Faculty *of* Homeopathy

MEMBERSHIP EXAMINATION – MFHOM
GUIDELINES 2022

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Section 1

1. Introduction

The MFHom examination has been developed for healthcare practitioners who have completed a Faculty-accredited training programme in integrative homeopathy. The MFHom qualification is a requirement for those wishing to undertake higher specialist training in homeopathic medicine in the context of either hospital medicine or community practice.

Please read **Section 1** of this document before applying for the examination. You should retain this document until you have completed the examination since you will need to refer to it at various times.

Section 2 provides detailed information about the format of the examination - how you will be tested, what you will be tested on and how your performance will assessed. To ensure that you are fully prepared for each part of the examination please read this section carefully.

An outline of the core curriculum is provided, as well as sample case histories and an example of the Objective Standardised Clinical Examination (OSCE).

Candidates, please note that a good standard of general knowledge of your healthcare profession and practice will be expected of you and the exam in part, may test this aspect of your knowledge.

This document will assist you by providing:

- guidance for applying for the MFHom examination
- information about the structure of the examination
- information on how to proceed through each stage

Information about courses leading to the MFHom examination can be obtained by contacting the Faculty Academic Officer or one of our accredited teaching centres. Contact details for these can be found on the Faculty website: www.facultyofhomeopathy.org.

2. The examination

The purpose of the examination is to evaluate the candidate's understanding of homeopathic **principles, therapeutics** and **materia medica** and skill in applying them, not merely the candidate's ability to memorise facts. A high standard of clinical healthcare is also expected.

In terms of passing or failing the examination, the essential criterion is whether or not, in the examiners' view, the candidate has demonstrated competence to practise homeopathy safely and effectively in:

- a general medical outpatient clinic in a homeopathic unit, in a non-training grade capacity (Specialty Doctor) with consultant cover.
- Primary Care/General Practice seeing the candidate's own patients with access to specialist help.
- a secondary referral capacity in Primary Care, with specialist supervision.
- independent (private) practice within the regulated scope of the candidate's profession, with specialist supervision.

The examination consists of the presentation of a clinical section and a viva voce, both of which usually take place on the same day.

In the event that there is a potential conflict of interest when a candidate and examiner(s) have a close relationship of one sort or another, (e.g., family member, partner, in a personal relationship (or have been), in a hierarchical work relationship such as manager) alternative arrangements for the examination will be made, wherever possible. It is the responsibility of the candidate and the examiner(s) to highlight any potential conflict of interest to the Academic Officer at the earliest opportunity.

The MFHom qualification is an entry point to higher specialist training in homeopathy and does not entitle the successful candidate to pursue independent specialist practice without supervision.

3. The application process

ELIGIBILITY CRITERIA
Candidates must be a Licentiate member of the Faculty of Homeopathy (or in some cases an Associate member) to be eligible to apply for the MFHom examination.

UPON APPLYING
Ensure you have correct supporting documentation for your application
1. GMC, NMC, HCPC, GPhC, PSNI or GDC number or copies of original medical/healthcare qualification certificates if resident outside the UK
2. Evidence of completion of Faculty-accredited training
3. Certification of readiness

CLINICAL EXAMINATION
Candidates will take a long case, a short case, two Objective Standardised Clinical Examinations (OSCE), and attend a viva.

MEMBERSHIP
If you are successful in the examination your membership will be upgraded automatically providing your membership fee has been paid.

4. Entry criteria

Important Note: the following regulations apply to all candidates entering the MFHom examination. The Faculty reserves the right to refuse admission to any part of the MFHom examination.

Applications for entry must be made on the appropriate form, available from the Academic Officer at lpeacock@facultyofhomeopathy.org or in the Members Only area of the website www.facultyofhomeopathy.org. The application form, fully completed and accompanied by the appropriate fee and any other documents required, must reach the Faculty before the published closing date. Late or incomplete applications will not be accepted.

The text in bold shows evidence that **must** be provided with the examination application form.

PRIMARY HEALTHCARE QUALIFICATION

- **candidates who practice in the UK or the Republic of Ireland must provide their current professional registration number OR**

- **if practicing outside the UK or the Republic of Ireland, candidates must present evidence that their primary healthcare qualification is registrable with the GMC, NMC or other relevant statutory body (for example a photocopy of their medical degree) as well as evidence that they are currently registered in their country of practice.**

PRIOR FACULTY MEMBERSHIP
Candidates must have been a Licentiate of the Faculty of Homeopathy for at least three months prior to applying to take the examination. Candidates must ensure their membership subscription is up to date to be eligible to take the examination.

COMPLETION OF FACULTY-ACCREDITED TRAINING AND COURSE-BASED ASSESSMENT
Candidates must have received formal teaching approved by the Faculty of Homeopathy or, present evidence of equivalent study and experience, in line with the Faculty's policy on Recognition of Prior Learning and Experience.

- **Candidates must provide a certificate of attendance and a signed testimonial letter from the Faculty-accredited training centre where they studied to confirm their readiness to take the MFHom examination. The letter must confirm that the candidate has successfully completed a Faculty-accredited course of training and course-based assessment.**

- **In the case of candidates whose training has been acquired at more than one centre, certificates for each stage of their training will be required, together with a signed letter from the teaching centre they attended most recently confirming their readiness to take the MFHom examination.**

Candidates must take the examination within three years of completing Faculty-accredited training (or passing the Part 1 written examination under earlier regulations). After this time, candidates should obtain an up-to-date testimonial, confirming their readiness to take the MFHom examination, which would normally be supplied after refresher training, supervision or assessment at a Faculty-accredited teaching centre.

Entry to the examination room

PROOF OF IDENTITY
Candidates will be admitted to the examination in their full name as given on their original medical/nursing/healthcare registration certificates, or medical/nursing/healthcare qualification documents, or official translations of these, or as in the current edition of the Medical Register of the General Medical Council of the United Kingdom, Nursing and Midwifery Council or other statutory body. **When candidates attend any part of the examination, they must produce upon request some means of official identification, like passport or UK driving license**. Admission to the examination will be at the discretion of the exam facilitator.

CHANGE OF NAME
Candidates who change their name by marriage or deed poll must submit documentary proof of this if they wish to be admitted to the examination in their new name.

PORTFOLIO
Candidates must email a digital copy of their portfolio to the Faculty 4 weeks before the examination.

5. Examination format

The examination consists of three elements:

- a clinical examination including one long and one short case
- two Objective Standardised Clinical Examinations (OSCEs)
- an oral examination/viva voce

The long case:

TIMING

The candidate will have a one-hour consultation with a patient, followed by half an hour with an examiner during which time they will be asked to present the case and discuss the patient's management. Candidates are warned that the time allocated for this section **will be strictly adhered to**.

ASSESSMENT

The candidate will be expected to approach the homeopathic management of the patient within the context of their general healthcare, and in relation to any conventional treatment that they are receiving or may require. The candidate should undertake any examination that is regarded as necessary to elicit symptoms and signs relevant to the general and homeopathic management of the patient (excluding any internal examination) but should not spend time on a comprehensive physical examination that does not have a bearing on the problem.

The candidate will not be expected to have repertorised the case, but should, if possible, leave a little time at the end of the consultation to use the repertory to help them explore key symptoms and possible homeopathic medicines. The candidate should not be concerned if s/he runs out of time and is not able to do this. The candidate should, however, at least have made a note of the key symptoms, and considered the rubrics that might prove useful for case analysis. The candidate should also have considered what their 'differential diagnosis' of possible homeopathic medicines for the treatment plan might be. The candidate will not be expected to have chosen 'the' right prescription, but to have thought critically about the medicines they consider to be indicated, and how they might be employed in a treatment plan.

When presenting the case, the candidate will be expected to review the patient's history at some stage but should not spend unnecessary time reporting routine information that has no direct bearing on their perception of the patient or the analysis of the case. The candidate may present the case in their own style, giving priority and emphasis to those aspects that are judged important, but without omitting any significant information.

An examiner may spend a little time with the candidate observing the consultation at some stage - if this is the case the candidate should continue as normal. Afterwards, the patient may be asked how they experienced the consultation. You may wish to explain to the patient how the artificial context of the exam may affect the consultation.

The clinical notes made by the candidate may be scrutinised and/or retained by the examiners.

In summary the long case examination will test:

- The quality of the candidate's relationship with the patient.
- Whether the candidate has identified the problems that the patient presents after taking an adequate conventional history and full homeopathic history and after any appropriate physical examination (a vaginal and rectal examination should **not** be carried out).
- What investigations the candidate would seek and his/her interpretation of these.
- The candidate's appreciation of the essential homeopathic features of the case.

