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ORIGINAL PAPER

Audit of outcome in 829 consecutive patients treated with homeopathic medicines

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An audit was conducted of 829 consecutive patients presenting for homeopathic treatment of a chronic illness, conventional treatment had either failed, plateaued in effect, or was contraindicated by adverse effects, age or condition of the patient.

Of the 829 patients, 503 (61%) had a sustained improvement from homeopathic treatment, of these:

- **357 patients (43%) had an excellent response;**
- **146 patients (18%) had a good response;**
- **6 patients (0.8%) became worse.**
- **233 patients (28%) were lost to follow-up**

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Keywords: outcome study; diagnoses; private practice; homeopathy

Aims and objectives

This work began with a simple aim: to assess whether the addition of homeopathic treatment to the existing management regime of patients with chronic illness could initiate and sustain improvement. Over the years this grew and became more formalized into a continuing audit of outcome in consecutive patients attending for homeopathic treatment to assess and explore:

- If a positive response can be initiated and sustained in
  (a) patients with mainly functional disorders and little destructive changes in tissues;
  (b) patients with physically destructive pathology;
- Potency selection, frequency of repetition and size of dose in patients in both the above groups;
- The influence of concurrent allopathic medication during homeopathic treatment in potency selection, frequency of repetition and size of dose;
- Ways to improve clinical performance on the basis of data and trends revealed.

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Setting

Patients are seen in a private practice setting in my home and in which I am the sole practitioner. The room set aside mainly for this purpose is 5 metres square. The patients sit opposite my desk, and have a choice of looking at me or out of a large bay window overlooking an enclosed garden with mature shrubs and trees. The room is a safe and interesting place for children with suitable toys and enough space to play.

Appointments are made by telephone for a mutually convenient time. First appointments are for one hour, 15 minutes. The first review appointment is 45 minutes, and subsequent review appointments are 30 minutes. Review appointments are generally at intervals of 6 weeks. The interval is increased as appropriate in patients who are responding to treatment.

Patients are not screened to see whether or not homeopathic treatment would be suitable prior to the first appointment. No patient who is physically able to get to my consulting room is rejected. Home visits are not available (the only exception to this rule was the in-patient seen in the local psychiatric hospital).

The frequency and length of follow-up varies with the nature and severity of each condition, and is tailored to the needs of each individual patient.

Patients with destructive physical pathology are usually monitored for at least 2 years. Patients with functional or episodic illness are usually monitored for 6 months after initial response, and then as the patient feels necessary.

No patients are allocated to a group not receiving homeopathic treatment. Only one patient was not given a homeopathic medicine at the end of the first consultation. This patient, who in the past was exposed to a high level of radioactive contamination, was dying of respiratory failure. Admission to hospital was arranged, and no fee charged.

The patients

In the period from 1 June 1993 to 31 December 1999, 829 consecutive patients were treated with homeopathic medicines. There were 755 self referred private patients, of these a steadily increasing number of patients are informally referred by their GP suggesting this course of action to the patient, but not writing an actual referral letter. There were 62 private GP referrals; 11 NHS GP referrals; and 1 NHS in-patient referral from a Consultant Psychiatrist.

The age range of the patients was from 3 months old to 88 years old. Twice as many women as men were treated. The majority of patients were from Cumbria, rural Northumbria and the border counties of Scotland and are from a range of social and economic backgrounds.

All patients had a diagnosis established by their GP and/or hospital specialists. fifty-seven (7.5%) patients had already had homeopathic treatment from another homeopath (either medical or non-medically qualified) without lasting benefit.

In every patient, allopathic treatment had either failed, plateaued in response, was contra-indicated by age or pregnancy, or had produced intolerable side effects. These patients had 'tried everything else' they could think of, and were now trying homeopathy. Many patients are at the extreme end of the severity range of their conditions: eg eczema uncontrolled by 50 g Dermovate® per week, plus 3 courses of systemic corticosteroids per year, plus antidepressants; rheumatoid arthritis patients after 5 or more years of second line drugs plus antidepressants, with progressive joint destruction; unstable angina only partly relieved by intramuscular morphine (relieved quickly and completely by *Latrodectus mactans* 200cH).

Non-homeopathic management

Care was taken to ensure that I practiced within my professional competence. Patients were encouraged to maintain contact with their GP and hospital specialist. Referral back to the patient's GP or to the relevant hospital consultant was arranged as required.

