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Empirical and Evidence-based Homœopathy: Back to Basics

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Abstract

That the theme of this issue is *Back to Basics* is a critical reminder of the problems faced by the Australian homœopathic community. This year, 2013, its practitioners may face political marginalisation and economic asphyxiation. The right of Australian consumers to choose and be rebated for homœopathy may be restricted by the National Health and Medical Research Council, a commission of the Australian Federal Government, as well as by the actions of the Friends of Science in Medicine[1]. Practitioners at the coalface practice a combination of empirical and evidence-based homœopathy. The results presented in this paper are part of a qualitative research study exploring the reasoning and decision making practices of Australian homœopaths. After gaining ethical approval from the University of Sydney in 2009, I observed, interviewed and recorded 12 participants in urban and regional Australia (2009-2012). Using interpretative phenomenological analysis (IPA) to explore and understand the participants' clinical reasoning behaviours and experiences, this paper asks why homœopathy needs to go back to basics. Their experiences strongly suggest the need for rigorous reproducible methods for the benefit of patients and for the sustainability of homœopathy.

Keywords: homœopathy, clinical reasoning, empiricism, evidence, evidence-based medicine.

[1] Friends of Science in Medicine: www.scienceinmedicine.org.au last accessed 26 March 2013

Empirical homœopathy

In semi-structured IPA interviews (Smith 2007 ; Smith, Flowers et al. 2009), the participants in this study revealed that the application of a reliable empirical method is the key to a sustainable practice, in particular when randomised evidence is unavailable, or insufficient to demonstrate clinical efficacy. Despite the prevalence of newer fashionable methods, the participants recognised their patients' demands for results, regardless of a theoretical model, of which some were openly critiqued. Bruce was very clear regarding the importance of empirical rigour (Bruce DS 42: lines 33-35).

> 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.

Reliance on empirical methods including observation and hypothesis testing distinguishes homœopathy from evidence-based conventional medicine, which theoretically retreats from a 'trying something and seeing if it works' approach. Hahnemann recommended rigorous empiricism, advising homœopaths to base prescriptions on exclusively *observable* phenomena (see for example aphorism 6 Hahnemann 1982) rather than on hidden theoretical causes of disease. Homœopaths have always been instructed to learn to trust their sense observations. Case by case empiricism was the central principle in every homœopathic practice examined in this qualitative study. The acceptance of error, the trust in empiricism and the recognition of limiting case evidence (an 'n=1' approach to each case) is theoretically unacceptable within conventional medicine, which – through the practices and ideology of evidence-based medicine (EBM) - claims an evidence-based, best practice approach to each and every disease. Bruce's empiricist remark (Gupta 2006 ch. 2) above, represented his approach in every case. For him, case-taking demanded scrupulous attention to detail, careful selection of his patient's characteristic symptoms, thorough analysis of the chosen symptoms, comparison of possible homœopathic medicines and finally the choice of a homœopathic prescription. Here, however, empiricism is predicated on assumptions about what constitutes a 'definite reaction', as well as how he tests for the selection of the 'right remedy.' This painstakingly time-consuming process was for Bruce and other participants the appropriate way to practice. He was quick to refute popular claims that homœopathy *lacks* a rigorous evidence base (Goldacre 2008 ; Hughes 2008 ; Ernst 2011). The fundamental features of empiricism practiced by many of the participants in this study are reflected in the case of a child with epilepsy Bruce had been treating. His description richly depicts the conscientious empirical rigour he demanded of himself (Bruce[2] DS 41 lines 52-92):

[2] All participants have been de-identified. DS 41 refers to the coded file for this text.

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'*[3] you know, I looked at the literature, the epilepsy literature and it says they're very uncommon, its 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; okay, let's start the remedy again so again thirty (homœopathic potency) in liquid but instead dilute in a tumbler of water, take one teaspoon and we did that for, I don't know for another three weeks I think, stopped, because she stopped having seizures (*yes)* yes, so that's where we're up to at the moment.

