

**PRACTITIONER BASED INQUIRY:
TAKING THE CASE OF HOMEOPATHY**

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ABSTRACT

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PRACTITIONER BASED INQUIRY: TAKING THE CASE OF HOMEOPATHY

After twenty years of practising and teaching homeopathy, I am concerned that research into treatment by professional homeopaths has become stifled by evidence based medicine discourse. Homeopathy's distinguishing features are obscured by erroneous assumptions that a homeopathic prescription is subject to the same biochemical pathways as pharmacological medication. Homeopaths are urged by external parties to 'prove homeopathy works' on biomedical terms. This reflexive inquiry is an attempt to redress the balance. From postmodern and pragmatic perspectives I reflexively engage with professional experiences (Smith, 2009) as a means of articulating practitioner based knowledge (Freshwater and Rolfe, 2001, Rolfe et al., 2001). The subjectivity of the practitioner researcher is transformed from a research problem into an opportunity to critically examine practitioner experience (Lees and Freshwater, 2008). The research process is a focus for the inquiry itself, with the intention of creating an open text that invites participation from the reader (Denzin and Lincoln, 1994). I 'take the case' of my own practice and its wider context, and enact a synergy of homeopathic practice and research methodologies. The thesis is organised around the eight principles of homeopathy. Case vignettes and homeopathy's visual iconography (Cherry, 2008) are used to integrate clinical experience into the thesis. Multiple analytical strategies evolved, including discourse analysis, action research, narrative analysis and writing as inquiry. These are not applied to pre-existing professional experiential data (Lees, 2005), but engaging with these strategies has shaped data creation and the inquiry itself. Use of multiple methods is not an attempt to triangulate, rather the dissonance between them is essential to achieving competing and multiple perspectives on professional experience. There is no intention to present a discrete set of findings. The inquiry is framed through the inquiry process, creating an innovative approach to practitioner based inquiry as a collage of reflexive, experiential interpretations and interactions with professional practice. I redefine evidence as being the inquiry process itself and the practitioner as integral to knowledge creation and application in practice. The open dialogic text invites practitioners to adapt this model of practitioner based research in their own practices. The self-critical iterative dialogue gives voice to the practitioner researcher in discourses that are congruent with homeopathic practice. I make original contributions to knowledge by examining homeopathic practice from different theoretical and experiential perspectives, including observations on the connections between homeopathy's enduring popularity and how the patients' own belief systems about health and illness are still influenced by the old humoural system of medicine.

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(Photo by Peter Macdiarmid/Getty Images). with permission of Getty Education Image Gallery. (p.22)

Image 2: **'Freud museum' Susan Hiller**

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Image 3: **Detail from 'Witness' Audio Sculpture, 2000 Susan Hiller**

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Image 4: **'Momento' Susan Hiller** Image at

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Image 5: **'Euston midnight' 1983 Susan Hiller**

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AUTHOR'S DECLARATION

The work presented in this thesis is original in conception and execution. I have published some of the material it contains as follows:

Smith, J.L., (2003) The trials and tribulations of a practitioner researcher. *Picture of Health*. 2:13

Smith, J.L., (2009) Practitioner experience. *The Homeopath*. 28:1, 13-15

1 INTRODUCTION

1.1 Welcome

I invite the reader into my homeopathic practice to engage in a reflexive dialogue about what it means to research your own practice with the intention of improving future practice. This thesis gives voice to a practitioner who daily encounters the complexities and uncertainties of practice. Mirroring the consultation process, I ‘take the case’ of homeopathy discourse, to re-evaluate my practical engagement with homeopathy’s philosophical framework and to challenge what I take for granted as a practitioner. Analogous to shaking the vial containing a highly diluted solution in the preparation of a homeopathic potency, I agitate homeopathy research discourse to discover what a homeopathic approach to practitioner research might look like.

The intention in this chapter is to introduce homeopathy practice and research, identify what motivates me to undertake practitioner research, how I understand the difficulties I face and what has informed my developing perspectives. The inquiry aims and objectives are presented along with an outline of the structure of the thesis.

1.2 Homeopathic practice

This inquiry is informed by numerous personal and professional experiences that suggest that homeopathic treatment can act as a catalyst (Thompson and Thompson, 2006) for enhancing a sense of well-being and improve management of symptoms. For over two centuries homeopathy has continued to attract patients, practitioners, doctors, veterinary surgeons and home users. There is a common experience that ‘something is going on’ when taking homeopathic remedies in therapeutic contexts. The use of the highly diluted doses are cited both as responsible for the excellent safety record (Endrizzi et al., 2005) and also by critics as lacking scientific legitimacy (Singh and Ernst, 2008). Like other forms of complementary and alternative medicine (CAM), homeopathic treatment ‘works’ differently to biomedical treatments. It is well documented (Thomas et al., 2001b, Thomas and Coleman, 2004, Woods, 2010) that treatment by a homeopath is an established and popular option as a complementary or alternative approach to a range of health problems. Homeopathic treatment is used for a range of acute and chronic conditions in all age groups, often where symptoms are medically unexplained or biomedical approaches have been tried and found to be unsatisfactory.

Homeopathy is a self-contained system of therapeutics with its own theories, medicinal preparations, research methods and conceptualisation of health, illness and recovery. Homeopathy originated in the late 18th century based on the observation of a relationship of similitude between what a substance can cause and its therapeutic effect. Emerging out of European Enlightenment discourses, homeopathy was empirically based, realised through experimentation and observation in opposition to the dogma of contemporary medical practices. A German doctor and chemist Samuel Hahnemann (1755-1843) reported correspondence between the symptoms of malaria and the effects of overdosing with quinine, which was well

known to offer effective treatment for malaria. After testing (called provings) other medicinal substances in use at the time, he proposed the ‘law of similars’ as a generalisable therapeutic phenomenon. The medicinal substance was initially diluted to reduce the toxic effect, but Hahnemann reported that contrary to his expectations, diluted doses appeared to enhance the therapeutic effect. Hahnemann’s procedure of serial dilution and succussion was used by later homeopaths, particularly in 19th century United States of America (USA), to produce highly diluted doses far beyond a single molecule remaining.

Historically homeopathic practice originated and has been predominantly located within the medical profession. There has been continuous provision in the National Health Service (NHS) since its inception in 1948. In the United Kingdom (UK) since the 1970s homeopathy has flourished outside the medical profession. Homeopathic remedies are used in a range of contexts: prescribed by professional homeopaths like myself (largely in independent practice, qualified from diploma courses or more recently undergraduate degree programmes), by medical homeopaths (medical doctors practising in NHS homeopathic hospitals, general practice or independently); by veterinarians and organic farmers; by osteopaths, chiropractors, physiotherapists and midwives as adjunctive treatment; by naturopaths as part of a repertoire of approaches; and by the general public bought over the counter in many high street chemists and health food shops.

1.3 Research into the use of homeopathic remedies

Homeopathic practice is founded on empirical observation and experimentation, and has its own established research traditions. Homeopaths work with rich phenomenological data from two hundred years of testing remedies (provings) and systematic clinical verification of data. Case reports of individual illness management and recovery experiences are an established means of communicating professional knowledge. The effects of the highly diluted preparations are the subject of competing explanatory models.

Homeopathy has played a significant role in the evolution of the clinical trial as the first medical discipline to subject its practice to a placebo arm in clinical trials in 1829, and by using placebo in provings since 1834 (Dean, 2004). However the experimental evidence of effectiveness of using homeopathic remedies is weak and subject to much debate for a number of reasons. The results of three large meta-analyses that have been published are generally positive but not conclusive (see section 0). A fourth meta-analysis (Shang et al., 2005) found homeopathy no better than placebo but was not included in the Cochrane Collaboration database due to methodological problems (Frass et al., 2006, Rutten, 2006). Evidence generated by clinical trials needs to be interpreted with caution and considered in the light of methodological issues (NHS Centre for Reviews & Dissemination, 2002). It has proved much more complex to apply biomedical clinical trial designs to individualised homeopathic treatment than anticipated. There is a common assumption that the prescribing of homeopathic remedies is a pharmaceutical intervention based on physiological responses and therefore should be tested in the same way

as other pharmaceutical products. The effects of the highly diluted preparations are the subject of many different research approaches (Baumgartner, 2002) and competing explanatory models. The diverse uses of homeopathic remedies, for example individualised, non-individualised, complex prescribing and isopathic treatments, has made it difficult to make meaningful reviews and to combine data. In addition trials are often underpowered as funding is limited in comparison with biomedicine. An open pragmatic design (Relton et al., 2010), comparing usual biomedical care with homeopathy as adjunctive to usual biomedical care, has been piloted (Relton et al., 2009) and seems to be offering a way forward in evaluating treatment by a homeopath. Observational studies offer insight into what is happening in practice, and thousands of consecutive patients (Spence, 2005, Witt et al., 2005) have reported positive responses to treatment of long standing conditions.

1.4 Identifying the problem

After twenty years of practising and teaching homeopathy, I am looking to articulate a self-critical and rigorous approach to appraising practitioner experience that recognises the distinguishing features of homeopathy. The motivation for this research arose because the discourses currently available did not appear to acknowledge this point of view.

During my professional career I have witnessed the arrival of evidence based medicine (EBM) discourse and this has reinforced a biomedical approach to research in homeopathy that prioritises meta-analyses of clinical trials. EBM is premised upon a hierarchy of evidence to direct clinical decision-making that prioritises meta-analysis of randomised controlled trials (RCTs), the ‘gold standard’ pharmaceutical research design (Sackett et al., 1996). In EBM terms homeopathy is defined as having a weak evidence base (Science & Technology Select Committee, 2010) and this has a disempowering effect on the profession. In the context of homeopathy’s individualised treatment approach, meta-analyses and systematic reviews of the use of homeopathic remedies have very limited, if any, application in practice. Results tend to be over-interpreted and overarching inferences are made about the use of homeopathic remedies, informed by the erroneous assumption that a homeopathic prescription is subject to the same biochemical pathways as pharmacological medication. British and European medical homeopaths are to be congratulated for making major contributors to research in homeopathy, but this has had the effect of shaping homeopathy research discourse in terms of how medical homeopaths negotiate their professional identities across biomedicine and homeopathy.

Professional homeopathy discourses that diverge from a biomedical orientation are open to being misinterpreted as claiming that homeopathy is a special case and treatment cannot be evaluated. When I argue that professional homeopaths’ discourse fails to convey a critical and a rigorous approach to appraising treatment, it feels as if I am adopting a hypercritical academic stance. The intention of this research is to take a homeopathic orientation to create a critical and rigorous approach to appraising practitioner experience. This is important as clinical governance

demands a self-critical approach to ensure that professional homeopaths are achieving the highest standards of patient care.

1.5 Locating this inquiry

This inquiry is located within a reflective framework, based on re-evaluating specific incidents in daily practice, to develop new perspectives that modify future practice. I take advantage of Schön's (1987) work to articulate and make visible practice based knowledge through reflective practice. This transposes the relations between research and practice, as research is generally regarded as informing practice. Following Schön's model, evidence can be generated from practice as well as reflecting on applying evidence to practice. Critical intent is essential to begin to transform the reflective practitioner into a practitioner researcher. Critical reflection involves "thinking about how you are thinking about practice" (Freshwater, 2008, p.216), situating yourself at a critical distance and reappraising reflection on practice from competing and diverse perspectives (Rolfe et al., 2001). I extend this trajectory to reflect critically on the reflective process itself in relation to the wider social, ethical, political and historical context. This is a form of meta-reflection (Freshwater and Rolfe, 2001) or reflexivity, moving beyond the personal, as a process of "turning back of reflection on itself" (Freshwater and Rolfe, 2001, p.529). In a reflexive approach the researcher is located as integral to the inquiry and to the phenomenon being researched. The subjectivity of the practitioner researcher is transformed from a research problem into an opportunity to critically examine practitioner experience (Lees and Freshwater, 2008). Analysis unavoidably remains partial, many values and beliefs that inform this inquiry will not be acknowledged. Critically reflecting upon my subjectivity as practitioner researcher is an iterative and critical discourse through the inquiry. This is an essential device to challenge beliefs, assumptions and highly personalised narratives. This reflexive inquiry may offer a way forward for other practitioners to research their own practices.

1.6 Key theoretical perspectives

Discourse analysis offers a way of looking at practice as being formed and reformed through competing discourses. The interdisciplinary term 'discourse' is used in the sense of forming a distinctive language, symbols and means of dissemination (Freshwater and Avis, 2004). Foucault (1977) examines how power and ideology are expressed through hierarchies of discourses, creating historically and culturally specific subject positions. How I experience practice is as a subject of homeopathy discourse. I cannot position myself outside the discourses through which this inquiry is produced (Bourdieu, 2000). This is why reflexivity is so crucial in offering a means of interrogating biases, blind spots, absences and contradictions implicit in practice.

Fundamental to this inquiry is the appreciation of the constitutive role of language in generating our view of reality and sense of identity. The approach to textual analysis is anchored in the hermeneutic tradition of the interconnectedness of interpretation, language and meaning. The hermeneutic circle offers a way of visualising the circularity of interpretation (Gadamer, 1979).

We cannot escape our cultural assumptions, and our interpretations inevitably rearticulate these values. Hermeneutics helps us to question judgements about evidence and how evidence informs practice.

A pragmatic orientation soon became apparent as I embarked out as a practitioner researcher. This is congruent with clinical practice where knowledge is most valuable when informing action and practical application. In the philosophical tradition of pragmatism meaning or truth is determined by what is useful, workable and practical. Research is evaluated by what it offers to a community of inquirers, where only the most useful truth will be retained. This has immediate relevance to practitioner research where its value resides in application in the researcher's and other practitioners' practices. Potential limitations of this approach include preoccupation with issues internal to the profession, lack of critical distance to challenge assumptions, failure to explore the heterogeneity of inquiry subjects and relativist interpretations (Baert, 2005).

The use of multiple analytical strategies evolved from the challenge of reflexively inquiring into professional experience. These are not applied to pre-existing data as a discrete activity, but engaging with these strategies has contributed to shaping the inquiry and data creation. Action research (Reason and Bradbury, 2001) is a formative influence and created opportunities for co-researching with other homeopaths. Critical discourse analysis (Widdowson, 2004) is an appropriate analytical framework for the foregrounding of textual sources. Narrative analysis (Elliott, 2005) is congruent with the narrative orientation of homeopathy. Writing as inquiry (Richardson, 2000) enhanced the role of reflective writing. There is no attempt to triangulate, rather the dissonance between them is essential in achieving critical and multiple perspectives.

To generate fresh appraisals of homeopathic practice, I have experimented with postmodern perspectives, something I had not previously encountered in homeopathy literature. I use the term in the sense of rejecting overarching theories, problematising a linear concept of progress, endorsing heterogeneity, plurality, fragmentation and indeterminacy (Fox, 1999, Cheek, 2002). Postmodernism is highly contested and much criticised, in particular for its arguments becoming lost in relativism and promoting Eurocentric values (Gaonkar, 2001). In this inquiry postmodern perspectives are used pragmatically to shift homeopathy research discourse beyond the impasse of polarised relations with biomedical evidence based discourse. Lyotard (1984) questions the status of science as the single "grand narrative" of our age, by placing value on the multifarious and competing ways of thinking, which he terms "little narratives". In this reframing, the dominant discourse of biomedicine is positioned as one of many competing and heterogeneous discursive frameworks. This creates the opportunity for homeopathy research discourse to speak on its own terms.

This thesis is not intended to be didactic, but to be catalytic in evoking fresh perspectives on research in homeopathy and to innovative in practitioner based inquiry in homeopathy. It is written with the intention of engaging the reader as an active participant in reflexive dialogue

(Freshwater and Rolfe, 2004). Discourse analysis is a formative influence (Widdowson, 2004), by challenging the authority of the author, dialogue with the reader is prioritised. Stylistic devices such as fictional dialogue, engaging with visual imagery (Cherry, 2008) and created personas (Hiller, 1996a), are intended to encourage different interpretative angles. The inquiry is highly innovative and poses questions about integrating research and practice. As you start to read the thesis, you will begin to assess if a meaningful approach to practitioner based inquiry is being crafted. It is my intention that as you participate, you may find yourself reflecting on how aspects of this inquiry relates to your own practice. It is not my intention to arrive at a blue print or mandate for research in homeopathy. This type of research does not claim that findings can be applied or generalised to other settings, but arguably there is potential to generate theoretical explanations that transcend the local setting.

1.7 Aims and objectives of the inquiry

This inquiry aims to take a reflexive re-appraisal of practice experience and homeopathy research discourse, as a means of articulating practitioner based inquiry in homeopathy. I inquire at the experiential interface of theory informing practice. The components of these aims are:

- A range of strategies are adopted to interrogate practice experience from fresh perspectives. These are concurrent activities rather than sequential.
- Reflexive engagement with my own day to day practice experiences, both explorative and testing out evolving concepts, with the intention of generating a conceptual framework for evaluating homeopathic treatment.
- Co-research and dialogue with other professional homeopaths.
- Dialogue with other professional homeopaths, to develop and test out evolving perspectives. This involves participating in a range of professional and academic activities and presenting papers at seminars and conferences.
- Critically reflecting upon my subjectivity as practitioner researcher facilitator as an iterative and critical discourse through the inquiry. Critical reflective writing to elucidate, contextualise and integrate my research participation within my clinical practice and wider debates in health and research.

1.8 Structure of the thesis

The thesis has two parts.

Part one: Towards practitioner based inquiry

I explain how the inquiry is taking shape. This involves examining the scene setting (chapter 2), conceptualisation (chapter 3), context (chapter 4) and discussing how I am creating the philosophical (chapter 5), analytical (chapters 6 and 7) and ethical (chapter 8) frameworks of the inquiry. The intention is not to present a finalised design but to offer an unfolding narrative exploring how and why the inquiry is evolving in the way that it is. The research process continues to evolve as I write and edit this thesis. These chapters are concurrent rather than sequential in the research process.

| |
|--|
| <p>Eight principles of homoeopathy:</p> <ul style="list-style-type: none"> Vital force <i>Similimum</i> Single Remedy Potentisation Susceptibility Provings Miasms Direction of cure <p>(Creasy, 1998)</p> |
|--|

Part two: Enacting practitioner based inquiry

This is organised into eight discussion or dialogue chapters. Each chapter takes as its focus one of the principles of homeopathy (for brief introduction to each principle see Context chapter 4 and fuller discussion see Philosophical Framing chapter 5). Through these eight chapters practitioner based inquiry is enacted. As all the principles are intertwined, the earlier chapters

tend to be lengthier as there is more to explain. To enhance reflexivity, I curate (Cherry, 2008) a visual image from my practice related to each principle. I also experiment with conceptualising homeopathic principles as artefacts as 'packed with cultural assumptions' (Einzig, 1996). Congruent with a non-linear, process orientated approach to practice, the chapters are written in a way that allows these chapters to be read in any order. Each of chapters tells its own story, but the potency, like the homeopathic principles themselves, resides in the wholeness of the text. The chapters comprise intentionally disjointed narratives, as practice and research are explored from different and sometimes competing perspectives and multiple sources of data are considered. To aid accessibility for the reader all except the final dialogue chapter follows a common schema:

- **Case vignette** is a fictitious case report synthesising multiple practice experiences and offering a practical interpretation of the homeopathic principle.
- **Orientation to the chapter** sets the scene and outlines what to expect.
- **Meditations on the artefact** represents a reflexive encounter with a visual image
- **Intertextual relations** illuminate how the principle articulates different aspects of practice. Discussion explores how homeopathy discourse is argued over, debated, colonised and reinvented. I experiment with exploring homeopathic practice from different theoretical perspectives.
- **Homeopathy research discourse** is a key focus as I reflexively engage as a subject of this discourse to explore how research into treatment by a homeopath is articulated, speaking from multiple subject positions as homeopath, homeopath researcher and patient. Through this process I examine practitioner based inquiry.
- **Analysis of professional experiential data** is generated as practitioner research and includes participant observation, action research and reflective writing. The term is borrowed from another practitioner based inquiry (Lees, 2001).
- **Reflective pause before moving on to the next chapter** draws out threads running between the lines of the chapter and makes connections with other chapters.

1.9 Orientation to the thesis

As the presentation of this inquiry is rather unusual, the next two chapters are dedicated to explaining the journey I have undertaken and the design of the thesis. Autobiography of the Inquiry chapter 2 tells the story of the how the inquiry started and developed. Ways of Seeing

the Inquiry chapter 3 introduces key concepts and gives a taste of the experimental presentation of the thesis.



[Image 1: A member of staff at Ainsworth Pharmacy makes up a homeopathic remedy on 26 August 2005
(Photo by Peter Macdiarmid/Getty Images)
Reproduced with permission of Getty Education Image Gallery.]

**PART ONE: TOWARDS PRACTITIONER BASED
INQUIRY IN HOMEOPATHY**

2 AUTOBIOGRAPHY OF THE INQUIRY

2.1 The intention

You may be wondering how can the inquiry have an autobiography? When I finished writing this thesis, by definition it is always incomplete, it no longer belongs to me. The text becomes subject to interpretations and readings by others (Barthes, 1977). In the same way the inquiry commenced long before I started to write it. I am merely a conduit drawing on many experiences shaped by an intersubjective engagement in discourse. It is more appropriate to talk about the life of the inquiry as it has taken on a life of its own. This chapter examines why and how the inquiry came about and what factors have shaped its development.

2.2 Backwards and forwards in time

I did not approach this inquiry with a blank sheet. On the contrary, there has been over twenty years of studying (since 1987) and practising homeopathy (apprentice 1988-90, qualified 1990), teaching (since 1991) and participating in professional activities (since 1988). The story started long before this. In this chapter I trace significant moments in my life that have shaped the production of this thesis.

Initially I submitted a research proposal to evaluate the use of clinical outcome measures in long term homeopathic care, but the focus gravitated to address more fundamental questions regarding how I interact with homeopathic practice and how I inhabit my professional role. Longevity and sustainability are important threads in this inquiry. I experience homeopathic treatment as having a supportive role through life transitions, for example puberty, managing menstruation, fertility issues, childbirth, menopause and bereavement to name just a few. A significant proportion of patients have been on my books for at least five years. I have regular contact with some, others return intermittently to address new or recurring issues. For some, like the old fashioned General Practitioner (GP), I have acted as homeopath for all their lives to help them to keep as well as possible. Some of my child patients are now using homeopathic remedies as they go off to college, start employment or become parents themselves. Another significant group of patients are much older with complex health problems where I am often prescribing alongside a plethora of prescribed drugs and hospital admissions. I have never conducted a breakdown of the gender ratio of patients, but I suspect that two thirds are female.

Whilst setting out to examine long term homeopathic care, what came to the fore was the need to take stock and to critically reflect on my own sustained engagement as a homeopath. Despite my best intentions at the outset, this inquiry has been slow in coming to fruition. I first registered in 2002 (part-time), and with interruptions from life events, it has taken nearly ten years to complete. Achieving under difficult conditions is a recurring pattern in my life. I only discovered my own potential through self-education after leaving school as I started to deliberately work my way through the ‘Penguin Classics’ as I commuted to work in an office. This gave me the

confidence to start studying for 'A' levels at night school and subsequently to apply to university as a mature student. The slow maturation of this inquiry echoes the pace of homeopathic treatment which, apart from for acute conditions, does not seek a 'quick fix'. This pace has been advantageous in creating time to reflect, to selectively make connections from diverse sources, to experiment and to allow a serendipitous route to emerge. Drawing on autobiographical narrative, I create an illusory sense of coherence and logical progression. Let us start out on what in retrospect appear to be formative moments in the life of this inquiry.

Feminism is such an essential aspect of my core narrative that it is a taken for granted premise for this inquiry. I first encountered homeopathy in the mid 1980s through feminist networks. In the UK, at this time, equal opportunities legislation was challenging social institutions including the NHS, for example, campaigns for women's autonomy during childbirth. Women's health was being redefined with greater visibility for minority groups, such as black women, women with disabilities and lesbians. I was enthused by aspirations for self-autonomy and self-sufficiency in my own healthcare. I participated in the London Women's Health and Environmental Network, and encountered medical herbalists and naturopaths. This reawakened my childhood experience of naturopathic home treatments for farm animals and personal experience of McTimoney chiropractic. Through participating in ecological discourses I was able to integrate my agrarian upbringing within an adopted urban environment. I am inspired by emancipatory values around health, constructed in opposition to dominant technological and male discourses. This phase of my life had been preceded by particularly rich educational experiences of studying for 'A' Levels in Adult Education night classes whilst working full-time. I now recognise this as significant period for shaping critical perspectives through reading and discussion with other mature students.

Enrolling on a professional qualification course in homeopathy (1987) was a rather tentative decision. As I learnt more, it felt like common sense and fitted with my values and aspirations. I was attracted to the potential to work collaboratively with patients. One of the motivations in setting up in practice, was to live and work in the Oxfordshire countryside, where I was born and grew up on a farm. I practice independently from my office at home, and also take a room one day a week in a multi-therapy centre at a GPs' surgery. This has implications for the service I offer, with limited acute, out of hours and home visiting services. Patients generally present with a medical diagnosis, and I see my role as helping them to understand their diagnosis and if I have any concerns regarding their symptoms or prescribed medications, I refer them back to their GP. In managing all telephone inquiries and appointments, I am able to screen potential new patients to assess if what I offer is appropriate to their needs. Colleagues at the surgery, informal networks of local CAM practitioners and University colleagues provide sources of referral and peer support. The catchment area for patients is approximately a 35 mile radius of both practice locations, but some patients come from much further afield. New patients predominantly come via word of mouth, through the GP surgery, website or via The Society of Homeopaths' (SoH) register or professional box advertisement in Yellow Pages. During this

inquiry I engaged in clinical supervision with a homeopath with over four decades of practice experience and I acted as a clinical supervisor for a newly qualified homeopath.

I have always combined my practice with part-time employment in CAM education, at private homeopathy colleges (1988-1999 registrar and later vice principal), the University of Westminster (1999-2011 senior and later principal lecturer), and as visiting lecturer at University of Birmingham Medical School, Oxford Brookes University, North Oxfordshire GP Post Graduate Education Centre, McTimoney College and Oxford School of Reflexology. These experiences and involvement with the Society of Homeopaths (SoH) have been formative in shaping my perspectives. In 1996 I taught and co-managed the launch of the first undergraduate programme in homeopathy in Europe at the University of Westminster. I was involved in pioneering innovative approaches to practice based teaching, learning and assessment. Teaching research methods to undergraduate complementary medicine students and supervising undergraduate dissertations enabled me to explore the interface between practice and research. Being involved in transforming training in homeopathy from privately run diploma courses to the first fully funded undergraduate course, is a personal achievement and a contribution to the development of the profession. This first degree course lent legitimacy to the study of homeopathy, elevated educational standards from training courses and prepared homeopaths to work alongside other health professionals. To this end I have also been active within SoH contributing to research and education policy and development.

Inner dialogue 23 October 2006

Writing this account gives me an uncomfortable sense of order. Am I tidying away the tensions, contradictions and disjunctions that vitalise the interaction of practice and research?

As a homeopathy student I was surprised to find that I was engaged in a training course with the trainer as expert. I was fortunate to encounter teachers who embraced a critical stance towards practice and theory. When developing the first degree course, it was a personal mission to encourage students to critically debate practice issues. The skills based approach to homeopathy was reinforced when National Occupational Standards were introduced for the profession (Healthwork UK, 2000). I am very disappointed that degree level provision was not welcomed or capitalised upon by the profession. This contrasts with allied professions, such as Western herbal medicine and acupuncture, where graduate only entry to the profession has been embraced. Like other health professions, such as psychotherapy (Shaw, 2000), osteopathy and chiropractic (Cant, 1996), charismatic style teaching is characteristic of both pre- and post-qualification seminars and courses. I am ambivalent about this didactic aspect of homeopathy's culture and this has shaped my engagement in professional activities.

The desire to engage in research is driven by dissatisfaction with how research into treatment by a homeopath is constrained by biomedical discourse, and the absence of critical debate about how practice is informed and enriched by research. I have been enthused by research since my undergraduate studies in the arts (1982-1985). On leaving university I curated arts and social history exhibitions. As a student homeopath (1987-1991) I participated as a prover in a

proving (controlled experiment to research the therapeutic potential of a specific substance). On qualifying as a homeopath I participated in two practice based studies conducted by the SoH and started using patient generated clinical outcome measures. As an educationalist I have sought to enthuse other homeopaths and students to develop research skills. This has included presenting at the SoH research days (2006, 2007 and 2008) and workshop for educators (2005) and acting as Research Theme Leader for the undergraduate courses at the University of Westminster (2007-2011). I served as a founding member on the the SoH Research Committee (1997-2003 and since 2007).

I began to engage with reflective practice when first involved with the undergraduate degree course (1996). From reading Schön (1983) I perceived that practitioners are also researchers, as all practice involves questioning what is happening. I recognised that using reflection was beginning to de-stabilise what I thought I already knew. Much of the reflective practice literature was in nursing (Rolle, 1998) and I recognised shared concerns with holistic care. This resonated with my concerns about patient perspectives, practitioner experience and voices of resistance in a field dominated by biomedical discourse. Reading on reflective practice gave me insights into innovative approaches to qualitative research in nursing (Koch and Harrington, 1996, Johns, 2000, Freshwater, 2002, Glaze, 2002). I had known Professor Dawn Freshwater as one of the external examiners at the University of Westminster, and was delighted (and a little amazed) when she agreed to supervise me. I registered for as a part-time PhD student in late 2002 at Bournemouth University. I take this opportunity to retrace the path that I followed in formulating the research proposal and significant moments of transition in the evolution of the inquiry as it provides a context for reading this thesis.

Initially I was enthused by using a patient-generated, health status questionnaire, referred to as Measure your own medical outcome profile (MYMOP) (Paterson, 1996) in my practice and a modified version in the University teaching clinic. My intention was to critically evaluate my experiences of MYMOP, and to use this as the basis for developing a specific outcome measure for homeopathy. I quickly realised that I first needed a far greater understanding of what was going on in my practice, and that critical reflection would provide the practice based approach I was looking for. Initially I set out to monitor continuing homeopathic care, in particular the tension between the patient's current concerns and a more holistic view of the case. I came to realise that I was projecting feelings on to my case load, and that at the heart of the inquiry was my own long term engagement in homeopathic practice.

Action research was a formative influence, and my learning was enriched by participating in an action research study

Reflection in action: November 2004
In writing my transfer document I experience Mezirow's concept of perspective transformation (Mezirow, 1981) as I gain awareness of constraints of how I see myself and my relationships. This has been through both sudden insights and a gradual process of disorientation.

group of nurse practitioner researchers at the City University School of Nursing and Midwifery. An opportunity arose in 2002 to co-research with other homeopaths and I secured modest funding from the University of Westminster's Educational Initiative Centre. With homeopathy clinic tutor colleagues we set up an action research project, Supervision through Action Research project (STAR) (2002-2005). Whilst the educational focus was not a direction I wished to pursue, STAR provided an opportunity to co-research with experienced and articulate practitioner teachers with the aim of accessing the understanding and knowledge embedded in clinical practice.

How I conceptualised the relations between evidence, research and practice has undergone a series of perspective transformations (Mezirow, 1978). As data creation and analysis ran concurrently through the inquiry, the history of the inquiry is written into the text. As I set up STAR I was working within a realist paradigm, taking a 'grounded approach' to practice and *practice based evidence*. Discussion at my transfer viva (2004) encouraged me to explore the incongruity between the embedded approach and how I was using critical reflection as a research tool. My journal became an increasingly important medium to critically reflect on clinical encounters and to experiment with innovative ways of capturing and transforming practice experience. A significant moment had occurred during my participation in STAR as I experimented with phenomenological analysis (van Manen, 1990, Benner, 1994). The device of bracketing out my own experiences was inconsistent with placing myself at the centre of a reflexive inquiry. This shifted evidence from being the product of an inquiry to the inquiry process itself, and I reframed the inquiry as *practice based inquiry*. I reconceptualised practitioner knowledge from being embedded in practice to being constructed through the dialogue itself and gained insight into how experience is constituted in our consciousness. I repositioned myself as integral to and not separate from the evidence. This trajectory changed again as I was finding that as my experiences were in the foreground, *practitioner based inquiry* (Lees and Freshwater, 2008) better described my intention of reflecting on my subject position in homeopathy discourse.

An unanticipated discovery has been how theoretical perspectives formed during my undergraduate studies have been integrated into my core narrative. Although separated by more than 20 years, these were privileged times of reflection and in depth study. As a mature student in the early 1980s, I was fortunate to be drawn into heated debates challenging the academic tradition of formalistic readings of painting, sculpture and architecture as autonomous and self-contained. In my studies and as student representative on the Faculty Board I contributed to arguments for a socially, culturally and politically informed interpretation of visual imagery from feminist, Marxist and post-structuralist perspectives. When I left university I had consigned encounters with writers such as Althusser, Barthes, Berger, Derrida, Foucault, Marcuse and Williams to past history, but I have found these perspectives extremely valuable in conceptualising the inquiry and locating homeopathic practice in relation to dominant scientific discourse. This was surprising as I had previously talked about homeopathy as a career change. This experience of 'going full circle' helped me to appreciate how I was using Bohm's

(1980) ideas about apparent fragmentation and interconnectedness of all things in exploring practice.

Whilst the ebb and flow of patients through my clinics has remained fairly constant over the ten years of this inquiry, the wider context has changed quite dramatically. When I set out on the inquiry, I was still enjoying conditions that had prevailed since the 1970s. At that time professional homeopaths were prospering and autonomously self-organising as a profession. We were rather diffidently moving towards a unified process of self-regulation and positioning ourselves alongside other healthcare professionals in Higher Education. In 2006 the environment became more hostile and public aspects of the profession were subjected to criticism, in particular NHS provision (Baum et al., 2006), Higher Education courses (Giles, 2007) and homeopaths' websites (Burchill, 2011). This background noise to the inquiry influenced how I reappraise practice and my engagement with the profession. Higher visibility of homeopathy in the media followed the publication of a meta-analysis of homeopathy trials (Shang et al., 2005), heralded by *The Lancet* editorial as "The end of homeopathy" (Horton, 2005). Responses to these two articles have contributed to creating a media based sceptics' discourse that presents homeopathy's claims to therapeutic effect as reducible to placebo, homeopaths as deceiving their patients and research in homeopathy as unjustifiable. This can be seen in terms of social institutions actively redefining their boundaries. The legitimacy conferred on homeopathic treatment by NHS provision and Bachelors of Science honours degree validation encroached on the officially sanctioned territory of biomedicine. It is not surprising that sceptical discourse has attempted to discredit degree courses in homeopathy, and at a time of contraction in the Higher Education sector, this has had an effect.

As I complete this thesis, there has been a significant reduction in Higher Education and diploma courses in homeopathy, reduced numbers of registered homeopaths and negligible progress towards a regulated profession. I resist being drawn into defending homeopathy and presenting clinical trial evidence to demonstrate effectiveness of homeopathic treatment beyond placebo. However I acknowledge that the profession's identity has been damaged. Through this inquiry narrative repair (Nelson, 2001) is being reflexively constructed as I reframe my engagement with homeopathy discourse.

I also experienced a biographical disruption at a very personal level as after nearly thirty years without any personal contact with biomedicine and possibly a degree of complacency about enjoying good health, I was unexpectedly propelled into the patient role with a cancer diagnosis. This shook my health beliefs to the core, particularly trust in my own sense of well-being. Whilst personal narrative repair is not in the foreground, patient experience of negotiating my own package of integrated healthcare, has enriched my learning as a practitioner. Whilst perceiving surgery and chemotherapy as unavoidable, I made active choices about reduced chemotherapy agents. In the remission phase, biomedicine has nothing to offer except watch and wait. I am more convinced than ever on the role of alternative strategies to keep yourself as well as

possible. At what every level these strategies are operating, rebuilding self belief and my own abilities to influence my health is crucial to my survival over and above quality of life benefits.

2.3 Reflective pause before moving on to ways of seeing this inquiry

Many facets of my life are woven into the inquiry. It is a dilemma to decide what to emphasise and what to fade into the background. I am tentative about the compatibility of constructing a core narrative, finding my voice as practitioner researcher, and questioning whether it is possible to have a coherent sense of self from a postmodern perspective. The idea of using the self in research is very attractive, as this seems to be the most honest stance for a researcher. All research is constructed through the researcher and it is not possible to detach yourself even in empirical laboratory experiments. As Dawn, my supervisor said “All research is autoethnographic”. I am accustomed to maintaining a professional persona and it has been challenging to write myself into the text. What might readers think of me? How will you judge my academic credibility, my skills as a homeopath, my creativity?

I wonder if this narrative fully conveys the rather random, chaotic and disordered route of this inquiry. As the thesis unfolds, changes in clinical practice will become visible. I hope that you are excited by the transformatory potential of this approach to research hinted at in this chapter. I look forward to the next chapter as it gives me the opportunity to share the more innovative aspects of this inquiry.

3 WAYS OF SEEING THIS INQUIRY

3.1 Case vignette

This account illustrates motivations for inquiring into my practice. Magda presents with complex pathology, uncertain diagnosis and possible adverse reactions to conventional medication. Her complex set of chronic conditions poses challenges for both conventional and homeopathic treatment. I am faced with many uncertainties in monitoring and evaluating the effectiveness of her homeopathic treatment.

Magda 78 year old, retired head teacher, widowed

Eight years ago Magda attended my clinic, presenting with recurrent urinary infections. She felt these infections were aggravated by anti-inflammatory medication prescribed for osteoarthritis. On commencing homeopathic treatment of the urinary symptoms, these seemed to become less frequent and less intense, but still persisted. By changing focus to more constitutionally-based homeopathic treatment, Magda was able to successfully reduce and finally stop anti-inflammatory medication, and subsequently the urinary symptoms ceased. From this and other experiences Magda became convinced that she is sensitive to conventional medication and avoids this as much as possible. Through this period of time she has developed pernicious anaemia, undergone a second hip replacement, a knee replacement, bladder repair and suffered from the effects of two road traffic accidents and a fall. I have continued constitutional treatment as well as providing more specific remedies for acute situations. Contact is generally maintained by monthly phone calls with periodic home visits. Magda says she is convinced that homeopathy helps and allows her to reduce her intake of conventional medication. Magda negotiates her own package of care through actively engaging with healthcare providers (GP, hospital consultants, physiotherapists and homeopath).

The aim is to keep the individual as well as possible for as long as possible and it is not appropriate to consider end points for treatment. Reflecting on such long term complex cases set me on a journey to discover how to think about best practice.

3.2 Introduction

The intention in this chapter is to examine practice and practitioner research. To give you a flavour of the inquiry, I explain how the experimental presentation of the thesis is integral to the inquiry's aims and we test out a fictional dialogue.

It would be disingenuous to conduct a reflexive inquiry to re-examine daily practice without at the same time also questioning the appropriateness of the traditional format of an academic thesis. I did not set out with a clear direction for the inquiry nor aim to arrive at 'the answer'. I do not imitate the decontextualised nature of scientific discourse, with the author absented from the text, a strict hierarchy of knowledge and certain types of text privileged over others. Academic convention presents research as a logical progression of one phase informing and leading into the next. With a retrospective gaze we reorganise our experiences into a linear narrative. I create a degree of coherence for the reader by weaving together the threads of narratives. Through experimenting with form, I hope to stimulate fresh thinking. I seek to engage the reader reflexively, whereby you are drawn into dialogue with a self-conscious account of production of knowledge as it is being produced. In creating an inquiry that is congruent with homeopathic practice, the challenge is to convey subtle qualities, an unfolding and open ended narrative, and an insider's perspective. Implicit in this approach is resistance to external pressures to conform to a biomedical evidence based approach.

Form and content interact dynamically; as the content shapes the form, so experimenting with form moulds the inquiry process. The validity resides in the reader's individual experience of the thesis.

This chapter is inspired by a favourite book from my undergraduate days. Ways of Seeing (Berger, 1972) played an important role in my understanding of the value laden and political nature of perception, and the fluid interplay of image, text and meaning. This way of looking at images informs how I look at my clinical practice. Berger argues that high art discourse functions as an arbiter of privileged taste, in the same way I perceive scientific discourse acting as the gatekeeper of acceptable research and evidence. I imitate Berger's commitment to widening participation in the visual arts, to open up homeopathy research discourse to more homeopathic approaches and to give voice to homeopaths and their patients.

3.3 How am I looking at practice?

3.3.1 The constitutive role of practice

National Occupational Standards in Homeopathy (Healthwork UK, 2000) provide a detailed description of observable tasks performed by homeopaths. A competency based framework cannot capture higher level skills, knowledge or understanding. Schön's work (1983, p.60-61) is influential in grappling with the complexities and ambiguities of professional practice. Schön draws attention to the repetitious nature of practice, as routine, spontaneous, tacit and taken for granted. I turned to Sennett's (2008) description of a rhythm to practice, not as thoughtless habituated practice, but allowing freedom for reflection-in-action. Writing in the pragmatic philosophical tradition, Sennett presents craftsmanship as an embodied experience of skills acquisition. He emphasises the role of imagination in technical understanding and the interconnection between problem finding and problem solving. Sennett's model of the 'doing' of

practice does not capture the feeling of 'being in' practice. It is not possible to examine practice without examining the practitioner. In the context of the individualistic aspect of homeopathy discourse (see Dialogue on Single Remedy, chapter 0). I am tempted by Cherry's (2008) personalised view:

"a person's practice reflects their individual and idiosyncratic integration of knowledge doing and learning, it is profoundly influenced by who they 'are' and in turn influences who they 'become'" (p.33).

My ideas are also shaped by a social constructionist view of practice as a social activity:

"in which knowledge and meaning are constructed through shared and joint practices....that share a common culture or language, codes and ways of seeing the world." (Parker, 2009, p.45).

The collective nature of professional practice is portrayed in Wenger's (1998) concept of 'communities of practice':

"encompassing process of being active participants in the *practices* of social communities and constructing *identities* [sic] in relation to these communities" (p.4)

This resonates with my experiences as a student member attending the SoH' Annual Conference for the first time. It was memorable not for the presentations or papers given, but for what happened in the tea breaks and at meal times. It was a process of enculturation (Lee, 2008) as I learnt to participate in

"its own networks and codes of interaction, social and conceptual framework that gives it meaning" (Armsby, 2000, p.42).

Wenger's conceptual model places learning in the foreground. This echoes my own sense that being in practice involves the interplay of tacit knowledge and lifelong learning. It is as much about being comfortable about not knowing as it is about putting knowledge into action, and the acquisition of new knowledges. The homeopath's sense of self is constantly being negotiated through exchanges (Armsby, 2000) with patients, clinic staff, students, colleagues and other healthcare professionals. A central focus for all qualification courses in homeopathy is observation in clinic, where students not only learn practical skills, but also as they take on patient responsibility, to re-create themselves as homeopaths. The complexity of practice involves the practitioner's whole being (Higgs and Titchen, 2001) and is always in the process of becoming (Johns, 2000). My experience is better described as integrating knowing, doing, being and becoming (Higgs and Titchen, 2001). This inquiry is not about what I do in practice, but the complexities of 'being in practice' and 'being a practitioner researcher'. I try to inquire at the experiential interface of theory informing practice. I describe this as engaging with the 'therapeutic framework'.

3.2.2 Practitioner research

Practitioner research must be evaluated by its own criteria (Reed and Biott, 1995, Freshwater, 2008) as the findings are inextricably linked with the researcher's experience. In common with other forms of qualitative research, findings have limited generalisability and the position of the

practitioner researcher cannot be replicated. Strategies questioning the trustworthiness of the inquiry include ‘sounding out’ with colleagues to identify commonalities and inconsistencies. The origins of homeopathic practice can be considered as a form of practitioner based research. Taking a self-critical approach with the aim of improving treatment, a research strategy was initiated from observations of illness and recovery. Self-experimentation evolved into detailed experimental protocols. Homeopathic practice developed out of critique of speculation and conjecture in contemporary medical practices. Theoretical texts were informed by years of systematic clinical observation (Hahnemann, 1987, 1st published 1921). Individualised treatment requires a fresh approach to every patient. Consultations are in depth with detailed questioning and avoiding closed questions and making assumptions. Clinical data is recorded in detail, verbatim where possible. This rich phenomenological data is analysed, followed by a systematic and rigorous investigation of *materia medica* data. Research is conducted into biomedical diagnosis and any prescribed medicines. Patient response is carefully monitored and treatment effects evaluated. I suggest that practitioner based research is ingrained in homeopathic practice, as homeopaths we are also researchers of our own practices. This thesis explores this proposition and proposes a way of conceptualising this.

Research conventions are challenged by acting both as researcher and practitioner. The stance of practitioner researcher determines the inquiry’s aims, perspectives and methods. How you frame a question is hugely influential on the potential answers generated by the research. CAM research conducted by biomedically trained researchers so often fails to ask the most appropriate questions (Lewith, 2004a). This is what Fox (1999, p.198) calls the “different world-views”; the researcher perceives data and the practitioner, people. The impact of research on practice and on the practitioner is an essential feature of practitioner research. This inquiry eliminates the infamous gap between research and practice by creating a symbiotic relationship: the inquiry transforms practice and the practitioner, and practice transforms the inquiry. Rolfe (1998) proposes:

“integrating practice and research in a single act whose aim is not primarily the generation of knowledge and theory but the implementation of clinical change, so that research becomes ‘built-in’ to practice and clinical change is built-in to research”. (p.176)

This is a passionate engagement from within the experience, but researching the culture in which you are embedded demands reappraisal from a range of theoretical perspectives and to address issues of surveillance of professional practice. Wenger’s model of communities of learning and practice is a useful way to consider the tensions arising from inhabiting both a community of professional practice and at the same time, interrogating my community’s interests through participation in an academic community:

“A learning community is therefore fundamentally involved in social re-configuration: its own internally as well as its position within broader configurations.” (Wenger, 1998, p.220)

This process of re-orientation between communities in flux is visible in the dynamic nature of doctoral supervision. I found group supervision with other practitioner researchers a particularly

valuable way of exploring fresh perspectives and new vocabularies. In the writing of the thesis I am constantly mediating between academic discourse and homeopathy discourse. Reflective practice (Schön, 1983) offered a starting point to engage critically with my tacit knowledge to create an inquiry based approach.

Lewith (2004b) asks whether the practitioner's conviction that 'what I do is effective for my patients' and their financial dependence on professional practice, precludes the critical distance needed to conduct research. He argues that CAM practitioners 'enter the belief system' of their therapy in a distinctly different way to medical doctors. Whilst agreeing that the context of research is different, this raises the question as to whether biomedical researchers challenge the underlying tenets of biomedical ideology? Lewith suggests that if the inquiry undermines the practitioner's beliefs, there is a risk of becoming less effective in practice. He advocates mentoring and supervision to assist the researcher to challenge themselves and their practice. I extend the trajectory of his argument. Through this inquiry I intend to demonstrate how a critically reflexive approach is essential for interrogating practice from competing perspectives within a social, ethical and political context. I intend to disrupt the apparent stability and order of habituated practice and to explicate taken for granted practices, with the aim of generating potential benefit of patients.

To illuminate tensions for the practitioner researcher, let us create a fictional dialogue between Homeopath, Homeopath Researcher VOICE OF THE RESEARCH TEXTBOOK and Conceptual artist Susan Hiller (represented in the text as Susan).

Homeopath: Reflective practice helps me to explore practice. To question what I do, with the aim of improving practice.

Homeopath Researcher: Every practitioner is also a researcher, as questioning what is happening, is crucial to all forms of practice. Reflective writing can reinforce your assumptions, focus on your strengths and brush over difficulties. I take a more critical approach exploring tensions, inconsistencies and contradictions.

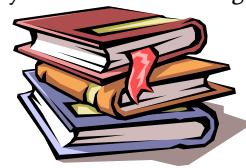
Homeopath: There's a problem here. As a practitioner I need to believe in what I do. If you come along and question everything I do, that may disrupt my relationship with patients.

Homeopath Researcher: Why can't we challenge belief?

Homeopath: Like many homeopaths, I wanted to study homeopathy because of personal experience of the positive effects of remedies. At college, the potential for homeopathy to improve health was regarded as commonsense. This was reinforced by what I witnessed in the teaching clinics. This became naturalised as intuitive in professional practice. Now I am more confident to allow for uncertainty in assessing response to treatment. However underlying this, is the belief that homeopathic treatment can be a catalyst for improving health.

Homeopath Researcher: This is a crucial aspect to explore together, and could contribute to understanding paradoxes of homeopathy, as part of the medical profession yet accused of being

unscientific, growing in popularity yet absence of established efficacy. It could be argued that.....(interruption)



A RESEARCH TEXTBOOK ON THE TABLE BECOMES ANIMATED, FLIPS OPEN....

VOICE OF THE RESEARCH TEXTBOOK: THIS IS NOT ACADEMIC RESEARCH! YOU CANNOT FULFIL BOTH ROLES, YOU ARE THE RESEARCHER AND YOU MUST USE OTHER PEOPLE AS THE SUBJECTS OF YOUR RESEARCH. THIS IS NOT LEGITIMATE DATA GENERATION AND YOU WILL NOT BE ABLE TO CRITICALLY ANALYSE YOUR FINDINGS. HOW DO YOU INTEND TO PROVE ANYTHING?

Homeopath Researcher: I appreciate your viewpoint. I have no intention of proving anything. The findings are inextricably linked with my experiences, and cannot be replicated or generalised.

VOICE OF THE RESEARCH TEXTBOOK: I DOUBT THAT YOU WILL COMPLETE YOUR PHD, LET ALONE HAVE PAPERS ACCEPTED FOR PUBLICATION!

Homeopath Researcher: I agree the inquiry will be incomplete. Representation is always provisional and partial. At best it is always in the process of becoming. What is important is taking critical perspectives....

(LOUD SIGH AND THE TEXTBOOK SLAMS SHUT)

Homeopath: Critical perspectives.... This makes me feel uncomfortable. I have lost the sense of solid ground. This destabilises what I thought I knew....

Homeopath Researcher: That's a good sign! We need to question what is going on in practice and in the research process. We are part of the research process, and through reflexivity, we are able to situate ourselves as knowers in wider social, ethical and political contexts and challenge habituated practice.

Homeopath: Knowers? I go to continuing professional development events to keep up to date and to increase my knowledge. Often I learn more during the tea breaks from talking with other homeopaths about their difficult cases or experiences of using specific remedies, than I do about the topic of the event. This sharing of experiences is very valuable to me but cannot be measured in research terms.

Homeopath Researcher: Yes this is practitioner knowledge that is intuitive and subjective. In this inquiry we explore how we account for and record this as evidence in ways that honour the artistry of practice. We draw on the idea that subjective ways of knowing are as valid as empirical evidence.

Homeopath: (in a troubled voice) But how can I challenge daily practice when I am integral to what I am researching?

Homeopath Researcher: We are both involved and at distance from clinical experience. I seek to examine homeopathy as a cultural phenomenon, its values, assumptions, customs and rituals, and to gain insight into factors that shape and influence our practice.

Homeopath: This is difficult as you are a product of the culture you are researching. I feel exposed and open to criticism. Other homeopaths may not appreciate our findings. Anyway research should be about important issues. Isn't it conceited to think that my practice knowledge merits this attention?

Homeopath Researcher: The value in this inquiry is that rather than an outsider looking in, I am seeking to re-examine our daily experience of clinical practice from an insider's perspective.

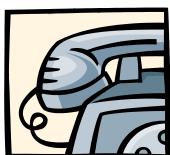
Homeopath: Yes I get fed up with hearing about the need to prove the remedy ‘works’. The remedy and consultation process should be explored together.

Homeopath Researcher: Homeopathy is a complex intervention, a process, evolving over time in response to the patient’s and practitioner’s perception of change. Analysis of your reflective journals reveals how you internalise the incantation of ‘prove it works’ and how we can develop language to articulate our own research-minded approach to practice.

(pause in the conversation)



[Thoughts not vocalisedI am struggling to conceptualise this inquiry. How do I present this inquiry in a way that is authentic and congruent with homeopathic philosophy? To critique from an insider’s perspective, I need to move between the intimacy of practice and critical distance. Do other research domains offer any inspiration? I know, I’ll call my friend Susan Hiller, who works as a conceptual artist. She tackles postmodern issues of representation, describing practice and art as epistemology]



Homeopath Researcher picks up the phone and dials, sets up a conference call.....)

Homeopath Researcher: Hello, Susan, can you help as we’re struggling here to conceptualise subjective and intuitive knowing in clinical practice?

[This account is entirely fictitious and is informed by my reading of Susan’s interviews and lectures (Hiller, 1996b)]

Susan: First let me congratulate you both on your curiosity and openness to inquire. “I made the decision when I left anthropology that I never wanted to be again an observer, that I didn’t believe there was anything called ‘objective truth’, and I didn’t want to be anything but a participant in my own experience” (Hiller, 1996, p.46).

Homeopath Researcher: Yes, this resonates with our position as practitioner researchers. Participants and observers are inseparable.

Susan: Let’s create an analogy. Are there connections between the role of an artist and the practitioner researcher. They both “modify their culture while learning from it... perpetuate their culture by using certain aspects of it...change their culture by emphasising certain aspects of it, perhaps previously ignored ... show hidden or suppressed cultural potentials... operate skilfully within the very socio-cultural contexts which formed them... are experts in their own cultures” (Hiller, 1996, p. 24).

Homeopath Researcher: I find being an expert in my own culture constraining.

Susan: My work offers a critical analysis of my role and function as an artist, in particular how I act as a carrier of societal values. I encourage you to visualise how your culture inscribes what you know.

Homeopath and Homeopath Researcher: (in unison) Maybe....

Susan: I am searching for a way to be inside all my activities and for the viewers/participants to get inside their own activities. I examine "how our embeddedness in culture and how the outline of culture inscribes what we know" (Einzig, 1996, p.1).

Homeopath: I'm beginning to feel more comfortable. Is it about how to be fully present in the consulting room and also to attempt to articulate the changing values and assumptions that shape my practice through the research process?

Homeopath Researcher: We explore homeopaths' ways of knowing. As my supervisor Peter suggests, homeopathy itself becomes the patient. We take the case of homeopathy using its own methods of analysis. I realise that as researcher I am also participant in the research. Critical perspectives are essential to challenge my biases and blind spots.

Homeopath: I use myself therapeutically in the consulting room in supporting patients' recovery, so does the researcher use themselves through the inquiry?

Homeopath Researcher: You are shifting from practice based to practitioner based research. This makes more sense. Susan, you explore our own culture through artefacts. I have an idea, we could explore homeopathic principles as artefacts of homeopathy discourse. Wow, what about using items from the paraphernalia of practice, to include texts, bottles and pills as reflexive devices?

Susan: Yes I encourage you to inquire creatively. I have enjoyed our conversation. Goodbye.

Homeopath and Homeopath Researcher: (in unison) : Susan, thank you for your insights. It has been thought provoking. Goodbye.

End of fictional dialogue.

Well reader, I hope this dialogue has illuminated the framing of this inquiry and created a sense of anticipation for the journey ahead. You may be wondering why I am using fictional dialogue, so let us turn to issues of representation and the relations between form and content.

3.4 Designing the thesis

3.4.1 Visualising the inquiry process

A metaphor for this thesis is weaving a piece of fabric of mixed fibres and plies. All the edges are frayed with long threads, some forming bundles and others free flowing. There are small raised areas of over-stitching with other threads. The irregular shape, texture and hues of this scrap of fabric represents the inquiry's layered interpretations and the multiple discourses through which practice and research experiences are constructed. I visualise touching the fabric, feeling its uneven textures, and looking at the blending of colours and rough finish. I make observations by placing the fabric at different angles or juxtaposing the two surfaces. It is only by twisting the fabric back on itself, can my fingertips trace individual threads running through the weave I endeavour to untangle individual threads, to unravel the complexities of homeopathic practice. The inquiry is also a process of undoing, creating the potential for making sense of practice experiences, but the threads cannot be separated from the whole context of

the fabric. As these threads unravel, they can be idiosyncratic, revealing surprising colour or texture that is hidden in the fabric. There is a sense that I am stitching my core narrative into the fabric. This imagery helps me to appreciate the muddled, chaotic and serendipitous nature of the research process. Numbered paragraphs are cross referenced in the text to help the reader to trace the different threads running through the chapters.

The search for a mode of presentation is formative to the inquiry itself. In addressing questions of representation, the nature of the inquiry begins to reveal itself. Writing is an integral feature of the research process (Richardson, 2000). The inquiry takes shape through the writing and creating of it. So I ask you to prepare yourself to be disconcerted by the somewhat idiosyncratic and personalised nature of this inquiry. Writing oneself ‘into the text’ in an articulate and transparent manner is essential in a reflexive account where insider knowledge is privileged. It would have been disingenuous to present a tidied up and sanitised version. As this text is dialogic, articulating my personal and practical experiences, it is essential to engage the reader’s imagination. I have experimented with modes of inquiry and representation that are personal, authentic and congruent with homeopathic practice and research. Creating this self-reflexive account is experimental with few exemplars. Inspiration was nurtured through participation in Performative Social Science Network workshops and email network, and the online journal Creative Approaches to Research. These are part of an increasing use of a range of media to conduct and disseminate research, and to initiate dialogue with wider audiences (Rapport, 2004). I experimented with poetry, collage, clay modelling and needlework. I studied art history (1982-1985) at a time when the academic discipline was being challenged by the emergence of more politically informed cultural studies. So I am familiar with issues of interpreting representations and the crisis of representation. In the formative stages of the inquiry I looked at the writings of visual artists describing the process of art production, as I recognised shared difficulties in articulating the artistry of practice, in particular with the conceptual artist Susan Hiller.

Hiller argues that appropriation of objects from other cultures reveals more about us than they do about the producers of those objects (Hiller, 1996b). The paraphernalia of daily practice, the material culture (Sennett, 2008) of homeopathy, for example glass vials, corked bottles, pills and tinctures, evokes associations of both antiquated medical practices and at the same time ‘standing the test of time’. The image of my consulting room is chosen to evoke the space between patient and homeopath. I do not perceive these images as embodying homeopathic values but as part of the vocabulary of homeopathy discourse. As Hiller (1996B) rather enigmatically states:

“We think of artefacts as being out there...they are not out there at all. Because the culture that forms us is the consciousness that we share of reality. So artefacts are, on the one hand, hypotheses, and on the other hand, conclusions.” (p.214)

I leave you to reflect on Hiller’s notions of hypotheses and conclusions, and we will re-engage with her ideas as we evaluate the role of artefacts later in this inquiry (16.2).



[Image 2: Susan Hiller's 'Freud museum' 1991-1996 (image available at www.moma.org)
Reproduced with kind permission of Susan Hiller Studio, London]

Reflecting on a visit to Hiller's work:

*To play with ideas about using images in the inquiry I visited London's Tate Modern (July 2006) to experience Hiller's *From the Freud Museum*. Since my undergraduate studies I have been critical of the elitism of high art practices, making visits to art galleries a rare event. The exhibit is displayed in its own room. Feelings of estrangement were heightened by the subdued lighting and hushed voices, evoking an aura of mystification and a sense of what is held sacred in our culture. It is a cliché, but this truly felt like visiting a temple or cathedral. Fifty identical cardboard boxes, each containing objects and a label, are placed in two parallel lines and set in a large glass cabinet. This caused me to reflect on the classification and naming of objects and knowledge in our culture. The information panel explained that the work was inspired by Freud's collection of classical and ethnographic artefacts, and that the objects represented an assemblage of "cultural ephemera and personal mementos". Within high art culture the artist's explanation of the work plays a pivotal role in constructing the viewer's experience. Hiller is quoted:*

"worthless artefacts and materials – rubbish, discards, fragments, trivia and reproductions – which seemed to carry an aura of memory and to hint at something".

I found myself looking for associations between the objects and texts, actively trying to create meaning for each box. This is analogous with the case-taking process as I try to make sense of the patient's narrative in the search for the similimum. Is this what Hiller meant about artefacts disclosing more about the viewer than the culture that produced them? What does this tell me how meaning is constructed in the homeopathic consultation? More about the homeopath than the patient? I also reflected on the nature of evidence, of the link between Freud's theories and the objects. I think about using images of the paraphernalia of practice in this thesis, it is important that they are contextualised within practice experience and not set apart. What meanings will my readers bring to them?

Another significant encounter in this search for creative approaches to practitioner research was with symbolic self-curation:

"as a form of reflection that encourages creative, scholarly engagement with a set of practicesin ways that clarify the past and present, while producing significantly new possibilities for the future". (Cherry, 2008, p.22)

Cherry describes curation as a reflexive process involving collecting objects, arranging, re-arranging and interpreting: "Such gathering reveals the stance of the gatherer" (2008, p.27). This resonates with Hiller's ideas and shaped the way I was organising the inquiry around the homeopathic principles as artefacts. Cherry prompts me to reflect on why I chose particular objects and what was revealed through this curation process. Her stated intention is to shift "the self, curating practice" to "the curation of the self as practitioner" (2008, p.22), in the sense of "gathering" of the self "across the dimensions of doing, knowing, being and becoming" (2008, p.22) and "meta-reflection on that self in ways that are reflexive" (2008, p.19). I have found it difficult to write myself into the inquiry, and the notion of "gathering" of self seemed a way of negotiating the postmodern fractured sense of self and at the same time sustaining a core

personal narrative. Achieving reflexivity is difficult, and whilst I was inspired by Cherry's approach, I do not claim to have followed this as a methodology. Hiller's work provides a route to make sense of my professional practice through examining the symbolism of objects of daily practice. Visual images of the paraphernalia of practice are used to stimulate critical reflection on my interaction with homeopathy's therapeutic framework.

3.4.2 Fragmentation and core narrative

Homeopaths are trained to perceive patterns in the patient's account of their health and life experiences. Frank's work (1995) speaks of illness experience as a sense of disintegration and disorientation, and looks at how people tell stories as a means to reconstitute a sense of personhood. The intentionally fragmented nature of this thesis mirrors the transitory nature of experience. This is informed by an understanding that multiple and competing epistemologies co-exist, and there is a plurality of ways of seeing and understanding. Practice experience is captured, momentarily and selectively framed for the reader. I question to what extent any doctoral thesis is coherent and linear, as a zigzag path is more congruent with learning. The thesis's fragmentary presentation is echoed in diverse sources of data. These include reflective journals, contributions from participants in a peer supervision action research project, reflective writing generated from participating in conferences and continuing professional development sessions; and anecdotal accounts from practice.

As this inquiry unfolded, I became aware of taking a self-interpretivist stance (Taylor, 1985b), being able to name this as such came retrospectively. Taylor argues that humans do not simply experience physical sensation, but have distinctive feelings that are 'subject-referring'. As self-interpretative beings, we use stories to communicate with each other. In relating the story to others, we explore our own experiences and dilemmas as an expression of our sense of self. Subjectivity is not an individual matter but is socially constituted (Taylor, 1985a). We cannot avoid being caught in the extended narrative web. This is an open ended process of 'entanglement of our stories with the stories of others' (Ricoeur, 1992). Intersubjectivity is used to express the idea that how I interpret meaning in practice is negotiated through the workings of discourse with other homeopaths and in relation to my own personal narratives. Just as both homeopath and their patient interact in the consultation process, each affected and transformed through it; so both the narrator and the audience interpret the narrative in relation to their own personal narratives.

It is questionable whether a coherent sense of self can be achieved. This is informed by a postmodern contention that any sense of being a rational, unified, autonomous subject is unsustainable. I explore my sense of self as a practitioner through narrative. I write myself and my values, beliefs and experiences into the fabric of the text. This offers a degree of coherence for the reader, knitting together disparate elements. Narrative does not act as a mirror to what is taking place in practice. My engagement in practice is dismantled and re-created through the narrative conventions of reflective writing. I write in the first person. As a researcher it is essential for the research process to be transparent, contextualised and to recognise my

participation in creating the inquiry (Webb, 1992). I seek to avoid narcissism by reflecting on the inquiry process. I perceive research, clinical practice and reflective practice as part of the dialogical process of situating self (Freshwater, 2008). The challenge for me is to offer a self-conscious account of what is happening. Engaging in narrative inquiry is congruent with the homeopathic consultation and draws on practitioner expertise.

There is a core narrative or personal narrative, informed by my personal experiences, values and truths. This is most visible in reflective writing at the close of each chapter as I try to make sense of what has unfolded in the chapter. In attempting transparency of process, this inquiry is enacted through moments of doubt, inspiration, hasty decisions, distraction, chance encounters and abstract connections. Text boxes are scattered throughout the thesis; situated on the right hand side of the page (in italics) to capture reflection in the act of writing and to record what is happening on the margins; and situated on the left hand side to feature incidental information including notes on the remedies referred to in the case vignette.

3.4.3 Many voices

The inquiry aims to articulate a practitioner's voice in research discourse. This voice is manifested differently through different discourses and I use polyvocal devices, such as fictional dialogues and text boxes to draw attention to different ways of looking, each articulating its own truths. The patient's voice is hardly audible in this inquiry, but is represented through the fictional dialogues and fictionalised case vignettes as each chapter opens in part two.

In writing reflexively my perspective continually shifts between the critical eye on my inner worlds of experience and personal theories, and exploring ideas and testing out conjectures in a wider context. This context extends beyond homeopathy into CAM and healthcare in general. I do not restrict the investigation to scientific knowledge, but challenge the pre-eminence of science by valuing a range of different ways of knowing. The sense of self is manifested differently through different discourses, different voices (for example practitioner, researcher, academic, teacher, student, critic, defender, woman etc), and different analytical approaches. Hiller's audio sculpture captures that sense of many voices with each microphone relaying



recorded voices. This image comes to mind at those moments when I feel overwhelmed by too much information and too much going on in the inquiry.

[Image 3: Detail from Susan Hiller's *Witness* Audio Sculpture, 2000 (Photo: Rosie Allimontos)]

Reproduced with kind permission of Susan Hiller Studio, London]

3.4.4 Participatory dialogue

This thesis is not presented as an authoritative account, but is constructed through relations between author and reader. Congruent with postmodern critiques and critical discourse analysis, the authority of the reader takes precedence over the expertise of the author (Barthes, 1977, Derrida, 1978). There are no fixed meaning to be ‘read off’, but rather the text is open to multiple interpretations – to include what is going on in the margins, hidden agendas, hints at what was unintended, assumptions, contradictions, what is absent or obscured, tensions, slippage between concepts and uncertainties. It is intended that the reader is encouraged to make sense of the text in the light of their own personal beliefs, experiences and readings of other texts. The thesis has intertextual relations within a whole complex of other texts, many that have gone before and others that will come after. As a reflexive inquiry I engage in intrapersonal, interpersonal and transpersonal dialogues.