- The selection of suitable rubrics for repertorisation.
- The ability of the candidate to plan the management and homeopathic treatment of the patient's illness.

EQUIPMENT
The candidate must bring a book or computer repertory of their choice, a stethoscope and a pen and paper into this part of the examination. Other essential equipment is provided.

The short case:

TIMING
There will be one short case during which an examiner will be present.

ASSESSMENT
Short cases will be chosen to present a circumscribed problem that can be assessed in the time available. A case may involve symptoms or signs that need to be elicited by brief examination, but it may require a verbal history only. The case will have been chosen to allow key prescribing information for the presenting complaint to be elicited in the time available by a competent candidate. Appropriate examination tools will be provided if the need for examination is anticipated.

Cases may present problems in any system which is amenable to targeted clinical prescribing. The presenting symptomatology will involve only one system. If a patient has a problem in a number of systems, they will have been coached to present only the symptoms of the problem selected for the purpose of the examination, unless the candidate specifically enquires about other symptoms in order to confirm or exclude a choice of medicine. Patients will have been instructed to give information only in response to direct questions from the candidate. They should not give information about current or previous homeopathic medication.

Candidates will be encouraged to spend 8-10 minutes questioning or examining the patient, as in a brief routine primary care consultation, allowing 5-7 minutes discussion with the examiner. However, candidates may tell the examiner if they are ready to discuss the case sooner.

Candidates will be expected to demonstrate awareness of the relevant symptomatology, and the ability to elicit and construe this intelligently in terms of possible, appropriate homeopathic prescriptions. They should not stray beyond the local aspects of the presenting problem, unless they deliberately intend to use general or psychological symptoms, concomitant symptoms or constitutional features to confirm or exclude the choice of a particular medicine.

Attention will be paid by the examiner to the candidate's technique in eliciting symptoms and physical signs, to their approach to, and consideration for the patient as well as to their interpretation of the information available and their ability to choose suitable management and homeopathic treatment.

Objective Standardised Clinical Examinations (OSCEs):

TIMING
There will be two short cases or specific clinical scenarios presented as OSCEs and twenty minutes will be allowed for the candidate to prepare each OSCE. An examiner will then ask the candidate to answer the set questions on each case.

ASSESSMENT

Objective Standardised Clinical Examinations will be chosen to present a wide range of clinical conditions, tasks and scenarios. Cases will usually take the form of written accounts but may also include photographs or video clips where appropriate.

Each case/scenario will be presented in the following format:

- Presentation of the case or scenario – including the conventional diagnosis, history of treatment, age of the patient, clinician's observations and clinical examination.

- The patient's description of their illness, usually in their own words.

After reading each case or scenario the candidate will be expected to consider:

- Various tasks to perform and scenarios/management decisions: e.g., the indicated homeopathic medicine, potency and dose regime, relevant rubrics, totality of symptoms, strange rare and peculiar symptom, hierarchy of symptoms.
- Patient management (relevant to the case presented) including integration of conventional and homeopathic treatment, assessment of vitality, anticipating or managing a homeopathic aggravation, consideration of evolving clinical scenarios after initial management and obstacles to cure.

Tasks and questions may cover any part of the core curriculum including principles of practice.
In this part of the examination candidates will achieve marks for each step or task they perform correctly rather than an assessment based on their overall performance.

EQUIPMENT

The candidate must bring a book or computer repertory of their choice as well as pen and paper.

The oral examination (Viva voce):

This will follow the clinical examination. It will normally last approximately 30 minutes but may be extended or reduced, according to the need to determine the outcome, including the award of distinction. All examiners will attend the oral examination but not all examiners will necessarily question each candidate. The candidate may be asked to use their book or computer repertory during this part of the examination. General questions on any aspect of homeopathic principles, therapeutics and case management may be asked.

Portfolio

Candidates must email a digital copy of their reflective portfolio (that has been prepared during their course-based assessment) at least 4 weeks before the examination to the Academic Officer at lpeacock@facultyofhomeopathy.org, as this will form part of their final assessment. (See Section 2A Course Based Assessment on page 11).

Number of examiners

For any MFHom examination there will be at least two Faculty of Homeopathy approved examiners present at the review of the long case and at the oral examination. One examiner will be present for the short case, and one examiner for each OSCE.

Trainee examiners

There may be trainee examiners shadowing the other examiners throughout the day. The shadow examiner may also ask you a question as part of the learning process but they are primarily there to observe and learn about the examination process rather than the performance of the candidates.

Assessment of the clinical and oral sections

PASS

A candidate who passes in all sections of the examination will pass overall.

FAIL

A candidate will fail the examination if he/she:

- fails even marginally in all the sections (long case, short case and OSCEs)
- fails clearly in any one of these sections
- fails marginally in any of these sections and does not compensate for this by scoring additional marks in the remaining sections

DISTINCTION

A candidate whose grades in the examination show overall excellence will be awarded a pass with distinction.

Review of the examination by the Faculty

After every examination the Faculty of Homeopathy will review that sitting. In the light of its findings, modifications to future examinations may be made where considered necessary.

6. Results

Results may not be collected from the Faculty office, nor can they be given over the telephone.

Final results of the MFHom examination will **normally** be emailed within one week of the clinical examination.

7. Practical details

Venues and fees

The examination will usually be held in the United Kingdom at one or more of the following locations – London, Bristol and Glasgow. Final exam location(s) will be determined by demand and numbers. This means candidates may not always get their first choice of venue. The examination may be held elsewhere (in the UK and abroad) by agreement with the Faculty.

Details of fees payable on entry to the examination are shown on the examination application form or are available by contacting the Faculty's Academic Officer.

Withdrawals and transfers

Notice of withdrawal from the examination must be emailed to the Academic Officer at lpeacock@facultyofhomeopathy.org.

The examination fee less a 50% administrative charge will be refunded when notice of withdrawal is received **up to 30 days before the examination is due to take place**. No other refunds will normally be made. The Faculty will consider a full refund on withdrawal because of illness or other extenuating circumstances

Candidates are limited to a maximum of **two** changes of examination date only.

Re-taking the examination
Re-applications by candidates who fail badly may be deferred at the discretion of the Faculty for a period of time. In this situation, the candidate will be informed in writing by the Dean after the examination and advised as to how they might improve their performance, and the interval of time recommended before re-sitting the examination.

If a candidate has failed the examination twice and wishes to make any further attempts, he/she must seek the approval of the Faculty.

Candidates re-applying to take the examination must provide an updated testimonial of readiness (as described in Section 3 on page 4).

Appeals
If you wish to appeal against your examination results, you must write to the Academic Officer at education@facultyofhomeopathy.org. Appeals should be sent within one month of receipt of results.

Faculty contact details
Email: lpeacock@facultyofhomeopathy.org. Tel: 020 3640 5903.
Website: http://www.facultyofhomeopathy.org

8. Faculty membership

Candidates successful in the MFHom examination will receive a certificate signed by the President of the Faculty. The names of successful candidates are presented to the Faculty Council for formal election as full Members of the Faculty of Homeopathy.

Shortly after receiving their results, eligible candidates will be invited to apply to join the Faculty's higher specialist training programme.

Members of the Faculty of Homeopathy are elected subject to the Faculty of Homeopathy Act 1950, including its current Byelaws and Regulations.

Section 2

A. Course Based Assessment: Teaching Centres

Students who are enrolled at one of the Faculty-accredited teaching centres will be required to do course work which will be assessed by the teaching centre. Students are only eligible to sit the MFHom exam once they have been deemed to have satisfactorily passed the coursework requirements set by their respective teaching centre. This coursework includes a reflective portfolio and ten case histories which are described in more detail below.

The reflective portfolio and case histories

Portfolios will be completed while a candidate undertakes a full course of training at a Faculty-accredited teaching centre. Full guidance on the preparation of portfolios will be given by the candidate's Faculty-accredited teaching centre, however, at minimum, a complete portfolio should contain a record of the following:

- All Faculty-accredited courses attended
- Additional homeopathic courses and study sessions attended
- Dates of sitting in on homeopathic clinics/video clinics
- Homeopathic articles and books or chapters read
- Course work marked by the candidate's teaching centre
- Ten case histories
- Mixture of formative and summative questions
- Any other appropriate teaching tools deemed useful by the teaching centre

The candidate's case histories constitute an important part of the portfolio and will be formally assessed and marked throughout their training by their teaching centre. Guidance on the presentation of case histories will be given by the candidate's teaching centre, however the expected content is also shown below.

