling and irritation at the old spot.

Rx *Psorinum* C100.

May 11th. She feels easier in the throat, but the tumor is returning.

Rx *Sulphur iodatum* 3x.

November 25th. The lump is still increasing.

Rx *Psorinum* C100.

This lady came again on February 15th, 1886, and for the last time on April 30th, 1886, when I discharged her cured. I see her son occasionally on his own account and thus know that she

> continues quite well, and has a very healthy general appearance. (1896: no return of the tumor, and patient continues quite well of herself.)

In this case Burnett saw the patient 24 times over a period of less than two years and changed the remedy 19 times. How does that fit with what we are all taught to do, namely to find the one simillimum which will safely see the patient to health?

At this point I want to remind you of your previous experience as a golf ball on the vast obstacle-strewn course. The direct path from the tee to the hole is almost never possible. Therefore the strategy is to move to an intermediary location which is closer to the goal and chosen so as to circumnavigate the various sand pits, ponds, trees, etc. on the way.

When we accept the metaphor of the golf game as a homeopathic course of treatment, the first prescription is our initial shot off the tee. Like a golfer we need to asses the (chronic and miasmatic) terrain and any obstacles (to cure) on the way. Taking also environmental variables into account, we choose the appropriate club, force, angle and so on. After all this consideration, you give it your best shot and hit the ball. There is nothing much you can do beside squirming or cheering until the ball has come to rest. Then, at what would be the follow-up visit, we evaluate the patient's condition and how far he or she has moved toward health.

Unlike in the game, when doing homeopathy you are not in a contest. What counts is to get the metaphorical ball in the hole at

all. It does not so much matter how many strokes it takes to get there. Therefore you see homeopaths like J.C. Burnett who, already from the beginning, choose to progress toward cure in a number of small steps. At each intermediate point he carefully assesses the situation anew and prescribes a remedy which takes him further along the case. This is quite different from what most homeopaths are taught to aim for nowadays. We strive for the one and only simillimum to the case and cure it—lock, stock, and barrel—with a single prescription. Akin to an imaginary golfer who attempts to pot the ball with one masterful shot.

There is nothing wrong with either the "strategy of small steps" or the "one remedy to cure" approach. Many times, in fact, we will strive for "one remedy to cure" and find ourselves converting to the "strategy of small steps" out of necessity. In order to master these situations competently, we need to be firm in both situations and leave as little as possible to chance as the case progresses. The question, therefore, is how do we adapt our prescribing in the light of all this?

The differentiating point is at which level to apply the law of similars. Say, for example, someone complaining of migraine attacks asks for your help. One starting point to investigate the case would be the headache itself, the local physical symptomatology. We can then expand our view and incorporate modalities, concomitants, and general symptoms. From there, it is possible to go on and take the emotional and psychological make-up of the person into consideration as well. Going still further, the family history and inherited miasmatic background comes into play.

You can see that starting from the surface, where only the headache itself was visible, we broadened our view and took more and more of the patient into consideration. Consequently, when we look for a remedy we will be looking for a match on a progressively deeper and more profound level the more of the patient's totality we take into account. The better and more detailed our understanding of the entire disease entity, the better our chance to get the golf ball into the hole with a single pitch (see also the chapter The Iceberg for an entirely different metaphor on this topic).

There are situations, however, where we cannot do this. Most frequently they arise from an unclear picture where we do not seem to be able to discern clearly beyond a certain point. Many a brave homeopath has gone astray at this juncture and succumbed to the temptation to venture beyond the point where firm evidence and clear symptoms lead the way. The result is invariably the same: botched prescriptions and unclear results, patient and practitioner frustrated. As metaphorical golfers we know how to deal with such a situation. We will not take a wild shot based on some obscure interpretation and wild guesswork on our part. The danger of landing the ball irretrievably deep in the woods is too large. Rather, we will base our prescription on that part of the picture which we can perceive clearly. Even if that comprises only the physical complaint, or maybe only one single and distinctive symptom. This will get us to an intermediary point closer to the goal and in a position, hopefully, to see past the former obstacle.

One hundred years ago the "strategy of small steps" used to be in more frequent employ for two main reasons. The number of available remedies was not as large, therefore requiring a succession of remedies approximating a course where a single remedy, then still unknown, would have been required. If memory serves me, somebody once said that most cases having been prescribed *Lachesis* followed by *Sulphur* would have been simply set right by *Apis*—had it only be known before 1856. The other reason has to do with the relative attention gained by emotional and psychological over physical symptoms. Our experience and knowledge of how to apply observations on that plane to find the simillimum has increased dramatically since the days of Sigmund Freud.

## Simillimum and Simile

I have sometimes heard the criticism that homeopathy itself is inconsistent. On one side it cherishes individualization and treats each patient as unique. On the other side, homeopaths only use a handful of remedies to treat all patients.

The pharmacist from whom I buy my remedies distributes his homeopathic products all over the world and supplies a large number of other practitioners. He also keeps a running tab on what percentage of all prescriptions are made up of which remedies. It turns out that a mere 300 remedies account for about 97% of all orders. Without too much speculation we may also infer that those 300 remedies constitute roughly 97% of all prescrip-

tions made and are probably responsible for about the same percentage of cures wrought by homeopathy. With more than six billion humans on the globe, how can we ever talk about individualization? Would there not have to be about as many different simillima as there are humans? How can we ever expect to cure one patient out of six billion by choosing one remedy out of 1500? Simple math says that on average four million patients would need the same remedy if the aforementioned numbers are anywhere near to reality. That does not sound much like the individually chosen simillimum if you have to share yours with 3 999 999 other patients. What all this boils down to is the question: How similar does a remedy have to be in order to cure? Maybe all we need is a "close-enough-icum"?

Here is another point where our golf metaphor comes in handy. Imagine that the hole sits at the bottom of a shallow crater. Would this not make it a lot easier to get the ball into it? You would only have to get it anywhere in the crater and it would roll down into the hole of its own accord. A situation like this in homeopathy would translate into a certain range of remedies resulting in essentially the same effect. You "only" have to choose a remedy sufficiently similar to the patient's condition—that is what is called a simile. This observation instills some measure of reassurance since it turns an otherwise virtually impossible task into merely a darn difficult one.

We can also use the observation that a group of remedies act similarly in a different way. Say, for instance, you are reasonably certain that a particular remedy ought to fit the case. Yet, the

patient keeps coming back to you with less than hoped for success. You may reason that the remedy you chose was somewhere in the right neighborhood but it still was not close enough to get the ball into the ditch. Before you return to square one of your analysis and start over you might look for remedies related to the one prescribed. Using the method of grouping remedies in families is an important tool that frequently can point you to a better-fitting prescription.

Turning to the issue of how to find the appropriate simile, let us see what insight our metaphor can provide in the process.

## Mapping the Terrain

There are many ways to conduct a homeopathic interview, probably as many as there are homeopaths. It is good to have some image in mind which, when you sit with the patient, serves as a mental guide to you. This will help you stay focused and put all the information in place, pointing out yet unexplored areas and giving you some clue about how to analyze the case and follow up on it. Personally, I have several such guiding images, the golf course being one of them. Let me show you how it works for me and you can try it out for yourself the next time when you see a patient for the initial interview. I will not, at this point, discuss basic case-taking skills such as aiming for complete symptoms, not asking any leading questions, etc. This is better covered in the chapter The Individuality of a Rose. My intention

is to offer a metaphorical structure, an image, which functions as a guiding thread through the interview and the emerging case history.

First, you need to map out the terrain. Unlike in a real golf game, where you can rely on your own senses for an evaluation of the course, during a homeopathic interview the map of the patient's terrain will be revealed to you through the patient as well as through your own perceptions. Begin from where you are now and get a clear picture of the starting point. Usually this will be the chief complaint that you hear when you ask: "How can I help you?" In my experience this will elicit physical complaints most of the time even though the focus of the case may later turn out to lie on the mental or emotional plain. I try hard to get down a detailed account of the chief physical complaint because it will offer good clues as to which direction to take next. It also establishes a patient–practitioner rapport which makes it easier to go on to more difficult topics later. Furthermore, those symptoms provide a measuring stick against which to judge the progression of the case down the line.

From there you move on to find the chief features of the course. Where are the sand pits, ponds, bends, trees, etc. that you have to take into account? I usually find it helpful to take the chief complaint as a starting point and move away from it by asking questions like: "How long have you had this?" "What was going on in your life at the time this started?" "What do you think caused this?" "In which area does this affect you most?" Anything that shifts the patient's focus away from the immediate

vicinity and helps you to see the terrain a bit further on. Sometimes analogies and associations are useful at this point, such as "body language." For example, if the patient complains of backache you may ask what load he or she is carrying. If the patient has digestive complaints—what it is that is so difficult to digest in his or her life. Just complete the map as you follow the patient along.

Remembering that a golf course comprises 18 holes, you need to know what happened at the previous hole, i. e., go into the family history of the patient. What is the miasmatic background? Are there important events in the past which might have cast their shadow on the patient? For young children this is sometimes the most important part of the interview, in my experience.

And then, of course, the golf course is set in a particular surrounding landscape with a particular climate. Are you playing in Scotland or in some tropical resort? This signifies the general cultural and social environment of the patient. Knowing the marital status, job and family situations, hobbies, etc. provides an important framework for the case history.

In the end you will be left with a clear picture of what lies ahead of you and where you want to go. You will then be able to decide on the strategy to take. Do you see an obstacle looming in the course which you want to approach carefully in order to circumnavigate it? If so, you need to base your prescription on the terrain between yourself and this obstacle. Do not let yourself be distracted by what you imagine to lie behind it. Self-deception is the prime enemy of a good homeopath.

## The Next Shot

Before talking about the second prescription I want to clarify something: the second prescription is the one following the first prescription which affected the patient. So, if you gave five remedies and only the sixth had a discernible effect, the seventh remedy will be your second prescription in that sense. Is it not the same in golf as well? When you whack the ball so far off the course that you cannot find it anymore you need to start again from the same spot. It is as if you had never taken this shot.

Many homeopaths consider the second prescription more difficult than the first one. Certainly I have known homeopaths who gave one remedy after the other without a clear sense of what they were doing and why. And that is a great way to lose a case. I myself, however, think that there are several things going in my favor when faced with making a follow-up prescription. First, there will be more and often better symptoms to base the next prescription on since a well-chosen remedy—even if it is only a simile—will help to clarify the case and make it easier to prescribe for. Second, the first remedy itself gives me some clue about where to look for the next; mostly the two remedies will be linked by some kind of relationship. The second one may be a complementary remedy to the first (*Natrum muriaticum* followed by *Sepia*) or its chronic counterpart (*Natrum muriaticum* after *Ignatia*). Or it may be closely related to it on the natural plain as, for example, *Nux vomica* and *Ignatia*, or *Aranea ixobola* and *Aranea diadema.*

It is paramount in golf as well as in homeopathy never to hit a moving target. You need to wait until the ball has stopped, then you take your time assessing the new perspective and decide on your next shot. The same applies to homeopathy. Are you looking at a transient picture which is part of a case still evolving from the impetus of the last remedy? Then you need to wait. Or are you looking at the dynamics of the disease after your remedy has done all it could do? Then it may be time to prescribe again on the new situation. At this juncture, it may well be that from the new perspective the case presents itself in a totally different light. You need to look at the case as you see it now and banish any pre-conceived notions.

I hope you will agree with me now that a well-managed case which needs a number of remedies on the way toward health is by no means to be frowned upon. Burnett once wrote to a critic:

> *You take exception to the number of remedies used in my last case and want to know "which cured the case?" Will you get a long ladder and put it up against the side of your house, and mount it so as to get into your house by the top window; and when you have safely performed the feat, write and tell me which rung of that ladder enabled you do it?*

# 7 The O-Ring

A model of the vital force

Acute and chronic diseases

A layered case

Miasms

## The Experiment

If you have ever tinkered with engines and motors of any kind you will most certainly have come across something called an O-ring. These elastic, black rubber rings come in all sizes and are indispensable whenever lubricants or other liquids need to be

sealed in or kept out of a particular piece of machinery. I suggest you get a specimen of about 10 cm (4 in) or larger in diameter for the ensuing little experiment. Short of dismantling a motor vehicle to find an O-ring, you can buy one cheaply in most hardware or automotive stores should you not chance upon one in your toolbox or basement.

What I would like you to do is very simple. Just play with the O-ring for a little while and observe its shape and elasticity. Try to deform and bend it into other shapes. Notice how it springs back immediately into its original circular form when you let go. You can actually feel its reluctance to being deformed and squeezed.

It is easy to deform the O-ring into an ellipse or egg shape. A triangle is already harder to achieve, particularly if you strive for well-defined corners. How about a square or four-pointed star? Take some time to experiment with whatever shapes come to mind. Which ones are easy and which difficult? Take a piece of paper and draw the shapes into which you have successfully coerced the O-ring.

## Chaos and the Vital Force

When you read the Organon you will meet something called the "vital force" in many instances. This shows how central to homeopathy Hahnemann deemed it to be. He referred to it in many different ways, calling it the spiritual vital force, the vital energy, the vital principle, the life principle, the natural healing power,

dynamics, life force, life principle, the sustentive power of life, and life energy. To Hahnemann the vital force constitutes the one thing which distinguishes inanimate matter from a living organism. Thereby he declared himself a vitalist: a believer that all living organisms are permeated by some kind of life principle which is lacking in any form of inanimate matter. There is, of course, also a name for the opposite philosophical approach: the mechanistic view. A mechanist believes that living organisms are, in principle, no different from any piece of dead matter; life is but a very complicated machine. The profound difference with which vitalists and mechanists view the world, and the resulting consequences, are an interesting area of study in the history of philosophy. Without deviating too far from homeopathy, it is well worth devoting a paragraph or two to the vitalist school of thought.

Vitalism is ubiquitous and can be found in virtually every culture. Thus, the concept of the vital force is called *qi* in China, *ki* in Japan and *prana* in India. Its roots are spiritual in nature. The conflict between vitalists and mechanists resulted in the one question: can living matter be made solely from inanimate substances? Alchemists and, later, chemists have devised numerous schemes to create a living being from purely inorganic substances—none of which have been successful. Therefore the news hit the scientific world like a bombshell when in 1828 Friedrich Wöhler, a German chemist, wrote in a letter to a friend: "I can no longer, so to speak, hold my chemical water and must tell you that I can make urea without needing a kidney, whether of man or dog; the ammonium salt of cyanic acid is urea." He had created

an organic chemical substance (urea is made by kidneys and excreted in urine) using only wholly inorganic starting materials. This discovery dealt a heavy blow to the vitalist point of view. Modern natural sciences have all since subscribed firmly to the mechanistic approach. It is thus all the more intriguing that a way out of the dilemma appears to come from the very heart of mechanism: science. Let me explain:

There is a field of study straddling the boundary between mathematics and physics called chaos theory. It investigates the occurrence of phenomena in the narrow region between order and randomness—the chaotic region. Contrary to common belief, chaos is not a state of maximum disorder but rather the pinnacle of order bearing the seed of randomness. Once you know what to look for, you can meet chaotic behavior in almost everything from ocean waves to sand dunes and from the beat of a heart to the shape of a snow flake. If we could only succeed in understanding the natural laws governing chaos we would have a handle on understanding a vast number of natural phenomena. Although we have not reached this goal yet, significant progress has been made. Researchers have discovered something they term self-organization. This is the tendency of natural systems to evolve their own internal structure and hierarchical organization. Whether this be the self-similarity found in fractal shapes like a bird's feather or the synchronized blinking pattern of a group of fireflies in a tree on a warm Mediterranean summer's night, they can all be understood as an organizational pattern emerging from within the system that governs the relationships among its con-

stituents. This fascinating field of research has given us insight into such vastly different problems as understanding earthquakes or predicting the onset of an epileptic seizure. How can it help us reconcile vitalism and mechanism and what does it have to do with Hahnemann's vital force?

Chaos theory has taught us that with increasing complexity, systems develop more and more intricate internal structures leading to new behavior and properties which cannot be understood from the individual parts alone. Even a simple system such as a molecule of hemoglobin (the red color of our blood which transports oxygen from the lungs to all body tissues) behaves in a way to preserve its integrity under varying environmental conditions. It changes its shape subtly to counteract the destabilizing effect of too high acidity, for example. Of course, we cannot call this reaction intelligent. It is, however, homeostatic in the sense that the molecule reacts to its environment in a self-preserving way. An amoeba is an infinitely more complex system even though it consist of only a single living cell. The vastly increased level of complexity over a hemoglobin molecule gives rise to a much richer and more detailed internal order. The life preserving mechanisms inherent in an amoeba are already amazingly intricate. It can propel itself, seek out areas of favorable living conditions and flee from unfavorable ones, find prey, and spawn new amoebae.

The originally clear distinction between living and dead matter has become blurry. Less than a hundred years ago it was still an easy task to decide what was alive and what was not. Life itself

seemed to be a property that either was or was not present; just as one cannot be a little bit pregnant. This explains the excitement of Friedrich Wöhler when he crossed the line by synthesizing a substance belonging to the living realm from starting materials which he took exclusively from the other side of the dividing line. Nowadays this simple view is breaking down. The discovery of viruses and even simpler entities, prions (the agent causing BSE in bovines), has shown us that things exist which refuse classification into animate and inanimate. Apparently life does not simply appear from one moment to the next in biological evolution but seeps into creation almost undetectably. The more highly evolved—and thus complex—an organism is, the more it seems to exhibit of the properties which we associate with life. Life has thus become closely associated with the degree of self-organization within a system. The higher the degree of self-organization, the more the system exhibits what we call "life." It is not a question of whether something is alive or not, it is only a question of how much. Thus the fence which divided vitalists from mechanists has suddenly disappeared. Life is not to be sought in matter but in the complexity of its arrangement. It is not a property of matter but of its arrangements and interconnections. Life is "between" the material parts, in the interstices of inanimate matter, so to speak. The amount of life is the degree of self-organization.

Hahnemann, predating chaos theory by more than one century, viewed the vital force as the entity which brings life to an otherwise dead arrangement of matter. In the light of what we just learned about self-organization, the vital force is the organi-

zational structure governing the mutual interplay of all parts within a living organism. As such it is immaterial. It is also not to be confused with the spiritual concept of soul. Hahnemann also referred to the vital force as the crude, senseless, automatic vital force, the instinctive vital force, and the irrational vital force. The vital force is what enables homeostatic equilibrium with the body, keeping all vital processes and variables "in the green": blood pressure, pulse rate, electrolyte levels, etc. You may want to refer to Figure **21** which shows the role of the vital force in the triple interplay of body, vital force, and spirit.

## Health, Disease, and the O-Ring

Let us leave these ruminations aside and turn to our more physical experience with the O-ring. Clearly, its natural shape is a circle. When we want to understand the nature of the vital force we can use the O-ring to guide us. The state which the vital force strives toward is health, just as the O-ring tries to stay as close to a circle as possible. Any external disease agent puts a strain on the vital force, which in turn tries to keep the body as close to its healthy equilibrium as possible. You can visualize this by pushing against the O-ring and causing a slight dimple in one spot. The rest of the O-ring will scarcely be affected by the pressure of your finger. Only the region on which you put pressure reacts to it reluctantly, always trying to push against your finger and waiting for the moment to spring back into its circular shape.

The metaphor shows us how the vital force reacts to disease: it tries to confine its manifestations so that the organism is least affected by the disease. This means that the disease is first relegated to organs that are not vitally important to survival, such as the skin. If that becomes impossible, successively more vital organs become involved and affected. We can rely on the vital force that in each disease the symptoms we experience are the least vitally threatening possible under the given circumstances. The reverse process happens when a patient slowly recovers from a disease. The most vital organs get better first, and the skin problems are often the last ones to vanish. The alert reader will recognize this as nothing else but Hering's law of cure. Clearly, Hering's law expresses the general strategy of the vital force and is therefore not confined to homeopathy in its validity. Disease symptoms are a reaction of the vital force itself. They give us a clear image of its state and are more indicative of the individual than of the disease itself.

## Acute and Chronic Diseases

It almost seems like a waste of space to belabor on the distinction between acute and chronic diseases. An acute disease is quick in onset (hours to days) and self-limiting, either by resolving to health within a comparatively short time or leading to the death of the patient, also within a reasonably short time (days to weeks). What acute diseases do not do is linger much beyond a time

scale of weeks. On the other hand, chronic diseases evolve over a number of years. Their beginnings are mostly lost in the mists of time and hardly ever remembered because they are so inconspicuous. Sometimes, though, a particular emotional stress or physical trauma can trigger the onset of a chronic disease. Chronic diseases never vanish on their own. Left to themselves, they worsen gradually and end with the death of the patient years or decades later. Examples of chronic diseases are hypertension, diabetes, and allergies. If someone says "I have never been well since that flu I had two years ago," it means that there is a chronic disease involved which was probably triggered or exacerbated by the flu, which by itself is an example of an acute illness. This is already an indication that to decide what is chronic and what is acute may be easy in theory but is sometimes anything but in practice. Hahnemann devotes several paragraphs in the *Organon* to the nature of acute and chronic diseases. To whet your appetite, I will quote from § 72 and encourage you to read the ones following yourself.

> *The diseases to which man is liable are either rapid morbid processes of the abnormally deranged vital force, which have a tendency to finish their course more or less quickly, but always in a moderate time—these are termed acute diseases—or they are diseases of such a character that, with small, often imperceptible beginnings, dynamically derange the living organism, each in its own peculiar manner, and cause it gradually to deviate from the healthy condition, in such a way that the automatic life energy, called vital force, whose office is to preserve*

**Fig. 7** A patient complaining about some local symptoms can be represented by a section of the whole circle (dotted line), showing only the deviation from the healthy state in that one area.

> *the health, only opposes to them at the commencement and during their progress imperfect, unsuitable, useless resistance, but is unable of itself to extinguish them, but must helplessly suffer (them to spread and) itself to be ever more and more abnormally deranged, until at length the organism is destroyed; these are termed chronic diseases. They are caused by infection with a chronic miasm.*

Let us look at a practical example. A mother brings her daughter with the complaint of an acute otitis media (infection of the middle ear). You examine the girl and note all the symptoms associated with this bout of ear infection. Using the image of our O-ring metaphor, the information you obtained may be represented by the pattern shown in Figure **7**. What you see is an obvious deviation from the healthy circle. However, since you confined your examination to the scope of the particular acute complaint, you only received information about a section of the circle.

Had you extended your patient interview to cover the entire patient, you might have got a total image which would have fallen into one of two cases (Fig. **8**). In the first case, the rest of the infor-

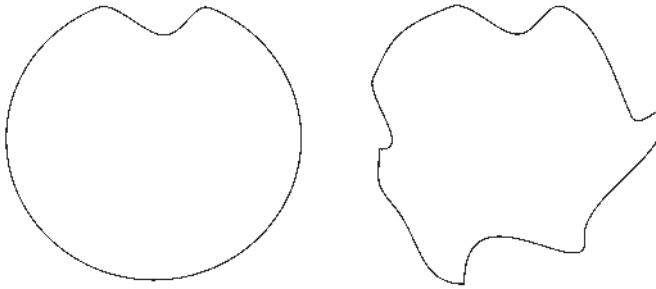


**Fig. 8** Acute and chronic disease shown in the O-ring metaphor. The same dimple present in the otherwise undisturbed O-ring on the left (acute disease) is superimposed on a badly distorted shape on the right (chronic disease).

mation does not indicate any remarkable deviation from the healthy state. The only indication for a disease is the ear infection, which, in this case, is an acute disease. If this is true, it is perfectly fine and advisable to base your prescription on the local information pertinent to the acute infection.

The situation represented by the shape on the right hand side is completely different. In this case, the mother might have told you that her daughter comes down with such an infection quite frequently. Every little draft can bring on a nasty inflammation and hardly a month goes by during the cold season without her daughter suffering from it. Clearly, what initially presented in the guise of an acute illness now looks like a chronic one. You would not have noticed this from the initial examination. The presenting otitis media is, in this case, part of an overall distorted vital force. If you want to treat this case successfully, you need to take

the overall state of the vital force into account and find a similli-mum for it.

Quite often a beginning homeopath may confuse the two shapes and treat what is in fact an ear infection on a chronic background as a simple acute manifestation. What happens is frequently an improvement of the current complaint which, however, does not last very long. The mother and her daughter will be sitting in your waiting room again very soon.

C An example might serve to illustrate the point further. William was a five-year-old boy when his mother brought him to me. He came to my office with an acute bronchitis and a nagging, unproductive cough. The season was just right for this kind of complaint and many patients had been seeing me with similar respiratory complaints. Some kind of virus was going around and causing all this. I felt sure that William was one of those kids. I had learned over the past weeks that two or three remedies, mostly *Corallium rubrum, Spongia tosta*, and sometimes *Luffa operticulata* were helpful and cured most of these complaints in a short time. I did not have to ask William to demonstrate a cough for me. He did a perfect rendition of the characteristic cough of *Corallium rubrum*: the rapid staccato of a machine-gun salvo. In addition, he was very sensitive to cold air. An open window in the same room would give him never-ending coughing fits. Without the shadow of a doubt I prescribed *Corallium rubrum* and was sure that I had seen the end of it. A call from the mother one week later confirmed that, indeed, the cough was

90% better. I told her to repeat the remedy and call me in a couple of days. The follow up call came four days later at which time William's cough had reappeared about as bad as it had been before beginning treatment. In addition, William had developed a fever. I became suspicious of my prescription and asked the mother to come in for another appointment. This time I specifically explored beyond the currently presenting cough and learned a good deal about William that made me doubt my initial choice of remedy. When he did not have his seasonal bronchitis, William had a rather hot constitution, wearing T-shirts when other kids would already favor sweaters. As a baby he suffered from a very itchy skin eruption on which I was unable to put a diagnostic label from his mother's description. Getting warm definitely made the itch worse. Together with other corroborating symptoms I now saw *Sulphur* as his remedy. A single dose of it removed the acute complaints in a matter of two days, never to return.

## A Layered Case

The reason for my initial choice of *Corallium rubrum* was the particular kind of cough, which is specific for this remedy. In the *Complete Repertory* the rubrics are: "COUGH; RAPID, until the patient falls back as limber as a rag" and "COUGH; PAROXYSMAL; minute-gun." Neither of them lists *Sulphur.* This is a good example of the differences in prescribing that result from a focus on

either the acutely presenting complaint or the chronic constitutional picture. The former leads to *Corallium*, the latter to *Sulphur.*

Prescribing for the currently presenting acute manifestation of a chronic disease is not necessarily a bad thing. Doing so is usually the first step in a series of steps toward tackling the underlying chronic condition. In the chapter A Game of Golf I described a strategy which approaches a case as a series of well-planned and carefully managed individual prescriptions instead of a single remedy. Setting out on the path of cure may well begin by focusing on a set of symptoms currently in the foreground. After the initial remedy, the presenting condition will have improved and some other set of symptoms will emerge. When you look at a case treated in this way, it looks like an onion: you peel away the topmost layer and another one becomes apparent just underneath. To some homeopaths this is the preferred strategy, and they approach all cases as if they were peeling onions. There is nothing wrong with this. I only want to make it clear that not the case *per se* is layered but the treatment approach (a well-known proponent of this method is the contemporary Argentinean homeopath Francisco Xavier Eizayaga). Even though apparently prescribing only for the presenting symptoms, this approach requires a keen awareness of the overall state as well. It is important not to mix symptoms belonging to different layers and to be able to assess the patient's state accurately in order to avoid dangerous suppression of symptoms (see also the chapter Cutting the Wire for more information on suppression).

## Miasms

There is yet another angle from which we can approach this chapter's metaphor. It has to do with chronic diseases. As astounding as the success of homeopathic treatment is, Hahnemann did not fail to notice that it was mainly confined to acute diseases; long-standing chronic ailments resisted its treatment stubbornly. It must have pained Hahnemann enormously to realize the limitations of his brainchild; nevertheless, he kept on searching for a solution. If you want to delve deeper into the peculiarities of chronic diseases and the miasmatic theory I suggest you pay the chapter A Map of Disease a visit.

Hahnemann's starting point were his patients' case histories. He began to look beyond the present situation into the past, taking note of anything peculiar that happened prior to the occurrence of the present disease. By doing so, Hahnemann expanded his view and began to perceive a patient as a person with a temporal dimension, a history. The conclusion he drew was to take significant symptoms from the patient's past into the case analysis, thereby expanding the disease picture accordingly. We could say that Hahnemann discovered the importance of taking the full extent of the deformed vital force into consideration when looking for a remedy. To me, this is his true contribution to the treatment of chronic diseases which gave homeopathy the power to treat them with confidence.

Comparing the stories of many chronically ill patients, Hahnemann found a common denominator among them. Some time

prior to the first appearance of the chronic disease there was either an itchy skin eruption or a venereal disease, namely gonorrhea or syphilis. He classified chronic diseases accordingly and defined psora as the group of chronic diseases which trace their origin back to an itchy skin eruption. Respectively, sycosis and syphilis are names for those chronic diseases belonging to gonorrheal or syphilitic origins. In homeopathic jargon, psora, sycosis, and syphilis are the three chronic miasms according to which Hahnemann classified all chronic diseases. The miasmatic theory, therefore, is a system of classification for chronic diseases. Since a system in itself does not bring health, Hahnemann associated remedies with them: antipsoric, antisycotic, and antisyphilitic. The three miasms somehow took on a life of their own, and psora along with its two siblings became the first three disease names specific to homeopathy.

Even though the theory of miasms is taught in every respectable course in homeopathy, it is frequently little understood and ill used in practice. When I studied it for the first time, it appeared to me at odds with what I had learned about homeopathy so far. I had understood that diagnostic disease labels had no significance in homeopathy and that each patient should be treated individually, irrespective of what happens to be the name of his or her disease. I had also understood that homeopathy looked at disease symptoms not as signs that need to be eradicated but as helpful features brought forth by the vital force, guiding us to the remedy. Suddenly I was confronted by antipsoric, antisycotic, and antisyphilitic remedies. The parallel to anti-

hypertensive, antibiotic, and all the other anti- drugs used in school medicine was confusing for me. Was I, then, to treat psora with antipsoric drugs just as a depression is treated with an antidepressant? Had Hahnemann suddenly refuted his own homeopathic principles?

It is the opinion of some homeopaths that the theory of miasms is incongruous with the rest of homeopathy and probably a product of the mind of a brilliant but aging curmudgeon. My own interpretation has changed considerably over the years. On the one hand, I have realized that successful treatment of chronic diseases does not need to refer to miasms at all, while on the other hand I have understood their meaning and place within homeopathy. I have come to value them as often valuable concepts. Let me explain how I understand miasms.

The most significant discovery which renders chronic diseases amenable to homeopathic treatment is the addition of the temporal dimension to each case. Only when we take the full history of a patient and consider the significance of past symptoms with respect to the present state do we perceive the full shape of the deformed vital force. Anyone who can do this will be in a good position to tackle chronic diseases, whether familiar with miasms or not. What Hahnemann discovered in the miasms was a classification of diseases which becomes apparent once you have the full view of the O-ring. Figure **9** shows how the three miasms might look in our metaphor.

You recognize a miasm as a basic deformation pattern. Compared to any particular disease, you will be able to find the one

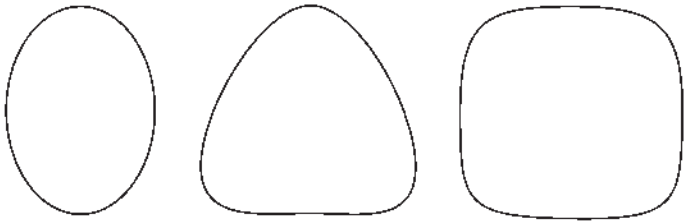


**Fig. 9** A convenient way to categorize shapes is according to their similarity with some pre-defined basic shapes like the ones shown.

basic pattern to which the disease is most similar. Take, for example, the distorted shape shown in Figure **10**. This one is a variation of the basic triangular shape of the previous figure. You can, therefore, say that this particular shape belongs to the miasm symbolized by the triangular shape. When looking for a remedy you can limit your search to the ones corresponding to this particular kind of basic distortion.

In the language of our O-ring metaphor, miasms are more or less arbitrarily defined simple shapes which serve as a conven-

**Fig. 10** Any given shape can be categorized according to the three basic shapes. In this image the shape drawn is most similar to the triangular shape.

ient way to describe the basic features of a more complicated distortion. Incidentally, there is nothing sacred about the number three here. You could just as well define four basic shapes, if you like.

## A Soil for Disease

I do not remember where I heard it or who said it, but it struck a chord inside me: miasms are the soil on which disease grows. I liked this image very much since it explained to me the use of miasms from a different angle.