This thesis is not intended to be didactic, but to be catalytic. It has been written with the awareness that the act of reading creates individual readings. The intention is to create an open text with sufficient ambiguity, incompleteness and scope for readers to engage with what is evoked in you and for you to participate in ways that are meaningful to you. Hiller’s work inspires me to explore the creation of this text as a performance itself with the aim of encouraging readers to be full participants in their own experience of the text. To enhance the dialogic nature of the thesis, the text addresses the reader direct as ‘you’. ‘We’ are ‘us’ are used to convey the collective endeavour of the researcher, supervisors and readers.

We spoke earlier of conceptualising the practitioner as always in the process of becoming (Johns, 2000), so the inquiry itself is also in the process of becoming. There are no clear starting or end points. Analogous to homeopaths’ critique of biomedical practice as a symptomatic ‘quick fix’, this inquiry gives priority to the journey rather than to closure. Just as claims for holism in CAM are untenable, so the thesis is necessarily incomplete. Some gaps I am aware of, others I am not. (This is an opportune moment to clarify that references to the ‘inquiry’ refers to the process of research and to the ‘thesis’ refers to the text.)

A commitment to an open text begs the question: Who am I intending to communicate with? In the first instance this is to my examiners, fellow doctoral students, colleagues, supervisors and a number of my patients who have expressed an interest in reading it. The role of the thesis in the examination process for a Doctor of Philosophy degree requires me to engage in academic discourse and this restricts the potential audience/participants. I hope that after I have completed the examination process, by writing papers for journal publication I will address a wider audience, primarily with health practitioners and users of CAM.

3.5 Reflective pause before moving on to the context of the inquiry

You may be thinking this is all a bit precious! Or this is a gimmick! In part I am deliberately parodying, in postmodern style, what I perceive to be the individualistic nature of homeopathic discourse. This approach is experimental and it is for you the reader to gauge how successful this creative synthesis is as a meaningful exploration of practice. The intention here has been to throw open the door on this inquiry, to give you an experience of something of its form and content. I was in a dilemma about what to reveal here of the learning through the research process, and what to keep until later in the thesis. There is a sense of starting to tell the story, but I am telling this in retrospect, as I am already changed through the inquiry. I hope you are tempted to accompany me on my endeavours to formulate an approach to practitioner research. Are you at least curious about what is to come?

4 CONTEXT

4.1 Introduction

This chapter offers a context for interpreting the inquiry. It is essential to explore assumptions, values and biases in reflexive research. In crafting an open text, I create an arena to negotiate shared meaning with my readers, or at least to make transparent how I locate myself and my practice within a wider healthcare context. It is also necessary to explore and negotiate the vocabulary used in this inquiry, as meanings are not fixed or stable, but fluid and context-bound. This is integral to the reflexive inquiry as terms previously employed without giving a second thought, during the course of the inquiry, become problematic and a focus for critical reflection. As explained in the previous section, this chapter does more than simply fill in the background to the inquiry. As the inquiry is not linear, this chapter was not completed before data collection or analysis. Initially I found myself trying to write as if I was appraising literature and the state of knowledge, trying to exclude myself and what I was learning through the inquiry. I abandoned this and discovered that by reflecting on key issues in my practice, I could produce a more informed and meaningful account.

This chapter begins by examining concepts of health, locating homeopathy in relation to CAM and biomedicine, and exploring the possibilities for integrated medicine. In examining homeopathy, we consider the professions, the practice and who consults homeopaths. Finally we turn our attention to research, firstly in CAM, then homeopathy, before considering the wider context of EBM rhetoric. This leads us on to reflecting how the difficulties posed by questions of evidence have shaped the trajectory of the inquiry.

4.2 Conceptualising health

I have deliberately avoided polarising health and illness. Our lived experiences of our state of health are constructed through the ways our society conceptualises illness and this creates expectations as to how we should experience our bodies. There are close parallels between homeopathy's conceptualisation of health and the World Health Organisation definition:

“Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity” (WHO, 1946)

Homeopathy discourse conceptualises health in a holistic context, with interdependence of body, mind, emotions and spirit. Notions of holism are constructed differently across CAM modalities, but they share an appreciation of health as a dynamic and shifting continuum constantly moving towards a sense of balance. Health is expressed in CAM discourse in terms of subtle qualities of energy, mood, well-being, quality of life and self-fulfilment. As our environment and circumstances are in constant flux, balance is not a fixed state, but being healthy resides in an effective homeostatic process. This resonates with a postmodern view of health as a constant state of becoming and as “human potential” (Fox, 1999, p.212).

'Well-being' is frequently used but often an unexplored term in CAM literature. Sointu (2006) emphasises the subjective quality of well-being, not reducible to physiological functioning. She argues that well-being is characterised by self-reliance, awareness and autonomy, and facilitated through therapeutic encounters that "encourage and enable personal meaning-making" (Sointu, 2006, p.346). This construct carries distinctive social values of autonomy, being well informed and empowered to be able to put together your own repertoire of therapeutic approaches.

Healing is conceptualised as taking place in energetic terms, as a sense of vitality. Shared with talking therapies, the treatment process has been therapeutic if the patient is able to "access their own healing potential" (Freshwater, 2008, p.211). For many of my elderly patients or those with chronic conditions, I describe treatment aims in terms of 'keeping you as well as possible, for as long as possible' within the context of what well-being means for that individual.

4.3 Locating homeopathy within CAM

CAM draws on a range of European and South East Asian healing practices to form a synthesis of reinvented healing traditions. Adoption of the terms complementary therapies or CAM is an attempt to organise a disparate set of practices under one umbrella, self defining as a form of healthcare and well-being practices. The collective terms obfuscate the diversity of therapeutic practices and diagnostic taxonomies. Some are identified as therapies and others, like homeopathy, are presented as systems of medicine. The diverse field is united by perceiving the potential to enhance self-healing. Homeopathy shares with many modalities a non-Cartesian view of health in recognising interdependence of body, mind, emotions and spirit. Like all cultural phenomena, people engage in CAM in diverse ways. For some, herbal preparations purchased off the shelf are substitutes for conventional analgesia; whilst others use meditation as a form of spiritual practice.

CAM as a set of therapeutic practices can be described as a paradigm, in so far as there are shared values, underlying models of health and therapeutic trajectories that distinctly differ from those of biomedicine. Implicit in descriptions of CAM practices are assumptions about naturalness and safety. These descriptions are juxtaposed with a harsher characterisation of the biomedical model as outcome orientated in eliminating, attacking and combating pathological change. This polarisation between alternative and orthodox is problematic, as what is regarded as alternative in one setting or at one time, could be regarded as orthodox in another setting or at another time (Saks, 2003b). Western logic is structured around tensions between pairs, privileging one over another. CAM and orthodox medicine are relative terms, constantly changing and culturally specific. The term 'complementary' is more politically acceptable than 'alternative', as it implies submissiveness to biomedicine, but both terms perpetuate the 'otherness' and political marginality (Saks 2011). Relations with biomedicine are not easy and Cant and Sharma (1998) observe that

"CM practitioners have tended to see themselves as beleaguered groups, threatened by the antagonistic power of orthodox medicine". (p.249)

Recent debates conducted in national newspapers have challenged individual's autonomy to exercise treatment choice and academic freedom in universities to teach CAM (Giles, 2007). Critiques of CAM practices (Coward, 1989) suggest that these practices privilege meaning making over physiological effects, perpetuate myths of what is natural and traditional, and function as indulgences made possible by a high standard of living. Other more personal critiques (Diamond, 2001) make allegations that false hope is offered to those suffering terminal illness.

In the UK CAM is practised under Common Law and located almost exclusively in the private sector. Practitioners can be easy targets for accusations of financially exploiting vulnerable individuals. The orthodoxy of biomedicine is created through institutions of state healthcare provision, education, academic journals and research. Marginalised by exclusion from many of these domains, CAM's strength comes entirely from its enthusiastic patient base and arguably it symbolises unfulfilled health needs. A survey (Thomas and Coleman, 2004) estimated that of the UK population, 5.75 million annually request treatment from a CAM practitioner and approximately one in four would like to access CAM on the NHS. Public demand for CAM was cited as the reason for Government attention (House of Lords, 2000) to professional regulation and public safety of CAM practices. Individual CAM professions have responded differently to external demands for validation of qualifications and research, higher levels of professionalism and evidence based practice. For example acupuncture and Western herbal medicine are moving towards graduate only entry into the professions.

Homeopathy occupies a paradoxical position on the margins of healthcare. The practice is part of mainstream healthcare, incorporated into the inception of the NHS by Act of Parliament in 1947. Currently NHS treatment is available from five NHS-funded homeopathic hospitals and four hundred GPs (BHA and FOH, 2008). Homeopathic practice draws on the medical culture of the consulting room and prescribing conventions. At the same time homeopathy is regarded as radically 'unscientific' in prescribing preparations diluted far beyond the molecular level. Arguably homeopathy's position as alternative or complementary is unstable and negotiated differently in each clinical encounter and context. Later in this chapter we consider CAM in historical terms and how it is shaped by key institutional texts and an emergent research culture.

4.4 Dominance of biomedicine discourse

The medical model of diagnosis, treatment and procedures is not an appropriate way of understanding homeopathic treatment. I avoid creating polarised relations between 'conventional' or 'orthodox' medical practices and CAM as this does not reflect the realities of contemporary healthcare where many individuals devise their own packages of care across conventional, CAM and self-care. Arguably experience of CAM treatment alters the way

individuals experience their interactions with biomedicine (Frank, 1995, p.34), for example expectations about therapeutic relationships and attention to social factors affecting health. From a Foucauldian perspective (Foucault, 1973) the term conventional or orthodox emphasises the establishment role of medicine making visible the functioning of medical discourse as a mechanism of social control. I perceive biomedicine as a social construct, formed through political and economic forces, that brings together a whole range of heterogeneous practices. The discourse perpetuates strict hierarchies for health professionals. We are socialised into lived experience of ill-health in terms of the classifications offered within biomedicine. Dominance is political and not clinical. I have chosen to use the term 'biomedicine' as this captures the dominance of biochemical discourse and of pharmaceutical based interventions in contemporary medical practice.

The difficulties I experience in arriving at a collective noun to refer to medical practices are revealing of my values and prejudices. My path into homeopathy, shared with many others was through dissatisfaction with the biomedical model of healthcare. However after over 25 years of reliance on CAM for all my healthcare needs, a cancer diagnosis propelled me into an intensive and prolonged engagement with biomedicine. My impasse is informed by Cassell's (2004) critique, after a lifetime of experience as a doctor, that by embracing science medicine has lost its humane therapeutic values. He argues that modern medicine is ill-equipped at a human level to care for people who are suffering, and treats diseases and not patients. Malterud (2002) highlights the way that the doctor is constructed as the neutral and objective observer of the patient, and that reflective self-awareness is absent from biomedical discourse. Biomedical practices have pursued a bio-technological trajectory that has brought scrutiny and manipulation down to the sub-molecular and genetic level. Highly technological investigations and treatments have both brought benefits and escalated healthcare costs. The doctor's role demands greater engagement with technology than with one-to-one relationships with patients. Gradual erosion of human values in medical care has been exacerbated by repeated Government led re-organisations of the NHS. Politics has led to medical care being 'delivered' according to treatment protocols in a target driven, audit culture, whilst resources are stretched to breaking point by the health needs of an affluent and ageing population.

The public image of contemporary medical practice was disturbed by concerns for patient safety raised by the GP Harold Shipman case. There are perceived benefits brought about by technological developments including health screening, preventative treatments, keyhole surgery and improved survival rates with cancers and AIDS. The discovery and development of new drugs has transformed healthcare in the 20th century, however the costs have been high. The Department of Health expenditure on drugs has risen by £7.5 billion since 1991, growing faster than the gross domestic product (Boseley, 2009). The full extent of adverse events associated with medicines receives little attention, with at least 2.68 million people (4.5% of the U.K. population) harmed by biomedical interventions (Leigh, 2006). The globalised pharmaceutical industry, controlled by a handful of multi-national conglomerates, has vested interests in promoting this dependence on pharmaceutical products. Maybe we will look back

and be dismayed at our generation's reliance on pharmaceutical products to manage a wide range of health problems and the lack of attention to developing other strategies, such as psychotherapeutic interventions. Within my years of practice there have been notable instances of *volte-face* in prescribing practices. Antibiotics, once hailed as the 'magic bullet', are now producing the predicted mutated resistant strains of bacteria. Recognition of increased risk of breast and uterine cancers, heart attack and stroke have become apparent from use Hormone Replacement Therapy by millions of menopausal women, and has led to significant changes in prescribing protocols (MHRA, 2007).

You may be thinking that this discussion devalues the contribution of science and biomedicine. The biomedical focus on classification and treatment of named diseases, according to failing or defective physiological and biochemical processes, has been highly successful in treating specific conditions, for example diabetes. Less attention has been paid to the subjective experience of illness as social and psychological factors interacting with biological processes. It is essential to recognise that health needs are complex and multifaceted. I offer a critique of the colonising force of biomedicine as a social practice that constantly expands its range of medically defined conditions, such as menopause and childbirth. The objective language of the dominant discourse obscures the uncertainties and contested practices inherent in any human activity. Allen Roses of Glaxo Welcome Research and Development comments that

"Classifications of disease change over time as research provides more information. Diseases are collections of symptoms and signs (phenotypes) that appear to be similar, and for many diseases there is no accurate single diagnostic test". (Roses, 2000a, p.1358).

Recent developments in personalised medicine and pharmacogenetics draw attention to the fact that a drug is rarely effective in all patients. The biomedical model of disease is being revised by identifying highly nuanced inherited metabolic variations that indicate heterogeneity within many common diagnostic categories, for example Alzheimer's disease subtypes (Roses, 2000a, 2000b). Later in this thesis we examine this as a trend towards convergence between homeopathy and biomedicine (see Dialogue on Miasms chapter 15). CAM can be regarded as dissenting voices to dominant biomedical discourse calling for more openness to multiple and more individualised approaches in healthcare.

4.5 Integrated healthcare

I have introduced this theme, not so much to capture current practice, but to highlight an aspiration. Power sharing between biomedicine and other therapeutic modalities would be required to realise this ideal. I have located myself in environments that share this aspiration, as an academic (formerly School of Integrated Health, University of Westminster), visiting lecturer (teaching medical students, nurses and CAM students) and practitioner (in multi-therapy centre in a GP surgery). In my practice I simulate this vision by forming, over many years, an informal local network of osteopaths, chiropractors, herbalists, acupuncturists, reflexologists, massage therapists, physiotherapists, counsellors, psychotherapists and dentists as well as personal contact with GPs and hospital consultants. This informal network of trusted individuals provides

sources of referrals, advice and peer support. I had firsthand experience of integrated NHS healthcare whilst acting as a homeopath at Marylebone Health Centre, one of the first (1988) in NHS primary care to offer an integrated service with CAM (Peters et al., 2002). I learnt that the regular team meetings and review of referral procedures were essential but time consuming, and that an integrated service relied upon trust between individuals that was difficult to sustain with turnover of personnel.

The most visible commitment to integrated healthcare was embodied within The Prince of Wales's Foundation for Integrated Health (PWFIH, 2002):

“It has a focus on health and healing, not just disease and treatment. It seeks to bring together body, mind and spirit so that healthcare encompasses the whole person....”

Twenty first century healthcare is complex and no single profession or therapeutic practice can possibly have the monopoly of effective diagnosis and treatment for all conditions. An increasing awareness that healthcare professions should work together is called for, so that scientific, psychological, nutritional, environmental and spiritual insights may be employed together to fully restore and maintain health (Fox, 2003, p.5).

My vision is that different therapeutic approaches suit different people, in different combinations, and at different times in their lives. The individual is best served by health practitioners who are educated in what different approaches have to offer, the limitations of their own therapy and the willingness to co-operate with other health professionals. This challenges homeopathy discourse which presents itself as a complete system of medicine with its own model of holism. One of the immense benefits of teaching in Higher Education was to break away from the insular world of homeopathy colleges and to participate in a multi-therapy learning environment.

So far the discussion has been practitioner led, it is essential to consider the patient's role within integrated healthcare. Self-motivation is a key aspect of health, and the impetus for recovery must come from the individual him or herself. Whilst I am committed to widening the availability of homeopathy through the NHS, the institutional context places the individual as a passive recipient. Active participation in treatment is integral to many CAM modalities. In the private economy of CAM, the individual takes the initiative to seek treatment and retains responsibility for negotiating their package of care. In my experience of receiving referrals from GPs, the treatment outcomes have generally been less favourable than anticipated. Whilst taking responsibility for your own health is integral to constructions of integrated health, this remains a rhetorical stance in NHS culture. My own NHS patient experience was that there is an implicit expectation that I followed the patient journey mapped out for my diagnosis, and that any sense of self-care, becoming better informed and exercising treatment choices were barely tolerated or even discouraged.

4.6 Introduction to the homeopathy professions

Homeopaths are divided into two groups – those qualified as medical doctors and those with a professional qualification. I am defined as a professional homeopath and registered with The Society of Homeopaths (SoH) (founded 1978), the largest membership organisation of professional homeopaths (1455 registered members 21 February 2008 personal communication) with the most developed self-regulatory functions. However SoH's dual regulatory and membership functions are long overdue to be separated. There are a number of other smaller registers of professional homeopaths. For the purposes of this thesis I use SoH as the collective representative of professional homeopaths. We have qualified either from privately run diploma courses or more recently undergraduate degree programmes. We were taught medical sciences by doctors or other health professionals. We practise independently and our role in publicly funded provision is limited to a number of NHS and social care projects, such as Sure Start, research studies in outpatient departments and charitable organisations. Medically qualified doctors practise both within the NHS and privately. Any doctor may prescribe homoeopathic remedies without training but may voluntarily choose to undertake a three year postgraduate programme leading on to certification from the General Medical Council and registration with the Faculty of Homeopathy (FoH), founded 1944 from the old British Homeopathic Society founded in 1843. FoH maintains registers for other statutorily regulated professionals trained in using homeopathy, such as dentists, midwives, pharmacists and veterinary surgeons (1100 international membership, Faculty of Homeopathy, 2010). For the purposes of consistent terminology, where distinctions are needed I refer to 'medical homeopaths' and 'professional homeopaths'. Where distinctions are not relevant, the term 'homeopath' is used to refer to both.

Professional homeopaths right to practise in the UK is protected under Common Law. Statutory regulation relates to the medical practitioner and not their homeopathic practice. Currently homeopathy is an unregulated profession, without restrictions on practising or calling yourself a homeopath. The only constraints on practice are in respect of duty of care, treating notifiable diseases and the use of the title of Registered Medical Practitioner. Homeopathic remedies are available for sale over the counter. In 1994 the Medical Control Agency introduced a licensing scheme for safety and quality of homeopathic remedies. The current review of UK medicines legislation by the Medicines and Healthcare Products Regulatory Agency may have implications for the availability and labelling of remedies.

Medical homeopaths negotiate their identity across two divergent paradigms. This is clearly visible in their journal Homeopathy, for example, in the commitment to 'modernise' homeopathic terminology. Medical homeopaths

"have to struggle to retain the credibility of their specialism within medicine, in the face of considerable hostility from some other doctors". (Cant and Sharma, 1996, p580)

Most published research is generated by medical homeopaths, and this may account for why some professional homeopaths are ambivalent about a perceived lack of convergence between

research and their practice. One patient's experience illustrates divergence of practice. As a patient and ethnographic researcher, Barry's (2005) consultation experience was unrecognisable as the same therapy. Her brief consultation with the medical homeopath led to homeopathic prescriptions based on biomedical diagnosis. The in depth consultation with the professional homeopath took a holistic approach. Whilst Barry's experiences offer a polarised view of practice approaches, there is a spectrum of approaches and prescribing styles. We can understand that there are competing discourses operating, articulated through the way in which homeopaths organise themselves and communicate about their work.

The medical registration, symbolic of education, career trajectory and authority, demarcates professional homeopaths as different and inferior. Medical homeopaths (Morrell, 1995) have portrayed professional homeopaths as trespassers on their territory, of practising a bastardised form of homeopathy and as lay practitioners. Professional homeopaths have criticised medical homeopaths on the grounds that many doctors prescribing homeopathic remedies have received only minimal teaching in homeopathy. This implies that a medical qualification is essential, but homeopathic practice can be easily 'picked up' through personal study and by applying rudimentary knowledge. However interactions between medical and professional homeopaths are becoming more common through shared participation in conferences, seminars, teaching and research. Greater unity is symbolised by the launch of 'Let people choose' on-line directory (June 2011) of homeopaths, both members of FoH and registered with SoH.

The history of homeopathy originates and is dominated by medical homeopaths. Dr Quin introduced homeopathy to Britain in the mid-1830s (Dean, 2001) and went on to establish the London Homeopathic Hospital. The collective identity of professional homeopaths is more fragile. Historically there have been influential homeopaths outside the medical profession, for example two lawyers Boeninghausen (1785-1864) and Melanie Hahnemann (1800-1878), Samuel's second wife. This has been described as a "leakage of homeopathic teachings from medically qualified homeopaths" (Cant and Sharma, 1996, p.583). A cultural divide can be traced back to the 19th century (Weatherall, 1996, p.181) represented by the two main homeopathic associations. The British Homoeopathic Society, forerunner of the Faculty, promoted homeopathy as a progressive science. The English Homoeopathic Association took a more 'spiritual and idealist' view (Weatherall, 1996, p.181) of homeopathy, more akin to today's professional homeopaths.

This narrative must be contextualised within historical perspectives on the establishment of the medical profession and CAM. A profession of medicine was created by political manoeuvring in the early 19th century (Saks, 2003b) and received legal protection in the 1858 Medical Registration Act. Legislation strengthened medicine as a function of the state, discriminated against any competitors and subordinated other health professionals. Saks argues that this process of differentiation in the latter part of the 19th century was political rather than scientifically justifiable. It is important to remember that before the 1920s it can be said that

medicine killed more than it cured (Wootton, 2006). Saks argues that with the medical profession's greater unity and advances in treatments, CAM practices were increasingly marginalised by the mid 20th century.

By the late 1960s an emerging counter culture expressed disillusionment with the orthodoxy of medicine and a desire for greater self-determination in healthcare. A revival of demand for CAM practices accompanied an exploration of self-realisation through esoteric and Eastern philosophies. In the 1970s non-medically qualified homeopaths in the UK emerged from two London study groups and apprenticeship style training. These individuals set up of the first college and professional association, The Society of Homeopaths (SoH) in 1978. During the 1980s I participated in CAM's growing popularity, by joining the increasing numbers of homeopaths – practitioners, colleges and organisations. From this vantage point now I perceive cycles of continuity and change for CAM in general and homeopathy in particular. In the 1980s I studied at a new college and in my second year of study I started working in an administrative role in another newly formed college. I was accepted as a registered member of SoH in 1991 and attended the first research conference run by professional homeopaths which led in 1992 to the founding of the SoH's Research Committee. The 1980s and 1990s was a period of embedding as a profession which included SoH developing a robust Code of Practice and appointing salaried officers. Alongside medical herbalists, acupuncturists and other CAM professionals, SoH worked on developing educational standards and the infrastructure for voluntary self-regulation. Having taught and managed courses for two of the private colleges, in 1996 I was involved in launching the first degree course in homeopathy in Europe. Before the end of the decade the course transferred to the University of Westminster and I was employed as a senior lecturer. This course was followed by two other courses validated in universities and one externally validated undergraduate course. According to Winston (1999, p.412), by 1998 professional homeopaths outnumbered medical homeopaths.

The context for this activity was greater receptivity of the Government to the professionalisation of CAM and lobbying for publically funding CAM treatments, most notably by HRH Prince of Wales. Sharma and Cant (1996) observed competition between homeopathy organisations to act as the 'official' representative. The House of Lords report of the Select Committee on Science and Technology on Complementary and Alternative Medicine (2000) recommended a single professional register for homeopaths, but on a risk based assessment did not recommend statutory regulation at this stage. In response to this recommendation nine organisations formed the Council for Organisations Registering Homeopaths (1999-2007) working collaboratively towards agreeing a self-regulatory process for professional homeopaths.

The new millennium witnessed a gradual retrenchment of the profession. The numbers of students declined leading eventually to college closures. One of the most significant factors in closure of all university based undergraduate courses was the increase in fees for graduates studying again at undergraduate level which adversely affected mature students wishing to enter homeopathic practice. Universities have diversified into masters programmes (for example

the on-line programme at the University of Central Lancashire). The 2006 SoH membership survey gives some indication of the profile of professional homeopaths (Partington and Chatfield 2007). Analysis shows that professional homeopaths are predominantly female (81% of respondents) with homeopathy as a second career. Most of us work from home and patients arrive by personal recommendation. Financial returns are limited and practice is predominantly a part-time occupation. The returns indicate only a small proportion of homeopaths conduct 40 consultations per week. If we regard the survey findings as an accurate portrayal of professional homeopaths, the limited income from practice is concerning. This portrayal indicates a significant difference with medical homeopaths, who often continue to work in the NHS either as a GP or by gaining consultant status to work in one of the homeopathic hospitals. However medical homeopaths have been badly affected by this phase of retrenchment. Campaigns were mounted for and against renewal of local Primary Care Trust contracts for the five regional homeopathic hospitals. In 2007 Tunbridge Wells Homeopathic Hospital closed and facilities were reduced at the Royal London Homeopathic Hospital, which symbolically in 2010 was renamed as the Royal London Hospital for Integrated Medicine.

Progress towards a voluntary self-regulation procedure for all professional homeopaths has faltered. In spite of the efforts of the independent chair appointed in 2002, funded by the Foundation for Integrative Medicine (FIM), the Council for Organisations Registering Homeopaths failed to agree a collective process and collapsed in the face of funding difficulties (2007). In 2006 the Prince of Wales' Foundation for Integrated Health (formerly FIM) launched the Complementary and Natural Healthcare Council, with the aim to set up a federal register for voluntary, self-regulating CAM practices. During the consultation process, a survey of SoH members declined the invitation to join. announced its intention to prepare an application to the Health Professions Council (SoH, 2009) set up under the New Labour Government as part of a wider programme of regulatory reform in response to major medical regulatory failures, most notably the conviction in 2000 of GP Dr Harold Shipman for murdering his patients. It is ironic that after a ballot (SoH, 2010a) indicated that SoH members were now in favour of pursuing statutory regulation, any opportunity was being closed off. To protect consumer choice following the European Union directive banning access to many herbal products in May 2011, the coalition Government announced its intention to enact enabling legislation for the statutory regulation of herbal medicine through the Health Professions Council (SoH, 2011) and that no further applications would be considered. This puts the onus back on homeopaths to collectively agree a voluntary self-regulation process, with the Council for Healthcare Regulatory Excellence having a remit for "setting standards against which the governance, procedures, registration criteria and performance of voluntary registers can be judged" (SoH, 2011, p.29).

A recent attempt to strengthen and unify the profession is the formation (October 2010) of an international campaigning body 'One Vision, One Voice' which brings together the main organisations representing medical and professional homeopaths (SoH, FoH, Alliance of Registered Homeopaths, British Homeopathic Association, Homeopathy Action Trust,

Homeopathic Medical Association and League of Friends). The aim is to promote homeopathy in the media.

This section sketched out the rather tortuous path of working towards a self-regulating and accountable profession. In the Dialogue on Single Remedy chapter 11 we explore further issues of collective identity as a profession.

4.7 Introduction to homeopathic knowledge

Homeopathic practice is founded on empirical observation and experimentation, and has its own established research traditions. It was initiated in the context of European Enlightenment view that knowledge comes from observation guided by reason. Provings represent an empirical and experimental innovation that distinguish homeopathy from contemporary medical practices. Hahnemann arrived at *similia similibus curentur*, through self-experimenting with ingesting repeated doses of *Cinchona* (the source of quinine) in 1796.

Homeopathic treatment is popular across the world, in particular Germany, France and India. This inquiry is culturally specific to professional homeopathy in the UK. Whilst homeopathy is a discrete modality, practises and discourses are influenced by the historical, political and cultural context. ‘Homeopathy’ is a broad term that slips between a number of applications: - as a therapeutic system, as remedies, as philosophical principles and as treatment by a homeopath. The looseness of the term is generally clarified by the context in which it is being used, however this ambiguity creates difficulties in debates around effectiveness and efficacy:

“Conclusions drawn from research on one aspect of homeopathy (e.g., homeopathic medicines) are often applied to another meaning of the term (e.g., the therapeutic system of homeopathy). This confounding of meaning is most obvious in systematic reviews of ‘homeopathy’, and reviews of systematic reviews of ‘homoeopathy’.” (Relton et al., 2008, p.153)

Homeopathic knowledge is divided into three areas of study: philosophy (understanding health, illness and recovery), *materia medica* (knowledge of therapeutic agents) and practice (application). Homeopathy has its own theories of pathology (miasms). With its history dominated by medical doctors in the UK, homeopathy discourse has incorporated changing biomedical ways of knowing but culturally has largely been self-generating and retained its own distinctive identity. Biomedical understanding of pathology and differential diagnosis is perceived to be an essential part of professional knowledge. Homeopaths are either previously medically trained or are taught by medical doctors either from a biomedical viewpoint or biomedical knowledge integrated into a more homeopathic approach (Ball, 1987).

Theory plays a dominant role in professional knowledge and this continues to be informed by two key philosophical texts (Hahnemann, 1987, 1st published 1921, 1988, 1st publication 1828). For this reason the thesis is organised around the homeopathic principles. Each principle is a discrete procedure in its own right, but only gains therapeutic meaning in the context of the whole philosophical framework. A brief résumé is set out below for readers unfamiliar with the

philosophy. Epistemology and ontology are considered in the Philosophical Framing chapter 5 and a glossary of terms appears after the appendices.

Vital force This encapsulates a view of health and illness founded on the observation that life cannot be adequately explained by mechanism alone, but characterised by an internal self-regulating, subtle capability. This is shared with a range of therapeutic approaches across the world, each using its own individual approach to harness the potential to self-recovery. Symptoms are regarded as indications rather than the cause of disturbance of health.

Similimum The therapeutic system is based on the observation that there is a relationship of similitude to what a substance can cause and its sphere of therapeutic effect. Treating with similars is considered to have been first articulated by Hippocrates and used throughout history, but Hahnemann is regarded as responsible for empirically testing (first reported 1796) this and proposing the ‘law of similars’ as a generalisable therapeutic phenomenon.

Single remedy Prescribing one remedy at a time, by selecting the remedy that most closely matches the symptoms of the patient.

Potentisation The process by which a remedy is prepared using serial dilution and succussion. Commencing with one drop of the original source, for example juice from macerated root of a plant in an alcohol solution (mother tincture), added to 99 parts of a water alcohol mix. The dilution is then shaken. The therapeutic system is based on the notion that this procedure prepares the substance to be reactive to the patient’s vitality. The potentised remedy is also known as the minimum dose, the least necessary to stimulate a healing response.

Susceptibility We have to be susceptible, before we can become ill. Using the example of susceptibility to influenza, why do some individuals not develop symptoms even though they have been exposed to other people who were infectious? The state prior to the manifestation of symptoms is considered to be the site of intervention in treatment. Susceptibility to illness and recovery is perceived to be integral to the individual’s constitution.

Provings The symptoms that a substance can produce must be ascertained precisely to be able to use this substance therapeutically. Innovative systematic protocol for testing highly diluted substances were first devised by Hahnemann and since 1834 have incorporated the use of placebo controls (Dean, 2001). Designs are developing in line with methodological and ethical standards of clinical trials.

Heredity (known as miasmatic theory) This is a theory of causation and treatment of long term illnesses. Inherited and acquired tendencies influence an individual’s susceptibility to different illnesses. Pathological tendencies are categorised into processes of under function, over function and destruction.

Direction of cure Criteria are used to interpret changes, including improvement of recent symptoms and well-being and possible temporary return of previous symptoms. The term ‘unravelling’ or ‘unfolding’ is often used to convey an understanding of improving levels of health expressed through shifting patterns of symptoms.

4.8 Who consults homeopaths? Problems of terminology

To give you some idea of the usage of homoeopathic remedies in the UK and beyond, I turn to statistics. A survey (Thomas and Coleman, 2004) indicated that in a 12 month period it was estimated that 2% of the population consulted a homeopath, and the annual expenditure on homeopathy was over £30 million (out of pocket) and £3 million (NHS). In the UK the market for homeopathy is recorded as increasing by about 20% annually and projected to reach £46 million in 2012 (Mintel, 2007). It was reported to the House of Commons Science and Technology Select Committee that an estimated 10% of the UK population, or 6 million people, now use homeopathy (Woods, 2010). FoH state that 55,000 patients are treated in NHS homeopathic hospitals annually (FoH, 2010). The European Central Council of Homeopaths (ECCCH, 2011) estimate that 29% of EU citizens use homeopathy. In India, where homeopathy is readily available in primary care, 100 million depend solely on homeopathy for all their medical care (Prasad, 2007).

I face a dilemma about how to refer to those who consult homeopaths. This dilemma is not just a matter of terminology but has significance for framing the therapeutic relationship. The term 'patients' is the common parlance of homeopaths but I find the connotations of passivity and compliance counter to what I perceive as the participatory and more egalitarian nature of the homeopathic treatment process. 'Patient' draws on the traditional power imbalance between doctor and patient, and medicalises the encounter. Many people consult homeopaths regarding life issues rather than illnesses, for example coping with bereavement, divorce or emotional upset. What alternative terms could I use? 'Consumer' suggests a sense of control, able to make choices about what service to buy and from whom in the healthcare market. The term 'consumer' like the term 'user' places emphasis on ingesting the remedy and obscures participation in treatment. Borrowing from the terminology of counselling and psychotherapy, 'client' could be more acceptable but does not seem acceptable. Having found all other options wanting, I return to the term 'patient'. I have used this term since entering homeopathy and it is such an established part of homeopathy discourse, that it would seem inappropriate to use another term. However taking a reflexive stance generates interesting insights.

Using a biomedical term emphasises that for most of its history, homeopathy has been practised by medical doctors. On the emergence of professional homeopaths in the mid-1970s, it is interesting that the term 'patient' was adopted, whilst in many ways the meaning and context of practice was quite different. This suggests that professional homeopaths continue to perceive their identity and role within a fairly formal medical context, whilst operating on the margins of healthcare. From the perspective of narrative analysis, illness experience is dominated by the doctor's explanation of illness or medical narrative (Frank, 1995). The power of this narrative is enacted through the performance and rituals of the consultation and medical tests. Central to this narrative, is "narrative surrender" (Frank, 1995), that in seeking medical treatment, you consent to follow the doctor's instructions and to tell your story in medical terms.

Frank argues that being able to tell the story of your illness experience, without reference to the medical narrative, represents a crossing from modernist to postmodern experience. The language of homeopathy is shaped by 19th century medical discourse but foregrounds the patient's personal experiences. The patient is encouraged to tell their story in their own words, to reflect on the meaning of their feelings and experiences in the context of their daily lives. I perceive the meanings attached to the term 'patient' perpetuate the dominance of doctors in homeopathy discourse, and is indicative of contradictions in the identity of professional homeopaths.

4.9 Developing CAM research culture

In the UK CAM research has been gradually taking shape as a new arena of academic study emerged in the 1990s but largely operating without a funded institutional base. A new profile academic emerged with CAM practitioner-teachers in the post-1992 universities, whose expertise resided less in their academic and research profile than with their professional experience. Locating CAM practices within Higher Education has been contested as lacking academic rigor and scientific validity (Singh and Ernst, 2008). Research capacity building in CAM within Higher Education has been supported by a three year Department of Health initiative (awards made in 2003, 2004 and 2005). Academic inquiry into CAM practices is not restricted to dedicated university departments, but increasingly CAM is regarded as a legitimate field of academic inquiry within established departments of health, nursing, sociology and psychology. The field is diverse with the nature and role of research defined by the academic context or CAM modality. As a practitioner my interests are in contesting the imposition of biomedical research designs and in adapting research technologies that are congruent with and inform daily practice

Significantly it has taken authority figures from outside the medical profession to bring stakeholders into dialogue and consensus building. Integrated Healthcare: A way forward for the next five years? A discussion document (FIM, 1997) was the culmination of a series of working groups set up on the initiative of HRH Prince of Wales. The aims of the discussion document was to encourage greater research awareness and skills among the CAM professions, utilise a wider range of both quantitative and qualitative research methods, make funding available for CAM research and improve communication with the gatekeepers to NHS resources. The charity Foundation for Integrated Medicine with HRH Prince of Wales as president (re-launched as The Prince's Foundation for Integrated Health in 2002 and closed 2008) was set up to promote the development and integrated delivery of safe, effective and efficient forms of healthcare through encouraging greater collaboration between all forms of healthcare.

The UK Government set up an inquiry into CAM's regulatory structures, evidence base, information resources, training and potential NHS provision. Over 15 months, the inquiry received more than 180 written submissions and took evidence from 46 different bodies. The

House of Lords Select Committee on Science and Technology report on CAM (2000) represented a significant landmark in CAM research and has continued to act as a point of reference in debates on CAM regulation. In an attempt to differentiate between CAM therapies, three broad groupings were identified. Homeopathy was categorised in Group One, alongside osteopathy, chiropractic, acupuncture and herbal medicine. Group One was defined as professionally organised disciplines with their own diagnostic approach, with some scientific evidence of effectiveness and recognised systems of training.

The report highlighted the paucity of 'high quality' CAM research and cited commonly given reasons for this including lack of research training for CAM practitioners, inadequate funding, poor research infrastructure and methodological issues. The report reinforces the importance of large scale randomised controlled trials (RCTs) to establish efficacy. The role of qualitative studies and the use of patient satisfaction in evaluating treatment was recognised. The report argued that the controversy over the underlying mode of action in homeopathy, should not inhibit the principle of clinical freedom, especially, where a treatment has few, if any, adverse effects. A lasting contribution to develop CAM research was the call for Government backing to make funds available for CAM research and the dissemination of research and research skills from academic centres. This is seen as the first step in enabling CAM to build up an evidence base with the same rigor as that required of conventional medicine.

These recommendations became reality when in 2003 the Department of Health announced a research capacity building initiative over three years. Each year, through a bidding process, five Higher Education institutions could host CAM research projects. This had a direct impact in homeopathy with projects funded at the University of Sheffield for RCT design under the direction of Elaine Weatherley-Jones and Brunel University for an ethnographic study under the direction of Christine Barry (both of whom are referenced in this thesis). Unfortunately the whole initiative was cut before reaching completion, possibly indicating a lack of political commitment to CAM.

Another landmark in developing CAM research culture was the two day seminar 'Assessing Complementary Practice: Building consensus on appropriate research methods', jointly hosted by the King's Fund and The Prince's Foundation for Integrated Health in October 2007. This event brought together leading figures in biomedical and CAM research, including the Chairman of the National Institute for Health and Clinical Excellence. As a participant I gained a sense of an intention to move the debate forward into action. The most significant discussions began to unpack how clinical research is shaped by reliance on funding from pharmaceutical corporations. Whilst it is impossible to reduce the event to a series of outcomes, I came away with a sense that CAM researchers articulated a distinctive approach to research congruent with CAM practices, and that representatives of institutionalised biomedical power were beginning to recognise that it is not always appropriate to demand that biomedical research methods are applied to CAM.

4.10 Introduction to homeopathy research

Informed by the prevailing dominant EBM discourse (discussed later in this chapter), you may be expecting a critical review of meta-analyses and individual high quality RCTs. Whilst interpretations drawn from key meta-analyses (see below) inform our discussion, this expectation misses the point of the inquiry. Homeopathy research discourse mirrors the evidence based hierarchy by according priority to debates over demonstrating efficacy in meta-analyses and improving the design of clinical trials. Clinical trials are in the foreground of homeopathy research discourse, but do not contribute significantly to advancing understanding of application, effectiveness nor safety of specific remedies. It is tempting to use veterinary studies and cost effectiveness studies to support the use of homeopathic treatment and this would not do justice to complex fields of research.

The relations between research, practice and pharmacies are radically different from those of biomedicine. RCTs are the dominant model in biomedical research, extending influence far beyond their purpose of testing efficacy of new pharmaceutical products. Clinical trial design has evolved to eliminate selection bias amongst trial participants (randomisation) and to reduce the risk of interpretation of outcomes being influenced by known and unknown factors (controlled). The authority of the clinical trial in homeopathy is linked to the erroneous assumption that homeopathic treatment is a pharmaceutical based intervention in physiological terms. The RCT design became established in medical research in the 1950s, and functions in a historically specific relationship between pharmaceutical companies and the medical profession. This orientation in clinical research is a function of the dominance of pharmaceutical based interventions in biomedical practice. Clinical research is not patient or practitioner led, but arguably driven by the financial imperatives of the multi-national pharmaceutical corporations.

The context of homeopathy research is quite different with provings as the most active area of ongoing research within the profession. Provings, not clinical trials, play a key role in advancing and expanding understanding of the pharmacopeia, including the introduction of new remedies. In the UK, homeopathic pharmacies are relatively small businesses. They contribute to clinical trials by dispensing placebo-controlled prescriptions, and to provings of new remedies by sourcing, preparing and dispensing. Provings follow an established rigorous and systematic protocol to explore the therapeutic potential of the substance and verified through clinical use (for fuller explanation see Dialogue on Provings chapter 14). This represents a long tradition of underpinning clinical practice with research. Developing the pharmacopeia is a gradual and practice based approach. Data derived from individual homeopath's clinical experience of using the new remedy is eventually incorporated in the synthetic repertories and communicated via case studies in professional journals, conference papers and books. Provings and case reports are the focus for research activity by professional homeopaths. The pharmacy is located as a service provider, rather than in a position to fund or to capitalise upon clinical trials and provings. Whilst the new remedy is added to their catalogue of over three thousand remedies, it will take a number of years for more and more practitioners to prescribe the newly proved

remedy. So the pharmacy's contribution to the proving is a long term investment, enhancing their profile in the profession rather than augmenting sales.

Homeopathy research discourse is dominated by medical homeopaths who conduct most of the published research. A UK research culture has been developed at the NHS homeopathic hospitals in Bristol, Glasgow and London, informed by research conducted by European medical homeopaths (mainly Germany and Italy) and to a lesser extent South America and India. The discourse is shaped by medical homeopaths negotiating their position across two divergent paradigms. In the 21st century professional homeopaths have become more research active. This development has been stimulated by university based homeopathy courses in particular an 'e-learning' MSc (University of Central Lancashire opened 2006). The Department of Health research capacity building initiative has generated research by a professional homeopath into the use of pragmatic RCT designs in homeopathy (Relton et al., 2010). Collegiate support is available for homeopaths active in research from the European Network of Homeopathy Researchers (ENHR) as an open membership group, established in 2004 with support from the European Council for Classical Homeopathy (ECCH). In the aftermath of the letter from eminent medics and scientists in *The Times* demanding withdrawal of NHS funding for homeopathic and other CAM treatments (Baum et al., 2006), research links have been forged between professional and medical homeopaths. The Homeopathy Research Institute (HRI, 2011) was set up by a professional homeopath in 2007 to promote and facilitate high quality scientific research. HRI has gained the support of a number of research active medical homeopaths and time will tell if this initiative is successful in the generation of a shared research culture or whether a few professional homeopaths will become accepted into the medical homeopaths' research community.

There are somewhat isolated pockets of qualitative research in homeopathy in universities, for example in centres of complementary medicine (for example University of Westminster, Southampton University, University of Central Lancashire), medical sociology (for example Birmingham University) and ethnography (Brunel University). In addition to provings, professional homeopaths have been using a clinical outcome instrument designed and validated by GP Charlotte Paterson for weekly acupuncture treatments. Measure Your Own Medical Outcome Profile (MYMOP) (Paterson, 1996) is well suited to homeopathic practice with as it is patient reported, monitoring well-being and activities (considered in detail in Dialogue on Miasms chapter 15).

4.11 Reviewing the experimental evidence

I approach this review of key papers in the experimental evidence base of homeopathy mindful that the subjectivity of the reviewer cannot be excluded, even in the application of rigorous selection criteria in systematic reviews (Ezzo et al., 2001). I am situated as a practitioner, without expertise in this area, trying to make sense of a considerable volume of literature and to deconstruct a polarised debate. We are working within evidence based discourse to interpret

experimental evidence. This provides a backdrop for the analysis of homeopathy research discourse in this inquiry.

The RCT has been used quite extensively in homeopathy, indeed homeopaths can be considered as pioneers in the evolution of the clinical trial design with the first trial employing a placebo arm dating back to 1829 in the Ukraine (Dean, 2004). However most published trials do not involve in depth consultations and individualised prescriptions. Many trials test one remedy administered to all participants in the verum arm, complex remedies (combinations of a number of remedies), isopathic remedies (potentised allergens and disease products) or the nature of intervention is not specified. Publication of trials and meta-analyses are often reported in the national press. This publicity tends to extrapolate findings far beyond the generalisability of the results (Goldacre, 2007) and the specificity of the findings become subsumed into questioning the efficacy of treatment in general, and demanding that homeopaths 'prove it works'.

A landmark series of replicated multi-centre studies tested the hypothesis that homeopathy is no more effective than placebo (Reilly and Taylor, 1985, Reilly et al., 1986, Reilly et al., 1994). As in so many RCTs, the protocol used isopathic prescriptions of individualised potentised allergens. With the exception of the subjective measure in the fourth trial (Taylor et al 2000), the meta-analysis indicated that 'the subjective and objective results show a trend across these four trials clearly pointing to homeopathy being different from placebo' (2000, p.475). In common with many trials, these studies were underpowered, however this did not prevent The Guardian newspaper (19 August 2000) running the headline 'Homoeopathic remedies really do work, doctors told'. The editorial describes homeopathy as 'nonsense' but advocates availability on the NHS on the grounds that it can do no harm, it is cheap and patients have the right to choose.

The NHS Centre for Reviews and Dissemination Bulletin evaluation of published systematic reviews and additional RCTs published 1995 to 2001(2002) offers an interpretation of the evidence that still has currency ten years later:

"The evidence base for homeopathy needs to be interpreted with caution. Many of the areas that have been researched are not representative of the conditions that homoeopathic practitioners usually treat. Additionally, all conclusions about effectiveness should be considered together with the methodological problems of the research" (NHS Centre for Reviews & Dissemination, 2002)

An extensive systematic review conducted by a professional homeopath analysed 205 prospective controlled clinical trials published since 1940 (Dean, 2004). Dean's review offers evidence of safety, specific and global efficacy in trials of high internal validity. Four large published meta-analyses occupy a significant place in research discourse:

- A criteria based review of 105 trials (Kleijnen et al., 1991) found positive but inconclusive evidence of clinical effect.

- The updated meta-analysis of 89 trials (reviewed 186 trials) (Linde et al., 1997) concluded that the difference with placebo was significant and that significance proved to be robust in sensitivity analysis that included correction for publication bias.
- An analysis of 184 trials (Cucherat et al., 2000) concluded that the quality of trials is low but that difference with placebo is statistically significant on the 17 ‘best’ trials.
- Comparison of eight trials with six matched biomedical trials (Shang et al., 2005) (reviewed 110 homeopathy trials and 110 matched biomedical trials matched for disorder and type of outcome) found homeopathy no better than placebo.

Publication of the Shang meta-analysis was heralded by *The Lancet* editorial as “The end of homeopathy” and this editorial was picked up by the national newspapers. The review generated considerable criticism for its lack of adherence to reporting guidelines, lack of transparency, methodological flaws and that the conclusions were dependent on the selection of trials analysed (Frass et al., 2006, Rutten and Ludtke, 2008). As the publicity is more significant than this meta-analysis itself, we take the opportunity to deconstruct extracts in Dialogue on Vital force chapter 9.

Throughout the period of this inquiry, issues of evidence, effectiveness and professional credibility of homeopaths has been fought out in the public arena. Homeopaths’ websites (Burchill, 2011) and university courses (Giles, 2007) have become targets for criticism. What we regard as evidence and how this is interpreted is central to this controversy. This is illustrated by the Parliamentary Evidence Check (Science & Technology Select Committee, 2010). The report concluded that:

“There has been enough testing of homeopathy and plenty of evidence showing that it is not efficacious” (paragraph 77)

Recommendations to cease NHS and research funding were rejected by the Government. The Committee was criticised for lack of balance by taking evidence from well known critics of homeopathy, no patients and only one homeopath. Arguably it is the lack of an ‘accepted’ mode of action of high dilutions that obstructs a fair evaluation of homeopathic treatment. I consider discourses around clinical trials in chapters 10 and 11.

4.12 Reviewing observational studies

Long term observational studies offer a more naturalistic view of daily practice, but cannot reach conclusions about the cause of any perceived therapeutic effect. Observational studies can review patient satisfaction, address safety issues and inform future studies. Let us look at the two large studies of homeopathic treatment.

A study of consecutive patients (total 6544) at the outpatient unit of Bristol Homeopathic Hospital (Spence, 2005). It is long term, sufficiently powered and features clinical conditions frequently encountered in practice. Referred by GPs, patients presented mainly with chronic

conditions that may not have responded to conventional treatment or the conventional treatment offered was unacceptable to the patient. Outcomes were scored on a seven-point Likert-type scale at the end of the consultation and were assessed as overall outcomes as compared to the initial baseline assessments. The findings suggest that 70% of patients reported positive health changes, with 50% recording their improvement as better or much better. These percentages are particularly impressive given the illness profile. A multi-centre (103 homeopathic practices in Germany and Switzerland) observational study (Witt et al., 2008) of consecutive patients (total 3,709) presented data of an eight year follow-up. The results are comparable to the Bristol Homeopathic Hospital study, with a significant decrease in disease severity and improved quality of life scores. In both studies, comparison is prohibited by the absence of a non-intervention control group.

It is tempting to regard these results as evidence of a specific clinical effect of treatment. In biomedicine, RCTs have overturned the results of observational trials (Vandenbrouke, 2004). Without randomisation and uncontrolled, observational studies cannot test cause and effect, and are open to confounding factors and biases. For example age or socio-economic status may be distributed unevenly across study groups. Whilst design could ensure population characteristics are the same for all groups, a more effective approach is random allocation, which is only possible in an experimental study. There are many possible explanations for clinical conditions apparently improving over time. These include the natural history of the condition whereby many chronic conditions seem to get worse, then improve before relapsing again. We often seek medical aid after the condition has peaked and when we begin treatment, the condition is beginning to improve unaided. Regression to mean is a group phenomenon that can occur when a group of people are measured with an inexact measuring tool, and then later re-measured. Those patients with extreme values will have a high probability of regressing towards the mean of the second measurement. Other causes of improvement include contextual factors, concomitant treatment, and the Hawthorne effect. An observational study may inform the future development of an RCT and address safety issues.

4.13 Evidence based rhetoric

Evidence based medicine (EBM) is a powerful discourse that now not only dominates discourse of health research, but also CAM practices. In homeopathy the evidence based rhetoric has marginalised other ways of researching that recognise what is important to that therapy. Recommendations of the report of the Select Committee on CAM (House of Lords, 2000), accepted by the UK Government, called for an evidence base for CAM with the ‘same rigor’ as that required of conventional medicine. Evidence based discourse defines what is acceptable research. Homeopaths have been drawn in to this approach, for example the 2006 European Council for Classical Homeopathy symposium “EBM: Defining the research agenda for homeopathy?” It would be contrary to the spirit of this inquiry to portray evidence based discourse as a unified grand narrative. I use the phrase ‘evidence based rhetoric’ to convey its

political nature and the persuasive dissemination of a set of ideas as neutral and value free. Arguably the original intentions (Sackett et al., 1997) have become distorted through the rhetoric, for example devaluing individual clinical expertise as a form of evidence informing clinical decision making (Malterud, 2002). Let us examine in some detail its origins and assumptions.

Evidence based discourse dictates that the most reliable form of evidence is that generated by meta-analyses and systematic reviews of RCTs. Systematic reviews offer an overview of clinical trials by following a formal method of systematically locating, appraising and synthesising the results from multiple RCTs. Meta-analyses go one step further by extracting the data from selected studies and re-analysing these data as a single study. Amalgamating data is problematic due to the potential heterogeneity of the trials, in crucial aspects such as populations, quality, interventions, clinicians' expertise, clinical relevance to contemporary practice, validity and reliability of outcome measures and the appropriateness of the follow-up period. The objective language of evidence based rhetoric obscures the role of subjective choice, judgement and interpretation in all forms of quantitative research. The rhetoric gives the illusion that all biomedical treatments are evidence based.

EBM employs the authority of 'science' to endorse empirical research derived evidence as the primary guide to clinical decision-making. In aiming to direct clinical decision-making through systematic and objective assessment of research, EBM displaces the skilled doctor to draw on their own experience. Controlled experimental scientific findings are prioritised over professional judgement and clinical expertise, all other sources of knowledge and understanding are devalued. EBM creates a hierarchy of evidence, with meta-analyses, systematic reviews and RCTs at the summit with case studies as the least influential. By stratifying research designs, the appropriateness of the question and the robustness is secondary, for example meta-analyses can be unreliable as statistical inferences can be drawn from heterogeneous data.

The movement for evidence based healthcare and clinical guidelines have come to dominate NHS policy (NHS Centre for Reviews & Dissemination, 1999). The all embracing rhetoric of EBM diverts attention from the many areas of biomedical practice that are not informed by research evidence, for example the multiple prescriptions used in primary care or blood transfusions. Miles and colleagues (2007) argue that EBM is politically more than clinically orientated. The ideology of market forces has had a major impact on how public expenditure in UK healthcare is managed. Notions of quality of care, effectiveness and efficiency are constructed through ideologies of market forces, technology and bureaucracy. Evidence based discourse is an integral feature of this environment. Professional practice has been reframed as 'delivery' of care according to targets, protocols and guidelines. Value is placed on what is measurable and testable in scientific terms. Delivery of care criteria has entered homeopathic practice through the imposition of National Occupation Standards for Homeopathy (Healthwork UK, 2000). This document reduced the complexities of individualised practice to a set of observable competencies, but has yet to be used as standards of care.

Behind the veneer of united support for EBM in biomedicine, there are dissenting voices and vociferous opponents. The rhetoric assumes that in practice EBM provides a higher quality of care, however there is 'no convincing direct evidence that shows that this assumption is correct' (Haynes, 2002) and critics assert that EBM has avoided testing its own hypothesis (Miles et al., 2007). Evidence based discourse has been criticised for its lack of examination of its theoretical underpinning. EBM was initiated as a 'new paradigm' in a paper entitled 'Evidence based medicine: A new approach to teaching the practice of Medicine' published in the Journal of the American Medical Association by a large group of almost exclusively North American senior physicians and academics (Evidence-Based Medicine Working Group, 1992). By deconstructing this founding text, Freshwater and Rolfe (2004) highlight the inherent contradictions, in both demanding scrutiny of evidence whilst presenting a ready-made 'paradigm' not open to peer review. The use of the term 'paradigm', alludes to Kuhn's notion of paradigm shift (Kuhn, 1970). According to Kuhn's criteria this is a very weak connection, as by its very nature it is premature to announce a new paradigm. Freshwater and Rolfe draw attention to the discourse's authoritative tone and appeal to collective action. Professional judgement is defined as a risk activity incurring possible personal liability where actions or professional judgement takes precedence over the research evidence. Miles and colleagues (2007) argue that:

"the real problem is the attempted imposition of a set of dogmas and practices upon a working population, in the absence of any demonstration of its benefits, the truth of its key claims nor even a detailed and consistent exposition of their meaning." (2007, p.482).

In response to the criticism that what counts as evidence is restricted to controlled experimental findings, the rhetoric shifted to call for a limited integration of different forms of knowledge. I quote a much cited source:

"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients...integrating individual clinical experience with the best available external evidence from systematic reviews" (Sackett et al., 1996, p.71)

Arguably this intention has never been realised (Tonelli and Callahan, 2001).

4.14 What are the problems with evidence based discourse?

This discourse is dismantled through the thesis (in particular see Dialogue on Single Remedy chapter 11). Questioning the relations between practice, research and evidence are integral to this inquiry. Talking about an evidence base in homeopathy implies that homeopaths can apply the public sector strategies to their independent practices. Let us briefly look at the assumptions of evidence based discourse that are discordant with treatment by a professional homeopath, an individual patient's interests are best served in healthcare when (adapted from Avis and Freshwater, 2006):

- emphasis is on what is measurable
- informed by population-based studies

- usefulness, reliability and validity of the evidence is determined by the type of research method employed
- study designs are objective and research findings can be interpreted in their own right, decontextualised from application in practice
- evidence is reliable and stable, and not subject to constant review and evaluation
- what is accepted as ‘evidence’ is scientifically sanctioned and this association with science implies efficacy
- only if there is no acceptable empirical research-derived evidence, then practice is based on supposition and conjecture
- experienced clinical judgement is inherently unreliable
- implementation of evidence into daily practice is a direct and unproblematic process.

Evidence based discourse anchors homeopathic practice within biomedical research and demands proof on its terms. The relations between homeopathy and biomedicine are not neutral but characterised by power inequalities. Evidence based rhetoric imposes the authority of biomedicine as arbitrator of the patient experience and takes no account of the different ways that people engage in individual treatments, their goals and expectations and reasons for continuing treatment.

Evidence based discourse orientates homeopathy research discourse to prioritise clinical trials and devalue other forms of non-experimental research. I question how published studies are interpreted (see Dialogue on Single Remedy chapter 11). Interpretation is not an objective exercise, our perception of empirical evidence is informed by our prior beliefs and understanding (Gadamer, 1979). How scientific evidence is evaluated is both subjective and political. Assessment of clinical trials are influenced by perceptions about the validity of competing scientific explanations of the activity of high dilutions. EBM is a social practice, with its own values, assumptions and practices.

4.15 Reflective pause before moving on to philosophical framing

You may be wondering how I engage in research in ways that are relevant to my practice and circumnavigates what I perceive to be an impasse created by evidence based discourse. I invite you to reflect with me on the perspective transformations (Mezirow, 1978) that occurred during the inquiry (for fuller context see 0). I take a postmodern stance to disrupt the privileged status of science and biomedicine, creating the potential to redefine concepts of evidence, effectiveness and therapeutic effects. I also embrace an extended epistemology (Reason, 1998) which values other forms of knowing including embodied, experiential, symbolic, intuitive and practical know-how. In the inquiry’s early stages I reconfigured research in terms of building ‘*practice based evidence*’ to bring practice into the foreground. By transposing the relationship between practice, research and evidence I intended to deconstruct evidence based discourse in homeopathy. I tried to reframe what is meant by evidence but soon realised that I was simply

creating competing classifications of evidence. So I shifted my attention to learning from practice, facilitated by changing the focus to '*practice based inquiry*'. I had however, overlooked the site and focus of the research which was the homeopath. Once I recognised this, a final shift was accomplished to adopt the term '*practitioner based inquiry*' (Lees and Freshwater, 2008). The term guides me to reflect upon my subjectivity as practitioner researcher as an iterative and critical discourse. The framing of the inquiry evolves through the inquiry itself:

"it is transient and dynamic, it is moveable, changing, and fluid, and perceives data as a series of moments, fragments knitted together through narrative time and space." (Freshwater, 2008, p.225)

I am not promoting practitioner based inquiry as a mandate for homeopathy research, but at this moment, it provides a vehicle to give voice to practitioner experience and to explore a more homeopathic approach to research that may offer insights that could potentially strengthen and enhance the autonomy of the discourse.

I feel confident that we are actively involved in the research process now, discovering fresh perspectives and testing out new theories. The chapter's narrative took a number of very personal turns. Rather unexpectedly I explored my vision for integrated healthcare and offered personal perspectives on the profession and biomedicine. I hope this has stirred your thoughts, may be you perceive parallels in your own work or perhaps you disagree. What is most significant here is that you are beginning to engage and to have gained some sense of the values and assumptions of the researcher. Now prepare yourself for the more theoretical features of the inquiry process in the following chapters.

5 PHILOSOPHICAL FRAMING

5.1 Introduction

This chapter explores the theoretical perspectives that inform this inquiry: homoopathy, feminism, pragmatism, hermeneutics, and postmodern perspectives. The philosophical framing did not pre-exist the inquiry, rather it was generated concurrently through the research process, and particular philosophical perspectives came to the fore as they appeared to inform aspects of the inquiry.

5.2 Homeopathic philosophy

As the thesis is organised around the therapeutic framework, this section does not consider philosophy in any depth. Indeed the thesis is not a scholarly philosophical treatise and to some readers this may appear superficial as I do not engage with competing translations, interpretations and contributions. I try to critically appraise the epistemology and offer personal perspectives on my own interactions in homeopathy discourse. I inquire at the experiential interface of theory informing practice. I describe this as engaging with the therapeutic framework. As distinctions between the terms used in homeopathy discourse are not clearly defined (Winston, 2001), I clarify the terminology:- philosophy refers to the intellectual endeavour to gain knowledge, theory refers to the system of general ideas, principles as fundamental tenets of knowledge and homeopathic methodology refers to a particular approach to prescribing.

Homeopathy discourse defines itself in terms of its historical origins and reifies Hahnemann as an innovator ahead of his time. His treatise The Organon of Medicine (six editions, 1810 -1842, the latter published posthumously in 1921) continues to be considered as the foundation text, with one hundred and ten different editions published in eighteen countries (Winston, 2001, p.2). This text is a complete guide to practice including preparing and testing remedies, taking the case, case management, communicating with patients, adjunctive therapies and understanding health and illness. The Organon is presented as a series of aphorisms in the contemporary German academic tradition, making a rhetorical claim to the authority of Ancient Greek medical texts. Hahnemann's voluminous textual legacy including books, published articles, and tracts can be considered as emerging in response to a perceived gap between 18th century medical practices and European Enlightenment ideas of experimentation and observation. His texts are written in opposition to what he perceived to be errant medical theories. The Organon can be regarded as scientific inquiry into medicine, with detailed experimental protocols, rigorous questioning and meticulous observations. Hahnemann's texts are informed by an extensive knowledge of medical texts in a number of languages. He challenges the reader to reject contemporary medical dogmas and to embrace a radical therapeutic approach. Any sense of a coherent set of concepts is illusory. Hahnemann's textual legacy is characterised by re-writings and re-workings. Doctrinal disputes are fuelled by the

difficulties in negotiating the inconsistencies in Hahnemann's oeuvre. Caution must be taken not to elide his writings with his practice. Studies of his later clinical records suggest that his practice did not accord with his later theoretical writing (Handley, 1997). To reflect its fundamental role in homeopathy discourse, I write the name 'The Organon' into sentences, often with numbered aphorisms (from the 6th and final edition). There is a sense that in discourse this text takes on a persona of its own.

Hahnemann's legacy of a coherent theoretical and methodological basis for practice is the core narrative and common language of homeopaths. In homeopathy discourse Hahnemann's texts occupy doctrinal status, and unlike many other forms of CAM, homeopaths inherited a voluminous textual legacy including books, published articles, tracts and case notes. There is a strong pluralistic tendency as individuals or schools of homeopaths promote their own methodological approaches, rising and falling in popularity on the international conference circuit, for example Vithoulkas, Scholten, Eizayaga, Herscu and Seghal. It is also important to draw attention to homeopathy as a living philosophy with renewed relevance in different cultural milieu. My early encounters resonate with other newcomers (Fordham, 1998) in finding homeopathic perspectives on health and healthcare as making sense and connecting with my own core narrative. Homeopathy discourse shares common values with current health and lifestyle discourses and is amenable to be appropriated in recreating individualised illness and recovery narratives, particularly in a postmodern context (discussed later in this chapter). This phenomenon is perceived to be part of the popularity of CAM (Siahpush, 2000). The Organon's emphasis on adapting treatment to the individual is an innovative contribution (Dean, 2001). Adaptation is a central to conceptualising health as being in a state of flux and ill-health arising when we are unable to adapt to our circumstances.

Coulter's scholarly five volumes of The Divided Legacy (Coulter, 1973, 1975, 1977, 1982, 1994) has become adopted as an 'official' history of professional homeopathy. Coulter offers a history of medicine that is polarised between rationalism and empiricism and between mechanical and vitalist approaches (see Dialogue on Vital Force chapter 9). Dean sums up Coulter's rhetorical stance as 'homeopathy is empiricism's final answer to 1500 years of Galenic rationalism' (Dean, 2001, p25). As a homeopathy student I struggled to understand the polarisation of empiricist and rationalist epistemologies. How could Hahnemann be emulated by Coulter as an empiricist when he articulated a rational foundation for practice? Use of the title The Organon is borrowed from Aristotle's six logical treatise and Bacon's (1561-1626) presentation of principles of inductive logic (Winston, 2001, p.2). This antecedence is reinforced by the title of first edition, The Organon of Rational Healing (1810). The second edition the title was changed to The Organon of Medical Art (1819) (Winston, 2001). Dean unravels this conundrum by suggesting that Hahnemann used

"the rhetorical structures of German academic medicine, while advancing an approach to healing fundamentally opposed to rationalist assumptions"
(Dean, 2001, p.19).

that appeared to gravitate more towards French ideas on the role of observation in medicine Dean reconciles Coulter's rationalist and empiricist divide by arguing that:

"Hahnemann favoured the biographical natural-history-of-disease approach to the empirical school, exemplified by Hippocrates and Sydenham, over the ontological claim of rationalists such as Galen and Brown to know the essential nature of disease". (2001, p.25)

With its history dominated by medical doctors, homeopathy discourse has incorporated changing biomedical ways of knowing, but culturally has largely been self-generating outside of dominant institutional structures and retained its own identity. The fundamental principles of practice, perceived to be a coherent body of knowledge, have remained fairly constant for the last two hundred years. Therapeutic and philosophy texts reinterpreting these principles in new contexts continue to play a prominent role in homeopaths' education. The classic literature is from 19th and early 20th century North American texts (Roberts, 1985, 1st published 1936, Kent, 1987, 1st published 1900, Close, 1993, 1st published 1924). This tradition has been continued into the present, for example the popularity of the Sensation methods (Sankaran, 2007) (see Glossary). This is akin to how the ancient texts of Chinese Medicine function in acupuncture practice, but is a distinctly different culture to that of biomedicine and antithetical to the modernist doctrines of progress and scientific innovation. Seminal texts are regarded as vehicles for the celebrated homeopath to speak for themselves. Critical analysis of textual sources is not a well developed aspect of publications in English, with notable exceptions (Handley, 1997, Dean, 2001), but is better represented in German. This absence is evident in how classical homeopathy is defined as an approach to practice, including mine own, without differentiating between Hahnemann's and Kent's contributions, or acknowledging inconsistencies in Hahnemann's texts.

