

SECOND PRESCRIPTION

General Analysis series

Homœopaths and the Law of Similars

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Abstract

A homœopath is a practitioner who uses the Law of Similars to select the remedy most needed by the patient at time of consultation, and prescribes the minimum dose of the remedy needed to produce a healing response. The Law of Similars can lead to a number of simillima, and the homœopath must decide which is needed most. At all times, the needs of the patient are paramount, and must determine the action taken.

I believe that a homœopath may be defined as one who chooses remedies according to the Law of Similars, and who prescribes the chosen remedy in the least possible dose needed to commence a healing response in the patient (known to some as the Law of Minimum Dose).

The need to use potentised medicines is not a core part of my definition, even though most homœopaths (including me) would use potentised medicines in almost all of their prescriptions. For example, Hahnemann practised homœopathy for some years before he developed potentisation. And it is well documented that highly regarded practitioners such as Compton Burnett used homœopathically selected tinctures to treat many conditions.

The reverse is also true: that there are very many people who prescribe potentised substances without their prescriptions being chosen using the Law of Similars. Kinesiologists; Mora, Thera, and Vega therapists (and numerous others who use “machines” to select remedies); and even some astrologers, dream therapists, and psychics are examples of practitioners who administer potentised substances without deeply considering symptoms of the patient, or their similarity to the proven

symptoms of individual remedies. This does not make the work of such prescribers invalid; it is just that they are not practising as homœopaths.

So the Law of Similars is the key in my view. But the Law of Similars is not as narrow as some homœopaths believe, and this is the next matter to be considered.

The Law of Similars

I believe that within the general structure of “classical homœopathy”—a term that means different things to different people—there are four types of simillimum that can be used appropriately to choose the remedy that is most needed by the patient at

events that are so crucial to selecting a needed medicine. Once this has been done, the following four simillima may be identified.



The basic symptom simillimum

This is the direct result of matching the patient’s symptoms with remedies that contain many or most of those symptoms. It is the central “simillimum” that is taught to new students of homœopathy. It is also the only level of similarity that some “classical homœopaths” accept as being truly homœopathic.

“Similar” remedies may be arrived at by repertorising the key symptoms in a case. Different methods may be used, including Kent’s two-matrix approach (where the mental/ emotional symptoms are repertorised first, and then the physicals in a second matrix), or variations of Boenninghausen’s

“complete symptom” (requiring location, sensation, modality, and concomitant). Any of the considerable number of available repertories may be used in the analysis. But the key is a structured analysis of the most important symptoms of the case, and

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time of consultation.

I am assuming here that the practitioner has already taken a thorough case, examining carefully the current complaints as well as the patient’s health history, especially considering those “never well since”

the comparison of these symptoms with those of the resulting short list of remedies in the *materia medica*.

These symptom comparisons are essentially what Hahnemann did prior to the development of his theory of chronic diseases (with its resulting need to find the appropriate antimiasmatic remedy for the patient). They will produce a remedy that has the potential to relieve the patient's condition to a small or significant extent.

But clinical experience shows us that it is not uncommon for such a remedy to reach only relatively superficial levels of disorder. This was of course Hahnemann's own experience, and the reason for which he embarked on his massive study over 12 years to find the true cause of disorder: the miasm.

If our true goal is to discover and treat the true cause of disorder, we often need to look past the basic symptom *simillimum*.

The miasmatic *simillimum*

When Hahnemann first published his work on chronic diseases in 1828, the homœopathic profession of his day split in two. Some followed Hahnemann in accepting that there were deep chronic disorders, which Hahnemann called "miasms", that caused the development of symptom groups in patients.

Others rejected his idea, and felt that any move away from the basic symptom *simillimum* that was the initial cornerstone of homœopathy was not justified.

One of their main concerns was that the recognition of miasms required finding something more in the patient's symptoms than was immediately obvious. It required an interpretation of the symptoms. Some declared that miasms did not exist, but were entirely inferential.

The same debate is still happening today, as many new students of homœopathy will sadly attest. "What should we believe?" is a commonly heard cry from students discovering that there is more than

one school of thought regarding Hahnemann's miasmatic theory.

