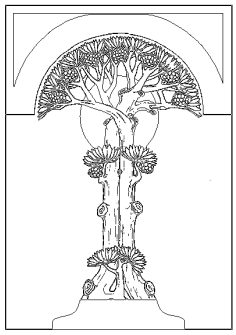
Centre for Integrative Medical Training
In Association with London Integrated Medical Health Education



Intermediate Course in Medical Homeopathy

A Blended Course in Homeopathic Medicine for Healthcare Professionals

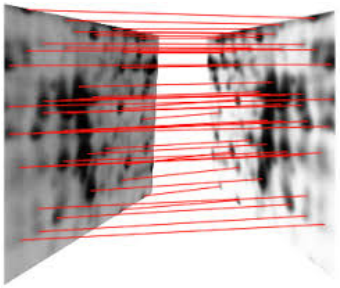
---

Unit 28

PRINCIPLES & PRACTICE - methodological studies for Week 8

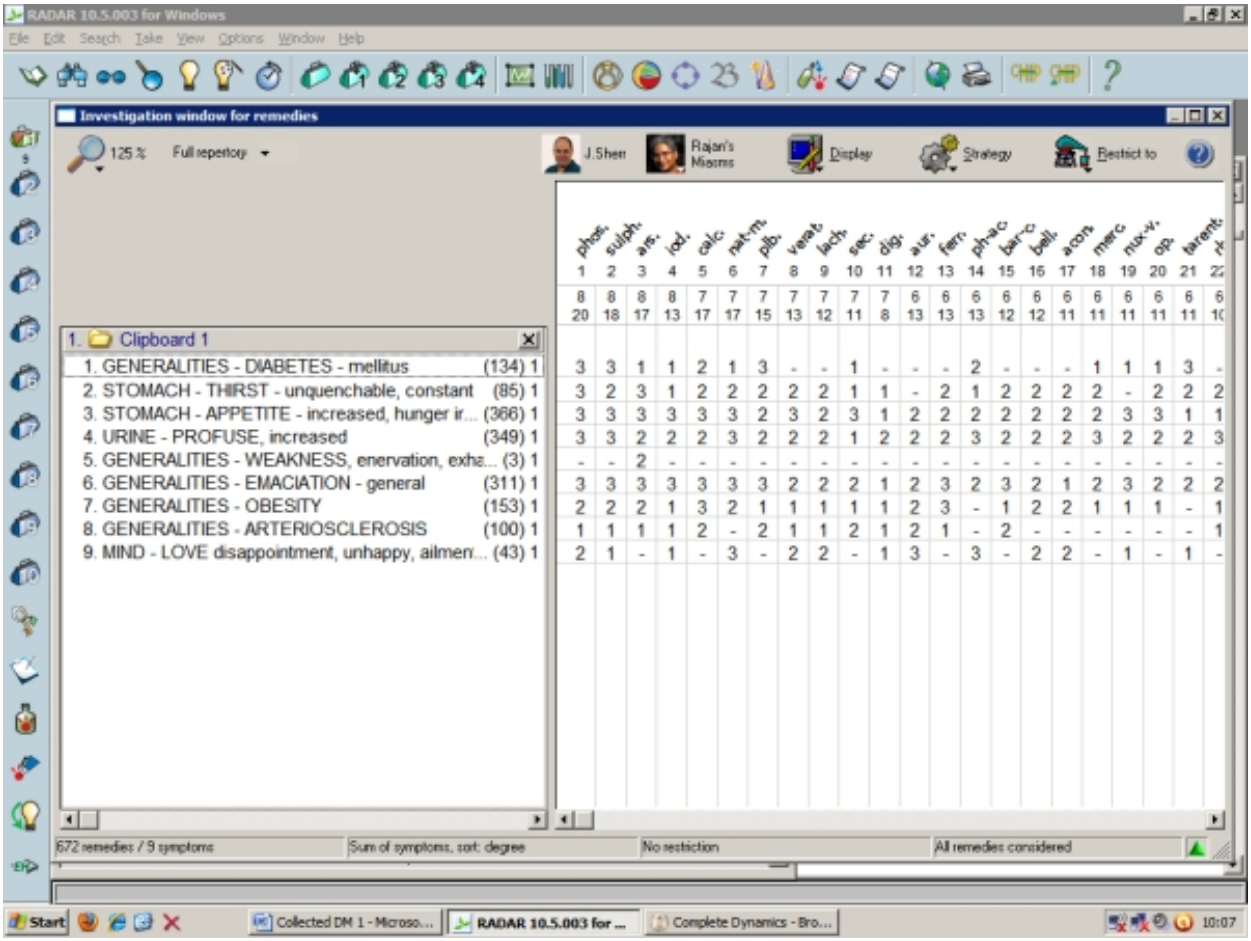
Study Text - Analysis Methodology I - Repertory

Methods of Case Analysis I



Because repertory development has a long and complex intellectual history, some students of homeopathy find it helpful to have an overview of the historical process.