Not every plant grows on every soil. That is why you will not find a cactus growing in a swamp, nor will you meet buttercups in the desert. When one botanist describes a climate and associated soil condition, this conjures up a long list of plant species, which are indigenous to this kind of surroundings and which you can commonly find growing there, before the mental eye of another botanist. Diseases, along with their associated symptoms, can likewise be grouped according to their miasmatic traits. When a homeopath speaks of a psoric taint, he or she subsumes such symptoms as itchy skin eruptions, dryness, or an introvert personality under this heading. You would not think of malformed teeth, drawing pains at night, and necrotic ulcers which grow on syphilitic soil.

The same classification used for disease symptoms can be used to group remedy symptoms. It is precisely this correspond-

ence which makes the miasmatic concept useful in practice. If you have discovered a preponderance of sycotic symptoms in your patient and hence concluded that the presenting state belongs primarily to this miasm, you have effectively limited the area in which to search for the fitting remedy. It has to have the same preponderance of sycotic symptoms. Know your remedies and what soil they prefer and you will be able to focus your search and reach your goal faster.

# 8 A Map of Disease

Miasms and how to use them to find the simillimum

Chronic and acute diseases

Layered cases

Mappa Mundi

Have you ever heard of white elephants? This nickname is given, for example, to people who are promoted to high levels yet fulfill no discernible function. The concept of miasms is first in line to be awarded the status of white elephant in homeopathy. We are taught about chronic diseases and how they relate to miasms, we read in all the classic texts about the importance of miasmatic prescribing in the treatment of chronic diseases, yet they are virtually absent in the everyday practice of homeopaths. Reading through the published accounts of cured cases we seem to be doing quite well without them, too. The concept of miasms in homeopathy goes back to Hahnemann who introduced it in 1828, all of 32 years after the advent of homeopathy. Why it took him so long, how they helped homeopathy to become more effective, and why they have fallen out of use today are some of the questions that come to mind.

## What Is a Miasm?

Historically speaking, there is a lot to be said about miasms, which is probably why this topic has been the feature of many talks and research papers. My excuse for dwelling on this point is simply to show the scope of the term miasm and to lend its definition a bit of historic profile. It is much easier to understand the concept once we know how Hahnemann and his contemporaries saw it. And we will be in a more enlightened position to find a way to use miasms to the advantage of our patients.

The notion of miasms as well as the particular term predate homeopathy by centuries. In their attempt to get at the root cause of diseases, many ancient physicians looked into how they spread and invade different organisms. This, today, would be the research field of bacteriology, virology, and epidemiology. Back then, it posed more of a philosophical and conceptual problem.

The word miasm has its origin in the Greek word for taint or fault. It was first used in the healing arts by the ancient Greek physician Hippocrates around 400 B.C. He used it to refer to the disease-bearing agent carried in dirty water or malodorous air. In the era of Hahnemann, in the late eighteenth century, this belief had grown strong roots, and it was commonly held that miasms were impure air currents that were responsible for the spread of epidemic diseases. Since most diseases at the time of the ancient Greeks up until just after Hahnemann were inexorably linked with bad hygiene, it was actually not so far off to blame these features of human existence for the sickness among the population.

The plague and cholera are just two examples which cost many lives in Europe and have been made extinct there largely by improving personal and public hygiene.

Hahnemann did not include miasms in his initial framework of homeopathy. From 1796 until 1828 miasms had not entered homeopathic teaching. What led Hahnemann to adopt and adapt the notion of miasms? In the theoretical preface to his book *Chronic Diseases*, Hahnemann speaks of his increasing frustration at not being able to cure deep-seated chronic diseases with the hitherto practiced homeopathic wisdom. In the preface he writes of patients treated unsuccessfully and relapsing continually:

> *When such a relapse would take place the Homoeopathic physician would give the remedy most fitting among the medicines then known, as if directed against a new disease, and this would again be attended by a pretty good success, which for the time would again bring the patient into a better state. In the former case, however, in which merely the troubles which seemed to have been removed were renewed, the remedy which had been serviceable the first time would prove less useful, and when repeated again it would help still less. Then perhaps, even under the operation of the Homoeopathic remedy which seemed best adapted, and even where the mode of living had been quite correct new symptoms of disease would be added which could be removed only inadequately and imperfectly; yea, these new symptoms were at times not at all improved, especially when some of the obstacles above mentioned hindered the recovery.*

Hahnemann realized that he was up against a new problem. Homeopathy had been exceedingly successful in treating acute diseases. Those are quick in the onset and usually self limiting. There is, however, another class of illness whose onset is insidious, whose progress is slow, and which will result in death after many years of steadily and slowly declining health: chronic diseases. It appeared as if homeopathy had nothing to offer against them. This is where miasms entered homeopathy.

Although Hahnemann adopted the word, he attributed a slightly different meaning to miasms. To him a miasm denoted a constitutional weakness contracted by parasitic infection which is somehow hereditary and can be transmitted over generations. What actually is inherited by the next generation is not the infection per se but the constitutionally weakened vital force. Someone born with this kind of weakness will develop a chronic disease whenever the stresses of life overtax the already weakened constitution. From then on the patient will experience a gradual but unstoppable downslide in his state of health and exhibit continually worsening symptoms until his death, which may be many years or even decades hence. Hahnemann set himself to discover the constitutional weakness in such patients and, in the process, traced them back to three initial diseases: scabies, gonorrhea, and syphilis. According to Hahnemann, these three diseases are at the root of all chronic diseases. He introduced three corresponding miasms, psora, sycosis, and syphilis, respectively. The seed of the psoric miasm gets laid by a scabies infection, which weakens the constitution in a particular way. This weak-

ness is transmitted to future generations who may develop a whole range of symptoms recognizable as belonging to the psoric miasm. Similarly, the sycotic miasm has a gonorrheal infection at its beginning, and the syphilitic miasm syphilis.

In order to treat chronic diseases homeopathically, one has to recognize the miasmatic background of the patient and select an appropriate antipsoric, antisycotic, or antisyphilitic remedy. In other words, the symptoms recorded during the patient interview will point to a particular miasm. The remedy selected as the simillimum will also have to match the prevalent miasm in order to cure the chronic disease.

This, in a nutshell, is Hahnemann's concept of how to treat chronic diseases. It has its firm place in every course of homeopathy and, almost without fail, will not make the slightest impression on the prescribing practices of those future homeopaths. The concept of miasms is slightly at odds with our current understanding of epidemiology, and we no longer think of scabies, gonorrhea, or syphilis as diseases powerful enough to hold the entire human race in their death grip. Today we think more along the lines of aids or cancer, and Hahnemann's original three appear a bit outmoded and arbitrary. Also, how does selecting a remedy for a miasm go together with selecting it for the totality of symptoms? If we consider the totality and prescribe for it, why do we need to take the miasm into account in addition? Thoughts and doubts like these are likely the reason that we study Hahnemann's theory on chronic diseases but do not practice it—or do not know how to practice it.

## The Exercise

Before we delve deeper into the subject of miasms I propose a little exercise that we will come back to further on. Think about the last time you left your house or apartment to go shopping. Maybe you walked the distance, took the car or bus, it does not matter.

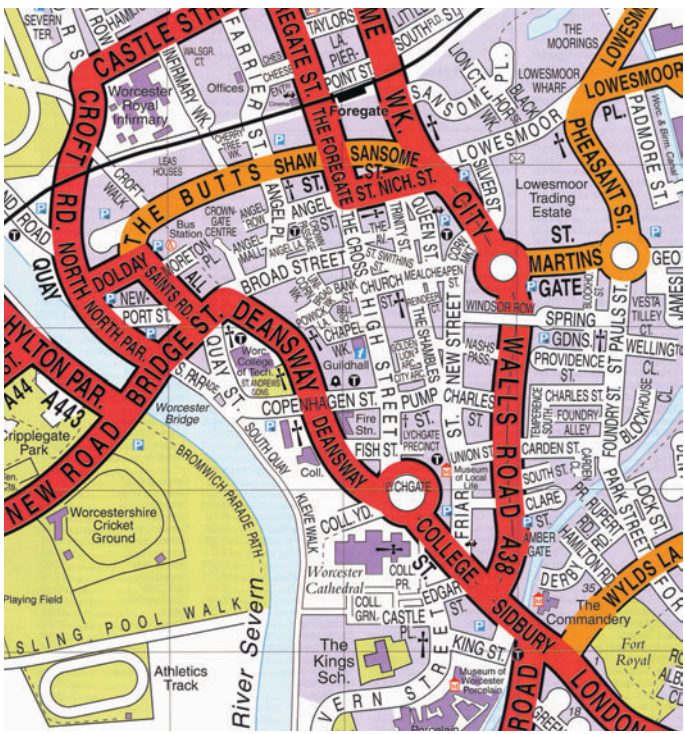



**Fig. 11** A map is a simplified version of reality which we use to help find our way. It is always a trade-off between the amount of detail shown and readability.

Just pick a location that you know how to get to. Try to describe the way to some imaginary person who is from out of town so that he could potentially retrace your steps and find the store you went to. Do not resort to drawing a map; use words to express yourself. To make things a bit harder, let us suppose your imaginary person cannot read and therefore you cannot rely on street names. Think carefully how to describe the way and write your directions down for reference.

Next, find a map of the area and try to locate the destination on the map. If you have it available, get a different scale map—one that shows either more or less detail than the first one—and try to locate it there as well. You may want to take a pencil and mark the way to the destination on both maps.

## Different Views on Miasms

The original three miasms—psora, sycosis, and syphilis—did not remain unaltered in homeopathic teaching. Even before Hahnemann's death, Constantine Hering suggested that there were actually two different miasms, psora and pseudo-psora, mixed together in the original psoric miasm. He identified the newly introduced miasm with an original infection of tuberculosis, resulting in two venereal miasms (sycosis and syphilis) and two nonvenereal (psora and pseudo-psora). The number of miasms did not change significantly over the next century, although a few homeopaths thought of other life-threatening diseases as being

miasms in their own right. Most notably, some homeopaths have talked of an aids and a cancer miasm. Rajan Sankaran, in his book *The Substance of Homeopathy*, however, favors a still larger number of miasms. He draws a diagram which relates the various miasms with each other; it resembles the one shown in Figure **12**.

Let us stop for a second and see where we are in this matter. Hahnemann began with three miasms, Hering expanded the number to four. Later homeopaths included various other diseases and now we are presented with at least ten miasms. Not all contemporary homeopaths agree on the number of miasms. Does the growing number of miasms reflect a correspondingly more

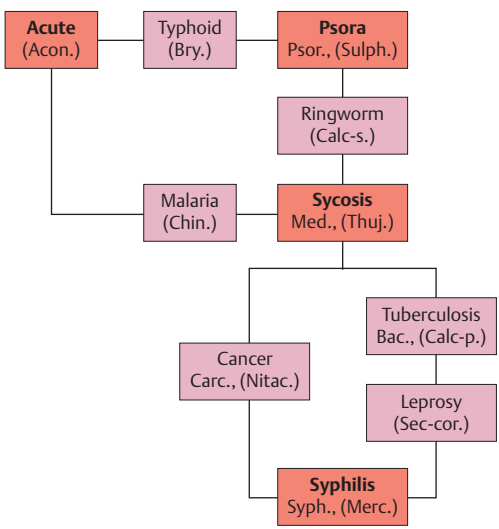



**Fig. 12** It has been a long way from Hahnemann's original three to this diagram showing ten miasms featured in the book *The Substance of Homeopathy* (Sankaran 1999).

detailed understanding of homeopathy? Is it a matter of personal preference, or merely splitting hairs? Let us also not forget that we are still in the dark and do not know how to apply any or all of this in practice.

## A Map of Disease

Now is the time to return to the previous exercise. When you examine your written directions you will notice several references to external landmarks. These are obvious in phrases like "turn left at the traffic light" or "continue straight past the Mexican restaurant," where a particular traffic light or the local Mexican eatery served as fixed points of reference. When you locate a destination on a map you get an especially good overview of how things relate to each other geographically. On a map of Europe it is easy to see that Vienna lies to the east and slightly south of Munich and that Prague lies to the north of Vienna. The map also shows you that these three cities form something like an equilateral triangle. Maps are essential when it comes to orienting yourself in unknown territory.

A new patient is, to the practitioner, unknown territory. To identify the important features on the human landscape, a homeopath has to become something of an explorer and cartographer (you might recall that a similar metaphor cropped up in the chapter A Game of Golf). I do not know if you are at all familiar with the work of a land surveyor or cartographer. The accuracy of their work

hinges critically on a network of referential points whose position is known accurately, and which are marked unambiguously in the landscape. Any new spot is located on the map with respect to its distances and directions from at least three reference points. Sailors do the same when they use sightings of well-marked features on the shore to get a fix on their boat's position in coastal waters.

What, though, are our reference points in homeopathy? Since we are describing forms of behavior and sickness, the terrain is the entire spectrum of human nature, physical and emotional. Furthermore, it turns out that, in order to be useful, we need more than two and fewer than, say, 20 such landmarks. A map just stops being useful when there is too much clutter on it. Three is about the smallest number of reference points. There is a reason why in nautical practice navigators are used to "triangulate" their position (remember, a triangle has three points). Now we understand why Hahnemann came up with three miasms. If you look at it that way, miasms are more or less arbitrarily chosen reference points on the map of human pathology.

Intellectual understanding requires a process of subdivision and categorization. All cultures have developed different frameworks with which to bring order to things. We find various systems building on duality (yin-yang), trinity (the holy trinity), or quaternity (the four elements). The multi faceted nature of human suffering has been the playground for several such categorization schemes. Well known are the four temperaments: sanguine, phlegmatic, melancholic, and choleric. Hahnemann offered us the three miasms as landmarks on the map of diseases.

Do not make the mistake of underestimating their usefulness, though. It is very easy to get lost without these reference points, and it behooves every homeopath to know his or her landmarks well. All I am saying is that there is no reason at all to start an argument about the particular choice of miasms. After all, if you are intimately familiar with your set of preferred landmarks they will serve you just as well as any other set.

## The Roots of Suffering

To make use of the miasms we have to dig deep and rediscover them at the roots of human suffering. Anyone who has read Hahnemann's *Organon* and, in particular, his *Chronic Diseases* is left without doubt that he thought of them as the root cause of disease. I would like to show you an approach to miasms from a particular angle which draws upon work done by Misha Norland. He sees an intriguing parallel between the miasms and the "three fires of suffering" of Buddha: delusion, desire, and aversion. The connecting thread is as old as humanity itself. You can find it in the evolutionary cycle of nature which is re-enacted with every new life that matures, ages, and dies.

The origin is a state of oneness. With the rise of consciousness comes self-awareness; the individual perceives itself as separate from the continuum of existence. Separation is the prerequisite for self-consciousness; without the distinction between "I" and "not I" no individual can exist. When an ego is born, it will

first regard itself and be concerned with matters essential to its survival. Each cry of a baby bears audible witness to this: it asks for food and protection. Quickly, the undifferentiated cry turns into the clearly articulated "I want" of a child.

One side of the coin that comes with self-awareness is independence. The other side is separation. Being independent of someone is a mutual state of being. Not only I am free to leave, so is the other person. Therefore, with a growing sense of self comes the fear of separation. We all know the feeling of insecurity and forsakenness a small child experiences and exhibits when it does not see its mother around. Similarly, we all develop strategies to cope with this emotion. It is not so much that as adults we are not subject to this anxiety anymore; rather we have adopted ways to hide it and means to provide ourselves with a sense of security, and we start to build walls around ourselves. Depending on our specific character these walls need not be literally constructed from bricks. Most people feel secure when they amass wealth. To them, wealth provides status and status makes you feel secure. They try to buy protection. Other people resort to a particular belief system which they abuse as a shield against everything foreign. Hiding behind "-isms" and "-ologies" is just another way of hiding behind dollars and yens.

Having replaced the spiritual security of the original oneness with the fragile security provided by material wealth, we are now in no better place than before: we worry constantly about losing our money. In our perception everyone turns into a potential

enemy whose only intention is to take it away. Gradually we slip into a state of anger and hatred.

The delusion of separation leads to the desire to amass material wealth, which in turn results in aversion and hatred. Delusion, desire, and aversion—the three fires of Buddha—are at the same time the three miasms of Hahnemann. Psora is the original disease and forms the soil into which other diseases and, indeed, sycosis and syphilis may implant themselves. At the core of the mental state of psora lies a sense of unrest and abandonment, often expressed in terms of fears and anxieties of every variety. Psoric patients react to this inner insecurity with inactivity and introversion; they retreat. Their unrest is banned as far away as possible and manifests as an itch on the skin. Hahnemann has called psora "the great itch" and, indeed, most psoric disease states involve some kind of itchy skin irritation. Examples are neurodermitis and topical allergies. The psoric person is an introvert who meets life with an inward and unexpressed "No" and is unsure of his own place in life. Naturally, we encounter existential fears and fear of failure frequently. Their strategy to retreat and hide reflects in dry skin and mucous membranes. They feel physically cold and freeze easily.

Sliding deeper into disease, the psoric develops a sycotic miasmatic taint. We are now on the level of desire. Since sustained desire leads to greed, the sycotic moves away from the psoric state of introversion and inactivity and becomes the opposite: an extrovert. In an attempt to pile up as much protection as possible, they feel hurried. There simply does not seem to

be enough time to acquire everything they think they need. Whether this be money, ideas, concepts, or food, the sycotic is compulsively driven to amass as much of it as possible. They become boastful and extravagant and want to take away from other people. Over time, this makes them feel guilty at a subconscious level. Projecting this feeling onto other people, they become fearful, jealous, and suspicious. Fear of supernatural phenomena and ghosts is not uncommon. In the extreme, this state develops into paranoia, the feeling of being watched constantly. The sycotic fear differs from the psoric in that the former is more prone to be expressed in hectic and violent action. It is more obsessive and fixed in nature than the quiet psoric retreat into hiding. We discover the hurried activity on the physical level in hyperproduction on every level. Mucous membranes develop catarrhs which may result in over-secretion. The typical discharge is yellow in color, muco-purulent. Hyperactivity on the tissue level exhibits in all sorts of growths—tumors, fibroids, polyps, and warts. One kind of wart in particular has been associated with the sycotic miasms: condylomata or figwart. As its name suggests, it looks like a cauliflower or fig.

As the disease progresses, aversion turns into hatred and with it sycosis into syphilis. A destructive process takes hold and fills the patient with a deep and destructive hatred. They feel themselves threatened by enemies, which drives them into a state ruled by the motto "better to kill than be killed." The fear of being attacked drives them to destructive actions themselves. Suicide and homicide are two sides of the same coin. Physically,

they tend toward serious and destructive diseases such as cancer and necrotic tissue changes. The syphilitic miasm may also manifest in certain physical deformities (stilted growth, peg teeth, club foot, among others, have been associated with the syphilitic miasm). Heavy drug abuse and alcoholism in the late stages are also a form of self destruction. Their pains tend to be insupportable and violent and may be described as crushing, piercing, as if the head were in a vice. Not surprisingly, their worst time is the night, when it is dark.

John Damonte, the renowned British homeopath, once used a bank robbery as an illustrative example to characterize the three miasms. The psoric plans the attack, the syphilitic kills the guard, and the sycotic steals the money.

You can use Table **1** as a brief summary and quick reference. Far from being complete, it will give you a sense of the central themes of each miasms.

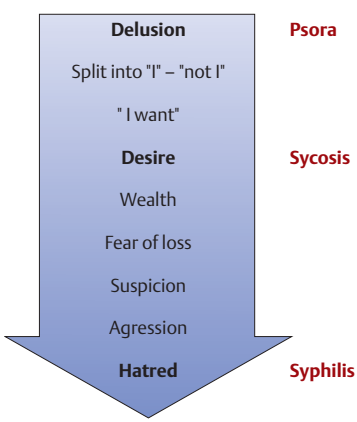



**Fig. 13** The "three fires of Buddha," the progressive pathology, and their correspondence to Hahnemann's miasms.

Table **1** A juxtaposition of the three miasms and their key elements

| Psora | Sycosis | Syphilis |
|---|---|---|
| Root of all diseases | Develops on psoric soil | Often occurs in combination with other miasms |
| Introvert, insecure, self-doubt. "I can't." Weak memory | Extrovert, boastful. "I want." High sexual drive, prone to passionate jealousy. Feeling of guilt | Hatred, violence, destructiveness. "I must." To kill or be killed, psychosis |
| Fear of failure | Fear of being watched, of the supernatural | Fear of violence, blood, war |
| "Hypo," underproductive on the physical level | "Hyper," overproductive on the physical level | Prone to destructive diseases of blood, bone, and central nervous system |
| Mostly cold and dry. Itchy skin manifestations | Hot. Prone to growths and tumors, warts | Cancer, psychosis |
| | Condylomata (figwarts) | Insupportable pain, worse at night |
| Main disease: scabies, the "itch disease" | Gonorrhea | Syphilis |
| Key remedy: *Sulphur* | *Thuja* | *Mercurius* |
| Nosode: *Psorinum* | *Medorrhinum* | *Syphilinum* |

A warning is in order: the distinctions drawn in the discussion above may sound very apodictic and dogmatic. In practice you will find that this is not so. When I listed jealousy under the mental characteristic of a sycotic patient I did not intend to imply that a psoric can never be jealous. What you will find is a very different kind of jealousy. The psoric is jealous because he feels inferior to the loved one and, deep inside, is afraid that his partner might discover his insecurity. Through the eyes of a sycotic person the loved one is an object of his possession and needs to be guarded against potential theft. A person centered in the syphi-

litic miasm will behave in concordance with the more violent nature of this miasm when he is jealous. Also, on the physical level, a psoric wound will be slow to heal but not pose a vital threat. A sycotic wound tends to proud flesh, scarring, and septicemia, whereas a syphilitic one tends to turn necrotic and fester.

## Isopathy and Nosodes

In the last three lines of Table **1** I listed the main disease, key remedy, and nosode for each miasm. Hahnemann did not define the miasms on the basis of theoretical speculation but rather on observations drawn from his vast practical experience. He noted that most people with a chronic disease had suffered either a cutaneous itch, gonorrhea, or syphilis. Whatever treatment conventional medicine had to offer at this time was directed toward suppression of symptoms. Heavy doses of sulfur, applied externally or in baths were widely common against scabies and like complaints. To treat syphilis, doctors of the time employed large, even heroic, doses of mercury, frequently leading to mercury poisoning in the patient. We have to understand that those three diseases epitomized by the miasms indeed accounted for a large proportion of patients at that time. Hahnemann also saw many cases in which the original disease had been apparently cured by allopathic medicine. However, the suppressive nature of the treatment over time lead to another disease (see also the chapter Cutting the Wire about suppression of symptoms). Through care-

ful questioning Hahnemann was able to find the disease at the root and hence identify the underlying miasm. The key remedies for the psoric and syphilitic miasms, *Sulphur* and *Mercury*, respectively, are at the same time those substances used in large doses by allopathic medicine to treat the corresponding key diseases. It is therefore interesting to note their use in potentized form as treatment for these same conditions. *Thuja*, the key remedy for the sycotic miasm, has shown to be capable of producing those very warts and discharges characteristic of a gonorrheal infection.

In treating infectious diseases, homeopaths have sometimes resorted to using disease matter itself in homeopathic preparation for treatment. Their reasoning is that nothing could be more similar to the disease than the disease itself. Strictly speaking, this kind of reasoning challenges the leitmotif of homeopathy, the law of similars. Instead of using the most similar remedy they proposed the use of the "same," the "isos" as Greek has it. Next to homeopathy there emerged isopathy. Isopathic practitioners use materials produced by the disease itself. This could be sputum thrown up in a cough of a tuberculosis patient or pus squeezed from an infected wound, for example. On the surface, this kind of reasoning appears to make sense. Closer inspection, however, reveals the inconsistency of the isopathic approach. As we have seen in the chapter The Lemon and the Dolphin, the law of healing is based on similarity and not sameness. The organism requires new information to start the process of healing. The information provided by the disease itself already permeates the patient and adds nothing new. The charm of isopathy lies in its

deceptive reasoning and the comparative simplicity of practice. There is not much consideration, weighing, and case analysis—simply get some disease matter and give it to the patient. Routinism is always more appealing than hard work.

Hahnemann was, of course, a staunch opponent of isopathy. He was afraid that fledgling homeopathy would be perverted into isopathy. For this reason he flatly refused to admit homeopathic remedies prepared from disease products. *Psorinum* is the seropurulent matter squeezed from a scabies vesicle and prepared in homeopathic fashion. To apply this remedy against psora indiscriminately would be isopathy. Constantine Hering, however, realized that through the homeopathic manufacturing process the original disease matter changes and turns into a remedy in its own right. As such, it can be subjected to a regular proving and used just like any other homeopathic remedy, namely according to the law of similars. In a long exchange of letters Hering was able to convince Hahnemann to accept *Psorinum* as a homeopathic remedy. *Psorinum* was the first member of a new class of remedies prepared from disease byproducts: nosodes. Other nosodes followed suit quickly and hence each miasmatic key disease contributed a nosode. *Medorrhinum* is prepared from the urethral discharge produced by a gonorrheal infection. The skin lesions produced by syphilis in the primary and early secondary stages yield the source for the homeopathic nosode *Syphilinum*. It is interesting to note that *Psorinum* itself has not proven routinely effective in the treatment of scabies proper. Apparently, the disease itself is too individually variable to yield to a single, specific

remedy. Incidentally, the same also holds true for the other nosodes. Since the late nineteenth century more nosodes have been added. Among the ones in more common use are *Carcinosinum* (cancer nosode), *Tuberculinum* (tuberculosis nosode), and *Lyssinum* (hydrophobia nosode).

Given their peculiar origin and direct link to specific diseases, is there anything that sets nosodes apart from the other remedies? Nosodes are selected—just like any other remedy—according to the law of similars. As a group they are not the only remedies linked closely to particular disease conditions. *Arsenicum*, for example, is the cause for arsenic poisoning. Yet we do not use it routinely and exclusively against arsenic poisoning. In fact, *Arsenicum* is a well-proven remedy and is used successfully in a wide range of conditions. The guide to its use is the similarity of symptoms and not the origin of the material.

Let us return to the original metaphor, our map of diseases. We have identified the miasms as landmarks which help us orient ourselves and locate other points on the map with reference to them. Extending this idea, we may say that if New York is psora then Manhattan is *Psorinum*; if Paris is the sycotic miasm then the Eiffel Tower is *Medorrhinum*; if Moscow is the syphilitic miasm then the Kremlin is *Syphilinum*. Nosodes are at the heart of the miasm and capture the core of it. It is not so much that they are specific to a particular disease but to the central theme of the miasm itself.

The map of diseases is also a map of remedies. We have already placed the nosodes on the map, but why stop there? We

can take any remedy and see where it falls on the map with respect to the miasms. Let us take *Arsenicum* as an example. I will assume, at this point, that you are familiar with this remedy. Let us look at some rubrics and symptoms of *Arsenicum* and in the process classify each one as to its miasmatic context.

1. Aversion to company, yet dreads being alone. This shows us that *Arsenicum* is afraid of being alone and requires protection—a psoric trait. At the same time it feels uncomfortable among people. *Arsenicum* has a problem trusting other people, it can be very suspicious. It is afraid of robbers and thieves. This is a typical sycotic dimension.
2. Excoriating nasal discharge. The runny nose with profuse discharge is psoric, while the acrid and burning quality puts the symptom in the realm of the syphilitic miasm.
3. Lack of vital heat. *Arsenicum* is a remedy which feels cold easily. It is one of the coldest remedies we have in our materia medica, which points us toward the psoric miasm.

From these three rubrics you can already see that *Arsenicum* shares all three miasms, albeit at varying degrees. If you study the remedy closely you will find that the sycotic element is the strongest, followed by psora. Although there is a syphilitic component present, it is not prominent. *Arsenicum* is a multi-miasmatic remedy with a characteristic share of each miasm. In this, *Arsenicum* is not alone. Most remedies share the miasms to varying degrees. *Acidum nitricum*, to take another example, is almost equally divided between the syphilitic and the sycotic miasms

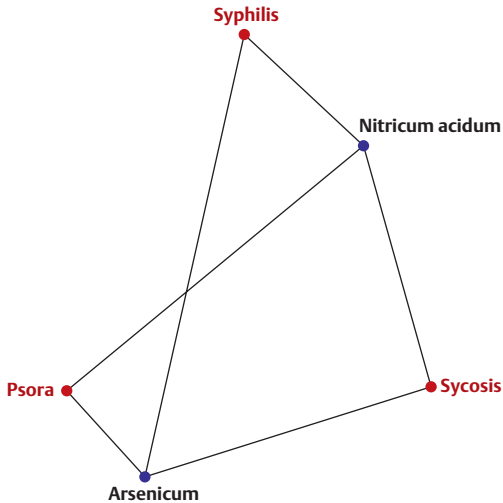



**Fig. 14** Most remedies have characteristics of all three miasms. Placing them on the map of diseases you can easily visualize and compare the different miasmatic elements in a remedy.

with a dabbling in psora. If we place those two remedies on the miasmatic map it starts to look like the picture shown in Figure **14**.

The value of Hahnemann's miasmatic theory in daily practice lies in the framework it provides. It can help you organize your thinking and understand the patient and materia medica better. After some time you will be able to recognize miasmatic components easily and quickly by mentally grouping and arranging symptoms on a map similar to the one shown in Figure **14.**

## Mappa Mundi

Let us stay with the image of a map for a little while longer. There is one further useful aspect of maps that I would like to point out. It must have occurred to almost everybody: finding yourself in unfamiliar territory, you desperately long for a map to give you the big picture and show you the way to your destination by magically changing what seemed unfamiliar and alien into familiar and known features. The desire for a map is the fear of darkness, of the unknown.

But how useful is a map which gives a 1:1 representation of reality? In effect, the 1:1 scale map is where you got lost in the first place. Therefore, a map needs to simplify what is found in the real world and present the information in an easily comprehensible way. We feel secure with a map since suddenly all the confusing details are gone and we recognize the underlying important features—we are able to look beyond the mass of trees and see the forest.

Besides the road maps, hiking maps, and tourist maps we all know, we are surrounded by many more maps, most of them in some degree on an unconscious level. Whenever we think in dualities, we have, in effect, drawn a crude map of reality. We have drawn a line which divides the world into two regions. Be that Yin–Yang, Black–White, Left–Right, Good–Evil, these concepts are really road signs which help us find our way in the sometimes confusing complexity of reality. Then there are the trinities, such as the holy trinity of the Christian churches

(Father, Son, and Holy Spirit). Next in complexity are the four-fold divisions (e. g., the compass rose), the four Greek humors (blood, phlegm, yellow bile, and black bile), among others.

The desire to find a "map of the world" is as old as humanity. Geographers and cartographers, fueled by this need, have produced ever more useful representations of the globe. However, even very early on, more spiritually inclined people interpreted the term "map of the world" to mean something entirely different. They thought of it as a representation of everything conceivable put into terms which can be understood by our limited minds. The "world" is the universe and all the material and immaterial things it harbors. This, incidentally, is the same spirit which propels modern-day physicists onward in the quest to discover their TOE (the acronym for "theory of everything"), the one equation which allows us to understand and calculate everything there is. Before the advent of modern physics, alchemists carried this very same torch. Their ultimate goal of understanding the true meaning, the essence, of the universe is epitomized in their search to turn everything into gold.

As homeopaths we are not too different from modern-day alchemists. Our quest is to find the essence of disease in our patients, to chart a map of their suffering and help them find a way out of it. Thinking in terms of a map in this context is a useful concept. In order to fold the universe up and turn it into a map, some ingenuity is required to identify the proper simplifications and analogues.

Different attempts at drawing such a map of the world have been made by different cultures at different times. There is, for example, the Indian Ayurvedic map, the North American Indian Medicine Wheel, the Chinese *I-Ging*, the planetary system of astrologers, and the western alchemical *Mappa Mundi*, which is Latin for map of the world. Common to them all is that they offer different ways of recognizing the common thread among seemingly disjoint things, thereby categorizing them into a small number of rubrics.

The map of the world, *Mappa Mundi*, having four categories, belongs in the family of four-fold maps, just like its brethren, the geographical maps (remember the compass rose signifying the four cardinal directions of two-dimensional space). The trick is to take a concept and divide it into four categories. Let us try a few examples. A year can be split into the four seasons: spring, summer, fall, and winter. The lifespan of a human can be divided into four eras: childhood, adolescence, maturity, and old age. I think you get the idea. One representation of *Mappa Mundi* is shown in Figure **15**. The cardinal axes are labeled to give you an impression of their respective qualities, the flavor each one carries. Between the cardinal axes are the four minor directions. Their qualities are derived from their respectively adjacent cardinal directions. It is a nice feature of *Mappa Mundi* that the minor axes coincide with the four human temperaments: sanguine, phlegmatic, melancholic, and choleric.