For those of us who accept Hahnemann's findings, however, and even for those who reserve judgment as to whether miasms are real or

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imaginary but find the system useful as a tool to classify both symptoms and remedies, the system leads us to remedies that may not rank highly when just the basic symptoms are analysed, but may be essential to treat the true cause of disorder.

The miasmatic *simillimum* is chosen by examining the same set of case notes, but finding within the collection of symptoms patterns of disorder that are characteristic of a miasmatic group.

The constitutional *simillimum*

Homœopaths can also be divided into two other groups: those who accept the concept of constitutional types, and those who do not. This is not the place to resolve the debate. But for those practitioners who do believe that there exist, for every patient, some fundamental and generally unchanging personality characteristics, the identification of the constitutional *simillimum* is of importance.

There is disagreement, however, among practitioners who look for constitutional patterns in the symptom totality. Some believe that if the constitutional *simillimum* can be found, then it should always be prescribed, because it will always be the remedy that benefits the patient the most.

Others, me included, believe that the activity of miasms and the effects of significant traumas will often mean that at the time of prescription, the constitutional *simillimum* will not necessarily be the most appropriate remedy to be used. I certainly do accept that once the active miasms have been

removed or rendered dormant, and once significant traumas have been addressed, then the constitutional *simillimum* will be of immense value.

The aetiological *simillimum*

Within many cases, we find significant "never well since" events. I believe that these traumas frequently hold the key to why, at times, any of the three *simillima* identified above will not work. Significant traumas

will, if unresolved, block the action of an otherwise seemingly well selected remedy.

This is the *simillimum* of cause, and if we fail to treat the cause, we will not succeed in assisting the patient to heal him- or herself. There can be many causes in a person's health history, and these may need to be dealt with if symptoms call for this.

This idea has been developed to its limit with sequential therapy, but I am not suggesting here that all events be considered, whether or not they appear to have had a major impact on the patient.

My personal experience is that if a patient has an unambiguous "never well since" event, then this event needs to be addressed through appropriate treatment. In some cases the trauma will activate a dormant miasm, and the miasmatic *simillimum* will be most needed. In other cases, the direct trauma needs to be addressed (e.g. Nat sulph. in unresolved head traumas).

Timing is everything: an example

The careful recording and interpretation of not only what has happened, but when it happened, is central to understanding why a patient is presently suffering. It also shows the practitioner which *simillimum* is needed at any point in time over the case.

The following simple chart will help to illustrate the point. It attempts to show how a patient's timeline might appear from birth to time of

consultation. Of course the graph of symptom changes is completely simplistic; symptoms don't change in neat ordered straight lines, but continually fluctuate within levels or layers of disorder. It is when the symptoms change to a fundamentally different layer that we say that the "never well since" state occurs.