The allopathic drug regime was continued at previous doses until sustained response was noted from homeopathic treatment. Allopathic drugs were then continued, gradually reduced or stopped as clinically appropriate. Certain drugs were always left to the original prescribing physician to manage, eg oral corticosteroids, major anti-inflammatories, major tranquillizers, lithium carbonate, mono amine oxidase inhibitors, cardiac arrhythmics, antihypertensives, anti-epileptics, etc.

Allopathic drug regimes which were causing problems such as significant adverse effects or harmful interactions were corrected as indicated. For instance one patient with migraine was observed to have some athetoid movements and she was advised to stop taking metoclopramide. Many patients with daily headaches take paracetamol or paracetamol/opiate combinations several times each day and benefit from having these drugs stopped. However, many are understandably reluctant to follow this advice until improvement from homeopathic treatment is clear.

Referrals to other therapists were made, when indicated, and include osteopathy, physiotherapy, occupational therapy, hypnotherapy, marital counselling and spiritual healing.

Method

Details of patient's name, age, sex, main diagnosis, remedy prescribed, potency, posology and outcome were recorded. Only one outcome was recorded for each patient. Each patient begins with an outcome of Unknown, and this is changed to Worse, No Change, Slightly Improved, Good or Excellent as appropriate.

Only one diagnosis was recorded per patient even though many patients are suffering from more than one illness or diagnosis. The diagnosis recorded is the most severe and most troublesome at initial presentation.

One outcome per patient was recorded. While changes in outcome do occur with time, the figures given represent the current or final known outcome in each patient.

There are no figures given for the patients who show a slight improvement, (equivalent to Glasgow Homoeopathic Hospital Outcome Study + 1), because I have found that these patients do not maintain their improvement with the passage of time. It is my experience that a slight improvement, found at a 6-week review appointment, is not maintained over the next 6 weeks. These patients then move into the *no change* group.

The audit was compiled using the Radar® computer system, version 6.2, Patient File Module, and Search Patient, Search Consultation modules. Searches can be made by patient name, diagnosis, outcome, medicine prescribed. The software in this version of Radar® was not specifically designed for audit, it is

only possible to search one parameter at a time, eg search by diagnosis, or search by outcome, not both diagnosis and outcome simultaneously.

To minimize human error in list counting, I counted for short periods and counted each list twice. Simple arithmetical errors in the production of the tables were corrected using a calculator and the spreadsheet facility in Microsoft® Works.

The number of patients in the Unknown group, 233, 29%, (ie patients who only attended once) was a surprise. In January 1998, I wrote to the 46 patients of 1996 and 43 patients of 1997 to try and learn of any recurring reason for non return. I became concerned that there may have been something about the nature, style or content of the consultation that had upset them. Of the 89, 18 replied. One was so much better that she did not even think of coming back; 10 thanked me for my kindness and continued interest but they did not wish to try again, of these none found the consultation to be difficult or emotionally trying. One other compared my consultation style to a Nazi interrogation! The percentage of patients only attending once (see Table 1) has fallen steadily from 42% in 1994 to 16% in 1999. An improvement in my consultation skills and increase in the numbers of patients returning for further treatment are likely to have proceeded in tandem.

Outcome measures

The outcome of a treatment is assessed:

- clinically,
- patient-reported response,
- when possible, by objective indices,
- visual analogue scale,
- by follow up questionnaire.

Clinically

Detailed notes in the patient's own words, with detailed enquiry into each of the patients presenting complaints, numerical pain and energy scales, actual measurement of, for example range of movement and number and size of inflamed joints and length of morning stiffness in rheumatoid arthritis, is vital, especially when a patient is managed over a period of years.

Patient-reported response

The reported response from the mother is vital in infants and children under 3. In children, the opinion of the parents, especially the mother is usually accurate. The reported response of those close to the patient can be of great help in assessing response in closed or reticent patients. Patients spontaneously remarking that friends have noticed a clear improvement in their illness or behaviour can help to confirm the clinical impression.

Objective indices

The results of blood tests, X-rays, peak expiratory flow rates, etc. can all be useful confirmatory findings to assess progress.