Describing his clinical observations Bruce emphasised the empirical quality of his homœopathic case-taking. Emphasising exact observations of the child's general behaviour ('wild child') as well as specific epileptic features ('myotonic jerking, absences, falling down and rotations after seizures'), Bruce was able to identify the medicine he believed most

[3] 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 homœopath to the selection of the appropriate homœopathic medicine.

likely to help reduce the seizures. Bruce evidently trusted his observations, trusting that the child's presenting behaviour and epileptic symptoms furnished him with the evidence he required in order to prescribe homœopathically. Unlike most of the other participants, Bruce subsequently *searched the epilepsy literature* – an evidence-based approach - to better understand the unusual features of this particular child and her condition. The combination of extensive case taking and observation, thorough symptom and analysis and attention to the clinical literature demonstrated Bruce's particular empirical rigour. Case analysis of such detailed, layered complexity was not uniformly demonstrated by the participants. Re-evaluating her case in response to Stramonium, and upon examination of the epilepsy literature, Bruce incorporated new information, adjusted his homœopathic diagnosis and prescribed the more suitable medicine (Belladonna) which apparently caused the child's behaviour to improve and her seizures to cease.

Clinical Evidence

Other participants in this study utilised more conventional clinical evidence. James demanded clinical evidence from his patients, although he did not necessarily depend upon the evidence for prescribing purposes (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 contradiction in James' clinical reasoning was striking. James' reliance on conventional evidence (pathology tests) was an uncommon feature in this study. In all likelihood this reflected the fact that many of James' patients came to see him with medically diagnosed conditions. This might be normative *medical* behaviour, only that all the participants were not medical doctors. Gathering clinical evidence by means of pathology tests was less common with other participants, for whom some patients had not necessarily been diagnosed. 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 searched for clinical evidence, for clarity in order to establish the certainty of diagnosis. On the other, an educated (albeit potentially wayward) guess was all he required of himself. Where he utilised test results he apparently did so with the conviction that the information could only serve to benefit the patient, an understandable position. This he justified in accordance with the need to search for causal certainty (DS 44: lines 350-351):

> Well that's when I order a test (*mmm)* and I'd say (to the patient) "well, this test will show us these things and from that we'll be able to make a diagnosis" (*mmm*)

Having demonstrated conviction for the clinical benefit of pathological tests, James subsequently told his patients that such information undoubtedly confirmed his diagnosis. This afforded James (and perhaps his patients) a sense of scientistic authority (Mitcham 2005), privileging his belief in the value of knowledge derived from clinical tests. In contrast, most of the participants relied upon patient-focused case taking, or caseness, as the usual and legitimate Hahnemannian method of inquiry, capable of revealing their patients' illnesses. Justifying his position, James reasoned that unlike other homœopaths, he sought to identify and understand the *specific causes* of disease (DS 44: lines 351-354):

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

Causative or aetiological reasoning models have been developed as one of many prescribing approaches in homœopathy (Watson 1991). Medical diagnosis is undoubtedly an influential medical and social tool (Jutel 2009) that might (and might not) enhance the accuracy of homœopathic prescribing (Dimitriadis 2004 ; Frei 2009). James' assertion reveals his belief that other homœopaths fail to recognise causes, which he claims to identify through tests before he conducts a typical homœopathic symptom analysis. Convincing his patients (and perhaps himself) of the certainty and authority of pathology tests, James concludes with the following logic (DS 44: lines 318-320):

> Sometimes I'll say "we're going to try this method, right, now if you don't get a response from this we'll need to do this test" so (*mmm*) they know where they're going, you know, I'm laying out the plan with them.

In this justification, James emphasises empirical method, testing and keeping to a plan, critical elements ideally culminating in correct diagnosis and appropriate treatment. At the very least, the contrast in James' and Bruce's approaches reflects the desire for rigorous empirical methods capable of delivering satisfactory patient results.

Discussion: Empirical rigour and clinical evidence, gone missing?

Other participants reflected what they perceived to be a distinct *lack* of empirical rigour, or evidence, even amongst some noted homœopathic theorists. Susanna revealed the following candid experience, with some hesitation (DS 89 lines 692-702):

> I went to one Scholten's seminars … ages ago now and it was just crap, it was absolutely just, it was the one on the Lanthanides and I read the introduction to the book and he did, he did the proving in the bath while he was listening to Pink Floyd and I wondered if he'd had a couple of joints at the same time and I just thought 'this is just' … and I just thought 'what's going on?' We're paying, people are paying this man huge money to, for a load of psycho babble … *I don't call that rigorous* … and I think some of his earlier work, like Homœopathy and the Minerals[4], I quite like some of what's in there, um and I can see that there are sort of connections, but I think he's just gone way out in a way which is just … mmm, yes. Whether that's maybe my own prejudice, I don't like to say that out too loud …