It is to a large degree thanks to Misha Norland that the connection between *Mappa Mundi* and homeopathy was made. In

his booklet *Mappa Mundi and the Dynamics of Change*, which appeared 2003 in the United Kingdom, he elaborates on the subject and shows in some detail how to use *Mappa Mundi* in a creative and constructive way as a homeopath. At this point, I will just give you a coarse outline of this topic and point you in the general direction. If you are interested in a more in-depth discussion, I suggest you purchase Misha's booklet, which may be bought online through www.minimum.com.

To apply *Mappa Mundi* to homeopathy, one needs to identify the common thread among seemingly different things and discover their common basis below the superficial level. It is easy when given a selection such as apple, grapes, oranges. Clearly the category fruit springs to mind as the uniting thread between all three objects. What about: heat, red, war, earth? This task is more difficult and requires some highly abstract thinking. Referring to Figure **15**, you will easily locate all four items in the southeast, the choleric, direction (remember, contrary to convention, north points downward in *Mappa Mundi*).

To cast *Mappa Mundi* onto our homeopathic materia medica it is an illustrative exercise to place each remedy on the compass rose. This is easiest when a remedy already epitomizes one axis of the map. Take, for example, *Lachesis.* Examining the symptoms of this remedy by looking through the rubrics in which it is listed, several thematic clusters stand out. One has to do with the color red as documented by numerous rubrics (see Table **2**).

Note that for such a well-known remedy as *Lachesis,* which is represented in over 9000 rubrics in my repertory, a single rubric

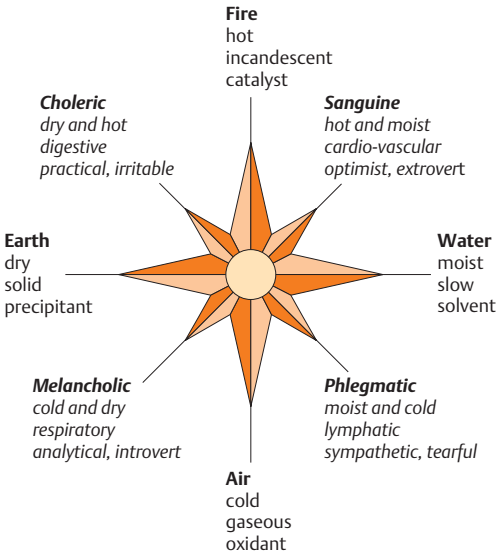



**Fig. 15** A representation of the *Mappa Mundi* used in alchemical tradition. By convention north points downward, which puts Earth east, Fire south, Water west, and Air in the north.

is not sufficient to establish a theme. You need to find confirmation and parallels in many parts of the body and in several different ways to pronounce it a theme. The fifteen rubrics I cited in Table **2** are by no means the only ones. In total there are 128 directly addressing the color red and *Lachesis*. Another theme has to do with heat (see Table **3**).

Further more, *Lachesis* is well known for its affinity to the cardiovascular system (I am going to leave it up to you to find characteristic rubrics this time). Their nature is generally flam-

Table **2** Selected symptoms of the remedy *Lachesis* addressing the color red

| Rubric listing | Rubric size |
|---|---|
| EYE; DISCOLORATION; redness | 262 |
| NOSE; DISCOLORATION; redness | 130 |
| FACE; DISCOLORATION; red | 360 |
| FACE; SWELLING; red | 23 |
| MOUTH; DISCOLORATION; redness | 192 |
| THROAT; DISCOLORATION; redness | 147 |
| ABDOMEN; DISCOLORATION; redness | 23 |
| URINE; COLOR; red | 179 |
| CHEST; DISCOLORATION; redness | 47 |
| CHEST; PERSPIRATION; axilla; red | 7 |
| EXTREMITIES; DISCOLORATION; redness | 178 |
| SKIN; DISCOLORATION; red | 178 |
| SKIN; ERUPTIONS; red | 92 |
| GENERALITIES; COMPLEXION; red hair | 5 |
| GENERALITIES; DISCOLORATION; redness; affected parts, of | 21 |

boyant, talkative, and quick-witted. This information shows how *Lachesis* falls squarely into the fire category of *Mappa Mundi*, the south. In a similar exercise you would find that the southwest has the quality of *Phosphorus,* the west looks like *Sepia,* followed in the northwest by *Pulsatilla*. I would place *Nux vomica* in the southeast, *Calcarea carbonica* due east, and *Arsenicum* in the northeast. I leave it as an exercise to you to find a remedy which matches the northern direction. By no means are the remedy choices written in stone. If you ask different people you might get different answers. It is important to find your own consistent interpretation of *Mappa Mundi* so that you understand it well, it agrees with you, and you know how to work with it.In homeopathy we want to use *Mappa Mundi* to chart a patient's disease

Table **3** Selected symptoms of the remedy *Lachesis* addressing heat

| Rubric listing | Rubric size |
|---|---|
| MIND; LOQUACITY; heat, with | 12 |
| HEAD; HEAT, general | 315 |
| EYE; HEAT; in | 119 |
| EAR; HEAT | 137 |
| NOSE; DISCHARGE; hot | 36 |
| FACE; HEAT | 299 |
| THROAT; HEAT | 128 |
| STOMACH; HEAT; flushes | 177 |
| ABDOMEN; HEAT | 178 |
| RECTUM; HEAT | 49 |
| STOOL; HOT | 33 |
| KIDNEYS; HEAT | 14 |
| URINE; BURNING, *hot* | 176 |
| FEMALE; HEAT | 56 |
| CHEST; HEAT | 163 |
| BACK; HEAT | 128 |
| EXTREMITIES; HEAT | 286 |
| PERSPIRATION; HOT | 67 |
| SKIN; HEAT; fever, without | 44 |
| GENERALITIES; HEAT; sensation of | 145 |

totality. The totality can be thought of as the thread which connects all the individual expressions and symptoms of a case on a single string, like a necklace. It must, therefore, wind itself through all levels of the patient's being and encompass all symptoms within itself. The process of analyzing a case is very abstract and requires that we trace out all the intricate connections which link otherwise disjoint symptoms. Thinking in analogies is what is needed here. This is precisely what *Mappa Mundi* encourages us to do. With its fourfold symmetry, we are forced to realize the

connection between, say, a tendency of bleeding, internal heat, and exuberance. All these fall plainly into the fire category at the top of *Mappa Mundi*. In this way the map forces us to think creatively and analogically.

*Mappa Mundi* gets us to think in analogies, which is a big help when we try to make out the underlying big picture of a case. When I study a remedy I try to think in analogies, too, and find the connecting thread along which all symptoms line up. *Lachesis* provided a simple example of how to place a remedy on the map. In most cases, however, you will find that the information does not cluster along a single point around *Mappa Mundi* but spans an axis.

Here is another example: *Bryonia.* First, let us identify the characteristic symptoms for *Bryonia*. You can later expand on this and chart other symptoms on the map. The following six clusters of symptoms, to me, belong to the core of *Bryonia.* Each cluster comprises many individual symptoms or rubrics, so we have already condensed the available information. Under the heading "immobility" I counted *Bryonia's* well-known aggravation from the least motion. "Dryness" subsumes the dryness of all mucous membranes, the dry cough, and dry skin eruptions as well as aggravation of most complaints in dry weather, and so on:

- dryness
- immobility
- business-minded
- money, fear of poverty

- drinks large quantities of water
- pleural and serous effusions

Turning to our representation of *Mappa Mundi*, we find the quality of dry associated with the east. The same direction also has to do with earth, materialism in the broader sense. We can place "money, fear of poverty" as well as "business-minded" on the same axis. Precipitation, also associated with the east, is the solidification of material that was formerly in solution, to make things so dense that they cannot remain dissolved anymore and fall down to earth. By this analogy, "immobility" also belongs there. The moist symptoms of *Bryonia,* i. e., "drinks large quantities of water" and "pleural and serous effusions" are easily identified with the watery west of *Mappa Mundi*. Hence, casting *Bryonia* on the map of the world gives us the picture shown in Figure **16**. What we learn from it is that *Bryonia* can be understood in terms of a disturbance along the map's east–west axis. I found it particularly interesting to realize how *Bryonia's* dislike for movement and aggravation from motion on the physical plane expresses as a mental dryness in the form of talking only about business and a preoccupation with money. As *Mappa Mundi* forces us to find a place for each symptom, I am frequently surprised by the sudden revelation of close relationships between unlikely companions.

Applying *Mappa Mundi* to a case works just the same. *Mappa Mundi* does not in itself point directly to the simillimum. Rather, the act of drawing up a map of the case is the catalyst which

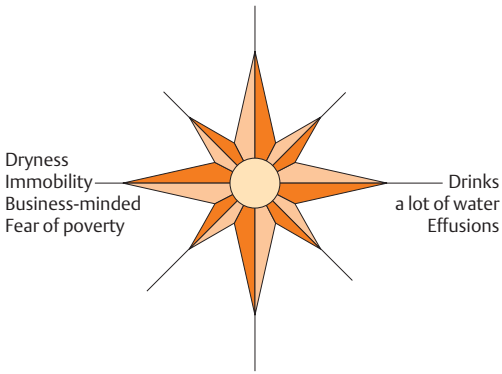



**Fig. 16** A chart of *Bryonia* on *Mappa Mundi*. It becomes clear how this remedy has a disturbance along the east–west axis.

exposes connections between different aspects of the case on a deeper plane. The central theme of a case will be found to repeat itself on many—if not all—levels of being. *Mappa Mundi* helps us realize the different expressions of the one central theme.

# 9 Invisible Ink

Constitution

Genus epidemicus

Homeopathic proving

Here is a little riddle. What is this: every country has one and a good homeopath can find a remedy for it. If it took you more than five seconds to come up with the answer "constitution" then you did not read the chapter summary at the top of the page. There are a lot of lawyers who spend their time studying and interpreting the constitution and how it applies to you as a citizen. Call it coincidence but, as homeopaths, there is a lot we need to know about the constitution and how we can use this knowledge to help our patients.

## Invisible Ink

It is time for a little experiment. What you will need first is some freshly squeezed lemon juice, a toothpick, and a sheet of paper. Now use the toothpick as a quill with the juice as ink and write or draw something on the paper. Of course, since the juice is almost colorless, it will only show up as a wet trace on the page. Do not worry. Think of it as a kind of secret message. When you are done, let the "ink" dry for half an hour or so and you will be left with

what, to the naked eye, looks like an empty page. I was about eight years old when I tried this the first time. You can easily imagine how this stimulated my fantasy and almost got me started on the career path of an international spy. By the way, if you have kids of the right age, by all means, let them participate in the experiment.

To make the page reveal its information, you need a source of heat. After experimenting with the open flame of a candle and almost setting my apartment on fire, I now full heartedly recommend a hot iron. Just be sure to turn the steam off before switching it on, though. Set the temperature as hot as it will go (usually the "linen" or "cotton" setting), wait until the selected temperature has been reached, and put it on the page. Leave it there for about 15 seconds, then check if your secret writing has already become visible. If not, let the iron sit on the paper for a couple of seconds longer before checking again. In any case, if it starts to smell and develops smoke, you know that you are past the point of recovery.

When you have done everything right, your secret writings will show as brownish letters on the page. Just in case your kids ask, here is the explanation: the citric acid in the lemon juice reacts with the paper in a way that renders it more easily flammable. When you heat the entire page up, those parts that were exposed to the acid turn brown at a slightly lower temperature than the rest of the page.

## Constitution

There are many references to constitution and constitutional prescribing in homeopathy. Some homeopaths ascribe a central role to the patient's constitution and use it as the foundation for their prescribing. A lot of interpretation has gone into this word, and Hahnemann's collected works have been searched forward and back for different contexts in which he used this term in the hope of understanding what he originally meant by *Konstitution*, which is German for—you guessed it—constitution.

You should, at some point, take up the *Organon* and read the paragraphs which deal with the concept of constitution. I recommend W.B. O'Reilly's edition (published 1996), because it includes a glossary and word index which will help you find the right pages quickly.

Basically, however, the concept is quite simple. At birth, we are all still relatively unaffected by social and educational influences, and what you see is essentially determined by genetics. The color of the hair, the shape and proportions of our various body parts, the color of our skin, all these are part of our genotype, which is fixed throughout our lives. These features can never be part of a disease in the sense that they cannot be cured. There is no cure for blond hair or a prominent nose (and I am not talking about dyeing your hair or having cosmetic surgery). Other properties, such as character and personality traits, temperature predilections, sleeping habits, etc., are also at least partially hereditary.

During a seminar, when I was apparently belaboring this point for a bit too long, a student interrupted me and said, "So basically what you are saying is that a cigarette vending machine will never be able to give me a Coke for my money." I must admit that this analogy caught me a bit off guard, but yes, in a sense this is what I am trying to say. "OK" you say, "this is not difficult to comprehend. What's the big fuss about constitution, anyway?"

It begins to get interesting when you remind yourself about how constitution relates to disease and symptoms of disease. What about the rubric "Complexion, red hair," which lists the remedies *Calcarea phosphorica, Lachesis, Phosphorus, Sepia,* and *Sulphur?* Are we to assume that these five remedies can cure red hair? And if red hair is not considered a disease symptom, why should we pay any attention to it in the first place? There are other symptoms such as preference of certain foods and temperature predilections. Some homeopaths have tried to identify color preferences with remedies (Welte 2003).

Apparently, we now have two groups of symptoms: those which are classical disease symptoms (e. g., "Headache alternating with abdominal complaints") and those which are not part of a disease. The latter group have also been called constitutional symptoms for they are more indicative of the healthy constitution. In our repertories we find both groups of symptoms next to each other with no distinction made. The homeopathic community is of divided opinion as to whether constitutional symptoms (i. e., those that describe the healthy state of the patient) are to be used together with disease symptoms, separately, as part of a

purely constitutional prescribing, or not at all. Some say that a purely constitutional prescription has no curative effect in itself but strengthens the general health and improves the immune response of the patient (c.f. A Well-Guarded House, in particular the section on homeoprophylaxis). How do we reconcile these views?

To gain a deeper insight into the concept of constitution let us turn to our initial kitchen experiment. We started with an unadulterated, blank sheet of paper, which we can associate with an ideal and perfect state of health. Next, we put some lemon juice on it, which had the effect of weakening the paper's resistance to high temperature. Although the page looked the same after the invisible writing, it was not the same anymore. The areas exposed to the citric acid had become less resistant to heat and therefore turned brown first when exposed to the hot iron. By now, I think you can already see in which direction I want to take the analogy. At the time of our birth we are already unique individuals. This uniqueness shows in externally visible features, such as the color of our hair, but it also gives us our personal strengths and weaknesses on a physical level. Of course, our family situation and lifestyle along with all accumulated events since our birth modify the original starting conditions. Still, we are born with a specific constitution which predetermines, to a certain degree, our future development. Therefore, even at birth, we are not like a virgin sheet of paper. We carry the writings of our constitution, which predisposes us to certain illnesses and not to others. The particular weak points, those areas of the page exposed

to the acid, become visible under external stress, advanced age, or an unhealthy life style. If you like, you can think of the hot iron as the sum total of all these factors.

Centuries of observation and experience have shown that a connection exists between outwardly visible features, the physiognomy, and the general constitution in a homeopathic sense. This is why Hahnemann tells us in § 5 of the *Organon*:

> *. . . In these investigations the physician should take into account the patient's:*
>
> 1. *discernible body constitution (especially in cases of protracted disease),*
> 2. *mental and emotional character,*
> 3. *occupations,*
> 4. *lifestyle and habits,*
> 5. *civic and domestic relationships,*
> 6. *age,*
> 7. *sexual functions, etc.*

We know that Hahnemann was familiar with the Hippocratic constitutional classification. Terms such as scrofulous, lymphatic, venous, nervous, and rheumatic constitution derive from the ancient Greek medical system, which still had a large influence on the medical sciences in the nineteenth century. You will find many rubrics in the repertory which address this. Here are a few examples:

1. MIND; TEMPERAMENT; choleric; bilious, dark hair and complexion, with firm fiber

2. GENERALITIES; COMPLEXION; fair, blonde, light; lax fiber, with
3. FEMALE; LEUCORRHEA; general; women; scrofulous
4. FEMALE; METRORRHAGIA; general; women; obesity, inclined to, with lax muscles and skin
5. GENERALITIES; COMPLEXION; dark eyes and fair, blonde hair
6. MIND; HYPOCHONDRIASIS; sanguine, lymphatic
7. MIND; TEMPERAMENT; sanguine
8. GENERALITIES; HYDROGENOID constitution
9. GENERALITIES; CONSTITUTION; carbo-nitrogenous
10. GENERALITIES; CONSTITUTION; dyscratic
11. GENERALITIES; CONSTITUTION; neuropathic
12. GENERALITIES; CONSTITUTION; oxygenoid

Unfortunately, these terms are no longer part of our medical language or homeopathic education. Therefore, few homeopaths really know how to use these rubrics correctly. A good resource to look up old and out-of-use medical terms to which I have turned many times is Jay Yasgur's *Homeopathic Dictionary* (Yasgur 1998).

In every patient, each symptom we observe can be classified as to how characteristic it is of the healthy patient and how much it describes the manifest disease (Fig. **17**).

A symptom that is specific to the patient and has no element of the patient's disease is of comparatively little value in finding the simillimum for the sick patient. Into this category fall the con-

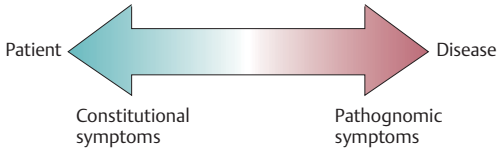



**Fig. 17** Symptoms we observe in the patient can be classified according to the extent to which they belong to the healthy patient (constitutional symptoms) and the extent to which they describe the disease (pathognomic symptoms). The symptoms most useful to the homeopath are the ones which express the disease in a way that is characteristic of the patient. They fall in the middle range of the spectrum.

stitutional symptoms that describe the healthy patient's constitution (e. g., red hair). This is what Hahnemann expresses in § 6:

> *The unprejudiced observer . . . perceives nothing in each single case of disease other than the alterations in the condition of the body and soul . . . That is, the unprejudiced observer only perceives the deviations from the former healthy state of the now sick patient . . .*

On the other hand, any observations specific to the disease which tell us nothing about the patient are also of limited use. These disease-only symptoms are called pathognomic symptoms and are those in which a conventional medical doctor would be most interested. Diarrhea in Crohn disease, cough in pneumonia, patches of dry skin in neurodermatitis are examples of pathognomic symptoms. They are the ones that most patients of a particular disease have in common, with consequently little value in differentiating between each individual patient.

It would be wrong to discard constitutional and pathognomic symptoms altogether, however. We already know that the healthy constitution can be a pointer to a particular predisposition for a broad range of diseases. As such, the constitution describes the terrain upon which diseases grow. If you find yourself in the desert, do not bother searching for buttercups. It is under this heading that we identify a stout woman who gets hot easily, has red cheeks, is loquacious and hectic as having a sycotic constitution. Miasms are nothing more than a broad classification of constitutions and their associated weaknesses (see also the chapter A Map of Disease). A psoric individual will develop psoric diseases and not syphilitic ones.

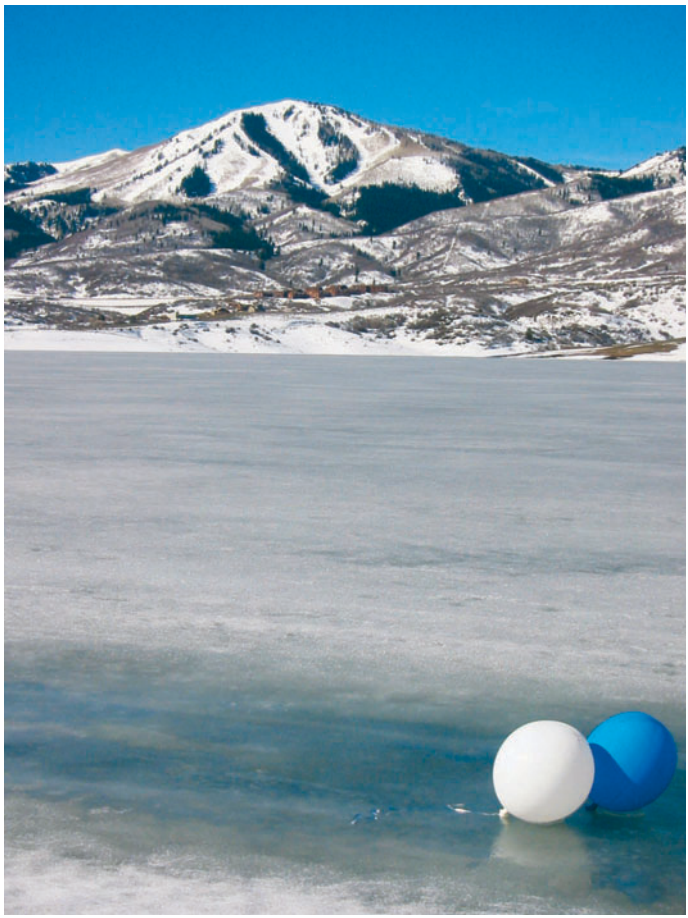
On the other hand, pathognomic symptoms have some value in finding a remedy which has a matching affinity for that particular organ or disease. This can be particularly useful in identifying small, little used remedies for which we only have some clinical information and no proving data. Take, for example, *Ornithogalum umbellatum,* which is known for its value in gastric and abdominal cancer—hence its presence in the clinical rubric "Stomach; cancer." As is the case with constitutional symptoms, it is a dangerous practice to settle a case with too much emphasis on pathognomic symptoms.

The place to look for gold nuggets is smack in the middle between constitutional and pathognomic symptoms. This is the interface where patient and disease meet with equal strength. Here we find characteristic symptoms of the disease which, at the same time, bear the unique stamp of the patient's individual con-

stitution. It is this middle ground where strange, rare, and peculiar symptoms live. Cast in the language of our "invisible ink" metaphor, focusing solely on constitutional symptoms corresponds to looking only at the white parts of the paper. It is equally unrewarding to examine exclusively those parts which have ink on them, since the shape of a line and letter lies in the shape of the boundary between ink and paper. It is the contrast between ink and paper that makes the writing visible.

## The Frozen Lake

Let us expand our understanding of constitution a bit. To this end I would like to introduce a metaphor which I suggest you not turn into an experiment. Imagine a beautiful, crisp and clear winter day. You have arrived on the shore of a frozen lake just like the one shown in the photo on the next page. You have already put on your skates and are about to step on the ice. Immediately, one question passes through your mind: is the ice thick enough to support my weight? A critical look across the lake only shows you the flat and more or less uniform surface. It does not give you any indication of how thick the ice is at every spot. Let us say you take heart and step out onto the frozen surface and—lo and behold—it does not crack. You take some long strides and leave the shore behind, heading for the center of the lake. What about the thickness of the ice there? Is it safe to assume that it will be sufficiently thick across the entire lake to support your weight?



The frozen lake is the patient's constitution. What is visible is only a layer of ice with no way to gauge its thickness. The only way to find out where the weak spots are is to put some weight on them until the ice breaks (hopefully, this weight is not going to

be you, though). Translating the metaphor into homeopathic terms, disease symptoms develop first in those areas where the constitution is weak and the metaphorical ice starts to crack under the sum of external stresses.

Clearly, there are two factors which determine our fate as metaphorical skaters: how strong the ice is and our weight. Similarly, disease is the product of personal constitution and external disease factors. Germs alone do not make one sick, as can be observed each flu season: not everyone comes down with the flu even though the virus is almost ubiquitous. At some point, however, the external stress can become so overwhelming that the ice will break even at its strongest spot. When this happens, we are confronted with an epidemic. The external influences are so overpowering that virtually no constitution can withstand them. The ice breaks, no matter what. When the weight is sufficiently heavy, the point at which the ice breaks is not an indication of the weak spots; it shows only where the weight first hit the ice.

Hahnemann tells us that during an epidemic one remedy will emerge which has the power to cure most cases as well as prove an effective prophylactic against it. He calls this remedy the *Genus epidemicus*, the specific remedy for this epidemic (in the chapter A Well-Guarded House you can read more on the topic of epidemics and *Genus epidemicus*). To find it, we have to pool the cases of many individual patients, combine their symptoms, and treat them as if they were one single case. In so doing, the individual characteristic of each single patient recedes in the resulting picture. What emerges is the individuality of the epidemic

instead. Through pooling the symptoms of several patients we trace out the features of the disease. Referring to our wintry metaphor, we are concentrating on the weight and not the ice. The justification to do this lies in the fact that no matter how strong the ice, the weight will always break through. Therefore, what matters is the weight and not so much the ice.

## A Homeopathic Proving

There is another topic where the weight matters more than the ice: the proving of a homeopathic remedy. In essence, there is no difference between the outbreak of an epidemic and a remedy proving. In both cases you have a sufficiently large number of individuals, in both cases you take their separate cases, and in either instance you combine the individual information and treat it as if it were one single patient. With an epidemic you are "proving" a disease with the goal of identifying the *Genus epidemicus*. When you do a homeopathic remedy proving you are subjecting the provers to the influence of a remedy and provoking a kind of artificial disease, whose image is recorded as the drug picture.

During an epidemic (as well as for a proving) you need a certain minimum number of cases to analyze. It is impossible that a single patient (or prover) has the capacity to express a sufficiently clear rendition of the epidemic (or remedy). The reason for this, again, has to do with the individual constitution.

In a very general sense, the constitution is our interface with the outside world; it is the window through which we perceive reality. In homeopathic terms this means that a homeopathic proving will produce symptoms in each prover, preferably in those areas which are most susceptible to disease influences. Someone who has a weak digestive tract will exhibit symptoms in this area first. Someone who has a constitutional weakness of the joints will produce most complaints there. Each individual's constitution is therefore a window through which we can catch a partial glimpse of the remedy.

Well-done, thorough remedy provings involve a lot of time and work with no immediate pecuniary return. The proving supervisor first has to find a number of reliable provers who are willing and able to subject themselves to a potentially uncomfortable process during which they have to keep a detailed written account of every notable sensation—mental and physical. Then he has to take the case of each prover in full detail for reasons already explained. After having taken the remedy, the supervisor keeps in touch with each prover to assess the onset of symptoms and coach each proving member. After the proving period he or she has to collect the individual journals, and this is where the tedious part begins: collating, organizing, and evaluating all symptoms, followed by publication of the result. For the reader who wants to learn more about the methodology of homeopathic provings I recommend Jeremy Sherr's book *The Dynamics and Methodology of Homeopathic Provings* (Sherr 1994).

Do you know the story of the blind men and the elephant? One day, four blind men were slowly making their way down a street when the they encountered an unexpected obstacle: an elephant. After the initial surprise, they cautiously started to explore it. The first one felt the hairy tail and exclaimed: "It's a horse!" The second one had his fingers on the soft tip of the elephant's trunk and mistook it for the nostrils of a camel. The third one, upon feeling the smooth, hard surface of the tusks proclaimed it the king's carriage. After hearing this, the fourth blind man became quiet for a moment and then started to laugh: "Oh, I get it! It must be an elephant!"

This parable is the process of a remedy proving. You might say that the three blind men performed a proving of an elephant with the fourth being the proving supervisor. Each prover perceives only that part of the remedy's gestalt accessible to him or her through his or her personal constitution. Only by using all impressions collectively can we gain an idea what the remedy totality might look like. The first step in a remedy proving therefore consists of thoroughly taking the case of each prover. This gives us a clear image of each participant's constitution, which is important for two reasons. First, it gives us a means to distinguish between old symptoms and proving symptoms; only the latter are part of the remedy totality. Second, the constitution gives us some idea in which area the prover is most likely to exhibit remedy symptoms, namely the constitutionally weak areas.

# 10 The Sunflower

Remedy process and evolution

Stages of a disease

Essence of a remedy

## The Experiment

I would like to head off this chapter with its metaphor. It is up to you how to structure this; you can either set aside some time for

the experiment first and read the chapter afterward or do it the other way around. Alternatively, you may want to skip the experimental part altogether, turning it into a meditation. If you have kids of the right age it might even be fun to stretch this out into a kind of botanical project and get them involved in it.

Get some sunflower seeds from your local garden nursery. The seeds available in grocery or pet food stores are frequently processed and will not do. Next we are going to germinate some of the seeds. To do this you will need a plate, a couple of paper towels, and a spray bottle filled with water. Put four layers of paper towel on the plate and spray water on it until it becomes damp. Next, spread about 20–30 seeds across the towel. Put another four layers of paper towel on top of the seeds and moisten them thoroughly. Be sure not to soak the towels too much or the seeds might turn bad and become moldy. Let them sit undisturbed at room temperature. You need to spray the top layer of paper towels with water every day to keep them moist. Every couple of days you should take a look at the seeds and check to see if they have already developed little sprouts. This usually takes anything from one to two weeks. Do not be disappointed if not all seeds start to sprout. It is normal that some may take longer or be already dead. If you wish, you can plant the seeds by putting them about half a centimeter (a quarter inch) deep in potting soil, watering them thoroughly. Given plenty of light, sufficient water, and some time you can grow your own sunflower patch. Alternatively, you may also go to a florist's shop and buy a couple of mature sunflowers. Maybe you can even find a stalk

with a still unopened bud and watch it come into full bloom at home. Incidentally, if sunflowers do not appeal to you, or are otherwise hard to come by, you may safely substitute beans, peas, or watercress.

Either way, in the end I would like you to put some ungerminated seeds, a couple of sprouts (preferably in different stages of maturity), and a mature flower in front of you. Examine each one closely (have you ever looked inside a seed with a magnifying glass?). Do you see any similarities between the different stages? Can you recognize the blooming sunflower in the tiny sprouts? Which parts of the previous stage develop into which parts of the successive stage? You might need to interpolate between the stages from memory in order to see the entire growth before your mind's eye. What happens after the fully abloom flowering stage? Can you complete the circle in your mind?

Be sure to have pen and paper ready to make some quick sketches or note any ideas or observations you come across in the process.

## The Process of a Remedy

You have to admit that a sunflower goes through some pretty drastic changes over the course of its life cycle. A sunflower seed looks nothing like the blooming flower, yet it contains its potential. Given the right conditions and some time, the whole process is set into motion, and the seed begins to germinate. Even though

everything seems predetermined, i. e., a sunflower seed will never give rise to a rose, there is also room for individual adaptation. Depending on the soil conditions, the size of the plant varies, and the lighting conditions influence the particular shade of green and yellow.

When we study one of the well-known polychrest remedies we are usually presented with an image rich in detail. To every student of homeopathy past the first year, *Pulsatilla* will conjure up a very specific gestalt. In this example it would most likely be a blond female, talkative and easily moved to tears, of yielding disposition, looking for a strong shoulder and comfort. On the physical side you would start to think, among other things, of thick yellow discharges and a rather warm constitution which is better outside in cool, fresh air. This is like the picture of a mature sunflower: distinctive and easy to recognize. But there are many more symptoms which seem to support an entirely different picture. We encounter *Pulsatilla* also as an easily angered and irascible person, taciturn, who shuns cold air and the outdoors. To almost every modality we find its opposite. Is it, then, not arbitrary which picture we extract and proclaim as "typical *Pulsatilla*"?

Here is where our metaphor can help us understand the situation better. Just as every plant undergoes a process of maturation which changes every aspect of its appearance profoundly, a disease is a process which follows a similar path. Since our remedies are linked to diseases through degrees of similarity, by analogy the same must hold true for homeopathic remedies. In the repertory we find mixed together symptoms taken from all dif-

ferent stages of the remedy (or, indeed, disease) process. Considering how little a sunflower sprout resembles the mature flower, we should expect to find a lot of inhomogeneity within the collection of symptoms of any given remedy. I remember when I was beginning to study materia medica and was confused by the sometimes contradictory nature of symptoms belonging to one and the same remedy. How can *Pulsatilla* at the same time prefer cool surroundings and warm places? Does this mean "anything goes"?

Take three photographs of the same person, one as a preschool girl, one as a teenager, one as mature woman, cut them into little pieces and throw them all on one pile. Would it not be somewhat challenging to assemble them into one seamless photograph of a single person? For a start, you will wind up with three different noses! Are you going to pick the biggest one and sweep the other two under the rug, pretending they do not exist? This is, though, what seems to happen to students of homeopathy a lot. In order to arrive at an easy-to-remember and vivid image of the remedy, certain symptoms are selectively ignored and the remainder arranged into a neat picture. What the sunflower tells us is that the same thing can assume very different shapes over time while still remaining true to its identity.