Visual analogue scale

The vertical visual scale. I have used the visual analogue scale (VAS) for the past 3 years at the end of each review consultation. I use unruled A4 to avoid lined paper giving visual clues to the patient. I draw a 1cm circle at the bottom of the page and say that inside this circle is health. As I draw the vertical line up the page I say and this is you walking away from health as your illness has got worse. I make a cross near the top of the line. I move my finger up the line from the circle to the cross while saying this is how bad everything had become before treatment. Make a cross to show where you are now. If they hesitate for more than a few seconds, I ask them to make the cross where their eyes first looked.

An opportunity can be taken after drawing the circle representing health to ask the patient 'Do you actually remember health?' It can be surprising to learn how many patients do not remember health, either because they have been ill for so long, or they have felt/been unwell their whole life. If the patient says no, this is a very important place in the consultation, and to allow time to sit in the moment with the patient. This can be a therapeutic intervention in itself. The opportunity can be taken to discuss the patient's expectations of homeopathic treatment and the probable rate of healing during treatment. Examples of vertical VAS's are shown in Figures 3 to 9.

Table 1 Outcome by years

	Excellent	*Good*	*No change*	*Worse*	*Unknown*	*Total*	*% Unknown*	*% Improved*
1993	31	9	6	0	21	67	31	60
1994	25	10	10	1	33	79	42	44
1995	40	13	11	1	39	102	38	52
1996	69	20	10	1	46	144	32	62
1997	70	53	19	2	43	191	23	64
1998	67	29	9	1	34	140	24	69
1999	55	12	22	0	17	106	16	63
Total	357	146	87	6	233	829	29	61

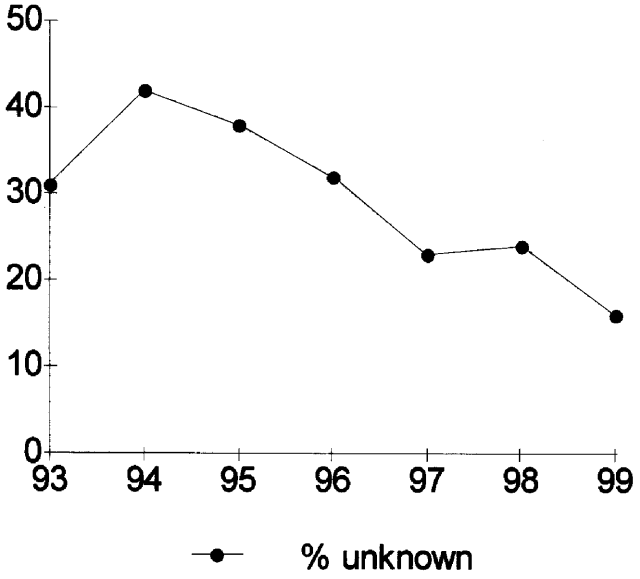

Figure 1 The percentage of patients only attending once has fallen steadily from 42% in 1994 to 16% in 1999.

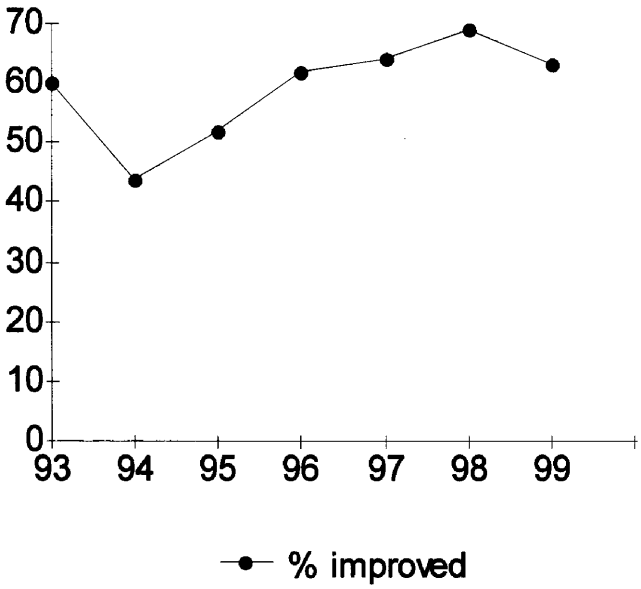

Figure 2 The percentage of patients improved by treatment has incresed from 44% in 1994 to 63% in 1999.

Follow-up questionnaire

A follow-up questionnaire was used in part of the Unknown group to try and discover reasons for not returning for review. This is discussed further in the next section.