To understand the significance of using homeopathic principles to structure this thesis, I must explain how lines of tradition function in homeopathy discourse. Engagement in practice is shaped by significant teachers in the formative years of study. From reading Autobiography of the Inquiry chapter 2 you may have detected ambivalence about the way that education in homeopathy is organised. Later I critique what I perceive to be the venerated status of charismatic male teachers (see 9.3.2). Of course I am also subject to this discourse. One of the strongest influences on my practice has been the teachings of Sheila Creasy, who brings over fifty years of in depth study of homeopathic philosophy into her practice (Creasy, 2007). These teachings are mainly conveyed orally, in colleges, post-graduate workshops and personal communication. In this context, philosophy specifically refers to the heritage of 19th and early 20th century literature. Do not be mistaken into thinking that this is an uncritical acceptance of dogma, rather I am drawn to her critical and analytical approach, informed by over fifty years of clinical experience. However it is helpful to be reminded (Fordham, 1998) of the dangers of an uncritical acceptance of homeopathic principles that perpetuate an idealised view of practice, where clinical decisions are perceived as applying a set of 'rules' and response to treatment can be predicted. To examine homeopathy discourse further, I look to parallels in another culture. In Buddhism the authenticity of a teacher is premised upon their position in the lineage of

distinguished teachers. Like in homeopathy, this conveys a sense of returning to the perceived purity of the original teaching and the study of the old ‘masters’. Only when you have satisfied yourself of the truths, can you begin to practise. As in Buddhism there are different ‘orders’ and these are influenced by different cultural origins. The different methodological approaches or schools in homeopathy (for example classical, practical, Sehgal’s, Scholten’s) are shaped by their cultural contexts, for example Sankaran’s Sensation methods by Indian Hinduism. Creasy’s articulation of the key philosophical tenets as principles of practice (Creasy, 1998) played a formative role in my education and provided an appropriate framework for this thesis.

5.3 Feminist critiques

You may have already identified a feminist critique running between the lines of this inquiry. Formative experiences of challenging normative values around notions of femininity led me to question other cultural assumptions. I recognise feminist perspectives are pluralistic and inconsistent. My formative experiences of CAM were shaped by involvement in feminist self-help health campaigns (Autobiography of the Inquiry chapter 2). I engage with homeopathy as a means of promoting self-autonomy both personally and as framing the therapeutic relationship. Scott makes the case for homeopathy as a ‘feminist form of medicine’ that ‘integrates personal, social and political change’ (Scott, 1998, p197). This causes me to reflect on the degree to which I experience convergence between professional practice and feminist politics. Women have been involved since Hahnemann’s second wife Melanie, became the first non-medically qualified homeopath. Women doctors made important contributions as practitioners and teachers, particularly in 19th century North America and the first half of the 20th century in the UK. Homeopathy has been colonised by women, numerically dominating as practitioners, patients and home users. Women’s home use of homeopathic remedies was encouraged from the 19th century onwards in the UK and USA through the proliferation of self-help manuals (Taylor Kirschmann, 1997). With this profile the profession should be female orientated, but like other professions, our histories continue to be narrated through a series of great men.

As a feminist critique is so much part of my taken for granted perceptions I do not make specific reference to texts. I find fresh inspiration in how performance artist Susan Hiller articulates feminist resistance to cultural assumptions. To emphasise Hiller’s feminist politics I use her first name in the thesis. I am inconsistent as this thesis features the work of many male academics and writers, and far fewer women. I had intended to make this visible by using first names when referring to authors, but this became unworkable as the first name was not always available. There are a number of male philosophers whose work has been particularly influential who I locate by using full name and dates.

5.4 Pragmatism

Reflecting on my position as a practitioner researcher, I recognise a pragmatic orientation. In the pragmatic philosophical tradition, attempts to represent reality are rejected and meanings are determined by what is useful, workable and practical. Pragmatism prioritises meaningfulness of knowledge when coupled with action and practical application.

A tradition of anti-intellectualism and concern to serve a useful purpose in social action is embedded in reflective practice as Schön was a student of the North American pragmatist John Dewey (1859-1952) (Bleakley, 1999). Dewey, active in education and politics articulated pragmatism as building upon experimental science. The value of an inquiry is determined by the sharing of evidence within a community of inquirers. Only the most useful truths will be retained. Dewey's ideas resonate with practitioner research, in particular with the action research methods employed in the early stages of this inquiry. Links between action research and pragmatism (Reason, 2003a) is explored in the next chapter. Dewey's name is linked with two North American contemporaries, Charles Sanders Peirce and William James, whose works have been collectively identified as pragmatism but cannot be considered as a self-defined movement (Freshwater, 2008). Delving into the revival of pragmatic philosophy in the work of philosophers Donald Davidson (living) and Richard Rorty (1931-2007) is beyond the scope of this inquiry. I look to others (Reason, 2003a, Baert, 2005, Avis and Freshwater, 2006) to interpret contemporary readings of pragmatism in the context of social research.

Pragmatic perspectives shape this inquiry and this is evident from the first paragraph of the Introduction:

This inquiry is informed by numerous personal and professional experiences that suggest that homeopathy can act as a catalyst (Thompson and Thompson, 2006) for enhancing a sense of well-being and improved management of symptoms.

The emphasis in this statement is placed upon what proves to be useful or, in other words, what is perceived to work. The inquiry does not take the empirical scientific model as the natural reference point and avoids getting caught up in questions about testing how homeopathy 'works'. A pragmatic stance questions what types of evidence can be applied in practice. I perceive a pragmatic approach in Hahnemann's writings, as he rejects competing contemporary speculations about the causes of disease and reiterates that it is 'no practical utility to the physician to know' (Wansbrough, 1994). Arguably Hahnemann's own theorising about the causes and treatment of chronic conditions was developed through practical application in clinic. However today's homeopathic philosophy is strongly influenced by 19th century North American homeopaths, most notably James Tyler Kent, who interpreted homeopathic philosophy in metaphysical terms that redefine vitality in essentialist terms (Kent, 1987, 1st published 1900).

A pragmatic stance has the potential to lead to a preoccupation with internal issues, relativist interpretations and lack of critical distance to challenge assumptions (Baert, 2005). I aspire to a

reflexive pragmatic perspective by questioning my thinking and actions, and giving attention to uncertainty and not knowing:

“what-is-yet-to-be-known-and-articulated inherent in every moment of clinical activity” (Freshwater, 2008, p.213)

5.5 Hermeneutics

Fundamental to this inquiry is the appreciation of the constitutive role of language in generating our view of reality and sense of identity. Textual sources are in the foreground, as practice is perceived as being constantly re-created through textual accounts including my own reflective and thesis writing. This is informed by a post-structuralist understanding that social interactions can be investigated or read as text (Derrida, 1978, Ricoeur, 1992). Whilst study of these major philosophical texts is beyond the scope of this inquiry, it is imperative to acknowledge that they inform its conceptualisation.

The approach to textual analysis is anchored in the hermeneutic tradition of understanding the interconnectedness of interpretation, language and meaning. The hermeneutic circle offers a way of visualising the circularity of interpretation (Gadamer, 1979). We cannot escape our cultural assumptions, and our interpretations inevitably re-articulate these values. Interpretation is central to all human experience (Gadamer, 1979, Taylor, 1985a). Interpretation is always context bound and shaped by the specific situation and aim of the interpretation. This helps us to question judgements about evidence of effective treatments and about how evidence informs practice. Investigating competing histories of homeopathy, highlights how historiography is shaped by our contemporary perspectives and interests (Burrows, 2007).

5.6 Postmodern perspectives

Seeking to disrupt what I perceive to be the stranglehold of biomedical evidence based discourse on research into treatment by a homeopath, led me to draw on postmodern ideas, an approach I had not previously encountered in homeopathy literature. Postmodernism, by its nature, is much disputed and defies definition. I use the term in the sense of rejecting overarching theories and a linear concept of progress, whilst recognising multiple epistemologies, heterogeneity, plurality, fragmentation and indeterminacy (Fox, 1999, Cheek, 2002). Postmodernism is used to convey the understanding of the world as far too complex and uncertain for us to be able to live by universal truths, rather truths are contextual and relative, determined by our time and situation. This point of view avoids questions about the truthfulness of reflective accounts (Frank, 1995, p.23), as truthfulness relies on assumptions about the nature of another person's perception of reality.

Postmodernism rejects the scientific method as value-free and the only means of realising knowledge. Lyotard (1984) questions the status of science as a dominant ‘grand narrative’ of our age, by placing value on multifarious and competing ways of thinking, which he terms ‘little

narratives'. Lyotard observes the waning of the legitimising power of 'grand narratives' and the growing recognition that all knowledge is incomplete, tentative and local. Biomedicine can be perceived as pluralistic in its nature, and one of many competing and heterogeneous therapeutic disciplines. As biomedical discourse is no longer the only 'natural' reference point this opens the field for evaluating homeopathic practice. In examining competing discourses and texts, all are central to this inquiry, but none are privileged above others. I try to adopt a postmodern stance to examine my own culture as a homeopath. Like all forms of practice or bodies of knowledge, what is relied upon as truths and facts, are inextricably tied to the paradigms and vocabularies used to represent them. Recognising that my thinking is limited by taken for granted or 'entrenched vocabulary' (Rorty, 1999) encourages me to be curious. Why things are the way they are? How else might they be? I question concepts of self, professional identity and how I write myself into the text. Mezirow's (1978, 1981) perspective transformation leads me on a journey of self-discovery, but a sense of being a rational, unified, autonomous subject is unsustainable. 'I' as author of the reflective account, am different from the 'I' who reads this text now and the 'I' who had the experience.

One of the problems of postmodernism is becoming lost in relativism and multiple truths. Without grand narratives to inform understanding, we are in danger of being unable to differentiate ideas. Nurse researchers have drawn on Rorty's pragmatic epistemology to avoid relativism (Rorty, 1991). This approach emphasises usefulness, convenience and

"values a range of modes of enquiry that generate evidence that can be integrated into existing knowledge" (Freshwater and Avis, 2004b, p.6).

Rolfe (2000:63) advocates an ironist's stance or epistemic relativism, whereby the researcher acknowledges that the account offered is not definitive and cannot be defended, and would be surprised by any assumptions to the contrary. Knowledge is understood as socially constructed and therefore contingent on the knower. Research methods are accepted by consensus as the best possible in the circumstances but acknowledged as potentially fallible and unfounded. Rolfe uses the image of a torch lighting up small areas of an unknown monument in a dark environment, to suggest that we can only perceive a partial and tentative view of a largely unknown reality. This alters the focus from questions of truthfulness to the degree of criticality used in checking for inconsistencies in our own belief systems and in the pressures operating to maintain a consistency of beliefs within our professional communities. Whilst Rolfe's image of the beam of torch light is useful, the monument to representing reality is untenable as it suggests that there is an ultimate truth 'out there'. I would replace the monument with a cloudy sky on a windy night. In the absence of light pollution, as you shine a powerful torch light skyward, you perceive glimpses of moving patterns in the clouds.

Using the term 'postmodern' presupposes a Eurocentric view of the closure of modernity and a new epoch. I draw on transnational and transcultural perspectives (Gaonkar, 2001) to illuminate assumptions about Western modernism and postmodernism. This is an important undertaking as this discussion exposes modernist assumptions about homeopathic practice. It is premature to announce the end of modernism as many global communities are engaged in their own

'hybrid modernities' (2001, p.14). These 'creative adaptions' of Western modernity manifest in multiple modernities, in diverse ways, at individual starting points, in different geographical and locations, and cultural contexts.

5.6.1 Deconstructing modernism

I invite you to reflect with me on what 'modernism' means. This has particular resonance with homeopathy as both emerged out of Enlightenment ideas in late 18th century Europe (see Dialogue on Vital Force chapter 9). Gaonkar characterises the European Enlightenment as 'limitless faith in the emancipatory potential of human reason...exemplified in scientific inquiry' (Gaonkar, 2001, p.8). Homeopathy, was one among many systems of medicine that were generated in a drive towards a rational approach to medicine. Representations of the European Enlightenment emphasise the rejection of dogma and belief, in favour of subjecting a whole range of practices to rational scientific inquiry. However discussion of the demise of modernism in 20th century Europe, illuminates how belief continued to play an empowering and sustaining role in modernist social practices. Two eminent sociologists, Bruno Latour and Max Weber converge in arguing that the demise of Western modernism comes down to a loss of belief. Latour (1993) provocatively states that 'We have never been modern', arguing that modernity relies on the fragile conviction that science distinguishes us both from nature and from our past. Gaonkar (2001, p.10) presents Weber's view as 'disillusionment with the Enlightenment project of modernity and the resultant loss of faith in reason'. Modernist discourse is inherently contradictory simultaneously promoting newness, denial of ageing and the impossibility of completing its mission (Gaonkar, 2001, p.22).

5.7 Reflective pause before moving on to analytical strategies

This chapter represents one of the most fulfilling activities of the inquiry and the most frustrating to write. The chapter does not do justice to the reading, thinking and navigating through ideas and perspectives that have gone on. However the most significant signposts that I have followed to open up homeopathy research discourse and to explore practitioner experience are represented. As an essential aspect of reflexivity, I attempted to explore the social conditions involved in defining myself as a feminist and homeopath. The boundaries are blurred between this chapter and the next, as methods are inextricably bound up with philosophical perspectives. We will return to these philosophical perspectives as we fashion reflexivity as meta-methodology in the next chapter.

6 ANALYTICAL STRATEGIES

6.1 Introduction

The choice of analytical strategies was not predetermined in the early stages of the inquiry as would be expected in an empirical scientific inquiry, but rather evolved from the challenge of reflexive engagement with professional experience. These approaches are not applied to pre-existing data as a discrete activity, but engaging with these strategies has contributed to shaping the inquiry and data creation. A single method, applied in a rigorous and systematic fashion, could have closed off the multiple narratives, interpretative angles and perspectives that are invaluable in illuminating the complexities and uncertainties of clinical practice. I have chosen to use the term ‘strategies’ rather than ‘methods’ because it suggests a more flexible approach more suited to the plurality of approaches.

I conceptualise the practitioner researcher in the guise of *bricoleur*. In contemporary French culture, *bricoleur* is an artisan, not a specialist craftsperson, who uses what is already to hand and their ingenuity to complete a task. I use *bricoleur* in the sense of being practice orientated and concerned with practice based knowledge drawn from and informing future experience. I use of the term ‘bricolage’ (Denzin and Lincoln, 1994) to refer to the concurrent application of

Addressed to the curious and impatient reader

This is a résumé (not in hierarchical order) of the analytical strategies that frame and facilitate this inquiry.

Meta-methodology: Reflexivity

Informed by :

- Action research
- Critical discourse analysis
- Writing as inquiry
- Narrative analysis

Reflexivity has the potential to generate knowledge from practice by turning reflection back on itself, questioning from different and shifting perspectives (Freshwater and Rolfe, 2001). Following an action research orientation (Kemmis, 2001), I inquire into daily practice and interact with colleagues and textual sources to tease out ideas and generate themes (Marshall, 2001). Writing is a means of inquiry itself (Richardson, 2000). I subject my own writing, reading and transcripts to textual analysis as the workings of discourse (Widdowson, 2004) and as narratives (Frank, 2006).

multiple qualitative methods. There is also resonance with anthropologist Levi-Strauss' (1966) use of bricolage as 'a heterogeneous repertoire' (1966, p.17) of cultural artefacts. The juxtaposition of different analytical approaches aims to achieve critical and multiple interpretations.

You may be asking: how can distinctly different analytical tools be combined? No one approach is privileged as more authoritative (Richardson, 2000, p.928). Critiquing methods and recognising situational limitations is essential. There is some congruence with shared concepts and assumptions. Crucially, each method has its own interpretative stance that facilitates different questions and multiple

perspectives. Each method has contributed to interpretation of experience, although this may not be signposted in the text. I could claim this to be a form of triangulation, whereby the different methods are used to check the trustworthiness of the analysis. But there is no attempt to triangulate, rather the dissonance between the methods is essential in achieving critical and multiple perspectives. The intention is to illuminate through fragmentation and dismantling, rather than through building cohesion.

Through writing this chapter, I aim to recreate the unfolding nature of this inquiry. I could have presented a highly selective account that ignored the insights gained through experimentation with different methods. The list of methods is not exhaustive, as I have synthesised ideas from many disciplines (for example sociology of medicine), papers and presentations that are not overtly signposted in the text. Some strategies take a more prominent role than others. You may well be frustrated by a somewhat superficial and highly partial approach adopted towards leading methods such as critical discourse analysis and narrative analysis. I aim to offer transparency about how I borrow conceptual devices and attempt to show how these have shaped and informed the inquiry.

The potential weakness in engaging with multiple methods is that none of them are documented or applied in a rigorous manner and that analysis, synthesis and interpretation of data remains superficial. Reflexivity is the meta-methodology. Other methods, for example narrative analysis, are sparsely considered to emphasise a more subtle role at the margins. I set out below a discussion of my appropriation of the six methods. Each explanation is selective and partial.

6.2 Meta-Methodology: Reflexivity

Developing a research strategy is best represented as a journey starting with reflective practice and arriving at reflexivity. I retrace these steps and the significant intertextual experiences that shape the way in which I engage in reflexivity.

6.2.1 A reflective framework

The inquiry is located within a reflective framework, re-evaluating specific incidents in daily practice, exploring ‘personal theories’ (Freshwater and Rolfe, 2001) and taking fresh perspectives that modify future practice. Reflective writing is central to data collection and analysis, as it promotes internal dialogue airing intentions, motivations, thoughts and examining what is implicit in my actions. Glaze (2002) advocates journal writing as a means by which the researcher becomes a participant observer in the research, learning by reflecting on her own research and enhancing rigor by documenting the research process. I challenge the division between self and the research process. Concepts of self, practice and inquiry are constantly being recreated through the text. I conceptualise the practitioner as always in the process of becoming (Johns, 2000). This shifts us from competencies and fixed values, to a sense of fluidity, continuity and change. Clinical practice can also be perceived as an evolving and transitory phenomenon.

I take advantage of Schön's (1983, 1987) model of reflection, to articulate and make visible tacit or practice based knowledge. Journal writing encourages me to engage in retrospective 'reflection-on-action', learning from past actions to improve future practice. Whilst practising I attend to my thoughts and try to reach a more advanced level of 'reflection-in-action' upon theories as I am in the process of acting. Schön perceives the practitioner as a researcher in the practice context, employing a number of research strategies. These include experimenting with exploratory trial and error; move testing as a deliberate action with an end in

mind; and hypothesis testing, as the practitioner begins with a theory about what is happening in a clinical situation and formulates a hypothesis. The hypothesis is either confirmed or rejected. Schön's major contribution was

Engaging with Susan Hiller's words and painting as an analogy to illuminate reflective practice:



[Image 4: Susan Hiller's 'Momento' (Image at www.josephklevinefineartltd.com/NewSite/Hiller...)
Reproduced with kind permission of Susan Hiller Studio, London]

Hiller calls these works on wallpaper as 'scripts':

'Wallpaper, ordinary domestic wallpaper, has interested me for a long time.....these patterns we choose to live with. My scripts are really a kind of diary for me that runs alongside more public works. It's writing or drawing, performed in solitude and for me, maybe maps showing me where I am at any particular moment.just like all my work, a look at 'culture', because they don't start with a blank canvas but with wallpaper, and with a self or selves that are culturally constructed.' (Hiller, 1996, p.169)

The wallpaper metaphor helps me to explore the 'inside' of homeopathy culture. Wallpaper aptly describes the taken for granted aspects of practice that are invisible and escape critical attention. I encourage you to notice the patterns in the wallpaper (what is ignored) as well as the patterns that are identified in the text.

"not merely to describe an epistemology of practice, but to outline a method for generating and articulating practice based knowledge" (Rolfe et al., 2001, p17).

By framing reflection as a knowledge acquisition strategy, Rolfe and colleagues (2001) argue that through reflection-on-action, or in their terms 'critical reflection', knowledge embedded in practice can be 'uncovered by a process of analysis and interpretation...an active process of transforming experience into knowledge' (2001, p.18). Rolfe defines reflexive research as:

"attempts to bring about an integration of practice and research in a single act.....the implementation of clinical change directly through the research process itself" (Rolfe, 1998, p.173)

Theory is generated from practice as well as being applied to it (Rolfe, 1998).

This provides a valuable stepping stone to research the complexity of practice, but can I take this at face value? This approach assumes that reflection is revelatory and transformative. There is the potential that reflection simply reinforces habituated practice, assumptions and values. Their epistemological stance suggests that knowledge has a tangible presence that needs to be 'uncovered'. This conflicts with my evolving ideas about the way that knowledge and evidence are produced through the researcher's discourse.

6.2.2 Becoming critical

Engaging in critiques of reflective practice assists us to bring critical intent to bear on reflection as a research instrument. The way that reflective practice itself is discussed is often uncritical and assumption bound. Taylor recognises that reflective practice is "much closer to the minutiae of everyday practice than EBP [evidence based practice]" (Taylor, 2003, p.246) but that the literature assumes a privileged access to practice using naïve realism to offer an authentic account of 'what really happened'. Taylor (2003) identifies a lack of acknowledgement that reflection is a social activity and itself textually constructed to frame a particular representation. I am not working with a notion of transparent personal agency, rather my subjectivity is problematic and the inquiry investigates how this is cultural constituted (Bleakley, 1999). I recognise that engaging in critical reflection shapes my experiences of practice, and it is essential to keep challenging representations of practice, raising awareness of selectivity, partiality and hindsight bias.

Foucauldian analysis (1977), for example (Gilbert, 2001), views reflective practice as confessional disclosure operating as a subtle means of surveillance. Foucault examines post-Enlightenment liberal humanism in terms of particular power/knowledge relationships that shifted disciplinary and punishment regimes from external control to self-discipline. The Enlightenment notions of liberty and emancipation are only relative terms, and any sense of autonomy is coupled with its own set of disciplinary codes (Bleakley, 1999). A Foucauldian critique draws attention to the historical and cultural context that shapes my subject position in competing discourses and to beware of assuming that I speak as an individual to make unique interpretations.

6.2.3 Towards reflexivity

Integral to my understanding of critical reflection is Mezirow's (1981) use of the term 'perspective transformation' to describe the process by which we become aware of the constraints of how we see ourselves and our relationships. Mezirow identifies two routes to perspective transformation. One route is a 'sudden insight into the structure of cultural and psychological assumptions that have limited or distorted our understanding of ourselves and our relationships' (Mezirow, 1981, p.7). The other route is a more evolutionary process, through a series of disorientating experiences that cause us to reflect on our view of ourselves. There are important links here with patients' experience of homeopathic treatment. Encountering homeopathy challenges many assumptions about health and illness. Habermas (1971) acknowledges that transformation limited to an intellectual level is often insufficient to effect change. Possibly the embodied experience of ill-health and homeopathy is powerful in bringing change through other levels of consciousness.

Mezirow's writings act as catalyst to the inquiry process. Perspectives are 'constitutive of experience, offer explanation of how we see, think, feel and behave' (1981, p.14). Pursuing this further, Mezirow refers to reflexivity as

"fostered with a premium placed on personalising what is learned by applying insights to one's own life and works as opposed to mere intellectualisation. Conceptual learning needs to be integrated with emotional and aesthetic experience." (Mezirow, 1981, p.19)

This encourages a more engaged stance to explore feelings, metaphors and visual iconography. Reflexivity is a meta-methodology "which has itself as the focus of its inquiry, and which constantly scrutinises and critiques itself as it is progressing" (Freshwater and Rolfe, 2001).

Marshall's (2001) account of her research process offers insight into the skills of critical attention and is worthy of being quoted at length:

"engaging in inner and outer arcs of attention and of moving between theseI have especially paid attention to the inner arcs, seeking to notice myself perceiving, making meaning, framing issues, choosing how to speak out and so on. I pay attention for assumptions I use, repetitions, patterns, themes, dilemmas, key phrases which are charged with energy or that seem to hold multiple meanings to be puzzled about, and more. I work with a multi-dimensional frame of knowing; acknowledging and connecting between intellectual, emotional, practical, intuitive, sensory, imaginal and more knowings." (Marshall, 2001, p.433)

Inner contemplation is juxtaposed by “outer arcs” of engaging with others to interrogate different perspectives, to question and test out ideas. This can be conceptualised as an emic stance exploring “experience-near” (Geertz, 1983) to question taken for granted assumptions. Simultaneously an etic stance evaluates “experience-distant” to encourage fresh perspectives. Extending the image of moving between different perspectives, reflexivity involves “turning back of reflection on itself, a kind of meta-reflection” (Freshwater and Rolfe, 2001, p.529). Meta-reflection encapsulates the potential for a more profound “reflection on the process of reflection” (Freshwater and Rolfe, 2001, p.529) and for extending ‘beyond’ the introspective gaze into the wider social and political context. Through a critically reflexive approach, clinical practice is interrogated from different perspectives and re-examined within the wider social, ethical and political context. I explore the potential to integrate research into practice and clinical change into research (Rolfe, 1998, p.176).

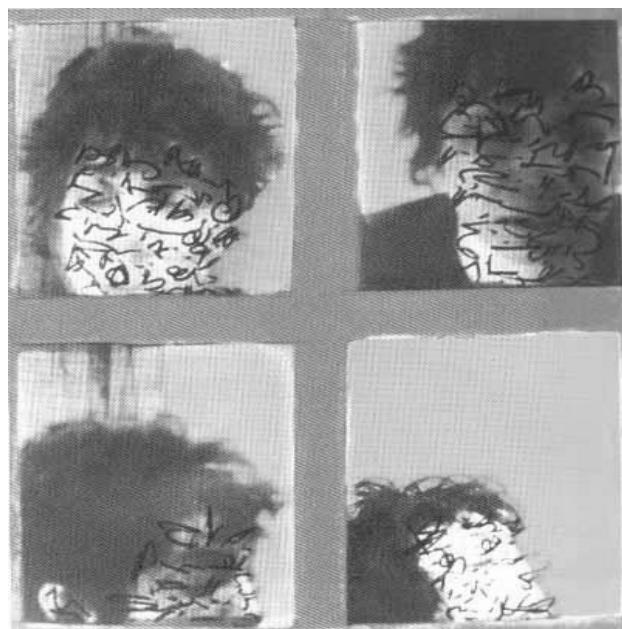
A tendency to narcissism is avoided by dialogue with others and reflecting on the research process itself. Marshall notes that self-inquiry is personal and at times it may be inappropriate to involve others (Marshall, 2001, p.433). I recognise that ideas generated by this inquiry may prove unpopular with colleagues. I invite you to examine the theoretical perspectives that shape my engagement with reflexivity.

6.2.4 Reflexivity informed by critical social science

Reflexivity has been influenced by critical theory’s notion of the transformative or “emancipator” potential of knowledge (Habermas, 1971). This involves critical awareness and questioning social norms, creating the potential for communication and politically-informed social action (Habermas, 1971). This influence is essential for giving a critical edge to reflexivity and underpins Mezirow’s concept of perspective transformation. Drawing on these sources does not assume false consciousness nor a true understanding of self.

Like Mezirow, Fay (1987) promotes liberation through increased self-knowledge. Fay recognises that our sense of ourselves is inextricably

Engaging with Susan Hiller’s visual imagery:



[Image 5: Susan Hiller's 'Euston midnight' 1983
(Image at mari-artisti.artline.ro/D-Susan-Hiller-1778-2...)
Reproduced with kind permission of Susan Hiller Studio, London]

Hiller’s work is self-reflexive, as she explores herself as a fragmented being, encouraging diverse means of thinking, seeing and articulating “to emerge and problematize one another” (Einzig, 1996, p.1). The notion of “problematising one another” is a valuable prompt to turn reflexive attention back on itself.

linked to our social context (1987, p.205). He identifies three barriers to self-knowledge, and it is significant to this inquiry that these resonate with homeopathy's theory of chronic illness (see Dialogue on Miasms chapter 0). Fay's first observation is that knowledge is contextually and historically bound. His second observation is how our perceptions and sense of self are an embodied experience. This resonates with the transformational potential of illness and healing (see Dialogue on Potentisation chapter 0). Fay argues that change is inhibited by inherited constitutional tendencies and somatised learning. This has close associations with how homeopaths perceive inherited traits as constituting our susceptibility to illness, and limiting our potential for well-being (see Dialogue on Miasms chapter 0). Finally, Fay argues that our sense of self is produced through a network of relationships and cultural traditions, invalidating any notion of autonomous action. Fay's (1987, p.213) conceptualisation of reflexivity advocates a self-critical account that is contextual, partial, local and hypothetical. He encourages awareness of the complex social systems, where a change in one place causes unpredictable reverberations throughout the system. This resonates with conceptualising homeopathy as a complex intervention.

6.2.5 Reflexivity informed by hermeneutics

As an interpretative process, reflexivity raises questions about how meaning is created. All interpretation is informed by the cultural, social and historical milieu. The hermeneutic circle (Gadamer, 1979) is a useful way to visualise the circularity of meaning. We cannot escape our cultural assumptions, and our interpretations inevitably rearticulate these values. Making sense of the whole is interdependent on coming to understand its parts. Koch and Harrington (1996) draw on the philosophical work of Georg Gadamer (1900-1998), to highlight the need to pay attention to self, both in questioning what is going on for the researcher and questioning the context in which interpretations are created.

6.2.6 Reflexivity informed by Bourdieu

Bourdieu's (1977) emphasis on how the point of view and power of the interpreter of others is produced has helped me to appreciate the crucial role of reflexivity in conducting any form of research. I have learnt to be cognisant that I am located within homeopathy and homeopathy research discourses, and cannot be positioned outside my clinical and academic practices (Bourdieu, 2000). My interpretations are never independent of the workings of prevailing discourses and the thesis is a product of this. Whilst I cannot speak from outside of discourse, reflexivity is essential to aid transparency and to strengthen a rigorous, systematic approach. Knowledge is 'advanced' by greater understanding of the 'social conditions of production' of the researcher (Bourdieu, 2000), and that self-inquiry is an essential aspect of all research.

6.2.7 Reflexivity informed by postmodern perspectives

In the previous chapter we raised problems with the term 'postmodern', but congruent with the pragmatic orientation, postmodern perspectives are useful in creating multiple and contested critical stances to interrogate practice, its assumptions and values. Concepts of self, professional identity and how I write myself into the text are contested through the text itself.

Reflexivity involves ‘not merely turning back of a text on itself, but on all other texts’ (Freshwater and Rolfe, 2001, p.531). I attempt to deconstruct the interplay of competing and contested perspectives that I negotiate in daily professional practice. In preference to the traditional ‘Literature Review’ or ‘Background’ sections, the term ‘intertextuality’ is used to elucidate how this thesis is related and only gains meaning in relation to other texts (see Intertextuality and Data Creation chapter 7).

6.2.8 Is this autoethnography?

You may have already identified similarities between this reflexive approach and autoethnography. Both share a common approach to a systematic analysis of the researcher’s personal experiences, acknowledging and accommodating the researcher’s subjectivity, to examine a cultural phenomenon (Ellis et al., 2010). Arguably autoethnography is fundamental to all research, as research is necessarily partial and inseparable from the researcher’s interpretations. A number of ethnographic studies have informed this inquiry in significant ways (Farquhar, 1994, Barry, 2005). Reflexivity and autoethnography are interdependent, and in methodological terms there are no significant differences to differentiate between them in the context of this inquiry. I identify the differences as more related to the emergent aims of this inquiry as directed towards a dialogue with other practitioners with a political agenda to offer a fresh approach to research into treatment by a homeopath and to act as a prototype to inspire other practitioners to research their own practices.

6.3 Multiple methods

6.3.1 Action research orientation

Action research was a formative influence in my engagement as a practitioner researcher. It is an orientation rather than a method in itself, embracing extensive, flexible, eclectic and multifaceted methods. Action research (Reason, 2003b) is congruent with the pragmatic framing of this inquiry:

“it is an approach to human inquiry concerned with developing *practical knowing* through participatory, *democratic process* in the pursuit of *worthwhile human purposes*, drawing on *many ways of knowing* in an *emergent, development fashion*.” [sic] (Reason, 2003b, p.108)

Action research can be situated within a range of theoretical and philosophical perspectives including technical scientific and positivist, collaborative and interpretivist, and critical and emancipatory (Whitelaw et al., 2003). Through the metamorphosis of this inquiry I gravitated towards the latter. The emancipatory potential to empower participants through the process of constructing and using their own knowledge has its antecedents in the work of critical theorists, in particular Habermas’s theory of communicative action (Kemmis, 2001). The historical origins of action research are traced back to the social psychologist Lewin and his social change process in tackling discriminatory racial practices in the 1940s (Carr and Kemmis, 1986, Hart and Bond, 1995).

Early drafts of my doctoral research proposal envisaged a collaborative inquiry with other homeopaths. With funding from the University of Westminster's Educational Initiative Centre, I set up an educational action research project in collaboration with homeopathy clinic tutors at the University of Westminster. We set out to investigate our shared clinic based teaching as a peer supervision group using action learning (Supervision through Action Research (STAR)). STAR (2002-2005) enabled me to develop facilitation and action research skills. As an arena for critical dialogue between homeopaths, STAR provided the opportunity to inquire into the nature of professional knowledge and with the permission of participants, a source of professional experiential data. The clinic tutors are experienced homeopaths and as teachers able to articulate theories in practice. Opportunistic sampling, congruent with action research, was used to inquire into existing practice to bring about change through the research process.

Action learning sets (Johnson 2003, McGill & Beaty 1995, Pedlar 1992) of up to four clinic tutors, collaborated together over a number of sessions. Each clinic tutor had the opportunity, through observation, reflection and sharing with others, to make sense of an experience from practice based teaching, with the intention of transforming practice (Kolb, 1984, Pedlar, 1992, McGill and Beaty, 1995).

STAR (2002-2005) objectives:

- to create a structured opportunity for reflection to inquire into shared practice in the teaching clinic
- to integrate reflective awareness into our practice based teaching
- to support peer learning and sharing of expertise

The process employs double-loop learning to challenge the assumptions and 'givens' of daily teaching practice. This creates the potential for new understanding of the discipline, of self and personal values (Argyris and Schön, 1974). Narrated experiences from the University Polyclinic provided foci for shared inquiry into practice. As experienced reflective practitioners, a spiral structure of inquiry was familiar territory. Each cycle consisted of phases

of planning, action and evaluation of that action and its impact. Data was generated through recording dialogue in group debriefing sessions, identifying emergent themes and sharing reflective writing. To analyse group debriefing transcripts I initially experimented with phenomenology (Husserl, 1970, van Manen, 1990, Munhall, 1994) and this was revealing about how knowledge and experience are constituted. The phenomenological notion of adopting an 'objective stance' by bracketing out my own experiences was unsustainable. In bracketing I tried to ignore my own experiences as a teacher and homeopath. This was inconsistent with placing my experiences centre stage in a reflexive inquiry. In abandoning the phenomenological approach, I adopted a simple model of thematic analysis to inform the cycles of reflection and action (Denscombe, 2007).

Before completing this section, I evaluate the STAR experience. You may consider this to be out of place in a 'methods' chapter, but as experience of action research has a formative role, it is important to explain how this has shaped the inquiry. The most significant learning arose from grappling with how to conceptualise and inquire into tacit knowledge. Initially I was looking to expose what is embedded in routine daily practice. Gradually conceptualisation shifted to

perceiving a constitutive role of language in generating our view of reality and sense of identity. Taking this perspective enables me not to look at homeopathic practice as a reality existing somewhere out there, but to examine how it is created through the homeopaths' reflective engagement and dialogue within a supervisory framework.

Whilst action researchers are critical of the passive role created for research subjects in other research approaches, we must question whether we achieved a participatory inquiry (Whitelaw et al., 2003). Relinquishing the power invested in the role of researcher is difficult. Despite the researcher's best intentions, inequalities persist in the perception of the other participants. I was caught in a fix between what I perceived to be colleagues' expectations of a more proactive facilitator and not wishing to contaminate the experiential data from a phenomenological view point. As the facilitator and originator of the project, the group looked to me for direction and to facilitate the group dynamics. I was reluctant to take on these roles, and this seemed to have a negative impact on the empowerment of the group. Whilst we all contributed reflective writing, I am cognisant that in co-ordinating the textual representation of STAR I took on the role as narrator. This could only be a partial representation of the collective experience.

Arguably action research has an idealist rhetoric and the literature does not support its claims to a transformatory and unique approach (Whitelaw et al., 2003). There is an assumption that the inquiry process generates developmental and educational benefit. Clinic tutors, collectively and individually, identified ways that the STAR experience had contributed to personal learning and changed practice. But was participation in STAR a transformatory experience? On a personal note, STAR represented my metamorphosis into the research role, particularly as it created a co-research environment that is more typical of research than the sole endeavour of my doctoral studies. Whilst the clinic tutors' accounts give examples of transformed practice (see Analysis of professional experiential data sections in Part two), these were unavoidably influenced by the perceived expectations of the facilitator.

To complete this section, I invite you to explore links between action research and reflexivity. Rolfe (1998) uses the term "reflexive action research" to describe the practitioner researcher's participation in their own inquiry. This is a problem orientated approach facilitating personal learning with each cycle informing the next. I place greater emphasis on multiple perspectives, multiple narratives and an unfolding inquiry. To cultivate the critical edge, I experiment with participant observation at seminars, conferences and continuing professional development workshops (see Professional experiential data in Part two of the thesis). This is informed by Marshall's (2001) self-reflective inquiry process.

6.3.2 Critical discourse analysis

Whilst action research and reflexivity are most influential within the analytical strategies, critical discourse analysis plays a more subtle role. Discourse analysis is a generic term spanning a range of analytical approaches across academic disciplines as diverse as linguistics, semiotics, cultural studies, social psychology and social research. It offers an examination of

"how institutions and individual subjects are formed, produced, given meaning, constructed and represented through particular configurations of knowledge" (Freshwater, 2007, p.111).

There is no intention to navigate its competing and contested literature (Fairclough, 1992, Widdowson, 2004), nor to examine one of its methodological approaches in any depth. Our interaction is limited to drawing on a number of the conceptual devices used with the aim of showing how these are used to enhance reflexivity. This section offers a superficial dialogue with critical discourse analysis, in particular interaction with Widdowson's (2004) critique of critical discourse analysis.

Critical discourse analysis provides an analytical framework appropriate for the foregrounding of textual sources in this inquiry. The term 'text' is generally used to indicate a whole range of word based records. In this inquiry texts include reflective writing, transcripts, research papers, books and leaflets. The most significant sources of data are professional homeopathic experiences narrated in reflective accounts, fictional dialogue and participant observation field notes. The use of the term 'text' is based on appreciating that language does not merely reflect reality but has a constitutive role in generating perspectives and identities. Critical discourse analysis is congruent with the social constructionist view of practice as social practice and context bound, and not dependent on empirical correspondence with notions of objectivity (Burr, 1995). Like all modes of data collection, reflective writing frames and creates experiences. Reflective writing has its own codes and rhetoric, and creates practice knowledge amidst many competing articulations. We revisit reflective writing as a source of creating knowledge in the next chapter.

The field of critical discourse analysis and the use of the term 'discourse' are interdisciplinary and open to a range of context-dependent interpretations. The term 'discourse' can be defined as a

"set of rules or assumptions for organising and interpreting the subject matter of an academic discipline or field of study" (Freshwater, 2007, p.111). (Freshwater, 2007)

Discourses are characterised by distinctive language, symbols and means of dissemination (Freshwater and Rolfe, 2004, p.29). The term 'discourse' has been strongly influenced by the philosopher Michel Foucault's concept of the "discourse of power", to describe the covert functioning of authority through social practices (Foucault, 1977, Cheek, 2004). Power and ideology are expressed through the hierarchies of discourses, creating historically and culturally specific subject positions and notions of individualism, that carry certain rights to speak and specification on what can be spoken. Dominant discourses create the norm and by default, define the deviant (Freshwater and Rolfe, 2004). A clear example is the dominance of biomedical discourse in shaping our experiences of illness and our role as patients. The authority of discourse is manifested through:

"language use anchored in an institutional context, expressing a fairly structured understanding or a line of reasoning with active, productive effects on the phenomenon it claims to understand 'neutrally'"
(Alvesson, 2002, p.48).

A key perspective in critical discourse analysis is ‘deconstructing’ the text, where the authority of the reader takes precedence over the expertise of the author (Barthes, 1977, Derrida, 1978). This involves examining texts to reveal how individual subjects or institutions are located in relation to language, ideology and power. There is no fixed meaning to be ‘read off’ the text, but rather the text is open to multiple activities to include; what is going on in the margins, hidden agenda, hints at what was unintended, assumptions, contradictions, what is absent or obscured, tensions, slippage between concepts, speculating on reasons why, and uncertainties. Deconstruction is not confined to the text itself and considers intertextual and contextual relationships. Deconstruction pays particular attention to the way that multiple meanings are used selectively to steer the text in a specific direction. Deconstruction is a process of turning things upside down, whereby the oppressed becomes dominant. This is significant for homeopathic practice, as it is located on the margins of healthcare and subject to repeated attempts by voices of authority within the medical profession to define homeopathy outside the boundaries of acceptable medical practice.

To explore in more depth how critical discourse analysis enriches the reflexivity of this inquiry, I turn to Widdowson’s (2004) critique of critical discourse analysis. Widdowson writes with brevity and clarity that is often absent from the dense literature of critical discourse analysis, but this is not the only reason for selecting his text. He emphasises the workings of discourse through texts and the role of contextual issues. I also detect a degree of pragmatism informing his approach that loosely fits with the emerging philosophical framing of this inquiry.

Let us start by considering the linguistic components of texts. Widdowson (2004, p.14) proposes that a sentence is ‘the overt linguistic trace of a process of negotiating the passage of intended meaning’. By referring to “negotiated” and “intended” Widdowson draws attention to the social role of language. A pragmatic view point is evident in his description of text that “exists as a symptom of pragmatic intent” (Widdowson, 2004, p.14). He describes the relationship between text and discourse as “a text can only be meaningful as a text when we recognise it as a product of the discourse process” (Widdowson, 2004, p.34). Internal co-textual relations within a text can be differentiated from external contextual relations that are brought to bear in creating meaning of the text. Terms ‘pretext’, ‘pretextual assumptions’ and ‘pretextual purpose’ (2004, p.87) are used to convey that the way we read a text is inevitably informed by our social purpose and shared values. He argues that analysis is always selective and partial, as it is impossible to pay attention to all textual features and the complex of co-textual features. He criticises the tendency in discourse analysis to offer a single, all embracing interpretation of the text, without acknowledgement of the text’s context and the motivations for conducting the analysis.

Widdowson distances himself from critical discourse analysts who concentrate on semantic understanding by arguing that:

“Interpretation is the process of deriving a discourse from a text and will always be a function of the relationship between text, context and pretext.

Any text has the semantic potential to mean many things, and which meaning gets pragmatically realised depends on how these other factors come into play."(Widdowson, 2004, p.35)

To reiterate, Widdowson assists me towards reflexivity by drawing attention to the workings of discourse through text, how contextual and pretextual factors influence our interpretations, and the inevitability of offering partial interpretations.

6.3.3 Writing as inquiry

It is essential when exploring methodologies, to assert the pre-eminence of the writing process. Congruent with promoting the socially constructed and contested nature of knowledge, writing does not play merely a representational role. The inquiry is constituted through the performances of writing and reading. In creating an open text, terms such as "interpretative turn" (Koch and Harrington, 1996) or "critical turn" (Clifford and Marcus, 1986) are valuable in exposing shifting perspectives and emerging insights. It is intended that this will enhance the potential for you to enter into a dialogic relationship with the text.

In exploring the analytical processes at play in this inquiry, the concept of writing as inquiry (Richardson, 2000) is fundamental. Writing is an essential activity integral to data collection, analysis and reporting. Whilst starting work on the research proposal, I was already collecting data and analysing through reflective writing. Committing words to paper is not a passive process of representation, but elemental to discovery, understanding and new ways of knowing (Richardson, 2000:923). I am learning from the experience of writing. Unlike the conventions of scientific papers, where the author is deliberately absented from the text, my intention is to write myself into the text, seeking transparency and reflexivity. The process of writing and the thesis itself is 'deeply intertwined' (Richardson, 2000, p.930); it is impossible to separate out form, content, author, writing process and epistemology.

6.3.4 Narrative analysis

In the same vein as the previous section, I engage with narrative analysis (Elliott, 2005) as a 'light touch' in contributing towards a reflexive meta-methodology. Narrative analysis is interpreted in different ways depending on the context, methodological approach and nature of the textual sources. Narrative analysis involves examining narrative as an entity in itself rather than as a container of facts (Baldwin, 2004, Elliott, 2005). This involves examining the structure, plot construction, how it operates as a narrative (Baldwin, 2004, Elliott, 2005) and underlying tension (Frank, 2006).

Viewed from a self-interpretative stance (Taylor, 1985b), in relating stories to others, we explore our own experiences and dilemmas. I perceive narratives not as projections of consciousness; but participating in the formation of consciousness (Frank, 2006). We are caught up in an extended narrative web. Engaging in narrative inquiry is congruent with homeopathic practice as the patient's account of their illness experiences is privileged; during the consultation, testing of remedies and in communicating with other homeopaths through case studies. My approach

to narrative analysis is influenced by Frank's studies (1995, 2000, 2006) on the centrality of narrative in illness and healing. He writes movingly about his own and others' illness experiences, characterised by speaking from the heart with clarity and insight. Frank explores the narrative resources available to individuals experiencing ill-health. He highlights the incongruity between lived experience of ill-health and the biomedical accounts of that experience. He argues that these individual's illness narratives have been overlooked, and by paying attention to them, it will help others to be empowered to narrate their own illness experience.

Narrative can be characterised as a sequence of events that are meaningful for a specific audience (Elliott, 2005). Frank (2000), by arguing that stories are more casual, informal and contingent, whilst narratives are premeditated and structured. He argues that narratives guide us in selecting what to attend to and how to evaluate our experiences (Frank, 2006). We create our identity and relationships with others by evaluating common stories in the same way. This shared evaluation of common stories creates affinity between people to form social or professional groups.

Linde offers the concept of coherence systems 'as providing the means for understanding, evaluating, and constructing accounts of experience' (Linde, 1993, p.164). We create the narrative's meaning only within the context of a set of beliefs or coherence system. Shared social discourse operates through individual narratives connecting into a belief system or a hybrid of common sense and expert knowledge. Elliott explains that

"in the very act of making those causal connections the narrator invokes the coherence system and indicates the framework within which he or she is interpreting his or her life" (Elliott, 2005, p.49).

Narrative analysis is featured more implicitly than explicitly, but using narratives to interrogate professional experience is key to this inquiry. Reflective writing is constructed as intra-personal dialogues through its own characteristic rhetorical and linguistic devices. They function to make sense of experiences and as a vehicle for experimenting and testing out identities and strategies. The potential for reflexivity is created through the split between the narrator and the protagonist, allowing the narrator to observe and reflect on the protagonist's performance (Linde, 1993). Within the reflective framework the practitioner is always in the process of becoming (Johns, 2000), perceived as an evolving and transitory phenomenon.

6.4 Reflective pause before moving on to intertextuality and data creation

I hope you do not feel overwhelmed by the expansiveness of this chapter. We have touched upon, in some instances quite briefly, disparate methods of analysis. It would be much easier to apply a single method, in a rigorous and systematic approach. I felt one method would direct the inquiry too much and obscure what was going on for the researcher. I wonder now why I felt it was important to wrap the inquiry up in quite such a mass of different analytical approaches. On reflection the attention to multiple approaches facilitates looking at practice from different

perspectives. It also reflects how difficult it is to articulate a critical voice on practitioner experience. It is as if I am searching here, there and everywhere ways of expressing distinctive perspectives on homeopathic practice, in a way that should be acknowledged (Couldry, 2010). You most certainly deserve to draw breath before moving onto the final two chapters that conclude the first of the two parts of the thesis.

7 INTEΡTEXTUALITY AND DATA CREATION

7.1 Introduction

In this section I explain the absence of the traditional literature review by examining the role of language, text and intertextuality in this inquiry. We explore how work with the literature, data collection and data analysis are inseparable processes. The term 'data creation' is used to draw attention to an understanding that the researcher is intimately involved in data collection, and that data are 'co-created' by the researcher.

7.2 Absence of traditional literature review

On embarking on this inquiry I assumed that by diligently searching databases, I would be able to make a comprehensive and critical appraisal of the current literature in related fields. I soon found this to be neither appropriate nor viable. The term 'literature review' has crossed over from the field of quantitative research and implies a thorough and systematic review of the relevant literature, from a detached and objective stance. This is incongruent with a reflexive study located in a postmodern context. Eisenhart's (1998) contends that reviewing literature in interpretative research must be consistent with the paradigm in which you are engaged. She characterises interpretative research by its potential to disrupt the received view by revealing something unexpected and to expand ways of understanding. An interpretivist-orientated review should

"offer surprising and enriching perspectives on meanings and circumstances' and it should 'shake things up, break down boundaries, and cause thinking to expand" (Eisenhart, 1998, p.396).

My interaction with the literature is highly selective and subjective. I make personal readings of the texts, explore avenues of interest to me at the time and ignore others.

7.3 Intertextuality

The term 'intertextuality' is used to indicate that we do not have an experience or read a text in isolation, rather this experience is shaped by our prior interactions with a multitude of other experiences and texts. This term derives from 1960s French literary theory to describe how any text is necessarily interdependent on the accumulation of pre-existing texts.

Any claim to original work is problematic, as my experiences and thinking are informed by an active interaction with papers, books, reports, journals, supervision, action learning sets, patients' and practitioners' stories, lectures, conferences, newspaper articles, radio and television programmes, films, chance conversations, websites, blogs etc. This thesis is created within a web of intertextual relations, its original qualities reside in the distinctive way that I have interwoven diverse sources. Fox's description of "the process whereby one text ...plays upon

other texts" (Fox, 1999, p.179) is helpful in unpacking the process of both writing and reading. Extending beyond the academic conventions of referencing sources, I seek to make "visible the layers of textual references" (Freshwater and Rolfe, 2004, p.9) by taking a dialectical approach to interacting with the different sources. You, the reader are also invited to engage in this dialogue, by questioning the text, participating in the intertextual discussion and by paying attention to what is evoked.

Intertextuality is a key aspect of a reflexive inquiry in appreciating that the process of research is also a topic for inquiry. As researcher, I am within the research setting so I become part of the intertextuality. Fox argues that:

"intertextual approaches break the distinction between researcher and researched, in as much as researcher becomes part of the world which is being explored and translated into text. The significance of the researcher's intertextual links in documenting the world must be recognized, and distinctions between the personal and professional responses of researchers in field settings are elided" (Fox, 1999, p.184).

This is a central tenet of a reflexive inquiry, but is valid for other forms of research, as it is impossible to separate off the effects the researcher has on research subjects and the researcher's role in designing and interpreting the research.

This transforms the traditional stance of objective critical appraisal of the literature, to situating the researcher within personal interactions with the literature and the relations between texts. I recognise that texts are open to multiple readings. Interrogating the text challenges passive reception of the dominant message of the text and seeks to identify the discourses at work through the text. Congruent with critical discourse analysis (see previous chapter), the authority of the reader takes precedence over the expertise of the author (Barthes, 1977, Derrida, 1978). This involves examining texts to reveal how individual subjects or institutions are located in relation to language, ideology and power.

In this inquiry the distinction between texts and data is blurred. All are central to this inquiry, but none are privileged above others. There is a continuum between intertextual work and data analysis. The research process is not sequential but concurrent, with interplay between reading, writing, data collection and analysis. I generate and analyse textual materials personally (for example reflective writing) and collaboratively (for example audio-recorded transcripts of action learning sets). Reflective writing and participant observation field notes offer a valuable source of 'field texts' (Clandinin and Connelly, 1994). I critically reflect on my shifting perspectives over the time span of the inquiry, re-reading reflective accounts as if they were written by someone else. A useful image for intertextual work is Marshall's "engaging in inner and outer arcs of attention and moving between these..." (2001, p.433).

7.4 Researching lived experience

Attempts at representing experiences are always transitory, they are part of the process of becoming (Johns, 2000). The suggestion that the meaning of experience is transparent and can be directly reported is untenable. Experience is illusive, unstable and difficult to capture. There is an assumption that experience speaks for itself. There can be no direct reading of the meaning of experience as this is mediated through language. Our means of making sense of our experiences are socially constituted through interaction with others (Taylor, 1985b) within in a social, political and ethical context. The best I can hope to achieve is an understanding that is local and particular, cognisant of the specific engagement within the wider intertextual and contextual environment. This inquiry draws on a number of analytical approaches, each offering a different conceptualisation of experience.

Perspectives as constitutive of experience (Mezirow, 1981) offer a conceptual tool through which to examine professional practice. Perspectives are formed through creating coherent explanations for how I see, think, feel and behave in a particular context. The coherence is temporary and unstable. The focus for this inquiry is into the processes of destabilisation and perspective transformation. By viewing these as “interpretative turns” (Koch and Harrington, 1996), it is possible to illuminate what is going on and the conditions under which transformed understanding is taking place.

Interrogating experiences as narratives is another useful device. Informed by understanding of the constitutive role of language, I perceive narratives not as projections of consciousness, but participating in the formation of consciousness (Frank, 2006). In seeking to capture experience,

“The truth of stories is not only what was experienced, but equally what becomes experience in the telling and its reception.” (Frank, 1995, p.22)

Frank’s notion of “learning to think with stories” (Frank, 1995, p.23) is also a useful way of exploring experience through narrative.

Critical discourse analysis recognises that experience is created through the workings of discourse. It involves examining texts to reveal how individual subjects or institutions are located in relation to language, ideology and power.

7.5 Sources of published texts

For the purpose of this chapter, textual sources as published materials and as data creation are considered separately. This distinction is for convenience only, as the two are interwoven.

So, finally I consider the sources of published materials, that in a highly selective manner, have informed and shaped this inquiry. These are diverse and scattered, ranging from homeopathy, CAM, healthcare, nursing, anthropology, sociology, biomedicine, clinical evaluation, history and philosophy. Where homeopathic literature has been lacking, I have looked to literature relating

to CAM, nursing or biomedicine. In recognising that I wish to bring new perspectives to bear on practice, I looked in other fields of health research. Reflective practice and postmodern approaches to nursing research have been particularly useful (Koch and Harrington, 1996, Rolfe, 2000, Cheek, 2002, Glaze, 2002, Freshwater and Rolfe, 2004, Avis and Freshwater, 2006).

The methods of accessing literature are as follows:

- **Following up citations in journal articles and conference papers:** This is a primary route to accessing literature congruent with the unfolding nature of this inquiry.
- **Participating in research and professional networks:** This is a vital means of being informed about recent publications, conference papers and developments in the field. These include: personal contacts with researchers, institutional links (School of Integrated Health at the University of Westminster and the School of Health and Community Studies, Bournemouth University), networking at conferences, membership of homeopathy research groups (for example the European Network of Homeopathy Research and Society of Homeopaths' (SoH) Research Committee), membership of research groups (Action Research Study Group at City University School of Nursing and the Performative Social Science network), bulletins from the Prince of Wales' Foundation for Integrated Health and the Research Council for Complementary Medicine.
- **Searching my own archive:** This is an archive of papers, books and conference notes, spanning nearly twenty years and provides a historical representation of my trajectory through practice and research.
- **Searching databases:** These include Glasgow Homeopathic Hospital, Hom-Inform, the Research Council for Complementary Medicine database, Medline, Web of Science and Cochrane Complementary Medicine reviews. The search terms used include: 'homeopathy', 'practice based', 'non-specific effects', 'clinical outcome measures', 'reflexivity' and 'practitioner research'

7.6 Strategies for data creation

Interactions in clinical practice are represented as a series of texts, described as professional experiential data (Lees, 2005). These are presented in the form of reflective research texts (Freshwater, 2008), fictional dialogue, transcripts and participant observation field notes.

7.6.1 Reflective journals 2002-2008

Foci for reflective writing:-

- clinical experience including supervision
- inquiry process including supervision
- the role of teacher and clinical supervisor

Reflective journal writing is more than documenting experience, it is a means of internal critical dialogue drawing on processes including exploring, reviewing, critically appraising and analysing. I have kept handwritten journals, as handwriting is a personal activity, promoting engagement and contemplation. Handwriting encourages an easier articulation of thoughts and feelings that seems more authentic to a self-inquiring process. Firsthand accounts of other researchers' journal writing provides inspiration and guidance (Johns, 2000, Marshall, 2001, Glaze, 2002).

7.6.2 Participant observation at conferences, seminars and workshops

Premised on the indivisibility of the observer and the observed, participant observation acknowledges that I have an effect on what I observe and that my observations are highly subjective. Pretextual relations and expectations (Widdowson, 2004) frame my perceptions. Reflective writing before, during and after the event enables me to capture my interactions. These texts are analysed in conjunction with textural representations of the event, for example promotional publicity, conference programme, conference paper abstracts, handouts and Powerpoint slides.

7.6.3 Supervision through action research project (STAR) 2002-2005

Data were generated through recording dialogue in group debriefing sessions, identifying emergent themes and sharing of reflective writing. I gained ethical permission (see Appendix 1) from the participants to use the transcripts generated from peer group discussion in this thesis. Transcripts provide valuable experiential data, and a number of short extracts are analysed (see Analysis of professional experiential data sections of chapters in Part two).

7.6.4 Peer consulting and review

Peer consulting is vital in providing a forum for homeopaths and researchers to question, critique, challenge and contribute to the evolving perspectives and conceptual framework of this inquiry. This has been conducted in a number of ways. I have presented papers and initiated discussion with colleagues at the University of Westminster at key moments in the research process. STAR provided a useful forum for peer consulting particularly in the early stages of the inquiry. Two homeopaths have read drafts and given feedback. Membership of the SoH Research Committee provides an arena for keeping up to date with new research developments. I presented papers at annual SoH Research Days (2006, 2008 and 2008), and initiated and facilitated a day dedicated to practice based research (2011). These events provided valuable opportunities to test out and share ideas with groups of homeopaths, including research active co-presenters. In terms of the wider CAM field, I presented papers at the annual conferences of the Alternative and Complementary Health Research Network in 2005 and 2006, and at their London seminar in 2008. Participation and presenting a paper at the 12th International Reflective Practice Conference 2006 was a significant turning point in the study. Writing papers for peer-reviewed journals would provide another valuable avenue for peer consulting and dissemination. Unfortunately due to competing demands on my time as a part-time doctoral student, this aspiration had to wait until after submission of the thesis.

7.6.5 Research field notes

These record verbal contributions, ideas and fresh perspectives, generated by interactions with friends, colleagues, patients, radio and television programmes, films, newspaper articles and discussions on websites.

7.7 Contextual relations

This section is intended to draw attention to the way that this inquiry is caught within a web of cultural, social, political, ethical and economic factors. The diagram below represents some of the key relations that are in the foreground of this inquiry. Absent from the diagram are the wider, less tangible background relations, that are either too numerous to mention or of which I am only vaguely aware of.

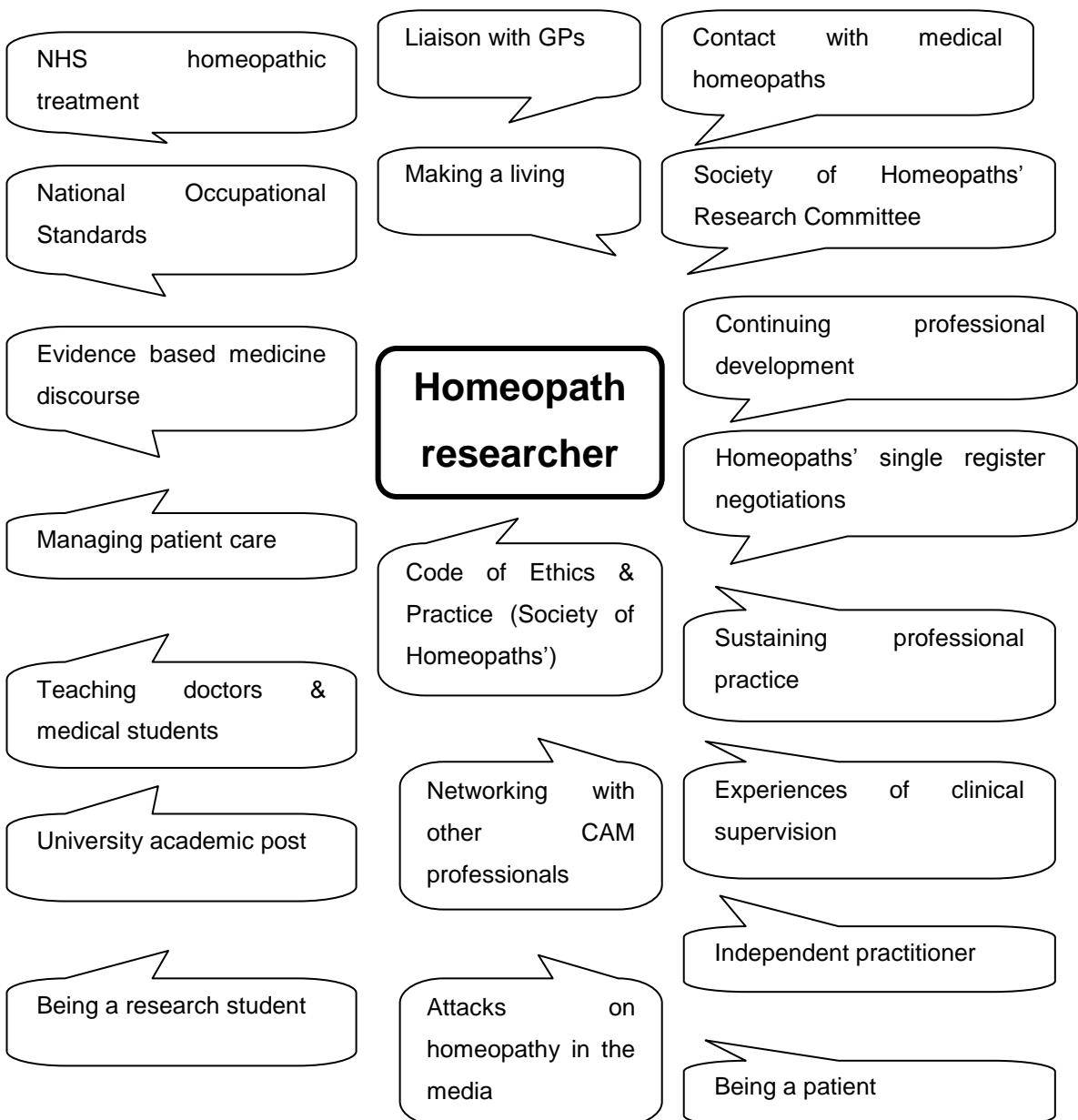


Figure 1: mapping contextual factors shaping this inquiry

7.8 Reflective pause before moving on to questions of quality and ethics

Phew I'm pleased to be moving towards the end of Part one. This first half of the thesis plays an important interpretative role as an attempt to show how I have developed theoretical approaches to practitioner based research. So let's move on.

8 QUESTIONS OF QUALITY AND ETHICS

8.1 Trustworthiness and rigor

Qualitative research is frequently criticised for a lack of scientific rigor, but such evaluations tend to be informed by criteria used in quantitative research referring to detached, objective and systematic application of methods, and with regard to generalisability to large scale randomised studies. As it is highly problematic to borrow criteria from a different paradigm, so I need to explore more appropriate criteria.

Practitioner research must be evaluated by criteria congruent with the aims and motivations that distinguish it from other forms of research (Reed and Biott, 1995). Data creation is inextricably linked with the practitioner researcher's experience so cannot be replicated. How do we assess the reliability of practitioner research? By acknowledging that the research arises out of the researcher's experience and interpretation is shaped by their local knowledge and their vested interest in the findings. Reed and Biott (1995, p.191) propose "catalytic validity" as a means of judging the quality of research by its potential to stimulate further research and practice development.

Congruent with a pragmatic orientation, the concept of 'narrative truth' fits with this inquiry "based on what a story of experience does – how it is used, understood, and responded to for and by us and others" (Ellis et al., 2010). Reflexivity is a strategy for establishing the trustworthiness of qualitative research by explicitly investigating the subjectivity of the researcher and providing transparency to the interpretative process (Murphy et al., 1998). Reflexivity has the potential to create a self-conscious account of production of knowledge as it is being produced. Plausibility depends upon the intrinsic, or internal, coherence and clear articulation of the reflexive exploration of the entire research process (Koch and Harrington, 1996, p.7). The textual account of the inquiry should enable the reader to scrutinise the inquiry process (Murphy et al., 1998). In reading this thesis you assess the quality and validity through resonance with your own experiences and the potential to generate significant insights to inform your own practices. Murphy and colleagues argue that rigor in qualitative research is also achieved by attention to negative cases and demonstrating fair dealing. By critically engaging with the doubts, discordances and contradictions arising from practice, I hope to meet Murphy's criterion. The inquiry should be judged according to the aims of the research (Freshwater et al., 2010). This is not to make objective observations nor to make generalisations associated with quantitative research, but to 'open up' homeopathy research discourse to critical analysis and to develop theories that could potentially inform the readers' practices. Your professional judgement and expert tacit knowledge determine whether the findings are applicable (Koch and Harrington, 1996) beyond the local site of inquiry. Generalisability resides in the potential to generate theoretical explanations of phenomena and universal principles that transcend the particular (Sharpe, 1998). Trustworthiness can also be achieved by member checking or peer

consulting. These provide opportunities to explore commonalities, inconsistencies and new avenues of inquiry. We return to these issues in the final chapter when I offer a reflexive evaluation of this inquiry.