When I study a remedy, I want to learn its life story; not just one interesting little episode but the whole spiel. I gather all the symptoms together and then look for features that help me identify pieces of the story. If you have ever tried to assemble a puzzle, this is a similar process. You start with the distinctive features

like a corner piece or something that is easily identified in the final picture. A piece showing nondescript blue sky would not be a good starting point. To show you what I mean, let us do an example together. We are going to examine homeopathic *Zincum* and see if there is a process hidden in the symptoms of this remedy. I am using the *Complete Repertory* to look for rubrics of *Zincum* which carry a clear meaning and are highly specific for this remedy. Mostly, these are small rubrics containing less then ten remedies or else featuring *Zincum* as the lone star in the third degree. You need to be a good detective and snoop when you are doing this. Keep asking questions and do not be satisfied too quickly.

First I notice that *Zincum* is a remedy which suffers from deep-seated fear. Rubrics like "Attempts to escape and is restrained with difficulty" or "Life-long fear" speak clearly of this. The question which arises immediately is: what is it that *Zincum* is afraid of? We get a hint from "Fear of persecution" and "Fear of being arrested" but here is an even better rubric which paints a vivid image: "Imagines she is called before court on account of wicked actions during her climacteric period." An even more intense expression is "Dreams of being smeared with excrements." Clearly, this is not the mental make up of a professional criminal but of someone who is deeply troubled and guilt-ridden. Now they are coming after him and he is afraid of being caught and put in jail. The fear of being persecuted is a common sentiment in metals: *Cuprum* is the persecuted general, *Plumbum* is the statesman afraid of assassination, *Niccolum* is afraid of the

police and comes closest to *Zincum*, and *Mercurius* is basically convinced that everyone is his enemy.

Now, let us see how *Zincum* reacts to the fear. We already get an idea from the rubric "Attempts to escape and is restrained with difficulty": apparently *Zincum* is not someone to hide under the covers but rather to jump up and run away. "Fear is driving him from place to place" is a rubric elaborating on the restlessness of this remedy.

Someone who has committed a crime and is consequently afraid of being caught has to be on constant alert. Every noise could signal approaching authorities and pending apprehension. *Zincum* is listed under "Oversensitive to voices, piano music, and crackling paper" but also under the more general rubric "Oversensitive to sensory impressions." No wonder; he gets very jumpy from being constantly on edge. This jumpiness is expressed in the well-known twitching and restless legs of this remedy. There are countless rubrics affirming to that but the most telling is "Jerking of lower limbs when a stranger enters the room," with *Zincum* as the only remedy listed.

Nobody can remain under such high emotional stress for long before he breaks down. The question is, what specifically is the *Zincum* way of breaking down? In search of the answer we stumble across several rubrics of anger and irascibility such as "Tendency to irascibility to voices of people." But *Zincum* is not usually a person easily angered. His angry mood vacillates and alternates quickly with timidity, sadness, and discouragement.

"Cowardice alternating with irritability" speaks of someone who is not normally an outwardly angry person.

Beyond this stage of anger and aggression everything turns numb. This is a sensory and emotional shut down, a complete introversion. "Closing eyes ameliorates," "Presentiment of death, thinks of death calmly," "Dullness, sluggishness, difficulty thinking and comprehending," "Unconsciousness and coma after suppression of eruptions." This last rubric has the interesting addition of ". . . after suppression of eruptions." When I search for rubrics for *Zincum* including the word "suppression" I find 43 hits in the *Complete Repertory*. Pretty much every aspect of disease worsens in *Zincum* whenever some eruption or outflow of bodily fluid is suppressed. Here are some choice examples: "Aggravation of mental symptoms from suppressed eruptions or hemorrhoids," "Vertigo after suppressed menses," "Complaints in extremities from suppressed foot sweat."

We now have a pretty good idea of *Zincum's* allegorical story. He is someone who has committed a crime for which he feels very guilty, almost like a social outcast. Hiding from prosecution he lives his life in constant fear, startling easily at strange noises. All his senses are tuned to warn him of approaching pursuers. He becomes very restless and cannot keep still. Eventually the emotional stress wears him down and he suffers from attacks of anger and violence, even toward people who do not wish him any harm. In between those attacks he likes company and feels better talking to people he knows and trusts. The final stage, however, is one of autism and emotional shut down.

We have so far relied primarily on rubrics from the Mind chapter, simply because their language is most easily woven into the thread of a story. However, if our story is to have any validity at all, it needs to be told by physical symptoms also. In order to discover it there, you need to be able to read the language of the body and think laterally, in analogies. The twitching and jerking extremities were easy to incorporate since they speak clearly of restlessness and a suppressed desire to run away. What about the theme of general aggravation from suppressed eruptions? An eruption is an external manifestation of an internal disorder. Our skin is the boundary between ourselves and the external world. A suppressed eruption at this level corresponds to a severed link between the inside and the outside. When we identified autism, shut down, and introversion as the key features of the final stage, the disappearance of eruptions, the suppression of sweat or menstrual flow are physical manifestations of this; being left to steep in one's own juice, while receding more and more from reality. But we find more pointers in physical rubrics: "Agglutinated eyes," "Opacity of lens," "Loss of hearing," "Diminished smell" speak of introversion and shutting out. I will leave it to you to allocate more physical rubrics to the various stages of *Zincum.*

In this exercise we have sifted through the heap of individual pieces of the puzzle and assembled them not only into one picture but rather an allegorical story. We have incorporated mental, physical, and general symptoms into this story and found that they all tell the same tale. Gastric symptoms, symptoms of the extremities; they all speak of the same theme even though their

language is much more restricted and difficult to interpret than expressions of the mind.

There is a nagging question that I can feel is bugging you at this point: "Is this the real story of *Zincum* and how does it relate to a patient needing *Zincum* as a remedy?" Some eminent homeopaths would shun anybody who puts an invented story into the mouth of a remedy. They argue that each symptom is an individual phenomenon that has to be accepted as fact, and anything beyond that is idle speculation. They are afraid that homeopathy could deteriorate to a daydreaming, speculative, esoteric discipline if thinking along the lines of allegorical stories is encouraged. I respect their opinion and would never force my understanding of *Zincum* down anyone's throat. But whenever I see a patient who tells me her story and I make notes and take down symptoms, those symptoms are clearly all connected. They are all part of this patient's life. Understanding them all in one context, to me, is the very essence of the meaning of the word "holistic." Homeopathy is a holistic therapy. What holds true for each patient must by the correspondence demanded by the law of similars also be true for the remedies we prescribe. I cannot accept the notion of a remedy as an arbitrary collection of symptoms and at the same connect it to the coherent story of my patient using the law of similars. I am deeply convinced that each remedy has its own story to tell and, ultimately, we are matching a remedy to a patient by identifying similarities of the two stories. Whether the above story I proposed for *Zincum* is the true and complete one is a moot point to argue. It is my personal

understanding for which I do not claim ultimate truth. It is, however, useful in practice and has helped me to prescribe *Zincum* successfully in cases where I would otherwise have over-repertorized the case and gotten nowhere.

One cautionary remark is in order: do not take the story literally. Someone who needs *Zincum* does not have to have committed a crime, he does not have to feel guilty and does not have to suffer from autism. You have to remember that the story itself is an allegory, a dramatization of an archetypical conflict. The patient behaves "as if" his life corresponded to the remedy's story. You will rarely find a correspondence of themes on the level of literal every day reality.

## Timelines

Hahnemann, ever on the search to improve his new found therapy, realized that homeopathy the way he had been practicing it for years was very successful in treating some diseases. In the majority of problems, however, he failed miserably. In these cases, his patients, although initially getting better, soon relapsed until remedies did not seem to affect them at all anymore. A lesser mind than Hahnemann might have thrown up their hands in frustration and admitted defeat. Hahnemann, however, hunkered down and started looking for an explanation. In his search for a clue, he started to expand the scope of his patient interviews and explored not just their present condition but also their past

history back into their childhood and beyond, their family history. Hahnemann found evidence of past diseases which he classified into three groups: an itchy affection of the skin, warts and venereal discharges resulting from a prior infection with gonorrhea, and syphilis. These three classes of diseases he postulated as the main roots of chronic diseases and referred to them as the three miasms (you can read more about miasms in the chapter A Map of Disease).

Hahnemann's theory of miasms formed the basis of his treatment of chronic diseases. He was able to apply homeopathy successfully in cases where before he could not. Today, Hahnemann's miasms are all but vanished from daily homeopathic practice. We still all learn about them but do not know how to apply them. Even so, modern homeopathy does seem to be doing quite OK treating chronic diseases. Apparently, knowing about miasms is not an essential prerequisite. Yet, why was Hahnemann able to treat chronic diseases only after he discovered miasms? This apparent paradox has been nagging in the back of my mind for some time. I discovered its resolution when preparing a lecture on timelines.

Before Hahnemann distinguished between acute and chronic diseases he focused on the presenting disease picture in his patients, recording everything observable here and now. In essence, this was a snap shot of the patient's current situation. Once faced with the realization that only acute diseases were amenable to this approach, Hahnemann expanded his focus and explored the past. Now he also wanted to know about his

patients' previous life stories. Instead of limiting information only to a snapshot he now recorded the important stages of the patient's life. In so doing he discovered that the origin of chronic disease often lies buried many years into the past and goes unnoticed unless one looks for it. This is a big difference to its acute counterpart, which has a limited temporal scope and can be treated without reference to the patient's past.

Time and again I have seen that only after establishing a clear timeline of the disease process did the features emerge which permitted me to prescribe a well-fitting remedy. Therefore, after I have a clear image of the main complaint, I direct my questions to the time the complaint started and begin to explore the life circumstances around this time. Particularly in babies and young children the timeline sometimes extends beyond the time of birth and includes one of the parents, most often the mother. As an example I remember the case of a five-year-old boy with a behavioral disorder. Exploring his timeline I discovered a traumatic experience in his mother's life about nine months before he was born. The mother managed to get over the situation but her child apparently did not. Questioning the mother about her emotional reaction to this event led me to the right remedy for the boy. The mother, incidentally, required a different remedy, not linked to this incident.

When we explore back along the timeline we have the chance to see the true, unadulterated reactions of the patient. Over time, people find ways to compensate for their idiosyncrasies which do not fall into the socially accepted range of normal

behavior. Even though their particular strategy of compensation can be revealing and give us an important clue for the simillimum, I prefer to get a clear view behind the mask, if at all possible.

When we analyze a case we have a choice about the level at which we apply the law of similars. We may limit ourselves to the first dimension and focus on the chief complaint, consciously ignoring symptoms belonging to other spheres. We are doing this when we make routine prescriptions like *Arnica* for a sprained ankle. As a matter of fact, we may not have a choice in a case presenting a paucity of symptoms, something which Hahnemann called a "one-sided disease." In most acute diseases, on the other hand, we take the totality of presenting symptoms into account in addition to the ones belonging only to the chief complaint. Actually, we need to be careful not to include symptoms belonging to the underlying chronic background in our acute analysis. The resulting remedy choice will affect the currently presenting symptoms but leave the chronic background untouched. Finally, chronic cases require us to establish the full three-dimensional disease gestalt. We are thereby applying the law of similars at a much more profound level than before and may correspondingly expect profound results in return. If we find a remedy at this most profound level which is a true simillimum to the case, it will have the power to cure flare ups of acute diseases as well.

Hahnemann, as a result of his research on how to adapt homeopathy to cure chronic diseases, found the miasms. Homeopathy's success in this area is generally attributed to the mias-

matic theory of chronic diseases. In my opinion the more important part in this context was that he expanded the scope of the disease gestalt to include a temporal dimension going far into the past. The law of similars now has to be applied to a three-dimensional disease entity which involves the main complaint as its first dimension, the entire living organism in the present state as its second, and the temporal dimension as its third.

# 11 The Iceberg

**Giving more than one remedy at a time: polypharmacy**

**At which level do we apply the law of similars?**

When listening to the tinkling sound of ice cubes floating in a beverage, who would think that it was just a larger version of the same stuff that claimed the Titanic? It is common knowledge that ice floats on water, with only one eleventh of its volume showing above the surface. The other ten elevenths are hidden below, invisible to the searching seaman's eye. If you have a penchant for little kitchen experiments, here is one for you. Get a small con-

tainer like an old ink bottle or small flask. One with a wide body and narrow neck works best. Fill it up to the brim with water and put it in the freezer. Do not screw it shut or put a lid on, though, or the ice will burst the bottle. Wait until all the water is frozen solid, which will, depending on the size of the bottle, take about twelve hours. When you take it out the next day, you will see the ice protruding well above the opening of the bottle, thus proving that, upon freezing, water expands. If your curiosity spurs you even further you can cut off the protruding part, let it melt, and measure its volume. It will turn out to be a bit less than 10% of the entire bottle. This is the amount by which ice expands upon freezing and, at the same time, the fraction of an iceberg's volume protruding above the surface.

If you cannot spare the space in the freezer—or are not so scientifically inclined—just pour yourself a glass of lemonade and throw in some ice cubes. You still get a good feeling for how much is above and below the water line by simply getting your nose up close and observing.

## Polypharmacy

If you want to offend a homeopath, accuse him or her of using polypharmacy, the practice of administering more than one remedy at the same time. In the chapter Cutting the Wire we discussed the definition of homeopathy and evaluated the merits of several proposed fundamental homeopathic tenets. We found

that the use of more than one remedy is at odds with the holistic interpretation of homeopathy and the law of similars. If you wish, you can leave it at that. If you stay in homeopathy long enough, however, you will come across polypharmacy sooner or later and may even be tempted to succumb to the practice yourself: "Can't make up your mind between two remedies? Why decide, give them both!" Conventional medicine uses this practice excessively. The majority of patients with a serious disease are on a veritable barrage of different drugs, each in itself comprising more than one active ingredient. The various—and seldom beneficial—interactions among them are the cause of much harm. In conventional medicine, which does not subscribe to a holistic view, it is permissible to aim at each symptom with a different gun, since they are not understood as a single disease entity.

Let us return to our iceberg, still afloat in the wide and bottomless ocean. Sometimes the shape of particularly large icebergs gives them the appearance of several smaller, unconnected chunks of ice, as shown schematically in Figure **18**.

Imagine yourself on a boat riding the icy waters in close proximity to the iceberg depicted in Figure **18**. You would see three individual peaks above the surface with no hint of their connection under water. Suppose you were on a hypothetical trip to demolish all icebergs. You would aim three guns, one at each peak. What do you think will happen after firing them? Sure, the three little peaks will be gone, thanks to the firepower of your guns. The big iceberg will rise up a bit and rotate some until it settles into a new equilibrium. When that has happened, there

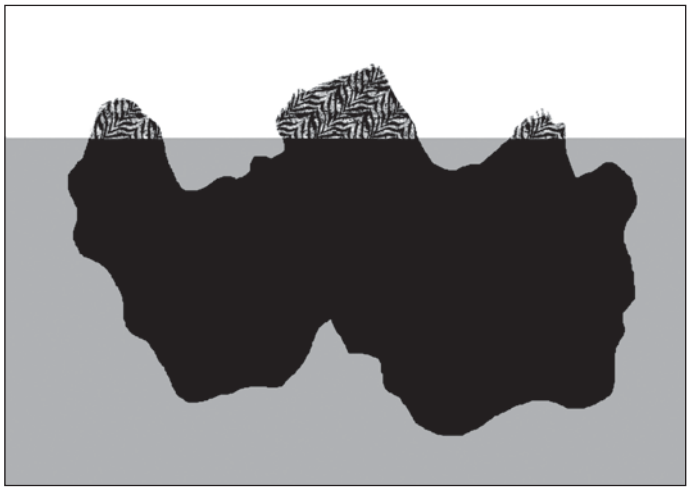


**Fig. 18** Large icebergs may sometimes appear as several smaller, unconnected chunks when viewed from above the surface.

will be different parts of it showing above the surface. Whenever you think you have finally blown the iceberg to smithereens, a new one will rise up. Although this sounds like a pretty mindless strategy, it is nonetheless practiced all too frequently. The patient never gets well and keeps returning to the doctor's office with ever new and changing problems.

Polypharmacy denies the indivisible unity of the patient. In this, it is similar to conventional medicine. A patient suffering from hypertension, chronic heart burn, and panic attacks is treated for each of these conditions separately, as if they were not combined in one body and, indeed, were not three expressions of a single disturbance of the patient's vital force. It is quite common

that such patients are prescribed a beta blocker and possibly a diuretic against the elevated blood pressure, an antacid to relieve their heart burn, and an antidepressant or sedative for the panic attacks. Fundamentally, there is no difference between prescribing several allopathic medicines or homeopathic remedies. Both times the patient is subdivided into three independent diseases, each combated with a different drug.

Classical homeopaths have an entirely different view of disease. They see disease as a state of being. A patient is in a particular disease state. It is inconceivable that, for example, the guts, the right toe, and the head, each being part of the same person, could possibly maintain independent states of being. Neither part of the organism is capable of maintaining life separately and on its own. It is an integral, connected part of the whole and subordinate to the organizing influence of the vital force. What is easy to see in the case of an iceberg is just as true when it comes to treating people. We have already discussed the justification of only giving a single remedy as an inescapable consequence of the law of similars in the chapter The Lemon and the Dolphin. There, we argued that any single entity can only be in one state at one time. You may feel compelled to interject that an elevated blood pressure and heart burn should be seen as two states since they also appear separately in other individuals and do not seem to depend on each other. If they are present in one person, however, they cannot be seen as separate and independent. Neither the stomach nor the cardiovascular system are independent organisms. A patient suffering from hypertension and heart burn is therefore

in a single disease state which encompasses those two systems as well as everything else. Homeopathy requires us to match the disease state to the state invoked by that particular drug which comes closest to the disease state. Thus, we are matching one state against another one, the result of which can only be the administration of one—and only one—remedy.

Once we have internalized this fact, it becomes apparent that homeopathy is not merely the continuation of conventional medicine by substituting homeopathic remedies for allopathic ones. The important difference is somewhere else entirely. It lies in the acceptance of disease as a state of being versus approaching it with the mindset of a mechanic attempting to repair a broken car. A car comprises individually viable and independent pieces of machinery; a state of being does not.

On a historic sideline, it is interesting to note that polypharmacy is as old as homeopathy itself. Contemporaries of Hahnemann—the German doctor Karl Julius Aegidi (1795–1874) is commonly attributed to have been the first—started to make use of it as early as 1830. We have letters which show that close associates of Hahnemann, most notably Clemens von Bönninghausen, and even Hahnemann himself, started to investigate it. They came to the conclusion that using more than one remedy at once is never necessary. The single remedy approach in accordance with homeopathic principles universally yields better results and fewer complications, even though it is sometimes frustratingly difficult to keep looking for the single best match instead of settling for two or more remedies. Hahnemann leaves

little room for interpretation when he writes in § 273 of the *Organon*:

> *In no case under treatment is it necessary and therefore not permissible to administer to a patient more than one single, simple medicinal substance at one time. It is inconceivable how the slightest doubt could exist as to whether it was more consistent with nature and more rational to prescribe a single, simple medicine at one time in a disease or a mixture of several differently acting drugs. It is absolutely not allowed in homoeopathy, the one true, simple and natural art of healing, to give the patient at one time two different medicinal substances.*

There are several places in the *Organon* where Hahnemann addresses the issue of considering the totality of the disease. I find the second footnote to § 7 (and you cannot help but admire those never-ending Victorian sentences) very enlightening. In it he urges us to consider the entire disease state and not focus on a single symptom alone: the iceberg is more than a single peak visible above the surface.

> *In all times, the old school physicians, not knowing how else to give relief, have sought to combat and if possible to suppress by medicines, here and there, a single symptom from among a number in diseases—a one-sided procedure, which, under the name of symptomatic treatment, has justly excited universal contempt, because by it, not only was nothing gained, but much harm was inflicted. A single one of the symptoms present is no more the disease itself than a foot is the man himself. This procedure was so much the more reprehensible, that such a sin-*

*gle symptom was only treated by an antagonistic remedy (therefore only in an enantiopathic and palliative manner), whereby, after a slight alleviation, it was subsequently only rendered all the worse.*

When we speak of polypharmacy this does not include the administration of several remedies, one after the other, in a sequential manner. Each remedy is in itself selected according to the remaining presenting disease state after the action of the previous remedy. In the chapter A Game of Golf we have already discussed the method of giving a number of remedies in sequence. This is well within the bounds of classical homeopathy.

Staying with our metaphor for just a bit longer, we return to our task of demolishing the iceberg. Previously we have talked about shooting at whichever part shows above the waves. A much better way would be to send a diver down below and to chart the entire shape of the iceberg. We can then decide exactly where to put an explosive charge which will shatter the entire chunk of ice into little bits in one big explosion. To find the perfect location we need a good map of the entire iceberg, of which—as you remember—only one eleventh is visible. To examine the remaining ten elevenths requires a determined effort to get into the cold water and dive all the way down to the bottom of it.

This, in essence, is our job as a homeopath. We cannot limit our investigation to the local complaint which the patient presents to us. There just is no other way than to explore into the deep and find out the exact shape and extent of the patient's disturbance. Sometimes we are lucky and there will be little hidden

beneath the surface. At other times almost everything remains below the surface and we have to spend a long time in the cold water to get a good impression.

Another question that I hear frequently from students has to do with keynote prescribing and the law of similars. How can we proclaim *Arnica* to be the remedy of choice for a sprained ankle and at the same time uphold the principle of individualization. Why, suddenly, are all ankles the same? Keynote prescribing is the selection of a remedy based on a single symptom which is specific to one remedy. When somebody suffers from shock we give *Aconitum;* a child who sweats profusely on the head receives *Calcarea carbonica*. How can we justify this approach? Is this not dangerously close to a "this-for-that" kind of therapy? From experience we know that *Arnica* does, indeed, work miracles with sprains and bruises. The difference between this superficial kind of homeopathy and the ninety-minute interview lies in the level at which we apply the law of similars. If we remain close to the surface we will see an accordingly smaller fraction of the iceberg than if we dive all the way down to the bottom. Luckily, a sprained ankle does not need a deep analysis and is easily helped by a dose of *Arnica.* I remember one teenage girl, however, who had weak ankles and could hardly do any outdoor activity at all without injuring her foot. In this case *Arnica* helped the immediate pain but left the general predisposition untouched. Finally I decided to put on my metaphorical diving gear and explored the hidden depths of the iceberg. What I found clearly pointed to *Strontium metallicum* as the simillimum. From then on she miraculously stopped hurting her ankle.

# 12 The Hammer



I still remember the moment when I bought my first repertory. It was a *Kent's Repertory* printed in India on the kind of paper which reminded me of a telephone directory. But instead of the names listed in a phone book, the repertory contains a list of symptoms. Under each symptom it gives the names of remedies known to have that symptom in their drug pictures. I imagined that armed

with that kind of book it was going to be easy to cure people left and right. I would just compile a list of symptoms of the patient's disease, look them up in my brand new repertory and note which remedy was listed under each symptom. The one which ran through my entire list of symptoms had to be the simillimum and, voilá, restore the ailing patient to perfect health. You are probably smiling at this amount of naivety, but if you already own a repertory, I bet you had something akin to my experience when you first got it.

I am going to assume that, as a faithful student of homeopathy, you already own a repertory. You might not yet have had opportunity to use it much, though, which is why I think it might be a good idea to give you a bit of background information on repertories in general.

As you might have guessed, as far back as 1817 Hahnemann compiled a personal list of symptoms and corresponding remedies known to cure them. He referred to them frequently when mulling over a case but did not publish them. He did, however, encourage Clemens von Bönninghausen to publish such a book, which appeared in 1832. The English title (the translation was published in 1899) was *Alphabetic Repertory of Homeopathic Remedies (Repertory of Antipsoric Remedies)*. It contained the symptoms of 52 remedies and thus was the first published repertory. James Tyler Kent published the all-time bestseller in 1897. He drew heavily on a number of different sources as well as individual, smaller repertories and his own experience. Kent also devoted a lot of thought to its structure and layout, creating an

easy-to-use repertory covering 642 remedies on 1423 pages. *Kent's Repertory* underwent several editions and revisions and is still in use today, although more accurate and complete repertories are now available. The two most widely used repertories are Frederik Schroyens' *Synthesis* and Roger van Zandvoort's *Complete Repertory*. Because repertory information has steadily grown, the most complete repertories have by now turned into heavy, unwieldy books which are inconvenient to lug around. What better than to turn them into electronic versions and to use the computer to assist you in your searches and case analysis? Both the above-mentioned titles, as well as most other repertories, are now available electronically.

## The Structure of a Repertory

Sometimes it is a quick glance, sometimes a long session, but rarely will I leave my repertory untouched when looking for the simillimum. What to a carpenter is his hammer, is the repertory to a homeopath. Do you remember the time when you tried to put a nail in the wall and hit your thumb instead (I will not ask you to repeat the experience now)? It is the same with repertories: if you are not well versed in their use they can hurt you—or your patient, for that matter—by leading you off in a totally wrong direction on the search for the fitting remedy. Therefore it is time well spent to become acquainted with their structure and idiosyncrasies, their strengths and weaknesses.

Despite the danger of telling you something you already know, I would like to outline the general features of a repertory in the next few sentences. When you open one to a random page, you will likely find an endless list of entries such as the one below (this specific example is taken from the *Complete Repertory*, but its general features will be the same or similar in all others):

> *1. EAR; CATARRH; eustachian tube (K285, G241) (Inflammation; eustachian tube) (HEARING; Impaired; catarrh of eustachian tube) (55): alf., alum., ars-i., Asar., ba-sv., bar-m., Calc., calc-i., calc-p., calc-s., caps., caust., cench., chin., con., dulc., ferr-i., ferr-p., gels., graph., hep., hydr., iod., jab., kali-bi., kali-chl., kali-i., kali-m., KALI-S., kali-sil., lach., lob., lob-s., mang., menthol, merc., merc-d., merc-i-r., mez., morg., nat-m., nit-ac., pen., Petr., phos., phyt., PULS., ros-d., sang., sanguin-n., sanic., sep., Sil., thiosin., visc.*

Every entry like this is called a rubric. Since there are many thousand different rubrics, it is convenient to group them into chapters, each chapter dedicated to a particular part of the body. Our example belongs to the "ear" chapter. The chapter name is followed by one or several subheadings called sub-rubrics such as "Catarrh" and "Eustachian tube." The expression in parenthesis following the rubric name (K285, G241) tells us that information in this rubric comes primarily from the rubrics found in *Kent's Repertory* on page 285 and the *Repertorium Generale* on page 241. Next is a list of cross references to other, similar rubrics such as "Inflammation of the Eustachian tube" or "Impaired

hearing due to a catarrh of the Eustachian tube." The strange way in which the symptoms are broken up has to do with making chapter and sub-chapters easier to recognize. The final number, in this case 55, tells you how many remedies are listed in this rubric.

Finally, you see the abbreviated names of those 55 remedies in alphabetic order, ranging from *Alfalfa* through *Viscum album*. If you look carefully, you will notice that some remedies appear in small letters (e. g., alf., alum.), some with initial capitals (e. g., Petr., Sil.), and some with all capitals (e. g., PULS.). This denotes the degree in which a remedy is listed in a particular rubric: first, second, or third degree, respectively. Incidentally, the particular style in which remedy grades are shown in your repertory may deviate from the cited example (Kent used plain, italic, and bold type in his repertory). More importantly, there is also some confusion about how best to interpret the grading of remedies. Originally, Kent assigned higher degrees if more provers exhibited the symptom. Other homeopaths afterward awarded higher degrees to those symptoms of a remedy which expressed themselves with the greatest intensity, regardless of the number of provers who exhibited them. Since in our repertories, today, additions from various people are mixed together, the use of symptom grading no longer follows a clearly discernable standard. About the only thing that I feel comfortable saying about the grade is: the higher the grade, the more important that symptom's contribution is toward the remedy picture. Consequently, I pay more attention to how often a remedy appears in the repertorization

than to its degrees in various rubrics. This implies, as per our example, that catarrh of the eustachian tube is more characteristic of *Pulsatilla* than of *Lachesis.*

What I described above are general features of all repertories. There are differences, however, in the chapters, the structure of sub-rubrics, and the order in which sub-rubrics are listed under the main rubric. Some repertories reference each remedy in every rubric to the source. This is sometimes valuable if you want to judge the reliability of the information; there may be some authors whom you trust less than others. Another difference lies in the number of degrees used to weigh each remedy in a rubric: most repertories use three or four degrees. Given that to a significant extent your success as a homeopath depends on how well you make use of your repertory, it pays off to become intimately familiar with all those aspects as they pertain to your specific choice of book.

## Limitations of a Repertory

I need not elaborate on the many uses of the repertory and its undisputed value in finding the fitting remedy. What I often find lacking is a good understanding of its limitations and shortcomings. Therefore I propose that every repertory be sold with a warning: "Caution! This book is the single most indispensable source of error in homeopathy!" The only responsible way to deal with this situation is to get to know the limitations and under-

stand them. There are, broadly speaking, three main shortcomings of every repertory:

- the structuring of information into rubrics and sub-rubrics
- the bias toward well-known remedies
- the incompleteness of rubrics and their varying sizes

Let us deal with them in turn and try to understand how they come about and how best to live with them.

How does a remedy become listed under a particular rubric? This is a good question. There are three sources of information that are pulled together: homeopathic drug provings, clinical information, and toxicology. Clinical information comprises cured symptoms in well-documented cases in which the remedy was prescribed successfully. A patient who was given a remedy based on the symptoms anticipatory anxiety and diarrhea might also be cured of a particular migraine headache even though this kind of headache is not known for the remedy. If this happens in several well-documented cases, it is safe to add the migraine headache as a clinical symptom to the drug picture of the remedy and list it under the corresponding rubric in the repertory. Toxicological information are symptoms observed in crude poisonings and overdoses of the remedy. There are, for example, many toxicological symptoms for the remedy *Cannabis indica* (hemp) listed in the repertory which were gathered from the well-documented symptoms one develops after smoking a joint. It is a weak point of the repertory that entries from either of the three sources are not distinguished. Hence, it is impossible to see which rubrics of

*Arsenicum* derive from a proving and which are observations from arsenic poisoning.

Another shortcoming of the repertory lies in the way a symptom has to be broken up. In order to fit into the existing structure of chapters, rubrics, and sub-rubrics, any symptom has to be divided into these parts and thereby loses many of its finer nuances and the particular context in which it was observed. On proving the homeopathic remedy *Chocolate*, one prover recorded this symptom:

> *Reading a few lines, and then I think of something else to do, get up, flunk it, sit back down to read again. Was reading a new book and had a sudden urge to cover it—went hunting for the covering, found it, but didn't have enough.*

How does one translate this into repertory language? There are several elements of this symptom: restlessness, indecisiveness, discontentment, fastidiousness are but a few. No one rubric covers them all, so the symptom is broken up and the remedy *Chocolate* is added to several rubrics which capture the flavor of this one symptom. This reminds me of a beautiful piece of art which gets chopped into pieces because it will not fit into the box as a whole.

It is interesting to note that the way we are adding information to the repertory from a homeopathic drug proving is essentially the same as repertorizing a patient's case. In both instances we start with a totality which we have to dissect into small pieces of information. You can see what I mean when you examine Table **4**.

Table **4** Parallels between the process of adding information to the repertory and the way we repertorize a case

| Remedy | Patient |
|---|---|
| Proving of a remedy | Interviewing of the patient |
| Emergence of a drug picture | Analyzing the case |
| Chopping up into rubrics and stuffing into the repertory | Chopping the case up into rubrics and searching for them in the repertory |

The remedy process on the left parallels the patient process shown on the right step by step. In the end we are trying to find a match between chopped-up pieces when we should actually compare entire totalities. The loss of information inherent in this is probably the biggest source of error of even the most perfect repertory. Unfortunately nobody has come up with a better idea to present complex information in a manageable and searchable way.

So what can you do to minimize the effects of this limitation? First and foremost, know your repertory so that you can find all rubrics pertaining to a particular expression of the patient. As the example taken from the proving of *Chocolate* shows, you have to find as many of the scattered rubrics as possible to piece together the original symptom expressed by your patient and the original prover. It is often helpful to consider the suggested cross references for each rubric and include them in your analysis. The chapter Solving the Puzzle provides an example of this.

The problem of losing the integrity of the whole is driven by the need to categorize information. This holds true for even the most complete repertory comprising all symptoms of all reme-

dies. This just points us to another big problem: none of our repertories are anywhere near to being complete. They can only list those symptoms we have thus far discovered about a remedy. Those remedies about which we have known for a long time are represented with a large number of entries, whereas the newcomers can only claim a few rubrics of their own. To show you what I mean take the two remedies *Sulphur*, listed in 17 692 rubrics, and *Asperula odorata* in a whopping 12. What is the likelihood of finding *Asperula odorata* on the basis of its presence in only 12 rubrics? The result of this is that well-known remedies get prescribed more often simply because they turn up in our repertory more often. As we prescribe them more often we have more experience using them and collect a large basis of clinical information which feeds back into the repertory adding yet more rubrics to already well-represented remedies. This is a never-ending spiral which ensures that remedies which we know well will stay on our list of favorites. The gap between "big" remedies and "small" remedies widens; the underdog never gets a chance to gain proportional weight in the repertory.