Results

Eight hundred and twenty-nine consecutive patients were treated with homeopathic medicines over a period of 7 years. Of these, 503 (61%) patients benefited from homeopathic treatment, Glasgow Homeopathic Hospital Outcome Scale[1] (GHHOS) score equal to or greater than +2 (Table 2).

Figure 3 This a 38-y-old lady with manic depressive psychosis/ bi-polar disorder. The scale shows her dramatic initial response to *Lac caninum* 200cH single dose, then 12 c once daily. She has been off Lithium for 6 months and is maintained on a simple anti-depressant, and has reduced the dose of Diazepam from 30 mg per day to an occasional dose.

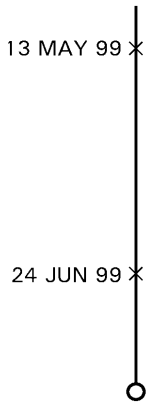

Figure 4 This shows the initial response of a 36-y-old lady with ulcerative colitis to *Kali phosphoricum* 200cH single dose, then 12c once daily.

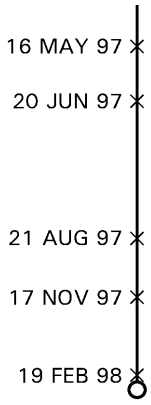

Figure 5 A 65-y-old lady with severe rapidly progressive rheumatoid arthritis with bilateral carpal tunnel syndrome. She responded steadily to *Causticum* 200cH single dose, then 6c twice daily. She was able to cancel her carpal tunnel decompression operation, discard her splints, and her C reactive protein fell from 70 to normal. She became pain free and the range of movement in her joints returned to normal, all signs of synovitis having resolved.

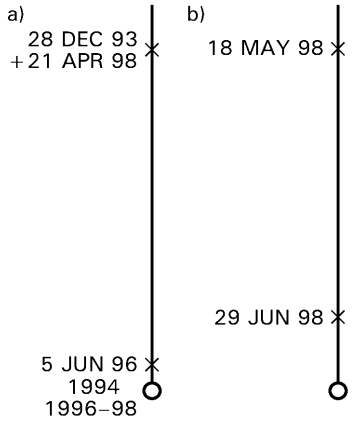

Figure 6 This is a 44-y-old man with severe irritable bowel syndrome. a) shows his response to *Aurum metallicum*. He became symptom free for 11 months from a single dose of *Aurum metallicum* 200cH, then relapsed. He next became symptom free for 2 years following a single dose of *Aurum metallicum* 10M. He then relapsed again and repetition of *Aurum metallicum*, in various potencies, produced no response. b) shows his response to a single dose of *Osmium metallicum* 30cH. This response is holding a year later.

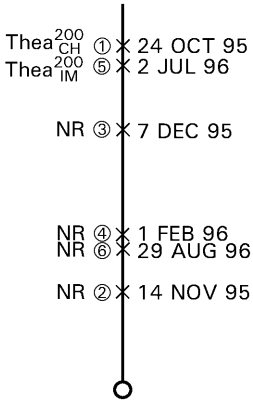

Figure 7 A 42-y-old lady with increasingly strong impulses to kill her 3-y-old son. This scale shows her response to a single dose of *Thea chinensis* 200cH. The apparent partial relapse from the 3-week level to the 6-week level spontaneously improved without repetition of dose, and was maintained for 9 months. An intercurrent acute bronchitis cleared rapidly with frequent doses of *Thea chinensis* 12c. After 9 months, her relapse to original symptoms again responded rapidly to *Thea chinensis* 200cH first day, 1MK second day. She has required treatment subsequently with *Nux vomica* and then *Sepia*. She has not experienced her original symptoms for 3 years.

Table 2 Overall outcome

Excellent	357	43%	GHHOS	+3 or +4
Good	146	18%	GHHOS	+2
No change	87	10%	GHHOS	0
Unknown	233	28%	GHHOS	0
Worse	6	0.8%	GHHOS	−2

Excellent = a considerable sustained improvement or resolution of presenting complaints; plus a sustained reduction or cessation of allopathic drug treatment; plus a sustained increase in energy level and mood; plus a sustained improvement in value of daily living.
Good = some sustained improvement in presenting complaints; plus some sustained increase in energy level, mood and value of daily living.
Worse = a worsening in the presenting complaints beginning soon after homeopathic treatment, greater than that previously experienced by that patient, and persisting for longer than previously experienced by that patient.