Each case should be between one and two thousand words, to illustrate different types of patient and clinical diagnoses, repertory rubric selection, case analysis and homeopathic treatment strategies.

Each case should indicate:

- a fictitious first name, the patient's initials or some other coding for identification
- sex, age on presentation (**not** date of birth), marital status and occupation
- the full history, examination and investigations necessary for establishing a clinical diagnosis and a homeopathic prescription
- choice of rubrics and the reasons for their use with the name and page numbers of the repertory used (not necessary for every case, e.g. acute patients)
- an explanation and discussion of the reasons for the particular management subsequently undertaken, including its integration with other aspects of the patient's care, where appropriate
- responses to treatment, history of the management, with at least three months follow-up of chronic cases
- a full appraisal of the results of the treatment given

A good case study should:

- Be complete: that is, sufficiently comprehensive in respect of the presenting problem.
- Be written using the patient's own words as much as possible
- Demonstrate competence in conventional clinical management.
- Show the quality of rapport with the patient, and awareness of non-verbal clues.
- Clearly identify key symptoms, and their relative value (weighting).
- Emphasise the individualising characteristics of the patient, the illness and the case.
- Show appropriate symptom selection for case analysis and repertorisation.
- Demonstrate appropriate and competent use of the repertory and/or materia medica.
- Include appropriate and intelligent discussion of the differential diagnosis of the homeopathic prescription.
- Explain clearly the rationale for the choice of medicine, potency and dosage regime.

- ❖ Demonstrate adequate and appropriate follow-up of at least 4 months in chronic cases
- ❖ Provide intelligent and critical appraisal of the case.

A variety of acute and chronic cases may be included of which a maximum of two may be acute. Acute cases should reflect some finer points of acute case analysis and/or management rather than commonplace, if correct, acute prescribing (e.g. 'sudden onset of fever and severe earache with scarlet right eardrum. Prescribed Belladonna' is not satisfactory).

Cases will be assessed not only on outcome but also where they demonstrate a good understanding of therapeutic principles, patient care, obstacles to cure, and integrated with conventional care where appropriate.

The candidate's own choice of repertory is permitted but he/she must ensure that the chosen rubrics are stated in full, and the print-out of the computer repertorisation is included with each case.

B. Core curriculum

GENERAL CONTEXT

Aim: to understand the scope and limits of homeopathy in contemporary medicine

- ❖ The development of homeopathy within the science and art of medicine
- ❖ The scope and limits of homeopathy
- ❖ The clinical and legal bounds of competence of different practitioners
- ❖ Integration/inter-relationship of homeopathy with other forms of treatment
- ❖ The development of homeopathy internationally
- ❖ The various "schools" of homeopathy and international variations

HISTORY

Aim: to have a broad knowledge of the historical and philosophical background to the development of homeopathic thought and practice; to understand the history and development of contemporary homeopathic medicine and its relationship to the growth of conventional medical thought

- ❖ The importance of historical primary sources, especially Hahnemann's *Organon*, to the understanding of modern homeopathy
- ❖ The work of Hahnemann and his initial provings
- ❖ Later and contemporary developments in homeopathic principles and practice

PRINCIPLES AND KEY CONCEPTS

Aim: to have a broad knowledge of the concepts of the homeopathic approach

Basic principles

- ❖ The Principle of Similars: *Similia Similibus Curentur*
- ❖ Individualisation of treatment
- ❖ Directions of cure
- ❖ Sensitivity in the ill person
- ❖ The totality of symptoms
- ❖ The minimum dose
- ❖ Theories of chronic disease and miasms
- ❖ Self-healing and placebo responses

Homeopathic concepts of health and illness, disease and cure

- Hahnemann's *Organon*
- Concepts of suppression and obstacles to cure
- The direction of cure
- The concepts of incurability
- The theory of chronic disease and miasms: Hahnemann's original ideas and the contribution of later and contemporary teachers.

MATERIA MEDICA

Aim: to gain a critical understanding of the development of homeopathic materia medica and knowledge of a large range of homeopathic medicines

The sources and development of homeopathic materia medica

Aim: to gain an understanding of the development and range of 'drug pictures', from keynote symptoms to polychrest remedies, and ideas of typology derived from –

- toxicology
- provings
- clinical symptoms

Materia medica of specified homeopathic medicines

Aim: to gain a working knowledge of a selected range of homeopathic medicines

There are some 3000 homeopathic medicines in existence and a vast amount of homeopathic materia medica information associated with them. Trainees will know how to access and evaluate materia medica information in general, and will know the materia medica of a number of medicines to varying depths of knowledge, namely -

- Full details of the materia medica of major homeopathic medicines
- Comparative materia medica of major medicines
- Key features of a selection of other medicines

- as specified in the list on pages 16-20.

Repertories of materia medica

Aim: to gain a practical working knowledge of the concepts and techniques of repertorisation

- The historical development of the repertories
- The structure and layout of Kent's Repertory, Synthesis or the Complete Repertory
- Rubrics and typeface conventions
- Commonly used repertories in book and computerised form
- Ways of using repertories
- The limitations of repertory use
- The practical use of the repertory

HOMEOPATHIC PHARMACY AND PRESCRIPTION WRITING

Aim: to gain a working knowledge of the preparation of homeopathic medicines, potentisation methods, prescription writing and essential aspects of pharmacy practice

- Source materials: vegetable, mineral, animal, synthetic, disease products
- Mother tinctures
- The processes of production:
  - Extraction
  - Insoluble substances – trituration
  - Potentisation
  - Serial dilution: X(D), C and LM scales

- Succussion
- Hahnemannian and Korsakovian production methods

- Complex and combination remedies
- Pharmaceutical forms
- Prescription writing
- Pharmacopoeias in common use

SCIENTIFIC BASIS

Explanatory models

Aim: to become acquainted with conventional scientific principles which show a relationship to homeopathic effects, and with possible explanatory models including biophysical models

- Hormesis
- Auto-regulation
- The properties of water

RESEARCH METHODS AND EVIDENCE

Aim: to understand the basic principles of research methodology and be able to make critical appraisals of research in homeopathy

- Clinical trials in homeopathy (including veterinary homeopathy), including meta-analyses
- Methodology design
- Critical assessment of historic and modern papers
- Evidence-based appraisal, audit
- Laboratory studies in homeopathy
- Research protocols
- Provings
- Possible scientific explanatory models including biophysical models
- The main approaches to conducting homeopathic research:
  - mechanisms of action
  - randomised clinical trials
  - placebo studies
  - qualitative studies
  - observational studies
  - outcome studies
  - attitudes and awareness studies

CONSULTATION AND CLINICAL SKILLS

Aim: to gain a profound understanding of how the homeopathic method can be used to enhance the therapeutic interaction; to learn to use therapeutic relationship to achieve a rapport and depth of understanding with the patient that will enhance the quality of the consultation and the case-taking process; a detailed working knowledge of the features of the consultation, history taking and analysis skills in homeopathic care

Homeopathic history taking

- In the acute and chronic case
- Awareness of the natural history of the disease process

- ❖ Placebo and nocebo effects and the possible impact of the non-remedy aspects of homeopathic care, such as the consultation and context
- ❖ Awareness of predisposing factors and causation (Never well since)

For a chronic case the history taking must include:

- ❖ Details of the presenting complaint(s). Use the patient's own words as much as possible.
- ❖ Modalities of the main symptoms
- ❖ Concomitants of the main symptoms
- ❖ Details of onset of symptoms, including mental / emotional experience / life event at the time
- ❖ General Temperature / Weather / Time modalities
- ❖ Food desires / aversions
- ❖ Menstrual history in women
- ❖ Dreams / Fears / Phobias
- ❖ Past medical history
- ❖ Family history

For an acute case the history taking must include:

- ❖ Details of the presenting complaint. Use the patients own words as much as possible.
- ❖ Details of onset of symptoms, including mental / emotional experience / situation at the time
- ❖ Modalities of the main symptoms
- ❖ Concomitants of the main symptoms
- ❖ Any change in the patient's usual temperature / time modalities since the acute symptoms
- ❖ Any previous episodes of similar symptoms

Case analysis

Aim: to identify key features of the case as indicators to the choice of medicines and prescribing strategies

- ❖ The significance of different elements of the history
- ❖ The significance of predisposing factors and causation
- ❖ Categorising and evaluating symptoms and modalities
- ❖ The concept of a hierarchy of importance of symptoms
- ❖ The role and techniques of repertorisation
- ❖ Discrimination between possible remedy choices
- ❖ The use of homeopathic decision support software