But it does not end there. When it comes to teaching homeopathy, students are taught those remedies which, according to public belief, are more frequently found to be the simillimum than others. These "big" remedies, commonly referred to as polychrests, are in many cases the only ones a student of homeopathy studies in his or her courses. The belief that polychrests are in some way more powerful, deeper acting, or simply more frequently encountered in patients is widespread.

Here is a revolutionary idea: all remedies are created equal! The only thing small about small remedies is our knowledge of them, and it is high time we did something about this. Why should we teach students *Sulphur* over *Asperula odorata* when they can pick up anything worthwhile knowing about *Sulphur* in any other textbook of homeopathy?

The upshot of this small vs. large remedy discussion is that you have to take into account the "size" of the remedy when you interpret the result of your repertorization. Finding *Sulphur* in five out of seven rubrics while *Asperula odorata* is listed in only one, should definitely make you prick up your ears. It is a big thing to find a remedy listed in only a handful of rubrics in the entire repertory in at least one of the few you chose for your case. The fact that *Sulphur* appears in five out of seven is, in comparison, nothing to write home about. Keep a look out for small remedies that appear in one or the other smallish rubric. I make it a habit to read up on them in the materia medica no matter what. You can only gain by doing so since, even if they turn out not to be the simillimum, you will have given an underdog a chance and learned about an otherwise all but forgotten remedy. When you use a computer repertory you can choose to give those small remedies a bit of a head start by telling the program to lend them more weight in the repertorization analysis. This will put them closer to the top of the stack and make it harder for you to miss them.

Next to the size of the remedy comes the size of the rubric. There are no hard and fast numbers to classify the size of rubrics

but you can call any rubric with five remedies or less small and with more than 100 remedies large. Somewhere in the middle, around 20 to 50 remedies are the comfortably sized medium rubrics.

There are actually many small rubrics in the repertory which list only one remedy. Does that mean that no other remedy can have that symptom? No, usually not. What it means is that we do not yet know any other remedy with that symptom. Since the holes are larger than the fabric of our knowledge (take, for example, the meager 12 rubrics for *Asperula odorata*) we cannot trust rubrics with only a few remedies. They are incomplete, and there ought to be more remedies listed than there actually are. Therefore we cannot exclude a remedy from our consideration merely because it does not appear in a small rubric we chose for our repertorization. On the other hand, if we pick a small rubric for our case, and a particular remedy is listed there as well, we should pay particular attention to it.

With large rubrics it is just the opposite. They are not very useful in directing our attention toward a particular remedy since they contain so many. However, it may be significant if a remedy is missing from a large rubric, particularly if the missing remedy is reasonably well known. Take the rubric "HEAD PAIN; GENERAL; periodic" which contains 120 remedies in the *Complete Repertory*. *Bryonia* is not among those, even though *Bryonia* is represented in a total of 8131 rubrics and counts among the polychrests. The absence of a rather well-known remedy from a large rubric therefore makes it rather unlikely that periodical

headaches are a symptom of *Bryonia*. That symptom would have been discovered long ago and added to the repertory. We can therefore say that large rubrics tend to exclude remedies not listed and small rubrics tend to focus our attention on remedies listed.

## Repertorization Pitfalls

When you are brooding over your patient's case and the time has come to choose symptoms from your notes for repertorization, it is tempting to pick those symptoms from your notes which are easily translated into rubrics. The chosen symptoms may not be the most important ones in the case but rather than spend a lot of time coming up with ways to approximate the patient's expression in repertory language, you leave this symptom out of your repertorization. Pitfall number one, therefore, is to let the choice of symptoms for repertorization be influenced by how easily you think you can find them in the repertory.

Closely associated with pitfall number one is the second one, which has to do with settling for a poor choice of rubrics rather than go hunting for one that fits the symptom better. If you use a computer program for repertorization, the search for rubrics has become a matter of a couple of mouse clicks. Using a book, you have to spend some time thumbing through the pages, a process made infinitely easier if you know the structure of your repertory well.

There are cases where, after looking through my notes, I was unable to identify a single well-defined symptom. On the other hand, there are those where almost every sentence the patient utters sounds like the name of a rubric. In the latter case you will find yourself with a lot of potential rubrics, which brings up the question: how many rubrics should you choose for repertorization? There really is no lower limit. One rubric may be entirely sufficient if it captures the essence of your case and contains the right remedy while at the same time not being too large. It is the upper limit to which you need to pay attention. Let us say you picked ten rubrics for repertorization. Since the repertory is built on incomplete information, you can never be one hundred per cent sure that the right remedy is indeed listed in every rubric it should be. Therefore you face the danger that even though you picked the right rubrics, you miss the simillimum simply because nobody has thought of adding it to the rubric yet. That potential danger increases with the number of rubrics, as Table **5** shows.

Let us say we picked five rubrics for our repertorization. And let us further assume that those rubrics are 90% complete, that is,

Table **5** More rubrics make it less likely that the simillimum will be present in all of them. The table shows the probability, assuming that each rubric has a 90% chance of containing the simillimum

| Number of rubrics | Probability of finding the simillimum in all rubrics |
|---|---|
| 5 | 59% |
| 10 | 35% |
| 15 | 21% |

that there is a 90% chance of the simillimum being listed in each individual rubric. Table **5** tells us that we can only expect a 59% chance of actually finding the simillimum in all five rubrics. And this quickly decreases the longer our list of rubrics gets. The upshot of this is to keep the list of rubrics as short as possible while still encompassing the core of the case. Furthermore, we should never exclude a remedy from the list of possible simillima simply because it is not represented in all rubrics.

Another reason why repertorization may fail can be buried in the sequence of steps involved until we see the result of our analysis:

1. The patient has the symptom.
2. We record it during the interview.
3. We choose to use it in our repertorization.
4. The simillimum is actually listed in the chosen rubric.

The case we hope for is when all four steps are completed successfully: the patient complains of the symptom, we actually write it down during the interview and consider it important enough to include in our repertorization. Lo and behold, it is also a known symptom of the remedy, which is listed under the chosen rubric.

Then there are instances where either one or more of the four steps fail. For example, the patient told you the symptom, you even wrote it down but did not think it was important enough to include in your repertorization. The patient is all about that one symptom but for some reason or another your mind has

latched onto another remedy prematurely and you subconsciously block out any information which does not confirm the remedy you have in mind. Whatever you miss in the second step is lost forever. That is why taking a good case is arguably the most important skill a homeopath can master (see also the chapter The Individuality of a Rose).

It is particularly frustrating when you got a good symptom from the patient, recorded it in your notes, and even managed to find a fitting rubric for it . . . but the right remedy is not listed under it. This is the problem of the incomplete rubric, which we have already talked about. When you have independent confirmation (either from other cured cases or further provings) that the remedy really ought to be listed in this rubric, you may add it yourself, preferably using an erasable pencil. Never forget that the repertory is a living document, which improves the more people contribute.

And then, of course, there is the problem which most people blame the repertory for but which is not really the repertory's fault at all. I see it most frequently with students who just bought a new computer repertorization program. They take the case, they breeze through the repertory and select great rubrics, they throw them all into the computer and have it do the repertorization. Out pops a nice and colorful graph with one remedy ranked topmost, which you prescribe to the patient. And nothing happens because it was simply the wrong remedy. How can that be? What I tell every proud owner of a new repertory (electronic or on old-fashioned paper) is that they need to review their attitude

toward the repertory. You should never look at a repertorization believing that it will tell you the simillimum. Just think of it as suggesting remedies to you to consider for the case at hand. I have been to many seminars where the lecturer presented a case with ensuing repertorization, which invariably showed the curative remedy coming out as the leader of the pack. The chosen rubrics were usually brilliantly selected and full of insight. The secret to this kind of repertorization is that they are usually done after knowing what the remedy was. Never expect to find the simillimum this way yourself, without the benefit of 20–20 hindsight. Think of the repertory as a knowledgeable friend whom you can always ask for an opinion. Nothing more, nothing less.

## Computer Repertories

If the printed repertory is a hammer, a computer repertory is a nail gun. What used to be a tedious and time-consuming job is turned into a fun and quick experience by our electronic companion. Repertories are, after all, nothing but a huge database of rubrics and remedies. If computers are good at anything then it is browsing through data. I would even venture so far as to say that a homeopath without a repertorization program should probably refrain from charging money for his or her services.

There are currently a number of repertorization programs available. According to their degree of sophistication and underlying repertorial information there are those aimed at the lay per-

son and those for the serious student or professional homeopath. As far as I am concerned, I do not really see the need for a computer program if you are only going to treat small acute problems in your immediate family and circle of friends. Most self-help books and some experience and practice get you to the remedy quicker and safer. Therefore, when I speak of repertorization programs, I only refer to those catering to professional homeopaths or anyone on the track to becoming one.

The general features of all repertorization programs are the same. They are electronic search and analysis engines that you can let loose on any kind of repertory book as long as it is in an electronic format that the program can read. This means you can buy a program and, independently, repertory books which you want to use with it. All repertory programs give you the ability to search for rubrics in various ways, making it easy to find a rubric if you only know a single word or a remedy. You can collect rubrics and perform a repertorization using different analysis strategies, presenting the result in some easy to read graphical way. They usually come with one or more electronic materia medica books so that you can browse the materia medica texts on your computer while having the repertorization results right before your eyes. And the nicest thing is that they do all this, which would otherwise take hours, in the blink of an eye.

I already mentioned that there are about a handful of repertorization programs available for professional use. In 1998 I wrote a review of the three best-known repertorization programs (Mac Repertory, RADAR, and CARA) in the online magazine *Homeopa-*

*thy Online* (http://www.lyghtforce.com/HomeopathyOnline/Issue5/). Although some time went by since then and new versions of those programs have been released, you will get a good idea of what each program is about by reading the review. Their respective strengths and weaknesses have changed little, although I would certainly advise you to request the latest information and pricing on them through their respective websites.

The big question I have been asked many times in connection with repertorization programs is: "When should I buy one?" My answer is simple: not before you have mastered the printed repertory. I am a strong advocate against using a computer repertory from the beginning of your homeopathic studies. This would be like giving first-grade kids a word-processing program instead of pen and paper. First you have to learn about the repertory, its structure, and how to use it. This is best done with a tangible book in front of you and your thumbs between the pages. There simply is no better way. You will absorb more information from a book and also learn about which remedies are listed in which rubrics better and more easily than from a computer screen. You will have to copy remedies and rubrics down on a repertorization sheet by hand, which is a great way to learn and is lost entirely with the computer. But adamant as I may be that a printed repertory book should be used in the beginning, I am in favor of switching to a repertorization program sometime during the second year of learning. This would be the point at which you are already a serious student of homeopathy beyond the initial stages, where a lot of emphasis in your education is on case anal-

ysis. And besides, owning a printed repertory and knowing your way around it will let you practise homeopathy even when your computer has spilled its guts or during a power failure.

Whenever you curse the book and long for a computer, remind yourself of a carpenter's apprentice who will be learning to use a hammer before laying a hand on the fancy power tools.

# 13 Solving the Puzzle

Strategies of case analysis

Repertorization

SRP symptoms

Totality

Doctrine of signature

After we have seen the patient and conducted a thorough interview comes the time when we have to sit down and analyze the case. Just as it is was impossible to give a definitive guideline on how to conduct the perfect interview (see the chapter The Individuality of a Rose), I am forced to admit that I cannot do any better when it comes to case analysis. There are a few standard techniques, none of them suited for all situations, and many individual variations. The gamut stretches from keynote prescribing, remedy essences, various repertorization techniques to family analysis, group analysis, and prescribing on remedy signatures. There simply is no one foolproof way to go about this. Just study as many different approaches as possible, try them out in practice and get to know their strengths and weaknesses. Over time you will become confident in choosing the right one for the situation and baffle everyone with a brilliant analysis and marvelous prescription. At least that is the game plan. What I can do to get you well on your way is to limber up your mind and introduce you to some important analysis strategies. I will also give you a case example wherever possible.

The situation you find yourself in just before starting to analyze a case is not unlike a handyman being called to fix a mechanical problem. He does not know exactly what is broken and simply takes his entire toolbox to the job. Once he sees what needs to be fixed he picks the right tool for the job and gets started. This may be a screwdriver to tighten a screw or a wrench to fix a dripping faucet. The key to a successful handyman is a good set of tools. To someone who only owns a hammer, every problem looks like a nail.

## Strange, Rare, and Peculiar

When was the last time you solved a puzzle? What I am talking about is one of the kind shown in Figure **19** that yields a picture when you successfully put the pieces together. You probably have one hidden somewhere around the house, even if it is one for young kids with only a few pieces. I would like to encourage you to go find it and spend a little time puzzling. This will prepare your perception for the following discussion.

Solving a puzzle, particularly larger ones with several hundred pieces or more, can be very frustrating if you do it haphazardly. Experienced puzzlers go about it very methodically. There is always a number of pieces that are easily identified and therefore can be put together relatively quickly. A dead giveaway are the corner pieces, because there are only four of them. Next come the ones on the perimeter. Their straight edge sets them apart

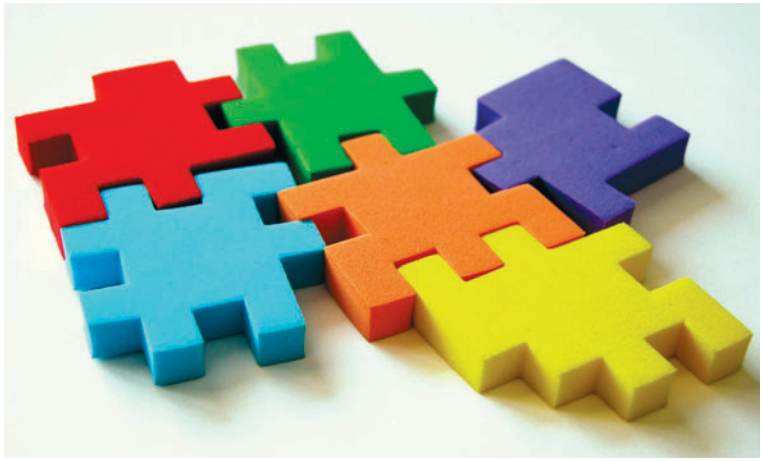


**Fig. 19** Solving a puzzle can teach you a great deal about analyzing a homeopathic case.

from the rest. And finally, when you look at the picture you are supposed to put together, not all areas of it are equally difficult. There will always be some distinctive feature which helps you find the pieces that belong to it. I, certainly, would not start a puzzle by trying to assemble a big chunk of blue sky or large expanse of green lawn. The pieces which make up those areas are just too much alike.

Go ahead and finish the puzzle. It always gives me a nice feeling of accomplishment when I put in the last piece that completes the picture.

Let us switch gears for a bit and return to homeopathy and solving homeopathic puzzles. I do not know how familiar you are with Hahnemann's *Organon* but I remember that, for a long time,

I used to own one because that is what you were supposed to do as a classical homeopath. Nobody ever told me to actually read it, and the circuitous, convoluted Victorian language added nothing to my desire. It is thanks to Wenda Brewster O'Reilly's edition of Hahnemann's *Organon*, which is based on a translation by Steven Decker (1996), that I became an *Organon* buff. I was amazed how much knowledge and practical information it contained. Let me share my appreciation of the book with you and start with a quotation from § 153:

> *In this search for a homoeopathic specific remedy, that is to say, in this comparison of the collective symptoms of the natural disease with the list of symptoms of known medicines, in order to find among these an artificial morbific agent corresponding by similarity to the disease to be cured, the more striking, singular, uncommon and peculiar (characteristic) signs and symptoms of the case of disease are chiefly and most solely to be kept in view; for it is more particularly these that very similar ones in the list of symptoms of the selected medicine must correspond to, in order to constitute it the most suitable for effecting the cure. The more general and undefined symptoms: loss of appetite, headache, debility, restless sleep, discomfort, and so forth, demand but little attention when of that vague and indefinite character, if they cannot be more accurately described, as symptoms of such a general nature are observed in almost every disease and from almost every drug.*

This paragraph describes a strategy of case analysis which focuses on so-called SRP symptoms, which is simply short for strange,

rare, and peculiar symptoms. The analogy with the puzzle strategy is clear. When analyzing a homeopathic case, look for the distinctive features. Do not focus on the uniform, common areas. Whenever you can spot an SRP symptom in a case it is a great starting point for finding the fitting remedy. The question is: how are SRP symptoms identified? I guess the name says it all—they are either strange, rare, or peculiar. Sometimes even paradoxical such as a coldness felt in the foot which is relieved by sticking it out in the cold air. Should you find this symptom in your patient, the simillimum will likely be either *Ledum* or *Camphora.* Of course, even such a beautiful SRP symptom does not have the power to overthrow the analysis of a case entirely if everything else goes against it.

**C** Let us look at the case of Susan, a 42-year-old kindergarten teacher, married, with two kids. I do not usually see patients in their home but this time it was convenient for both of us and I made an exception. When I arrive, calm music is softly playing in the background. Susan comes across as timid, introvert, and cautious.

Her main complaint is a nasty sinusitis which she has been unable to get rid of for the past two months. Even antibiotics only palliate the symptoms and a week later she is back to where she started.

She is prone to colds which are accompanied by the sensation of a swollen upper eye lid. Her nose is completely obstructed, worse when lying down. At the root of the nose and along her

eye brows she feels a pressing pain which improves on application of external pressure and worsens considerably when outside, particularly in windy weather. There is a yellow–green discharge from the nose. Susan only has these bad colds in spring and fall.

Susan's mother was over 40 when Susan was born the youngest of three daughters (17 and 19 years her elder). "I had three mothers," says Susan. "Ever since I was born I had some kind of illness—angina, ear infections, etc." Susan mentions that she was born before term, although she does not know how much. At age five she had a tonsillectomy.

Since the birth of her daughter 14 years ago she has been suffering from recurrent sinusitis. Susan's sister and father suffer from the same problem. I ask her if she has a hypothesis for her recurrent infections. "Maybe because my mother was already old when I was born. Somehow physically worn out. Since the birth of my two children I have become more susceptible to those infections, too," she replies.

I ask her what she knows about her early childhood. "I was extremely weak. The first couple of years I did not want to eat anything and had to be fed for hours. As a child I had three mothers: my two sisters and my real mother. I always wanted younger parents. Every night I crawled into my parents' bed."

She describes herself as sensitive, empathic, and a bit impatient. She takes a long time to come to a decision and would like to be more spontaneous and lively. Shy and introvert, Susan has trouble speaking in front of people. She envies people who come

across as self-confident. Her voice is soft and Susan sometimes gets hoarse at work.

Asked about her husband she says that he is the complete opposite: sportive, a mountaineer, biker, and hiker, and an extrovert with a positive attitude. Susan thinks of herself as pessimistic and distrustful toward strangers.

The death of her father haunted her for one year, and she could not sleep at night.

"I would never want my daughter to go out alone in the dark," she says. Even as a child Susan was mortally afraid of the dark. She was unable to fall asleep alone and was extremely scared of being alone.

Her fears are that something should happen to her husband, that she should become seriously ill, and being amongst a large group of people (big city, railway station, public gatherings). She is afraid of strangers, particularly men, and mentions that, apparently, her three mothers doted very much on her.

Asked about her dreams, Susan describes a conflict with her boss at the kindergarten. In the dream her boss had everything put away so that Susan could no longer find anything. They had a terrible fight and Susan quit her job.

Susan's blood pressure is on the low side (112/65 mmHg). This makes her tired.

After a meal she cannot see very well: "Everything becomes blurry when I want to read after eating."

She suffers from recurrent upper respiratory tract infections (laryngitis, angina) as well as bronchitis.

Her menstruation is regular with a period of 30 days and lasts seven days. Three days prior to her period she develops a bad mood. Sometimes she observes a yellow, bland leucorrhea.

Susan likes white bread, rolls, and sweets. Onions, garlic, and coffee make her nauseous and cause griping pains in the stomach. Drinking coffee in particular can leave her feeling nauseous for weeks. Consumption of alcohol leads to a burning plain in her bladder and burping.

She feels chilly very easily but does not like it too hot either.

The one-million dollar question, of course, is: what is the SRP symptom in this case? Susan's blurry vision after a meal has all the required features. And to make a good thing even better: we find several rubrics in the repertory that cover this symptom:

1. VISION; DIM; eating; after: *calc., carbn-s., nux-v.*
2. VISION; FOGGY; eating, after: *bar-c., calc., zinc.*
3. VISION; LOSS of vision, blindness; eating, after: *calc., croto-t., sil.*

Isn't this great? The SRP symptom has narrowed the field of likely contenders for the simillimum from about 2000 down to a mere seven! What remains to be done is to see if one of the seven also fits the rest of the case. So, get out your materia medica references and read up on them. When you do, you will find that *Silicea* fits Susan's case best.

One cautionary note with respect to SRP symptoms: never rely on them blindly. Always check that the remedy thus identified indeed covers all of the case and not just one symptom. Also, be aware of the possibility that the repertory rubrics you use to

describe an SRP symptom may not be complete. The remedy you are looking for may be missing from them. You may notice that rubric three above is not exactly the symptom Susan described. Susan talked of a blurry vision after eating. Still, you must be careful not to be too literal when translating a symptom into repertory language. In this case I would argue that a remedy which can cause blindness after eating also has the power to cause blurry vision.

Shortly after receiving *Silicea* in a Q3 potency Susan developed pimples on her forehead. This is a favorable sign, indicating that the body is in the process of clearing out toxins. Her sinusitis subsided and never returned. Even though Susan did catch an occasional cold (like we all sometimes do) it never developed into a sinusitis. When she attended the funeral of the father of a colleague of hers, Susan was pleasantly surprised that, although she felt sadness, the wound which the death of her own father had caused was gone. At work she asserted herself and even became the elected spokesman of her colleagues. In general, she became more self-confident and outspoken.

In another case the patient complained of cardiac arrhythmia and panic attacks. In general, his case was a sycotic one. He appeared to have considerable clairvoyance and took on the weight of caring for his sick wife while holding down a full-time job. My SRP symptom detector starts beeping when he tells me how he feels when he lies down in bed. Usually, when he is relaxed, the attack starts. He feels as if his entire body is shaking longitudinally, like in an earthquake. Objectively, however, he

does not move and the bed stands still too. There is this one rubric in the repertory which reads:
1. MIND; DELUSIONS, imaginations; motion; bed and ground, of, on waking (1),
with *Clematis* as the only remedy listed. I prescribed *Clematis* and the patient was subsequently free of his arrhythmia. Again, I want to point out that after this rubric put my mind on *Clematis*, I went ahead and read up on it in several materia medica books. Only once I was convinced that the entire case indeed fit *Clematis* did I prescribe it.

## Totality

From the beginning of my homeopathic education I recall being told to find the totality of the symptoms. What, however, is the totality? My first interpretation was that totality meant "all the symptoms." I remember vividly my first transcribed practice case. True to my understanding of totality I hunted down every little symptom. In the end they filled a page and a half, numbering close to 50. My teacher, looking over my shoulder, just smiled and encouraged me to go on and try to find a matching remedy. Only when I was unable to find one that covered more than 10 or 15 symptoms out of the whole lot did it dawn on me that I must have missed something.

I would like to share this emotional experience with you. To this end, take a look at Figure **20**. Examine it as closely as possi-

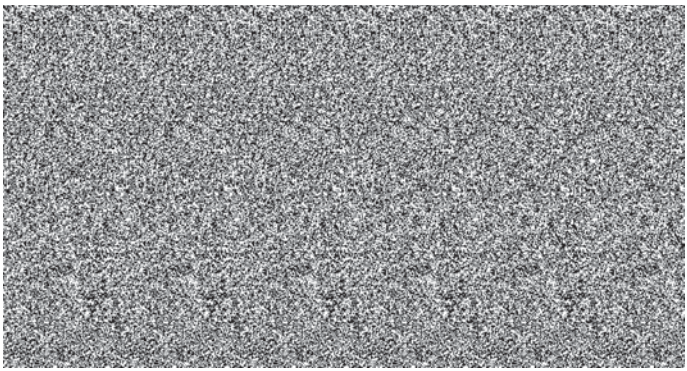


**Fig. 20** This picture will reveal a homeopathic remedy in 3D to anyone who looks at it in the right way.

ble. What do you see? If you are frowning now you are feeling about the same as I did. On the surface, Figure **20** is a confusing conglomerate of oodles of tiny black dots—just like the drifting snow on your TV screen when you disconnect the antenna. If you look at it long enough, you may be able to make out some abstract swirls and clusters but nothing that would qualify as a meaningful picture.

Would you be surprised if I told you that when you look at it the right way, you can see clearly the name of a remedy floating above a surface in 3D? Figure **20** is a so-called "single image random dot stereogram." You have probably already seen this kind of 3D image in malls or book stores (they also come in a colorful variety). The way to see the hidden image is to relax your eyes and kind of look through the page, as if you were actually looking at something a foot further away. Try to look at the whole picture

at once without focusing on any detail in particular; just relax your eyes. Some people are able to recognize the 3D image after only a few minutes' practice, for others it can take considerably longer. You do not "think you see it," you will definitely know when you are doing it right. This is no subtle 3D effect, it really jumps out at you. Here is a nice site that probably answers all the questions you have and also shows you some tricks to help you see these images: http://www.cs.waikato.ac.nz/~singlis/sirds.html

So what is the point of all this? The message is that totality is the forest and not the trees. When you focus your attention on the individual trees you miss the forest. "OK," you say, "I understand what you mean. How do I translate this into the homeopathic context?" This is best explained with the help of an example.

**C** I am going to use the case of a 23-year-old woman, let us call her Jane, who came to me because of the consequences of a stroke she had suffered two years earlier. The day before she had the stroke, Jane's father died. Because of the stroke, Jane's entire left side and her face were paralyzed. She had to spend four months in a wheelchair.

Now she still suffers from an inability to concentrate. She has difficulty sticking to one topic during a conversation and looses the thread easily. Her spatial memory is impaired. Jane feels angered easily, becomes aggressive and starts shouting, particularly when she feels disturbed by somebody. She rarely cries but

when she does, it comes spontaneously and out of the blue. She feels better for it. Jane has difficulty accepting consolation or help. Earlier, she frequently quarreled with her boyfriend, from whom she separated shortly before the stroke.

Jane happened to have her menstrual period when she suffered the attack. She sleeps soundly, mostly on her stomach. Her left arm is spastically paralyzed, the fingers contracted, particularly her thumb and index finger. She can get loud easily when debating.

Her skin is hypersensitive to touch. Immediately after the stroke she felt each touch as a burning pain. Jane did not want to accept that her left arm is paralyzed. The spasticity is worse after exhaustion. Particularly emotional stress aggravates her general condition. Mornings are her best times. Jane has a strong desire for warmth, which eases her spasms. She has much thirst.

Her facial nerve is still impaired, and she has not regained her left field of vision. During physiotherapy Jane notices that the spasms are worse in the beginning and improve as she continues to exercise.

Jane feels that time passes a bit too quickly, probably because of her slow pace due to her disability. She can come to a decision very quickly. She startles easily. Jane is loquacious and complains of a slight photophobia (sensitivity to light). She desires open air. Her tongue shows a brownish coat, the margins are red. Jane loves to eat sweets.

This is the condensed report of a 90-minute interview. I count between 40 and 50 individual symptoms in this brief account.

Let us not fall into the same trap as I did and confuse the totality of a case with the sheer number of symptoms. Instead, let us relax our eyes a bit until they are slightly out of focus and try to see what the central theme of Jane's problems is. Here is what we know:

We know that Jane went through an emotionally difficult period just prior to her stroke: she separated from her boyfriend and her father died.

She seems to be on edge, like someone who has exhausted herself for a long period. This shows in her quick temper and spontaneous crying. Jane's reaction to that is to withdraw. We see this in her aversion to consolation and particularly in her anger when someone penetrates her private sphere. She says, "I get aggressive and start shouting whenever someone disturbs me." Her eyes tell the same story when they are hypersensitive to light. Even through her skin Jane says, "Don't disturb me!" Remember, she feels pain at the slightest touch. Her being startled easily, too, is a sign of a certain disconnection with her surroundings—a result of her withdrawal.

Jane appears to be in a certain state of obtuse confusion: she cannot concentrate, looses the thread of a conversation, has difficulty with spatial orientation. Everything seems to happen too quickly for her, which is another way of saying that her mental processes are slowed.

Last, we have the symptoms closely associated with her stroke. These are the general left-sidedness (loss of vision on the left, spastic paralysis of the left arm), and the local symptomatology

of her paralysis (face, left arm, first and second fingers of the left hand).

It helps to find a short heading, a word or two, for each of the four groups of symptoms. I suggest "emotional exhaustion," "withdrawal," "obtuseness," and "spastic paralysis." This is our understanding of the case so far. Now we need to find a remedy which covers those four main areas. To this end, we turn to the repertory.

I called the repertory an indispensable source of errors in the previous chapter. On the one hand, it is a great tool to help us find the simillimum. On the other hand, it just as easily leads us astray. Even if we put in the best information available after a meticulous analysis the resulting answer can be misleading if we forget that the repertory itself has pitfalls and limitations built in. With this caveat in mind, let us see how we might use the repertory in this case. I am basing all repertory discussion and analysis on the *Complete Repertory*. There will be differences in wording or remedy content when you use a different book but the general process and end result will be the same.

There are many rubrics for emotional exhaustion in the repertory. We choose all those which pertain to our case (numbers in parenthesis indicate the number of remedies listed under the rubric):

1. MIND; AILMENTS from; excitement; emotional, mental symptoms from (92)
2. MIND; AILMENTS from; grief, sorrow, care (89)
3. MIND; AILMENTS from; bad news (64)

4. MIND; AILMENTS from; grief, sorrow, care; emotional, mental symptoms from (24)
5. MIND; WEEPING, tearful mood; tendency; causeless (41)

For "emotional withdrawal" I found these rubrics:

1. MIND; ANGER, irascibility; tendency; interruption, from (10)
2. MIND; DISTURBED, averse to being (40)
3. MIND; INTOLERANCE; interruption, of (3)
4. MIND; STARTING, startled; easily (84)
5. MIND; TOUCHED; aversion of being (64)
6. SKIN; PAIN; burning; touch, on (4)
7. EYE; PHOTOPHOBIA (214)

Next comes obtuseness:

1. MIND; CONFUSION of mind; mental exertion, from; agg. (49)
2. MIND; TIME; passes too quickly, appears shorter (17)
3. MIND; CONCENTRATION; difficult; conversation, during (6)
4. MIND; CONCENTRATION; difficult; talking, while (3)
5. MIND; DULLNESS, sluggishness, difficulty thinking and comprehending; mental exertion; from (48)

And lastly the collection of rubrics pertaining to Jane's stroke symptoms:

1. EXTREMITIES; CONVULSIONS; clonic (20)
2. EXTREMITIES; PARALYSIS; Fingers; extensors (6)
3. VISION; HEMIOPIA (67)
4. EXTREMITIES; PARALYSIS; hemiplegia; left (29)
5. GENERALITIES; PARALYSIS; one-sided, hemiplegia; left (43)

Let us take a step back and review what we have achieved so far. We started by identifying central themes which run through the case. For something to qualify as a theme it needs to be clearly identifiable and important to the case. A theme is never something confined to a single location but surfaces in many places. To identify a theme, think in analogies. A good example is our "emotional withdrawal" theme. There we have symptoms from different areas which all express the same idea, each one on its particular plane (it might be helpful to read the section on *Mappa Mundi* in the chapter A Map of Disease). Then we searched the repertory for rubrics which describe our themes. Experience shows that it is best to have between three and eight rubrics to each theme. It is best to get a good mix of small and medium rubrics. Avoid large rubrics (more than 100 remedies); you will only wind up with lots of remedies in it with little distinction.

Having proceeded up to this point with care and consideration, we can be reasonably sure that the remedy we are looking for is going to be present in at least one rubric in every theme. It turns out that there are 30 remedies which appear in each theme at least once. They are (in alphabetical order): *Agar, Anac, Apis, Aur, Aur-s, Calc, Calc-s, Caust, Chin, Cic, Cocc, Gels, Hep, Ign, Lach, Laur, Lyc, Nat-c, Nat-m, Nit-ac, Nux-m, Nux-v, Op, Petr, Phos, Ran-b, Sep, Sil, Staph, Sulph.* Now is a good time to take a break and pat yourself on the shoulder. You have started with something like 2000 remedies in the pool and narrowed it down to 30, with a reasonable chance that the simillimum is indeed among them. Now

you have to make a decision: will you try to narrow it down further—with the proportional danger of accidentally losing the simillimum on the way—or are you going to stop here. If you choose the latter then you will have to turn to your favorite materia medica books and decide on which remedy to prescribe based on materia medica information.