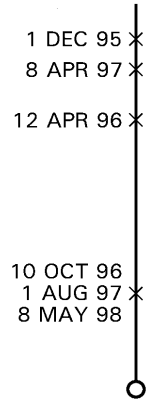

Figure 8 A 55-y-old lady with severe generalised osteoarthritis for 30 years following smallpox vaccination. The scale shows her steady response to *Thuja*, LM1 to LM4 with occasional doses of 30cH. She had two partial relapses (not shown on the scale). The first responded to *Malandrinum* 30cH, the second to *Medorrhinum* 30cH.

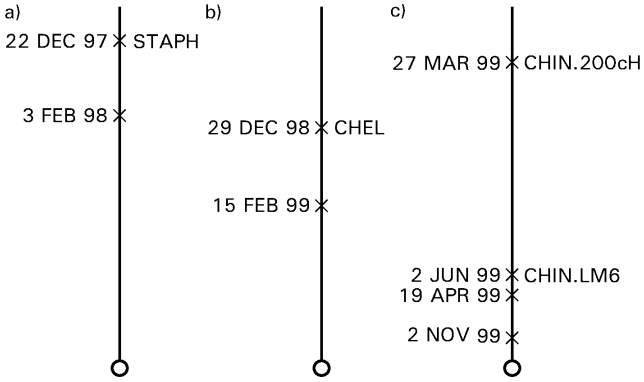

Figure 9 A 57-y-old lady with primary biliary cirrhosis. Before treatment she was clinically jaundiced, and in constant pain over her liver. a) shows her initial response to *Staphisagria* LM 4. This response continued for a further 10 months then stalled. b) shows her further progress with *Chelidonium*, initially as mother tincture then LM1. This response stalled after 3 months and she relapsed, but this time with all the functional symptoms felt from late teens to early forties. c) shows her dramatic response to *China officinalis* initially as a single dose of 200cH. Recently she has begun *China* as LM6. She became pain free most days soon after treatment began in 1997, and her liver function tests have gradually resolved to almost normal levels.

There are no figures given for the patients who showed a slight improvement, equivalent to a GHHOS score of +1, because I have found that these patients do not maintain their slight improvement with the passage of time. It is my experience that a slight improvement, found at a 6-week review appointment, is not maintained over the next 6 weeks. These patients then move to the *no change* group. If a more suitable treatment is found, they may then move into the *good* or *excellent* group. Six patients in 1999 had an initial response of slight improvement and then moved into the *no change* group.

Relapse from the *excellent* or *good* groups to *no change* was rare, and is known to have occurred in only three patients. One patient with rheumatoid arthritis in the *excellent* group relapsed. Her previous

excellent response to *Calcarea carbonica* ceased and repetition in various potencies/frequency of dose was of no benefit. This occurred after a deep vein thrombosis and pulmonary embolus, which developed while flying across the Atlantic. The relapse appeared to begin as soon as she was treated with Warfarin. One patient with a severe cyclical depression for 30 years in the *good* group relapsed. Her response to *Aristolochia clematis* ceased after she decided to stop the monoamine oxidase inhibitor that she had taken for 27 years. One patient with migraine plus a continuous headache for one year since a subarachnoid heamorrhage relapsed from the *good* group. His response to *Carboneum sulphuratum* simply seemed to cease, and attempts to find a better medicine were unsuccessful.

All 829 patients were treated for a chronic disease in which conventional treatment had either: failed; plateaued in effect; or was contra-indicated by side effects, age or condition. Length of follow-up was between 6 months and 7 years.

One diagnosis per patient is recorded and illustrated throughout this paper. The majority of patients have more than one problem at presentation. Patients in the *excellent* outcome group with several problems often gain sustained improvement in most of their other problems, eg a patient with eczema in the *excellent* group, who also has pre-menstrual tension and menstrual cycle irregularity, will usually have sustained amelioration of PMS and a return to a normal menstrual cycle.

The time span of Table 1 reflects increasing knowledge and experience during the years from MFHom qualification through Level 3 training to Specialist Registration. The results should be viewed in this light.

One outcome is recorded per patient. This is updated at each review appointment. Any increase in success year on year is reflected in the entries for previous years. The current success rate is best reflected in the 1999 figures.

Table 3 shows the disorders most frequently seen in my practice, and illustrates responses in both functional and destructive pathologies.

Outcomes in diagnostic groups

Table 4 shows outcome of all patients by body system.