8.2 Ethical considerations

This chapter assesses the ethical issues raised by this inquiry, from inception, design, undertaking through to dissemination. A reflexive inquiry does not require ethical approval either from Bournemouth University nor the Society of Homeopaths Ethics Committee. Bournemouth University Research Ethics Code of Practice (September 2009) provides the ethical framework. To ensure that ethical issues were addressed throughout the research, they were discussed at regular intervals in supervision and monitored annually by the School's Research Committee. Membership of the SoH Research Committee provided a forum for discussing ethical issues situated in the profession. To use STAR data in my doctoral inquiry, I submitted to the Dean of the School of Integrated Health (December 2005) a 'Statement of Class 1 Ethical Approval' (see Appendix 1), demonstrating how my research activities with STAR complied with 'University of Westminster Code of Practice governing the ethical conduct of investigations, demonstrations, research and experiments' (2004). Arrangements for one-to-one interviews and focus groups were included in the University of Westminster Class 1 ethics statement. These were not conducted as sufficient data were generated through STAR and reflection on my own professional practice. Let us now consider key ethical principles. These are conceptualised not as abstract principles but situated within the context and trajectory of the inquiry.

8.2.1 Use of researcher as participant

I negotiate a fine line between transparency and honesty, and considerations of self-exposure for both myself and other professional homeopaths. As a reflexive inquiry, the use of self in research raises many dilemmas. How much do I disclose to be able to illuminate my work without risking a sense of inappropriate self-exposure? This is an iterative theme in my reflective writing to reach some sense of equipoise. I operate self-surveillance as I police what I imagine other homeopaths may find potentially damaging to their professional identities. I am emboldened by reflecting on John's statement:

"The risk of compromise to make narratives acceptable is to sanitise them and risk their potency." (Johns, 2000, p.61)

8.2.2 The visibility of others in the text

Continuing to draw on Johns' insights:

"Self is always viewed in relationship with others....others become visible within the narrative, and because the narrative is subjective and contextualised, the other is more easily recognised." (2000, p.58)

Other homeopaths contribute to this inquiry as I reflect on my participation in professional activities, such as continuing professional development and conferences. I use my own reflective narratives and impressions of the discussion as data. I acknowledge that there is a fine line between my impressions of a discussion, as distinct from what others said or did. As

homeopaths are a relatively small profession, I have been vigilant to avoid any details that could identify individuals.

Another important group of inquiry participants are the people who consult me for homeopathic treatment. A number of long term patients have taken quite an interest in my doctoral studies, and have volunteered to contribute and asked to read the completed thesis. Whilst maintaining patient confidentiality, patient's comments and accounts are vital to this inquiry. Reflection on practice attends to practitioner experience and not patients or their clinical cases. As the practitioner experience involves working with others, it is not possible to separate off the homeopath. To avoid using patient's narratives or their clinical information, I have given attention to the clinical process rather than the patient. I employ the clinical report genre to present constructed narratives which synthesise multiple clinical experiences and fictionalised personal stories.

8.2.3 Am I providing ammunition for critics of homeopathy?

This is a reference to a homeopath's comment. After reading an early draft, she was particularly concerned that I was presenting homeopathy as 'unscientific' and drawing attention to the lack of reproducibility in prescribing regimes between homeopaths. All texts are open to multiple readings, and by inviting readers to participate in this text, the field of interpretation is wide open. The political context for homeopaths has changed during the course of the inquiry, with high profile scepticism in the popular media. This has changed potential readings of the text. The inquiry will be judged by its credibility. I am in dialogue with my 'internal supervisor' (Casement, 1990) about how to explore my doubts, uncertainties and the contradictions of practice. I attend to multiple truths, whilst also being cautious not to bring the profession into disrepute.

8.2.4 Deception

Constructed clinical reports respect patient confidentiality and fictional dialogues obscure individual contributions from patients and colleagues. As fictional narratives, do they falsify patient reported responses following homeopathic treatment? Am I misrepresenting the view points of others? How do I present an authentic self with integrity to my own practice? Answers to these questions rely on your view point. If you read this thesis from a realist deterministic standpoint, you may consider these accounts to be of minimal research value. Truthfulness relies on assumptions about the nature of another person's sense of realities. This inquiry is offered within a postmodern framework that is open to multiple and competing view points and rejects the certainty of describing a single truth. The constructed accounts are not truth claims but attempts at exploring, reappraising and analysing experience. These attempts offer different facets of my professional experience and I ask you to configure these to make our own interpretations.

8.2.5 Informed consent of participants

Consent is socially constructed as conferring trust on the researcher to have the participants' best interests at heart and not to cause any harm. As STAR was a staff development activity for a team of clinic tutors, we did not require ethical approval. We developed, agreed and renegotiated our ground rules for group work. At the end of the project I submitted a 'Statement of Class 1 Ethical Approval'. I emailed each participant an information sheet and a request for permission to reanalyse the STAR data they had contributed (transcripts of discussion, action learning sheets and reflective papers) as a source of professional experiential data in my doctoral inquiry. The consent form also asked each individual to indicate if they would be willing to be approached for permission to quote specific extracts from their contributions (see Appendix 1). As this request was retrospective, participants already had agreed copies of transcripts and could make an informed decision about withdrawing all or any of their contributions.

8.2.6 Coercion for colleagues to act as participants

This principle is particularly pertinent to STAR. At the proposal stage I verbally explained my personal motivations to all participants individually. When exploring action research in an earlier chapter (Analytical Strategies chapter 6) we questioned whether action research can be truly participatory and egalitarian because of the perceived authority of the researcher. STAR was a potential site for the exercise of power of the facilitator/researcher and loss of autonomy of co-participants. This power dynamic was heightened as I was in a more senior academic position to most of my colleagues, with some line management responsibilities. Dependency on the researcher to preserve a 'good working relationship' can persuade colleagues to participate (Butler, 2003). There is potential for role conflict and confusion. The working relationship shapes the data produced and 'openness and truth-telling could be compromised' (Butler, 2003, p.21). Keeping a reflective journal on my facilitator experiences and regular supervision with a colleague, who was experienced as a facilitator, was essential to help me manage group dynamics and group processes in the most effective ways. Colleagues said that they wanted a more proactive facilitator at times and I resisted this. There is a definite risk that participants felt duty bound to be involved in STAR and to offer me access to the data. I sought to manage the risk by emphasising, both verbally and in documentation, that they were free to decline or to withdraw. They all participated throughout STAR and offered me access to their data, indicating perhaps that they felt duty bound to do so.

8.2.7 Protection of participants from discomfort, harm or risk

All contributions from others used in this thesis are anonymous and any identifying details have been removed. Arguably the data is not sensitive as it primarily concerns constructions of clinical knowledge, rather than specific points of view or personal experiences. However, the 'Information sheet for STAR participants' draws attention to the difficulties of ensuring anonymity as within the relatively small professional community, individuals are easily recognisable. In the Ethics Statement I outlined strategies to manage this as far as possible.

8.2.8 Degree to which risks are balanced against potential benefits

With integrity and thoroughness, my intention is to increase understanding of the practice of homeopathy. Undertaking this inquiry has had a profound effect on the way I view and conduct my clinical work and professional activities. Whilst the time commitment has impinged on my availability to patients, undoubtedly the experience of researching my own practice has benefitted the quality of care I provide.

8.2.9 Debriefing of participants and peer review

STAR provided an arena for knowledge transfer as I disseminated learning from my doctoral studies through participation in peer supervision. For example I contributed a model of action learning, different supervisory models and theoretical perspectives on reflection-in-action, and also contributed my evolving perspectives on professional knowledge in homeopathy. All STAR participants were invited to attend and contribute to a presentation to the funding panel and I presented a paper on my doctoral inquiry in the School of Integrated Health (March 2009). As I am drawing on my professional experiences, peer review is indispensable and I am committed to contributing to the development of research in CAM. For details of papers presented see 7.6.4).

8.2.10 Confidentiality

All identifying information has been removed from STAR transcripts excerpts and reflections on discussions/encounters with others. All data provided by STAR participants has been stored confidentially in a locked personal filing cabinet and computer data is password protected. Data collected is not subject to the Data Protection Act 1998 as it does not affect participants' privacy in their personal lives nor in their professional capacities.

8.2.11 Copyright

Permissions gained for use of copyright images (see appendix 2).

8.3 Reflective pause before moving on to part two of the thesis

I suggest you pause now. We have generated a model of practitioner based inquiry, and considered its background and theoretical underpinning and on turning the page, we move into enacting the inquiry itself. The next eight chapters are presented in the form of dialogues with of the principles of homeopathy. Each opens with a case vignette followed by an 'orientation' section designed to set the scene for the chapter. The main discussion is divided between 'Meditations on the artefact' offering insights into the homeopathic context of the principle, followed by 'Homeopathy research discourse', 'Intertextual relations' and 'Analysis of professional experiential data'. The eighth chapter takes a slightly different form as it is presented as a follow up consultation critically appraising the inquiry. Finally the Conclusion critically appraises the final weave of the inquiry. I hope you feel prepared and inspired to embark on the next stage of your journey. I feel some trepidation on the threshold of presenting the 'substance' of the inquiry.

**PART TWO: ENACTING PRACTITIONER BASED
INQUIRY IN HOMEOPATHY**

9 DIALOGUE ON THE VITAL FORCE

9.1 Case vignette

This account illustrates how a patient explains the effects of homeopathic remedies.

Belinda: 35 years old

Extracts from telephone conversation with Belinda:

"Three months ago I was in hospital on an intravenous drip with a severe oral infection of herpes. My tongue swelled and I could hardly swallow. I have not fully recovered yet. I need a boost as I'm afraid that the herpes will return. I have used homeopathy since I was a child. After coming out of hospital I purchased a homeopathic remedy at a local chemist and took one tablet three times daily for 3 days. I know I have not responded to them. Homeopathy always works really well for me and I usually get such a strong sense of responding to the remedy. I would like to book an appointment as soon as possible."

Following Belinda's consultation, I prescribe daily dosage of Nitric acid in LM potency.

Extracts from Belinda's feedback at the first follow-up consultation:

"I feel so much better. My energy is improving. For the first time in months I have resumed my aqua-aerobics classes, so I must be feeling better. My inner confidence is back. It's hard to explain, like a confidence in my own body, it won't let me down. This is just like responses to homeopathic remedies in the past. I can feel my reaction to the remedy continuing and gaining momentum day by day."

Extracts from our telephone conversations three months later:

Belinda has continued taking Nitric acid in LM potency daily.

"Until a week ago I was doing really well. Then I started to develop a heavy head cold, night sweats and painful glands. Now I am recovering really quickly, I'm pleased as head colds usually drag on for weeks. My energy is now getting back to normal. Since starting Nitric acid I feel much less vulnerable and stronger inside. The remedy acts like flicking a switch, suddenly all the lights are on. Before I was not coping with the illness, the remedy has helped me to feel more positive and able to deal with life events as they arise."

This account is not presented as anecdotal evidence of either efficacy of the prescribed remedy or of my competence as a homeopath. I draw your attention to the way that Belinda describes her intuitive and intangible response to treatment. The patient I had in

Notes on the remedy: The corrosive action of Nitric acid was used medicinally in the 18th century. First proved by Hahnemann (Hahnemann, 1988, 1st publication 1828). Well established indications for homeopathic use include severe and painful inflammation and ulceration of mucus membranes. Nitric acid is also indicated for anxiety which is a significant feature of Belinda's case.

LM potency scale is one drop of mother substance to 49,999 drops of dilutent fluid. Administered diluted in liquid form and taken daily (see Glossary).

mind in creating this fictionalised account has over the last five years continued to consult me at intervals for a variety of health concerns. She has not experienced a relapse and has referred other members of her family.

9.2 Orientation to the vital force chapter

The vital force is the most potent symbol of homeopathy. I invoke its dynamic nature to promote the transformative potential of practitioner research. This chapter represents the formative era of homeopathy and of this inquiry. I look at how homeopathy discourse is constructed through traditions of vitalism (9.4.2) and scientific discourses (9.5.2). I begin to reflexively interact with the therapeutic framework and encounter epistemological difficulties inherent in vitalist discourse. Homeopathy discourse self-defines itself in relation to an iconic founder and I deconstruct the archaic and patriarchal associations (9.3.2). Inquiring into the historical narratives offers a way of understanding how practice has been created through continuity, change and disruption in the past (Alvesson, 2002) and to begin to examine how I am constituted as a subject of homeopathy discourse in relation to the body of knowledge (Foucault, 1977). I examine the vitality of homeopathy research (9.5). You may be disappointed not to be offered a critical review of research into subtle energy. Whilst it is tempting to validate clinical practice in this way, this would detract from the critical edge of the inquiry and replicate the tendency in CAM literature to appropriate specialist knowledge without the expertise required to make a rigorous analysis. I engage with viewpoints that are sceptical about the legitimacy of homeopathic practice (9.6.1) and imagine what it would be like to participate in a paradigm shift (9.6.2).

Reflection: March 2007

To revitalise research in homeopathy, the collective vital force requires stimulation!

9.3 Meditations on the vital force artefact

9.3.1 Vitalism

Through the vital force, homeopathy is connected to a continuing global tradition of medical vitalism, expressed in the East as *qi* or *prana* and implicit in the Western notions of the humours. Vitalism views living things as not adequately explained by mechanism alone, but can be characterised by an internal self-regulating, subtle capability. The intention to harness this potential to self-recovery is the only shared aspect of the diverse practices assembled under the CAM banner. The granulation of a healing wound is often

*Extract from reflective journal August 2005:
Realising that the patient's aspirations to feel better need to be nurtured, I'm working with a powerful force – the patient's self-healing response. I recognise that response to treatment is achieved both psychologically and through response to remedies. Being conscious of this, I seek to engage with humility. The patient is their own healer and their process starts long before our first consultation, as they decide to take action about their health concerns.*

cited as a visible manifestation of the self-healing principle.

Homeopaths interpret embodied experiences and symptoms as an expression of the intensity, weakness or suppression of vitality. As the mediator of health, illness and treatment, the vital force is conceptualised as a homoeostatic mechanism, operating through action and reaction (The Organon aphorisms #63 and 64). Health and illness are a dynamic continuum, characterised by constantly moving to gain balance. Vitality or level of health can be ascertained from evaluating the individual's reported sense of well-being and the homeopath's interpretation of pathological and non-pathological signs. Examples of non-pathological signs include persistent physical coldness, lack of enthusiasm or need for stimulation for example caffeine. Symptoms are not considered to be isolated events but function as expressions of the patient's vitality. In common with other healing traditions, symptoms are perceived as protective, rather than as causative of the disturbance of health. Exhibiting signs and symptoms are an embodied attempt to resolve the disturbed state of health, for example the pyrexia in acute infections. Responses to unfavourable stimuli or treatment are not presented as a linear process of cause and effect. Transition from health to illness is perceived to take place prior to the manifestation of symptoms. The vital force 'receives' an unfavourable stimulus, for example, an unexpected bereavement. There is a pause between stimulation and response, perceived to be the whole person response. This is conjectured to be the site of intervention of homoeopathic treatment. In other words the intention is to treat the individual's susceptibility to develop ill-health rather than the signs and symptoms of illness. Susceptibility extends beyond physical factors, to consider the role of emotional states in disposition to illness. Homeopathic treatment is perceived as a minimal impetus, in the form of a potentised remedy, to stimulate the patient's vitality. The reaction to treatment, mediated via the vital force is individualised and unpredictable. This diverges considerably from the biomedical model of the local action of pharmaceutical agents on specific drug receptors.

Reflection: March 2007

The benevolent quality of the homeostatic model of health is attractive. Are homeopaths offering an inappropriately optimistic view of the individual's state of health? Are we avoiding the realities of pathological change? Or are we encouraging the individual to take a positive view of their recovery and to be pro-active in their own well-being?

How the vital force is articulated in homeopathy discourse raises epistemological difficulties (Scott, 1998). You may have already noticed that there is an inherent dualism between the patient's illness account and the homeopath's observations of the expression of the vital force. This is most clearly visible in the classical texts of homeopathy, for example (Kent, 1987 (1st published 1900)), where agency is attributed to the expression of the vital force as an all knowing and higher intelligence:

"[the] speaking, experiencing body can never fully represent an 'essential' non-material self" (Scott, 1998, p.207).

For example, presenting with recurrent pharyngitis, a woman explains that her symptoms recur every time her husband is away on a long business trip. The homeopathic analysis places more emphasis on the expression of symptoms than the patient's explanation. Although she says that she is not upset by her husband's prolonged absences, the symptoms are interpreted as contradicting this statement. Scott observes that:

"Homeopaths believe they can enter into a dialogue with this deeper self through a bodily based discourse of symptoms and remedies."
(Scott, 1998, p206)

Arguably we can collapse this dualism if the vital force is conceptualised as a quality, as one of many ways of exploring the multi-faceted self. Vital force is a way of conceptualising illness and recovery in terms of accessing our 'own healing potential' (Freshwater, 2008), in contrast to the pathologising language of biomedical discourse.



9.3.2 The iconic status of Hahnemann

In the same way as the vital force is perceived to be an organising principle, so the figure-head of Hahnemann is constructed as the protagonist of homeopathy. Hagiographies create the mythology of one man's scholarly endeavours to discover the true therapeutic approach at great personal suffering. He is represented as taking a heroic stand against the deficiencies in medical practices in the face of attacks from his contemporaries.

[Image 6: Engraving by John Hall, entitled Christian Hahnemann (1755-1843). Reproduced with permission of Getty Education Image Gallery]

These heroic tales are not confined to the populist literature (Cook, 1993), but are produced by more scholarly texts (Haehl, 2001, 1st published 1922). Histories of medicine (Porter, 1996) present Hahnemann's work as an aberration, tangential to the advance of medical sciences.

Visual images of Hahnemann almost exclusively portray an elderly man with a bald head and prominent forehead. In the context of the contemporary interest in phrenology, the latter possibly alludes to intellectual powers. As commissioning a portrait is restricted to the wealthy, the image conveys respectability and achievement or nobility. Possibly Hahnemann's portraits, and there appear to be a number, were commissioned by appreciative patrons as he is known to have struggled financially. The image appears plain, possibly alluding to his Lutheran upbringing. Today reproductions of this image evoke longevity and 'standing the test of time',

but also out of date practices superseded by modern scientific medicine. From a feminist perspective with the majority of professional homeopaths being female, I question how I collude with this patriarchal construct.

Dominance by a figure-head can be seen as having an infantilising effect on the profession and establishing a propensity for didactic teaching and charismatic teachers. This situation is not unique to homeopathy, for example there are clear parallels in psychotherapy (Shaw, 2000) and likely to be prevalent in many other disciplines. Winston's (1999) account of the revival of homeopathy in USA describes the iconic status of charismatic European and South American teachers as creating a 'guru mentality' (1999, p.395). I recognise that legacy today. He argues that in the mid 1970s homeopaths sought:

"homeopathic enlightenment'; looking for that *one* thing that would let them 'get it' with complete clarity, and little effort. They looked for the teacher who would give it to them." (Winston, 1999, p.395)

Winston explains this in terms of the enthusiasm for self-realisation through Eastern philosophies in the 1960s. Many of the 'first' generation of British and North American professional homeopaths were drawn to homeopathy through counter-cultural experiences. By joining the profession in the 1980s, I did not share these formative experiences and entered a profession already dominated by figure-heads. I am subject to this culture also, and the teachings of Sheilagh Creasy have been a sustained influence on my practice. This is a pragmatic choice of a female colleague, who has over fifty years of experience and has an in depth and critical understanding of theory and practice.

I am drawn to take historical perspectives both by having studied cultural history as an undergraduate and by my self-defined orientation as practising according classical principles. Classical prescribing conveys sense of a continuity of practices established by Hahnemann and reinterpreted by subsequent generations of homeopaths – in the 19th century by E.A. Farrington, Lippe, Boger and Boenninghausen; in the early 20th century by Kent, Roberts, Close, Puddephatt, Speight and Tyler; and later 20th and early 21st century by Creasy and Vithoulkas. Classical prescribers adhere to the essential elements of practice: detailed consultation, prescribing the *simillimum* and allow time to observe change. All forms of social practice, including science and biomedicine, are subject to modernist

Reflections on text in Hiller's artwork

'Residue (left over)'

'To articulate the past historically does not mean to recognize it 'the way it was'. It means to seize hold of a memory as it flashes by at a moment of danger' (Hiller, 1995).

This text appears inside the lid of an archaeological collection box containing dried leaves. The leaves are presented as a specimen, labelled, pinned down and contained. This highlights for me the way that artefacts become disconnected from a meaningful context. I am reminded that historical accounts tell us more about ourselves, than about the past. The evocation of the transitory and subjective nature of memory counters the illusion of stability created by historical narratives.

fashions and reinventions. Competing ‘new’ methodologies are promoted as offering radical improvements on what is perceived to be the ‘old’ ways. These draw on a range of different knowledges and cultures, as diverse as Chinese medicine, biomedicine and Hinduism. Classical approaches are of course pluralistic and have many influences, most notably the 18th century Swedish theologian Swedenborg (Kent, 1987, 1st published 1900). Currently professional homeopathy discourse is dominated. You may detect a sense of antipathy to what I perceive as reinvented ‘methods’ that are packaged around the persona of the ‘inventor’ and promoted through books, computer software, seminars and training courses. How far, for example the current popularity of the Sensation methods (Sankaran, 1991, Sankaran, 1996, Samuel, 2006) is actually creating a lasting change in delivery of patient care is unknown. How different methodologies are integrated into practice is a thread running through the inquiry.

9.4 Intertextual relations on the theme of vital force

9.4.1 Constructing historical narratives

I approach historical analysis with the view that each era has its own ways of understanding health and illness in a particular context using the available tools. The meaning of terms, such as vitalism, are not universal but reconstituted within specific historical discourses. To gain insight into how I engage with homeopathy’s therapeutic framework, I need to make sense of its historical origins. Just like taking a homeopathic case, I examine what was happening at the time homeopathy emerged and how it developed. This is motivated by dissatisfaction with homeopathy’s historiography, but this account is itself fraught with difficulties. Historiography, like any other form of activity, is neither objective nor neutral. It is infused with personal perspectives and current pre-occupations. The 19th century historian Burckhardt’s dictum is particularly apt: “History is the record of what one age finds of interest in another” (Burrows, 2007). The potency of narrative resides in the potential for transforming the storyteller. In rejecting the modernist constructs of progress and the evolution of knowledge, I adopt the conventions of historiography to create an illusory sense of order and stability, out of the constantly shifting perceptions of the body, health and illness within the context of social and political change.

9.4.2 Medical vitalism

The origins of vitalism in the West are traced back to Hippocrates’ (BCE 400) concept of *physis* as a self-healing response (Wood, 1992). Paracelsus (15th to 16th century), who gained a considerable reputation across Europe for his revolutionary views on treating illness, is frequently cited as a figure-head of vitalism in Western medicine (Wood, 1992). Paracelsus’ *archeus* is interpreted as a dynamic life force capable of acting through the medical substance to affect change in the individual’s health. This has direct antecedence to Hahnemann’s work, although this link is not acknowledged in Hahnemann’s writings. The vital force shares with the *archeus*, a self-regulating and self-healing intelligence, manifested only through its effects.

As mechanical explanations for the internal workings of the human body began to evolve in 17th century Europe, vitalism was increasingly marginalised as archaic mysticism. Vitalism represented an explanation of life that was counter to the newly emergent bodies of knowledge of biology, chemistry and physics (Greco, 2005). However contrary to modernist accounts of medicine as a continuous project of reform and scientific progress (Porter, 1977), vitalistic ideas in medical practice (medical vitalism) persists and becomes highly visible in the late 18th century (Dean, 2000, Williams, 2003). There is a tendency to assume that an innovative set of ideas, for example in anatomy and physiology, are soon followed by advances in medical practices. This assumption rests on a sense of rational application of knowledge and overlooks medicine as a social practice:

“The history of medicine has to be something more than just a history of knowledge; it has to be a history of emotion. And this is difficult because our own emotions are involved.” (Wootton, 2006, p.22)

The theory/practice gap is even more relevant today as EBM rhetoric tends to overlook how research findings are actually applied in clinical practice.

Sociologist Greco draws attention to the French philosopher of science Canguilhem's notion of the 'vitality of vitalism' (Canguilhem, 1988):

“we treat as significant the historical ‘vitality of vitalism’ – the fact that the imperative to refute vitalism has had to be continually reiterated up until the presentThe imperative to refute vitalism, in a sense, is superseded by the need to account for its permanent recurrence.” (Greco, 2005, p.17)

Currently there is a shift away from mechanical explanations in relation to systems theory, quantum mechanics and relativity theory, but articulated in a distinctly different way from notions of vitalism. However Greco argues that there is a convergence between Canguilhem's 'vitality of vitalism' and Stengers' (Stengers, 1997) observations on complexity in science:

“Complexity expresses the demand that we acknowledge, and learn to value as the source of qualitatively new questions, the possibility of a form of ignorance that cannot simply be deferred to future knowledge.”
(Stengers cited Greco, 2005, p24)

Complexity theory cannot simply be appended to the epistemology of science, as it challenges the assumption that all natural phenomena are explicable in biochemical terms. This resonates with not knowing and uncertainty in practice when working with those intangible aspects of an individual's illness and recovery experiences that cannot be adequately explained using biomedical concepts.

9.4.3 The emergence of homeopathy

Homeopathy emerged at a time of intellectual fluidity, retrospectively identified as the European Enlightenment. This era is posthumously characterised as a belief in the power of knowledge and application of systematic thinking in areas of life. Historians describe the drive for reason and rationality as the ascendancy of scientific rationalism, laying the foundations of scientific inquiry and modern medicine (Gay, 1969). This portrayal relegates practices that do not appear to fit within this trend, such as medical vitalism, to the margins as outmoded adherence to dogma. Arguably this is the starting point for accusations that homeopathy is anachronistic and

'unscientific'. To contest this dichotomised view let us look at the historical context, the plurality of medical discourses and in particular at the contributions of the Montpellier School of Medicine in France.

In late 18th century Europe medical practices were more likely to do harm than good. The achievements of biomedicine cannot be considered in isolation from the impact of improvements in living conditions, sanitation and nutrition. The marked reduction of epidemic illnesses in the second half of the 19th century pre-dated the introduction of vaccination programmes and antibiotics. The turning point for effective biomedical treatments did not occur until 1865, with the introduction of antiseptics in surgical procedures (Wootton, 2006) and significant improvements were not achieved until after the First World War (Saks, 2003b). It is salutary to reflect that the simple measure of hand washing is again top priority in managing hospital infections.

Documentary evidence indicates that medical vitalism still played a significant role in medical practice in France at the turn of the 19th century. Williams (2003) suggests that in Montpellier physicians promoted medical vitalism and challenged the limitations of a mechanistic view of the human body. Williams argues that

"it is our understanding of the nature and impact of Enlightenment science that is, in fact, flawed. Not only did the standards and character of science vary to a much greater extent than has been thought..... vitalism was never placed outside the scientific pale. Indeed vitalists supplied key points of reference on a range of issues that were crucial to physicians..."
(Williams, 2003, p.329)

As Hahnemann spent his final years in Paris, we can speculate that his writings were informed by contributions from the Montpellier School of Medicine. The language and theories articulated in the Montpellier texts bear a striking resemblance to homeopathy discourse, including references to the vital force. Vitalist ideas were also articulated in the German Principalities, influenced by contributions from Stahl (1660-1734), who coined the term '*autocratie*' which was adopted by Hahnemann.

Reflection: August 2007

On editing this text, I am struck by my tendency to polarise homeopathic practice with biomedicine. Is this a defensive posture? Defensive of what? A poignant recollection is sharing a guesthouse breakfast with a retired GP whilst I was away at the homeopathy college. By the end of the conversation, I felt totally deflated, as I was unable to 'defend' homeopathy from his scathing opinions. Standing back now, the power imbalances of gender, age and professional status are conspicuous. This sense of disempowerment and frustration is rekindled by the negative media coverage of homeopathy. This feeling is counter to my daily experience of constructive relations and communication with the medical profession; as colleagues, as teachers, as students, and as patients. I am often assisting patients to understand their diagnoses and supporting them through biomedical treatment and recovery.

The French philosopher Foucault's (1973) study of medical examination in the late 18th century offers insight into the confluence of European Enlightenment ideals and Hahnemann's use of observations from practice as the means to generate theory. Foucault does not refer to homeopathy, which is perhaps surprising given the popularity of homeopathy in France, however his argument can be read in terms of homeopathy:

“It is as if for the first time for thousands of years, doctors, free at last of theories and chimeras, agreed to approach the object of their experience with the purity of an unprejudiced gaze” (Foucault, 1973, p.195)

There is a striking resemblance between Foucault's 'unprejudiced gaze' and Hahnemann's emphasis on the 'unprejudiced observer'. Both terms are problematic as observation is value and theory laden, and the idea of suspending one's values and assumptions is untenable. However the close resemblance between these two terms suggests that Hahnemann participated in medical discourse that prioritised practice based observation.

9.4.4 Homeopathy rooted in humoural medicine?

As a physician, chemist, linguist and classical scholar, Hahnemann was well placed to synthesise earlier and contemporary medical theories. His texts offer strong critiques of contemporary practices and contribute his own medical system to compete with many others in the discursive reframing of medicine as based on scientific rationalism (Waisse Priven, 2008). Dean (2001) identifies the emergent medical theories that informed Hahnemann's practice as integrating:

“*similia* hypothesis with a Hippocratic natural-history approach to nosology, Stahl's homeostatic vitalism, Plenciz' germ theory, John Hunter's theory of medical counter-irritants, placebo controls and many other disparate and previously unrelated influences” (Dean, 2001, p.28)

However I diverge from Dean's emphasis on the shared origins with biomedicine, by making a more innovative argument, that the continuing influence of humoural medicine is clearly visible in homeopathy's therapeutic framework. I refer to humoural theory as a metaphor of the universal principles of health as harmony with the natural features of fire, air, water and earth. This proposition is contentious on two counts. Hahnemann's discourse of medical reform (Brewster O'Reilly, 1996) condemns the depleting effects of treatments such as bloodletting and emetics. Furthermore humoural medicine is generally viewed as an anachronistic set of practices that continued to be popular well into the 19th century, thereby delaying the advance of Western medical science (Porter, 1995). In terms of the ascendancy of scientific rationalism through the European Enlightenment, my proposition anchors homeopathy as pre-scientific practice. This may account for the apparent reluctance of historiographers of homeopathy to identify links with humouralism, although it is a clearly visible in homeopathy discourse (Norland and Norland, 2007). The significance of this novel proposition is that even today our everyday talk of health and illness is infused with the language of humouralism and this legacy could be responsible in part for the popularity of homeopathy today.

The Ancient Greek understanding of the human body in terms of four 'elements' (earth, wind, fire and water) was articulated by Aristotle (BCE384-322). Therapeutic approaches based on

the four elements are attributed to Hippocrates (BCE 400) and have been integral to many therapeutic traditions around the world, for example in a highly sophisticated form in Ayurvedic and Chinese medicine. Galen's (CE129-200) writings re-presented these ideas as a rational system of medicine, based on a self-regulating concoction of four fluids: bile, yellow bile, phlegm and blood. This essentially static system dominated Western medical practices for almost 1500 years (Arikha, 2007).

Humoural theory was more than an explanatory model, it had become popularised into everyday language as a way of explaining behaviour, emotions and temperament. Each humour evolved specific affinities with an element; hot or cold, dry or damp, colour, taste, season, time of day, body organ, period of life, astrological signs and planets (Arikha, 2007). For the wealthy, diet and lifestyle were guided by what suited your humoural disposition. Medical practices sought to restore health by the removal of excessive humours, for example venous blood. I propose that fundamental concepts of humoural theory, such as interdependence of mind and body, self-regulation, balance and adaptation are vitalistic, although this is obscured by dominant view of the rationalist Galenic framework. Balance becomes the metaphor by which the human body is understood. Illness arises from imbalance and health can be achieved through restoring balance.

The lasting dominance of the humoural model can in part be attributed to its flexibility that allowed assimilation, additions and diverse reinterpretations across East and West. The Islamic Empire from 9th to 15th century CE played a crucial role in collecting scholarly texts from China, India, Greece and Persia and creating a synthesis of learning (Conrad, 1995). The Hippocratic and Galenic medical approaches were infused with Persian and Indian traditions (Nasr, 1987). These philosophies all share vitalistic qualities with integration of physical, energetic and spiritual aspects and offer a self-regulatory system that responds to environment, diet and life style factors. This cross fertilisation of therapeutic traditions has thrived in the late 20th century and many homeopaths (for example Norland, Munday, Sherr) have integrated Chinese medicine principles into their teaching.

Notwithstanding treatment by contraries through discharging perceived excesses, homeopathy shares features of the humoural model. Both function with a notion of holism. To understand what is happening inside, study of the effects of humoural fluid imbalance is not so dissimilar to homeopathy's attention to the outward expression of signs and symptoms. Homeopathic philosophy identifies the effects of 'outside' factors as exciting causes of ill-health, as differentiated from fundamental causes which relate more closely to the individual's constitutional tendencies. Like the humoural model, exciting causes include reactions to heat and cold, change of weather conditions, locations, foods and emotions. The humoural and homeopathic models both individualise the patient in terms of thermal reactions, temperament and disposition, physiognomy, preferences for foods, times of day when you feel better or worse and seasonal preferences. The application of four elements in homeopathic practice was first

explored in depth by Reves (Reves, 1993) and continues to thrive in 21st century teaching (Norland and Norland, 2007).

The influence of humoural medicine waned as the perception of pathology shifted from internal to external causes, facilitated by increased levels of magnification. The humoural model is presented as finally becoming redundant when treatment according to germ theory was demonstrated to be effective using statistics (Wootton, 2006, Arikha, 2007). However the polarisation of germ theory and the humoural model is ideological, as the latter attends to factors that predispose the individual to a particular bacterium or virus, rather than denying their role in the disease process. The notion of susceptibility to disease is key to the homeopathic understanding of pathology and will be considered in more depth in the Dialogue on Miasms chapter 15.

9.4.5 Homeopathy resonates with our common sense understanding of illness

In practice I began to notice humoural concepts cropping up in patients' illness narratives. Our language and lived experience of health and illness appears still to be suffused with these self-regulatory concepts, for example the man who is prone to bilious headaches and heart burn, and attribute this to becoming annoyed and sitting in an overheated office. Arikha (2007) supports this view by arguing that the explanatory power of humours has never dissipated and in the 19th century there was a merging between humoural doctrines and contemporary medical models.

Two studies illuminate how humoural concepts continue to infuse everyday talk about illness. A GP (Helman, 1978) observed that his patients' often attributed to episodes of acute illness to changes of external or internal sensation of temperature. Helman examined how two distinct models of illness, the patient model and the biomedical model, operate in conjunction with each other during the consultation. Explanations in common usage of 'why I become susceptible to a virus and you do not', and culturally specific phrases such as 'I caught a chill', relate more to the 18th century humoural medicine than to 21st century epidemiology. He describes the consultation as a 'process of negotiation between doctor and patient' (p.108). He found that the patient model is 'more functional and resistant to change' (p.108), and that germ theory has been incorporated into patient understanding without challenging it, and that it may even strengthen the patient model. The persistence of humoural concepts is also identified by a quantitative study (Rippere, 1981). Participants (n=64) were asked to choose between ten pairs of opposing beliefs on factors influencing depression. Half the statements were derived from Galenic beliefs about the health effects of climate, sleep, activity, diet, excretion and regulation of emotion. The majority of participants selected eight of the ten Galenic statements. Reviewing this study over thirty years later, it is significant to note how far biomedical approaches have gravitated towards the Galenic beliefs, in recognising some forms of depression can be helped by exercise, a positive approach, life style, diet and sleep.

I experience an ease of dialogue with patients when talking about homeopathic concepts. This view is supported by studies indicating that patients' value the homeopathic consultation as a means to make sense of their illness experiences (Barry, 2005). Today's common parlance, such as cold and warm blooded to describe if you are sensitive to cold or hot temperatures, are of humoral origin and play a significant role in differentiating between remedies in prescription selection. Is homeopathy's enduring appeal and anecdotal reports of effective treatment in part accounted for by the way that it makes sense of, and resonates with, our embodied illness experience? Possibly the sheer longevity of humoral medicine and its roots in universal elements of air, earth, fire and water, continues to provide useful, suggestive and malleable metaphors that has shaped a British explanatory framework for illness.

Homeopathy is part of a global tradition of self-regulatory function to strengthen constitutional health and reduce susceptibility to illness. Anecdotally CAM appears to attract users with high educational attainment, possibly related to ability to pay. This indicates that the popularity of CAM does not rest on being easily swayed by simplistic solutions. Biomedical expertise in pathology at a microscopic level does not fully meet social and psychological needs. There is a therapeutic effect in reconstructing your sense of self through talking about your illness experiences (Frank, 1995), and this is addressed by the homeopath's attention to the patient's subjective illness and life experiences.

9.4.6 Reflecting on historical narratives

Before moving to the next section, I invite you to reflect with me on the implications of these historical narratives. I have gained a sense of locating my practice historically within the plurality, contradictions, continuity and change in medicine as a social practice. We are socialised into a culture where conventional healthcare is talked about in objective and rational terms, ignoring the highly complex social interactions involved. Homeopathic practice is characterised by apparent stability and longevity, largely immune to the pressures of modernist discourses. Facets of early 19th medical practice, such as sugar pills and concepts of miasma, have been locked into homeopathy's system and remained intact as practice has diversified and adapted to different contemporary and international contexts. My perspectives have been enriched by ethnographic studies (Farquhar, 1994, Scheid, 2002) examining continuity and change in Chinese medicine. An apt way to close this section is to draw an analogy with thousands of years of tradition informing current practice in Chinese medicine (Scheid, 2007) :

“this continual coming into being of practice – a coming into being that simultaneously stretches forward and backward in time” (p.12).

Later in this thesis we consider homeopathy as a 'pre-modern' discourse, and as such, well placed to contribute to postmodern healthcare.

9.5 Homeopathy research discourse on the theme of vital force

A key activity of this inquiry is to deconstruct homeopathy research discourse. I reflexively engage as a subject of this discourse to explore how research into treatment by a homeopath is

articulated. I speak from multiple subject positions as homeopath, homeopath researcher and patient. We commence with considering the vitality of the research and how vitalism is constructed in dominant scientific discourse.

9.5.1 What is the state of vitality in homeopathy research?

Making a homeopathic assessment of a patient's case involves judging the state of their vitality, for example: Do you feel tired during the day? How is your recovery from minor ailments? How is your mood? How is your appetite? So, what is the state of vitality in homeopathy research? This is a rhetorical question that I do not propose to answer here. I trust that by reflecting on the discussion in the Context chapter (4.10) you are already forming your own views and will continue to mull over this as the thesis unfolds. Let us first establish the context for this question. From the perspective of practitioner based research, vitality is considered in terms of research enriching, advancing and improving practice; its potential for engaging homeopaths, CAM practitioners and patients; and the potential for learning, discovery and innovation. Freshwater (2008) includes vitality as a criteria for evaluating the quality of practitioner research (16.4.2). Vitality is described in terms of the research's importance, meaning, vibrancy and innovation. The intention here is to briefly highlight activities, approaches and issues for research informing practice.

Practice based research is ingrained in homeopathic practice, as homeopaths we are researching of our own practices (see 3.3.2 for discussion) and homeopathy's research traditions are still active. Provings and research into improving proving methodology and ethical frameworks is actively being conducted with direct application to practice (see Dialogue on Provings chapter 14). In journals, case reports transmit practitioner knowledge with the potential to be transformed into research (11.5.3). HRI is planning to create a case reporting research resource and has facilitated access for all homeopaths to data bases of clinical trials. Explanatory frameworks, for example concepts from quantum mechanics, are offering speculative explanatory models. New vocabularies offer the potential to illuminate fresh perspectives on practice and to shift the research paradigm from Newtonian mechanics and Cartesian mind/body split. However reflexivity, rigor and critical thinking are not well represented in professional homeopathy discourse. This notable absence motivated me to venture on this inquiry and is a thread through the thesis.

Homeopathy research discourse obscures this vitality as it is primarily orientated towards EBM with attention to building evidence for effectiveness from meta-analyses of clinical trials. There is a paradox, homeopaths describe practice as different from biomedicine, whilst adopting a biomedical frame of reference. If we look at vitality in terms of its potential for discovery and learning, we must question the meaningfulness of some trials and the dearth of qualitative approach to examine users' experiences. Assumptions about effectiveness and efficacy need to be deconstructed, so that homeopaths can look at more meaningful ways of evaluating treatment and improving patient care.

9.5.2 Breaking down the polarised relations between vitalism and scientific inquiry

Let us start off by discussing what scientific means in the context of this inquiry. The word ‘science’ comes from the Latin word *scientia*, meaning knowledge. Controversy over the scientific validity of homeopathic remedies is essentially a dispute about the nature of knowing. The scientific experimental method has facilitated technological development by generating and testing knowledge through empirical verification and replication. Mathematics has extended the potential to explain complex phenomena. In this thesis the phrase ‘dominant scientific discourse’ refers to the institutional power of science with its own assumptions and values, articulated through objective and depersonalised language. Taking a postmodern stance, the status of science as a ‘grand narrative’ (Lyotard, 1984) is displaced by science as a plurality of competing science practices. Scientific work does not take place in vacuum, rather science is a set of social practices shaped by political and economic factors.

Let us take an historical lens to deconstructing the objective and realist perspectives of modern science. Scientific developments are a function of wealth and empire. The geographically dominant Islamic empire from 9th to 15th century hosted highly developed and sophisticated science practices predating those in the West. Islamic scholars studied texts from China, India, Greece and Persia, and learnt to organise knowledge about the material world and to test ideas through experimental observation. The mystical tradition of Islamic alchemy metamorphosed into classification according to chemical properties. By the 15th century, developments in science shifted westwards as with the disintegration of the Islamic empire there was an influx of Islamic texts and translations of Ancient Greek texts into Western Europe. Scientific practices, in particular laboratory techniques, emerged from alchemical practices (explored further in Dialogue on Potentisation chapter 12), taking a mechanistic trajectory to examine only what is perceptible and explicable to the senses. Pursuit of scientific progress and modernism have achieved global hegemony over the last century. Consideration of wholeness, interconnectedness and harmony with the forces of nature (Nasr, 1987) have only more recently gained attention (Margulis, 1998). Whilst I am not advocating a return to mysticism nor denying transformations brought about by application of scientific method, the self-referential position that knowledge is limited to what can be empirically tested is problematic. We explore how homeopathy comes to be labelled as ‘unscientific’ at particular historical moments in the Dialogue on Single Remedy chapter 11.

Vitalism is considered to be antithetical to the trajectory of Western scientific thought. Enlightenment discourse prioritised reason and rationality, and other sources of knowledge are marginalised as archaic. Twentieth century science can be perceived as continuing to be dominated by a Newton-Cartesian paradigm (Grof, 1984) originating in the previous century. Newtonian mechanics conceptualises the world as composed of fundamental building blocks and interacting forces operating according to universal laws. In the Cartesian split between mind and matter, we are placed as the impartial observers of reality. Vitalism is antithetical to a reductionist, mechanistic and materialistic world view. Einstein’s theories challenge the

Newtonian model and perceptions are changing to view the universe in energetic terms as a unified network of events and relations (Grof, 1984, p.10). Academic disciplines have emerged such as quantum mechanics, cybernetics and systems biology with interests in complexity and self-organising principles. As considered earlier complexity challenges the epistemology of science (Greco, 2005).

What constitutes science is historically, politically and socially located. The divide between biomedicine and CAM is not over issues of science, but is cultural. The scientific trajectory of biomedicine has been at the expense of its more humane therapeutic values (Cassell, 2004). CAM's popularity can be seen as filling this void, and this is portrayed in biomedical discourse as manipulating a placebo effect and as an act of deception by the practitioner.

As the use of high dilutions is presented by scientific discourse as implausible, it would be tempting here to attempt to validate homeopathy's mode of action in scientific terms by referring to the multiple theories postulated (see Dialogue on Potentisation chapter 12). But in so doing, I would merely reinforce dominant science discourse and fail to address critical issues for homeopathy research discourse. Frequently interpretations of the results of clinical trials and meta-analyses refer to the implausibility of the use of high dilutions (Kleijnen et al., 1991), with the implication that 'it doesn't work because it can't work'. In the next chapter (Dialogue on the *Similimum* chapter 10) we question if the RCT design is fit for the purpose of evaluating treatment by a homeopath. In the Dialogue on the Single Remedy chapter 11 we consider how at particular historical moments, boundary disputes occur and homeopathy is publicly excluded from the zone of 'acceptable' in scientific terms. Homeopathy research discourse reproduces the biomedical agenda by prioritising clinical trials above other approaches to evaluate treatment outcomes. As most research is conducted by medical homeopaths, the research discourse is shaped by their difficulties in negotiating their identity across two different paradigms.

Reflection October 2008:

I struggle not to reproduce what I perceive as polarised relations with biomedicine in homeopathy discourse. Predictably, a sense of 'wanting to be taken seriously' surfaced early on in research supervision. Years later I experienced this tension gradually increasing as a scientific critique of homeopathy gained credence. It was helpful to learn from another practitioner researcher that "polarization is an abstraction from reality, since it does not take into account the complexity and fluidity of human experience" (Lees, 2008, p.5).

9.6 Analysis of professional experiential data on theme of vital force

I deconstruct debates critical of homeopathic treatment generated by the publication of a meta-analysis of homeopathy trials (9.6.1). I describe this as sceptics' discourse. In response to this I play with the idea that sceptics' discourse is participating in a paradigm shift (9.6.2).

9.6.1 Deconstructing the ‘sceptics’ discourse’

In the Context chapter 4 we considered the publication of the most recent meta-analysis on homeopathy trials (Shang et al., 2005) as more significant to homeopaths as a media event than contributing to the evidence base. Given that the review has been criticised for lack of rigor and transparency (Frass et al., 2006, Rutten and Lutke, 2008), and excluded from Cochrane Library database of Abstracts of Reviews of Effects, it is surprising that The Lancet editorial welcomed the results so stridently as “The end of homeopathy” (Horton, 2005). This editorial was picked up by the national newspapers and the coverage contributed to an emerging media and web based sceptics’ discourse. Self-appointed experts, demonstrating little or no understanding of homeopathic treatment, claimed speak on behalf of medicine or science, presented homeopathy’s claims to therapeutic effect as reducible to placebo, homeopaths as deceiving their patients and funding for research in homeopathy as unjustified. I explore the vitality of this discourse through analysis of three media texts:- The Lancet editorial (Horton, 2005), a national newspaper report (Frith, 2006) on the editorial and an article (McCarthy, 2005) in the same issue of The Lancet.

‘The end of homeopathy’ or is it?

The Lancet editorial (Horton, 2005) opens in an authoritative tone launching a series of negative comments about homeopathy. The editorial is set within a political context of debates over provision of CAM within the NHS. Supporting references to other systematic reviews and meta-analyses are notably absent, and the sources used are weak and ill-defined. Reference to ‘150 years of unfavourable findings’ draws attention to the longevity of homeopathy rather than to the vague illusion of ‘unfavourable’. The report of the Parliamentary Select Committee on Science and Technology (House of Lords, 2000), is a general reference to CAM treatment rather than specifically to homeopathy. Comments on withdrawal of funding for homeopathic treatment by the study’s sponsor, a Swiss health insurance company, are misleading. The Shang meta-analysis forms part of an evaluation programme of effectiveness and cost-effectiveness for the inclusion of complementary therapy treatments in its insurance scheme. Neither the The Lancet editorial nor the Shang et al. paper mention criticism by the evaluation programme management in 2003 of Shang’s methods and conclusions. Reports of the evaluation programme present a different view, that homeopathic treatment is more economical, patients experienced greater improvement, reduced side effects and reduced hospitalisation as compared to conventional treatment (Rutten, 2006).

What emerges between the lines is that the continued public demand for CAM and homeopathy is at least in part a response to biomedicine’s failure to meet patients’ needs. This is recognised by the editor in his advice to doctors to improve their ‘personalised care’. Homeopathy patients and users are viewed as a ‘threat to conventional care’. The editorial ends with a moralistic address instructing doctors to cease ‘a politically correct laissez-faire attitude’ and to advise their patients against homeopathic treatment. An explanation as to how a poorly reported meta-analysis can deny patient choice is not absent.

How is the debate constructed in the national newspapers?

An article in The Independent entitled “Effects of homeopathy ‘are all in the mind” (Frith, 2006). is used as an example of coverage in national newspapers. Use of inverted commas in the title suggests an ambivalent attitude towards the The Lancet editor’s comments. An ambivalent tone is established in the first line with the reference to ‘no real health benefits’. Drawing on the Cartesian divide of mind-body, imagined effectiveness is demarcated from real, presumably physical, changes. There is a shift in attitude part way through the text signalling divergent opinions, “there is room for both”. Consumer power begins to emerge with reference to royal patronage, CAM practitioners outnumbering GPs and the millions of pounds spent each year on CAM treatments. Critics are described as scathing and suspicious, and unfavourably compared with the old fashioned image of a family GP who “embraces alternative therapies”.

Conspiracy theories? The making of a controversy to obfuscate other issues?

By examining the context in which the editorial appeared, we can identify other factors at play. This issue of The Lancet also featured a short piece on a leaked draft of the forthcoming, to my knowledge still unpublished World Health Organisation (WHO) report on homeopathy: “Critics slam draft WHO report on homeopathy” (McCarthy, 2005). There have been suggestions (Rutten, 2006) that the editor’s vociferous argument against homeopathy was designed to create a diversion from WHO’s findings that

“the majority’ of peer-reviewed scientific papers published over the last 40 years ‘have demonstrated that homeopathy is superior to placebo in placebo-controlled trials and is equivalent to conventional medicines in the treatment of illnesses, in both humans and animals.”
(McCarthy, 2005, p.705).

Conflicting interests between WHO and the British medical establishment are visible. The WHO draft report sets the use of both complementary and traditional forms of healing within an international context and thus opens wider perspectives. The costs of drugs places the Western medicine beyond the reach of many people in the world and traditional forms of healthcare are mainstream. As a relatively recent Western invention, through the work of 19th century Christian missions, homeopathy plays an essential role in healthcare in subcontinents such as India and South America.

Setting these texts within the context of sceptics’ discourse

The media reporting of the Shang meta-analysis participates in a wider discourse of scientific scepticism. Whilst scepticism is an essential feature of the scientific method, it can lose its criticality and veer towards dogmatism. This discourse is distinctly different from philosophical scepticism that questions our ability to make knowledge claims. Scientific scepticism is promoted through the activities of Sense about Science, websites (www.skeptic.org.uk, www.skeptic.com), publications by the Committee for Skeptical Inquiry and Skeptical Inquirer, and social media networks. These sites have organised campaigns against Bachelor of Science degrees in CAM (Colquhoun, 2007) and mass complaints to the Advertising Standards Authority about homeopath’s websites (Burchill, 2011). Journalism distorts science discourse by over-interpreting the results and constructing polarised debates. Science journalists have achieved

the status as experts and their influence is visible in the House of Commons Science and Technology Select Committee evidence check on homeopathy (2010).

The sceptical discourse questions the veracity of knowledge claims that are perceived to lack rational justification through empirical or reproducible evidence. It venerates scientific truths, and distorts the role of scientific method as supporting the *status quo* in science rather than in disproving theories. Whilst the scientific method is the best method so far to find out from a realist standpoint about how the natural world works, the sceptics discourse loses sight of the fact that science is not about belief, as current theories and models are always provisional until better explanations are generated. Sceptics' discourse represents itself as 'myth-busting' but is itself promoting a myth of salvation through science. From a feminist standpoint, I find emphasis on rational argument problematic. Rationality can be viewed as a male construct (Johnson et al., 2000), relying on abstract values of autonomy, domination and mastery. Knowledge is always subject to the limitations of understanding through the human mind. Whilst designating certain practices as pre-scientific and irrational, the discourse itself does not embrace current scientific thinking that perceives the natural world as far more complex than previously anticipated. Mathematical physicist and philosopher North Whitehead expresses the sense of how scientific inquiry can become trapped within orthodoxies:

"The Universe is vast. Nothing is more curious than the self-satisfied dogmatism with which mankind at each period of its history cherishes the delusion of the finality of its existing modes of knowledge. Sceptics and believers are all alike. At this moment scientists and sceptics are the leading dogmatists. Advance in detail is admitted: fundamental novelty is barred. This dogmatic common sense is the death of philosophical adventure, The Universe is vast." (1948 cited (Dossey, 2000) p1737)

We are currently witnessing a fundamental rupture of scientific understanding as research is contradicting Einstein's Theory of Relativity by suggesting that sub-atomic particles can travel fractionally faster than the speed of light. Given that this has radical implications for our understanding of time, questions about the activity of high dilutions appear quite plausible by comparison.

There is a sense that professional homeopaths do not have a voice that is acknowledged in the public sphere (Couldry, 2010). Spokespersons tend to be medical homeopaths speaking with the legitimacy conferred by the prefix doctor. I recognise that professional homeopathy discourse does not demonstrate reflexivity or critical thinking, but campaigns to censor homeopaths' websites is an example of how homeopaths' voices are being stifled (Burchill, 2011). I embrace the criticisms levelled at homeopaths as creating an impetus for positive change and as an opportunity to deepen and strengthen our understanding of what we do and why, on our own terms. The formation (October 2010) of an international campaigning body 'One Vision, One Voice', represents an attempt to fill the absence of an articulate voice to represent homeopaths in the public arena.

9.6.2 Is homeopathy participating in a ‘paradigm shift’?

Let us take a provocative stance here – the popularity of homeopathy and other CAM practices challenges dominant ways of thinking. To make sense of our experiences, our perceptions are shaped by specific ways of thinking or belief systems. Whilst we may hold contradictory or conflicting beliefs, our sense of self is constituted through these beliefs so it can be very threatening to have our belief system challenged. Drawing on a Kuhnian notion of paradigm shifts (Kuhn, 1970), it could be argued that the Newtonian-Cartesian paradigm, that has dominated Western scientific and philosophical thought since the 18th century, is beginning to be undermined. Quantum-relativistic physics is part of the formation of a new paradigm (Capra, 1982, Grof, 1984) within which vitalist ideas may play a role.

Kuhn’s model offers a way of conceptualising the interaction between vitalism and scientific discourse. This model must be used with caution, as the emphasis on a linear and rational notion of progress, implicit in modernism, is incongruent with the framing of this inquiry. Also Kuhn’s use of the term ‘paradigm’ is ambiguous (Gutting, 1980). Kuhn elaborates a ‘life cycle’ of science practice, where a particular cognitive framework and set of values and beliefs dominate practice, and over time gradually a new framework begins to articulate a different perspective until a ‘paradigm crisis’ occurs. Initially advocates of this new framework are marginalised by the old vested interests, but gradually they gain a critical mass and begin to undermine the old framework. Ultimately the latter collapses and the new framework becomes dominant.

So are CAM researchers participating in a paradigmatic shift? Certainly if we are at the vanguard of change, we are experiencing fierce attacks from the establishment. Peters (2005) proposes “21st century vitalism” informed by research into self-organisation, homeostasis, subtle energy and embodied consciousness. He proposes 21st century holistic healthcare based on a model of entanglement between the biochemical, biomechanical and psycho-social aspects of self-organisation. The term entanglement is from the vocabulary of quantum mechanics, and we will meet this concept again when we consider explanatory models for homeopathy in the Dialogue on Potentisation chapter 12.

*Reflection on what would it feel like to be in a paradigm shift:
Homeopathy appears to be singled out from other CAM practices for condemnation. It feels like our presence, (medical and professional homeopaths alike), our patients' preferences, and our two hundred year history offend certain individuals, who use the media and institutional positions to denounce us. Our difference from biomedicine is presented as grounds for ceasing all NHS provision and further research. Yet there are shared values with biomedicine, such as patient choice and engagement, reducing the use of antibiotics and anti-depressants. Are the two related? Is homeopathy criticised by certain groups precisely because we offer another trajectory? We are caught in two counter forces. The Kuhnian model suggests that we should not be passive, but forge ahead in changing the political climate.*

9.7 Reflective pause before moving on from vital force to *similimum*

Reflecting on this chapter unsettles me. Starting with the vital force in opening up homeopathy's epistemology to critical re-examination, I fear that a proportion of readers may feel estranged by the esoteric nature of our discussion. This concern may well mirror my own reservations about how vitalism is articulated in homeopathy discourse. The vital force is a way of making sense of health and recovery. However the vital force is conceptualised prior to the advent of haematology, histology, serology and imaging, and relies on the idea that changes are perceptible to the individual and/or the practitioner. My own experience of a life threatening diagnosis without feeling unwell, shook my health beliefs to the core. Through the process of narrative repair (Nelson, 2001) I have come to engage with uncertainty at a profound level. I recognise that up until now uncertainty had been consigned to a cognitive role. Now I am forced to realise that I live with imminent uncertainty.

Through this chapter I have learnt that vitalism is an expression of the very subtle qualities of the spectrum of health and illness. It also represents the intangibility of trying to capture illness and recovery experience in a research context and this encourages me to clarify the direction of this inquiry. I am finding that to conduct a reflexive inquiry into practice, I need to re-examine how I interact with the therapeutic framework in daily practice. It was a revelation to realise that I talk about biomedical practices in polarised terms. I was not previously aware of this as daily practice constantly shifts focus between biomedical diagnostics and homeopathic analysis. Considering what I have termed sceptics' discourse causes me to question my own orthodoxies and sets of beliefs. I have replicated the tendency to define practice in terms of its founder. Am I so held back by the weight of history that I am not open to more innovative perspectives? To what extent does Hahnemann's textual legacy function to create stability and coherence, and to withstand the vicissitudes of modernist progress and methodological fashions? I leave the reader to ponder this dilemma. Evoking the experience of a paradigm shift helps us to envision holistic health with energetic and self-regulatory principles at its heart. Homeopathy could be well placed to embrace the challenges of postmodern healthcare.

I argue that aspects of humoral theory, such as interdependence of mind and body, self-regulatory function, balance and adaptation, are fundamental to homeopathic philosophy. I suggest that the humoral explanatory model is so integral to patients' belief systems of health and illness that this link could have contributed to the longevity of homeopathy. This causes me to reflect that illness experience is not biologically determined, but influenced by cultural factors such as age, gender, ethnicity and locality. All forms of medicine are social practices that are in constant state flux. Diagnosis is not a universal phenomenon but is also culturally determined. My professional practice is shaped by contextual factors of white, middle aged female homeopath, academic, PhD student, located in rural middle England, practising privately in a GP surgery. This social context shapes practice, for example in Holland, Germany, France, Russia, India or South America, homeopathy is practised differently based on culturally specific contexts. Indian (Sankaran, 1996) and South America teachers (Ortega, 1986) have enriched

British practice in profound ways, however their approaches cannot be imported into your practice without realising that there will be differences in your understanding and application.

Finally there as a timely reminder that popularity, longevity and wide geographic distribution of homeopathy does not, like humoural medicine in the past, infer effectiveness of treatment. How we evaluate what effectiveness means is a thread running through the thesis. The next chapter examines a distinctive feature of homeopathic practice, treatment by similars, in the context of the universal principles of symmetry and perspectives in Chinese medicine.

10 DIALOGUE ON THE SIMILIMUM

10.1 Case vignette

I often use this scenario as an example to illustrate the ‘like cures like’ principle when talking to new patients or making presentations to the public.

A case of hay fever

During the summer, many people seek homeopathic treatment for acute hay fever symptoms. Let us consider the young man, attending my clinic in August, who sneezes as soon as he enters the consulting room. A watery discharge streams from his nose and he complains of a tickle in the larynx. Unusually for hay fever, his symptoms improve out of doors. I notice that the skin under his nose is raw and excoriated. When I ask about this, he explains that although he is very careful to use soft handkerchiefs, the nasal discharge is so acrid that the skin burns on contact. The homeopathic prescription is chosen on the basis of finding the remedy most closely matching the symptoms. In this case I would prescribe Allium cepa, the common red

Notes on the remedy: The medicinal use of onions reportedly stretches back to the ancient Egyptian civilisation. Dioscorides (CE100), a Greek pharmacologist, is recorded as using the tincture to treat symptoms on the *simila* principle. The red Connecticut onion was proved by Constantine Hering in 1847 (Clarke, 1988 (1st published 1901).

onion. Most of us have experienced within a few minutes of starting to peel and slice onions that our eyes stream and nose runs. If the nasal discharge continues, it is excoriating. I am not suggesting that this man is allergic to onions, rather that his reaction to specific allergens, possibly pollinating grasses or moulds, is very similar to the discomfort caused by cutting up onions. Through the process of serial dilution and succussion, the homeopathic remedy Allium cepa neither tastes nor smells of onion. Homeopathic

philosophy suggests that in responding to the homeopathic dose of Allium cepa, the individual’s susceptibility to his allergens is reduced. If the remedy match is accurate, treatment may be limited to two or three doses, or a regular dose may be required to maintain the improvement during the individual’s hay fever season. To improve symptoms in next year’s season, constitutional treatment before the next hay fever season is recommended.

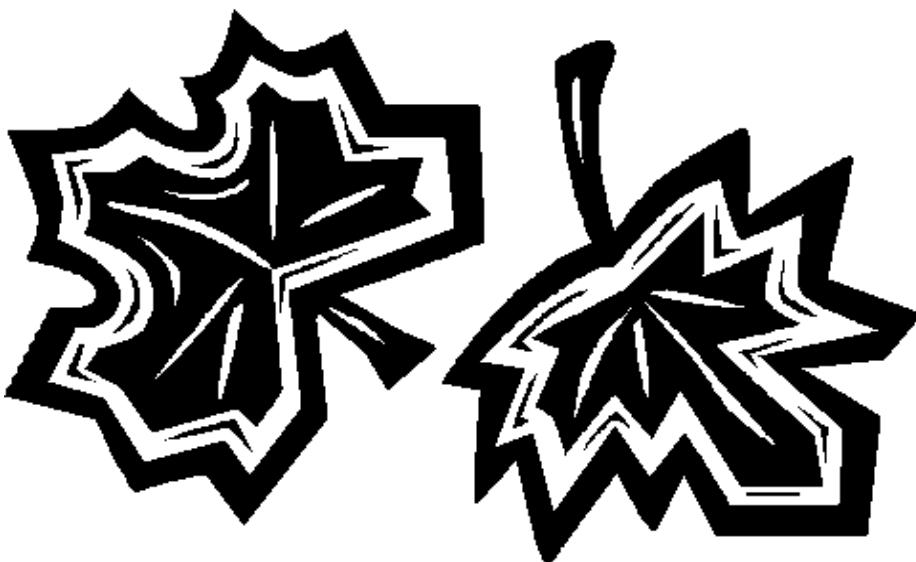
10.2 Orientation to the *similimum* chapter

This chapter focuses on the process of selecting a homeopathic prescription. Creating a synergy between the totality of the patient’s ‘case’ and the remedy profile is central to homeopathic practice. Articulated in objective terms as the ‘right remedy’ for the patient, this obscures a complex set of narrative relations, co-created through the consultation process and its context. How this relationship of similitude is constructed lies at the heart of debates over prescribing methods and styles. I question if homeopathic prescribing is a consistent and reproducible procedure and consider the implications of this for practice based evidence. To

engage in practice based dialogue, we discuss with other homeopaths how the prescription is selected (10.6.1) and how methodological approaches are adapted in practice (10.6.2). This raises further questions about reliability and consistency of prescribing (10.7). I explore the pervasiveness of symmetries in nature and the role of pattern recognition in our everyday lives and in other therapeutic approaches (10.4.1).

The *similimum* is chosen by a process of individualisation based on how the homeopath perceives the totality of the homeopathic case. This chapter opens discussion on individualisation and totality and these threads continue into the next chapter (Dialogue on Single Remedy chapter 11). We explore how far it is possible to evaluate the effects of individualised treatment by a homeopath in RCTs and observational studies (10.5.1).

10.3 Meditations on the *similimum* artefact



[Image 7: Leaves (Microsoft Office Clip Art Web Collection)]

10.3.1 Similar not identical

Hahnemann arrived at *similia similibus curenur* or ‘treatment of like with like’, through self-experimenting with ingesting repeated doses of *Cinchona* (the source of quinine) in 1796. Through experiencing malarial type symptoms as he continued to take *Cinchona*, Hahnemann perceived a relationship of similars between what *Cinchona* could cause and its well established therapeutic benefits. Hahnemann and his colleagues experimented with nearly one hundred single and unadulterated substances initially at toxic levels and subsequently diluted doses, and published the results (Hahnemann, 1990, 1st published 1822-1827). The word ‘*homoöpathie*’ was invented by Hahnemann in his essay ‘on a new curative principle’ in Hufeland’s Journal 1796 (Fisher, 1998, p.74). Therapeutic similarity implies that an individual’s healing response is increased or hypersensitive to a ‘similar’ stimulus to its current state. The term ‘homeopathic remedy’ is misleading as to be considered active, that is *homeopathic*, it must be prescribed according to this relationship. Observations from a prospective case series study (Thompson and Thompson, 2006) supported the hypothesis of therapeutic similitude.

Patients for whom a close match with a homeopathic remedy had been identified tended to show better improvement in treatment outcomes than others, where the match was not considered to be so close. Researchers speculate that “closeness of matching may correspond with outcome” (Thompson and Thompson, 2006, p.83), but as practising homeopaths, the researchers expected this relationship. There is an imperative to select the ‘right’ remedy, the *similimum*, as this is regarded as synonymous with effective treatment. This process of “individualised treatment on the basis of pattern differentiation” (Scheid, 2002, p.271) is not unique to homeopathy, as Scheid is describing Chinese medicine. Could diagnostics in biomedicine be described as pattern recognition? It may be a common feature of many practices.

Homeopathy participates in a continuing tradition of prescribing according to similar qualities. Hippocratic texts are cited as the source of this principle, thereby claiming the authority of Classical Greek medicine to endorse its clinical validity. Paracelsus, who we met in the previous chapter (9.4.2) as a protagonist for vitalistic medicine, recognised the therapeutic value of ‘like curing like’ from observation of folk medicines and the effects of poisonings (Wood, 1992). Paracelsus’ texts promote the doctrine of signatures, the ancient idea that the therapeutic application of a plant is indicated by its appearance, perhaps by colour or shape resembling a feature of the human anatomy. The dark lines on the foxglove petal (*Digitalis purpurea*) look like capillaries suggestive of its centuries’ long use as heart medicine. *Digitalis purpurea* is used in herbal, homeopathic and biomedical prescribing, each discipline with its own distinct rationale for its use. The doctrine of signatures, although rejected by Hahnemann (Dean, 2001) still informs the study of *materia medica* and some methodological approaches.