Personally, I like to take the middle way: if I come up with more than, say, 10 remedy suggestions after the initial repertorization I will have another go with the repertory. My goal this time, however, is not to exclude any remedy but to decide on the order in which I will read up on them in the materia medica. Doing it this way will increase the chance of finding the simillimum among the top five or so remedies without inadvertently missing it altogether.

For the second round I will pick one or two rubrics from each theme which best express the feeling of the case. Then I do a repertorization on them, limiting the pool of possible answers to those remedies which made it through the first repertorization.

Here are the rubrics I chose:

1. MIND; AILMENTS from; grief, sorrow, care (89)
2. MIND; ANGER, irascibility; tendency; interruption, from (10)
3. MIND; TIME; passes too quickly, appears shorter (17)
4. MIND; CONCENTRATION; difficult; conversation, during (6)
5. MIND; CONCENTRATION; difficult; talking, while (3)
6. GENERALITIES; PARALYSIS; one-sided, hemiplegia; left (43)
7. VISION; HEMIOPIA (K280, G236) (67)

The choice of rubrics for this kind of repertorization is not too critical since we do not use it to eliminate any remedies. Its sole purpose is to suggest an order in which we are going to leaf through our materia medica resources. Note that I combined the two rubrics pertaining to difficulty concentrating. Here are the initial 30 remedies in descending order of their frequency in the chosen six rubrics: *Cocc* is the only remedy appearing in five out of six rubrics; *Op*, *Nux-v*, *Lyc*, and *Sulph* are present in four. The rest is listed in three or fewer rubrics. Clearly, this suggests that we should read up on *Cocculus indicus* first.

Indeed, *Cocc* appears to be a very good match to Jane's case, and I prescribed it to her in an LM1 potency. Jane took the remedy, with several breaks and increasing potencies, over the course of one year. At the end of this time Jane's health had improved considerably, although her left arm remained paralyzed. Whereas, on the first visit, she could hardly climb up the few steps to my office, now she walks fluidly and with ease; one hardly notices any limp in her gait. Her speech improved greatly, and her ability to concentrate returned to a normal level.

The analysis technique I have demonstrated on Jane's case is what I call a totality repertorization. This works well where we have a well-rounded basis of symptoms covering all important areas. We can approach the case with the goal in mind to find one or several themes which cover the entire case. Remember, we are looking for the forest and not for the trees. The repertorization strategy I used here is well suited to this approach and helps you focus on

the right group of remedies without limiting the scope unnecessarily.

## The Signature of a Remedy

C This time I think it is best to start with a case. The patient, let us call him John, is 80 years old and comes to see me because of almost constantly and profusely lacrymating eyes and a watery nasal discharge that will just pour out of his nose. John has been through a lot of conventional medical treatment but without success. He is surprisingly fit and agile for his age, has a weathered face, a big nose and huge ears that stand out. He used to be a butcher before he retired.

He sits down and, without introduction, says, "I take aim and want to shoot and then the game is gone because I can't see."

As the interview evolves, I learn that John is a passionate hunter and has had the troublesome discharges for at least 15 years. It comes on so suddenly that he does not have time to pull out a handkerchief. Like water. It is worst in the morning. In the first hour after getting up he regularly uses one whole package of handkerchiefs.

"I don't drink alcohol, don't smoke, and am afraid of women," he says in a way that makes me uncertain about how serious he is about the last part. His only addiction is hunting. Then he says: "One day I will keel over in the forest, go belly up, and a red wild boar will devour me." Asked whether he considers that to be a

frightful idea, he says that, on the contrary, this will be a nice way to go.

"I like to tease people, and when they are almost ready to start fighting I get up and leave. That's what I like to do."

He likes to eat fish but is not fond of game.

"When I am 95 years old I'll be too old to go to jail. Then I'll kill all the socialists in town!" he says and laughs. Referring to a business scandal which made the news he remarks: "I would simply put the entire management against the wall of the town hall and liquidate them. I am a pretty straightforward guy."

John was wounded eight times and shot down three times in World War II. He is proud of it and says, "I didn't give a dime. Nobody could tell me what to do." Asked what he regrets most, he replies spontaneously, "Nothing!" John describes several appallingly bloody war accidents he witnessed and remains totally cool and untouched.

He owns enough fire arms to outfit a small group. John is proud of his weapons arsenal. He owned his first gun at age 13. Asked why he needs weapons, he has not thought about it.

John describes himself as superficial. "When I take a measure of something, I only estimate. It has to be quick."

He gets cold easily and his hands and feet freeze.

John feels a close relation to all animals. He says that he is not a mindless "shooter."

He gets dizzy when he has not eaten, and he has been operated on for a perforated gastric ulcer. John tends to be somewhat

constipated. On a few occasions he has had cramps in his calves, which woke him up and improved on stretching and moving.

This is certainly a colorful and interesting case. Whatever his simillimum is going to be, it has to capture his ferocity and love of hunting. I found it very interesting that, however cruel his statements were when he spoke of humans, it was very important to him not to appear as somebody who kills animals mindlessly.

On analyzing this case I realized that John's statement near the beginning is a beautiful and succinct summary of it: he wants to die in the forest and be devoured by a wild boar. Closing my eyes I see him sitting in front of me, almost a creature of the woods with a wild sparkle in his gray eyes. I just could not help thinking of him as a hog in human guise. It was at this point that I decided to let my remedy choice be guided by the signature of the case and prescribe a homeopathic remedy made from the blood of a wild boar. Unfortunately, it turned out that such a remedy had not been proved yet, and consequently no materia medica is known about it. What should I do? I decided to follow my interpretation of John's case and had the remedy prepared by a well-known pharmacist. John received *Sanguis suis scrofae* LM1.

I would not be writing about this case had the remedy not effected a complete and thorough cure of his condition. Within two weeks his eyes and nose had stopped their hypersecretion. When I saw him at the follow-up visit John could not believe it himself. Even now, more than two years later, he has not had a single relapse.

I had a difficult time deciding whether it was a good idea to share this case with you. Finally I decided in favor of it, mostly because together with the other two cases it shows how broad the spectrum of case analysis strategies can be. The reason for my doubts is that this case may be construed as doing homeopathy by imagination. Nothing is farther from the truth; I would never condone a thoughtless airy-fairy speculative approach to homeopathy. But to demand that the simillimum be the result of a rote computerized repertorization, devoid of any intuition and even a sprinkle of speculation, would be equally misleading. "He who heals is right," goes the saying. And whenever we do something new and it turns out to be right, there is an opportunity to learn.

There are homeopaths who would adamantly disagree with the mode in which I arrived at the simillimum in John's case. Their argument is that there is only one way to find the simillimum and that is to match disease symptoms with the recorded symptoms of a drug that underwent a homeopathic proving. Clearly, *Sanguis suis scrofae* has not had a proving yet. Therefore I did not have any reportorial basis for its prescription. But what matters is that John was cured by a homeopathic remedy which could not have been found by repertorization. Clearly, the remedy was homeopathic to the case, as demonstrated by the remarkable healing response. The only point of contention one may find is the way in which I arrived at it, which was very much based on intuition. As a physicist, I recognize and respect an approach based upon the balance of intuition and existing knowledge. This is exactly how the natural sciences advance: first somebody

poses a new hypothesis, then someone does an experiment and either verifies or falsifies it. Without a good measure of intuition there would hardly be ground-breaking achievements. Science cannot build upon experiments alone (it would likewise be doomed if all experiments were done away with and replaced by intuition). The key lies in the proper balance between intuition and existing knowledge. Rely too much on either and you are doomed. What I did in John's case was to pose a hypothesis of a new remedy's drug picture. May this case be sufficient motivation to subject *Sanguis suis scrofae* to a proper proving and let John's case be the first to demonstrate its curative power so that further generations of homeopaths will be able to use it out of their repertories.

## Doctrine of Signatures

From the collection of three cases I presented to you in this chapter you can begin to glance the variety of possibilities through which we can find the simillimum. John's case takes us to an important topic near the perimeter of the homeopathic prescribing methods. Right up to the line beyond which we find ourselves in the land of the avant-garde. I do not want to leave you standing there without having introduced you to the doctrine of signatures—DOS, for short.

The DOS is an ancient concept whose beginnings cannot easily and accurately be identified. Humans long since turned to the

healing powers of plants to relieve their sufferings. But how do we know which plant to use for what ailment? In medieval times in Europe, religion permeated every aspect of life. People turned to the stars and believed they were a way through which God foretold them the future. It was only a small leap to think that God must have also left signs, a signature, by which the curative power of each plant could be told. The key was to examine each plant closely and to find the signature which tells us how to apply it beneficially to cure certain illnesses. This approach, to look for a key signature, incidentally, is not unique to our western heritage and was also practiced by many other cultures.

The most famous proponent of the DOS was a Swiss physician–philosopher by the name of Philippus Aureolus Theophrastus Bombastus von Hohenheim who lived from 1493 to 1541 and later adopted the Latin name Paracelsus. During the first half of the sixteenth century, Paracelsus traveled throughout Europe and to Asia and Egypt, curing people with his concoctions. As a professor of medicine at the University of Basel, Switzerland, he drew heavily on the teachings of the ancient Greek physician Hippocrates and developed the DOS into a highly refined system.

Many vernacular plant names tell a story of how they were once used to cure human ailments. Such uses were fueled by fertile imaginations. In general, long-lived plants were used to lengthen a person's life, and plants with rough stems and leaves were believed to be effective against diseases that destroyed the smoothness of the skin. Plants with yellow sap were cures for

jaundice, and roots with a jointed appearance were the antidote for scorpion bites. Flowers shaped like a butterfly became cures for insect bites. For example, the yellow sap of *Chelidonium majus* is reminiscent of the skin color of someone suffering from a liver disease such as jaundice. Hence, *Chelidonium* was thought to have a special affinity to this organ. In this context it is interesting to note that homeopathic *Chelidonium* does indeed have a disproportionally large number of symptoms associated with the liver. Or, as a second example, take the flowers of *Digitalis purpurea,* which have a network of darker stripes. They look similar to blood vessels, and consequently *Digitalis* was soon used as a drug to cure heart and circulatory diseases. Even today, *Digitalis* is renowned for its influence on the heart and is used widely in conventional medicine as well as in homeopathy. Another graphic example is the banana which Hawaiian natives—for obvious reasons—held in high regard for its ability to relieve male potency problems.

It is clear that such widespread a theory must have made its entry into homeopathy as well. Hahnemann did not approve of it at all and condemned the use of the DOS in no unclear terms as "the folly of those ancient physicians determining the medicinal powers of crude drugs from their signature." In the preface to the remedy *Chelidonium* in his book *Materia Medica Pura*, Hahnemann elaborates on this:

> *The ancients imagined that the yellow color of the juice of the plant was an indication (signature) of its utility in bilious diseases. The moderns from this extended its employment to*

*hepatic diseases, and though there were cases where the utility of this plant in maladies of that region of the abdomen was obvious, yet the diseases of this organ differ so much among one another, both in their origin and in the attendant derangements of the rest of the organism; moreover, the cases in which it is said to have done good have been so imperfectly described by physicians, that it is impossible from their data to tell beforehand the cases of disease in which it must certainly be of use; and yet this is indispensably necessary in the treatment of diseases of mankind which are of such serious importance. Hence, a recommendation of this sort is of but a general, undefined, and dubious character, especially since this plant was so seldom given simply and singly by physicians, but almost always in combination with heterogeneous, powerful substances (dandelion, fumitory, watercress), and along with the simultaneous employment of the so-called bitters, which vary so much in their effects.*

*The importance of human health does not admit of any such uncertain directions for the employment of medicines. It would be criminal frivolity to rest contented with such guesswork at the beside of the sick. Only that which the drugs themselves unequivocally reveal of their peculiar powers in their effects on the healthy human body, that is to say, only their pure symptoms, can teach us loudly and clearly when they can be advantageously used with certainty; and this is when they are administered in morbid states very similar to those they are able to produce on the healthy body.*

What is interesting in this quotation is not only Hahnemann's outspokenness against the DOS but the alternative he offers in the second paragraph. Whereas idle speculations and superficial observations formed the basis for guessing a substance's potential medicinal merits before Hahnemann, he now offered another tool: homeopathic provings. The controlled and clearly defined circumstances of a homeopathic drug proving yield the information required for a drug's curative powers and give it a unique place within the materia medica of homeopathy. The case seems clear: DOS is out, homeopathic drug proving is in. This is also the context in which we have to understand Hahnemann's attitude toward the DOS.

Why is it, then, that the DOS is still very much a topic of hot debate and controversy? What arguments do its proponents cite, and are they to be taken seriously? We need to take another look at the DOS as it presents itself today.

What Hahnemann condemned was the simplistic and superficial extrapolation of a plant's appearance to its medicinal properties. Connections made on this basis are arbitrary most of the time, anyway. For example, there are many plants which have a network of dark lines on their petals. Why pick *Digitalis* over any other one as having a strong predilection to the cardiovascular system?

What the DOS is really saying is that there is a correspondence between a substance in nature and its potential use. It presupposes a unifying and unique purpose which connects every and all aspects of any one thing. The common daisy (*Bellis peren-*

*nis*) has, over many hundreds of thousands of years, adapted to particular surrounding circumstances in order to live harmoniously within a well-circumscribed habitat. Everything comprising *Bellis perennis* is geared toward survival under a set of natural conditions. By examining the plant we may, for example, deduce the climate in which it grows best. On the other hand, we may have a close look at the daisy's habitat and conclude some aspects of what kind of flower it must be in order to strive under these circumstances. In short, a thorough investigation of the plant and everything pertaining to it will reveal information about its role within nature as a whole. But since we, as human beings, are also a part of nature, is it really so inconceivable that we may learn how *Bellis perennis* relates to us by trying to learn everything about the plant itself? There really is no definitive answer to this rhetorical question. We may, however, approach the matter from a purely pragmatic angle.

In homeopathy we are told to gather all information pertaining to the patient. In paragraphs 83 through 104, Hahnemann goes to great lengths instructing us how we should examine our patients, paying close heed to objective observations, subjective descriptions, the timeline of the patient's life, other people's statements about the patient's disease. In short, he instructs us to leave no stone unturned in our examination. Should not the same principle apply when we study materia medica? Should we not strive to unearth every least bit of information available to us when we study, for example, *Bellis perennis*? Of course, homeopathic provings provide us with information which we can use

directly, without further translation. We only need to match proving symptoms with disease symptoms to find the simillimum. What about information coming from mythology, history, or natural sciences such as biology, zoology, and chemistry? In my opinion, we should not disregard them but use them constructively to enhance our understanding and paint a vivid image of the drug, making it come alive before our eyes. In doing so, we are only applying the same method used in interviewing our patients to a kind of "drug interview."

The DOS interpreted in this way really is not a doctrine anymore. In fact, it bears little semblance to the superficial practice of the DOS against which Hahnemann ranted. It is the practice of using all other information in addition to homeopathic provings to form a better understanding of the drug picture.

In John's case, for which I prescribed the unproved remedy made from the blood of a wild boar, I based my prescription on my understanding of the role which a wild boar plays in nature. As such, I have applied the DOS without the basis of a homeopathic proving to back up and enhance the information. The danger in doing this lies in the temptation to give in to one's own speculation rather than doing the sometimes hard labor of repertorization and thorough case analysis. Instead of going through the troubles of selecting symptoms, translating them into rubrics, and looking them up in the repertory, you could just close your eyes and pick the first animal, plant, or mineral that comes to mind. Do not go there, do not do this! This is not homeopathy, and if you think that in any way I am encouraging this kind of

practice, you are wrong. What I propose as a kind of new form of the DOS is the process of pulling in all kind of information and synthesizing a clear picture from all of it. A rather difficult process requiring a lot of hard work, mental discipline, and a profound knowledge of homeopathy if you do not want to go off the deep end.

# 14 A tape recording

The scientific method

The relationship between science, medicine, and homeopathy

What is a homeopathic remedy and how does it act?

There have been times when I had the audacity, ignorance, and sometimes sheer misfortune to enter into a discussion about science and homeopathy. At the end I usually came out feeling misunderstood or simply drained, no matter if I had been talking to homeopaths or scientists. Since I am—like the proverbial Dr. Jekyll and Mr. Hyde—a physicist as well as a homeopath, I find myself getting drawn into this kind of debate more frequently. My problem is that I can understand both sides, the homeopathic as well as the scientific, and see how problems can and do arise out of the dialog.

In this chapter we will take a look at how homeopathy relates to natural science. This is important, since whenever something gets labeled "scientifically approved" we stop questioning it and it gets adopted as truth. Conversely, when science withholds its sign of approval, whatever has not been approved is tainted by the faint smell of fraud and will never become mainstream. It is this fact that drives many among the homeopathic community to seek scientific approval of some kind. Who has not felt at a loss to reply with confidence and from a position of knowledge to questions like "What scientific proof is there for homeopathy?" and

"How does it work?" It is high time we were taking a closer look at what exactly science can give to homeopathy and vice versa. Are we chasing the holy grail when we look for a scientific answer to the "how" question? This chapter will show you a way in which to argue the homeopathic cause in a way that a died-in-the-wool scientist can more easily relate to.

## Empty or Not?

In keeping with the book's tradition, I am going to start off with a little thought experiment. It addresses the point most often raised by critics of homeopathy: "It can't work, there's nothing in it!" As you know, for potencies exceeding a 12C or 24X, the likelihood of finding even a single molecule of the original substance is virtually nil. Through the serial dilution process used in the manufacture of our remedies, all chemical traces of the crude drug have been removed, and not even the most cunning chemical analyst will be able to find one. The contention of our critics is certainly right in this point.

I hope you are in the mood for a little thought experiment. Imagine yourself buying a set of two old-fashioned, identical cassette tapes, just like the ones shown in the Figure **21**. At home, you record Beethoven's Ninth Symphony (you may substitute any other piece of music, if you like) on one of them. Weeks later you want to listen to the recording and are looking for the tape. Since you forgot to label it, you cannot tell which cassette holds the


**Fig. 21** Here you see two identical cassettes. On one I recorded Beethoven's Ninth Symphony. If you were allowed to run every conceivable chemical analysis on them, could you tell by the result on which I recorded the music and which one is empty?

music and which one is empty. At this point, let us assume you cannot for some reason do the obvious thing and pop one of them into your tape deck. Rather, you hand the two cassettes to a chemist and ask him to identify the right one for you. You might be surprised to learn that no chemical analysis in the world is capable of distinguishing between them (that is, of course, assuming that there is no tape deck sitting around somewhere in the lab).

By recording the music on the tape you did not add anything material to it. Its chemical composition remained unchanged. Still, there is a lot of nice sounding information stored on it which goes completely undetected by chemistry. Physically, what happened is that the microscopic ferrous particles embedded in the tape became magnetized in a pattern generated by Beethoven's music during the recording process.

The analogy with a homeopathic remedy becomes clear now. No chemical analysis will be able to distinguish between the solvent (usually diluted alcohol) and a homeopathic remedy. The only difference between them is that the remedy has undergone a kind of "recording process" which involved repeated dilution and shaking of the liquid. After that, it has become chemically indistinguishable from the solvent. We can carry the analogy one step further. With the right decoding device we can read the imprinted information. For the cassette tape the right decoding device happens to be a simple tape deck. For the homeopathic remedy it is a living organism.

The point raised by the critics is therefore moot. They are right when they claim that there is no chemical trace of the original substance left in the remedy. But this is inconsequential. The information is now stored in the remedy and can be transmitted to the body which has the ability to decipher it and use it to become healthy. Clearly, homeopathy is about the transfer of information and not the ingestion of material drug doses. In the chapter The Lemon and the Dolphin we argued that disease is essentially a lack of information on some level; we now under-

stand that healing is all about information and less about ingestion of chemicals.

### The Street Lamp

Gathering all the information unearthed by science on homeopathy so far, we can confidently make two statements which summarize our scientific understanding of the matter:

1. The good news is that homeopathy contradicts no known law of nature.
2. The bad news is that, unfortunately, we do not yet know of a natural law which pertains to homeopathy in a way that would help us understand it scientifically.

These two statements raise an important question: Does homeopathy lie within the realm of natural sciences at all? To illustrate my point, I will resort to a well-known joke.

A policeman, on his rounds at night, sees an apparently inebriated fellow next to a street lamp who is crawling around on his knees. He walks up to him and asks, "What are you doing?" The man replies, "I have lost my keys, Officer. Will you help me search, please?" The policeman, being in a particularly good mood, consents. After half an hour of crawling around on his knees in the dim light of the street lamp, the policeman gives up and says, "I can't find any trace of your keys. Are you sure you lost them here?" "Oh no," replies the man, "I lost them over there in the dark." The police man can hardly contain his anger and asks in frustration, "Why are you looking for them here when you lost them over there?" The man looks at him blankly and replies, "Because it's light here! How am I supposed to find my keys in the dark?"

In the light of the metaphor it becomes clear that one street lamp will never be able to illuminate the entire town. It is not even a matter of the amount of light emitted by the lamp: simply turning up its brightness will not enlarge the beam of light. It will

only make clearer whatever was already within the beam. In this way I consider it presumptuous to assume a priori that as a matter of principle the scientific method were fit to tackle and solve any problem. Most people have the wrong idea about what science really is. They confuse it with the store of knowledge amassed over time. Science is the method with which this knowledge was gained.

You can think of science as driving a car. There are lots of places you can visit by car, but if you want to go to the small island of Santa Catalina you had better board a ship. And if you are bound for the moon, only a rocket will get you there. Each destination has its proper means of transportation to get you there. Just as each question has own its way of finding an answer. A car cannot get you to Santa Catalina—science might not get you to the answer to how homeopathy works.

Currently, we have accepted that certain kinds of questions fall squarely outside of the natural sciences—religious or ethical problems, for example. Some others we know for sure are best solved by the scientific mind—matters of physics and chemistry, for example. That still leaves a large class of problems which may or may not be fruitful objects of scientific investigation. In which category homeopathy comes to lie, we will only begin to learn once we start to examine it from all angles, including the scientific one. It is dangerous, however, to limit ourselves exclusively to that angle. An even bigger danger, however, lies in dismissing homeopathy simply because we have not made any headway using the natural sciences as our vehicle.

## Homeopathy and Science

The relationship between homeopathy and science is based on the relationship between the mechanistic and the holistic way of thinking. Just as I argued above, neither is right, neither is wrong; both need to be judged according to their usefulness in solving a given problem. In the case of homeopathy, the questions we are asking have to do with living organisms, human beings. Let us examine the mechanistic and holistic approaches in this context.

We recognize the three hierarchical levels which Hahnemann already described in § 15 of the *Organon*—body, vital force, and spirit—which interact in a living organism. The body by itself is dead. In combination with the vital force it becomes capable of maintaining all processes essential to life. Breathing, blood circulation, body temperature, etc., are maintained in a homeostatic equilibrium. This equilibrium is kept up by means of autoregulation (self-regulation) so that we may speak of a living body which nonetheless is still unconscious. The ability to act purposefully

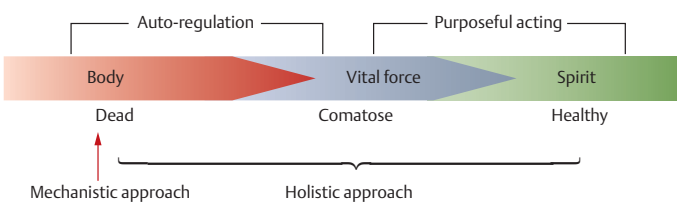



**Fig. 22** The mechanistic and the holistic approaches view the living organism from different perspectives and use different strategies to gain knowledge.

(i. e., consciousness) is added by another hierarchical level which, for the sake of this discussion, I will call spirit.

Each level has its own language and expresses its symptoms in a distinctive way. On the level of the physical body we find expressions like "Pain in the right knee." The vital force expresses its symptoms as generals, such as "I get cold easily." And, finally, on the highest level we find mental and emotional symptoms, such as "I am afraid of spiders." A homeopath needs to be familiar with all three entities to make a successful prescription. Therefore, homeopathy is rightly called a holistic treatment modality. Conventional medical practitioners mostly confine themselves to the physical level, as do most natural sciences such as physics and chemistry. It is interesting to note that, at least in Austria, beginning medical students spend most of their time with the inanimate, dead body instead of with the living patient.

## The Three Questions

The scientific investigation of homeopathy is roughly divided into three areas of research, each one epitomized by a single question:

1. Is there a therapeutic effect of homeopathy which exceeds the placebo effect?
2. What is the active principle in a homeopathic remedy?
3. How do homeopathic remedies interact with the organism to promote healing?

These questions form a pyramid of increasing complexity. One needs to start with the first one, and before proceeding to the next the current question needs to be answered. There is no point in trying to isolate the active principle in a homeopathic remedy unless we have already established that homeopathic remedies do have therapeutic powers. Also, before we thoroughly understand this principle, it is pointless to ask how the body interacts with it. Moreover, each question has associated with it a different field of research as the prime contributor to its answer. The answer to the first question lies within the realm of medical research and its tools such as clinical trials. Physics, chemistry, and related fields concern themselves with question number two, and the biosciences are called upon in the third question.

Where do we stand at the time of this writing? Even though critics loudly cite homeopathy for lack of clinical evidence of its effectiveness, I have rarely met one from this camp who was familiar with published work on this subject. The widespread demand for more clinical evidence is raised by people who are unfamiliar with what evidence there already is. Sadly, the same must be said for homeopaths as well. If I were to assign a homework for this chapter it would be to read—pars pro toto—two articles. One was written by Jennifer Jacobs and her team of homeopaths who went to the poor areas in Nicaragua and examined the effectiveness of homeopathy in the treatment of diarrhea in small children (Jacobs et al. 1994). This is a good example of a well-written research paper with sound methodology. The other article, by Klaus Linde and co-researchers, examined all available

clinical trials since 1945 and performed a so-called meta analysis of the available data in order to compare homeopathy's effectiveness to placebo (Linde et al. 1997). In this article, Linde concludes that:

> *The results of our meta-analysis are not compatible with the hypothesis that the clinical effects of homeopathy are completely due to placebo.*

It is therefore safe to say that the therapeutic value of homeopathy as a treatment modality for a wide range of diseases has been established beyond reasonable doubt. This is the necessary conclusion anyone with an unprejudiced mind has to reach after familiarizing oneself with the available published material. There will always be the demand for more clinical evidence but it comes mostly from people who cannot accept a phenomenon challenging their preconceived notions, even when they are confronted with overwhelming evidence. Apparently Linde also realized this when he wrote in the paper cited above:

> *Whilst randomized placebo-controlled trials hold an important place, simply doing more, bigger, and better trials of this type in homeopathy is more likely to perpetuate than to resolve the debate.*

What about the second question? Now that we know homeopathy is effective, can we put our finger on exactly what it is in a remedy that makes it effective? Or, in other words, can we build a machine that is capable of distinguishing a viable homeopathic remedy from a bottle of placebo? To do this we would need to

know exactly how the information is recorded in the remedy during its manufacture.

To date, we have come nowhere near to answering this question or building such a machine. Although there is much paper wasted on new and exotic conjectures, there has been no substantial progress. Many self-proclaimed scientists have put forth their own theories which do not hold up to even a cursory examination by an honest scientist. The liberal use of words like "quantum dynamics," "chaos theory," "electromagnetic field," and the likes proclaims more ignorance than it conveys knowledge. Even worse, it drives away serious scientists to whom it becomes quickly apparent that the field is full of people who do not know what they are talking about. To be conceived as being professionally associated with one of those is the worst nightmare of a physicist.

There are many people who are mesmerized by words such as "quantum mechanics" and its ilk. These concepts have a well-defined meaning only when used in the specific context of their corresponding fields. Outside of them they lose their power and turn into empty shells, used by non-scientists to fill them with their own home-cooked ideas. It is almost as if someone tried to pry the newest computer chip from a PC and drop it into his car's fuel tank in the hope of making the car go faster.

I do believe that homeopathy is a fruitful field for scientific exploration. First, however, we have to leave science to the scientists and refrain from perverting science speak. As homeopaths we have to learn to admit that nobody has the foggiest idea of

**Fig. 23** A hunter can visualize the animal which left the tracks even long after the animal has disappeared.

how homeopathy works. We have ample proof *that* it works but not how. If you are not a trained scientist I would advise you to stop right there and resist getting drawn into the discussion any further. To describe a homeopathic remedy to a physicist it is best to refer to it as a means of conveying information relevant to the organism to get started on the way to cure. Just think of the metaphor of the two tape cassettes. You can use it to point out that there is no molecule of the original substance required and yet still it retains its original information. Another metaphor which I often use is this:

A homeopathic remedy is like the tracks left behind by an animal on the ground. Even though the animal is long gone, the hunter can visualize its presence by reading the tracks it has left behind.

Having established that word on the second question is still out, where do we stand on the third one? Here the answer is quite simple: we have not even begun.

# 15 The Dam

Posology

The LM potency regimen

The second prescription

Hering's law

There are several decisions we have to make in order to arrive at a prescription. We have to decide on the remedy, select the potency, decide on the size of the dose (how many globules) and how often to repeat it. Getting all these variables right results in one of those gratifying experiences where patients return with a beaming smile, only to tell us that their problems have vanished and they feel as healthy as a newborn baby. The time we devote to the four decisions reflects the importance generally attributed to each. In my experience this looks something like this:

- **Which remedy?**
- **Which potency?**
- **What dose?**
- **What repetition?**

**Fig. 24** Not all decisions necessary to arrive at a prescription are usually given equal consideration.

What do these four questions in Figure **24** have in common? They are questions of posology. Posology is a composite of two Greek words: *posos* (how many) and *logos* (teaching, science). Posology therefore is the "science of how many." In other words, posology is concerned with everything in case management following the remedy selection. Considering the amount of time we spend on finding the remedy, is it justified to cut corners when it comes to questions of posology?

You guessed it! The last question was a rhetoric one and, of course, it is in no way justified to skimp on posology. I have observed many times how a well-chosen and constantly adapted posology regimen can turn a frustratingly slowly progressing case into a speedy recovery. Hahnemann, too, devoted much space to it and considered posology a key factor to achieve the ultimate goal: a rapid, gentle, and permanent restoration of health. In the footnote to § 246 of the *Organon* Hahnemann expresses his dissatisfaction with his previous posology guidelines and announces a new schema that does away with many of its shortcomings:

> *What I said in a long footnote to this paragraph in the fifth edition of The Organon of the Medical Art was all that my experience allowed me to say at the time. It was written with the purpose of preventing these adverse reactions of the life principle. However, during the last four to five years, all such difficulties have been fully lifted through the modifications I have made since then, resulting in my new, perfected procedure (for LM potencies).*

Hahnemann finished the sixth edition, from which the above quotation is taken, in 1843. Let us go back two editions of the *Organon* and see what he advocated then. Doing this, we find ourselves in the year 1829, when the fourth edition was published. Hahnemann was living and practicing in Coethen, Germany, to where he had moved eight years previously. The *Chronic Diseases*, Hahnemann's seminal work on miasms and the treatment of chronic diseases, saw the light in 1828.

When we examine Hahnemann's case notes from that time we find that his materia medica encompassed roughly 80 remedies. This is a far cry from the one or two thousand we know today. Among those 80 remedies, *Sulphur* was the one most often prescribed. He used centesimal potencies and would sometimes raise the potency stepwise, from, for example, 24C to 25C. The highest potency in use was the 30th. Hahnemann would give one or two globules ground up and mixed with milk sugar. In about a quarter of his cases he used placebo before or between doses of the remedy. Sometimes he also administered the remedy dissolved in water or by having patients smell a bottle which contained a dissolved remedy globule. Repetition was varied, ranging from every five minutes in life-threatening situations during the big cholera epidemic up to once every couple of weeks or months in some chronic diseases. He changed the remedy quite frequently, more often so in acute cases. The need to antidote a wrong prescription is also well documented, as is the use of intercurrent remedies after which he would again prescribe the original remedy.

## A Historic Detour of Posology

Every student and practitioner of homeopathy has read Hahnemann's *Organon*. When you check your copy (you do have one, don't you?) you will undoubtedly find that it is the sixth edition, which is the most widely read and has the widest circulation. How is it then that the overwhelming majority of cases are prescribed for and managed according to the fourth edition? What happened in those 13 years it took Hahnemann to evolve homeopathy from the fourth to the sixth edition, and what is it we are missing today by essentially ignoring the important evolution which homeopathy underwent in those 13 years?