In Table 5, 40 of the patients with rheumatoid arthritis had been on disease-modifying anti-rheumatic drugs (DMARDs) for at least a year, and still had pain and progressive joint destruction. In the *excellent* group, 22 of 26 patients were able to stop and stay off these drugs, and continue on a reduced dose of non-steroidal anti-inflammatory drugs (NSAIDs). The savings to the NHS in cost of blood tests and out-patient attendances to Rheumatologist, Physiotherapist, Occupational Therapist is considerable. Two other patients in the *excellent* rheumatoid group had refused DMARDs when these had been recommended, and at presentation were only taking simple NSAIDs. These two patients had a deeper and quicker response to the prescribed remedy, and all signs of synovitis resolved, and their blood tests returned to normal. Of these two patients, one was listed for urgent surgical decompression of severe bilateral carpal tunnel syndrome. She was able to cancel the operation. A reproduction of her response on visual analogue scale is shown in Figure 5.

In Table 6, the 37 *excellent* eczema cases were able to stop and stay off steroid creams. One lady had been using 50g Dermovate per week. The 21 *excellent* psoriasis cases were able to stop and stay off all medicated creams.

In Table 7, the 28 *excellent* asthma cases were able to stop taking steroid inhalers twice daily, most were able to stop entirely, some restarting only during respiratory tract infections.

In Table 8, the 40 *excellent* depression cases were able to stop and stay off anti-depressants. The 35 *excellent* anxiety cases were able to stop and stay off anxiolytics (doses of Diazepam up to 30 mg daily). In the Miscellaneous *excellent* 10 entry, two of the patients had bi-polar disorder. One of these patients was able to stop and stay off Lithium carbonate.

In Table 9, the 22 *excellent* irritable bowel syndrome patients were all able to stop and stay off their anti-spasmodics, laxatives and opiates.

In Table 10, 11 of the 14 *excellent* migraine patients were able to stop Imigran® entirely, and five were able to substantially reduce their use of Imigran®.

In Table 11, three of the *excellent* hypertension patients were unable to tolerate any anti-hypertensive drugs (because of intolerable adverse effects) when they presented for treatment. In all three of these patients a return to normal blood pressure was induced and maintained with Homeopathic treatment alone. Follow-up in these three patients has been for over one year and their blood pressures remain normal.

In Table 12, all 10 of the *excellent* chronic fatigue syndrome patients completely recovered, nine went back to full time work, and one returned to a very active golfing retirement.

The patients who deteriorated with homeopathic treatment

Six patients (0.8%) became worse with homeopathic treatment. I have made a working definition of worse as a sustained increase in the presenting complaints beginning after homeopathic treatment, greater than that previously experienced by that patient, and persisting for longer than previously experienced by that patient. Three of the patients had skin problems, one osteoarthritis, one anxiety state, and one back pain and muscle spasms.

Accidental antidoting of remedies

From 1 June 1993 to March 1996, I advised patients to stop drinking coffee and avoid strong aromatics. During

Table 3 Outcome in disorder treated most frequently

	Excellent	*Good*	*No change*	*Worse*	*Unknown*	*Total*	*% Improved*
Rheumatoid	26	8	5	0	6	45	76
Osteoarthritis	29	27	14	1	11	82	68
Eczema	37	22	23	2	17	101	58
Asthma	28	16	13	0	17	74	59
Anxiety	35	9	9	1	7	61	72
Depression	40	5	10	0	9	64	70
Irritable bowel	22	7	8	0	12	49	59
CFS/ME	10	11	6	0	14	41	51
Migraine/headaches	26	10	8	0	21	65	55

Table 4 Outcome by body system

	Excellent	*Good*	*No change*	*Worse*	*Unknown*	*Total*	*% Improved*
Mind	85	17	23	1	20	146	70
Neurolog	32	20	14	0	22	88	59
CVS	15	13	6	0	2	36	78
Resp	50	19	23	0	30	122	56
GI	37	14	9	0	18	78	65
GU	18	6	2	0	6	32	75
Locomotor	62	41	20	2	27	152	68
Skin	73	30	27	3	32	159	65

Table 5 Rheumatic disorders

	Excellent	*Good*	*No change*	*Unknown*	*Worse*	*Total*	*% Improved*
Rheumatoid arthritis	26	8	5	6	0	45	76
Osteoarthritis	29	27	14	11	1	82	68
Other	7	6	1	10	1	25	52
Total	62	41	20	27	2	152	68