Before we discuss Kent's approach to case analysis, briefly look over the diagrams overleaf. These do not cover the innovations that have become possible through computerisation in the last few decades. They will, however, help you to orientate yourself to the way that the different schema for this vital prescribing tool have evolved over time.

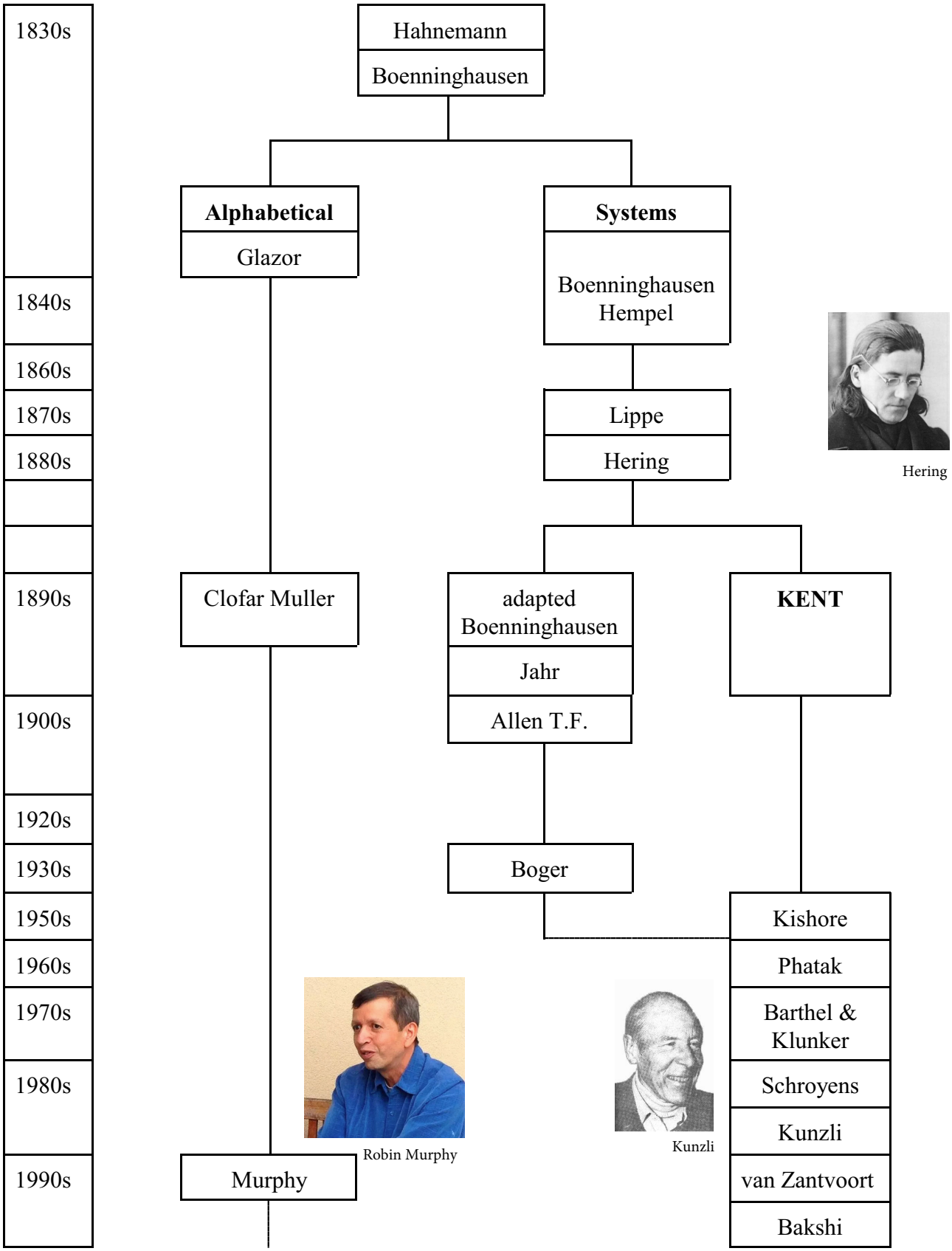


Evolution of Repertories (A) According to Clinical Orientation

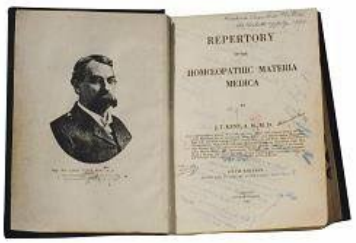
Charles Hempel

Richard Hughes

Evolution of Repertories (B) According to Layout and Indexing Conventions



Kent's Approach to Case Analysis



By the 1890s the homeopathic materia medica had increased greatly, with the addition of many new remedies, but at differing levels of detail and confirmation.

So awareness of ***Constitution*** became more important, as an extended form of pattern-recognition:
Descriptive character profiling allowed prescribers to select from a range of polychrest remedies.
Each polychrest remedy is associated with a well characterised and contrasting personality type, in addition to information on typology, physiognomy, behaviour and illness predisposition. (See also Tyler, Coulter, Blackie and others)

For cases that could not simply be constitutionally recognised, the ***individualisation*** of the case became more important as the range of treatment possibilities expanded in the late 19th century and as Kent and others developed larger repertories and taught repertory skills.

According to Kent, ***Totality*** is not regarded just as the sum of disconnected symptoms, but rather as one grand and meaningful symptom-pattern. The meaning and significance of the pattern is, to a large degree, determined by the corresponding ***remedy picture***.

As a basis for treatment, the concept of the *remedy picture*, as a holistic but flexible therapeutic concept, should be contrasted with the concept of ***diagnosis,*** which is far more compartmentalised and deterministic.
Both modes of thought have their limitations, but when each is applied, in ways that are appropriate to the nature of the case, then both have an equal role in medical practice.

Extending on Kent's concept of Totality, we might also consider the totality of the case as a kind of context for all the locals and particulars. Context in medicine is reflected in those phenomena that either **involve the whole system, or modify the response of the system as a whole.** These phenomena are to be found in the Generals and Mind sections of Kent's Repertory.