Case Management

Aim: to integrate homeopathy appropriately and effectively with conventional medical practice in both adults and children

Therapeutic strategies

Aim: to gain detailed knowledge and practical experience of using different prescribing strategies

- ❖ Differences in acute and chronic case management
- ❖ strategies based on different perspectives of the patient's history / health status:
  - o Prescribing in layers and the current status
  - o Conventional aetiology and other aetiological influences
  - o The relevance of conventional diagnosis and pathology
- ❖ Patient's disease reactions
  - o Constitutional characteristics
  - o Biographical and past history including family history
  - o Typology and drug types

- Keynotes
- Totality
- Essence
- Strange, rare and peculiar reactions
- Theory of chronic disease and miasms
- Isopathy
- Tautopathy

Patterns of response to homeopathic prescriptions, their interpretation and management
Aim: to develop the ability to understand and manage the responses which can follow a prescription

- In acute, sub acute, chronic and incurable cases
- The differing schools of interpretation and practice
- Speed of responses
- Initial reactions and aggravations
- Direction of cure
- Suppression
- Obstacles to cure
- Repetition of doses
- Changing dosage
- Changing remedy

C. Materia medica A-Z

Grade 1 remedy
Comprehensive knowledge required

Grade 2 remedy
Knowledge of the key mind, general and local symptoms and common clinical presentations

Grade 3 remedy
Knowledge of important local symptoms and clinical indications required

Elements, Acids and Salts

Grade 1	*Grade 2*	**Grade 3**
Argentum nitricum	*Adamas (Diamond)*	Amyl nitrosum
	Alumina	Antimonium tartaricum
Arsenicum album	*Ammonium carbonicum*	Argentum metallicum
Aurum metallicum	*Antimonium crudum*	Arsenicum iodatum
Baryta carbonica		Aqua marina
Calcarea carbonica	*Cuprum metallicum*	Aurum muriaticum
Calcarea phosphorica	*Ferrum metallicum*	Aurum muriaticum natronatum

Carbo vegetabilis	*Ferrum phosphoricum*	Borax
Causticum	*Iodum*	Calcarea fluorata
Graphites	*Kali bichromicum*	Calcarea silicate
Hepar sulphuris calcareum	*Kali phosphoricum*	Calcarea sulphurica
Kali carbonicum	*Kali sulphuricum*	Carbolic acidum
Mercurius solubilis		Carbo animalis
Natrum muriaticum	*Magnesia carbonica*	Fluoricum acidum
Phosphorus		Glonoine
Silicea terra	*Magnesia muricata*	Hydrogenium
Sulphur	*Magnesia phosphorica*	Kali arsenicosum
	Natrum carbonicum	Kali muriaticum
	Natrum sulphuricum	Lactic acidum
	Nitricum acidum	Mercurius corrosivus
	Palladium metallicum	Mercurius dulcis
	Petroleum	
	Phosphoricum acidum	Natrum arsenicosum
	Platinum metallicum	Natrum phosphoricum
	Plumbum metallicum	Nitrogenium
	Stannum metallicum	Ozone
	Strontium carbonicum	Picricum acidum
	Zincum metallicum	Plutonium nitricum

The Plants

Grade 1	*Grade 2*	Grade 3
Aconitum napellus	*Anacardium orientale*	Actea spicata
	Bellis perennis	
Arnica montana	*Caulophyllum thalictroides*	Adonis vernalis
Belladonna	*Chelidonium majus*	Aesculus hippocastanum
Bryonia alba	*China officinalis*	Aethusa cynapium

Chamomilla	*Cimicifuga racemosa*	Agnus castus
Gelsemium sempervirens	*Cina*	Ailanthus glandulosa
Ignatia amara	*Cocculus (Menispermum cocculus)*	Allium cepa
Lycopodium clavatum	*Colocynthis*	Aloe socotrina
Nux vomica	*Conium maculatum*	Arundo mauritanica
Pulsatilla nigricans	*Dulcamara*	Baptisia tinctoria
Rhus toxicodendron	*Hyoscyamus niger*	Berberis vulgaris
Staphisagria	*Hypericum perforatum*	Cactus grandiflorus
Thuja occidentalis	*Ipecacuanha*	Calendula officinalis
	Lilium tigrinum	Camphora officinarum
	Opium	Cannabis indica
	Phytolacca decandra	Capsicum
	Ruta graveolens	Cicuta virosa
	Spigelia anthelmia	Clematis erecta
	Stramonium	Colchicum autumnale
	Symphytum officinalis	Collinsonia canadensis
	Veratrum album	Convallaria majalis
		Cyclamen europaeum
		Digitalis purpurea
		Dioscorea villosa
		Drosera rotundifolia
		Eupatorium perfoliatum
		Euphrasia officinalis
		Hamamelis virginica
		Helleborus niger
		Hydrastis canadensis
		Kalmia latifolia
		Ledum palustre
		Lobelia inflata
		Mezereum

		Nux moschata
		Paeonia officinialis
		Podophyllum peltatum
		Ranunculus bulbosus
		Rhododendron
		Sabadilla
		Sabal serrulata
		Sabina
		Sanguinaria canadensis
		Squilla maritima
		Tabacum
		Urtica urens
		Viburnum opulus

The Animals

Grade 1	*Grade 2*	Grade 3
Apis mellifica	*Asterias rubens*	Ambra grisea
Lachesis mutans	*Cantharis*	Coccus cacti
Lac caninum	*Falco peregrinus*	Corallium rubrum
Sepia officinalis		Crotalus horridus
Tarentula hispanica	*Lac delphinum*	Elaps corallinus
	Lac equinum	Haliaeetus leucocephalus (bald eagle)
	Lac lupinum	Latrodectus mactans
	Spongia tosta	Medusa
		Moschus moschiferus
		Murex purpurea
		Naja tripudia
		Oncorynchus tschawytscha (Salmon)

The Nosodes

Grade 1	*Grade 2*	Grade 3
Carcinosinum	*Bacillus No. 7(Paterson)*	Anthracinum
Medorrhinum	*Bacillus No. 10 (Paterson)*	Bacillus Faecalis
Psorinum	*Bacillinum*	Glandular Fever Nosode
Syphilinum	*Coccal Co (Paterson)*	Morbillinum
Tuberculinum bovinum (Kent)	*Dysentery Co (Bach)*	Parotidinum
	Gaertner (Bach)	Pyrogenium
	Proteus (Bach)	Staphyllococcin
	Morgan Pure(Paterson)	Streptococcin
	Morgan Gaertner(Paterson)	Varicellinum
	Mutabile	Variolinum
	Sycotic Co (Paterson)	

The Mycota (Grade 3)

Agaricus muscarius, Secale cornutum

Miscellaneous (Grade 3)

Folliculinum; Isopathic nosodes e.g. mixed tree pollens, mixed grass pollens

Topical treatments (Grade 3)

- Arnica montana
- Calendula officinalis
- Hypericum perforatum
- Hypericum and Calendula Tincture
- Rhus toxicodendron .
- Ruta graveolens
- Thuja occidentalis
- Urtica urens

D. Sample format for case histories

These examples are included as a guide and are not prescriptive. The format may be adapted to reflect your own style of case taking, provided that all the relevant elements of the case history exemplified here are clearly represented, and the case fulfils the criteria set out above. The presentation should use some form of grading to identify those symptoms or other features likely to be of most value for case analysis.

CASE Example One:

Presentation: *Brenda is a married 64 year old retired office worker with renal cell carcinoma who was referred by her oncology specialist nurse for advice regarding symptoms associated with the side-effects of her chemotherapy. I first saw her on 11 February 2011.*

Current medical history

2010: Diagnosis of Renal cell carcinoma and multiple pulmonary metastases.

2011: Investigation for spinal cord compression – nil found. Symptoms felt to be due to chemotherapy side-effects

Current medication

Sunitinib (chemotherapy) 4 weekly cycle

Ranitidine 150mg one twice daily as required for indigestion associated with side-effects of chemotherapy

Aloe vera (self-prescribed) to aid digestion

Past Medical History

Childhood: Nothing unusual that she can remember other than childhood illnesses such as chicken pox and measles.

History of recurrent cystitis, for which she has had diagnostic cystoscopy and urethral dilatation.

1991: carpal tunnel decompression and trigger finger release; repair epigastric hernia; sebaceous cyst left neck removed

2009: rotator cuff sprain

Family History: Her husband had a stroke 3 years ago. History of glaucoma on her mother's side and maternal grandmother and uncle both had dementia. Her adoption aged 7 weeks has made it difficult to find out further information.