Table 6 Skin

	Excellent	*Good*	*No change*	*Worse*	*Unknown*	*Total*	*% Improved*
Eczema	37	22	23	2	17	101	58
Psoriasis	21	7	2	0	2	32	88
Urticaria	5	0	0	0	3	8	63
Alopecia	2	0	0	0	0	2	100
Miscellaneous	7	1	1	1	4	14	57
Total	72	30	26	3	26	157	65

Table 7 Respiratory

	Excellent	*Good*	*No change*	*Unknown*	*Total*	*% Improved*
Asthma	28	16	13	17	74	59
Allergic rhinitis	11	1	4	5	21	57
Emphysema	3	2	3	1	9	56
Miscellaneous	8	0	3	7	18	44
Total	50	19	23	30	122	57

Table 8 Mind

	Excellent	*Good*	*No change*	*Worse*	*Unknown*	*Total*	*% Improved*
Depression	40	5	10	0	9	64	70
Anxiety	35	9	9	1	7	61	72
Schizophrenia	0	1	2	0	0	3	33
Miscellaneous	10	2	2	0	4	18	67
Total	85	17	23	1	20	146	70

Table 9 Gastro-intestinal

	Excellent	*Good*	*No change*	*Unknown*	*Total*	*% Improved*
Irritable bowel(s)	22	7	8	12	49	59
Ulc. colitis	2	1	0	1	4	75
Miscellaneous	13	6	1	5	25	76
Total	37	14	9	18	78	65

Table 10 Neurological

	Excellent	*Good*	*No change*	*Unknown*	*Total*	*% Improved*
Migraine	14	4	4	10	32	56
Headache	12	6	4	11	33	55
Multiple sclerosis	2	3	2	1	8	63
Miscellaneous	4	6	4	0	14	43
Total	32	19	14	22	87	59

Table 11 Cardio-vascular

Excellent	*Good*	*No change*	*Unknown*	*Total*	*% Improved*	
Hypertension	11	6	4	1	22	77
Angina	3	3	1	0	7	88
Miscellaneous	1	4	1	1	7	71
Total	15	13	6	2	36	78

Table 12 Cancer and chronic fatigue syndrome

	Excellent	*Good*	*No change*	*Unknown*	*Total*	*% Improved*
CFS	10	11	6	14	41	51
Cancer	7	1	1	7	16	62
Total	17	12	7	21	57	51

this period I had three patients who reported antidoting of remedies from coffee; one patient with clear immediate antidoting after prolonged exposure to moth balls sufficient to cause marked rhinorrhoea and epiphora.

From March 1996 I gave no advice about coffee or aromatics. I found: no patients with accidental antidoting of remedy action from coffee; one patient who had an antidote from using gloss paint; two patients who are painters and decorators have not experienced antidoting from daily exposure to undercoat and gloss paint; and two aromatherapists have not antidoted.

I had five cases of antidoting from prolonged dental work, and one patient who had 27 amalgam fillings replaced with white ones without antidoting the action of a single dose of *Mercurius vivus* 200cH.

Nuclear magnetic resonance scans were performed on seven patients. All seven patients felt immediately that their healing response ceased during the procedure, and returned on repeating the remedy.

It appears that the accidental antidoting of remedies by coffee, strong odours or dental work depends largely on the sensitivity of the patient.

Discussion

These results compare favourably with previous studies of outcome in homeopathic treatment of out-patients[2] and in-patients;[3] and with previous studies in asthma,[4] depression and anxiety,[5] eczema[6] and arthritis.[7]

The assessment and exploration of potency selection, frequency of repetition, and size of dose has been successful and useful in that it has led to changes in practice based on findings, not fashion. Advice given to patients about accidental antidoting of remedies has changed and a gradual evolution of prescribing methods in skin cases and those with destructive pathology is unfolding.

The discovery that a few patients can become worse with homeopathic treatment has led to changes in practice.

Screening

Patients are not screened to see whether or not homeopathic treatment would be suitable prior to the first appointment. In the present state of knowledge it is not possible to predict in advance which illnesses and, in particular, which patients may benefit from homeopathic treatment. A decision was made at the onset of my homeopathic practice not to provide home visits to housebound patients. At the time I did not have sufficient homeopathic knowledge or experience to deal with such deep, severe advanced

pathology. These patients are probably best assessed as in-patients in a homeopathic hospital.