The answer to this question is important for understanding LM potencies, whence they came, how they developed, and how to use them best. Rather than simply jump to conclusions, I would like to take you on a bit of an historical tour, examining how Hahnemann's view on posology changed by reading and quoting relevant parts from the *Organon*. Afterward, you will have a much better founded knowledge of LM potencies than the majority of homeopaths today, since this part of Hahnemann's work is little understood and even less applied.

Published only one year after the *Chronic Diseases*, the fourth edition of the *Organon* has strong philosophical ties with it. In it Hahnemann introduced the single unit dose of a few poppy seed sized pellets, only to be repeated after long intervals if and when there was a definite relapse of symptoms. Paragraph 242 of the fourth edition reads:

> *As long, therefore, as the progressive improvement continues from the medicine administered, so long we can take for granted that the duration of the action of the helpful medicine, in this case at least, continues, and hence all repetition of any dose of medicine is forbidden.*

Later, at the end of § 245, he sums up:

> *In one word, we disturb the amelioration affected, and still to be affected from the first dose, if we give a second dose of the same originally well chosen remedy before the expire of the period of action of the first.*

During this period, also, Hahnemann stated that the 30th potency should be the limit of dynamization. As David Little, an American homeopath now living and practicing in India, aptly observed, the fourth edition of the *Organon* can in many ways be called the "Limit Maker." Through it Hahnemann sought to give the quickly growing homeopathic movement some strict guidelines and prevent its deviation from the scientific path. So we find that he limits the size of the dose to one or two poppy seed sized pellets, limits the repetition to the expiry of action of the previous dose, and suggests the 30C as limit to the potency scale. Soon thereafter his closest friends, Stapf and Gross, prevailed on him to admit potencies beyond the 30C, and Hahnemann took up experimentation with them. We now know that he used remedies up to the 200C and above (see, for example, the footnote to § 287 in the fifth edition: ". . . one carries on with the dynamization beyond the 30C, now up to the 60C, 150C, 300C, and higher . . .").

Initially, Hahnemann was led to the idea of diluting (and later dynamizing) crude substances after observing the severe aggravations they caused in his early patients. He treated many of the very first patients according to the newly found simile principle with still undiluted, un-potentized substances; they often experienced life-threatening aggravations. At the end of the fourth edition he saw himself closer to, but still far away from, his goal of the rapid, gentle, and lasting cure. Hahnemann realized that the size of the dose has as much to do with the severity of the aggravation as the potency (c.f. § 276):

> *For this reason, a medicine, even though it may be homeopathically suited to the case of disease, does harm in every dose that is too large, and in strong doses it does more harm the greater the homeopathicity and the higher the potency selected . . .*

Therefore he advises us in § 279 to use the minimum dose:

> *Pure experience shows universally . . . that the dose of the homeopathically selected and highly potentized remedy . . . can never be prepared so small that it shall not be able to overpower the disease, at least in part, and extinguish it from the sensation of the principle of life and thus make a beginning of a cure.*

In countless instances throughout the *Organon* Hahnemann emphasizes that the smallest possible dose should be administered. Impregnating tiny poppy seed sized pellets with the medicinal solution and prescribing a single one of those was a first step in this direction. Later, he found that the best way to decrease the size of the dose was to dissolve one pellet of the

remedy in a glass of water and give only a few teaspoons of the solution as a dose. Surprisingly it turned out that a remedy administered in this way not only produces fewer aggravations but also seems to act more deeply. The fifth edition states this important result of 36 years' worth of research in § 286:

> *For the same reason the effect of a homeopathic dose of medicine increases the greater the quantity of fluid in which it is dissolved when administered to the patient, although the actual quantity of medicine it contains remains the same.*

The administration of remedies as dry globules was abandoned with the fifth edition, and the watery solution remained as the correct from of administering medicine in the sixth edition.

Speeding up the progress of a case by repeating the remedy has always been a great temptation. We have been told by James T. Kent as well that a remedy can only be repeated if the previous dose has exhausted its action. This agrees with Hahnemann's experience up to the fourth edition of the *Organon*. Later, he modified his statement by saying that a repetition of the remedy is contraindicated only if the previous dose produced a strikingly increasing amelioration. In the case of only slow progress, however, the remedy may be repeated if three conditions are met (c.f. § 246 of the fifth edition):

1. One must be sure that the correct remedy was chosen.
2. The remedy must be given in an aqueous solution in the smallest possible dose.
3. The dose is only repeated after "suitable" intervals. The homeopath has to observe the patient closely, repeat the

indicated remedy every seven to 14 days, and use intercurrent remedies if the patient has stopped reacting favorably to the original remedy.

In the sixth edition we see the logical continuation and progression of ideas which started already in its predecessor. Most strikingly, Hahnemann changes his direction as to how remedies are to be prepared. Having long since experimented with different ratios of dilution to succession, he now settles on a 1:50 000 ratio in dilution and 100 succussions between each step; the LM remedies are born (c.f. § 270, sixth edition).

The other major improvement to homeopathic practice which appears first in the sixth edition is the variation of potency with each dose. By giving the remedy bottle a certain but individually variable number of succussions before taking a dose, the potency of the remedy increases gradually. This permits frequent and beneficial repetition of the same remedy without the need for intercurrent remedies. Table **6** summarizes the progressive changes introduced successively over the 14 years between the fourth and sixth editions of the *Organon*.

The trend is clear: Hahnemann has evolved homeopathy into a direction which requires more and more individualization. Apart from the right remedy and potency, we now have to choose the size of the dose on an individual basis. The “split dose” in which a small part of a single globule can be administered in the form of an aqueous solution permits this. In addition, this mode of administration seems to let the remedies take hold at a deeper

Table **6** Juxtaposition of posology traced across three editions of the *Organon*. Most changes occurred from the 4th to the 5th edition; the 6th edition introduced the LM potency scale but added little in terms of basic posology

| | **4th edition (1828)** | **5th edition (1833)** | **6th edition (1843)** |
|---|---|---|---|
| Potency | Not higher than 30C | No limitation | Ascending LM potencies, individually adjusted by succussing each dose |
| Dose | 1 poppy seed sized pellet, dry on the tongue | 1 pellet dissolved in water, an individually adjustable number of teaspoons | As in 5th edition, only with LM potencies |
| Repetition | Never repeated if any action at all is still left from the previous dose | Repetition possible when no strikingly increasing amelioration from previous dose. Often, though, intercurrent remedies are needed | As in 5th edition, but no intercurrents required with LM potencies |

level than previously possible. Furthermore, in the sixth edition we are advised to vary the size of the dose as well as the number of succussions between each administration according to the patient's need. What Hahnemann promised us in return was a faster cure, which was at the same time also gentler. Homeopathic aggravations, he claims, are a thing of the past if his instructions are followed accurately (c.f. § 161).

I have asked myself why it is that everybody reads the sixth edition of the *Organon*, which speaks only of LM potencies, but so

few people follow its direction. The reason, I suspect, has to do with the late publication date of the sixth edition. You have to know that, although Hahnemann finished it in 1842, it was first published in 1921. In the meantime, such influential people as James T. Kent shaped the face of homeopathy. Their knowledge of Hahnemann's legacy was still based on the fifth edition; Kent never read the last one, and the biggest part of the homeopathic community has been following Kent's word on posology out of mere inertia.

## The Dam

So far so good, but what does it all mean? Have we not already found a convenient and efficient way of practice in the familiar centesimal potency scale and dry sugar pellets? The answer is "yes" if we accept as inevitable the slow progress of many chronically ill patients and are willing to take up the gamble of causing very unpleasant and sometimes dangerous aggravations. To illustrate the difference between posologies in the centesimal and LM potency scales I would like to evoke a metaphor. In Figure **25** you see a photograph of a huge dam holding back a big lake. Just imagine what it would be like to blast away the dam in one big explosion. Not only would all the rubble of the collapsing concrete structure be flying around, the entire dammed up lake behind it would be released at the same instant. The water would be rushing into the valley behind the dam. Its unstoppable force

**Fig. 25** Blowing up the dam will create a huge flood wave devastating everything in the valley downstream.

would be likely to flatten everything in its way. There would be nothing anyone could do after the detonation but to wait until things had settled down sufficiently to allow the area to be approached again.

What I have described in an admittedly graphic way is the action of a high centesimal potency. Once you put the remedy on the patient's tongue, there is nothing, really, you can do but sit tight and wait things out. If the potency was too high, a formidable aggravation may ensue—like the dammed up water released

all at once. This is what Kent had in mind when he wrote in 1900 in his *Lectures on Homoeopathic Philosophy*:

> *It is sometimes a dreadful thing to look upon, and the physician may be turned out of doors. Let him meet it as a man; let him be patient with it, because the ignorance of the mother or the friends can be no excuse for his violation of principle, even once.*

The alternative is to remove the dam slowly, brick by brick. When you do it this way, you have close control over how much water spills over at any time. If it becomes too much, just slow down dismantling the wall. If you want to move faster at any time, it is easy, you are in complete control of the entire process, from beginning to end. This is what Hahnemann describes as the right posology with LM potency. Ultimately, the case will progress faster, smoother, and with better patient compliance.

The price you have to pay is a more demanding case management. The correct choice of the homeopathically indicated remedy must still be the most important thought in our minds. However, the choices that come afterward have the potential to turn a slowly progressing partial success into a rapid, gentle, and lasting cure. The need for individualization does not stop at the time we close our repertory books. We read in Hahnemann's *Chronic Diseases*:

> *Nevertheless, the incredible variety among patients as to their sensitivity, their age, their spiritual and bodily development, their vital powers, and especially their nature of disease necessitates a great variety in their treatment, and also in the administration of the doses of medicine to them.*

I hope that by now I have piqued your interest for the proper use of LM potencies. Since information about them is much harder to come by, I think it will be helpful to devote a section to describing how they are prepared. Knowing what they are will make it more logical and easier to explain how they are best used in practice. The last section of this chapter will therefore discuss case management with LM potencies.

## Preparation of LM Potencies

You probably guessed it already: Yes, Hahnemann described in detail how to prepare LM potencies (c.f. § 270). I will summarize the procedure and convert the old units of measurement to ones in use today so that you get a clearer idea of the whole process. You begin by weighing 6.4 g of milk sugar and dividing it roughly into three parts. The first part goes into the mortar together with 0.064 g of the source material you wish to potentize. Now comes a sequence of hefty grinding for six minutes followed by four minutes of scraping. Repeat this sequence once for a total of 20 minutes. Now add the second part of the milk sugar and start to grind and scrape in the same way for another 20 minutes. After that, in goes the last of the milk sugar followed by another 20 minutes of grinding and scraping. After this one hour of arm-numbing labor you are looking at a 1C trituration.

Next, you again prepare 6.4 g of milk sugar and put one third of it in a mortar together with 0.064 g of the 1C trituration from

above. Follow the same 60 minutes' procedure of grinding and scraping from the previous paragraph and you wind up with the 2C trituration. Repeat the previous step, starting with the 2C and working it up in the manner described to the 3C trituration. All together, preparing the 3C trituration requires three hours of grinding and scraping.

The 3C trituration is the "mother of all potencies." From it you can either prepare conventional centesimal potencies or, by the procedure described below, LM potencies. I strongly urge you to make a 3C trituration of a remedy yourself at least once. Only then can you appreciate the work and energy that goes into the process and that must somehow manifest itself in the final product. I was once on a homeopathic expedition in the rainforest and had to triturate under tropical conditions in the field. The most difficult thing was to prevent the copious perspiration from dripping into the mortar. Everything else was child's play in comparison.

Now dissolve 0.064 g of the 3C trituration in 500 drops of 43% alcohol. Put one drop of this solution into a vial together with 100 drops of 90% alcohol. Give the tightly corked vial 100 strong succussive strokes against a hard but elastic body (Hahnemann suggests a leather bound book). With this, you thoroughly moisten fine sugar globules. The size of the globules is such that 500 of them can barely absorb one drop. Then you let the sugar pellets dry, put them in a bottle and label it LM1.

To prepare the LM2 you dissolve one pellet of LM1 in one drop of water, add 100 drops of 90% alcohol, succuss the solution 100 times and moisten a new batch of sugar globules with it.

These you label LM2. In this manner you can prepare all higher LM potencies.

The procedure is always a liquid dilution by the ratio 1:100 and then a "dry" dilution by the ratio 1:500. The latter happens because each single pellet absorbs only the 500th part of a single drop. Therefore the overall dilution ratio between successive steps of LM potencies is 100 x 500 which equals 1:50 000; the number of succussions between them is 100. Centesimal potencies have a dilution ratio of 100 and only 10 succussions. Incidentally, it is dangerous and altogether misleading to attempt to find a correspondence between C and LM potencies. An LM1 has about the same dilution as a 5C but corresponds to a 13C in terms of succussion strokes. An LM12 is similarly diluted as a 31C; its succussions, however, are those of a 123C. There simply is no coherent correspondence between these two potency scales, and it would be totally wrong to conclude that an LM1 is a low potency simply because it has the same dilution as a 5C. If you are going to use LM potencies, you have to think in LM potencies. In the following section on case management I am going to show you how to do this.

## Case Management with LM Potencies

Even though we called the dry sugar pellets, whose manufacture is described in the previous section, LM potencies, they are not what the patient receives. In fact, the dry pellets are just a con-

venient way of storing LM potencies. When dispensing LM potencies to a patient, the pharmacist dissolves a single one of those pellets in 100 ml of diluted alcohol. It is this solution that the patient receives. Never the dry pellets. This fact is, unfortunately, often disregarded. I suspect it is the similarity to the familiar form of centesimal potencies that wrongly suggests to some practitioners to give also dry pellets of LM potency as a dose.

But the story does not end here. The patient does not simply take a prescribed amount from the solution bottle. The procedure to follow is this:

1. Before each dose, the patient succusses the bottle five times.
2. The patient puts one teaspoon of the solution into a glass containing about 100 ml water and stirs vigorously.
3. From this dilution, the patient takes one teaspoon as a dose and discards the remainder.

The important part here is that each dose has a slightly higher potency than the previous one because the solution bottle is succussed each time before taking the remedy. Second, the solution is a concentrated form of the remedy which is not meant to be taken undiluted; it needs to be diluted in water.

Neither the number of succussion strokes before each dose nor the amount of dilution afterward are fixed. Either or both may be—and, indeed, need to be—adapted to the unique situation of each patient. When I recommended to succuss the bottle five times and put one teaspoon into a glass of water, I intended these quantities to be mere guidelines. I have had patients who

required anything from two to 10 succussions between doses. For some very sensitive patients I had to reduce the dose by having them put one teaspoon of the dilution into a second glass of water and take a teaspoon of the second as a dose. Sometimes it was necessary to have the patient put three teaspoons into the dilution glass. A few times, most notably in cases of migraine, I advised patients to place a single drop from the undiluted solution bottle directly on the tongue when they felt an attack coming on. Where, previously, there was very little room in terms of individualization with centesimal potencies, now there is ample. The beauty of it lies in the adaptability to each individual case, thereby preventing aggravations and speeding recovery.

The graphic in Figure **26** demonstrates the difference between the two posologies. The heavy black line denotes the

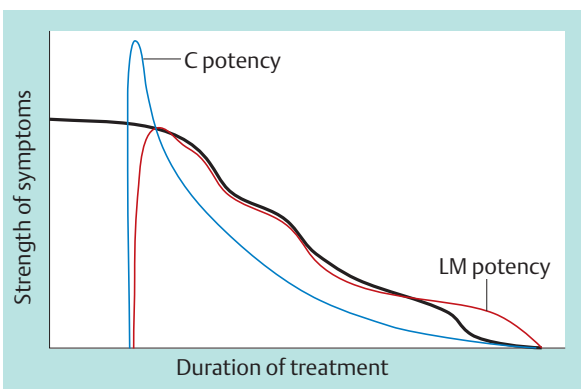



**Fig. 26** LM potencies allow a posology which is closely adaptable to the current strength of the disease. Conventional regimes with centesimal potencies do not permit this.

strength of symptoms exhibited by the patient, which gradually diminishes over the course of treatment. A single dose of a C potency results in a very quick and strong action, just like the explosive charge with which we blew the dam away in our previous metaphor. Often the remedy action is stronger than the patient's disease, resulting in a marked and frequently very unpleasant initial aggravation of symptoms. This feature is represented by the spiked gray line protruding above the black one. After administering the dose, the practitioner has to sit back and be patient until its action has completely expired. Even though after the initial aggravation has subsided the patient could potentially tolerate a stronger stimulus (the gray line lies well below the black one after the initial spike), the practitioner has to wait. There simply is not enough control built into this kind of posology to modify the strength of each dose and model the remedy action according to the symptom strength.

The situation is totally different when we switch to an LM regimen. Due to the gradual and variable increase in potency from dose to dose as well as the adaptable size of each dose, the stimulus provided over the course of treatment can be made to match closely the strength of the disease as it evolves over time. There is no initial aggravation. In the language of the metaphor we are dismantling the dam gradually without any potentially hazardous and catastrophic release of a flood wave from the built-up lake.

Let us now turn to the practical application of this new-found knowledge. How do we decide on the number of succussion

strokes and the size of the dose? What is the potency to start the case and when do we raise it?

As Hahnemann recommends and experience shows, a case is best started with a low LM potency, usually LM1. Going through my case files I see that I started about 80% of all cases with an LM1 and the remainder with LM2 and LM3. I cannot find a single case that I started with a higher potency. If you are just beginning to explore LM posology I recommend you start your cases with an LM1. Only if you would otherwise consider giving a centesimal potency above a 1M would I consider opening a case with an LM2 or even LM3. The argument that lower potencies act primarily on the physical plane and leave the mental/emotional functions untouched is not borne out in practice with LM potencies. You can safely assume that even an LM1 has all the overtones to reach into the mental/emotional realms.

The starting point for an average patient is usually five succussions between doses, one teaspoon of the solution into a dilution glass and one teaspoon as a dose. If the sensitivity of the patient is much higher than average I would consider using half a teaspoon of the solution and half a teaspoon as the dose, effectively cutting the amount of remedy ingested by four. If that proves still too much, I use a second dilution glass. The patient then puts one teaspoon of the first dilution into the second glass and takes a teaspoon from that as a dose.

Many homeopaths think that LM potencies are routinely repeated every day. This is absolutely wrong. They *may* be repeated if called for, but should definitely not be repeated on a rou-

tine basis. A repetition is definitely and absolutely contraindicated when the initial dose produces a striking amelioration. Therefore the way to begin a case is to have the patient take a one-time test dose of the remedy and wait; how long depends on the nature of the disease. In chronic diseases I usually have the patient call me in one week. In acute cases the wait may be much shorter, maybe even only one hour or less. It is not uncommon for this one-time dose, if the remedy is truly the simillimum, to carry the patient so far toward health that a second dose is not needed and the patient is cured. Most cases, however, particularly chronic diseases of long standing, require repeated doses. In this case, the patient will call after one week and tell you that he or she felt a little bit better for a day or two but that everything then went back to normal. In this case you may repeat the remedy. If the remedy did not cause any untoward new symptoms, I will tell the patient to take the remedy daily in the previously described manner. I want to be informed immediately if new symptoms arise or the disease seems to worsen. In any case I tell the patient to call me not later than in two weeks. Several things may happen on the follow-up call.

The best news is when the patient tells me he or she feels better. In this case I continue the remedy in the same fashion, true to the motto "don't fix it if it ain't broke." The next check-in is usually in another two weeks.

It may be that the patient has started to develop some new symptoms. If they are not troublesome and belong to the drug picture of the prescribed remedy this is an indication that the stimulus is getting to be too strong—we need to reduce the dose.

First, I tell the patient to stop taking the remedy altogether and wait until the symptoms have subsided. Then I start the remedy again, but with a reduced dosage,that is, higher dilution or taken every other day instead of daily.

If the newly developed accessory symptoms are not minor but have become very uncomfortable or troublesome I question my remedy choice. The remedy needs to be stopped immediately, of course. A few days' wait will show how quickly the symptoms subside. If you are still sure of your choice you may want to lower the potency, for example from LM3 to LM2, or decrease the number of succussions between each dose, with two being a practical lower limit.

If the patient has stopped progressing and reached a plateau, raise the potency first by increasing the number of succussions between doses. If you are already using 10 strokes and the situation has not changed, go to the next higher potency. Do not skip and jump, just go up one step at a time.

In most cases you will quickly find a regimen of dilution, succussion, and repetition that keeps the case progressing nicely. Patients will then call you when they are about to run out of remedy in their solution bottle. Depending on the individual posology, a solution bottle usually lasts anywhere from one to four weeks. This is also a natural time scale to increase the potency by one step, so if they have run out of LM2 solution, the next bottle will be an LM3. Exceptions exist, but I have found this to be a good rule of practice. If you need to change the remedy, you start again with a low LM potency, usually an LM1.

Managing a case with LM potencies generally requires more frequent check-ins with the patient. I rarely let more than two weeks go by without at least a telephone consultation. The closer contact with the patient is necessary because cases evolve faster and the posology may need to be adapted to the new situations. I have found three distinctly different time scales in the evolution of a case following a new prescription:

**Short term:** within 24 hours of taking the remedy.

The first dose sometimes elicits a strong response in the patient and you definitely need to hear about this. Therefore I am very insistent that my patients call me immediately if things change dramatically as a reaction to the remedy. Even if there is no such reaction, a quick check-in may reveal subtle changes and makes me feel more confident about my choice of remedy. Often the change is a particular dream or a slightly increased sense of well-being. If you wait too long after the initial dose, this kind of information is too fleeting and will be forgotten.

**Mid term:** one to two weeks.

After at most two weeks I expect to see some noticeable improvements. If nothing at all has changed—even after thorough questioning—and I am still sure of my prescription, I will increase the number of succussions or potency.

**Long term:** two to eight weeks.

In the majority of chronic cases, this is the time scale when an adaptation of the posology is likely to become necessary.

What sounds rather theoretical and complicated on paper will remain frustrating and elusive in practice if you do not follow

this one advice: document your cases meticulously! Without proper documentation of each follow-up visit you will not be able to learn from your failures and successes. On the other hand, if you follow this advice, LM posology will quickly become second nature to you, and you will not want to miss the close control it gives you over each case. I would like to conclude this chapter with several typical case examples.

## Some Case Examples

Since the focus of the following cases is on posology, I am focusing on information necessary to clarify my choices in this regard. Symptoms and information required to select the remedy have been omitted.

**C** Susan is 35 years old and comes to me because of her chronic sinus complaints. She has frequent acute flare-ups with severe headaches at the slightest exposure to a cold draft. She appears very sensitive, almost frail, and speaks with a soft voice. Because of this, I prescribed the remedy (*Silicea*) in LM1, five succussions, half a teaspoon of the solution in one dilution glass, and half a teaspoon to be taken as a dose. Susan was to take the remedy only once and report back to me after one week. When she called it was only two days after her visit and she was exuberant. Her boring frontal headache had been gone since the first day and she was feeling much more energetic. Because of this

I told her not to take any more doses and to call me back after two weeks or when symptoms started to return. She called me after two weeks, at which point she told me that she had been having a terrible nasal discharge for the last couple of days. She was completely flabbergasted by the sheer amount of discharge. I interpreted this as a healing reaction according to Hering's law and an indication that Susan was still moving along toward health at a good pace. No repetition of the remedy was required. Susan was to call me in another two weeks. When I heard from her, she told me that the discharge had stopped soon after her last call to me. She now felt great, able to breath through her nose freely.

Susan's case is a nice example to counter the common misconception that LM potencies require daily repetitions and take a long time to act. In my experience, they are not slower than C potencies and have the same potential to cure a case with a single dose. Therefore routine repetition is never a good idea.

I heard from Susan about three years after our last conversation. Her sinusitis had not been a problem since. The reason she was contacting me now was a vaginal yeast infection with itching and a bland but copious discharge. It came on after a course of antibiotics taken for a bout of flu and would not stop. My first prescription was *Silicea* LM2. Since her demeanor had changed since the first dose of *Silicea* and she no longer appeared as frail and over-sensitive, I went with the standard posology (five succussions, one teaspoon from the solution, one teaspoon as a dose). I expected a quick reaction but was disappointed when

Susan called three days later to inform me that nothing had changed. I told her to start taking the remedy daily. A check-up call a week later revealed that the remedy had had no substantial effect. At this point I re-examined the case and came to the conclusion that *Silicea* was no longer the right remedy. I changed my prescription to *Pulsatilla*, the complementary remedy in her case, and settled on an LM1 and the standard posology. Since I was not afraid of strong adverse reactions and wanted to see an improvement fast, I told her to take the remedy daily and to call me immediately when her symptoms changed. After a week she called me to report an improvement of about 50 % in the itching and discharge. Continuing in the same manner, we scheduled a follow-up call in another week. When I heard from her, she was a bit disappointed because there had been no further improvement. I increased the number of succussions from five to 10 and left everything else unchanged. Another week went by and Susan's symptoms continued to improve slowly. Even though the itching was gone and the discharge had also improved some more, she was not yet completely free of symptoms. The solution bottle was nearly empty and I prescribed *Pulsatilla* LM2, returning to five succussions. It took another couple of days, after which Susan was symptom free and stopped taking the remedy.

It is pretty clear that in Susan's first complaint, when she received *Silicea*, the remedy was probably her simillimum and a near perfect choice. For the yeast infection, *Pulsatilla's* less than stellar performance was probably due to its being not quite the

simillimum. With a customized posology, however, the remedy was able to clear her infection.

Greg, 28 years old, suffers from year-round allergies. He has tried pretty much everything to alleviate his at times substantial sufferings, including Beclomethasone and various antihistamines. I learned a lot from this case since the acute symptoms of the allergy proved to be a reliable indicator for Greg's reaction to the remedy.

Greg was taking cortisone, a hormonal drug which has the potential to block homeopathic treatment. To minimize the chance of the cortisone antidoting the remedy, I wanted to have the option of repeating the remedy daily, if necessary. At the same time I sensed that he also needed some form of constant support and reassurance to stay clear of other suppressive allopathic medication. These considerations led me to prescribe the remedy (*Calcarea phosphorica*) in LM1 potency. I wanted to start with a sufficiently small dose of the remedy to avoid any potential aggravation of symptoms, dissolving one pellet of LM1 in 150 ml of diluted alcohol. After telling him to succuss the bottle six times before each dose, I prescribed one teaspoon of the solution to be diluted in a glass of water, of which he was to take one teaspoon as the dose and discard the remainder left in the glass. Apart from the slightly higher dilution (150 ml of water instead of the usual 100 ml, and six succussions instead of five), this is pretty much the standard posology.

What ensued was an immediate amelioration of his acute allergy symptoms after the first dose. As per my advice, he had taken

the remedy only once; I wanted to see how long he was able to "coast" on this single dose. On the third day he called me and complained that his allergy was returning. From then on he took the remedy in the manner described above every third day, which kept his allergy symptoms at bay without causing a noticeable aggravation. He was able to stay off allopathic medication completely.

Three months later he complained about an aching pain in the knees, an annoying post-nasal drip, and inability to concentrate for long periods. At this point I interpreted these symptoms as proving symptoms of *Calcarea phosphorica*. Because of Greg's already improved condition, the impetus of the homeopathic remedy was starting to become stronger than the disease itself, hence the proving symptoms. He stopped taking the remedy and the symptoms subsided quickly. We found that now he needed to take the remedy only once every other week. A decrease in the number of succussion strokes from six to three also helped to avoid a sneezing attack he experienced each time when taking the remedy. Nine months after the initial visit he was able to stop taking the remedy. His allergy problems, which I used as an indicator for how close to space repetitions, were gone. The last follow-up information I have is more than three years after the initial visit. He had not had a single allergy attack and was feeling well. Should the attacks return, I plan to start Greg with *Calcarea phosphorica* LM2.

This case is a textbook case because it exhibits all features of LM posology beautifully: a nice reaction to the first dose, some

proving symptoms three months into the case, and a slight reaction to a too fast increase in potency in response to which I reduced the number of succussions.

In summing up, I would like to mention a few other advantages apart from the ones already commented on when following Hahnemann's advice:

- The selection of potency is much less ambiguous since LMs are almost always started with the LM1. No more high/low potency controversy.
- With centesimal potencies there is always the danger of running out of higher potencies. Most pharmacies will be able to supply a 1M or 10M, but a CM or MM is hard to come by. Beyond that, manufacturing time and costs become prohibitive. No such problem with LMs. It is always the same effort to raise the potency in the LM scale. You will never run out of high potencies again.
- The more frequent repetition of the dose minimizes the danger of accidental antidoting of the remedy as, for example, in Greg's case above.
- In case the remedy action needs to be antidoted, for example due to an incorrectly selected remedy, this can be achieved very easily since the involved doses are much smaller (c.f. § 283). Decisions to change the remedy or potency can be made on a much faster time scale.
- Active involvement of the patient in the treatment is possible by letting the patient decide how frequently to repeat and/or

how often to succuss the remedy. The increased motivation and compliance thus achieved is not to be underestimated.

I hope that this treatise will encourage you to let go of the conviction that "one pellet is as good as a thousand." Instead, I suggest we view the choice of dose and repetition as another possibility to individualize the treatment. However, to take advantage of this opportunity we have to move beyond the dry-unit dose; routinism in any form is detrimental to successful prescribing. Hahnemann said: "Copy, but copy accurately!" In light of this it is only prudent to catch up with Hahnemann first before breaking new ground.

# 16 A Well-Guarded House

Vaccination

Homeoprophylaxis

Genus epidemicus

I have thought long and hard whether to include a chapter on vaccination in this book. It is a controversial topic sure to incite not only homeopaths but also members of the allopathic community. What tipped the scale was the sheer number of questions relating to this topic that I receive, mostly from interested lay

people. Unfortunately, the knowledge of homeopathic practitioners—be they medical professionals or not—is often not firm enough to answer confidently. There are many books available specifically on this topic which argue the contra-vaccination stance. What I have to say in this chapter is not meant to supplant but to complement the information presented in the available literature.

## The Metaphor

Over the years a wealthy man acquired a large collection of valuable objets d'art. He kept the priceless collection in his private home, a formidable mansion situated in a solitary yet picturesque spot in the country. Only one month previously he had added a priceless and most beautiful piece to his collection. Yet since this time a single thought kept nagging at the back of his mind: "What if someone wanted to steal my collection?" It gradually worsened until it reached the point where he tossed and turned at night, unable to fall asleep.

He decided to do something about this and hired a security team to guard his house. Initially, this seemed to help. He worried less and slept better. After some time, though, he was concerned that the guards were not doing their job with sufficient vigilance. Therefore he staged a false alarm and watched the guards respond. Not entirely happy with their efficiency he continued this practice of false alarms and fake break-ins. To satisfy his

paranoia the wealthy man increased the frequency of these training exercises beyond all reason. The continuous and increased level of stress on the security force started to wear on their nerves. It did not help that the man's attitude toward them was anything but understanding. He was never satisfied and constantly cracked the whip.

After several months, the security force had turned into a sorry bunch. They had ceased to take alarms seriously since they knew they were only false training alarms anyway. Their attitude toward their employer had changed considerably, also. Initial respect had given way to open dislike. Were this a ship, mutiny would not be far off.

## The Vaccination Strategy

The aforementioned wealthy man was a fervent believer in the vaccination strategy. His house, guarded by a security force, corresponds to our body protected by the immune system. The attempt to push the guards to their limits by staging false training alarms is what vaccination does to our immune system. Instead of strengthening it, we run the risk of overtaxing and weakening it. The final mutiny could be the immune system turning against ourselves—auto-immune diseases are the result.

Before false notions arise I would like to state clearly that I do not condemn vaccinations out of principle. Instead, I would like to see a higher level of public awareness and knowledge about all

sides of a vaccination decision. Vaccines can be an effective protective measure when applied judiciously. What we see today, however, is an across-the-board, blanket application of immunization programs that needs to be counterbalanced by more information. Thomas Jefferson, a former president of the United States of America, wrote in 1820:

> *I know of no safe depository of the ultimate powers of the society but the people themselves, and if we think them not enlightened enough to exercise control with a wholesome discretion, the remedy is not to take it from them, but to inform their discretion by education.*

Unfortunately, few medical practitioners who administer vaccinations inform and educate patients. In Great Britain, doctors receive a financial bonus of more than 3000 U$ when they have successfully vaccinated in excess of 90% of their patients under the age of two years (McTaggart 1999). This conflict of interest is certainly not helpful in furthering unbiased information on this topic.