Certainly, homeopathy is one of the most context-sensitive branches of medicine. Nevertheless, we must try to disentangle the concept of *causation* from the necessary awareness of *contexts for illness*. Bearing in mind that all illness has some impact on mental and emotional wellbeing (and may even extend to affecting self-image, behaviour, relationships and beliefs), not all pathologies have their genesis in the mind. (Compare this with Kent's mystical Swedenborgian life-philosophy and the concept of 'original sin'. These ideas are no longer helpful to modern day practitioners and they are potentially a source of prejudice and judgement).

Kentian repertory method realigned Hahnemann's and von Boenninghausen's hierarchy of symptoms to be more individualising. Among the particular, local symptoms there was new emphasis placed on:

> **Mind** - If highly characterised and contextually significant this is the most individualising information available from the case.
>
> **SRP** - (strange rare and peculiar)
>
> **Keynotes** - (characteristic, often paradoxical, leading symptoms subtending only a small number of remedies. Sometimes even specific to only one known remedy)

Note:

Keynotes should be understood in comparison to von Boenninghausen's ***'Genius Symptoms'***.

There is an important difference between these two categories of symptom, that must be understood.

The *Genius Symptom* is a strong confirmatory symptom for a remedy because it is unequivocally seen in most of the proving subjects.

In contrast a *Remedy Keynote* is highly idiosyncratic and may only be encountered rarely in provings. It is therefore only associated with a few remedies.

How does this difference affect the analysis method?

- If contradicted by the patient, a *Genius Symptom* can often be used to discount a remedy (eg. when a modality expressed by the patient is in direct contradiction to a genius symptom of the remedy)
- The **absence** of a *Remedy Keynote,* however, should not be used to exclude a remedy.

Other symptoms included in a Kentian ***Totality*** analysis are:

appetite / sexual / signs / modalities (time, periodicity, weather etc)

And especially in pathological cases:

cough / expectoration / fever / chill / perspiration / pathological locals

The least significant symptoms for the purpose of repetorisation are the **common symptoms** ie. those that appear frequently in both provings and everyday clinical practice.

Sometimes however a common symptom can be very intense or disabling, in which case it is the job of the practitioner record it as a **complete symptom** with all its features, modalities, concomitants.