Susanna's distress with the lack of empiricism, indeed her perception of the lack of apparent method displayed by an eminent homœopathic educator, justifiably alarmed her. Acknowledging that there were 'sort of connections' in his earlier theoretical work she reluctantly vented her displeasure. Reticence to engage in discourse and to critique historical and contemporary homœopathic masters is also problematic in homœopathy. As a homœopathic educator, Susanna adopted a critical stance and expected her students to develop their critical thinking skills (DS 89 lines 713-720):

> I've been very clear about my feelings towards Sankaran, Scholten … and I've taught them to be critical as well. So I get them to be, to read whatever articles that they read in any journal, if someone starts saying "look you can cure this with um dinosaur poo", you know, read through it and think to yourself, 'does this sound right, where are they getting this information from?' You know, where's the proving? Who did the proving? How many people did that proving? How was it conducted? You know, so go back to that and ask yourself, you know, and look at those references at the end of that article and see if it's been well referenced, that's the sort of thing that I've been doing.

Despite her acute discomfort with the contribution of some acclaimed homœopathic teachers, Susanna was careful to distinguish what she considered rigorous empiricism from improvised experimentation. The participants' attitude to provings is one clear example. Most, including Susanna, maintained a high regard for provings as a valid source of knowledge. As she articulated, she demanded that her students considered the proving protocols closely (Sherr 1994) in order to distinguish reliable empirical knowledge from spurious and uncertain claims. Rigorous provings were randomised double blinded experiments; the substance had to be proved in at least two homœopathic potencies against placebo (Sherr 1994 ; Signorini, Lubrano et al. 2005). Susanna inferred that the

[4] Scholten, J. (1993). Homeopathy and Minerals. Den Haag, Cip-Data Koninklijke Bibliotheek.

reliability of homœopathic source materials including materia medicae (Dantas 1996) and repertories (Gadd 2009 ; Adler 2011) is, or ought to be, a genuine concern for homœopathic clinicians; the response of every patient under treatment being dependent on the veracity of these resources. A critical distinction can be made between empiricism as a framework for observing and examining the patient, and empiricism as a reliable source of knowledge for diagnosis and disease classification. As a framework for patient observation and examination, empiricism in the form of caseness was the central decision making approach for the majority of participants. Critics, however, claim that the dependence of homœopathy on the empirical tradition and its methods is not commensurate with the principles of EBM (Bayley 1993 ; Smith 2012). The pervasiveness of the current EBM orthodoxy rather diminishes the capacity of historically valid, and clinically valuable, empirical methods. As a trustworthy source of knowledge for diagnosis and disease classification, empiricism in the form of homœopathic caseness may be more problematic. For example, faced with a clinical decision in the treatment of an acute condition (such as influenza) an evidence-based strategy may reveal valuable research data leading to a well-informed choice. Applying empirical caseness in this circumstance may produce a rich description of the illness, yet lack rigorous symptom classification leading to the correct homœopathic diagnosis.

Conclusion

Contemporary Australian homœopathic practice is an interpretative methodology, a process that merges empiricism and clinical expertise, while also acknowledging patient experiences and preferences. Between the historical practice of empirical methods and the extant demand for an increasingly evidence-based homœopathy, the participants were caught, as Susanna expressed it, between trusting observation and experience, and the need for rigorous evidence. Australian homœopathy faces the same predicament. In the absence of abundant clinical research, the participants practiced an empiricism built upon rich, individualised case taking and detailed analysis, together with research evidence where it was available. In order to survive and be sustainable, homœopathy must demonstrate empirical rigour *and* clinical evidence. Where such evidence is unavailable, homœopaths must participate in the production of evidence through rigorous systematic research. Through the experiences of the participants described in this paper, I have attempted to highlight the tension between empiricism of variable rigour, and the critical demand for robust clinical evidence. The participants' experiences reflect the very real tensions in daily practice, and while not an attempt to resolve them, they are a salient reminder that anecdotal reports and published successful cases will never satisfy our critics. The future of a sustainable Australian homœopathy must be built upon rigorous empiricism and clinical evidence. These remain the basics to which we must always return.

Conflict of interest

The author is a peer reviewer of *Similia*. According to protocol, this paper was submitted for blinded peer-review.

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