Social History: She lives with her husband and they have 2 sons and 2 granddaughters. She says that she does not miss work but misses the contact with people. Hobbies tend to be solitary such as computer games, or one to one such as scrabble.

Appearance: Brenda was waiting quietly in reception and although she was invited to bring someone with her she chose to attend alone.

Her build is small and her handshake was sure but gentle. Her verbal delivery was quick but wandering, and her body language was restless.

Presenting complaint: From week 2 to 4 of her chemotherapy regime she experiences a burning sensation in her mouth [gesture: flaps her hand in front of her mouth]. She states that her tongue feels sore with a burning sensation. On examination her mouth and tongue are moist and clean, but her tongue is very red. She is thirstless and her symptoms are worse for hot drinks. The burning sensations quickly resolve when not having her chemotherapy.

Generals: She describes herself as a 'chilly' person - averse to winter – *'hate it with a passion';* normally desires hot weather (dry and humid), but currently finds that warmth aggravates. She has an aversion to bananas and ice-cream; and generally feels worse late afternoon and early evening. She states that she sleeps very well and is unable to recall her dreams.

Mentals: Brenda describes herself as being busy and practical and house proud, with attention to detail. She likes to organise others, but not in a controlling way. She feels better for consolation, unburdening - talking about her problems and health *'I would happily go up to someone in the street and tell them about my cancer'.*

Rubrics and sub-rubrics: Schroyens F., Synthesis TE 9.1

1	1234	1	MOUTH - PAIN - burning	156
2	1234	1	MOUTH - PAIN - Tongue - burning	186
3	1234	1	MOUTH - PAIN - Tongue - sore	112
4	1234	1	MOUTH - DISCOLORATION - Tongue - red - fiery red	8
5	1234	1	STOMACH - THIRSTLESS	220
6	1234	1	GENERALS - COLD - applications - amel.	26
7	1234	1	GENERALS - FOOD and DRINKS - bananas - aversion	3
8	1234	1	GENERALS - FOOD and DRINKS - ice cream - aversion	7
9	1234	1	GENERALS - FOOD and DRINKS - warm drinks - agg. - hot	41
10	1234	1	GENERALS - HEAT - lack of vital heat - warmth agg.; and	47
11	1234	1	MIND - FASTIDIOUS	76
12	1234	1	MIND - CONSOLATION - amel.	33
13	1234	1	MIND - PRACTICAL	2
14	1234	1	MIND - BUSY	109

	apis	**puls.**	**phos.**	**bell.**	**sep.**	**caust.**	**ruta**	**ars.**	**bry.**	**lyc.**
	10/22	**9/19**	**9/15**	**8/14**	**8/12**	**8/11**	**8/8**	**7/14**	**7/12**	**7/12**
1	2	-	2	3	2	2	1	3	1	1
2	2	1	2	2	2	2	1	3	1	2
3	2	1	-	1	2	1	1	1	-	2
4	3	-	-	2	-	-	-	-	-	-

5	3	3	1	2	2	1	1	2	1	2
6	3	1	1	1	1	-	-	1	1	1
7	-	-	-	-	-	-	-	-	-	-
8	-	1	-	-	-	-	1	-	-	-
9	1	3	3	2	1	1	-	-	3	-
10	3	4	2	-	-	1	-	-	3	3
11	-	1	1	-	1	2	1	3	-	1
12	-	4	2	-	-	1	1	-	-	-
13	1	-	-	-	-	-	-	-	-	-
14	2	-	1	1	1	-	1	1	2	-

Prescribing Indications

I chose Apis mellifica [Apis] as it was clearly indicated for her chief complaint, of burning sensation. Brenda also exhibited the Apis characteristics of being busy and practical, with hasty speech and restless body movements.

Plan:

1. Advised Apis Mellifica 12c one daily late afternoon as time modality indicates general aggravation of all symptoms about 5pm (Vermeulen, 2000: p 135), having checked that she had not had a previous reaction to bee stings, week 2 to 4 of chemotherapy, on occurrence of symptoms, stopping on improvement or aggravation.
2. Information leaflet on how to obtain and take the remedy given
3. Also suggested Calendula mouthwash and toothpaste; Manuka honey and Propolis mouth spray to ease discomfort, and gentle reflexology.
4. Reviewed Brenda's awareness of signs and symptoms of spinal cord compression and action to be taken should she be concerned.
5. Telephone in 6 weeks, or sooner should she encounter any aggravation/difficulties in taking the remedy.

Posology

When the symptoms occurred they were acute but as Brenda was on an intensive course of chemotherapy I decided to use a low potency as I was uncertain how she would respond and wanted to avoid intense aggravation from a higher potency.

Telephone Follow-up 29th March 2011

Brenda used the 12c potency as advised and thought that her symptoms were mildly better. She chose to use the remedy until the sensations ceased at the end of week four of her regime. The oncologist reduced the dose of her chemotherapy to try and minimise the side-effects of the treatment and she felt she no longer needed the Apis. She was finding the reflexology helpful and thought the topical preparations were also helping. It is therefore difficult to ascertain to what degree the Apis helped.

Consultation 21st July 2011

Although her mouth symptoms had improved she was experiencing intense burning sensations in the soles of her feet. She had used Apis and found it did not help. Sometimes the burning would be stinging in nature followed by a 'lack of feeling'. At this consultation she appeared more relaxed and so I took greater account of the 'mentals' to inform my repertorisation.

'It's the chemotherapy that's going to kill me, not the cancer … I don't feel like doing anything, eating anything, just want to curl up … hide, to disappear'. [she weeps when telling me how she feels] *'I can talk to my husband, but we don't have conversations … he buries his head in the sand … complains if I go out … I cope by writing things down, or talk to myself, or mum and cousin*'. Friends? *'I have acquaintances, not friends.'* I was an only child, and only had a few friends at school.

At age 15 she discovered that she was adopted *"… deep down I think I always knew I was adopted – may be that is why I went snooping in their wardrobe."* She did not tell her adoptive parents of her discovery for 2 years and she describes her behaviour during that time as being 'very difficult' with her 'parents'. She 'found' her birth mother 3 years ago and has a very good relationship with her but admits to feeling the loss of being 'given away'.

'I have to put on a good persona, but inside I'm a mess … turmoil. I've been lucky in life really – comfortably off … its all gone sour – bloody disease.' The feeling here is: *'anger… a need to go out into the middle of the desert* [hand gesture: palm facing down, hand moving out horizontally and evenly] *and scream, shout, kick …'* [hand gesture again] and the feeling here?: *'flat like the desert, remote, distant'.* The desert? *'keep it to myself … no one to see me let rip … don't like to draw attention to myself'.*

Sour is?: *'40 years in our previous home … moved 2 years ago, it was a difficult move … husband didn't want to move. The seller made it difficult – I blame him for this – my cancer – he ruined my life. I feel bitter, but I'm not a bitter person'.* She worries how her husband will cope without her.

She states that she is principled and has *'deep morals … I nearly lost my job twice in the past because of it … standing up for what is right … I'm the one in the shop or the restaurant complaining if service isn't good enough.'*

She describes herself as a people person - she likes to be liked, likes to please others: an example is? *'playing games - I'm not competitive, I'm willing to lose to make others feel good'.*

Anything else important to mention? *'I feel guilty I asked my husband to dig up a plant in the garden and then he had a stroke … I feel he blames me … I worry the family will find out and then they will blame me … the guilt will grow like my cancer'* [she weeps again].

Rubrics chosen include many more mental symptoms

1	1234	1	EXTREMITIES - PAIN - Feet - Soles - burning	131
2	1234	1	EXTREMITIES - NUMBNESS - Feet	194
3	1234	1	STOMACH - THIRSTLESS	220
4	1234	1	GENERALS - FOOD and DRINKS - bananas - aversion	3
5	1234	1	GENERALS - FOOD and DRINKS - ice cream - aversion	7
6	1234	1	MIND - FASTIDIOUS	76
7	1234	1	MIND - CONSOLATION - amel.	33
8	1234	1	MIND - PRACTICAL	2
9	1234	1	MIND - PLEASING - desire to please others	14
10	1234	1	MIND - ANGER - taciturnity; with	12

11	1234	1	MIND - WELL - says he is well - sick; when very	24
12	1234	1	MIND - WEEPING - telling - sickness; when telling of her	20
13	1234	1	MIND - INJUSTICE, cannot support	64
14	1234	1	MIND - REMORSE	93

	puls.	**nat-m.**	**ign.**	**ars.**	**caust.**	**carc.**	**phos.**	**sep.**	**sulph.**	**con.**
	12/25	**9/11**	**8/11**	**7/14**	**7/12**	**7/11**	**7/11**	**7/11**	**7/11**	**7/10**
1	2	1	1	1	2	-	2	1	3	1
2	2	1	1	3	2	-	3	1	1	3
3	3	1	1	2	1	-	1	2	1	2
4	-	-	-	-	-	-	-	-	1	-
5	1	-	-	-	-	1	-	-	-	-
6	1	2	1	3	2	2	1	1	1	1
7	4	1	-	-	1	1	2	-	-	1
8	-	-	-	-	-	-	-	-	-	-
9	1	-	-	-	-	2	-	-	-	-
10	1	1	2	-	-	-	-	-	-	-
11	3	-	-	1	-	-	-	-	-	-
12	3	1	1	-	-	1	-	3	-	1
13	2	2	2	1	3	3	1	1	1	-
14	2	1	2	3	1	1	1	2	3	1

Prescribing indications:

The Apis characteristics of hasty speech, busyness of character and restlessness were no longer evident. Her sensitivity and wandering nature of narration suggest a plant remedy (Sankaran). Brenda exhibited many of the characteristics of Pulsatilla, including its keynotes of changeability, weeping on telling her symptoms, and amelioration from talking about her problems. Physically the effect of the chemotherapy meant that her symptoms were changeable – fluctuating with burning and then lack of feeling. Emotionally her way of coping was changeable and contradictory, a guiding characteristic of Pulsatilla (Vermeulen, 2000, pp 1296) - *'I have to put on a good persona, but inside I'm a mess … turmoil'; 'I would happily go up to someone in the street and tell them about my cancer'; 'no one to see me let rip … don't like to draw attention to myself', 'bitter … but not a bitter person'.* There was also a mildness and gentleness to her as seen in her need to make others feel good by not winning at games with them. Also her history of being adopted and 'given away' reflects the forsaken feeling of Pulsatilla.

Emotionally she fits with characteristics of the Ranunculaceae plant family, (to which Pulsatilla belongs), where many emotions are excited together/one on top of the other (Sankaran, 2007). She has many intense emotions such as anger, remorse, embitterment. The burning pain is intense, then the passive reaction pattern of the physical lack of feeling after the burning is mirrored in her emotional state: 'flat … remote … distant'.

She also presented elements of the sycotic miasm, to which Pulsatilla belongs: to hide - wanting to go into the desert - avoid people - to be unobtrusive, to put on a brave face to the world, to hide her knowledge of her adoption, and yet also shows acceptance of her situation with her willingness to discuss her illness with people. She has the sense of guilt and remorse as demonstrated in her feelings toward her husband. Sankaran (2007) also describes 'feeling of being exposed' for the Ranunculaceae family, and Brenda exhibited this when talking of her fear that the family would find out that she asked her husband to dig the garden just before he had his stroke.

Plan: I advised Pulsatilla 12c daily in the evening when symptoms occurred during chemotherapy, and stopping on improvement or aggravation. I chose 12c potency daily as I wanted to be cautious in my approach

Follow-up visit 1st September 2011: Brenda stated that she had not noticed any improvement, or aggravation of her physical symptoms. As she was sitting down she spontaneously said *'you know its funny but my feet feel heavy when I'm showering.'* [gesture: both hands palm down, making a pressing down motion]. The other aspect that she found difficult was that she constantly needed to take her socks off, her feet feeling worse for warmth, and she also preferred fresh air around her, despite her chilly disposition.

1	1234	1	EXTREMITIES - PAIN - Feet - Soles - burning	131
2	1234	1	EXTREMITIES - HEAVINESS - Feet	126
3	1234	1	EXTREMITIES - NUMBNESS - Feet	194
4	1234	1	STOMACH - THIRSTLESS	220
5	1234	1	GENERALS - FOOD and DRINKS - bananas - aversion	3
6	1234	1	GENERALS - FOOD and DRINKS - ice cream - aversion	7
7	1234	1	GENERALS - UNCOVERING - amel.	49
8	1234	1	GENERALS - AIR; OPEN - desire for open air	170
9	1234	1	GENERALS - WARM; BECOMING - agg.	90
10	1234	1	GENERALS - WARM - bathing - agg.	28
11	1234	1	MIND - FASTIDIOUS	76
12	1234	1	MIND - CONSOLATION - amel.	33

13	1234	1	MIND - PRACTICAL	2
14	1234	1	MIND - PLEASING - desire to please others	14
15	1234	1	MIND - ANGER - taciturnity; with	12
16	1234	1	MIND - WELL - says he is well - sick; when very	24
17	1234	1	MIND - WEEPING - telling - sickness; when telling of her	20
18	1234	1	MIND - INJUSTICE, cannot support	64
19	1234	1	MIND - REMORSE	93

	puls.	**nat-m.**	**sulph.**	**phos.**	**sep.**	**caust.**	**ign.**	**spong.**	**ars.**	**calc.**
	17/38	**13/21**	**12/21**	**12/19**	**11/18**	**11/16**	**11/16**	**11/12**	**10/20**	**10/16**
1	2	1	3	2	1	2	1	-	1	3
2	3	3	3	3	3	1	2	1	3	2
3	2	1	1	3	1	2	1	1	3	2
4	3	1	1	1	2	1	1	1	2	1
5	-	-	1	-	-	-	-	-	-	-
6	1	-	-	-	-	-	-	-	-	-
7	3	-	1	1	1	-	1	-	1	2
8	3	2	3	1	1	1	-	1	2	1
9	2	2	2	2	2	1	2	1	-	1
10	2	3	1	1	-	1	-	1	-	-
11	1	2	1	1	1	2	1	1	3	1
12	4	1	-	2	-	1	-	1	-	-
13	-	-	-	-	-	-	-	-	-	-
14	1	-	-	-	-	-	-	1	-	-
15	1	1	-	-	-	-	2	-	-	-
16	3	-	-	-	-	-	-	-	1	-
17	3	1	-	-	3	-	1	-	-	-
18	2	2	1	1	1	3	2	2	1	1
19	2	1	3	1	2	1	2	1	3	2

I questioned her closely as to how she had been taking the Pulsatilla to ensure that she was not anti-doting the remedy and was assured that she had followed the written instructions.

Repertorisation indicated that Pulsatilla remained the similimum, so I chose to increase the potency to 30c daily as physical symptoms occurred, stopping on improvement or aggravation.

Follow-up

Brenda took the remedy daily from the first day that she noticed the burning sensation occurring. She phoned at the end of October to update and said that she felt the Pulsatilla had really helped, both physically and mentally, scoring 2+ (Mathie and Robinson, 2006).

Follow-up 15th December 2011

Brenda's chemotherapy is continuing and she has chosen to use the Pulsatilla daily on first experiencing the symptoms of burning and/or heaviness of her feet and then stopping at the end of the chemotherapy cycle. Although I based the potency selection on the level of the physicals she feels that her emotional state is more even in nature and notices that she is crying less. If the 30c had failed to work I would have considered trying 200c as I still felt Pulsatilla was the similimum. She had not had any further cystitis symptoms.

Clinical Reflection

The regime of daily use suited Brenda psychologically and it gave her support and did not cause harm or aggravation. I completely missed the importance of her history of cystitis and this demonstrates the importance of past history and recurrent illnesses in the case taking. Pulsatilla is in the rubrics: KIDNEYS - COMPLAINTS of kidneys - scoring 3; GENERALS - HISTORY; personal – cystitis; of recurrent - scoring 1 and: BLADDER – INFLAMMATION (= cystitis) - scoring 3; and BLADDER - INFLAMMATION - chronic cystitis - scoring 2. Vermeulen (2007, pp 1296) states that Pulsatilla affects Genito-Urinary organs. Building a therapeutic relationship was vital to understanding the mentals of the case. Interestingly Pulsatilla was second to Apis in the first repertorisation and a greater understanding of her mentals would have led me to Pulsatilla at the outset.

I chose to record this case because it demonstrated how focusing on the physicals and acutes did not allow me to address the chronicity, such as recurrent cystitis, and the mentals such as effects of adoption, which would have afforded 'the total disease image always before him' (Hahnemann [aph 104] in O'Reilly, 1996: p141). Pulsatilla was clearly evident for the mentals and previous genito-urinary history.

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CASE EXAMPLE 2:

KN, age 79. Presenting complaint : Chronic leg ulcer for 4 months

KN has had varicose veins in both legs for the past 15 years. 5 years ago he had thrombophlebitis and deep vein thrombosis in the left calf and has been on Warfarin since. He has always been careful to prevent injury to both legs. His leg ulcer started following a fall 4 months previously when he bruised his leg on the inner side of the left ankle (he pointed to an area just below the left medial malleolus). This has caused a break of the skin and ulceration of bluish colour about 3-4 mm deep and 2x2 cm in size. The ulcer was tender to touch but not painful, there

was also some contact bleeding. He had been applying Chloramphenicol ointment to dressings and using daily compression bandages. Although the lesion has not been causing him much problem, he is concerned that it might get larger or deeper, or infection might set in. All these he would like to prevent and he is willing to try other ways of treatment to see if they can help. He knows that in the context of varicose veins healing of this lesion might be prolonged, and also that excessive physical activity and inadequate rest can slow healing down.

When he is more physically active, he usually gets a sense of heaviness in both legs and overall tiredness to the point that every day he has to rest twice a day (midday and at around 6 pm) by sitting in an arm chair and elevating both legs at least 45 degrees for at least an hour, then he is able to continue with his activities again. If he does not rest, the heaviness and tiredness become so intense that he becomes very irritable, moody, wants to be left alone and finds it very difficult to concentrate on any activity properly. He says the pain exhausts him mentally. Elevation of both legs relieves the very unpleasant dullness in them and as a result he feels more energised again. His leg pains are worse in the evening. He elevates his legs on a pillow at night in bed.

2 years ago he had a leg ulcer in the same area - on the medial side of the left ankle. It was only superficial, not inflamed and approximately 3x3 cm in size. It was painless and there was no itching. He applied antibiotic ointment to it. He also had local treatment with laser on the ulcer area and says that this was very helpful at that time. It took about 4-5 months to heal. Otherwise he feels well in himself.

SLEEP: He always goes to bed after midnight, sometimes at 1-2 am and has done so all his life. Sleeps normally about 5 hours. Does not dream.

FEARS: Denies any.

WEATHER: Prefers cold. He is not chilly.

FOOD: Always had a very good appetite and likes to eat a lot. He has been overweight all his life and tried various weight reduction diets with minimal success. Over the past year he has lost about 10 kg, his current weight is 107 kg.

He grew up on a farm and likes to eat all fruit, apples, pears, plums, also meat, milk and pastries. He is not too keen on fats, but would have butter on bread. When he is under stress and gets anxious he tends to eat a lot. Being born on a farm, since early childhood he helped his parents to look after the animals (cows and horses) and worked in the fields. He says this hard manual work made him strong for life. Since childhood he was an avid

reader of history, poetry, philosophy, dramas and also science. His father expected him to get the best grades at school. When he was at grammar school he joined a drama group and performed a leading role in a play at the theatre. He thoroughly enjoyed art and acting and was told he had a talent for it. He was also good at maths. He did well in all his exams and when it came to the choice between art school to become an actor or study at veterinary school, his father decided that he would study veterinary medicine as this would be more in line with the family farming background. His father always wanted him to achieve the best results, and always left a list of tasks for him to do when he returned from school. He was brought up with a very strong work ethic and has always been motivated to work hard, often feeling that other people were not working hard enough. He was devoted to his job as a vet and was the leading vet in his practise. Work is the main priority in his life. He has one son and one daughter. His son did not follow in his footsteps and this has been a big disappointment for him as he wanted to hand over his business to him. During his working life he came home from work late in the evening and left for work early in the morning. His mood could be quite changeable at times, for no reason he could get very moody and irritable, then depressed with a sense of hopelessness and heaviness. He cannot stand contradiction. He could also go through phases when he would not talk to anybody and would stay in his office at home in solitude. He has been questioning what the point of his life has been - having worked hard to provide for his family and having a sense of disappointment about life and his family not living up to his expectations of working hard enough and achieving in life. He got divorced after 23 years of marriage and lives with a partner for the past 18 years. He has continued to work through his retirement and still does limited hours. He finds it very difficult to give up working altogether, although there is no financial need to do so. He has noticed he has been getting more forgetful recently.

PAST MEDICAL HISTORY

He had rheumatic fever when 12 years old

When he was 54 he had a viral keratitis in his right eye and this was treated initially with Zovirax and later by a corneal transplant. His vision has never been fully restored, but was reasonable and remained relatively static for many years now.

He was a heavy smoker for 20 years (30-40 cigarettes a day) until he was 57 years old when he stopped completely. He has had raised blood pressure for the past 15 years and was on Amlodipine - this caused leg oedema

and was replaced by Ramipril and Doxazocin which keeps his blood pressure under control. He has also been on statins for many years. He was diagnosed with 1st degree heart block on a routine ECG but this is not causing him any problems.

He has had severe osteoarthritis of both knees and had both replaced 4 and 2 years ago with marked improvement and reduction of pain and some improvement in function. When he was 74 years old he suffered perforated sigmoid diverticulitis and had an emergency laparotomy with bowel resection. Intraoperatively he was found to have a fistula between bowel and urinary bladder. He was on several courses of antibiotics and this gradually healed. He has made a remarkable recovery from the surgery and has had no bowel problems since. He still attends regular urology follow ups, mainly for symptoms with his enlarged prostate (nocturia 1-2 a night).

He has bilateral varicose veins and has had thrombophlebitis and deep vein thrombosis in the left calf 5 years ago, since then he has been on Warfarin. He has no allergies.

FAMILY HISTORY

Mother (died when 76 years old) – type II diabetes, obese, leg ulcers

Father (died when 66 years old) – lung cancer

He has one brother (72 years old) who is obese and has heart disease.

Paternal grandfather died of stomach cancer.

ASSESSMENT

He is of a strong built, 6ft tall and weighs 107 kg. BP 156/ 86, HR 66/min, regular.

Grey hair and dark brown eyes. Heavy, stoical. He answers to the point trying to be as precise and as helpful as possible. There was a sense of heaviness about him.

He has varicose veins with dermatitis in both calves. Under the left medial malleolus there was a small area 2x2 cm well-demarcated ulcer with surrounding skin paper-like, shiny and erythematous. No swelling, some tenderness to touch. No leg oedema.

ASSESSMENT Rubrics (Clinical Repertory by Robin Murphy)

MENTAL

Mind; WORKAHOLIC, industrious, overworks (p1715)

Mind; MOODS, changeable, variable (p1659)

Mind; HOPELESS, feelings (p1620)

Mind; CONTRADICTION, intolerant, of (p1544)

Mind; ANXIETY, eating, amel (p1517)

GENERAL

Generals; PAIN, general, night, pain (p950)

LOCAL

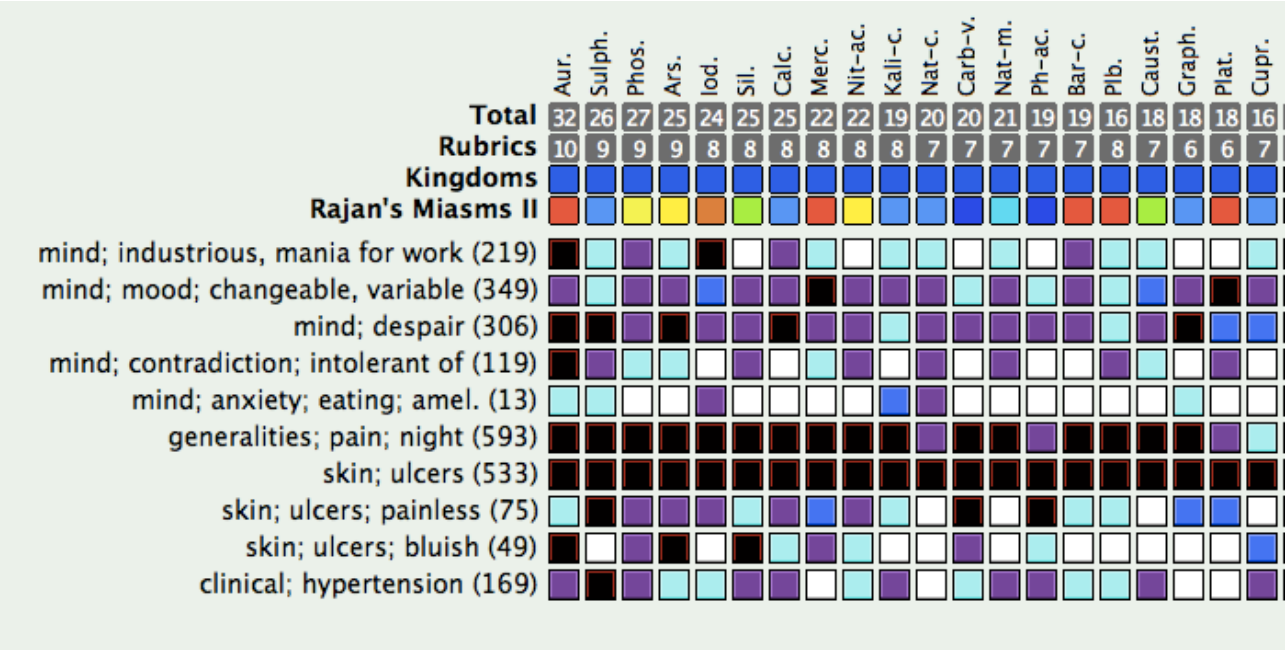
Clinical; ULCERS, general (p482)

Clinical; ULCERS, painless (p487)

Clinical; ULCERS, bluish, red (p483)

Clinical; HYPERTENSION, high blood pressure (p432)

REPERTORISATION:



DISCUSSION

The main affinities in this case are cardiovascular and venous circulation, mental and bone. Other systems involved are gastrointestinal and prostate gland.

The main miasm is a syphilitic (ulcer – destruction, cardiovascular disease, bone pain).

There is a family history of cancer.

This patient has several co morbidities (hypertension, ischaemic heart disease with AV conduction block on ECG; bilateral varicose veins and previous thrombophlebitis and deep vein thrombosis – continued anticoagulant therapy; diverticular disease with a history of bowel resection for bowel perforation; hyperplasia of prostate and osteoarthritis with a history of bilateral total knee replacements. He has been thoroughly investigated in the past including regular blood tests – last blood test 3 months ago showed normal full blood count, INR 2.1, renal function normal, normal PSA, ESR and CRP. I did not feel further investigations were needed at this stage.

His blood pressure is well controlled on current medication Ramipril and Doxazocin.

On the basis of the skin ulceration, cardiovascular disease and his mental picture (lifelong workaholic, changeable moods alternating despair with irritability, sense of heaviness), I prescribed Aurum metallicum. I felt there was a need to cover not only the physical plane, but also the emotional and mental. I therefore chose 1M potency to be taken one a day for 3 days. I have advised to continue with application of sterile dressings on the affected area on the left leg.

It was likely that Syphyllinum would be needed in future in view of the skin ulceration – destructive lesion.

1st Review 17th October 2011

Following taking the remedy he felt more energetic. He has noticed that he could do more than usual before he got tired. There has been no change in the appearance of the ulcer. We discussed the need to rest and elevate his legs more to support ulcer healing.

No new symptoms. BP 148/86 and HR 72/min, reg.

I prescribed Syphilinum 30C one to be taken daily for 5 days.

2nd Review 5th December 2011

Following Syphilinum he felt a definite “boost” in energy and also noticed his “thinking got clearer”. He spends a lot of time working on the computer. He continues with sterile dressings of the leg ulcer area which seems to be getting smaller, still sensitive, but no bleeding or signs of inflammation or infection. I prescribed a single dose of Aurum metallicum 10M (to cover physical, emotional and mental spheres).

3rd Review 23rd January 2012

He has been resting more over Christmas and reports that the skin ulcer has completely healed. He benefited from resting generally, but still leads an active life – working limited hours in his vet surgery. Has complained of getting

up to pass urine 3-4x at night with no other urinary symptoms. He was offered medication by his GP for enlarged prostate but wondered if there was any homeopathic treatment which he would prefer to try instead. I suggested Sabal serrulata mother tincture 10-15 drops twice a day.

E. Sample format – Objective Standardised Clinical Examination

1. OSCE Eczema

Clinical scenario

A 31 year old woman presents with a flare up of her eczema.

Patient: "I'm getting married in 6 weeks and 1 month ago my eczema got the worst it's ever been, especially around my eyes. My eyelids got very dry and swollen, and there was a lot of mucous coming out, the lids were stuck together in the mornings. There were cracks in the outer corners of my eyes, which often happens. There was also a hot spot on my right cheek. On my body it was like a heat rash … all bumpy on my trunk, and my hands flared up. My right index finger was oozing clear, slightly sticky liquid. When my skin is really bad, it always starts oozing. I developed cracks over the knuckles, and the tip of my right index finger started to flake badly. I got some spots on my arms, red and scabby. It's slightly better now but I'm really worried it'll flare up again before the wedding ... I really want my face to be clear by then."

Dr: When did the eczema start?

Patient: "After my father died. He also had eczema on his face. We had a good upbringing, we went to church together every week. My father played the organ in the church and so did his grandfather. I still play the piano. My father taught me to play the organ and I played at my sister's wedding, but I find church music can make me feel very emotional and weepy."

Case Analysis Tasks:

(a) Select the appropriate rubrics and repertorise

(b) Select one remedy that best covers all of the symptoms

Therapeutic and Clinical Management Tasks:

(c) What potency and frequency of repetition would you choose in a patient like this with troublesome eczema?

(d) When would you choose to see her for her first follow up?

(e) How would you advise her about the direction of cure expected with a well indicated eczema remedy?

Materia Medica Knowledge:

(f) Name three mental symptoms not mentioned in this case that are very characteristic for this remedy

(g) What weather / temperature modalities would you expect this lady to describe?

(h) Name two of the typical food aversions in patients requiring this remedy

2. OSCE Faecal incontinence and haemorrhoids

Clinical Scenario

A 30 year old lady presents in the 32nd week of her first pregnancy complaining of recent incontinence of faeces and four weeks of troublesome haemorrhoids with altered bowel habit. She is clearly very upset. The worst thing is "I am no longer sure of my bottom. I cannot tell clearly whether I wish to pass wind or whether I wish to pass a bowel motion."

She begins to weep … "I soiled myself 3 days ago at work. I thought that I was going to pass wind and it wasn't – it was faeces – liquid with jelly lumps. Everyone in the office noticed the smell and me rushing out. I felt like a leper."

She begins to weep again….

"I have to keep my mind on my bottom all the time as I feel that I will soil myself if I don't. I have to go sit on the toilet every time I think I need to pass wind in case it isn't wind. For the last four weeks I am woken most mornings at about 5 a.m. by an urge to move my bowels. For a few days in a row it is loose like custard with lumps like jelly. Then I miss one or two days and the next day I pass a huge lump then loose jelly and then I bleed a little from my bottom and there is a little lump like a cherry that goes back in by itself or I help it back in.

Are you sure that the homeopathic medicine is completely safe for my baby?…"

Clinical examination reveals:

- normal anal tone
- normal increase in anal tone when asked to grip
- normal sensation to light touch and pin prick in perineum and around anus
- haemorrhoids protrude from anus when asked to push & recede spontaneously

Core Clinical Management Tasks

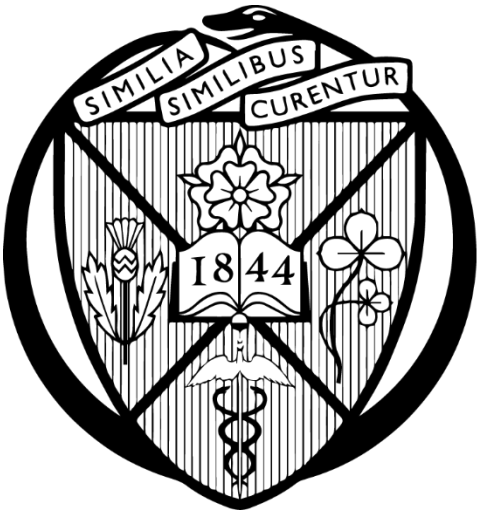
- Consider how best to answer her question "Are you sure that the homeopathic medicine is completely safe for my baby?"
- Consider whether to offer her homeopathic treatment

Principles of practice – Case analysis tasks

- Identify the totality of symptoms
- Identify any particular, strange rare & peculiar symptom(s)
- Identify which symptoms merit extra weighting in anaylsis
- Identify appropriate rubrics

Therapeutics & Clinical management tasks

- Identify the most appropriate homeopathic medicine for this patient
- Identify the potency & frequency of dose of the homeopathic medicine to be prescribed



Faculty *of* Homeopathy

Faculty of Homeopathy
The Clubhouse Mayfair
50 Grosvenor Hill
Mayfair, London
W1K 3QT

020 3640 5903

lpeacock@facultyofhomeopathy.org
www.facultyofhomeopathy.org