In latter years Sankharan has placed great emphasis on the skill of recording **sensations** to new levels of significance, and contextualising these by insistence on a refined approach to case history method.

CONCEPT OF TOTALITY (quoted in Harinadham)

1. Quis - changes of personalty and temperament
2. Quid - peculiarities of disease
3. Ubi - the seat of the disease
4. Quibus auxalis - concomitants
5. Cur - the cause
6. Quomodo - modalities
7. Quando - time.

Other Non-Kentian Methods of Case Analysis
(provided here in summary and explored later on)

a) Boenninghausen / Hahnemannian method

This uses the less hierarchical rubric structure in the TPB and emphasises modalities (see above)

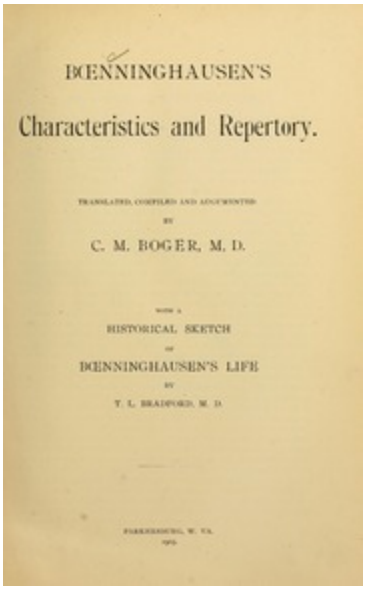
Hierarchy of symptoms:

Generals ➙ Characteristics ➙ Particulars ➙ Common

Clemens von Boenninghausen developed the first significant Repertory in the 1840s in correspondence with Hahnemann. In its scope, it was restricted mainly to the remedies in Hahnemann's *Materia Medica Pura*. Boenninghausen's ***Therapeutic Pocket Book*** was published in 6 editions. In its last edition it contained refinements influenced by Boenninghausen's discussions with Dunham.

Boenninghausen method relies on the ***Complete Symptom*** or Sensation:

Location x **Sensation** x **Modalities** - with great emphasis on modalities


BOENNINGHAUSEN'S
Characteristics and Repertory.
C. M. BOGER, M. D.
HISTORICAL SKETCH
BOENNINGHAUSEN'S LIFE

Boger - Boenninghausen

b) **Boger's method** (which promotes a different hierarchy of symptoms and is more algorhythmic)

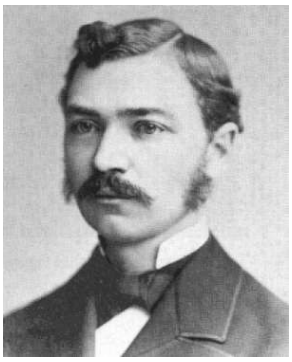
Causation, Modalities, Sensation, Pathology, Location

c) **H. A. Roberts'** approach
includes highly idiosyncratic information, eg. 'Symptoms As If'

Location, Sensation, Modalities, Concomitant

d) **Garth Boericke's** approach (after Kent)

'The seemingly unimportant peculiar, contingent symptoms of the patient: sensations/modalities/subjective experiences, though valueless for the purpose of diagnosis, are in the chief guiding symptoms for the selection of the homeopathic remedy.'



Garth Boericke

e) **Stuart Close** (after Kent)
Totality is defined as the symptoms of the case which are capable of being logically combined into a harmonious and consistent whole, having form, coherency and individuality.

f) **Vithoulkas method** ('essence' features are selectively sought).
Vithoulkas Expert System - roots out coincidences of essence features which increase the remedy significance above the background totality.

More recently Layers of Health is a way of modeling disease and Vithoulkas Compass is a work in progress to improve the confirmation of the data and gain insights into user behaviours concerning computerised repertory analysis.

g) Jan Scholten's method : cross tabulation of mineral themes and 'confirmation' through regional affinities and keynotes, time modalities etc)

h) Rajan Sankaran's method: extrapolation of sensations and expressions to link-concepts or conceptual fields (miasms, kingdoms, groups) and cross tabulation

i) Post-Boenninghausen Methods

Polarity Analysis was developed by Heiner Frei. A method of profiling the physiological state of the patient using ***polar symptoms*** and matching the polar skew of the patient's state to the polar skew of the remedy proving data. Uses a computerised version of Boenninghausen's *Therapeutic Pocket Book* to generate a ***Polarity Score*** for each repertorisation.

j) Other Hybrid methods: (discussed in pre-membership studies)

Broad Analysis Hints (expanded later)