Randomization

No patients are allocated into a group not receiving homeopathic treatment. It seems to me to be part of the implicit contract made with patients who book an appointment, that they are attending for homeopathic assessment and treatment. Therefore, such treatment will be given if at all appropriate. However, two groups of patients might be regarded as forming a sort of involuntary control group:

- Patients who remain in the *no change* group have been treated with homeopathic medicines which did not act. These medicines did not produce a positive placebo response either.
- Patients who show an initial slight improvement (equivalent to GHHOS score of +1) and then move into the *no change* group. Do these patients show a weak simile effect which is not maintained? Do these patients show a temporary placebo response?

Diagnosis

All patients attend with a diagnosis already established. This does not remove my responsibility of confirming/correcting/modifying the diagnosis. It is a reflection of the high standard of medical care generally available in Cumbria, Northumbria and the border counties of Scotland that:

- in only four patients the diagnosis had to be modified,
- very few allopathic drug regimes required modification because of previously unnoticed adverse effects or harmful drug interactions.

Clinical vigilance is also required to detect or suspect the development of significant new problems. Two patients who developed recurrent chest pain, between review appointments, were successfully diagnosed as having angina pectoris. One patient, who had had chronic tubercular cervical adenitis as a child, was suspected to have active tuberculosis and referred back to her GP for investigation.

Patients not followed up

The cost of treatment may have had an effect on willingness to continue with treatment when the first prescription produced no discernible benefit. The patients seen reflect the entire spectrum of socio-economic groups of the population. Some patients will have had to save to have enough money for the initial, long and more expensive consultation. Even those who were relatively well off would have had to decide whether the continued expense was likely to be worthwhile.

Change in advice on the use of coffee before and after March 1996 may have affected patients' decision on whether homeopathic treatment was right for them.

In the earlier years of this study, excess zeal from focusing on the attempt to find the best medicine for each patient, combined with inexperience in eliciting symptoms of a deeply personal nature, may have resulted in a perceived lack of care, tact or sensitivity in protecting the emotional needs and boundaries of the patient. While this was not apparent in those who replied to my questionnaire, it may have had a part to play in those who did not reply.

Gradual change in the perception of the effectiveness of homeopathy in the general population over the years may have had some impact. Successful homeopathic treatment may have influenced the GPs of these patients.

Patient expectations, the specificity of action of each remedy, the speed of onset and rate of healing, and the anticipated length of follow up have been addressed more specifically over the years. This may be especially important in patients who have tried everything else.

Allopathic drugs

Allopathic drugs (even systemic steroids, methotrexate, lithium carbonate) do not appear to prevent the action of homeopathic medicines. The continued use of essential allopathic drugs often requires special consideration in selection of potency, frequency and dose of homeopathic medicine in order to initiate and maintain the action of the medicine.

Cost/savings implications

Savings to the NHS in the cost of patient care:

- in allopathic drug costs,
- in cancellation of planned surgery,
- in reduction of attendance to hospital specialists,
- in reduction of attendance to physiotherapy, occupational therapy, counsellors,

have become apparent during this study. In all 357 in the *excellent* outcome group (43% of patients) sustained reduction or cessation of allopathic drug treatment has occurred.

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References

1 Reilly D. *The Evidence for Homeopathy*. (Produced for Grampian Health Board.) Glasgow: Academic Departments of Homeopathy, 1995.
2 Royal London Homeopathic Hospital, Audit Report 1994/5. London: RLHH.
3 International Data Collection Centres for Integrative Medicine. A review of inpatient care integrating complementary and orthodox medicine at Glasgow Homeopathic Hospital. Interim Report, 1998.
4 Eizayaga FX, Eizayaga J, Eizayaga FH, Homeopathic treatment of bronchial asthma: retrospective study of 62 cases. *Br Hom J* 1996; **85**: 28–33.
5 Davidson JRT, Morrison RM, Shore J, Davidson RT, Bedayn G. Homeopathic treatment of depression and anxiety. *Alternative Therapies and Health and Medicine* 1997; **3**: 46–49.
6 Spence DS. Homeopathic treatment of eczema: a retrospective survey of 130 cases. *Br Hom J* 1991; **80**: 74–81.
7 van Wassenhoven M. Retrospective study of rheumatological patients in a private homeopathic medical practice. *Br Hom J* 1996; **85**:198–204.