Example of interpreting the *materia medica* using the doctrine of signatures:
The remedy *Calcarea carbonicum*, is often prescribed in glandular conditions, for example glandular fever or tonsillitis, for people who do not enjoy physical activity, sprain tendons easily, tendency towards obesity and constipation, feel the cold and sweat easily. They are often careful and hard workers, and tend to be quite obstinate. The remedy is sourced from the inner surface of an oyster shell. Drawing on Paracelsian articulation of the doctrine of signatures, the remedy’s affinities are visualised as the oyster shell clamping shut, its lack of mobility, coldness, wetness, soft interior and hard exterior.

Histories of homeopathy (Cook, 1993) regard Hahnemann’s self-experimentation with Peruvian bark (*Cinchona*) (see 14.3.1) as innovative, but others (Waisse Priven, 2008) argue that self-experimentation by healthy individuals was common practice. Furthermore Hahnemann’s experimentation was informed by the prevailing theory of artificial or antagonistic fever and Hunter’s theory of counter-irritation. Medicinal substances, widely used to treat fever symptoms, were chosen on account of their potential to create artificial fever symptoms. Hahnemann’s “epistemological break” (Waisse Priven, 2008) was identification of specific similarities between the symptoms provoked by a healthy person taking Peruvian bark and the symptoms of the intermittent fever it was well known to treat.

Therapeutic similarity delineates homeopathy from biomedical strategies that counter pathological processes, such as anti-inflammatories, antacids and antibiotics. The principle of cure by opposites, also attributed to Hippocrates and his followers (Wootton, 2006), was first practised as lifestyle advice, for example of physical exercise for sedentary lifestyles and diets for the tendency to overeat. The polarisation in homeopathy discourse between similars and opposites obscures examples of the *similia* principle employed in biomedicine, for example capsicum as a counter irritant in shingles, and examples are also cited in immunology and chemotherapy (Coulter, 1980).

10.3.2 Totality and degrees of similitude

As in most therapeutic approaches, there are competing interpretations, techniques and strategies shaped by the health beliefs of the practitioner, treatment aims and context. Within a spectrum of homeopathic methodologies or prescribing strategies, each recreates the *similimum* in its own terms. In other words, the definition of *similimum* is not fixed, but contingent on the methodological approach that identifies it (Watson, 1991). For example, using Eizayaga's model of disease, the *similimum* is matched to the perceived uppermost 'layer' of the disease state. Homeopaths are preoccupied with improving their performance in selecting the most appropriate remedy and this is the driver for multiplication of methodological approaches.

These competing notions of similitude are constructed on different perceptions of holism. Holism is shared by many CAM modalities but each constructs holism according to its own therapeutic approach. Holism can be vaguely defined as interdependence of mind, body and spirit. Ill-health is perceived as a whole person experience, not limited to an identifiable site of pathological change or an isolated event. Holism in homeopathy is constructed in particular and culturally specific ways, as narrated subjective experiences of health and illness. Holism is talked about rather than experienced in physical function. Since the 1970s psychology has shaped attention to cognitive and emotional symptoms (Coulter, 1986, Bailey, 1995), eclipsing the importance of general physical symptoms (Creasy, 1998). Completeness and holism are illusory as this ignores the partial nature of perception. We are aware of some gaps in our perception, but we are generally oblivious to how limited our view is.

Extract from journal January 2003:
After nine months of treatment, I feel frustrated by what I perceive to be an apparent lack of progress in his case. Having already made two prescriptions based on the totality, I now make a symptomatic prescription based on the current physical symptoms. I did not explain to the patient my rationale. His description of the response amazed me:
"Like a layering of dust all over me, smothering me. This reminds me of my reaction to anti-depressants."
This is congruent with the theory of symptomatic treatment, as an attempt to work palliatively on a limited number of symptoms. Why do I feel ashamed? I deviated from the patient's request for holistic treatment and have been found out! This prompts me to regain focus on the totality and to pay greater attention to what the patient was telling me.

Interpreting homeopathy in terms of quantum mechanics (Milgrom, 2003a), offers a more complex and unbounded conceptualisation of holism. This is considered in discussion of explanatory models of homeopathy in the Dialogue on Potentisation chapter 12. Totality, a more flexible term than holism, is used to describe the full extent of the disturbance of health, that is of the vital force, expressed as signs and symptoms. Defining the totality of a case is tentative, as it takes into account the constantly changing state of health, whereby new symptoms emerge, latent aspects come to the fore and other features recede. In acute prescribing, where the prescription is driven by pain and urgency, the totality is limited to changes arising since the acute complaint started.

Kurtz (2005) argues that homeopathy is intrinsically holistic as “the only possible relationship between two totalities is their degree of similarity” (2005, p.23), and that prescribing according to contraries ‘is not amenable to a holistic approach, since by its very nature, it is not applicable to whole entities’ (2005, p.25). The term ‘the degree of similarity’ is a reference to the work of 19th century North American homeopaths (Kent, 1987, 1st published 1900, Farrington, 1994, 1st published 1887, Dunham, 1997, 1st published 1878). In practice I use this term to conceptualise how well matched the remedy appears to be for the individual. Where there is a good match and/or apparent excellent response I conceptualise this as hitting the centre of the target. Where the match and/or response are fair, I have hit the target’s outer rings and in the absence of a discernible response and there do not appear to be reasons why the indicated remedy fails to act, I have missed the target altogether. Another aspect of the *similimum* is the choice of potency, or level of dilution and succession of the remedy (see Dialogue on Potentisation chapter 12). Potency choice is matched to the perceived vitality of the patient.

10.3.3 The homeopath’s tools: *materia medica* and repertory

Just as medical training shapes doctors’ perception of the patient in terms of pathological changes, so the homeopath learns to co-narrate the patient’s illness accounts and to decode these narratives in terms of *materia medica* literature. Whilst a proportion of remedy sources are shared with the herbal pharmacopeia, for example *Hypericum* (common name St John’s Wort), the way that the therapeutic effects are articulated is completely different. Herbal medicine relies on the phytochemistry of the plant, whilst homeopathic *Materia medica* symptom profiles are ascertained through homeopathic provings and toxicological reports (fully explored in Dialogue on Provings chapter 14). *Materia medica* texts identify patterns, or key characteristics, from what appears to be apparently a disparate collection of physiological features, symptoms and temperament traits. This is organised into an array of schematised profiles of pathological signs and symptoms, including head to toe lists of symptoms; vivid characterisations, doctrine of signatures, erudite essays, cartoons and drawings. Let us take for example the remedy prepared from flint, *Silicea*. Lack of stamina is a key characterisation of *Silicea*. This is manifest in features including shyness, low self-esteem, slow healing abscesses, sluggish bowel movements, sensitive to cold, and swollen glands. In the Dialogue on Provings chapter 14 we explore how *Materia medica* data is sourced.

In the previous chapter we discussed the influence of humoural theory both on the emergence of homeopathic therapeutics and as a metaphor for understanding health and illness that has persisted into current times. The influence of the humoural typology of constitutional types is clearly visible in *Materia medica* texts. Constitutional types were perceived to arise from deficiency or excess of one of the humoural fluids, identifiable in terms of different temperaments, aversions, desires, physical ailments and physiognomy. Whilst Hahnemann's provings are presented as lists of signs and symptoms (Hahnemann, 1990, 1st published 1822-1827), recognisable character types emerge in later writings (Kent, 1987, 1st published 1905, Tyler, 1987, 1st published 1942). Characterisation becomes highly developed (Vithoulkas, 1988), for example, *Nux-vomica* is generally referred to as the high-living, irritable and stressed out business man, or likening the remedy to a well known public figure. Typology extends into psychological interpretations (Coulter, 1986, Bailey, 1995). These appear to participate in tendency in CAM to make psychological interpretations. Samuel (2006) describes 'psychologised' mapping of charkas in Western acupuncture. The distinction between remedy and patient can become blurred in talk between homeopaths creating stereotypes such as 'We have a *Lachesis* in our book club, she keeps talking all the time and is very possessive if a woman chats to her husband in the refreshment break.' The most recent development in *Materia medica* knowledge has been in studying remedies according to their 'family' genus, as plant species, minerals, metals, birds etcetera with notable contributors from Johnston, Mangialavori, Sankaran, Scholten and Vermeulen. These offer a more scholarly and systematic approach to incorporating verification in practice, but not always supported by proving data. Books on therapeutics outnumber all other sectors in homeopathy publishing (Winston, 2001). The popularity of therapeutics offers an insight into a diagnostic focus that deviates from the person centred approach. The clinical use of remedies is considered in terms of diagnostics (for example hay fever, eczema) or on a particular affinity (for example liver) or specialism (for example paediatrics, childbirth).

To select one remedy from the three thousand remedies in the homeopathic pharmacopeia requires reflexive skills to decipher qualities in the patient's case. Unavoidably there is a tendency to favour the more familiar remedy profiles. The repertory, a vast index of signs and symptoms, acts as a tool to mediate this process. Each symptom descriptor is called a rubric. For each rubric remedies are listed that are known to share that symptom, either through provings or clinical verification. This way of organising data is traced back to Hahnemann's notebooks, with Boenninghausen's first comprehensive repertory published in 1832 (Winston, 2001, p.54). Repertorisation involves selecting the most appropriate rubrics for the most significant symptoms in the patient's case. Through a process of elimination of the remedies listed for each rubric, the remedy or small group of remedies that occur in all or most of the selected rubrics is considered to be best indicated for the patient. The structure and function of the repertory is well suited to computerisation, and software producers now compete to offer the most effective aids to practice. Electronic databases and the worldwide web have transformed access to homeopathic data, and contemporary practice has been shaped by the unparalleled levels of accessible information. Discussion of the language of certainty surrounding the choice

of *similimum* for each individual case is resumed (10.7.1) after we have examined Professional experiential data.

10.4 Intertextual relations on the *similimum* theme

10.4.1 Playing with conceptual models to illuminate the *simila* principle

Let us unravel the therapeutic use of the *similimum*, by taking a conceptual leap to make an innovative exploration of symmetries. The subtleties of symmetry go beyond reflective or mirror symmetry, to rotational symmetries of highly complex, multifaceted patterns, where symmetry is achieved by rotating patterns on an axis or series of axes. Symmetry is analogous to the *simila* principle as both involve pattern recognition. Extrapolating this further, in reaching this level of understanding with an individual patient, the homeopath and patient are united in a shared therapeutic encounter. This shared experience can perhaps also be conceptualised as a state of symmetry?

Looking through a mathematician's lens (du Sautoy, 2008) allows us to appreciate that a therapeutic system founded on pattern recognition is entirely compatible with a fundamental organising principle of living organisms. Du Sautoy argues that over the millennia we have become highly sensitive to recognising symmetry and patterns. Symmetry shapes our sense of beauty and underpins the sciences. Symmetry is a stable and efficient state of natural phenomena. He cites examples such as bees attracted to symmetrically shaped flower heads or your survival depending on discerning the pattern of leopard's spots in the dappled light of the forest. A mathematician's way of seeing is encoded in numbers and shapes, perceiving highly complex patterns in apparently chaotic phenomena. This is clearly analogous with how homeopaths as well as doctors are trained to differentiate patterns in the apparently random presentation of signs and symptoms.

Another route to understanding symmetry as an organising principle is offered by fractal geometry observed by mathematician Mandelbrot. Replicated self-similarity suggests that in nature there are shapes and structures that, although they appear to be irregular and random, have a pattern of regularity. This regularity is replicated at all levels of magnification (Rosenberg, 1999). For example the Beech tree is structured through progressively branching fractal networks on a diminishing scale of size to the outermost tips of the branches. This resonates with the homeopathic case where the likeness to the *similimum* is identified through every aspect, from expression of feelings, general sensations and individual physical symptoms. On a different tact, a relationship of similars is evident in the biological phenomenon of synchronisation between individuals. Alignment with others occurs in the menstrual cycles of women living in the same house and in the voices of group chanting or a choir. This resonates with the self-regulating model of health in homeopathy.

You may be wondering where this discussion is going. I use perspectives offered by symmetry in mathematics, replicated self-similarity and synchronisation to suggest that a therapeutic system founded on pattern recognition and the *similia* principle is entirely congruent with how fundamental organising principles are conceptualised. This disrupts the assumption that treatment by opposites is a self-evident truth. Homeopathic practice creates the potential for therapeutic effects by engaging our heightened sensitivity to recognising symmetry and patterns. Possibly a process of entrainment or harmonisation occurs through the influence of the homeopathic remedy moving the individual's state of health towards balance. We resume intertextual discussion before the end of the chapter after turning our attention to research issues and engaging with other homeopaths on practice based issues.

10.5 Homeopathy research discourse on the *similimum* theme

The *similimum* and the individually tailored remedy are synonymous. We anticipate discussion of individualisation in the context of single remedy prescriptions (chapter 11) by turning our attention to evaluating the effects of individualised treatment by a homeopath, both by conducting randomised controlled trials (RCT) and observational studies.

10.5.1 RCTs – the challenge of designing trials to evaluate individualised treatment

Let us consider some key RCT design issues for individualised treatment. In an attempt to minimise bias and to make reasonable estimates of effect, patients recruited to trials are randomly assigned to two or more arms of the trial (active intervention/s or placebo). Neither the patient nor the clinician know who is receiving verum (double blind). In comparison with the difficulties of treating with sham acupuncture or sham chiropractic, the little white pills of homeopathy lend themselves easily to disguising placebo. Historically clinical trials were designed to test a specific homeopathic remedy on a group of patients sharing the same biomedical diagnosis. More recently attempts have been made to conduct rigorous high quality RCT studies, whilst minimising disturbance to routine homeopathic care and assessing treatment effects over an appropriate time scale (Weatherley-Jones et al., 2004a, Relton et al., 2009).

Individualisation in practice is not confined to the choice of homeopathic prescription, but is integral to the flexible and unfolding treatment process. This is difficult to track in the RCT design (Weatherley-Jones et al., 2004b). Post-trial feedback indicated that blinding disrupted clinical decision making, case management and the consultation (Weatherley-Jones and Relton, 2003). In instances of an apparently poor response to treatment, homeopaths were uncertain whether this was poor prescribing or a placebo prescription. The homeopath is guided by an ongoing process of analysis, and treatment is tailored to the individual and their changing needs. Case management is directed by treatment effects evolving over time and new information or symptoms arising during the course of treatment. The patient is not a passive recipient, but an interactive participant in a joint venture. Researchers speculate that the ill-defined result of the RCT (Weatherley-Jones et al., 2004a) may in part be due to possible

"benefit for chronic fatigue syndrome patients in non-specific or contextual effects of a homeopathic consultation" (p.196). These contextual effects of treatment include the consultation, feeling listened to, narrating of the illness and, patient and practitioner expectation. The treatment setting and context also affects outcomes (Di Blasi, 2001, Weatherley-Jones et al., 2004a).

The homeopaths' feedback indicates that there are potential interactions between specific effects of the remedy and the contextual effects of participating in the trial (Weatherley-Jones et al., 2004a). This disrupts the central tenet of the RCT design, that the specific effects of the prescription can be isolated from other effects arising from participating in the trial. In other words:

"the specific effects of the medicine (as manifested in the patients' reactions), may influence the nature of subsequent consultations and the non-specific effects of the consultation may enhance or diminish the effects of the medicine" (Weatherley-Jones et al., 2004a, p.4).

This supports observations by Kleijnen and colleagues' (1994) that "the implicit additive model of the RCT is too simple" (Kleijnen et al, 1994, p.1349) suggesting that the experience of the homeopathic intervention is greater than the sum of its parts. The Cartesian duality of mind and body is untenable in the evaluation of CAM treatment where the characteristic effects of medicines cannot be separated off from the therapeutic relationship (Paterson, 2005). The CAM intervention and the consultation process are integral aspects of the same phenomenon (Paterson, 2005).

Let us consider two trials evaluating the relative size effect of contextual and characteristic effects of homeopathic treatment. In a four-arm feasibility trial (Fisher et al., 2006) patients with chronic dermatitis were randomly allocated to open verum, double blind verum or double blind placebo and the waiting list as the control group. Results were inconclusive with design problems and higher dropout rates in the placebo arm. A five arm study (Brien et al., 2011) concluded that it was the consultation and not the remedies that are "associated with clinically relevant benefits" (p.1071) in adjunctive homeopathic treatment of rheumatoid arthritis patients. However this conclusion is not reliable as it is based on partial outcomes and it is underpowered (Relton, 2011). Furthermore because of the adjunctive role of homeopathic treatment alongside conventional medication including oral steroids, it would be difficult to discern a response to homeopathic treatment.

This discussion highlights the limitations of RCTs to address questions of effectiveness of treatment by a homeopath. The Medical Research Council framework for evaluating complex interventions (MRC, 2000), such as post-stroke rehabilitation, provides a medical model that can be used to describe treatment by a homeopath in terms of a system of multiple independent and interdependent components. The report, whilst situating a range of methods of evaluating a complex intervention only as precursors to conducting a RCT, offers a legitimated medical vocabulary that we can use to deviate away from the assumption that homeopathic treatment can be tested in the same way as a new pharmaceutical product. Homeopathy as a complex

intervention is congruent with conceptualising health and illness as a function of the whole individual within the context of their life, in which becoming ill is not an isolated event. Exploring homeopathic treatment as a complex set of dependent and interdependent elements has significant implications for developing experimental designs to tease out and isolate the specific effects of the highly diluted dose. A systems approach enables us to perceive that if the experimental conditions of a clinical trial alter one variable only fractionally, outcomes can alter radically. For example using a standardised case-taking protocol could disrupt response to treatment. The elements of treatment are not additive or separate. The integrity of the system (intervention) could be destroyed in an RCT by attempting to disassemble specific from non-specific effects of treatment. By arguing that the characteristic (specific) and contextual (non-specific) effects of treatment are inseparable, the central tenet of 'control' in RCTs is invalidated. In the next chapter (11.5.1) we challenge the assumption that RCTs are the most appropriate means to test effectiveness of complex interventions and consider the potential of pragmatic trials to evaluate the effects as a package of care.

Observational studies (4.12) provide a useful way of holding up a mirror to see an image of what is going on in practice. They can provide insight into patient satisfaction, referrals and safety, but cannot be interpreted in terms of causal effects.

10.6 Analysis of professional experiential data on the *similimum* theme

In dialogue with other homeopaths in the Supervision through Action Research (STAR) project and at a professional conference, we explore fractures in the *similimum* artefact. We look at how the notion of the 'right' remedy for the patient is constructed through practice based teaching (10.6.1) and experiment with the idea that as the homeopath is integral to the prescription, the homeopath can be considered as the *similimum* stimulus in the therapeutic encounter (10.6.2).

10.6.1 Learning to select the *similimum*

Extract from STAR group discussion transcripts:

Clinic tutor A: 'We had an interesting *materia medica* discussion about how to lead students to remedies or not, as the case may be, and what sort of control we have over that. ...remedies that come up and may not repertorise – what do you do about that when we are meant to be justifying to students what we do? Whether you give up like I do or whether you stick to the bitter end....until they get to where you're going with it.'

Clinic tutor B: 'a patient that I wanted to give a remedy that wouldn't repertorise. I was concerned that I couldn't justify it on paper. But you're responsible as well and if that's the remedy, you have to give it, and that's what I did.' (STAR May 2004 lines 902-908 and 916-919)

This text illuminates *similimum* selection and how this involves tacit knowledge. Practice based teaching creates tensions between the novice learning according to formal procedures (repertorisation) and the experienced practitioner adapting theory to individual circumstances. Clinic tutors face dilemmas when the students' repertorisation does not lead to a prescription

that can be fully justified by the available *materia medica* data. Whilst repertories are constantly updated and enlarged, there are inevitable limitations in any systematic presentation of data. The expression of the patient can be lost in translation into repertory language, which is still informed by its 19th century origins. Experienced practitioners rely on tacit knowledge and are shown to use their intuition with a high level of certainty. This extract reveals how difficult it is to explain tacit knowledge.

A more critical reading might suggest that if the prescription cannot be justified by a reproducible system of repertorisation, then the choice of *similimum* is not reliable and has an improvisational quality. This would be to place too great an emphasis on the reliability of the repertory, as like any tool, it can only be used indicatively. The repertory and *materia medica* are guides for checking remedies, and from this extract it is clear that remedy choice involves an interaction between tacit knowledge and theory. Questioning the reliability and consistency of *similimum* selection is the subject of the intertextual discussion below (10.7.1).

10.6.2 Interpretation of the *simila* principle in the context of plurality of prescribing styles

Participant observation at SoHMars and Venus: Men, women and homeopathy" 11 September 2005, Nottingham

My intention was to observe how professional identity is constructed through conference proceedings. Two extracts from my reflective writing with recollections of reported speech:

We all need to find our identity, "our individualised practice".... Conference speakers borrow from other therapeutic approaches, including Chinese medicine, Buddhism and psychodrama. I am conscious that in practice we appropriate different models all the time, but do not always acknowledge our sources, and without necessarily demonstrating any expertise nor awareness of the limitations of our appropriation.

Sensation methods dominates the conference ... my attention was caught by a homeopath's contributions about how she uses the Sensation methods in treating xxxx patients. This is what I heard:

"a tool-kit approach, try anything, ...a way of connecting the physical and the mental in a way which is helpful for the patient too...I need a framework to show colleagues what we do." I recognise in this contribution that rather than practising in accordance with a 'method', clinical practice is more of an adaptive process.

The reflective account draws attention to the pluralistic and eclectic nature of homeopathic practice and the different kinds of knowledge that are drawn on. In the context of the current popularity of the Sensation methods, my attention is caught by this particular homeopath as she illuminates how homeopaths take a pragmatic 'tool-kit' approach, adapting methodological approaches to suit their needs. I selected this extract as it resonates with what I perceive as a personalised or individualised therapeutic framework. This is fluid and adaptive. This redefines the *similimum* as constructed pragmatically through adapting different methods to suit the homeopath and the context of their practice.

10.7 Resuming intertextual relations on the *similimum* theme

10.7 Questions of reliability and standardisation

My intention in this discussion is to disrupt the language of certainty surrounding the *similimum*. The *simila* principle can be considered as “an ideal of treatment that can only be approximated in any case of illness” (Dean, 2001, p.43). This illusive quality of perceiving the *similimum* generates plurality in prescribing methods, each promising to provide the ‘answer’ to more effective prescribing. Different methods are reinventions, each claiming to have developed a truer understanding of homeopathic practice, promoting themselves as ‘new’, ‘revolutionary’, ‘ground-breaking’ and ‘innovatory’. The European Committee of Homeopathy identifies twelve ‘schools’ of ‘distinctive doctrines’ in Europe and America teaching (ECH, 2007). Schoolism (Winston, 1999, Shaw, 2000) occurs with allegiances to one method or style of prescribing but I detect that there is a divergence between how homeopaths talk about their practices and how they practise. My own practice is a prime example, as it has evolved to be an individualised approach integrating a range of different influences. The art of prescribing is making the best decision at that moment, in often complex and unpredictable situations.

Homeopathic discourse portrays the choice of the *similimum* in definite and objective terms as the ‘right’ remedy for the patient. Given the highly complex nature of an individual’s health, Scheid argues that biomedicine “invokes an inappropriate sense of objectivity as integral to medicine” (2002, p.4). Attempts have been made to investigate inter-practitioner reliability in selecting the remedy (Fisher, 1998). Case studies were posted to homeopaths and the homeopaths’ recommended prescriptions compared (Aghadiuno, 2002). Predictably there was limited consistency in the choice of remedy as working from case studies on paper is a poor imitation of clinical practice. Even if video recorded consultations was used, an integral aspect of perceiving the *similimum* through the consultation process is lost. However even if design flaws could be overcome, I would anticipate that it would be difficult to achieve a consistent and objective view of a homeopathic case. I am not arguing that many homeopaths are unable to identify the *similimum*, rather that the aim of achieving consistency is untenable. From our discussion of mathematics we learnt about the complexity involved in replicating highly intricate symmetries. Given the complexity of illness and recovery narratives, there are multiple ways of looking at similitude, so consistency will remain elusive.

To bring fresh perspectives, I turn to research in Chinese medicine. Scheid (2002) reminds us that all medical practices, including those of biomedicine, are intrinsically pluralistic, diverse and experimental. Unlike homeopaths, Chinese medicine practitioners see no reason to apologise for this phenomenon:-

“No two doctors diagnose, prescribe, or treat in quite the same way.Chinese physicians and their patients seem little perturbed by this. Both view personal experience, accumulated through years of study and clinical practice and by definition diverse, as a cornerstone of Chinese medicine. Doctors pride themselves on their individual styles or prescribing or needling.” (Scheid, 2002, p.9)

In response to this view, prescribing debates in homeopathy could be thought of in terms of a polemical dialogue between advocates of different models and treatment strategies. The notion of the homeopath's personal therapeutic framework is supported by Scheid's comments:

"Practitioners may use the same stylised terms taken from the canonical literature to describe a therapeutic intervention, but in practice they apply to it their own interpretations." (2002, p.31)

Furthermore Scheid describes 'self-cultivation and the development of personal styles of practice' (2007, p.317) that celebrate 'individual virtuosity and innovation' (2002, p.49). This brings a different perspective on the rather negative construction of the role of charismatic teachers, the search for 'homeopathic enlightenment' (Winston, 1999) and the plurality of practices (9.3.2).

Let us relate this to the *similimum*, by shifting our attention to the homeopath's presence in the therapeutic process. In the consultation room I experience a sense of becoming a chameleon, as I gradually adapt my manner to accommodate to the patient's persona. How I respond to a teenager girl whose health is being affected by difficulties in fitting in at a new school, is very different than middle aged man with fatigue from radiotherapy treatments. The homeopath's intention to identify the *similimum* blends with the patient and homeopath 'tuning into' each other. Could the homeopath be considered as potentially embodying the *similimum*? Does the patient 'tunes in' to the homeopath's understanding of the case? This could be a quality of the therapeutic value of contextual effects. Along the same line of argument, the popular international conference speaker embodies a sense of potentising the practitioner by offering inspirational insights. We pick up this thread again in the Dialogue on Potentisation chapter 12 as we explore how the idea of the homeopath as an embodiment of homeopathic values.

In valuing personalised practice and exploring the tenuous nature of consistency, I turn to an analogy, in questioning whether it matters if acupuncture needling is in the right or wrong point location? In Chinese, Western and Tibetan acupuncture there are different descriptions of the charkas (Samuel, 2006). Samuel contends that the charkas are like maps, they are not objectively present in the body. He argues that when working with the complexities of health, how you learnt to use one of the maps is more important than which map to use. This resonates with the conceptualisation of a personalised therapeutic framework in homeopathy. By looking at the artistry of prescribing (Shaddel, 2005), I can focus on the quality of the homeopath's engagement rather than be distracted by critiquing the plurality of 'new methods':

"It is an art, because, every person can adopt a particular method to determine and prescribe the remedy, according to his abilities, characteristics, and interests. This is why most great Homeopaths such as Dr Sankaran, Sehgal, Kent and Boeninghausen...have been successful in spite of their fundamental differences in their methods." (Shaddel, 2005, p.32)

Whilst the charismatic teachers are still popular, I recognise that homeopaths' practice has moved on from the 1970s. By appreciating that homeopath's use a 'tool-kit approach' to devise the most suitable approach for that patient at that moment, helps to make visible the higher level skills involved in prescribing. In my teaching experience, I observe student homeopaths

without a sound grasp of homeopathic philosophy, become confused by experimentation with new methods. I cannot detach myself from my commitment as a practitioner to what I experience as a coherent understanding of homeopathic philosophy (homeopath readers may well disagree that I convey a sound grasp in this thesis). This is crucial to my effectiveness in practice. But I also recognise that in this commitment there is a sense of being attached to something definite, which is conceptually much looser and transient than I as a practitioner can accept. The plurality of prescribing styles is a function of each homeopath's engagement practice. Learning a new approach to prescribing is an important form of continuing professional development for many homeopaths. Learning a new approach entails dedicated attention and this will have beneficial effects on patient care. Whilst the discourse of new methodologies encourages homeopaths to learn from the 'master', in practice, homeopaths integrate new approaches into their existing personalised approach in practice. In looking to articulate critical perspectives on practice, I have to look beyond the rhetoric to recognise that critical engagement is happening in practice and is visible in some published case reports (Hardy, 2011). You may feel I have laboured this point, but it represents an important conceptual shift in how I perceive practice.

10.8 Reflective pause before moving on from the *similimum* to the single remedy

This chapter has been a long journey around homeopathy's most symbolic artefact. We started to explore practice and research issues raised by the individually tailored prescription. On reflection a priority in this chapter appears to have been shifting the dominance of the biomedical model and challenging the commonsense view that therapeutic interventions are achieved only by creating opposite effects. I argue that a therapeutic system founded on pattern recognition and the *similia* principle is entirely congruent with how fundamental organising principles are conceptualised in mathematics and the natural sciences. We identified limitations of the RCT design to test the effectiveness of complex interventions. In the next chapter we consider if pragmatic trials are as a means to test the effectiveness of treatment as a package of care and if large scale observational studies can provide valuable insights into patient satisfaction and safety.

The *similimum* gains meaning through the process by which it is selected. The *similimum* is an unstable concept, reinvented through individualised prescribing styles. The *similimum*, like the concept of holism, remains an elusive potential, operating at the level of intention. Both are context-dependent terms, and their meaning is predicated on the homeopath's individualised, adaptive appropriation of prescribing methods. Interpretations from quantum mechanics (Milgrom, 2003a) offers a more complex and unbounded conceptualisation of holism, and this is explored as a thread running through the thesis. The therapeutic value of the process of remedy selection is considered in the context of the consultation (Dialogue on Susceptibility chapter 13).

Notions of consistency in prescribing have been destabilised as I have become more aware that it is difficult, and may be undesirable. I suggest that issues of reproducibility and standardisation are not priorities in practice, but engagement by homeopath and patient is crucial. Patients do not seek homeopathic treatment to be given the same remedy as the previous patient. Part of the attraction of CAM is being treated as an individual. A highly individualised approach is celebrated in Chinese Medicine. This challenges the assumption that we must standardise treatment approaches to accommodate the audit and EBM discourses of the NHS. This is congruent with a trajectory of biomedical personalised healthcare that is beginning to identify sub-sets within diagnostic categories and to use genetic markers to specify treatment strategies to suit the individual (Dialogue on Miasms chapter 15). This represents completing a full cycle with homeopathy originating as a pre-industrial form of medicine treating the individual, overtaken by modern medicine's strategies for treating large urban populations, and now biomedicine's attention is returning to individualised treatment.

I am evolving a model of practitioner based inquiry that values clinical expertise, where an individual's interaction with a personalised therapeutic framework is a strength rather than a limitation. I am also beginning to understand that pluralistic approaches to homeopathic prescribing play an important role in the homeopath's engagement in the therapeutic process. Whilst not rejecting the need for clinical trials with standardised treatment protocols, I adopt a more pragmatic approach to embrace subjectivity and the art of individualised prescribing – personalised for both the patient and the homeopath. Whilst at the same time I recognise the danger that this relativist stance could be a 'safe haven' that obstructs critical inquiry into practice.

11 DIALOGUE ON THE SINGLE REMEDY

11.1 Case vignette

The classical homeopath aims to prescribe a one remedy at a time, covering the totality of the chronic case. This account illustrates the experience of treating a patient over a number of years with occasional repetition of the same constitutional remedy. This supports the theory that if there is a good match between the remedy and the constitutional state, a range of complaints can be treated with the same remedy. The choice of remedy for the patient is based not only on the biomedical diagnosis, but through identification of reiterated patterns in the presenting signs and symptoms. The term ‘constitutional’ refers to a treatment strategy addressing recurrent symptoms, enhancing well-being and reducing susceptibility to illness.

Sally: teacher and mother of two young children:

Sally presents in autumn 1996 with recurrent sinusitis. At the end of the consultation I identify the simillimum as Lycopodium. This remedy is well indicated for sinus symptoms, and

*particularly the right-sided polarity of her symptoms, including right-sided tension headaches and right lower abdominal pain. The *materia medica* profile of Lycopodium features Sally's enjoyment of sweet foods, as well as her tendency to low self-esteem and heightened sense of responsibility. After starting treatment she telephones to report progress and continues to take Lycopodium in LM potency daily. She reports that her*

Notes on the remedy: *Lycopodium* is a commonly used remedy, regarded as a polycrest, literally meaning many headed, with proving and clinical verification data for a wide range of symptoms and complaints. The source, spores of Club-moss, has a long history of medicinal use including as an inert dusting powder to prevent chaffing. First proved by Hahnemann (Kent, 1987, 1st published 1905).

presenting symptoms have resolved and general sense of well-being is improved. Sally stops treatment, but after six months, makes contact again, reporting recurrence of sinusitis after a period of stress. Again the sinusitis symptoms resolved after resuming the remedy.

After an interval of two years, Sally presents with persistent indigestion. Lycopodium is again indicated by its affinity with the digestive tract, symptoms being worse late afternoon and early evening, flatulent feeling with tightness around the waistband and return of right sided headaches. The decision to represcribe Lycopodium LM was supported by Sally's previous positive response to this remedy. After a month of taking the remedy she reports that the digestive symptoms are much improved. Occasional contact over the next three years is prompted by relapse of either the sinus or digestive symptoms following periods of intense stress. Sally reports that each time, Lycopodium taken over two to three months has helped her considerably, reporting symptomatic relief, improvement in energy and ability to cope with work and family pressures.

11.2 Orientation to the single remedy chapter

This chapter explores the theme of oneness - one remedy at a time, independent sole practitioners, one professional body and the RCT as the only way to research treatment effects. I explore threads left dangling from the last chapter – individualisation and totality. The individually tailored remedy in the form of a pilule or tablet is located in the rituals and traditions of medicine. In embracing a multiplicity of prescribing approaches, the single remedy prescription is a site of ideological struggle between homeopaths. The concept of individualism is integral to the identity of the self-employed independent homeopath and I conjecture that this obstructs the establishment of one ‘official’ self-regulating association. Questions of identity are explored through analysing dialogue with a medical student (11.6.2) and between homeopaths on the subject of shared practice (11.6.1). I examine the role of single case studies in communicating and expanding professional knowledge (11.5.3), and their potential to contribute to practice based evidence. Disentangling the duality of homeopathy as art and science provides a great opportunity to prise open professional knowledge (11.4.1) and to reconfigure practitioner based inquiry. In the margin loiters the question of the viability of combining the role of practitioner and researcher. I encourage you to question if I achieve this and whether I am successfully able to articulate critical perspectives on professional practice.

11.3 Meditations on the single remedy artefact

11.3.1 Pure and simple

Historically the single remedy prescription can be considered as a reaction against 17th and 18th century polypharmacy. Proprietary nostrums, sedatives, tonics and narcotics, including toxic preparations such as mercury and lead, were very popular among the wealthy classes. The only reference to homeopathy in Porter’s (1977, p.271) history of medicine suggests that safety concerns motivated Hahnemann to insist upon the purity of medicaments, minimal dosage and on dispensing his own prescriptions. Whilst NHS prescriptions are dispensed by specialist homeopathic pharmacies, the physician dispenser role has been perpetuated in private homeopathic practice.

The single remedy is the site of doctrinal struggle. It is symbolic of classical prescribing in the Kentian tradition (Vithoulkas, 1980, Kent, 1987, 1st published 1900, Creasy, 1998, Vithoulkas, 2010) and has been contested by more ‘practically’ orientated approaches. After protracted

debates, SoH removed all references to the single remedy from its literature in 2004. This represented a turning point in how the organisation defined itself in relation to homeopathic philosophy. Coulter’s account (1982) of the popularity and subsequent decline of homeopathy in late 19th century United States of America, reminds us of the importance of retaining a coherent identity for homeopathy. Coulter suggests that homeopathy became lost within eclectic

[Image 8: A tablet (Microsoft Word Clip Art)]



practice at a time of a growing consumer market place of proprietary branded medications. Parallels can be drawn. Sceptics discourse has stripped out the therapeutic framework, reducing homeopathy to the perceived implausibility of the mode of action of the highly diluted doses. In the same way there is the potential that pluralist styles of prescribing, alongside the untrained use of homeopathic remedies as adjunctive care by other healthcare professionals, such as osteopaths, could dissipate the coherence of the therapeutic framework to such an extent that the only common factor defining becomes the use of high dilutions.

11.3.2 A pill for every ill

So far we have emphasised the singular identity of the artefact and ignored its form. The invisibility of the tablet is indicative of the anonymous nature of the lactose or sucrose tablet most commonly used as the dispensing vehicle. The shape, texture and size of the tablet varies (powder, granules, tablet, pilule, cylindrical shape) according to practitioner preference. The use of lactose or sucrose is a legacy from 18th century medical practices. The tablet's anonymous white appearance and neutral or sweet taste has close associations with placebo, reinforced by the controversy as to whether 'the tablet contains anything at all'.

Whilst the homeopathic consultation has close associations with talking therapies, such as counselling and psychotherapy, the prescription at the end of the consultation, frames the encounter. The act of prescribing is a medical ritual and has powerful cultural connotations. The 'little white pill' draws on the reliance in biomedicine on pharmaceutical preparations. Homeopathy has a two hundred year tradition of home self-prescribing for acute and first aid ailments. This reinforces links with the myth of 'a pill for every ill' and connects us to our childhood experiences of being nurtured. The negative connotations of the 'pill culture' alert us to the dangers of dependence and the displacement of inner distress by reliance on medication.

11.3.3 Unity is an anathema?

Earlier in the thesis (4.6) we discussed the division between medical and professional homeopaths. There have been tentative alliances in the face of pressures on NHS funding of homeopathic treatment and efficacy questions. These have included shared research initiatives under the auspices of HRI and an on-line directory of FoH and SoH homeopaths (2010). However these fragile alliances do not appear to be accompanied by collective organisation of professional homeopaths.

In a profession originated and dominated by doctors, professional homeopaths are defined by an absence. How does being defined by a negative, as non-medically qualified, disrupt our sense of ourselves as a profession? Is it appropriate to talk about a profession at all? Using the 'communities of practice' model (Wenger, 1998) we can conceptualise professional practice, as an

"encompassing process of being active participants in the *practices* of social communities and constructing *identities* in relation to these communities"
(Wenger, 1998)(p.4).

This provides a way of thinking about homeopaths as an “emergent community of practitioners” (Cant and Sharma, 1998, p.249) where diversity is valued but there is some degree of consensus. Ethnographic researchers (Cant, 1996, Cant and Sharma, 1998) (Cant and Sharma, 1998) observed professional homeopaths involved in “a professional project” and perceiving “themselves to be engaged in a struggle about professional status and credibility” (Cant and Sharma, 1998, p580). Does this refer to being defined by a negative? Defining ourselves as a profession implies that we are self-regulating, electing representatives to maintain internal and external credibility (Freshwater and Rolfe, 2004, p.93). There has been intense competition between organisations to act as the ‘official’ representative (Cant and Sharma, 1998) of professional homeopaths. Continuing debates (over twenty years) about regulation indicate a wish by some members to participate in wider discourses of regulation and the NHS. There are mixed views about regulation among homeopaths, and in common with other CAM practitioners, some are opposed to more formal regulation. Independently minded individuals may have chosen to enter the profession to avoid bureaucracy, and to work in harmony with values of egalitarianism and individualism (Saks, 2003a). This discussion has assumed that professionalisation involves voluntary self-regulation, and that regulation is beneficial in protecting the public, establishing education and professional standards and gaining recognised expertise. There have been advantages to being an unregulated profession - lack of constraints have allowed the profession to develop organically, in tune with homeopaths’ values and flexibility in responding to change. Taking a Foucauldian perspective (Foucault, 1973), discourses around regulation and safety function as a mechanism of social control. Speaking from experience of the nursing profession, Freshwater and Rolfe comment that

“behind the liberal facade of diversity and the promotion of difference lies a core value of convergent conformism that serves to constrain individuality and stifle creativity.” (Freshwater and Rolfe, 2004, p.94-5)

Professional boundaries are well defined for medical homeopaths but much less definite for professional homeopaths, as other practitioners such as naturopaths and osteopaths use homeopathic remedies as adjunctive treatment. It is pertinent to consider the role of ‘expert knowledge’ as pivotal in seeking legitimacy and credibility. Homeopaths’ expert knowledge is arguably undermined by an egalitarian perception of practice. The therapeutic relationship is constructed as non-hierarchical, and the homeopath’s duty is to ‘educate the patient’ and to encourage them to take responsibility for their health (1.6 Key Principles and Practice) (SoH, 2010b) (see 0 Dialogue on potentisation chapter 12). Sharma and Cant (1998) identify “knowledge of prescribing” as demarcating the boundary between professional and amateur use of homeopathic remedies. However they argue that this area of expertise is not well defined in the “structure of homeopathic knowledge” due to its complex, tacit and experiential nature. This is familiar territory in this inquiry, and we consider the boundaries of professional practice as the thesis evolves.

11.4 Intertextual relations on the single remedy theme

11.4.1 The art and science of homeopathy

I take the opportunity of the ‘one by itself’ theme to collapse a troublesome dualism, that of art and science. Binary oppositions create hierarchies, designating one term as subordinate to the other. Homeopathy is presented as both scientific practice and as an art of prescribing (Roberts, 1985, 1st published 1936, Wright-Hubbard, 1990). Texts on the science of homeopathy function to legitimise homeopathic practice (Coulter, 1980, Vithoulkas, 1980, Gray, 2000, Chibeni, 2001).

To open this discussion let us examine how healthcare is shaped by science discourse. Biomedical discourse presents healthcare as an objective and rational activity, taking place in a social vacuum. Cassell (2004) argues that science and medicine are distinctly separate discourses, and by embracing science, biomedicine has become distanced from its humane therapeutic values. Cassell contrasts how scientific practices function in objective measurable terms, devising methods to predict and generalise, whilst medical practice prioritises the individual’s interests and operates through subjective experiences. He contends that in embracing science, biomedical discourse obscures the fact that changes in scientific understanding do not directly influence practice.

What constitutes science is politically and socially located, so it is important to examine these debates in their historical contexts. From common roots in the late 18th century, homeopathy and biomedicine have diverged and followed different trajectories. During the 19th century formation of a medical profession, doctors became empowered by association with the dominant discourse of science. At particular moments, boundary disputes occur and homeopathy is publicly excluded from the zone of ‘acceptable’ in scientific terms. It is illuminating to look at a specific historical site of struggle over the scientific status of medical practice following the 1858 Medical Act in Britain. When Bayes, a homeopathic doctor, (Weatherall, 1996) was barred from practising at his local hospital, he claimed the Act’s protection for a practitioner’s liberty to practise whatever system of medicine he saw fit. Bayes argued that homeopathy employed progressive scientific procedures. He became embroiled in an argument with his local medical elite. Both sides laid claim to empirical science, whilst accusing the other of irrational dogma and speculative theories. Weatherall argues that homeopathic treatment was excluded not due to therapeutic ineffectiveness, but because medical practice was being defined through exclusion of certain forms of practice. This supports Dean’s (2001) contention that during Hahnemann’s lifetime, politics rather than scientific ‘implausibility’ of the high dilutions was implicated in discrediting homeopathic practice. This resonates strongly with current critiques of homeopathy and demands for homeopathic practice to be removed from NHS provision. At any one time there may be colliding and conflicting perspectives between homeopathy and scientific practices. Examples of recent colliding perspectives are personalised healthcare and epigenetics (see Dialogue on Miasms chapter 15).

This discussion highlights the political nature of scientific and medical practice. Our understanding of science is informed by the Newtonian paradigm with its attention to identifying physical causative agents for observed effects. However this paradigm is being challenged by developments in a number of areas including quantum mechanics, particularly by theories of non-locality and entanglement, which suggest that an occurrence can be associated with particles in multiple places at one time. I do not dispute the value of the scientific method:

“Science actually produces the best descriptions and explanations that it can in a particular historical context with the tools available to it.”
(Murphy et al., 1998, p.4)

I raise problems with the way that popular scientific discourse claims to speak objectively to assert universal truths. By its very nature scientific knowledge cannot be complete, and therefore high dilutions cannot be dismissed on the grounds that observed effects cannot be ‘explained’. The authority of scientific discourse creates the assumption that the scientific method is the only valid means for generating evidence (Rolfe et al., 2001) to inform clinical decision making.

The dichotomy of art and science is false, as ideas and skills permeate across the disciplines. Conceptual thinking in the sciences is enriched by concepts borrowed from the arts and *vice versa*. Appreciating that science has aesthetic qualities (Ball, 2008) erodes the polarisation with the arts. Ball argues that between themselves scientists talk about beautiful experiments and elegant theoretical propositions. This is part of a covert language that is censored in the public domain. Mathematician du Sautoy’s (2008) sense of wonder at the beauty of rhythms highlights strong affinities between music and mathematics. There have been attempts to rekindle the artistry of biomedicine, for example a conference entitled ‘The Science and Art of Healing: Understanding the Therapeutic Response’, hosted by a collaboration of the Royal College of Physicians, Royal College of General Practitioners and The Prince’s Foundation for Integrated Health (3 September 2007).

Understanding the divide between art and science as a cultural construct opens a way for us to interrogate the assumptions in evidence based discourse. Homeopathic practice has been characterised by stability and coherence, and it has not been subject to the modernist belief that ideas are continually overturned by a new set of knowledges and discourses. Taking a postmodernist stance, I challenge the assumption that the onward march of progress is inevitable and desirable. Does the rise of popularity of CAM since the 1970s coincide with less attention to the humanistic aspects of medical practice? Science is explored as a broader term, drawing on sociological models of science as a social practice. This shifts the focus from scientific method as an objective measure of truth, to reflect on science positions.

11.4.2 Artistry of practice

In exploring the artistry of clinical and research practice I have been inspired by interactions with texts, conversations, images and workshops. Most of these interactions have been lost in memory, but the highlights are important in enacting practitioner based inquiry.

Schön's (1987) description of professional practice integrates scientific knowledge and artistry. Good clinical practice is more than problem-solving by following a set of procedures and drawing on technical knowledges. Imagination is needed to frame the problem in terms of professional knowledge and interpreting the context to fit these perceptions. Creativity is involved in working in uncertain, ambiguous, complex and novel situations that cannot be adequately explained by the technical rational approach. Schön's use of the term 'unique' is problematic, as our perception of each situation is informed by our previous experiences. He champions the 'irreducible element of art in professional practice' (1987, p.87), but a distinction between scientific knowledge and artistry I would argue is not sustainable. Like the scientist, the reflective practitioner is also a researcher in their own practice (Schön, 1983), testing out new ideas, challenging preconceived ideas and reframing dilemmas.

I met Della Fish at SoH workshops for educationalists in the 1990s. She identifies similarities between the artist and the health practitioner (Fish, 1998). Both are personally involved in their work, motivated to develop their practice, and use practice as a means of communication. McCormack and Titchen (2006) promote the role of creativity in practice development. Fay's critical theories for practice (6.2.4) are synthesised with their own experiences of creative activity in practice development and action research. "Critical creativity" claims to enhance the transformational potential of practice development. Whilst the authors' theoretical positioning is not central to the argument here, my lasting impression from experiencing their workshop is the importance of a holistic, emotional and aesthetic engagement in encouraging innovation, self-exploration and envisioning the potential of your practice.

I am inspired by conversations (Einzig, 1996) with and art produced by conceptual artist Hiller. I identify with Hiller's perspectives on feminism, postmodern dilemmas and working within a social constructionist framework. It is significant that I resonate with Hiller's writings more, but not to the exclusion of her visual art practices. I am attracted to learning about how Hiller makes sense of her process of 'art' production and using these encounters to bring insight into my professional

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I experienced a sense of 'coming home' during McCormack's experiential workshop. I was inspired to research in ways that are congruent with what I most value about homeopathic practice – enabling, holistic, individualised and transformational. Could I inquire into practice through emotional, aesthetic and embodied engagement? Could the transformational potential I experience in homeopathic treatment, be mirrored in a transformational inquiry? I hope to capture something of this excitement in my inquiry.*

**12th International Reflective Practice Conference 3 July 2006, Cambridge*

artistry. I perceive her oeuvre (using a wide range of media including writings, installations, paintings, video) as an inquiry process. Her exploration of self-representation as a woman artist is akin to the practitioner researcher. I identify a parallel process to my own, in terms of subverting academic and scientific convention and putting forward more meaningful methods of inquiry. Hiller's art practices critique her own academic background in anthropology, in particular the 'objective' view of other cultures and the appropriation of ethnographic artefacts and primitive art. For Hiller (1996b) the meanings of these objects tell us more about our culture than the cultures that created them. Her question 'is that really what it says on the label?' challenges me to ask 'what is evidence?' If experience is fluid, fragmented and pluralistic, this has ramifications for understanding evidence. By transposing Hiller's view of art as a social practice onto homeopathy, we have 'a particular form of training, a particular lens which one is given to look at the world' (1996B, p.218).

This attempt to integrate creative approaches into this inquiry is an act of resistance to being assimilated into the biomedical research culture and seeks to reframe evidence based practice beyond the domain of realist objective concepts of truth. I have learnt that practice based inquiry must engage at the level of artistry, rather than be confined to the technical rational knowledge.

11.5 Homeopathy research discourse on the single remedy theme

In this section we continue to deconstruct evidence based discourse, as the primary discourse of healthcare research. We question the supremacy of the clinical trial in homeopathy research discourse and question the nature of evidence. Finally descending down the evidence based hierarchy, we develop the theme of oneness to explore the tradition of the case report as a means of communicating practice based knowledge and the potential of case series as a practice based research tool.

11.5.1 Are RCTs the only reliable way to evaluate treatment by a homeopath?

I break this down to consider two distinct aspects of this debate: trial design and interpretation of results.

Design issues

Evidence based discourse has elevated RCTs from the most reliable and rigorous way of testing the efficacy of new pharmaceutical products in terms of physiological mechanism, to the best means to evaluate all forms of medical intervention (Kaplin et al., 2011). Rigorous RCTs offer internal validity in questions of efficacy of pharmacological interventions, but external validity is compromised in non-pharmacological interventions. The imperative to test the effectiveness of treatment by a homeopath in clinical trials is predicated on the erroneous assumption that homeopathic treatment is a pharmaceutical based intervention in physiological terms.

In the last chapter (10.5.1) we identified challenges in designing clinical trials to accommodate the individualised treatment approach, let us briefly summarise these (first bullet point) and

consider other methodological problems in designing RCTs to evaluate treatment by a homeopath:

- **Individualised treatment approach:** The potential interactions between characteristic (specific) effects of the remedy and contextual effects of the treatment process disrupts the central tenet of RCT design, namely that the specific effects of the prescription can be isolated from other effects arising from participating in the trial.
- **Multi-factorial and subjective nature of perceived outcomes:** The holistic focus requires attention to a wide range of health related factors. Patient's self-reported and subjective experience of ill-health is prioritised in evaluating treatment outcomes. Translating the patient's subjective assessment into measurable outcomes can be unreliable.
- **Diagnostic versus holistic focus :** Diagnostic criteria are applied before participants enter the trial. In homeopathy, conventional diagnostic criteria may be used to pre-select participants, but the homeopathic evaluation is integral to the treatment process. It emerges from and in turn informs the consultation process (Paterson, 2005). In evaluating outcomes the diagnostic focus is often inappropriate for the holistic and multi-focus approach, where change may take place in one aspect of the patient's health long before change in another.
- **Existing patient population presenting with co-morbidity and co-existing conditions:** The diagnostic criteria employed in trials are not representative of the patient population (Van Wassenhoven and Ives, 2004).
- **Patient preference:** Randomisation into different treatment arms does not reflect daily practice where self-referral is common, both for private treatment and NHS provision. It is possible that outcomes for patients who have been referred by a medical practitioner are poorer than for those who self-referred (Richardson, 1995). Disappointment bias in open trials may influence outcomes (Torgerson and Torgerson, 2008).
- **Disruption of treatment process:** Elements of treatment are not additive or separate. Altering one aspect in what is perceived to be a complex intervention (MRC, 2000), for example standardising case-taking protocol, can have a disruptive effect on the integrity of the treatment approach. Attempting to isolate the characteristic effects from the contextual effects of treatment could also be disruptive.
- **Non-linear response to treatment:** Individualisation is not limited to the choice of prescription, but is integral to the flexible and unfolding treatment process.
- **Under-powered trials:** Lack of funding and sponsorship results in too few participants to draw statistically significant conclusions.
- **Long term follow-up:** In chronic health conditions trials end prematurely for treatment outcomes to be identifiable.

Pragmatic trials represent one response to methodological limitations of RCT designs (Schwartz and Lellouch, 1967). Open pragmatic parallel group randomised controlled design offer a way forward in evaluating homeopathic treatment as a package of care and avoids some of these methodological difficulties. Treatment as usual compared with treatment as usual plus

adjunctive care by a homeopath, demonstrates acceptability of homeopathic treatment and clinically relevant effect on function at 22 weeks for patients with fibromyalgia (Relton et al., 2009). This must be interpreted with caution as conventional drug regimes (anti-depressant, analgesic and non-steroidal anti-inflammatory drugs) could obscure or interfere with the effects of homeopathic treatment. Difficulties were encountered with high dropout rate of the normal care group who had no incentive to participate. The reported outcomes of this group may have been coloured by the perception of not being offered additional treatment. Relton and colleague's study could provide a design that could be adapted for future open pragmatic trials.

Problems of interpretation

It is important to make a distinction between the context in which a trial is conceived and conducted, and what happens to the reporting of the clinical trial in the intertextual world. This is further complicated by publication bias – what is put forward for publication, what is accepted for publication as well as how the paper is edited for publication. There is a tendency for the over interpretation of results to draw inferences on the efficacy of homeopathy in general. This is in part due to the vague use of language when the term 'homeopathy' fails to differentiate between the use of homeopathic remedies, the therapeutic approach in general and treatment by a homeopath (Relton et al., 2008, p.153).

Interpreting results is not a neutral activity. Contrary to the objective and neutral rhetoric of scientific discourse, prior belief and socio-political factors play a significant role in interpreting research papers. Interpretation is often overtly linked with the writers' views on the use of high dilutions. This is articulated as the need to provide a 'higher level' of evidence (NHS Centre for Reviews & Dissemination, 2002) or the requirement of a 'scientifically' acceptable explanatory theory for the activity of high dilutions as a precondition to 'accepting' the results (Kleijnen et al., 1991). This over-interpretation could also be happening in the homeopath's response. If as I have argued, the clinical trials offer minimal application in practice, I wonder how homeopaths perceive trials. If in the intertextual arena concerning NHS provision, a published trial is perceived as either showing good 'evidence' to support treatment or ammunition for the sceptics? Reflecting on my own position, I perceive that 'prove it works' dominates homeopathy research discourse, and I am drawn into this argument to defend the availability and legitimacy of treatment. Whilst a handful of professional homeopaths, through Department of Health funding, are research active in clinical trials, I perceive the clinical trials agenda to be the domain of European medical homeopaths, and to be produced through how they negotiate their professional identity on the edge of the medical profession. Turning the 'prove it works' argument back on itself, I assume a divide between research for 'us' that has potential to inform practice and research for 'them'. This begs the question of who are 'them'? Trials rely on patient participation, but they are not the beneficiaries. Is 'them' a device to signify that as a practitioner I do not need to satisfy myself of treatment efficacy under experimental conditions? Is this a conceit? Maybe a defensive stance? Returning to the theme of one approach, the dominant discourse of EBM closes off avenues for research that could advance practice and improve patient care.

11.5.2 Returning to the vexed question: what is evidence?

Holmes and colleagues (2006) critique what they describe as the hegemonic and privileged status of evidence based discourse. The highly normative discourse limits the co-existence of multiple epistemologies, a plurality of research approaches and the potential to ask different types of questions. Tonelli and Callahan (2001) argue that evidence based agenda in CAM is not a “scientific necessity”, but a response to the demand that a particular epistemology is “the primary arbiter of all medical knowledge” (p.1213). Evidence based discourse is a homogenising process, whereby discrete professional knowledge is redefined. This could lead to homeopathy losing its essential qualities that make it attractive to patients.

Alternative mapping of evidence have been suggested in CAM such as a mosaic of evidence (Reilly and Taylor, 1993) or a circular model of evaluation of complex interventions (Walach et al., 2006). The mosaic metaphor implies multiple sources of evidence of equal value, offering potential congruence with pragmatic and postmodern perspectives, and for different types of questions to be asked to inform the multiple realities of daily practice. The circular model is less radical by proposing “to triangulate different methods to achieve homogeneity” (Walach et al., 2006, p.7), which returns us to the notion of a single outcome. Reflexivity is a strategy for appraising clinical reasoning, and validity is strengthened by taking multiple perspectives, encouraging practitioners ‘reflect upon their own positions as knowers in the process of situated knowing’ (Malterud, 2002, p.125).

11.5.3 Case reports and case studies

Following the thread of one remedy at a time, let us explore the role of case reports (anecdotal accounts of individual clinical cases) and case study research, both single ($n=1$) and case study series. Clinical observations captured in case reports have provided important new insights in healthcare (Kaplin et al., 2011), whilst RCTs are used secondarily to validate the intervention. The use of case vignettes in this thesis draw on a two hundred year tradition of homeopaths reporting their own cases to colleagues through journals, conferences and on-line resources. Rich phenomenological data is generated by reporting the patient’s subjective experience. Chibeni (2001) draws on the philosophers of science including Popper, Kuhn, Feyerabend and Lakatos, to argue that the rigor of the phenomenological approach renders homeopathy “a genuine scientific research programme” (p.98). We could regard this as reframing science discourse to incorporate phenomenological exploration of experience.

Case reports of individual illness and recovery experiences generate clinical knowledge. In peer review journals case reports are an accepted form of expanding biomedical knowledge (online Journal of Medical Case Reports (JMCR). Reports of practitioner and patient experiences can be used to illuminate specific aspects of treatment - biomedical diagnosis, specific remedies, prescribing styles, integrated care, mind/body relationships etcetera. Case reports contribute to *materia medica* knowledge by augmenting proving and toxicological data to verify indications for use of a specific remedy. Verification from practice is offered where lasting improvements in symptoms and health status follow treatment using a specific remedy evaluated over a

significant period of time. The Faculty's journal *Homeopathy* adopted guidelines (2002) to encourage the submission of clinical case histories that met criteria for rigor and trustworthiness. The research value of case reports is limited by possible hindsight bias, lack of transparency about selection criteria and lack of means to authenticate reporting. Robust critical appraisal is required to highlight the homeopath's and patient's preconceived ideas about the benefits of the treatment, claims for causal links and confounding factors such as the natural history of a biomedical diagnosis.

Formal case studies have been proposed as a rigorous approach to research questions that cannot be addressed by clinical trials (Thompson, 2004). Rigor is sought by sampling strategies, different data sources and thorough data analysis. Thompson recommends that trustworthiness can be achieved by "groundedness" in the data, exploring alternative explanations, peer review, triangulation, respondent validation and reflexivity. In a prospective formal case study series (Thompson and Weiss, 2006) patients were interviewed before and after a five consultation package of care. Multiple patient generated data was collected: consultations transcripts, generic and condition specific patient questionnaires, patients' artwork and reports from patients' significant others. Textual data were analysed thematically. This explorative study aimed to identify and evaluate potential 'active ingredients' in homeopathic treatment. Although comprehensive and systematic data collection is not matched by rigor of analysis and triangulation, some issues are illuminated. The response to the remedy is regarded as the most characteristic or specific effect of treatment. The quality of interaction during the consultation is considered to contribute to treatment response. Thompson and Weiss claim that the "closeness of matching may correspond with outcome". In other words, where a synergy is created between the patient's case and the remedy profile, suggesting a sound connection had been established between homeopath and patient, these cases have shown better improvement in treatment outcomes than others. Whilst their data and reporting does not allow us to scrutinise this proposition, this further casts doubt on attempts to separate contextual and characteristic effects in RCTs. Thompson and Weiss speculate that:

"the consultational activity within homeopathic care has aspects that are specific to homeopathy. If these aspects are therapeutically active, which is a reasonable working hypothesis, then comparison of placebo and non-placebo arms in homeopathy trials will not constitute a fair test. This is because the patient in the placebo arms will be receiving an active and specific part of homeopathic care" (2006, p.83).

We must temper our enthusiasm for the innovativeness of this design. Do not assume that mixed methods produces more insightful findings. However it has played a role in opening up discussion on the range of data that could be analysed to make case studies more rigorous.

In EBM discourse, case study series research is low down the hierarchy of evidence. However pharmacogenetics and advanced diagnostics indicate a shift to more personalised medicine. This has implications for clinical trial design, and may open up a more significant place for the n=1 study. In terms of practice based research, case study facilitates in depth research into a specific phenomenon drawing on multiple sources and multiple methods as part of daily practice

(Yin, 1994). Reports of exceptional individual responses to treatment are usually regarded as of little research value. However since 1991 the National Cancer Institute (USA) Best Case Series (NCI, 2010) has been evaluating well documented cases submitted from CAM practitioners showing partial or complete tumour regression. The criteria require evidence of a definitive cancer diagnosis, documentation of disease response and absence of confounders (other concurrent treatment). This resource is used to inform further research.

Before breaking off from this discussion I invite you to take a reflexive look at case study. This facilitates a different stance and orientation. The divide between observed and observer dissolves, and the focus is on the effect the practitioner researcher has on her own clinical practice. This inquiry is influenced by case study methodology. I found reflective case study (Rolfe, 1998) a useful vehicle in guiding homeopathy students to reflectively explore an aspect of their clinic based learning.

11.6 Analysis of professional experiential data on the single remedy theme

This section seeks to amplify the concept of the single dose followed by waiting to observe the reaction. I explore the experiences of oneness: through the tensions in shared practice (11.6.1), embodied experience of individualism in homeopathy discourse (11.6.2) and talk of the transformative potential of the 'one remedy wonder' (11.6.3).

11.6.1 Practitioner identity in the context of the tensions of shared practice

I have identified that individualism is a key facet of the homeopath's identity as an independent self-employed practitioner. We now examine experiences of a group practice (the homeopathy team in the University of Westminster Polyclinic) as a means to illuminating the normative experience of independent practice. This dialogue is juxtaposed with my own reflections on shared practice with students in the Polyclinic.

Two extracts from STAR group discussion transcripts:

'do you think it's important to know that students know you and how you work?.....I always say to the students: 'The patient we're looking at is an individual, but so is every practitioner'we work differently'

January 2004 lines 735-739

'everyone works differently and I was not able to take on your role [pointing to one colleague] or your role [pointing to another colleague].. It was about developing my role.'

June 2004 lines 734-735

Extract from reflective journal on the experience of acting as locum clinic tutor (16 August 2005):

A loss of what I value one-to-one with patients.....I'm struck by what I focus on in the case - of how I get my bearings on the pathology – 'what's going on here?' Most of all I'm aware of how I quickly decide on what's important. Students spend ages wading around the case with no sense of direction. I

know what I need to know. So how do I know? Colleagues have said it's like finding the parts of a jigsaw and fitting them together or a puzzle that needs to be solved. I don't feel there is a puzzle to be solved. It's more like a multi-dimensional kaleidoscope, you get a glimpse of the pattern and in an instant it changes. That's what is happening in the space between the patient and the homeopath.... I realise how idiosyncratic I've become, I found myself saying to students 'I do it like this, it works for me'. How do I know it's best practice? My practice is like a well-worn shoe, comfortable and easy. Suddenly I am in an environment where I have to expose this to others...

In the teaching clinic, the needs of both patients and students have to be met and this is reliant on collaboration between team members, with students, clinic staff and with practitioners of other disciplines. Shared practice between homeopaths is an atypical mode of working. STAR enabled the team to explore tensions arising from shared practice and to explicate independent practice as a foil against which shared practice is compared. Individualism is prominent in the dialogue and shared practice is negotiated through developing your own role or identity within the team. This is achieved by learning from each other and accepting each other's differences. There appears to be compromise, both preserving your individuality and facilitating share practice. Collaborating with student practitioners creates a sense of self-exposure. I became conscious of my reliance on tacit knowledge and of using myself therapeutically. Was my professional identity threatened when I felt marginalised in the clinical encounter?

11.6.2 Reflecting on dialogue with a medical student

The theme of individualism prompts me to reflect on an encounter with a first year medical student. I teach sessions on homeopathy at a large medical school. On this occasion I was asked, 'If conventional medicines have to be subjected to extensive and rigorous testing, why shouldn't homeopathic remedies?' I took the question in my stride and talked about testing of homeopathic remedies and developments in homeopathy research. I also highlighted the erroneous assumption that all biomedical practice is evidence based.

Critically reflecting on this encounter, I wonder if I had embodied the individualistic nature of homeopathy discourse. Whilst the assumption that biomedical research strategies should be applied to homeopathy could be contested, I had failed to convey how homeopathic practice is appraised. Did I voice the conceit that homeopathic practice has its own ways of doing things and is not subject to the same scrutiny as other medical practices? If we look at the power relations the picture alters. I was located within an institution of biomedicine, as a guest, or even could be considered as a specimen from a different and much less influential tribe. Is the assumption that homeopathic practice should be subject to the same modes of inquiry and validation an imperialist stance? Perhaps the homeopaths' conceit is not the product of homeopaths' attitudes but created through the hegemony of biomedicine. This encounter highlighted experiences from the first year of my doctoral studies. With hindsight I recognise, that I deliberately chose to register within a conventional healthcare research setting rather than a CAM orientated environment. The feeling of 'needing to be taken seriously' kept surfacing during supervision. This clarifies for me that a fundamental motivator to this inquiry is the need to communicate how as a homeopath I critically appraise my practice. The encounter with the medical student resonates as, at that moment, I felt I did not achieve this goal.

11.7 Reflective pause before moving on from single remedy to potentisation

As this chapter opened, I asked you to question the viability of the role of practitioner researcher and whether or not I am achieving critical perspectives on practice. The encounter with the medical student illuminated the difficulties I experience in successfully communicating a research minded approach. EBM discourse set the parameters of that conversation and I needed to shift the paradigm to redefine evidence in the context of homeopathy treatment.

I invite you to review with me our learning about practice based inquiry. Whilst there is a role for clinical trials, their dominance in homeopathy research discourse constrains study designs that are more compatible with practice and may offer the potential for improving patient care. There are different models of evidence building available, as a mosaic of different forms of evidence (Reilly and Taylor, 1993) and a circular approach to triangulating different methods (Walach et al., 2006). Both of these facilitate a diversity of approaches, but neither fundamentally shift the discourse towards research informing practice and patient care. The prospective case study series design (Thompson and Weiss, 2006) represents a potential way forward in exploring the experience of homeopathic treatment and practice. By employing diverse patient data sources, including artwork, interview and consultation transcripts, overcomes many of the limitations of retrospective case reporting. Trustworthiness can be achieved by transparency to the interpretative process, peer review, triangulation, respondent validation and reflexivity. This explorative study, possibly because of its breadth of data, failed to fully and rigorously analyse all the data collected but provides a viable prototype for future studies.

Another avenue to explore is to take a more radical step out of rationalist scientific paradigm towards an integration of the art and science, towards critically creative approaches to research, as articulated in Hiller's work and hinted at in critical creativity (McCormack and Titchen, 2006). To enable research to inform practice the priorities include exploring a wider range of experiences, not limited to what is observable and measurable, and allowing patients' and professional homeopaths' voices to be acknowledged within research discourse. This trajectory evolves its own discourses and makes connections with academic disciplines. Looking at homeopathy as both art and science has opened the way to capture and transform my professional knowing in critical and innovative ways. This is an opportune moment to reconfigure practitioner based inquiry as a collage of reflexive, experiential interactions.

In illuminating facets of the artefact of the single remedy, we recognised that the 'little white pill' draws on the dominant mode of biomedical practice. The erroneous assumption that responses to homeopathic remedies follow conventional pharmacological pathways has the effect of de-contextualising the homeopathic remedy from the treatment process. In the next chapter we look at how homeopathy discourse empowers the prescription rather than the patient, and this leads us on to consider the role of the homeopathic consultation in the chapter after that.

12 DIALOGUE ON POTENTISATION

12.1 Case vignette

This fictionalised case from my practice examines how the transformatory potential of homeopathy is experienced.

Adam aged 8 years

Adam attended my clinic presenting with a very painful red inflamed area around his anus. No improvement from the use of topical antifungal, antibiotic or cortisone creams. Bowel movement normal for him (up to three times daily). He has always been double incontinent. Adam has severe learning disabilities and seizures. The soreness around the anus causes him great distress particularly when his mother is wiping his bottom. Adam's mother reported that the problem first came on after he had severe and persistent diarrhoea which was treated with antibiotics (Campylobacter infection at his school) almost nine months earlier. She says he has never fully recovered from that episode and is generally under the weather. He is more restless, particularly at night and during the day his moods are more up and down than before. Prescribed medications for seizures have not changed in the last year. Seizure occurs two or three times daily.

Notes on the remedy: The toxic effects of Mercury were well known to Hahnemann as Mercury was a common treatment for syphilis which was endemic in the 18th and 19th century Europe. Before starting his experiments that ultimately led to homeopathy, Hahnemann invented this milder and less corrosive preparation. First proved by Hahnemann (Hahnemann, 1990, 1st published 1822-1827).

symptoms persist.

Adam responded positively to four days of treatment and the skin around the anus began to heal up by the end of the fifth day. The soreness reappeared after a month, and after resuming treatment for three days the skin healed again with no recurrence.

Adam's mother reports that the improvement has transformed both their lives. Adam is back to his old self, he appears so much more comfortable, less disturbed at night and more even tempered. As his toilet hygiene had become so distressing for him, it was a great relief to Adam's mother that she no longer has to practically pin him to the ground to clean him up.

12.2 Orientation to potentisation chapter

The preparation of the remedy by potentisation is the most striking artefact of homeopathy, demarcating it from other prescribing therapies. Also known as dynamisation, it is the transformation of a minute amount of a substance into a therapeutic agent. Potentisation has



links with the alchemical traditions of releasing the latent powers of a substance. The theme of this chapter is transformation for the patient, the homeopath, the researcher and possibly the reader as well. Shared with pharmacology, homeopathy discourse empowers the prescription (12.6.3) and practitioner (12.6.2) rather than the patient. Transformation is considered from different perspectives and I reflect on how this is happening in practitioner based research (12.4.4).

[Image 9: Mortar and pestle (Photodisc Collection)
Reproduced with permission of Getty Education Image Gallery]

I consider competing explanatory models for high dilutions, including observations on the behaviour of water molecules, changes in the structure of dilution and quantum mechanics (12.5.1). The diverse nature of this discussion highlights the pluralistic nature of science practices, reminding us that there is no single narrative and that the body of natural scientific knowledge is incomplete and subject to review and re-validation.

We pick up a thread of the homeopath as embodying the *similimum* (10.7.1), and re-examine this from the perspective of embodiment of homeopathic values as ‘being homeopathic’ and of potentising the practitioner (12.6). We also turn to alchemical traditions, to consider the physician as the ‘inner alchemist’ (Whitmont, 1980) (12.4.3). Through critical reflection, I become aware of how feeling constrained within homeopathy discourse, leads me to break out, only to become the subject of a different discourse.

12.3 Meditations on the potentisation artefact

Potentisation is the process of serial dilution and succussion. These procedures remain largely unchanged since they were developed through the six revisions of The Organon. Reduction in size of dose was initially driven by the need to reduce adverse effects from the use of a toxic substance. For equally pragmatic reasons, succussion originated as an effective means of mixing the substance with the dilutent (Dean, 2001, p.49). The minimum dose, the least needed to stimulate a therapeutic response, has a renewed significance in the 21st century, positions homeopathy as a sustainable form of medicine.

Reflections on succussion:
Symmetrical patterns in the Mali wedding blankets of West Africa provide a beautiful analogy for the process of enhancing the therapeutic potential through potentisation. A repeating diamond pattern becomes progressively smaller towards the centre of the blanket: ‘with each repetition of the pattern, more and more spiritual energy is being sealed into the blanket’ (du Sautoy, 2008, p.249). This explanation captures the way that energetic potential increases as physical form decreases.

The image of the mortar and pestle connects homeopathy with 18th century hand preparation of individual concoctions and medicaments, and also to alchemical processes. Homeopathic pharmacists continue to use mortar and pestles in preparing dry plant matter or insoluble substances (trituration) before putting into solution. The similar principle is used in choosing the potency that most closely matches the vitality of the patient. Potency refers to the number of times the remedy has been diluted and succussed. Ascending stepping-stones in the scales of centesimal potency (6th, 30th, 200th) have become adopted through custom and practise. In homeopathy's inverted view, the more times the remedy has been diluted and succussed, the greater it's therapeutic potential. Hahnemann used low potencies, diluted 1:9 (decimal potency) early in his practice and later is known to have used up to 30th centesimal (Gray, 2000). Nineteenth century North American homeopaths, in particular Kent, extended centesimal potencies to the highest levels (1,000th or 10,000th). See Centesimal potency and LM potency in the Glossary for explanation of the two scales of potency.

Homeopathy's identity as a prescribing modality is paradoxical. Whilst sharing many of the medical conventions, the mode of preparation of the homeopathic remedy transgresses established scientific conventions and does not follow the conventional pharmacological pathways. Homeopathy has shared origins with pharmaceutical approaches in biomedicine and draws on the medical customs and prescribing rituals. Yet the mode of preparation of its medicines is perceived to be radically unorthodox, and the highly diluted dose is erroneously assumed to follow conventional pharmacological pathways. As an energetic or dynamic system of healing, homeopathy shares common features with acupuncture and shiatsu. Maybe it is by appearing in the guise of a prescribing medical modality, at the same time transgressing dominant scientific doctrine that stirs up vitriolic sceptics. Homeopathy often excites powerful emotions in its supporters and opponents. Passion is a theme running through the stories by doctors who often at great cost to their careers, retrained in homeopathy (Shohet, 2005). Passion is a quality of practitioner engagement.

Sceptics discourse ignores homeopathy as a system of medicine to focus solely on the scientific implausibility of the highly diluted dose. According to Avogadro's hypothesis, by the time a remedy has been potentised thirteen times (in a dilution 1:99) no molecules of the original substance remain. However a linear relationship between dose and response is not universal. Endocrinologists observe a biphasic dose-response curve, suggesting that hormones, drugs and other chemicals that act via hormonal, receptor mediated mechanisms, show increasing effects in human tissues at very low and very high levels of exposure but not at moderate levels of exposure (Welshons et al., 2006).

Potentisation, sometimes known as dynamisation, signifies a transformational process, linking homeopathy with the alchemical traditions of releasing the latent powers of the substance. Homeopathy discourse focuses on "on the remedy as the primary agent of therapeutic change" (Thompson and Thompson, 2006, p.82), empowering the prescription rather than the patient. Individuals seek out treatment not only during illness but also at times of transition, such as

bereavement, relationship down and problems at school. I avoid interpreting the treatment effects in terms of the remedy as the causative agent. Changes start to occur before making the appointment as the individual decides it is time for change and making the appointment is part of a number of initiatives to improve well-being, possibly diet, exercise or speaking to a friend. Homeopathy discourse tends to obscure these experiences and to rationalise why some patients who do not experience beneficial treatment effects. Homeopaths must be honest about what is happening in practice.

12.4 Intertextual relations on the potentisation theme

12.4.1 Different constructions of transformation

Notions of transformation weave through this chapter with implications for patient, homeopath, researcher and reader. Influenced by critical theory (Fay, 1987), critical reflection has been framed as an emancipatory practice (6.2.4). Emancipatory interests involve critical awareness and questioning social norms, which in turn create possibilities for communication and social action (Habermas, 1971) and promote a sense of liberation through increased self-knowledge (Fay, 1987). These views are tempered by a Foucauldian perspective which holds that Enlightenment notions of liberty and emancipation are only relative terms, and any sense of autonomy is constructed through subjectivities available in particular discourses (Bleakley, 1999). CAM practices participate in changing discourses around health and illness that articulate “personal, social and political change” (Scott, 1998, p.197). Our embodied sense of ourselves can have more effect on action than changing ideas (Habermas, 1971) or can inhibit change (Fay, 1987). May be the embodied experience of ill-health and recovery is influential in bringing change through other levels of consciousness? In the next section we consider parallels with Jungian psychotherapy.

To add potency of this discussion let us draw analogies between the succussion of the remedy and postmodern ideas. It could be argued that, having not taken up the modernist cause, homeopathy is coming into its own in a postmodern era? Frank (1995) characterised contemporary experience of illness as dominated by the biomedical view of illness. He suggests that being able to tell the story of your illness experience, without reference to the medical narrative, for example in a CAM consultation, represents a crossing from modernist to the postmodern experience.

12.4.2 Feminist liberation?

Feminism is one of the taken for granted conditions of this inquiry and shapes how I perceive the transformative potential of therapeutic encounters and research. I take this opportunity to reflexively engage with two women researchers, Rosalind Coward and Ann Scott, representing different academic discourses, whose textual contributions have been significant on this research journey.

Cultural historian Coward's critique of CAM (1989) is significant as her work informed my undergraduate studies and the era is contemporaneous with my entry into the homeopathy profession. I participated in 1980s feminist campaigns where women's health was being redefined by liberationist politics highlighting the neglect of women's autonomy in the male dominated state system of medicine. Coward argues that CAM promotes a form of personal responsibility that co-exists with, rather than challenges existing social structures. The personal is perceived to be a preoccupation with the body and health, as a luxury of a high standard of living and the absence of threats from epidemic diseases. The text articulates socialist feminist discourse that prioritises mass social change and challenges the feminist principle that the 'personal is political'. The context of Coward's argument is the rhetoric of the 1980s Conservative Government that promoted individual responsibility in the face of retraction of social welfare provision. This is revamped today as Prime Minister Cameron's 'big society'. Arguably by pursuing a career predominantly located in private healthcare, I have endorsed individual transformation and ignored the wider public good. Whilst actively providing homeopathic care within the public sector (GP surgeries, universities and community based projects), this has enhanced the legitimacy of practice and experimented with integrated models of care, but not made significant inroads into health inequalities. However this may be too harsher a judgement as possibly the media profile of homeopathy sceptics' discourse, could be interpreted as a backlash to CAM encroaching into the domain of biomedicine.

Within sociology discourse, Scott perceives that 'homeopathic medical treatment can act to catalyse wider personal and social change' (Scott, 1998, p.192). She draws attention to the intention of the practitioner in choice of prescription. This can empower the patient, but equally there is potential for moralistic and normative motivations to be reflected in this choice (p.204). For example my interpretation of what needs to be 'cured' for two female patients who both present with depression, may for one be a lack of confidence in making her own life choices, leading to prescription of *Pulsatilla*; whilst for another it may be her ambivalence about her pregnancy and lack of maternal feeling leading to a prescription of *Sepia*. I sometimes reflect that I am able to perceive a male case more clearly, as my perceptions are less clouded by my own reactions. I am less prone to make assumptions, and more inquisitive in seeking to make sense of his health and illness narratives.

Reconnecting with my motivations for becoming a homeopath is illuminating. The transformatory potential is unavoidably shaped by personal experiences and values. I leave dangling this thread of personal and social transformation, and we will stitch this back into the weave later in the thesis.

12.4.3 Alchemical transformation

The alchemical purification of matter to enhance medicinal effect is perceived in terms of the transformation of both the healer and the recipient. I draw parallels between homeopathic potentisation and alchemy to explore the notion of transformation. I understand alchemical

practices to be pluralistic and metamorphosing in different historical, religious and cultural contexts.

Let us first consider transformation in homeopathic pharmacy. Dean argues that whilst there is no evidence that Hahnemann pursued alchemical interests (Dean, 2000), he suggests that Hahnemann used alchemical techniques:

“Serial dilution and potentization appear to be the only elements derived from medieval alchemical medicine, but Hahnemann only accepted them into homeopathy after empirical testing.” (Dean, 2001, p.45)

Hahnemann makes reference to the medicinal use of gold by Islamic alchemists', but this attribution cannot be verified (Dean, 2001, p.55). Islamic alchemical texts (Martin, 2001) were likely to be part of the influx into Western Europe from the 15th century onwards of Islamic texts and translations of Ancient Greek texts. Trituration of gold by grinding with lactose in a mortar and pestle was a significant development of homeopathic pharmacy as this extended the pharmacopeia to include insoluble sources (Dean, 2000, p25). Hahnemann referred to trituration as the ‘dynamization’ of matter to produce ‘potencies’ (p.24).

Clear distinctions cannot be made between alchemical and emergent scientific practices in early modern Europe. Bibliographies of mathematicians and scientists, such as Sir Isaac Newton (1642-1727) responsible for the law of gravity; and polymath John Dee (1527-1608), indicate that activities that have retrospectively been hailed as contributing

Aside to the reader:

Are you wondering why we are straying into such esoteric territory? Does it further undermine the legitimacy of 21st century homeopathic practice? Alchemy is ridiculed as medieval mysticism with charlatans making false promises to turn base metals into gold. If we sidestep this modernist perspective and take a wider temporal view of millennia of alchemical tradition, I aim to deconstruct the way that I interact with transformation potential as practitioner researcher. I leave you to make of this what you will.

to the progress of science, are linked with their mystical and alchemical interests (Martin, 2001). Alchemical practices are recognised as the precursor to chemistry, personified by alchemist and ‘father of chemistry’ Robert Boyle (1627-1691). Laboratory techniques were introduced by alchemists, most notably heating the contents of a flask and observing changes, alcoholic distillation and identification of Phosphorous. Chemistry, Hahnemann’s first profession, provides a link between alchemy and homeopathic pharmacy.

Homeopathy’s strongest link with alchemical tradition is personified by Paracelsus (15th to 16th century) (9.4.2). Homeopaths, not Hahnemann himself, have assimilated Paracelsian ideas (Dean, 2000), most notably homeopath and Jungian psychologist Edward Whitmont (Whitmont, 1980, 1993). Jungian interpretations of alchemy (Whitmont, 1993) highlight the role of the Paracelsian *archeus* both in the medicine and in the physician. The *archeus* was described by Paracelsus as a dynamic self-regulatory life force capable of acting through the medical substance to affect change in the individual’s health (Wood, 1992). The physician has to be

made ready by the alchemical process, then the physician acts as *archeus*. This inner contemplative work of alchemy, as personal transformation, appears in the work of Carl Jung (1875-1961). This resonates with discussion earlier about a sense during the consultation of the homeopath gravitating towards embodying the *similimum* (see Dialogue on the *Similimum* chapter 10). The homeopath's intention to identify the *similimum* merges with the patient and homeopath 'tuning into' the consultation. Later we experiment with understanding this as entanglement in terms of quantum mechanics (12.5.1). Drawing on alchemical notions of preparing the physician, as the inner alchemist, we experiment with the idea of the embodiment of homeopathic values as 'being more homeopathic' later (12.6.1).

12.4.4 Practitioner research is transformatory

Practitioner research is about change, to clinical practice and to the practitioner researcher themselves. But what does change mean? How will I know if change is happening?

All practices are fluid, inconsistent and influenced by the changes in the wider context. However self-critical observation creates the potential to take an organised and proactive role in making change more meaningful. As soon as you commit yourself to undertake research, there are changes, as your way of seeing is different. Reflective writing is essential for exploring and monitoring change as it can be difficult to remember how you looked at the situation before. Turning the experience back on itself, creates a different way of looking at the experience. Perspective transformation (Mezirow, 1978) represents significant moments of change, when the a new way of looking as a lasting effect. Implementing change in clinical procedures is easier to track and evaluate, than changes for the practitioner themselves. Our sense of self is produced through a network of relationships and is contextually and historically bound, invalidating any notion of autonomous action (Fay, 1987). This reflexive inquiry has taken place through an inter-play of different discourses, such as academia, science, biomedicine, CAM and homeopathy. I cannot position myself outside these discourses (Bourdieu, 2000) and self-transformation involves re-negotiating the workings of prevailing discourses.

This inquiry has created a more rigorous and critical engagement with the therapeutic framework, and responding more critically to wider contextual issues such as understanding research into placebo effects. Here are two examples. I am more aware of how I co-construct the patient's narrative and frame the consultation process. Asking open questions and giving minimal direction to the patient's narrative is not neutral, as soon as my attention is on differentiating between possible prescriptions, I am shaping the narrative and closing off other possibilities. Regarding personal change, I aware of how my professional identity is shaped by my personal history, coalesced in the 1980s and 1990s and has followed a particular trajectory as practitioner researcher and resisted the changing popularity of different methodological approaches.

12.5 Homeopathy research discourse on the potentisation theme

In this section I do not set out to justify homeopathic treatment in scientific terms, rather to resist assimilation into the biomedical research culture. I explore how my practical engagement in homeopathic practice is shaped by scientific and biomedical discourses, and consider different theoretical contexts within which to think about homeopathy. I ask you to reserve judgement and to travel along the experimental and unfolding strands of inquiry.

12.5.1 Laboratory and theoretical research into high dilutions

As a prescribing modality it is assumed that responses to homeopathic remedies follow conventional pharmacological pathways and furthermore that these effects must be explicable in biochemical terms. The scientific establishment does not currently accept that the observed effects of the therapeutic use of high dilutions can be explained in theoretically coherent terms nor have they been demonstrated experimentally. Use of high dilutions is often cited as grounds for requiring higher levels of evidence to demonstrate clinical efficacy (NHS Centre for Reviews & Dissemination, 2002). This is not perceived as a limitation of the Newtonian paradigm to identify a physical causative agent for the observed effects of homeopathic dilutions. The responsibility is directed to homeopaths to provide a ‘rational’ scientific explanation. Whilst we do not expect GPs to be fully conversant with the pharmaceutical action at a molecular level of each prescription, as homeopaths we often feel compelled to elucidate unfamiliar specialist areas of knowledge. As most of us do not have the scientific expertise to present a rigorous well-informed argument, we expose ourselves to further scepticism. With reservations about reproducing this trend, I review the current state of the theoretical debates and tentatively explore explanatory models that may help us to explore practice.

Detailed protocols for preparing medication by potentisation were published in the [The Organon](#) about a century before the atomic and molecular definitions of matter had become tenets of scientific thought. Homeopathy contravenes Avogadro’s hypothesis that states that at the same temperature and pressure, the molecular weight of any pure substance contains the same fixed number of molecules. According to Avogadro’s hypothesis, by the time a remedy has been potentised thirteen times (in a dilution 1:99) none of the molecules of the original substance remain. Homeopathy not only challenges this scientific theory, but follows a divergent trajectory, by claiming that the more times the substance has been potentised (hence more dilute) the greater the potential therapeutic effect of the preparation. This 13th centesimal potency

Reflection in action: March 2008

As I start to write this, the first thoughts that emerge are ‘The inability to explain how a homeopathic remedy works...’. This is typical of my tendency, and arguably shared with other homeopaths, to take a reactive stance. It is not a lack of explanatory models nor lack of replicated multi-centre laboratory trials – it is a perceived lack of consensus or acceptance from the ‘scientific establishment’ (what does that mean? who is the establishment?) that a response can be elicited from high dilutions. This is the workings of dominant scientific discourse that position homeopathy as inferior.

is regarded as a low potency and the majority of prescriptions made by professional homeopaths are more diluted, probably 30th to 1,000th (known as IM).

A review of basic laboratory research conducted since 1923 into the physical properties of high dilutions identifies over fifty published papers forming five research areas; electrical properties, optical properties, nuclear magnetic resonance, thermo-dynamics and surface tension (Baumgartner, 2002). Research into the effects of high dilutions hit the national newspapers when Jacques Benveniste (1935-2004), influential in the field of immunology in France, was personally condemned by the editor (Nature, 1988) for reputedly making unreliable claims that human basophil degranulation was inhibited by high dilutions of histamine in the same way as undiluted histamine (Devenas et al., 1988). This *in vitro* protocol has been refined and tested in a pan European multi-centre study with a small but statistically significant inhibition of basophil activation with high dilutions of histamine (Belon et al., 2004). This empirical evidence that high dilutions may have a biological effect does not appear to have shifted scientific opinion. Multi-centred controlled studies of allergic responses in human subjects have yielded robust evidence for the effect of diluted and succussed preparations (potentised) acting differently than placebo (Taylor et al 2000).

The highly complex properties of water have provided a rich source of hypotheses but none have been shown to be sufficiently stable to explain observations of the long term action of high dilutions (Chaplin, 2007). Observations have been made of atoms and molecules exhibiting collective behaviour forming ‘coherent domains’ when closely packed together, in a similar way to laser (Del Guidice et al., 1988). Wavelengths of water molecules appear to polarise around any charged molecules storing and carrying its frequency. A cluster effect has been observed (Samal and Geckeler, 2001) as molecules diluted in water clump together and as dilution increases, the clusters grow large enough to interact with biological tissues.

Quantum mechanics offers a different way of perceiving reality which could illuminate observed effects of homeopathy and other CAM treatments. These theories fit well with a postmodern orientation and homeopaths’ attention to subjective experience. This is a highly specialist field and I rely here on interpretations by CAM researchers. Quantum mechanics defies the positivist assumption that reality is independent of observation, in quantum terms, “the state of reality is not determined until observation takes place” (Hyland, 2004, p.199). Weak quantum mechanics has been used to suggest a non-localised interaction or entanglement occurs between the patient and homeopath and remedy (Walach, 2000, Hyland, 2004). Quantum entanglement describes ‘correlatedness’ between the quantum states of two or more objects defined in relation to each other, but occupying different ‘quantum systems’.

“Under these circumstances, measurements performed on one system may be interpreted as ‘influencing’ other systems with which it is entangled.”
(Hyland, 2004, p.199)

It has also been suggested that entanglement occurs between the remedy and its preparation, the patient’s experience of the homeopathic encounter and the therapeutic context (Walach,

2003). Milgrom proposes (2002, 2003a, 2003c, 2003b, 2004c, 2004b, 2004a) a non-local therapeutically entangled triad between the patient, practitioner and potentised medicine. This modelling accommodates the idea that a remedy is only homeopathic when it 'cures' the case (Kent, 1987, 1st published 1900). Setting to one side difficulties with the meaning of the term 'cure', Milgrom suggests:

"remedies can be considered homeopathic when their locality, as defined by preparation and potency, becomes by prescription entangled with the non-local therapeutic interaction between patient and practitioner; the triadic totality curing the case" (Milgrom, 2002, p.243).

Milgrom's interpretation of entanglement appears to provide a theoretical model to describe homeopaths' experience that engagement in the process of homeopathic treatment by both homeopath and patient to 'tune into' the potential of the treatment process is a significant feature of successful treatment outcomes. However I have not found reference to applying quantum mechanics to the most popular use of homeopathic remedies as self-care purchased over the counter. In home use the selection of the *similimum* may only be approximate by the novice prescriber from the limited range of remedies on sale.

Quantum mechanics has implications for designing RCTs as the entanglement in the therapeutic process is broken up by the act of blinding and attempting to isolate the effects of the remedy under experimental conditions. This could explain why systematic reviews suggest that studies deemed to be of a higher quality and more rigorous methodology, that is the more severe the disruption to therapeutic entanglement, tend to show less significant results than studies of lower quality (Linde and Melchart, 1998, Linde et al., 1999). Walach (2006) suggests that uncertainty and not knowing are the best pre-condition for entanglement, and that intentionality of outcome destroys the effect. Walach also argues that Hahnemann did not observe the effects he expected and his empirical approach embraced uncertainty. On this basis the RCT forces entanglement into a causal model, and if interpreted as causal, entanglement is destroyed, particularly when seeking to replicate studies or when treating a specific diagnostic condition. Walach's solution to this problem is to conduct open pragmatic trials in naturalistic settings.

I invite you to reflect with me on these theoretical speculations, as it is easy to become caught up with what I perceive to be an externally driven demand to explain the therapeutic use of high dilutions in theoretically coherent terms and to demonstrate this experimentally. This appears to be a concern for medical homeopaths, as many of the papers cited are published in their journal Homeopathy. Whilst the Governmental view was that "mechanisms of action are of secondary importance to efficacy" (House of Lords, 2000, 4.4), we know that evidence of efficacy is interpreted in the context of the plausibility of the observed effects. What is striking from our discussion is the plurality of approaches and interpretations. The editor of Homeopathy (Fisher, 2003) expresses bewilderment by this multiplicity, but anticipates that as the:

"debate unfolds and data accumulate the picture will gradually clarify, and some schools of thought will be vindicated while other(s)...fade." (Fisher, 2003, p.2)

A postmodern perspective allows us to appreciate the potential enrichment from diverse theoretical explanations of the complexity of therapeutic responses. This reiterates pluralistic science practices, although obscured by the deterministic language of dominant discourse, there is no single narrative and all scientific truths are subject to review and re-validation. Quantum mechanics offers a new scientific vocabulary to talk about homeopathic treatment in non-deterministic terms, but these:

“approaches make few physical predictions, which could be tested experimentally, and hence are hard to prove or disprove.” (Tournier, 2010)

This discussion has been a superficial brush with competing explanatory models as a more extensive or in depth investigation is beyond the scope of this inquiry. Whilst critiquing homeopathy discourse for engaging in specialist areas without the necessary expertise, we have possibly replicated this activity.

12.6 Analysis of professional experiential data on the potentisation theme

In this section we play with notions of potentising the homeopath in the context of the experience of participating in a community of practice (Wenger, 1998). We reflect on how the homeopath embodies homeopathic values and the lack of reflexivity in homeopathy discourse (12.6.1), and the homeopath's perceptive powers to transform the patient's state (12.6.2).

12.6.1 ‘Being more homeopathic’

Participant observation fields notes: SoH continuing professional development workshop ‘Life-long learning from Practice’ London June 2005

Selected quotes from the workshop’s promotional leaflet:

The seminar gives you the tools needed for life-long learning in being more homeopathic.
Being homeopathic is itself life-long learning....
Homeopathy more integral to your life....
Learning to be homeopathic in our lives.....
An inquiry for the whole homeopathic community....
A homeopathic approach to clinical supervision.....
Specifically a homeopathic way of teaching.....

Pre-text: The workshop’s focus on taking a homeopathic approach to practice based learning presented an excellent opportunity to examine what practice based research in homeopathy looks like. My participation was shaped by Wenger’s concept of “communities of practice” (Wenger, 1998), perceiving that the interactions with other homeopaths function to reproduce a collective identity. With the idea that practitioners are always in the process of becoming (Johns, 2000) I critically examine how shared identities are being constructed through the day’s activities.

Analysis of key concepts used during the day:

‘Being homeopathic’ ‘Homeopathic’ extends beyond clinical practice, to a way of seeing, embodying and living homeopathic values. ‘Being’ emphasises a meditative role, with focus on the homeopath as an agent of change. ‘Homeopathic’ carries implications for taking

responsibility for one's own health, taking a holistic view and acknowledging the wisdom of the whole person.

'A specifically homeopathic way' Homeopaths' case taking skills are applied to practice based learning. Analogous to the role of the observer in triads, we were encouraged to place ourselves in the role of the observer on our own clinical practice and to aspire to a "supervisory way of looking" (Ryan, 2004). This resonates with the practitioner researcher role, but is compromised by relying on the problematic notion of the 'unprejudiced observer'. Observation is unavoidably value and theory laden, so the idea of suspending one's values and assumptions is untenable. Clinical practice is subject to inquiry but reflexivity is notably absent.

The homeopath as an embodiment of homeopathic values This highly personalised language unites how you approach practice with how you live. There is a danger of encouraging a self-contained, inward looking and complacent profession.

How is 'being more homeopathic' enacted through this event? Co-operation, in the form of developing networks and peer support is presented to counter the image of an isolated independent practitioner. The orb web spider is used as a metaphor to show how by casting out a single thread, it is possible to spin a web of a learning community. Whilst the day set out to provide the 'tools' for practice based learning, I felt the 'tools' were notably absent. There was a conspicuous absence of encouraging participants to use reflective practice skills to learn more from their practice experience. The didactic charismatic teacher slipped into the discussion when the facilitators talked about their own significant learning experiences taking place at international seminars. This had the effect of diminishing the resourcefulness of each homeopath to bring about their own changes. I was disappointed that the workshop did not provide the opportunity to explore practice based research in the way that I had hoped for. Possibly setting such high expectations prevented me from making the most of what was enacted. In feeling constrained within the workshop discourse, I break out, only to become the subject of an academic discourse that takes a critical approach as if I am assessing another teacher. What I learnt from this workshop is that whilst congruence with the therapeutic framework is a priority for practitioner based inquiry, simply employing homeopathic concepts does not create homeopathy based learning. Reflexivity is a crucial element in enabling you to reflect on their position as a knower in discourse.

12.6.2 'Crack the case'

Extract from STAR group discussion transcript:

because I feel that the patient is not complying, there's no learning situation for the students, you know, it's frustrating for everybody; another supervisor might see it completely differently and might find it challenging to have the patient. They might want to crack the case or see it as symptoms, so that's why it needs discussion of the whole. (STAR May 2004 lines 825-829)

In this dialogue a clinic tutor describes the 'difficulties' encountered in providing treatment for a patient in the University Polyclinic. The totality of the case is perceived to what the homeopath is experiencing in delivering treatment. The patient's behaviour becomes pathologised and used as indications for choice of *similimum*. 'Crack the case' captures the assumption that a well

chosen remedy has the potential to transform the patient's state. 'Crack' evokes the homeopath's power to perceive what is needed to transform the patient's state. This patient is placed in a passive role.

12.6.3 One remedy wonders

Extract from reflective writing May 2006:

The myth of a 'one remedy wonder' suggests that the patient's health can be transformed by a single well chosen prescription. Like most myths, it is based to some extent on life experience. I recognise that 'miracles sustain practice'. By this I mean that the sense of myself as a 'successful homeopath' is maintained by those handful of exceptional instances where the individual appears to enjoy a sudden and lasting transformational experience following taking a remedy. This may be a marked improvement in symptoms or in sense of well-being. These accounts appear to be miraculous as they appear to defy explanation. These are memorable events not only for the patient concerned but also for the homeopath.

Case presentations at conferences tend to be these 'best' cases. False expectations can be set up for the inexperienced homeopath or student as these cases are not representative of daily practice. These cases are often presented in a way that invests power in the homeopath in solving the patient's problems, health or even life circumstances. This rhetoric is used to promote the exceptional claims of the particular prescribing methods. Well established teachers such as Sheilagh Creasy, pay more attention to the role of the homeopathic prognosis, which helps to set realistic expectations for potential change in the case and keeping the patient as well as possible.

Use of the terms 'wonder' and 'miracle' carry connotations of the supernatural and lack of rational explanation. This account highlights both what attracts people to homeopathy, and what attracts the label of unscientific practices. The popular press carry stories of celebrities' positive experiences of homeopathic treatment (Sawalha, 2010). These stories have an important place in homeopathy culture. In my experience of interviewing applicants to study homeopathy, positive personal experience of treatment is often cited as a key motivating factor. This is mirrored in the importance of 'word of mouth' referrals from existing patients in financially sustaining practice. Amongst patients and homeopaths (Shohet, 2005) there is an emotional commitment that is based on personal experience of treatment effects. This emotional commitment is anathema to scientific discourse, but an integral feature of homeopathy discourse, indicative of how the practitioner is also a recipient of homeopathic treatment.

Significantly in the text the transformative experience is attributed to the remedy, other factors such as the patient's self-care or life events, consultation process and therapeutic relationship are absent. This suggests the influence of the pharmacological interpretation of homeopathy where the prescription is de-contextualised from the treatment process. Biomedical discourse shapes the way we talk about our practices, and can create a lack of congruence with the therapeutic framework.

How the practitioner negotiates scepticism and belief is illuminating. Tensions are managed by recognising that occasionally a patient's response is extraordinary and apparently inexplicable,

whilst at the same time advocating a practical strategy to set informed expectations for change. Out of context, these anecdotal accounts can be interpreted as making extravagant claims for the efficacy of homeopathic treatment. However the National Cancer Institute (USA) Best Case Series suggests that when fully documented, these anecdotal accounts have the potential to lead to research into new treatment strategies (NCI, 2010).

12.7 Reflective pause before moving on from potentisation to susceptibility

You may feel this chapter has been rather ethereal, so let us ground ourselves by reflecting on our discussion. We start with the thread of personal transformation. I am becoming more aware of how my core narrative acts as the script for how I engage professionally. The early years of practice in the early 1990s created formative experiences. My identity has since been shaped by University appointments and by pursuing a trajectory into practitioner research. A thread running through the thesis is emotional agitation in relation to the dominance of didactic teaching and the plurality of methodological approaches. Engagement in the therapeutic encounter is evident when homeopaths write about how they actively integrate ‘new systems’ of prescribing into their practises in individualised and pragmatic ways (Hardy, 2011). However the 1970s guru culture (Winston, 1999) persists in the discourse. This agitation is hypocritical as my own professional learning is shaped by didactic teaching. I veer towards an academic stance that creates a hypercritical view and a sense of separation from other homeopaths. On mining more deeply into the feeling of agitation, my frustration is about what I perceive to be a need for more critical thinking and reflexive dialogue in professional homeopaths discourse. Possibly I am imitating the enlightened teacher and reproducing the call to ‘follow me’. To fill this gap I look outside the profession to engage with theoretical models, social theories and research methods, to articulate a vision of a reflexive approach to clinical practice. I learnt from the continuing professional development workshop (12.6.1.) that whilst congruence with the therapeutic framework is a priority for practitioner based inquiry, simply employing homeopathic concepts does not create homeopathy based learning.

The alchemical tradition of transforming the practitioner as well as enhancing the effect of the substance, creates a powerful analogy for practitioner based inquiry. Homeopathy discourse by prioritising ‘the remedy as the primary agent of therapeutic change’ (Thompson and Thompson, 2006, p.82), obscures the role of the patient. Through this inquiry we are testing out different ways of viewing the homeopath’s role in the therapeutic process. We tried out concepts of nurturing the ‘inner alchemist’, ‘being homeopathic’ and ‘potentising the practitioner’. We speculated about what is happening in the contextual effects of the consultation, with patient and homeopath ‘tuning in’ to each other in the process of identifying the *similimum*. An anathema to scientific discourse is the emotional commitment to homeopathy shown by patients and homeopaths alike. Passionate involvement cannot be excluded from practitioner inquiry.

With the energy of potentisation we traversed paradigms in this chapter. Frank (1995) offered the view that the CAM consultation as a form of postmodern practice by creating space for the

patient's illness and recovery narrative to be separated from the medical narrative. Of course our experience cannot escape from the influence of the dominant biomedical view of illness. By widening the field of explanatory models to include quantum mechanics, this offers a way of contextualising the remedy as a signal within a complex package of care. This has greater congruence with practice experience than more deterministic vocabulary. The process of evolving a framework for inquiring into practice is experimental, pragmatic and fragmented. In the next chapter, I examine the importance I attach to a sense of coherence in the therapeutic framework to practise effectively.

13 DIALOGUE ON SUSCEPTIBILITY

13.1 Case vignette

This case vignette of a patient presenting with progressive pathology is designed to give a sense of the unfolding nature of treatment and how this challenges the homeopath's perceptions.

Kathy 60 year old musician, treated 'on and off' for over eight years

She was first referred to a neurologist as a school student. Despite numerous consultant appointments the diagnosis is unclear and her condition remains untreated as conventional medications have been discontinued due to unacceptable adverse reactions. No treatment, conventional or complementary, had improved Kathy's physical symptoms. The leading characteristics in the homeopathic analysis of her case are the pain, weakness, destructive diathesis, tolerance of high levels of pain and her ability to vividly describe her embodied self-awareness. The severe physical distress and disability are the priorities in choice of remedy. I prescribe a number of remedies over a period of months without discernable benefit. This challenges my vocational desire to ease suffering. I record in my reflective journal:

I am always optimistic in her presence. Is this a sound strategy? In contradicting her feelings of hopelessness, is this my coping strategy? I don't know how to be in the best interests of the patient. (June 2004)

As a matter of routine care, at intervals over the course of treatment I ask the patient what they are seeking from treatment. This is part of a contracting and re-contracting process, and I share my expectations of treatment. With Kathy it took months for me to realise that she had not come to me to aid her physical symptoms.

She tells me 'my crisis has disappeared' and I am 'adjusting my mind set to enable me to live with the pain' (January 2005)

This needs careful interpretation. After over a year of homeopathic treatment, had she become resigned to no improvement in the persistent pain? I feel I am watching on the sidelines with few practical resources to assist her. In other cases, having clarified the patient's aim, I would have encouraged referral months ago, possibly to work psychotherapeutically or to a physical therapy. Kathy has already pursued numerous routes without significant benefit. She has developed her own strategies of self-care. I was troubled by not know how best to assist her. This was heightened every time she thanked me at the end of the consultation. I re-prescribe with more attention to her vivid descriptions of living with constant pain, than to the nature of the pain and physical limitations. I select a low potency, 30th centesimal, as she has become so weak. After a number of different remedies, something seems to change very slightly. I am surprised by her comment:

'I have found a way of being with the pain and not wanting to die'
November 2006

The case that this fictionalised account is based on reminds me how hard it is not to make assumptions. I was so distracted by the desire to relieve her severe pain that I had not really listened to what she was saying. This is a matter of subtlety but it made a difference in the

choice of remedies and changed how I responded to her. She reports that treatment is helping her to manage her condition. I remain dissatisfied that I cannot do more. On reflection I may talk about a holistic process, but I realise that I was actually looking for symptomatic responses. Kathy continues to use homeopathic remedies periodically. I change the remedy much more frequently than I would have anticipated, possibly due to the gradual deterioration of her health. This gives me the sense of walking alongside the patient and I am gradually learning to accept this is the best I can do.

13.2 Orientation to the susceptibility chapter

Susceptibility can be considered as openness to change, both in vulnerability to experiencing ill-health and to being responsive to the potentially beneficial effects of a therapeutic intervention. I look at the role of susceptibility in terms of a self-healing response (13.4). I consider in what ways the consultation is homeopathic and this leads us to consider the symbolic role of the homeopathic remedy (13.5.3). I briefly examine the process of negotiating between practitioner and researcher roles (13.6). This discussion is experimental and raises more questions than it answers. The therapeutic value of the consultation process (13.5) raises questions for clinical research and how I perceive my practice.

13.3 Meditations on the susceptibility artefact



[Image 10: My consulting room]

This image represents the space between myself and the patient. It is in this space that the therapeutic encounter is enacted. The consulting room is at the heart of my practice and the venue for this chapter.

Susceptibility is a key artefact in homeopathic philosophy, acting as a pivotal link between internal and external influences. In physics the term is used to describe the ratio of

magnetization to magnetizing force. This is illuminating as the Organon of Medicine refers to the therapeutic use of magnetism promoted by Mezmer that was both popular and controversial in Europe at the turn of the 18th century. This raises the question of how far Hahnemann's conceptualisation of the vital force and susceptibility is influenced by the contemporary therapeutic use of magnetism and electricity. The artefact susceptibility carries implications of vulnerability and openness to be influenced by others. Since the 19th century women and children have been recognised as particularly amenable to successful homeopathic treatment (Ruddock, 1899 , undated).

With attention to the interior, rather than to external causes, susceptibility is conceptualised as the adaptive process by which we respond to both restorative influences and malevolent disturbances. Health is constructed as essentially a homeostatic process promoting physical and emotional health and well-being. Shared with other CAM practices, manifestations of symptoms are perceived as an attempt to regain health. Infections are the consequence not a cause of the interaction between micro-organisms and the resistance of the host. This is not a causal model, response is mediated through the individual's constitutional traits, and this is greatly influenced by hereditary factors (see Dialogue on Miasms chapter 15). Treatment is presented as looking further than the patient's current illness, to the wider context of their health.

Susceptibility is the means by which the individual responds to the homeopathic prescription (aphorism 31, Organon of Medicine). This makes the connection between the vital force and the potentised substance. Susceptibility is key to treatment by similars as the individual is responsive to the potentised remedy only if they are susceptible to it, that is if there is correspondence through similitude. The aim of treatment is to provide the most appropriate minimal stimulus in the form of the *similimum*, to initiate a therapeutic response. A pause in time is quintessential in this dynamic model of health. The most significant moment in the natural history of an illness is the interval before changes in the state of health start to manifest themselves. This represents the primary response, whilst the appearance of signs and symptoms of illness is secondary. After taking the homeopathic remedy, there is usually an interval before any response is evident. In treating acute symptoms this may be within the first hour after the remedy, whilst in long term conditions, there may only be the first signs of a response within the first month.

This model of health opens up questions that are not so prominently addressed by biomedicine. What makes you susceptible? In a confined space where airborne viruses circulate freely between individuals, for example in a crowded office during an influenza epidemic, why do some of the office workers succumb to influenza and others not? Whilst immunisation programmes identify vulnerable individuals according to age and certain pre-existing chronic conditions, for the majority of the population biomedical discourse does not ask this question. The individualised discourse of homeopathy pays attention to changes in susceptibility, looking for factors that may have predisposed us to allow one of these micro-organisms to proliferate in

our bodies. Remnants of the humoral theories that dominated medicine for centuries are still visible in the attention given to causative factors including becoming chilled, overheated and intense emotions. Rather than directly combating the pathological factors, such as viruses and bacteria that surround us, the therapeutic emphasis is on strengthening the whole organism. The most significant factor influencing susceptibility is our constitutional state, the underlying predisposition to illness. This predisposition is characterised in terms of recurrent patterns of illness, the individual's disposition and family medical history. This topic is explored in the Dialogue on Miasms chapter 15.

13.4 Intertextual relations on the susceptibility theme

13.4.1 Placebo: enabling the individual to access their own healing potential

Susceptibility has negative associations with terms such as 'suggestible' and 'easily led'. These derogatory associations are mobilised in critiques presenting homeopathy as 'only a placebo response' (Shang et al., 2005). This dismissal as placebo is often predicated on the absence of 'acceptable' scientific explanations for phenomena. The ability to intentionally stimulate the self-healing response is a powerful, shared concept across CAM practices and a hugely under-rated resource in biomedicine. Our beliefs and expectations about medical treatment impact on our health. In my early years of practice, I reacted defensively to suggestions of placebo response in homeopathic treatment. I felt accused of being a fraud, manipulative, relying on patient's expectations and those consulting me as gullible. With more experience, I perceive my role as encouraging rather than forcing recovery. I have come to embrace placebo response as offering insights into the untapped potential of natural recovery. The clinical application of placebo was embedded in nascent homeopathic practice, in 1810 Hahnemann wrote about use of placebo as a psychological factor in patient care (Dean, 2001).

Let us first unpack the concept of placebo in biomedical terms. The term 'placebo' comes from the Latin, *placere* to please. In biomedicine, placebo refers to inert medication prescribed more for mental relief of the patient than its actual effect on a particular disorder. Biomedical discourse creates a nonentity category of 'contextual or non-specific' effects of treatment, referring to effects of the therapeutic relationship, consultation process and patient expectation, as distinctly different from specific or characteristic drug effects. This is informed by the Cartesian mind-body duality. The power of placebo response is implicit within the elaborate strategies adopted in RCTs to eliminate these 'non-specific' effects. In a RCT around 60% of the control group (taking placebo treatment) experience a response to treatment (Helman, 2001). The placebo response is perceived as a problem in the experimental design. Biomedicine can be considered in general terms as an interventionist approach that operates with emphasis on technical, predictable and measurable factors. Placebo as an uncontrolled phenomenon, that blurs the Cartesian divide of mind-body, threatens the stability of the discourse and is dismissed on account of its intangibility and uncertainty.

Paradigm differences between biomedicine and CAM are highlighted by the divergent perspectives on placebo response. The assumption that CAM practice ‘only works if you believe in it’ dismisses an active ingredient in the treatment process. An ‘inactive’ or inert ingredient that could have an effect is a contradiction in terms. This critique does not take into account that the self-healing response is crucial to all forms of recovery and therapeutic interventions. Across the diverse field of CAM practices, there is a common language of stimulating a self-healing response. However CAM discourse can adopt the cause and effect model regarding treatment effects, rather than maintaining uncertainty about what has brought about change for the patient. Kienle and Kiene (1996) suggest that verum and placebo responses can be distinguished and the latter tend to be neither consistent nor linear.

The question becomes: how can I maximise the catalytic effect of treatment? I have learnt to value patient expectation and experience. Patients’ self-appraisal of their response to treatment is the most significant feedback. The essential aspects of treatment appear to be the quality of the encounter between patient and professional, in terms of the homeopath’s compassion, empathy, awareness and responsiveness. One medical homeopath’s observations (Reilly, 2006) are that through medical training and assimilation into the professional ethos of biomedicine, the ability to facilitate a fully human encounter has largely been displaced. Patients’ illness experience and its meaning in their lives are sidelined by attention to pathophysiology at the cellular and genetic level. Reframing the placebo effect as a response to the meaning of a therapeutic interaction (Moerman and Jonas, 2002), enables me to engage as practitioner to maximise the meaningfulness of the interaction, in the belief that this will enhance treatment effects. I pay more attention on ‘being’ than on doing in both research and practice.

13.5 Homeopathy research discourse on the susceptibility theme

This section inquires into how the consultation is constructed in homeopathy discourse and its role as a therapeutic tool.

13.5.1 What is homeopathic about the homeopathic consultation?

Homeopathy is essentially a dialogical and narrative experience. The framing and functioning of the consultation process is constructed through an individualised approach to the therapeutic framework (Paterson, 2005). There is a rigorous phenomenological approach with attention to individualised subjective accounts of illness and recovery, combined with the patient’s account of the biomedical narrative (diagnoses, blood tests, imaging *etcetera*) and physical examination. Case-taking can be characterised as:

“the homeopath’s attention to idiopathic symptoms (no significance to conventional diagnosis) and their intent to elicit detailed and nuanced histories of bodily sensations.” (Thompson and Thompson, 2006, p.83)

By contrast, Richardson (2001) describes ways of seeing in biomedicine:

“Disease is what practitioners are trained to see, so they reconfigure the patient’s problems as narrow, technical problems, and are unconcerned with patients narratives and causal beliefs” (p.134).

It is not unusual for the duration of the first consultation to be at least an hour. The patient is encouraged to narrate their health and illness experiences, to relate these to life events and to explore the reasons why they are seeking treatment. In situations where verbal communication is limited, for example with a young child, an autistic young person or adult with dementia, observations are more important. Attention to description and subjective experience in CAM practices diverges from the biomedical understanding of illness in terms of what is perceptible to the ‘medical gaze’ (Foucault, 1973). I resist the term patient, but fail to find a viable alternative. Associations of passivity and compliance are alien to my intention as I regard the people who consult me as active participants in their own recovery and as experts on their own conditions.

The term ‘to take the case’ implies that the homeopathic case pre-exists the consultation. I am most acutely aware of this when acting as a clinical supervisor. Student homeopaths are so concerned to ‘get all the information’, they cannot perceive the patient’s case. I encourage them to ‘receive the case’, by allowing the consultation to unfold and to be guided by how the patient constructs their own narrative. The patient’s narrative is shaped by the homeopath’s intention (Scott, 1998). As discussed earlier all therapeutic interventions are bound up with the practitioner’s values and assumptions, possibly normative and moral judgements. These difficulties are obscured by the use of Hahnemann’s term ‘unprejudiced observer’. This term suggests that you should not allow your persuasions and speculations to distort your view of the case. This is a naïve untenable stance, at best the reflective practitioner can try to raise their self-awareness and consciousness of how their own values shape their perception of the case. We discussed earlier in the thesis (9.3.1) the problematic nature of the construction of an intimate dialogue between homeopath and the individual’s vital force as an all knowing and higher intelligence. The homeopath’s approach creates a framework for the patient to integrate their experiences. The consultation process can deter some individuals from starting treatment as it is not neutral and may conflict with their own values and expectations. The consultation does not create an objective or single narrative, but a blending of the homeopath’s framing, the patient’s narrative in that moment, alongside the story shaped by previous biomedical and therapeutic encounters.

The homeopathic case is translated through the homeopath recording case notes. Keeping notes by hand or on laptop computer dominates the homeopath’s activity during the consultation. These case notes create another layer of interpretation of patient experience, as the homeopathic case is produced in a highly stylised form. Particularly with the first consultation my aim is to keep this process of recording case notes as unobtrusive as possible. This is not always possible and sometimes it is difficult to engage eye contact with the patient as they are persistently looking at my notepad as they speak. When treating individuals over a number of the years, in my experience the case notes, like the remedy, take on the role of a vehicle of communication. There is a shared value to the notes for recording the interplay between life and health events. The textual focus of this inquiry is congruent with the case notes as a dominant representation of practice.

Generating a homeopathic case from the encounter in the consulting room is a pre-condition for potential making a match with a remedy profile. The case-taking process and case analysis are concurrent processes rather than sequential, even though dedicated case analysis may be performed after the consultation. Case analysis organises the patient's narrative into patterns of symptoms. In shaping the illness narrative, a plot and subtext are co-created and this plot becomes the focus of case analysis.

13.5.2 What is therapeutic about the homeopathic consultation?

I have learnt to work more consciously with the therapeutic value of the consultation process. Whilst this is acknowledged anecdotally, it is an under-explored concept in experimental research (Di Blasi, 2001). Schön (1987) helps us to perceive how biomedical practice foregrounds technical rationality, using technical knowhow in a problem solving approach. This strategy obscures how the problem is constructed and the selective view of what is considered to be relevant. Schön describes this as a process of imposing coherence. This raises the question of how homeopaths and their patients recreate coherence through treatment to catalyse self-healing responses. Reilly (2001b) encourages practitioners:

"to begin to think of *therapeutic history taking* [sic], the actual act of history taking being an act of therapy – not only a diagnostic act but a therapeutic act, with intention and focus and respect and listening, and wonder, present." (p.414)

This statement prompts me to ask: What is it about the homeopathic consultation that is potentially therapeutic? What aspects of the encounter can be claimed as offering a unique therapeutic approach?

The therapeutic relationship is presented as non-hierarchical. Encouraging patients to take responsibility for their health is written into professional code of ethics and practice (paragraph 1.6 in (SoH, 2010b)). This can include educating patients to self-prescribe homeopathic remedies for acute and first aid ailments. This egalitarian view of practice has the potential to erode perceptions of expert knowledge (Cant and Sharma, 1996). I have argued elsewhere (see Dialogue on Vital Force chapter 9) that homeopathy discourse continues to share with common parlance, an understanding of health in which the remnants of the humoral explanatory model are still evident. However there is also potential for mystification in the use of Latin names for remedies, and unfamiliar terms such as miasm and vital force. The homeopath's *modus operandi* to observe, make copious notes, ask many questions including unexpected ones and make little or no physical contact to conduct physical examinations, can make the homeopath appear aloof and unapproachable.

Let us consider in some detail the generic aspects of 'holistic' case-taking, with reference to research into the acupuncture consultation (Paterson, 2005). From the opening of the first consultation, the acupuncturist signals that all aspects of the individual's life and embodied experience are valued in this process. During the course of treatment any new concerns receive attention, and the treatment plan is adjusted accordingly. As understanding the patient's embodied experience is central to most CAM interventions, the practitioner's attention and

listening skills are ‘tuned into’ the individual patient. Paterson (2004) contrasts this sense of ‘being listened to’, with the socialised expectations of what to tell the doctor, which she describes as ‘constraining talk’. The nature of the acupuncture dialogue is participatory, and the patient may over time feel they can become more involved and share more intimate concerns. The dialogue is constructed with the understanding that health encompasses self-awareness, self-confidence and self-responsibility. Whilst the patient’s account, in their own words, is essential in the individualisation of the homeopathic prescription, it also functions by valuing what is important to the patient, and empowers the patient by regarding them as experts of their own condition and collaborators with the homeopath. This more egalitarian approach may suit some people and not others.

Interest in the role of narrative in medicine has become an influential area of study. This inquiry has been influenced by Frank’s work (1995, 2000, 2006) as his perspectives resonate with my own experiences as a patient and a practitioner. Giving an account of your illness experience has a profound purpose;

“the *need* of ill people to tell their stories, in order to construct new maps and new perceptions of their relationships to the world” (Frank, 1995, p.3).

Frank highlights the incongruity between lived experience of ill-health and the biomedical accounts of that experience. He argues that illness narratives can have an empowering effect on the narrator and helps others to narrate their own illness experience. Homeopathy discourse, like other CAM discourses, attracts patients who wish to or are able to talk about their emotions, willing to make connections between life events and illness experience, and to talk about their health in particular ways. Does this openness to mind-body connection and ability to narrate illness experiences create an essential predisposition to be susceptible or responsive to homeopathic treatment?

Another facet of the therapeutic potential of the consultation resides in the power of touch. In my experience professional homeopaths are reticent about physically examining patients, and the role of touch in the consultation is generally minimal. This reflects the primacy accorded to subjective experience, and possibly influenced by some homeopaths’ ambivalence about engaging in biomedical practices using biomedical symbols such as stethoscopes. I find physical examination a useful tool in differential diagnosis and more intimate observation. Touch contributes to building trust and giving the patient confidence in my skills as a health practitioner.

Thompson and Thompson (2006) propose an interdependent relationship between the therapeutic and diagnostic functions of the homeopathic consultation. They connect the meaningfulness of the consultation, as therapeutic for the patient, with how the meaningfulness of the interaction is reflected in the homeopath’s conceptualisation of the case and accuracy of the prescription. They contend that:

"the process of remedy selection has a large impact on the consultation process and constitutes something relatively unique to homeopathy" (Thompson and Thompson, 2006, p.83).

I suggest that both the homeopath's commitment to the *similimum* and the patient's awareness of this, is integral to the therapeutic effect.

Thompsons' papers (Thompson and Thompson, 2006, Thompson and Weiss, 2006) gives us the opportunity to question whether, on a conceptual level, is it possible to establish a connection between the therapeutic qualities of the consultation and the potential to select an appropriately individualised remedy. These are interdependent aspects of the consultation, unique to homeopathy and not shared with other talking therapies. Thompson and Thompson draw a tentative inference to suggest that: "closeness of matching may correspond with outcome" (Thompson and Thompson, 2006, p.83). They do not elaborate on how 'closeness' was determined, but an explanation is available in a more detailed account of the study (Thompson and Weiss, 2006). The concept of "homeopathicity" is used to convey the degree of perceived similitude between the case as interpreted by the homeopath and remedy choice. Prescriptions were assigned as "match clear" or "match unclear", and these were plotted separately against the three global outcome assessments. The connection between outcome and homeopathicity was identified retrospectively (Thompson and Weiss, 2006). A connection was hypothesised as follows:

"This could be due to the action of the correctly matched remedy, or reflect the fact that the practitioner developed a very clear (and therefore therapeutic) understanding of the person's situation – an understanding reflected in the 'accuracy' of the remedy choice. By either interpretation, it is beyond reasonable doubt that the process of remedy selection has a large impact on the consultation process and constitutes something relatively unique to homeopathy, including the homeopath's ability to prescribe individually from a range of three thousand or more remedies from all kingdoms of nature." (Thompson and Thompson, 2006, p.83)

A connection between the therapeutic qualities of the consultation process and the potential to select an appropriately individualised prescription is a very attractive proposition, as it validates homeopathy's therapeutic framework. But is this sophistry? Is this an example that you see what you look for? How you respond to this question depends entirely on your view point. What is less contentious is that this proposition disrupts the internal validity of the RCT design for evaluating homeopathic treatment.

Whilst self-critical examination of practice challenges taken for granted values and assumptions, there is also a place for reaffirming and appreciating homeopathic values. In the professional experiential data section below we encounter treatment described in terms of 'getting alongside the patient' and the homeopath's sense of 'being more homeopathic'. Eagger's contributions on being and intention (Eagger, 2006) may help to illuminate the therapeutic value of the consultation. As a doctor herself, she laments the absence of the doctor 'being there' for the patient. With the exception of hospice care, she argues that any sense of a meditative presence is precluded by the task orientated, target driven and time limited ethos of biomedicine. Without making any reference to CAM, Eagger explores the concept of presence in vitalistic and

energetic terms. She proposes that rapport is achieving a sense of ‘resonance’ with the individual. In acupuncture Paterson describes this quality as ‘tuning’ into the patient (Paterson, 2005, p.1203). Eagger’s comment that biomedicine has lost this quality caused me to reflect on how homeopathy has continued to value the therapeutic potential of interaction between patient and practitioner. With the integration of medicine into a scientific domain (Cassell, 2004), the traditions of the family doctor have been lost. This essential difference between biomedical and homeopathic consultations is not down to the individual practitioner nor the length of consultation, but is a function of the different theoretical models underlying biomedicine and homeopathy (adapted from Paterson 2005).

We can now extend Thompson and Thompson’s model to include Eagger’s concept of ‘resonance’. Does the therapeutic value of the homeopathic consultation reside in three interconnected forms of communication? ‘Resonance’ between patient and homeopath, the patient’s increased self-understanding and potential for change, and the basis for making a ‘fit’ with a remedy in the context of homeopathy’s therapeutic framework?

13.5.3 Contextualising the therapeutic effects of homeopathy

I turn to anthropological writings to gain insight into how engagement with contextual factors has the potential to catalyse self-healing responses (Dow, 1986, Helman, 2001). Helman refers to “ritual symbols” in the medical encounter as not limited to physical objects, but to include also interpersonal aspects such as body language and use of time. In a social constructionist sense these objects, gestures, ways of organising time and space are made meaningful in the context of a particular discourse or discourses. Helman (2001) argues that meaning of the therapeutic encounter is created through an interaction between local and wider contextual factors. The ‘micro-context’ of the encounter is:

“an ambience, or atmosphere, in which belief in the efficacy of a healer and of their treatments (whether placebo or not) can be created, maximised and then maintained over time.”(Helman, 2001, p.5)

The ‘macro-context’ provides ‘the script’ of social expectations, behaviours and values. This script, or in terms of this inquiry, discourse functions to validate the healer and the effectiveness of their treatments. Helman contends that our search for meaning is heightened at times of vulnerability and illness, and a coherent explanatory framework for illness is essential to most traditions of healing. The belief in the power and efficacy of medications prescribed or purchased ‘over the counter’ is an essential component of the non-specific effects of biomedicine (Helman, 2001, p.11). Following the pragmatic slant of this inquiry, my reading of Helman’s text offers a way of understanding therapeutic encounters and places homeopathy in a continuum with other healing traditions.

So let us continue with an anthropological view to provide a framework for examining homeopathic practice. This complements Paterson’s (2004 and 2005) description of acupuncture we discussed earlier. I adapt a symbolic model of healing (Dow, 1986) to

conceptualise how the contextual effects of the homeopathic consultation can catalyse recovery with the patient as an active participant:

- The homeopath offers the patient an explanation for the onset and nature of their complaint/s in terms of homeopathy's therapeutic framework.
- The homeopathic model of health and illness helps the patient to make connections (in Dow's terms a 'symbolic bridge') between their personal experiences and wider social and cultural meanings. This is achieved through interpreting experience in terms of the vital force and the protective role of symptoms. The patient participates in the symbolic ritual of medical prescribing.
- The patient's perceptions are framed by their prior experiences of healthcare and values around health. The homeopath comes to embody belief in the therapeutic potential of homeopathic treatment.
- The patient integrates their own experiences of illness and recovery with reference to the metaphors and symbols of homeopathic treatment.
- As well as intellectually, the patient needs to feel to some degree emotionally engaged with homeopathic treatment. This involves attaching their hopes and fears to a sense of their symptoms as exterior signs of an inner disturbance, and to recovery through their innate healing capacity.
- The patient reframes their experiences and expectations as the homeopath guides them through therapeutic change. The homeopath uses homeopathy's therapeutic framework to interpret change. The patient, in addition to hopefully enjoying an improved level of health and learning strategies of self-care, also reconceptualises their health with a greater sense of autonomy.

This model can also be used to explain placebo response. It is generally assumed that deception or disguise is required for placebo treatment to have clinical effects. This assumption is undermined by the results of a recent clinical trial (Kaptchuk et al., 2010). Irritable bowel syndrome patients were randomised to receive 'open-label placebo in the context of a supportive patient-practitioner relationship' (p.5) together with a plausible explanation of the clinical benefits of placebo (31 participants completed). The control group (39 participants completed) participated in the same consultation process but without placebo tablets. This 'no-treatment' group reported some symptomatic improvement, whilst the open-label placebo treatment group reported statistically significant and clinically meaningful improvement. The researchers claim to demonstrate that the placebo effect is not 'neutralised' by knowing you are receiving placebo. They recognised a number of limitations of the inquiry. As participants were recruited by responding to an advertisement for a 'novel mind-body' trial, the sample was not representative of the general population. Although irritable bowel syndrome is a functional condition which is often associated with stress and a mind-body link, the diagnostic category is reliant on subjective reporting. The researchers identified a number of preconditions for openly utilising the placebo effect. Participants received an explanation of the current understanding of placebo effects, they were encouraged to take an open and positive attitude to the treatment

process and asked to follow specific instructions on how to take the tablets. The researchers recognise that participants could have been influenced by positive media reporting of the power of placebo. This inquiry can be interpreted as hinting at the therapeutic potential of participating in an embodied medical ritual in which trust and hope are invested in the treatment. The preconditions outlined by the researchers are close to Dow's adapted model above and this raises questions about the role of placebo effect in all forms of prescribing therapies. The short duration of the study (21 days) limits relevance for clinical practice.

Let us consider theoretical contexts that may help us to explore what is happening during the consultation. I recognise those moments of being totally involved with the patient in Reilly's description of a feeling like the walls of the consulting room have disappeared (Reilly, 2001a). To conceptualise this I borrow concepts from David Bohm, one of Einstein's pupils. Bohm (1980) articulates something that I have thought about since childhood, that our sense of reality is but one aspect of multiple realities. What we observe, Bohm describes as the explicate order. Whilst the implicate or enfolded order exists on another level, only accessible episodically, at moments of altered consciousness, deep meditation or mystical states. During the homeopathic consultation, the intense moments of empathy and shared understanding, could be perceived as accessing Bohm's implicate order. This facilitates the *similimum* to be identified and for the patient to be predisposed to respond to the remedy.

Now we consider the symbolic role of the homeopathic remedy in the context of the transformational qualities shared with alchemy and Jungian psychology (Whitmont, 1980). The symbolic role extends beyond participating in the ritual of prescribing. The remedy is endowed with the quality of signifying 'something else' other than itself. In Jungian terms symbolic perception is

"the experiencing of events and images in terms of a significance that transcends their immediate and so-called commonsense meaning."
(Whitmont, 1980, p.53-4)

On a symbolic level the remedy is a 'picture' (this term is used to describe the *Materia medica* profile) of what is co-created through the consultation. In common with other symbolic systems, for example ancient fables and Classical Greek tragedies, these contrivances play an important role in illuminating and communicating meaning. In some instances it may be helpful to offer the patient an interpretation of their condition from the *Materia medica*. In the case of bereavement, there is a cramping effect of *Ignatia* on an emotional and physical level. An alternative is to offer an interpretation in terms of the doctrine of signatures (see 10.3.1). For example post-operative internal bruising of *Bellis perennis*, the common daisy, that is crushed as we walk across the lawn . Homeopaths communicate with each other through descriptions of remedy pictures. Referring to the suicidal state of *Aurum metallicum* (gold) has practical value in differentiating types of depression. Another homeopath would understand this depressive state as someone suffering from failing to meet their own very high expectations and for whom the negative feelings are unendurable at night.

Unfolding from this discussion is the symbolic role of homeopathy, in creating correspondence between human experiences and the homeopathic interpretation of the therapeutic potential of a substance. This draws on alchemical notions of transformation. However this symbolic perception has to be used with great caution. There is a potential to disempower the patient as the homeopath manipulates this language and speaks from within homeopathy discourse to claim to perceive the action of the vital force that is imperceptible to the patient (Scott, 1998). I invite you to pause here and to reflect with me on practice experiences, before resuming this discussion in the final section of this chapter.

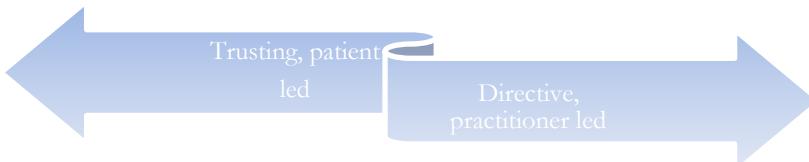
13.6 Professional experiential data on the susceptibility theme

In this chapter we have challenged core issues in clinical practice. Discussion of contextual effects of homeopathic treatment detracts from practitioner focus on the remedy as the active agent of treatment effects. So let us return to explore the interface between research and practice, and in particular the tension between belief and uncertainty for the practitioner researcher.

13.6.1 Developing a collaborative relationship with the patient

Reflective writing May 2006

I reflect on how I negotiate patient autonomy. CAM use is patient led. Practising in the private sector, the patient is paying for treatment so they operate a degree of control. The patient selects the homeopath, chooses what to disclose as I don't often have access to NHS records. They make their own choice to seek and terminate treatment. Janet (Richardson, 1995) suggests from her experience that this initiative to seek treatment and engage in the treatment process is key to patients' valuing the treatment and outcome. This prompts me to question how I establish a collaborative relationship with patients, balancing their autonomy and practitioner expertise. I visualise this as points along a spectrum:

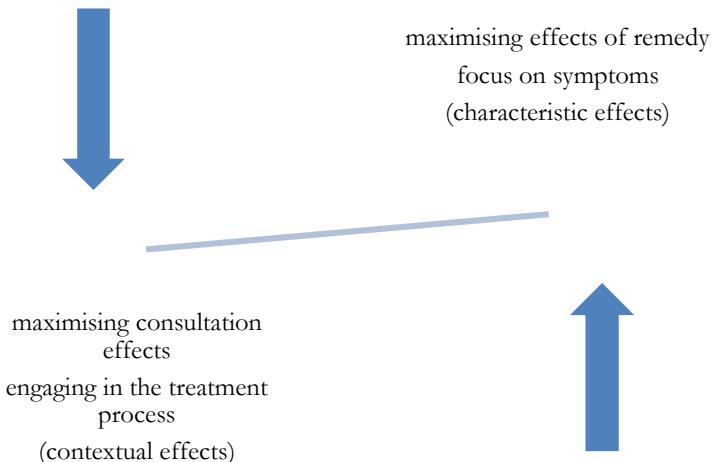


Giving or withholding a prescription is an element of the homeopath keeping control in the interaction. In the same way that the patient seeks out treatment, so they are at liberty to terminate treatment, either in discussion with the homeopath or of their own accord. Patients discontinuing treatment without prior discussion always cause me to reflect on why and how this came about.

This reflection constructs the consultation as a financial, customer led transaction. I do not often reflect on the money transaction, but it is an important component of practice, which I do not entirely feel comfortable with. I find it very hard to cost my time. Some of the most needy patients are those least able to pay.

13.6.2 Evaluating therapeutic effects

Reflective writing May 2006



How I analyse therapeutic effects is being influenced by engaging in debates about the difficulties of distinguishing between characteristic and contextual effects in clinical trials. A pair of scales is a way of visualising two inter-related aspects of treatment, both are influencing outcomes but to variable degrees for individual patients at distinct moments over the course of treatment. When I experience a successful therapeutic relationship, the treatment outcomes seems to be less reliant on the response to the remedy. However when I experience only minimal engagement with the patient, maybe influenced by their approach to treatment or a sense of incompatibility, health changes seem to be more attributable to a reaction to the homeopathic remedy or remedies. This has helped me to pay attention to nurturing the patient's engagement in the treatment process as well as to interpreting responses to the remedy. Why was I perplexed by Reilly's (2006) observations? He estimated that 40% of his patients do not require a remedy, the consultation itself is a therapeutic catalyst for promoting a self-healing response. I was surprised not so much by the figure, than by the practicalities. In a number of instances I have prescribed but the patient has later reported that they did not need the remedy. Does Reilly assess retrospectively that the remedy was unnecessary? Is it made clear at the outset that they may not receive a prescription? When is the assessment made?

This extract indicates that research is impacting on practice. There is a pragmatic engagement with the contextual effects of treatment, with an awareness that these can be manipulated and effects vary considerably between patients, and possibly between consultations. How do I feel about Reilly's proposition that nearly half of patients consulting him experience health benefits without homeopathic prescriptions? Are we performing a holistically orientated counselling service? I reflect that both the symbolic prescribing transaction and the effects of the potentised dose play a role in the effects of the homeopathic consultation. In regarding homeopathy as a complex intervention, it is futile to attempt to separate characteristic and contextual effects. The phrase "numerous positions on the continuum of possibilities" (Farquhar, 1994, p32) seems most apt to this discussion.

13.7 Reflective pause before moving on from susceptibility to provings

This chapter has been dedicated to what is happening in the consulting room. Kathy's case highlighted the divergence between espoused theories and actions. In this extreme situation my view of the case contracted down to the desire to reduce her chronic pain. This did not help her and eventually I began to hear what Kathy was telling me. It is disputable whether it was the change in the quality of listening or change in the remedy that appeared to make the difference to Kathy's management of pain.

A theme emerging from this chapter is adaptation. This quality is implicit in the homeopathic model of illness and recovery and integral to individualised homeopathic care. We questioned whether openness to a mind-body connection, a proclivity to narrate your illness experience and active engagement, are essential preconditions to being susceptible or responsive to homeopathic treatment. By viewing medical systems as social practices, the negative connotations around placebo in biomedical discourse are turned inside out to reveal the untapped reserve for enhancing our own healing potential.

Do I take a reflexive stance on the susceptibility theme? Did I demonstrate this in my reflective writing? I am subject to homeopathy discourse, and it is difficult to challenge my own cultural assumptions. Have I noticed how I look at what is going on? How am I framing arguments? What do I choose to speak about and what to ignore? Perceived patient satisfaction is still used to affirm practice in an uncritical manner. I am drawn to the re-affirmation of the internal validity of the therapeutic framework offered by Thompson and Weiss's (2006) claim to demonstrate that "closeness of matching may correspond with outcome" (Thompson and Thompson, 2006). In other words, where a synergy is created between the patient's profile and the remedy profile from provings, possibly suggesting a sound connection between homeopath and patient, these cases have shown better improvement in treatment outcomes than others. However this does not satisfy my initial motivation for embarking on the inquiry. I was looking for ways to more effectively monitor progress in long term homeopathic care. My experience contradicts Thompson and Thompson's assertion. In cases where treatment has continued over many years, I found that the well established therapeutic relationship can obscure rather than clarify my grasp of the homeopathic case on which to prescribe.

This dilemma is captured in the Professional experiential data (13.6.2). Initially I set out in professional practice with strong attachment to the remedy as "the primary agent of therapeutic change" (Thompson and Thompson, 2006, p.82). Over years I have taken a more pragmatic approach and paid more attention to engaging with the therapeutic potential of the contextual effects of treatment. I now see this as an adaptive process according to the perceived needs of the patient at that moment. I am more open to evaluating response to treatment in terms of the complex interaction between specific and contextual effects. Both are operating, but in different ratios at each stage of treatment. This is lived experience of the state of not knowing, which previously I had only grasped intellectually. I am more mindful about how I articulate this uncertainty to the patient as it could inhibit the contextual effects of treatment.

Let us unravel this further. Does the conviction of finding the 'right remedy' sustain the belief that therapeutic changes can be achieved? This could be interpreted as supporting the critique that 'homeopathy only works if you believe in it'? I am questioning whether therapeutic similitude operates through the consultation as well as through the remedy itself. Remedy profiles provide a framework for interpreting the patient's narrative. For example, the effects of grief and loss in the remedy *Natrum muriaticum* are long lasting, and sadness is often kept hidden with a reluctance to weep or talk about feelings. During the consultation I consider if *Natrum muriaticum* could be indicated. This speculation influences the way I perceive the patient and how I respond to their slightly abrasive manner, being careful not to pursue too many questions about feelings. The patient may then be more comfortable and will be more positively disposed to the prescription?

The consultation can be therapeutic. Some may find it irritating, with far too many questions. Selecting the prescription and advising on self-care are intertwined with the prescription itself. This reinforces the view that in designing RCTs the specific effects of the prescription cannot be separated from the contextual effects of treatment. By recognising the potential benefits of patients feeling actively engaged in the treatment process, this is one step away from validating a sceptical view that the perceived effects of treatment are due solely to placebo. However this is an aspect of all therapeutic interventions. I continue to reflect on how this effects the care I offer and revisit this issue in the Dialogue on Direction of Cure chapter 16.

We are reaching a stage in the inquiry where many threads or themes are tangled up. It is important that we leave these dangling and as we proceed the different strands of transformative learning will become differentiated.

14 DIALOGUE ON PROVINGS

14.1 Case vignette

This is an account of an unintentional proving:

A few years ago I was acting as locum in a colleague's practice. A 58 year old woman attended for a first appointment. She told me that she had self-prescribed homeopathic remedies for many years for minor ailments but her friends had persuaded her to consult a homeopath as they claimed she had become overly anxious. From our discussion it emerged that going out of the house was becoming an ordeal. When I asked about her home use of remedies she said that two years ago she had started taking a daily dose of Sepia in 6th centesimal potency. Using an introductory guide, she had selected Sepia to ease itchy and uncomfortable haemorrhoids and found this to relieve the problem. She was therefore most upset when at the end of the consultation, I advised her to stop taking Sepia. She exclaimed 'But what about my haemorrhoids?' I explained that I suspected that her anxieties and reluctance to go out may be caused by overdosing on Sepia. I suggested that if she stopped, we could find out if her anxiety improved. If this was the case we would then be able to prescribe a constitutionally based remedy, which would be intended to ease the discomfort of the haemorrhoids on a more permanent basis without requiring constant dosage. On inquiring later, my colleague confirmed that the situation was as I had anticipated. This suggests that by taking repeated doses of Sepia, she had begun to 'prove' the remedy, in other words, to manifest symptoms of the remedy.

Notes on the remedy: Sepia is prepared from cuttlefish ink. I was taught that its therapeutic use was discovered from observing poisoning symptoms in Parisian artists who, in applying sepia washes to prints, licked the tip of their brushes to form a fine point. First proved by Hahnemann (Hahnemann, 1988, 1st publication 1828)

I explained that I suspected that her anxieties and reluctance to go out may be caused by overdosing on Sepia. I suggested that if she stopped, we could find out if her anxiety improved. If this was the case we would then be able to prescribe a constitutionally based remedy, which would be intended to ease the discomfort of the haemorrhoids on a more permanent basis without requiring constant dosage. On inquiring later, my colleague confirmed that the situation was as I had anticipated. This suggests that by taking repeated doses of Sepia, she had begun to 'prove' the remedy, in other words, to manifest symptoms of the remedy.

As a partial similar Sepia only provided temporary relief for the haemorrhoids. The likelihood of experiencing proving symptoms depends on your sensitivity to homeopathic remedies. In my experience in the course of treatment most people do not experience proving symptoms, but some are so sensitive that they experience 'new' symptoms that appear to relate to the remedy after only a few doses, particularly if taken at a higher potency, such as 200th centesimal.

14.2 Orientation to the provings chapter

This chapter is dedicated to the most active area of research by professional homeopaths. Provings are experimental studies designed to investigate the effects on healthy human volunteers of substances at non-toxic levels, serially diluted and agitated. The aim of a proving is to ascertain pathogenetic and, in accordance with the law of similars, therapeutic effects of a specific substances. This research tradition is integral to homeopathy's epistemology. Discussion of homeopathy research discourse and intertextual relations are explored as a

fictional dialogue debating whether provings can be considered as a systematic and rigorous form of clinical research (14.4). The reliability of proving data as the basis for 'accurate' prescribing is challenged and comparison with phase one clinical trials is considered.

Participant observation at a medical homeopaths' international conference (14.5) provides the opportunity to deconstruct the use of more contemporary scientific terms such as 'homeopathic pathogenetic drug trials' (HTP) (Dantas, 1996, Kaptchuk, 1996). Closing the chapter, I draw out common threads running through the discussion of experimental research, both provings and RCTs (14.6).

14.3 Meditations on the proving artefact

Provings are the experimental and empirical foundation of homeopathic practice and represent one of the first double-blind placebo controlled clinical trials. Provings do not address questions of efficacy or effectiveness but are positioned in relation to practice in a similar way to clinical trials in biomedicine. Provings, not clinical trials, contribute significantly to *materia medica* knowledge. Whilst clinical trials play a more public role, in terms of examining the effects of treatment as a therapeutic approach, not testing the therapeutic effects of specific remedies.

Homeopathy research discourse presents good quality provings as a rigorous and systematic approach to advance understanding of the pharmacopeia. Substances not already in use are tested and existing remedies re-tested, particularly where only partial knowledge of therapeutic effects are known. Healthy volunteers are screened before recruitment into a double blind study and randomised to receive a course of placebo or repeated doses of the remedy being tested. Each prover (participant) is allocated to a proving supervisor, who is responsible for ascertaining a baseline profile of their healthy state. The aim is to provoke transitory symptoms that are specific to the remedy being tested. When symptoms occur dosage is stopped. Each prover's objective and subjective reactions are monitored in detail by a proving supervisor until they cease. Some provers experiences are more intense than others and this helps to identify who may be sensitive to the remedy's therapeutic use. These individual phenomenological accounts are collated and synthesised to identify the distinctive symptom profile of the potentised remedy. Data analysis generally combines qualitative and quantitative approaches. The data is edited for publication and translated into repertory rubrics.



[Image 11: Open bottle of Pulsatilla 1x on repertory. Reproduced with kind permission of Nicky Howard Kemp]

14.3.1 Experimental foundations of homeopathy

Provings represent how homeopathy is defined by its historical origins and testament to its quality of standing the test of time. Provings were initiated in the context of European Enlightenment view that knowledge comes from observation guided by reason. Self-experimentation was common practice (Wisse Priven, 2008) and Hahnemann's experimentation was informed by the prevailing theory of artificial or antagonistic fever and Hunter's theory of counter-irritation. Hahnemann's "epistemological break" (Wisse Priven, 2008) was identification of specific similarities between the symptoms provoked by a healthy person taking Peruvian bark and the symptoms of the intermittent fever it was well known to treat. In an era of polypharmacy and potions, he and his colleagues experimented with nearly one hundred single and unadulterated substances initially at toxic levels and subsequently diluted doses, and published the results (Hahnemann, 1990, 1st published 1822-1827). These experiments were described in German as *prüfungen* (Dantas et al., 2007) or *probieren* to test a substance on an individual (Brewster O'Reilly, 1996). This was translated into English to 'prove' meaning to try, to test the qualities of or to learn by experience (Dantas et al., 2007). Talk of 'testing' remedy action continues to be used today (ECCH, 2009). Provings continue to be conducted largely according to Hahnemann's protocol [see *Organon of Medicine* 6th edition aphorisms #105-145]. This was "methodologically innovative" (Dantas et al., 2007, p.5) at the time and continued to be innovative with the introduction of placebo controls in 1834 (Dean, 2001), pre-observation 'run in' period (Medical Investigation Club of Baltimore, 1895) and multi-centre double-blind design (Bellows, 1906). The phenomenologically rich accounts from provers of their experience of developing symptoms whilst participating in a proving, has been recorded for over two hundred years, representing a huge resource of research directly informing practice.

The numbers of provings being conducted has increased since the mid 1990s. With sustained attempts to update designs in line with current RCT methodology, the quality and methodological rigor of Hahnemannian provings is being improved (Sherr, 1995, Riley, 2007). A counter-culture of meditative and dream provings (Evans, 2000) emerged that utilises provers' intuition to explore the therapeutic potential of a substance.

14.3.2 Relations between homeopath and pharmacist

In the UK homeopathic pharmacies are long established small scale private companies. Unlike the pharmaceutical industry, homeopathic pharmacies are not in a position to fund provings or other forms of research. They do not generate significant revenue from a newly proved remedy and cannot patent remedies. They are located as service providers preparing a new remedy or sourcing fresh supplies of an existing remedy, and dispensing placebo-controlled prescriptions.

14.3.3 Provings are practitioner research

Homeopaths' research into expanding the pharmacopeia and deepening understanding of remedy action is key to homeopathy's epistemology. Proving and practice are interdependent:

"homeopathic methodology and epistemology is circular. Unusual and prominent symptoms produced by healthy volunteers are being used for prescribing..... If the prescribing heals the patient, the symptom, by proxy the HPT [homeopathic pathogenetic trial or proving] is verified...The proof of the symptom is not in the methodology of the HPT as such, but in the pragmatic verification in clinical application..."(Walach, 2008, p.544)

Practice is based on observations that under experimental conditions (provings) repeated doses of remedies can induce distinct and reproducible symptoms in healthy volunteers. Patients' prescriptions are selected by matching the patient's symptoms with the symptom complex identified through provings. Clinical confirmation is used to verify proving symptoms. Observations of responses to specific remedies are communicated via case reports in professional journals, conference papers and used to compile synthetic repertories. Interdependence of provings and clinical confirmation can be considered as a strength or a flaw in homeopathy's epistemology. We explore this dilemma in the next section.

14.4 Homeopathy research discourse on the proving theme

To illuminate contested perspectives on provings, let us create a fictional dialogue between *Questioner*, *Homeopath*, *Homeopath Researcher* and *patient*:

Questioner: Please explain how provings can be considered to be a scientifically rigorous form of research.

Homeopath: The use of a systematised protocol and placebo arm predated the introduction of placebo controls in clinical trial design in the late 1950s (Beecher, 1955). Eliminating bias is prioritised as the remedy being tested is known only to the 'master prover' who is running the proving and provers are randomised. Some provings are cross-over design with run-in phase (Riley, 2007). The double blind control promotes reliability, as spurious symptoms relating to factors other than the remedy can be eliminated.

Questioner: Equating provings to RCTs is problematic as provings do not test effectiveness.

Homeopath researcher: I agree the two should not be confused but there are similarities with phase 1 trials of new pharmaceutical products. Both investigate the subjective and objective effects of potential new medicines on healthy volunteers (Dantas, 1996). Phase 1 trials assess drug toxicity, drug tolerance and generate pharmacological data. Proving are different in many respects, most particularly with the intention to produce symptoms, greater attention to idiosyncratic symptoms (Duckworth and Partington, 2009), non-toxic dosage and generating qualitative data (Dantas et al., 2007).

Questioner: I have concerns regarding the ethics of provings. Whilst you speak of non-toxic doses, I have concerns regarding the safety of provers. I have read papers that suggest many provings are conducted without an adequate ethical framework (Dantas, 1996).

Homeopath: I took part in a proving as a student with the aim of improving my observational skills. It was a very valuable experience and I felt a sense of contributing to my new professional community. Now I question the ethics of homeopathy colleges' involvement in provings, particularly if it really was my decision to participate and if there were covert pressures by peers and the college.

Homeopath researcher: I agree there are many potential problems with colleges being involved. It is essential that provings are conducted within a clearly defined ethical framework. Homeopathic treatment has an excellent profile on safety (Endrizzi et al., 2005). Whilst provings are considered to generate only transitory symptoms (Riley, 2007) reporting of adverse events is not always clearly defined (Dantas et al., 2007). Recommendations to improve ethical standards include risk assessment, ethical review committees, declaration of conflict of researchers' interests, inclusion and exclusion criteria, confidentiality, fully informed consent particularly regarding risks and uses of data (Duckworth and Partington, 2009). In legal terms provings are considered to be clinical trials and accordingly are subject to the International Conference of Harmonisation Guidelines for Good Clinical Practice, the Helsinki Declaration and national/European requirements (ECH, 2011). The European Committee of Homeopathy (ECH) proving protocol (ECH, 2011) is designed to meet these requirements.

Patient: I am pleased to learn that ethical standards are coming into line with conventional medicine. I want to be reassured that the homeopathic medicines that I rely on are being researched ethically.

Questioner: But are provings reliable sources of data for prescribing? A systematic review of 156 provings (Dantas et al., 2007) suggests that whilst provings do not appear unsafe, design and reporting are predominantly poor quality. The majority of provings had problems with randomisation, blinding, placebo control and criteria for analysis of outcomes.

Patient: Oh dear, that does not give a good impression of the profession. Please explain what is going on.

Homeopath researcher: Yes the review (Dantas et al., 2007) raises important questions about methodological quality and the reliability of proving data. It is important to bear in mind that the time span of 1945-1995, predates the routine use of placebo controls in biomedical trials. The heterogeneity of proving design was heightened by the inclusion of meditative provings which were shown to be of poor quality and reporting disproportionately high numbers of mental symptoms. The reviewers acknowledge that assessing the provings was limited by the incomplete methodological information provided in published provings. The use of quality indices to analyse and score the published provings is controversial (Juni et al., 1999). However the Methodological Quality Index used was developed from an earlier study (Dantas, 1996), and has been recognised as providing a checklist for designing future provings (Signorini, 2007). The reviewers make valuable recommendations for future provings; to verify a symptom in at least three provings, and to select only substances toxic to humans, as pharmacological and toxicological data can be used to corroborate effects. Since 1995 the methodological quality of provings is improving (Riley, 2007, ECH, 2011).

Patient: Sorry to keep interrupting, but I am pleased to learn about improvements in the last ten years and I know biomedical trials are not always of the highest quality.

Homeopath: This systematic review highlights the importance for homeopaths to use proving data in practice with caution, to research the sources of *Materia medica* data and not to rely on uncollaborated data from methodologically weak provings.

Questioner: A discriminating approach is to be applauded but what evidence is there that provings provide clinically relevant data? The review suggests that 84% of provers report at least one symptom (Dantas et al., 2007, p.13). As the reviewers suggest

if this is accurate there would be high levels of adverse reactions observed during homeopathic treatment. I reiterate the reviewers' question: "How can we discriminate the effects due to the substance tested from incidental effects?" (Dantas et al., 2007, p.13).

Homeopath researcher: Recent provings, double blind, placebo controlled, of remedies already in use demonstrate that it is possible to distinguish and reproduce the specific effects of a remedy from placebo controls with a high statistical significance using rigorous experimental designs (Walach et al., 2008, Mollinger et al., 2009, Walach, 2009). Research suggests that provings can meet the standards of current clinical trial methodology and national drug regulations (Teut et al., 2010). Alongside statistical analysis, this study piloted content analysis as a systematic qualitative approach to identifying the characteristic symptoms of the remedy from the reported proving effects.

Questioner: Dantas and colleagues (2007) suggest that there is a significant over-reporting of effects attributable to the remedy being tested and that provings of lower methodological quality report more effects for each prover. They suggest that over reporting is encouraged by the 'conditioning and expectancy' of supervisors and provers, self-observation and daily recording.

Homeopath: It is important that reporting effects is not disrupted by communication between provers and their prior expectations.

Homeopath Researcher: There is a contrary view that participants who have previous experience as provers appear to be more able 'to distinguish potentially new symptoms from rather trivial or known individual reactions' (Walach, 2008, p.549-550).

Homeopath: Yes by the end of the proving I was more perceptive and able to describe my symptoms. I kept a detailed proving diary and my supervisor was very attentive. We met up three times, so she relied on me to report changes.

Questioner: Thank you for raising this matter, if objective assessments and biochemical tests are not prioritised, how can you claim to be investigating the full therapeutic potential of a substance?

Homeopath: To answer this question, we must consider what homeopaths need to know to be able to aid recovery. To quote from the Organon, I have a copy here, let me read it out. The homeopath:

"perceives what is to be cured in diseases, that is to say, in every individual case of diseasewhat is curative in medicines, that is to say, in each individual medicine.....and if he knows how to adapt, according to clearly defined principles, what is curative in medicines to what he has discovered to be undoubtedly morbid in the patient" (aphorism #3) (Hahnemann, 1987, 1st published 1921).

Homeopath Researcher: We return to issues of safety here. Proving data is predominantly phenomenological, identifying pre-clinical signs. Pathological changes are elicited from toxicological reports and clinical confirmation.

Questioner: Let us return to the conditioning and expectations of provers and supervisors that effects will occur. Explain how placebo is used in provings.

Homeopath Researcher: There are two uses of placebo in good quality provings. Firstly in a placebo run-in phase all provers receive placebo for a defined period prior to the proving. This provides a wash out period and a baseline against which to identify proving symptoms. With randomisation and blinding, a proportion of provers receive placebo. This is designed to highlight the proving symptoms from the background effects of the proving. This is in fact a complex question and there is evidence of a cross-over of symptoms between verum and placebo. I will try to explain as briefly as I can with reference to three provings. Firstly in a reproving of *Belladonna* (Lewith et al., 2005) with 206 provers, researchers' observed that provers 'who reported symptoms during the placebo run-in period were

more likely to report symptoms during the treatment period' (Lewith et al., 2005 p.92). The researchers suggest that these 'presentiment' provers are individuals who are more susceptible to exhibit *Belladonna* type symptoms than others. In a reproofing of *Cantharis*, researchers observed symptoms of *Cantharis* in the placebo group and explained this in terms of non-local effects from quantum mechanics (Walach et al., 2004). This emphasises the need for large scale provings, rigorous methods and reproofing well known remedies.

Homeopath: Surely this interpretation disrupts the concept of the placebo as a control?

Homeopath Researcher: Yes that is a sound observation. If you're happy for me to keep talking, I would like to discuss reproving. With reproving we can compare proving symptoms with symptoms of long established clinical verification. A clear differentiation of proving symptoms between two remedies chosen at random, and the placebo group was produced over seven days (Mollinger et al., 2009). However in an earlier reproofing of two less well known remedies (Walach et al., 2008), following a similar protocol over a longer time scale, there was a cross-over of symptoms of one remedy occurring for provers of the other remedy. The placebo groups exhibited some of the remedy symptoms but to a lesser extent than the verum groups. Walach and colleagues use quantum mechanics to explain the observed cross-over effect as a non-local effect (Walach et al., 2008, p.550). This challenges the assumption of a causal and linear chain of events, and suggests that effects can be taking place in multiples places at the same time.

Homeopath: Are the supervisors immune from the effects? This makes issues of expectation and conditioning even more complex. What are the implications for the difficulties in clinical trial design to isolate the effect of the remedy from the patient's participation through the homeopathic consultation?

Questioner: *I am not sure if we can discover anything from such a small scale studies. You appear to be avoiding the question of the reliability of provings to generate *materia medica* data.*

Homeopath researcher: Just to remind ourselves that provings do not evaluate the effectiveness of remedies. The intention is to elicit what in clinical trials would be considered as adverse effects of the drug. In evaluating treatment outcomes, arguably placebo effects are distinguishable from verum (Kienle and Kiene, 1996). As proving symptoms can be transient, subtle and idiosyncratic, the distinction is less clear. Furthermore we cannot ignore possible contextual or trial effects of participating in a proving.

Homeopath: You have raised important questions. Can you summarise your main points please.

Patient: Yes, please do summarise. I too am concerned about how reliable the information is for the homeopath to use in prescribing, but I am reassured that homeopaths are paying attention to theoretical issues.

Homeopath Researcher: With over two decades of experience of conducting provings, Walach (2009) has developed rigorous methodological approach to test the proving methodology using remedies well known and well used in practice. There appears to be a cross-over of symptoms under proving conditions between the verum and placebo groups. More research is needed to be able to evaluate if the phenomenon arises from problems with design or whether quantum mechanics can provide a robust explanation.

Homeopath: As a profession we have a responsibility to contribute rigorously to empirical validation through clinical observation. I need to re-evaluate the contribution of non-Hahnemanian provings. I

dismiss dream and meditative provings, as unreliable in eliciting *materia medica* data. This is supported by the systematic review (Dantas et al., 2007).

Homeopath Researcher: Meditative provings (Evans, 2000) draw on the group consciousness to explore the therapeutic potential of a substance. This contradicts key fundamental principles of the Hahnemannian design. Provers rather than being isolated from each other, gather together as a group. Provers are not ‘blinded’ to the source of the remedy, but are asked to meditate on the feelings arising from the remedy’s identity and presence in potentised form. The remedy is not always ingested. The collective contributions are synthesised and the collators look for common themes in participants’ experiences.

Homeopath: How do you evaluate them?

Homeopath Researcher: In recognising the power of group meditation to influence embodied experience, meditative provings obscure the potential of the substance to have an effect on the group. Meditating on the source of the remedy, relies on conceptual associations and the rationale for prescribing is not homeopathic but based on the doctrine of signatures.

Homeopath: That’s interesting, the doctrine of signatures, is a traditional means by which the form of the plant is suggestive of its therapeutic uses, for example the yellow flowers and shape of the leaves of *Chelidonium* indicate affinity with the liver. I had not made this connection before.

Homeopath Researcher: You (turning to the Questioner) have been very quiet. What are you thinking?

Questioner: *Thank you, for this illuminating and thought provoking discussion. I am not sure any of my questions have been satisfactorily answered, and so much of what we have discussed is speculation. I sense of a developing field of research and I have learnt that provings must be evaluated in the context of homeopathic practice. Thank you, let us bring this discussion to a close.*

End of fictional dialogue.

14.5 Professional experiential data on the provings theme

14.5.1 Updating the terminology of homeopathy

Participant observation at the International Research Conference ‘Improving the Success of Homeopathy 5: A Global Perspective’ hosted by The Royal London Homeopathic Hospital 26-27 January 2006

This section presents cycles of reflection on the changing use of language by medical homeopaths to construct homeopathy’s identity as modern and scientific practice. This is both pertinent to provings and anticipates the theme of the next chapter on the archaic term ‘miasms’ still used to refer to the theories of chronic health conditions.

Participant observation January 2006: An undercurrent running through the conference proceedings was up-dating homeopathic terminology into contemporary scientific terms. Homeopathic pathogenetic trials (provings) is widely adopted by medical homeopaths and their UK journal Homeopathy, as arguably it better represents the methods and aims of provings. Other terms proposed included isostatic polymers (infinitesimal dose), biocybernetic processes

directed to homeostasis (reaction to treatment) and histocompatibility (individualised treatment) (Guajardo and Wilson, 2006). The sense at the conference is that homeopathy's outmoded antique 19th century explanatory model of healing inhibits communication with medical colleagues, patients and grant awarding bodies. Updating language is part of an agenda to demonstrate rigor in research and scientific validation. This modernisation is not a neutral process. Whose interests are these proposed changes serving? To aid communication with whom? Not patients in general, as studies (Paterson, 2004) suggest that patients' positive experience with CAM is in part due to the accessible ways of talking about illness. Is the intention to reduce the paradigmatic gap with biomedicine? This reframing rejects what is regarded as 'scientifically implausible'. There are difficulties in this project as experts in particular scientific fields could be critical of this appropriation of terminology, possibly misappropriation, of 'their' vocabulary. There are inherent dangers in that by the nature of its discourse, science is always reinventing itself, whilst the coherence of homeopathy's therapeutic framework is characterised by its apparent stability. By attaching new scientific concepts, homeopathy runs the risk of becoming outmoded again and open to ridicule by 'experts'.

Reflective review June 2007: In the interval since attending the conference, research in homeopathy has received critical reports in the newspapers and medical journals (see 9.6). Medical homeopaths have been under fire from their medical colleagues. In retrospect the participant observation has a naïve quality as the doctors' agenda to repackage homeopathy seems more urgent. The term 'repackaging' is significant as this is a media and commercial event, patient perception is marginalised. Increasingly medicine and science establishments are attentive of their public profiles, for example a number of university posts in 'the public understanding of science' and the Wellcome Trust's funding policies to promote public engagement in science. Is this 'repackaging' a negative force shaping practice? It is reactive rather than proactive, driven by external forces. There is a danger that the very qualities that attract patients may be lost.

Reflective review November 2011: The public profile of homeopathic treatment is still a very pertinent topic, but we have not undergone a revolution in our discourse. In fact there is evidence that some changes in terminology have reverted. For example whilst homeopathic pathogenetic trials is a widely used term by medical homeopaths (Walach et al., 2008), but has not been unanimously adopted as the term 'homeopathic drug proving trial' is circulating (Teut et al., 2010, ECH, 2011) and the term 'homeopathic provings' is still in use (ECH, 2009). There appears to be a greater confidence that homeopathy research can meet the standards of good clinical practice and current drug regulations (Teut et al., 2010). Homeopathy as a scientific practice continues to be promoted by medical homeopaths and a minority of professional homeopaths. For example HRI emphasises its 'strong scientific foundations' and aims to facilitate 'scientific research'. From personal involvement in running SoH research seminars over the last five years, I am aware that more professional homeopaths are recognising the importance of research. Often professional homeopaths' discourse lacks critical

thinking, rigor and research mindedness. It is noticeable that the SoH journal The Homeopath, with a change of editor and responding to a membership survey (Hamilton, 2010), no longer requires papers to be fully referenced and the research content of the journal has diminished. Whilst the sceptics' discourse presents homeopathy and CAM in general as unscientific, developments in personalised healthcare and epigenetics (see next chapter) are sites of greater convergence between biomedicine and homeopathy. On reflection there is ebb and flow to terminology changes, some new terms will persist and become part of the language, others will disappear. The scientific orientation of homeopathy is being driven forward by medical homeopaths and researchers, whilst professional homeopaths are ambivalent about this cause. Is the divide between good methodological quality provings and the more esoteric dream or meditative provings, indicative of deeper attitudinal differences among professional homeopaths?

14.6 Reflective pause before moving on from provings to miasms

So far we have discussed the two different arenas of experimental research in homeopathy: provings and RCTs in isolation from each other. It is well overdue to explore their interconnections. I resist viewing provings as 'research for us' and clinical trials as 'research for them' as this closes off dialogue. Although similar in structure, provings and RCTs serve distinctly different functions: provings are exploratory and RCTs hypothesis testing. Both are designed to identify the specific effect of the remedy. Is it inconsistent to argue that RCTs cannot separate the specific effect of the remedy from the contextual effects of treatment by a homeopath, whilst accepting provings as a means to identify the specific effects of a remedy? The role of placebo in provings is ambiguous. I turn to quantum mechanics as an explanatory model because this shifts the discussion away from a causal and linear chain of events to the possibilities of non-local effects and entanglement. Using this model we can view a scattering effect of proving symptoms between those taking verum and those taking placebo. With rigorous and systematic, qualitative and quantitative analysis verum has been shown to 'produce more symptoms typical for a remedy than non-typical symptoms' (Walach et al., 2008, p.543).

This argument is precarious so I need to unpick the threads. I return to the observation (see Dialogue on Single Remedy chapter 11) that publication of RCTs contribute to debates about the effectiveness of homeopathic treatment in general, but have very limited application in practice to benefit patients. Meta-analyses, the highest form of evidence, magnify the effects of the methodological problems of the RCT design and amalgamate such heterogeneous studies, that the results have little or no impact on practice. In contrast provings are practice based in their origin, conduct and function. Currently there is no rigorous evidence that contradicts my observations over twenty years that something happens during homeopathic treatment, for patients for whom the consultation does not carry the cultural associations, for example of treating babies, young children and animals, treatment effects still occur.

So what is my current position on the trajectory for homeopathy research? To address questions of effectiveness I consider pragmatic trials (Relton et al., 2010) to be a way forward, as a means to investigating the effectiveness of individualised treatment by a homeopath as a package of care as compared with usual care. Provings are an essential means to research *Materia medica* data. Proving data is valid, reliable and ethical if a rigorous and ethical framework is used, and proving symptoms are verified by replicating provings more than twice, and by selecting only substances toxic to humans, corroborate with pharmacological and toxicological data (Dantas et al., 2007). There is an interdependence between provings and practice, in other words a circular relationship between homeopathic methodology and epistemology (Walach, 2009).

Have I taken a reflexive view of provings as a form of practitioner research? Or have I merely recycled my biases and left my blind spots unexplored? I am caught in a tension between situating provings in a homeopathic context and within modernist discourse that promotes progress through technical rational knowledge. We now take a break before the final dialogue chapter re-engages with EBM discourse and explores the experiences of using clinical outcome instruments as a form of practice based research.

15 DIALOGUE ON MIASMS

15.1 Case vignette

This account is intended to illustrate how homeopaths perceive and respond to indications of miasmatic diathesis. The meaning will become clearer as you read the chapter.

Trevor, aged 53, runs a building firm

Trevor presented with fibromyalgia that started two years ago. During the first consultation he identified that the symptoms appeared soon after the settlement of his divorce. The divorce had been acrimonious and he still could not forgive his ex-wife for her 'behaviour'. He was living in the family home with one of his grown up sons. He described his life as 'pleasantly quiet' and himself as 'over anxious' about the future prospects of his business. He also complained of migraines which occurred after a period of stress. After three months' treatment with Natrum muriaticum, Trevor reported some improvement in fibromyalgia symptoms but with frequent relapses, his energy was still low and migraines unchanged in frequency and intensity. I felt the

Notes on the remedies: Both *Natrum muriaticum* (sodium chloride, common salt) and *Calcarea carbonicum* (middle layer of oyster shell) are commonly prescribed polycrest remedies with anti-psoric affinities. First proved by Hahnemann (Hahnemann, 1988, 1st publication 1828).

*remedy was still clearly indicated by the symptoms, aetiology and temperament. However as a sufficient time had elapsed without significant improvement in energy and symptoms, I consider the remedy not to be fully addressing the under function tendency (psoric) which is uppermost in his case. With this in mind, I retook the case and re-repertorised giving less attention to the exciting cause (difficult divorce) and more weight to the general under functioning in the case. I prescribed *Calcarea carbonicum*. Six weeks later he reported a slightly improved sense of well-being and on further questioning he was beginning to rebuild his social life. Over the course of six months the general trend has been to improved energy, less frequent and less intense migraines, and fewer and milder relapses of the fibromyalgia. Trevor discontinued treatment after eighteen months as he felt symptoms were at a manageable level and he was 'back to his old self'.*

15.2 Orientation to miasms chapter

Miasmatic theory represents homeopathy's explanatory model of pathology and informs how the homeopath perceives the totality of the patient's case. Miasmatic theory offers a way of understanding causation, progression and treatment of long term illnesses as inherited and acquired diatheses. Pathological traits are categorised into three processes of under function, over function and destruction. The term derives from 18th century medical terminology, and is regarded by some (Guajardo and Wilson, 2006) as an antiquity that needs to be discarded for homeopathy to be recognised as a 21st century scientific medical modality. I make the case that

understanding miasms is fundamental to prescribing and resonates with current health issues. A thread running through chapter is mapping the evolution of the state of ill-health and working with pathological change. I apply this to homeopathy research discourse and to recognising my own pathologies as a practitioner (15.6.2). Miasmatic theory offers a way of perceiving and treating an individual's presenting symptoms with reference to their medical and family medical history, and their potential for ill-health in the future. I reappraise how holism is constructed in homeopathy discourse (15.6.1). As we approach closure of this thesis, so we are also at the beginnings again. I set out on this inquiry with the intention of adapting existing patient-generated clinical outcome measure to evaluate long term homeopathic care. I revisit the conversations that led me to question the relationship between practice and research (15.5.1). I examine the challenges posed by measuring change over a course of treatment in the context of the highly subjective, changeable and unpredictable nature of illness experience and the non-linear character of treatment. I experiment with critical theory as a means to illuminate our understanding of miasmatic theory (15.4.3).

15.3 Meditations on the miasms artefact



[Image 12: My physical examination equipment]

In taking the case of homeopathy, the miasm artefact is a strange, rare and peculiar symptom. The term 'miasm' has archaic associations of a long defunct theory of disease arising from intangible miasma present in noxious atmospheres. The concept is rarely mentioned in academic papers and receives a one line entry in ECH Homeopathic Thesaurus (2007). Many methodological approaches to prescribing have so fundamentally altered miasmatic theory that

Extract from reflective journal:

Without the conceptual model of miasmatic theory, I am treating symptomatically without any way of grasping the symptoms significance within the context of the whole case. All too often I fall back to chasing symptoms and prescribing symptomatically.

it is either unrecognisable or miasms are omitted entirely.

Miasmatic theory represents an explanatory model of pathology and connects key homeopathic concepts - the dynamic, predisposition, susceptibility, totality, individualised characteristics and the unfolding case. In situating an individual's presenting

symptoms within a much broader context, miasmatic theory informs perceptions of both the totality and individually tailored remedy. Long term conditions are perceived as a chronic evolution of shifting patterns of symptoms gradually subsiding to be replaced by another set of symptoms. In this way one miasmatic discrasia can be traced as ascendant whilst another is receding. The presenting symptoms are perceived to be but a small feature of a deeper underlying systemic condition that will eventually lead to ill-health. Treatment is conceptualised as a process of addressing the individual's different illness tendencies in the reverse order of their appearance. Rather than perceiving each complaint in isolation, miasmatic theory provides coherence and through this framework the homeopath is able to interpret and anticipate developments in the course of treatment. Constitutional prescriptions can be made even when the individual is feeling healthy with the intention to keep them as well as possible for as long as possible. Symptoms are perceived to be arising from the active miasm and the choice of prescription must also match this tendency. Two centuries on from Hahnemann, it is generally acknowledged that miasmatic tendencies have become more complex, that is mixed together and rarely present singly.

I reflect on whether I in fact apply the miasmatic framework in all cases. I am drawn into prescribing symptomatically as each minor complaint that presents, thereby losing sight of the totality of the case. Indeed, this question prompted the inquiry in the first place. Patients', and sometimes my own, expectations are shaped by biomedicine for a 'quick fix' approach. In biomedicine discharging the patient from treatment and monitoring, tends to be regarded as a successful treatment outcome. Like other forms of CAM, treatment is regarded as successful if patients use homeopathy for their continuing health needs over an extended period. This differentiation is indicative of how notions of health are constructed through competing health and illness discourses.

Miasmatic theory is not a single narrative. It has always been contentious among homeopaths, even among Hahnemann's contemporaries. This artefact creates disquiet especially among medical homeopaths (Montfort-Cabello, 2004) and is rarely discussed in published case reports. Miasmatic theory has been subject to radical reinterpretations for example influenced by the teachings of the 18th century Swedish theologian Swedenborg (Kent, 1987, 1st published 1900), by Hindu philosophy (Sankaran, 1991), or reinvented in terms of manifesting as lesions, layers

Reflection in the act of writing July 2008:

This is a carefully constructed account. Am I writing in a defensive style? I am conscious of internal surveillance. Will this be acceptable to homeopaths? Will this be a credible account for other readers? Why is this such contentious territory? The term 'miasm' has pre-scientific connotations and this is unhelpful in sustaining an up to date image of homeopathy.

(Eizayaga, 1991) or levels (Vithoulkas, 2010). However the most enduring interpretations of Hahnemann's miasmic theory are the 19th century classic authors (Roberts, 1985, 1st published 1936, Kent, 1987, 1st published 1900, Close, 1993, 1st published 1924). Protagonists today (Saxton, 2006, Creasy, 2007) demonstrate through their casework how miasmic theory underpins constitutional prescribing.

15.4 Intertextual relations on the miasms theme

15.4.1 Historical readings

To read a case miasmatically the symptoms express the history of the case, and the history gives character to the totality (Allen, 1960 1st published 1908). This mirrors the way this inquiry negotiates historical perspectives to make sense of the current state of practice. I contend that by examining historical perspectives, we can get beyond the initial difficulties of outmoded medical terminology, to explore constructs of long term illness that have relevance to today's healthcare challenges.

Miasm carries archaic associations and gives the misleading impression that homeopathic philosophy is informed by the once popular, yet abandoned miasmic theories of intangible miasmata as causative to illness. Noxious atmospheres were thought to cause ill-health, most notably from marshland causing malarial fevers, and overcrowded and insanitary housing conditions of the growing populations in cities causing typhus (Porter, 1977). Eighteenth century Europe was ravaged by epidemics with high mortality rates. Successful homeopathic treatment of epidemic diseases, such as scarlet fever, was an important factor in homeopathy's early popularity (Haehl, 2001, 1st published 1922). Hahnemann's rhetoric (Hahnemann, 1988, 1st publication 1828) claimed to be rejecting speculative theories of disease by taking an empirical approach based on the observation that after apparently successful treatment many illnesses later relapsed. Yet he also interpreted his observations in terms of speculative theories.

Hahnemannian theory of 'chronic disease' is constructed as a complete history of humanity's suffering of disease. Itching skin complaints are located as the earliest manifestation. The sequel to suppression of itching is described as the psoric miasm, characterised by systemic under-function, and attributed by Hahnemann as responsible for the vast majority of all illnesses (Hahnemann, 1988, 1st publication 1828). The word '*psora*', has no direct translation from Hebrew, the nearest being stigma or taint. References in the Old Testament are cited to support this argument (Kent, 1987, 1st published 1900) and some writers give Jewish sources (Creasy, 2007). Hahnemann proposed two further pathological processes of destruction (syphilitic miasm) and over-function (sycotic miasm), linked to the treatment of two prevalent late 18th century conditions, syphilis and gonorrhoea respectively. Hahnemann's rhetorical stance accused contemporary medical practices of suppressing the primary symptoms of the infection leading a progressive undermining of health. By taking the long view, he argued that the health of our predecessors has an influence on the type of illnesses we are susceptible to. For

example, great grandfather dying from tertiary syphilis may predispose us to destructive pathologies, such as ulcerative colitis and aggressive forms of cancer.

The word ‘inherited’ appears frequently in the literature on the miasms but little attention is paid to the mode of transmission. The language of medical genetics seems to be misappropriated and the paradigmatic differences ignored. It must be remembered that Hahnemann’s texts predate the publication of Darwin’s *Origin of Species* in 1849 (Darwin, 1996, 1st published 1849), so we cannot interpret Hahnemann’s use of the term according to our popularised view of neo-Darwinian genetics. More complex modelling in epigenetics (Pembrey, 2002) suggests that feedback from environmental factors ‘switches’ genes on and off. Epigenetics offers a theoretical context within which to conceptualise how miasmatic traits can be acquired as the sequel of suppression of the external manifestations in earlier generations. Although continuing to inform medical practice over the 19th century, the influence of humoralism’s constitutional types was gradually replaced by attention to external causes of illness, in particular germ theory (Dean, 2001). I suggest that homeopathic philosophy crystallised in this shift of the locus of pathology from predominantly with the host or constitution to residing in external causes. This attention to the role of the host corresponds to the humoral model of illness and it is significant that Hahnemann’s writings participate in the mêlée of ideas that eventually cohered into germ theory. Earlier we drew parallels between the humoral and homeopathic concerns with constitutional health (9.4.4), yet Hahnemann’s ideas were also influenced by nascent ideas about contagion. The word ‘infection’ appears in translations to describe the origin of miasmatic traits. We cannot read off our contemporary understanding infection and contagion. Dean argues that Hahnemann’s chronic disease theory was “an early manifestation of germ theory” (Dean, 2001, p.71), paralleling Plenciz’s (1705-1786) notion of specific contagious diseases transmitted by micro-organisms. Dean goes on to suggest that Hahnemann rejected Plenciz’s ideas of the anti-bacterial potential of specific medicines, and gravitated towards a notion of predisposition. Although beyond the scope of this thesis, it is possible to identify an amalgam of contemporary ideas in Hahnemann’s construction of chronic disease theory. Brown (1735-88), whose work was popular in German speaking countries, proposed that all ill-health was one disease, assuming a myriad of forms (Porter, 1977, p.262). This bears a striking resemblance to Hahnemann’s concept of *psora*. Brown viewed sickness as due either to over or under stimulation. Whilst Brown’s single disease process and Hahnemann’s tripartite modes of pathology, have been superseded by biomedical diagnostics, yet such theories have some relevance to current research into chronic inflammatory conditions. A wide range of apparently unrelated medical conditions, such as cardiovascular disease and cancer, share a chronic inflammatory process (Brod, 2000). The iterative nature of scientific theories suggests that polarised relations between homeopathy and biomedicine are far more elastic than is often suggested.

Hahnemann’s participation in a maelstrom of nascent debates regarding family traits and contagion suggests that homeopathy evolved from the cutting edge of medical thinking in the early 19th century and has pursued a different but not unrelated trajectory to biomedicine. Now

in the context of antimicrobial resistance and greater understanding of genetic predisposition, homeopathy has renewed relevance. Whilst Hahnemann recognised the role of social conditions on health, in the absence of social democratic structures, the impact on population health of deprivation and poor living conditions could not be conceptualised. Hahnemann advocated strict lifestyle regimes for his wealthy patients, to remove what he regarded as maintaining causes of ill-health. This has been a persistent theme through history as it bears a striking resemblance both to Hippocrates and to today's public health campaigns promoting increased consumption of fruit and vegetables and exercise.

15.4.2 Personalised medicine

Personalised medicine articulated as individualised treatment is a recurrent theme in this thesis. It is significant that this resonates with some of the latest developments in biomedicine. Pharmacogenetics (Roses, 2000a, 2000b) highlights the role of polygenic and complex disease inheritance. These are distinctly different from mutations in single genes that are so highly predictive of rare diseases such as Huntingdon disease. Geller and Francomano (2005) argue that both "genetics and CAM share fundamental philosophical roots and scientific/therapeutic goals" (2005, p.346) and that the contributions of each could be "highly synergistic". They perceive shared objectives in individualised treatment of disease and "targeting interventions on individual susceptibilities or genotypes" (2005, p.345). As a site of convergence between biomedical and homeopathy discourses, it is significant to note the pivotal role of 'susceptibility'. The following statement on pharmacogenetics is equally applicable to homeopathy:

"The advantage of information on disease-susceptibility genes derived from patients is that, by definition, these genes are relevant to the patient's contributions to disease" (Roses, 2000b, p.858).

Debates about RCTs in homeopathic practice can be reappraised in the light of developments in pharmacogenetics, which are identifying the heterogeneity of many common diagnoses, such as Alzheimer's disease subtypes. Highly nuanced inherited metabolic variations provide explanations for why only a percentage of patients appear to respond to a particular drug (Roses, 2000b). Increased drug efficacy, individualised dosage and reduction in adverse drug effects are being sought by targeting according to an individual's disease-susceptibility gene polymorphisms. This has implications for the pharmaceutical regulation and surveillance (Roses, 2000a). For example in chemotherapy trials, only participants with pharmacogenetic efficacy profile are enrolled. This process of individualisation of participants resonates with clinical trial protocols embracing the individually tailored remedy.

15.4.3 Using theoretical frameworks to explore miasmatic theory

In this section we explore miasmatic theory in terms of the ideas and vocabulary of quantum mechanics, morphic resonance and critical social science. These have been selected as aspects of each resonate with miasmatic theory and is congruent with the reflexive and postmodern orientation of this thesis. This is a highly tentative discussion with the purpose of stirring up ideas about health, illness and therapeutic approaches.

A thread running through this thesis is utilising the concepts and vocabulary of quantum mechanics as an explanatory model for observations of homeopathic treatment, provings and clinical trials. Drawing on weak quantum mechanics, a non-local therapeutically ‘entangled’ triad has been proposed as an analogy for patient-practitioner-remedy entanglement (2002, 2003a, 2003c, 2003b, 2004c, 2004b). Miasmatic theory can also be interpreted within a quantum system with backwards in time communication between entangled entities (Milgrom, 2004c). Milgrom proposes a more ‘active’ coherent form of non-locality with the potential to affect the past, present and future, and with the possibility to change patterns of susceptibility also simultaneously in the past, present and future. I find this very difficult to grasp, but it offers a new way of thinking about how case taking. It involves both travelling into the past to identify inherent disease potentials acquired earlier in life or by previous generations, and forwards in time, speculating about future patterns of ill-health. Milgrom’s interpretation of non-locality also provides a novel way to conceptualise homeopaths’ observations that in the therapeutic process, symptoms arise and resolve in the reverse order of their appearance.

This discussion brings to mind controversial ideas about ‘morphic resonance’ (Sheldrake, 1981). These fields evolve and are transmitted from generation to generation through non-local resonance, called morphic resonance. He argues that morphogenetic fields work by imposing patterns on otherwise random or indeterminate configurations of activity. This provides a potential model for homeopathy that both encapsulates inter-generational communication and also the miasmatic pattern recognition process.

In developing dynamic relations between inquiry and practice, I draw correspondence between miasmatic tendencies as limiting the potential for health and Fay’s (1987) three limitations on emancipating yourself through self-knowledge. You may remember Fay’s critical social science informed our reflexive approach (6.2.4). Fay’s first observation is that knowledge is contextually and historically bound. The homeopath’s knowledge of the patient’s case is framed by the therapeutic framework and is always incomplete. The homeopath learns about the patient’s case as treatment progresses and through the changing interactions with the patient. The homeopath’s assessment of miasmatic traits is constantly reviewed as the patient responds to treatment and the changing states of health. Fay’s second observation is that our perceptions and sense of ourselves is an embodied experience. Fay suggests that change can be inhibited by our inherited constitutional tendencies and somatised learning. This closely parallels the homeopath’s perception that miasmatic tendencies shape our susceptibility and limit potential for health. Fay’s final observation is that our sense of self is produced through a network of relationships and cultural traditions, and that this invalidates any notion of autonomous action. Health is a highly subjective experience and our expectations are shaped by historically specific social, cultural and political factors.

I use these analogies to explore the internal coherence of miasmatic theory and to shift from archaic associations by exploring in current scientific terms.

15.5 Homeopathy research discourse on the miasms theme

15.5.1 Monitoring change through patient reported clinical outcome measures

A thread running through this chapter is the unfolding nature of illness narratives and long term homeopathic care. I take the opportunity to revisit earlier experiences in this inquiry of collecting patient data. We discuss the process and problems of practice based data collection not on analysing the results.

To explore experiences of using a patient reported clinical outcome measure let us create a fictional dialogue between *Questioner*, *Homeopath*, *Homeopath Researcher* and *patient*

Questioner: Hello, thanks to you all for agreeing to speak with me today. Can I start by asking about your collaborative work?

Homeopath: Hello. I have been using a patient reported clinical outcome measure in my private practice on and off for two years. I wanted to discover if it could improve monitoring patient response to treatment.

Questioner: What is the purpose of using this tool?

Homeopath: A patient reported clinical outcome measure offers a systematic way of recording patients' perception of changes in health over the duration of treatment. I used the tool for my own professional purposes with the intention of understanding of patients' priorities and perceptions of treatment effects. I also hoped that if I was able to collect data on a systematic basis that this might be useful to inform future research.

Questioner: Tell me what instrument you selected and why?

Homeopath: I was familiar with using the Measure Your Medical Outcome Profile (MYMOP) in my clinic tutor role at the University of Westminster (Sternberg, 2009). I had already participated in a SoH pilot data collection project and used MYMOP in the National Service Evaluation (SoH, 2006). Can I refer you to my research colleague? She has helped me to use MYMOP.

Homeopath researcher: Hello. Clinical outcome research is a generic term referring to qualitative and quantitative data collection, patient or practitioner or observer reported. MYMOP (Paterson, 1996) is a patient-generated, health status questionnaire that allows patients to report and score their most pressing symptoms in their own words. As well as reporting and scoring an activity that is affected by the symptom, MYMOP also allows for scoring general well-being. MYMOP was designed and validated by a GP for use in weekly acupuncture treatments. It was well suited to homeopathic practice in respect of considering well-being and being patient reported.

Questioner: Did the literature support outcomes research in homeopathy?

Homeopath researcher: The European Committee for Homeopathy (ECH, 1999) published a review of outcome scales, quality of life measures and coding systems used by medical homeopaths. The seven instruments identified used Likert style scales in simple numerical or category scoring of change over time in a number of symptoms and well-being. Whilst difficulties were recognised 'in standardising the design of prospective documentation projects' (ECH, 1999, p.1), the review recommended practice based outcomes research as an important contribution to evaluating treatment under 'real life' circumstances. Given how difficult it is to fund RCTs that are sufficiently powered

and of significant duration to be able to expect to be able to monitor change, observational studies can make a valuable contribution to the evidence base. Two observational studies (Spence, 2005, Witt et al., 2008) using outcome measures to collect data from 6,544 and 3,709 consecutive patients respectively, showed a significant decrease in disease severity and improvement in quality of life scores over a course of homeopathic treatment.

Questioner: *Caution must be exercised not to overstate the function of clinical outcomes research.*

Homeopath researcher: Yes absolutely. In the absence of controls and randomisation, observational studies cannot answer questions of effectiveness or efficacy. However outcome measures can give indications of perceived change over a course of treatment, how treatment is progressing and how useful the treatment modality might be in certain conditions and, in patient reported outcomes, provides feedback independent of the practitioner.

Homeopath: My experience is that capturing what happens during a course of treatment in both a systematic and meaningful manner is very difficult.

Questioner: *So let us look at the practicalities of using MYMOP.*

Patient: I completed the forms before every consultation. As I first consulted the homeopath with a number of problems it was difficult to choose just one symptom to put on the form. In retrospect I did not choose the most appropriate activity that was affected by the symptom. The 'well-being' question was much easier and it was interesting to see how the scoring changed. The homeopath explained it very well before we started but when you do something, you understand it better. If I started again, I'd completed the forms differently.

Homeopath: That's really interesting as you and I have not talked about this. I was surprised how complicated it was for my patients to use MYMOP. Most present with complex long term health problems and it was not easy to identify just one symptom to monitor. People consult homeopaths for a whole range of reasons, for example to help at times of change such as divorce, birth of a child, bereavement. These situations are not suited to record on a symptom-specific questionnaire.

Questioner: *What are the experiences of other homeopaths?*

Homeopath Researcher: The use of MYMOP in homeopathic practice has been documented since 1997 and appraised (Thomas et al., 2001a, Thompson, 2002). Although the literature suggests that MYMOP is an appropriate tool for evaluating homeopathic treatment (Relton and Weatherley-Jones, 2005, SoH, 2006), discrepancies have been identified between MYMOP scores, the patient's perceptions of change and the homeopath's view of patient response (Peters et al., 2000, Peters et al., 2002).

Homeopath: Yes I agree with Peters that:

"MYMOP has to be used skilfully with homeopathic patients, especially where psychological distress is identified as one of their main complaints." (Peters, 2000, p.14)

Sometimes my patients did not choose the most appropriate symptom to monitor but I felt it was their choice. Some like you were very good and continued to use it every time. If there was a single presenting symptom that was much easier but for others it became meaningless and they gave up.

Patient: (laughing) I felt I would have let you down if I gave up completing the forms!

Questioner: That's really interesting, what motivates the patient is a significant factor in reliability of the data.

Homeopath: I found that some patients needed assistance, to quote Peters again, with selecting "an appropriate symptom that is likely to be a fair indicator of clinical change" (2000, p.19).

Questioner: Questions of reliability and validity are raised when the homeopath influences the patients' choice and self-assessment.

Homeopath: Yes I agree. I found that patients exhibited quite individual approaches to selecting and scoring their symptoms. Sometimes the impression gained from the patient's description is quite different from their reported scores. For some people migraines dominate and disrupt their lives, for others acute pain forcing them to go and lie in the dark for a few hours is described as an inconvenience. I assess symptom change in the context of the patient's personal criteria and values. I found asking patients to allocate numbers to a sensation or function is meaningful to some and others find it an alien concept.

Patient: I find it much easier to talk about how I feel rather than decide on a numerical value.

Questioner: Umm, these are important issues, but...

Homeopath: MYMOP was difficult to use for patients with illnesses that recur at intervals, as scoring relates to the previous week. It is quite common for patients only to return for appointments when they need to, for example during the hay fever season. Then the scores do not reflect their overall response to treatment.

Questioner: You are referring to the limitations of outcomes research in general. Let us explore issues specific to homeopathic practice.

Homeopath: OK. I wanted to discover if using MYMOP would improve monitoring patient response to treatment. The major limitation for me is that it is problem specific. So if the patient returns for a follow-up consultation with a new presenting complaint, a new MYMOP form for the new complaint is completed and progress for that complaint is monitored separately. This conflicts with considering the patient's state of health as a whole. For long term treatment, where the original purpose in attending was less specific or changed during the course of treatment, I found MYMOP was difficult to administer and did not help to review the ongoing management of the case.

Homeopath Researcher: I don't think homeopathy is unique in this respect, much of the research is in acupuncture and has relevance for other CAM modalities. The creator of MYMOP investigated the extent to which the perceived treatment effects are 'encompassed and measured' by the revised MYMOP₂ as compared with two other subjective health status questionnaires (Paterson and Britten, 2003, p.671). Over a six month course of acupuncture treatment, patients were interviewed three times and before each interview they completed the three questionnaires. From the interview data, patient response to acupuncture treatment is shown to be individualistic, subtly expressed, holistic, with changes that are interdependent and follow individual time sequences. However these 'whole-person' changes were frequently not identified on the health status questionnaires. This confirmed my impression that homeopathy patients' expectations and treatment aims change over time. Initially presenting with a particular problem, patients then wish to continue treatment for more general

health benefits. This is confirmed by interviews with people who had been using acupuncture for up to twenty years (Schroer, 2004). A high proportion of these people reported that the original complaint persisted but that they continued treatment as they experienced other health benefits.

Questioner: *So what have you learnt from these experiences?*

Homeopath: MYMOP is premised upon the biomedical model of getting a problem fixed or controlling chronic symptoms. MYMOP fails to record the whole-person unfolding effects of homeopathic (Peters et al., 2000) or acupuncture treatment (Paterson and Britten, 2003).

Homeopath Researcher: I agree with Paterson and Britten (2003) that to begin to evaluate treatment of long term health problems, a whole range of potential treatment effects must be taken into account. I support Bell's (2003) view that

“new research is needed to develop and validate homeopathically-orientated global and multi-dimensional outcome tools” (2003, p.24).

Homeopath: On the plus side, using MYMOP has not disturbed the consultation and at times enriches case management. Collecting MYMOP data has been valuable in systematically recording patients' impression of changes over time. It adds another dimension to the case review process. It keeps the patient's priorities in the foreground.

Homeopath researcher: MYMOP is not validated for homeopathic treatment. We collaborated together to see how well MYMOP captured homeopathy patients' perceptions of treatment effect. MYMOP has been individually informative in reviewing some patients' perceptions of treatment and not in others. MYMOP has limitations as a problem specific questionnaire and linear based analysis, and it cannot be used to evaluate the complexities of holistic treatment. An evaluation of patient outcome documentation in the University Polyclinic (Walach, 2008) suggests that to begin to draw out more generalised findings that could provide meaningful comparison with other studies, a more generic, standardised and validated questionnaire based outcome measures needs to be administered such as Short Form 36 (Short Form 36) alongside MYMOP.

Patient: Do you mean 36 more questions? It has been enough of a task to complete one form at each consultation, I would find it a burden to complete another one that has 36 questions! If you are interested in learning more about what patient's experience, please consider what you are expecting of us. I enjoy my visits to the homeopath and lots of form filling could spoil that for me!

Questioner: *This discussion has raised important questions to consider in practice based research. Thank you for all your contributions.*

End of fictional dialogue.

At the end of this chapter I reflect on this dialogue in the context of issues raised around miasmatic theory and working with pathology.

15.6 Analysis of professional experiential data on the miasms theme

With reference to miasmic theory, I reappraise how holism is constructed in homeopathy discourse (15.6.1). The thread running through the chapter of working with pathological change is applied to homeopathy research discourse and to recognising my own pathologies as a researcher practitioner (15.6.2).

15.6.1 Deconstructing holism

Extract from STAR group discussion transcript:

when you listen to the other disciplines and how they approach their caseload, it seems to be quite minimal compared to our approach to it. We have a much more in-depth and holistic approach to the patient.

(STAR February 2004 lines 336-338)

This extract stands out provocatively from the text. Perhaps this was the intention of the speaker. My reaction is to make a joke out of the 'more holistic than though' attitude. Holism acts as an ideal that is constructed within the framework of the particular therapeutic approach. This text represents the individualistic nature of homeopathic discourse, in defining itself as specialist approach, distinct from other therapeutic approaches. As a prescribing therapy, homeopathy could be considered as being one dimensional, as not meeting the patient's individual needs through multiple therapeutic approaches such as exercise, posture, diet, supplementation, manipulation or self-help strategies. I suspect that most homeopaths also use supplementary strategies to aid recovery. Some practise more than one therapy, or as in my case, I have developed a repertoire of self-help strategies or I refer to CAM colleagues. This text is open to a range of interpretations, but my interest here is resonance with miasms. An aspect of 'in depth' is mapping the evolution of the patient's state of health, from previous generations through their unfolding illness narrative. However this is only holistic when applied to prescribing and case management strategies.

15.6.2 Recognising my own pathologies as a practitioner

Extract from meta-reflection written May 2006:

I share a commonly held belief in the profession that your patient base is personal to you and that your patients will help you to address your own personal issues. There is a tension between working within the comfort zone of habituated practice and challenging my limitations as a practitioner. What is effective practice? My experience is of a blend of what I do well, what I do competently and what I do poorly or ignore.

It is fitting that this final piece of professional experiential data focuses on personal learning through inquiry. I take this opportunity to reflexively engage with the long evolution of this inquiry. I selected this extract because it disturbs me. Why is this? Admitting that at times I am incompetent? No. It is recognising that my practice felt like a well worn and very comfortable old shoe. I slipped into it and did not have to think about it. I was at ease with my patients. I did what I have learnt to do, what worked for me. This evokes a sense of self-satisfaction. This reactivates my concern about monitoring long term care and also questioning whether I fully embrace the opportunities presented by new information technologies.

As an independent practitioner, my core narrative plays a considerable role in shaping my practice. For the purposes of this discussion I consider an example from this reflexive inquiry. I began to realise that I am motivated by belief in self-help. When I applied to study homeopathy I was actively engaged in women's health campaigns. Understanding about illness and being able to do something for yourself and others seemed to be the next step towards self-autonomy. I entered practice with the aim of supporting others to achieve their own goals. My experience of self-help dependent upon the advantages I have enjoyed in life. I am committed to widening access to homeopathic treatment, but what have I done to challenge health inequalities? Patients have told me that I am a good listener and empathetic. However, both personally and professionally I have found it challenging to support those who I perceive to be unable to help themselves or who are immobilised by fear and anxiety. So when I reflect on the statement 'patient base that is personal to you', I shudder to think that I may be referring to a select group of like-minded individuals. Without a reflexive approach there is a danger of allowing your 'issues' to direct practise.

Reflecting on the idea that homeopaths attract and retain patients with whom we share an affinity triggers a connection with the homeopath as *similimum*. We speculated in the last chapter that 'tuning in' to the patient, both enhanced the therapeutic relationship and also facilitates an easier identification of the individually tailored prescription. Milgrom (2003) uses the language of quantum mechanics to explain the relations between patient, homeopath and remedy as non-local entanglement. Developing the theme of attracting like-minded patients, I speculate if this is heightened in homeopaths, as we are trained to recognise symmetry and patterns?

15.7 Reflective pause before moving on from miasms to direction of cure

This chapter anticipates the next, where I will draw out threads from this inquiry and examine implications for research and clinical practice for homeopathy and more generally in CAM. With this in mind, I invite you to reflect with me on the learning in this chapter. We negotiated the archaic associations by deconstructing the miasms artefact to reveal a typology of ill-health informed by humoral theories and nascent debates around inherited susceptibilities and contagion. Homeopathic philosophy crystallised during this shift from pathology perceived to be predominantly within the host or constitution to residing in external causes. Miasmatic theory is a form of meta-symptom pattern recognition. It provides the context of the greater totality of the patient's unfolding illness narrative. This defines what homeopaths mean by 'holism'. Totality is used flexibly to describe the case as it presents at any one time. Miasmatic readings provide the fullest totality of the patient's case, stretching back to diatheses present in earlier generations and into the future to consider possible pathological propensities. As we prepare to close the thesis, my mind is going back through all that I brought into the inquiry and into its future trajectories in the hands of the readers.