Use Boenninghausen where complete symptoms are available

1 Use Polarity Analysis where the patient provides clear modalities

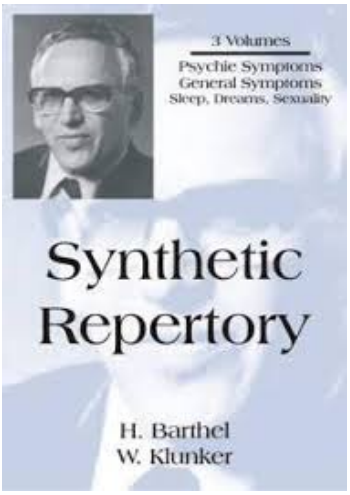
Use Kentian totality method where mind and physical generals dominate and particular symptoms are available

Use Scholten analysis where the case is driven my mental imperatives and when 'Life purpose through work' is a strong theme that dominates the long-term themes underlying the patient's behaviour, values and choices.

Use keynotes restricted to striking SRPs when qualified physical and mental generals are lacking.

When only common symptoms exist: use every individualising feature available: temperament, complexion, typology, organ/tissue/regional affinities, aetiology

The Internal Workings of the Repertory - Russell Malcolm



Introduction
Repertorisation is the name given to a process of matching remedy data to a patient's 'symptom-picture'.

It is, in effect, the matching of complexity with complexity, or the matching of dynamic with dynamic, or the matching of pattern with pattern.

Finding the Similimum
To make this match, we require to search for the remedy which provides the patient with the optimal 'systems stimulus'. By definition this stimulus must be a multidimensional entity, because biological systems have long been evolved to resolve simple problems for themselves. The exception to this rule would be, of course, a single causation which happens to be so intense and overwhelming that it threatens the integrity of a fundamental system required for life (eg. insulin overdose).

To invoke a healing response in a living being, a homeopathic stimulus therefore needs to have 'systems relevance'.
In terms of the *Principle of Similars*, this optimal stimulus is known as the *Similimum*. Our patient will respond, usually in two phases, to the Similimum (Primary and Secondary Response) But, in order to progress to healing, the similimum must have sufficient points of conformity to the problems which are most fundamental to the patient's illness.

Sometimes remedies appear to address only a non-essential part of the overall systems-disturbance. Such treatments evoke only minor, short-lived changes.

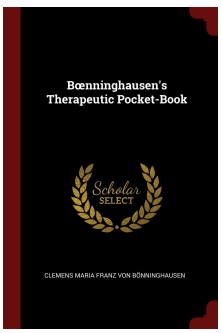
Search Parameters
The challenge for every homeopathic prescriber is how to discern the *Similimum*, from range of possibilities, by means of:

a) the patient's stated symptomatology,
b) observed clinical phenomena and
c) subjective descriptors of emotional, general and local reaction, as the basis for the analysis.

Reference Data Sets
Since the proving data and clinical observations for any given remedy can run to many pages of text and there are hundreds of remedies described, how do we to make a treatment selection which is optimal for the patient?

Generations of homeopaths have ordered the remedy data into searchable indexes of data, which allow a practitioner to identify the remedies which are associated with each particular symptom or clinical feature.

The First Repertory Accepted by Hahnemann
Clemens von Boenninghausen is credited with preparing one of the first symptom-remedy indexes. Based on Hahnemann's *Materia Medica Pura*. His *Therapeutic Pocket Book* is a structured codex of remedy data derived from a lifetime of proving experiments and clinical experience. It could be argued that this primary source represents the core materia medica for homeopathy to this day. It is also one of the only repertories which has been developed throughout using a consistent methodology.



The Scope of the Therapeutic Pocket Book is only around 120 remedies, yet these remedies are very well balanced in their representation within the repertory.
It could be argued that the discriminatory power of von Boenninghausen's rubrics is unparalleled, due to the consistent and careful way the remedies are weighted within each rubric comparative to one another.

The Scope of the Materia Medica after von Boenninghausen
Following the publication of Boeninghausen's *Therapeutic Pocket Book*, the materia medica expanded over subsequent decades, to encompass more than 4000 remedies. These are described to various levels of detail in, for example, Allen's *Materia Medica* and many others.

Toward the End of the Nineteenth Century, James Tyler Kent produced a huge and exhaustive repertory incorporating many of the remedy additions of his near contemporaries. The final editions of *The General Repertory of Homeopathic Materia Medica* went into print in around 1921.
Kent's rationale for the structure of this huge symptom-index is still widely used by modern repertory developers.