On the one hand, the American Center for Disease Control (CDC) recommends 19 separate immunizations before the age of 12 months. On the other hand, pediatricians warn parents not to give cow's milk to their babies before 12 months of age to prevent the still immature immune system from developing allergies. A study of more than 2000 children showed that feeding them with cow's milk during the first nine months resulted in seven times more frequent complaints of eczema afterward (Keller/Wiskott 1991). If the developing immune system of a baby should not be

exposed to cow's milk, why is it that it can safely be exposed to eleven different pathogens in 19 vaccine shots? Seeking to avoid contact with allergens on the one hand while massively promoting it on the other by means of vaccinations seems inconsistent.

Arguments brought forth in favor of vaccination fall into three major categories:

1. Vaccinations are effective preventative measures.
2. Vaccinations are a safeguard against deadly diseases.
3. Vaccinations are safe and pose no risk by themselves.

The available clinical and research data do not support any of these claims unequivocally. Recent research, for example, shows that whooping cough vaccine is only about 36% effective (*Journal of the American Medical Association*. 1995;274(6):446–7). According to official statistics, more than 75% of all measles incidents occurred in supposedly fully immunized individuals.

Lynne McTaggert mentions in her book *What Doctors Don't Tell You* (McTaggert 1999) an article in *World Medicine*, from September 1984, which shows that a baby's risk of contracting encephalitis as a sequel to whooping cough resulting in permanent brain damage is 1 in 38 000; this is comparable to the risk of suffering from brain damage as a consequence of the vaccination itself, which is 1 in 25 000. Similar numbers exist for other typical childhood diseases such as measles, mumps, rubella, and even polio.

When proponents claim the decline in infectious diseases as a victory of mass immunization, we should not exclude the other

side of the medal, namely the precipitous rise of auto-immune diseases starting at the same time. Seasonal allergies were virtually unheard of prior to 1850, as were many other today all too common chronic illnesses belonging to the sphere of auto-immune disorders. What this suggests is not that vaccinations are dangerous in themselves. Rather, that the risks and benefits of vaccinations should be evaluated carefully in each case. Individualization, the cornerstone of homeopathy, must be applied here as well.

## Childhood Diseases

The role played by the so-called childhood diseases in the development of children has been the subject of many discussions. Often the development of a child seems to take a leap after such a disease, although reports by proud parents are not very objective, of course. There are, however, some observations that childhood diseases do not just harbor risks but can be quite useful. The following case is by no means the only example (Chakarti and Lingm 1986):

> *In 1984 a five-year-old girl presented with a bad case of psoriasis. She showed large affected areas on her body and extremities, also involving to a significant degree her scalp. During the following year she was treated by paediatricians and dermatologists with coal tar preparations, local steroids, UV light, and dithranol wraps. Despite these therapies and two hospitaliza-*

*tions, the psoriasis was refractory and remained essentially unchanged until she came down with measles. As the measles rash began to spread over her skin, the psoriasis disappeared. Since then she has been free of psoriasis.*

An article taken from the prestigious journal *Lancet* shows the intrinsic value of childhood diseases (Ronne 1985):

*Persons who have never had any visible indication of measles, i. e., never developed the skin rash of measles, suffer more frequently from non measles associated diseases. . . . The data show a highly significant correlation between lack of measles exanthema and auto-immune diseases, seborrhoeic skin diseases, degenerative diseases of the bones and certain tumors.*

The measles vaccination suppresses full development of the rash, giving the virus the chance to become persistent. Furthermore, in a vaccinated population childhood diseases are prone to develop later in life and become more serious.

Childhood diseases such as measles, mumps, rubella, and whooping cough are easily managed through homeopathic care. The decisive question one has to ask is whether the expected short-term benefit of vaccinations outweighs the potential long-term damage. We all tend to concern ourselves only with the problems at hand. Illnesses and diseases which threaten us now are more important in our eyes than possible complaints in the future. The fear of post-measles encephalitis is bigger than the fear of the rheumatic pain of the 30- or 40-year-old adult. Considering that homeopathic treatment and prophylaxis can reduce

the number of sequelae in childhood diseases significantly, the indiscriminate and routine practice of vaccination becomes even more doubtful.

## Treatment of Vaccination Side Effects—Vaccinosis

James Compton Burnett, whom we have quoted already on an entirely different topic (see p. 74), has also distinguished himself as the first to recognize a new disease he called vaccinosis. By this term he understood ". . . the profound and often long-lasting morbid constitutional state engendered by the vaccine virus." It is well worth reading his treatise in full, which appears as a small pamphlet (Burnett 2004).

The first immunization to be introduced on a large scale was against smallpox. The vaccine itself was derived from cows. Since the Latin name for cow is *vacca*, the immunization procedure itself was called vaccination (I guess "cowification" did not have the same appeal). During Burnett's time, smallpox was the only disease against which there was a vaccine. He found that *Thuja* was the most important remedy to treat vaccinosis (i. e., the chronic illness many people came down with after being vaccinated). Even today we find *Thuja* listed as the chief remedy for ailments arising from an immunization shot, although the original vaccine of Burnett's time is long gone. In the experience of many homeopaths (including my own), *Thuja* is not appropriate anymore for the multi-faceted modern-day vaccinosis syndrome.

Some homeopaths, among them Tinus Smits, Netherlands, and Isaac Golden, Australia, have gained significant experience with the homeopathic treatment of vaccinosis.

In my practice I see many children with allergies, neurodermatitis, asthma, or recurrent respiratory tract infections. It has become routine for me to ask about prior immunizations and how the child reacted to them. Not infrequently the mother will tell me that her child reacted badly to the shots. Usually these reactions take the form of a general and unspecific malaise with fever. Sometimes they develop into a more serious form with cramps and disturbances of the central nervous system. In other cases the mother will tell me that the child did not exhibit any openly adverse reactions but soon developed a bad cough every fall that nobody had been able to do anything about. It appears as if vaccinations may be able to strengthen the immune response to a very specific disease while at the same time weakening the overall immunological response. The metaphor of the well-guarded house comes to mind.

In such chronic post-vaccinal cases I proceed as usual, taking the entire case and looking for the best-fitting remedy. If a clear simillimum emerges you should give it and it will most likely cure the case. In my experience, however, there remains a significant fraction of patients who do not exhibit sufficiently distinctive symptoms to point to a clear simillimum, or else they do not react to what I thought was the simillimum. In these cases I turn to the vaccine nosode of the particular vaccination which first triggered the problem. Here is a typical example of a boy, Misha,

five years old, who visited me with his mother. Below is an abbreviated summary of his case.

C Misha suffers from recurrent, long-lasting upper respiratory tract infections. They come every year when the weather starts to turn cold and linger persistently over the winter. During this time Misha suffers from a severe cough which has a tendency to develop a wheezing quality and borders on a spastic bronchitis. His nose is blocked, his tonsils are enlarged, and he suffers from nasal polyps. The polyps have already been surgically removed once but grew back only one year later. Because of his difficulty breathing, he sleeps badly at night and wakes frequently. When he has had a bad night he can be very difficult and quarrelsome. Misha tells me that he has bad dreams, too, although I could not elicit more information about them beside that they make him afraid. His digestion does not tolerate onions well; they make him bloated, and he harbors a strong dislike for them. He is afraid of heights inasmuch as when he gets up he is afraid to go down. I ask his mother about Misha's history of immunizations, and she tells me that he took badly to the DPT (diphtheria, pertussis, tetanus) shot. The day after, he developed a bad fever and frightful hallucinations. The doctor denied that this could have anything to do with the recent vaccination and prescribed an antipyretic (anti-fever drug). The acute situation resolved completely within a week but the first of those troublesome coughs appeared soon thereafter. Initially, they were treated with con-

ventional medications (broncholytic, antispasmodic, and antibiotic drugs) but without lasting results.

On analyzing the case, the repertorization suggested *Phosphorus* as the most similar remedy, yet I did not see the typical *Phosphorus* mentality or features in Misha. He simply did not strike me as being *Phosphorus.* Given the clear etiology of the DPT immunization I looked up the vaccine nosode and, not surprisingly, the remedy picture fit nicely with the symptoms Misha exhibited. I prescribed *DPT* in a 30C to be taken in the evening of the first day and a 200C the following morning. This was in the winter of 2002, when Misha had a real bad time with his cough. A week after this, his mother called to tell me that his cough had all but subsided and a diarrhea had taken its place. I judged the diarrhea a favorable sign of elimination according to Hering's law and told the mother to wait and call in one week. At her next call Misha had already gotten over the diarrhea and his cough was gone. He slept better at night, apparently being able to breath through his nose more freely. Toward the end of the season the cough reared its ugly head once more but was responded beautifully to a single dose of *DPT* 30C. After that, there was no cough that year or the following year. A visit to the ear–nose–throat specialist showed Misha's tonsils to be of normal size.

The best treatment according to my experience is to use the potentized vaccine and to give it in two potencies over two successive days, 30C on the first and 200C the following day. If the

symptoms are unusually severe, the child is in bad health with a low vitality, or I expect aggravations for some reason, I dissolve three globules of the 30C in a glass of water and have the child take a sip every two or three hours for one day. Tinus Smits recommends progressing from the 30C up to the 10M on four days. I have seen no case where this proved to be necessary, and therefore I suggest not to give such high potencies routinely and without clear indication.

Unfortunately, vaccine nosodes have not yet been proved and therefore cannot be prescribed on the basis of their symptom similarity. For this reason I only prescribe them in cases where a clearly indicated, well-proved remedy does not present itself. It is, of course, helpful to document such cases well so that these nosodes can at least be prescribed on clinical data until the time of a future proving.

## Homeoprophylaxis and Genus Epidemicus

As homeopathic remedies are quite safe to use and do not come with all the risks associated with conventional vaccination, would it not be nice if homeopathy could be used to prevent infectious diseases? Such a thing does indeed exist, and it goes by the name of homeoprophylaxis. It is by far not as common as classical homeopathic treatment and is also a contested subject within the homeopathic community. Still, some homeopaths practice it and have gathered valuable experience. Isaac Golden

has published his findings on homeoprophylaxis in the slim paperback *Homeoprophylaxis—A Practical and Philosophical Review* (also available online).

The idea is to give a remedy before a disease has developed to prevent future contraction of this disease. And this is the point where critics jump in and interject that homeopathy works by matching symptoms present in the patient with those of a homeopathic remedy. How can one match symptoms of a disease that the patient does not have at the time? Proponents refute this contention using a footnote to § 73 in which Hahnemann names *Belladonna* as a cure and prophylactic for scarlet fever. But if you read all of Hahnemann's writings on this topic, a subtly different view emerges. True, the scarlet epidemic of 1801 found its prophylactic remedy in *Belladonna.* Another epidemic, sweeping Germany a few years later, did not respond to *Belladonna* but required *Aconitum* as a prophylactic as well as simillimum. In his article *Observations on the Scarlet Fever* published in 1808, Hahnemann provided a careful and individualizing description of these two scarlet fever epidemics. From this we already get a glimpse that homeopathic prophylaxis requires a closer and more differentiated look. Hahnemann holds that:

No epidemic disease should be taken for any previous one and treated in the same way, since all that break out at different times are different from each other.

Apparently Hahnemann spoke out in favor of a different prophylactic strategy. One which still requires individualization on the level of the particular epidemic. The remedy which he arrived

at for a particular epidemic is called the *genus epidemicus* of that epidemic. Thus, Belladonna was the *genus epidemicus* for the 1801 scarlet fever epidemic in Germany, whereas in 1808, the second big scarlet epidemic, it was Aconitum. For the cholera epidemic which hit Germany hard beginning in the year 1830, Hahnemann identified Camphora as the *genus epidemicus*. The *genus epidemicus* has the potential not only to cure the disease in the very early stages—before individually differentiated symptoms emerge—but also to immunize healthy people against it.

Since the *Genus epidemicus* needs to be found for each epidemic, how do we find it? Come next winter, the flu season is sure to approach; how do we find the *Genus epidemicus*? Permit me to quote Hahnemann from the *Organon*, § 101 and § 102:

> *Usually the physician does not immediately perceive the complete picture of the epidemic in the first case that he treats, since the collective disease reveals itself in the totality of signs and symptoms only after several cases have been closely observed. Nevertheless, an observant physician can often come so close after seeing only one or two patients that he becomes aware of the characteristic picture of the epidemic and can already find its appropriate homoeopathic remedy.*
>
> *From writing down the symptoms of several cases of this sort, the outline of the disease picture becomes more and more complete – not more extensive and wordy, but more characteristic, containing more accurately the peculiarity of the particular collective disease. The ordinary symptoms—e. g., loss of appetite, sleeplessness, etc.—become more precisely qualified, and those*

*that are more exceptional, special, and, in the circumstances, unusual, and belong to only a few diseases, reveal themselves and constitute the characteristic picture of this epidemic.*

*All those who catch an epidemic at a particular time have a disease flowing from the same source and therefore the same disease. But the entire scope of such an epidemic disease, the totality of its symptoms (which we need to know in order to grasp the whole disease picture and choose an appropriate remedy for it) cannot be perceived in any one patient, but can be fully distilled and gathered only from the sufferings of several patients with different physical constitutions.*

*In subsequent cases either the appropriateness of the homoeopathic remedy chosen in the first cases will be corroborated or else a more appropriate one, the most appropriate one, will be revealed to the physician.*

So, when you see the first cases of an epidemic, you treat them as if they were one single case, pooling their symptoms and finding the remedy for the bigger scope. This remedy will be the *Genus epidemicus*. Sometimes you will find that the complaints of your patients fall into two classes. I once saw this during the peak of the flu season where roughly half of the patients complained of a severe pain in their limbs, feeling bruised like after a good beating. The other half did not have that but complained instead of a severe headache which was only bearable when lying quietly in bed, avoiding any motion. This went so far that one such patient told me he could not even bear seeing the curtain move! The *Genus epidemicus* for the latter group turned out, not surprisingly, to be

*Bryonia* whereas it was *Eupatorium perfoliatum* for the former. In this case I advised my patients to take *Bryonia* 30C as a prophylactic on one day and *Eupatorium* 30C the next. I do not know of anyone who followed my advice and came down with flu that year.

Cases where a well-chosen *Genus epidemicus* fails to protect are rare. I suspect that people with a strong miasmatic background will develop individual symptoms already from the beginning. Hence, a remedy selected for the general disease picture is bound to miss the mark.

I should not forget to mention that one of the best preventative measures is to take the constitutional remedy chosen on a carefully taken complete case including the chronic picture. If the remedy is very close to the simillimum it is my experience that it will act best to strengthen the entire organism and thereby effectively prevent infectious diseases. A good sign for a spot-on simillimum is that it will help the patient not only in his or her chronic complaint but will act promptly and reliably in most acute situations as well. If the constitutional remedy was only a simile, the patient will likely require a change of remedies for acute illnesses. Also, a simile has very limited prophylactic qualities.

What we have discovered so far is that multiple strategies of homeopathic prophylaxis exist. In order of descending degree of individualization, they are:

- a constitutional remedy that is very, very close to the simillimum
- the *Genus epidemicus* selected individually for the particular epidemic

- a homeopathic remedy which is known to have the characteristic symptoms of the expected epidemic
- the vaccinal nosode of the epidemic

The *Genus epidemicus* can only be selected once several cases of the specific epidemic have been examined and treated successfully. Therefore it cannot be used in advance of the epidemic's approach. Sometimes, however, homeopaths in a geographic region team up and exchange their experiences to establish a *Genus epidemicus* quickly. The constitutional remedy needs to be selected far in advance and independent of the epidemic crisis. Therefore it is of no use for new patients at the time the crisis

Table **7** Remedies and vaccinal nosodes for homeopathic prophylaxis of several common diseases

| Disease | Characteristic remedy | Nosode |
|---|---|---|
| Influenza A | *Eupatorium perfoliatum* | *Anas barbariae cordes et hepatice,*[1] *Influenzinum* |
| Scarlatina | *Belladonna* | *Scarlatinum* |
| Measles | *Pulsatilla* | *Morbillinum* |
| Mumps | *Phytolacca* | *Parotidinum* |
| Pertussis | *Drosera* | *Pertussis* |
| Tetanus | *Ledum* | *Tetanus toxin, tetanus* |
| Spring diarrhea | *Bismuthum* | – |
| Borreliosis (tick bite) | *Ledum* | *Borreliosis* |
| Meningoencephalitis (tick bite) | *Ledum, Apis* | *FSME*[2] |

1 The remedy *Anas barbariae cordes et hepatice* is available under the trade names Oscillococcinum from Boiron or ABC remedy from Remedia pharmacy (www.remedia.at)

2 The remedy *FSME nosode* is available from Remedia pharmacy (www.remedia.at)

hits. A characteristic remedy or the vaccinal nosode, however, can be given in advance of the epidemic and without individualization. Note, however, that they should only be given to healthy persons who have not yet contracted the disease. In Table **7** you will find a list of common epidemic diseases and their characteristic remedies along with the nosodes I find most effective in prevention.

Regarding posology, I suggest using the 30C potency of both the remedy and nosode, taken once a week as long as the epidemic lasts. Another personal note: I have found *Anas barbariae cordes et hepatice* exceptionally effective as a flu prophylactic. Even when taken as late as 24 hours after onset of symptoms it aborts most cases. Cases of meningoencephalitis spread by tick bites have in some regions become a serious threat while still unheard of in others. Borreliosis (Lyme disease), however, is far more common. Fortunately, a single preventive dose of *Ledum* after a tick bite will help in both cases.

# 17 Above and Beyond

A broader view of sickness and health

The placebo effect

Throughout the book we have talked quite a bit about some pretty basic and some fairly advanced topics in homeopathy. We have explored the meaning of health and disease, taken a close look at the law of similars, examined the miasmatic theory, expanded our view on case taking, and then some. What we have not yet done is put homeopathy in context with whatever surrounds it and in whatever it lies embedded.

If you have read the book up to this point you may safely stop now. What I collected in this chapter is not going to add directly to your homeopathic knowledge. Here I want to talk about the big view, the cake in which all the raisins are hidden. The problem is that there is no objective way to present this. In the best of all worlds I would have liked this to be a discussion between you and me with the chance to correct misunderstandings as they arise. But if you want to read on anyway and are willing to accept this shortcoming, so am I.

## Mind and Matter

The realm of homeopathy is the intricate interface between mind and matter, form and substance. Homeopathic remedies convey information to the diseased organism. The very word "information" comes from "in-formation," that is, lending form to something. Healing is a creative process which transforms immaterial form into a tangible shape; an idea transformed into material action such as the closure of a wound. Carrying the specific heal-

ing idea from the immaterial world of mind and spirit into the physical world of body and substance is the catalytic action of the homeopathic remedy.

When we speak of the two worlds we are drawing an artificial dividing line through the indivisible wholeness of nature. From the beginnings of recorded history up until the seventeenth century those two worlds were quite naturally perceived as one. Early religions were always surrounded by their gods, their divinities being present in everything material. A stone, a flower, a river were all inextricably linked with divine representations. This close tie between the worlds gradually became more distant and tenuous during the eighteenth and nineteenth centuries. Religion, and with it all spiritual things, was separated from everyday life. Science drew the dividing line by lending credulity only to things measurable which necessarily all belonged to the material world. Religion—and spirituality at large—was considered opium for the masses. The impetus which started to slow down the swing of the pendulum and eventually reversed its motion manifested in science again. Emerging quantum mechanics questioned the stolid separation of material and immaterial. The mechanistic interpretation of the universe started to look increasingly like a simplistic image destined to be replaced by something new. James Jean (1877–1946), an influential British physicist and mathematician, summarizes this evolution in a quote from his book *The Mysterious Universe* (Jean 1930):

> *Today there is a wide measure of agreement that the stream of knowledge is headed towards a non-mechanical reality; the*

*universe begins to look more like a great thought than a great machine.*

Even more succinctly, the famous Austrian physicist Erwin Schrödinger (1887–1961) phrased it thus:

*(The universe) is pure shape, nothing but shape.*

What does it matter to us? Well, what is true for the universe must be true for ourselves as well. Is the human body form or matter? Every moment we shed old and dying cells, replace them with new ones. We cut our toe and finger nails, our skin replaces itself continuously, the average life span of a red blood cell is 120 days. No cell of our body lives anywhere near as long as the entire human. There is a constant stream of matter through our body, and it has been calculated that after an average of seven years there is not a single cell left of our "original" self. Even though no molecule stays the same, we as a whole remain apparently unchanged. What guides the molecules in their place? What guides foreign matter into its proper place and thereby makes it a part of our self? All living organisms are like a building under constant reconstruction. The building's plan has precedence over the constantly changing collection of bricks.

Cast in the language of homeopathy, the vital force is the plan according to which our material self functions. Any error in it will manifest as disease. And healing is enacted by rectifying the information contained in the plan. We arrive again at the point where disease is tantamount to misinformation, and health can be restored by providing the correct information.

## Dramatic Conflict

Disease is but a single word yet it encompasses so many different interpretations. The mechanistic point of view sees the human body as a grand machine which simply wears out and develops flaws: disease as wear and tear. To the patient, disease may pose as a threat. It is something bad that needs to be feared. Medical doctors also see disease as an enemy which has to be combated and driven away. Disease, in this view, is not a part of life or the patient. As modern psychology has revealed, disease can also be a particular strategy of the patient, employed to reach a certain goal. It can be used in this way to manipulate the environment to provide constant support. Next to disease as strategy lies disease as illusion. Rajan Sankaran elaborates on this idea in his book *The Spirit of Homeopathy*, where he identifies a central delusion at the root of every disease. The patient behaves as if he or she were stuck in a particular situation which is incongruent with the surrounding reality. A different aspect of disease focuses on its ability to enact metaphorically a problematic situation. An example of this are chronic digestive problems through which the patient subconsciously expresses that he or she cannot "stomach" something. Or the pain in the neck which points to some issue that has become a "pain in the neck" for the patient.

As Edward C. Whitmont has pointed out in *The Alchemy of Healing: Psyche and Soma* (Whitmont 1991), disease is a dramatic play enacted on the stage of life. Disease is conflict between the old and the new. It is our opportunity to incorporate new insights

and expand our awareness. Growth, however, is only accomplished by relinquishing some part of one's self while at the same time incorporating something new. Disease is the conflict arising from this. To effect healing means to resolve this conflict constructively by incorporating its message into one's life. In doing so, we expand our awareness and move forward on our personal path of self-realization. Hence, disease is not something to be driven away but rather something that needs to be incorporated. A good example of this are the common childhood illnesses such as measles, mumps, rubella, and chicken pox. A child who comes down with one of these illnesses frequently makes a jump in his or her development when the disease is allowed to run its normal course. Suddenly, after a bout of the measles, the child will be able to do things that he or she could not do just weeks before. Nowadays, children are afforded this opportunity less and less often because of stringent vaccination programs starting only months after birth.

Life is the opportunity to grow, it is an ever-expanding spiral of increasing awareness. Positive resolution of conflicts and healing crises are the force which turns disjoint concentric circles into a continuous, connected spiral. Healing, however, can never be performed on the same plane as the conflict. I do not know if you ever heard the story of the famous Baron Muenchhausen. He fell into a treacherous swamp while riding on his horse. Nobody was around to help him, therefore he simply and resolutely gripped himself by his hair, clamped his legs tightly around the horse, and pulled himself and his horse out of the swamp. I do not know of

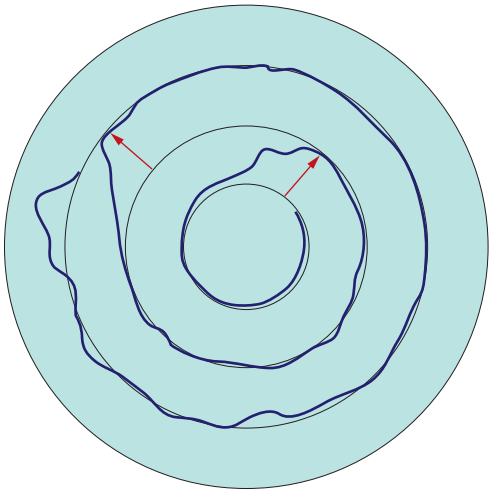


**Fig. 27** Life is an ever-expanding spiral of increasing awareness. Through positive resolution of conflicts and disease (symbolized by the two arrows) we gain insight and attain a higher level of self-realization.

anybody who was able to perform this feat before or after Muenchhausen. Therefore, unless you are a direct descendant of Baron Muenchhausen, the healing impetus must be grounded in the current plane to reach us and at the same time on the next level to teach us. This, incidentally, is nothing but the law of similars rephrased.

For most people, this expanding spiral of awareness is not perceptible as such. Our conscious mind that helps us with such mundane tasks as finding a parking place is too firmly rooted in the here and now. Its overall scope is very limited in favor of richness in details. Our other self, the unconscious, provides us with the big picture but is not so much into the details. The strengths and limitations of these two views complement each other, allowing us to draw more upon one or the other, as the situation

requires. In the language of our metaphorical life spiral, our unconscious mind sees the overall shape of the curving circles whereas the conscious is focused on the immediate vicinity of the pen drawing the line. The unconscious communicates with the conscious in a language rich in drama, images, and metaphors. A language we experience as our dreams.

Another way to think of homeopathic remedies are as crystallized dreams of nature.

## Placebo and the Evolution of Science

Placebo is one of the great mysteries of medical science: someone takes a fake pill and is cured of a disease. If that does not strike you as miraculous, what does? Since placebo is a name for any therapeutically inactive substance, homeopathy has been put in the same drawer as placebo. This also places homeopathic remedies on the same level as placebo and therefore is merely a somewhat polite way to say that any therapeutic effect of homeopathy is merely wrought by the mind of a gullible patient. Personally, I consider the placebo effect one of the great miracles of medicine. Therefore I would like to devote this last part of the last chapter to it.

Let us first turn to the historical evolution of science. When we follow the time line of modern chemistry back into the past we encounter alchemy at its root. Similarly we find astrology at the root of modern-day astronomy. The evolutionary process

which took us from alchemy to chemistry or from astrology to astronomy is characterized by a progressive loss of metaphors. Logical thinking took the place of analogical reasoning. Pictures and images were replaced by concrete formulae and equations. Associations gave way to cause–effect chains. In this, we recognize a gradual shift away from a holistic strategy. As scientists began to tackle increasingly difficult problems they adopted a simple and successful strategy: when the answer to a problem cannot be found, divide the problem into smaller subproblems and look for answers to those. Thus, it becomes obvious why science over time lost the big picture and got enthralled in the minutiae.

But the evolution of science did not happen smoothly. Science does not progress in an orderly fashion from lesser to greater truth, but rather remains fixated on a particular dogma or explanation—also called a paradigm—which is only overthrown with great difficulty and a new paradigm established. Thus the Copernican system (the sun at the center of the universe) overthrew the Ptolemaic one (the earth at the center), and Newtonian physics was replaced by relativity and quantum physics. Science thus consists of periods of conservativism ("normal" science) punctuated by periods of "revolutionary" science. Thomas Kuhn recognized this process first and devoted his book *The Structure of Scientific Revolutions* to it.

Therefore, the key evolutionary moments are those where the old paradigm is torn down and a new paradigm emerges from the ashes. This happens when anomalies or inconsistencies arise within a given paradigm and present problems that cannot be

solved within it. Our view of reality must change, as must the way we perceive, think, and value the world. We must take on new assumptions and expectations that will transform our theories, traditions, rules, and standards of practice. We must create a new paradigm in which we are able to solve the unsolvable problems of the old paradigm.

How does this apply to medicine? Starting from shamanism, modern medical knowledge has grown by a similar process as described above for chemistry or astronomy. In contrast to those, however, there have been no noteworthy paradigm shifts in medicine. The medical understanding of health, disease, body, mind, etc. is remarkably unaffected by past and current revolutionary insights in physics. Even though doctors use ever more sophisticated diagnostic equipment, they still make their therapeutic judgments on the basis of a mechanistic framework which is approximately 100 years out of synch with modern science. On this evidence, a radical shift in the medical paradigm appears to be overdue.

As mentioned before, such paradigm shifts are usually heralded by badly explained, ill-fitting phenomena, which may be perceived as "uncomfortable" by the establishment. Frequently such seminal phenomena have been sitting right before our eyes for a long time before their meaning and importance are recognized as such. Based on what we know so far, what can we surmise about a possible anchor point for a new paradigm in medicine?

First, it appears startling that so many different therapeutic modalities coexist, which all seem to have powerful curative

effects. Serious chronic diseases can be cured by acupuncture, ayurveda, homeopathy, herbalism, and others. Despite their wildly different methods of intervention—be they needles, herbs, massage, changes in lifestyle, or homeopathic remedies—they strive for and frequently achieve the same goal. All alternative treatment modalities are based more or less on a holistic understanding of health and disease.

It appears that even without treatment it is sometimes within patients' power to cure themselves of "incurable" diseases such as cancer, leukemia, and multiple sclerosis. Reports of spontaneous healing are by no means isolated phenomena and have been the subject of coordinated research. Or, as Andrew Weil (1995) puts it:

> *Even when treatments are applied with successful outcomes, those outcomes represent activation of intrinsic healing mechanisms, which, under other circumstances, might operate without any outside stimulus.*

Placebo is a pharmaceutically inactive substance given to the patient with a therapeutic intention and consciously accepted by the patient as such. It is indistinguishable to the patient from a pharmaceutically active drug and is introduced to the patient as such a drug.

How has an empty pill suddenly acquired such importance? Researchers quickly realized that the individuality of a patient renders their scientific tools useless; a patient comprises too many immeasurable and unknown variables. The way out of this dilemma was to postulate that a large number of individuals

behave as a statistical ensemble, where all the individual idiosyncrasies disappear on average. In order to apply statistical tools in a clinical context, however, an established base line is required against which the pharmacological effect of a new drug can be measured. It is with this intention that placebo is used in medical research.

Considering that placebo controlled trials are the gold standard of clinical research today, it is surprising how little is known about the gauge with which we measure the efficacy of our pharmaceuticals. The placebo effect is essentially inseparable from the therapeutic effect of a pharmaceutical substance. If a drug lowers blood pressure by 13 mmHg in the verum group and the control group shows a decrease on average of 6 mmHg then we cannot simply subtract the two values to arrive at the pharmacological effect of the drug alone. The human body is a highly nonlinear system, where the effect of two actions is not simply the addition of their individual effects taken independently. It has been shown that placebo, in comparison to a strong analgesic, acts much more powerfully than when compared to a weak one.

Similarly, when compared to an antihypertensive drug, placebo lowers blood pressure, yet in comparison with an antihypotensive drug it raises the same. The one single parameter used today as a measuring stick in much of clinical research is one of the biggest unknowns.

So we realize that at the same time that medical researchers have effectively removed the individual from their research and replaced it with statistical averages, placebo has made its

entrance. However, in the attempt to remove one unknown (the patient), another unknown entered in its place: placebo. The original plan to circumvent the problem of dealing with holistic entities using statistical ensembles thus backfired badly (for the interested reader, an in-depth critique of the methodology of placebo controlled double-blind clinical trials can be found elsewhere (Coulter 1991).

Since the placebo effect is inextricably linked with the interaction between patient and therapist, it is present in all therapeutic modalities, alternative and conventional. Furthermore, it incorporates the holistic idea as well, since there is no material interaction with the physical body. The entire curative response comes from interactions with either or both of the other two hierarchical levels. Therefore, if we are looking for a general law of nature governing healing, the best place to begin is the placebo effect. I contend that once we truly understand the placebo effect, we will have discovered the nature of health and disease as well as the laws by which cure happens.

As a physicist I remember when I was still taught a multitude of natural forces: gravity, electric force, magnetic force, the nuclear force, the weak interaction force, etc. Today, physicists recognize that all these forces are only manifestations of one single force. Instead of many equations to remember, there is now only one. I cannot help but see a parallel in this with the current situation in the medical field.

I would, however, like to emphasize that in no way do I suggest that all therapies are essentially placebo. Far from it! As has

been shown in a meta-analysis by Klaus Linde (Linde et al. 1997) for the case of homeopathy, the placebo effect alone is not sufficient to explain the effectiveness of homeopathic treatment. Clearly something similar can be said for other alternative therapies as well (and for conventional medicine, too). Maybe, however, once we see the placebo effect in a different light, we can rephrase each therapeutic intervention in terms of its power and mode to activate and guide the placebo response.

My proposition, therefore, is to start interdisciplinary research on the nature of the placebo effect. Since all therapies overlap in this area, it should be possible to generate interest in a broad range of therapeutic modalities. The challenge we face is to discover the nature of disease and health. From there we will be able to formulate a natural law of healing. It is with great pleasure that I conclude quoting the second paragraph from Hahnemann's *Organon*:

> *The highest ideal of cure is the rapid, gentle and permanent restoration of health; that is, the lifting and annihilation of the disease in its entire extent in the shortest, most reliable, and least disadvantageous way, according to clearly realizable principles.*

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