Miasmatic theory's continued relevance to current health concerns is suggested by convergence with some newer biomedical approaches, for example in personalised healthcare and research into the role of inflammatory processes (Brod, 2000). We discussed novel approaches to conceptualising miasmatic theory by drawing analogies with limitations on self-knowledge in critical social sciences, morphic resonance and non locality in quantum mechanics. There are parallel relations with miasmatic theory and the potential of non-locality to change patterns of susceptibility affecting the past, present and future. This chapter has to look into the past to see what has happened and out into the future to look at how what I have learnt that could be of use to other practitioners.

In the next chapter we consider: What has changed? How will I recognise change? These questions are pertinent to our dialogue on using clinical outcome instruments. What do we mean by change in the therapeutic context? This inquiry was instigated by asking how to most effectively monitor and evaluate long term care. This remains a vexed question. Observational studies give some insight into how thousands of people appraise their response to homeopathic treatment (Spence, 2005, Witt et al., 2005). However through examining my personal experience of using a clinical outcome tool in practice, it became evident that it was only able to capture a very partial representation of what is happening for the patient. The limitations are even greater if used to evaluate long term treatment for complex chronic conditions where the homeopath would anticipate a non-linear and unfolding trajectory of symptom change. Critically reflecting back on Kathy's case in an earlier chapter (13.1) causes me to ask 'What do outcomes look like in treating long term illness?' I was looking for outcomes in terms of pain reduction and had to reframe my aims in terms of the patient's priorities. Findings from interviews with users of acupuncture also challenge the assumption that outcomes are primarily in relation to symptomatic change. Acupuncture patients identified that the process of creating a sense of order, naming the condition in their own terms, changes in self-identity and self-knowledge, can be just as valuable to them as embodied symptomatic change (Paterson and Britten, 2003). This causes me to reflect that outcomes are determined by the patient and the context of the therapy, and are likely to change over time.

In relation to examining outcomes and in anticipation of the next chapter, we should consider 'cure' as a problematic feature of the homeopathy vocabulary. Whilst 'cure' is used liberally in the 19th century and early 20th century literature, it is less common in contemporary literature. The notion of cure is at odds with Hahnemann's theory of the inevitable evolution of chronic disease. I am prompted to ponder 'what is cure?' 'whose role is it – the patient, the remedy or the homeopath?' More recently any statement in the public arena that could be interpreted as suggesting effective homeopathic treatment has come under scrutiny and RCT evidence is demanded to back it up (Burchill, 2011). Insistence on 'the evidence' out of context the treatment approach is an expression of the hegemony of EBM. This is the problem I set out on this inquiry. How has that changed now? I hope this has stimulated your interest as we engage on the last leg of this journey together.

16 DIALOGUE ON DIRECTION OF CURE - TAKING THE CASE OF THE INQUIRY AND THE THESIS

16.1 Orientation to the direction of cure chapter

The eighth and final artefact is the set of criteria that has evolved as a guide to interpret change in the individualised responses to treatment. This assessment is complex as responses are seen in terms of the individual's vitality reacting very briefly to the potentised dose and then initiating a response. The response is not expected to be a linear, predictable or immediate. Direction is perceived in terms of an unfolding course of symptoms disappearing in the reverse order of their appearance, moving from interior to exterior, from more important to less important organs and from above downward. An allied activity when reviewing a case is making a homeopathic prognosis. This is an assessment of the individual's vitality, interpreted from the response to the first prescription, in order to give some indication for long term response to treatment.

Analogous to reviewing the patient's case, this chapter conducts a follow up consultation to critically appraise the model of practitioner based inquiry that has been enacted. This is a device to tease out what has happened, evaluate and identify the inquiry's implications and trajectory. There are three parts to the evaluation and review: a self evaluation (16.3), followed by evaluation using external criteria (16.4) and finally recommendations for further research (16.5). Threads are intertwined through this review; evaluation of the thesis as a performative and open text; and of the enactment of the inquiry. Closure of the text is for the purposes of completing a thesis for submission, as the inquiry predates first enrolling on post-graduate studies and the story will continue far into the future of my professional career. I am ambivalent about describing the final chapter as a conclusion, but for simplicity sake that is what it is called.

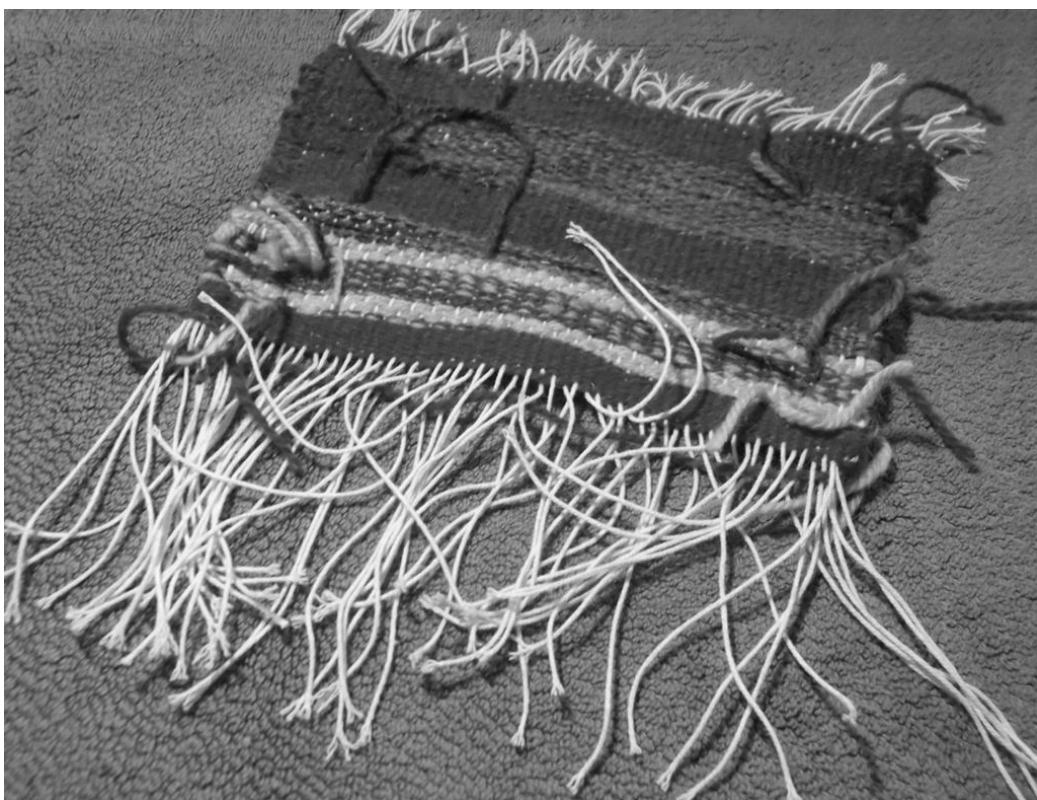
16.2 Meditations on the inquiry's metaphor

The artefact of this chapter is the metaphor of the inquiry itself, the loosely woven piece of fabric. This chapter pulls at the threads, examines the weave and draws out fresh perspectives on the patterns created in fabric. There is no intention to tie all the threads together to form a knot, nor to resolve the dilemmas, competing and contested perspectives; but to expose these and to examine how uncertainty is managed in practice. The weave illuminates multiple, competing and contested perspectives.

We have created the weave together. We have agitated its loosely woven texture, picked out individual threads, fingered its uneven texture, held it up to the light and looked through it. We have come to know its hues, textures and patterns. We have an intimate knowledge of each vividly coloured thread as it stands out from the background. The weave never ceases to surprise us, as we see something different in its highly complex patterns and textures. In this

chapter we examine the patterns and identify the most significant threads. We also explore the gaps between the threads, what is not there as well as what is.

We must not forget the artefacts from my practice that have featured in the chapters. They are a reminder that in the same way that evidence is only meaningful in the context of the discursive practices that create it. The artefacts, in words and images, are only meaningful in articulating my interaction with homeopathy's therapeutic framework in the context of this inquiry. We can now return to Hiller's (1996b) comment "So artefacts are, on the one hand, hypotheses, and on the other hand, conclusions." (p.214). From this vantage point hypotheses suggest that the artefacts symbolise propositions or potentials for what research into practice could look like. Conclusions offer closure once we have attempted to unpack the cultural assumptions.



[Image 13: Woven sampler, I made September 2011]

16.3 Conducting the follow-up consultation on the inquiry and thesis

This section is a self-evaluation of the inquiry process and of the thesis itself.

16.3.1 What is the original contribution to knowledge?

Any claim to original work in this thesis is problematic, as research is informed by actively engaging with and necessarily dependent upon the accumulation of pre-existing texts. I ask you to join me in reflecting on what I have achieved. My original contribution to knowledge is in developing and enacting practitioner based inquiry in homeopathy. This is presented as a collage of reflexive, experiential interactions and interpretations of professional practice. The concept of research findings as a collage is not new (Clandinin and Connelly, 1994), but the

collage concept has been shaped through the inquiry rather than adapted from the literature. The collage evolved during the inquiry drawing on a range of theoretical perspectives, analytical strategies and visual image work. Findings offer novel interpretations to elucidate homeopathic practice. Significant insights include how homeopaths engage with the therapeutic framework, contextual effects of treatment, the role of reproducibility and standardisation in prescribing and the significance of pattern recognition and symmetries as fundamental organising principles in the natural sciences. Furthermore I have made novel connections between homeopathy's enduring popularity and how the patients' own belief system about health and illness are still influenced by the old humoral system of medicine.

16.3.2 Have I achieved what I expected to achieve?

I have met the research aims and objectives (1.7) but my aim is not to resolve but is to conduct an open ended exploration of practice. The achievement has been to create an approach to practitioner based inquiry that is congruent with homeopathic practice and offers the potential for homeopaths to develop critical thinking, a reflexive approach to practice and a vocabulary to articulate this. Probably the most challenging aspect of my doctoral studies has been not being able to see where I was going and just believing I would know when I got there. The slow evolution of the inquiry was heighted by accommodating full-time work commitments and absences due to ill-health. The time constraints on practitioner researchers, needing to juggle practice, teaching and life events, makes finishing the thesis an achievement in itself.

This model of practitioner based inquiry has been in a state of transition and will continue to be so. It evolved from 'practice based evidence' then 'practice based inquiry' and finally 'practitioner based inquiry'. This was a significant process in conceptualising the relations between research and practice, and realising that all routes of inquiry led to the practitioner as the protagonist in researching practice experience. Adopting the term 'practitioner based' clarified what I had already been doing. As this is innovative in homeopathy, I did not have any models to adapt or learn from. The process of research was frustrating because I was feeling my way, not knowing where this was leading. I came to appreciate that in practice I manage uncertainty and complex situations by engaging with what I conceptualise as the 'therapeutic framework'. On reflection because of the tentative steps I was making, analogous to feelings of uncertainty evoked in practice, I looked to focus the inquiry on something that created a sense of coherence. It is easier to research theories than to reflect on putting espoused theories into action.

16.3.3 What are the limitations of the inquiry?

Your assessment of this inquiry is influenced by your values and assumptions. To address the general reader with no prior knowledge or experience of homeopathy, the scope of the inquiry is extensive. This was advantageous in so far as it required me to look afresh and to challenge assumptions and values. However, examining homeopathic treatment in its entirety prevented a greater depth of analysis and engaging in actual day-to-day clinical experiences. I am disappointed that I did not have the opportunity for in depth study of homeopathy texts. The

range of literature available would have been greater if I had been able to read German. The broad scope of intertextual relations generated illuminating perspectives but also meant that I encountered a range of science practices, and could not study any one in depth. The choice of texts and interpretations made are personal and reflect my viewpoints on practice.

The design of the thesis was formative to the inquiry itself. The original intention was that the thesis in its entirety would fit into the eight chapters each dedicated to one of the homeopathic principles and using one of the multiple methodological threads. This may well have been over-ambitious given that it has been a long journey from the original intention to redesign a clinical outcome instrument. I chose to allow the inquiry to grow synergistically, arising from critically reflecting on practice and interaction with texts and professional activities. The different analytical strategies have been applied implicitly as and when appropriate. This may have been too diffuse and weakened the criticality of the reflexivity. On reflection I wrapped myself up in elaborate theoretical and methodological approaches, again seeking some stability in an uncertain inquiry. The use of symbolic curation of visual images (Cherry, 2008) and visual representation of artefacts (Einzig, 1996) were innovative and brought a breadth of my personality into the text. Whilst they functioned within the analysis, their role could have been developed further and used more critically.

Whilst I identify the lack of critical thinking in homeopathy discourse particularly the way that perceived patient satisfaction is used to affirm practice. I do not escape from these assumptions myself, as I am drawn to reaffirm the validity of practice. For example I was perhaps not sufficiently critical of research findings that concurred with my own views (Thompson and Weiss, 2006). As this thesis was completed over a number of years, it has been more difficult to keep up with current social and political issues. Sustainability has risen up the political agenda since I first started this inquiry, and it has been a missed opportunity not to consider treatment by a homeopath as a sustainable and carbon neutral medical practice. This resonates with the notion of homeopathy standing the test of time with its epistemological sustainability. We return to these issues when considering external evaluation criteria.

16.3.4 What has changed in practice and how do I know that it has changed?

I did not take easily to the role of protagonist, but it was inevitable. In a sense I feel that I am back to where I started, as if for the first time. I am still perplexed by how to effectively monitor and evaluate long term homeopathic care. I still have a coterie of elderly patients with complex health problems. However nothing has stood still. Only by looking back through reflective journals do I realise how much has changed. The ways in which I understand what I do and how I engage with patients is different. Like method acting, thinking differently changes practice, even though I may not always be aware of this at the time. The alchemical tradition of transforming the practitioner as well as enhancing the effect of the substance creates a powerful analogy for practitioner based inquiry. The reflexive orientation has raised my awareness of what I now understand as my core narrative. Self-knowledge improves your ability to offer care to others. As a subject of homeopathy discourse, it has been difficult to see how I am as a homeopath

constructed through discourse. I have tried to draw on a range of academic discourses to reflexively interrogate practice from different perspectives. I could not speak from outside discourse, when I broke out of homeopathy discourse, for example at a continuing development workshop (12.6.1), I found that I had become subject to an academic discourse. Reflecting on this dual role as homeopath and academic brought a critical edge to reviewing practitioner knowledge. I am able to work within the discourse with a greater agency as I can engage reflexively and can take up different positions in research discourses.

16.3.5 What impact has the inquiry had on homeopathic practice?

This question follows on from considering change. Practitioner based research is shaped by the pragmatic stance that presents knowledge as a form of action (Baert, 2005). Impact on practice is an outcome of practitioner research. I found it easier to explore theoretical and methodological perspectives than to monitor implementation of change in practice. It was difficult to integrate into the text the nitty-gritty, minute by minute experiences of daily practice. Application in practice is an underexplored aspect of the inquiry, but on reflection I appreciate the elusive character of practice, that is constantly in a state of becoming which is difficult to capture. It is easier to talk about values than it is to live out our values.

Practice and research are no longer distinct activities, through “a reflexive spiral” (Rolfe, 1998, p.196) I continuously observe, critically reflect upon and develop my clinical practice. A significant aspect of knowledge transfer to practice is insight gained through experiential knowing. I now know from critically reflecting on my own experience that any research instrument that seeks to translate experience into observable and measurable outcomes is limited in complex cases and can at best produce very partial representations. Taking a rigorous approach to critically reflecting on case management issues is an effective tool for monitoring patient care and brings about improvements in delivery of care.

Questions about the reliability of proving data has a direct impact on prescribing. It is important for homeopaths to understand the need for proving designs to be improved in the light of observations that there is a cross over effect between verum and placebo groups (Walach, 2009). Interacting with research literature engenders a more informed approach to practice. Turning the clinical trials discourse back on itself shifts the perception of contextual effects of treatment as a problem in study design to a powerful and safe therapeutic resource. Reframing homeopathy as a complex intervention (MRC, 2000) has been useful in creating a way forward for open pragmatic trials (Relton et al., 2009) that compare usual care with treatment by a homeopath as a form of an adjunctive package of care alongside usual care. To date findings from clinical trials have offered little in terms of improving patient care, but have addressed a wider audience on effectiveness issues of homeopathic remedies. A prospective case study series (Thompson and Weiss, 2006) using multiple and holistically orientated data collections sources, has potential as a form of practice based research.

By creating the inquiry to be congruent with practice, I have learnt a great deal about the qualities of practice. I work more effectively with the fluidity of practice, taking a more pragmatic approach to uncertainty and complexity. I am more conscious of clinical decision making, aware that I am actively assembling coherence through a conceptual framework. I appreciate that the therapeutic framework is not static, but is constantly being reinvented through adaption and individualisation. Practice is created through critically reflecting-in-action on how I am interpreting or making clinical decisions in the specific context of that consultation at that moment. I realise that the crucial factor is the homeopath's engagement in the therapeutic process. I continue to value the sense of coherence in the therapeutic framework, but also recognise how pluralistic methodologies function to enhance this engagement. On reflection I could have paid more attention to the context of practice such as ethics, clinical governance and accountability issues.

In terms of contributing to the homeopathic community of learning, I created opportunities to present papers at homeopathy conferences and workshops (see appendix 3), as a peer consulting strategy and to promote discussion of practice based research. STAR enabled other homeopaths to research their own practices in a shared inquiry. I have also used my role on the SoH Research Committee to raise the profile of practice based research and organised a well attended day workshop on practice based research and another is being planned. The intention behind creating an open text that is dialogic and performative, is to entice readers to participate and reflect on their own practices, so I intend to review how I will disseminate and share my learning with other homeopaths.

16.3.6 What are the implications for homeopathy's evidence based discourse?

Feeling constrained by this discourse was one of the factors that motivated me to start the inquiry. What I have discovered has loosened this grip considerably and I have been able to articulate a practitioner's voice to critically assess the relative merits of this discourse in my own practice. As stated earlier (16.3.3) critically reflecting on my experiences of using a clinical outcome instrument has made me aware of how translating experience into observable and measurable outcomes is limited in highly complex cases, can at best produce very partial representations. I suggest that issues of reproducibility and standardisation in prescribing are not priorities in practice, but the homeopath's engagement is a crucial element. Patients do not seek treatment to be given the same remedy as the previous patient. Part of the attraction of CAM is being treated as an individual. These observations challenge the assumption that we must standardise treatment approaches to accommodate the audit and EBM discourses of the NHS.

16.3.7 What are the implications for CAM and for dissemination of knowledge?

The potential for knowledge transfer to other contexts is an important factor in evaluating research. Whilst each CAM therapy has its own research traditions and research debates, issues such as contextual effects and naturalistic studies are of relevance across the sector. As I have always practiced in integrated health environments, the inquiry is informed by a shared

CAM research agenda. I presented papers on the development of this inquiry to colleagues and at CAM conferences (see appendix 3) and this represented a useful form of peer consulting. The model of practitioner based research presented in this thesis is not automatically reproducible in other contexts, as it is created in the context of a doctoral inquiry into my own practice at this time. However there is potential for others to learn about the value of this approach, to evaluate its limitations and to adapt it for their own use.

Without a deliberate literature searching strategy, some of the most insightful perspectives informing this inquiry have come from Chinese Medicine and acupuncture literature. Issues shared across the two modalities include how current practice is self-defined in relation to its historical heritage (Farquhar, 1994), the role of pattern recognition and individualised approach to practice (Scheid, 2002, 2007) and practice based research (Paterson and Britten, 2003, Paterson, 2004). This suggests that perspectives generated by this inquiry could also feedback into Chinese Medicine, acupuncture and other CAM modalities. On reflection I could have highlighted the transferability to CAM of many of the threads running through the thesis and this could be the subject of further research and dissemination.

16.3.8 How has the inquiry enriched practice?

There is a sense that my core narrative as a homeopath and University lecturer was damaged by the negative media reporting on university courses and NHS provision. Deconstructing what I termed sceptics' discourse revealed the way that representing homeopathy as scientifically implausible rested on decontextualising the remedy from the treatment process. Together with deconstructing the polarised identity of homeopaths defined by biomedical discourse, this has had the effect of narrative repair (Nelson, 2001) and opened up the field to explore how homeopathy works differently to biomedicine. This required careful negotiation to avoid being defined as being anti-science and taking an uncritical view of homeopathic treatment. The sceptics' critique provided a stimulus for positive change, an opportunity to advance understanding of practice and to discard aspects of practice that do not appear to benefit patients. Taking a postmodern orientation and using discourse analysis, shifted the power imbalances sufficiently to allow the critical appraisal of homeopathy discourse from fresh perspectives. The inquiry creates a sense of empowering or potentising the homeopath. Enrichment has also been derived from reflexively engaging with different theoretical perspectives, for example anthropology, feminism, quantum mechanics, mathematics and conceptual art. These interactions have created new vocabularies and fresh perspectives to explain homeopathic practice. This is particularly important in homeopathy where the language used tends to create associations with 19th century medical practices.

16.3.9 Where is the inquiry stuck?

A thread running through the thesis is how homeopathy discourse self defines itself in terms of historical origins even though homeopaths practise today in radically different contexts to Hahnemann. I used historical analysis as a means to examine how the present has been created through change in the past (Alvesson, 2002) and how I am constituted as a subject of

homeopathy discourse in relation to bodies of knowledge and the power (Foucault, 1977). As the inquiry progressed, the historical references became an obstacle to looking at practice from fresh perspectives. Taking a reflexive approach suggested that the conditions prevailing when I entered the profession have been formative in forging my professional identity. I realised that it is important to avoid being held back by the past. This was particularly pertinent with regard to the changing vocabulary of homeopathy discourse, some changes will sustain and others will disappear.

16.4 Evaluation using external criteria for evaluating practitioner research

To bring a systematic and critical approach to evaluation, I use two sources, each taking a different approach.

16.4.1 Using Reed and Biott's eleven criteria

(Reed and Biott, 1995, p.195)

1. ***Integral with the practice of healthcare:*** Inquiry into my practice.
2. ***A social process undertaken with colleagues:*** Action research orientation.
3. ***Educative for all participants:*** Impacted on practice, my own and on others' practices as indicated by STAR participants.
4. ***Imbued with an integral development dimension:*** Professional development integral to the inquiry and to STAR.
5. ***Focussed upon aspects of practice in which the researcher has some control and can initiate change:*** Influence on roles as independent practitioner, member of professional body, educationalist and researcher.
6. ***Able to identify and explore socio-political and historical factors affecting practice:*** Fundamental to a reflexive approach.
7. ***Able to open up value issues for critical enquiry and discussion:*** Fundamental to a reflexive approach.
8. ***Able to integrate personal and professional learning:*** Achieved through critical reflection and analysis of professional experiential data.
9. ***Likely to yield insights which can be conveyed in a form which make them worthy of interest to a wider audience:*** Open dialogic approach is designed to stimulate interaction with readers. Papers at seminars and conferences well received.

The remaining two criteria are slightly ambiguous, making them difficult to use.

10. ***Designed so as to give a say to all participants:*** This is vague. What does "give a say" mean? I consider each group of participants in turn. STAR participants: in common with all forms of action research, the degree to which participation was fully realised in STAR is open to question. Patients: indirectly involved as they play a central role in my practice. I discussed the inquiry with some patients. Homeopaths and students: I had informal discussions, tested out ideas and asked for feedback. Readers: the design of the text as dialogic, open and incomplete encourages reader participation. I would suggest that this criterion has been met.

11. ***Able to exercise the professional imagination and enhance the capacity of participants to interpret everyday action in the work setting:*** This has two aspects, I consider each separately. “Professional imagination” is an appropriate term to describe the creative approaches used. The second aspect is difficult to interpret, but the intention is to have an effect on participants’ practices. I leave you the reader to judge this.

16.4.2 Using Freshwater’s adaption of Garman’s nine criteria

(Garman et al., 2007 adapted by Freshwater, 2008, p.225)

1. ***Verity:*** The inquiry presents my view of being in practice. It makes no claims to speak on behalf of other homeopaths. Peer consulting has included inviting feedback on drafts copies of the thesis. This could only be judged by other homeopaths. Written in an open manner inviting readers to interact in the inquiry and to judge if this has relevance to their experiences as practitioners.
2. ***Integrity:*** The reflexive stance encourages readers to make up their own minds about the experience of reading the thesis.
3. ***Rigor:*** The reflexive approach encourages readers to participate in the arguments enacted through the inquiry and to judge their intellectual rigor and relevance to the context.
4. ***Utility:*** The model of inquiry enacted is relevant in a range of different professional settings.
5. ***Vitality:*** This criteria has is highly relevant to homeopathy. In the context of practitioner based research, vitality is considered as research enriching, advancing and improving practice; its potential for engaging homeopaths, CAM practitioners and patients; the potential for learning, discovery and innovation. The thesis taps into the passion that characterises homeopaths’ and patients’ commitment to homeopathy. Writing the thesis has been a meaningful experience, and I would hope that a sense of discovery and enlightenment is conveyed to the reader. Vitality is present in both its innovative form and also in the content.
6. ***Aesthetics:*** Artefacts and visual images are used as a means of inquiry. The metaphor of the untidy loosely woven piece of fabric runs throughout the thesis to convey a tactile sense of how the different threads are interwoven.
7. ***Ethics:*** Ethical requirements have been met with regard to participants’ contributions (see 8.2). Dialogue does not claim to represent the views of others. Reflexivity challenges view points and to seek transparency of interpretation.
8. ***Verisimilitude:*** The postmodern orientation attends to multiple truths. The thesis presents a partial view and does not make generalisations about homeopathic practice in the UK. I do not make claims for effective treatment but acknowledge that homeopathy discourse uses anecdotal accounts and perceived patient satisfaction to affirm practice in an uncritical manner. Whilst deconstructions of discourse are necessarily personal interpretations, the reflexive meta-methodology should ensure transparency for the reader to make their own interpretations. There have been

dilemmas about putting into the public arena candid views about what I perceive to be the weaknesses and limitations of homeopathy's epistemology and ways of organising as a profession. Undoubtedly I have overlooked issues that I do not wish to acknowledge or that do not fit with the inquiry's discourse. The dialogic approach and open text has enabled me to share the dilemmas, contradictions and inconsistencies of homeopathic practice.

9. **Resonance:** The performative orientation and open text is designed to stimulate readers to reflect on their own practice issues and on the nature of knowing. This is for you the reader to judge. Resonance may have been enhanced by the passionate qualities in homeopathy discourse, and way this inquiry has enriched, informed and advanced my understanding of practice.

16.5 Making a prognosis: recommendations for further research

The model of practitioner based research that has evolved is designed to be further developed and adapted in the context of other practices. As an open ended inquiry, research in my own practice will continue. There is scope for other homeopaths, CAM and other healthcare practitioners to learn from this inquiry and to adapt this design in the context of their own practices. I recommend pursuing more specific aspects of practice to facilitate a greater depth of analysis, but with sufficient flexibility to allow the inquiry to evolve. The structure and design of the text congruent with the homeopathic approach, or equally an approach congruent with another therapeutic practice, has great potential to be developed to stitch practical experience into the text.

Reflection:
Winterson (2012) talks about a book have a quality of "beingness". It is not just about something, it communicates something essential to the reader. She describes art as vital. If this inquiry has a sense of 'being', I have successfully moved away from a technical rational approach. A sense that engaging with the text communicates something with each reader in a way that is meaningful to them. "Beingness" is not only a useful criterion for evaluating this inquiry, but also as a quality of a 'good consultation'; that is not just about 'taking the case' but that something else happens for the patient in the space created by participating in the consultation.

There are prospects for a flourishing of the profession as homeopathic treatment, having kept to its own trajectory for the last two centuries, is coming into greater relevance in a postmodern context. For example there are shared interests with biomedicine in personalised approaches, narrative medicine, patient participation and concerns over anti-microbial resistance. However with cuts in public spending and recession economics, expenditure on homeopathy is likely to fall. This will impact on the financial and human resources available for research. However this reduction will have less impact on professional homeopaths as the availability of funding for research away from the NHS homeopathic hospitals and a handful of university departments has been almost negligible. In this climate there could be a role for practitioner based research as a low budget approach that directly informs practice. My vision is that practitioner based

research could play a role in stimulating more interest in research, reflexivity and critical thinking among professional homeopaths. I am involved in promoting this through continuing professional development programmes and workshops have been well attended. In the long term, practitioner based research could contribute to a shift in homeopathy research discourse to take a more radical view of evidence based practice.

The inquiry participates in a growing interest in performative social sciences among academics and practitioners from different fields. The use of visual images could be developed and other forms of media, used more effectively to explore how meaning is produced around the therapeutic encounter and the work of the homeopath. The image work with symbolic curation (Cherry, 2008) and artefacts (Hiller, 1996a) has great potential to be developed into a more meaning generating role in further studies.

17 CONCLUSION

The experience of conducting this inquiry has had a transformative effect on my practice and enabled me to articulate critical perspectives on practice and patient care that are congruent with homeopathy. The research is not evaluated in terms of outcomes, but in the direct application of research in practice through changes for the homeopath. Perspective transformations have taken place in terms of a reflexive engagement with the therapeutic framework, influencing change in areas such as managing uncertainty, more efficient monitoring of change in long term care, the role of reproducibility and standardisation in prescribing and working with the contextual effects of treatment.

This thesis demonstrates that engaging in a reflexive practitioner based inquiry is a viable and useful form of research to advance understanding of practitioner experience. The inquiry achieves a homeopathic approach to research by using the principles and practice of homeopathy as its organisation and process. The homeopathic orientation creates an experiential interface between research and practice, and offers the general reader an experience of practice. The inquiry is conducted through practice, and as the practitioner, I am integral to creating the evidence that is enacted through the inquiry. The findings of practitioner based inquiry in homeopathy can be conceptualised as a collage of reflexive, experiential interactions and interpretations of professional practice. Exploration of homeopathic theory and practice in different theoretical contexts provides fresh insights and modern vocabularies. These are too numerous to mention, but one of the most significant is the significance of pattern recognition and symmetries as fundamental organising principles in the natural sciences. Furthermore I made novel connections between homeopathy's enduring popularity and how the patients' own belief systems about health and illness are still influenced by the old humoural system of medicine.

The self-critical iterative dialogue gives voice to the practitioner researcher. This is particularly illuminating at moments when perspectives diverge between researcher and homeopath over pluralistic approaches to practice and an individualised engagement with the therapeutic framework. Critical perspectives were achieved by applying multiple analytical strategies, and I curated different ways of seeing by using visual images. Critical discourse analysis and reflexivity were essential approaches to enable me to question how I am constituted as the subject of the discourses under examination. Reflexive engagement with homeopathy research discourse offers a re-examination of research from a practitioner's perspective.

This type of research does not claim that findings can be applied or generalised to other settings, but theoretical explanations and the inquiry design itself transcend the local setting and can be of use to practitioners in other fields. By creating an open dialogic text it is anticipated that readers will be drawn in to critically reflect on their own practices. Each reader/researcher will adapt this model to meet their individual needs. It was difficult to research practice issues and I found myself caught at the level of espoused theories and not at the nitty-gritty of what

was happening with patients. This is indicative of the intangible nature of practice. I started off with a sense of a lack of sufficient criticality in professional homeopathy discourse, and I reproduced this in certain aspects of the thesis. Symbolic self-curation and working with artefacts of homeopathy brings another dimension and this could be developed further as a tool to bring a critical edge to future practitioner based inquiries.

17.1 Bringing together all of the methodological threads to create a picture of the final weave

The multiple methodological threads form complex patterns in the weave. As a way to synthesise these, I invite you to reflect with me on the overall woven design. I perceive a path to finding an authentic voice as a homeopath researcher. I use voice 'as a form of reflexive agency' (Couldry, 2010), in that it is reflective and dialogic. Voice represents an ongoing process of critical reflection and narrating experiences that are personally meaningful. Voice is also about value (Couldry, 2010). The thesis articulates knowledge, values and truths that I wish not only to express, but also to be acknowledged. Voice being valued is a striking aspect of the weave and needs to be understood in the context of the inquiry's origins. This research was initiated to challenge the way that dominant evidence based discourse reduces experiences of homeopathic treatment to contested representations of effectiveness in clinical trials, systematic reviews and meta-analyses. This quest gained greater significance over the course of the inquiry as sceptics' discourse emerged in the media and the legitimacy of homeopathic treatment was publically contested. This background noise lent urgency to research what is going on in practice and to re-examine espoused theories that were being publically discredited. Unevenness in the texture of the weave is indicative of attempts to negotiate, often unacknowledged and ambivalent, tensions inherent in homeopathy discourse. I can neither reject the role of clinical trials in legitimising practice nor position myself outside the bounds of offering a complementary service to biomedical healthcare. There is no intention to resolve these tensions but rather the rough texture of the weave captures the contradictions and inconsistencies inherent in my professional identity. Returning to the issue of acknowledgement, the doctoral education and examination process is crucial in lending academic credibility to this homeopath researcher's voice. Having entered academia as a practitioner lecturer, I felt to 'be taken seriously' I needed a higher academic award. Wide reading of philosophical and qualitative research texts was motivated by the intention to research in a way that is both meaningful to CAM practice and academically rigorous. On reflection I perceive that these contextual factors played a significant role in choosing a theoretically orientated and multiple methods approach. I sought to muster allies to enhance the critical and reflexive qualities of the inquiry. I now reflect on the how successful the multiple methods approach has been.

The intertwining of philosophical threads evolved from experimenting with different ways of looking at practice and creating a setting that is conducive to exploring practice based inquiry. The most conspicuous pattern in the weave is this pragmatic orientation (Baert, 2005). A rather eclectic design is created by using what appeared to be helpful from different philosophical

traditions to inquire into practice and to generate findings that can be integrated back into practice. The most visible threads represent those philosophical positions that proved most functional. There is no intention to blend these philosophical threads together, but at moments, they become entwined. The postmodernist approach is the most contentious and perhaps fragile thread. However it does contribute significantly to the pattern by facilitating circumnavigation of biomedicine's dominant role in polarising homeopaths' identities and therapeutic approaches. This stance opened up a way to examine evidence as produced through the researcher's discourse, to consider how homeopathy works differently and to question the necessity for standardisation and reproducibility.

To challenge what I thought I already knew, to get inside my own practices and professional culture I experimented with qualitative methodological approaches that were novel in homeopathy research. On closer examination, the individual methodological approaches are not threaded continuously through the weave. Taking a homeopathic analogy, multiple methods can be likened to complex prescribing, where more than one remedy is prescribed at a time in a combined prescription. The therapeutic potential of each remedy (or its analytical potential) is limited by interacting with the other remedies in the combined prescription. This is an imprecise prescription as the combined effects have not been tested. The multiple methodological threads could be considered as creating rather diffused patterns that lack depth and clarity.

However the patterns created in the weave do capture a sense of the elusiveness of researching practice experience. Reflexivity is created through the split between self as narrator (researcher) and as protagonist (homeopathic practitioner). This is most visible, yet not always fully acknowledged, in the tension between the practitioner's attachment to espoused theories and how the practitioner actually navigates the novel situation by using what is most appropriate from the 'tool-kit' of available strategies. I now conceptualise the qualities of my practice as constantly assembling coherence through engaging within a therapeutic framework. The treatment process is individualised for each clinical encounter, involving the homeopath in reinvention and adaption. The final weave is inevitably unfinished. Practice remains elusive. Attention to the more practical aspects of practitioner experience are notably absent from the inquiry and this invites future research. The experiential and experimental nature of the inquiry is captured. The visual impact of the fabric resides in the weaving process itself. The patterns capture the transformational process for one homeopath's research journey, within a particular set of social conditions. This is not offered as a completed design to be replicated but to inspire other practitioners to embark on their own research.

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APPENDICES

APPENDIX 1 ETHICS DOCUMENTATION

University of Westminster Statement for Class 1 Ethical Approval

Information sheet for STAR participants

Consent form for STAR participants

University of Westminster
Statement for Class 1 Ethical Approval
Doctoral Research

1.1 TITLE OF THE INQUIRY: (working title)

A doctoral study:

A reflexive self-inquiry into practitioner-research within homeopathic practice

1.2 APPLICANT DETAILS

| | |
|--|---|
| Name: Julie Smith | Email: smithju@wmin.ac.uk |
| Address: School of Integrated Health 115 New Cavendish Street London W1W 6UW | Telephone Number: 020 7911 5000 |

2. SUPERVISOR DETAILS

2.1 FIRST SUPERVISOR:

| | |
|--|--|
| Name: Professor Dawn Freshwater | Email: dfreshwater@bournemouth.ac.uk |
| School/Department: Institute of Health and Community Studies, Bournemouth University, 1 st floor, Royal London House, Christchurch Road, Bournemouth BH1 3LT | Telephone Number: 01202 504126 |

2.2 SECOND SUPERVISOR:

| | |
|---|---|
| Name: Dr Peter Davies | Email: daviesp@wmin.ac.uk |
| School/Department: School of Integrated Health University of Westminster | Telephone Number: 020 7911 5038 |

3. AIM OF THIS STATEMENT

I interpret the University of Westminster Code of Practice governing the ethical conduct of investigations, demonstrations, research and experiments (2004) to classify this *doctoral inquiry* as Class 1.

In accordance with requirements for Class 1 ethical approval, this statement aims to

demonstrate how the study complies with The British Psychological Society Ethical Principles for Conducting Research with Human Participants (1992) (copy attached).

This statement sets out arrangements for seeking informed consent from two groups of participants. Group 1 University of Westminster Polyclinic Tutors who have already participated in a peer supervision project (September 2003- June 2005) and this application is in respect of seeking consent to use material generated during the project. This project is called Supervision through Action Research or STAR. Arrangements are also set out for seeking consent from this same group to participate in future interviews and/or focus groups. In respect of Group 2 professional homeopath, arrangements are set out for consent to participate in future interviews and/or focus groups.

4. OUTLINE OF THE PROPOSED INVOLVEMENT OF HUMAN PARTICIPANTS

4.1 Background for the inquiry

As part of this inquiry I set up and facilitated an action research project with the homeopathy Polyclinic tutor team (ten staff either on fractional posts or employed as part-time visiting lecturers). This 'Supervision through Action Research' project (referred to as STAR) took place between September 2003 and June 2005, funded by the Centre for Research in Education. The STAR project involved clinic tutors in monthly peer supervision sessions using action learning sets and group discussion. Clinic tutors tracked their action learning cycles. At the beginning of each academic year the STAR participants negotiated and verbally agreed to ground rules. Below are extracts from the ground rules relating to research:

Ground rules negotiated for STAR September 2003 –June 2004 agreed verbally 21 October 2003 that:

1. Contributions within the sets are confidential and permission to refer to them in the preview and review discussions would be sought in advance.
2. Group discussions are audio-recorded and transcribed. Transcriptions are circulated to all members in advance of the next session. Tapes and transcripts are kept by me to be used for the purposes of this project.
3. Transcripts, action learning record sheets and reflective papers prepared for evaluation, form part of the data collection for this project. Authors are anonymised. Permission to quote individual contributions for the purposes of presentation or publication on the research project is sought in advance by email.

Ground rules re-negotiated for STAR October 2004 –June 2005 agreed verbally 1

November 2004 that:

1. Contributions within the sets are confidential and permission to refer to them in the group discussions would be sought in advance.
2. Group discussions are audio-taped. On request from the group, transcriptions are prepared and circulated to all members. Tapes and transcripts are kept by me to be used for the purposes of this project.
3. Notes recorded during group discussion on a flip chart by me or one of the group, and added to by me by listening to the audio-recording, are circulated to all members in advance of the next session. A copy of the notes are kept by me to be used for the purposes of this project.
4. Transcripts, action learning record sheets and reflective papers prepared for evaluation, form part of the data collection for this project. Authors are anonymised. Permission to quote individual contributions for the purposes of presentation or publication on the research project is sought in advance by email.
5. My learning through participation in the project is one of the elements informing my doctoral study. In accordance with the University's Code of 'Practice governing the ethical conduction of investigations, demonstrations, research and experiments', informed consent will be sought in the event of wishing to use this data for the purposes of my doctoral thesis or future related scholarly activity.

4.2 Intention for involvement of human participants

It is intended to involve participants as follows:

Group 1 University of Westminster Polyclinic Tutors who participated in STAR September 2003- June 2005. The ground rules negotiated and agreed by STAR participants in October 2003 and October 2004, indicated that written consent would in future be requested to use STAR data for the purposes of my doctoral thesis or future related activity. The statement sets out this request for written consent:

1. to extend consent in the previously negotiated and agreed ground rules, to give me permission to write up the research process as part of my doctoral thesis. This will also require me to seek email consent for all quotations of individual's written or verbal contributions.
2. to consent to the re-analyse of the audio-recordings and transcripts of the STAR group discussions to analyse as anonymous dialogue between professional homoeopaths on homeopathic practice (see objectives below)
3. to participate in future interviews and/or focus groups to respond to the preliminary findings from this inquiry.

Group 2 professional homeopaths This statement sets out the request for written consent to participate in future interviews and/or focus groups seeking feedback on the preliminary findings from this study to inform the second stage of data analysis.

5. AIMS AND OBJECTIVES OF THE STUDY

5.1 Aim

To conduct a reflexive self-inquiry into practitioner-research within homeopathic practice

5.2 Objectives

1. To establish a forum for co-research and dialogue on practice issues with other professional homeopaths
2. To re-examine homeopathic literature to generate a theoretical context through which to interpret how professional homeopaths evaluate treatment in practice
3. Through reflective and critical dialogue with other professional homeopaths, to develop and test out evolving perspectives.
4. To analyse the way in which professional homeopaths construct and apply knowledge in informed practice to abstract a conceptual framework for evaluating homeopathic treatment
5. To pursue a reflexive inquiry into my day to day experiences of homeopathic practice both explorative and testing out evolving concepts
6. To reflect upon my subjectivity as practitioner-researcher-facilitator as an iterative and critical discourse through the study.

6. DESIGN AND METHOD OF THE STUDY

This critical reflexive inquiry draws on my own experiences as a professional homeopath to make explicit homeopathy's pragmatic epistemology. Critical discourse analysis and post-modern approaches to social research both shape and facilitate this open-ended exploration of practice as complex, contradictory and uncertain. The reflexive action research orientation involves action learning with colleagues who are working as homeopathy clinic tutors to provide an arena for accessing the articulation of homeopathic knowledge in practice.

7. PROPOSED TIMETABLE FOR THE INQUIRY

Phase 1:STAR project: September 2003 – June 2005 (completed)
 Phase 2: Data analysis stage 1: September – December 2005
 Phase 3: Proposed interviews and/or focus groups: January-May 2006
 Phase 4: Data analysis stage 2: February – September 2006
 Phase 5: Write up and Submission: January 2007

8. ETHICAL PRINCIPLE: INFORMED CONSENT AND DEBRIEFING

All participants *who took part in STAR (inquiry timetable phase 1)* and the other professional homoeopaths who will be invited to participate in interviews and focus groups (*inquiry timetable phase 3*) will be provided with the information sheet and consent form (see attached). The information sheet for participants explains the researcher's aims and intentions. As this inquiry adopts an action research orientation, opportunities are taken throughout the study to share ideas and insights with colleagues and to involve informed participants within the critical dialogue. Interactions with and contributions from participants, both intentionally and unintentionally sought, will be valued by the researcher. The researcher will pay attention to the participants' experience of the research in order to monitor any unforeseen negative effects of misconceptions.

All participants will be *asked* to return a signed consent form if they wish to participate. Professional homeopaths outside University of Westminster will be initially contacted by email or phone. If they are interested in participating, they will receive *an* information sheet and consent form by post or email.

9. ETHICAL PRINCIPLE: DECEPTION

It is not the intention of the researcher to mislead or deceive or withhold information from the participants. The researcher recognises that as the structure and focus of this study is unfolding, it is not possible to anticipate the final direction of the inquiry. The information sheet for participants will explain the researcher's intentions and describe this characteristic of the inquiry. Following the ethos of action research, the researcher will take opportunities to keep participants informed, involved and seek feedback at regular intervals during the inquiry.

10. ETHICAL PRINCIPLE: CONFIDENTIALITY

All information provided by participants will be stored confidentially in my *locked* personal office filing cabinet and on my personal *password protected* computer, and if published will not be identifiable as their's. The information sheet for participants draws attention to the fact that every effort will be made to exclude details which could identify them.

11. ETHICAL PRINCIPLE: PROTECTION OF PARTICIPANTS FROM DISCOMFORT, HARM OR RISK

There are no anticipated physical discomforts.

The information sheet for participants will draw participants' attention to the fact that given the UK homeopathic profession is relatively small, the collective identify of participants could be recognisable within the profession (for example homeopaths teaching at the University of Westminster). The researcher is aware that professional colleagues recognising a participant's contribution to the study could be experienced by the participant as an invasion of privacy or as affecting their professional reputation.

The potential emotional risks to participants will be managed by the following procedures:

1. the researcher will make every effort to anonymise and obfuscate identities of participants in writing up the study and subsequent publication
2. consultation and information during the recruitment phase
3. STAR participants *have already* received copies of transcripts and/or summaries of discussion points after each session. Participants in the *proposed* interviews and/or focus groups will be shown transcripts of recordings. All participants can request at any time exclusion of any information.
4. as the study is taking place within a reflective framework, the researcher and other STAR participants are available to participants for support
5. participants will be able *at any time* to cease their participation and / or request that specific sequences not be written up in the analysis
6. participants will be informed of procedures for contacting me.

12. ETHICAL PRINCIPLE: WITHDRAWAL FROM THE INVESTIGATION

All participants will have the right to withdraw from the research at any time. Participants are informed of this right on the consent form. If the participant exercises this right retrospectively, recordings *and transcripts* of their contributions will be destroyed.

13. ETHICAL PRINCIPLE: COERSION FOR COLLEAGUES TO ACT AS PARTICIPANTS

I recognise that researchers are often in a position of authority or influence over participants. I am aware that this dynamic could be *emphasised* with participants who are my colleagues and for whom I also act as Co-Course Leader. The potential risk that participants feel pressurised to take part in and remain in the study will be managed by clearly identifying this as a potential danger within the information formally provided to participants and emphasising that they are *under no obligation to participate and free to decline to take part or may later wish to withdraw*.

14. ETHICAL PRINCIPLE: DEGREE TO WHICH THESE RISKS ARE BALANCED AGAINST POTENTIAL BENEFITS

The risks incurred by this research with the negotiation and support available are unlikely to be significantly greater than regular interaction with professional colleagues. In addition the STAR project has provided a resource for personal and professional development of the clinic tutor team and it is anticipated that participation in the interviews and focus groups drawing on participant's skills of reflection will be an interesting and beneficial experience for

participants.

15. FINANCIAL MATTERS

Travel expenses will be paid to participants. No other financial reward will be made.

16. DECLARATION BY APPLICANT

The information I have given on this form is true and to the best of my knowledge correct:

Signed:

Date:

Submitted to the Dean of School of Integrated Health, University of Westminster

INFORMATION SHEET FOR STAR PARTICIPANTS

REQUEST FOR PERMISSION TO USE YOUR RECORDED CONTRIBUTIONS TO THE SUPERVISION THROUGH ACTION RESEARCH PROJECT (STAR) 2003-2005 IN WRITING UP MY PHD

The focus of my PhD research

Working title: A reflexive self-inquiry into practitioner-research within homoeopathic practice

As a practitioner-researcher I am inquiring into my own practice. I am using a critical reflexive inquiry to draw on my own experiences as a professional homeopath to explore a shared understanding evolving from the application of theory and knowledge in practice. A post-modern approach facilitates an open-ended exploration of practice as complex, contradictory and uncertain. As the structure and focus of the study is unfolding, it is not possible to anticipate the final direction of the inquiry. I have chosen an action research orientation as I wish to involve professional homeopaths in discussion on practice issues to develop and test out evolving perspectives.

Supervision through Action Research Project

Through the research and linked with my work as Co-Course Leader for homeopathy, I prepared successful applications for funding for peer supervision and collaborative research with colleagues. We successfully secured funding from the University's Centre for Research in Education and the School of Integrated Health's Teaching and Quality Enhancement Fund for the peer supervision project with Homeopathy clinic tutors. The motivation for these bids was threefold. Primarily to make provision available to meet the team's identified need for peer supervision. Secondly for us to engage in a research activity as a team. Thirdly to develop my own research/facilitation skills and to generate discussion on practice issues which could inform my research. As the homeopathy team, we created 'Supervision through Action Research' project (referred to as STAR), which started in September 2003 and ended in June 2005.

I greatly appreciate your participation in STAR. The evaluations we undertook suggest that through STAR we developed a useful framework for peer supervision, which continues to inform our work together. The discussion of practice issues was stimulating and thought provoking. I found everyone's contribution valuable in developing understanding of our shared practice.

Seeking your written consent to use information from STAR for the purposes of my PhD research and related scholarly activities.

I attach extracts from the ground rules we negotiated at the beginning of each year of STAR relating to use of STAR transcripts and analysis. I am now at the next stage of seeking permission to use records of discussion and analysis generated during the STAR project. The purpose of this analysis is to explore how as professional homeopaths and clinic-based

teachers, we articulate our working knowledge and also how we worked together to develop a model of peer supervision. This analysis will inform the writing of my thesis and any associated articles and journal papers. However you are under no obligation to contribute should you not wish to.

I set out below the ethical considerations which govern my conduct as a researcher:

Anonymity

In analysing and referring to STAR discussion I will respect your anonymity at all times and will make every effort to exclude details which could possibly identify you. I will not be identifying comments from particular individuals , as I perceive group discussion to be a collective activity. As the UK homeopathic profession is relatively small, the collective identity of participants as homeopaths teaching at the University of Westminster, could be recognisable within the profession. I will endeavour to minimise any possibility of invasion of privacy or negative affects on your professional reputation. Whilst I felt I should raise this issue with you, I anticipate that the emphasis of my analysis will be on understanding the nature of shared practice rather than on individual contributors.

Confidentiality

STAR records (audio, paper and electronic) are stored confidentially in my locked personal office filing cabinet and on my personal password protected computer.

Protection of Participants from discomfort

Typed up transcripts and/or summaries of points raised in group discussion were circulated to all participants after each session. I will supply duplicate copies if requested. You have the right to exclude any sections of your contributions in the transcripts. If you have any concerns, please contact me.

Right to withdraw

You have the right to withdraw use of all or part of your transcribed contributions to the STAR project at any time. Please be aware that my role as Co-Course Leader for homeopathy is totally separate from STAR and my research interests. Our formal relationship within the homeopathy team should not prevent you from withdrawing retrospectively, in full or part, if you wish to do so. Should you withdraw all or part of your audio recording and transcripts of your contribution will be destroyed.

Keeping you informed

I am committed to the collaborative ethos of the inquiry and will seek to keep you informed of developments, as well as to create opportunities for future involvement and feedback. If you wish to participate, please keep this sheet for your records.

Thank you.

Julie Smith

Email: smithju@wmin.ac.uk

School of Integrated Health

University of Westminster, 115 New Cavendish Street, London W1W 8UW

Tel 0207 911 5000 ex 3799

Date:

Ground rules negotiated for STAR September 2003 –June 2004 agreed verbally 21

October 2003 that:

- Contributions within the sets are confidential and permission to refer to them in the preview and review discussions would be sought in advance.
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- Transcripts, action learning record sheets and reflective papers prepared for evaluation, form part of the data collection for this project. Authors are anonymised. Permission to quote individual contributions for the purposes of presentation or publication on the research project is sought in advance by email.

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- Notes recorded during groups discussion on a flip chart by me or one of the group, and added to by me by listening to the audio-recording, are circulated to all members in advance of the next session. A copy of the notes are kept by me to be used for the purposes of this project.
- Transcripts, action learning record sheets and reflective papers prepared for evaluation, form part of the data collection for this project. Authors are anonymised. Permission to quote individual contributions for the purposes of presentation or publication on the research project is sought in advance by email.
- My learning through participation in the project is one of the elements informing my doctoral study. In accordance with the University's Code of Practice governing the ethical conduction of investigations, demonstrations, research and experiments, informed consent will be sought in the event of wishing to use this data for the purposes of my doctoral thesis or future related scholarly activity.

CONSENT FORM FOR STAR PARTICIPANTS

PhD research working title: A reflexive self-inquiry into practitioner-research within homoeopathic practice

Please read the attached information sheet and then put a circle around either 'yes' or 'no' to the following states to indicate your response:-

| | | |
|---|------------|-----------|
| REQUEST FOR CONSENT: ANALYSIS OF CONTRIBUTIONS I give permission for my audio-recorded contributions to STAR group discussion, and also action learning sheets and reflective papers submitted during STAR (September 2003 to June 2005) to be ANALYSED in the writing up of Julie Smith's PhD thesis and any related scholarly work. | yes | no |
| REQUEST FOR CONSENT: QUOTATION OF CONTRIBUTIONS I am willing to be approached for permission for specific extracts from my recorded contributions to STAR group discussion, action learning record sheets and reflective papers submitted during STAR (September 2003 to June 2005) to be QUOTED in the writing up of Julie Smith's PhD thesis and any related scholarly work. | yes | no |
| I am willing to be approached to participate in one-to-one interview and/or focus group in the future | yes | no |

| | | |
|------------------|----------------|-------------------|
| Print name: | Signed: | Date: |
| Contact address: | Email address: | Telephone number: |

Thank you for taking the time to complete this form.

Please return completed to Julie Smith, School of Integrated Health, University of Westminster,
115 New Cavendish Street, London W1W 8UW

I will return a duplicate copy for you to keep.

APPENDIX 2 COPYRIGHT PERMISSION TO USE SUSAN HILLER IMAGES

REQUEST:

On Dec 22, 2008, at 23:31, Julie Smith wrote to:

studioassist@artesian.org.uk

Permission to use images

To whom it may concern

I am contacting you to request permission to reproduce four images from your website (see details below) in my PhD thesis. I will be submitting the thesis to Bournemouth University early in 2009 entitled 'Taking the case of homeopathy: critical perspectives on practice-based inquiry'. I engage with Susan Hiller's work texts and images to as a conduit to critical self-reflexive inquiry into my own clinical practice. Please advise of the full permission statement for use and credits.

Thank you

Julie Smith

1. 'Witness' - Susan Hiller, Audio Sculpture, 2000

Photo: Rosie Allimonos at: www.abc.net.au/arts/visual/stories/s597706.htm

2. 'Freud museum' image at: www.moma.org/.../hiller_freudmuseum.html [1991-97]

3. 'Momento' at www.josephklevenerfineartltd.com/NewSite/Hiller...

4. Midnight Euston: image at: mari-artisti.artline.ro/D-Susan-Hiller-1778-2... [1980-89]

PERMISSION RECEIVED:

On Dec 23, 2008, Julie Smith received:

Dear Julie

It's OK with Susan for you to use these as low res images. She sends best wishes for your thesis.

Sunil

Sunil Rashel

Studio Assistant, Susan Hiller studio, London

APPENDIX 3 CONFERENCE AND SEMINAR PAPERS FROM THIS STUDY

Practice base inquiry: Taking the case of homeopathy

University of Westminster School of Integrated Health Seminar Programme, March 2009

Taking the case of homeopathy: critical perspectives on practice based inquiry

Alternative and Complementary Health Research Network seminar, London September 2008

A critical reflexive inquiry – a transformational process as a practitioner researcher

12th International Reflective Practice Conference: Being and Intention in Health and Educational Care, Cambridge July 2008

Qualitative approaches to researching treatment by a homeopath

Society of Homeopaths' Research Day, London July 2008

Researching your own practice

Society of Homeopaths' Research Day, London July 2007

Developing a conceptual framework for evaluating homoeopathic treatment grounded in professional experience of homeopathic practitioners

Action Research Study Group, City University School of Nursing and Midwifery, London August 2006

Deconstructing homeopathic practice

Alternative and Complementary Health Research Network National Conference, Nottingham July 2006

Reflective practice as research: How can I research my own practice?

Society of Homeopaths' Research Day, London June 2006

A critical reflexive inquiry – a transformational process as a practitioner researcher

Alternative and Complementary Health Research Network National Conference, Nottingham July 2005

APPENDIX 4 KEY TO ABBREVIATIONS

| | |
|-------|--|
| ACHRN | Alternative and Complementary Health Research Network |
| BCE | before Christian era |
| BMJ | British Medical Journal |
| CAM | complementary and alternative medicine |
| EBM | evidence based medicine |
| ECCH | European Council for Classical Homeopathy |
| ECH | European Council for Homeopathy |
| FoH | Faculty of Homeopathy |
| GP | General Practitioner |
| HRI | Homeopathy Research Institute |
| HTP | homeopathic pathogenetic drug trials |
| JMCR | Journal of Medical Case Reports |
| MRC | Medical Research Council |
| MYMOP | Measure your own medical outcome profile |
| NCI | National Cancer Institute, USA |
| NHS | National Health Service |
| PWFH | The Prince of Wales's Foundation for Integrated Health |
| RCT | randomised controlled trial |
| SoH | Society of Homeopaths |
| STAR | Supervision through Action Research project |
| WHO | World Health Organisation |

APPENDIX 5 GLOSSARY OF TERMS USED IN HOMEOPATHY

ACUTE ILLNESS Generally self-limited and of short duration.

CASE Elicited by the homeopath during the consultation and provides the basis for **case analysis**. Known as the homeopathic or the patient's case.

CASE ANALYSIS This involves analysing the **totality** and identifying what is most characteristic of the patient, causative factors and **miasmatic** tendencies. Case analysis leads to evaluating the **symptoms** to be used in **repertorisation**.

CASE TAKING During the consultation the homeopath uses open questions to encourage the patient to describe their health concerns. The consultation also involves detailed questioning to ascertain precise **symptom** expression and physical examination is conducted if appropriate.

CENTESIMAL POTENCY The scale of dilution of one drop of the original (or mother) substance in 99 drops of the dilutent. The dilution is succussed to produce the potency. One drop of this potentised liquid is used to prepare the next potency. Lower centesimal potencies (diluted by a factor of 1:99, six or twelve or thirty times) are often used in **acute** complaints, especially of recent origin or in complaints relating to local parts of the body or where vitality (see **vital force**) is perceived to be weak. Lower potencies are perceived to be more limited in their sphere of effect. Higher centesimal potencies (diluted by a factor of 1:99; 200 or 1,000 or 10,000 times) are considered to be more powerful. Higher potencies are used in conditions more profoundly affecting the individual, often of mental or emotional origin, or affecting the individual overall (for example debilitating fatigue) or of long standing duration.

CLASSICAL PRESCRIBING Holistic approaches that involve conducting a detailed consultation, prescribing one **remedy** at a time and waiting (a number of weeks in chronic conditions) to observe the patient's response to the prescription. **Acute** prescribing takes into consideration changes in the person as well as local symptoms, and includes repetition of dose and change of **remedy** as the **acute** symptoms change. Theory and practice are articulated in terms of textual sources from Hahnemann and interpretations by Kent and other 19th century homeopaths including Roberts, Close, E.A. Farrington, Lippe, Boger and Boenninghausen. 21st century proponents are Creasy and Vithoulkas.

COMPLEX PRESCRIBING Using potentised preparations containing more than one source or administering more than one homeopathic **remedy** simultaneously.

CHRONIC ILLNESS A condition that is long term or recurrent, that is unlikely to fully resolve without intervention.

CONSTITUTION Refers to the overall physical, mental and emotional makeup of the individual including physical characteristics and appearance. Factors considered in determining the constitutional state include: chronic and recurrent **acute** illness, past medical conditions, personal history, inherited propensities to illness, life style and environmental factors.

CONSTITUTIONAL REMEDY This is chosen to match the **constitution** as it is perceived by the homeopath at that time.

CONSTITUTIONAL TREATMENT Treating holistically rather than individual complaints. The intention is to reduce persistent and recurrent symptoms, reduce susceptibility to illness and enhance well-being.

DIRECTION OF CURE Criteria are used to interpret changes occurring after taking a homeopathic prescription. These include improvement of recent **symptoms** and well-being and possible temporary return of old or **symptoms**. The term 'unravelling' or 'unfolding' is often used to convey an understanding of improvements in health expressed through shifting patterns of **symptoms**.

GENERAL SYMPTOMS Physical and mental/emotional **symptoms** relating to the whole person, not limited to a particular illness or condition. These include factors that improve or

aggravate the individual's sense of well-being or comfort, such as warmth, walking and being alone.

INDIVIDUALISATION The process from **case taking** to selecting the prescription, based on the individual and not the common symptoms of their medical diagnoses. In **case analysis** priority is given to **symptoms** that are unusual to the diagnosis; **general symptoms** and aspects that are perceived to be characteristic of the individual.

ISOPATHY Literally translated as identical suffering. The use of potentised substances derived from the cause of the illness itself. For example, use of potentised allergens in the treatment of allergic conditions.

LM POTENCY The scale of dilution of one drop of the original or mother substance in 49,999 drops of the diluent fluid in serial dilution to obtain the homeopathic **potency** by **succussion**. The **remedy** is generally administered in liquid form, taken further diluted and succussed, often daily or repeated at intervals. This system of **potency** was devised by Hahnemann in his final edition of the Organon of Medicine (Hahnemann, 1987, 1st published 1921).

MACERATION Extraction process of soluble matter from organic material by placing the vegetable matter in liquid until the cell structure dissolves. This is used to prepare the original or mother substance.

MATERIA MEDICA The body of knowledge of medicinal substances and their applications.

MENTAL SYMPTOMS Cognitive and emotional attributes of the individual used in the analysis of the case.

METHODOLOGY A system of applying homeopathic philosophy in practice.

MIASMATIC THEORY This is a theory of the causation, progression and treatment of long term illnesses as inherited and acquired diatheses. Pathological traits are categorised into three main processes of under function, over function and destruction.

MINIMUM DOSE The least repetition of the potentised substance (**remedy**) as is necessary to stimulate a healing response.

PHARMACOPEIA Official documents listing all homeopathic remedies with specific directions for sourcing, properties, preparation, manufacture and quality control.

POLYCREST This literally means many headed. A **remedy** is described as a polycrest when, from **provings** and clinical application, it is known to have a wide sphere of action affecting many aspects of the mind and body.

POLYPHARMACY Use of multiple medicinal agents simultaneously. (see **Complex prescribing**).

POTENCY Refers to the number of times the **remedy** has been diluted and succussed. The more times the **remedy** has been diluted and succussed, the greater its therapeutic potential.

POTENTISATION The process by which a homeopathic **remedy** is prepared using serial dilution and **succussion**. Commencing with one drop of the original source, for example juice from macerated root of a plant in alcohol solution (mother tincture), added to 99 parts of a water alcohol mix. The dilution is then shaken. Therapeutic claims of homeopathy are based on the premise that this procedure prepares the substance to be reactive to the patient's vitality (see **vital force**).

PROVINGS The systematic experimental testing of a substance to elicit its full range of effects on healthy volunteers. Proving symptoms provide **materia medica** data.

REMEDY A homeopathic medicine.

REMEDY PICTURE The complex of **symptoms** that the **remedy** is known to produce, including emotional, mental and physical **symptoms**. Derives mainly from **proving** data and includes clinical observations on the remedy's use in practice.

REPERTORY This is a **symptom** dictionary, with a highly detailed index of **signs** and **symptoms** with modifiers (factors that aggravate or ameliorate) categorised into sections mind to head to toe, and general symptoms. Each **symptom** entry (called a rubric) lists all the abbreviated names of all the known remedies to share that symptom, either through provings or clinical verification. This was first published in book form in 1832 and is now most popular as computer software packages.

REPERTORISATION Using the **repertory** to identify the **similimum**. To look up and cross reference symptoms to discover the **remedy** or remedies that share all or most of the significant symptoms in the case

RUBRIC see **Repertory**

SENSATION METHODS A late 20th century approach to case taking and analysis developed by Sankaran and colleagues in Mumbai. 'It is based on a new understanding of the nature of diseases (level-concept) and the grouping of the homeopathic remedies according to common characteristics (kingdom-concept). Working with the 'level-' and 'kingdom-concept', this method is focussed on figuring out the deepest knowable level of the disease (vital sensation) and the kingdom to which a patient can be assigned.' (ECH, 2007, p.72)

SIMILIA PRINCIPLE The key principle of homeopathy that there is relationship of similitude between what a substance can cause in healthy individuals and its sphere of therapeutic effect.

SIMILIMUM The **remedy** that most closely matches the **totality of symptoms** of the patient.

SIGNS Objective **symptoms** perceptible to the homeopath and laboratory test results.

SUSCEPTIBILITY Vulnerability to illness, to outside influences (eg becoming overheated) and reacting to a homeopathic **remedy**. Susceptibility is integral to the individual's **constitution** and to demonstrating **miasmatic** tendencies.

SUCCUSION The vigorous shaking with impact, of the vial containing the **remedy** in dilution between each stage of serial dilution in the preparation of the **remedy**.

SYMPTOMS The interpretation and experience of change in any aspect of the body and its function, mental faculties and emotional state. Symptoms are regarded as indications rather than the cause of disturbance of health.

SYMPTOMATOLOGY The study of **symptoms** and **signs** in homeopathic therapeutics.

THERAPEUTICS The study of the clinical use of remedies (Winston, 2001).

TOTALITY OF SYMPTOMS The complete clinical picture of the patient during the illness comprising all the mental **symptoms**, **general symptoms** and local symptoms, and any laboratory test results. Defining the totality of a case is tentative, as it takes into account the constantly changing state of health, whereby new **symptoms** emerge, latent aspects come to the fore and other features recede. In **acute** prescribing, where the prescription is driven by pain and urgency, the totality is limited to changes arising since the **acute** complaint started.

TRITURATION Trituration was a significant development in Hahnemann's **remedy** preparation as this extended the pharmacopeia to include insoluble sources. The method involves progressive reduction of a dry substance to a minute amount. Using a mortar and pestle the substance is ground with a set quantity of lactose for a set period of time. An exact proportion is discarded, further lactose added and grinding repeated. This process is repeated. Each trituration is considered equivalent to a **centesimal potency**. After the third trituration the triturate is soluble.

VITAL FORCE This encapsulates a view of health and illness founded on the observation that life cannot be adequately explained by current scientific approaches. Vitality is characterised as an internal self-regulating, subtle capability.