Development Considerations
How remedies are represented in the repertory depends on judgements around the quality and nature of their data sets. Myriad decisions of this kind have been undertaken over the course of several generations of clinicians and repertory developers in Europe and USA, since Kent's time.

The parameters for creating the *indices of association* (weightings) between each remedy and its homeopathic symptoms has not always been clear in the past.

However, in *Towards a New Repertory* (Schroyens et al.) provides much clearer frameworks for this than were previously available.
His team in Belgium, who effectively expanded and adapted Kent's General Repertory for the computer age, provide important information on the considerations that determine how (and whether) new remedies should be incorporated into *Synthesis*, as well as some important insights concerning the basis for remedy weighting within rubrics.

Computerisation
Today computerisation has allowed us to collate the symptom data for thousands of remedies. This data can now be accessed and analysed using relational databases. These have been constructed around *indices of confidence*, using scores for the strength of association between remedies and their associated symptoms. (Sometimes called 'remedy weighting').

Data Sources and 'Validation'
Given their diverse sources, it is almost inevitable that the internal validity of the data sets for different remedies varies quite widely. This is partly because the remedies themselves have not yet been subjected to consistent proving methodologies.

Repertories like *Synthesis* have incorporated some remedy groups on the basis of collated clinical experience rather than provings, most notably the Bowel Nosodes of Bach & Paterson.
These so called *clinical provings* should be contrasted to traditional (Hahnemannian) proving methodology. (Provings are probably better described as *pathogenetic clinical trials* - a term coined by Flavio Dantas and Peter Fisher).

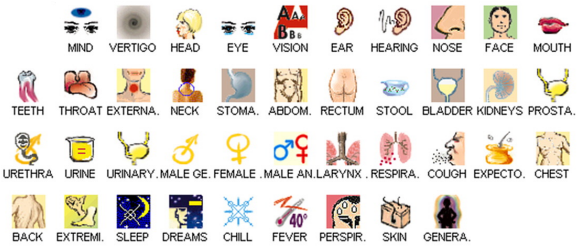
The data sets for some of the later remedy additions in repertories like *Synthesis* have been based on modern proving experiments, whose methodology has diverged considerably from that described by Hahnemann and other key figures in the history of homeopathy.

How the Remedies are Weighted within Rubrics (Kent)
The symptoms and clinical remedy features in repertories are weighted internally, according to their significance. This assessment of significance is based on:

1. how consistently that feature is expressed by proving subjects, and

2. whether there is documented confirmation for the resolution of the given symptom in patients who have been treated homeopathically with the remedy

Clinical Decision Support Tools
(Computerised Repertories in Homeopathy)



Most computer systems have a data-base 'engine' at their centre. This is designed to help the user 'cross-match' the associated remedy fields with whichever patient symptoms are entered for analysis.

Functioning as a clinical decision-support tool, the computerised repertory collates these *indices of association* between individual remedies and the symptoms that are entered by the clinician. The system then calculates a cumulate score for each of the different remedies that are found to be linked to one or more symptoms. The software then graphically displays the remedies in decreasing order of association for the symptoms entered.

Analysis Reporting
The user can ask the system to order the remedies in the analysis report according to how well they appear to 'cover the case' (*Totality* or *Sum of Symptoms*) or, alternatively, how the significance scores add up for each remedy against the symptoms entered (*Sum of Degrees*)

User Selections and Refinements
Newer computer systems have a variety of features that additionally allow the user to add weighting schemes to the symptoms. So that symptom rubrics which appear to be of central importance to the case are selectively isolated or weighted in a way that emphasizes their remedy sets in the final analysis.

Duplication and Reinforcement
Sometimes to or more rubrics are selected that describe closely allied features in the case. These rubrics may have considerable overlap in the remedies they contain. If all such rubrics were used in the final analysis, the duplication of data would skew the analysis unreasonably.

Some computer systems will allow the user to combine rubrics which are allied. This means that all the remedies in both rubrics are represented only once in the final analysis, without omitting materials which would be lost to analysis if only one or other rubric were chosen.

Skill & Judgement
Even with these refinements, it can be very difficult to make a final choice of remedy. There may be a number of materials which appear to cover the case, particularly if large rubrics were selected for analysis.

Conversely, analysis of only the smallest rubrics can be unreliable because some of the smaller rubrics often fail to present all the remedies which are potentially associated with the symptom or feature.

Notes: