

Clinical Reasoning and Decision-Making in Homeopathy: an Interpretative Phenomenological Analysis

By

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A thesis submitted in fulfilment of the requirements for the award of the
degree of

Doctor of Philosophy

Centre for Values, Ethics, and the Law in Medicine

Faculty of Medicine

University of Sydney

2017

Supervisor's Certification

I, Dr Claire Hooker, certify that the PhD thesis titled "Clinical Reasoning and Decision-Making in Homeopathy: an Interpretative Phenomenological Analysis" by David Levy is in a form suitable for examination.

A handwritten signature in black ink that reads "Dr. Claire Hooker". The signature is written in a cursive style with a large, stylized 'H'.

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02-12-2016

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Author's Declaration

I, David Claude Levy, declare that this thesis, submitted for the award of the degree of Doctor of Philosophy, in the Faculty of Medicine, University of Sydney, is wholly my own work unless otherwise referenced or acknowledged. This document has not been submitted for qualification at any other academic institution.



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Acknowledgements

This thesis is all my own work. However, I must formally acknowledge various people whose intellectual contributions have enhanced it. I wish to acknowledge my principal supervisor, Dr Claire Hooker, for editorial suggestions made in response to close readings of the entire text, as is standard for supervisory input, but that the result is entirely of my choice and making. Dr Hooker's expertise in the history of medicine specifically, which far exceeded my own, had some direct editorial input into the first half of chapter 2, in addition to guiding me to relevant scholarly literature. My profound thanks to Dr Hooker for her sustained critical insight, her humour, and for the enduring belief and patience she has shown me.

I would like to acknowledge my associate supervisor, Professor Ian Kerridge, in particular for his conceptual and theoretical knowledge which informed my reading and the arguments developed in this thesis. I acknowledge the contributions of Ben Gadd, co-author in two peer-reviewed publications, as well as that of Professor Paul Komesaroff. I wish to acknowledge my previous supervisors, Dr Rola Ajjawi and Associate Professor Chris Roberts, for their original attention to this research and for their sustained interest.

I am extremely grateful to Emeritus Professor Miles Little for our many robust discussions and for one vital neologism. Thanks to Professor Joy Higgs and Dr Gary Levy for their intellectual input; Barbara Ryan for her graphic artwork; and Susan Ryan. My colleagues at the Centre for Values, Ethics, and the Law in Medicine shared knowledge, offered encouragement and good humour: Camilla Scanlan, Bronwen Morrell, Jane Williams, Siun Gallagher, Jonnie Kennedy, Narcyz Ghinea, Chris Jordens, Stacy Carter, Lucie Rychetnik, Christiane Klinner, Jen Fleming, Wendy Lipworth, and Seamus Barker. Thanks to Gary Liew for his technical advice, Elizabeth Pigott, and Jay Lee. To the participants and their patients who made this study possible, my sincere thanks. Thank you to my examiners for the care and thoughtfulness with which they read the thesis and offered constructive suggestions for improvement. To Bach, Handel, Mahler, and other musical giants, thank you for nourishing me and inspiring creativity. **I dedicate this thesis to my family:** Helen, Jacob and Rose, for allowing me to pursue this research at the cost of valuable family time.

Abstract

“I want the patient to have an experience of healing as well as to experience the right medicine.” (Allan)

Preamble

Homeopathy has been practiced globally for 200 years. Despite its widespread application, there has been limited investigation of clinical reasoning and decision-making practices, and no such investigation in Australia. This thesis explores practice through an examination of the lifeworld of Australian professional homeopaths. Coincidentally, the research was undertaken during a period of contestation of the epistemology and ethics of homeopathy.

Objectives

The primary aim of this thesis was to explore the multiple dimensions of homeopathic clinical reasoning using interpretative phenomenological analysis (IPA). This thesis also aims to make the results of this study available and useful for the educational and professional development of homeopathy.

Background & Literatures

Chapters 1 to 5 investigate literatures spanning the relevant history and theoretical and conceptual development of homeopathy with particular emphasis on the sources and modes of knowledge that inform clinical reasoning and decision-making.

Methods

Chapter 6 is an account of the methodology employed throughout this thesis. This study used IPA as its qualitative methodological framework. Data sources included observation,

semi-structured interviews and audio recordings with twelve consenting Australian homeopaths during their daily practices. The data, notes, and memos were coded, categorised and analysed using IPA. Emergent themes were iteratively and reflexively developed.

Results

What emerged in this research was that clinical reasoning was as much *performed* as *practised*. I approached clinical reasoning as something that was itself profoundly hermeneutic. Participants constructed the practices of 'reasoning' within a *contextual space*, with highly systematised forms of pattern recognition and quantification strategies at one end, and engaged, embodied, and existential understandings of a patient at the other. Although these 'ends' were represented as antithetical to each other (as for example, when emotional connection was constructed as an impairment of neutrality), my analysis found that participants also frequently complicated (and destabilised) these oppositions, shifting flexibly between, or connecting, practices that at other times were constructed as being at opposite ends of this space. Taken as a whole, the participants drew on a range of reasoning and hermeneutic practices, situated within the clinical relationship.

Chapter 7 explores the systematic mechanisms and techniques utilised, while Chapter 8 examines the epistemic and clinical authority underpinning clinical reasoning and decision-making. While participants were explicitly committed to theoretical principles and historical texts, my observations revealed that, practised and performed within a narrative framework, homeopathic clinical reasoning was informed by multiple epistemes.

Chapter 9 explores the clinical relationship, noting the ways in which the participants utilised the relationship to closely investigate the phenomenology of lived illness. Here, I analyse how clinical encounters, the performance of clinical reasoning and the knowledge (of individual 'cases') that is generated, resembles IPA research: both attend to the interpretation of lived experience in immersive, but analytically rich, ways, and to the co-production of meaningful understanding.

Chapter 10 extends these insights as it explores the influence of participants' value commitments, worldviews and previous professional experience on clinical reasoning, and explores reflexivity to ask what constitutes practising with integrity in this context.

Discussion

In general terms, the results of this study were in keeping with recent models of homeopathic reasoning, in particular the PHIRM¹ model (Burch, Dibb, Brien 2008) and PPR² entanglement theory (Milgrom 2006). Chapter 10 extends and complements these models by attending to the nuances, complexities and situatedness of what is best understood as the authentic performance of clinical reasoning. I also discuss the congruence between the results of this study and the ways in which clinical reasoning is constructed and conducted in conventional³ medicine – where, similarly, doctors' values and worldviews are part of practice, and where reflexivity is similarly urged as an important ethical and cognitive strategy. I further explore the significance of reflexivity for homeopathy, drawing parallels with its importance in the methodologies of qualitative inquiry, and considering its role in a discipline in which hermeneutic work in clinical encounters may bring significant therapeutic benefit (and also some risk).

These findings have important implications for how homeopathy can be practised, learned, researched, and evaluated, and sometimes defended. The thesis includes published work; from my early conceptualisation of homeopathic clinical reasoning (Appendix 4), and recent work which applies these findings in what I and my co-authors term 'a gentle ethical defence' of homeopathy (Appendix 5).

¹ PHIRM is an acronym for the Pattern Recognition, Hypothetico-Deductive Reasoning, Intuition, and Remedy Matching model.

² PPR is an acronym for Patient-Practitioner-Remedy entanglement theory.

³ The term 'conventional medicine' is used interchangeably with related terms including biomedicine, orthodox medicine and western medicine. This reflects the inconsistent and interchangeable use throughout the literature. The term 'allopathy' is frequently used by homeopaths to differentiate homeopathy from the allopathic principle of opposites employed in conventional medicine. It has a secondary, pejorative connotation among homeopaths.

Table of contents

Supervisor’s Certification.....	2
Author’s Declaration.....	3
Acknowledgements.....	4
Abstract	5
Preamble.....	5
Objectives.....	5
Background & Literatures	5
Methods.....	5
Results.....	6
Discussion.....	7
Table of contents	8
CHAPTER 1	16
Introduction.....	16
1.1 Background.....	17
1.2 Tensions in homeopathic epistemic claims	18
1.3 Situating homeopathy in the Australian healthcare landscape.....	19
1.4 Justifying knowledge claims	21
1.5 Thesis structure	23
CHAPTER 2	25
Historical and conceptual framework of homeopathy giving rise to contemporary clinical reasoning	25
2.1 Organisation of this chapter.....	26
2.2 Emergence of homeopathy in historical context	27
2.2.1 Hahnemann, ‘rationalism’ and ‘empiricism’ in late eighteenth century medicine	28
2.2.2 Hahnemann’s resistance to emerging ideas.....	28
2.2.3 Conceptualising disease	29

2.2.4 Paradigm shift	31
2.2.5 Paris hospitals: Hahnemann's continued resistance	33
2.2.6 Hahnemann: visionary?	34
2.2.7 Anton von Störck.....	36
2.2.8 Empiricism and rationalism in Hahnemann's methods	38
2.3 Growth, status, and professionalisation	41
2.3.1 Homeopathy in Britain	42
2.3.2 Homeopathy in the United States: Nineteenth and early Twentieth Centuries	43
2.3.3 James Tyler Kent, Spiritualism & Emmanuel Swedenborg.....	44
2.3.4 Political and economic demise of American homeopathy.....	46
2.3.5 Cultural adaptation: Indian homeopathy	47
2.3.6 Homeopathy in Israel	49
2.3.7 Homeopathy in nineteenth century Australian colonies	49
2.3.8 Status of homeopathy in Australia.....	50
2.3.9 Homeopathy in Australia today	51
2.4 Chapter summary	52
CHAPTER 3	54
Epistemic and conceptual foundations of homeopathy.....	54
3.1 Conceptual foundations.....	54
3.1.1 Holistic (mind-body) ontology	55
3.1.2 Individualisation	56
3.1.3 Minimum dose	58
3.1.4 Vital force or energy.....	58
3.2 Knowledge generation.....	60
3.2.1 Toxicology	60
3.2.2 Provings	60

3.2.3 The case study.....	64
Historical notes on the case study.....	64
What cases are like	69
Pedagogical value	70
Theorisation of case study methodology.....	71
Critiques of case study methodology.....	72
3.4 Chapter summary	76
CHAPTER 4	77
Contestation of evidence and efficacy for homeopathy	77
4.1 Background.....	77
4.2 The construction of evidence in homeopathy	78
4.3 Discourse not dismissible.....	82
4.4 Epistemology of homeopathy in the context of EBM	83
4.5 Empiricism challenged	85
4.6 A recent history of critiques & defences	87
4.6.1 Benveniste & Nature	87
4.6.2 Systematic reviews & counter reviews	89
4.7 Chapter summary	91
CHAPTER 5	93
Analyses of homeopathic clinical reasoning	93
5.1 Background to existing clinical reasoning research	93
5.2 Clinical reasoning research and models	94
5.3 Research exploring the application of algorithms.....	94
5.4 The PHIRM model.....	96
5.4.1 Reasoning without bias: freedom from prejudice.....	98
5.4.2 Intuition in PHIRM and in clinical reasoning.....	100
5.4.3 Patient-practitioner relationship in PHIRM.....	101

5.5 Practitioner experiences of the consultation.....	101
5.6 Chatwin: studying interaction through conversation analysis.....	102
5.7 Brown’s survey of reasoning and prescribing	103
5.8 Chapter summary	104
CHAPTER 6	105
Research methods	105
Part One: Objectives, contributions & research questions.....	105
6.1.1 Research objectives	105
6.1.2 Research outcomes and contributions	105
6.1.3 Research Questions	106
Part Two: Theory and methods	109
6.2.1 Lifeworld research	109
6.2.2 Preconceptions & reflexivity	110
6.2.3 Research paradigm and theoretical framework.....	113
6.2.4 Constructivism	114
6.2.5 Philosophical framework: Interpretative phenomenological analysis (IPA).....	115
6.2.6 Phenomenological traditions	117
6.2.7 Hermeneutic traditions.....	119
Part Three: Practice.....	122
6.3 IPA practice: How I conducted the research.....	122
6.3.1 Ethical requirements and considerations	128
6.3.2 Recruitment.....	128
6.3.3 Notice of intended research.....	129
6.3.4 Sampling and selection of participants.....	130
6.3.5 Further ethical considerations: the reflexive turn	130
6.3.6 Informed consent	131
6.3.7 The participants: Professional experience and qualifications	132

Table One: Participants: Clinical experience and tertiary qualifications	133
Part Four: Data collection and management	135
6.4.1 Interview procedures	135
6.4.2 Field notes	137
6.4.3 Audio and video recording	138
6.4.4 Data analysis	139
6.5 Chapter summary	143
CHAPTER 7	144
Understanding and performing caseness	144
7.1 Overview of results: Chapters 7 to 10	144
7.2 Caseness	147
7.3 The justification	149
7.4 Algorithms, patterns, and portraits	154
7.4.1 Algorithms	154
7.4.2 Pattern recognition	156
7.4.3 Portraits	157
7.5 Heuristics	158
7.5.2 Pattern-portrait heuristics	160
7.6 Beyond justification: grappling with uncertainty	161
7.7 Intuitive 'reasoning'	167
7.8 Chapter summary	169
CHAPTER 8	171
Epistemic and clinical authority in clinical reasoning	171
8.1 Chapter introduction	171
8.2 Clinical (self) authority	172
8.3 Received authority	179
8.4 The authority of theory	184

8.5 Authority of theory: Vitalism and holism.....	188
8.6 Authority of theory: Individualisation	190
8.7 Authority of theory: Constitutional approach	192
8.8 Pragmatism & praxis: the return to clinical authority.....	194
8.9 Other epistemes	199
8.10 Chapter summary	202
CHAPTER 9	203
Dual processes: Therapeutic relationship and hermeneutic space.....	203
9.1 Chapter introduction	203
9.2 Dual processes: Therapeutic presence & action	205
9.3 Enacting empathy	208
9.4 Iatrosynergy.....	210
9.5 Empathy and phenomenology: Theoretical and empirical overview	215
9.6 Phenomenological space and hermeneutic engagement	217
9.7 Hermeneutic, therapeutic, and context effects.....	225
9.8 Narrative engagement.....	228
9.9 Trust & rapport.....	233
9.10 Chapter summary	235
CHAPTER 10	236
Suspended judgment: Ethical frameworks, clinical reasoning and practising from the margins	236
10.1 Chapter introduction	236
10.2 Values & clinical reasoning.....	238
10.3 Dissonance between stated and implicit values	238
10.4 Privileged healer	246
10.5 Practising from the margins	248
10.6 Values in conflict.....	255

10.7 Communicating reasoning	258
10.8 Ethical reasoning re-examined	259
10.9 Chapter summary	262
CHAPTER 11: DISCUSSION	264
Praxis: The multiplicity of homeopathies.....	264
11.1 Emerging discourses	264
11.2 Summary of results.....	266
FIGURE ONE: The Performance and Mechanisms of Homeopathic Clinical Reasoning and Decision-making	269
11.3 Contextualising praxis.....	270
11.4 Caseness, praxis & evidence	272
11.5 Performing praxis.....	274
11.6 Empathy as praxis	275
11.7 Is iatrosynergy the same as entanglement?	277
11.8 Moral status of praxis	279
11.9 Context effects	282
11.10 Convergence and divergence	285
11.10.1 Convergence	286
11.10.2 Divergence	289
11.10.3 Internal divergence.....	289
11.11 Homeopathy and qualitative (IPA) research.....	291
11.12 Hermeneutics and the products of caseness.....	294
11.13 The status of knowledge claims	297
11.14 Summary of discussion	299
CHAPTER 12	301
Implications and conclusions.....	301
12.1 Limitations of this study.....	306

APPENDICES308

Appendix 1: Ethical approvals 308

Appendix 2: Information and consent for participants and patients 316

Appendix 3: Sample interview questions 323

Appendix 4: Levy, D. Ajjawi, R. and Roberts, C. (2010). How Do Homeopaths Reason and Make Decisions? Integrating Theory, Practice, and Education. *The Journal of Alternative and Complementary Medicine* 16 (12). 1-7..... 326

Appendix 5: Levy, D. Gadd, B. Kerridge, I. & Komesaroff, P. (2015). A Gentle Ethical Defence of Homeopathy. *Journal of Bioethical Inquiry*, 12 (2) 203-209..... 334

Appendix 6: List of Publications and Presentations Related to this Thesis 342

References346

CHAPTER 1

Introduction

In the often polarised discussions of homeopathy,⁴ many claims are made about what constitutes homeopathic clinical reasoning. Yet there is very little research about what actually occurs in practice. This thesis is an empirical study of clinical reasoning and decision-making in homeopathy, as experienced by homeopaths themselves. I studied the experiences of twelve homeopaths in a naturalistic setting, their own clinical practice, using interpretative phenomenological analysis (IPA). In-depth semi-structured interviews and observation were the main tools used to explore and understand the interior of their professional lifeworld. Iterative, reflexive, thematic and conceptual analysis revealed that the relational dynamics between homeopaths and their patients were not merely a feature of, but inseparable from, cognitive reasoning and decision making processes. Through the results in this thesis, I will argue that homeopathic clinical reasoning is infinitely more complex than traditional reasoning models involving cognitive mechanisms and algorithms. The journey of this research illustrates how my understanding of homeopathic clinical reasoning has been transformed; from an understanding of mechanisms to a far broader conceptualisation that incorporates novel ways of understanding ‘reasoning’ as much more than cognitive functions, representing an enormous intellectual shift.

Studies of reasoning and decision-making in healthcare practices have often been limited to cognitive processes and algorithms, but my study reveals homeopathy as a profoundly qualitative, hermeneutic practice, in which it is impossible to disentangle the multifaceted qualities of relational interaction from other forms of decision-making. This thesis provides a significant extension of understanding homeopathy necessarily as entanglement between patient, practitioner, and remedies, by demonstrating in detail how ethical qualities of a

⁴ The American spelling for homeopathy has been adopted throughout this thesis. Hahnemann understood Greek and preferred Homöopathie (German spelling) or Homœopathy (eliding the diphthong in English). Today, although some might disapprove for historical reasons, homeopathy is the preferred spelling of the British Homeopathic Association and British Homeopathic Pharmacopoeia. Those preferring the traditional German, Greek, and earlier English usage consider it important to perpetuate tradition. I have opted for convenience and ease of recognition as the preferred reasons for the American usage.

therapeutic relationship are enacted in practice. It offers new and deeper insight into both the qualities of ethical practice, and potentially, to the dimension of context effects.

1.1 Background

Developed by Samuel Hahnemann (1755-1843), a German physician, chemist, and translator, homeopathy is based on the principle that *like cures like*; derived from the Greek *homoios* (similar) and *pathos* (suffering). The object of homeopathy is to apply this principle⁵ to determine the most similar (and therefore most *homeopathic*) medicine in every case.⁶ Hahnemann's principle, embedded in pedagogy and in clinical practice, has been reinterpreted and practised in diverse ways since his time. One of the central objects of this study was to understand how practice is reinterpreted and constructed through the research participants' experience.

Homeopaths view themselves as practising a system of medicine that is based on both a rational principle (that of similars), and empirical observation of the therapeutic effects of remedies. Notwithstanding, there have been considerable shifts in homeopathic theory and practice over the course of 200 years, and internal disagreements about particular components of practice, such as Hahnemann's theory of potentisation (Adler, Ambrosio et al. 1996) persist today. An overview of the history of homeopathy that attempts to offer contextual insight into how and why homeopathy has developed as it has is provided in Chapter 2.

The use of the term 'medicine' has particular importance and meaning in the context of this thesis. Homeopaths regard homeopathy as a system of medicine. As do conventional doctors, homeopaths interpret and evaluate symptoms; they diagnose⁷ and manage their patients. Homeopaths also prescribe medicines, commonly known as *remedies* (Bell,

⁵ Most homeopathic literature refers to the *law* of similars. I have deliberately chosen to refer to the *principle* rather than the law as laws are, in theory, incontrovertible, while principle acknowledges the distinction.

⁶ Hahnemann, S. (1810). The Organon of the Rational Art of Healing. New Delhi, B Jain Publishers. Hahnemann described in exacting detail every step required to understand and in order to apply the principle of similars, and so, ideally, to achieve the best outcome in each and every case of disease.

⁷ Non medically-trained homeopaths *do not* make medical diagnoses, while they can make homeopathic 'remedy diagnoses' in order to prescribe for patients.

Howerter et al. 2012, Lenger, Bajpai et al. 2014), for the relief of symptoms. Sometimes, *medicine* can seem to designate orthodox medicine (only); and sometimes it has a particular meaning within homeopathy. My participants used the terms *medicine* and *remedy* interchangeably. This invites the philosophical question of what we think *a medicine* (and a *system of medicine*) is and what work we expect it to do.

As a means to navigating this thesis, and in order to understand my reflexive position as the researcher, it may assist the reader to have some (albeit brief) knowledge of my professional background. I studied homeopathy (and naturopathy) in Australia for four years in the 1980s and have been in continuous clinical practice since that time. This period coincided with the renaissance of homeopathy in parts of Europe, Australia, and the USA. The ostensibly complete and congruent model of practice I learned and developed reflected the dominant homeopathic episteme. As my clinical experience grew, I began to recognise how my practice was shaped by other sources of knowledge, for example from psychology and the social sciences. As my practice evolved in both explicit and more understated ways, I became increasingly curious about the internal mechanisms of clinical reasoning and decision-making. During every stage of the development of this thesis, my professional journey is present, constituting a critical, reflexive device for the exposition of the data and the analysis that follows.

1.2 Tensions in homeopathic epistemic claims

This research was underpinned by my observation that homeopathy makes epistemic claims to uniqueness, and at the same time, wants to claim legitimacy on the same terms as conventional medicine. Homeopathy wants to validate itself by its theoretical framework and its empirical evidence, much of which is contested by conventional science and medicine. Homeopathy has a coherentist view of what constitutes valid reasoning, based on what it considers internally valid foundations (Haack 1993). These contrasting claims reflect a deep and implicit epistemic (although not necessarily moral) contradiction. This tension permeates the historical, conceptual and empirical literatures examined (in Chapters 2 to 5). It was also evident in the results, depicted through the contextual space and multiple modes

of reasoning demonstrated by the participants (in Chapters 7 to 10). In asserting that critiques are unreasonable and unjustified, homeopathy transitions to being *the other*, claiming that evaluating it by using the same tools with which conventional medicine is evaluated fails to accommodate the unique theory and empirical evidence for homeopathy (Oberbaum, Vithoulkas et al. 2003, Mathie, Van Wassenhoven et al. 2015). This thesis retains a critical grasp of these tensions, without purporting to resolve them.

1.3 Situating homeopathy in the Australian healthcare landscape

Having developed alongside conventional medicine in 18th century Europe, homeopathy today is globally practised by doctors as well as non-medical professionals. In countries including Canada and Australia, most homeopaths are regarded as *complementary and alternative medicine* (CAM) professionals (Kelner, Wellman et al. 2006). There is widespread application of, and global demand for, homeopathy. At the same time, its epistemology and ethical legitimacy are vehemently contested. This shifting discourse is blurred by definitions of ‘what is’ and ‘what is not’ acceptable practice, according to different authors and journals (Ng, Boon et al. 2016).

In Australia, the context of this research, the homeopathic profession is not officially tied to conventional medicine. Although having a presence in Australia for more than 150 years (Armstrong 2006, Armstrong 2006, Armstrong 2007, Armstrong 2007), the homeopathic profession is fragmented, being represented by multiple professional bodies.⁸ Homeopaths do not share a singular professional identity. Consequently, like the multiple disciplines that encompass and identify as CAM therapies (Tovey and Adams 2004) and the very particular philosophical frameworks that characterise each of them (MacArtney and Wahlberg 2014),

⁸ Although the majority of homeopaths are registered with the Australian Homeopathic Association, it is not a regulatory requirement to be a professional member. Many homeopaths practising naturopathy and other CAM therapies are registered with the Australian Traditional Medicine Society (ATMS) and the Australian Natural Therapists Association (ANTA), umbrella organisations representing CAMs and not homeopathy exclusively. In addition, some homeopaths are members of professional bodies with less than 100 members, such as the Homeopathic Education and Research Association (HERA) and the Australian Association of Professional Homeopaths (AAPH). One professional group (Hahnemann Institute Sydney) numbers only 6 members.

homeopathy is represented by diverse beliefs and interests within a relatively small profession.

During the progress of this research, an organisation of doctors and scientists (Friends of Science in Medicine)⁹ launched a public agenda to contest the epistemology and hence practice, of homeopathy (and other complementary and alternative health modalities). At the same time, a systematic review of research evidence for the efficacy of homeopathic remedies was conducted by the Australian National Health and Medical Research Council¹⁰ (NHMRC). Its 2015 report concluded that homeopathy cannot demonstrate clinical effectiveness. These socio-political critiques were continuously in the background (and sometimes the foreground) during the development of this research. The homeopathic profession in Australia faces intense political and public scrutiny, and these circumstances, and the participants' response, unavoidably shaped this thesis (as discussed especially in Chapter 10). This thesis does not aim, nor attempt to enter into, let alone resolve, disputes about homeopathic epistemology. Nonetheless the thesis was undertaken in and necessarily speaks to this context of polarised debate and dispute of the legitimacy of homeopathic practice; and I discuss some implications of my findings in the final chapters.

Recently, investigators have explored practitioners' experiences of the challenges facing naturopathic medicine in Australia (Wardle, Adams et al. 2013), examining the extent to which CAM practitioners implement evidence-based practice (Leach and Gillham 2011). Many naturopaths recognised the need for further training in the use of evidence-based practice. These investigations acknowledge that despite the need for increasing educational regulation (Wardle, Steel et al. 2012) there is emergent rigour in the Australian CAM sector. Naturopathic professional regulation and registration continue to be contested issues (Wardle, Steel et al. 2013). As the landscape of Australian CAM professionals intersects, these findings have implications for the homeopathic profession and for clinical reasoning.

⁹ www.scienceinmedicine.org.au last view 17 August 2016

¹⁰ <https://www.nhmrc.gov.au/guidelines-publications/cam02> last viewed 5 September 2016.

1.4 Justifying knowledge claims

Throughout this thesis, I develop an argument that homeopathy can be better understood, and ultimately warranted, as an interpretative method. In many respects, it demonstrates strong resemblance to qualitative research. The participants' diverse techniques and methods, constituted by forms of knowledge both within and beyond homeopathy, bring attention to the interpretative and performative character of homeopathic clinical reasoning. Although both biomedicine and homeopathy are usually represented as the application of a set of organised principles, homeopathy is, much more than that, an interpretative practice in the qualitative sense. The diversity of participant experiences reflects and reinforces this assertion. This claim, however, challenges the prevailing public representations about what homeopathy is and is not, among both advocates and opponents of homeopathy. Much of the rhetoric, however, does not describe what actually happens in practice, which this thesis seeks to redress.

Conventional medicine is widely discussed as being both an 'art' and a 'science,' and there is considerable scholarship devoted to the gap between the aspirations of a purely technical 'evidence-based' scientific medicine, and the complex (sometimes termed 'messy') uncertain, uneven, and interpersonal characteristics of medicine-in-practice. These themes and perspectives have shaped this thesis also. Through interpretative work, part of the thrust of this thesis was to try to come to grips with the epistemic and practical implications of the different clinical reasoning methodologies employed, and the ways in which knowledge is created. I must reiterate that the object of my thesis is not to resolve epistemic disputes. However, I cannot avoid or ignore questions of epistemology for a number of reasons. First, it is a part of the discursive landscape. Second, epistemologies are what underpinned much of clinical reasoning and decision-making processes. And, these are also what are to be assumed as underlying reasoning and decision-making processes. Therefore, at various points in this thesis, the reader will see that I try to come to grips with what different methodologies provide, and to understand how they are linked with clinical reasoning and decision-making. The reader will see that this has made me give more value to the hermeneutic and individualising case-based practices, over what are typically described (among medical reasoning practices) as having more to do with cognitive

mechanisms and algorithms which come from methodologies that look to provide validity, reliability, and generalisation. The latter provides a useful, although limited, way of understanding the various epistemologies which give shape to homeopathic clinical reasoning in particular. Thus, rather than trying to solve the philosophical questions of homeopathic epistemology, what it alerts us to is the range of methodologies and behaviours to which binary distinctions (of 'art' and 'science') cannot do justice. I, and the reader, need to be aware of what methodologies are being used, in what circumstances, and for what purposes.

In reality, health and medical practices use a range of methodologies and epistemic strategies which yield warrantable knowledge sufficient for a clinical intervention. These range along what could be described as a spectrum that is always interpretative, but which has formalised quantitative strategies at one end whose goals are warrantable knowledge through reliability, validity, and generalisability. One of the primary strategies at this end of the spectrum are methods that work by identifying and isolating (as much as possible) single factors that impact, often causally, on the conditions/outcomes under study. RCTs and large scale epidemiological studies work on this basis. On the other end of the spectrum is context-sensitive, 'deep' or 'rich' multifactorial meaning-oriented analysis, such as the many forms of qualitative research. Positivism sacrifices sensitivity for robustness, whereas homeopathy, like qualitative research, privileges sensitivity derived from the individuality of patient symptoms and expressions. Consequently, critics of homeopathy assert that homeopathy sacrifices robustness. Positivist and qualitative methodologies don't need to be construed as polar opposites or even as dichotomies – each involves acts of interpretation, often linking relations with context, and can overlap more than the 'work of purification' (Latour 1993) would suggest – but a lot of the discursive structure of biomedicine has been vested in these dichotomies. Acknowledging this, homeopathy may in fact benefit by abandoning its effort at self-justification according to the criteria established for the warranty of biomedicine, its discourses and research enterprises.

1.5 Thesis structure

Understanding how homeopaths actually practise reasoning and decision-making, exploring their lived experience, was always at the heart of this thesis. This required extensive investigation of the epistemology of homeopathy, considering the sources of knowledge, its historical construction and development as the context for this study. These are examined in Chapters 2, 3, and 4. Chapters 2 and 3 help the reader to consider why the participants might refer to or utilise a 'purely' Hahnemannian, or a Kentian, or a hybrid perspective. Chapter 4 considers how and why the continued contestation of homeopathy causes the participants to value what they are doing, and to practice ethically, and how they construct clinical reasoning praxis. Despite the contested discourse, the reader will increasingly see the gap between the rhetoric about constructions of homeopathy, and the reality of practice which this thesis attempts to occupy.

Despite its sustained practice for 200 years, there is comparatively little empirical research that investigates what homeopaths *actually do* in practice. Chapter 5 examines recent empirical evidence for homeopathic clinical reasoning, and gives particular attention to the PHIRM model (Burch, Dibb et al. 2008). I assert that while the PHIRM model constitutes a foundation for understanding homeopathic clinical reasoning, the results of my thesis extend this understanding. In particular, this thesis enriches an understanding of the relational aspects of clinical reasoning and their therapeutic importance, as well as the value of context effects.

In chapter 6, I provide a thorough description of the methods and theoretical framework employed throughout this thesis. This includes a detailed examination of IPA, and of the phenomenological and hermeneutic traditions that underpin it. This chapter also affords a comprehensive description of how the data were ethically collected, managed, and analysed.

I asked each participant in what ways different sources of knowledge contributed to their clinical reasoning. Chapters 7 and 8 explore how theory was always entwined and reviewed with reference to the participant's clinical experience, and also with other work, life

experience and perspectives. The reader will see in these chapters the complex relationship between pattern recognition and algorithms, remedy-matching and intuition, and the multiple other sources of knowledge that shape reasoning. No two participants utilised the same style, method or approach. Thematic and iterative analysis gradually pointed me to the key understanding that homeopathic clinical reasoning is constituted by *many forms of praxis* rather than being a singular system of practice.

How the participants *performed, interacted* and *engaged* in therapeutic ways with their patients became increasingly important components of clinical reasoning, a phenomenon I have called *iatrosynergy*. Chapter 9 explores the relationship between the participants and their patients. Here, the data suggest that this relationship serves dual processes, being therapeutic itself as well as facilitating the participants' understanding of the patient's lived illness.

It must be acknowledged that the representations of the lifeworld portrayed in this study convey only a portion of the complex phenomena of homeopathic practice. Abstracting salient and meaningful data from each text was an intensely interpretative process. Each representation came at the expense of other data that might yield other valuable and important findings. I could not adequately capture the participants' lifeworld without giving some attention to their beliefs and collective personal meanings, integral to the forms of clinical reasoning and decision-making and to the development of professional identity. This chapter also acknowledges that despite (and perhaps because of) the contextual issues confronting homeopaths and homeopathy, the participants aspired to reason ethically, and to make decisions with integrity. These are discussed in Chapter 10.

In Chapter 11, I discuss the implications of my results for existing understandings of homeopathic reasoning practice and for intra-professional training and disputes about homeopathy. I consider multiple forms of praxis that permeate and shape the phenomenon. Drawing together existing research, in particular the PHIRM and PPR entanglement models with participant performativity and therapeutic interaction, enriches an understanding of the phenomenon. In regards to the legitimacy of homeopathy, the empirical data in this

thesis suggest that many contextual features within homeopathy are powerful, and still not fully understood. Further investigation of these would be beneficial.

In the concluding chapter, I assert that, like the many methods of qualitative research, including IPA research, homeopathic clinical reasoning is highly nuanced and characterised by attention to the particular in each and every case. Consequently, reconceptualising and acknowledging it as an interpretative practice can create new opportunities for homeopathic research, vital to pedagogy and to practice.

CHAPTER 2

Historical and conceptual framework of homeopathy giving rise to contemporary clinical reasoning

This chapter provides a summary and description of existing scholarship on the historical origins and development of homeopathy. In this chapter, I identify the main traditions, concepts, political forces, and social influences that have informed and shaped homeopathy in Australia, in particular the elements shaping Samuel Hahnemann's intellectual approach and defining clinical methods. This history, with its complexities and tensions, forms the background against which the participants in my research were acting.

We might consider briefly what the world was like when Hahnemann was thinking and practising. Hahnemann's work needs to be understood as located in a specific time: a time of significant change in the history of medicine, with the new interest in *method* and in *empirical observation* that was associated with the 'Paris hospitals' school of thought and practice. Hahnemann both held to elements of the Hippocratic-Galenic tradition, such as vitalism and aspects of humoralism, while eschewing some of its associated practices, such as bloodletting, explicitly to develop what he considered a safe, reliable empiricism. In developing his new methods, Hahnemann retained the sense of authority and links with the past, for example in his attention to the patient's story in the Hippocratic-Galenic tradition. In consequence, Hahnemann developed a method that he believed to be consistent and reproducible, while based on clear principles, both of his own and in keeping with long-accepted traditions. The tension in Hahnemann's evolving work - between theory and empiricism, between adherence to a set of rules and the need for practical flexibility – remains visible and unresolved, confronting homeopaths today, as will be seen in my data.

2.1 Organisation of this chapter

This chapter has two main sections. The first section considers how and why situating homeopathy within the history of medicine is important to understanding the structure of homeopathic clinical reasoning today. Homeopaths and homeopathic literature often make epistemological claims on the basis of what are perceived as the enduring strengths of its traditions, and indeed, in many instances on the basis of the coherence of and continued connection to tradition. We can gain more insight into these traditions by situating them within the history of medicine generally, and specifically by better understanding the context of nineteenth century debates about empiricism. Here, I focus on specific people and concepts that shaped Hahnemann's thinking and methods.

The second section explores the establishment and development of homeopathy as an independent profession. One of the central questions of this section is the degree to which homeopathy can be regarded as a 'complementary' or 'alternative' therapy at multiple

points during this time. I consider how the global spread of homeopathy inevitably exposed it to other influences, many of which changed ideas within homeopathy itself. Here, the emergence of American spiritualism in the work of James Tyler Kent is discussed as a major influence within homeopathy. Finally, I consider the political and social processes by which homeopathy has been marginalised, and the structure of critiques and defences that have emerged over time. While the focus in this section is on the decline of American homeopathy, simply because this has received more attention from researchers, I consider how this material is relevant to my research because of the degree to which it is illustrative of the status of Australian homeopathy.

Chapters 3, 4, and 5 will use this chapter as background for the discussion of contemporary debates about homeopathy that occur therein. These chapters necessarily revolve around the contestation of conceptual and empirical evidence, which form the main focus of these debates. This chapter allows us to better understand how and on what basis theorists have defined '*the evidence*' for (or against) homeopathy, by having more insight into how homeopathy has connected theory and practice – evidence and reasoning - in the past.

2.2 Emergence of homeopathy in historical context

'Complementary' and 'alternative' healing practices are defined (as these terms indicate) by their difference from conventional or orthodox medicine (which often goes less explicitly defined). This requires, of necessity, that any analysis of such practices consider the degree to which they are different or similar to this norm. And that degree has changed over time. In this section, somewhat contrary to mainstream medical and even medical-historian perceptions (Porter 1992), I argue that homeopathy may be most usefully understood, not as a strange and isolated endeavour, but as just one of many very similar responses to new ideas and developments in medicine that were occurring in the late eighteenth century in Europe. To truly argue such a position would be another thesis in itself (one in the history of medicine), and there is not space here for a detailed discussion about representations of homeopathy as constructed in the historiography of medicine. What follows in this section is a rather schematic overview of the historical emergence of homeopathy, and serves

primarily to provide insights into homeopathy's main philosophical commitments and their enactment in research and treatment methods, as these continue to be important in understanding the lifeworld of homeopathy today.

2.2.1 Hahnemann, 'rationalism' and 'empiricism' in late eighteenth century medicine

The concerns, interests and ideas that prompted Samuel Hahnemann – a German physician with a good quality but otherwise unremarkable and average medical education – to develop homeopathy in the late eighteenth and early nineteenth century, were those general to his times (Porter 1992, Porter 1995). They included renewed debates about the relative merits of 'rationalist' versus 'empiric' approaches to medical knowledge and practice (and the different healing practices that properly enacted these), and interest in constructing a firmer epistemological basis for medicine by developing new methods, above all (in German medicine) by systematising and better understanding the *materia medica* specifically. Like many others of his era, Hahnemann engaged in critique of the frequency and scale of the negative effects of the conventional medical treatments of the day (Hahnemann 1810). He also upheld a worldview that was, and continued to be, fundamentally dominated by the Classical (Aristotelian-Hippocratic-Galenic) model of the body and of disease. In accordance with this model, Hahnemann championed a philosophy of utilising what was perceived as the natural healing properties of the body as a major therapeutic tool.

2.2.2 Hahnemann's resistance to emerging ideas

There is widespread agreement between historians of medicine that the second half of the eighteenth century, particularly following the emergence of the Paris hospitals and medical schools, was a period of transformative change in medicine. Here, the origin of modern scientific medicine may be meaningfully located - always understanding that 'origins' are fuzzy concepts, and that continuities stretch backwards and forwards much further in time. Until this period, what I will, for simplicity's sake, term the 'Classical' (Aristotelian-Hippocratic-Galenic) model of human physiology and the 'humoral' theory of disease, had continued as the dominant medical paradigm (Kuhn 1970, Habrich 1991, Porter 1992) as

they had been in Europe for close to two thousand years. In this model, the body was understood as a system of ‘humors’, liquid-like substances produced within the body and subject to change with a person’s changing circumstances. A person’s health was dependent on internal bodily regulation that produced and maintained a finely-tuned balance amongst those humors; a primitive version of what today we understand as physiological homeostasis. The Classical model was complex and also contained concepts of ‘soul’ or spirit, themselves considered in multiple ways, such as the distinctions between nous, thymos, menos and psyche (Bennett and Hacker 2002); along with other concepts such as character, vitality and energy, these were considered forces that gave the body animation, perception and responsiveness (Bennett 2007).

2.2.3 Conceptualising disease

Disease, or imbalance, as represented in this model, was understood in terms closer to ‘ill-health’: as an experience produced by the specific set of circumstances that generated an imbalance of humors within the individual. While external circumstances – including the weather, the immediate natural environment, airs and waters, and the quality of the food one had eaten – played their roles in the complex structure of disease causation, the immediate causes and processes of a disease were all located *within* the body. Notably, there was only a limited sense of disease specificity and nosology (classification) in the late eighteenth century. Thus it made perfect sense that someone might *start* by becoming ill with ‘malaria’ (a term with a very different meaning then, one relating primarily to a set of symptoms), only to have the disease change course and *become* scarlet fever – a course of events that would make no sense after the advent of germ theory and the subsequent changing concept of disease specificity and diagnosis (Bynum and Porter 1993). Nonetheless, by the late eighteenth century, there was a growing interest in developing more consistent pictures of disease and disease process, hence the emergence of pathobiology.

The development of a thorough case history was part of a scrupulously detailed methodology appropriate to such a model of disease, and it remained pre-eminent for

Hahnemann.¹¹ The art of diagnosis, one of the key and most honoured features of medical skill and experience, also reflected the paradigm of being attentive to the individual case: it involved the careful observation and discrimination of symptoms by colour, consistency, smell, timing, correlation, and a host of other factors.¹² Case histories in the major medical schools throughout the nineteenth century would report on fine distinctions in descriptions of secretions or eliminations, and on the context of weather, diet, constitution, habits and recent events and behaviour when discussing the appearance, diagnosis and history of a case. A mode of discernment and thoughtful scrutiny was a hallmark of high quality medical practice (Shorter 2006).

Concepts of disease and of contagion drew on a range of analogies, including with putrefaction – the observation that a rotting apple could spread the rot to its adjacent neighbour, for example – or fermentation, in which it seemed one could observe disease processes arising *de novo* in previously clean and healthy food (Pelling 2001). Other analogies particularly relevant to Hahnemann could be derived from observing the process of dyeing, in which a small quantity of input material could spread its main property across a whole mass. Like many of his contemporaries Hahnemann's concept of disease causation also included a range of diseases thought to result from 'miasms.' Prior to germ theory, the enormously destructive and fearful epidemics of what we now identify retrospectively as diphtheria, scarlet fever, typhoid, yellow fever, plague and smallpox and so forth, that were a feature of the industrialising world of the time, were predominantly understood as the product of 'miasmas': literally, bad, rotting air generated by industrial and human waste and affecting the humoral functioning of the many hapless human beings who were forced by circumstance to inhale the miasms (Porter and Porter 1989, Porter 1999, Bashford 2001). Miasmatic theory posited that inhaled miasms generated processes of putrefaction and fermentation in the body with (depending on the individual) concomitant excesses or pooling or loss of humors, and consequent overall 'lowering' or 'over-excitement' of the whole bodily system, with fever or depletion accompanying.

¹¹ This was also a major part of the Hippocratic method.

¹² During the 19th century, descriptions were more of physical signs and pathology than the patient's history.

The 'humoral' model of disease was holistic, in the sense that it offered a framework that integrated and connected all aspects of someone's life (how they ate and slept, the environment they lived in, the activities they undertook, and their emotional state). There was little distinction between 'mental' or 'emotional' disturbances and 'physical' diseases, since thought and emotion were interconnected as different aspects of physiological (humoral) functioning. Melancholia, for (a famous) example, made perfect sense as a disease with emotional, behavioural, cognitive and physical symptoms, and indeed was understood in arguably far richer (even if inaccurate) terms two centuries ago than the concept of 'depression' can adequately capture now (Horwitz and Wakefield 2007). It behoves us to remember at this point that this comparison is also somewhat problematic, as it assumes that the melancholia historically described is the same 'thing' as depression.

Traces of the Classical model can still be found in current discussion of concepts such as 'balance,' 'integration,' and 'homeostasis' in health; and they continue far more prominently in current public and lay discourses on health at least (Lipworth, Hooker et al. 2011). Examples of this model, and its antecedents, were evident in the data presented in this thesis.

2.2.4 Paradigm shift

As is well known, the Classical model had been increasingly challenged since the period of the scientific revolution, particularly as a result of new investigations in anatomy and pathology; and by Hahnemann's day might well be said to fit Kuhn's 'crisis' period; or rather, although 'crisis' is a rather emotive word for a period spanning a couple of centuries, existed as part of a sort of interregnum between paradigms (Kuhn 1970). Since Vesalius (1514-1564) and the emphasis on dissection and anatomical research in Renaissance Italian (and French) medical schools, it had become increasingly clear that neither the humors nor the structures by which they had been considered to be produced and move within the body could be verified, and instead research yielded evidence that questioned the entire conceptual foundations of the human organism. Paradigm shifts are, however, slow to occur, and even

slower to move from the medical academies to the practices of lowly apprentice practitioners. It is questionable that there was continuity between the colleges and academies. Accordingly, we might reasonably say that the seventeenth and eighteenth centuries were chiefly a period of experimentation and conceptual flux in the history of medicine, as various academician-doctors proposed new theories of the body and of disease. These new theories were often applications of the concepts being developed in the 'natural philosophy' (physics) or chemistry of the period. Thus, for example, Boerhaave proposed a 'hydraulic' theory of disease (Orland 2012).

One might consider that what was significant about the 'scientific revolution' was not so much the new ideas per se, as the development of new *methodologies* for discovering (or, perhaps we should say, constructing) them (Shapin 1994). In the eighteenth century, academic leaders were interested, not only in new ideas in their respective areas, but in questions of epistemology (as was Hippocrates and Aristotle), of how new ideas and new claims might be justified, or seen to rest on a more reliable basis than those that preceded them. The eighteenth century, therefore, produced its own version of medical arguments and traditions that still went by the terminology of schools of thought in Classical Greece: the rationalists and the empirics, which very loosely corresponded to a division between theory-driven and observation-driven approaches to medical research and practice. Rationalists considered that the main task of medicine was to understand the basic mechanisms of disease, which would then provide a basis for rational clinical treatment. The empirics, in contrast, rejected abstractions and theories – often considering the underlying mechanisms of disease to be both too complex and too much hidden from human perception to be truly understandable - in favour of basing clinical treatment on careful observation of *outcomes* and what deductions could be made from these (Newton 2001).

Certainly, in general terms, we may consider there to be an unavoidable and iterative relationship between theory and observation, so too between induction and deduction, with inferences running in both directions (Kuriyama 1995) and very few academicians past or present can be placed solely in one or the other camp. Nonetheless, the terms were meaningful in the past, and it is fair to say that in the eighteenth century the empirics had the upper hand. From the Edinburgh medical school, which was closely connected with

Scottish and British scientific empiricism (then and now for its emphasis on experiment and observation in contrast to theoretical natural philosophy on the Continent), to the physician-naturalists working on the voyages in the age of European colonisation, the emphasis was on observation and systematic description. The best known of the empirics is perhaps James Lind, known for his early version of a very schematic comparative trial of potential remedies for shipboard scurvy (Porter 1995, Short 2013) in which sailors were divided into groups that were issued different remedies, the consumption of citrus amongst them. This is a celebrated example of methodological innovation in the history of medicine.

2.2.5 Paris hospitals: Hahnemann's continued resistance

The Paris hospitals themselves were defined chiefly by the entirely new conceptual and methodological possibilities of pathology and statistics, and their academic leaders held an aggressively empiric philosophy; indeed they defined themselves as those who stood contrary to 'the spirit of system', as John Harley Warner has described it (1998). By this, they meant they rejected all the complex theories of the body and of disease that the eighteenth century had spawned, in favour of *purely observational* learning from dissection and particularly from the identification of pathological changes in bodily tissues with the use of that new instrument, the microscope. Whereas this approach indeed produced a revolution in medical thinking, including a strong sense of disease specificity as manifest in pathology, the Paris hospitals were also known for the brutality of their often 'heroic' approaches to treatment, which continued to emphasise the bleeding, leeching, purging and toxic treatment for which medicine in that period is well known (Ackerknecht 1967, Porter 1992). The objectification of the patient, the severity of suffering and the recoil of horror from the experimental vivisection of animals received considerable critical attention in its day, was often accompanied by a quite justifiable cynicism about medical efficacy (Warner 1998) (as articulated, for example, by another methodological innovator from the Paris medical schools, statistical pioneer Pierre Louis).

While some doctors were excited by the intellectual vistas opened up by the Parisian approach, many others cautioned of the dangers of losing the advantages of other healing practices that were obscured or swept aside by the Parisian approach, including the fine art

of diagnosis and the work of evoking the body's capacities for self-healing, which was a central strategy in Classical medicine. The Parisian excitement over pathology and what it implied about disease causation, also tended to marginalise the clinical importance of the *materia medica*, gathered and considered over centuries; incorporating philosophies of preventive and natural health (Martyr 2002).

This is the historical context in which Samuel Hahnemann completed his medical training and arrived at homeopathy. As I have noted, Hahnemann trained in unremarkable medical colleges in Leipzig, Vienna, and Erlangen in the late 1770s. However, his medical training largely created in him what Roy Porter (1997 p 390-391) describes as a contempt for the arbitrary and destructive prescribing habits of regular polypharmacy medicine, including the common occurrence of poisoning patients with the battery of arsenic, mercury, strychnine and so forth with which the doctors of the day conducted their clinical work. His disquiet became so extensive that he gave up practice for a few years, and the desire to avoid harm became one of the guiding principles for homeopathy, underpinning his commitment to minimalist intervention. Hahnemann remained strident in his abhorrence of the harms wrought by the 'old school' (allopathy¹³) in his day, and this is a commitment that remains as a methodological as well as ethical commitment in homeopathy (at least discursively) today.

2.2.6 Hahnemann: visionary?

In conformity with the cultural norms of gentility of the era, Hahnemann was a widely read man, a Renaissance man knowledgeable in many fields (De Schepper 1999 p xiii). He had worked for many years as a professional translator who specialised in translations of scientific and medical works, and he continued this work, and to undertake his own experiments in chemistry, after his MD was awarded. Hahnemann thus fitted the profile of the gentleman-scientist-doctor typical of the period, a German version of George Eliot's much-loved Dr Lydgate (Daiches 1971). He was clearly familiar with the broad debates

¹³ Allopathy refers to the then prevailing conventional method of treating diseases with drugs opposing the symptoms, against which Hahnemann wrote and spoke vociferously. See, for example Morrell, P. (2004). "Hahnemann's View of Allopathy as Seen in the Prefaces and Introduction to the *Organon*." from <http://www.homeoint.org/morrell/articles/viewallopathy.htm>.

about method and substance in natural science and medicine, and like many physician-naturalists, especially in Germany at the time, he was especially interested in and influenced by research in *materia medica* specifically.

There were many intellectual and practical challenges in this domain. Describing eighteenth century medicine as a *basso-continuo* of Hippocratic-Galenic humoral thinking with a series of new melodies and variations drawn from new scientific ideas layered on above, Habrich (1991) termed the pharmacopeia a 'special problem' for eighteenth century physicians to sort out. In addition to the abundance of the Classical *materia medica*, there were all the Paracelsan new chemical preparations, sympathetic magic products (the 'Dreckapothica'), drugs from the new world, and a plethora of folk medicines to understand and integrate (Habrich 1991, Wood 2000). As Linnaeus and other systematisers did in the related field of botany, many doctors of the time perceived the need to systematise, clarify and hierarchise the pharmacopoeia for use. And indeed there were some seventeenth century models of such a task that were highly regarded in the eighteenth (Orland 2012).

Thus we can see that, appalled by the harms caused by conventional therapeutics, but intellectually fired by the possibilities of systematically creating a firmer basis for a modern therapeutics based on evidence collected through careful observation (in both impulses, no different to the majority of academically inclined doctors of the age), Hahnemann saw his own work and interests in terms of this larger project of the rationalisation of therapeutics in the empiric tradition. Like many others, Hahnemann was drawn to the purist empiric philosophy and systematising approach of Thomas Sydenham (1624-1689), and we know that he translated works by the Edinburgh empiric William Cullen.¹⁴ Hahnemann was clearly also strongly engaged by the legacy of Philippus Aureolus Theophrastus Bombastus von Hohenheim (known as Paracelsus, 1493-1541), whose extensive alchemical researches formed the foundation of scientific chemistry. Like Paracelsus, Hahnemann was interested

¹⁴ It was in fact during the translation of Cullen's *Materia Medica* that Hahnemann paused to question Cullen's claims in respect of *Cinchona Officinalis* (Peruvian bark, or 'bark', as it was known) and so to experiment with *Cinchona* on himself.

in developing methods to identify and produce the ‘purest’ forms of chemical substances, and to distinguish between toxic and therapeutic dosages.¹⁵

2.2.7 Anton von Störck

The most significant and immediate influence on Hahnemann however, was likely the Viennese academic physician Anton von Störck (1731-1803), one of the dominant figures of late eighteenth century German medicine; a thorough academician (despite an obscure social background) who became physician to Austrian royalty and the author of several much-cited treatises that were prominent in European medicine. His research focus was the therapeutic potential of plants considered as poisonous, if administered in appropriate, very minimal, doses. Like Sydenham, Cullen and others whose chief interests were *materia medica*, von Störck worked explicitly in the empiric tradition, and was as well-known as James Lind as a methodological innovator and antecedent of the clinical trial. Porter (1995) indeed claims that in Continental Europe (certainly the German-speaking part of it) von Störck’s experiments served as the first model for the scientifically planned and documented clinical experiment. Von Störck developed a three-stage process of testing and applying his therapies, first to animals, then on himself, and then in his patients, at varying dosages. Herein lay a part of the historical problem for homeopathy, which attempted to establish both safety, and effectiveness, using these stages of experimentation. In the course of these researches von Störck suggested that plants that created serious symptoms in healthy people could *cure the same symptoms* in sick people – the central idea that Hahnemann would develop into his homeopathy principle. Hahnemann also included many of the plants von Störck investigated, including the Hemlock (von Storck 1760)¹⁶ and Pulsatilla (Habrigh 1991), in his own research (Hahnemann 2010).

¹⁵ I remind the reader that in this period – the period before ‘oxygen’ was conceptualised as such, and where ‘purity’ held tangled moral and physical meanings - ‘chemical’ substances were considered to produce effects on the ‘spirit,’ on what we now would term mood, emotion and thought, and had vitalist elements that made sense within a world in which crystals were considered likely to have a kind of life force, since they seemed to grow in the ground, and magnets similarly seemed to have some of the properties of life. At that time, to postulate a ‘life force’ was no more fanciful or spiritual than to postulate the notion of a ‘germ’ or a magnetic ‘field.’

¹⁶ The translator of von Störck’s original Latin work is anonymous. Hahnemann was a busy translator, however, being born in 1755, was not likely the translator of this drug monograph.

Von Störck had taught Joseph Quarin, one of Hahnemann's mentors at the Vienna medical school (Gantenbein 2000), who in the small world of academicians of the day was presumably familiar to Hahnemann. We know that in the early period when he relinquished medical practice altogether, Hahnemann made his living from translating scientific and medical manuscripts, and continued at the same time his own chemical researches, interested in methods of purification. His translation of Cullen's *A Treatise on Materia Medica* prompted his (and so others') fascination with the apparent power of Peruvian bark in the treatment of fevers (those we would now call 'malaria'). In keeping with empirical traditions, Hahnemann took the drug himself and noted that it induced in him malaria-like symptoms. This prompted him to pursue von Störck's idea that substances may induce disease-like states in healthy individuals, which he found to be in keeping with existing case studies of poisoning in the toxicological literature. So, while von Störck developed the proving concept, Hahnemann was considered the first to develop this into a systematic methodology (Nicholls 1988 p 31). This body of evidence altogether seemed sufficiently extensive to suggest a more generalisable principle of similars.

Hahnemann was also strongly in sympathy with von Störck's emphasis on the utility of minimal dosages to avoid the toxic effects of powerful plants – an emphasis that Hahnemann greatly extended through the methods of purification used in chemical research, which were the basis of the processes of 'potentisation' (a concept closely related to purity) and 'succussion,' two of the key components of classical homeopathic practice that are still utilised to this day, and both, as I discuss below, arising in some measure from the vitalism that underpinned Hahnemann's approach to therapeutic action. The logic for Hahnemann was as follows: toxic substances (for example Aconite, or Belladonna) were diluted using an exact dilution scale, and were vigorously shaken an exact number of times between each stage of dilution. The resulting *dilutions*, according to Hahnemann were both safe but increasingly powerful (potent), retaining their therapeutic potential while eliminating their toxic effects.

2.2.8 Empiricism and rationalism in Hahnemann's methods

We have now, at least in part, a timeline of the conceptual and ideological influences that may have shaped the key dimensions of Hahnemannian homeopathy. At its core was a primarily empiricist philosophy in which the systematic study of effects of different therapies at different dosages was key. Hahnemann's central method of 'provings,' utilised healthy drug testers whose reactions and reported symptoms were scrutinised with a deliberate stance of careful discernment, finely tuned detail, and systematic coverage of a number of categories and qualities of experience. While Hahnemann's writing emphasised what he called 'empiric' methods, his work iteratively called on and perhaps increasingly focused on its theoretical ('rationalist') element, the doctrine of similars.¹⁷ In many ways – certainly at least on par with his contemporaries elsewhere in European academic medicine – this looks very much like a representation of the scientific process as conventionally presented, in which theory-laden hypotheses are tested by their outcomes – indeed it has been regarded (by a non-homeopath academic historian of medicine) as one of the clearest forms of this process in that period (Habrich 1991).

However there were more rationalist elements in early homeopathy than the doctrine of similars alone. Hahnemann's vitalism – another core aspect of homeopathy that appears particularly inconsistent with orthodox medicine today – also deserves some commentary. It too was unremarkable for its time: so unremarkable, indeed, that it was assumed and not even considerable for empirical testing through his methods of proving and succussion, which relied on it. Vitalist doctrines were slowly declining in prominence, marginalised by ways of thinking made possible by new technologies that made physical disease visible or at least materially perceivable (including the microscope, pathological dissection, and the stethoscope). Indeed, Leary (1987) suggests that Hahnemann developed his theory of medicine twenty or more years too late, somewhat after his contemporaries had abandoned Kantian idealism and vitalistic-metaphysical ideas about medicine. Nonetheless, the reader should recall that Hahnemann's primary interest was in chemistry and that the

¹⁷ Hahnemann was careful to distinguish the doctrine of similars from the doctrine of *signatures*. Bennett, B. (2007). "Doctrine of Signatures: An explanation of medicinal plant discovery or Dissemination of knowledge?" Economic Botany 61(3): 246-255. The two doctrines have been repeatedly confused when in fact they are theoretically and empirically unrelated.

chemistry and 'natural philosophy' (what would later become 'physics') of the day constantly grappled with how to identify and understand the unseeable forces, including gravity, magnetism, flammability, and precipitation, by which the world seemed to be moved; and how these might be connected to the forces that raised life in the bodies that breathed, consumed and otherwise were affected by them. Certainly the Romantic scientists of late eighteenth century salons, figures such as the poet Samuel Taylor Coleridge (1772-1834) and his colleague, chemist and inventor Sir Humphrey Davy (1778-1829), would have found nothing startling or unusual in the concept of a vital force with strong therapeutic powers; and indeed, discussion over what forces guided and shaped both life and the physical world, was to continue into the early twentieth century (Bergson 1911).

Hahnemann was thus uncontroversial in his assertion that a spirit-like Vital Force animated the human organism (*Organon of Medicine*, aphorism 9), and it was not, for that time, such a leap to suggest that a similar force remained latent within each substance until it was liberated through the processes of serial dilution and vigorous shaking or succussion, developed by him. Heating water and oxygen and other substances clearly changed their form and function, and others were similarly interested in processes of purification, not least with a view to strengthening therapeutic impact. In the late 19th century, as scientific practices moved forward, the Kentian school sustained and emphasised the vitalistic stance, a factor possibly contributing to the decline of American homeopathy. This is essential to understanding both the criticism Hahnemann faced, as well as contemporary critiques of homeopathy.

We can thus see that the empiric and rationalist elements were historically in play in homeopathy. While not inconsistent in Hahnemann's formulation, there is tension between them that remains in homeopathy today. Indeed, some tension is evident between Hahnemann's *Organon* (1810) and his later theorisation of the causes of chronic diseases (1816-1828). As will be seen in subsequent chapters, this tension has implications for the current context of practice, and in debates over the legitimacy and status of homeopathy, factors that I hypothesised might also influence my participants. This could be summed up as follows: the empiricist element and to some extent, its methodology (provings) in Hahnemannian homeopathy left open the possibility of falsifiability – of empirical critiques

that might ultimately be a disproof of theory (Popper 1983).¹⁸ And indeed, theory of miasms remains controversial in contemporary homeopathy (De Schepper 1999p 357). Meantime the rationalist components of his thinking, especially his form of vitalism, have arguably been central toward much of the continued attraction of homeopathy for practitioners and patients alike.

In sum, Hahnemann advocated a system of therapeutics based on the principle of similars, singular rather than complex medicines, and on the individualised treatment of disease. This system, he asserted, was both rational and gentle (Schmidt 1992), in contrast to contemporary medical practices including gastric purging and bloodletting. Within this tradition, Hahnemann maintained that medicine should be built upon a body of knowledge derived from exacting empirical observation and measurement. A physician, he noted, should be knowledgeable in understanding disease and human biology, in medicines known through careful testing, and in how to apply medicines for diseases according to easily comprehensible principles (Hahnemann 1810).

The similia principle persists as the foundation of homeopathic practice up to the present day. It was also the unifying prescribing principle among the participants in this research, irrespective of their specific clinical reasoning methods. From this principle, Hahnemann deduced that medicines should be applied *individually* in order to observe their specific effects, in contrast to the historically preferred method of combining them. Hahnemann critiqued Brownian complex medicines in 1801 in Hufeland's Journal (Bradford 1895 p 72), claiming that the smallest quantity capable of producing a therapeutic effect was the required dose in every case of disease. Hahnemann perpetually advocated *safe, gentle and effective methods* (Hahnemann 1810) – qualities intrinsic to, rather than merely features of, his philosophy.

¹⁸ This movement from observation to theory and again to observation is an intriguing feature of homeopathy, and I was interested how this understanding was represented and practiced by the research participants.

2.3 Growth, status, and professionalisation

The homeopathic system spread rapidly in Europe between 1812 and Hahnemann's death in 1843, even despite Hahnemann's growing marginalisation from academic medicine. The new method became entrenched in Europe and laid the foundation for later theoretical and practical developments. The following details map homeopathy's historical and geographical trajectory and its professional development.

In Europe, Hahnemann found loyal advocates among his students and colleagues, many of whom, like him, were frustrated with the injudicious abuse of poisonous medicine. As early as 1812 Hahnemann found enthusiastic collaborators including Drs Stapf, Gross, and Hartmann. In his student and colleague Bönninghausen (previously a magistrate) Hahnemann collaborated with a man regarded as a meticulous practitioner and scholar who enabled him to collate his growing research into an accessible, methodical format. Bönninghausen's *Therapeutic Pocket Book* (1846),¹⁹ a detailed taxonomy of symptoms, enabled homeopaths to select individualised medicines for their patients based on systematic symptom analysis. The systematic repertory system remains in practice today, for ease of use primarily in electronic format.

Following the deaths of Hahnemann (1843) and Bönninghausen (1864) the fundamentals of orthodox homeopathy were well established. Hahnemann's major theoretical treatises *Organon of the Rational Healing Art* and *The Chronic Diseases: Their Peculiar Nature and Homeopathic Treatment* (1810, 1828) laid the material foundation for homeopathic practice. Bönninghausen's contribution simplified symptom analysis and case evaluation.

The global status of homeopathy, and whether it ought to be considered an orthodox, heterodox, complementary or alternative profession, is intricate and contested across different contexts. German homeopathic doctors are philosophically divided. Some practice homeopathy predominantly, some in parallel with biomedicine, and others as an exclusive

¹⁹ A homeopathic repertory is an inventory of symptoms designed to facilitate selection of the most similar homeopathic medicine for a diseased individual.

alternative (Frank 2002, Frank 2002). Barry notes the paradoxical claim that homeopathy is *alternative*, considering its entrenchment and support, for example by the British Royal family and aristocracy (Barry 2003). Barcan (2011), on the other hand, unambiguously asserts that homeopathy ought to be understood as an alternative system, being paradigmatically opposed to the principles of conventional medicine. This may be true for homeopathy per se, but not for all homeopaths. It diminishes the fact that homeopathy is practised in many countries, by doctors who recognise and utilise it within conventional diagnostic frameworks and taxonomies.²⁰ Certainly, although homeopathy was contested, homeopathic doctors retained a license to practice, and professionalisation progressed at least up until the US Flexner Inquiry and Report. It is possible that the Australian context better fits Barcan's position, since here homeopathy is practised predominantly by non-medically qualified practitioners, and is generally regarded as an alternative or complementary system. How my participants positioned themselves or expressed their sense of these tensions was an ongoing question in my research.

Professionalisation of homeopathy was essentially inseparable from conventional allopathic professionalisation as both disciplines sought to assert themselves. At the turn of the 20th century around 8% of American physicians were homeopaths, trained at one of twenty-three homeopathic medical colleges²¹ (Jonas, Kaptchuk et al. 2003). Although the scope and quality of training and practice were inconsistent, homeopathic hospitals continued as an established - though still contested - system of medical therapeutics.

2.3.1 Homeopathy in Britain

By 1850 homeopathy had spread throughout central and eastern Europe. In 1832, Dr Frederick Hervey Quin, an associate of Hahnemann, was the first doctor to practice

²⁰ The Faculty of Homeopathy, UK, established in 1844, provides the services of registered medical practitioners, veterinarians and nurses. It does not represent professional homeopaths such as the participants in this study.

²¹ These homeopathic medical colleges included Boston University School of Medicine (then the Massachusetts Homeopathic Hospital, founded 1855), New York Medical College (founded as the New York Homeopathic Medical College in 1860) and Hahnemann Medical College Chicago (founded 1860) as well as colleges in Pennsylvania and other states.

homeopathy in London, and by 1849 the first homeopathic hospital²² was opened. This development coincided with the 1854 cholera epidemic, the treatment of which was considered more successful with homeopathy than with conventional treatment (Joslin 1854). Mortality under homeopathic care was around 16% while records suggest that it was greater than 50% for those in conventional hospital care at the time (Oliver Kennedy, Couzigou et al. 1983). This notable outcome fostered public support for homeopathy in England and Scotland, where two hospitals and around 500 doctors continue to provide homeopathic care under the National Health Service (NHS) today.²³ Although once again facing intense scrutiny after the UK Science and Technology Report (2011),²⁴ homeopathy continues to receive limited NHS support.

Today in the UK²⁵, doctors practising homeopathy do so with some legitimacy and privilege (Campbell 2008). Being medically qualified and then specialising, homeopathic doctors practice within the NHS and are registered with the Faculty of Homeopathy.²⁶

2.3.2 Homeopathy in the United States: Nineteenth and early Twentieth Centuries

By 1825, homeopathy had crossed the Atlantic. It was first practised in New York by Dr Hans Burch Gram (1786-1840), a Bostonian of Danish immigrant parents. Gram practised and translated some of Hahnemann's early theoretical work, fostering interest and the spread of homeopathy in the US. By the middle of the 19th Century homeopathic medical colleges had been established in Chicago, Philadelphia, Cleveland, Detroit, Boston and New York. Some American medical schools taught homeopathy exclusively, some allopathy and others a combination of medical modalities including osteopathy, itself professionally established during the late 19th century.

²² The Royal London Homeopathic Hospital (now the Royal London Hospital for Integrated Medicine) has been under Royal patronage since 1920.

²³ <http://www.nhs.uk/conditions/homeopathy/pages/introduction.aspx> last viewed 17 November 2015

²⁴ <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmsctech/45/4502.htm> last viewed 17 November 2015

²⁵ Medical doctors with homeopathic qualifications in the UK are registered with the Faculty of Homeopathy. Their services are largely funded by the National Health Service.

²⁶ The British Faculty of Homeopathy was established in 1844.

Chief among these was the Hahnemann Medical College of Philadelphia established by German-American Dr Constantine Hering (1800-1880).²⁷ Having been recruited to discredit the new method, Hering concluded that it was a rational system based on reproducible principles. Hering later conducted botanical and homeopathic research in Surinam²⁸ before settling in the US. In response to critiques of homeopathic therapeutics, erudite defences had already appeared around the middle of the nineteenth century (for example Everest 1842, Sharp 1856).

To establish their rights to practise and prescribe, homeopathic doctors became professionally organised, forming the American Institute of Homeopathy in 1844 (Baer 2001 p 13), just prior to the establishment of the orthodox American Medical Association in 1846 (Jonas, Kaptchuk et al. 2003). The professionalisation of homeopathy was parallel to that of conventional medicine, incorporating an integrated institutional structure of training, accreditation and practice. Homeopathy was neither *alternative* nor *complementary* during this period. Rather, it was one among a number of competing heterodox systems of therapeutics that included chiropractic, osteopathy, and spiritualism (Baer 2001).

2.3.3 James Tyler Kent, Spiritualism & Emmanuel Swedenborg

Spiritualism and faith healing emerged within a range of medical systems in the United States. Traditions including Christian Science asserted rigorous spiritual beliefs, their proponents seeking spiritualist doctors and healers, some qualified doctors, others not. Some American spiritualist traditions renounced both conventional and homeopathic methods, appealing to spiritualist interpretation as the source of true healing (Baer 2001). This tradition had a significant historical effect on American homeopathy.

Swedish philosopher and theologian Emmanuel Swedenborg (1688-1772) profoundly influenced James Tyler Kent (1849-1916), his interest awakened after the death of his first

²⁷ In 1982 the Hahnemann Medical College formerly became the Hahnemann University. Subsequently, in 2002, Hahnemann University merged and became Drexel University of Philadelphia. <http://www.drexel.edu/medicine/About/History/> last viewed 17 November 2015

²⁸ Hering empirically tested the South American bushmaster snake *Lachesis Muta* on himself. He was also the first to introduce Nitroglycerine (or Glonoine) known today as Anginine widely used for the symptomatic relief of angina pectoris. This occurred at least 30 years prior to its introduction into allopathic medicine.

wife (Schmidt 1964). Kent, his colleagues, and many of their students in the United States mid-west and on the east coast developed a clinical approach that transformed the orthodox homeopathic tradition established by Hahnemann and Bönninghausen. Kent maintained that disease in the human organism reflected and represented imbalance on a higher *spiritual plane* of human existence. His *Lectures on Homeopathic Philosophy*, first published in 1900 and derived from his post-graduate lectures at the Homeopathic Medical College in Chicago, espoused Swedenborgian philosophy not formerly taught or practiced. Although Kent advocated Hahnemann's philosophy (Kent 1900), his interpretation resulted in a modified philosophy and method of case analysis, one emphasising the patient's psycho-spiritual state *as causative* in the development of their specific physical disease state. While Hahnemann noted that the patient's mental state was likely be *disordered* within a disease state, he did not assert that it was the fundamental cause of their disease. In this, Kentian homeopathy departs significantly from Hahnemannian. Hahnemann's framework is very explicitly modernist, and one of its moves is to dissociate morality from disease, in deep contrast with the prevailing discourse both within and outside medicine of the day. Kentian quasi-spiritual hybrid homeopathy has considerable tensions with Hahnemann's model, but it dominated the American schools during the second half of the 19th century and remains a significant part of the landscape of homeopathic practice today. This context was also something I held in mind in observing my participants.

The inclusion of Kent's philosophy in some streams of homeopathic practice has some similarities with the intersections between conventional medical reasoning and the emerging humanistic psychological tradition (for example see Whitmont 1980). One example is the debate between the so-called *lows and the highs*. The 'lows' advocated the use of material homeopathic doses (still matched according to the principle of similars) that stimulated the physical organism, while the 'highs' advocated the deployment of high homeopathic potencies (ultra-dilutions) that were believed to stimulate a higher or spiritual plane (Coulter 1973). Despite, or perhaps because of tensions amongst divergent schools, homeopathy steadily developed in the US, amalgamating Hahnemannian and Kentian methods. Variants of Kent's method, reinterpreted and reconstructed, were identifiable among the clinical reasoning strategies of some of the participants.

2.3.4 Political and economic demise of American homeopathy

At the turn of the twentieth century, American medical education lacked standardisation. Although homeopathy had become medically, professionally and socially established, the 1909 Flexner report into the condition of American medical education led to the gradual closure of many medical schools and hospitals, including some which trained homeopathic physicians (Winston 1999, Beck 2004). After Flexner's report was tabled in 1910, only 15 homeopathic medical colleges remained active (Barzansky, Gevitz et al. 1992).²⁹ Flexner spared neither the allopathic, homeopathic nor eclectic traditions. It is also possible that some church-affiliated medical colleges for African-American students were closed after the Flexner inquiry (Savitt 1992). Social historians have commented on the intersections between US conservative political affiliations and ideologies, the exercise of social power by new pushes towards orthodox American medical professionalism and early twentieth century American race relations, in the scrutiny and regulation of medical education in this period.

The contemporaneous development of pharmaceutical drugs including Sulphonamides in the early 1920s witnessed a decline in the use of homeopathy. Between 1920 and 1960 government support was withdrawn from homeopathy, yet it continued to be practised privately from state to state. Homeopathy struggled for professional recognition during this period, being highly contested, and was banned altogether in some states (Nicholls 1988). Simultaneously, homeopathy remained established in countries as culturally distinct as India, Mexico and the United Kingdom. In Mexico, for example, homeopathy was promulgated through the clinical teaching of Dr Proceso Sanchez Ortega (1919-2005), founder of the Mexican Homeopathic Medical School.

²⁹ For an examination of the social and political conflict arising from the advent of homeopathy in the United States in the middle of the 19th century, and the return to ideal Hippocratic empiricism, see Warner's *Making History in American Medical Culture: The Antebellum Competition for Hippocrates* in Cantor, D. (2002). Reinventing Hippocrates. Aldershot, England, Ashgate Publishing Limited.

2.3.5 Cultural adaptation: Indian homeopathy

During the period of its establishment in the United States, homeopathy was also introduced in distant India. Allopathic medicine had been established during the reign of Mughal emperor Shahjehan in the 17th century (Saxena 1992), while homeopathy was introduced into India much later. In 1839, German Dr Honigberger successfully treated the Maharaja Ranjitsingh of Lahore (today in Pakistan). For his reward, the Maharaja granted Honigberger the right to practice homeopathy in India. Honigberger later moved to Kolkata (Calcutta), then the capital of British-ruled India. Acclaimed allopathic physician Dr Mahendra Lal Sircar became a convert to homeopathy in 1867 (Frank and Ecks 2004, Ghosh 2010), promoting the concepts through the Calcutta Journal of Medicine. Homeopathic colleges began to be established by Bengali homeopaths in the 1880s, promoting the *new German system* of medicine, as distinct from colonial British regular (allopathic) medicine. In addition to providing the new German system, support for homeopathy was connected with two other critical social developments: these were 1) the movement away from princely state control by the wealthy maharajahs, and 2) the enlivened debate within anti-colonial socio-political discourses. Homeopathy was therefore a curious component of social and political changes in Bengal.

Its wide-reaching popularity in India is intriguing. Saxena (1992) has compared Hahnemann's theory of chronic miasms with the philosophies of the Ayurvedic and Unani systems of medicine. These are traditional Indian methods based on models of systemic physiological imbalance that also give close attention to psychological and spiritual qualities. Due to this claimed similarity, Saxena maintains homeopathy became an adaptable and acceptable system in India. Although at times also meeting with resistance, the popularity of homeopathy has been relatively consistent. Philosopher and second president of India, S. Radha Krishnan declared in 1953 that the recognition of body, mind and spirit in homeopathy demonstrated its correlation with Upanishadic philosophy. Mohandas 'Mahatma' Gandhi advocated that the Indian government should recognise and support homeopathy (Ghosh 2010 p 135). Both believed homeopathy ought to be promoted as a valid component of the Indian public health system.

Training and practice were not regulated during the colonial period (Ghosh 2010 p 131). The 1932 establishment of the All India Homeopathic Medical Association heralded the beginning of a regulatory framework for education and practice. While homeopathy spread across India, it was only formally recognised by a 1947 act of parliament, unanimously ratified in 1948.³⁰ Today, it is widely taught and practised in some states (West Bengal, Maharashtra, Uttar Pradesh and Kerala) while hardly practised in others, such as Jammu and Kashmir (Frank and Ecks 2004 p 308).

In India today some 200,000 doctors practice homeopathy in diverse languages including English, Hindi, Bengali, Marathi, and Tamil. Twelve thousand homeopaths graduate from colleges and universities each year. Bachelor degree and postgraduate medical training is provided in 184 registered colleges³¹ and care is provided in approximately 5000 government-funded clinics and hospitals. Today, homeopathy is regulated through state registration boards, and government-accredited homeopathic doctors provide care in public hospitals, outpatient centres and private facilities.³²

Doctors of the homeopathic, Ayurvedic and Unani medicine have had the same privileges bestowed as allopathic doctors since the 1956 Dave Committee. Parliament introduced legislation to establish the Central Council for Homeopathy (CCH) in 1964 (finally ratified in 1973), ensuring five and a half year nationally accredited training with internship for all homeopathic doctors. The CCH establishes and evaluates all aspects of education and professional regulation. The Central Council was instrumental in establishing a Research arm, responsible for conducting homeopathic pathogenetic trials as well as for the enduring

³⁰ <http://www.cchindia.com/homoeopathy.htm> last viewed 28 July 2011.

³¹ <http://www.cchindia.com/colleges.pdf> at 7.12.2010 last viewed 28 July 2011.

³² I have personally visited - for the purposes of professional development - teaching hospitals in Mumbai and New Delhi, outpatient facilities and private practices in Kolkata. Doctors I observed in Mumbai spent up to an hour with mostly educated middle class patients attending for the treatment of chronic diseases. These cases were conducted in English. Three or four junior doctors, students and observers were present in the consulting room at any one time. In Kolkata, on the other hand, one doctor (formerly a military engineer) spent no more than 3 minutes with each patient, many of them suffering from acute conditions. These cases were conducted in a mixture of English and Bengali. He fired rapid, specific questions, scanned a textbook and immediately wrote a prescription to be filled at a local homeopathic pharmacy. The diversity of clinical reasoning methods and practice styles reflects the multiplicity of educational, economic, ethnic, and religious discourses that typify pluralistic Indian society, and are equally visible in the world of homeopathic clinical practice.

management of the Indian Homeopathic Pharmacopoeia (Ghosh 2010) both critical to the preservation and growth of homeopathic materia medica. In addition to publically supported education, research and clinical facilities, thousands of homeopathic doctors also operate private practices in cities, towns and villages across India.

2.3.6 Homeopathy in Israel

In Israel, CAM practitioners including homeopaths hold a different status, being permitted to consult in some public hospitals (Mizrachi and Shuval 2004) although Israeli pharmacists have tried to remove homeopathy (Fenton 1992, Menczel 1995). Driven by patient demand, homeopaths are employed as hospital contractors. Although permitted to consult and prescribe in these hospitals, they are excluded from the critical ritual of ward rounds. They are, in effect, simultaneously included and marginalised. Australian professional homeopaths, by comparison, have no such hospital privileges.³³ If their patients need to be hospitalised, for example for acute care or surgery, they hold no professional visiting or treatment rights regardless of their patient's preferences.

2.3.7 Homeopathy in nineteenth century Australian colonies

Homeopathy was first practiced in Australia in the early 1840s in the colonies of Van Diemen's Land (Tasmania), Victoria, South Australia and NSW (Armstrong 2006, Armstrong 2006, Armstrong 2007). During the gold rushes of the 1850s, the practice of homeopathy spread beyond the main colonial cities to regional cities and towns, where homeopaths were required to carry their own medicine chests (Treuherz 2006). The earliest practitioners were medical doctors trained in England and Scotland. As professional training and clinical competence were inconsistent, it is unsurprising that many were publicly pilloried as 'quacks' in the colonies. At the same time, some homeopathic doctors claimed that homeopathy itself – "a revolutionary scientific movement" - would put an end to quackery and iatrogenesis (Martyr 2002 p 79). A number of German, French and British ministers or priests of the Anglican and Catholic faiths (with limited homeopathic training) also

³³ A handful of doctors continue to provide homeopathy to outpatients at the Sydney Homeopathic Hospital Clinic at Balmain Hospital, Sydney NSW.

established themselves in regional locations (Treuherz 2006). Their primary objective was to operate Christian missions, not to practice homeopathy, unlike Kent, who, although a devout Swedenborgian, was a practising physician. These included the Benedictine monks at New Norcia Western Australia (Owen 2005, Treuherz 2006) who were among the earliest institutional homeopathic practitioners in Australia, and where a small homeopathic library can be found today.

Recognising the vast distances people travelled for medical assistance and the lack of available doctors, a growing number of non-medically qualified homeopaths began to prescribe homeopathic medicines. Medical regulations and laws related to practising and prescribing rights during the second half of the 19th century varied from state to state. Understandably, there was considerable opposition to the practice of any system of medicine by unregistered or less than fully-qualified physicians (Armstrong 2007), such as the British Medical Association's ban on medical registration of homeopaths in Western Australia in the mid-1890s (Treuherz 2006). This development was congruent with the shifts in medical training, as well as regulation and registration between the 1860s and 1890s.

2.3.8 Status of homeopathy in Australia

Although the training and regulation of homeopathy was inconsistent, not all medical doctors and academics were opposed to the rights to practice of unqualified practitioners. Professor John Smith, first Dean of the Faculty of Medicine at the University of Sydney, was opposed to legislation protecting doctors from the competition of unqualified practitioners. Smith's position attracted much scorn and ridicule (Lewis 1988).³⁴ Smith claimed there was ignorance both inside as well as outside the medical profession and vehemently opposed 1875 legislation in New South Wales that would create a medical monopoly. Not alone in his opposition to legislation that would privilege medical practitioners, Smith was greatly concerned by the monopolistic interests sought through professionalisation. Smith's concerns were a portent of the tensions in the contemporary practice of medicine, its ideology and hierarchies, and the delivery of healthcare services. His concern reflects

³⁴ Smith was also in favour of the establishment of an Arts School prior to the establishment of a Medical School.

debates that characterised the period of regulation; some about competition for its own sake, some about the limitations of knowledge, some about the privileging of specific epistemic and practice positions at the expense of others without due consideration for the range of harms and benefits, some social critiques of the ‘winners’ and ‘losers’ in such processes.

At approximately the same time, non-medically qualified homeopaths continued to practise in spite of medical opposition and fear of reprisal (Treuherz 2006). As a side note, other traditions, notably traditional Chinese medicine, have similarly had a controversial yet widespread and long sustained existence in Australia (Martyr 2002). Many self-trained homeopaths practised with mixed fortune, a professionally and ethically tenuous situation that continues to this day.

2.3.9 Homeopathy in Australia today

Across Australia today, one might encounter ‘homeopathy’ in diverse ways – a landscape made more complex by the commercialisation of many ‘natural’ remedies. There are those who practice according to the homeopathic *method* and those who *dispense* homeopathic medicines (Torokfalvy 2005). Many naturopaths, chiropractors, medical doctors and other health professionals prescribe and dispense homeopathic *complex* medicines,³⁵ possessing minimal traditional homeopathic training. This situation is unsurprisingly controversial among homeopaths. The claims against complex prescribing can be considered both normative and dismissive. They uphold a particular view of the authority of Hahnemann and his propositions about simplex prescribing. This unrestricted situation is in part a function of the unresolved issue of regulation of homeopathy and other CAM practitioners (AHA 2003, Torokfalvy 2005).

³⁵ Traditionally, homeopathic medicines are prescribed and dispensed as simplexes (single, individual substances). This conforms to the homeopathic principle of ‘the single remedy’, developed by Hahnemann to represent the concept that the patient requires individualised homeopathic treatment. These single remedies or ‘simplexes’ are distinguished from a popularised method of prescribing ‘complex remedies’ or combination remedies, containing as many as 50 separate homeopathic substances. Since the time of Hahnemann, homeopaths have prescribed individualised simplexes, whilst others resort to a random, ‘shot-gun’ approach through the application of complexes. This method requires little training and no understanding of homeopathic philosophy or practice principles and will not receive any attention in this study. Additionally, RCTs of homeopathic complexes have been conducted. The participants in my study did not use complex medicines.

Taken together, this historical context raised a number of issues that directed some of the observations of my participants. I was interested in what traditions and theories they might associate themselves with or explain their practices through, and I was also interested in whether regulatory issues or systems or contemporary controversies might be reflected in their experiences. Indeed, regulatory issues grew in significance during the course of my research, at least in terms of the participants' professional identity, given the drafts and final report by the NHMRC, the peak public body responsible for medical research and reporting. This report and its reception by the homeopathy profession and the research participants constitute pivotal moments during the course of this study.

In Australia, medical doctors practising homeopathy utilise a range of clinical approaches.³⁶ Non-medically qualified professional homeopaths, including my research participants, although trained to government-endorsed competency standards, do not enjoy the privileges of statutory regulation and face persistent professional challenges (evident for example in Freckelton 2012). This professional dissonance is less apparent in continental European countries (for example Germany and France), where the majority of practising homeopaths are medical doctors. In the context of sustained critiques, I was interested in their effects on the participants; how it affected their professional identity and whether it caused them to evaluate or modify their clinical reasoning.

2.4 Chapter summary

Homeopathy is a system of therapeutics entrenched within the history of European medicine. In this chapter, I have considered the relationship between homeopathy and developments in medicine during the eighteenth and nineteenth centuries. I have examined how Hahnemann adapted and explored rationalism and empiricism within homeopathy, and how he developed a theory of disease while adhering to empirical investigation of the sick.

³⁶ It is estimated some fifty doctors practice homeopathy across Australia. Many of these were formerly members of the Australian Medical Faculty of Homeopathy (AMFoH), although this organisation ceased to exist (personal correspondence with Dr NG, 2008). There are also many veterinarians who utilise homeopathic medicines in the treatment of certain animal pathologies and conditions.

Due to its distinctive historical development, I take the position that homeopathy remains epistemically and philosophically incommensurable with modern biomedicine to a very significant degree. During the lives of Hahnemann and Bönninghausen, homeopathy was practiced according to very clear principles. These principles demonstrate that it was designed to be an uncomplicated, methodical and reproducible system. As homeopathy grew and spread, for example through the Kentian tradition in the United States, and to India and Australia, it changed according to the social, political, economic and cultural institutions shaping these societies.

Despite recurrent scrutiny, and at times being close to extinction in the United States, homeopathy remains widely practised. While it continues to develop new theoretical elements, and incorporates an empirical research base, its epistemic foundations mean that it occupies a relatively marginal niche within the healthcare landscape.

The following chapter explores the epistemic and conceptual foundations of homeopathy examining the development of the case method as the mechanism for individualised care and as the primary means of teaching and learning homeopathy. The subsequent chapter considers internal and external discourses, both critiques and defences of homeopathy, in relation to the issues of evidence and efficacy.

CHAPTER 3

Epistemic and conceptual foundations of homeopathy

This chapter outlines existing scholarly positions on how to understand homeopathic epistemology as the foundation for clinical reasoning. Homeopathy is grounded in a series of conceptual principles, constituting the foundations of clinical practice, as much as it is in the evidence of sets of provings. Reviewing these principles will help to situate this research between the discourses about evidence and the research participants' experiences.

3.1 Conceptual foundations

Hahnemann's law (or principle) of similars (1810, 1828) sets homeopathy apart from all other methods and systems of medicine. A homeopathic prescription is based on a drug or substance that has *produced similar symptoms* in healthy volunteers rather than on the (allopathic) principle of opposites, such as an *anti-biotic* for an infection. A case of influenza with fever might proceed as follows: symptoms such as fever, chill, headache, thirst, perspiration and nausea were observed and individually examined, considering the timing, character and circumstances of every symptom, then *compared* against the known similar symptoms from the database of homeopathic provings (drug monographs) contained in volumes of materia medicae. Once matched for similarity, the single or *individualised* medicine would thus be clinically applied.

More than the principle of similars defines homeopathy. Here I examine three other conceptual issues: the notion that illness is an inherently mind-body phenomenon, the epistemology of individualisation, and the notion that a vital energy or force underpins life, illness and the action of homeopathic treatment.

It should be noted that homeopathy does not lay exclusive claim to these elements. These claims intersect with philosophical and theoretical truth claims made by other CAM therapies, such as naturopathy (Leach 2013). In some cases they can be equated with or

define 'holistic' care, something attractive to many patients and offered in some conventional medical contexts such as integrative medicine (Grace and Higgs 2010), psychology and psychiatry (Cox 2008). I now consider each of these epistemic positions more closely.

3.1.1 Holistic (mind-body) ontology

As a therapeutic modality, homeopathy conceptualises human existence as non-dualistic (Reilly 2001). And while this was conceptually explicit to Hahnemann, it remains an underdeveloped aspect of homeopathic theory (Schmidt 2012). Mind and body are ontologically understood as an indivisible whole, linguistically separated to facilitate description and to convey meaning. These premises extend into homeopathic theory and pedagogy, but how this is put in practice was something I presumed would vary from practitioner to practitioner.

Along with and partly stemming from the non-dualistic model of the body in homeopathy has been a focus on the body as a whole, in contrast to the tendency in biomedicine to increasingly specialise on particular parts of the body. Homeopathy is not theoretically limited by anatomical and pathological specialisation, although some homeopathic doctors engage with specialised diseases, for example breast cancer (Jacobs, Herman et al. 2005) and paediatric cancers (Längler, Spix et al. 2011). Nevertheless, even where specific disease entities are treated homeopathically, each case is individualised, including an individualised examination of all mind-body phenomena manifest in every patient. In this sense, homeopathy's holistic ontology bears some resemblance to bio-psycho-social conceptualisation of illness and disease in orthodox medicine (White 2005), and also to patient-centred and person-centred medicine (Cohen, Krackov et al. 2000).

Interestingly, this philosophical holism may in part account for the diverse medical pluralism and integration of homeopathy in some Asian countries, notably Sri Lanka and India (Broom, Doron et al. 2009, Dekkers 2009, Sheehan 2009, Broom, Wijewardena et al. 2010), where it is utilised in urban as well as impoverished rural communities (Dutta-Bergman 2004)

accustomed for centuries to non-dualistic mind-body constructions in its Yoga, Ayurveda and Unani systems of indigenous therapeutics.

Mind-body ontology is embedded in homeopathic pathogenetic trials (HPTs) known as 'provings.' Provers and proving supervisors are instructed to take detailed note of even subtle psychological and physical changes experienced during the proving (Hahnemann 1810, Sherr 1994), categorised descriptively to accommodate the unquestionable constraint of language. The subjective language of the substance is considered *to be spoken in and through* the symptoms and sensations experienced and recorded by the prover. In clinical practice, the complete phenomena of symptoms and expressions represented in a proving is reflected in the search for the most suitable homeopathic remedy, matched against each and every *characteristic* symptom experienced by the diseased individual.

Whereas certain models of homeopathic case analysis (such as Kent's) privilege the patient's psychological or *mental state*, Hahnemann emphasised the significance of the *characteristic* and *unusual* symptoms experienced by each prover and each patient (aphorism 153). The symptoms of mental *disease* and those of the mental *state* are one salient example of an important distinction in understanding and interpreting homeopathic theory.

3.1.2 Individualisation

Individualisation is embedded within homeopathic epistemology. Individualisation is an implicitly recognised expression of the principle of similars. The proving phenomenon demonstrates an individualised response to the substance being examined. Equally, patients exhibit different symptoms when sick, even though they may suffer the same diagnosed disease or illness. This phenomenon is an acknowledged cornerstone of homeopathic philosophy and prescribing. Individualisation is entrenched in every well-articulated clinical case (Thompson and Weiss 2006). Clinical effectiveness is (theoretically) commensurate with the degree of similarity between the patient's symptoms and those in the proving, upon which the medicine is selected. Conversely, a homeopathic case which lacks individualisation is less likely to produce a significant clinical outcome. Ideal practice

therefore rests upon an *individualised examination* of every case of disease (Hahnemann 1810 aphorisms 6, 83, 153).

Patients experiencing the same *diagnosed* disease (for example *bronchitis*) may be prescribed different medicines, according to the individualised characteristics of their disease state. A bronchitis patient with an extremely dry cough and chest pain on coughing and inspiration might receive *Bryonia Alba*, while another bronchitis patient with loose cough and thick yellow sputum might be prescribed *Pulsatilla*. These *homeopathic diagnoses* would depend upon the individualisation of symptoms as well as careful physical examination. In this example, diagnosis serves a dual function. It would not be enough for the homeopath to diagnose bronchitis; she needs to individualise the patient's symptoms, to determine their relative value, and to compare them with the known symptoms in *materia medica*. The *Bryonia* patient, in addition, is likely to be thirsty, irritable, and with a preference for solitude, while the *Pulsatilla* patient often demands company and is thirstless. Thus, we have the images of the *Bryonia* and the *Pulsatilla* bronchitis, and the respective patients needing them.

The image or *pathography* of the patient's characteristic disease picture must be differentiated in order for the correct medicine to be prescribed (Swayne 2002, Dimitriadis 2004). This restricts the suitability of randomised analysis, making generalised evaluation of homeopathic interventions difficult (Witt 2009), in particular of the classical or traditional method (Oberbaum, Vithoukias et al. 2003).

At the same time, many patients seeking an individualised understanding of their illness experience take a disparate view of their condition from that of their health professional. This is particularly the case among patients with medically unexplained conditions, a not uncommon phenomenon (Carel and Cooper 2013). While well recognised in conventional general practice, empirical study of lived illness experience is constrained by the lack of a gold standard (RCT) against which to make comparisons (Stone 2013). The importance of case individualisation in homeopathy, a conventional part of practice, lends cogency to the need to understand lived illnesses as they are *the actual phenomena* that patients experience and inhabit.

3.1.3 Minimum dose

Possibly the most contentious principle for the epistemology of homeopathy is the *minimum dose*, surrounded with conjecture and debate both within and outside the discipline. Hahnemann asserted that the method of potentisation of substances developed by him caused them to be *more dilute* while simultaneously *more powerful* (or potent). Potentising homeopathic medicines produces dilutions beyond Avogadro's number (over and above the 12th Centesimal potency) making them theoretically devoid of even a single molecule of the original substance. Critics understandably consider any effects of substances at or beyond the 12C potency to be placebo effects and entirely implausible (Bayley 1993, Ernst 2005). Homeopaths themselves are internally divided, particularly in regard to the application of so-called low (pharmacologically measurable) potencies and high potencies (beyond Avogadro's number). While most advocate that clinical results are both plausible and possible utilising potentised medicines (Rutten, Mathie et al. 2012) others acknowledge evidence of the successful application of both low and high potencies (Jütte and Riley 2005).

Once matched for similarity and selected individually, homeopathic medicines are prescribed in doses sufficient to stimulate a therapeutic response. The medicine may, at the homeopath's discretion, be administered in a high potency, so small that a pharmacological reaction would be theoretically impossible. In the above case of bronchitis, the patient might be prescribed a 6th potency (still discernible) or a 30th centesimal potency, a dilution well beyond Avogadro's number according to conventional molecular theory. The uncertain mechanism of action for homeopathy surely demands critical examination among homeopaths themselves. The implications of high dilution research are considered in the discourse below regarding Benveniste and Nature.

3.1.4 Vital force or energy

Homeopathy maintains that human beings have a mechanism of internal homeostatic governance (Bayley 1993) that enables them to engage freely with the world in a healthy state. Hahnemann claimed this homeostatic mechanism to be a living *vital force*, a *dynamic*

or *spirit-like energy* (Hahnemann 1982, Aphorism 9) that could be neither felt nor apprehended yet was responsible for the maintenance of health. Although Hahnemann's conceptual understanding of the historical theories of vitalism is not clearly articulated (Leary 1990), he asserted repeatedly in the *Organon* that illness manifests in symptoms when the vital force is disturbed and can no longer maintain homeostatic equilibrium. Disturbance to the vital force results from multiple factors, including maladaptation to the environment, altered living conditions, psychological trauma, as well as bacterial and viral pathogens (*miasms*, as Hahnemann understood them).

It is understood that in an illness or disease, no matter how trivial, the homeopath will always consider changes in the individual's *state* – *state* representing the imbalance or disturbance of the vital force. Even comparatively subtle changes felt by the patient and observed (either by family members or the homeopath herself) are compared with the known symptoms of provings (Hahnemann 1810 aphorisms 210-212). The vital force is always considered to be manifest through signs and symptoms of the mind-body. Homeopathic medicines – prepared according to Hahnemann's specifications - expend their energy initially on the vital force, subsequently generating a physiological reaction.

Other medical traditions, such as Traditional Chinese Medicine (TCM) understand *qi* (or *chi*, life energy) to be integral to its philosophical foundation as well as being substantive and action-oriented (Kim 2008) in practice. Energy, or *chi*, is said to 'move' within meridians (pathways) that cannot be detected or measured by conventional anatomical and physiological mechanisms, but can be detected utilising TCM diagnostic tools (for example pulse and tongue signs). So too, vital force in homeopathy holds both inherent philosophical meaning and has an important practical application. Homeopaths utilise their understanding of the vital force as a means of conceptualising each patient's state of wellness/illness (Bell, Lewis et al. 2004). The perception of the patient's vital force is, in effect, an interpretative measure reflecting perceived mental function, energy, and other positive dimensions of the individual, not merely the absence of disease symptoms. In this sense, the experience of vitality is synonymous with wellness as much as illness.

3.2 Knowledge generation

Knowledge in homeopathy is historically constructed from four key sources: toxicological data, provings, clinical trials and case reports. Provings and case reports are most often cited by homeopaths (and by the research participants) as the major sources of knowledge, being regularly utilised in clinical practice. As the data from clinical trials bear the least resemblance to clinical practice, I will not examine them in detail as a source of knowledge. The participants seldom referred to clinical trials, inferring both their limited relevance to practice as well as the participants' restricted understanding of the importance of clinical trials, a finding similar to that in Heirs' British study (2012, 2015). I shall, however, consider clinical trials in the latter section of this chapter, within the context of a discussion of systematic reviews and counter reviews.

3.2.1 Toxicology

Toxicological data are empirical data gathered outside homeopathy, for example observations and reports of accidental poisonings from the stings and bites of various insects (e.g. Stein and Medhurst 2000) and sea animals (e.g. Bonnet 1999). The data observed and recorded are utilised clinically when the toxicological symptoms match (are most similar to) a patient's disease symptoms. Advocates argue that, being external empirical phenomena, toxicological data are more reliable than provers' symptoms (which are subject to interpretative bias). This criterion meets Hahnemann's desire for objective and reproducible data. Critics contend that unlike provings and case studies, toxicological data are one-dimensional, that they are not representative of lived illness experience.

3.2.2 Provings

Since Hahnemann, homeopathy has recognised the proving as a methodologically and epistemically valid tool (Dantas 1996) although for Hahnemann it was not equal in importance to the law of similars, the central defining principle (Adler, Ambrosio et al. 1996). These trials, some 200 years old, and the core texts generated by them (Hahnemann 1828, Hahnemann 2010) constitute the foundations upon which medicines are prescribed.

Provings were the enactment of Hahnemann's empiricist philosophy. Hahnemann unequivocally asserted that medicines must be thoroughly and carefully distinguished from one another, tested by *careful pure experiments on the healthy body* in order to obtain accurate knowledge of them (Organon 120). Animals are not used in homeopathic provings; neither are children, pregnant women or persons known to be suffering from illness at the time of the experiment.

As we have seen, for Hahnemann, empiricism in provings served to validate homeopathy (Schmidt 2009). However, among homeopaths today, including those closely engaged in conducting provings, there is disagreement with the appropriate methodology and the reliability of much of the data generated (Sherr 1994, Gray 2005, Goote 2011). Much of this discourse centres on symptom rigour and validity, and asks whether *primary symptoms* (those immediately experienced by the prover due to the impact or stress of the substance (Herscu 1996) - or *secondary symptoms* (those representing the prover's physiological reaction, or strain in response to the substance) should be considered when evaluating a patient's symptoms (Dimitriadis 2004 p 143-153). Some contemporary provings contain extensive descriptions of dreams and psychological narratives. These represent some aspects of the development of homeopathy over time, but their value is contentious (Dam 1993, Sharma 2004) and most do not belong within Hahnemann's rigorous guidelines, so there is considerable internal disagreement over what value to accord them.

Hahnemann's chief empirical tool was the diligence of provers, and he underscored the need for close scrutiny of the symptoms they reported. As with some of his contemporaries like James Lind, Hahnemann sought *reliable* empirical data that could later be generalised. According to him:

'everything that is conjectural, all that is mere assertion or imaginary should be strictly excluded; everything should be the pure language of nature carefully and honestly interrogated' (Hahnemann 1810 aphorism 144).

Reliability was sought through the methods available to him at that time in history (prior, I remind the reader, to the invention of medical statistics, indeed, to most statistical

methodology of any kind), chiefly, through scrutiny and questioning. Symptoms were not transcribed into primary source books unless verified by further questioning and confirmation of the exact character of the symptom. If Hahnemann or his supervising colleague doubted the legitimacy of the symptom, it would be bracketed, considered more likely a pre-existing symptom of the prover and not a response to the substance itself being investigated.

I note here that a parallel between Hahnemann's symptom bracketing, and the bracketing of phenomena in Husserlian (Husserl 2006), and later Heideggerian (Overgaard 2003) phenomenology, is apposite. Husserl, like Hahnemann, aimed at empirical rigour and reliability, but like Hahnemann, also confronted the inherent subjectivity of perception. In both cases, bracketing was a means of being interpretivist while maintaining scrutiny of distorting bias. Both circumstances acknowledge that pure phenomena cannot be observed without being interpreted by the observer.

Hahnemann did not think of using randomisation or a control group, and hence he had no mechanism to disentangle what symptoms might be unrelated to the substance being examined. Critiques of the proving methodology point to problems of prover and experimenter bias (Kaptchuk 1996) coupled with resistance to exploring more rigorous and theoretically unbiased experimental methods such as the RCT (Dantas 1996). Despite this omission, some proving coordinators argue that placebo and control groups are not necessary (Walach 1994). Walach argues that it is historically valid and sufficient that the experience of provers and the director of the provings act as controls, a frail argument in the context of randomised controlled trial design.

Methodologically, the contemporary proving is becoming more rigorous. In contemporary HPTs, a double-blind protocol is employed (Sherr 1994). Sample size varies from 10 to 50 persons, of whom 10-20% are administered a placebo. It is also recognised that genetic variability and susceptibility of provers themselves must have an effect on the reliability of the symptoms produced in provings (Bodman 1987). Nevertheless, the lack of a *standardised* universal trial methodology, and inconsistent data interpretation by proving supervisors remain contextual problems (Dantas and Fisher 2007). HPT methodology is yet

to be taken to a level that is highly internally reliable and reproducible. Reliance on the subjective impressions, language and experiences of the experimental prover make demonstrably repeatable interpretation difficult.

Further complicating the validity of provings, it is argued that if provers collectively discuss their proving experiences, for example at meetings and seminars (Goote 2011 p 16) they may inadvertently influence one another. Indeed, that they can also be persuaded by the charisma of the proving organiser, a matter of considerable concern (Gray 2005 p 7-9). This group dynamic, or field effect (Watts 2011), may be indistinguishable from the proving symptoms, in particular those psychological symptoms that may be primary symptoms. For many homeopaths, these phenomena challenge the trustworthiness of some provings, and perhaps the validity of the methodology itself.

The resources required for HPTs suggest that, as a discipline, homeopathy retains an implicit commitment to the methodology. To facilitate the clinical application of provings and to increase the accuracy of homeopathic diagnoses, programs containing Hahnemann's original work as well as more recent provings have been developed.³⁷ Hahnemann's 200 year old drug provings remain in print and in use to this day. In the face of critiques of HPT methods and results, new provings continue to be conducted, for example in Europe (Sherr 1994, Sherr 1997), Australia (Hatherly 2004, Gray 2005) the US (Herscu 2002) and India (Central Council for Research in Homeopathy).³⁸ At the time of reviewing this chapter, the UK-based Homeopathy Research Institute's second international conference was planned in Rome, at which a workshop was to be held discussing Harmonising Proving Guidelines,³⁹ indicating increased recognition that proving methodology is inconsistent and demands greater rigour.

It has been interesting to reconsider debates about provings from the perspective of the methodological challenges of qualitative research. Qualitative inquiry must continually question when and how the 'richness' (or multidimensional and particular experience) of

³⁷ Programs include Radar (Belgium), Macrepertory (US), Vision (UK) and Hompath (India). These are developed and distributed for professional use in many languages.

³⁸ <http://ccrhindia.org/drug%20proving.asp> last viewed 8th June 2015

³⁹ <http://www.hrirome2015.org/conference-seminar-agenda/> last viewed 12th May 2015

specific people and phenomena can be appropriately used to understand others. IPA, the methodology I employed, focuses attention towards the particular. Acknowledging that meaning is embedded and primarily constructed within language, and that experience is idiographic, interpretative phenomenology endeavours to reveal the uniqueness of phenomena. Thinking about this led me to wonder whether, while the methodological limitations of the HPT inhibit the clinical generalisability (or more accurately, reproducibility) of homeopathy, its focus on experience might not make it meaningful as a form of *qualitative* inquiry. The inherent properties of the provings remain historically and clinically important, and always intrinsically interpretivist. How would we assess homeopathy if provings were considered as a valid method of *qualitative* inquiry? And what status would we then accord this evidence?

3.2.3 The case study

Case studies comprise the other main historical source of knowledge in homeopathy. In conjunction with provings, case studies have significant relevance to clinical practice. A case study can be defined as an empirical inquiry that investigates a contemporary phenomenon within its real-life context (Yin, 2003 in Taylor 2013). In terms of homeopathy, indeed in regards to the study of health and disease broadly, this definition is satisfactory. In qualitative research, case study is regarded as an investigative tool, a method, and as a methodology. As a methodology, it is important to consider that methodological definitions are abstracted by researchers according to *their logics* (Carter and Little 2007). So too, to understand the logic of the case study in homeopathy it is important to recognise its historical and contextual development.

Historical notes on the case study

The use of case studies as an epistemological tool in medicine predates homeopathy, perhaps originating with the ancient Greeks, gaining prominence during the 17th century (Lukoff, Edwards et al. 1998). Case studies were a dominant form of evidence in Hahnemann's day as they had been for some 100 years prior. They continue to be prominent (indeed, dominant) in homeopathy today.

In Hahnemann's time, the case study comprised the detailed examination of the individual patient's case. As the first to develop the homeopathic case method according to underpinning principles, an 'orthodox' method of homeopathy can rightly be attributed to Hahnemann. The facilities for detailed clinical tests and investigations did not exist, thus Hahnemann's empirical focus was on the presenting complaints. The patient was required to describe in detail each and every circumstance modifying the complaint (movement, rest, sleep, weather changes etc). To this extent, the case study performed the function of organising data, in order to develop some coherence. Hahnemann proceeded to gather the same level of detail for every other (secondary) complaint. The history of the complaint, and the patient's entire general history, were all carefully noted. Hahnemann would conduct a thorough physical examination. Finally, he would ask the patient (and the patient's family or carers) what changes to his disposition and behaviour were notable as a consequence of the disturbance. A complete guide to history taking, with exacting reasoning, can be found in the *Organon of Medicine* (Hahnemann 1810).

Matching the patient's *characteristic* symptoms with the symptoms of medicines already proven, Hahnemann selected the *simillimum*, the most similar (most *homeopathic*) medicine.⁴⁰ The degree of characterisation of the patient's symptoms is theoretically congruent with the principle of individualisation, increasing the likelihood that the patient would receive (and respond to) the most similar medicine. In parallel, for qualitative inquiry, individualisation is in tension with generalisation. For homeopathy to generalise its principles, it must also consider how to generalise case method and case outcomes used in knowledge construction. For qualitative inquiry, demonstrating rigour and reliability is often in tension with individual experience, and the risk of compromising sensitivity through generalisation.

⁴⁰ The correct – or most similar – medicine in each and every case is denoted the *simillimum*. Among the complex decisions required in order to 'find' the *simillimum*, the participants were at the same time immersed in a performative process. At each stage of the interaction there existed the possibility that the dialogue might move in a different direction, changing the focus, and so distracting the homeopath from finding the most suitable, most similar homeopathic medicine.

Contemporary practice and its case study methods have evolved, shaped by multiple cultural, social, political, and economic factors. The resurgence in homeopathic practice and education since the late 1970s has generated several theoretical and clinical reinterpretations. Among the more significant reinterpretations, and those cited by the participants in this study, were European (Vithoulkas 1973, Vithoulkas 1979, Vithoulkas 1980, Watson 1991, Scholten 1993, Sherr 1994, Scholten 1996, Sherr 1997) Indian (Sankaran 1991, Sankaran 2000, Sankaran 2002) and Australian (Dimitriadis 2004, Dimitriadis 2005, Gray 2005) representations. These reinterpretations provide diverse theoretical and clinical approaches. Some were discussed and regularly utilised by the research participants, while others were challenged and critiqued. As a product of my own historical and professional journey, Vithoulkas' narrative case study method (1973, 1980) was dominant during and immediately after my training, whereas most of the participants referred to it infrequently.

In the late 1970s, Greek homeopath George Vithoulkas generated resurgence in European clinical homeopathy. Educated by students of Kent, the renaissance of teaching and practice adopted a distinctly Kentian psychological perspective. Vithoulkas maintained that homeopaths needed extensive training and understanding in psychology (1980), especially in order to work with chronically ill patients, over and above fundamental training in biological and biomedical sciences. Neither Vithoulkas nor his associates adhered closely to the orthodox model developed by Hahnemann and Bönninghausen, instead expanding the Kentian model. The ramifications of these interpretative distinctions were, to some extent, evident in the reasoning practices and behaviours of the research participants.

Through Vithoulkas' expertise a variety of post-Kentian clinical styles have been developed in Europe (Scholten 1993, Scholten 1996) and the US (Coulter 1986, Zaren 1993, Zaren 1994). During a period witnessing the growth of psychological approaches, homeopathic theorists adopted Jungian (Whitmont 1980), Adlerian (Kaplan 2001) and other narrative psychological frameworks. Others have reimagined homeopathy as a feminist form of holistic medicine (Scott 1998). Paradoxically, the erroneous term *classical homeopathy* was developed during this period; erroneously, as the term *classical* suggests an orthodox mode

of practice, one historically associated with the classical arts, such as music and literature.⁴¹ The term *classical homeopathy* has come to represent an exclusive model based on certain practice assumptions (De Schepper 1999). These assumptions include the patient's 'constitution,' the hierarchy of a patient's symptoms, and how specifically the *classical* homeopath ought to investigate the case. Many contemporary homeopaths consider themselves 'classical homeopaths' practising in the Hahnemannian tradition, when in fact their practice is a hybrid method derived from Hahnemann's approach while incorporating Kent's psycho-spiritual accent. Gray (2010 p 112) notes that the terms 'classical' homeopath and 'constitutional' homeopath have been adopted and used interchangeably, a source of some contention for homeopaths, regulatory bodies, and of uncertainty for patients when making inquiries with a homeopath.

Case taking evolved with the spread of homeopathy from Europe to the United States and beyond. In the late 19th century, the emphasis in case study method began to shift. Kent and his associates continued to record cases along with detailed analysis, symptom differentiation and treatment rationale. However, elaborate and richly descriptive case narrative became popular as Kent attributed greater relevance and meaning to the patient's psychological and emotional state. The primary reason for Kent's case narrative enrichment was his commitment to Swedenborgian philosophy, emphasising the core belief that disease was simultaneously moral and physical. Kent therefore privileged the patient's psychological and spiritual state (Kent 1900). Kent's reinterpretation of Hahnemann's method has been dismissed by some as irrational and misguided (Cassam 1999) and his work critiqued as unsystematic (Rutten, Stolper et al. 2006). Despite critiques of the man and his method, the legacy of the narrative case method has become entrenched in practice and pedagogy.

The narrative case study form has been extensively incorporated and developed in recent years (e.g. Whitmont 1980, Coulter 1986, Sankaran 1991, Saine 1999, Sankaran 2013). Whitmont (1980) combines his vast experience as a psychoanalyst with deft understanding of materia medica. Coulter (1986) provides a case canvas for materia medica study, with

⁴¹ Here, of course, we might be more specific: one who enjoys Bach, Mozart, and Ravel might say she enjoys 'classical' music, but in historical terms, only the work of Mozart is considered to be from the 'classical period' in the canon of Western music.

particular emphasis on descriptive paediatric portraits. Saine's psychiatric cases (1999) merge broad knowledge of materia medica and case analysis with modern pathology and disease management. Driven by the need for greater systematisation and rigour (Sankaran 1991), Sankaran has slowly re-theorised homeopathy (Sankaran 2013). This re-theorisation incorporates a new sub-classification of chronic disease (miasm) categories, within which homeopathic medicines are grouped and matched accordingly. Sankaran has also theorised a model of *the levels of disease*, from the level of overt pathology, to the theoretically subtle levels of feeling, sensation and energy. These examples demonstrate how case study epistemology is shifting and dynamic, incorporating multiple perspectives and traditions despite critiques that homeopathy has not evolved from its 18th century origins. And there remains a level of tension between so-called 'classical' and 'modern' approaches.

Homeopathy, I remind the reader, is neither psychotherapy nor psychoanalysis, although Sankaran (1991) has proposed 'homeo-psychotherapy' as a potential clinical model. He asserts that a disease state is ultimately no more than a delusion, a false perception of reality. While narrative interaction and engagement potentially facilitate this type of approach, the suggestion that the *narrative alone* is therapeutic is contentious, and perhaps fallacious. The homeopath is continuously guided by the principle of similars; her object remains to match the most suitable medicine for each patient, for every illness state. In homeopathy, narrative, metaphor and homeopathic medicines interact, enabling contextual healing to develop (Konitzer, Renee et al. 2003). The suggestion that metaphor and narrative alone initiate healing would situate homeopathy within the domain of psychotherapy, negating the possibility for the pharmacodynamic effects of medicines in living organisms. While some research into the relationships between psychotherapy and homeopathy has been conducted (Ferris 2008, Davidson and Jonas 2016), the two disciplines remain methodologically distinctive. Davidson and Jonas (2016) consider homeopathy as a form of Rogerian humanistic therapy, as did my research participant Susanna. Ferris (2008) reports experiencing profound and rapid symptom relief when she first used homeopathy (with psychotherapy), yet subsequently experienced little or no change after continuous treatment with another homeopath.

What cases are like

For homeopathy, the individual case has been the centrepiece linking theory, empirical observation and clinical practice. Capturing the phenomenology of the case requires an understanding of its generalities, its idiosyncrasies and nuances; and how it might have been constructed by Hahnemann and his colleagues. This will facilitate an understanding of contemporary practice as it was constructed by the research participants.

The interior of homeopathy practice remains predominantly focused on the patient's story, the central narrative which the patient provides; a window to symptoms, sensations, and experiences representing the whole person or the totality of the patient's disease (Hahnemann 1810). In some sense, homeopathic method remains decidedly *pre-modern* (Svenaesus 2000 p 29), omitting much of the testing that might occur in conventional medical practice. Although some homeopaths (in particular homeopathic doctors) view the results of clinical investigations, modern homeopathy retains a more person-centred than disease-centred approach. The results of this research document, illustrate, and explore this understanding.

The homeopathic case study is a contextual phenomenon. No two consultations or patients are identical, thus case analysis can never be the same. As a pedagogical tool, the case study is as diverse as the homeopaths utilising them. I have witnessed *and experienced* effective and efficient case studies in India requiring only three to four minutes between the patient and the doctor. After the consultation, the doctor would briefly explain (to me) his case analysis with exact reasoning and specific reference to a particular page in materia medica. The specific pathology and striking symptom characteristics were the primary focus of inquiry and analysis in this context.

At the other extreme, I have observed two-hour video recorded cases that required an additional two hours to analyse, synthesise, and debate. These were typically cases of patients suffering from a chronic condition (or conditions), frequently after the failure of, or in the midst of, conventional treatments. Some are etched in memory as exemplars of a previously unknown or under-utilised medicine. The presenter used the case to portray her reinterpretation of the medicine, sometimes extrapolating to develop the meaning of a

symptom, group of symptoms or some specific illness phenomenon. She would then return to the proving to examine particular symptoms, and to connect this reinterpretation with her understanding of the case narrative itself. Once satisfied that the case study is complete, the homeopath is usually ready to prescribe for her patient. In certain cases of complex chronic disease, she might elect to spend time further analysing the case. This process would entail a detailed comparative analysis of two or three medicines, against the patient's symptoms, ultimately leading to the selection of a single (simplex) medicine.

Successful cases are frequently recorded; less often unsuccessful ones (Mitchell 1950), a situation that is problematic for a balanced appraisal. Multiple volumes of homeopathic case studies have been recorded and published since the 19th century. Published cases vary from five or ten line synopses (for example Lilienthal 1879) to extensive anatomical and pathological descriptions (for example Guernsey 1873). Today, authors typically publish extensive cases utilising a range of narrative styles (Bailey 1995{Sankaran, 2013 #1649, Sankaran 2002}). The criteria and standards for case publication are inconsistent. Some are detailed examinations of the case through every characteristic symptom, supported by extensive reasoning, while others rapidly suggest a diagnosis and treatment plan.

Pedagogical value

Case studies have broad pedagogical value, being utilised in teaching, learning and communicating homeopathic materia medica. As the currency of communication between homeopaths case studies are used to develop and enrich the formal skills of case taking, anamnesis, diagnosis, pathology investigation, disease management, and to re-examine theoretical premises. As a student, I learned the fundamentals of materia medica in lectures. The lecturer provided a detailed monograph of each new medicine followed by one or two case exemplars to understand specific features and symptoms.⁴² Sometimes, a lecturer utilised recorded video cases, pausing to analyse and discuss discrete components of the patient's narrative, systematically linking these with repertory symptoms and references to one or more volumes of materia medica. Occasionally, a lecturer might utilise a cluster of cases to examine the treatment and management protocol for a specific

⁴² Some lecturers utilised oral, some written and some videorecorded cases.

(named) disease. In this way, thematic and disease generalisation superseded case individualisation. An ever growing body of case studies exists from which to reinterpret provings and materia medica.

Theorisation of case study methodology

Case study methodology has for some time been considered a valid scientific method for researching alternative therapies (Lukoff, Edwards et al. 1998). This is because the case study can provide both qualitative and quantitative data from multiple sources sensitive to both context and experience. According to Edwards (in Lukoff, Edwards et al. 1998), case studies can be sub-divided into four types: exploratory-descriptive case studies, descriptive-dialogic case studies, theoretical-heuristic case studies, and the crucial or test case study. Considering the homeopathic case study in the context of Edwards' four types, it is apparent that the homeopathic case study does not belong to one exclusive category. Let's consider this more closely.

Contemporary homeopathic case studies - those published and/or presented at conferences – bear the hallmarks of Edwards' exploratory-descriptive category. They are elaborate descriptive accounts of illness phenomena, merging the Husserlian 'back to the things themselves' with Hahnemann's direction to ascertain the pure phenomena of illness. However, while Edwards submits that the objective is not to generalise to other cases or to develop theory from exploratory-descriptive case studies, some contemporary homeopathic authors do exactly this. After presenting detailed *single* case studies, Scholten (1996) and Sankaran (Sankaran 2002, 2013) subsequently theorise how a homeopathic medicine might be used in other hypothetical cases. Generalising from the single case is beset with assumptions about interpretative reliability.

Edwards' theoretical-heuristic category presupposes that certain cases may be more instructive than others for theory building. Lukoff et al (1998) reason that the focus is on testing the appropriateness of specific aspects of existing theory, and so not all cases will be suitable. In the homeopathic context, Scholten, for example, employs this type of case study for his theoretical model of the periodical table of the elements (Scholten 1993, Scholten

1996). Retrospectively reanalysing a single case after a favourable clinical outcome, Scholten theorises that the medicine effectively employed for the single case ought to be effective for a range of other conditions. Here, he deduces that adjacent elements in the series *ought to* exhibit similarities to those minerals already proven and well-known. Claiming that the theoretical-heuristic case can be generalised to other cases, he extends his argument to build theory, for example that this and other cases represent the Iron, Silver or Gold 'series' in the periodic table. Generalising and theorising from single cases is understandably contentious in homeopathy, contradicting the principle of individualisation developed in provings and applied in practice. This raises critical questions about generalisability and pattern making, established in qualitative research but as yet under-developed in homeopathy.

The iterative process utilised in homeopathic case study development and analysis mirrors certain behaviours within qualitative research. The homeopath (like the researcher) collects, extracts, and analyses the data, coding and categorising it prior to drawing any conclusions. She searches for patterns in the symptoms, building an inductive understanding of the patient's illness from within the narrative, much as the qualitative researcher seeks to develop new knowledge, for example theorising through grounded theory (Reichertz 2007), in which themes are developed from participant experiences.

Critiques of case study methodology

As the product of historical and theoretical traditions in addition to the contributions of generations of practitioners, the homeopathic case study retains a central position. The rigour of the case study, however, despite its ubiquitous application, is ambiguous. I will now consider some of the pedagogical and epistemic critiques.

As a pedagogical tool, the case study has been internally critiqued due to the reliance on potentially unreliable single-case observations and interpretations (Teut and Linde 2013). Baas (2003, 2004) cautions researchers against inherent problems with the case study, including how to communicate a case, what criteria to observe for case quality, and how to conduct a meta-analysis of a group of cases. He also pinpoints the need for greater

attention to legal and ethical questions, as well as the perception of prejudice in peer review of clinical cases.

Edwards' crucial or test case study can be utilised to critique the pedagogy of materia medica. Taking the widely-theorised and frequently utilised medicine *Pulsatilla*, Sankaran proposes that *Pulsatilla* will *tremble from anger*, although the symptom is not found in the provings or the repertory (Sankaran 2013 p 246). He argues for the use of a confirmatory question in order to falsify his theoretical proposition and for refinement of his model of *Pulsatilla*. This test case challenges what is known within the proving and confronts the reader to consider the subsequent theoretical development of *Pulsatilla*. It also demands deeper scrutiny of the reliability of the confirmatory question used for the crucial or test case, and of the conceptual validity of the confirmatory question itself. One might consider, in how many cases must the confirmatory question be confirmed? And does this matter? Or, to what extent is the confirmatory question a function of the individual homeopath's experience? And finally, is it possible that a more reliable *universal confirmatory* question could be selected in the case of *Pulsatilla* (and for any/every other homeopathic medicine)? Perhaps the context is more important than the detail in some cases, while not in others. These critical questions arise in an analysis of the case literature. I was not able to predict the degree to which my research participants were conversant with, or able to address these questions.

The epistemic development of the case study by a spectrum of practitioners and pedagogues has resulted in the multidimensional, multivalent variation of description and narrative structure. This approximates the richness of the typical dimensions of qualitative inquiry, and gives practitioners an extensive palette of models with which to compare, contrast and explore their own patients. The disadvantage is that there is little consistency in the method of constructing and reporting case studies (Taylor 2013). Nonetheless the case study retains a privileged position in homeopathy.

For critics of homeopathy, from the vantage point of evidence-based medicine (EBM), case study methodology is not generalisable and must therefore be largely discounted as a source of evidence about the effectiveness of medicines. Often, what is regarded within homeopathy as 'evidence' or 'data' drawn from case studies would be construed by critics as 'purely anecdotal' and therefore not 'evidence.' Indeed, we may note for the purposes of comparison, that the status of case studies within conventional medicine is also somewhat ambivalent (McGloin 2008, Ankeny 2011), both sometimes valued for their uniqueness but often discounted or absent in practice in the context of level one evidence (which dominates).

The prevalence of the case study within homeopathy is perpetually in tension, not only with the demands and rhetoric of EBM but with internal discourses. In response to inconsistent case reporting, Thompson argues that using the RCT to study the homeopathic method cannot provide the methodological sensitivity to account for the nuances of practice (2002, 2004). He has proposed a *formal case study* methodology to enhance validity. Such a method would require considerable analysis around existing theory, cross-case comparison and a search for deviant (anomalous) cases. He proposed utilising qualitative methods to increase the rigour and sophistication of case studies (2004), and that all cases be recorded and transcribed, a method that has become prominent during the past twenty years, in particular at international case conferences. Thompson's critique points to a comparative absence of detailed, open and critical discussion regarding homeopathic case method within the profession; issues which constituted reference points in my investigation.

The tension within homeopathy (similar to that within qualitative inquiry more generally) can be located between the search for 'richness' - understood as multidimensional, detailed, contextual and nuance-sensitive - and the desire for validity in the form of reliability, reproducibility, and generalisability of its evidence base. Thompson's response to this tension is to adapt case study methodology to access and emphasise robustness and generalisability to the extent possible within a case study approach. He therefore argues that through triangulation, groundedness, respondent validation and reflexivity – each a material component within qualitative research (Denzin and Lincoln 2008) - the *formal case study* allows for naturalistic inquiry into the players, processes and outcomes of

homeopathic practice, enabling the practitioner-researcher to develop a rich understanding and contribution to the evidence base for homeopathy (Lukoff, Edwards et al. 1998, Thompson 2004). By naturalistic inquiry, I believe Thompson refers to the capacity to conduct research in the natural setting in which the participants live or experience their lifeworld (Tullis Owen 2008).

I hypothesised that the diverse participant data would constitute the 'middle way' Thompson proposed, somewhere between the reductivity of RCTs and the richness of formal case studies, as a means to a deeper understanding of homeopathic method. Interpretative phenomenological analysis gave rise to data that demanded detailed exploration analogous to formal case study analysis. The methods utilised in Thompson's formal case study analysis were therefore kept in sight during the iterative analysis.

In summary, the case study has notable strengths as well as intrinsic weaknesses. It is a mechanism for the detailed study of materia medica. It enables homeopaths to engage in knowledge communication. It is a vehicle for the development of a narrative style suitable to contemporary practice. However, case study construction is inconsistent and lacks generalisability. Subject to author preferences and experiences, the case study can lack rigour. There are no unqualified criteria with which to determine the value of symptoms from one case study to the next. These inconsistencies mean that the practising homeopath is left with the task of distinguishing reliable from unreliable case studies and methods.

Case databases are currently being developed according to theoretically more rigorous criteria.⁴³ The evidence base for homeopathy continues to be embedded in provings, case studies and toxicological reports. Recently, however, homeopathy researchers have invested resources in more conventional clinical research methods.

⁴³ For example databases being developed by the Homeopathic Research Institute, UK. <https://www.hri-research.org/resources/research-databases/> last viewed 19 October 2015

3.4 Chapter summary

This chapter charts the epistemic and conceptual foundations of homeopathy. Particular attention has been afforded to the case study, its development and theorisation, as it constitutes the critical connection between theory and practice. Understanding the case study also predicates understanding particular discourses about evidence in homeopathy. The conceptual and epistemic foundations of homeopathy have been cast as implausible by critics (Smith 2012) while staunchly defended by its proponents (Bellavite 2012, Rutten, Mathie et al. 2012). The result is that the status of homeopathy and its evidence base is contested. This is explored in the next chapter.

CHAPTER 4

Contestation of evidence and efficacy for homeopathy

4.1 Background

This chapter examines the contestation relating to homeopathy. It describes critiques of homeopathy, and the defences made in response. The central issues concern the nature and status of evidence, and the efficacy of homeopathic medicines. Critiques of homeopathy tend to decouple these questions from assessments of homeopathic practice as a whole. As a result, this chapter revolves around three main points: the existing discourses about evidence; what counts as actual evidence; and the challenges of attempting to adequately discuss these questions in the context of such a highly polarised debate. This chapter, and this thesis, will not resolve these tensions. It provides a summary of the existing literature, considering both critiques and defences. It probes the reader to consider the difficulty in exploring such a highly contested discipline dispassionately.

Acknowledging the contested status of homeopathy enables a nuanced appreciation of how the discourse of contestation influences clinical reasoning and professional behaviour. In considering forms of evidence, I will look at approaches to, and the status of, population-aggregating and also individual case-based evidence within homeopathy; how experimental evidence is considered (and used); and what methods are used to produce these forms of evidence.

The legitimacy of the law of similars, accepted and implicit within homeopathy, is externally contested (Ernst 2005, Sehon and Stanley 2010). Sehon and Stanley (2010) argue that homeopathy *cannot* possibly work given what we know about chemistry and physics, appealing to the philosophical logic of the simplicity principle in order to refute entirely its epistemology. With an inexact mechanism of action and inconsistent empirical evidence, several researchers (Sehon and Stanley, Ernst and Baum) argue that homeopathy *must* be rejected (2010). It is on these grounds that the debate over the legitimacy of homeopathy

becomes most polarised (and heated). Outside the reassertion of the principle of similars, defenders of the legitimacy of homeopathy - and other CAMs – point to patient and practitioner experiences of effectiveness and the significance of other factors such as practitioner empathy (Levy and Gadd 2012, Spence 2012, Levy, Gadd et al. 2015). For me, as a practitioner, one of the striking issues is the gap between critics who see homeopathy as deceptive and hence immoral (Freckelton 2012, Crawford 2016), and the integrity and care that I try to practice daily, endeavouring to deliver within my scope of practice, focusing on my patient’s concerns and what can be safely achieved. This gap, and my interest in exploring what constituted integrity in practice, informed this study.

4.2 The construction of evidence in homeopathy

It must be stressed that the effects of homeopathy - its outcomes - represent extraordinarily complex inputs. A ‘valid’ trial, therefore, would need to meet a whole series of complex criteria including standardised diagnoses so that groupings could be made, and then interventions based on the case formulation, individualisation, potentisation and so on, in order to decide what *component* of homeopathy produced the claimed benefits. Since the division of homeopathy into components is not conceptually acceptable, there seems limited possibility of producing the relevant evidence, certainly not the relevant evidence to satisfy critics.

In Australia, this discourse has been dominated by the NHMRC report and associated response from the homeopathic profession, together with media coverage, all of which formed a contextual background during the period of my research. The NHMRC report, and the ensuing discourse, coincided with similar inquiries in the UK and Switzerland. Based on its assessment of the evidence, the NHMRC concluded that there is no health condition for which there is *reliable* evidence that homeopathy is effective. It determined that most of the evidence examined was of poor quality, and for most conditions homeopathy was therefore no better than placebo. (Let us put aside for a moment the question of just how large placebo responses and context effects may be; that they are often considered to be quite clinically significant, an issue I will discuss later (Kirsch 2013)). An interpretation of

NHMRC's conclusion is that homeopathy has no independent effect on specific outcomes. Critics of the NHMRC's report claim that much of the existing evidence in support of homeopathy was excluded and that the investigating committee did not include an expert homeopath. In the ensuing discourse, both advocates and critics focused on the question of evidence.⁴⁴

Elsewhere, I have noted (see Appendix 5) that arguments about the *ethics* of homeopathic practice are not the same as arguments about efficacy (Levy, Gadd et al. 2015). Some have thus argued that regardless of the status of evidence for homeopathic medicines per se, overall, homeopathy may be providing some benefit and little harm and the pragmatic choice may be therefore to accept it. The argument runs: although homeopathy may be an unverified science, it provides relief for many patients and produces only a fraction of the adverse effects attributable to conventional medicine and pharmaceutical medication (Spence 2012). Moreover, patients derive significant therapeutic value from consultations that are accepting, reassuring and supportive. Additionally, in the UK, the public NHS cost of homeopathy is negligible, equivalent to one week of anti-depressant medications (which, such a critic might and often does add, meta-analysis may demonstrate to be no more effective than placebo (Kirsch, Deacon et al. 2008)).

In contrast, advocates of homeopathy make the following epistemic claims. First, that it is demonstrably effective, not just clinically, but via reproducible statistically significant results (e.g. Fisher, Greenwood et al. 1989, Fisher 2012). That is, many homeopaths claim that homeopathy is epistemically defensible *on the terms set by standard scientific methodology*, the parameters for EBM. But second, and in tension with the first claim, advocates also claim that scientific methodologies, and especially RCTs, are inappropriate to, and indeed unable to, adequately assess the clinical impact of homeopathy (Oberbaum, Vithoulkas et al. 2003). The RCT is considered methodologically inappropriate to evaluate a primarily individualising clinical strategy, such as psychotherapy (Bothwell, Greene et al. 2016). So,

⁴⁴ <https://theconversation.com/no-evidence-homeopathy-is-effective-nhmrc-review-25368> last viewed 2 November 2016.
<https://theconversation.com/homeopathy-isnt-unethical-its-just-controversial-5859> last viewed 2 November 2016.
<https://theconversation.com/does-the-weight-of-evidence-signal-the-end-of-homeopathy-25645> last viewed 2 November 2016.

advocates want to claim scientific consistency with the tenets of EBM, or incommensurability with them, but also epistemic difference. This is ultimately problematic.

Before detailing how evidence is understood in homeopathy, I will outline the grounds on which homeopathy is critiqued from the perspective of orthodox medicine. There are three major grounds for critique: 1) weak and unreliable evidence for the effectiveness of homeopathic medicines; 2) implausibility or absence of explanatory mechanisms; and 3) theoretical absurdity. Those claiming homeopathy is absurd contest its fundamental theoretical and philosophical foundations, including the law of similars, the vital force, methods of potentiation and individualised treatment (Risjord 1993, Sehon and Stanley 2010). For those in this group, there is no point in looking for evidence that by definition cannot be present. Indeed, from this position, testing dilutions (potencies beyond Avogadro's number) of homeopathic medicines challenges the value of any data from randomised clinical trials.

Those in the first two groups claim homeopathy is weak and unreliable as its medicines lack a known mechanism of action. But the defence can be (and is) made, that some conventional drugs, for example such as Gabapentin, similarly do not have a clearly known mechanism of action, although this does not preclude their use (Ng, Bertrand et al. 2001, Luo, Calcutt et al. 2002). The corollary is that we should be able to settle these questions empirically and look for evidence of efficacy, and/or clinical effectiveness. The primary methodology employed to assess this, is the RCT. This is of course the methodology typically applied to the assessment of all new pharmacological therapies in conventional medicine, within the larger epistemic framework of 'evidence based medicine' (EBM). As do many, I will treat 'EBM' in the same way as these critics - as rhetorical shorthand for a hierarchy of evidence, and the methodologies used to produce that evidence. These include meta-analyses, systematic reviews, and RCTs at the top as the most rigorous forms of evidence available, and by which the evidential validity of homeopathy must be assessed (Howick 2011). EBM has established this hierarchy of evidence in order to fulfill particular functions, primarily to eliminate observation bias and placebo effects. This is achieved by looking for population averages, for results reproducible across different patient populations.

We should note, at this point, that EBM has had transformative and profoundly important impacts on various aspects of clinical practice. However, EBM is also contested in many ways *within* conventional medicine. There are extensive critiques of EBM as both discourse and practice within medicine (Tonelli 1998, La Caze 2008, Kerridge 2010), some of which will be very relevant in a discussion of the value (or not) of homeopathy as well. First, the hierarchy of evidence effectively devalues the lowest levels of evidence and thus often fails to capture many important aspects of clinical care, including the therapeutic impact of the qualities of the relationship between doctor and patient or of the meaning and narratives of illness (Frank 1995, Charon 2006, Carel 2008). Case studies, clinical observations and clinical expertise, individualised treatments, and illness experiences, are all forms of evidence that receive little value within EBM, but are often of profound importance in practice. Secondly, even meticulously controlled conventional studies cannot account for every individual response (Ioannidis and Lau 1998), so individual effects and variations are obscured. RCTs deliver probabilities across a population but not certainties to individual patients. Thirdly, an EBM framework often obscures the fact that a considerable amount of medical practice simply cannot be assessed by RCTs, including much of surgery and nursing. And finally, in addition to its epistemic power, “EBM” is a discourse as well as a practice; it also has rhetorical and symbolic power, some of which at present functions in ways that limit debate and critical inquiry (La Caze 2008).

We should also note that using an EBM framework to evaluate homeopathy requires treating homeopathic remedies as if they were drugs, and that this is a contested position within and external to homeopathy. Critics of homeopathy contend that there is no credible evidence within EBM’s evidence hierarchy (Smith 2012). Proponents counter claim that plausibility bias inhibits a fair assessment of the evidence for homeopathy (Rutten, Mathie et al. 2012). Consequently, the result of this hierarchy is that clinical evidence for homeopathy, and patient experiences in particular, are disregarded (Thompson and Weiss 2006).

Disentangling diametric positions is necessarily difficult. While as a clinician, and as a hermeneutic researcher, my own biases cannot be bracketed from the various claims made, in the following sections I endeavour to unpick the complexities of these arguments. This

seemed an important precursor to observing how practitioners were (or weren't) influenced by or engaged with any of these issues through their processes of clinical reasoning.

4.3 Discourse not dismissible

In this section, I explore the question of how assessments of homeopathy are caught between two polarised positions: On one hand, persistent debate has led the most ardent critics to assert that as homeopathy lacks plausibility, demonstrated effectiveness, and solid evidence based on efficacy, it must ultimately be ignored. On the other, advocates argue that homeopathy cannot be simply ignored as it continues to be widely utilised by doctors and professional homeopaths alike, and because many patients claim to experience clinical benefits.

On the critic side, earlier agnostic positions, in which some critics had conceded the need for further systematic research and to have suspended judgment, acknowledging homeopathy may indeed 'work' even without a plausible mechanism (Ernst and Kaptchuk 1996), have recently given way to a more trenchantly critical position. This is because given recent research, and the inquiries such as that by the NHMRC and those in the UK and Switzerland, critics have now concluded that RCTs confirm that homeopathy is no more effective than placebo (Ernst 2005, Goldacre 2008, Freckelton 2015).

Despite the conclusions of these reports, homeopathy has continued to be widely sought, with estimates that it is utilised by more than 550 million people worldwide (Ong, Bodeker et al. 2005). Homeopaths and patients observe and claim sufficient benefits and successful outcomes as to make homeopathy both valid and persuasive for them (Thompson and Weiss 2006). Therefore, at the very least, critics must be able to account for the effectiveness experienced by patients and doctors alike (Ernst 2005). They may, and often do, account for it by simply dismissing all such advocates as deluded and deceived (Freckelton 2012). Even so, this seems an inadequate explanation for *why* patients and homeopaths experience benefit.

Against this, advocates assert that valuable (and valid) contextual elements including the homeopathic consultation and the therapeutic process itself are under-researched, warranting more explicit investigation (Chatwin 2003, Thompson and Weiss 2006, Eyles, Walker et al. 2009). I will return to this point in my discussion of research findings.

4.4 Epistemology of homeopathy in the context of EBM

While homeopaths have confidence in the validity of their evidence base and in the methods that generate it (Heirs 2015), they also want to demonstrate that it can be proven and defended by the same methods as other forms of medicine. This section therefore explores the drive to demonstrate the efficacy of homeopathy in clinical trials.

In response to the increasing focus on EBM, researchers have incorporated RCT techniques including randomisation, placebo control and double blinding to test the efficacy of homeopathic remedies. These methods have also been employed in an effort to enhance internal validity, including of proving methodology (Sherr 1994). Homeopathy clearly wants to lay claim to increasingly rigorous methods. However, at the same time homeopaths do not wish to abandon attention to the nuances of individualising disease expression, experience and treatment. Researchers therefore face competing interests; between the aspirations to demonstrate validity through the robustness of RCTs, while preserving the capacity for individualisation.

And homeopathy unquestionably lacks the overwhelming body of evidence from robust clinical trials which EBM demands (Levy, Gadd et al. 2015) – even taking into account the possibility that some have asserted, that the reporting of homeopathic trials is biased (Frass, Schuster et al. 2005). Lack of RCT evidence, however, fits with the view held by many homeopathic researchers, which is that conventional research design is unsuitable for the examination of homeopathy because homeopathic treatments are tailored to individuals (Oberbaum, Vithoukas et al. 2003).

Some researchers have attempted to resolve the methodological challenges to capture individualisation with minimal loss in rigour. For example, Mathie and colleagues have

developed the model validity for homeopathic treatment (MVHT) a method seeking to accommodate evaluation of *individualised* treatment (Mathie, Roniger et al. 2012, Mathie, Van Wassenhoven et al. 2015). This model, based on six assessment domains – rationale, principles, practitioner, outcome, sensitivity and follow-up – was used to evaluate 46 identified RCTs. Of the 32 trials meeting their inclusion criteria they found that 19 were acceptable, 9 were uncertain and 4 were inadequate. They concluded that future RCTs of individualised homeopathy must aim to maximise the MVHT and to improve the clarity of reporting.⁴⁵

How methodologies are used *in practice* is, of course, the question that chiefly concerns me in this thesis, and there's evidence to suggest that this is very significant in terms of evaluating outcomes – benefits and harms – for patients. For example, critiques of EBM have raised the question of whether benefits might be balanced against harms resulting from less flexible, narrowly focused practice in conventional medicine. For example, Lipworth et al (2008) note that while EBM claims to incorporate clinical case judgment, medical decisions are predominantly driven by population-based statistical data. In the present moment, homeopathy and other CAMs present a contrast by privileging evidence from individual case studies and clinical expertise (Tonelli 1999, Kerridge 2010), the forms of knowledge lower in the EBM hierarchy.

⁴⁵ For readers interested, one might pursue the parallels between homeopathic wrestling with the tension between measuring reliability and generalisability, and capturing individual benefit, and similar wrestling in conventional medicine around the growth of 'personalised medicine' Miles, A., M. Loughlin and A. Polychronis (2008). "Evidence-based healthcare, clinical knowledge and the rise of personalised medicine." Journal of Evaluation in Clinical Practice **14**: 621-649.. For example, Mathie's MVHT is little different from the n=1 methodology of various medical models McEachron, T. A., K. B. Zabokrtsky, A. F. Sassoon, S. Nasser, T. Izatt, C. P. Garner, D. W. Craig, J. D. Carpten and L. S. Sender (2016). "Precision medicine for newly diagnosed and refractory/recurrent pediatric cancer patients: Lessons learned from "N=1" studies." CLINICAL CANCER RESEARCH **22**.. The differences are to be considered in 'what counts' once again, as reliable and sufficient evidence for an individual case. For conventional medicine, an n=1 personalised approach still takes into account epidemiological evidence, against which an individual's data/profile can be compared. For homeopathy, an individual case can only be examined against another individual case because epidemiological evidence is absent for many diseases and conditions.

4.5 Empiricism challenged

It has been noted how Hahnemann endeavoured to generate precise symptoms through systematised observation of healthy subjects.⁴⁶ But whether we discuss homeopathy or evidence based conventional medicine, clinical practice is never simply an application of evidence; judgment is involved, and therefore the possibility – indeed, inevitability - of biased thinking and decision-making (Tversky and Kahneman 1974, Souter 2006, Kahneman 2011). Given internal as well as external concerns about quality control (at minimum), understanding more about how this occurs and with what effects in homeopathy is important. Arguably, homeopathy as a domain needs to develop quality control mechanisms to enhance clinical reasoning and decision-making coherence. The following section examines these issues through the prism of HPTs, and prover's experiences.

In HPTs, the prover's expectations and understanding of the experiment may affect their response, the symptoms they *experience*, and potentially the outcomes of the trial. It should be noted that provers sometimes participate in a single experiment for weeks, even months. Expectancy can be a component in any human research, and may be integral to placebo effects (Jütte 2013). Both expectancy and placebo effects are more likely to be complex and confounding considerations in provings, in particular those utilising sub-molecular (ultra-dilute) doses of homeopathic remedies, in which pharmacologically active principles are clearly absent. Definitive symptoms must therefore be striking, intense and, at least theoretically, experienced by more than one solitary prover in order to be considered as part of a demonstrable response to the substance. Unsurprisingly, even scrupulous proving organisers at times question the validity of the data generated (Gray 2005).

Experimenter expectancy is an acknowledged phenomenon in research, for example the so-called Hawthorne effect. An extremely complex set of phenomena (Holden 2001) the Hawthorne effect was coined to describe how research participants' behaviour changes when they are knowingly observed during a study. Some studies propose that certain

⁴⁶ Sherr (1994 p 66) suggests that Hahnemann asked provers to swear on the bible as to the authenticity of their proving symptoms.

interventions, for example in practice-based research, are not necessarily subject to these effects (Fernald, Coombs et al. 2012).

Prover and researcher expectancy has also been theorised within homeopathy specifically. Milgrom theorises the relationships between the patient, the practitioner, and the remedy in clinical practice. These phenomena, he asserts, constitute an indivisible triad, articulated as patient-practitioner-remedy (PPR) entanglement (Milgrom 2006, Milgrom 2007, Milgrom 2010, Milgrom 2012). PPR entanglement theoretically embodies the intersubjectivity between patients and homeopaths, in conjunction with the dynamic effect of the remedy, acting as a conduit between the players. Milgrom proposes that the *specific* and *non-specific* effects of homeopathic therapy are not simply cumulative, and so PPR entanglement is not an output or endpoint of therapy (Milgrom 2005, Milgrom 2006); rather, they are integral, inseparable, and not readily reducible phenomena (Milgrom 2005, p 831).

One can anticipate the methodological challenges if this theory captures something valid about homeopathy (or about context effects in general). Among them: these phenomena might also play a part in a proving among provers and supervisors who engage in discussion during the HPT process. This is distinct from discussion after the proving has concluded (Sherr 1994 p 66). Verification of the genuine symptoms attributable to the remedy is subjective (Dantas 1996). Determining and selecting reliable symptoms can therefore be problematic and may be contentious (Gadd 2009, Adler 2011). I was curious to examine PPR entanglement through the research participants' experiences in order to understand how they balanced the traditional empirical skills laid down by Hahnemann, with the increasing explanatory demands of biomedicine. I shall return to this issue in the discussion chapter.

The results of this thesis are in any case neither contingent on the efficacy of clinical trials nor the outcomes of clinical decisions. I will, however, consider Milgrom's PPR entanglement, and contemplate whether the non-specific effects of the intervention (Weatherley-Jones, Thompson et al. 2004) were distinguishable or interdependent elements informing homeopathic clinical reasoning.

4.6 A recent history of critiques & defences

Over the past 30 years, the landscape of homeopathic practice has been marked by a series of public critiques followed by associated defences, prompted sometimes by individual studies and sometimes by organised reviews of evidence. This section offers a chronological overview of these critiques and defences, for the use of readers who want such a summary and to identify the major authors and studies in this landscape as a backdrop to my study.

Homeopathy is an enigma. The demand for homeopathic clinical care (Vallance 1998) and the considerable number of doctors practising homeopathy (Reilly 2001) contrasts abruptly with the highly contested research evidence, shaping the dialectic within and beyond homeopathy (Ernst 2005, Goldacre 2007, Lister 2010).

The years 1980-2015 have witnessed resurgence in homeopathic practice. Training programs and professional self-regulation in the UK, US, Europe and Australasia fostered a wealth of new materia medica, and renewed interest in HPTs. There was also increased interest in clinical trials of medicines for specific conditions, especially in the UK, Germany, and France. At the same time, this renaissance was enveloped in vexatious scientific controversy. It is portrayed here as the key example of persistent epistemic discourse about the contested evidence for homeopathy.

4.6.1 Benveniste & Nature

In 1988, a French INSERM⁴⁷ research team headed by Dr Jacques Benveniste published in *Nature* that basophil degranulation could be detected in *sub-molecular* histamine dilutions (Benveniste 1988, Benveniste 1991, Benveniste, Ducot et al. 1994). The outcome of this research proposed that homeopathic ‘ultra-dilutions’ were capable of exerting a measurable

⁴⁷ INSERM is the French National Institute for Medical Research. See <http://english.inserm.fr/> last viewed 5 February 2015.

physiological effect at dilutions beyond Avogadro's number.⁴⁸ Vociferous debate unfolded in *Nature* (Benveniste 1988, Maddox, Randi et al. 1988, Benveniste 1991, Benveniste, Ducot et al. 1994), resulting in Benveniste's professional humiliation, in addition to a substantial reduction in his research budget.

Maddox, editor of *Nature*, employed James Randi, a widely-known sceptic and magician, to ridicule Benveniste's research amidst claims that a major French homeopathic manufacturer had funded the research (Maddox, Randi et al. 1988). Maddox concluded his investigation had 'exposed the delusion' of homeopathic ultra-dilutions which Benveniste had proposed exerted physiological effects (Davenas, Beauvais et al. 1988).

Benveniste's ultra-dilution research was subsequently repeated at the University of Berne (Guggisberg, Baumgartner et al. 2005) and at Queen's University Belfast (Brown and Ennis 2001, Belon, Cumps et al. 2004). The Guggisberg study concluded that even minor methodological variables could lead to significant differences in results if not properly controlled. The Brown and Ennis study (2001) acknowledged that basophil degranulation appears to be regulated by histamine even in homeopathic concentrations, supporting Benveniste's hypothesis. They concluded that they could not provide an explanation for the activity of these ultra-dilutions. Nor was their research an attempt to validate homeopathy. Ennis asserted that science has a responsibility to continue to investigate these phenomena until they could be explained.⁴⁹ Benveniste subsequently conducted privately funded research regarding the alleged memory of water hypothesis (Schiff 1994), which was also scientifically discredited; humiliated, he died soon after (Pincock 2004, Edwards 2005).

⁴⁸ Avogadro, 18th century Italian mathematician, is considered the first to calculate that the constant 6.02×10^{23} represents the number of molecules in a gram atom of any substance. Beyond a homeopathic 12c dilution it is unlikely that a single molecule of the original substance can be detected. This is a source of scientific controversy as some provings and many homeopathic prescriptions utilise dilutions of substances *beyond* Avogadro's number.

⁴⁹ Homeopathy, the test: Reality or Myth <https://www.youtube.com/watch?v=uEbhjmP3zaE> last viewed 10th February 2015

4.6.2 Systematic reviews & counter reviews

Since the Nature debate, a succession of systematic reviews and meta-analyses of randomised homeopathic trials have been reported in the *British Medical Journal* (Kleijnen, Knipschild et al. 1991), the *Lancet* (Linde, Clausius et al. 1997, Linde and Melchart 1998, Shang, Huwiler-Muntener et al. 2005) and the *European Journal of Clinical Pharmacology* (Cucherat, Haugh et al. 2000). Each review sought to determine whether homeopathic medicines are more effective than placebo. A *Lancet* commentary (Goldacre 2007) declared all five meta-analyses of homeopathic trials confirmed that homeopathic medicines produced no statistically significant benefit over placebo, an assertion misrepresenting the conclusions of the Kleijnen (1991) Cucherat (2000) and Linde (1997) analyses. Despite claims of publication bias, the Linde (1997) study included a funnel plot for publication bias and was corrected accordingly. Ernst however subsequently declared that a reanalysis of Linde's data could not constitute proof of efficacy (Ernst 2005).

Kleijnen and Knipschild (1991) submitted that their findings were positive, although insufficient to draw definitive conclusions due to low methodological trial quality and because of the unknown role of publication bias. This finding was reiterated by Cucherat and colleagues (2000) who proposed further *high-quality* studies in order to generate more conclusive evidence.

The two *Lancet* meta-analyses (Linde, Clausius et al. 1997, Shang, Huwiler-Muntener et al. 2005) present diametric conclusions. Linde concluded that results were *not* compatible with the hypothesis that the clinical effects of homeopathy are completely due to placebo, and proposed further rigorous and systematic research. Shang and colleagues, on the other hand, claim that even when accounting for biases that there is weak evidence for a specific effect of homeopathic remedies, and conclude the effects are placebo. Critics have claimed Shang's meta-analysis to be based on a handful of heterogeneous trials (Frass, Schuster et al. 2005), biased from the outset (Peters 2005), and so yielding indefinite results (Lüdtke and Rutten 2008).

It has also been argued (Fisher 2008) that Shang's meta-analysis used a data-dredging procedure in order to provide the *least positive* result, failing to publish which homeopathic

clinical trials were considered of sufficiently high quality for inclusion. Fisher asserts that Shang also neglected to provide a sensitivity analysis and did not comply with quality of reporting of meta-analyses (QUOROM) research publishing guidelines (Moher, Cook et al. 1999). Reinforcing Fisher's critique of Shang's methods, Chatfield and Relton (2005) contend that there was significant author bias in Shang's method, a claim often made in defence of CAM critiques (Reilly 2005). Nonetheless, bias must also be considered when taking into account Chatfield's sponsor, the European Council for Homeopathy.

Shang's comparative meta-analysis is arguably methodologically flawed and biased, having reported trials selectively (Kiene and Kienle 2005, Peters 2005) and without clear justification of inclusion criteria. Both Maddox (1988) and Shang (2005) claimed that all the earlier meta-analyses (Kleijnen, Knipschild et al. 1991, Linde, Clausius et al. 1997, Cucherat, Haugh et al. 2000) lacked rigour and were not reproducible. Peters (2005, p 779) and Kiene (2005) exposed the lack of precision demonstrated by these apparently rigorous, unbiased and eminent researchers. Vallance (1998) argues that whether or not ultra-dilution effects are proved or not is determined by the beliefs and behaviours of scientists in their particular communities (Mayes, Hooker et al. 2015). This is an acknowledgement that evidence – in all its forms - is never value-neutral (Lipworth, Carter et al. 2008, Kerridge 2010). More recently, Linde argued that publication bias, inclusion criteria and research material beyond conventional electronic databases need close scrutiny for complex and controversial CAMs such as homeopathy (Linde 2009).

In their discussion of trials and critiques, Walach et al conclude that the lack of a clear theory for the mechanism of action of homeopathic medicines has resulted in scattered, heterogeneous laboratory, clinical and observational studies (Walach, Jonas et al. 2005). They propose that the dilemma of local and non-local effects in homeopathic research trials must be underpinned by a distinct theoretical model of remedy action, still currently lacking. Perhaps distinctions between the multiple therapeutic effects evoked by homeopathy need to be more clearly differentiated in order to be tested. Indeed, as previously stated, for a valid homeopathic trial it continues to be difficult to determine what component of homeopathy produced the claimed benefits – especially in view of the individualisation of diagnosis and remedy-match.

Discourses defending the evidence for homeopathy on scientific grounds, focus on the comparative value of outcome studies in contrast to RCTs (Riley, Fischer et al. 2001, Mathie 2003, Whitmarsh 2004, Milgrom 2005). In a discourse burdened with suspicion, the dialogue continues to be acrimonious.

4.7 Chapter summary

In this chapter, I have framed the discourses regarding the evidence for homeopathy, and the epistemic and philosophical claims to which homeopathy is wedded. Homeopathy privileges individualised patient-based treatment more than treatment driven by epidemiological evidence, which it lacks. It also privileges case studies and forms of detailed empirical and to some degree, subjective observation in its methodologies. These commitments are in tension with the desire of many homeopaths for scientific validation of their discipline via the methods of EBM.

A hermeneutic lens has galvanised my appreciation of the inexorable struggle to be neutral regarding claims and counter claims. As a clinician embedded in practice, I tried to remain neutral in respect of the critiques and counter critiques of evidence bases – especially since it was never my aim to resolve them during or through this study. Reliance on clinical results has been the foundation of continuous homeopathic practice. I had also been hesitant towards professional colleagues who held bold presumptions about the accuracy and efficacy of experiments conducted more than 200 years ago. I kept these debates in mind, however, while undertaking the empirical component of this project, and endeavoured as much as is possible to allow participants' experiences to speak for themselves.

Interpretative analysis recognises phenomena under study as products of their time and place, and homeopathy is no different. Equally, an interpretative analysis of the practices of clinical reasoning cannot be separated from the players, their beliefs and values, as well as the context of their lives both personal and professional.

It is not possible to regard claims about evidence as ever purely empirical. Often, they are intimately connected with and inextricable from a commitment to certain values and types

of knowledge. Hahnemann's philosophy of empiricism is inseparable from his ethical commitment to non-invasive, gentle modes of therapeutic practice. Both were of interest to me as I approached the observation of contemporary practice.

CHAPTER 5

Analyses of homeopathic clinical reasoning

5.1 Background to existing clinical reasoning research

Despite the wealth of words invested in critiques and defences of homeopathy over the past two decades, there has actually been very little attention paid to what actually happens in homeopathic clinical practice. Yet we know from studies of conventional medicine, just how complex practice actually is when viewed in situ, from the interior (Usherwood 1999, Mol 2005, Iedema, Mesman et al. 2013).

A number of narrative accounts explore practice based on professional experience and theoretical re-interpretation. They represent what one would expect to find about the practice of clinical reasoning from the praxis of expert clinicians. These include reflections on the value of the therapeutic relationship between homeopath and patient (Kaplan 2001, Gray 2010) and the importance of diverse communication and therapeutic skills (Kaplan 2001). Others provide systematic case-based approaches for the treatment and management of specific conditions, such as psychiatric cases (Saine 1999). Some authors present recent provings (Sherr 1997, Herscu 2002, Gray 2005), supported by case exemplars, the methodology and veracity of which, as discussed in the preceding chapter, is inconsistent. In developing their models, these authors primarily employ selective case-based reasoning as justification for their particular method or style of practice. Collectively, these secondary sources provide the professional homeopath and student with novel approaches to case taking and analysis, such as the *sensation method* (Sankaran 1991, Sankaran 2000, Sankaran 2002, Sankaran 2013), and with techniques to systematise and reduce the volume of data recorded in provings (Schroyens 1995). The diversity of methods and styles is representative of the predominantly practice-based development of homeopathy.

I turn now to an investigation of existing empirical evidence concerning homeopathic clinical reasoning. This further informs the particular context of my research and provides the foundation necessary for a critical examination of the phenomenology of clinical reasoning. In particular, I will discuss important recent studies that have explored clinical reasoning in its naturalistic context.

5.2 Clinical reasoning research and models

Six studies have investigated the structures and characteristics of homeopathic reasoning and decision-making (Van Haselen and Fisher 1992, Van Haselen and Liagre 1992, Brien, Prescott et al. 2004, Burch, Dibb et al. 2008, Brien, Dibb et al. 2009, Eyles, Walker et al. 2009). Collectively, these studies represent clinical reasoning as a process that can be identified, analysed and hence improved.

The two studies by Eyles (2009, 2012) explore the relationship between homeopath and patient as a way of understanding the unique context of homeopathic practice. A nest of studies utilising conversation analysis (Chatwin and Collins 2005, Chatwin 2008, Chatwin 2009) explore the predominantly verbal interaction between homeopaths and their patients, and how conversation informs the development of decision-making and the therapeutic encounter. The Brien (2004) and Van Haselen (1992) studies endeavour to systematically investigate homeopathic decision-making as a series of cognitive processes. These were based upon relatively limited questionnaires and statistical analyses that cannot accommodate or capture the flexible responsiveness of reasoning in an actual clinical setting. These studies are examined more closely in the following section.

5.3 Research exploring the application of algorithms

Researchers have sought to understand whether clinical reasoning can be more systematic and more robust by looking at reasoning *processes*. Predominant among them are the use of algorithms. Algorithms have been utilised to enhance decision accuracy in medicine for almost 50 years. The algorithm or decision-tree is a visual flow chart widely used in medical

and surgical decision-making. It is a structured mechanism with predictable pathways designed to reduce intuitive physician bias and to limit decisions to specific foci within clinical events and their outcomes (Djulbegovic, Beckstead et al. 2014).

The first researchers to carefully investigate homeopathic decision-making examined the utility of an algorithm in homeopathic diagnosis, specifically in the treatment of otitis media (Van Haselen and Liagre 1992) and rheumatoid arthritis (Van Haselen and Fisher 1992). These were an attempt to achieve systematic outcome correlation (Van Haselen and Fisher 1992 p 120), enhancing prescribing consistency and reproducible results.

Van Haselen and Liagre (1992) argue that homeopathic decision-making is a complex process involving subjective interpretation of observations and patients' symptoms, and suggest that decision matrices are both feasible and sufficiently flexible as to be useful in clinical practice. This is difficult to ascertain from Van Haselen and Liagre's study because it provides little insight into the homeopaths' actual thinking or behavioural processes. Van Haselen and Liagre do however logically suggest that *symptoms* need to be more closely defined before being investigated. For example, if a child is described as *irritable when sick*,⁵⁰ the homeopath must ascertain which features and expressions can be taken as indicators of the character and extent of the child's irritability. This approach, aiming for exacting symptom definition is consistent with conventional medical decision-making (Pearson, Margolis et al. 1992), where exact comparison of patient symptoms against disease diagnosis is critical, and effective management demands a low margin of error (Sudrial, Birlouez et al. 2010).

By limiting question and answer pathways, algorithms and decision matrices theoretically enhance the degree of treatment accuracy and reproducibility. This might be appropriate for clinical encounters in which the medical diagnosis is already well-confirmed, such as the otitis media and rheumatoid arthritis examples van Haselen and Liagre examined. Reproducibility, however, comes at the expense of sensitivity. This can diminish the potential for more refined questioning into the character of a particular symptom, and so to

⁵⁰ A symptom reproduced in homeopathic materia medica and repertories, and considered valid in case symptom analysis.

the possibility of alternate remedy pathways and decision outcomes. But patients frequently present with undiagnosed conditions and this may require extensive consultation with very broad initial questioning necessary to make sense of their illnesses. Complex narrative cases are not conducive to methods that lack flexible responsiveness.

Clinical reasoning pathways have been extensively researched in the biomedicine literature, predominantly using the perspectives and methods of cognitive psychology. Historically dominant among these pathways is procedural reasoning (Elstein, Shulman et al. 1978, Mattingly and Fleming 1994, Elstein and Schwartz 2008), incorporating the logic of induction, hypothesis generation, and deduction. However, there is also ample evidence that procedural reasoning accounts only partially for human thinking and response to most situations. Non-inductive reasoning, tacit knowledge, personal understanding, intuition, and wisdom borne of practical experience, are all phenomena that are acknowledged by health professionals as being fundamental to reasoning (Higgs and Titchen 2001, Bleakley, Farrow et al. 2003, Loughlin, Bluhm et al. 2012).

Reductive and procedural mechanisms contrast with decision-making in therapeutic settings characterised by rich, detailed narratives. Homeopathy is a complex and highly *interactive* process in which decision-making is driven less often by disease diagnosis and more by illness interpretation. Loftus (2012) argues that health professionals learn clinical reasoning and become adept at reasoning through dialogue, generating meaning through interaction. This is confirmed in narrative-rich domains including occupational therapy (Mattingly 1991, Ryan and McKay 1999) and physiotherapy (Jones, Jensen et al. 2008). Homeopathic clinical reasoning *links* and *integrates* the procedural and communication elements of practice, like nursing and physiotherapy reasoning (Christensen, Jones et al. 2008).

5.4 The PHIRM model

Contemporary homeopathy is characterised by narrative interaction (Thompson and Weiss 2006, Swayne 2008, Hartog 2009). Questioning, reasoning and decision-making are typically non-linear; rather, they are iterative and exploratory, gradually leading to the emergence of a meaningful symptom totality. Achieving a meaningful understanding of a patient's

symptom totality may require one, and in some cases many, sequential consultations, without necessarily achieving a fixed diagnosis. In various studies to better understand real world practice, researchers have begun to explore homeopathic clinical reasoning using qualitative methods.

In 2004, Brien and colleagues asked “How do homeopaths make decisions?” in a given clinical scenario (Brien, Prescott et al. 2004). Three experienced homeopaths were asked to rate the symptom diaries of 206 proving participants. They discovered that inter-rater reliability was contingent on both *the facts*⁵¹ given to the inter-raters, as well as *intuition*,⁵² though neither is comprehensively defined in their model. In their comparison, they rated their use of clinical facts and intuition when assessing whether provers had responded to the medicine (Belladonna) or not. The data revealed intuition to be an important component of clinical decision-making. The authors concluded that inter-rater reliability is poor and that further research is necessary to understand why homeopaths are so inconsistent in their decision-making (2004 p 130). Other skills and methods such as creative writing and narrative work were considered important to be developed in the practitioner.

Acknowledging the limited extant evidence, Burch and colleagues (2008) conducted the first⁵³ qualitative study of homeopathic decision-making. This approach represented a methodological departure in homeopathic research. Three researchers conducted in-depth semi-structured interviews with 14 professional (non-medical) homeopaths and conducted analysis informed by IPA (Smith 2004). Four themes and two sub-themes were identified, culminating in the PHIRM model of homeopathic clinical reasoning. The four major themes of this model were pattern recognition (P), hypothetico-deductive reasoning (H), intuition (I) and precise remedy-matching (RM). The two important sub-themes were practitioner awareness of avoiding major bias, and the role of the patient-practitioner relationship in influencing decision-making. These themes, including the sub-themes, were held in mind during the data analysis.

⁵¹ The authors *accept* that the details in homeopathic materia medica are ‘facts.’

⁵² The authors *accept* intuition as ‘the instinctive feel for what the decision should be.’

⁵³ Curiously, this study was first published in English in a German language journal.

The PHIRM model is the most comprehensive empirical model of homeopathic clinical reasoning to date. Here is a short summary of the model. As an operational model it recognises overlaps in thinking and reasoning, merging constructed knowledge of materia medica with a psychosocial conception of the patient as a human being. The cognitive processes in the PHIRM model have been fittingly compared with both nursing and conventional medical reasoning and are arguably similar, as the model is not content or even practice bound. An intuitive element is incorporated within each reasoning level in the model. It is well suited to expert homeopaths but may not be appropriate for novices lacking knowledge and experience to make pattern recognition decisions and consequently heavily reliant on HDR, maximising the resources required of the patient and the homeopath. While the operations and extent of intuition in decision-making were not yet clearly understood in the model, Burch and colleagues suggested two types of intuition: a cognitive type based on beliefs, experience and clinical knowledge, and a *pre-cognitive* type that refers to gaining information about the future without inference to the past or present (Burch, Dibb et al. 2008 p 223.). Accounts of intuition in the psychological literature seem to concur with Burch, indicating that it is a pre-cognitive expression of implicit learning (Reber 1989, Sinclair 2010).

5.4.1 Reasoning without bias: freedom from prejudice

The PHIRM sub-themes have particular resonance with my study. Here, I would like to comment on the interesting question of what it means to consider reasoning *without bias*, as the participants in Burch's study (and my own) did. This is also a question that applies to my own research process: could I, as an IPA researcher, *bracket* my assumptions and my knowledge of existing scholarship (for example Burch's study) and approach my own data unbiased and yet able to search for and extend concepts that this study, above all, had sensitised me to? These questions were a source of perpetual reflexive pre-occupation during my data collection and analysis.

Awareness of avoiding major bias had dual relevance, demanding close attention considering my participants' and my own experiences. It also had critical application as an aspect of IPA. Here, I consider the latter before returning to the former. In qualitative

research such as IPA, researchers theoretically make known to themselves (and others) their beliefs, values and presuppositions. They acknowledge that these must undoubtedly shape the conduct of research (Pillow 2003, Gearing 2004) and so endeavour to bracket them. Simplifying the relationship, Ahern proposes that reflexivity and bracketing are *fruit from the same tree* (Ahern 1999). Gearing (2004) has proposed a detailed typology of bracketing associated with the phenomenological tradition. Pillow (2003), conversely, argues that researchers need to accept being uncomfortable with reflexivity in order to get better data and to become more engaged with the complexities of qualitative research.

Homeopaths are trained to be dedicated to a philosophy of empiricism. According to Dempsey and Swayne (1990) homeopathy is an empirical and inductive science, upon which its academic reputation and therapeutic success depends. Based on a Data Collection Survey (1987-1988) of the prescribing patterns of 119 British homeopathic doctors, the results demonstrate a determined attachment to empirical observation, vested in confidence that the physician is an objective observer. The objective stance is derived from Hahnemann's instruction to practice with *freedom from prejudice* (Hahnemann 1810 aphorisms 6, 83).

Indeed, the rhetoric that homeopathy simply necessitates freedom from prejudice retains a level of acceptability within homeopathic discourse (Swayne 2013, Whitmarsh 2013). In homeopathy, Swayne asserts 'our perception of a patient and the patient's story *must be free of anything* that our formal medical education has led us to expect or believe' (2013 p 158). Comparing homeopathy with Husserlian phenomenology, Swayne privileges pure observation 'unprejudiced by any preconceptions.' Whitmarsh (2014) declares that Hahnemann has accounted for bias, and that we should take what he has written at face value. These positions obfuscate the need for bias-awareness within homeopathy as a discipline, a point acknowledged in the Burch (2008) study. At the same time, however, such comparisons acknowledge that homeopathy can be reconstructed, reframed in ways that emphasise parallels with qualitative inquiry (Levy 2014).

The meanings and operations of bias have profound implications for homeopathic practice (Levy 2014). We must consider whether a practitioner can suspend bias (prejudice), all prior experience ignored in the face of a new patient; at the same time, why they would want to;

whether there are advantages in doing so; whether an experienced homeopath can practice with the relative impartiality of a novice (or vice versa); ultimately, whether a state of neutrality is desirable for either the practitioner or the patient; and whether such an attitude is possible. Gadamer claims that the suspension of prejudice in hermeneutics is neither possible, nor desirable. Instead, he proposes a merging of horizons, accepting that interpretation is always intersubjective (Gadamer 1975).

5.4.2 Intuition in PHIRM and in clinical reasoning

Returning to the PHIRM model I will now examine intuition. Reber (1989 p 232) asserts that there is probably no cognitive process that suffers from such a gap between phenomenological reality and scientific understanding. Within the PHIRM model, Burch et al construct two types of intuition; one type based on beliefs and prior experience, the other a pre-cognitive type. Burch suggests that their research participants used the former definition of intuition, without asking or clarifying what was meant by the term itself. Their model does not articulate whether the researchers actually asked participants what *they* understood by the term intuition, and its application. There is also dissonance between intuition and bias as mechanisms of interpretation. Perhaps the two are interdependent phenomena. In their subsequent study (Brien, Dibb et al. 2009), intuition is examined more explicitly and builds onto the PHIRM model.

Acknowledging that the PHIRM model identified intuition to be related to features within nursing, medical and CAM reasoning, Brien et al sought to understand the ways in which homeopaths used intuition, the extent to which they recognised its utility, and whether they considered its use deliberate or habitual. Utilising IPA, they ultimately sought to understand what intuition meant to homeopaths and how it arose in daily practice (2009 p 2).

The participants recognised experiencing intuition through numerous *felt phenomena*, as a *gut feeling*, a *sense*, as *an awareness*. They had difficulty giving a specific definition of intuition. Many recognised it as a rapid form of cognitive inference, and stated that it was difficult to pinpoint what exactly led to the intuitive thought or judgment. Cognitive research suggests that initial, *intuitive* answers are accompanied by a *feeling of rightness*, a

metacognitive phenomenon (Thompson, Prowse Turner et al. 2011). Reber argues that the kinds of operations identified under the rubric of *implicit learning* represent the epistemic core of intuition (Reber 1989). Reber's (1989) work using psychological testing seems to demonstrate that rapid pre-conscious reasoning is improved with time and experience, and is relatively accurate. This reflects similar findings regarding the circumstances in which nurses trust their intuitions (Benner 1984, Effken 2001).

5.4.3 Patient-practitioner relationship in PHIRM

The second sub-theme of the PHIRM model is the role of the patient-practitioner relationship and its function in the context of decision-making. As participant Henry noted in Burch's study (2008 p 223), if rapport is not well established then the homeopath will be *unable to elicit 75% of the important information* that the patient needs to share. While the figure seems arbitrary, Henry clearly considered rapport to be essential to eliciting critical information. Participant Philip described the development of a *relational field* between himself and his patient, central to a deep understanding, and to accurate prescribing. This signalled to me the importance of being attentive to such phenomena in my study. The lived, relational qualities of reasoning practice also brought me closer to considering the nuances of IPA as a research methodology.

My study, which was conducted contemporaneously with Burch and Brien's research, and draws on the basic PHIRM framework, has been directed at expanding our understanding of the action of clinical reasoning, and of the therapeutic relationship being integral to modern reasoning in contemporary practice.

5.5 Practitioner experiences of the consultation

Having developed the PHIRM reasoning model and beginning to advance a richer understanding of intuition within reasoning, Eyles, Walker and Brien (2009) utilised grounded theory (Glaser and Strauss 1967, Bryant and Charmaz 2007) to explore how homeopaths view and enact the consultation. The researchers declare that the homeopath is an important component of the therapeutic context. They conclude, however, that the

ways in which the homeopath enacts the consultation is not necessarily connected to reasoning and decision-making. Rather, they theorise that empathy and enablement are generic to all therapeutic contexts and are important for the patient, but not unique to homeopathy. These critical observations led me to closely explore the nuances of empathy, enablement, and therapeutic engagement, being central to the homeopathic consultation experience, and, I suspect, intimately connected to reasoning and decision-making.

Subsequently, Eyles, Leydon and Brien explored the connections that are formed between homeopaths and their patients, and their contextual meanings (2012). They sought to explore components of the therapeutic encounter in order to understand its popularity and satisfaction for patients, and perhaps to understand its clinical effects. Their model of the encounter comprises five interconnected themes, or levels: connecting, exploring the journey, finding the level, responding therapeutically, and understanding self. *Connecting* is described as the central category linking the five themes. Connection is apparent in the relationship between homeopaths and their patients, and between the players and homeopathy as a process facilitating the exploration of lived illness. The authors go so far as to suggest how the therapeutic encounter may account for the success and popularity of homeopathy, a result that may also support the argument that contextual (or placebo) effects explain the experience of benefit from homeopathic consultation and treatment (Brien, Lachance et al. 2010).

5.6 Chatwin: studying interaction through conversation analysis

Theorising that interaction between health professionals and patients is inherently therapeutic, Chatwin and Collins (2005) endeavoured to better understand this phenomenon in the homeopathic context. The difference, they assert, is that this dimension, and its effects, has become diminished in conventional medicine, while it remains central to CAMs including homeopathy. They declare that homeopathic consultations are interesting as therapeutic encounters in their own right, not as a possible source of 'holistic tricks' that might be assimilated into conventional medicine (2005 p 24). Chatwin and Collins employ conversation analysis in order to understand the ways in which

the homeopath incorporates the patient's own reasoning into the dialogue. This generates greater equality between the players, a sense of collaboratively exploring symptoms in order to complete a diagnostic framework.

In a series of transcript excerpts, Chatwin (2008) demonstrates that although therapeutic engagement can be enhanced through narrative, it can at the same time be side-tracked by the patient, leading to the inclusion of extraneous and potentially irrelevant information. The net effect is undesirable, disrupting the homeopath from remaining focused on the patient and her presenting complaints, a difficulty that the homeopath should be able to pre-empt.

In a subsequent set of interviews, Chatwin proceeds to analyse the patient-homeopath interaction as a series of activity transitions (Chatwin 2009). The segments demonstrate that, aside from the opening (initial symptom-gathering) and closing (final treatment) stages, transitions are rather unsystematic and inconsistent, being directed at some transitions by the patient, and at others by the homeopath.

Chatwin's decontextualised methodology invites further exploration through more naturalistic enquiries – possibly even other interpretations of what he saw as a continuum of practitioner- and patient-led transitions. For example, it seems likely that the extent to which power and decision-making are negotiated within and through these transitions may be more ambiguous than Chatwin's continuum can accommodate.

5.7 Brown's survey of reasoning and prescribing

Other researchers have collected data regarding the prescribing habits of professional homeopaths. A questionnaire-based investigation of clinical methods has been conducted in South Africa (Brown 2006). Brown surveyed 220 professional homeopaths of which 74 responded. Her objective was to profile the practices of South African homeopaths by analysing their clinical methods, treatment procedures and treatment outcomes. The data collected (Brown 2006 p 35) were broad but not rich. The statistical analysis provides some insight into the complexity of prescribing methods, although the survey method is unable to

convey the details of the participants' actual reasoning behaviours. Two thirds of the participants claimed to prescribe on the basis of the patient's symptom totality (although the term has not been clearly defined) while only one participant claimed to utilise the Scholten and Sankaran methods (Brown 2006 p 43).

5.8 Chapter summary

Empirical research exploring homeopathic clinical reasoning and decision-making is in its infancy. The PHIRM model (Burch, Dibb et al. 2008) represents the most clearly theorised attempt to articulate homeopathy as it is actually practiced. Notably, intersubjectivity and practitioner bias are considered sub-themes rather than major components of this model, but hold sufficient interest to warrant further investigation – as will be found in the results and discussions sections that follow.

Utilising IPA, my study in the Australian setting mirrors aspects of Burch's methodology. In the following chapter, I will explore the reasons for this approach and provide the explicit details with which the investigation was conducted.

CHAPTER 6

Research methods

Part One: Objectives, contributions & research questions

6.1.1 Research objectives

The principal objective of this research was to develop a coherent discussion, analysis and explanation of homeopathic clinical reasoning *as it is practised* by exploring the lifeworld of Australian professional homeopaths. Specifically, this research aimed to explain how homeopaths practise, theorise and make clinical decisions. In view of current and controversial socio-political discourses it also sought to understand how they have positioned themselves within the Australian healthcare landscape. I anticipated that this would generate critical dialogue both within and outside the homeopathic profession, subsequently informing the development and enhancement of homeopathic practice and clinical education in Australia.

6.1.2 Research outcomes and contributions

The results of this research make two significant contributions to homeopathy: the first is that it provides an empirical account of contemporary homeopathic practice in Australia; the second is that it provides the basis for a coherent and relevant model for homeopathic education, one more congruent with practice in the lifeworld. This research therefore generates important outcomes, providing a significant contribution to the fields of homeopathic practice and education.

6.1.3 Research Questions

Qualitative research seeks to explore, illuminate and understand particular human phenomena (Minichello, Sullivan et al. 2004). Homeopathy is oriented to investigating and understanding human illnesses in order to produce therapeutic change. IPA research and homeopathy are similarly oriented; both seek to understand the meanings of specific phenomena in a particular context, although only homeopathy seeks to deliver a therapeutic response. The relationship between IPA research and homeopathy formed a continuous thread in this study, drawing together the questions asked, the methods used, and the emerging results.

This research explores four interconnected questions. The framework for these questions was driven by two intersecting factors: my professional experience, which was inexorable and foregrounded the entire study; and the recognition of significant gaps in an understanding of homeopathic clinical reasoning in Australia. This gap in understanding also extends, to some degree, to the principles underpinning reasoning. The first and second questions encompass the need for the development of a coherent understanding of the contextual practices of homeopathy. The third question explores how the therapeutic context between the homeopath and her patient influences the process as well as the outcome of clinical reasoning and decision-making. The fourth question explores the relationships between professional experience and the production of practice knowledge. Each question explores the phenomena of clinical reasoning through the lived experiences of professional homeopaths in their naturalistic setting (Van Manen 1997), the context of daily clinical practice. These questions precipitated the research and informed the initial data collection. As the data were analysed, subtle modifications were made to the next iteration of questions. This modification was significant for the development of the latter two questions pertaining to the therapeutic relationship, and the impact of the participants' ethical framework on clinical reasoning. I could not anticipate how the iterative process would unfold prior to the study. The need to be equally systematic and flexible is integral to qualitative research coherence (Carter 2010), as it is integral within homeopathy. Maintaining flexibility without being rigid and being systematic while being creative are

central to good research practice, skills similarly important in the search for a homeopathic solution with each patient.

The broad concern for this research was how homeopathic clinical reasoning and decision are experienced. The primary question this research asked was:

‘How do Australian professional homeopaths experience, practise and develop clinical reasoning and decision-making?’

There is a central relationship between the knowledge sought or generated and the research approach employed (Higgs 1997 p 3). In order to understand the lifeworld of the research participants, I needed to investigate the various intersecting elements forming and influencing clinical reasoning and decision-making. This question identified the research as an investigation of specific professional processes and expert know-how. To explore these processes required a series of related sub-questions.

The first sub-question this research asked was:

‘How do theory, established texts and professional knowledge interact and shape homeopathic clinical reasoning and decision-making?’

This question recognises the values assigned to a historical theory, to established texts and traditions. These were explored in the preceding three chapters. With this in mind, I anticipated collecting and analysing data capable of exploring complex phenomena in order to demonstrate their relationship to clinical reasoning. Drawing questions from observations made while the participants saw their patients, and during our subsequent interviews, I asked the participants how, for example, they used theory and texts in that moment, why they asked specific questions, or made particular comments about a symptom. These were the phenomena in the lifeworld needing to be explored in order to make meaning and sense of them.

As data sets were accumulated and analysed I increasingly recognised the value that many participants gave to the relationship between them and their patients. This phenomenon

was both strongly observed as well as elicited through questioning. I was concerned to know how and in what ways this relationship interacted with clinical reasoning. The following sub-question was subsequently developed:

‘What is the purpose of the therapeutic relationship in homeopathic clinical reasoning and decision-making?’

With this question, I was able to explore the relationship between the homeopath and her⁵⁴ patients in its naturalistic context. This phenomenon is underrepresented in empirical research and warranted a full investigation.

Finally, this research sought to understand the ways in which contextual elements beyond conventional texts, clinical experience and the therapeutic relationship impacted upon homeopathic clinical reasoning and decision-making. The fourth question therefore asked:

‘How do the values, beliefs and life experience of professional homeopaths shape their clinical reasoning and decision-making practices?’

Together, these four questions comprise the phenomena explored with the research participants. The research framework, its underpinning theory, methodology and methods are now described in detail.

⁵⁴ The female pronoun reflects the gendered context of this research. Three quarters of the participants were women. Furthermore this is largely representative of the homeopathic profession in Australia.

Part Two: Theory and methods

6.2.1 Lifeworld research

In this section, I explain in detail the research methodology that illuminates the research questions. Primarily, this research explores the ways in which Australian professional homeopaths reason and make decisions in clinical practice, how they experience reasoning within their professional lifeworld. The lifeworld is the *taken-for-granted world* in which we work, live or inhabit (Heidegger 1962, Smith, Flowers et al. 2009 p 13), a world with which I was familiar from more than twenty years in clinical practice. The lifeworld of homeopathic practice in which the phenomena of clinical reasoning are experienced is the subject of this research. I envisaged the development of a ‘phenomenology of homeopathic practice,’ hopeful that it might provide a useful model to approach issues and concerns arising in the lifeworld of professional practitioners (Van Manen 2001). While there is abundant literature concerning the lifeworld in conventional medicine (for example Turnbull, Flabouris et al. 2005, Leanza, Boivin et al. 2013) and the allied health professions such as physiotherapy and occupational therapy (for example Ajjawi and Higgs 2007, Higgs and Jones 2008), there has been limited lifeworld study in homeopathy.

The secondary objective was pedagogic, to determine how a developed understanding of contemporary reasoning might inform and supplement homeopathic education. Like other internally varied CAM therapies (such as Traditional Chinese Medicine) homeopathy faces critical epistemic challenges. These were discussed in Chapters Two to Four. Exploring the lifeworld enables an examination of the gaps in our understanding of the epistemology and practice of homeopathy.

Theory, domain-specific knowledge, and professional expertise constitute the building blocks of clinical practice (Norman 2005). Professional practice, however, is encompassed within and constituted by the lifeworld, which is as diverse as the practitioners who practise it. Lifeworld research demands concentrated attention to the individual details and nuances of the phenomena of interest, to clinical reasoning and to the experiences of the

participants engaged in it. Similarly, a homeopath must orient herself to the nuances of each patient's symptoms in order to make sense of them. She cannot fall to the temptation to generalise them to (or from) another case. For IPA research, and for homeopathy, an ontological problem perpetually exists in needing to understand 'what is' without making generalisable epistemic claims. As interpretative research is not theoretically generalisable (see Chapter 5 Lincoln and Guba 1985) it is appropriate for the substance of this study. IPA research however, is idiographic, and analysis moves iteratively from the parts to an understanding of the whole. This enables general features of the phenomenon to become clear by analysis, and conclusions drawn from the analysis.

6.2.2 Preconceptions & reflexivity

As an insider clinician, this research was inescapably permeated with my perspective (Lewith, Brien et al. 2006), my preconceptions or *fore-structures* as they are understood in hermeneutic and IPA research. An insider is familiar with the entire field of practice, its history, language, instruments and methods of analysis. This constitutes the insider as both privileged *and* prejudiced. Making the lifeworld knowable demanded exposing it, making it accessible, allowing the familiar and the ordinary to become unfamiliar and strange (Larkin, Watts et al. 2006). Prior intimate experience can lend the researcher to struggle between being an immersed insider, and a theoretically detached outsider (de Jong, Kamsteeg et al. 2013). Making sense of the participants' experiences demanded uninterrupted awareness of my horizons of experience (Finlay 2008), my habits, and all my preconceptions about homeopathic clinical reasoning.

As qualitative research is intrinsically and unavoidably interpretative, researcher subjectivity needs to be acknowledged, for it is manifestly present throughout the research process. Who I am, who I have been, who I think I am and how I feel about data collection and analysis are all inseparable from how knowledge is acquired, organised, and interpreted, and to the relevant claims that I might make (Pillow 2003). Situated in the interpretive paradigm, I intended to explore the subjective lifeworld, the lived experiences of

professional homeopaths in the clinical setting. As Greatrex-White asserts of researchers (2008 p 1844):

... very often we are unaware of the deeply embedded structures, processes and practices that shape our being in the world and determine what and how a person sees; what a researcher offers as knowledge on a given topic and what those researched give as data.

As a professional homeopath and clinical educator, I brought to bear more than twenty years of clinical experience. This understanding necessitated continuous reflexive attention to my preconceptions, to contemplate my taken-for-granted experience rather than to consider it normatively. I recognised, for example, the complex and the nuanced questions that the participants asked their patients, as they mirrored the questions I was accustomed to asking. I was acutely familiar with the differential diagnosis skills I observed in the hands of each participant. Reflexivity and attention to one's fore-structures are central to IPA research. The comparison for the homeopath is to understand illness phenomena; to interpret the patient's lived illness experience. This is theoretically achieved, as Hahnemann asserted, by remaining *free from prejudice*, sufficiently distant from prior case knowledge and experience in order to understand its individuality.

Prior to commencing this investigation, the main objective was to describe and understand the phenomena of homeopathic clinical reasoning and decision-making. This reflected my preconceptions regarding what I *should* and *could* expect to find. I was already engaged in a kind of reflective *glancing at* pre-reflective experience (Smith, Flowers et al. 2009 p 189), curious regarding many unanswered (unasked) questions about the experience of homeopathic clinical reasoning. I needed to understand how the participant *experiences* and *enacts* clinical reasoning pre-reflectively, prior to interpretation (Dowling 2007). Upon more attentive reflection, and having collected the data, it became apparent that analysis required understanding the lifeworld through deeper and more deliberate reflection. Smith articulates this as the layer of *phenomenological reflection*, though in practice, the layers of reflection remove binary distinctions (Smith, Flowers et al. 2009p 189). Ultimately, I had to understand experience-in-action (Schon 1983), to understand the particularity of these

participants, and to make sense of their experiences. Gradually, it becomes possible to abstract, to find the patterns, rhythms and meanings within the experience of reasoning.

I had anticipated that the participants, some experienced clinicians of more than twenty years, would be capable of analysing, reflecting, and discussing their clinical reasoning skills. Actually, an epistemic gulf existed between reasoning as it was experienced and how it could be (de)constructed and explained; a finding congruent with reasoning communication in other domains, such as physiotherapy (Ajjawi and Higgs 2012). Equally problematic was the incongruence between my expectations of these experienced clinicians and their ability to explicate their reasoning practices. This can, in part, be explained by the consideration that although experienced clinicians, most had limited experience of hermeneutic, phenomenological, or any other qualitative research.⁵⁵ Perhaps, as Benner discusses in the nursing context, the more automated or non-analytical practice becomes, the more difficult it may be to describe experience unless such articulation is a regular habit or practice (Benner 1984).

The experiences that the participants shared and the interactions I observed between them and their patients became imbued with my own professional experience. At first, I wrestled with the tension between bracketing and non-bracketing, with the challenge to bring participant experiences reflexively to the fore. This led me to accept that meaning and understanding were necessarily a co-construction between the participants and me. This brought both challenges and rewards. At times the construction enriched my understanding; at other times it created tension and uncertainty as to whether I was being sufficiently prudent in my data interpretation. These insights increase the complexity of engagement in empirical research practice in a clinical setting. It also stimulated curiosity in and critical reflexivity toward the status of the clinician-researcher in qualitative health research. During data analysis, the commitment to hermeneutic and phenomenological frames compelled me to integrate, rather than abandon, my assumptions, as they added depth of understanding to the research product.

⁵⁵ Three of the participants had a master's degree in homeopathy and one in psychotherapy, each as coursework or non-research programs.

The practice of homeopathy, like conventional medicine, demands broad knowledge of medical sciences as well as artistic skill (Malterud 2001). As discussed in the preceding chapters, homeopathy asserts that its epistemology is rigorous, while practice requires creativity and artistry. In order to examine these assumptions, I explored phenomena in the lifeworld, adopting a naturalistic approach (Lincoln and Guba 1985, Malterud 2001). I therefore observed, recorded and questioned homeopaths in the context of their ordinary working lives, simultaneously interpreting and subsequently analysing their lived experiences.

6.2.3 Research paradigm and theoretical framework

In qualitative health research the researchers are positioned within a particular worldview that provides a theoretical framework for their investigation. Similarly, professional homeopaths view the world through historical, cultural, philosophical, theoretical, moral, temporal and spatial lenses (Swayne 2002). Qualitative health research is not without its critics, some claiming it merely adds curiosity to well-designed randomised research, without adding new knowledge and lacking methodological rigor (Daly 2009). Qualitative health research actually seeks to explore meanings, to build understandings and to develop theory based on diverse human experiences. Being located in the world of the phenomenon allows the researcher-observer the possibility to develop a close appreciation and understanding (Denzin and Lincoln 2008). The phenomena being investigated are imbued with contextual, historical and socio-cultural meanings,⁵⁶ making their interpretation richly complex.

⁵⁶ Atkinson and Gregory, for example, provide numerous examples of medical conditions named according to the Victorian and Edwardian historical period in which they were construed Atkinson, P. and M. Gregory (2014). *Constructions of Medical Knowledge. Handbook of Constructionist Research.* J. Holstein and J. Gubrium. New York, The Guilford Press: 593-608.. These observations have dual importance to this study. Firstly, they denote the construction of the phenomenon of 'the diagnosis' in medicine, as distinct from attempts to understand signs and symptoms as phenomena of some type of dis-ease or imbalance; a medicine of symptoms as Foucault described it Foucault, M. (1973). *Birth of the clinic: an archaeology of medical perception.* London, Routledge.. Secondly, the homeopathic framework originally developed in mid-nineteenth century Europe and is built upon the kinds of conceptual understanding of illness phenomena which Foucault, and Atkinson and Gregory, apply in their critiques of the social construction of medical knowledge.

6.2.4 Constructivism

The task for an IPA researcher is to piece together various representations and findings, like a quilt or a photographic montage (Van Manen 1997, Denzin and Lincoln 2008), to become a *bricoleur* (Ricoeur 1981, Schwandt 2007).⁵⁷ In the qualitative research framework, the researcher necessarily accepts a worldview that knowledge and theory are constructed, and that they cannot be generated without a priori suppositions. Meaning is not inherently contained (Maines 2000). Rather, meaning is always contingent, a co-construction between the researcher and the participants. This understanding necessarily shapes the research process and its outcomes.

Qualitative research has a diverse and established history in clinical reasoning investigation. Phenomenology has been employed to explore physiotherapy reasoning (Ajjawi 2006, Abrams 2014), nursing practice (Dowling 2007, Miles, Francis et al. 2013), and hermeneutics in dentistry reasoning (Loftus 2006) and oral health experience (McGrath and Bedi 2002). There are also studies of clinical reasoning in integrative medicine (Grace and Higgs 2010, Grace and Higgs 2010), bridging biomedicine and CAM. Few researchers have applied these methodologies to the study of CAM or to homeopathy in particular.

Ultimately, this research asks questions about the construction of knowledge and its practical application. Being a homeopath and practising clinical reasoning are illustrative of the roles and forms of meaning that are embedded in the lifeworld. Like other health professionals, homeopaths have particular ways of being in the professional world (Crotty 1998), in relation to patients and to their symptoms. And so, investigating the lifeworld of clinical reasoning phenomena turned my attention to what was constructed, in contrast to the ways in which clinical phenomena are usually constructed as objectively real. Interpreting and understanding a patient's abdominal pain, insomnia, or existential despair is as much contingent on the worldview of the homeopath as it is of her knowledge of anatomy, pathology, psychology, or materia medica. Distinctions between the 'known' and

⁵⁷ Like the handyman surrounded by a garage full of tools accumulated for past purposes, the moral philosopher takes stock of the problem at hand, surveys her shelves for available conceptual resources, and then attempts to solve the problem by taking things apart, reordering, culling out, weighing, specifying, splicing in, and putting them all back together. <http://plato.stanford.edu/entries/theory-bioethics/> last viewed 14 November 2016.

the 'knowable' world lie at the very foundation of the various theoretical perspectives that underpin all research. According to van Manen (2001 p 460) the task for the phenomenologist is to ceaselessly brush away layer upon layer of matter in order to reveal the world, *the world of meaning*.

Homeopathy is predicated upon a multiplicity of clinical styles and models. The meaning of this multiplicity became evident throughout the course of this study. Consequently, this research challenges the traditional (or *classical*) construction of homeopathic reasoning which, having emerged historically within medicine, has its epistemological and ontological roots within empiricism. For Hahnemann, empirical knowledge construction was inductive and deductive; its products were designed to be reproducible. This was articulated in Chapters Two and Three.

From a constructivist standpoint, knowledge and interest in knowledge are contingent, rendering objectivity, as Habermas asserts, an illusion (Habermas 1971, Colburn 1986). Contemporary clinical reasoning is a dynamic phenomenon, evolving, being constantly constructed; in contrast to the more static form evident during and after Hahnemann's time. These perspectives concur with IPA research, to which I will now turn.

6.2.5 Philosophical framework: Interpretative phenomenological analysis (IPA)

Attention to lived experience was the primary focus of this research; indeed, understanding homeopathic clinical reasoning as a lived phenomenon was the driving reason for this study. Interpretative Phenomenological Analysis (IPA), developed from hermeneutic phenomenology, was the methodology chosen to interpret the phenomenon (Smith 2007, Smith, Flowers et al. 2009). While other methodologies might be suitable including grounded theory (Bryant and Charmaz 2007) and action research (Lingard, Albert et al. 2008), I was particularly drawn to the congruence between hermeneutics and phenomenology, methodologies seeking to intensely explore, interpret and construct meaning from lived experience. The need to examine the intricacies of the everyday

homeopathic lifeworld made IPA an appropriate exploratory lens. This in turn led to the development of the research questions.

Coincidentally, one of the existing key studies of homeopathic clinical reasoning had utilised interpretative phenomenological analysis (Burch, Dibb et al. 2008). Extensively examined in Chapter 5, the PHIRM model gives limited attention to the relational interaction between homeopaths and their patients embedded within reasoning. This is integral to understanding how the products of knowledge interact with forms of engagement. IPA is capable of mining as yet unexplored elements of clinical reasoning, generating new knowledge about the lifeworld of professional practice.

IPA is a comparatively new methodology developed in the field of health psychology, for example to explore the experience of adapting to technology when faced with spinal cord injury (Verdonck 2012). Built upon German and French phenomenological and hermeneutic traditions, IPA offers a rigorous, systematic, and flexible approach to the exploration of human experience within which the researcher can modify the steps and stages of data collection and analysis (Smith, Flowers et al. 2009). Research rigour is represented in its core principles: a commitment to understanding the individual participants' point of view, a focus on personal meaning-making in specific contexts, and rigorous analytical method (Smith, Flowers et al. 2009 p 79). IPA research also accommodates creativity and innovation, necessary components in interpretative research. The relationship between systematic rigour and interpretation is managed with reflexivity in regards to all perceptions and processes, ensuring that the results are neither too fixed nor too fluid. The comparison with homeopathic clinical reasoning is apposite: effective reasoning demands knowledge, understanding, and application of principles, yet sufficient flexibility as to accommodate the uniqueness of each patient and every illness state. IPA owes its philosophical and theoretical origins to a multiplicity of significant theorists and historical developments, to which we turn.

6.2.6 Phenomenological traditions

As a distinctive research methodology, IPA has emerged from continental philosophy, in particular German and French phenomenological and hermeneutic traditions. Evolving historically within diverse philosophical and theoretical scholarship, the phenomenological tradition cannot be specifically defined. Its emergence was in part a reaction to the dominance of positivism (Reiners 2012), to the specific claim that knowledge and meaning are pre-determined, needing primarily to be observed in order to be understood. Being the study of the logic (logos) of phenomena (Macann 1993 p 66), phenomenology is a branch of philosophy that attempts to explore the structures of experience and consciousness. Its original Husserlian form was an attempt to understand perception (Zahavi 2003). Meaning, in both the natural and the human world is always regarded as being constructed, not pre-existing. Through an examination of what is taken for granted, phenomenology is an exercise in explanation (*erklären*) and understanding (*verstehen*) rather than being merely descriptive, a claim against which phenomenology defends itself (Larkin, Watts et al. 2006). Giorgi asserts that Smith's IPA ignores the *reduction*, a critical component in Husserl's phenomenology (Giorgi 2011). Smith responds that IPA balances prescription and flexibility in order to focus sharply on individual experience (Smith 2011).

Phenomenology, Husserl asserted, demands that we go back, '*back to the things themselves*' (Crotty 1998, Husserl 2006). These things are the *objects* to which we relate, the *circumstances* in which we live, and the people with whom we have a conscious *relationship*. For homeopathy, these objects are the participants and their patients, *the circumstances* of their relationship, *the contexts* of their engagement, and the homeopathic prescription.

In concrete terms, phenomenological research demands that the researcher acquires *the conscious lived experiences* of participants. Husserl asserted that these objects must be reduced to their fundamental essences in order to be understood (Sanders 1982). He proposed exploring consciousness itself by bracketing the contents of experience⁵⁸ (Zahavi

⁵⁸ In addition to philosophy, Husserl was an accomplished mathematician which helps to explain his bracketing and eidetic reduction, techniques designed to increase experimental rigour and certainty.

2003). Bracketing, according to Husserl, requires the phenomenologist to put *all* his existing assumptions regarding the external world into brackets at once.⁵⁹

Martin Heidegger (1889-1976), at one time Husserl's student, rejected bracketing. He asserted that observations are *always* necessarily an *interpretation* of phenomena. Some critics contend that bracketing merely creates an illusion of detachment (Ahern 1999, Gearing 2004), an attempt to increase research rigor by mitigating unacknowledged preconceptions (Newman and Tufford 2012). Further comparisons can be drawn between Smith's IPA and other phenomenological methodologies employed in psychological research. IPA critic, Giorgi (2011), asserts that no research work can be considered *purely* phenomenological without at least some sense of the reduction (essence) being articulated (Giorgi 1997). Sceptical of the rigour of IPA, Giorgi asserts that Smith enters the phenomenological attitude by means of reflection rather than by assuming the attitude of Husserl's phenomenological reduction (Giorgi 2011), the avenue that he clearly privileges. Evidently, Giorgi disputes any claim to phenomenology that he believes neglects the Husserlian reduction (epoché) as its central method. Giorgi's phenomenology results in a third person narrative of the phenomenon, while Smith's methodology strives to achieve an idiographic interpretative commentary (Smith, Flowers et al. 2009) incorporating the participants' accounts. Giorgi's method is Husserlian, and I have already argued that idiography is preferred to the reduction.

Ultimately, however, bracketing is not philosophically congruent with the aims, methods and results of my research. Rather, I endeavoured to be reflexive at every turn, fully aware that meaning was constantly co-constructed with the participants. This interpretative attitude is supported by the hermeneutic lens, embedded within IPA, facilitating interpretative inquiry that *can never* be a reduction.

In phenomenological research practice the researcher needs to be reflexive, in relation to personal embodiment, and in consideration of the relationships with the research participants (Smith, Flowers et al. 2009). Merleau-Ponty (1908-1961) asserted that our relationship with the world is embodied, not merely of essences or being in time (Merleau-

⁵⁹ <http://plato.stanford.edu/entries/husserl/> last viewed 30 May 2016

Ponty 1945). Sartre, similarly, primarily engaged with lived experience as an existential process of becoming (Macann 1993, Smith, Flowers et al. 2009). Examining lived experience in a healthcare setting requires an appreciation of embodied awareness as much as cognitive understanding. Each represents researcher reflexivity, being central to an emerging ontology in a therapeutic context. Reflexivity also increases the possibility that idiographic IPA research will be sufficiently rigorous in order to be consistent, at least across related domains (Yardley 2000, Carter, Ritchie et al. 2009).

6.2.7 Hermeneutic traditions

Hermeneutics, dating to Greek exegesis of sacred texts, is a philosophy of textual interpretation. Hermeneutics, and hermeneutic phenomenology, have evolved from the continental philosophy of Schleiermacher (1768-1834), Dilthey (1833-1911), Heidegger (1889-1976), Gadamer (1900-2002), and Ricoeur (1913-2005). Hermeneutics acknowledges that texts (including written texts, images, music and other materials) are not intrinsically meaningful, rather, that the interpreter attributes meaning to them. In homeopathy, textual interpretation is historically the province of the homeopath, while this research explores interpretation as a product of the interaction between homeopath and patient, and between homeopath and researcher. Interpretation also includes observations that I made of practitioner-patient interactions, as well as iterative reflection on those observations.

In this context, the hermeneutic lens acknowledges that the various elements of homeopathic clinical reasoning constitute parts of a text. Each text represents the authentic experiences of the individual participants. And, because experience is always idiographic, concerned with the particular, there can be no 'right' or 'wrong' use, interpretation or explanation of those experiences (Smith, Flowers et al. 2009 p 29). Meaning is singular to the participant having the experience and the interpreter interpreting this experience (Ricoeur 1981). This singularity is examined in the relationship between the context of the text's production and the context of its interpretation (Smith, Flowers et al. 2009).

Acknowledging Heidegger's contribution to hermeneutics, IPA research is sensitive to the momentariness of temporal experience (Leonard 1989), to the notion of '*dasein*' or *being-in-time*. Relations are never static, ahistorical or atemporal (Overgaard 2003). Similarly, 'one can never step into the same river twice' (McGilchrist 2009 p 30 after Heraclitus 6th-5th BC) and so the phenomena examined would not be the same a second time. Such a comparison acknowledges both the distinctiveness and the momentariness of experience. Like homeopathy, the phenomena would be similar, yet not identical. Although, as anticipated, this research examined the cognitive characteristics of clinical reasoning, it was the homeopathic experience of *knowing, understanding, and engagement* that came to be of particular and unanticipated interest. It was these *ordinary phenomena* that provided shape and meaning for the study as a whole.

In the particular context of clinical reasoning and decision-making, phenomenology seeks to explore *the act or the experience of knowing*, not merely the *nature* of knowledge (Zahavi 2003), although undoubtedly knowledge and knowing are interdependent phenomena. How the participants experienced knowing and understanding, and how they articulated these experiences were strikingly complex phenomena. As homeopathic clinical reasoning and the experiences of homeopaths had only been partially examined in earlier empirical research (Van Haselen and Liagre 1992, Brien, Prescott et al. 2004, Burch, Dibb et al. 2008, Brien, Dibb et al. 2009) they deserved further examination.

The proper task of hermeneutics, according to Ricoeur (1981), focuses on the unique character of individual text derived from and expressed through the subjective, personal construction of meaning. From an IPA perspective, the hermeneutic lens recognises that participant subjectivity is always to be considered and not negated, and that research findings are inevitably co-constructed from engagement. Careful to avoid merging the particular with the general, the researcher accepts that an individual case may be representative of experience derived from a larger body of inquiry. Smith et al, proposing an argument for the case study (2009 p 30), assert the possibility that the research can, through distinct analytical procedures, move from the single case to more general statements, without ever making *universal* generalisations.

Smith's claim for IPA research has some resonance with Thompson's (2004) argument that the formal homeopathic case study, once rigorously modeled, might be used to elevate the case study in an evidence hierarchy. Like hermeneutic inquiry, homeopathy attends to the particular, to the individual case. Whether case study data can tell us about a non-individual problem, or what particulars can allow us to make claims about, are questions with which this method of inquiry will contend. Thompson's claim supports his endeavour to make the formal case study generalisable, while hermeneutics is cautious about making such claims.

I must pause here, to acknowledge that IPA is also not without its critics. Chamberlain (2011) questions whether IPA is philosophically or methodologically committed to phenomenology, and suggests that IPA must articulate its position in regard to the kind of phenomenology it is attempting to be. This thesis, while not a defence of IPA, is committed to explanation (*erklären*) and understanding (*verstehen*) rather than being merely descriptive. Secondly, Chamberlain questions whether IPA is genuinely interpretative, asserting that IPA is strikingly similar to grounded theory and frequently produces similar results. The fundamental issue is that hermeneutics (as a methodology and as the basis of philosophical inquiry) is debated and contested, and so distinguishing *hermeneutic interpretation* from other interpretative methods is unresolved. Kaptein (2011), on the other hand, suggests that IPA research brings the researcher *close to the real world*, in particular to the world of illness experience. IPA has been used for elucidating the experiences of minorities and patients in health psychology research. This makes IPA ideally suited for the examination of homeopathy, itself both a minority and marginal profession.

Inevitably, culture imposes certain values and meanings and at the same time excludes other possible values and meanings. Consequently, the phenomenologist endeavours to penetrate the limitations as well as the freedoms experienced within and through his research culture. All representations in this investigation are ultimately mine (Pillow 2003) making me accountable for their rigour, credibility and authenticity (Tracy 2010).

Part Three: Practice

6.3 IPA practice: How I conducted the research

While IPA research practice has guidelines, the integrity of an IPA study is not dependent on their linear application. Being exploratory, IPA may appear formless, in particular for the novice. This is because phenomenological research is discovery-oriented, exploring the meaning and purpose of experiences in a naturalistic context, not merely describing them. IPA's techniques and methods are iterative, developing in relation to the findings *as they emerge* within the data. This is also in keeping with the hermeneutic tradition, in which understanding and interpretation grow as the research unfolds (Trede and Loftus 2010). This unrestrictive approach allowed the participants and me the freedom to explore the phenomenon fully, unfettered by fixed rules and routines. At first, as an inexperienced phenomenologist more accustomed to specific clinical questioning, symptom coding and categorising, the seemingly unbounded approach was unsettling. As the participant sessions and interviews accumulated I grew more confident in my observations, and equally willing to accept doubtful moments, comments and answers.

IPA practice rests upon three interconnected objectives. The primary objective for IPA research is to remain open to the revelation of meaning, with the possibility of challenging and expanding understanding of the phenomenon. By challenging and expanding understanding, I refer to both my own reflexive understanding and analysis, as well as by contributing to those described in the literature. It was not my endeavour to challenge (or confront) the participants' understanding; this would have been in breach of the privileges I had already acquired. Nor was it my endeavour to make bold generalisations beyond the scope of this study. The researcher strives to be sensitive to the phenomena they interpret and to recognise their impact on the participants' agency in the research process (Greatrex-White 2008). IPA embeds the researcher as an instrument at every stage of the research, from its initial conception and through to the collection, evaluation and analysis of the data. These dimensions were a part of Smith's model (1994) which he developed for the practice of health psychology research.

The second objective of IPA is to develop a more explicitly *interpretative* analysis (Larkin, Watts et al. 2006 p 104). This second-order account tries to provide a critical and conceptual annotation upon the participants' personal *sense-making* activities. This helps the researcher think about *what it means* for participants to make such claims about sense-making. At times, a participant became aware of their discomfort with my dual roles, expressing unease and alarm at the experiences they had inadvertently and unexpectedly shared. Bruce, for example, insisted that a particular case analysis was not fit to share with his students, subsequently joking that I would not be welcome to attend his student clinical practicum. There was therefore some tension between my ethical obligation to respect the participants' confidentiality and the need to interpret with fidelity without minimising moments of critical insight. IPA scholars have acknowledged the difficulty of grappling with participants' intensely personal experiences (Wagstaff, Jeong et al. 2014)⁶⁰.

In accepting the limitations of their individual experiences, the participants were encouraged to be free from any assumption that their experiences and clinical decisions might be adjudged *true* or *final*. This was carefully explained to the participants prior to the data collection. I explained that their ordinary, particular, as well as unique experiences would be sought and valued. It constituted an important ethical and practical *step into the discourse*, as most had had no prior experience of qualitative research in any capacity. IPA encourages participants to explore the multiple meanings of experience without the risk of reducing those experiences to *mere essences* or symbols in the Husserlian sense.

Phenomenological research seeks to understand the experiences of those situated within the phenomenon (Van Manen 1997), living and breathing the phenomenon *in their own unique way*. An IPA researcher does not try to experience the participants' experiences as might be expected within the framework of symbolic interactionism. As a member of the profession being investigated, I was in a privileged position, able to access the particular professional vernacular (Fontana and Frey 2005). Familiar jargon enabled an easy, fluid understanding between the participants and me. Equally, awareness of and experience

⁶⁰ An IPA researcher exploring the experiences of members of a cult notes the shock she herself experienced, '*knowing that a large amount of people are still trapped in the cult and suffering the same abuse that the participants went through,*' and her subsequent difficulty in trying to keep sufficient distance from the participants' texts. IPAANALYSIS@yahoo.com viewed 26th February 2016.

within the vernacular may have caused me to inadvertently attach meaning to words, bringing preconception to phrases or expressions used by the participants. A researcher's insider knowledge and experience may also prove emotionally challenging, particularly in the context of a long and arduous research project (Newman and Tufford 2012). In order to manage this, van Manen suggests that the researcher adopts and maintains *hermeneutic alertness*, reflexively stepping back to critically consider the meaning of situations (Van Manen 1997, Ajjawi and Higgs 2007). Reflexivity of this kind became an iterative feature, involving the recording of notes, memos and questions I had to regularly tackle. Notes and memos were recorded (into my voice recorder or iPhone) after each data collection, and these were repeatedly examined in view of the transcripts, comparing them for irregularities as well as to confirm particular insights.

Collecting the data over a two-year period I learned to develop reflexive alertness, increasingly aware of my capacity to project meaning onto the participants' expressions. In order to obviate this, I adopted the habit of highlighting any assumptions, preconceptions and projections in my analytical field notes after the interviews were completed. This reflexive step became an important way of checking for my influence on the participants, particularly after the early data sets had been collected. It was critical to listen to the recorded interviews as soon as possible in order to retain the aesthetic and the temporal 'being-in-time' qualities of each. At subsequent sessions, my awareness became more acute, mindful of the nuances of participants' expressions, but also more relaxed and confident with the responsibility. IPA has clear practical research guidelines yet still considerable room to manoeuvre (Smith, Flowers et al. 2009), while hermeneutic phenomenology, from which it has developed, 'tries to ward off any tendency towards a predetermined set of fixed procedures, techniques and concepts that would rule-govern the research project' (Van Manen 1997 p 29).

Reflecting on the robustness of IPA, Smith developed a set of guidelines for quality and evaluation, based on an analysis of 293 empirical IPA studies (Smith 2010). Criteria critical for *acceptable studies* demonstrate a commitment to IPA's core principles (phenomenology, hermeneutics and idiography), as well as to transparency, coherence, plausibility, and sufficient sampling to demonstrate appropriate evidence for each emergent theme (Smith

2010 p 17). Smith's evaluation accommodates the particular strengths and weaknesses of specific types of studies, noting that IPA is a relatively new methodology, applied within the (then) narrow domain of health psychology.

In conjunction with its philosophical roots in hermeneutics and phenomenology, IPA is built upon idiography, the third key technical element. Idiography is an investigative frame; a practice concerned with the particular details and individual character of the experiential phenomenon being explored. Idiography commits the researcher to meticulously analyse each case in a body of work (Smith 2010 p 10). Idiography can be contrasted with traditional nomothetic, rule-based investigation which seeks to explore phenomena in order to generalise at the group or population level (Smith, Flowers et al. 2009). Arguably little different from van Manen's (1997) hermeneutic phenomenology, IPA's idiography adds perspicacity to the meaning of individual, particular experiences. Idiography constitutes an exploration of experience for *this* person at *this* particular time and how each particular person makes sense of what is happening to *them*. Together, IPA's three interpretative frames reaffirm a commitment to the sensitive and sensible discovery and understanding of the lifeworld of each individual. Woven together, these elements combine philosophical traditions with a series of practical, grounded research instruments capable of producing new knowledge.

Building upon the hermeneutic features already developed (by Van Manen 1997), Smith articulates the so-called *double hermeneutic* which considers how the researcher interprets the experiences and meanings of the participants' interpreted experiences (Daly 2007). The double hermeneutic facilitates layer upon layer of interpretation; an approach reaffirming that bracketing would be naïve. As the researcher cannot be excluded from the research process, the double hermeneutic characterises the researcher's role as the conduit between the participants and the phenomenon. It is, however, the researcher's primary role to access and reveal the participants' own experiences.

Making sense of and interpreting that experience is the researcher's secondary role (Smith, Flowers et al. 2009). Sense-making distinguishes IPA research from related methodologies including discourse analysis, in which the analysis focuses on learning how participants

construct accounts of experience through oral language (Smith 2010). Although attention towards and analysis of the participant-patient dialogue formed part of the data, I considered IPA capable of exploring other dimensions of how phenomena held meaning for my participants. The commitment to IPA became stronger as the analysis increasingly led me to explore therapeutic interactions, and to analyse clinical reasoning as performative. The saturated, multivalent dimensions of IPA brought this analysis more richness than would an exclusive focus on dialogue.

A further theoretical distinction between the hermeneutic phenomenology of van Manen and the IPA of Smith (2007, 2009) is the quality of focus on particular experiences. For van Manen (1997), the *ordinary everyday* experience deserves to be explored in order to be understood. Smith refers to *major life experience*. What, it must be asked, constitutes a *major life experience*? Clearly while constituting a *major part of life*, ordinary daily work may not be a *major life experience*. Rather, it was the ordinary, the particular, the everyday, which this research investigated. Certainly, there were *major* moments, pearls of insight that occasionally emerged (Smith 2011). Although ordinary daily working life experience may contain critical moments (repeatedly verified by the data) it cannot be inferred that the lived experience of daily life necessarily constituted a major life experience.

The discrepancy between the value of the *ordinary* and the *major* (profound) experience can be reconciled by the phenomenological precept *to make the familiar strange*. Doing so requires sensitive illumination of the phenomenon and continuous researcher reflexivity. In making the familiar strange, phenomenology seeks to capture the general wisdom of the phenomenon. IPA research moves deliberately (but also seamlessly) between the ordinary and the exceptional in order to develop a rich understanding of the whole phenomenon. IPA research has an essential *interpretiveness* that is transient and connected at some level to ineffable moments of understanding between the researcher and the participant.

A critical or profound moment will be expressed and best understood when examined within the context of the ordinary events of daily working life. Through a recitation of the ordinary and the common lived experiences, the so-called major life experiences or critical moments can be brought into relief. Making potentially subtle distinctions demands

practice, patience, knowledge and close attention to case nuances. Critical insights may also have important pedagogical value; when, for example, students are confronted with learning to recognise the common symptoms of disease (in this context homeopathic disease pictures) while memory is more likely to recall only those exceptional cases and striking circumstances, or the peculiar symptoms that are depicted in homeopathic textbooks.

Being committed to IPA research (as a clinician and researcher) was not without its limitations. I was mindful to avoid misconstruing first-level observations (constructs) as a clinician-observer with second-level analysis (abstractions) as a researcher. It was difficult, in other words, to observe without always engaging in some level of interpretation. This concurs with being a privileged, and therefore prejudiced, insider. At times, participants shared anecdotes of their reasoning experiences with me as a clinician-colleague, subsequently recognising that while I was a co-participant, I was primarily the researcher interpreting and analysing their experiences. The distinction between observing *participant* and a participant *observer* is pertinent. In my own case, while I had inside experience, I adopted the more orthodox role as observer (Skinner 2010). Although I was physically and morally in the clinical space, I did not engage in any discussion during the clinical interviews, instead relying on my observations and field notes to guide me during the post-consultation interviews. Although I could feel and sense many of the remarks, questions and gestures made by the participants, my primary responsibility was to observe, not to actively participate.

Reflexivity brought important ethical implications to my attention. As a clinician and as a member of the professional community, I held an enduring interest in the research questions, and the possibilities of interpretation and discovery. These were not mere random or independent events; they were analogous components of *this* particular field of inquiry, driven by a personal and professional need to explore, discover, capture and construct meaning with the participants. And as the participants (and the profession) faced increasing public scrutiny, the need to handle the texts with sensitivity grew in magnitude. This understanding enhanced the importance attached to interpreting participant experiences ethically.

6.3.1 Ethical requirements and considerations

This research was approved by the University of Sydney in February 2009. As a practice-based empirical investigation, considerable effort was made to consider the accountability of every aspect of the research (Groundwater-Smith 2010). Key principles including the avoidance of harm, the maintenance of transparency, participant equity, professional integrity and the demonstration of care towards all participants (and their patients)⁶¹ were paramount and consequently upheld during the entire conduct of the study. Balanced attention to the voices of all participants is critical for the ethical conduct of qualitative research (Groundwater-Smith 2010 p 78). This was chiefly important as the sample size was relatively small, and the participants recruited came from a comparatively close professional community.

6.3.2 Recruitment

A good participant,⁶² according to Morse (1991) and Denzin and Lincoln (2000) has the knowledge and experience the researcher requires, has the ability to reflect, is articulate, has the time to be interviewed and is willing to participate in the study. In order to elicit diverse data I decided it was important to recruit participants with a minimum of five years full time professional experience practising homeopathy in Australia. This figure seems arbitrary. Many professional homeopaths in Australia operate part-time practices, primarily due to economic constraints.⁶³ I recognised also that length of professional experience did not necessarily guarantee the quality or rigour of that experience. Questions about the constructedness of experience could not be avoided (Scott 1991). However, I anticipated that professional homeopaths shared some commonality in the depth and breadth of clinical experience required to explore the research questions. In addition, and upon reflection, I recognised that my own practice had taken 3-5 years in which to develop a

⁶¹ http://sydney.edu.au/research_support/ethics/human/committee.shtml

⁶² Morse argues that although the relationship between the researcher and the researched may be an unequal one, that the term participant suggests the active, participatory role of the persons being studied. It is the preferred term in this study.

⁶³ The number of practising professional homeopaths has declined approximately 20% since 2010 (according to personal correspondence with the administrator of the Australian Homeopathic Association).

broad range of clinical reasoning knowledge, skills and experience. During this period I had been exposed to a range of illnesses and conditions, as well as to patients representing diverse cultural, religious and other demographic characteristics. I had also faced numerous ethical decision-making dilemmas.

Medical doctors practising homeopathy were excluded from the study as their clinical training and experience tends to resemble an altogether different, disease-centred model of practice. Participants comprised nine female and three male homeopaths, ranging in clinical experience from seven to twenty-three years, with an average of more than sixteen years of clinical experience. Participants all spoke English as a first language and their patients were also all English speaking.⁶⁴

6.3.3 Notice of intended research

In March 2009, a recruitment notice (see Appendix 2) was placed in the national Newsletter of the Australian Homeopathic Association (AHA). Interested recruits were required to possess a minimum of five years full time professional experience, Professional Membership of the AHA⁶⁵ and registration with the Australian Register of Homeopaths⁶⁶ (ARoH). The notice produced fifteen responses from four Australian states. Three subsequently declined to participate. One respondent did not feel comfortable with the use of research techniques, including recording (Downing 2008), while the other two potential participants expected me to provide patients in a simulated setting. On learning that this was not part of the research protocol they ultimately declined. The final figure represented close to 3.5 per cent of the Association's professional membership.

⁶⁴ A very small number of patients spoke English as a second language, albeit with sufficient fluency to engage in this study.

⁶⁵ Australian Homeopathic Association Inc. www.homeopathyoz.org It should be noted that not all Australian professional homeopaths are members of the Australian Homeopathic Association. There are smaller associations in South Australia, NSW, Queensland and Victoria which together comprise approximately one hundred members.

⁶⁶ Australian Register of Homeopaths www.aroh.com.au

6.3.4 Sampling and selection of participants

Sampling was both voluntary and fortuitous (Denzin and Lincoln 2000, Minichello, Sullivan et al. 2004, Denzin and Lincoln 2008). These sampling methods suit the central objective of IPA research, which is to generate detailed descriptions and understandings of the phenomenon under study (Smith, Flowers et al. 2009). Sampling ensured that a geographically diverse group of participants met the inclusion criteria. This was imperative as the objective was to understand and explore the lived experiences of a sufficiently diverse sample (ten to twelve participants). Although the number of participants was relatively small, each was eager to engage with the research questions (Minichello, Sullivan et al. 2004). The final number was sufficiently large by IPA standards (Wagstaff, Jeong et al. 2014).⁶⁷

6.3.5 Further ethical considerations: the reflexive turn

During the course of this research I recognised moments of uncertainty and discomfort in some participants. The desire to participate might have been predicated upon a perhaps unconsidered or unconscious need for reflexive dialogue. Pillow (2003) has examined the functions of reflexivity as a methodological tool, already acknowledged in hermeneutic research (Greatrex-White 2008). To be reflexive demands an '*other*', and some self-conscious awareness of the process of self-scrutiny. Pillow (after Chiseri-Strater 1996) identifies four common trends: reflexivity as self-recognition, reflexivity as recognition of other, reflexivity as truth, and reflexivity as transcendence.

Challenging both the researcher and the researched, Pillow extends us to consider the reflexivities of discomfort. We are challenged to do ethical research in an unethical world. How, as a male researcher, was I to ethically represent the voices of the majority of participants, the women in this study (Patai and Gluck 1991)? How to manage sensitive data that might emerge regarding a participant or one of her patients? How, also, to

⁶⁷ Considerable discussion among IPA researchers suggests that sample size must ultimately be determined by the richness and idiography of the interviews as well as their capacity to capture and explore themes. See IPANALYSIS@yahogroups.com

authentically interpret and analyse the experiences in a domain as contested as homeopathy? Reflexivity demands being accountable to people's struggles for self-representation and self-determination (Pillow 2003) and to be unfailingly sensitive to the microethics of daily research practice (Komesaroff 1995, Guillemin and Gillam 2004). Ethical challenges arose and were continually examined during the course of the research.

6.3.6 Informed consent

Extensive effort was made to ensure that all participants understood the aims and methods of this study. Some participants expressed initial concern about the possible intrusion of this research in their professional privacy, a common and understandable concern (Minichello, Sullivan et al. 2004 p 235). Others expressed concern as to the vulnerability of their patients. In each case, participants were reassured that clinical reasoning experience was the phenomenon being explored, not their patients' outcomes, and that their patients were not the subjects of the investigation.

Informed consent is determined by researcher disclosure (Sim 1986, Minichello, Sullivan et al. 2004, Bhattacharya 2007), the comprehension of the participants and the competence of patients to participate. As the patients were not the subjects of the investigation their competence was not critical, yet the research could not have proceeded without their informed consent. Lastly, the participants understood that they could withdraw from the research at any stage. All the participants were provided with Participant Information and Consent Statements (see Appendix 2). In providing their informed consent, the participants agreed to me being a non-participant observer in their professional rooms for an entire day; allowing me to observe and make field notes; allowing video and audio-recording of them (but *not* their patients, which was not permitted) and to initiate a semi-structured interview with them about their experience of clinical reasoning.

Some respondents requested examples of specific questions that would be asked. A draft interview schedule (Appendix 3) was provided on request, and I explained that the precise nature of the questions would depend on the interaction, my observations, and the response of the participant to previous questions. At this point I reminded participants that

they (and their patients) were free to exclude themselves from the study at any stage, and that all the data would be de-identified. This was ethically important, particularly in the context of a small professional community.

All audio and video files were de-identified and copies were kept securely at the university. A similar de-identification process was applied to all my field notes, memos and jottings in order to preserve confidentiality. At every stage of data collection and analysis I remained sensitive to the confidentiality, physical and moral wellbeing of the patients. They, the patients, were informed from the start that their willingness to participate would help to build the data regarding the experiences of their professional homeopath. Patient Information and Consent forms (Appendix 2) clarified that they could ask questions of the participant and the researcher at any stage and that they may withdraw from the study without deprivation of professional service. In all, only two out of eighty-four patients decided that they were not comfortable with a researcher in the room during the consultation with their homeopath. I immediately removed myself, and all technical equipment from the participant's consulting room.

Of the twelve final participants, one agreed to participate on condition that there would not be a video camera present in the room (Downing 2008). Interestingly, the data that this session yielded was among the most valuable and interesting data in the entire set. Whether the presence of video equipment enhanced or inhibited any other participants' comfort and capacity to respond remains open to critical investigation (Downing 2008, Forsyth 2009). My intuition suggests that the presence of the video camera inhibited rather than enabled the process. Reflexively, I would not opt to make video recordings in any similar future research.

6.3.7 The participants: Professional experience and qualifications

The homeopathic community in Australia is relatively small, numbering at most one thousand professionals. Many other CAM practitioners practise homeopathy in conjunction with other modalities including naturopathy, clinical nutrition and herbal medicine. For the purposes of this study it was important to recruit homeopaths committed to specialisation

in homeopathic medicine, as these were more likely to represent the scope of practice within the *homeopathic* profession. Data collection commenced in May 2009 and was completed in November 2011. The extended period of participant recruitment resulted from my own mode of (part-time) study and the fact that the participants were busy practitioners in different parts of Australia. Long periods between the data collection allowed me to code, analyse and become genuinely familiar with each case. This ensured that subsequent data collection episodes developed iteratively, becoming increasingly focused.

The twelve research participants were all experienced homeopaths, averaging sixteen years in professional practice. Five were from Sydney, two from regional NSW, two from Queensland and three from Victoria. The demographic details of the participants are described in Table One.

Table One: Participants: Clinical experience⁶⁸

Participant	Gender	Code Name	Clinical Practice (years)
1	F	Fiona	20
2	F	Rebecca	10
3	F	Pauline	20
4	M	Allan	18
5	F	Monique	12

⁶⁸ Table 1 originally included details of the professional qualifications of the participants. As a recommendation of one of the thesis examiners, I have omitted these details in order to render the participants less recognisable to other members of the Australian homeopathic community. These details may be obtained upon request from the author.

6	F	Rosanne	11
7	F	Veronica	20
8	M	Bruce	7
9	M	James	23
10	F	Leanne	20
11	F	Charlotte	15
12	F	Susanna	20

Table one reveals the diversity of professional experience (and qualifications) of the participants. Notably, some of the participants had prior experience in branches of conventional health care, a fact reflecting the Australian homeopathic landscape. They had backgrounds in nursing (3), psychology (2), psychiatric nursing (1), osteopathy (1), psychotherapy (1), counselling (1), and health science (2). Three participants had a Master of Homeopathy from a university⁶⁹ in the United Kingdom. The diversity of professional qualifications and clinical experience is at least partially representative of homeopaths in Australia, many who come to study and practice homeopathy as a second (or third) career. Each of the participants also described other diverse life experiences, foundational beliefs, values, preferences and attitudes. It became evident as the data grew that these phenomena brought to bear on their experience of practice as well as informing their clinical reasoning and decision-making.

⁶⁹ http://www.uclan.ac.uk/information/courses/msc_homeopathy.php last viewed 7 June 2012

Part Four: Data collection and management

6.4 1 Interview procedures

In qualitative research the interview can be described as *a conversation with a purpose* (Smith, Flowers et al. 2009 p 57), a detailed and meaningful discussion between the researcher and the participant (Van Manen 1997) resulting in the development and construction of new knowledge. Smith has described IPA interviews as an attempt to come at the research questions sideways (Smith, Flowers et al. 2009 p 58), from an oblique (though not an obscure) angle.

Attentive to the interpretative *double* hermeneutic, IPA privileges the use of semi-structured interviews. These are neither too narrow nor rigidly structured (limiting the depth and diversity of data for discussion), nor too unstructured or obtuse in terms of context and content, and so not too difficult to analyse for emergent themes and patterns. Semi-structured interviews were appropriate in that questions relating to the actions and experiences of clinical reasoning engaged the participant without constraining or restricting them from relating other aspects of the experience of homeopathic practice. Thus, the interview schedule provided structure and was not restrictive. As the researcher I was consistently aware of the multiple, shifting dynamics between the researcher and the participants (Debesay, Nåden et al. 2008, Smith, Flowers et al. 2009) and of the complexities within the interpretative context. As the many parts emerged, the whole phenomenon slowly started to become visible. There was at times a temptation to describe the whole phenomenon without having fully elucidated the parts. This I tried to manage reflexively, conscious that as additional data were collected, they were likely to produce both concordances and differences from the data already collected and partially analysed. I endeavoured to avoid generating themes prematurely. At the same time, I persisted in trying to maintain a space between my pre-conceptions and new understandings of the participants' lifeworld (Smith et al 2009 p 89).

Good interviewing *requires us to accept, and indeed relish, the fact that the course and content of an interview cannot be laid down in advance* (Smith, Flowers et al. 2009 p 65). This insight was appreciated as the data were collected over a two-year period. During this period I observed and listened to the participants' striking remarks, comments, questions and behaviours. These were first noted and coded, in conjunction with observations of both ordinary and unusual phenomena that drew my attention. Analysing subsequent interview sets I began to notice that some of the coded actions and behaviours were being reproduced by other participants, albeit in nuanced ways differing in frequency and intensity. Initial moments of unease usually abated as the participants began to engage with the first question '*tell me about your reasoning experience with the patient we have just seen.*' As is often the case in qualitative research, although the interview schedule provided some reassurance that interviews could be controlled, I seldom referred to it (Appendix 3). Certainly, specific broad questions were asked of each participant, ensuring that the content, depth, consistency and quality of the data sets could be compared (Minichello, Sullivan et al. 2004).

Gradually I developed a collection of useful techniques to enhance the fullness of the discussions. I utilised predominantly descriptive and narrative questions (examples in Smith, Flowers et al. 2009 p 60) in order to generate the rhythm of the discussion; excavating the unique or particular character of the lifeworld of each participant with further probing and prompting questions (Minichello, Sullivan et al. 2004). Most importantly, I consistently tried to focus my awareness and listening skills in order to understand the *participants'* experiences, as these were indispensable to the integrity of the research.

I had originally planned to interview the participants between appointments with their patients, in order to ask specific, focused questions relating to the preceding interview. This proved to be impracticable in terms of the ordinary daily practice arrangements of some of the participants. In general, homeopaths tend to see a number of patients during the course of the working day, stopping for lunch and to make important phone calls (referrals, calls back to other patients) and to attend to other business such as email and administrative tasks. Expecting the participant to stop for interviews between appointments was disruptive

for the participant and her patients. Additionally, short interviews were less likely to allow participants the necessary time to engage in rich, meaningful and uninterrupted discussion.

Consequently, after the first set of interviews, I checked with each participant prior to my arrival to get some sense of the likely timing and opportunities to conduct uninterrupted interviews. Each subsequent interview (lasting on average between thirty and ninety minutes) was occasionally conducted during lengthy lunch breaks or (predominantly) after the last patient had been seen at the end of the day. The participants were interviewed once only. Remarkably, although often fatigued after seeing numerous patients, the participants were never rushed, were always willing to engage in extended discussions and intrigued with the scope of the dialogue that emerged. Participation provided valuable opportunities to reflect on their reasoning, beliefs, behaviours and theories. Discussion often revealed previously unexplored and often firmly held ideas about clinical reasoning, and practice as a whole.

6.4.2 Field notes

During the clinical observation sessions (each lasting between eight and nine hours) I took extensive field notes. I divided blank pages, in landscape format, into two unequal columns. A smaller column on the left side allowed me to make limited, salient observations about the patient and his or her condition, the expressions they used and their symptoms. This performed two functions. The first was as an aide-memoire regarding specific observations representing clinical reasoning *events*, *methods* or *techniques* that I might pursue in the subsequent interview. The second was to reassure the participant that I had been listening attentively and observing the process carefully, and could ask questions relevant to each participant's actual clinical experience. The larger column on the right side allowed me to note down all my observations about the participant. These included the allocation of ordinate themes (Smith, Flowers et al. 2009 p 96) such as how she engaged with her patient, the manner in which she set the tone for the consultation and the arrangement of the chairs, desk, and computer. Collating these data and abstracting their relationship led to the super-ordinate theme of *context*.

Field notes were also recorded regarding the particular style and content of the questions asked of each patient. These observations generated codes representing the pace, timing and placement of these questions, and the responses the participant made to the patient's explicit questions about their condition or the proposed therapy. Super-ordinate themes of *action* (what exactly is she doing?) and *behaviour* (how is she being?) became more easily detectable when reading back over the field notes collected (Smith, Flowers et al. 2009 p 97). During subsequent observational sessions, the right hand column became increasingly rapidly populated. Actions and behaviours became more obvious, as did their relationship to the participants' particular clinical styles. Thus field notes, already partially analysed and coded, began to be incorporated into the development of themes. For example, *reasoning as action, as a performance*, emerged as a significant theme.

6.4 3 Audio and video recording

Interviews with all twelve participants were recorded using an Olympus DS-30 digital recording device. After each interview, audio files were copied and backed up to my hard drive in addition to two external hard drives. An additional copy was always stored on a password-protected server at the University of Sydney. The recorded interviews were then transcribed by a professional transcribing service and returned to me in Microsoft Word Document format to my secure email address. Data files were transferred via a password-protected web-based file transfer protocol (ftp) facility. The transcribed documents were checked for accuracy in regards to the use of specific medical terminology and for obscure homeopathic nomenclature. At this point, the names of the participants were de-identified and replaced with suitable pseudonyms (see Table One).

Video recording was conducted using a tripod-mounted Sony Digital video camera. Where possible, I positioned the camera in the farthest corner of the consulting room; the mounted camera was always beyond the view of all patients. After each session the video footage was copied to DVD discs.

Transcribing and managing video recordings was actually beyond the material scope of this research. Due to cost and time constraints, the video recordings were not coded. They were

however repeatedly viewed alongside my field notes, allowing me to confirm, question and explore specific elements of the texts. Reflexively, I would question the value of video recordings for an IPA study. Although all but one participant consented (and only a few patients requested the equipment be removed from the consulting room) the video equipment caused some participants to be more self-conscious than they might already be due to my physical presence. The videotapes and DVD copies were de-identified to facilitate searching by participant pseudonyms. Originals and copies were stored safely at the University.

Reflexively, in the course of doing this research, I became aware that although situated unobtrusively in the corner of the room with the video camera focused only on the participant, two human beings were engaged in *a clinical encounter* both unique and ordinary (Svenaeus 2000). I felt privileged in each and every clinical setting, witnessing ordinary and extraordinary experiences shared between them, without the pressures I might normally experience in my role as the clinician.

The participants were offered the opportunity to review the transcripts and video recordings to check their accuracy and authenticity, facilitating internal validity (Carter 2010). Only one participant expressed interest in reading the transcripts. The remaining eleven participants deferred to me, trusting me to maintain the integrity of the data. The one participant who checked the transcripts offered very limited reflections and was satisfied with the representativeness of the data.

6.4.4 Data analysis

IPA analysis is guided by processes, such as moving from the particular to the shared, and from the descriptive to the interpretative; and principles, including a commitment to an understanding of the participant's point of view. Yet IPA is not restricted to a *single method* for working with data (Smith et al 2010 p 79). Flexibility is critical in order to accommodate the data, its collection methods, and the particularity of the study's participants. Interpretation and analysis are iterative, inductive, and circular, in accordance with the hermeneutic tradition.

Alert to the possibility of a third person narrative I endeavoured not to misapprehend the participants' meanings (Giorgi 2011). I would repeatedly ask a participant to restate or reframe a particular remark in order to clarify the veracity of my understanding. I therefore endeavour to test the rigour and credibility of IPA through analysis and exploration of the data, leading to the production of holistic knowledge. Through IPA, I sought to ensure that the actual context and the phenomena of clinical reasoning in homeopathic practice were preserved.

Moving between the whole texts and their components and developing codes demanded critical attention to the transcripts, field notes, memos and observations. I recognised that the interpretative process was complex and demanded considerable craft. Honouring the participants' experiences required unremitting focus on the texts as well as reflexive attention (Gearing 2004), taking into account the culture and traditions shaping my own clinical reasoning experience. The possibility that the participants' texts and the phenomena as a whole might constitute a *hermeneutic circle* (Bontekoe 1996, Debesay, Nåden et al. 2008) seemed an ideal, particularly during the early stages of data collection and analysis.

As immersion in data analysis progressed, I experienced an unavoidable tendency to reflect on key personal clinical moments. Some of these were uncomfortable, yet I recognised the need to make them explicit at distinct points in the results, augmenting particular themes.

Data initially collected required line-by-line analysis. I listened repeatedly to the audio files and read the transcripts multiple times. With each listening and reading episode I isolated curious observations, asking what made them ordinary, characteristic or perhaps unique. This is in keeping with IPA's commitment to analysing a single case, before moving to the next case. I pursued the same techniques with the next set of data. (Smith, Flowers et al. 2009 p 82-83).

Initially, I applied codes representing the participants' behaviour, and common questions asked of their patients. These included questions regarding the patient's medical, social, family, and life history. Codes enabled me to build an inductive portrait, reflecting the elements acquired and practised by most homeopaths, and already well mapped in Burch's

PHIRM (2008) model. Collectively, these codes were developed into clinical reasoning and decision-making categories.

Having conducted preliminary analysis of the early data sets, I subsequently focused my questions and observations on the interaction itself. In later sessions, I noted and coded the ways in which the participants engaged and developed an empathetic relationship with their patients, and how they navigated extensive patient narratives. I was drawn to the development of more detailed questions with which they explored these narratives. Abstracting within and across the data, I recognised that the relationships between the participants and their patients were embedded within reasoning. A super-ordinate theme of action, or performance, emerged as central to the process of clinical reasoning (Smith, Flowers et al. 2009 p 96-97).

Categories were subsequently developed into four emergent themes. The first two themes reflected the participants' *knowledge of clinical reasoning*, how it was developed and applied in practice. These themes incorporated the use of homeopathic texts, the significance of sources of authority, and the extant traditions of philosophy, materia medica, and repertory. The third emergent theme represented the *relationships between the participants and their patients*, and the inseparable relationships between the context and the processes of reasoning. I understood that *the performance of reasoning* was tacit, and embedded, a striking and underexplored phenomenon.

The fourth theme emerged after prolonged reflexive interpretation and analysis. Reviewing the coded transcripts, memos, and reflections, I recognised that I had highlighted numerous comments and underlined observations regarding the participants' stated and unstated values and beliefs about reasoning. Reflexively, I was aware that my own values and beliefs, as a clinician-researcher, constituted an inseparable interpretative lens. This is acknowledged in IPA research, not as a limitation, but as crucial to the development of a coherent, themed investigation (Wagstaff, Jeong et al. 2014). I therefore coded and collected those instances during which my cognitive and instinctual responses were aroused, and the particular moments in question. Value statements, for example generalisations pertaining to *unquestionable truths* about homeopathy, especially captured

my attention and curiosity. Collectively, these represented what I interpreted thematically as *the participants' ethics and beliefs*. The function of these ethics and beliefs, and how they might shape, influence and interact with clinical reasoning, emerged as a discrete theme, resulting in the evolution of Chapter 10.

Although this research had clear questions and objectives, the analytical process itself was never linear. This is typical in qualitative health research, during which meaning, insight and questions of interest can emerge iteratively and abductively (Reichert 2007) *from within* the research process. It will not necessarily answer the exact questions it sets out to investigate. Abduction, according to Daly (2007) is more likely to generate an explanation based on a process of imagination, metaphor, and analogy. Abduction highlights the way reason and creativity comes together. An abductive research strategy is not represented by traditional linear inductive-deductive and data-theory (or theory-data) strategies. Rather, abduction requires a willingness to wander between theory and data in order to generate new, perhaps strange, questions and evidence. The specific questions I asked participants had to be refined as the data were gathered and analysed. This more abductive process was an unplanned (and at times uncomfortable) feature of my research. The abductive character of data-generation started to mirror a similar process within homeopathic practice. Gradually, I came to recognise a striking parallel between IPA research and the interpretative processes in homeopathy. This unanticipated parallel is foregrounded in the results, and examined in the discussion.

Through the combined processes of observation, interviews and reflection during and after actual clinical encounters, I sought to bring pre-reflective experience into action (Schon 1983, Schon 1987) and into the present. This research focused on the lifeworld: on human action, clinical interaction, meaning-making and understanding. It demanded a methodology capable of exploring the particularity and the ordinariness of the phenomenon (Smith 2007). Meaning-making and sense-making were experienced by the participants as emerging from within each unfolding homeopathic case. Meaning- and sense-making, in other words, were not and could not be anticipated or constructed a priori. This allowed me to adjust, during the course of the research, to focus on the production of knowledge specific to this

(homeopathic) domain. Through pre-reflective experiences, a descriptive and exploratory discourse was generated, enabling meaning to be co-constructed.

6.5 Chapter summary

This chapter describes significant methodological questions relevant to the investigation. Situated in the lifeworld of professional homeopaths, four key interconnected research questions were developed pertaining to the operations and performance of clinical reasoning, and to the broader domain of practice. These questions encompass the mechanisms of clinical reasoning, the role of theory texts and expertise, the impact of subjective clinical experience, and the importance of therapeutic relationships in the lifeworld between the participants and their patients.

The philosophical traditions of phenomenology and hermeneutics, and the major theorists shaping the theoretical framework, research aims and questions have been discussed. The utility of IPA research has been articulated and examined. Data collection and analysis techniques have been described, giving particular attention to their suitability for the examination of clinical reasoning operations. The value and conduct of ethical human research have been substantially acknowledged.

I now turn to the data themselves and the particular results of this investigation. The following four empirical chapters describe the character of the lifeworld of homeopathic experience and the particular phenomena of homeopathic clinical reasoning and decision-making. These chapters consider some of the key epistemological and ontological questions that confront homeopathy, without necessarily being able to resolve them.

CHAPTER 7

Understanding and performing caseness

7.1 Overview of results: Chapters 7 to 10

The following four chapters describe the contextual nuances of homeopathic clinical reasoning in the data. Together, the assembled results are a hermeneutic interpretation of the interior of homeopathic practice reflected through the participants' experiences. First, I should briefly remind the reader that the practices of 'reasoning' and hence the construction of knowledge (warrantable or otherwise) from them, can be represented within a *contextual space*,⁷⁰ with highly systematised forms of pattern recognition and quantification strategies on one extreme, and highly qualitative, interpretative, and multivalent understanding on the other. These aspects are often, indeed, we may say normatively, constructed as dualistic opposites, at some level and for some people, as antithetical and incommensurate. This construction is deeply embedded in homeopathy, in medicine more generally, and in scholarship and society.

These results chapters begin and are framed by the observation that homeopathy, similarly, is often structured around this contextual space, and often constructs it in similarly dichotomous terms. I noticed first what gaps and tensions existed between how homeopathy was *theoretically* practiced (Levy, Ajjawi et al. 2010) and how the participants in my study actually engaged in practice. On one 'extremity,' the participants attended to practice demonstrating the forms of non-speculative empirical rigour Hahnemann espoused, searching for plausible and consistent outcomes. They used systematic forms of reasoning including pattern recognition and hypothetico-deductive methods. At the other 'end', in other aspects of the multidimensional space, the participants attended to meaning-

⁷⁰ The term contextual space has been deliberately chosen. I use it in order to distinguish the multi-dimensional qualities of homeopathic clinical reasoning and decision-making, which cannot be captured by linear concepts including 'continuum' and 'spectrum.' The latter concepts are restrictive and cannot accommodate all that the lived phenomenon genuinely encompasses.

making, engaged in understanding illness, diseases and states of being in an often gestalt-like, responsive, or as I will suggest, existential mode of meaning-making.

I also observed how participants frequently complicated and destabilised these oppositions, shifting fluidly and flexibly between, or connecting, practices that at other times were constructed as at opposite ends of this space. Participants were also not consistent (where consistency is judged through the lens of the space), but gravitated at certain points towards one aspect or the other, according to the circumstances of each individual case. That is, a participant who articulated an analysis of their reasoning as objective and reliant solely on remedy-matching in one moment might simultaneously express a kind of existential grasp of the patient's suffering, without experiencing this as in some way dissonant; they might also craft an explanation of their reasoning in terms that reify the apparent dichotomy between elements that they do not experience as contradictory in practice.

Homeopathy, as we have seen in previous chapters, is internally structured around these tensions, between commitments to objectivity and systematic reasoning and those to 'qualia', to the unreduced holistic qualities of patient experiences. This tension, I argue, is manifest in the multiple forms of what I call 'caseness': the individualised development of every case – with this tension emerging as the central structure governing the data. This tension moved within the contextual space, each participant attending to particularity and detail, demonstrating the desire for accuracy and for broader meaning-making at different stages of caseness. Over and above this tension, I argue that clinical reasoning may always be understood as a lived phenomenon, a response to changing circumstances and the nuances of each moment.

In this chapter, my focus is on the divergent mechanisms and performance of practice.⁷¹ Mechanisms refer to the skills, techniques, and tools of homeopathic practice representing

⁷¹ As you read the following four chapters, you may also wish to keep in mind the PHIRM and PPR models, in order to consider how my work extends, interacts with, and questions them, questions I will take up in the discussion.

a form of rigorous practice, and approximating the aspiration to surety that drives conventional medicine. But I immediately acknowledged that what I observed was far beyond this: that the use and experience of these systematic forms of reasoning occurred as part of a performance, and enacted forms of existential engagement. Understanding reasoning as performative from the beginning opens up these possibilities, which I will pursue in the remainder of this thesis. I recognise these as inseparable from reasoning 'strategies.'

Chapter 8 extends the framework of chapter 7 by exploring the tension between the sources of knowledge and authority, how these give rise to reasoning, and how they are actually utilised in practice. Tension is evident in the contrasting interpretation and use of theory, texts, and clinical expertise. While referencing historical texts – in particular Hahnemann's – as key sources of authority, it is clear that theoretical knowledge and *praxis* are in tension.

Understanding reasoning as performative opens up an analytic space in which we can really get to grips with understanding reasoning not as it is narrowly understood (as I anticipated it) but as a form (or forms) of praxis. Praxis, while represented in professional action based on clinical experience, also includes practical knowledge, ethics, and professional wisdom (or *phronesis*). Praxis connects theory and clinical practice, at the same time also reflecting individual professional understanding. The results, taken together, demonstrate that homeopathic clinical reasoning incorporates multiple forms of interpretative praxis, and it is predominantly what I observed the participants doing.

Praxis as a form of close engagement and existential meaning-making was highly valued by the participants. It is examined in Chapter 9. Here, I describe the phenomenological space and hermeneutic engagement between the participants and their patients, as a means to understanding how the meaning of symptoms and illness experience is co-constructed. Understanding that reasoning is genuinely performative, I then consider it as a form of ethical practice.

Knowledge, and the production of knowledge, is axiological; it is never value-neutral. Knowledge, and the application of that epistemology, is necessarily permeated with the values of its practitioners (Carter and Little 2007, Little, Lipworth et al. 2012). The participants expressed divergent values, attitudes, and beliefs about the meaning of illness and disease for their patients. This tension, explored in Chapter 10, acknowledges that while practice is imbued with practitioner values, it is still enacted ethically. While this appears paradoxical, it illuminates that ethical practice is at the core of the relationship between clinical reasoning as an enterprise, and the development of professional identity.

7.2 Caseness

The core mode of activity that I observed among my participants was taking a case. This is what absorbed most of their time; it is what they used as the overall structure and framework for determining a diagnosis and a treatment plan; and it was the overarching social and conceptual structure in which reasoning occurred. I have called the framework of this activity *caseness*, although a literature investigation confirmed that the term was widely used in the 1970s and '80s, mainly in the psychiatric context (Selzer and Carlin 1997, Ostergaard, Foldager et al. 2010)

Caseness is as it were the architecture within which contextual space is framed. What follows is an exploration of the phenomena of caseness. Caseness encompasses the inseparable components of clinical reasoning. This chapter explores caseness as the tension amid *empirical mechanisms* and the *interactive performance* between the homeopath and her patient. This tension was manifest in the diverse strategies I observed, and confirmed in our post-consultation discussions. Here, the main focus is the mechanisms; performance is considered, but is examined more closely in Chapter 8.

Caseness entails a cycle of interpretation and reinterpretation of narrative dialogue. Interpreting narratives in order to isolate the salient features and symptoms from the background noise can be difficult, and this was not easily explained by the participants. The participants utilised caseness as the central interpretative device. All of their observations,

insights, notes, questions, reflections and decisions were interpreted within a caseness framework, through which meaning was at the same time constructed.

As I observed a multiplicity of techniques, in aggregate homeopathic clinical reasoning amounted to considerably more than the mechanisms described in the PHIRM model (Burch, Dibb et al. 2008). The participants unquestionably demonstrated pattern recognition, hypothetico-deductive reasoning, intuition, and remedy matching, but they did much more than this. Most striking were the *interactive*, *performative* and *intuitive* qualities of engagement, demonstrating that reasoning is a lived, dynamic phenomenon. As the data were collected and coded, I noted a recurring relationship between specific clinical skills and techniques, and an overarching interpretative connection enacted between the participants and their patients, a phenomenon recently explored (Eyles, Leydon et al. 2012). The impression was that performing caseness was *a hermeneutic process*, a recursive, interpretative activity geared to the production of meaning.

While the term *case* is integral within the homeopathic vernacular, *caseness* is not; I have adopted the term caseness because it embodies the dynamic relationships between cognition and action, between understanding and behaviour, between context and relationship, between the homeopath and her patient. The diverse constructions of clinical evidence and representations of *the case* described in this thesis reflect the multiple ways in which the participants *understand*, *interpret* and *perform caseness*. Notably, earlier references to caseness were as much to do with defining the criteria whereby a patient might be made to 'fit into' a formal definition of a disorder, thus becoming a 'case of' a particular diagnostic category.

The *case*, *case history*, *case taking*, *a case of disease*, *the case of a specific medicine*, *understanding the case*, and *case management* were utilised repeatedly and interchangeably by the participants. Case variously referred to the patient, to the disease or condition, to the remedy selected, as well as to the process and the interaction. Once coded these were collectively incorporated into caseness as an analytical category. *Caseness* was constructed and performed in multiple ways by the participants, representing its value as ontological and epistemological frames.

7.3 The justification

Caseness is constructed within a dialogic narrative between the homeopath and her patient (Kaplan 2001). Eliciting and exploring clinical symptoms, historical medical details and narrative experiences constituted the core components of caseness. These are standard structures for homeopathy, being the central features of case taking.

Caseness demands attention to detail, systematic selection of characteristic symptoms, thorough differentiation of the chosen symptoms, comparison of possible medicines and finally, the selection of a homeopathic prescription. Bruce's approach is predicated on assumptions about what constitutes a *definite reaction*, as well as how he *tests* for the selection of the *right remedy*. In short, Bruce does not tolerate a high margin of error. He was quick to refute popular claims that homeopathy lacks an empirical evidence base (Goldacre 2008, Ernst 2011). Reflecting at length on a child with epilepsy he had been treating, his description depicts the rigour he demanded of himself (Bruce DS 41 lines 52-92):

She had so many symptoms. I mean she wasn't being (allopathically) treated, that helps in a sense because you get this florid picture yes, she had this bizarre thing where I saw her, and she would come in to the consultation room. First of all she just tore the place apart; she was a wild child, she was throwing books around ... normally when a child comes in I'll get the toys and she was yes, she was, both her parents were here and they were trying to manage her and all that kind of stuff. So she had all of those symptoms, in a sense the child was doing the remedies, that really, in terms of case taking ... but her symptoms were you know, she would have myotonic jerking, where her arms would just seize up like that and she'd do it repetitively like that, she would have absences and then sometimes she would fall down and I could see her during the seizure so it was a nice observation of the case going on there. So yes, as I said, we tried the Stramonium, her behaviour improved, they wanted to continue, they liked the improvement in her behaviour but there was not change in the seizures and (*none*) no, none at all which was interesting (*yes interesting*). Because actually

when I looked at the good reliable Materia Medica, Stramonium seemed better indicated than Belladonna on lots of levels (*yes*) actually. Yes and as I say there was this thing with her seizures where she would turn around where should do a 360 rotation after a seizure, I thought *that was very strange* and *when I looked at the literature* about rotation seizures *they're very uncommon*, so I thought that was a useful symptom, so I looked up at all this kind of rotation, turns in a circle and the Stramonium had that, I thought you know *that's a nice little '153 symptom'*⁷² you know, I looked at the literature, the epilepsy literature and it says they're very uncommon, it's very rare, so *I take that as a characteristic symptom*. So it all looked like Stramonium but they (the parents) say improvement in behaviour, general amelioration but no change in the (epileptic) complaint ... So anyway I changed to Belladonna. Her behaviour improved and her seizures improved, they got better, less frequently and then it kind of plateaued a little bit ... she stopped having seizures (*yes*) yes, so that's where we're up to at the moment.

Reflecting on his clinical observations Bruce emphasised the pull towards assurance. Combining close observation with pattern recognition, Bruce steadily built a portrait of the child's condition, confirming the salient ('153') symptoms through hypothesis generation and deduction. For Bruce, this attention to observation, to empirical data, is evidence that the accusation that homeopathy is not based on reliable evidence is groundless. Emphasising exact observations of the child's general behaviour (*wild child*) as well as specific epileptic features (*myotonic jerking, absences, falling down and rotation after seizures*), Bruce identified the medicine he believed most likely to help reduce the seizures. Confident in his observations, Bruce clearly trusted that the child's presenting behaviour and epileptic symptoms furnished him with the evidence he required in order to prescribe accurately. Unlike most of the participants, Bruce subsequently searched the academic epilepsy literature in order to better understand the unusual features of this particular child

⁷² Bruce's 'nice little 153 symptom' refers to aphorism 153 in Hahnemann's Organon of Medicine. Here, Hahnemann points explicitly to the importance of the 'striking, peculiar and characteristic' symptoms in every case of disease as being the most likely to direct the homeopath to the selection of the appropriate homeopathic medicine.

and her condition, and to confirm the relationship between her symptoms and those most closely matching in the materia medica.

Bruce (DS 42: lines 7-9) was explicit regarding the need for diligence in order to capture every detail:

When I take the case, I take a good first case, that's important. I want to get a clear understanding of their disease, their different diseases, and their history, all of that kind of stuff.

Caseness here is clearly both a process and a product or outcome of that process. In Bruce's experience, *understanding* the patient's disease, perhaps their *different* diseases⁷³ is driven by the need for warranty, reminiscent of the empirical rigour Hahnemann practised and made explicit in his *Organon*. The combination of close observation, systematic symptom analysis and reference to the clinical literature demonstrated Bruce's attention to holism through the conscientious attention to detail.

Bruce made pertinent observations and tried to find a 'right' answer, particularly by consulting the *Organon*. He then compared the outcomes of one prescription with the outcomes from another. According to Bruce's standards, this demonstrated the empirical rigour of caseness. Caseness of the detail and rigour that guided Bruce was not demonstrated to the same degree by all of the participants. The diverse mechanisms utilised by the participants ranged from structured and formal check lists to more informal and casual symptom gathering and analytical strategies. Fiona commenced every consultation with a structured list of introductory questions, collecting a broad range of information regarding the reasons for presenting. This approach enabled her to generate an initial sense of the patient's problem or problems. For the participants, as information was processed a

⁷³ Generally speaking, patients visiting a homeopath present with one or multiple symptoms and problems. The homeopath's duty of care, like the general practitioner, may require clinical analysis, prescribing and management as well as referring the patient for specialised consultancy and tests.

subsequent set of questions tended to yield better articulated symptoms and medicine hypotheses.

Movement between formal and informal structures mirrors the assertion that experienced doctors do not consciously distinguish between analytical and intuitive reasoning approaches in practice, the likes of which they are taught in medical schools (Custers 2013). Rather, most of the participants, like Bruce, expressed a strong *need to know*, and to *understand their patient's diseases* in great detail. In order to *know*, they oscillated between analytical and non-analytical skills, while remaining firmly engaged in hermeneutic interaction in order to generate meaning. In a sense, what I observed the participants doing is difficult to capture analytically, because what they were doing was in some way *anti-analytical*. Part of the problem of articulating lived experience is that any interpretation unavoidably loses what can only be captured while engaged in the act of observation. The participants therefore operated within complex forms of knowing that cannot be mapped hierarchically (Barcan 2011), while incorporating knowledge, skills, beliefs, values, and intuitions about their patients.

Other than Fiona, the participants seldom utilised case taking forms or questionnaires;⁷⁴ there were few fixed data collection tools employed. This contrasts the predominantly mechanistic history taking method acquired by homeopathic students, focused on presenting complaints, medical history and body systems (the 'head to toe') analysis.

In contrast to the majority of the participants, James preferred to gather conventional 'hard' clinical data. For James, medical tests emphasised the value of his justification, both for himself, and for his patients. First developing a medical diagnosis in order to then consider the patient's symptom totality, James explained (DS 44: lines 377-381):

Well that's when I order a test ... and I'd say "well this test will show us these things and from that we'll be able to make a diagnosis." I think a lot of (the

⁷⁴ During my visits to homeopathic clinics and hospitals in India, I had noted the ubiquitous use of case questionnaires. Although useful for data and patient management, I found such questionnaires privileged the collection of static data, while reducing the capacity of the homeopath and the patient to explore meaning, for example, through psychosocial phenomena.

problem with homeopathy practice is that people prescribe on the totality of symptoms, without knowing what they're treating. I think that *knowing what you're treating has to come before you choose the remedy*, before you repertorise the case.

James emphasises the need for diagnostic certainty as a priority. Bruce identified that his clinical reasoning rested upon conventional elements derived from Hahnemann (DS 42: lines 454-457):

We need to understand *the case* ... and we need to understand *characteristic symptoms* ... and we need to understand *our remedies* through *the proving*. The proving is an exact mirror of your case and we have to match these two together. That's the process. There's *not much room for intuition* there.

Let's test if it works (*yes sure*). I wanted to see a *definite reaction* to that. If not, it's not the *right remedy*; I'll try Lycopodium ... good (Bruce DS 42: lines 33-35).

Reliance on observation and hypothesis testing distinguishes homeopathy from (conventional) evidence-based medicine which (at least in clinical trials) theoretically retreats from trying something and seeing if it works. Knowledge derived from laboratory tests was not mandatory, although Bruce, James and others utilised it sometimes. A homeopath is instructed to trust her sense observations. Bruce tested the individualised homeopathic medicine according to homeopathic convention, while James preferred to confirm his homeopathic analysis with data from diagnostic tests.

Bruce balanced careful history taking, clinical understanding through recognition of symptom hierarchy, knowledge of materia medica or pharmacotherapy, and professional or clinical judgment, or how to combine knowledge of medicine with knowledge of disease. Bruce's statement more or less replicates Hahnemann's theory.⁷⁵ Bruce's framework had

⁷⁵ In the Organon of Medicine (Hahnemann, S. (1810). The Organon of the Rational Art of Healing. New Delhi, B Jain Publishers.), aphorism 6, Hahnemann succinctly describes what is needed in order to be a judicious and rational physician: knowledge of disease, knowledge of medicine and knowledge of how to adapt the former and the latter in each and every case of disease. This framework is more or less a mirror of conventional medicine, despite the fact Hahnemann depended on clinical findings as pathology tests were non-existent.

little tolerance for intuition. He acknowledged that pattern recognition may rapidly yield a potential homeopathic diagnosis, much as rapid pattern recognition has been demonstrated to be central, although not necessarily accurate, in expert conventional medical reasoning (Norman and Eva 2010). So, while Bruce accepts that caseness is embedded within the patient narrative, paradoxically he only trusts the narrative up to a critical point. That point, for Bruce, ends with the recognition that the search for, and interpretation, of his patient's actual *symptoms* is privileged in his analysis.

Justification in caseness meant different things to the participants, representing the tension between the forms and degrees of knowledge required in order to diagnose, prescribe and manage each case.

7.4 Algorithms, patterns, and portraits

In this section, I explore the clinical reasoning tools - typically useful in conventional medicine - which the participants utilised, sometimes deliberately, more often tacitly and intuitively. This reflects the way that reasoning has been conventionally understood as a set of cognitive tools, and the ways that it has been analysed and characterised. This enables us to consider the way many of the core aspects of conventional reasoning have become embedded in caseness, though they are not explicit in homeopathic pedagogy. Most of the participants consequently lacked the knowledge with which to practice these skills deliberately and confidently. Some, including Bruce, James and Fiona applied these tools relatively systematically. Others, including Veronica, used pattern recognition as an analogue, adapting it from conventional medicine as a bridge connecting parts of the case to the whole in order to make meaning. This finding points, once again, to how I am treating reasoning as existing within a contextual space between empirical and existential modes of understanding and engagement.

7.4.1 Algorithms

An algorithm is a logical step by step process designed to solve a problem after a limited number of steps. Prior to the data collection, I had anticipated that the implementation of

algorithms would constitute an important tool for the participants, and one needing to be investigated. This differs considerably from the spacious mechanisms and unrestricted performance that the participants employed. Fiona, describing how she processed information, discussed the mechanisms she deliberately employed (DS 14 lines 56-78):

Fiona: *I've got a little bit of a pattern* that I go through where I get the information *I like* to get, so that I've got a good foundation for understanding the case overall. ... I also find I guess I work through a tick box system in my head where there are specific things that I know help me for my prescribing in terms of how I understand a case, so I like to get that information in so I can tick a box or cross a box.

David: Yes, how do you go through that tick box in your head?

Fiona: I guess it's like shutting gates, opening gates, shutting gates, opening gates, according to the responses they give to particular things, because already I guess I'm flagging remedies in my head that might be appropriate for this person and bringing them in, ruling them out, bringing them in, ruling them out and going down different pathways to see whether the gates open for that remedy or whether they're shut for that remedy; can't explain it any better than that.

Reflecting on her analytical process, Fiona identified how she used a modified algorithm to guide her behaviour. Fiona articulates how she deliberately collects, deductively filters, and refines the data-symptoms in each case, somewhat analogous to Bruce's filtering and funnelling. Her approach approximates research into homeopathic clinical reasoning which pursued the effectiveness of algorithms (Van Haselen and Liagre 1992), for example in the treatment of acute and chronic middle ear infections. Importantly, in terms of limiting possible pathways, the use of an algorithm is more effective where a prior correct medical diagnosis has been made. In many cases however, the participants were confronted with patients with undiagnosed illnesses. This limits the utility of an algorithm.

Bruce was *the sole* participant to make specific reference to the use of algorithms as a reasoning procedure (DS 42 lines 157-163):

In terms of your algorithm, it's very structured and limited, and when I was, because I was still nursing when I was training (to be a homeopath), so I used to interview patients, I used to stop doing that and I used to kind of just say "like, tell me what's going on" and be *very much more flowing or directed* about what the patient was interested in and I used to get more, much more interesting information from that. So when I used to go to hand over I used to say "did you know that the patient has this or had this experience?" and people would say "how did you know that, how did they tell you that?" It's not the sort of thing that you ask from a routine, clinical assessment of someone in psychiatry.

Bruce's experience captures the polarisation between empirical techniques and data generation, and reasoning as a narrative and performative phenomenon. Bruce draws our attention to the trade-off between accurate (but limited) data and a rapid diagnosis (at least a diagnostic reference point) on one hand, and the subsequent loss of rich patient narrative, on the other. His perception of the limiting effect of an algorithm challenges the possibility that its careful employment might generate a rapid (and accurate) diagnosis. Bruce could not justify the loss of rich narrative an acceptable cost of rapid diagnosis, having formerly experienced psychiatric nursing interviews as limiting. While arguably suitable in urgent circumstances such as the assessment of suicidality, or hypertension in the emergency department (Fisher, Greenwood et al. 1989), the *deliberate* application of algorithms was seldom identifiable in the data.

7.4.2 Pattern recognition

Predicating the entire theory of homeopathy, the principle of similars can be reinterpreted as a method of pattern recognition. Homeopaths theoretically match patient symptoms to known HPT pictures, and patient portraits to rich descriptions in materia medica. The praxis

of homeopathy engages the homeopath and her patient to elicit all the symptoms, gradually distilling them so as to identify those which are characteristic for the patient, and equally distinctive in the closest matching homeopathic remedy.

The 'little pattern' Fiona enacted was actually a well-rehearsed sequence blending her modified algorithm (opening and shutting gates) with pattern recognition (flagging remedies). I had noted that she utilised this little pattern from the outset in each case, with *every* patient. Her internal tick box system enabled her to rapidly check for the reliability and validity of the available evidence. Opening and shutting gates and flagging remedies demonstrated internally filtering and reducing the evidence, carefully eliminating certain homeopathic medicines and hypotheses in preference for others. The logic and order of her sequence had an algorithm-like orientation, although it was not limited to a fixed set of questions and pathways, and so not necessarily reproducible. Importantly, Fiona herself never articulated her tick-box system as an algorithm.

7.4.3 Portraits

For Bruce, constructing a portrait represented a conscious process of filtering and funneling. This contrasts with the rapid, diagnosis-driven filtering and funneling he was accustomed to in psychiatric nursing (DS 42: lines 156-160):

Consults that are driven, that are directed, that are, to use the funnel metaphor, are *funnelled too early* as they are in psychiatry or in medicine in general ... you come and see me and you're depressed and automatically I'm thinking "well alright well I need to check his early morning wakening and his appetite and his diurnal mood variation blah, blah, blah ... and I need to assess his suicidality."

Bruce viewed conventional (psychiatric nursing) practice as too limited, and was cautious as a homeopath not to *narrow his frame* prematurely.

In my own practice, a child may present with an undiagnosed condition (which, for example, may or may not be chronic otitis media), and so a specific algorithm may be inappropriate.

Similarly, many participants treated patients with undiagnosed conditions. In medical homeopathy, where a clinical diagnosis has been made, an algorithm might be appropriate, for example in the management of fibrositis (Fisher, Greenwood et al. 1989) and to inform the decision-making and treatment options in patients with chronic hearing loss (Spence, Thompson et al. 2005). My data do not support the routine application of algorithms, although some authors (such as Souter 2006) assert that Hahnemann intended homeopathic reasoning to adopt algorithmic principles. This claim is appropriate if we consider Fiona and Bruce's experiences.

In his quest for a coherent justification, Bruce understood that certain situations demanded focused attention towards limited information. In his desire *to know* his patient, he could be flowing or directed, not constrained by the diagnostic mechanisms. Most of the participants did not have the experience with which to draw this distinction.

7.5 Heuristics

Heuristics are 'strategies that ignore information to make decisions *faster, more frugally, and/or more accurately* than more complex methods' (Gigerenzer and Gaissmaier 2011). Conventional medicine seeks to minimise decision error, while acknowledging the complexity of decision uncertainty (Charon, Brody et al. 1996).

Heuristics theorists Tversky and Kahneman identified three fundamental general purpose heuristics: *availability, representativeness, and anchoring and adjustment*, each associated with the capacity to make probabilistic judgments according to information in a given context (Tversky and Kahneman 1974). Heuristics serve the purpose of reducing the effort associated with a task such as decision-making when faced with complex information (Shah and Oppenheimer 2008). Algorithms, in contrast, follow a defined sequence of steps which in theory yield a definite outcome (although, once applied, not necessarily the correct outcome).

For most of the participants, the manifestly obvious heuristic device was the 'keynote symptom,' a commonly employed shortcut to homeopathic remedy selection. Keynotes are

employed tacitly, automatically, and are geared towards saving resources in the decision justification. The participants never suggested that the keynote, or any other heuristic device, was a form of probabilistic decision-making. In all likelihood, this reflects the fact the participants (non-medical homeopaths) are not usually confronted with critical (emergency) decisions.

There were many examples of the use of keynotes. Pauline provided an example of keynotes as a heuristic device. Referring to the explicit, abrupt behaviour of a three year old boy in her consulting room, she remarked (DS 19: lines 165-169):

I'm thinking "oh maybe Sulphur has come up now" but it wasn't there in that rubric.⁷⁶ Then I saw Hyos was and I went "oh *of course*, he came in on his tippy toes" and then I noticed his hands down his pants, and so a few things kind of gelled for me and of course he's been bashing into his brother and *I went click, click, click in my head ... this is Hyos.*

Deconstructing what she meant by '*click, click, click in my head*' Pauline rapidly arrived at Hyoscyamus as the most likely medicine. In this instance, the behavioural features (*walks on toes, fondles his genitals*) represented striking or *keynote symptoms* that Pauline had memorised. Keynote symptoms therefore form a cluster of information representative of a homeopathic remedy, and may be applied with some clinical effectiveness. Pauline subliminally accessed representativeness and availability heuristics. Once Pauline's decision had been made, she did not retract it. She did not, however, reflect the possibility that bias – such as her knowledge and experience of certain medicines to the exclusion of others, or her subjective observation – might lead to errors of judgment or decision-making. This advances questions of the salience of symptoms, whether the homeopath utilises the representative heuristic habitually, and whether it is deliberately or unintentionally applied.

⁷⁶ The term rubric denotes a symptom (or sub-symptom) within a repertory (or symptom index). Each rubric contains the abbreviated names of one or many homeopathic medicines. Each of the abbreviated medicine names is printed in one of three fonts (or four, depending on the specific repertory used). The font applied to the medicine in each rubric acts as a code for a particular value (or weight) given to each specific medicine.

The anchoring and adjustment heuristic is theoretically recognisable when making an estimate from a starting point (the anchor), which will shift (adjustment) as further data and measurements are obtained. Examining a child with a skin condition such as eczema, Rebecca observed *marked redness, inflammation, dryness* and *skin irritation*. She employed the anchoring heuristic in the selection of the homeopathic medicine Sulphur. Here, Sulphur acts as a diagnostic reference point, or anchor. As further information is elicited regarding the modalities - the circumstances aggravating and ameliorating the child's eczema - and other symptoms from which the child suffers, adjustments will be made, theoretically resulting in a broader differential homeopathic diagnosis. Problems with anchoring and adjustment are attributable to factors including anchoring too early and rapidly, as well as to under- and overestimation in adjustments, leading to potentially significant errors.

In the quest for rigorous decision-making, algorithms, pattern recognition and heuristics are overlapping tools. Although technically discrete cognitive mechanisms, their use by the participants was mainly instinctive and often rather haphazard.

7.5.2 Pattern-portrait heuristics

Reflecting on how she interpreted the preceding case, Veronica observed (DS 37: lines 144-146; 160-163):

Yes, definitely it's a pattern, it's *almost like* a pattern recognition, because that's what the Materia Medica is; that you're recognising the pattern of the person, with the pattern of Materia Medica that you have.

... a doctor's looking for a pattern recognition of a *certain part*, whereas we're looking for a pattern recognition of *the whole*, you know, like so it's not just ... it's *the mind and body and spirit of the person* that we're looking for, that we're trying to recognise the pattern of, yes.

In homeopathy, recall of recognised *disease patterns* and of homeopathic *medicine patterns* depicted in homeopathic materia medica is conditional upon understanding the case and

prior experience of similar or matching cases. This is typical within homeopathic praxis, and can lead to the formation of a rapid decision.

Veronica's interpretation speaks to two distinct discourses within homeopathy. Firstly, the discourse that pattern recognition can be taken literally, understood as a metaphor for the principle of similars. In as much as a pattern can be perceived within the patient's symptom matrix, homeopathy strives to find the pattern, to understand the pattern within portraits described in materia medica and to make sense of, and with, the patient.

The second discourse to which Veronica's interpretation speaks is the distinction between a pattern in some *specific part*, such as liver disease, and pattern recognition of the *whole person*. Veronica's interpretation infers the central discourse of holism in homeopathy, distinguishing it from theoretically reductionist reasoning in conventional medicine. This discourse, while drawing a theoretical line in the sand between homeopathic and conventional medical reasoning, is less clear in clinical practice. The data reveal that each participant constructed her own understanding when determining which symptoms constituted *the parts* and which represented *the whole* case. Variation was observed and noted from participant to participant, and from case to case. Arguably, the distinctions Veronica makes capture the essence of the two discourses: the former acknowledging that the principle of similars represents pattern recognition; the latter that an understanding of the patient's symptoms and their relationship with homeopathic materia medica underpin the holistic quality of the homeopathic clinical reasoning process.

7.6 Beyond justification: grappling with uncertainty

The search for reliable information, characteristic data and a reproducible method – in short, the quest for accuracy - was not representative of all the participants. For some, the absence of an apparently deliberate structure was evident, approximating the *woolly model* Allan described. When asked whether a theoretical framework or model underpinned his clinical reasoning, Allan replied (DS 28 lines 24-34):

If there's a model that underpins it then no, you know. I often think about a lack of, well the way in which our instructions in case taking have changed over the years from Hahnemann through Kent and Schmidt and Jonathon Kaplan ... and Sankaran ... but a model? No I don't. I mean I'm aware that for example now when I do supervision I use, you know, god what are those models? I've forgotten already but I've realised that there are, there's quite significant work happening in nursing and psychotherapy on the development of a model, you know, like a really sensible model (*yes*) but as far as I know, *we've got a pretty woolly model.*

The woolly model Allan describes is pertinent in view of the tension between empirical and existential modes of clinical reasoning. Allan's woolly metaphor can perhaps be equated with an eclectic 'flitting from approach to approach' that has been described (Souter 2006). Allan and others acknowledged a range of theoretical traditions (Hahnemann 1810, Kent 1900) and case analysis models (Sankaran 1991, Sankaran 2000, Kaplan 2001, Schmidt 2009), without necessarily utilising or committing to one model exclusively. The impression of wooliness, the lack of structure Allan described, was not evident among my observations or field notes. Rather, the inconsistency he describes represents the contextual tension, how the participants were drawn towards different aspects of the contextual space. They attended to empirical justification at one extreme, to existential meaning-making at the other, and moved between them in an apparently random manner. For Allan, the absence of a model disturbed him as he was aware that models were well developed in other disciplines.

At certain times and points within the contextual space, some participants adjusted their reasoning posture. James, while usually gathering empirical (medical) evidence – could also be far more pragmatic (DS 44: lines 262-265):

All patients who come are told to bring any relevant test results with them, when they come (*yes*) and that's necessary to rule out those kinds of things I've just talked about (such as thyroid) ... tests that I would organise myself, (in) maybe 50% of the patients I will organise some tests myself, I rely very heavily

on pathology tests. Where the patient doesn't want to do that, *I will have a guess, an educated guess.*

The tension between well-reasoned justification and uncertainty was conspicuous. James' reliance on pathology tests was an uncommon example of *conventional* empirical data collection. In all likelihood, this reflected the fact that all of James' patients came to see him with medically diagnosed conditions. This might be an appropriate *medical* behaviour, only that the participants were not medical doctors. Gathering clinical evidence by means of pathology tests was less common among other participants. Most salient was the contrast in James' reasoning in regards to clinical tests. However, if his patient did not want tests (for example due to the associated cost) an *educated guess sufficed*. This represents a curious reasoning paradox. On one hand, James demanded 'evidence,' in order to establish a clear and certain diagnosis. On the other, an educated guess was all he required. Where he utilised test results he apparently did so with the conviction that the information could only serve to benefit the patient. The paradox can undoubtedly be rationalised. This he justified in accordance with the need to search for an accurate understanding of causation (DS 44: lines 350-351):

Well that's when I order a test ... and I'd say "well, this test will show us these things and from that we'll be able to make a diagnosis."

Most of the participants were accustomed to patients presenting with undiagnosed conditions. This is not uncommon in homeopathy and mirrors my own experience. Allan, distinguishing the typical case from this particular case, emphasised the quality of *being situated* in relation to his patient's world – *being* in the sense of the Heideggerian 'dasein' (Lavery 2003) - as the very essence or central feature of caseness in his hands (DS 27: lines 24-30):

It wasn't a normal case, you know. A normal case, I think, is 'I have this problem, therefore we find about it,' but there's no modalities, sensations, concomitants to explore which is what I would normally do (yes)... it was more, actually to be honest with you ... my focus was *just about being with her (mmm) and finding*

out who she is and then the remedy is secondary to that. So that's, it's not always my approach, but it's my approach with her.

Determining that this particular case was not a *normal case*, Allan focused on the performance of *being with* his patient. In this instance, *being with* was the deliberate means with which Allan sought to know his patient in the deepest sense (although, one might argue, he could not know her even superficially without *being with her*). Here, caseness was primarily constituted in knowing and being with her as a person; disease diagnosis and remedy selection were secondary tasks. The focus on *being with* her is symbolic of the hermeneutic engagement between the participants and their patients. For Allan, being with this patient holds the possibility of actually knowing her, which he values ahead of remedy selection.

Critically, I understood Allan's interpretation of this particular case as being *not normal*. His patient had a diagnosed terminal illness, for which there was no known effective conventional treatment. For more than an hour, Allan took brief hand-written notes, seldom moving his attention from his patient. The casual and relaxed orientation facilitated the performance, caseness unfolding as a narrative interaction. As Allan tried to make sense of his patient's lived experience, living with a terminal illness, I tried to understand and interpret the composition of his experience, conscious that hermeneutic reinterpretation was inescapably imbued with my clinical experience. Allan's caseness was a trade-off between warranted reasoning and meaning-making. Given the patient's precarious disease state, Allan apparently accepted that meaning-making was of greater value for this patient, in this uncertain situation.

Caseness is not only cognitively constructed. It is performed, enacted, embodied, and experienced by players; modes of reasoning that contain existential value. The participants consistently referred to the importance of being *engaged* with and *connected* to their patients, both as a means to understand their humanity, and as a mechanism to generate clear symptoms and accurate diagnoses. This helps us to understand the contextual space, between an empirically precise homeopathy, and practice as a lived, enacted phenomenon, often ambiguous, and more oriented to meaning-making. It is not that the participants were

no longer engaged in the search for the correct (most similar) medicine. As Allan said “I’m a homeopath, looking for the (correct) medicine.” Rather, for some participants, being performative meant that reasoning required other forms of engagement. Here, I begin to explore these experiences, and will take them up in Chapters 9 and 10.

For Charlotte and Rosanne, narrative and narrative engagement were central to reasoning, enabling meaning-making, within which they achieved a degree of certainty in their analysis. Patient-focused, Charlotte shared her understanding of the meaning of her patient’s suffering through the following reflection (DS 53: lines 736-744):

I think the centre of all of it is suffering, that’s the central point for me, to understand the person’s suffering *before I’m thinking about my analysis or materia medica*, and in fact it’s why I still to this day never prescribe on a first consultation ... never do ... I’ve given myself the luxury and the patient the luxury of a full consultation, *pure case taking*. Can I really, really understand a person’s case before I make a first prescription? So they can start to work together, but the meaning, the central meaning to all of this, is about a person’s suffering and can I effect a change there.

Charlotte’s reflection holds some profound value – the notion of *pure case taking* without the need or compulsion to be other than wholly patient-focused. Her approach also has ontological value in that it endorses the real existence of a diagnosed condition; that it brings the suffering of the patient within a realm of reality. Charlotte’s approach reveals something of the therapeutic force manifest in her *pure case taking*. This therapeutic power is conceptualised in many other domains, and is examined in Chapter 9, and in the Discussion. Forgoing any urgent need to prescribe when her patients presented at their first consultation, she permitted herself and her patient *the luxury* of complete engagement in the process and as a foundation for a therapeutic relationship. Charlotte’s preference for pure case taking meant the deferral of any diagnosis or treatment intervention, while other participants preferred immediate decision-making. In their idiographic way, the participants enabled their patients to explore meaning in their illness narratives, each within a dialogue

that revealed the patients' beliefs and values, in addition to a catalogue of important and characteristic symptoms.

Charlotte focused on engagement, interpretation, understanding, and meaning-making, though not necessarily clinical or disease diagnosis. The relationship between performance and the acquisition of knowledge useful to understanding her patient was similarly expressed by Susanna (DS 87: lines 66-69):

Being able to be open, *and to be able to receive* whatever it is that someone has got to say is really important, because if that's not there, then they're not going to give you the information that *they need* to give you in order for you to make an accurate prescription.

Some participants utilised engagement skills as a means of interpretation, attaching significance to the qualities of their patients' behaviour. Veronica deliberately embodied her own gestures – intentionally mirroring her patient's – a mechanism she believed enabled her patient to feel at ease, enhancing a sense of empathy with him (DS 37: lines 38-44):

I do yes, sometimes I do, sometimes I notice it and sometimes I'll try to match it, so there'll be a couple of times when I'll try and do what they're doing, yes (*Why?*) Just I think the idea of trying to *make them comfortable*, you know, like trying to, you know, *just be the same as them* and just, you know try and maybe show some understanding as well, that *I'm understanding what they're saying* and sometimes when they do that it can be quite a difficult time, so if you can just sort of be there and show them that, I think that's really, really important, yes.

I had observed Veronica and her patient, a man in his thirties presenting with depression and insomnia, struggling to describe the difficulties in his marriage and his working life. Through embodied action Veronica enabled her patient to share his distinctive narrative, his gradual exposé facilitating the subsequent individualisation of his symptoms. Matching and mirroring her patient (*making them comfortable, being the same as them*), Veronica demonstrated reflective empathy (Bandura 2002). Within the informal setting, Veronica

broadly interpreted her patient, constructed *the case as a whole* allowing time and engagement for the case to unfold (Kliems and Witt 2011). Veronica utilised very few specific questions, her physically engaging approach the antithesis of Fiona's questioning, and opening and closing gates.

Interpreting and making sense of each patient narrative was predicated on subtle as well as overt techniques. Veronica and Susanna were each acutely aware of the need to be entirely transparent in order for their patients to feel comfortable to disclose themselves. At this end of the space, the existential interaction I observed, and which the participants tried to describe, was entirely non-analytical. In field notes I had repeatedly written *performance, engagement, space, connection, and meaning-making*. These performances were imbued with detailed narrative, depicting life histories and significant events, with few references to actual physical symptoms per se.

7.7 Intuitive 'reasoning'

Without necessarily being able to conceptualise what intuition is, all the participants in my study acknowledged that some perceptions about their patients were based on intuition. Only one participant thought that intuition arose from some kind of power outside herself. Participants acknowledged intuitive perceptions, in addition to intuitive hypothesis generation, in the form of intuitive homeopathic remedy hypotheses. Critically, most participants only utilised their intuitions when they felt they were valid and trustworthy.

Participants including Allan, Charlotte, Veronica and Rebecca openly acknowledged the role of non-analytic and sensory phenomena, such as *gut feeling*, in their reasoning. For some, intuition constituted a spontaneous function, while others were more cautious in response to their own intuitions, preferring to support their feelings with other types of evidence.

Allan differentiated intuition, or gut feeling in questioning, from decision-making that combined cognitive and visceral elements (Allan DS 28: lines 476-480):

You see for me ... my decision-making is a mixture of reasoning but feeling as well, because I don't choose remedies based on feeling but I ask questions based on feeling, so ... how I ask is as much visceral as intellectual ... yes.

Rebecca, reflecting on the development of her intuitive capability (DS26: lines 183-228) oscillated between trust in her own internal knowing, and the effect of intuition on the enhancement of therapeutic relationships. At length, she described embodied qualia, her sense of trust *felt as a visceral phenomenon*; a feeling quite literally *in her gut* enabled her to feel confident in her own judgment. Rebecca displayed explicit freedom and a sense of ease in her use of intuition (DS 26: lines 70-77):

It can be a gut feeling, like literally, *a gut feeling in the stomach*, it can be that I'll be drawn to what that patient says or stands out for me and then I'll hear it come up and up again throughout the consultation process, it might be simple as I said before, I open up the repertory and it lands on a remedy and I think "oh yes, why didn't I think of that before" and then you'll start reading (*materia medica*) and you think "oh my god yes, this fits perfectly".

In marked contrast to Rebecca's trust in her intuition, and Allan's attempt to balance reasoning and feeling, Bruce remained skeptical and non-trusting of *his own* intuition, with which he wrestled. In his practice, Bruce reflected (DS 42: line 457):

That's the process. There's not much room for intuition there.

Bruce's statement replicates Hahnemann.⁷⁷ Within Bruce's theoretical framework intuition was not acceptable. While Bruce accepts that caseness is embedded within the patient narrative, he only trusts the narrative up to a critical point. That point, for Bruce, ends with the recognition that the search for, and interpretation, of his patient's symptoms is privileged. Paradoxically, he distrusts the veracity of narrative while simultaneously

⁷⁷ In the *Organon of Medicine* (Hahnemann, S. (1810). *The Organon of the Rational Art of Healing*. New Delhi, B Jain Publishers.), aphorism 6, Hahnemann succinctly describes what is needed in order to be a *judicious and rational physician*: knowledge of disease, knowledge of medicine and knowledge of how to adapt the former and the latter in each and every case of disease. This framework is more or less a mirror of conventional medicine, despite the fact Hahnemann depended on clinical findings as pathology tests were non-existent.

depending on it as the vehicle containing the patient's disease state. This was problematic for him, apparent in the tension between his need for accuracy, over and above claims based on narrative and existential forms of engagement. For Bruce, being certain also points to issues of ethical reasoning, recognition of his responsibility for every decision, for every prescription, and for every patient.

Intuitive feelings at the end of the consultation were more likely to be trusted than those that arose early on, corroborating the participants' conviction in adhering to the logical rules of the prescribing process. These findings appear somewhat contradictory; indeed, the participants may have been inclined to provide answers and explanations that were non-controversial, aware that their experiences would be reported in the peer-reviewed literature. There remains a paradoxical disconnect between intuitive phenomena within the consultation experience, and having control over the intuitive process: as one participant noted, they felt uncomfortable talking about intuition, as they *feel that homeopathy needs to be seen as something that has a basis in science and in logic and in principles* (Brien, Dibb et al. 2009 p 5).

Other participants privileged narrative in their analysis, resulting in divergent reasoning outcomes. The point here is not a question of the *right* or the *wrong* clinical approach. Rather, the tensions in the data acknowledge the diversity of clinical reasoning forms, as well as defining questions regarding homeopathic epistemology. The implications of these tensions for homeopathy will be considered in the discussion.

7.8 Chapter summary

Clinical reasoning in homeopathy is constructed within and performed through particular forms of caseness. Caseness develops within a contextual space that moves between empirical symptom collection and differentiation, and existential meaning-making. Within the multidimensional space, caseness incorporates a complete symptom history as well as a psychosocial profile, including aspects of individual, social and family health. Additionally, participants explored important life events, significant milestones, key stresses and the manner in which each patient responded or adapted to their stresses and illnesses.

Symptoms and experiences were recorded in detail. The participants asked their patients to clarify and explain exactly what they meant, for example, by *personal loss* or *disappointment* in the context of their lived illness.

Hermeneutic interpretation linked the participants with their patients, and with their patients' illness states. The participants moved seamlessly between empirical and narrative styles (Greenhalgh and Hurwitz 1998). They demonstrated patient-focused communication, skills recognised in one study to be practiced more effectively in homeopathy than in other health professional domains, including conventional medicine (Hartog 2009). Some of the participants had clinical experience in non-homeopathic disciplines, including Charlotte, a qualified psychotherapist, Bruce, a psychiatric nurse, and Veronica, an art teacher. Most demonstrated sensitive and well-articulated communication skills, evident in the multiple complex cases I observed.

In order to understand the interaction between hermeneutic interpretation and reasoning mechanisms, I observed that participants needed to explore with flexibility, employing tacit and intuitive processes they took for granted in their ordinary daily work (Malterud 2001). Reflexively, I also recognised a methodological and clinical fusion of horizons (Gadamer 1975). Hermeneutic analysis, requiring detailed coding categorising and thematic development of participants' experiences into a coherent and meaningful whole, is not unlike the performance and mechanisms employed by the participants in their search to understand patients' illness experiences.

CHAPTER 8

Epistemic and clinical authority in clinical reasoning

8.1 Chapter introduction

Continuing the examination of theory and practice through the contextual space framed in Chapter 7, this chapter explores how the participants understood and utilised different sources of authority. The data explore how the participants utilised theory and iconic texts, in addition to sources of authority including clinical and received expertise. I endeavour to depict the flexible movement between theory-driven and praxis-oriented homeopathy. Once again, it should be kept in mind that the contextual space is a representation of the multiple modes of reasoning. Sometimes the dimensions of this space were emphasised through theoretical elaboration, more often by praxis, and sometimes they were guided by knowledge, skills and behaviours derived from other epistemes. The participants predominantly detour theory and historical authority, ultimately leaning on praxis: acting on their own experience, observation, and prior clinical results.

Each participant was unique in the composition of the sources of authority utilised. In most instances, the participants had few preconceived ideas regarding such distinctions. While some participants, notably Allan and Bruce, drew on specific theoretical frameworks, others, such as James, suggested that reasoning was less theoretically grounded. Clinical authority, however, received from teachers and mentors as well as personally accumulated, was consistently the dominant form of knowledge. In essence, praxis subsumed theory. This chapter explores the ways in which the participants experienced and engaged with this tension. It reconstructs the tension between theory, text and expertise in the clinical lifeworld.

The participants repeatedly cited examples of the relationships between canonical texts,⁷⁸ historical and contemporary authorities, and the development of their decision-making capabilities. Relatively few references were made to ancient medical or philosophical wisdom. This is curious, considering the principles (such as similars, vitalism, and Galenic humours) that historically predate homeopathy, yet which shaped homeopathy during Hahnemann's lifetime.

It would make sense to organise this chapter beginning with history and theory as sources of epistemic authority. I will instead first turn to the participants' clinical experience and received authority as sources of reasoning and decision-making. This reflects the key finding that epistemic and clinical authority was pre-eminently driven by praxis. However, this organisational preference should not distract the reader from the lived experience, the deliberate as well as the tacit movement between theory and practice across the contextual space that is being utilised to explore them.

8.2 Clinical (self) authority

As the data were collected and coded, a selection of references to sources and forms of clinical authority was organised into categories. Epistemic authority and clinical experience were predominantly bound together in the data, reflecting their implicit practical relationship. In the following texts, I have tried to disaggregate epistemic authority - for example knowledge of theoretical homeopathy, of biosciences, as well as propositional ('other forms' of) knowledge - from authority derived from the participants' professional experience. The self as primary authority emerged as a distinct driver of clinical reasoning, supported by textual knowledge in decision-making. The functions and value of clinical authority and its impact on the construction of clinical reasoning were pursued and developed.

⁷⁸ Certain homeopathic texts are canonical, 'classics' such as the original publications of Hahnemann, Bönninghausen, Kent, and Hering, being prime examples. Scholars might debate whether the works of Kent and Hering are as important as those of Hahnemann and Bönninghausen.

Although the participants sometimes recognised the relationships between established theory and their own practices, the texts revealed that they primarily trusted their own clinical experience as the preferred authority and as the key source of evidence for their decision-making. Unless they have some theoretical underpinning for their practices, personal clinical experience cannot provide self-justification; otherwise the epistemology of homeopathy would be circular or redundant. The authority of theory appeared limited to core principles and texts, which was then modified by the participants, becoming implicit in their practices.

The participants expressed this in various ways. Evaluating empirical observation and theory in her remedy selection, Rebecca (DS22 lines 17-28) remarked:

It's probably more of not so much a feeling but *a learned experience*. I've had situations before where I've chosen remedy A, B or C instead of the classically known constitutional medicine, which may not be the highest ranked or the most indicated at the time, but *from my experience in clinic, from clinical experience*, I find that going with the constitutional is a better choice than going with something that's a better fit for the chief complaint or the current symptom. So that's why I went that way in the end.

Rebecca's assessment reflects the tension between theory (utilisation of a constitutional approach) and practice (clinical experience), resolved through the assurance in her own clinical experience. For Rebecca, reliance on theory was not sufficient to justify the selection of remedy A, B or C. Her decision is underpinned by trust in her own clinical judgment, confined perhaps by the dogma of the materia medica. That is, she did prescribe within the repertoire of the homeopathic canon. Without either pedagogical reference or an evidence-base, trust in one's own praxis was expressed as an essential and justifiable attribute of clinical reasoning among the participants.

In her interpretation and analysis of an infant in utero with hiccups, Pauline theorised the following (DS 19: lines 321-329):

Pauline: Now, when babies have hiccups in utero *it's always a sign* that already the baby is reacting to something in the mother's diet. So I go back and I take a detailed diet history of the pregnancy. And she craved coffee.

David: Is that always the case in your experience?

Pauline: Yes, absolutely always the case ... absolutely always the case, it's a sign the baby will be colicky.

I could find no research to support Pauline's theory or her clinical experience.⁷⁹ I was struck however by the conviction with which she asserted her claim – diet was *always a sign*, and *absolutely always the case* - in her experience. Pauline's unsubstantiated claim was based on repeated empirical observation, which she privileged and of which she herself was the authority, in this and other clinical scenarios. With this *evidence* in mind, she calmly advised the patient to abstain from drinking coffee in order to avoid the baby's hiccups in utero as well as the *later risk* of her child suffering from colic. Privileging her own observation was central to Pauline's clinical reasoning. Rather than researching the literature for theories of hiccup in utero (as might Bruce), she expressed complete conviction in her belief, and subsequently shared this with equal confidence with her patient.

After she had finished taking the case of a three year old girl, I asked Pauline to explain her reasoning and interpretation of the case, to which she unhesitatingly responded (DS 21: lines 3-21):

So Medorrhinum⁸⁰ has this fear of being observed, you know, through the window (yes) ... that whole thing that they're going to be attacked from the back, that sort of thing, and I think that that seems to be quite big with her

⁷⁹ Research suggests that the neurological aetiology of hiccups is poorly understood Kahrilas, P. (1997). "Why do we hiccup?" Gut **41**: 712-713. although it is a normal element of foetal development. Most pregnant women report their foetuses having hiccups and it is known that the foetus drinks liquor (amniotic fluid) in utero Swann, I. (1978). "Intrauterine hiccup." British Medical Journal **2**(6150): 1497-1498.. It may therefore be a primitive reflex to prevent amniotic fluid aspiration. Hiccup may even, though rarely, be a presenting symptom in pulmonary tuberculosis Perry, S. and J. Stevenson (1996). "An unusual case of hiccups." Journal of Accident and Emergency Medicine **13**: 361-362..

⁸⁰ Specific homeopathic medicine prepared from an infectious pathogen.

(*mmm*) you know, with the clicking fingers and the excessive vomiting, I'm thinking Medorrhinum, maybe Thuja⁸¹, but then she moves her bowels as soon as she gets out of bed in the morning which is a Sycotic-co⁸² symptom (*mmm*) and you know, this is all about the gut, you know, she has this horrible feeling of nausea after she eats, obviously the gut flora is not doing what it's supposed to be doing ... she's really out of balance there and craving the sugar, craving sweet things. Which, I kind of thought about going with Saccharum⁸³ because of the thumb sucking and the wanting the mother ... but then she said she'd be happy with her father ... So it's not necessarily an obsession with the mother.

In our post-consultation discussion, Pauline positioned herself as the expert, the central source of authority in her decisions, which were executed with deliberate action (Benner 1984). As the observer and interpreter, I struggled to recognise (in any proving or other sources) multiple features that she described. I shall explain this for the reader.

Without further discussion, Pauline's initial point of reference was the homeopathic materia medica, the source of epistemic authority. Listening to Pauline reflect on the case my attention was drawn to the rapid, immediate links she drew between the child's symptoms (nausea after eating, excessive vomiting, and urge to stool on waking) and her apparent behavioural characteristics (including a fear of being observed, clicking fingers, thumb sucking and a craving for sugar). Swiftly generating homeopathic remedy hypotheses including Medorrhinum, Thuja, Sycotic-co and Saccharum, a process well described in the PHIRM model (Brien, Prescott et al. 2004, Burch, Dibb et al. 2008), Pauline simultaneously constructed a theory of the child's relationship with her parents, finally asserting that '*obviously* the gut flora is not doing what it's supposed to be doing.' Rapidly and confidently connecting these phenomena, she concluded that the child probably suffered from worm infestation. The execution of swift – though not necessarily accurate - heuristic reasoning is typical of expert or highly experienced clinicians (Bleakley, Farrow et al. 2003, Hilbig 2010, Gigerenzer and Gaissmaier 2011). Although I failed to immediately understand her logic (her observations, and her reasoning were not so *obvious* to me, my remit being to interpret her

⁸¹ Medicine prepared from a Coniferous plant, Arbor Vitae or Thuja Occidentalis.

⁸² Also a specific homeopathic medicine prepared from organisms within the human large intestine.

⁸³ Medicine prepared from sugar cane.

experience, not to analyse her patient), Pauline's diagnostic conviction and certainty in her own authority could not fail to impress the child's mother, or me.

Discussing a subsequent case, Pauline shared her excitement in discovering an accurate match between her patient's symptoms and those in her repertory. Pauline explained (DS 18: lines 71-79):

Well, I didn't expect to see the rubric in there; not so much the remedy but the rubric, and I'm always delighted when the rubric is there, the words that the patient says if they're in one of our texts, I just think "ahhh" you know ... isn't it just precious that the words people say have been said before and you know, *it's just the pages of human history really* just being repeated ... I get very excited.

Pauline had a sense of reassurance in the reliability of homeopathic texts. Its pages were reproduced, often accurately, through her patients' symptoms and expressions. Conversely, homeopathic rubrics and symptoms are subject to diverse interpretation, a phenomenon I recognised after some years in clinical practice. Reflecting on her patient's habit of snapping or cracking his knuckles, Pauline discussed the clinical application of two medicines (Thuja and Medorrhinum). Subsequently referring to the rubric 'Extremities, Hands, Fingers, cracking' Pauline understood this to be a behavioural (psychological) symptom. I, on the other hand, understood this symptom to represent involuntary crepitus – painless joint cracking – described by many patients when extending their limbs, for example their knees, on rising from a seat. The distinction here may lie with the inexactness of the rubric or the repertory selected, an acknowledged problem (Gadd 2009, Adler 2011). Variability between patients (and provers) must be considered. More often, and quite understandably, error (or rather inconsistency) lies in the interpretation of the homeopath. The reliability of the homeopath's interpretation of symptoms has been investigated (Brien, Prescott et al. 2004). In response to Pauline's interpretation, I explained mine (DS 21: lines 43-49) yet Pauline insisted that the behaviour was part of an obsessive-compulsive condition.

This interpretative distinction, one salient example, has broad implications for the accurate application of homeopathy. Pauline and I were familiar with the same symptom, as a clinical

phenomenon and as a rubric in our repertoires, yet our understandings were shaped by our distinct interpretations of its meaning. We utilised this symptom according to our interpretation of the same canonical texts. We each assumed a certain authority in our interpretation. And the data suggest the tendency to construct and reify them as we experience them. Reflexively, one cannot 'own' authority any more (or less) than any professional's authority is his or her own. Our individual decisions were not wayward fancies, but decisions crafted from different interpretations of iconic texts. Symptom observation and especially interpretation are intersubjective, like hermeneutic interpretation. Despite the exacting demand to find the most similar, suitable homeopathic medicine – the simillimum – the data demonstrate that *the pages of human history* are by no means fixed, but are interpreted and reconstructed (Schmidt 2012). And, once again, these *pages* are reinterpreted from within established theory and authority. Homeopathy would not still be homeopathy if this were not true, any more than conventional medicine would still be conventional medicine given all the changes in dogma and doctrine since ancient times.

Like Pauline, other participants explaining their clinical reasoning had the habit of taking lines directly from materia medica and merging their observations with clinical experience. In regards to the composition of the sources of authority giving rise to reasoning and decision-making, the impression was that most of the participants privileged their professional judgment, their own experience, over dominant theories.

After observing Allan with a patient he had seen for many years, I asked Allan to reflect on his reasoning (DS 28: lines 306-312):

I've sure got lots of clients like her. You know, she's a ten year work in progress ... With clinical reasoning, what underpins it, reasoning? *It's experience, clinical experience*, if that doesn't work, try that approach, try that, try that, keep them interested, keep them coming back, try that, try that, try that.

Guided by his own praxis, an experimental pragmatism permeated Allan's approach with this patient. Without reference to theory or other authority, Allan adopted a trial-and-error

strategy guided by experience. Allan's pragmatism is also guided in part by his observation that homeopathy is 'rather woolly,' lacking a definitive or consistent model (discussed in Chapter 7).

Pauline, displaying a sense of knowing deeper than mere *authority*, achieved three distinct hypothetical outcomes, pertaining to materia medica differentiation, to family dynamics and to a clinical diagnosis (DS 17: lines 71-78).

It's partly that because, you know, I go back to the body, she's definitely got some kind of, you know, inflammation in the nerves in the dermatome which, of course ... you're looking at Shingles or a remedy that has an affinity for the central nervous system ... But I don't know, *I'm privileged that having been a teacher that you know, you get to learn things twice and my knowledge of Materia Medica is very good* and ... so the phrases that come up, you know, *you kind of know where to direct it* (the consultation).

Pauline claimed that her capacity to *direct* the consultation was the result of greater than average knowledge of materia medica coupled with an ability to recognise specific key phrases that her patients used. Drawing upon her extensive praxis, she integrated propositional knowledge (of anatomy, pathophysiology and materia medica) with her professional craft knowledge (Higgs, Titchen et al. 2001). Utilising a phrase-recognition (availability) heuristic every time she heard a particular phrase or expression, Pauline rapidly accessed her extensive internal knowledge of materia medica and then asked her patient further questions in order to build and clarify the case portrait. Pauline possessed the self-assurance that her analysis was accurate and appropriate for this patient. While not a feature among all the participants, self-authority as well as confidence in such authority was implicit for Pauline. My field notes reflected numerous episodes of expressed self-confidence (some perhaps excessively ebullient), and the *knowing, accepting nod* I observed – a sense of diagnostic satisfaction, or relief - in many of the participants' patients in response to their homeopath's apparent clinical authority. Observing Pauline, I witnessed something barely tangible, an apparently deeper quality of her *self* as an authority. Pauline's

complete self-assurance was, as she expressed it, a manifestation of inner knowing, a level of knowing founded upon deep inner trust.

8.3 Received authority

Clinical experts were a highly regarded category of clinical authority among the participants. In the main, received authority was experienced favourably, having regard for the knowledge, experience and wisdom of past and living ‘masters’ of homeopathy. At other times, participants expressed concern regarding the knowledge imposed by specific authorities. Here again, it is crucial to acknowledge that epistemic and clinical authority are not entirely distinguishable in practice. In order to understand the diversity of participants’ experiences, it is important to think of these experiences across the contextual space that collectively gives structure, substance and meaning to clinical reasoning.

References to Hahnemann and his theoretical work in particular were frequently hagiographic. For some, there was little distinction between Hahnemann and his contribution to homeopathic medicine. At other times, participants struggled to identify the source or veracity of the authority shaping their decision-making. This gave an impression of the ambiguity of certain traditions, beliefs and practices. Despite these uncertainties, most spoke with conviction in the reliability of their historical mentors. Conceivably, the experience of being closely observed and questioned compelled the participants to be reflexive regarding sources of knowledge and reasoning, an experience to which most were not accustomed. They were clinicians habituated to being the observer, being the one who gazed, listened and interpreted, not to being the observed.⁸⁴

Veronica drew repeatedly upon Hahnemann and his theory as a central driver in her reasoning. It is worth reproducing here the almost poetic English translation of the aphorism to which Veronica referred, and recited verbatim:

⁸⁴ As Foucault observed: A hearing gaze and a speaking gaze: clinical experience represents a moment of balance between speech and spectacle. A precarious balance, for it rests on a formidable postulate: that all that is visible is expressible Foucault, M. (1973). Birth of the clinic: an archaeology of medical perception. London, Routledge..

In the healthy condition of man, the spirit-like vital force, the dynamis that animates the material body, rules with unbounded sway, and retains all the parts of the organism in admirable, harmonious, vital operation, as regards both sensations and functions, so that our indwelling, reason-gifted mind can freely employ this living, healthy instrument for the higher purposes of our existence (Hahnemann, 1982 aphorism 9).

Reflecting on her homeopathic training in the UK, Veronica explored the manner in which her mentor enlivened Hahnemann's philosophy. Paraphrasing her mentor, she remarked (DS 37: lines 208-216):

Yes, (aphorism 9) ... *the verb* is what the person must do, so that relates to *sensation* and *function* ... which is my favourite aphorism ... *So it's learning to listen to their language to find out what it is, where it is* ... I think I've taken lots of bits and pieces from all of my different teachers and lecturers and listened to them and put it all together into my own way of looking at it.

Developing her appreciation of aphorism 9, Veronica described how her mentor breathed new life into her understanding of the theory of Vital Force. Subsequently, Veronica acknowledged that her practice was an amalgamation of theory, expertise received *from various mentors*, and *her experience*, modelled into her own unique praxis. This example is typical of other participants who expressed how they fashioned together multiple sources of authority into clinical reasoning, an approach described in allied health (Higgs and Titchen 2001).

References to historical authority were embedded, as well as more structured and deliberate theoretical elaborations, sometimes given as justification for a particular diagnosis, prescription or management plan. Discussing a case that involved a complex sequence of life events, and her patient's reaction, Pauline reflected (DS 17: lines 11-17):

Oh, and there was a whole thing last time about ... there was an unexpected pregnancy and ... her father wanted her to be aborted and her mother rejected her. She was brought up by nannies and then horrible nuns and she had, you

know, she wasn't nurtured at all as a child (*yes*). So, I was thinking about all of that. Then, I often find that Tinus Smit's schema does pop up, you know, I often find after *Lac humanum*; oh, the other thing was she was given *Folliculinum* before.

Sharing her immediate interpretation, Pauline drew a series of connections, at the same time pathologising the patient's emotional state and her lived illness experience. Committed to her theoretical understanding and case analysis with reference to the *schema* of Tinus Smits,⁸⁵ she concluded that her patient required two specific homeopathic medicines. Smit's schema proposes that illness, including severe pathology, arises from imbalance of Seven Universal Layers, each layer being represented through the patient's level of emotional and spiritual disturbance. His treatment, rather than being based on provings in *materia medica*, is derived from medicines proved unconventionally by Smits and his colleagues.

In the case Pauline described, there were no physical symptoms or sensations, no named condition to confirm the diagnosis or prescription, an observation I made of cases with some other participants. Extrapolating from the patient's narrative, Pauline theorised that the patient had not been nurtured as a child and so lived in a particular *illness state*. Employing her knowledge of Smits' *schema* as a heuristic, she attributed particular meaning to the patient's emotional stasis, *Smits' schema* leading to her a rapid conclusion. At the same time, I understood Pauline's attempt to capture her patient's actual illness experience as a standard phenomenon for the participants. Possessing a commanding knowledge of *materia medica* and considerable clinical experience, rapid pattern recognition and heuristic schemas were straightforward practice for Pauline, and Fiona.

In reference to an elderly male patient with sciatica, Bruce (DS 42: lines 149-172) described how he had learned to deconstruct a case using a *wheel and spokes model* attributed to British homeopath Misha Norland.⁸⁶ In this gestalt-like model (Perls 1973), each spoke of the wheel represented one aspect of the patient's life or disease state. Viewed more closely, each or any one of the spokes analysed was considered capable of portraying the patient's

⁸⁵ <http://www.tinusmits.com/3734/home.aspx> last viewed 20 November 2016

⁸⁶ <http://www.yondercottagepress.com/authors/misha-norland/> last viewed 28 November 2016

whole, central disease disturbance. The patient's chief complaint, chronic right-sided sciatica, was represented by the materia medica of Kali Carbonicum, the symptoms of which *also matched* his psychological state *and* his respiratory condition. For Bruce, understanding the totality of the patient and his condition required an understanding of the condition, sciatica, knowledge of materia medica, and the capacity to determine the appropriate posology (strength or potency of medicine) necessary for *this patient at this particular time*. Beyond his epistemic construction of the case, Bruce described the process of drawing his patient into a relaxed narrative; a narrative which grew around an open, curious question about the patient's interests, in this instance his irritation with the selection of certain cricketers for the national cricket team. Reconstructing his interpretation, Bruce described how he had perceived and interpreted the patient's nervous irritability, manifested as annoyance about the cricket, and his chronic sciatic pain, as *two spokes of the patient's wheel*, or disease totality. Norland's 'wheel and spokes' represented the challenge to construct an understanding of the whole beyond static symptom details, through an examination of each and every sign, symptom, narrative feature, and historical characteristic.

Bruce, accepting the general utility of Norland's model in this case, retained a critical lens, diverging in his interpretation of its underpinning principle (DS42 lines 150-152):

You want to get to the centre of the wheel if you have *a centrist view* of prescribing, *which I don't*, but it doesn't matter which spoke you go down, you'll get there.

The point is that not all the participants accepted received authority uncritically. In the same manner, not all received authority was regarded with equal enthusiasm. While Hahnemann and his work were effectively quarantined, the participants were sometimes vehement in their critique of other experts. Reflecting on the influence of the prevailing culture of international experts, Leanne remarked (DS 59 lines 353-356):

I just remembered some of the examples when I have had my fingers burnt in the past. Do you remember years ago Dr Jones⁸⁷ came into an amazing seminar and it was all about Aurum? There was Aurum Sulph, Aurum Arsenicum, and Aurum Sil and so on. I was so impressed after that remedy, I was 'so Aurum' it lasted for a couple of days ... I mean, that's the mistake that I think I don't make so much anymore, of getting kind of *sucked in* by thinking "oh well, that's great, somebody from overseas has come and given a seminar" and I'm kind of ... "*this is not a good reflection on our profession or our professional integrity is it*"?

Leanne's reflection reveals how the feeling of being seduced by the wisdom of an eminent international educator led her into clinical errors, mistakes she recognised were the result of a lack of reflexivity. Knowledge received from an authority should complement comprehensive education, critical thinking, and cautious clinical application. Reflexively, Leanne recognised that careless prescribing had adversely affected her practice and her patients' results. On further self-analysis, Leanne demonstrated awareness of the ethical implications of her actions for the public and for the profession.

Susanna, too, had been reluctant to express her critique of another renowned international homeopathic educator (DS 89 lines 700-702):

I think he's just gone way out in a way which is just ... mmm ... yes. Whether that's may be my own prejudice, I don't like to say that out too loud ...

Susanna's experience revealed a paradox between the simultaneous need to defend and critique her profession. Reluctant to engage in careless or inflammatory critique, she was simultaneously attentive to the need not to accept a lack of precision among her mentors and colleagues. Susanna returned to this dilemma, alerting me to a related methodological dilemma: how to consistently engage the participants with fidelity in order to reveal the clinical reasoning lifeworld, devoid of being a conspirator in their professional frustrations, and without failing to reveal these difficulties.

⁸⁷ A pseudonym has been used here.

8.4 The authority of theory

The texts revealed the various modes of thinking, types of knowledge and interaction that underpin homeopathic clinical reasoning. Taken together, they suggest that reasoning is derived from multiple sources of authority and that practice operates as a complex, distinctly individualised phenomenon. Selected observations and participant remarks regarding these sources of reasoning provide insight into the phenomenon.

Within the data, the balance and relationship between epistemic and clinical authority was mostly indistinguishable. Coding and categorising the narrative texts allowed me to more or less disentangle the sources of authority, and their impact in the lifeworld. As a customary source of authority in clinical reasoning, the participants explored diverse understandings of theory, its scope and value in clinical practice. In this section, I examine specific theoretical phenomena as they were experienced.

During interviews I asked each of the participants in what ways homeopathic theory contributed to their clinical reasoning. Foundational theory including principles such as holism, disease, vitalism, the principle of similars, the selection of homeopathic medicine, and choice of potency were the main elements discussed. Other theoretical elements for example, Hahnemann's theory of miasms, or chronic diseases received little attention and appeared to bear limited relevance to clinical practice. This was surprising; given the regular attention the participants gave to Hahnemann's fundamental work I had anticipated greater insight into the participants' experience of his theory of miasms.

Bruce regarded homeopathy as theoretically founded upon a holistic ontology that establishes the *restoration of health* as the ideal form. Hahnemann is given as the authority (DS 40: lines 200-204):

So, aphorism one, at least in the Boericke translation, *a restoration of health*, it means that we have to take someone back along that road ... it's like a piece of furniture that you're restoring, you have to take off the bits that have been added and ... get rid of that awful 70s paint up and stuff like that. But, you have

to *understand the whole first*, and that's the purpose of the *therapeutic relationship*.

The holistic ontology Bruce depicts reflects Monica Clark-Grill's study of homeopathic doctors (Clark-Grill 2010). In Clark-Grill's account:

What we believe health and illness to be, or the ontology of illness, determines what kind of healing approach we use. Ontology of illness shapes the scope of the diagnostic gaze and defines what therapeutic responses are suitable. It also influences which methods can be used in the search for more knowledge (Clark-Grill 2010 p. 79).

Like Dr B in Clark-Grill's study, who was attracted to practising homeopathy because of its focus on *health* rather than the specific *treatment of disease*, Bruce understood holism as the *restoration of health*, underpinned within a *therapeutic relationship*. He perceived the holistic ontology as the guiding principal in homeopathy, distinguishing it from psychiatric nursing. For Bruce, the patient's entire illness is gradually interpreted through the vehicle of the therapeutic relationship. The distinctions between restoration and treatment, and between health and disease, epitomise an overarching holistic ontology of illness that is embedded in homeopathic philosophy and ritualised in practice.

In Bruce's experience, paraphrasing Hahnemann's theory in the Organon, the disturbance of the vital force reveals the symptoms of disease (DS 40: lines 17-21):

The symptoms are the expression of the disease, how the vital force shows itself, reveals its disturbance, and so for me homeopathy is simple, it's about matching the totality of characteristics, the most characteristic symptoms in the patient with that of the remedy and when you find that, and that works well, people are on their remedy for a while.

The participants were unequivocal in their commitment to the principle of similars. Deeply embedded in theory, and operationalised throughout caseness, it hardly warranted

discussion. In regards to prescribing, and the application of specific potencies, experiences diverged, as did the participants' understanding of the supposed source of authority.

Rebecca (DS 25: lines 19-32), reflecting her reasoning when prescribing *Calcarea Carbonica* 200c for a child, explained that she gave *only one or two doses of this medicine and potency* due to its *potentially long-lasting* effects. When I inquired regarding the historical or clinical authority for her reasoning, Rebecca referred hesitatingly (DS 25: lines 34-40) to a popular contemporary text (Sankaran 1991). This particular prescribing principle has been evident at least since the time of Kent in the late 19th century. Her erroneous reference reflected other participants' orientation to current homeopathic texts. In this sense, clinical reasoning exhibited certain logic, although not necessarily historical accuracy. Her reasoning, though inaccurate, gave an impression of assuredness in received theory. The error itself poses questions regarding the veracity of theory and the history of pedagogy, questions that cannot be answered here. It also invites questions regarding the robustness of prescribing practices, many of which were apparently based on received expertise, rather than being based on research or other empirical evidence.

Conversely, reference to homeopathic theory was never entirely distant and was sometimes a means of deconstructing and making sense of a patient's condition, in particular when assessing their response to an earlier treatment plan. Reference to theory was also used as a justification for a particular treatment plan. In regards to her interpretation of a child with eczema, Rebecca reflected (DS22 lines 33-39):

I was just looking to make sure whether the location had changed; is it now worse on one side as opposed to another; are the upper limbs affected? Because it's been on his arms and also his legs I wanted to see whether there was any change; the arms really improved and the legs not so much, so once again that's a whole *direction of cure* thing, that whole *Hering's law* in the back of your mind.

Hering's law, the direction of cure, a significant development in homeopathic theory and an important element in clinical training, was seldom discussed in this study. This law, or

principle, is considered the key theoretical contribution of Constantine Hering (1800-1880). It is utilised to determine the favourable or unfavourable *direction* of the patient's treatment. The reliability of Hering's principle is, however, not without some controversy in its interpretation. Applying Hering's principle, patients are considered to be improving when their symptoms are responding in a particular manner and direction. A lack of response according to Hering's principle may be considered a sign of an unfavourable outcome for the patient.

Reflecting further on her reasoning strategy (including the medicine, potency and repetition she had selected in treating a young child), Rebecca explained that these decisions were predominantly experience-driven (DS23 lines 15-32). Despite her theoretical knowledge and her understanding of prescribing frameworks, her immediate reference was to personal experience. Acknowledging her preference for clinical experience over theory, she then referred to what she called the *golden rules* of prescribing. These she stated (DS25:28-32):

... The more the match to the patient the higher the potency; you know, the less the simillimum the less (lower) the potency I use; the lower the potency the more frequent the dose; the higher the potency the less frequent the repetition.

Attributing these *rules* to Dr Sankaran (Sankaran 1991, Sankaran 2000), Rebecca was referring to the principle of selecting a highly diluted (yet theoretically stronger) homeopathic potency if the patient's symptom picture very closely matched the *materia medica*. The *rules* of the selection of potency and repetition were discussed by other participants. Others referred to prescribing *guidelines* and some to potency *theory*. The evidence from the texts as a whole suggests that these decisions are subjective and not universal, having evolved within a practice-driven oral tradition. This observation generates questions regarding the rigour and reproducibility of homeopathic prescribing methods and has implications for homeopathic education.

8.5 Authority of theory: Vitalism and holism

Although not unique to homeopathy, nor claimed by the participants as such, vital force and holism together constitute a distinct theoretical departure from the framework of conventional medicine. Indeed, holism has a tradition in conventional medicine, which is being re-energised by patient-centred and person-centred movements in clinical practice.

Homeopaths recognise the relevance and currency of vital force in the context of symptom interpretation and analysis. Vitalism, predicated on empirical (clinical) observation but as yet not verified, predates homeopathy by millennia rather than centuries (Rosner 1987). Although a core theoretical concept in Hahnemann's *Organon* it is contested (Bayley 1993, Bell, Lewis et al. 2004, Milgrom 2007). The claim of vitalism may require scientific evidence if it is to ever satisfy its critics, a position that has generated debate (Dean 2000, Jonas 2000, Vickers 2000).

Similarly, in Traditional Chinese Medicine, the principle of *qi* (or *chi*) is epistemically bound within its theory and practices (Herfel, Rodrigues et al. 2007). Vital force has neither theoretical nor epistemic relevance within the conventional medical paradigm, although it continued to be contested until at least the early 20th century (Windle 1920). Despite inconsistency in the way they apply the principles in practice, the participants concurred that homeopathic medicines *act upon* or *influence* the vital force in some cause and effect manner, resulting in measurable physiological effects within the material organism. Veronica (DS 38: lines 275-285) reflected on her ardent belief in the centrality of the vital force to the practice of homeopathy. Her adherence to Hahnemannian theory was more or less indistinguishable from her hagiographic appraisal of Hahnemann the man. Every participant made repeated reference to the vital force; as a theoretical principle, as an outcome of the patient's response to homeopathic treatment (change, increase or decrease in vitality) and as one of the core determinants in the selection of the dose, or potency, of the homeopathic medicine prescribed in every case. Vital force was entrenched in participants' narratives, part of an established discourse with which they framed their case analysis, and upon which they rested their clinical decisions and constructed their individual practice model.

Homeopathy is regarded as a holistic therapeutic intervention by homeopaths and their patients (Chatwin 2009, Eyles, Walker et al. 2009, Hartog 2009). Hahnemann repeatedly instructs the homeopath to investigate every aspect of the patient's disease state, incorporating symptoms of the mind *and* body as a non-dualistic totality. Beyond its theoretical status, holism is embedded in the ontology of homeopathic practice. Clark-Grill (2010, p 20) asserts that vitalism and holism distinguish homeopathy philosophically from conventional medicine. Holism, she suggests, constitutes the ontological, epistemic and moral difference between conventional medicine and CAM (after Tauber 2007). In her thesis (2010), Clark-Grill explores the practices of five Austrian homeopathic doctors for whom vitalism and holism are distinguishing theoretical and clinical feature. Although my research participants were not medical doctors, each decisively referred to holistic qualities of homeopathic reasoning, caseness and practice, representing Clark-Grill's holistic ontology. Veronica's case example demonstrates how she understood her patient's symptoms holistically (DS 37: lines175-181):

Meagan used the word water, so she had water and tears. So it's recognising, you know ... from Meagan's nocturia (urination at night), came all of the stuff about tears, about you know, wetting the bed, water ... fluid retention ... we were opening that whole spectrum and *that's where I see it as being different*, that we're doing it holistically, rather than looking for the one thing.

In Veronica's analysis, Meagan's illness could be interpreted through each or any of the particular symptoms from which she suffered: water and tears represented her emotional state (grief, loss and disappointment) as well as her physical suffering (urge to urinate at night, bed-wetting and fluid retention). Each particular symptom represented, or embodied, the whole of Meagan's illness, for which she selected a single, individualised homeopathic remedy. Veronica concluded that Meagan's illness was representative of – and would be relieved by – the homeopathic medicine Natrum Muriaticum. In contrast, a holistic approach might actually be beyond the reach of the homeopath. *The doctor has access to no more than a fragment of the patient's life—that part for which he or she has come to the clinic for attention* (Lingus 2008p x). Equally, despite her philosophical commitment to holism, the homeopath cannot possibly access *every fragment* of the patient's life, although

she will endeavour to establish the most complete portrait of the lived illness. The data and discussion confirm that the holistic ontology is deeply embedded in homeopathic caseness, having been deliberately employed at various stages of case analysis, evaluation and management by Veronica and other participants.

8.6 Authority of theory: Individualisation

Despite reference to the authority of theory from the work of Dr Hahnemann up to contemporary European, American, Indian and other theorists, clinical reasoning as practiced appeared individualised rather than theoretically or taxonomically consistent. As early as 1805, Hahnemann had proposed that homeopathic practice was fundamentally an empirical science. In his paper, *The Medicine of Experience* (1805) and in the *Organon*, Hahnemann states that medicine is a science, consisting of knowledge of disease, knowledge of the therapeutic effects of medicines and knowledge of their application. So too, in the *Organon* (footnote to aphorism 1) he cautions the homeopath not to construct theories nor to search for so-called internal invisible causes of disease, but to recognise the visible symptoms as an expression of the disturbed vital force. In many instances the participants theorised causes, their theories leading them to speculate and individualise the case according to their understanding.

An example of the theory of case individualisation was the concept of *susceptibility*. Distinguishing homeopathy from naturopathy, Bruce proposed that the homeopath's goal should be the delivery of individualised treatment resulting in change in the patient's degree of susceptibility to diseases. Susceptibility, Hahnemann asserted (*Organon of Medicine* aphorisms 30-33) must be altered in order for disease (in particular chronic disease) to be cured. Concurring with Hahnemann's theory, Bruce asserted (DS 42: lines 177-178):

You don't change someone's susceptibility by focusing on those (gastrointestinal) areas and that's what we're in the business of ... that's our goal.

This distinction, a covert critique of conventional medicine (Bruce was formerly a psychiatric nurse), is also a critique of naturopathy, which Bruce believed removes disease *symptoms* but does not address *susceptibility to disease*, which is his aim and *the business, or the goal* for homeopathy. Contrasting what he regarded as the genuine holism of homeopathy with the naturopathic focus on gastrointestinal diagnostics, Bruce remarked (DS 42: lines 715-720):

I gave this case to some naturopaths (students) and they said “oh, well, this is about the gut, all about the gut.” *There’s no holism there*, it’s a preconceived, “she has gut symptoms, so it has to be about the gut.” What about *her*, what about *how she got to this place*? That (gut) may be her affinity, but what’s her susceptibility, what aspect is her susceptibility reflecting, you know, what’s the trigger here, you know? Because she might not have got that had she not been in that situation or it might have come from a different ... you have to work all of that out.

For Bruce, homeopathy is holistic in theory *and* in practice, while some CAMs such as naturopathy purport to be holistic but do not achieve this in practice. This perspective and distinction are apposite, given the predominance of naturopathic rather than homeopathic practice and education in the Australian context of this research (McLaughlin, Lui et al. 2012, Wardle, Steel et al. 2012, Wardle, Adams et al. 2013). Privileging the holism of homeopathic philosophy, Bruce considered naturopathy to be holistic in theory but mechanistic in practice, with its specific focus on the digestive system as the seat of imbalance, illness and disease. Conversely, he concluded that homeopathy is genuinely holistic because the individualisation of every case proceeds from theory through to the totality of characteristic symptoms in practice. And so, Bruce summarised his position regarding the holism of homeopathy (DS 42: lines 707):

I think our holistic view is pretty rare. I don’t think there are many disciplines that do that.

8.7 Authority of theory: Constitutional approach

Contemporary homeopaths predominantly utilise a *constitutional approach* (Swayne 1998). With this approach, treatment progresses through regular narrative consultations in order to construct a holistic understanding of the patient, to restore health *and* to treat disease. Reference to the practice of constitutional homeopathy was consistent among the participants, as all had had prior theoretical training in the identification and construction of the patient's *constitution* or *constitutional type* (for example Coulter 1986). Despite the similarity of their clinical training, application of the term constitution differed considerably from one participant to another. It was used by many to represent a committed and authentic depth of care as well as an ethical respect for the patient (Rudnick 2001).

For many, a constitutional approach to caseness and analysis was synonymous with trying to understand the patient on a *theoretically* more complex psychological-emotional level. Fiona (DS 15 lines 72-87) constructed depth of understanding as follows:

I think that you can actually treat at various levels with homeopathy ... but *the deeper that you can go the better you can treat or the more overall holistic changes you can make* and I guess that's what I'm always trying ... and I guess that's part of practice too, understanding when you need to treat an acute level and when you need to go deeper ... but I work at the deepest level I'm able to and I'm always trying to perceive more.

In Fiona's hands, depth of understanding correlated with her intention to try and facilitate *overall holistic changes* in her patients, an important consideration given that the majority of her practice supported children diagnosed with Autism Spectrum Disorder. *Depth of treatment* and *holistic change*, while not ontologically unique to homeopathy, remain central to the lived experience. As guiding principles they are fundamental to a range of CAMs including traditional Chinese medicine (Herfel, Rodrigues et al. 2007) and integrative medicine (May and Sirur 1998, Grace and Higgs 2010) and are equally valued by nurses (Effken 2001, King and Clark 2002).

Central to the holistic ontology, each of these disciplines declares a patient-centred or patient-focused stance. The assumption, however, that the holistic ontology is inherently patient-centred has been ethically challenged (Scott 1999). Rather than supporting the genuine needs of the sick patient, Scott contends that holism may actually reinforce a suppressive social order of *physician*-centred medical hegemony. While clearly central to Fiona's practice, depth of treatment and holistic change were not uniformly articulated by the participants. While she sought to prescribe for the *deepest level* of disturbance she could perceive, Fiona acknowledged that the patient might prefer a superficial level of treatment. Implicit here is the belief that Fiona knows what is best for her patient, challenging the patient-focused approach favoured by the participants discussed in Chapter 7, and supporting Scott's (1999) ethical critique.

Distinguishing between a diagnosed *condition* and the *constitutional state* of her patient, Fiona continued (DS 15: lines 22-27):

I'm basically treating *the person* with Aspergers and I need to treat them at *that deeper* constitutional level to stimulate that true part of them to deal with this superimposed condition that's affecting their whole life. So the better I can understand what they're like as a person and their tendencies and reactions to things around them, the better I can treat them rather than just treating the complaint.

Like the doctors in Clark-Grill's (2010) study, Fiona expressed interest in the way that illness affected the *whole life* of the patient, not illness as a disease entity *separate from* the living being; not merely constructing the person as a disease or illness and thereby reducing them and their world to their pathological state (Carel 2008). Instead, her diagnostic and therapeutic gaze are directed towards the constitution, *the whole being*, an ontology with which she believes she can achieve a more effective clinical outcome, and a more holistic experience.

8.8 Pragmatism & praxis: the return to clinical authority

As we have seen in the data, theoretical principles such as vitalism and holism, once historically extolled (Windle 1920, Bodman 1935) have become pragmatically integrated within homeopathic praxis. This is in all likelihood a natural development in medicine, in which theory ultimately gives way, superseded by praxis. In this sense, the tension between the forms of authority becomes more apparent than merely hypothetical; the distinctions in practice between clinical authority and the authority of theory much more ambiguous.

In conventional medicine, reasoning is guided by epidemiological evidence, clinical research, inductive theories, empirical observation and clinical judgment. In contrast, the data in this study reveal the pervasiveness of individual clinical judgment over other forms of evidence, of praxis overwhelmingly dominating theory and research. The participants seldom referred to their knowledge or application of research, empirical or theoretical. Rather, the texts revealed their diverse clinical reasoning practices, the diminishing of theory and the preference for received authority and personal expertise.

Guided by the confidence of her own experience, while still grounded in principles, Leanne recognised the limitations of theory in order to achieve satisfactory results (Leanne DS 58: lines 82-89).

I think probably twenty years ago, probably I might have even talked about Hahnemann ... and I might have talked about all different kinds of parts of the theory and philosophy of homeopathy. I certainly don't ever do that anymore, *it's just not relevant*. Yes, I've totally realised all they really want to do is get their kid better; they don't really give a toss about the theory and philosophy of homeopathy.

Having dispensed with some of (for her) the uncertain elements of homeopathic theory and philosophy, Leanne had a pragmatic, outcome-oriented approach. Laying bare her evolving approach to practice, Leanne revealed a distinctly and unashamedly pragmatic reasoning style. Focusing on her patients' needs in a predominantly paediatric practice, Leanne had

come to recognise the importance of achieving satisfactory results for her patients, regardless of the underpinning theoretical dimensions. Theory might be embedded in her work, but it had no relationship to her patients' immediate needs. Nevertheless, Leanne works within the supportive constraints of professional acceptance and accreditation as a homeopath, and so she must draw on its theory and authority to some extent.

While, formerly, Leanne might have offered her patients a theoretical explanation, incorporating a brief biography of Hahnemann, she no longer explained theory, instead opting for pragmatism. Action and change, she believed, were what her patients genuinely required. Beyond theoretical knowledge as the source of decision-making, Leanne critically valued her own praxis, craft knowledge and self-knowledge (Higgs and Titchen 2001, Higgs, Titchen et al. 2001). Such knowledge forms, acquired from professional experience, have little to do with theoretical understanding.

As Leanne remarked (DS 58), her patients' only concern was in achieving a favourable result. Rather than searching for a generalisable or theory-driven approach, *patients and clinicians want what works* for them as individuals. Understandably, clinical success generates advances in theory, perpetuating a valuable practice-research-theory cycle. It was not always clear whether the participants' preferred prescribing methods were an acknowledgment of their patients' demands, a response to their (received or personal) experience, or a combination of these and other factors.

The practice-driven and patient-focused dimension of James' reasoning superseded adherence to theory. Reflecting on the eclectic quality of his practice, James remarked (DS 45: lines 306-307:

I don't subscribe to any homeopathic belief system because there are so many of them, 'A to Z,' but I dip in to the tool box depending on what the patient needs. *I try not to have those theoretical ideas in my head* when I'm being with the patient.

Guided by his patients' needs, James suspended attachment to the available theoretical systems (Watson 1991). In all likelihood, James was not entirely aware that his observations

were theory-laden, an inevitable and established philosophical and methodological dilemma. In this regard, as I examine the participants' experiences within a hermeneutic framework, observation and interpretation are also neither value-free nor ahistorical (Leder 1990); so too, the patient and the patient's text are never static (Baron 1990). Consequently, trying to empty the mind of *those theoretical ideas* ignores his ineluctable subjectivity.

James went so far as to suggest (DS 46: lines 177-178) that homeopathy was:

One of the tools in the tool box; as it happens it's the main tool in my tool box, but it's not the only tool in my tool box and *it may not be the appropriate tool* for some patients (*yes sure*).

James' tools included a variety of other diagnostic and prescribing procedures drawn from his naturopathic knowledge and experience. These he eclectically combined into his homeopathic practice. James' posture echoed the historical voice of Hahnemann,⁸⁸ beseeching the physician 'to treat sick people, not to weave so-called systems from fancy ideas and hypotheses, *not to speculate, not to theorise.*' For James, and Leanne, the pragmatic service of patients was the primary consideration, subordinating the authority of theory.

A similar commitment to theoretical neutrality was expressed by Rosanne (DS 35: lines 276-283):

I want to be objective ... even though I'll do homeopathy the Rosanne way ... I don't want to influence my practice in a way that's not objective. I want to maintain my objectivity. So I want to be that blank slate; *the most important thing for me in my practice is not to be judgmental and to be a completely blank slate to absorb that client* ... like even now, I'm still going "mmm, I need to think

⁸⁸ Hahnemann, S. (1810). The Organon of the Rational Art of Healing. New Delhi, B Jain Publishers. Footnote Aphorism 1. Hahnemann, being a product of the social and philosophical forces of his time, notably the Paris school, eschewed theory, systems and fancy ideas, rejecting them all as useless (see for e.g. Richard Haehl's Life of Hahnemann; and Peter Chappell's lecture Eight Themes of Hahnemann seen through Richard Haehl).

about that” like there are a few things that came up but I still need to think about that. So I’m trying, I don’t want to put myself on my client.

Theory can never be completely abandoned; otherwise the participants would not be engaged in the practice of homeopathy. This appears to be in conflict with Leanne’s stance, the suggestion that praxis subordinates theory, while it actually submits that the participants both accommodate and to some extent reject theory. However, the participants expressed individualised approaches to theory, congruent with their nuanced practice styles. James subscribed to the use of *what worked for him and his patients* in clinical practice, a pragmatism responding to his patients’ needs and demands. Acknowledging that he may not necessarily know what was (diagnostically) wrong with his patient, he affirmed his commitment to his patients by selecting from a multitude of clinical tools at his disposal rather than being exclusively dependent on homeopathy. James’ pragmatism was unequivocal, challenging the comparatively theory-driven approaches of Hahnemann and Bönninghausen (Dimitriadis 2004, Dimitriadis 2005).

In contrast to James, Bruce insisted on a theoretically demanding approach in order to prescribe on *clear, grounded* symptoms. Bruce required that his students learn to develop a theoretically grounded, evidence-based case, one not built upon assumptions, spurious and uncertain observations. Reflecting on a recent scenario in which he provided clinical supervision to a senior student, Bruce told the student (DS 42: lines 286-294):

You haven’t actually taken a case and, you know, *everything that you’ve told me is speculation based on assumptions that are not grounded in anything*, based on what you observed, based on information that he told you that’s got nothing to do with his disease, nothing.

Bruce demanded and expected caseness grounded in theory from his students, and no less of his own reasoning. James, on the other hand, practiced a more atheoretical and ahistorical pragmatism in order to understand and manage each patient’s needs and problems. The preference for clinical experience concurs with research that patients, too, prefer clinical acumen and clinical experience rather than a theoretical justification for a

particular approach to practice (Oberbaum, Vithoulkas et al. 2003). The ascendancy or diminution of theory did not greatly concern him; only patient outcomes really mattered. But the belief in theory neutrality is philosophically indefensible (as was the belief in freedom from prejudice).

All of clinical practice is to some degree attributable to its theoretical foundations. Caseness can never be a random or entirely atheoretical act. The nuanced experiences of James and Bruce suggest that homeopathy as it is practiced is contested and dynamic. Sharing and valuing the centrality of holism and vitalism, Bruce gave greater emphasis to theory, while James eschewed theory in preference for pragmatism. Although homeopathy retains theoretical integrity in its fundamentals, such as the principle of similars, it is contested in other ways, at times vehemently, driven by pragmatism and praxis, and by the *interpretation of evidence* in a given case. Consequently, some participants prescribed on the basis of morbid (disease) symptoms, as theoretically directed by Hahnemann, while others prescribed on the basis of healthy (non-morbid) symptoms. Campbell, inconclusive in his evaluation of the scientificity of homeopathy (1978), attributes the theory of prescribing for non-morbid symptoms to Kent or Hering, yet both theorists also claimed to be treating the patient's diseased constitution.

Differences in the value of theory and authority bring into consideration how the participants determined other aspects of practice, such as the consultation length and frequency, matters for which there are no agreed professional standards. Participants averaged 60 minutes for initial consultations and 40 minutes for subsequent consultations. Some recommended subsequent consultations every three weeks, others only every six weeks. The reasons were not clear, and were not necessarily connected to patient care or clinical outcome, but rather to appointment scheduling, pointing to questions about practice management and ethics.

8.9 Other epistemes

Most of the participants had prior experience in professions other than homeopathy. It was clearly important to understand the ways in which diverse epistemologies impacted their particular homeopathic clinical reasoning. Participants referred to backgrounds in branches of healthcare including general nursing (Leanne and Monique) and psychiatric nursing (Bruce), while others had expertise in fields as diverse as art teaching (Veronica), lactation consultancy (Pauline) and psychotherapy (Charlotte). The lived clinical experience described and explored was as much an amalgamation of their diverse professional and other life experiences. The participants brought craft and personal knowledge, religious and spiritual experience and other forms of knowledge including Reiki⁸⁹ into the consultation room, tacitly and deliberately. In practice, these epistemes are inseparable from more conventional medical and homeopathic knowledge.

Higgs and Titchen (2001) propose that professional practice knowledge takes three forms: 1) propositional, theoretical or scientific knowledge (for example, *knowledge of pathology, anatomy and physiology, materia medica*); 2) professional craft knowledge, or *knowing how* to do something, including the performance of homeopathic reasoning; and 3) personal *knowledge about oneself* in relationship to others. Propositional knowledge is formal and explicit, while professional craft knowledge and personal knowledge may be tacit, implicit and embedded.

The data in chapter 7 describe homeopathic reasoning as performed and deeply embedded; these being specific examples of craft and personal ‘knowledge.’ These nuances help explain, for example, Veronica’s reflection when first questioned about her reasoning methods. Referring to the tacit, embedded quality of her reasoning Veronica alluded to the convergence of knowledge and practice (DS 38 lines 191-192):

It’s difficult to put in words and I haven’t really thought about it. *I just do it, you know, I just ... that’s a kinaesthetic thing.*

⁸⁹ Reiki, a traditional Japanese healing therapy, involves the application of the therapist’s hands to some part of the patient’s body to allow the movement of energy. Pauline (DS 20) described the use of Reiki in her practice in conjunction with counselling.

Without needing to disaggregate theory from practice, Veronica was comfortable sensing, feeling her way in each case, demonstrating an unconscious performance, an intuitive blend of professional craft knowledge and personal experience (de Vries, Witteman et al. 2010). *Knowing* her practice from the *inside*, rather than knowing how to theorise about her practice (Kemmis 2005) Veronica reasoned skilfully and sensitively. For many of the participants, theory and received expertise were inextricable. What was difficult for Veronica to articulate reveals a lack of reflexivity about her reasoning behaviour, not necessarily a lack of ability to do so. Evident was an absence of distinction between the operations of practice and the relationship between theoretical knowledge and reasoning expertise.

Some participants openly acknowledged the importance of authoritative theorists in disciplines beyond homeopathy, some well outside the medical domain altogether. Allan, reflecting on the key influences in the development of his reasoning cited the founder of Gestalt therapy, Fritz Perls, and transpersonal psychologist Carl Rogers. Only contemporary homeopath Misha Norland ranked among his living homeopathic mentors. Similarly, Susanna (DS 87 lines 11-20) reflecting on her later studies in family therapy noted that the Rogerian framework (Rogers 1951) had helped validate her own philosophy, values and practice model. Susanna continued (DS 87 lines 17-22):

It was very validating for me because I felt that sort of I had Rogerian sort of ideas myself, around you know being collaborative and being genuine and um that sort of, having empathy for people, those sort of Rogerian principles, the sort of unconditional positive regard, all of those ... and there he was naming those sort of core principles and I was thinking "yes that really rings true for me, that's really sort of integral to attach to the way that I practice as well" yes.

For Susanna and Allan, the Rogerian framework and its underpinning values essentially merged with their existing practice philosophy. Rather than feeling a need to transform her style of practice, Susanna recognised that Rogers' framework added structure to her practice style, validating the work she had already been doing for some years. Reflecting

further, Susanna discussed the need to incorporate and develop a family therapy or related framework within homeopathic curricula.

Reflecting on his earlier training and experience in psychiatric nursing, Bruce (DS 42 lines 112-122) explained that this experience afforded him confidence in how *and how not* to proceed with his homeopathic patients:

Well I think first of all my psychiatric nursing had a big influence on me as a practitioner. First of all I learnt how I *didn't* want to do it (*right*). Secondly, there's nothing quite like working in those kind of settings, for giving you confidence to deal with pretty much anything, in terms of what patients can throw at you, and I think the whole training model, you know ... you spend half your time in hospital wards, you know, you have to do a minimum of fifteen hundred hours of patient contact when you qualify. So what I noticed different from other people that I (homeopathically) trained with was that when they came to see patients they were very unsure of themselves and very hesitant, I mean I think that's a normal part of learning homeopathy but I think if you come from that (medical/psychiatric nursing) background or work in that field then you have a lot more confidence, just in terms of dealing with the everyday interactions with patients. It's *a natural mode*, so to think, so I think that helped me a lot in my homeopathy, definitely.

Acknowledging what he valued and did not value in his experience as a trained psychiatric nurse, Bruce particularly recognised the confidence he had developed to manage *pretty much anything* as a clinician, unlike homeopathic colleagues with whom he later trained. Bruce had already developed confidence in what he considered a *natural mode*, a relaxed, ordinary way of being with patients, an ontological relation identified in homeopathy (Plunger 2007), one that his peers apparently lacked and struggled to develop. Already experienced in psychiatric nursing by the time he retrained as a professional homeopath, Bruce understood implicitly how consultations could become *overly clinical* and *funnelled too early* into a fixed psychiatric diagnosis. The confidence Bruce had developed in his

clinical skills and in himself as a competent clinician were important elements of personal knowledge that sustained him in his new profession.

8.10 Chapter summary

Homeopathic clinical reasoning is connected and imbued with multiple sources of authority. Epistemic authority was evident in reference to the use of key historical texts and their theoretical foundations, including vitalism, individualisation, and the holistic ontology. Equally, clinical authority was central to reasoning, not only incorporating professional experience, but the sense of internal knowledge and knowing that develop into competent personal praxis. Samuel Hahnemann continues to be a revered authority. In addition, theorists and mentors within and beyond homeopathy are important sources of clinical authority. Some participants acknowledged themselves as sources of clinical authority, demonstrating a depth of professional maturity, assurance, and clinical insight. Finally, the participants acknowledged the contribution of values, preferences and beliefs in the development of clinical reasoning. These are explored in chapter 10. This acknowledgement helps to account for the interconnectedness of clinical reasoning, constituted as a collection of epistemes and methods as well as an intersubjective, hermeneutic performance between homeopaths and their patients.

CHAPTER 9

Dual processes: Therapeutic relationship and hermeneutic space

9.1 Chapter introduction

In chapters 7 and 8, I explored the core features of caseness, understanding practice as constituted by the mechanisms and performance of clinical reasoning. Subsequently, I explored the tension within and between the applications of diverse sources of authority, and considered how these sources are interpreted and implemented. Actually, in truth these were not the most dominant features of what I *observed*, regardless of their supposed functions in the conduct of clinical reasoning. My observations were increasingly dominated by the qualities of connection between homeopath and patient. Clinical reasoning as a lived phenomenon clearly meant much more in practice than the isolated components of reasoning and decision-making. This chapter begins to attend to ‘seeing’ and interpreting the lived experience through these observations.

Different modes of therapeutic engagement were evident during each of the consultations I observed. Already sensitised to the hermeneutic relations between context and human behaviour, I gave close attention to the interaction, endeavouring to understand how therapeutic relationships were formed and developed, and why this is important to clinical reasoning. Having observed and understood homeopathic caseness as performative, this chapter explores the meanings of therapeutic engagement. The data, and their interpretation, draw us closer towards comprehending what is therapeutic about homeopathic caseness, and how it is performed in practice. The object was to understand the participants’ experiences, not to expediently map them against existing theories or models (such as those from medicine or nursing). A nuanced understanding of therapeutic engagement will be used to extend our understanding of existing accounts of therapeutic relationships in healthcare.

The data demonstrate the dual intersecting processes of *being connected to the patient* and seeking to *find the correct homeopathic medicine* for each patient. Here, I argue that the participants utilised the therapeutic relationship for its own sake on one hand, and as a vehicle for nuanced homeopathic caseness on the other. This intersection extends the discourse of the contextual space established in the previous chapters. I therefore use the data to examine what appears to be a polarisation, in reality a dynamic contextual space within which the participants situated themselves and their patients according to the needs and circumstances of each case episode.

In this chapter, I describe the forms, meanings and distinctions of the therapeutic relationships that I witnessed. I explore associations between the therapeutic relationship and context effects, and I provide a series of hermeneutic accounts of the customs of interaction that give shape, structure and meaning to clinical reasoning practice. Reflexively, I should note that some relationships, and some encounters, are better described as *clinical* rather than *therapeutic*,⁹⁰ as not every patient-clinician relationship, or each individual clinical encounter, was necessarily or inherently therapeutic. In any case, it was not the purpose of my study to make judgments about this, only to understand how the participants were constructing and interpreting it.

Reflexively, I acknowledge my preconceptions. Concepts including *context* and *therapeutic relationship* are informed by my clinical experience. While I was bound up in the hermeneutic task of making sense of the phenomenon, I tried to disengage from being too familiar with concepts in order to appreciate their distinctiveness through the participants' experiences. Trying to *see afresh* is a perpetual demand of hermeneutic and phenomenological research (Finlay 2013), as it is of practitioner-based inquiry such as homeopathy (Smith 2012). Although both iteratively examine textual data, IPA research seeks to understand what is idiographic, to make the familiar seem strange (Van Manen 1997), while practitioner-based inquiry is reflexive, demanding experiential interpretation and interaction with professional practice (Smith 2012 p3). This reflexive understanding formed an ongoing part of the research process. As the research developed, I continued to

⁹⁰ Medical, psychology, nursing and other literatures abundantly describe therapeutic relationships in their particular contexts. To suggest, however, that these professional-patient relationships are inherently therapeutic makes numerous assumptions about both the processes and the outcomes of these relationships.

examine the similarities between homeopathic clinical reasoning and IPA research, and began to consider homeopathy as a method of interpretative inquiry.

9.2 Dual processes: Therapeutic presence & action

As I observed the complex synthesis of skills, techniques, and practice behaviours, the contextual interaction between the participants and their patients was equally compelling. By and large the participants sat quietly and listened patiently. They seldom moved or interrupted their patients. There always appeared to be an expanse of time available to listen, to engage. Allan, for example, explained that it was imperative *to be with his patients*. This would seem to be an obvious, perhaps superfluous remark. Having made this statement *emphatically*, I asked Allan what he specifically meant, to which he responded (DS 27: lines 155-160):

Meaning be *fully present with a patient*, understand their stories so that they have an experience of healing, yes, but not turning off my brain ... because I'm a homeopath, I'm not a therapist, I'm a homeopath looking for a medicine, but I'm wanting to be with them at the same time. So *it's a dual process*.

In Allan's conceptualisation, his patients will have an experience of healing if their narratives are understood. For this to happen, he needs to be meaningfully, *fully present*. At the same time, Allan establishes that his job, most importantly, is to find the most suitable medicine for his patient. Allan clearly establishes the simultaneous interaction of dual processes. Being meaningfully present and searching for the correct medicine recurred in the texts. While some participants emphasised the therapeutic importance of presence, others constructed their presence as a part of the narrative, the vehicle within which the patient's lived illness was shaped. Presence for Allan serves dual functions: his patient has a healing experience, and he is more likely to understand them in order to correctly select their medicine. The two processes are interdependent and intersecting, experienced inseparably.

For Bruce, the action of the consultation augmented the therapeutic process; the process and its key objective (identifying the *correct* medicine) constituting two facets of the same

phenomenon. Here, he articulates how he experienced the functions of the homeopathic consultation (DS 42: lines 269-273):

I want my patients to have a sense of being really understood, because ... *what the consultation is about is the same as the remedy, it's just on a different level* ... I'm giving them their simillimum as an interaction, as an understanding and empathy but as well as giving their simillimum in terms of their remedy.

Here, Bruce distinguishes his intention to understand the patient and for his patient to have a therapeutic experience, a sense of being understood. This intention is twofold: he needs to understand his patient in order to find the simillimum (the *most similar* medicine), being his fundamental object; but he insists that his patient needs to have a sense of *being really understood*. Interacting for close to two hours in an interpretative space, a familiar, intersubjective understanding developed between the two. Through his knowledge, experience and recognition of the remedy, *Sepia*, Bruce simultaneously gave his patient *an experience* of this remedy; reflecting to the patient the exact reasons for which he intended to prescribe it. Bruce constructed reasoning and empathy as concurrent modes of understanding, as ways of being therapeutically engaged with his patient. There is considerable historical literature investigating intersubjectivity in healthcare, and in qualitative health research (Malterud 1993). Sixty years ago, Perkins began to explore gestalt psychology and intersubjectivity (Perkins 1953), heralding the later exploration of mirror neuron theory (Iacobini 2011). Gallese submits that imitation, empathy and mind-reading depend on the constitution of a shared, meaningful intersubjective space (Gallese 2003). Lengermann and Niebrugge (1995) assert that intersubjectivity is characterised by dominant and subordinate roles, and while an important set of assertions, this thesis is not an analysis of clinical power relations. Shortly, I will give particular attention to empathy as it emerged as a central feature of caseness and an important category in an understanding the dual processes.

At the conclusion of each consultation two key outcomes were typically generated.⁹¹ The participants identified the most suitable (similar) homeopathic medicine for the patient's condition. This outcome – the matching remedy - was undoubtedly the primary goal of every participant, corresponding with the principle of similars, and being the fundamental objective of homeopathic treatment. The second outcome – for most participants and their patients - was the reflection of some kind of positive experience for the patient, such as the *experience of healing* Allan alluded to. I developed increasing interest in these remarks, curious about their relationship to the process of reasoning as well as the outcome.

The participants transitioned between observation and attentive listening, to skilled questioning, simultaneously evaluating and interpreting layers of physical symptoms and verbal expressions. These transitions were iterative and circular rather than linear, as they returned to explore some previously expressed symptom or phenomenon in order to obtain clarity from a patient (“*what exactly do you mean by that?*” and “*can you please tell me what that’s like for you?*”), and to reduce uncertainty. I witnessed the familiar to-ing and fro-ing between signs and symptoms, the recording of multiple observations. Then followed clarifying questions: Fiona closed specific gates in order to eliminate particular pathways; Rebecca employed seemingly unrelated, circuitous questions. The practice observed was not unlike trying to demystify data in qualitative research (Higgs 2010), to the process of meaning-making in IPA research (Larkin, Watts et al. 2006), as each participant set about achieving a level of meaningful interpretation congruent with the patient’s experience.

How the participants practiced being and presence - situated as the listener, observer, interpreter, and healer - was not automatically obvious. Neither was it apparent at times whether the act of engaging patients in lengthy narrative was for the patient’s or the homeopath’s benefit; an act of curiosity, of altruistic kindness, or whether in fact it was crafted in response to the patient’s illness narrative.

⁹¹ At the conclusion of one consultation, Veronica explained to her patient that she was not intending to prescribe any medicine until she had further analysed and considered the symptoms. This is not uncommon in homeopathic practice, in particular at the beginning of the treatment of chronic conditions, and especially those conditions that have not had an accurate medical diagnosis.

As Charon et al remark of the physician (1996): “Where ... are the boundaries between his patient the teller and himself the listener, between his work and his play, between the doctor he is and the person he is?” These remarks, and my observations, compelled me to consider that the homeopathic therapeutic relationship is not well understood; that therapeutic presence and intersubjective action augmented some patient experiences and perhaps inhibited others. The therapeutic relationship, its structures and functions are not exclusive to homeopathy, yet its distinctiveness and the contextual space in which it was developed require further exploration.

9.3 Enacting empathy

A comment in a subsequent interview with James took my interpretation of *being and presence* to another perspective of understanding (James DS 46: lines 177-182):

First there has to be the being with the patient and some entering into their energy field in some way, so you have a sense, which may not be a verbal sense of what the problem is. It might just be a feeling sense. *I guess I'm talking about empathy really.* Then, once all that has happened and once I've got a fix on what it is I'm treating then I use the mind and think; I'll look up my books if I need to.

I had not anticipated the fundamental importance of empathy and the complex association between the therapeutic relationship and clinical reasoning prior to this research. Rather, I had anticipated an examination of predominantly cognitive features and functions. Repeated observation of the connection between the participants and their patients drew me in to explore the relational phenomena. I therefore digress briefly here, to define, consider, and situate empathy as an emergent result in the context of this chapter. I also provide a summary of relevant theoretical and empirical literature.

In regards to *being with the patient and entering their energy field in some way*, James concludes that his behaviour is simply an enactment of empathy. This description, following an hour-long encounter with his patient, characterises *his lived experience of being empathic*. James' experience depicts empathy as though it were a conscious instrument that

can be controlled. Equally implicit in James' construction is the proposition that being empathic precedes cognitive engagement, setting up the dualism typical in theories of empathy.

What I observed, and noted, however, was something subtle, spontaneous, and at the same time more explicit; the antithesis of the detached clinical equanimity historically articulated, for example, by Sir William Osler (Halpern 2003). My field notes emphasised James' complete focus, his physical stillness and visual engagement with his patient. Never losing his attention, he made no written notes until she had finished her narrative.⁹² There were no interruptions. Empathy was an embodied experience for both James and his patient. On further reflection, James deliberately engaged, *enacting connection*, prior to rationalising about his patient. When he required them, James resorted to his books, homeopathic repertories and materia medica, almost as an afterthought.

Reflexively, my observations and interaction with the participants suggest that empathy is *embodied and relational* and that it is embedded in homeopathic praxis. It appears to have therapeutic benefits for patients (and possibly for homeopaths themselves), reaching well beyond the perceived limitations of homeopathy proposed by Brien et al (2010). While the participants valued empathy, and believed it to be central to the therapeutic relationship, it is constructed as one part of a dual process. As Allan succinctly pronounced, he was *not* a therapist (meaning *psycho*-therapist), but a homeopath, *still looking for a medicine*. Allan's insight helps us to consider empathy enactment in homeopathy as distinct from empathy in other healthcare contexts. Allan's comment also serves to remind me that despite the increasingly apparent similarity between homeopathic caseness and IPA research, the homeopath must interpret not only to understand each patient, but in order to prescribe.

I will propose, following Marshall and Hooker (2016) and others in the empathy literature including Pedersen (2008, 2010), and Zahavi (2010, 2012) that dualistic empathy constructions have never worked, and that in fact empathy is *an embodied* phenomenon. My observations of James support this. A better theoretical understanding might be to ask

⁹² Hahnemann instructs the homeopathic physician to note the patient's description verbatim, a practice encouraged in homeopathic students. James, with more than 20 years' clinical experience, apparently had no need of noting every expression verbatim.

what *empathied bodies* can do. Theorising this helps us to understand empathy as a lived phenomenon. This understanding might also provide an internal (or lived) understanding of extant conceptual frameworks of empathy, including neurone or mirror theory (Goldman 2011, Iacobini 2011).

In homeopathy, I suggest that embodied empathy is what I call *iatrosynergy*, a form of relational embodiment that is context specific and possibly understandable as therapeutic. Iatrosynergy – empathic synergy between the healer and the patient – is *performed* and *embodied* in the interaction, establishing connection through a shared ontology.⁹³

9.4 Iatrosynergy

Empathy does not require verbal engagement. Quite the reverse, non-verbal engagement, such as that displayed in *Charlotte's pause*, has been explored as a mechanism to which patients respond with greater disclosure of significant information (Suchman, Markakis et al. 1997, Halpern 2003, Gillett 2004). Halpern describes the tension between the physician's need for detachment in order to remain objective, sensitive to every sign and symptom, and the patient's need for empathy, for genuine engagement (Halpern, 2003). Negotiating this tension, Charlotte demonstrated empathy as a lived phenomenon, her consummate pause being transformative for her patient, leading to disclosure and deeper understanding of her illness for both participants. Contrary to the silence of the medical setting and its legitimated discourses (Gillett 2004), I witnessed in Charlotte the deliberate use of silence, patiently encouraging words to be spoken, tears to be shed, meaning to unfold, and empathy embodied.

Patients have described their homeopaths as human beings with whom they can talk in an *ordinary way* (Plunger 2007), demonstrating empathy as a relational, bi-directional, intersubjective feature. The *ordinariness* in these discourses served dual purposes. Allan explicitly described the dual purpose of this ordinary presence (DS 27: lines 155-160):

⁹³ I am indebted to Emeritus Professor Miles Little for the emergence and development of the concept of iatrosynergy. I had been grappling with the data and my observations, and after our discussions he suggested this neologism.

Meaning be *fully present with a patient*, understand their stories so that they have an experience of healing, yes, (*mmm*) but not turning off my brain ... because I'm a homeopath, I'm not a therapist, I'm a homeopath looking for a medicine, but I'm wanting to be with them at the same time. So *it's a dual process*.

Ordinary talk was empathic, avoiding unnecessary jargon, creating trust and respect between the players. Ordinary talk enabled Bruce to pursue two avenues simultaneously in order to *understand* his patient, and ultimately to *select* the most similar homeopathic medicine. Ordinary talk is the language at the heart of caseness, central to the operations of reasoning and perhaps critical to the clinical result. Moreover, for Allan above, being fully present, and understanding the patient's stories (of illness experience), created *an experience of healing*. In this dual process, empathy is enacted, developing therapeutic potential greater than only being for the purposes of engaging trust and facilitating disclosure. Without the haste typical in brief medical consultations (including the *very short* homeopathic consultations I have witnessed in India), patients were able to talk at length, the participants facilitating this talk through open, mostly unstructured questions. In summary, ordinary talk enabled participants to investigate lived illness as much as it facilitated depth of relational engagement. As Bruce described (DS 42: lines 182-184):

If he wants to talk about cricket, you talk about cricket. You find out more about them *engaging them in their interest* in cricket than if you do talking about their piles or whatever.

Through iterative analysis I recognised that the relational, performative aspects of caseness featured with increasing prominence. Reflexively, it is likely that as the importance of these qualities of caseness grew in my mind, I subsequently attended to its manifestations with increasing curiosity. This relational quality and its processes is *iatrosynergy*, partially informed by theory (based as it is on the principle of similars) but actually deeply embedded in praxis, in the lifeworld. This might convey the impression that *similar*, and *synergy*, are synonymous, phenomena that can be 'found' in all healthcare settings. This is not necessarily the case. A doctor and patient in a conventional medical setting may experience

empathy, though not necessarily relational iatrosynergy, which employs similars. As a distinctive, contextual phenomenon, iatrosynergy is the coming together of *homeopath* and *homeopathic patient* in order to disclose the *simillimum*, the most suitable homeopathic medicine, being, as Allan claimed, the *object* for the homeopath.

As an enacted praxis iatrosynergy has a parallel in Gadamer's fusion of horizons (Gadamer 1975, Svenaeus 2003). In the Gadamerian framework, a homeopath and patient meet in the world together, forming verbal and non-verbal understanding. In meeting they engage, a meeting of *beings*, not simply a meeting of intellects. Iatrosynergy cannot be solely attributable to *iatros* (the healer/homeopath); it is a process and a product of the relational dynamic. This explains, at least in part, the *therapeutic encounter*, and may also go some way to explaining why this encounter is regarded as being clinically effective (Eyles, Leydon et al. 2012). Embedded in the ordinary, the fusion experienced may, from time to time result in an epiphany, "a moment of recognition or revelation, a sudden insight or understanding that gives a deep sense of meaning and value" (Hawkins 1997 p 155). Again, in the Gadamerian framework, this epiphany constitutes hermeneutic understanding, embodying shared meaning, a fusion of horizons, and manifesting in therapeutic change. As Bruce and Pauline reflected, after five minutes they sometimes knew which medicine their patient needed; the remaining time they used to engage the patient, and to deepen their understanding of the lived illness.

Though evidently a dynamic process it is vital to reflect whether *iatrosynergy* is inherently therapeutic, or whether it is a vehicle within which cognitive and embodied understanding emerges. Is iatrosynergy more than a context-specific form of empathy? What, for example, did Allan mean by *being fully present* and facilitating *an experience of healing*? Can the act of listening attentively actually liberate the sufferer's discomfort, as it reputedly does, for example, in psychotherapy (Sedgwick 2001, Gelso 2011)? While empathy has been demonstrated to enable the patient (Mercer and Reilly 2004), the data ask whether the lived illness can be demonstrably altered through the enactment of iatrosynergy. Measuring enactment of course presents an altogether different set of problems.

For Susanna, knowing and understanding her patient were plainly embodied, felt phenomena (DS 89 lines 63-75):

There is another physical thing that comes with it, it's like a tingle, with that in breath and that sort of feeling of dropping in the shoulders ... and then with that there is that feeling of excitement, there's sort of a feeling of "oh" it is a good feeling, yes ... you're able to open things up, that's again when I'll get that feeling "*aha I'm in, I'm actually in now, this is, I'm able to work with this person now*", or "*this person feels able to work with me now,*" yes.

Knowing that, reaching a point of understanding her patient is an embodied, visceral phenomenon. Susanna trusts this embodied knowing, manifested in the physical sensations she experiences at the point of knowing, of understanding her patient, approximating the 'phenomenological nod.' Knowing, in the phenomenological sense, is experienced more than it is based upon factual knowledge of her patient, the patient's clinical condition or life situation. Knowing is practical and personal, and can be distinguished from professional or formal pedagogical knowledge required, for example, in teaching (Tirri, Husu et al. 1999) which requires knowing oneself.

Not alone in trusting her embodied knowing, Monique explores the process of deep understanding, developed through her praxis (DS 33 lines 51-57):

Just the understanding of people and the process, it's like evolving and getting deeper and *with time I can just see that, how it works*; and ... looking at how I do cases now than I did even five years ago is different and I go to a deeper place with people and find a remedy on a deeper level as well as trying to find that kind of core thing. And I've always looked for the centre of the case, but it's a *deeper centre* somehow that I'm looking for and in a lot of people ... sometimes they can even have those moments where they can say "I've never put that together before" and that can be just as therapeutic as a remedy, I think.

Monique's experience reflects the trust and confidence in *internally knowing* what her patients required. Again, it raises the theoretical possibility that iatrosynergy - the shared

profound understanding between the participant and her patient – *initiates therapeutic change*, rather than homeopathic medicines themselves (Chatwin and Collins 2005, Brien, Lachance et al. 2010). The power of this sort of therapeutic engagement is little understood. If it can be verified empirically it also presents a critical challenge for homeopathy, necessarily questioning the purpose of prescribing homeopathic remedies. At the same time, comparisons with other modes of inquiry and therapy including psychology and psychotherapy are apposite.

I recognise resonance from my own clinical experience. Specifically, I acknowledge the endeavour to engage and be empathic, to know my patients, while trying to remain sufficiently detached, necessary in order to be objective regarding ‘actual’ symptoms. Practising and achieving balance between knowledge as learned (for example core biomedical knowledge or homeopathic materia medica) and knowledge as felt and experienced, is clearly complex.

In some instances, participants struggled to differentiate empathic knowing from intuition, referring to them interchangeably. For James, intuition was not possible without prior empathic engagement. He constructed intuition as a product or outcome of empathy, remarking (DS 46: line 457):

I think having that empathic communication with someone *then gives rise* to intuition.

Empathy is contingent on two persons engaged in some type of social relationship. Intuition, on the other hand, requires some epistemic foundation, whether the acquisition of prior knowledge and experience (as in professional judgment) or the capacity to internally check information which is perceived through one or more of the senses. James’ interpretation caused me to consider the relationship between empathy and intuition, and their subsequent relationship to clinical *reasoning*. Where empathy requires no specialist knowledge per se, intuition is dependent on some form and quality of prior knowledge against which a professional (an ‘intuitionist’) can intuit or apprehend the possibility of

understanding phenomena, which may be incomprehensible or meaningless without such prior knowledge.

9.5 Empathy and phenomenology: Theoretical and empirical overview

This is not the place (nor am I the person) to engage the entire theoretical and empirical scholarship concerning empathy. However, some of the most important recent approaches to empathy attempt to retheorise its historical emergence within phenomenological philosophy (Zahavi 2010, Stueber 2012). While I have no intention to debate philosophical phenomenology, or the theory and philosophy of empathy, my methods and results confirm that a phenomenological construction of empathy is critical in order to advance a coherent understanding of empathy within homeopathic clinical reasoning.

The word empathy, from the German *Einfühlung* literally means *feeling into* (Coplan and Goldie 2011p xii) according to Theodor Lipps, German translator of David Hume's 1738 *A Treatise of Human Nature*. By the early twentieth century, empathy, associated with *Verstehen* (*understanding*) in the German phenomenological tradition of Husserl, Stein and Scheler (Coplan and Goldie 2011p xiii), became prominent in psychology, aesthetics, and in the philosophy of social science. Despite considerable empirical research and interest in empathy, there is still no agreement on what it is precisely (Zahavi 2012), whether or not particular forms of empathy are dependent on context (Hollan 2012, Stueber 2012), and whether it is an instinctual response (Zahavi 2010). There is also a current literature on its evolutionary value and its brain localisation (Goetz, Keltner et al. 2010). This complex discourse makes the discussion of empathy within homeopathy all the more multifaceted.

Considerable empirical research on therapeutic relationships has focused on the development and application of clinical behaviours. These include empathy, rapport building, and attentive listening (Preston 2002, Halpern 2014). Empathy is regarded as a central human feature in *all* healthcare contexts (Agledahl 2011). It is important for enablement, the patient's capacity to cope with and understand their illness (Mercer, Watt et al. 2001, Mercer, Reilly et al. 2002). Since the seminal theoretical and empirical work of Carl Rogers, empathy has been regarded as essential for health professionals (Rogers 1951),

being synonymous with ethical, caring practice. A lack of human empathy has been associated with specific psychopathologies (Hayward 2005).

Empathy must by all accounts be distinguished from compassion, which can be defined as the feeling that arises in witnessing another's suffering, motivating a subsequent desire to help (Goetz, Keltner et al. 2010). Of certain evolutionary value, compassion can be considered an instinctual response to suffering, while *feeling into or imagining* another's suffering can be cognitively modified.

Empathy facilitates access to the knowledge, feelings and emotions of others (Matravers 2011). The importance of empathy to the clinical interaction between homeopaths and their patients has been examined in a hospital setting (Mercer, Reilly et al. 2002, Bikker, Mercer et al. 2005, Thompson and Weiss 2006). Results from this study suggest that relational empathy between homeopaths and their patients is always present to some degree, that it enables the consultation, and may also enhance a patient's clinical result.

Although it was valued and embodied by the participants, empathy is certainly not unique to homeopathy, in contrast, for example, to the specific process of remedy matching (Thompson and Weiss 2006, Burch, Dibb et al. 2008). Clinical empathy may be nothing greater than intuition or some degree of intersubjectivity between the physician and patient (Philipp, Philipp et al. 1999), yet this assertion diminishes the value of both empathy and intuition in all clinical disciplines. A high degree of homeopathic physician empathy has also been correlated with greater communication and patient satisfaction (Hartog 2009). However, in a qualitative study of German homeopathic physicians, patients considered the availability of time, rather than empathy, as the most important factor in determining what characterised *a good doctor*, regardless of their area of specialisation (Kliems and Witt 2011).

Clinical empathy may be defined as the capacity for one person to understand the experiences, thoughts and feelings of another person (Halpern 2003). Halpern's earlier definition underplays the subtlety, power and the relational qualities of empathy. Relational empathy develops as one human being listens – *feels into* - the suffering of another. More

recently, empathy has been redefined and extended by newer approaches that see it as intersubjective and as embodied (Halpern 2014). Understanding, in the embodied rather than strictly cognitive sense, becomes possible as the listener feels into the lived experience of the other. In this way, empathy (as *verstehen*) is a form of knowledge that appears to be interwoven with more conventional clinical reasoning skills and knowledge.

The relationship between empathy and clinical understanding resonates with the participants' experiences. They utilised empathy consciously and deliberately, as well as implicitly and intuitively. The question for homeopathy is whether empathy is a mechanism that explains or is necessary for therapeutic efficacy. In order to examine interaction within the relationship more closely, I now explore data depicting the phenomenology of the space, and the hermeneutics of engagement between the participants and their patients.

9.6 Phenomenological space and hermeneutic engagement

The participants routinely engaged their patients in phenomenological illness accounts. Patients were encouraged to explore their symptoms in detail, in particular traumatic life situations and complex sensory phenomena. I will argue that on physical, social and metaphorical levels the participants did this by constructing *phenomenological spaces* that are tied to sets of cultural values and professional discourses. The phenomenological space is, as it were, a device that is constructed and within which illness accounts can be revealed. Phenomenological space cannot be described in terms of its dimensions, which are difficult to fathom. Rather, this space is described and constituted in the participants' lifeworld (I observed the space and the interaction, but I was not active in it). The logic of searching for similars particular to homeopathy evidently requires a level of phenomenological discrimination that, as a corollary, elicits a detailed picture and also (though perhaps not always) a powerful therapeutic response. This particular logic, and its practices, does not occur in isolation. Rather, it is tied to a set of cultural values and professional discourses (for example about 'natural' health, 'spiritual' wellbeing, psychotherapy etc) that inform the current practice of Australian homeopaths.

Slowly building phenomenological (idiographic) accounts, the participants frequently asked their patients: “how does that (pain) feel; tell me more about how that feels; can you describe that sensation in more detail?” Veronica specifically asked her patients (DS 37: lines 679-684):

“If you were to give me that pain, describe exactly how it would feel?”

I had never experienced or heard the use of this particular mode of questioning. Veronica’s idiosyncratic question invited the participant to reflect the pain/sensation accurately in order that she might better understand the lived experience, as though vicariously through her patient. Her strategy also utilises the double hermeneutic in that *she tries to experience* what her patient experiences, rather than typically interpreting the patient’s pain description, not the pain itself. These data also recall the problematic dualism in the endless arguments about whether empathy entails *feeling* or *imagining* another’s feeling (Pedersen 2008, Macnaughton 2009). The exploratory questions utilised demonstrate the implicit value of phenomenology in homeopathy, enabling the patient to enter and describe her lived pain. With each level of questioning, Veronica gained a clearer interpretation of her patient’s illness experience, empathically finding her way (*feeling? imagining?*) into the experience, while her patient seemed appeased and understood. An example also of the therapeutic potential of the interaction, I observed that Veronica’s patient nodded emphatically each time she saw, heard, or felt that Veronica understood how her pain felt, and what it meant.

Generating connection and therapeutic engagement was to some extent mutual: patients often reported a sense of being “heard, understood, and listened to” while the participants themselves described the value they attached to empathy, towards understanding their patients in the hermeneutic sense, not restricted to cognitive or epistemic structures that assumed their *knowledge of* the patient. As a method of hermeneutic understanding, the participants’ preconceptions and historical situatedness constituted a part of that understanding. Utilising their clinical knowledge, skills and behaviours, I observed and noted the participants consistently engaging their patients: listening, observing, questioning,

acknowledging, responding, querying and clarifying every symptom, sensation, and expression.

According to Charlotte (DS 53: lines 71-73), empathy has a telos that is empowering and therapeutic:

When somebody feels comfortable to sit down and talk about the things that are *really distressing* for them, knowing that this person isn't going to tell them what they should do or what they should feel, then that is incredibly therapeutic, and a really important part of health care.

Recognising that central to homeopathic therapy she needed to interpret and understand her patient's physical condition (diffuse chronic eczema) and her *real distress*, Charlotte enacted empathy as she listened without interruption to her patient's psychologically complex narrative. For Charlotte, *the act* of listening and engaging was empathic, *therapeutic*, and vital to health care. For the homeopath, being *in that state* might lead to a loss of distance, at least the proximity necessary to maintain critical reflection and in order to make informed clinical decisions (Lingus 2008), maintaining as Carl Rogers asserted, awareness of one's own perspective (Goodman 1991). Here, once again, this understanding mirrors a similar dilemma in qualitative research; the need to balance fidelity to participant accounts and analytic responsibility to the data.

In this sense, clinical empathy must also be distinguished from a perhaps too intimate friendship. Reflexively, I was concerned how Veronica and Charlotte retained the distance necessary in order to make detached clinical decisions. Clinical empathy necessitates that the clinician remains alert, aware of her professional and ethical responsibility at every moment (Komesaroff 2008). While empathy enhances clinician understanding and has therapeutic potential, the benefits can be diminished if the clinician errs into friendship that compromises skilled professional judgment.

Like Charlotte, a similar pivotal moment was enacted by Rosanna, a moment within which, in her experience, healing occurred within a connected space (DS 35: lines 336-339):

I actually think the space of being actively listened to, like the intent, like the fact that I sit there, completely observant trying to watch for everything. *There's something really healing in that space, take the homeopathy out of it, the observation ... that capacity to be fully present, I'm totally merged in you*⁹⁴.

Importantly, Rosanna herself acknowledges that enacting empathy and creating an existential healing space are not exclusive to homeopathy. *'Take the homeopathy out of it'* she remarks, in so doing extrapolating her observation to the possibility that *the space* is embedded in other modes of therapy. Rosanna's reflection points to the need to consider empathy as a universal phenomenon enacted in different contexts. I seek, therefore, to continually explore and understand the nuanced contextual features and functions of empathy within homeopathy.

Rosanna repeatedly referred to *a space which she held* with and for her clients. I asked Rosanna (DS 35: lines 148-171):

And what goes on, what goes on so that you can hold the space, what does it mean?

To which Rosanna replied:

Okay, that's an extremely hard question to answer ... I'm using how I feel the client, how I hear the client, how I see the client ... I'm 'all senses on' ... so I'm a completely blank slate⁹⁵ ... *I empty myself before a client comes ... and for me to hold that space I have to be full senses on to try and get in at that moment ... I will move towards the client, my body language, my vision, everything about*

⁹⁴ In his Client-Centred Therapy (1951) Rogers proposed empathy as 'perceiving the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto *as if one were the person* (my emphasis) but without every losing the '*as if*' condition. Goodman, G. (1991). "Feeling Our Way into Empathy: Carl Rogers, Heinz Kohut, and Jesus." Journal of Religion and Health **30**(3): 191-205. Later, in the 1980s, Rogers considered empathy as part of a dynamic process between the client and therapist.

⁹⁵ In an effort to be authentically present, and to enable empathy, Garden suggests that physicians should suspend their role as experts in order for patients to speak about themselves, their illness experiences and their associated meanings. Garden, R. E. (2007). "The Problem of Empathy: Medicine and the Humanities." New Literary History **38**(3): 551-567.

me, says “I can do this if you’re not afraid, I can hold your hand, I can go in and it won’t hurt, trust me, subconsciously, trust me to go in, it’s okay we can do this together.”

Firstly, Rosanna articulates the simultaneous use of her senses, feeling, hearing and seeing her client in order *to hold* the space. Secondly, Rosanna consciously *empties herself* before she sees each new client, constituting the space for interaction, an ideal space that is neutral and accessible to both her patients and herself. Engaging her senses, emptying herself, and being blank are *embodied, enacted* components of hermeneutic action. These deliberate actions (she believes) enhance her capacity to interpret with clarity, linking embodiment and interpretation within the phenomenological space. In emptying herself, Rosanna foregrounds her preconceptions in order to be receptive to the unique phenomena in every case, at every moment. Rosanna is, if you will, alive to the nuances of hermeneutic interpretation. Together, her actions and words represent her intentionality; inviting her patient to trust her fully in order to create a meaningful understanding of her illness state.

Hermeneutic interpretation demands constant attention to the intersubjective, to the particular, to the narrow nuanced frame of the individual experience. James described the premeditated creation of an undistracted therapeutic space between himself and his patient (DS 46: lines 29-32):

You focus on being with the patient by moving aside the sort of cognitive obstacles; the computer is there but it’s not flashing at you. The books are out of the way on the book shelf, they’re not sitting in front of you, yes, there’s nothing between you ... *there’s just a space.*

For James, space encompasses physical and metaphorical phenomena, each mode being potentially meaningful and clinically valuable. For Rosanna, James and Allan, the therapeutic space is an assumed (imaginary) existential place of *being together* with the patient. This space is the phenomenological *thing itself* that predicates meaning and connection, and within which healing is theoretically experienced. In this space, hermeneutic engagement contains some seed of therapeutic possibility. I observed lived illness experiences being

represented through detailed narratives; accounts that moved between physical symptoms, histories, critical events and life texts, and back again to the nuances of physical sensations.

The phenomenon of eliciting illness experiences at first appeared typical and unremarkable, '*the usual thing*' in contemporary practice, as Bruce described it. This reflected my preconceptions and clinical experience, which I had determined not to bracket. Caseness, *the usual thing*, could be many things: it was deliberate, focused and directed (Fiona, Monique), dynamic and rapidly oscillating between the physical symptoms and the illness narrative (Pauline, Allan) as well as predicated on (or in) a phenomenological space (Rosanna, James). Beyond their obvious likeness and straightforward similarity of intent, participant behaviours were much more nuanced; subtle interpretation enabled detailed illness experiences to be revealed, and, at times, a therapeutic response occurred.

Illness experiences, however, do not necessarily unfold conveniently, sequentially or homogeneously. Nor do illness discourses exclusively emerge through conversation, but likewise through embodied expression and gestures, and at times also through powerful silence (Gillett 2004), itself an equally important dimension of phenomenological space. Reflexively, the case encounters I observed were complex, typically non-linear and iterative. This non-linear approach is epistemically altogether different from the singular discursive account of the clinical process that dominates conventional medicine (Komesaroff 2001). In orthodox medicine, insofar as it is imagined to be, the physician investigates the symptoms in order to produce an object, namely the disease diagnosis. Within homeopathy, phenomenological illness accounts can reach far beyond the body as a fixed anatomical-physiological structure, into the lived illness experience, merging social, cultural and historical distinctiveness. The participants by and large needed to know their patients *as human beings* (Plunger 2007), as much as to explore their illness experiences, in the process achieving homeopathic (remedy) diagnoses. Therapeutic engagement, functioning as a performative background matrix, connects the players to each other and to the process.

Many of the participants, including James and Bruce, asked a series of direct questions in order to engage and understand their patients, enabling their patients to become familiar

with homeopathic caseness. Reflecting on his patient, a married woman in her sixties with hypertension, migraine headaches and depression (DS 40: lines 63-67), Bruce remarked:

About an hour and a half into it, she [the patient] gets it, something changes in her, she understands all of a sudden what information I want and why that might be important and then she starts opening up and talking about all kinds of things, things she's never told anyone in her life; all that kind of, you know, the normal process.

Here, therapeutic connection was important not only for the patient but facilitated the unfolding caseness, essential in order for the participant to apply the principle of similars. The very *normal process* to which Bruce referred required an hour and a half of caseness before the patient *starts opening up*. Normalising the process through which both Bruce and his patient navigated her case (for more than two hours), diminished their temporal commitment, as well as the intrinsically hermeneutic quality of the engagement; the interpretative movement between symptom expression and clarifying question/s towards an eventual state of mutual understanding. At all times, Bruce expressed interest in his patient, slowly building particular understanding of her common and characteristic illness symptoms, her history, her life situation, her entire phenomenological lifeworld. This *normal process* is an example of the lived illness experience that patients shared in order to be understood and acknowledged. Hermeneutic engagement was predicated on the interpretation of every nuanced expression, leading to the construction of meaningful understanding. This process was embedded in the participants' performance.

Investigating the patient's lifeworld is central to caseness, and interwoven with homeopathic clinical reasoning. While the patient may present, for example, with conditions such as hypertension, or migraine headache (or both), the homeopath needs to explore every other symptom from which the patient suffers, in order to establish those symptoms that most clearly *encapsulate the totality* of the patient's disease state (Hahnemann 1810).⁹⁶ Lifeworld exploration theoretically achieves the dual purposes stated for example,

⁹⁶ Hahnemann repeatedly implores the homeopath to thoroughly ascertain every symptom, and to explore the value of every observation that can be made of the patient.

by Allan: for the patient, there is the possibility of therapeutic connection, of being genuinely heard, listened to, and understood; while the homeopath is more likely to understand the illness experience and the lifeworld as a whole if the patient experiences a sense of connection and trust. In clinical reasoning terms, the outcome is a greater understanding theoretically culminating in more accurate prescribing and better case management.

As Bruce and James patiently engaged their patients, Charlotte employed an equal restraint (DS 53: lines 143-149). I observed Charlotte, engaging with an acutely anxious patient. A woman in her mid-forties, she was physically restless, emotionally agitated, and spoke hastily. Charlotte sat silently, engaging her patient, listening intently, asking nothing yet repeatedly gesturing – nodding her head, and responding ‘*aha*’ - as if to acknowledge that she heard and understood her.

During a prolonged pause, a period of silence, I observed Charlotte slowly inhaling and exhaling, yet otherwise motionless. Her patient began to breathe in a more relaxed fashion and began to weep, after which she divulged the personal anguish underpinning her visible anxiety. During the silent space, her patient began to describe how she had been scratching, attacking her skin day and night, and sleeping fitfully. What most tormented this patient, it emerged, was the recent violent death of a close friend, leaving her engrossed in profound grief, anger and a sense of powerlessness.

Charlotte’s pause, as I have come to understand this episode, represented an opportunity for therapeutic engagement. Imbued with potential meanings and therapeutic power, Charlotte’s pause and its immediate impact on her patient struck me, although its potency was perhaps diminished by my presence in the encounter. The meaning of Charlotte’s deliberate pause is located in the double hermeneutic interpretation of the encounter, of my observations, and of our ensuing discussion, the actual meaning of which remains locked in the patient’s experience, in that specific moment in time.

I should note here that the pause, or silent space, is by no means always or necessarily therapeutic. The phenomenon of agonising silence has been reported in homeopathy (Gadd

2010 p 332). In this application, silence is employed to encourage the patient to speak without being prompted. This can be agonising, the patient being compelled to consider painful memories, or to re-experience an unpleasant symptom, during which the homeopath waits and waits for the patient to divulge her experience. These techniques, although well developed in some methods of psychology and psychotherapy, can be positively harmful for the relationship between patient and homeopath leading to a perceived lack of empathy and trust, after which effective caseness will not emerge.

9.7 Hermeneutic, therapeutic, and context effects

I now re-examine data depicting the association between the context and therapeutic relationship. This helps the reader to consider interaction as a form of hermeneutic inquiry. Although I describe features that are grounded in the data, as observed in practice they constitute overlapping and intersecting effects of the performance. In essence, these *effects* are inseparable and interdependent, hermeneutic components that constitute each other. This exploration then seeks to distinguish what is understood about context and its function in the therapeutic relationship, from what is meant and understood by placebo effects. This will be taken up in the discussion.

The *tuning in* process or the *engagement* process ... well to me ... that's part of the therapeutic relationship ... I can't work without that, I can't just go through a set of questions about physical and emotional wellbeing ... if that's not there ... that tuning in for me is part of *developing and maintaining* that therapeutic relationship, *yes, it's essential* (Susanna DS 85: lines 36-40)

Irrespective of the particular context, a patient-clinician encounter should, in some way, be therapeutic. Tuning in and engagement, for Susanna, are fundamental to *developing* and *maintaining* therapeutic connection. Susanna's experience points to the significance and the value of the therapeutic relationship, at least from her perspective⁹⁷ (Gadd 2010). The

⁹⁷ It was not within the scope of this research to interview the patients, so I can only surmise as to whether each or any of their experiences was in some way therapeutic. There is however considerable research that suggests patients of homeopaths experience significant therapeutic effects, as distinct from clinical outcomes.

extent to which a clinical encounter is therapeutic is contingent on multiple intersecting factors including clinician skills, patient receptivity, and the specific mode of therapy or intervention (Steinsbekk, Lewith et al. 2008). In this research context, demanding at least hour-long consultations for the exploration of a range of mainly chronic illness states, the value of the therapeutic relationship is clearly important.

At the time, I did not ask the participants to explain the rationale for the physical spaces in which they practiced as I regarded this as being tangential to clinical *reasoning*. My reflexive understanding is based on observations and field notes. Every participant had living plants or flowers in a waiting or consulting room. Four participants worked from home-based clinics; their consulting spaces were adorned with landscape paintings, water features and fine art objects. Two of these consulting spaces faced directly onto attractive gardens. These physical spaces were the antithesis of the *seemingly innocuous* presence of environmental art described in hospital ethnography (Evans, Crooks et al. 2009). Nature enhances the visual aesthetic, and may also contribute to the therapeutic effect (Sternberg 2009). My own waiting room walls are occupied with enlarged high-resolution Australian landscape photographs. These frequently attract appreciative remarks from my patients; context and therapeutic effects are woven into the fabric of the space. The contextual space of engagement, like the therapeutic relationship itself, increases patient comfort and wellbeing, maximising therapeutic possibility.

For some participants, certain contextual elements were not always necessarily therapeutic. Regarding the implications of the term *clinical*, some participants experienced a *clinical encounter* negatively. They equated *behaving clinically* with performativity that is detached, aloof and disconnected from their patients' illness experiences. The very word *clinical* was frequently utilised pejoratively, representing conventional medical performativity from which these participants were keen to distance themselves. Charlotte reflected on what she perceived to be a correlation between *being very busy* and being *terribly clinical* (DS 53: lines 17-21):

See, for example, Spence, D. (2012). "Good medicine: homeopathy." *British Medical Journal* **345**(e6184): 1.; Spence, D. S., E. A. Thompson and S. J. Barron (2005). "Homeopathic Treatment for Chronic Disease: A 6-Year, University-Hospital Outpatient Observational Study." *The Journal of Alternative and Complementary Medicine* **11**(5): 793-798..

I notice about myself that if I'm very, very *busy* I can become very *efficient* about taking a case around the symptoms and that was one of the things that very early on I was aware that *I had to change*, because I think that can be *terribly clinical* and if someone's holding a lot of emotion inside, like she is, she could leave here and yes, I might fix her skin ... but I actually care about the people who come in.

Performing in a *terribly clinical* fashion hints at the loss of engagement, of connection, a way of being that she deliberately attempts to avoid. At the same time, Charlotte demonstrates reflexivity, recognising that in order to *actually care*, she needed to change the way she practised. Representations of *care* and of a *clinical experience* were often a re-interpretation of patients' reported experiences of encounters with medical doctors.

Regarding the contextual importance of care, Charlotte was emphatic (DS 53: lines 40-42):

We're in a health *care* (her emphasis) profession and I think one of the greatest complaints I hear from people is that a lot of the time they go and see a practitioner, mostly orthodox [practitioners], but that you know, 'the care's gone out of health care.'

At other times, and in opposition, the participants acknowledged the contextual *value* of behaving clinically. Describing the ways in which they liaised professionally with medical doctors and specialists, some participants referred to their *clinical* expertise, *clinical* knowledge and the imperative for *clinical* excellence. The status of the term *clinical* was therefore represented in the tensions between two distinct yet intersecting professional roles. Contextualising themselves as homeopathic professionals, the participants oscillated (intentionally and perhaps intuitively) between their dual identities, *healer* and *clinician*. Towards their patients they constructed themselves as therapeutic healers, while to other clinicians as rational-scientific clinicians. In therapeutic relationship, the participants mainly positioned themselves as holistic and empathic, caring for the patient's mind, body and spirit. Yet, when required to systematise and medicalise their patients' conditions, the participants behaved more like conventional medical clinicians.

The extent to which professional identity shaped or merged with clinical reasoning and decision-making emerged as a significant finding (see Chapter 10). The data suggest a tension between the participants' espoused and enacted behaviours. An opportunistic habit of assuming different perspectives according to the context of interaction was unconsciously embedded in the participants' behaviour.

9.8 Narrative engagement

Detailed attention to story, to narrative, although diverse in its manifestations, was consistent among the participants. The production of a narrative enables the patient to share her illness experience. The narrative becomes the representation of her illness experience. For the participant, narrative constitutes a critical part of the dual process; the action within and through which she gains access so as to interpret the lived experience. Here, I consider the functions of narrative in caseness, and the ways in which the participants utilised narrative to engage and build empathy, trust and rapport with their patients.

Narrative interaction enabled the participants to understand their patients, to *be homeopathic*, to be meaningfully similar in order to genuinely know them. In this sense, homeopathy might be considered a type of mirroring, a form of Gestalt interaction, in that the participants described a form of mirroring behaviour. Is it possible that both the remedy and the interaction are homeopathic? The question was more or less answered by Allan and Susanna.

Having previously trained in Gestalt therapy, Allan drew the following analogy with homeopathy (DS 27: lines 172-178):

In Gestalt therapy you talk about congruence ... and that is where two people are there ... in the moment, present. That's it, and I think for me it's a much more elegant slightly more sophisticated way of describing it (than homeopathic engagement).

As a mode of engagement, interaction between participants and their patients was verbal and non-verbal; embodied through laughter, silence, facial cues (smiling, frowning and grimacing), as well as more subtle expression including hand gestures and changing position in a chair.⁹⁸ Caseness encouraged patients into lengthy narratives, and for the participants to listen, reflect and to ask pertinent questions relating to the differentiation of symptoms and finally to the possible selection of homeopathic medicine. Susanna described the phenomenon as follows (DS 85: lines 22-29):

It's something organic that unfolds ... it's not that I have a set way of doing it, it will be different for every person that comes in ... I guess it depends on what happens between them and I ... it's about tuning in I think, about tuning in with that person to see where they're at and that happens in lots of different ways, not just through the questioning. It's also about, you know, the look on their face, how they sit, their attitude when they come in. I can tell straight away if someone's very stressed, like with Katrina, it was very obvious when she came in that she was restless even as she was sitting down.

During her training in the UK, Susanna had learned to utilise a standardised questionnaire for collecting patient information. Describing her earlier practice in the United Kingdom, she referred to the *lack of engagement* she and her patients had experienced (DS 85 lines 56-60):

We had a clinic for example, a friend and I ... and we tried different ways of doing things and we found that if we were just doing the set questioning, often people wouldn't come back, so it sort of grew out of just experience and out of need ... and then in realising the importance of it then I actually did do some further training as well.

Recognising that her patients had been reluctant to return to follow up their homeopathic treatment, Susanna understood that gathering clinical data through fixed questioning did

⁹⁸ These and other gestures are representations of affect theory, which can be applied universally according to affect theorist Sivan Tomkins (1911-1991). Tomkins, S. S. and C. E. Izard (1965). *Affect, cognition and personality: empirical studies*. New York, Springer..

not engage her patients. Subsequently developing a Rogerian style, and training in family systems therapy facilitated the improvement of her counselling skills. These skills were observed and noted in her relaxed engaging manner with her patients. Attention to narrative was commonplace, being central to caseness.

The data illustrate the narrative style generally preferred by the participants, in contrast to the restrictive questioning described above by Susanna. Fiona utilised standard questions, although not a formal questionnaire. For the majority of the participants, informal narrative facilitated open-ended and individualised caseness.

Bruce asked his patient (DS42 line 135) *'tell me what's going on'*, inviting his patient to direct the narrative. Bruce's broad, non-specific question demonstrates his lack of concern for time, as well as considerable trust in the narrative process, a sense that the patient will ultimately disclose what needs to be expressed. Narrative connects the players, permitting them the time and space to engage in the patient's lived illness experience. Narrative, in this sense, has a hermeneutic telos, or purpose, in that it acts as a bridge between understanding and explanation. Susanna articulates the value of narrative, developing an explanation of lived illness based on her understanding of the patient's narrative (DS 85 lines 85-89):

I think I see people very differently, I don't just see them ... as someone who's walking in with a problem; I really do see them as a person that's come and ... *there's a story and there's a family and there's all these other things that influence their health* besides just, you know, what's happening right here in this moment.

Susanna specifically identified the value of Carl Rogers' theoretical framework (Rogers 1951), a framework she believed validated what she had been doing implicitly for some years (DS 87 lines 24-27). Although she didn't identify herself as a counsellor, family systems therapy had become a part of her practice model. Susanna encouraged each patient to narrate her story, while patiently reflecting feeling and content, in the Rogerian tradition.

For Bruce, narrative served a different purpose, in contrast to the dual processes of presence and action. Providing a counter argument to his own claim that narrative is integral to reasoning, Bruce critiques the utility of the narrative discourse. He refutes and distrusts the narrative for its own sake, claiming that his analytical search for *objective signs* and *verifiable symptoms* remain the cornerstones of accurate prescribing. This distrust demonstrates an irreducible tension, between Bruce's willingness to engage with the patient in detailed narrative, and his conscientious attention to unearthing empirical evidence in the form of concrete *signs and symptoms* of illness. While he allows time to hear the patient's story, paradoxically he claims a resistance to the value of the narrative, all the while endeavouring to identify objective details. He claimed (DS42 lines 143-144) that he *was prepared to look a little bit beyond what their symptomatology was or what their presenting complaint was*. Bruce's critique of the narrative method is paradoxical. Without narrative, signs and symptoms cannot emerge, while a dependence on it represents (for him) a move away from the need to *identify the facts* of the case.

Observing Bruce, I did not have the sense that narrative was primarily an empirical tool to establish objective facts. Bruce listened attentively. He *appeared* closely engaged in the patient's narrative, yet by his own account, he was engaged with the patient, but *not with* their narrative. Bruce, it should be recalled, was an experienced psychiatric nurse prior to retraining as a homeopath. Perhaps the paradox of how he performed (at least how he appeared to perform) narrative engagement is incommensurable with his focus on the search for the correct remedy. In tension, Bruce claims that the consultation *is the same as the homeopathic remedy* (DS 42: lines 269-273). He thus had no need to engage in the patient's narrative. Yet he asserts that his listening presence was therapeutic, partially constituting the means with which healing could take place. Bruce appears to pursue two modes simultaneously, and without apparent cognitive dissonance, which helps to explain the irreducible tension in his comments.

These distinctions contrast sharply with Allan's statement that caseness was *all about the relationship*. Is this possible? Can interaction between two people in a clinical setting be therapeutic, the actual *remedy* for the patient? The phenomenon conceivably mirrors psychotherapeutic and psychoanalytic settings that establish the interaction and context as

the setting within which therapeutic change begins. In his interpretation, Bruce, like Svenaeus (2000) construed homeopathy as a hermeneutic process between two willing participants, a means of enabling and constructing understanding of the patient's disease or condition; in this case the need for the remedy *Sepia*. Bruce equates the value of empathic connection with an individually selected homeopathic medicine. This, again, represents dual processes; being genuinely present, and developing authentic understanding of the other. Hermeneutic method is not, however, and can never be *the same as* the felt or lived experience. In this instance, the lived experience belongs to Bruce; the observations are mine, while the interpretation and meaning are a co-construction belonging to us both.

Allan (DS27 lines 210-215) described a nearly identical experience of the phenomenon Bruce had articulated:

The ideal is to understand the patient ... so that they have an experience in the consultation room as well as leaving with a medicine. You know, when you go to a massage practitioner, it feels good and then you leave, you know, it's that ... it's touching them *without touching them* ... that's right.

Allan raises a conceptual model in which the patient has a therapeutic experience within the interaction of the consultation. Drawing an analogy with a massage experience – being touched without being physically touched – is pertinent. In addition to leaving the contextual space with the (ideally correct) homeopathic medicine, Allan and Bruce's experiences suggest that the interaction is inherently therapeutic, and that it is perhaps augmented by the symbolic ritual represented by the prescription.

Dialogue between a homeopath and her patient may or may not differ markedly from the dialogical interaction between other health professionals and their patients. Giving medicine *as an interaction*, as understanding and as empathy, requires further examination. As the patient has the desire to get better and the homeopath has the intention to assist the patient, there may be little that differentiates homeopathic interaction from interaction in other healthcare settings. However, the data suggest that context-specific forms of interaction between the participants and their patients were also somehow inherently

therapeutic, and served dual purposes for the participants. These contextual nuances are examined in the discussion chapter.

9.9 Trust & rapport

The endeavour to practice without judgment, with care, empathy and engagement, is ultimately contingent on the development of trust and rapport. Some participants acknowledged their propensity to judge patients, recognising, however, that a non-judgmental attitude was important to the development of trust-based therapeutic relationships. Rebecca summarised this succinctly (DS25: lines 650-655):

If I can't get that person to trust me and feel like we're *connecting* - and I don't know whether I can explain connecting any more deeply than having a rapport with each other - then I don't think that they're going to give me the information that I need in order to help them to put all those jig saw puzzle pieces (of illness) back together.

Clinical relationships are not necessarily or inherently therapeutic. As empathy is in all likelihood a key determinant of therapeutic practice, so non-empathy or detachment might also be a factor in some circumstances. I asked the participants whether, and how, they anticipated that a patient was or was not satisfied with the relationship. Rebecca explained (DS25: lines 671-682):

How do I know if they're not going to come back? Probably when I feel that we're not gelling; I think people either need to laugh or cry with you and you've made a connection with them, and if that hasn't happened and they're reluctant to impart, and you get rolling of eyes ... it's all important. If I then get to the remedy stage, and I'm thinking "oh God, I've got no idea" that's when I pretty much know I'm never going to see them again, because I don't feel that I've done my job properly and they probably pick up on that, I'm sure.

Bruce, like Rebecca, recognised that emotional expression in the form of laughter or tears represented trust, a level of genuine engagement. Reflecting how he recognised that he and his patient had established rapport enabling therapeutic connection, he remarked (DS 40: lines 134-138):

I think Carl Jung said everyone should cry once and laugh once in a consultation, and that's right, it's kind of, people should, it shows that when people are laughing there's a nice little energy leakage there, you know, it's kind of when people cry, there's a nice kind of, you know, you've got to a nice point where there's something significant in the case.

The expression of laughter and/or tears marked embodied representations of rapport, of therapeutic connection and engagement between Rebecca, Bruce, and their patients. Echoing Rebecca's remark, Bruce interpreted laughter and tears as *energy leaks*, embodying the release of something substantial, something critical that the patient had to share, from which he experienced the development of therapeutic connection.

By his candid admission, James acknowledged that the engaging presence that typified the majority of his clinical interactions was not always felt or experienced. I had observed James, late in the day, taking the case of a child with a skin condition (DS 46: lines 355-366). He had appeared detached and indifferent to her suffering, in obvious contrast to his engaged attitude towards each adult patient he had consulted that day. Asked why he omitted asking the child about her emotional state, James frankly replied (DS 46: lines 355-357):

Well, Rosie, one her age, she's not capable or probably doesn't want to answer those kinds of questions or may feel irrelevant anyway. Secondly, the time of the time of the day, because I was getting weary, and thirdly because of the type of the case, it was (a) skin (condition), which *I have no interest* in treating.

At times, a non-empathic state can be experienced by clinicians. It was very late in the day, James was understandably tired and he confessed he had little interest in children's skin disorders. Fundamentally, James lacked rapport with this child, confessing little interest in

her condition; it was not a lack of respect or interest in Rosie as a human being. Arguably, an ethically and clinically more appropriate response would be to refer the child and her family to a homeopath with expertise in the management of skin diseases. Other participants enjoyed the challenge of treating children, demonstrating empathy, interest and engagement towards them. James' experience acknowledges that clinical empathy has limitations. Clinicians are human, they become weary, distracted; they are not equally interested in the concerns of every patient.

9.10 Chapter summary

In this chapter, I have tried to see afresh the status and meaning of the relationships within homeopathic practice. I was guided by my observations of the striking interaction and the multiple forms of connection between the participants and their patients. Through the participants' experiences, their claims, and my observations, it is apparent that homeopaths engage tacitly in dual processes: being connected with their patients, and finding the correct medicine. The relationship between these phenomena determines the value of patient-practitioner interaction, and conceivably shapes the outcome of treatment. At each stage, the participants understood and valued the therapeutic relationship, recognising that empathy and engagement are embedded and underpin effective practice (Gray 2009).

The participants understood the importance of context and interaction, creating hermeneutic, interpretative spaces that facilitated therapeutic relationships. Although caseness was not always experienced as therapeutic, the participants expressed common objectives: to develop trust and rapport, to build empathy, and to listen, interpret and respond to their patients without judgment. Some participants acknowledged that the capacity for empathy and engagement has limitations. The participants were nevertheless conscious that relationships between themselves and their patients contain considerable therapeutic potential.

CHAPTER 10

Suspended judgment: Ethical frameworks, clinical reasoning and practising from the margins

10.1 Chapter introduction

In the preceding chapters I charted the mechanisms and strategies that provide homeopaths with the necessary evidence and warranty for their clinical decisions. I described how these are embedded in a performative clinical practice that focuses on the quality of therapeutic engagement. I suggested that this can be understood as a shifting epistemic orientation, between methods whose aims are positivist and those whose aims are profoundly experiential and qualitative. The relational dyad was embodied as the core of co-constructed meaning, a narrative process that involves sharing phenomena, making sense of and constructing the meaning of illness; interpretative practices that approximate the hermeneutic in IPA research (Larkin, Watts et al. 2006).

Studies of clinical reasoning, notably in conventional medicine, frequently focus only on the specific cognitive tasks and intellectual concerns of a particular issue, and treat the rest of the reasoning person as irrelevant to the reasoning process. Similarly, studies of clinical reasoning rarely explore the clinician outside the specific decision under discussion. But this study sees all this as not only relevant, but intrinsically connected to practice, like an invisible toolbox upon which the homeopath draws. The point is that the participants were demonstrating clinical reasoning as an embodied and profoundly ethical practice, not merely a set of discrete cognitive mechanisms. It's not just that there's a gap between the 'homeopathic imaginary' and actual practice, but that this is in itself critical for how to think about clinical reasoning as lived and embodied, rather than strictly cognitive.

As I observed and interviewed the participants, I began to recognise how clinical reasoning cannot be isolated from the clinician's sense of identity. They constructed reasoning primarily around ethical and philosophical values and concepts to which they were

committed. I consistently noticed the hidden packages of experience that they shared, each imbued with their particular values. This is not surprising, given that most have had prior careers in addition to holding diverse religious/spiritual/formative beliefs that shape how they construct practice. The 'surprise' is in the realisation that there is significant incongruence between the imaginary (and theorised) 'unprejudiced observer' and the reality of values-imbued practice that is primarily oriented towards meaning-making. I will describe one participant who had built and used a judgmental moral framework as her chief conceptual structure for understanding illness. The dissonance between the philosophy and the practice of homeopathy becomes evident in the lived experience, shaping this tension. A similar dissonance can in all likelihood be identified in an examination of conventional medicine, or any other health profession. This raises potentially troubling ethical questions. Despite explicit inconsistency between their espoused beliefs and their practices, the participants demonstrate commitment to the deliberate suspension of judgment as a key component of an ethical stance for homeopathy.

The data advance an understanding that while practice is imbued with practitioners' values and beliefs, it is, in the main, enacted ethically and with integrity. I consider some arresting data demonstrating the relationship between clinical reasoning and professional identity. This complex behaviour is also partly a reaction within the context of critiques confronting the participants (and I) during the conduct of this study (Musgrave 2011, Smith 2012, Smith 2012). How the participants navigated persistent marginalisation clearly had an impact on their clinical reasoning, and on their professional identity. I consider all of this as not only relevant, but intrinsically connected to practice, and this helps us to think about clinical reasoning as a dynamic, lived phenomenon. This approach sensitises us to see the gap between the homeopathic imaginary (ideal), and practice as it is actually experienced. Homeopaths, like all health professionals, are human. They are driven by their beliefs and pre-commitments, by personal and conceptual ontologies of health, illness, and disease. The participants expressed explicit recognition and respect for the values and preferences of their patients.⁹⁹ They were also contradictory and inconsistent. The results illustrate the

⁹⁹ This recognition is in accordance with the code of ethics and professional behaviour determined by member organisations such as the Australian Homeopathic Association <http://www.homeopathyoz.org/images/aha/codeofconduct.pdf> last viewed 22 July 2014

complex relationship between reasoning and decision-making and the underpinning values and beliefs of their proponents.

10.2 Values & clinical reasoning

The practice of homeopathy, indeed all of healthcare, is founded upon human and social values, these being the basic commitments that justify professional judgments, beliefs and practices (Little, Lipworth et al. 2012). Value theory (axiology) concerns the notion that knowledge is inevitably imbued with value, especially the values of those forces that structure such epistemology (Carter and Little 2007). The social and historical conditions of its epistemology are understandably concordant with the values of homeopaths and of patients seeking homeopathy (Degele 2005). The values and commitments of homeopaths are embedded in the framework of the consultation (Milgrom 2007). Particular ways of engaging with patients, with illness and health resonate with and differs from other healthcare domains. These different modes of engagement represent certain ontological commitments and implicit values held by the participants and their patients.

Commitment to the epistemology of homeopathy is reinforced by the experience of clinical results, together driving praxis. As Jonas (2011) asserts, whether one *practices* homeopathy or not can ultimately be reduced to whether one genuinely believes that ‘it’ works, or ‘it’ doesn’t work. For the participants, a core value of practice is the belief that it works, which is deeply embedded in practice and performance. It is clear that they *both held and valued* the belief that homeopathy works. Bruce alone was willing to examine the possibility that placebo effects are inextricable from the claim that homeopathy indeed ‘works.’ The following sections reflexively explore the tangled values that are implicit and explicit in reasoning practice.

10.3 Dissonance between stated and implicit values

Swayne (2008) proposes that homeopathy is a pioneering scientific enterprise, a theoretically coherent process built upon *reality truth and knowledge*. The participants,

committed to homeopathy, were certainly driven by the desire to relieve suffering. Responding to his critics, Swayne asserts that homeopaths are engaged in the pursuit of truth. The data (Chapters 6 and 7 in particular) demonstrate that homeopathic clinical reasoning is individualised, non-linear and praxis-driven, and deeply imbued with practitioner values and beliefs. They do not support Swayne's unwavering argument that homeopathic clinical reasoning reveals a singular warrantable truth. Rather, hermeneutic interpretation suggests that the participants have confidence in homeopathic epistemology, and trust that knowledge, clinical experience and the therapeutic relationship are together capable of altering illness.

Reasoning, as we have seen in the previous chapters, entails much more than a series of discrete actions and behaviours. Praxis is forged by the relationship between values and professional identity, as much as it is by theory and episteme. The participants, like all health professionals, bring their professional, personal and ethical selves into the consulting room. They do so intentionally and instinctively. This discourse is prevalent in conventional medicine in which the physician occupies the theoretical position of impartial observer (Rudnick 2001, Pedersen 2008). Both homeopathy and orthodox medicine share a similar modernist imaginary of the clinician as a neutral, unbiased, impartial observer, a foundational ideology of the physician as subject since the eighteenth century. Then, as extensive scholarship over the past few decades has been devoted to demonstrating, this imaginary is not realised in practice. Among the more recent critiques, I am interested here in theories of *values-based medicine* which have emerged as critiques of the epistemic dominance of evidence-based medicine (Miles 2009, Fulford 2011, Little, Lipworth et al. 2012, Loughlin 2014). Tacit values have been examined in medical philosophy (for example Pellegrino and Thomasma 1993, Davis 1997). Each clinical encounter is imbued with knowledge, experience and professional wisdom (phronesis). The detached, impartial observer was after all 'invented' in order to mitigate the prevailing subjectivity of the doctor.

I remind the reader that the object of this thesis *was not* to investigate what constituted ethical practice in homeopathy. Ethical questions were and are however inseparable from clinical reasoning, and so part of what emerged were constructions of *moral practice* among

the participants. Theories of ethical practice, for example in medicine (Beauchamp and Childress 2013) and nursing (Ulrich 2012) establish the governance of professional behaviour. These theoretically ensure that health professionals acknowledge their beliefs, enabling them to practice with greater impartiality. The discourse of ethical practice in homeopathy is less formal and has not been clearly explicated.

While some participants espoused unexpected beliefs, they left little doubt regarding their ethical intentions. They reasoned logically, given the premises and axioms upon which their epistemology was constructed. Reasoning is based on beliefs, and while criticisms about those beliefs are one thing, the logic of clinical reasoning is another. They endeavoured to reason ethically, with an integrity guided by reflexivity, turning experience back on itself so as to sharpen critical understanding. This understanding was unambiguous for some participants, acknowledging that decision-making requires a balance of intellectual reason and caution in response to visceral feelings and intuitions. Allan captured this in the following reflection (DS 28 lines 477-480):

My decision-making is a mixture of reasoning but feeling as well, because *I don't choose remedies based on feeling but I ask questions based on feeling*, so what I, how I ask is *as much visceral as intellectual*.

Though largely implicit, values and beliefs that were at times in tension with their stated commitments were palpable in the consulting room action. The participants were categorically committed to the core values of neutrality, holism and individualisation, each being standard within homeopathic philosophy and practice. Neutrality is enshrined as *unprejudiced observation* in homeopathic philosophy, practice and pedagogy. Considered as a hermeneutic enterprise, however, neutrality, and its practices, is problematic. Praxis, as Foucault asserts (1973), is undeniably imbued with inherent moral values and pre-commitments representing the false polarity of knowing subject (homeopath) and passive known object (patient) in the medical gaze. This critique is not an assertion of professional wrongdoing; rather, it is a question of whether a homeopath practises with sufficient reflexivity and integrity, recognising the need to balance self-interest with the health and interests of the patient (McCammon and Brody 2012). Acknowledged or otherwise, the

homeopath has an agenda. Guided by the participants' professed neutrality, I was drawn particularly to texts and observations representing this tension.

Veronica asserted a practice style reflecting an 'accepting openness' towards her patients (DS 38 lines 134-141):

I think my homeopathic beliefs are quite broad and accepting. I give a range of potencies, I give a range of medicines, I don't stick to one and not the other, you know like it's so individual ... you can't have a vehement belief that something is right, because if you've got that then ... you're losing the majority of the population ... you've got to have that open funnel, you've got to have that kind of accepting openness.

Paraphrasing Hahnemann's Organon, Pauline advocated (DS 20: lines 83-86):

The practitioner is the unprejudiced observer, and *for me it's everything about being in the moment* when I'm with the patient, and then as soon as they walk out of the room that's it, I've forgotten them ...

Some participants, including Rebecca (DS 26) and James (DS 44), while declaring impartiality, expressed beliefs in an ontology that privileged the reality of spiritual beliefs. These beliefs appear to have merged with their reasoning praxis. Responding to my question about her beliefs, and how they might shape her reasoning, Rebecca's account underscored a hermeneutic framework that constructs disease as providing redemptive meaning through punishment (Kopelman 2002, Liang 2008). Here, she reveals her attitude to her patients' problems (DS 25: lines 136-152):

My spiritual beliefs would *definitely have a huge impact* on the way I see things ... I'm very much in the belief that *we all come with our set of lessons* and learning and journeys and things are pretty well mapped out before we get here ... I really think it's that person learning, they need to approach their life differently in order to get beyond this particular problem with their health.

Rebecca, above, introduces the Buddhist (also Hindu and Jain) concept of karma, or karmic law, into the illness discourse. For her and others including James, symptoms are conjoined with spirituality, co-components of an illness ontology. Although conventional medicine acknowledges the psychosomatic within its biopsychosocial model, the spiritual component that Rebecca privileges represents a fundamental point of difference from biomedicine (Barcan 2011 p 28). The spiritual value of illness also has direct reference to Kent's Swedenborgian model (Kent 1900). Illness also has a pedagogical function, in that it provides the sufferer with a set of lessons that *need to be learned* if they are to experience recovery. This *set of lessons*, for Rebecca, affirms a belief among some CAM therapists that illness is an inherent part of the sufferer's spiritual life experience or journey.

For traditional Hahnemannian homeopathy, illness had no relationship with karma, or the need to learn 'life lessons.' Although Hahnemann asserted that *health* was a balanced state of the Vital Force enabling humans to engage with *the higher purposes of existence* (footnote to aphorism 9), he did not conceive illness as either pedagogical or punitive. Hahnemann attributed chronic disease to some maladaptation to the environment, or to a miasm (infecting agent). While he acknowledged that an excess of particular emotions (for example anger, jealousy, or indignation) might be associated with an imbalance of the Vital Force, he did not regard these as specific aetiological factors; and this manner of thinking was congruent with the humoral theory of his time. Instead, Hahnemann proposed that one could *only speculate* about exact aetiology in many instances. Kent, on the other hand (after Swedenborg) attributed particular physical illnesses to discordance of the human will or understanding, or to some morally reprehensible action. This type of Christian evangelicalism was not exclusive to homeopathy but prevailed in 19th century American medicine (Albanese 2007). Hahnemann's framework is explicitly modernist, one of its moves being to unambiguously dissociate morality from disease, in contrast to the prevailing discourse of the day both within and outside medicine. It is difficult however, to reconcile Hahnemann's relatively modernist stance (written more than 200 years ago) with Rebecca's moral judgment about the status and the balance of the illness journey. Homeopathy as lived and theorised has inherited a profound internal tension between the Hahnemannian and the Swedenborgian positions. This internal tension, explored in Chapter 3, appears

continually in the multiple forms of practice and the underpinning beliefs of the participants.

Some participants believed that symptoms were not merely heightened sensations and disturbed functions, as Hahnemann proposed; rather, symptoms were implicitly meaningful for the homeopath and the patient, such that *meaning made sense* to both players in the narrative. Barcan (2011 p 80-82) points to the notion of the psychoanalytical meaning of symptoms and the obvious debt that CAM owes to Freud in this regard. The comparison, however, alludes to the *psychological* meaning of symptoms, rather than theorising meaning and meaning-making on some physical or existential plane. The paradox for homeopathy is to disaggregate a theory of *pure, meaningless* symptoms (expressions of the disturbed vital force) from the notion that all symptoms represent layers of meaning. In this respect, homeopathy faces an arguably indeterminable internal dilemma. The participants seek a meaningful understanding, and an explanation of their patients' symptom totality. As they gather experience ('evidence'), they also aspire to make warrantable claims regarding the epistemic validity of homeopathy. Patients too, by and large, seek a meaningful understanding of their lived illness (in particular those for whom conventional medicine has not provided an 'answer'). Hermeneutic method on the other hand asserts that human discourse is predicated upon meaning-making, and so the discourse accepts the construction of multiple meaningful (or meaning-*less*) interpretations.

In contrast to Rebecca's manifest spiritual beliefs, James was more reflexive. Aware that his beliefs might be favourable for his reasoning, but have a less sympathetic effect on his patient (DS 46: lines 317-335) he remarked:

James: Well I'm a Buddhist, so you know, I suppose my personal ethical structures come from there, actually I shouldn't say that because I had them anyway, Buddhist practice was just one way that they were nicely encapsulated, but I had them anyway.

David: Yes, so how does your Buddhist practice shape or in some way influence the way you work?

James: Well, the ethical structures of Buddhism fit perfectly well with the way I work, provided it doesn't get in the way of course, because spiritual or religious theories can also get in the way of processes as well, and nor is it incumbent upon me to try and influence the patient to think in that way necessarily.

David: So it can enhance but it could also inhibit.

James: It could also inhibit, yes, yes, there has to be a respect for *the patient's* own ethical or spiritual structures ... and it's not really up to us to affect that or change those, unless they're in some way destructive to someone.

James acknowledges what he considers to be the positive relationship between his personal ethical structure, Buddhism, and clinical reasoning. Equally, he recognises the potential to inhibit his patients by projecting his personal ethical/Buddhist belief, as might be the case with Rebecca. There is a distinct contradiction between explicitly theoretical practices, and implicit professional (and personal) beliefs. It is a contradiction that reveals something of the inconsistency of professional homeopathic identity and professionalisation. While the scientific method instrumentalised in biomedical institutions offers some internal coherence, homeopathy also shares certain features in being organised around a body of knowledge and a set of practices. Certainly, medical doctors also have implicit beliefs, spiritual ones among them. All health professionals are theoretically faced with the gulf between the complexity of the patient's biopsychosocial experience, and the tools they have for engaging with that experience. Implicit beliefs are in this sense an extension of the clinical reasoning toolbox. Their use, however, is clearly determined by individual professional wisdom.

Rebecca, on the other hand, adopted a judgmental moral framework as the chief conceptual and evaluative structure for interpreting illness. I observed Rebecca at length, interacting with the mother of a young child with eczema. During our subsequent discussion, I asked her to explain how she approached parents, to which she responded (DS 22: lines 146-156):

I try and get a feel for each particular patient because you know, some don't want to know ... it's a bit like bringing up something like (the use of) vaccination or using antibiotics, some patients you just don't ... you do the best you can with them; they don't want to know about it. One extreme example I can think of, both parents were psychologists, so they knew everything when it comes to child behaviour and there's certainly nothing I, as a humble homeopath, could tell them. But you know, a lot of the time I just try and address the ... 'if you let this behaviour continue, or if we can't come up with some mechanisms to manage it, you know, you're going to have a child who in twelve years' time they're going to be treating their school friends like that and consequently aren't going to be able to form good relationships with other people' ... *I don't want to appear as though I'm judging or blaming the person.*

Field notes taken in the presence of mother and child confirmed Rebecca listening carefully; she appeared relaxed, impartial, and engaged. The above disclosure reflects the overt dissonance between stated and implicit values; here, personal and professional judgments prevail. She would like to appear non-judgmental, when in fact she harbours firm beliefs regarding vaccination and antibiotic use, as well as in regards to parental behaviour and its effects on a child's psychological development. The ironic and self-deprecating remark (being a *humble homeopath*) deflects the dissonance between Rebecca's espoused and actual beliefs. Such incongruence reflects Rebecca's precarious professional identity, in addition to the vulnerable status of the homeopathic profession.¹⁰⁰ In preserving the integrity of the therapeutic relationship with the child's mother, Rebecca chose to ignore (or perhaps suppress) her personal, deeply held values. Reviewing a memo I observed that she remained fully engaged as she listened to the mother, nodding responsively to her concerns; there was no evidence of concealed, unexpressed values or judgment.

Concluding that 'thoughts create reality'¹⁰¹ Rebecca unquestionably privileges a strongly held belief that her patients' thoughts were *responsible for, or the cause of*, their disease state. I recognised in multiple references to her patients' conditions that this framework

¹⁰⁰ This particular interview was conducted shortly *after* the NHMRC announced its Homeopathy Working Committee would investigate homeopathy for evidence and efficacy.

¹⁰¹ A belief system popularised by Louise Hay <http://www.louisehay.com/index.php> viewed 13 September 2012

unreflexively positions the homeopath as one who can see more clearly than the patient, and extends healing practices to insights well beyond the body. The data highlight the complex relationship between personal values, professional conditioning, and reasoning and decision-making. Neutral or unprejudiced observation continues to be in tension with what I observed. The paradox between espoused principles and observed beliefs and values demonstrates inherent and unresolved ethical and professional contradictions.

10.4 Privileged healer

As the data were collected and analysed I recognised that some participants considered the practice of homeopathy to be a privilege. The sense of privilege was not without irony, given the contemporaneous marginalisation the homeopathic profession faced during my research. For Pauline, this privilege pervaded her role as the clinician (Pauline DS 21: lines 191-202).

Look it's a great privilege to be in this profession, because people let you intimately into their lives and tell you things that they've often never told someone before. I suppose it's a bit like a priest in a confessional, it's almost like that process of being shriven, especially when someone's case is taken initially, it's like you take a load off them and sometimes people say to me at the end of the initial consultation "look, you know, I've never looked at things in my life in this way before" and already they can see meaning or threads or a pattern, *even in itself* that is healing. So it's almost like I see myself, as I said before, as a facilitator for someone else's process, it's a very humbling profession really and I try not to dwell too much about it.

In the preceding narrative, Pauline reflects her experience of the homeopath-as-healer, as the recipient of her patient's existential anguish. Multiple values are embedded within Pauline's narrative. Pauline speaks frankly about the composition and meaning of professional identity in relation to knowing her patients. Imbued with an equal sense of *privilege* and *priestly* significance, her narrative alludes to the physician-as-healer archetype (Gray 2009), as religious intermediary (Barnard 1985). Barcan, (2008) after Foucault,

examines alternative therapies as modes of confessional practice. Perhaps ingenuously, Pauline depicts herself as a benign observer rather than an active inquisitor, yet she attaches theological value to the narrative. Medicine has been historically regarded as a *noble* vocation (Souba 2002), and some American homeopaths derive theological and even cosmological meaning from the practice (Holden 2004). Each of these identity roles has little to do with clinical reasoning and remedy selection, yet they represent a stance made by some of the participants.

Inferring the sense of dignity within the *humbling* healing profession,¹⁰² Pauline felt *privileged* to witness the emergence of *meaning, threads or a pattern* through the patient's narrative, perhaps never previously uttered. Barnard (1985), reflecting on the nature of illness and healing, echoes Pauline's experience, considering it *inevitable* that physicians adopt a ministerial aspect in their medical work. Conversely, Barnard asserts that physicians should pursue what they know best, namely the biophysical aspect of disease. For the research participants, patients brought much more than their biophysical needs with them into the consulting room; they revealed their anxieties and phobias, they re-imagined their dreams; they wept at their acrimonious relationships and shared unresolved conflicts. Implicitly, as Pauline reflected, she had to be prepared *to hear things that had never been told* before, to *shrive* the patient of their suffering.

As the *privileged* facilitator of her patient's illness experience, Pauline assumed the dual roles of physician and personal priest. She positions herself as the imagined impartial, objective observer, reasoning via mechanisms and strategies that have as their goal reliability and validity. On the other hand, this is antithetical to the priest, the maker and custodian of moral judgments about responsibility for illness and healing, and a kind of repository for the patient's moral wrongs. This dual positioning is intellectually and ethically challenging. For Pauline, the patient's unburdening promised the connection of threads and the revelation of meaning, which she believed were inherently healing for the patient. Pauline ultimately asserts that she is merely the facilitator of her patient's process. While she feels privileged to be the conduit, she acknowledges the relationship between context

¹⁰² Hahnemann asserts in aphorism 1 that 'the physician's *high* and only *mission* is to *heal* the sick, to restore the sick to health. Hahnemann, S. (1810). The Organon of the Rational Art of Healing. New Delhi, B Jain Publishers.

and the players in the narrative, as co-drivers initiating therapeutic change. Walach (2000), like Milgrom (2006), proposes that the locus of meaningful relationships between the homeopath, the patient and the context together constitute the non-local causality to which healing can be attributed.

Pauline, unlike James, did not openly acknowledge (perhaps was unaware) that connecting threads was not necessarily healing for her patient, and might in fact cause harms. Perhaps she hadn't made this connection. Preferring *not to dwell* on her dual roles, the intersection between unprejudiced observation, clinical reasoning and healing apparently caused her little conflict, while it caused me some ethical disquiet. My discomfort was magnified by the concurrent marginalisation of the homeopathic profession. I wondered whether some of the participants were so removed from public discourses as to be unaffected. The very marginalisation of homeopathy may have led practitioners to look for those elements of privilege, such as the Swedenborgian approach to finding meaning in illness, that were most different from and incommensurable with orthodox medicine, a sort of celebration of alternative or counter epistemologies. The collocation caused me to continue to explore the relationships between values, ethics and identity, and the ways in which they contribute to the shape and function of clinical reasoning.

10.5 Practising from the margins

To this point, the results portray certain beliefs and values embedded in clinical reasoning practice for these participants. It is evident that the capacity to practice confidently and competently was also closely tied to their professional identity. I anticipated that with between six and twenty-five years clinical experience there must be some correlation between experience and clinical competence, although experience and its authority is itself profoundly imbued with value (Scott 1991). Textual analysis revealed that clinical reasoning was in part a function of the participants' sense of professional identity and the impact of mentors and experts, as much as it was a product of clinical training. At the same time, the sustained marginalisation of homeopathy during the course of this research has resulted in an identity shift among some of the participants.

Fiona and Rebecca, the first and second research participants respectively, were transparent regarding the importance of their professional identity. Comparing her professional identity to that of a psychologist, Rebecca described herself as a *humble homeopath* (DS22: line 151). As I coded the data for representations of *identity* (at that point not obviously linked to reasoning) I asked each subsequent participant how their experience of clinical reasoning was related to identity. In response, the participants expressed a collection of experiences reflecting their diverse values.

In mid-2012, utilising telephone and email interviews, I collected additional data from six of the participants. The impetus for the collection of this additional data was the persistent Australian media coverage of homeopathy,¹⁰³ as well as the discussion of an imminent National Health and Medical Research Council (NHMRC) report on the regulatory status of homeopathy and subsequently of CAM education and practice^{104,105} (for an analysis see Freckelton 2012). The participants, responding to the persistent scrutiny of the profession, constructed their response around marginalising arguments that homeopathy is not evidence-based, or that it lacks sufficient rigorous evidence. I was interested in understanding how the context of marginalisation influenced participants' clinical reasoning and professional identity, as well as the general impact on their professional lives.

While demonstrating empathy for students and even towards his zealous critics, Bruce remained mindful regarding his professional identity.

My professional identity is *not greatly affected* by external references. I feel empathy for students. I think I struggle a lot with this as I have some feelings of compassion towards our Friends of Science in Medicine, and sceptics in general.

¹⁰³ For example: Sydney Morning Herald (January 26 2012) *Scientists urge unis to axe alternative medicine courses*. Sydney Morning Herald (February 4 2012) *Should universities teach alternative medicine?* Sydney Morning Herald (February 15 2013) *Research lacking in some alternative medicine programs*. The subsequent release of the NHMRC draft report on Homeopathy (April 2014) generated an even more vociferous media response and counter-response from the homeopathic profession. See, for example: <http://theconversation.com/what-does-the-public-really-think-about-homeopathy-21827> and <http://theconversation.com/no-evidence-homeopathy-is-effective-nhmrc-review-25368> to which I replied <http://theconversation.com/does-the-weight-of-evidence-signal-the-end-of-homeopathy-25645>

¹⁰⁴ www.scienceinmedicine.org.au

¹⁰⁵ <http://www.theguardian.com/world/2009/sep/28/homeopathy-baby-death-couple-jailed> last viewed 30th March 2014

It isn't necessarily an easy or a healthy way to go about viewing the world (Bruce, subsequent interview 2012).

Allan, not immune to professional critique, experienced personal harm as a consequence, going so far as to reconstruct his professional identity.

Without a doubt I am less enthusiastic about being a homeopath in 2012 than I was in 1990. I notice that often I describe myself as a *natural medicine practitioner* ... whereas before always I was passionate and enthusiastic about my identity as a practising *homeopath*. To my mind I've had to develop a thick skin and ignore a constant barrage of criticism. To hear that I take advantage of vulnerable people, and people mean it when they say that, has been painful. Without a doubt this is taking a toll on me (Allan, subsequent interview 2012)

Professional identity is clearly not peripheral to clinical practice; rather, it occupies a central place in the participants' lifeworld. For Fiona, homeopathy was not merely a job, an occupation; her professional identity defined her ontology in the world:

I'm not a person who does homeopathy, *I'm a homeopath*; you will never be able to cut me away from homeopathy because *it's kind of like who I am* (DS 16: lines 271-273).

The distinction between modes of professional identity was not always clear or well-articulated. This was most evident among the participants who had training in counselling (Veronica and Susanna) and psychotherapy (Charlotte). Veronica, Susanna and Charlotte referred to be *being a homeopath* as well as *being a counsellor* or *adopting a counselling role*, inferring that dual identities were independently constructed and separately enacted. As the observer during caseness, these identity distinctions were less apparent. Iteratively, I developed clarity regarding the function and meaning of dual identity for these participants, subsequently reflected when I questioned other participants what it meant to them *to be a homeopath* and to *think like* a homeopath.

Responding to the recurrent critique, Allan was engaged in a process of identity transformation, while Fiona remained steadfast. These contrasting experiences represent the uncertain narrative of homeopathic professional identity. This uncertainty is linked, as we have seen, both to the contested epistemology of homeopathy (Schmidt 2009) and, as I have argued extensively, to the ethics of professional practice (Levy and Gadd 2012, Levy, Gadd et al. 2015). Coupled as it is to multiple levels of experience, professional identity is unpredictable (Luckmann 2008). The participants' experiences clearly reflect the uncertainty of contemporary Australian homeopathy and its practices.

The six participants recognised and experienced some impact to their professional identity. Fiona, undaunted by claims that homeopathy lacks an epistemically rigorous and coherent evidence base, remained critical of much evidence-based research. Despite the suggestion that homeopathy is an *aberrant* science (Little 2006) and that it can *never be* evidence-based (Tonelli and Callahan 2001), Fiona remained unshaken in the face of critique (DSS 99: lines 168-171):

I am less influenced by the evidence-based model and research - when compared to real-world patient outcomes - there is either something horribly wrong with the research or it has been corrupted. I think people are increasingly feeling this way about science which is a real shame as it is a useful tool - but still just a tool and one of many.

Suspicious of EBM and its advocates, Fiona instead privileged *real-world patient outcomes* as the preferred sources of evidence. In her perhaps overly substantive defence, Fiona declares EBM to be corrupted despite it being entrenched and widely accepted (Guyatt, Cairns et al. 1992, Sackett, Rosenberg et al. 1996, Howick 2011). In spite of persistent ideological and institutional vilification of homeopathy, Monique, like Fiona, believed her practice continued to thrive because her patients were fundamentally satisfied with their *treatment results*:

If anything, the media attacks have brought more awareness about homeopathy in Australia. As I have said to the media on many occasions, it won't stop people

going to see their homeopath, because they get results. No matter what is going on, at a grass-roots level, if homeopathy is relieving the suffering of a person, they will want to continue with the treatment.

Patient outcomes were evidently utilised by Fiona and Monique as an interpretive frame, reinforcing their fundamental belief in these results as the valid basis of evidence-based practice. Homeopaths, including these research participants, believe that they are constantly validated by achieving good outcomes, as defined by their patients and themselves.

Other participants were less comfortable with the impact of critiques on their reasoning, identity and professional wellbeing. Allan had become more clinically cautious, noting that:

I'm far more conservative and conscientious about what I say and do.

Bruce reflected on the ideological subversion of CAM, and of homeopathy in particular, represented as both a marginal therapy (Degele 2005) and an aberrant form of science (Little 2006):

On my darker days I feel like homeopathy is being pushed underground and as if I am part of a counter-culture ... I have always worked in areas where the client group or the therapy is marginalised in some way. On my lighter days I just feel like I'm practising another, better, form of medicine. I feel lucky to be able to do that.

Bruce, formerly an experienced psychiatric nurse, was familiar with the stigmatisation of both mental illness and the marginalisation of psychiatric nursing (Holmes 2006). Feeling subverted and professionally marginalised, Bruce recognised the parallels between the patients that consulted him and the career paths he had chosen. And yet (like Pauline) he managed to maintain the self-belief that practising homeopathy – *a better form of medicine* – advanced the credibility of homeopathy (Campbell 2008) and so privileged him in some way. The *darkness and light* metaphor highlights the experience that despite engaging in a polemical profession, the participants believed that homeopathy was valid and

worthwhile. For them, patient satisfaction was an everyday interpretative frame. It reinforced the validity of their experience and confirmed the epistemic value of the profession, over and above interminable critiques. Empathising with marginalised groups and therapies including homeopathy, Bruce alluded to the collective crisis in Australian homeopathy and its precarious future. Despite institutional marginalisation, Bruce, Fiona and Monique remained certain in the belief that clinical results and patient satisfaction substantiated the moral worth of their professional work.

Many homeopaths, including most of the research participants, have had other lives, careers in other professions. Consequently, professional identity appears to be shaped by the associated values and experiences with which these are constructed, as much as they are by the particular beliefs, principles and ideology common to the collective homeopathic lifeworld. Bruce's experience of the stigmatisation of psychiatric patients and the marginalisation of psychiatric nursing is one distinct example (Holmes 2006). While each participant shared particular elements of their own identity narrative, their collective lifeworld was universally grounded in the philosophy and practice of homeopathy (Gross 2010); not in other CAMs that are sometimes misconstrued with homeopathy, such as naturopathy (Wardle, Adams et al. 2013), and not in conventional medicine. It is obvious that the epistemic and ethical pursuit of homeopathy is the singular universal narrative the participants shared. Homeopathy is characterised by foundational propositions and axioms that are open to different interpretations. And while it is marked by iconic reference points, how it is pursued is highly individualised. The participants collectively constructed a discourse of ethical practice in homeopathy, in which the core component was the ethical stance of the practitioner. How this framework was mobilised in practice varied across the participants.

Monique reframed her identity within the context of her earlier lifeworld as a mother and a nurse (DS 34 lines 403-405):

I do call myself a homeopath but it's changed. Before I would say I'm a mother, a nurse, and a homeopath, now I just say I'm a homeopath, without the other

two, even though I'm still doing them ... so it's become *more of my identity* I guess.

As well as experiencing institutional marginalisation, some homeopaths express a sense of self-marginalisation, casting themselves as *the outsider* (Fraser 2006). Allan, for example, had reconstructed himself as a *natural medicine practitioner* rather than a homeopath (and certainly not a practitioner of *mainstream* or *real* medicine). Conceivably, individual homeopaths and their professional representatives share a burden to stake a more positive claim with the healthcare landscape (Levy 2007). Anthropologist turned medical doctor, Melvin Konner, depicts the evolution of professional identity (Kaiser 2002), *moving between* professional worlds. Never static, identity is framed as a construction of multiple roles and duties in each particular lifeworld. Each participant developed a nuanced practice, based on a combination of established texts and theoretical frameworks, available research, received clinical authority and individual praxis. Despite their similar pedagogical foundations, the participants' identity experiences were diverse, evident in the preceding texts. Whether because of their nuanced praxes or as a response to marginalisation discourses, the participants experienced variability in the degree of comfort and confidence in their professional identity.

Against (or perhaps because of) the background of social and political critiques, not only of homeopathy, but equally of marginal practices such as psychiatric nursing, the participants were unflinching in their effort to enact virtuous practice. While the identity of some participants was profoundly altered during the course of this research, each retained their basic commitment to homeopathic principles, and to virtuous practices in support of patients and the wellbeing of the profession. The self-perception about virtuous practice and how it is enacted is presented by conventional practitioners in much the same way (Little, Gordon et al. 2011).

The data and discussion suggest that while the participants are partially coherent in their reasoning and decision-making practices, they are less assured regarding their professional identity. For Bruce and James, professional identity grew from a practice base into an ideological and philosophical posture in opposition to mainstream critiques. There is

disproportion between what makes for consistent clinical reasoning, such as the reliance on key texts and the adherence to principles, and how this translates into professional identity. Retaining a resilient identity in the face of institutional opposition was undoubtedly a challenge among the participants, and reflects the individual and collective effort required by the profession in order to secure its future. The importance of professional welfare and the status of collective identity has motivated the AHA to address concerns as far reaching as the right to practice homeopathy.

10.6 Values in conflict

The professional identity discourse revealed two distinct ethical concerns: the wellbeing of patients, and the welfare of the profession. Although patient wellbeing and professional welfare are separate concerns, the following data expose the close relationship between them, and the complex ethical decision-making consequently required. Here, I must reiterate for the reader the two strong replies to critiques of homeopathy. Firstly, as mentioned earlier, is that homeopaths are constantly validated by achieving good outcomes, at least as defined by their patients and themselves and within the scope of practice for which homeopathy takes responsibility. On the other hand, a counter-critique of this self-validation might well include the apparent absence of traditions of scepticism and critique. For example, in an upfront reply to my patient about the lack of clinical experience in her illness, described below. Or, for example, in Bruce's willingness to refer his patient back to orthodox medicine if they showed no improvement. There is limited discussion of treatment failure or when patients decide treatment was inadequate, or of the patients who go from homeopathy to orthodox medicine (which parallels those that come to homeopathy, in and out of frustration with orthodoxy). So, although homeopaths are validated by patient satisfaction, it is not known what they do with patient dissatisfaction.

Secondly, orthodox medicine itself is a movable feast from time period to time period and from country to country. Consequently, in some countries there is no apparent problem with having medically trained and registered doctors who *are also* trained and registered as practising homeopaths (without apparent cognitive dissonance). In Australia, a limited

number of medical doctors continue to practice homeopathy, albeit at the margins of their profession.

Patient wellbeing was the central object among the participants, linking clinical reasoning with professional identity. For most of the participants, attending ethically to their patients represented a core identity component. Bruce's protracted discussion of the case of the child with epilepsy (chapter 6) raised important questions regarding the relations between ethics and reasoning. Exercising care in his examination of the child's case, and in his estimation of what could be achieved, Bruce was confronted with complex and competing values and decisions. This episode also demonstrates the ways in which ethical practice can be embodied, performed and constructed within the framework of reasoning. As the child's clinician he was well aware of his legal and ethical duties, recognising the scope of professional practice for Australian homeopaths.¹⁰⁶ As the parents engaged him professionally in the care of their child, Bruce deliberately exercised a values- and rights-based approach to her care (Grill, Hansson et al. 2005). Reflecting on a phone call he had taken from a government consultant about the need for the child to have conventional medical care, Bruce recalled his conflicted response, carefully evaluating his legal position against his obligation to respect the parents' intentions and the child's needs.

Acknowledging the framework of different cultural values that the parents held, and their struggle to accept the hegemony of biomedicine in Australia, Bruce reasoned that it was his duty to respect the parents' values as long as he was not occasioning risk to the child's safety and wellbeing. Critics of homeopathy assert that such decisions should remain the exclusive domain of medically trained and qualified professionals (Freckelton 2012) and that homeopathy may be directly and indirectly harmful to consumers (Shaw 2010, Posadzki, Alotaibi et al. 2012). They argue that inconsistent training standards and lack of statutory regulation of the homeopathic profession means that the standard of care and decision-making may be equally inconsistent.

¹⁰⁶ Legal and ethical requirements for Australian homeopaths are administered by the Australian Homeopathic Association and regulated by the Australian Register of Homeopaths.

The following anecdote reflexively demonstrates my own values in conflict, and highlights the ethical complexity of the boundary landscape for homeopathy. In 2007, a 55 year old woman came to see me regarding the treatment of Machado-Joseph Disease, a degenerative autosomal dominant neurological condition (Ahmad 2012, Costa and Paulson 2012). The condition, primarily characterised by ataxia (incoordination and falling episodes) has no known conventional medical treatment. It is incurable and fatal. The patient's 77 year old mother lived in an advanced degenerative state with the condition. My patient had consulted a number of prominent neurologists and was unable to obtain any relief of her symptoms, and felt that her condition was deteriorating. Understandably, seeing her mother deteriorate, she lived in a perpetual state of anxiety regarding her own condition.

Subsequently, based on her own investigation, she decided that homeopathy might be of some benefit to her, and that it was not likely to cause her any harm. She consulted me and I took a detailed history in order to understand the common as well as the idiosyncratic characteristics of her disease condition and of the patient as a whole. I explained to her that I had had no experience in the treatment of this condition, and that neither was there specific homeopathic research available. Despite both the lack of clinical research and my admission not to have treated this condition previously, she gave her informed written consent. I received her complete case history and life story. We established a comfortable rapport and began to develop therapeutic engagement. I prescribed for her over a period of six months, during which, according to her subjective experience as well as my clinical notes and observations, she began to make significant improvements. She had fewer and less severe ataxic episodes and she felt generally more confident in her mobility and ability to function in daily life. After a subsequent review with her neurologist, she phoned in an agitated state to advise me that she was no longer able to see me. Her neurologist, she advised, insisted that all of complementary medicine, including homeopathy, could not possibly be of any benefit to her. Moreover, he advised that should she continue to choose to see me, he would no longer agree to be her consulting neurologist.

In an inversion of Bruce's ethical predicament her neurologist apparently had little regard for his patient's ethical dilemma, yet she was distressed and clearly conflicted, and decided she could not see me again, despite having apparently made some progress with

homeopathy. Confronted with this epistemic paternalism (Grill, Hansson et al. 2005) the patient's values and choice were not respected. At the same time, having no recourse (I had offered to speak to her neurologist if it was her wish) I had to respect the patient's decision not to continue consulting me, despite her suggestion that she had been intimidated into her withdrawal. The experience was morally distressing for the patient, and for me. The patient had been denied from continuing treatment with me, despite having made an informed decision. It also demonstrates that for some patients, despite the clinical benefits experienced, homeopathy has limited epistemic and clinical authority. I experienced distress at the loss of continuity, as we agreed she was making some clinical progress, as well as a sense of moral and professional disempowerment. I lost contact with the patient as I felt I no longer had the moral authority to engage with her, a situation entirely against my professional values and contradicting my duty of care (for an extended discussion and similar dilemma see Fadiman 1998).

10.7 Communicating reasoning

In any consideration of the value and ethical practice of homeopathy, the mechanisms with which homeopaths communicate with their patients and with other health professionals need to be examined. Communication represents an important reference frame for professionalism.

Communicating with patients is often problematic; for example, communicating the need to inform their doctor about the choice to have homeopathic treatment. While I always advise patients to notify their medical doctor that they are consulting me for a particular symptom or illness, some are reluctant to tell their doctor. This can be professionally and ethically problematic.

Some patients are embarrassed, conflicted, and anxious about discussing their healthcare preferences, even with family members. As Susanna remarked of patients in conflict (DS 89: lines 334-336):

I've got a few people in that position; they would rather use homeopathy in acutes (acute conditions) but have partners that don't, or mother's in law, or ...
mmm.

James summarised the dissonance between representations of homeopathy and how it is communicated by veteran homeopaths such as him. Drawing an analogy between the vilification of Galileo and the marginalisation of homeopathy, James reassured himself that *the light* of homeopathy would continue to assert itself:

Galileo was attacked because he dared to suggest that the earth was not at the centre of the universe. The ultra-conservative forces seem to have a cycle of resurgence throughout history, and try to stop creativity which is outside the box. There's nothing new about this, this is human existence, nothing has changed in the way people behave. But similarly, nothing prevents the light from poking through.

The relationships between professional identity, experience, and clinical reasoning contrasts between professions. While some participants reflected on the development of their professional journey, it was unclear how this was communicated, and whether this was connected to their reasoning and decision-making. At the beginning of their professional careers, for example, student doctors and physiotherapists have underdeveloped professional agendas (Lindquist, Engardt et al. 2006). Professional acculturation among Australian homeopaths is largely dependent upon initiatives including continuing professional development programs, seminars and webinars provided by professional associations. These are critical to professional training and identity development in the absence of institutional internship.

10.8 Ethical reasoning re-examined

I continued to explore how identity shapes and informs clinical reasoning, in order to understand how reasoning experience consequently shapes identity. For homeopathy, professionalisation stems from its identification with the central tenets of homeopathic

philosophy.¹⁰⁷ While students are routinely imbued with its theoretical principles and philosophy, they are not inculcated with the typically rigorous social and professional acculturation experienced, for example, by medical students (Kaiser 2002). Many Australian homeopaths, including nearly all of the research participants, studied homeopathy within larger CAM colleges rather than in government universities and hospitals. Upon graduation, most homeopaths establish private practices yet they frequently cite isolation¹⁰⁸ as a critical obstacle to their professional development. Each of these factors contributes to professionalisation and identity formation, to the subsequent development of reasoning and its intra- and extra-professional communication.

Throughout the data analysis, I have drawn attention to the dissonance between the participants' stated and implicit values; in particular the declared *freedom from prejudice* and observed evidence of judgment. This paradox is deeply embedded in practice. The data and discussion demonstrate that the neutrality of theory is philosophically indefensible, and prejudice an inevitable consequence of hermeneutic interpretation (Gadamer 1975). In this final section, I consider the data in which the participants expressed *conscious awareness* of their internal judgment, and the techniques they employed to remain impartial.

Hermeneutic data analysis is itself an ethical act. Rita Charon articulates how the narrative style realises the ethical nature of the interpretative form. As I disclose the lifeworld of the research participants through their stories, interpreting their experiences is similarly a moral undertaking; a feature of narrative ethics (Charon 2006). Before their stories are told they are private experiences; once shared they are made public, and the hermeneutic act of interpreting and telling their stories renders me morally responsible for their reinterpretation. This can be experienced as a moral burden, but also as a privilege.

The data visibly demonstrate the intersection between beliefs, ethics, and clinical reasoning. It is less clear whether a hierarchy exists between these elements. The participants certainly valued ethical behaviour as a process within and an outcome of clinical engagement with

¹⁰⁷ In its preamble, the Code of Conduct of the Australian Homeopathic Association asserts that "The homeopathic physician is one who adheres to the principle of the single remedy and the minimum dose, selected according to the Law of Similars."

¹⁰⁸ Personal correspondence with an executive of the NSW branch of the Australian Homeopathic Association.

patients. A corollary was that the participants frequently felt their ethical behaviour facilitated the therapeutic relationship. These phenomena are embedded in clinical reasoning, as the following data demonstrate.

Susanna (DS 86-89) privileged being empathic, collaborative and transparent, inside and outside her practice. Emphatically, she stated that there was *little distinction between who you are in the world and who you are in your practice* (DS 87: lines 5-6). While she emphasised the importance of the practice of these values and behaviours, she also privileged them in her personal dealings (DS 86: lines 3-8). In regards to ethical behaviour, Susanna articulated the core value of treating patients the way she would want to be treated (DS 87: lines 58-64):

I like to treat other people the way I would want them to treat me ... so for example, withholding judgment that's really important, so that people do really tell you things, they're not feeling judged yes, that's really important ... because if that's not there, then they're not going to give you the information that they need in order for you to make an accurate prescription ... I know that's something that people have commented on, is that they feel heard and that they feel that I'm not judgmental.

Not only has the practice of withholding judgment ethical currency, it is linked to the patient's trust, and subsequently to her capacity to reveal critical information, enabling Susanna to prescribe more accurately. Susanna withheld her judgment. She acknowledges being judgmental, but has developed skills to avert projecting judgment. Utilising a metaphorical bubble on her shoulder in which she *put any judgmental thoughts*, she explained (DS 87 lines 99-104):

It's like a bubble, so I've got this bubble and then anything that comes in (judgment) that shouldn't, that could come between me and what's happening in the room, goes in there (points to her shoulder), *because it doesn't have any place in here*, between us, between whoever's in here, whether it's the children or the mother, so it just goes in there, into this bubble ... it's almost like a bin, it

just goes in there, and it stays in there, it doesn't come back out again, it just stays in there.

Ethical behaviour ostensibly connects withholding judgment to more accurate clinical reasoning and, ideally, better patient outcomes. The values Susanna embraced are arguably no different from the values advocated in medicine or nursing, indeed in all health professional practices. If so, their behaviour demonstrates that homeopathy – as lived and practised – is not significantly ethically different from any other health profession. These values were identified by the participants as being critical to (an ethics of) professional care.

The attention to detailed caseness and hermeneutic engagement demonstrated the value of care as a conduit between ethical behaviour and clinical reasoning, an acknowledged relationship (Mol 2008). Homeopathic patients crucially value the time spent in the homeopathic consultation (Kliems and Witt 2011) in part a reflection of the level of care and interest shown by their practitioner. The participants unconsciously privileged care as practice behaviour. Yet the ethical value of caring is clearly central to all health professional ethics, for example in the nursing care of the elderly (Jonasson, Liss et al. 2011). It should be incumbent on homeopaths, indeed all health professionals, to provide *quality care* reflecting attention to both professional (universal) codes of ethics as well as to societal expectations of health professionals.

10.9 Chapter summary

Homeopathic clinical reasoning is imbued with the diverse values and beliefs of its proponents. The conviction with which some participants expressed their personal beliefs raises questions about the origin and status of these beliefs, and their contextual relevance. These values and beliefs are at times in opposition to a philosophical commitment towards professional neutrality.

Acknowledging the subjectivity of beliefs and values is critical to understanding that what actually occurs during a homeopathic consultation, the knowledge produced and the relationships that produce it, is axiological. Praxis and its underpinning professional beliefs

appear to be less informed by theory and clinical evidence than by complex and contradictory pre-commitments, resulting in diverse reasoning and decision-making behaviours. Some homeopaths hold arresting spiritual and religious beliefs. It appears that spiritual beliefs (although vaguely defined) are strong predictors of the use of homeopathy, naturopathy, chiropractic and of medical doctors who also practice CAM therapies (Petry and Finkel 2004). It is not clear however, whether CAM practitioners including homeopaths share the values and beliefs of the patients who choose to see them, and the extent to which these values and beliefs shape or influence their clinical reasoning and decision-making capabilities.

In the face of sustained critiques of practice, the identity of homeopaths and the profession itself is unsettled. It is conceivable that, while its epistemic and professional authority is challenged, homeopaths nevertheless claim an ethical commitment that authorises and legitimates practice.

CHAPTER 11: DISCUSSION

Praxis: The multiplicity of homeopathies

“It’s very unique ... I don’t think there’s any other system of medicine that is quite the same.” (Bruce DS 43: lines 10-11).

11.1 Emerging discourses

This chapter bridges the history and conceptual foundations discussed in chapters 2 to 5 with empirical data grounded in the lifeworld, explored in chapters 7 to 10. Detailed analysis of the dynamics of clinical reasoning practice helps us to understand the multiple ways in which homeopathic clinical reasoning occurs, is evolving, how in some respects it remains unchanged, and what this means for practice and pedagogy.

Much of the work that lies behind this chapter was expended on the development of analytic insights, the core of IPA research. And yet as I drafted and redrafted this chapter, I became more and more aware of the need for high quality sociological, philosophical and theoretical scholarship to better explore the issues and ideas that I interrogate here. And so I warn the reader at the outset, that providing this level of theory and philosophy for the concepts that the results of my research here raise as important, is beyond the scope of this thesis. I am, sometimes keenly, aware that those who are expert in the philosophy of ontology or the sociological theorising of, for example, being and identity, or the phenomenology of illness, or perhaps of the philosophic bases of therapeutic relationships, might well find aspects of this thesis undertheorised or underdeveloped;¹⁰⁹ it simply wasn’t possible to extensively pursue all of these issues and perspectives. One particularly obvious limitation of my thesis is the absence of a focus on gender. A gendered analysis would be of particular interest in view of the predominance of women practising homeopathy, and the

¹⁰⁹ See for example Butler Butler, J. (2006). Gender trouble: feminism and the subversion of identity. New York, Routledge. and Mol Mol, A. (2005). The body multiple: ontology in medical practice. Durham and London, Duke University Press, Mol, A. (2008). The Logic of Care: Health and the Problem of Patient Choice. Abingdon, Oxon, Routledge..

ways in which CAM discourses that frame *feminine intuition* in opposition to a supposedly dethroned *masculine reason* (Barcan 2011 p 3) intersect with my observations and analysis. Future empirical investigation might enhance our understanding both of iatrosynergy and context effects as potentially gendered phenomena, and at the same time, of how gendered constructions are interwoven with representations of both practitioner and patient experiences in complementary and alternative healing modalities. But again, this thesis could not encompass this work.

When I step back from the sustained immersion in patterns and gates, pauses and nods, remedy-matching and, shall we say, remedy-enacting, how might we capture in words this phenomenon of homeopathic clinical reasoning? How can we understand the warrants for knowledge, as they are constructed from both mechanistic pattern recognition and checking, and the immersive, focused, existential, qualitative absorption my participants enacted? Like a portrait-painter considering the best angle from which to view his image of his subject, I am drawn ineluctably to the Aristotelian concept of *praxis* to capture this phenomenon of clinical reasoning. In Aristotelian terms, *praxis* concerns doing or action,¹¹⁰ a concept closely matching what I observed; reasoning in action, as a performance, as opposed to reasoning as an exclusively (or predominantly) cognitive or conscious phenomenon. In this chapter, I will explore *praxis*, as I understand it in homeopathic clinical reasoning, through the complex interaction and diverse performance between the players, and as ways of engaging ethically in order to understand and manage illness.

Some advocates acknowledge that homeopathy cannot be commensurable with scientific biomedicine and that, indeed, it is best understood as an Aristotelian *praxis*, a practical activity for the sake of healing sick humans (Schmidt 2009). Considering homeopathy as *multiple* forms of *praxis*, I suggest, is an authentic representation of the lifeworld in this thesis. This lifeworld bears little resemblance to representations of homeopathy in public discourses. Discourses critical of CAMs and homeopathy specifically, for example such as those advanced in Australia by the Friends of Science in Medicine, focus only on the plausibility and scientific evidence for the epistemology of homeopathy. But they do not represent accurately what happens in practice. They make assumptions about, but have no

¹¹⁰ <http://plato.stanford.edu/entries/aristotle-politics/> last viewed 9 August 2016.

engagement with, the lifeworld, the interior framework of reasoning, decision-making and therapeutic engagement, praxis that has been explored in this thesis. The frame of praxis, however, not only challenges representations of homeopathy in public discourses; it is also likely to disrupt the historical construction of rational homeopathy depicted in internal *homeopathic* discourses, and by homeopaths themselves. Therefore, based on the results, the following discussion also represents considerable discontinuity with the dominant tradition in homeopathy that seeks to justify homeopathy as a science.

11.2 Summary of results

In this thesis, I have described and explained the practice of homeopathic clinical reasoning through the lived experiences of 12 Australian participants. My interest in this research stems from engagement in clinical practice and teaching for more than 20 years. IPA enabled me to get to grips with phenomena that are difficult to explore, challenging to apprehend, and even more difficult to explain. This is in keeping with phenomenological investigation. I have explored how homeopaths engage in and perform homeopathy to understand how theory and the multiple sources of authority inform practice.

Through the interpretative lens of IPA I have found that a new understanding of homeopathic clinical reasoning is emerging. An emic, internal interpretation is that homeopathic clinical reasoning is constituted as multiple forms of praxis. The intriguing components of praxis visible in the data are relational, ethical and performative. In this chapter, I will explore and progress a model of homeopathic clinical reasoning representing how we can understand contemporary Australian homeopathy. I therefore ask the reader to refer continually to Figure One.

Among the results of this research are the concepts of iatrosynergy and caseness. Figure 1 provides conceptual representation, demonstrating the connections between clinical reasoning as it is performed, with its underpinning theory and mechanisms. Central to this connection (and to Figure One) is the relationship between the players and the processes upon which it is built, a manifestly contextual relationship represented through the architecture of caseness. Caseness is the gestalt-like holistic grasp of the patient and her

symptoms in their many dimensions and expressions, simultaneously. However, 'caseness' is not simply 'knowledge of' (or 'diagnosis'), which is how clinical understanding is largely constructed. Rather, we should understand caseness as forms of *doing* and *being*, as *dynamic action*. In this model, clinical understanding shifts from being knowledge the homeopath 'has', to being knowledge the homeopath performs, a kind of knowledge-in (and through) action.¹¹¹

Caseness is performed and embodied within narrative, and its coherence is founded on and derived through the ethical integrity of the participants. It is worth noting that there are aspects of my research findings that fit very well with the perspectives that have developed from looking at narrative in health and medicine. As space does not permit the extensive discussion that the topic doubtless deserves (a task left to the future), I turn to consider narrative only momentarily. Narrative underpins all healthcare interaction (Greenhalgh and Hurwitz 1998, Greenhalgh 1999, Svenaeus 2000), without which there could be no dialogical exchange between patient and physician, and no access to symptoms or clinical findings. Narrative allows the articulation of lived illness experience (Carel 2008). In this study, narrative was the vehicle for the development of caseness, for the nuanced symptom interpretation shaping reasoning and decision-making, and for the relationship between the participants and their patients. Caseness is an inherently dialogic process, and homeopathy has sometimes been considered a form of narrative therapy (Whitmont 1980, Coulter 1986, Levy 2001).

Critics (Ernst 2011) argue that narrative is merely a non-specific effect that should not be confused with *good medicine*. The paradigm for narrative medicine, best exemplified by Rita Charon, would frame narrative as *a part of* good medicine (Charon 2006), more than 'merely' a non-specific effect. Patients of homeopathy have ideas about *what works* for them; for example, claiming to judge results by *their experience* rather than by the conventional standards of evidence and efficacy (Barry 2006), and may similarly frame 'narrative competence' more as intrinsic to healing and less as a separable non-specific

¹¹¹ I acknowledge here the theoretical perspectives of Anne-Marie Mol Mol, A. (2005). The body multiple: ontology in medical practice. Durham and London, Duke University Press, Mol, A. (2008). The Logic of Care: Health and the Problem of Patient Choice. Abingdon, Oxon, Routledge. and Judith Butler Butler, J. (2006). Gender trouble: feminism and the subversion of identity. New York, Routledge. in my thinking here, albeit with limited exploration of these perspectives.

effect, though doubtless this would vary from patient to patient. How each practitioner and patient construct the centrality of such phenomena will be important for their experiences and the outcomes of their interactions also.

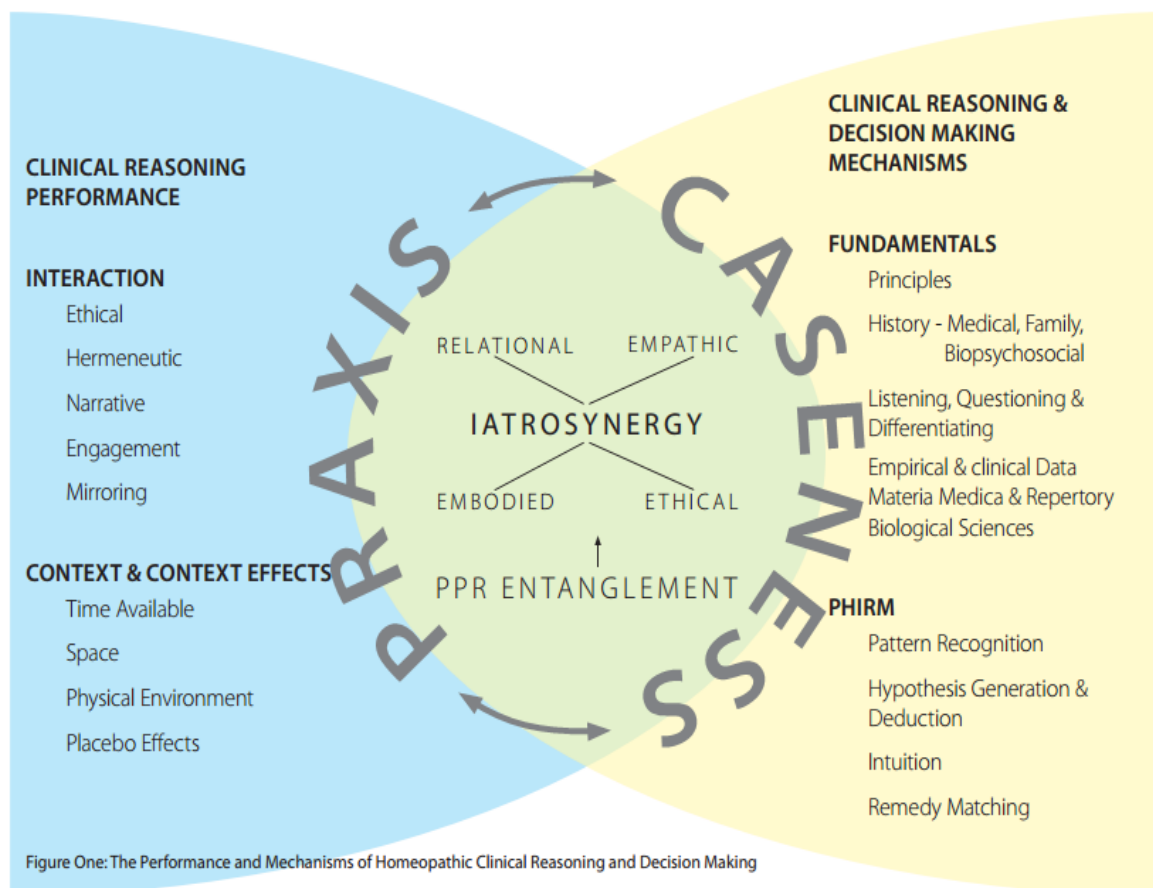
My analysis suggests that performativity, relationality, and ethical practice constitute core components of homeopathic praxis. In writing about these, however, I don't want to elide the central work of the theoretical foundations of homeopathy, namely finding the simillimum, the application of provings, and the processes of remedy-matching, described in the PHIRM model. Rather, these components were linked and constantly interacting. Mechanisms (including pattern recognition and hypothesis deduction) remained continuous, central, and very specific components of reasoning. The relationship between the clinical interaction and the mechanisms of clinical reasoning was always bound together in caseness, a collection of forms of praxis particular to homeopathy.

As a corpus of scholarly investigation, clinical reasoning is the subject of widespread theoretical, academic, clinical and professional discourses (Higgs and Jones 2008). Knowing how health professionals such as doctors think (Montgomery 2006, Groopman 2007) helps to inform practice, guides research, and enhances professional development. Clinical reasoning in medicine (and healthcare more broadly) has been predominantly constructed as a complex composition of cognitive skills and ability, coupled with intuition, professional expertise and clinical judgment. There has been less academic interest in the practice, and virtually none in the performance, of homeopathic clinical reasoning. This thesis goes some way towards addressing this gap and to extending our understanding of the phenomenon. Before exploring prominent aspects more closely, let me summarise the main results.

The results collectively demonstrate the multiplicity of homeopathic clinical reasoning experiences, practices and behaviours. From the characteristic cognitive mechanisms (which were anticipated) to the phenomenon I've proposed – iatrosynergy - reasoning and decision-making can be understood as intersubjective and interpretative, utilising knowledge and processes that are contingent on multiple sources, influences, and traditions. This is represented below in Figure One. In addition to blending skills and

knowledge, it emerged that reasoning was a contextual performance between the participants and their patients, incorporating relational, discursive and narrative processes.

FIGURE ONE: The Performance and Mechanisms of Homeopathic Clinical Reasoning and Decision-making



During the course of this study, a series of related qualitative studies of homeopathic clinical reasoning were contemporaneously conducted in the UK, and published. Prior to that, research by homeopaths attempted to demonstrate that homeopaths could achieve consistent results through the application of algorithms (Van Haselen and Liagre 1992). This project faltered, as more recent research has found that the level of agreement between homeopaths given the same dataset was generally poor (Brien, Prescott et al. 2004). These events prompted new approaches to understand homeopathy in the British research mentioned above, from which the PHIRM model emerged, enumerating the core cognitive

components of homeopathic clinical reasoning, as discussed in Chapter 5 (Burch, Dibb et al. 2008). This model includes the role of the practitioner as well as the remedy in homeopathic practice, but thus far has left the ‘therapeutic relationship’ more or less as a black box, underexplored. As a result of this research, I scrutinised the sub-themes *therapeutic relationship* and *awareness of bias* in my research, but quickly found I was foregrounding them, to the extent that they became emergent themes in the results. I also drew on the research of Brien, Dibb et al (2009) on the role of intuition in clinical reasoning and two studies that explored how and why homeopaths form connections with their patients (Eyles, Walker et al. 2009, Eyles, Leydon et al. 2012). Bridging this body of research with the data I have collected, analysed, and described in chapters 7 to 10, I recognise that the performative and relational phenomena of clinical reasoning are profoundly contextual, and that they are still poorly understood. They demand further empirical investigation, since they seem of great importance to practitioners and patients, and yet tend to be treated somewhat dismissively (both within and beyond homeopathy) as ‘merely’ context and placebo effects. This is a point to which I will return.

11.3 Contextualising praxis

Having bridged clinical reasoning research with the results in chapters 7 to 10, I will now explore a series of emerging issues through an exploration of praxis in homeopathy. Praxis encompasses, and is much more than, clinical practice as it is theoretically and pedagogically constructed. By praxis, once again, I refer to the diverse habits, customs, values and ethical traditions of professional practice (Hofman 2002, Wilding and Whiteford 2009). These were, after all, what I observed in the multi-faceted reasoning skills, techniques and mechanisms performed together within a hermeneutic context. These are also the very things that are *invisible* in public debates about homeopathy.

Understanding the participants’ experiences as forms of praxis helps to account for the *woolly model* that Allan described (DS 28), enabling us to follow the co-constructed, dynamic and nuanced aspects of reasoning-in-action. Praxis focuses our attention on action, on the practical applications visible in the lifeworld, rather than (but not ignoring or

excluding) underpinning homeopathic theory. It must not be forgotten that the unifying theoretical objective in homeopathy is to apply the principle of similars, and so the multiple dimensions of praxis serve a collective teleology. Homeopathic theory, continuously present and utilised by the participants, was embedded in the nuances of praxis, depicted in Figure 1.

Performance is of course not only linked to, but is constitutive of, professional identity. I came to appreciate how this was, and can be fruitfully understood as, ethical practice also. Praxis can account for the values giving shape to moral practice in the lifeworld (Wilding and Whiteford 2009). The nuances of performance, described in chapters 9 and 10, both reflected and (re)constructed the participants' mostly implicit beliefs and values (for example, about the symptoms of illness and their proximal causes). Beliefs and values were powerful components through which patient-practitioner relations were constructed, and were themselves reshaped and given nuance in and through the interaction. 'Reasoning', as something performed and relational, was thus intimately shaped by, and shaped, the ethical qualities of the patient-practitioner interaction. Further research is clearly needed to connect this insight with philosophies of clinical ethics (and ethics *as* or *in* action), which I have insufficient time and space to undertake here.

Homeopathy (and homeopaths) must ultimately confront the assertion that the contextual features of praxis (including interaction and performance as context effects) might conceivably account for the clinical changes claimed by patients and sometimes reported by researchers (for example Brien, Lachance et al. 2010, Brien, Leydon et al. 2012). Framing homeopathy as praxis is therefore a necessary step in a reflexive process, part of a response to the circumstances changing and challenging the continuity of homeopathy. Nursing praxis, by comparison, has been through a similar reflexive process for at least twenty years (Lutz, Jones et al. 1997), examining its multiple dimensions. Praxis is therefore necessarily at the heart of this discussion. Let us consider these challenges, and their implications.

11.4 Caseness, praxis & evidence

‘His mission is to treat sick people, not to weave so-called systems from fancy ideas and hypotheses.’¹¹²

What I have called ‘caseness’ has always been central to homeopathy. Indeed, caseness represents forms of praxis that in some ways, certainly in form and process, are particular to homeopathy. (In other ways there are close resemblances with narrative-based and person-centred medicine, practices having developed since the work of Peabody (1927)). Caseness encompasses multiple continuous representations, including the case study, case report, case analysis, and case comparison. Caseness merges practices that are methodically rigorous in some ways, and artistically nuanced in others, reflecting each participant’s interpretative approach. And it must be emphasised that the discourse of ‘rigour’ versus ‘artistry’ is itself a dichotomous construction; we might better understand praxis as destabilising this dichotomy, shifting along a spectrum from recognising patterns of individual elements, to those that seek qualitative or synthetic grasp of their subjects. Nonetheless, understanding what I saw as a balance or relationship between art and science from time to time has been represented in the same terms, within (orthodox) medical discourse (Pellegrino and Thomasma 1993, Davis 1997, Hofman 2002). It certainly captures something of the balance of what sometimes seem like incommensurable ways of thinking, as my participants frequently did.

One of the challenging issues in disputes about the validity of homeopathy is the status of case studies. The clinical and empirical value of case studies in homeopathy has always been considerable, driving knowledge of *materia medica*. The case study is also a pivotal pedagogical tool, fundamental to clinical education. Making cases a valid source of knowledge has driven research (Thompson, Owen et al. 2002, Relton, Viksveen et al. 2014). Case study reports remain the evidence cornerstone for homeopathy, central to praxis, and to the development of *clinically relevant* information for individualised treatment¹¹³ (Bell

¹¹² In each edition of his *Organon of Medicine* (footnote to aphorism 1), Hahnemann emphasised the value of theory, but never at the expense of the primary objective to treat sick people.

¹¹³ Bell (2007, Table 24.1) situates case reports at the top of the hierarchy of evidence among types of research applicable to the homeopathic method. The case report is valued because of the effectiveness it can

2007). The participants reasoned and constructed meaning through the lens of caseness. They seldom referenced homeopathic theory – it was implicit – but they constantly referred to case studies from the homeopathic literature. My research reaffirms that case studies are necessarily of importance in homeopathy because they provide the body of knowledge that is the foundation for the active praxis of caseness. However, a nuanced interpretation of my research suggests that we should understand them less as ‘case studies’ and more as models for interpretative performance.

Tools including the formal case study (Thompson 2004) and the PHIRM model (Burch, Dibb et al. 2008) arguably represent positive steps towards increasing case study rigour and consistency. Although particular case study tools were identified by the participants and could be observed among their skills and techniques, praxis was diverse, evident in their highly individual styles. The case study, in its multiple dimensions, is nevertheless endorsed in most homeopathic literature. A considerable tension therefore exists between the desire to establish a case standard, such as the *formal* case study, and the nuances of caseness, explored through the praxis of the participants in this study. This tension can be seen as representing the contextual destabilisation between rigour and artistry.

The case study remains central, principally to practice, and to the generation of evidence (and claims for that evidence). The case study is also of the first importance in homeopathic research, setting it methodologically apart from conventional medicine¹¹⁴ (Relton, Viksveen et al. 2014). As this thesis demonstrates, the rigour demonstrated by the participants in this study has little in common with the types of rigour that characterise conventional medical research. The biggest disconnect between homeopathy and conventional medicine that I observed from the perspective of immersion in the lifeworld was between methods that give priority to reliability and generalisability, and those that give primacy to the holism of caseness. It is for this reason that critics of homeopathy dwell on how difficult it is to extrapolate from individual cases, especially where extraordinary cases are emphasised (Rutten 2013), and why homeopaths, in response, reject the RCT as an important tool, let

demonstrate in a subset of a particular clinical condition, rather than it demonstrating definitive efficacy for that condition.

¹¹⁴ This may be true now, but how will it look if personalised medicine ever becomes a reality? The case study would then seem to be the ultimate ‘gold standard’ epistemic claim.

alone standard, for demonstrating efficacy in homeopathy (Oberbaum, Vithoukias et al. 2003, Bell 2005, Frass, Schuster et al. 2005, Milgrom 2005, Walach, Falkenberg et al. 2006, Kaplan, Giesbrecht et al. 2011).

11.5 Performing praxis

Foregrounding praxis as performative takes us closer to the nuances of caseness, to the relations I observed, to the hermeneutic interaction between homeopaths and patients. Taking a performative perspective is fruitful for understanding clinical reasoning as diverse forms of action and interaction between the participants and their patients, the continuous interplay between performance and mechanisms, which I try to convey in Figure 1.

Skilled listening, a component of praxis I observed among the participants, is part of the performance of clinical action and interaction. The therapeutic effect of skilled professional listening is categorically valued in diverse healthcare fields including psychology (Lee and Prior 2013), psychotherapy (Gelso 2011) and critical nursing care (Kemper 1992, Lekander, Lehmann et al. 1993). Its therapeutic value is confirmed in historical and existing empirical studies (Sommer, Mazo et al. 1955, Mercer, Reilly et al. 2002, Lee and Prior 2013). This therapeutic effect is also valued by patients engaged in homeopathic care (Mercer and Reilly 2004). It has been suggested that therapeutic listening may be exemplified in the homeopathic context (Mercer, Reilly et al. 2002, Chatwin 2009, Hartog 2009), although any such comparison is difficult to reasonably evaluate and may be a function of the considerable time homeopaths (including the participants) spend with their patients (Kliems and Witt 2011). It has been empirically demonstrated that patients and homeopaths share the value of the connections they form within the consultation process, which they experience as therapeutic (Eyles, Leydon et al. 2012). These praxes were observed in the intimate relationship between many of the participants and their patients.

Moral philosopher Robin Downie has suggested that multiple qualities of the ancient Hippocratic and Asklepian healing traditions have contextual relevance (Downie 2012). In homeopathy, a *theoretical* distinction can be made between the rational (*Hippocratic*) Hahnemannian method, and *iatrosynergy*, the (*Asklepian*) praxis of relational healing, visible

among the participants in this study. Downie frames the Hippocratic tradition as the basis of rational scientific medicine, while the Asklepian tradition is oriented towards healing *from within*, which can be mediated with empathy, and even induced by the mystical hypnotic gaze. Downie asserts that while Hippocratic medicine provides an *explanation* of the patient's behaviour, empathy in the Asklepian tradition is directed towards an *understanding* of the patient. This distinction appealed to me as having resonance with what I observed in my participants, who, however, largely did not construct the 'Hippocratic' processes of remedy matching as an *opposite* to the 'Asklepian' emphasis of holistic engagement with patients, but rather destabilised the binary framing by interweaving and interconnecting both modes constantly, to produce their knowledge, understanding and therapeutic effects. Once more, both for homeopathy and orthodox medicine, binary distinctions are inadequate, any such *balance* between the traditions not being evenly distributed.

I will now examine performativity as forms of praxis, dividing the discussion into four sub-sections. First, I argue that empathy has an important role as a distinctive form of praxis within the homeopathic framework. The second sub-section reconsiders Milgrom's PPR entanglement model, and asks whether iatrosynergy is the same as entanglement. The third sub-section explores the moral status of praxis, and suggests that the practice of homeopathy is ethical. Here, I will suggest that prudence and phronesis characterise the performance of an intellectually and morally sound clinical reasoning praxis (Braude 2012, Frank 2012). In the final section, in contrast, I consider the common representation of empathy and PPR entanglement in mostly dismissive terms as 'merely' placebo or context effects, and argue that this frame misconstrues the value and therapeutic power of contexts.

11.6 Empathy as praxis

In Chapter 9, I discussed how the qualities of the relationship between homeopaths and their patients emerged as a principal theme in my analysis. Earlier in this research journey, I suggested that clinical reasoning is situated and interactive, with clinical discourse holding

substantial meaning (Levy, Ajjawi et al. 2010).¹¹⁵ Subsequently, I proposed that understanding clinical reasoning demanded a closer examination of contextual engagement (Levy, Ajjawi et al. 2010). The importance of this situated interaction became increasingly apparent during data collection and analysis; whether, for example, the relationship and its performance provided some non-specific therapeutic function, in addition to being the context of clinical discovery.

My understanding of empathy is as a phenomenon that is relational and enacted, not a concept limited to describing a cognitive construct or mechanism. While medical and pharmacy students can learn the value of empathy (Lor, Truong et al. 2015, Emily Teding and Malouff 2016), the nature and specific effectiveness of clinical empathy remain undertheorised (Neumann, Bensing et al. 2009). Empathy enables some kind of intersubjective engagement with the patient's experiencing of their illness (Zahavi 2010, Zahavi 2012, Marshall and Hooker 2016). Most study participants performed well-developed empathy, and some were able to articulate their sense of empathy as an embodied phenomenon. Homeopathy utilises the principle of similars in order to select the correct medicine. Empathy, as it is embodied in homeopathy, might also be understood as bearing some resemblance to the principle of similars, as the homeopath builds engagement with, sometimes explicitly through mirroring, the patient's expression or experience in some way. Bruce wanted to *give the patient their remedy*, as well as giving it *in the form of the consultation* itself, as an embodied experience. This most unusual expression from Bruce, demonstrates how empathy might be understood as performed, or as an emergent phenomenon in the context of an individual consultation (Pedersen 2008). The interaction Bruce describes represents what I would call *embodied iatrosynergy*, a contextual form of empathy embodying hermeneutic engagement with a mutual purpose; for the homeopath to understand, and for the patient to experience healing. This concept is productive as it combines the healing power that many practitioners and patients experience with a grasp on some of the conditions of emergence – Marshall and Hooker, for example, ask, *what can empathied bodies do?* (Marshall and Hooker 2016) - and I suggest that it deserves more thorough theorising and empirical research in the future.

¹¹⁵ See Appendix 5.

Empathy is, importantly, not the same as intuition. Empathy (in particular affective empathy) entails *feeling-with* and *being-with* another person (Coplan and Goldie 2011), while intuition has a narrower, more cognitive focus, a kind of perceptive and decisional shortcut. Empathy, as with intuition, is understandably not equally regarded among all clinicians. Bruce, critically engaged with the lifeworld, was careful to differentiate empathy and intuition as experiential phenomena (forms of praxis). He acknowledged the clinical utility and the therapeutic value of empathy, and remained sceptical of the deliberate use of intuition at the expense of knowledge in the face of critical decisions. For other such as Allan, empathy was an end or object in itself, represented in his proclamation that “it’s all about the relationship.”

In considering the reported clinical benefits that may be derived from the consultation (Brien, Lachance et al. 2010) I became increasingly interested in the nuances of performance and interaction. Eyles (2012) declares that *connections* between homeopaths, their patients and the entire process are predicated on the homeopath as a therapeutic component of the context (Eyles, Leydon et al. 2012). These observations correspond with Milgrom’s PPR entanglement model. It is difficult to isolate the apparatuses of homeopathic therapy from the effects of the participants within the context as a whole (Frank 2002, Steinsbekk, Lewith et al. 2008, Milgrom and Chatfield 2011), such that any effect of the *therapy* might in fact be attributable to the *therapist*, or the therapeutic *relationship*, indeed to entanglement, *rather than* the therapy (medicine administered) itself. In addition, any effects attributable to one or more of the ‘components’ of the therapy will in all likelihood vary from therapist to therapist, and from context to context. Further empirical research must consider whether the therapeutic benefits of the context (including the consultation and therapeutic relationship) are *derived from*, or *embodied within* the context, and why the production of meaning is powerful (Boon 2013, Moerman 2013).

11.7 Is iatrosynergy the same as entanglement?

As discussed in Chapter 9, embodied interaction involved *doing* and *being* within an existential spectrum. I understand this engagement as hermeneutic, as an interactive and

interpretative process representing both emergent and generalised entanglement (in Hyland's PPR model, *doing* is predicated on first *being*). Most significantly, Hyland proposes that the state of entanglement is *in and of itself therapeutic* by virtue of the *therapist's intentionality* to heal (Hyland 2004). The therapist needs to be oriented towards the patient (iatrosynergistic) not merely an observer. It is this intention to heal, it is argued, which may be associated with a clinically relevant therapeutic benefit (Brien, Lachance et al. 2010).

Patients themselves consider the homeopathic consultation a framework within which they are more able to cope, for example with rheumatoid arthritis (Brien, Leydon et al. 2012). They describe their homeopath as 'open, calm, sensitive, caring, positive, non-judgmental' and demonstrating 'genuine intention' and 'interest' (2012 p 508). The crucial question is whether these patients might experience a similar non-specific therapeutic effect in response to another form of therapy, for example osteopathy or acupuncture (White, Bishop et al. 2012, Bradbury, Al-Abbadey et al. 2016).¹¹⁶ Entanglement and the therapeutic response do leave unresolved questions, such as homeopaths' attitudes and beliefs regarding prescribing, dispensing and administering the homeopathic remedy. I noted earlier that Fiona was the only participant to ritually prepare and dispense the remedy in view of her patients. Regrettably, as it was an uncommon praxis, I did not investigate this further and it warrants additional exploration. I note that my emphasis on the qualities of entanglement here also invite questions about how we are going to understand the response to the use of over the counter homeopathic products since in this scenario therapeutic effects experienced cannot be ascribed to the consultation (Reid 2002).

Entanglement, despite Hyland's assertion, does not necessarily constitute an exact theory of therapeutic interaction, other than to assert that the patient, practitioner and remedy constitute a process that *may lead* to clinical outcomes (which were not within the remit of my research). These effects cannot account for the fact that PPR is a still poorly understood contextual phenomenon.

¹¹⁶ The comparison with other CAM therapies has limitations. Osteopathy and acupuncture consultations both incorporate the use of hands-on techniques, while the homeopathic consultation embodies narrative forms, culminating in the prescription and dispensing of 'the remedy' which is the theoretically therapeutic component.

Although iatrosynergy provides an embryonic model for understanding PPR interaction, it cannot tell us about the inherent *moral* attitude of homeopaths, about their intentions, values, and behaviour in relation to their patients. Iatrosynergy is an embodied form of praxis in Australian homeopathy, utilised consciously and implicitly in order to develop a nuanced understanding of every patient, in every consultation. At the very least, the data and my analysis are the beginning of some fresh insight into homeopaths' moral intentions. While entanglement as a model for the relationship between the players performs an epistemic role, we might also consider the moral value of the healing intention.

11.8 Moral status of praxis

The preceding examination points to the understanding that praxis is deliberate (requiring and being constituted through action) and implicit (reflecting embedded behaviour). The degree to which these qualities of praxis are deliberate and implicit (perhaps both; like much of clinical reasoning) is understandably nuanced, and varies from homeopath to homeopath. Praxis is also a complex set of moral behaviours, shifting from moment to moment, reflecting the values and beliefs of the players (Komesaroff 1995). And so ethics, or moral qualities, became a question that constantly thrust itself on my attention. Repeatedly observing (and noting) the sensitivity and integrity that the participants demonstrated, I began to acknowledge the value of these small, microethical behaviours as forms of praxis (Komesaroff 1995, Komesaroff 2008).

What, therefore, does it mean to practise ethically in this context? The ethical qualities of each clinical interaction engaged me as being powerful and of intrinsic importance. This was affirmed in the participants' empathetic attention to the minutiae of patient narratives, and to their commitment to their patients' concerns. Observing and considering praxis as moral action resulted in the development of Chapter 10. Reflexively, I have considered what the moral praxis of homeopathy 'looks' like.

Among the nuances of ethical patient-clinician relations are some key reflections. For James, moral praxis was contextually embedded in the clinical space, and through his completely focused engagement. James deliberately constructed praxis within a Buddhist moral

framework, being explicitly impartial towards his patients. Rebecca similarly claimed to privilege the homeopathic rhetoric of ethical, *non-prejudiced* practice, but was more typically illustrative of the paradox that Ruth Barcan (and others) have observed (2011), in which many CAM therapists (not exclusively homeopaths) claim a stance of neutrality yet actually practise within a restricted and restricting ethical framework, constrained by their beliefs about health and disease, and insisting that their patients adhere to these beliefs. Australian homeopathy is enculturated within a set of values and discourses about *natural health, spiritual wellbeing, psycho (narrative) therapy, being and presence*, and so forth. These beliefs sometimes include a particular (and somewhat narrow) moral framework regarding the causes of disease, and the responsibility of the sufferer for his or her predicament.

Bruce understood diverse and substantive ethical concerns. His interaction with the epileptic child's conflicted parents represents his complex moral praxis. Part of the ethical dilemma for homeopathy is that patients (and parents) sometimes resist a particular set of biomedical explanations or beliefs (Freckelton and McGregor 2016). Homeopaths at times confront the refusal of orthodox medical care and need to evaluate the varying demands of honouring patient autonomy against potential treatment beneficence (Beauchamp and Childress 2013). Bruce, attentive at the same time to a potential professional breach in treating a child with epilepsy, evaluated the implications and the risks for the child, her parents, and himself.¹¹⁷ Here, moral praxis and empathy were guided by *phronesis*, the praxis developing from knowledge balanced with experience (Hofman 2002, Svenaeus 2014).

Most homeopaths (including the participants) like most doctors and other health professionals, practise in accordance with their code of ethics and to approved standards; their praxis demonstrates care, empathy and caution towards their patients, at the same time they recognise the limitations of their knowledge and skills. The discipline and reflexivity this requires is itself a cultivation of an ethical, professional self. And that was a compelling aspect of what I observed in my data. It was thus borne in upon me that the

¹¹⁷ See General Principles of Professional Conduct for Professional Members of the Australian Homeopathic Association www.homeopathyoz.org last viewed 13th August 2015.

status of a discipline, and the evidence that supports it (itself never value-neutral) should not be confused with the moral status of those who practice it (Smith 2012, Smith 2012). Most homeopaths privilege the values and preferences of their patients, who seek out and willingly consent to professional treatment, as one component of ethical professionalism. In an ethical defence of homeopathy, I have argued that utilitarian critiques that deliberately conflate epistemic and ethical discourses (Levy and Gadd 2012, Levy, Gadd et al. 2015) fail to observe much that is of ethical relevance in CAM consultations.

This thesis illustrates how Australian homeopaths integrate moral praxis in their reasoning and decision-making. Confronted with competing decision-making pressures, and in the context of hostile social and political forces, the participants were prudent (some more resolute than others). Phronesis, according to Pellegrino and Thomasma (1993), is distinct from both the art and science of clinical judgment. Prudence reflects Aristotle's *phronimos* (Curzer 2012), the one who is endowed with the moral virtue of phronesis. Hofman (2002) and Braude (2012) propose that phronesis can be employed as a *moral* basis for the challenges that medicine faces. Phronesis, moreover, is oriented to the processes of right and good action in the healing relationship (Davis 1997), phenomena performed within homeopathic iatrosynergy. Fittingly, iatrosynergy therefore holds moral value as well as clinical utility. James, Bruce, and others consciously balanced ethical reasoning with grounded clinical decision-making. Regardless of any moral value of praxis however, phronesis is not a surrogate for warrantable clinical knowledge. Rather, virtuous praxis must support and extend rigorous epistemology and skill development.

The participants implicitly demonstrated some awareness of this finely balanced performance. The point of balance is never the same for any series of patients; and so moral praxis and sound clinical decision-making are indivisible rather than dichotomous.

Homeopaths, like medical and other health professionals, are concerned with the ethical care and healing of sick people (Mol 2008, Clark-Grill 2010). Care, arguably implicit and intuitive, holds a central place in homeopathic praxis (Thompson and Weiss 2006) as it does, for example, in nursing practice (Crotty 1996, Welsh and Lyons 2001). The results in

chapters 9 and 10 suggest that although moral praxis may be implicit in homeopathy, considerable reflexive practice can develop it more explicitly.

11.9 Context effects

In homeopathy discourses, critics expediently construe and dismiss the clinical effects of homeopathy as non-specific, contextual, or due predominantly to a placebo response. Repeatedly, critics declare that homeopathic remedies, being extremely diluted, can only harness placebo effects (Ernst 2005), while advocates assert that critics misrepresent the magnitude of the placebo effect in homeopathy (Bellavite, Pitari et al. 2006, Ross 2010). In these discourses placebo is construed as 'inert', 'inactive' and 'non-specific', and a placebo control is a 'dummy' or a 'sham.' In other words, placebo is consistently defined negatively, by what it isn't, rather than what it is. These arguments were outlined in Chapters 4 and 5.

Although it is stigmatised, the placebo concept engages the attitudes, beliefs, and expectations of both physicians and patients. According to Arnold et al (2014 p 398.), however:

Placebo [and nocebo] effects are embedded in the very fabric of therapeutic relationships and are both a manifestation and outcome of the rituals that characterise clinical practice.

My research suggests that the hypothesis that context effects are powerful in homeopathy seems very plausible. Taking into consideration the perspectives, the praxis, and the rituals of homeopathic context provides more detailed insight into how the performance is directed towards producing *context effects* and to valuing them, through co-constructing them.

In considering the performative value of context effects, distinctions are necessary. A placebo *response* measures the control response in a clinical trial, while a placebo *effect* is the difference between the placebo response and the changes that would be observed without the administration of a placebo (Kirsch 2013). Among the constructions of placebo

and placebo effects, there are overlapping biological, psychosocial and ethical considerations (Finniss, Kaptchuk et al. 2010, Bishop, Aizlewood et al. 2014). Research investigating psychosocial-induced chemical changes in the brain suggests that placebo effects are sufficiently powerful to affect the course of disease and response to therapy (Benedetti 2008, Finniss, Kaptchuk et al. 2010).

Context effects are a component in all clinical encounters, regardless of the specific domain (Di Blasi and Kleijnen 2003, Miller and Brody 2011, White, Bishop et al. 2012, Relton 2013). For example, in a homeopathic RCT of irritable bowel syndrome, the authors concluded that the effect of the patient-practitioner relationship constituted the *most robust component* of placebo effects (Teixeira, Guedes et al. 2010).

Setting aside empirical research into therapeutic encounters, my study participants attributed value and meaning to the context of these relationships. Many, including Veronica, Susanna, and Charlotte, openly discussed the therapeutic potential of these relationships. However, they also acknowledged that the therapeutic relationship is hermeneutic; that it is an interpretative vehicle through which the patient's narrative unfolds, enabling them to develop a more coherent symptom picture, exemplified in Allan's *dual process*. The participants, therefore, did not deny the importance of context effects; however, most were unable to distinguish (or naïve to the possibility of) context as an independent effect, from the value of context as facilitating hermeneutic understanding between them and their patient. The participants certainly 'employed' context effects, but not with the deliberate and pejorative intention that critics claim. Context effects including patient *and* clinician motivations and expectations operate in shaping the process and the outcome of clinical interaction (Hyland 2003, Benedetti 2008).

Kirsch has suggested that there are multiple context effects. These depend on the condition being treated, and how it is being treated (Kirsch 2013). And if there are multiple context effects, the patient-practitioner relationship among them, it must confidently be considered that the effects of this relationship will vary from therapy to therapy, context to context, and patient to patient. This draws our attention even more critically to the hermeneutics of context and to the unique relationship *in each and every* clinical setting, and to how the

experience of being a patient in a homeopathic context differs from patient experiences in other contexts.

Context effects are embedded within the performance of homeopathic rituals (Chirumbolo 2015). The power of rituals in complementary therapies is diverse and cannot be underestimated (Kaptchuk 2002), evident for example in acupuncture trials (White, Bishop et al. 2012). Ritual elements in homeopathy include the thing bearing a therapeutic expectation (the tablets or liquid dispensed), the expectation that the thing dispensed is a 'natural product', and the trust that this thing is devoid of adverse (nocebo) effects (Chirumbolo 2015 p 8). James created an unobstructed physical space; Rosanna constructed an internal blank slate. Charlotte and Bruce demonstrated empathy with their patients during extensive interviews, without disconnection. Fiona, in a ritual only she (among the participants) practiced, dispensed homeopathic medicines in direct view of her patients, medicating a prepared bottle of solvent with a homeopathic remedy, before succussing it¹¹⁸ and then labelling the bottle. These contextual features, while related, are part of the praxis particular to each participant. The participants acknowledged the value and utility of these behaviours in their contribution to the patient's therapeutic experience. Context effects in homeopathy appear to be a powerful if underestimated feature of the clinical experience (Chirumbolo 2015).

There remain questions about the degree to which homeopaths realise or are prepared to acknowledge the possibility of context effects in their practice (Chirumbolo 2015 p 7). This question is germane to the claim that homeopathy requires *deception* in order to achieve effects (Shaw 2015). But 'deception' is a wholly inaccurate way of framing the lifeworld of homeopathic consultation. Even placebos can apparently be administered ethically, without deception (Kaptchuk, Friedlander et al. 2010, Greville-Harris, Bostock et al. 2016). I hope that this research will help discourse progress to a more nuanced grasp of context effects in homeopathy. For homeopathy, researchers and practitioners would do well to come to terms with the evidence that suggests that contexts are remarkably powerful (Di Blasi and Kleijnen 2003), and that homeopaths like all practitioners, do generate, and utilise, context

¹¹⁸ Succussion involves vigorously striking the medicine against a firm but elastic surface (such as a leather-bound book) a fixed number of times.

effects (Miller and Kaptchuk 2008), as my participants were comfortable with implying, on their own terms.

Nocebo, as a context effect in homeopathy, has attracted less attention than placebo. A nocebo response is predicated on some expectation of experiencing negative effects due to an intervention (Teixeira, Guedes et al. 2010). In homeopathy, the nocebo effect revolves around the theoretical concept of an 'aggravation' (initial worsening of symptoms) induced by the similarity (or correlation) between the homeopathic medicine and the patient's disease symptoms (Reilly 2000, Stub, Kristoffersen et al. 2015). Establishing a nocebo response in homeopathy first demands a level of acceptance that homeopathy utilises context effects, an assertion that many homeopaths still refute. Leanne was the sole study participant who had given the subject consideration (DS 58: lines 62-75). Her praxis was framed to reduce patient uncertainty and to enhance therapeutic effect:

We don't call it an 'aggravation', because that's kind of a negative word, we call it 'a spring clean' because that's kind of a positive word ... [our patients] all use the same kind of language and tell their friends what to expect, [so] we're creating our own culture.

A more sophisticated discussion of context effects represents both a critical theoretical challenge for homeopathy, and an opportunity for homeopaths attached to foundational principles to explore their beliefs about what constitutes homeopathic *therapy*. Acknowledging and researching the power of homeopathic context effects will go some way to meeting this challenge.

11.10 Convergence and divergence

There is ongoing and unavoidable tension between homeopathic claims to being distinctively different from conventional biomedicine and yet similar to or occupying the same role as medicine. I revisit this question here, highlighting the distinctiveness of praxis.

Firstly, it must be noted that the representations of homeopathy – whether this be the dismissive claims of Friends of Science in Medicine at one pole, or proponents and defenders at the other – are political and hypothetical. Quite simply, neither were representative of the homeopathy-in-practice that I examined in this study. Homeopathy, in its multiplicity, is far more nuanced; its praxis – abundant in the results - encompasses the knowledge, understanding and especially the experience of every participant. Like conventional medicine (and like qualitative research), the praxis of homeopathy is messier and more non-linear than the tidy, concise and logical case studies presented in journals and at case conferences.

11.10.1 Convergence

After empirical investigation, it appears that homeopathy and conventional medicine *converge and diverge* as forms of praxis. I suggest that homeopathic praxis, like conventional medical praxis, embodies forms of hermeneutic engagement, and utilises methods of hermeneutic interpretation (Baron 1990, Daniel 1990, Leder 1990, Svenaeus 2000 p 120). These are embedded within an ethical framework that privilege patients' values, beliefs and preferences. This approach can be understood as convergent with certain developments in conventional medicine such as patient-centred and narrative styles (Miles, Loughlin et al. 2008) but not others, such as genetically personalised approaches.

Practitioners and philosophers might agree that a formal evaluation of the *logics* of homeopathy and conventional medicine would show that they had a great deal in common. However, they might part company on the status of the *propositions* from which the logical processes began. Logic, in homeopathy, is built upon the proposition of similars, manifest in the multiple forms of caseness described in this thesis. For example, pattern recognition and portrait-building, while noticeably heterogeneous in the data, results in deductive remedy matching. Homeopaths implicitly use logics that are *internal to* homeopathy. These internal logics help to explain both the unremitting necessity for the epistemic justification of homeopathy, and for the incommensurability between homeopathy and biomedicine.

Clinical reasoning and decision-making in homeopathy nonetheless converges with many elements of biomedical reasoning. This convergence can be best illustrated in the PHIRM model (Burch, Dibb et al. 2008), broadly accounting for the mechanisms giving homeopathy its distinctive shape (Figure 1).

Experienced conventional physicians generate a first problem formulation (a preliminary pattern) within thirty seconds of seeing patients (Elstein, Shulman et al. 1978). Logic, in the form of general observations such as *psychological problem* and *respiratory problem* can be rapidly formulated. Observations are frequently reinforced by statistical evidence that supports diagnostic and decision frames. Homeopaths have fewer high quality RCTs available, and so most of the data utilised in homeopathy is derived from mid-level EBM evidence (including case reports and professional expertise). They can, however, reach rapid differential homeopathic diagnoses, as for example did Pauline (DS 19), within minutes of meeting and interviewing a new patient. These diagnoses are based predominantly on received authority and professional experience.

Homeopaths explore patterns through sustained narrative caseness, iteratively comparing the patient's illness symptoms with the known symptoms in provings, toxicological reports and case studies. The continuity of this praxis was evident in the lifeworld of every study participant. Clinical knowledge of biosciences (for example pathology), while advantageous for homeopaths, is not always utilised.

Pattern recognition in homeopathy is mirrored in the principle of similars. In biomedicine, pattern recognition is one of many cognitive mechanisms or frames used to organise knowledge and to solve clinical problems (Offredy 1998, Coderre, Mandin et al. 2003, Norman 2005). It is usually swift and may be intuitive, especially in expert or experienced clinicians (Bleakley, Farrow et al. 2003).

Both conventional biomedicine and homeopathy subscribe to an ideology of the physician as a neutral, objective and unbiased observer – and both must confront the gap between ideology and practice.

The role of intuition is an interesting and sometimes vexed issue here. Narrative theorists assert that intuition is a tacit everyday skill employed by expert conventional physicians (Greenhalgh 2002) including nurses (Offredy 1998, McCutcheon and Pincombe 2001, Lyneham, Parkinson et al. 2008, Green 2012). In homeopathy, intuition is deliberately utilised by most homeopaths (Brien, Dibb et al. 2009) and yet is not always trusted. For most of the study participants, intuition was valued, while for homeopathy as a whole, the relationship between rational and intuitive mechanisms is still somewhat ambiguous

Bruce and Allan were concerned that intuition might lead to bias (Souter 2006). As a corollary, the aspiration to *freedom from prejudice* in homeopathy, which was explicitly stated by many of the participants and found correspondingly commonly in conventional medicine (Pedersen 2008) is equally problematic. Instead, I argue that it is time we understood homeopathy as an inherently hermeneutic phenomenon, and no longer imagine that it is ever possible to produce completely unprejudiced observation or an unassailably neutral stance. The uncertain status of neutrality in homeopathy also provides an easy target for critics of its episteme (Baum and Ernst 2009, Ernst 2011).

My interest here moves to the value of homeopathic praxis. Praxis in Australian homeopathy privileges time and care in order *to understand* patients, not only the details of their illnesses. A similar form of praxis is valued in German homeopathy (Plunger 2007, Kliems and Witt 2011) and in the UK (Relton, Viksveen et al. 2014). In this respect, praxis in homeopathy has more in common with nursing than biomedicine (Tanner, Benner et al. 1993, Miles, Francis et al. 2013). The therapeutic power of the time spent with patients and therapeutic listening cannot be underestimated as forms of praxis, having been historically valued (Peabody 1927, Kliems and Witt 2011, Sommer, 1955).

This study demonstrates that the embodied, relational, and performative components of clinical reasoning are embedded in multiple forms of homeopathic praxis. Consequently, an enhanced taxonomy of clinical reasoning must account for these phenomena. A taxonomy that incorporates hermeneutic engagement in the form of iatrosynergy (vital to therapeutic possibility) is indispensable. Figure 1 locates these relations and points to an emerging taxonomy, one shifting in focus from the mechanistic to the performative elements of

clinical reasoning. In this regard, divergence between homeopathy and conventional medicine is more apparent, particularly in regards to praxis.

11.10.2 Divergence

Through close engagement and hermeneutic interpretation homeopathy individualises the patient, diagnosis, prescription and management, including where multiple patients have the same medical diagnosis.¹¹⁹ The case encounters I observed were long, complex, iterative, and non-linear. Epistemically, this non-linearity is altogether different from the imagined discursive account of the clinical process that dominates conventional medicine (Komesaroff 2001). Conventional medical diagnosis, prescribing and management utilise evidence predominantly within the boundaries of the RCT (Derkatch 2008) in order to produce an object, namely the disease diagnosis. Within homeopathy, in which medical diagnosis is not the primary object, illness accounts can reach far beyond the body as an anatomical-physiological structure, into the phenomenology of lived illness. And, while many biomedical doctors also engage in non-linear, multifaceted illness accounts (Carel 2011), diagnosis holds a particularly profound organisational as well as epistemic status in biomedicine (Jutel 2009, Jutel 2011). These examples demonstrate the fundamental epistemic (we might even say cultural) divergence between the two systems.

11.10.3 Internal divergence

In addition to being divergent from biomedicine, homeopathy itself struggles to be internally convergent. In contrast to my research participants, many homeopathic doctors practice within a modified biomedical paradigm (see for example Swayne 2012) guided by medical diagnosis. While some homeopathic doctors adopt the Kentian *constitutional* approach (Bailey 1995, Kaplan 2001), many non-medical *classical* homeopaths privilege a strictly Hahnemannian approach (Dimitriadis 2004). For the latter, the viability and distinctiveness of homeopathy rests upon strict adherence to Hahnemann's principles and Bönninghausen's methodology (2004). Such simple categories also tend to obfuscate the

¹¹⁹ It is possible that a population in the midst of an epidemic illness, such as dysentery, would be prescribed the same homeopathic medicine (or one of a *small group* of medicines), while patients suffering an infection, such as pneumonia, would be prescribed only individualised medicines.

multiplicity of techniques and models that have been developed (Watson 1991, Schmidt 2009), evident among the participants in this study. While congruent conceptually and philosophically, praxis is internally diverse. Each study participant demonstrated praxis congruent with her personal understanding of illness, and consistent with her own interpretation of homeopathy. The *woolly model* Allan described represents the multiplicity of praxes.

Although attention to core theoretical principles was uniform for the participants, diagnostic tools (such as Fiona's 'opening and closing gates' and Veronica's 'if you were to give me that pain, how would it feel') were far less consistent; praxis is ultimately variable. Attachment to iconic texts (notably Hahnemann's work) meant that some of the participants were simultaneously suspicious of certain contemporary theorists, especially those whose theoretical contribution had not been developed through the conventional methodology of provings. Those, for example, who prescribed on the basis of patients' dreams (Dam 1993, Sharma 2004). Although cautious regarding the reliability of some unconventional texts, the participants retained a fundamental respect for theory, especially Hahnemann's contribution.

The lack of internal consistency in homeopathic clinical reasoning can be correlated with the absence of an agreed taxonomy. Unlike conventional medicine, homeopathy does not generally adopt a *best practice* model for the diagnosis, treatment and management of illness and disease. Faced with the same patient and the same disease presentation, a group of homeopaths will in all likelihood reach a slightly different diagnosis and management plan.¹²⁰ My empirical research demonstrates that homeopaths develop an implicit *personal best practice* approach, reflecting their individual praxis. Given that few homeopathic studies attend to the recognised principles of best practice, such as Heirs' attention deficit hyperactivity disorder study (Heirs 2012), and that critics take full advantage of this omission (Ernst 2002), I wonder whether further research in developing reflexivity and its consequences and some methods of generating personal best practice approaches more consciously, might be fruitful. In this way we might begin to mediate between the diversity

¹²⁰ The differences in their diagnosis and management plans might be considerable, as for example the selection of different medicines, different potencies, and different methods or routes of administration.

in homeopathic praxes and how this is understood to relate to or make judgments about the quality and integrity of research, or of clinical practice.

11.11 Homeopathy and qualitative (IPA) research

To some degree, both biomedicine and homeopathy can be understood as a miniature research process whose aim is to identify what is causing a patient's illness or suffering, and what might ameliorate it. Similarly, as this research progressed, I became increasingly interested not only in the status of homeopathy, but that of qualitative research, and IPA research in particular. Irrespective of their co-utility, they face similar methodological critiques. I began to consider the similarities between homeopathic methodology and IPA research as knowledge-generating disciplines. Below, I examine the intersection between homeopathy and IPA, and drawing attention to some of the arguments in their defence.

The diverse modes of clinical reasoning experience described in the results suggest *multiple idiographic homeopathies*, rather than a singular form. Consequently, like IPA research, homeopathy is confronted by questions of rigour, reliability, coherence and consistency. The following reflexive discourse includes a discussion of difficult questions about claims to the warranty of knowledge in homeopathy, and in qualitative research. I suggest that homeopathy can be reframed and reconsidered as a form of, or in the same ways as, qualitative inquiry (inquiry that is focused on one individual case at a time). Reframing homeopathy in this way would help accommodate its internal diversity. In doing so, homeopathy we can draw parallels with the contingencies of hermeneutic interpretation and see that homeopaths might use similar logics as are used in qualitative inquiry as warrants for the resulting understandings constructed about and with the patient. These assertions and the comparison with IPA need discussion.

In considering the strengths and limitations of IPA research, I was compelled to reflexively consider the methodological intersections between homeopathy and IPA research. Three insights have emerged. In summary: 1) that homeopathy and IPA do indeed intersect; 2) that I have been *doing IPA* in ways similar to the ways a homeopath investigates a case – so perhaps, with the preconceptions of a homeopath; and 3) that both homeopathy and IPA

(and qualitative research more broadly) are confronted by related methodological critiques against which they must respond.

A striking parallel understanding began to emerge, between the individualising methodology that pervades and governs homeopathy, and the idiographic commitment to the particular in IPA research. For IPA, idiographic commitment precludes generalisation; that is, at least until the phenomenon of interest has been rigorously compared across a range of participants' experiences. Smith (2009 p 29-30) argues that single-case idiography underpins the research case study, and that IPA can, through distinct inductive analytical procedures, move from the single case to more general claims, without ever making *universal* generalisations. This distinction - that through idiography some level of generalisation might be cautiously claimed - resonates with Thompson's (2004) formal homeopathic case study methodology. Thompson, however, asserts that once the formal case study has been thoroughly modelled, it can be used to generalise and so to increase the value of the case study within the homeopathic evidence hierarchy.

These claims provoke questions regarding the criteria with which the individual homeopathic case can be legitimately generalised. Whether, for example, the craving for sugary foods typically experienced in *Lycopodium Clavatum* cases can be generalised to metabolic disorders such as Type 2 Diabetes. While the symptom may be clinically significant, and a useful diagnostic guide for type 2 Diabetes, it is insufficient for a rigorous diagnosis of *Lycopodium*. In any event, both diagnostic frames have limitations; neither *Lycopodium* nor Type 2 Diabetes can be accurately diagnosed on the basis of an isolated symptom. Some would argue that the craving for sweets is insufficient and not a diagnostic criterion.

Although unrelated disciplines, homeopathy and IPA both investigate, interpret, and ask particular questions about the meaning of lived phenomena. In IPA, idiography draws the researcher's attention to the particular, to the nuances of the lifeworld. Similarly, the homeopath seeks to identify the characteristic, subtle, and individual symptoms through caseness. Each homeopath employs a methodology derived from and committed to extant philosophical and theoretical premises. Critically, however, homeopathy and IPA do not

share the same objectives. While the *process* of each can be understood as interpretative and performative, the goal of the homeopath is to find the most similar remedy in order to restore health for each patient, while the object of IPA research is to interpret a set of phenomena in order to understand them, and so to construct meaning. I did think, however, that in many circumstances and as illustrated by the concept of giving the simillimum as the consultation, remedy selection functions sociologically in the same way – as a means of interpreting a set of phenomena and so to construct meaning.

As an IPA researcher, I reflected on several key remarks made by Smith, Flowers and Larkin (2009 p 80-81). Firstly, that the route through analytical strategies is not linear (and the experience challenging) and that there is no *right* or *wrong* way of conducting this type of analysis.¹²¹ This resistance to declare a fixed method has attracted critique; the claim, for example, that their absence makes IPA research methodologically unreproducible, and so unscientific (Giorgi 2011). Positivist and interpretivist epistemologies at some level are and remain incommensurable; they speak different languages, they employ different research tools, and they appeal to different logics (Hacking 1983).

Secondly, that the result of an IPA study is always a *double* hermeneutic account; an account of how I interpret the participants' interpreted accounts of their lived experience. I have endeavoured to reveal the participants' lifeworld, yet it is inevitably an interpretation imbued with my experience and forestructures. The same can be said in regards to the double hermeneutics of clinical case interpretation.

Thirdly, and most paradoxically, an IPA researcher learns only retrospectively that the steps guiding IPA research ultimately teach one how *not to be fixated* by those steps. IPA is 'an approach and sensibility, as much a way of thinking about seeing and doing, as of doing something' (Smith, Flowers et al. 2009 p 81, Finlay 2014). These vital remarks drew me, as an IPA researcher, to re-examine assumptions, in particular those representing any justifiable knowledge claims (of both the research process, and its products), a predicament that confronts both interpretative research *and* homeopathy.

¹²¹ *Flexibility* in the production of IPA analysis is regularly debated and confirmed in an IPA forum IPANALYSIS@yahoo.com last viewed 31 July 2016.

11.12 Hermeneutics and the products of caseness

Throughout the data collection and analysis, I noted the complex layers of interpretation common to both homeopathy and IPA research. The participants moved temporally with their patients, returning to a particular remark or observation necessitating clarification, much as IPA research moves iteratively from the particular and idiographic towards more general observations. I have described how homeopaths and patients participate in a hermeneutic dyad, exchanging symptoms, sensations, and emotions, making sense of and constructing the meaning of illness together, in a practice similar to IPA research (Larkin, Watts et al. 2006).

Rather than being inhibited by the tools of caseness or IPA, I value the attention to nuanced caseness of homeopathy, and the discerning hermeneutic interpretation made possible through IPA methodology. Not only are the analytic processes similar; so too are the 'products' of analysis. The homeopath and IPA researcher each endeavours to produce legitimate knowledge. The homeopath accumulates an inventory of managed cases contributing to knowledge of the application of remedy X; each case constitutes a small piece of research contributing to a defensible episteme about the use of particular reasoning strategies in the construction of an evidence base for that case. These products ultimately acquire pedagogical value, being utilised in teaching and study. Similarly, through IPA, the researcher endeavours to produce warrantable knowledge about a phenomenon. These 'products' might include how that knowledge is constructed and interpreted, and consequently how the phenomenon is valued. This thesis produces knowledge about the process of homeopathic clinical reasoning, and, at the same time about the acceptability of that knowledge. I will return to this claim.

Observation and interpretation in both biomedicine and homeopathy are indivisible. Hermeneutic interpretation is necessarily subjective, may be ambiguous and has room for disagreement (Leder 1990 p 10); so too, the patient and the patient's illness text are never static (Baron 1990). As I examine the participants' experiences, the act of observation is neither value-free nor ahistorical. Epistemology holds values, it makes axiological and normative claims and so cannot remain neutral (Carter and Little 2007). For example,

emergent themes in this study including *patient context* and *therapeutic interaction* hold particular value, and are inseparable from my own preconceptions, meanings that were informed within years of clinical experience. I had my own sense of the normative value of the components of caseness, how and when the particularity of the patient's context and the therapeutic relationship might be effectively utilised in decision-making. Reflexively, all interpretation and understanding representing the distinctiveness of context and therapeutic interaction are imbued with value. Inevitably, values and hermeneutic interpretation are intersubjective, and meaning is contingent on how and by whom it is constructed. Foregrounding my own experience (a methodological requirement) allowed me to interpret the events and the intentions of the participants.

Hermeneutic and IPA methodologies assert and accept that human discourse is predicated upon meaning-making engagement, and so the discussion accepts the construction of multiple meaningful (or meaning-less) interpretations. The paradox for homeopathy, on the other hand, is to disaggregate a theoretical attachment to *pure, meaningless* symptoms from the notion that all symptoms represent layers of meaning. Is homeopathy a method of applied phenomenology capable of value-free, pure interpretation, as has been proposed (Swayne 2013, Whitmarsh 2013)? This discourse represents a perpetually detached, neutral form of homeopathy, somewhat naïve in failing to see how interpretative it is. Subsequently, Swayne and Whitmarsh assert, like participant Rosanne that the accomplished homeopath is capable of unprejudiced observation in order to distil what the patient needs. The comparison between homeopathy and phenomenology (Whitmarsh 2013), while apposite, does not adequately account for what is actually meant by the study of *lived experience*. Any discreet application of phenomenology must surely acknowledge that the homeopath interprets, that phenomena cannot *simply be observed*, and that clinical observations are always the products of interpretation (Levy 2014). This observation is evident in the results, in particular in Chapters 9 and 10. The explicit attention to interpretation on the one hand, and the desire to be objective on the other, *to be that blank slate* as Rosanne depicted it, presents an ontological and epistemological tension. While the participants uniformly agreed on the need for neutrality, they simultaneously practiced with a degree of proximity that bordered on intimate, engaging their patients in detailed and very personal dialogue in addition to investigating their physical symptoms. Figure 1

suggests that the context, interaction, and performance of clinical reasoning are indivisible from its fundamental principles. I suggest that homeopathy, like hermeneutic phenomenology and IPA, is a process in which the researcher perpetually observes and interprets every word, gesture and behaviour, every nuance of lived experience (Van Manen 1997, Larkin, Watts et al. 2006). Acknowledging the inevitability of interpretation dismisses the construction of unprejudiced observation, enabling the homeopath to practise reasoning with interpretative flexibility – a kind of ‘situated knowledge’ (Haraway 1988).

As the participants listened and engaged their patients at length, turning observations into symptoms, and collecting symptoms into a meaningful whole, I was engaged in a similar interpretative activity: each participant demonstrated visible fragments of clinical reasoning; together, the whole of the participants’ experiences emerged; *not the entirety* of homeopathic clinical reasoning per se, but at the very least a meaningful composition, enabling me to construct a more useful epistemology and an increasingly coherent map of homeopathic reasoning. Reflexively, these observations are an interpretation – and a reconstruction - of the participants’ actions as much as the participants constructed hermeneutic interpretation of their patients’ lived illness experiences.

I am interested in whether through hermeneutic engagement homeopathy might more explicitly use the perspectives of IPA research. IPA research is iterative; the insights IPA achieves are not expected to be neutral. Each cycle of data analysis produces new insights, some subtle and others more explicit (Finlay 2013). Reflexivity increases the integrity of qualitative research (Guillemin and Gillam 2004). Through hermeneutics I acknowledge that participant experiences are a representation, merging with my interpretation. There can be no pure essence, no Husserlian phenomenology of clinical reasoning. I could not bracket my values, beliefs or experience any more than Rosanne could genuinely be *that blank state*. In the same way, scholars of hermeneutics acknowledge the inescapable stance of interpretation, for example in medicine, in which making a diagnosis is essentially a hermeneutic exercise (Bowman 1990, Leder 1990). Clinical understanding in homeopathy is unavoidably interpretative, often dependent on the subtle qualia of human sensation (Sankaran 2002). IPA research, however, compels the researcher to be reflexive, recognising intersubjectivity, and constantly accepting that the meaning of experience is co-constructed.

The techniques of homeopathy can certainly be informed by IPA, in particular through the practice of reflexivity. Just as qualitative researchers ground their claims of ethical practice in a cultivated reflexivity, homeopathy can be practiced ethically and with integrity from a similar consciously interpretative position (Levy and Gadd 2012, Levy, Gadd et al. 2015).

11.13 The status of knowledge claims

The preceding analysis raises important concerns regarding the status of epistemic claims in homeopathy. Examining these claims assists in understanding how homeopathy can be positioned in future discourses.

Building upon rational principles, Hahnemann (despite having few tools available to him) developed an empirical method appropriate for the era, geared to observation as rigorous and reliable as he could devise it. The development of provings on healthy people, the study and application of the 'pure effects' of medicines, and the attention to individualised treatment represent claims that homeopathy is epistemically sound.

An enduring school remains committed to Hahnemannian methodology (Dimitriadis 2004, Dimitriadis 2005). On the other hand, and increasingly evident in this thesis, homeopathy also makes implicit claims to being an interpretivist methodology. This tension has always been embedded in homeopathic epistemology (Schmidt 2009). And so it can be argued that Hahnemann himself unwittingly laid interpretative foundations in the attention to particular rather than to generalisable claims, effectively setting up homeopathy for later critique. The result is that by its multiple commitments to empiricism and the scientific method, and its simultaneous commitment to interpretivism, homeopathy perhaps contained the seeds of its own historical demise.

Through the process of writing this thesis and scrutinising carefully through all the evidence, I could not avoid the conclusion that any defence of homeopathy as empirically validated by the same methods as are used in orthodox medicine, were doomed to failure. This is often inadmissible for many homeopaths; but the reality is, challenges are numerous and the response from within homeopathy has been limited. Homeopathy is only beginning to

acknowledge, for example, the problem of confirmation bias in case analysis (Souter 2006, Rutten 2013). The formation of symptoms (data) into clusters is subjective and so may be unreliable, particularly for homeopathic research design (Oberbaum, Vithoulkas et al. 2003). Homeopathy ultimately faces questions regarding its epistemology, its beliefs and practices, in order to warrant it. It is not sufficient to assert warranty based on continuity of practice and claimed outcomes.

Qualitative research has faced and continues to face similar objections. The prestigious BMJ, for example, recently declared that it privileges quantitative research over all other forms of research, a position attracting ardent rebuttal (Greenhalgh, Annandale et al. 2016, Webster 2016). Homeopathy, in particular if it intends to claim justifiability on interpretivist grounds, might do well to be attentive to the strategies and concepts used in qualitative research to increase rigour and reliability and at the same time to value depth and multifaceted analysis, and the bases on which some generalizability might be claimed and re-examined or checked within the necessarily subjective and interpretivist view of the analyst. Criteria including validity, trustworthiness and rigour are critical in order for qualitative research to produce justifiable knowledge (Koch and Harrington 1998, Rolfe 2006, Carter 2010).

Hermeneutic research has the potential to transform thought, action and behaviour, for the participant *and* the researcher (Higgs 2010). Similarity between participant and researcher behaviours became increasingly recognisable as integral to the research process and the results.

IPA encourages the researcher to examine the relationships between personal experiences and their social context (Smith 2011). I have tried to fulfil this obligation, acknowledging the evolution of homeopathic clinical reasoning within the antagonistic context of social and political change. This attitude has produced unexplored questions and perhaps uncomfortable insights, including insights into being a researcher (Koch and Harrington 1998).

Reflexivity enhances and reinforces the methodological rigour of a study (Koch and Harrington 1998, Rolfe 2006), and so functions in the defence of interpretative research. It is

asserted that a reflexive understanding of the relationship between the participants' experience and the research process increases the coherence of the results (Carter 2010). This perception, supported by this discussion, proved to be an unanticipated product of the study and is, I suggest, a contribution to IPA research. IPA is better suited to understanding homeopathy as a lived phenomenon than I had anticipated.

Through the development of this thesis it is clear that *what counts* as warrantable knowledge in homeopathy is inconsistent (at least not as consistent as the participants would want). Acknowledging that praxis is hermeneutic and interpretative, homeopathy would do well to develop the rigor, reflexivity and integrity – to embrace the richness - that characterises qualitative research, including IPA. Appropriately situated in the interpretative paradigm, the multiplicity of homeopathies can operate with the flexibility required. At the same time, homeopathy must abandon its attachment to the scientific method within which it wins no favour and has little future. Critically examining praxis while retaining its epistemic principles can bring research closer to understanding what and how homeopathy works for its many patients and advocates.

11.14 Summary of discussion

This thesis proposes a coherentist view of valid clinical reasoning, demonstrating the foundations on which reasoning is based. Homeopathic reasoning is coherent from the theoretical foundations that *it accepts*. However, there remains a discontinuation between foundations, reasoning and results, and the lived experiences of homeopaths, which are not always consistent. Taken as a whole, this thesis encompasses more than the phenomenological observations from the data. It provides a clear introduction to homeopathic foundations, and then an interpretation of the lived experiences of those who put the foundations into practice.

Homeopathy has hardly acknowledged and less still carefully examined its critiques, in particular those from within placebo research. Instead, it remains attached to defending itself from marginalisation (Fisher and Ernst 2015), a defence reflected in the participants' lifeworld. Chirumbolo, in his examination of placebo effects in homeopathy (2015 p 4)

asserts that the lack of analysis of PPR entanglement and of homeopathic context must be considered an over-simplification. However, he does not resist the claim that despite the possibility of placebo effects, patients trust homeopathy, and homeopaths trust homeopathy, proposing that 'people are anthropologically bewitched' by the minority outcry (2015 p 26). And, *all* forms of therapy seem to contain context effects (Miller and Kaptchuk 2008, Brody and Miller 2011, Miller and Brody 2011). In that respect, homeopathy is no different to any other form of healing. The larger question, so far unanswered either by proponents or critics, is whether context is the *only* mode of action for homeopathic therapy. Given the intense iatrosynergy between patient and therapist, described in this study, context must presumably be significant, and the symbolic giving of the remedy reinforces that. Current literature about placebo points to the power of context, so that attempts by detractors to dismiss homeopathy ethically or epistemically on these grounds seem to fail. If homeopathy were to be renamed 'placebopathy' it would still work as it does now. Then, who would be most critical – homeopaths for being chastised as dispensers of placebos, or critics who were confronted with a praxis that engaged with an increasingly acknowledged form of 'indirect' therapy? What these claims mean for ethical praxis, and for the discourse as a whole, must in future be considered.

Homeopathic clinical reasoning and its underpinning theoretical framework is much more than a set of discrete skills and practices. Reframing clinical reasoning as praxis incorporates the interactive, relational and performative aspects that have not been closely examined and are still not well understood. These emerged as important features in the lifeworld of homeopathy, being central to the praxis of clinical reasoning.

CHAPTER 12

Implications and conclusions

Before concluding, it is necessary, and I trust of reflexive value to the reader, to return to the hermeneutic circle (perhaps more elliptical than circular) that depicts my research journey, and to carefully consider the implications emerging from this study. Through IPA, homeopathy can be understood as a method of healing that is richly hermeneutic as much as it is phenomenological; it is through hermeneutic interpretation that the lived illness experience comes to life and from which meaning is ultimately constructed.

My results have clear implications for practice, teaching, and for the defence of homeopathy. They may also, at least in theory, have implications for the public discourse that surrounds homeopathy.

A discursive turn is emerging in how homeopathy is practised and how clinical reasoning and decision-making are understood and constructed. Research in the last two decades explored decision standardisation and reproducibility (Van Haselen and Fisher 1992, Van Haselen and Liagre 1992, Brien, Prescott et al. 2004), shifting to the PHIRM model incorporating intuition (Burch, Dibb et al. 2008, Brien, Dibb et al. 2009). Subsequent research acknowledged decision bias and began to explore the patient-practitioner relationship (Eyles, Walker et al. 2009, Eyles, Leydon et al. 2012) and forms of PPR entanglement (Milgrom 2006). My concurrent research acknowledges and extends the PHIRM and PPR research. This new turn emerges from similar methodological and philosophical commitments, acknowledging that despite its rich clinical history, understanding the phenomenology of homeopathic decision-making has been lacking. While my conclusions are similar, this study emphasises that homeopathic clinical reasoning consists of multiple forms of praxis, informed by theory and texts, and built upon relational and hermeneutic features. My study can therefore be rightly regarded as consistent with the discursive turn in homeopathy.

The implications of this research stand in opposition to the claim that a unified homeopathy must be reproducible. If homeopathy wants to be reproducible, regarded as a *unified method*, it must grapple with this opposition. If the goal for homeopathy is to demonstrate effectiveness, then considerable research needs to be done to eliminate context, entanglement and placebo effects. Research of this kind has been limited so far, and largely unsuccessful. My study suggests and accepts, moreover, that context, entanglement, and placebo effects cannot be eliminated; and, that rather than trying to eliminate them, they need to be acknowledged, understood, and perhaps utilised for their therapeutic potential. If homeopathy wants to defend itself from a stance of unification, it has to grapple with this too. If, in other words, it lets go of unification, what parts of homeopathy remain that can be defended, and who decides? On the other hand, if the goal is to practise the multifaceted skills of interpretation and performance, then considerable reflexive work is necessary in order to develop these modes of reasoning. This recommendation sits comfortably in the sociology of medicine, which has explored how therapeutic acts and forms of engagement are hermeneutic acts or acts of interpretation (for example Svenaeus 2000). Within the context of homeopathy, the same observation does not sit so comfortably. Let me elaborate.

Having been recently appraised as an unprejudiced phenomenological method (Swayne 2013, Whitmarsh 2013), this thesis suggests that the discourse needs to shift considerably. Homeopathy is unquestionably grounded in lifeworld exploration through the nuanced examination of illness experience. However, an observer *is always* an interpreter. Grounded in rich narrative it is evident that detailed consultations demand not seven minutes but one to two hours. Empirical research confirms this is important for patient satisfaction (Kliems and Witt 2011). This thesis demonstrates a strong correlation between symptoms and narrative, leading to the co-production of meaning, and finally to the prescription of a homeopathic remedy. This interpretative praxis necessitates letting go the pretence of detached, unprejudiced observation, including not accepting at face value any forestructures or assumptions (Whitmarsh 2014).

Symptoms, sensations, and meaning become co-embodied between the homeopath and her patient. They constitute a holistic set of phenomena, expressing the illness experience.

Exploring them elicits characteristic symptoms, and ideally the correct homeopathic remedy, but the iterative process engages much more than symptoms. The very forms of questioning (re)connect body and mind. And for some patients, in some consultations, this process is also uniquely therapeutic (Eyles, Leydon et al. 2012), although the remedy might not produce a discernible response (Brien, Leydon et al. 2012). And so, do patients come back for homeopathy because of benefits derived from the homeopathic remedy, or because of relational iatrosynergy, or for some other reason, or reasons?

My results found that something powerful occurred in these contexts. Despite the claim that homeopathy can *only* confer placebo effects, it is clear that context matters. Context effects are extremely powerful across the spectrum of healthcare and specific therapies. Orthodox medicine is grappling with placebo discourses (Arnold, Finnis et al. 2014, Arnold, Finnis et al. 2015) acknowledging that placebo effects are not uniform (Kirsch 2013) and that their therapeutic potential can be enhanced if they can be destigmatised. Homeopathy, in its mode of being *the other*, needs to acknowledge the power of placebo and context effects without defensiveness. This assertion will unavoidably create restless tension for many homeopaths and homeopathic researchers, attached to the explicitly decontextualised effects of homeopathic remedies.

Understanding phenomena demands an interpretative framework, as well as skill in the extremely complex and diverse methods of interpretation (Levy 2014). Ultimately, interpretation is bound up in the multifaceted meanings of experience. An authentic examination of homeopathy (and of clinical reasoning in particular) must do more than accommodate the lifeworld. It must critically approach homeopathy as praxis, through hermeneutic endeavour, demonstrating the multiplicity of praxes. Discursively, such an endeavour will, in all likelihood, result in one of the following possibilities: either homeopathy remains attached to fundamental principles, to a singular, orthodox, epistemic form; or it embraces the interpretative forms of praxis visible in the relational and performative themes articulated in this thesis. The discourses are not entirely dichotomous, and in fact the fluid contextual space depicted in this thesis will continue to be shaped by forces both within homeopathy and by those beyond its control.

The hermeneutic features of clinical engagement - iatrosynergy, and reasoning as performative - are striking results of this research. I propose that an enhanced epistemology of homeopathic clinical reasoning must incorporate contextual and relational phenomena, components of praxis that are typically regarded as context effects. As an already marginalised discipline, homeopathy must in addition confront the stigmatisation of placebo (and nocebo) effects (Arnold, Finniss et al. 2015). Further empirical research needs to examine the non-specific as well as the particular context effects within homeopathy. An honest appraisal of therapeutic outcomes must first acknowledge that placebo and context effects are real, powerful, and extremely difficult to isolate from the effects of homeopathic remedies, themselves already critiqued as a placebo. If the goal of homeopathy is to demonstrate effectiveness, considerable research will be necessary in order to explore the misconstrued areas of context, entanglement and placebo. If the object is to demonstrate clinical efficacy, studies must be methodologically rigorous without exception, otherwise the endless invective of methodological weakness and bias will continue to tarnish homeopathy.

This reflexive journey has, not surprisingly, generated some intra-professional response, including certain uncomfortable insights (Koch and Harrington 1998). After presenting some of the results of this research at the 8th Australian Homeopathic Medicine Conference (Levy 2012), one delegate was adamant that the results of my research '*were incongruent with her experience and might be detrimental to the cause*' of homeopathy. She formally urged the conference organisers to censor if not *suppress altogether* the publication of my results. The critique points to the latent divisiveness of my results, to the tension between interpretative and foundational constructions of homeopathy, about what practice is and is not, and who decides. The absence of a uniform reasoning taxonomy is implicit in this critique, and highlights the historical lack of consistent internal definition within homeopathy (Campbell 2001, Schmidt 2009).

This thesis contains significant pedagogical implications. The emergent themes depicted in the results constitute a valuable contribution to homeopathic instruction. Students of homeopathy require training that incorporates candid critique of its methodological weaknesses and inconsistencies; not claims of miraculous cures. The exceptional instance, or symptom, distracts the student or novice from the ordinariness of the rest of the case,

indeed of most cases that are not exceptional, those that occupy most of ordinary daily (clinical) experience. Making the familiar strange in an interpretation of homeopathic clinical reasoning ought not to generate new knowledge for its own sake but should engage the lifeworld of those who experience it (patients *and* practitioners), striking a balance between the ordinary and the strange or exceptional.

The results of this thesis actually deeply challenge certain pedagogic fundamentals. The lifeworld of the participants in this study reveals that certain iconic texts and sources of authority are frequently revered rather than rigorously critiqued. This requires careful examination and revision. If, on the other hand, the object of homeopathic education is to teach students interpretation and performance, then considerable work needs to be done to develop the practice of reflexivity. Encouraging students to develop praxis can transform clinical reasoning and decision-making. For example, by learning to understand relational empathy, and to practice iatrosynergy in a clinical simulation, students can be challenged to develop genuine empathy (Pedersen 2010). This can increase therapeutic outcomes and patient satisfaction with homeopathy.

Upon close examination of the phenomenon of interest, it has emerged that homeopathy and IPA are similar research processes: both attend to interpreting and making sense of the lived experience of human action in particular contexts; both strive to understand and interpret the unique and general features of the lived phenomenon, although neither can make a strong claim to generalisability; and both acknowledge that interpreting experience is always contingent, on the participants and the researcher. However, the object of homeopathy is to understand lived illness in order to identify a solution, a similar remedy that restores wellbeing; while the object of IPA research is the idiographic exploration of a phenomenon in order to construct meaning. Hermeneutic research can be transformative (Higgs 2010), demystifying experience for the research participants and researchers. This research has the potential to be transformative for others in the field of homeopathy, if not also for IPA research.

In this thesis, I have asserted that despite its contested epistemology, homeopathy remains viable and ethical because homeopaths endeavour to meet their patients' values, goals, and

treatment preferences. In addition, *it works* for many people, resolving their illnesses and improving their health and wellbeing.

If one were to take seriously the results of this study, then it does draw attention to the many ways in which homeopathy and conventional medicine are similar. They converge, for example, in regards to their structures, reasoning instruments, and their values. And this could provide the basis for a more informed, tolerant exchange between practitioners of both, each of whom currently position themselves in adversarial terms. However, given how deeply these positions are entrenched, then this is likely a vain hope.

12.1 Limitations of this study

This study has intrinsic limitations. I was unable to utilise the wealth of homeopathic literature published in German, French, Portuguese, Russian and other languages. Qualitative studies require only a small number of participants, and so the data and results represent the lifeworld of *these* participants and while the themes and issues that I have discovered here are likely to resonate with many other Australian homeopaths at least, they certainly are not expected to comprehensively represent the spectrum of views and experiences to be found even in one country, and I am very aware of how different the practice of homeopathy can be in other countries. Exploring features of experience over a wider group of participants would be an interesting next step.

Ultimately, the limits of a methodology are best understood in reference to the questions it can and cannot answer. And so, I return to the underpinning research questions. The primary object of this study was to develop a coherent exploration of the lifeworld of homeopathic clinical reasoning. IPA enabled me to get close, in order to understand participant subjectivity through the lived experience. Iterative and idiographic processes allowed the participants to excavate the nuances of reasoning and decision-making, to explore routine practices in novel ways, often in ways that they had never previously considered. It enabled a close examination of the texts, traditions and sources of authority that shape homeopathic clinical reasoning, much of which is unconsciously held and has not been critically examined. The emergent themes also reveal that homeopathic clinical

reasoning is underpinned by deeply held professional and personal values and beliefs, all of which are embedded within a powerful therapeutic relationship. Consciously foregrounding my experience and perceptions, while observing clinical interaction and interviewing the participants, compelled me to consider clinical reasoning as intersubjective, a hermeneutic process of meaning-making.

IPA answers the questions that were designed for this study, and much more. It has generated an enriched understanding of the relational, intersubjective and ethical phenomena, each being central to homeopathic clinical reasoning, as much as those cognitive and analytical components which are now better understood. It has given shape, context, and contrast to the multiplicities of homeopathic praxis that were not formerly visible. An additional and unanticipated outcome is the emergent correlation between homeopathy and IPA, a result having implications for research in other CAMs, and deserving closer investigation.

APPENDICES

Appendix 1: Ethical approvals

A1 p1

A1 p2

A1 p3

A1 p4

A1 p5

A1 p6

A1 p7

Appendix 2: Information and consent for participants and patients

A2 p1

A2 p2

A2 p3

A2 p4

A2 p5

A2 p6

Appendix 3: Sample interview questions

A3 p1

A3 p2

Appendix 4: Levy, D. Ajjawi, R. and Roberts, C. (2010). How Do Homeopaths Reason and Make Decisions? Integrating Theory, Practice, and Education. *The Journal of Alternative and Complementary Medicine* 16 (12). 1-7.

A4 p1

A4 p2

A4 p3

A4 p4

A4 p5

A4 p6

A4 p7

Appendix 5: Levy, D. Gadd, B. Kerridge, I. & Komesaroff, P. (2015). A Gentle Ethical Defence of Homeopathy. *Journal of Bioethical Inquiry*, 12 (2) 203-209.

A5 p1

A5 p2

A5 p3

A5 p4

A5 p5

A5 p6

A5 p7

Appendix 6: List of Publications and Presentations Related to this Thesis

A6 p1

A6 p2

A6 p3

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