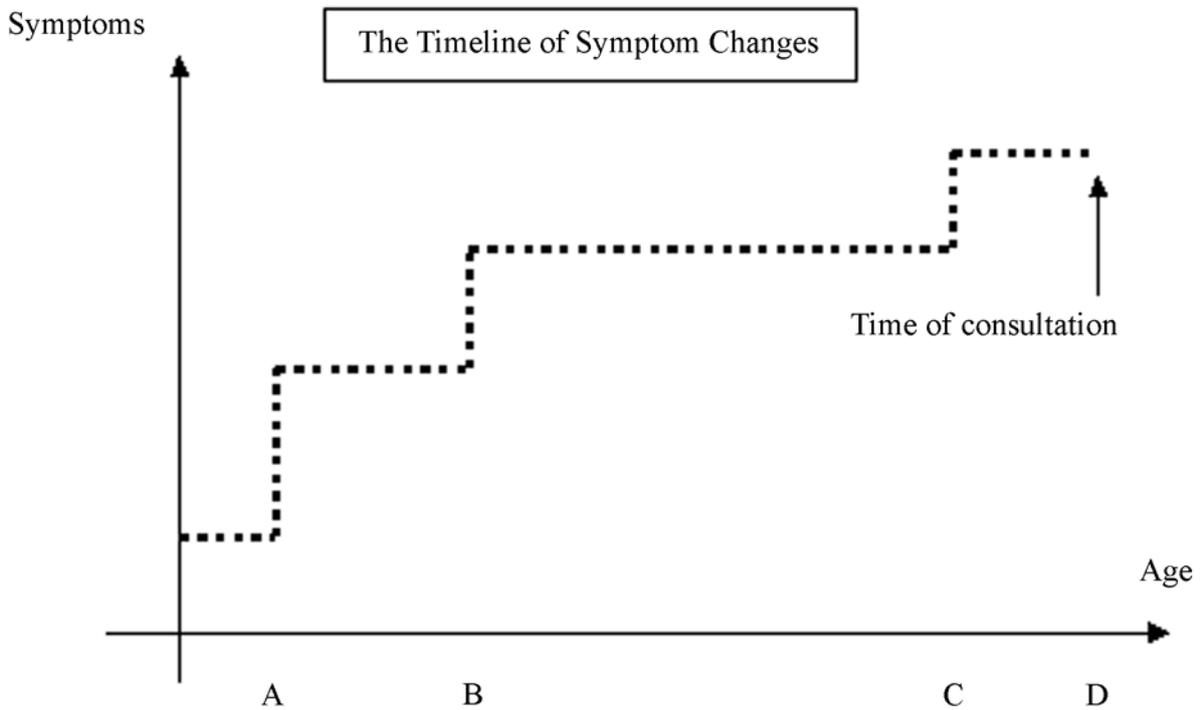
Let us assume that the following major "never well since" events happened in the life of our hypothetical patient.

A. Age 2
MMR vaccination
Patient developed chronic sinus infections

B. Age 7
Father died suddenly
Patient became withdrawn

C. Age 19
Sexually active
Patient happier, but drinking more regularly

D. Age 23
Presents for consultation
Drinking often, gum disease, depressive



At first consultation, the practitioner is most probably dealing with someone with an active syphilitic miasm. The miasm was acquired or activated when the patient became sexually active at 19 years of age. The miasm has subsequently progressed, and we see the destructive effects of the miasm appearing both physically (gum disease) and psychologically (alcohol addiction and depression).

It may further be assumed that the patient is carrying a grief "layer" from age seven, and probably the activation of a sycotic miasm at age two caused by vaccination.

At the time of consultation, the

patient needs a simillimum from amongst the antisyphilitic (miasmatic) remedies. This is not necessarily the nosode Syphilinum, but may come from any of 100+ antisyphilitic remedies. The constitutional remedy, which may have perfectly suited the patient at birth (let's assume he was a Calc. phos. type, with a slightly active tubercular miasm), will not be similar to the presenting symptoms at the time of consultation, due to both miasmatic changes and a trauma layer that caused symptoms to change.

If the patient is treated successfully, and over time the syphilitic miasm is either removed

or becomes dormant, the patient's symptoms will fundamentally change, leading to the need for a new simillimum. At this point, the effects of past grief may become obvious. If so, then a grief remedy which is also consistent with the sycotic miasm will be indicated. A remedy like Nat. sulph. is a possibility.

If that layer is subsequently removed, another remedy may or may not be needed in order to remove the vaccine layer. This may be a potency of the MMR vaccine (the direct aetiological causative simillimum), or a different remedy altogether.

Then finally the patient's true



constitutional picture may be revealed. The practitioner may not have known at time D that the patient was constitutionally a Calc. phos., and it actually didn't matter, because Calc. phos. was not similar and would have had little impact on the case.

The above is an example of the classic "retracting" we expect to see when Hering's Law of Cure follows successful prescribing.

Which simillimum?

So: which simillimum? The answer always should be: let the patient's symptoms direct what the practitioner does.

It is essential that we work to satisfy the patient's needs, and not simply follow our own pre-conceived belief systems. Those practitioners who adopt rigidly defined prescribing methods, and use the same method no matter how the patient presents, are doing themselves and their patients a disservice. I strongly believe that the most successful practitioners are those who work within the Law of Similars in a flexible and responsive way, and

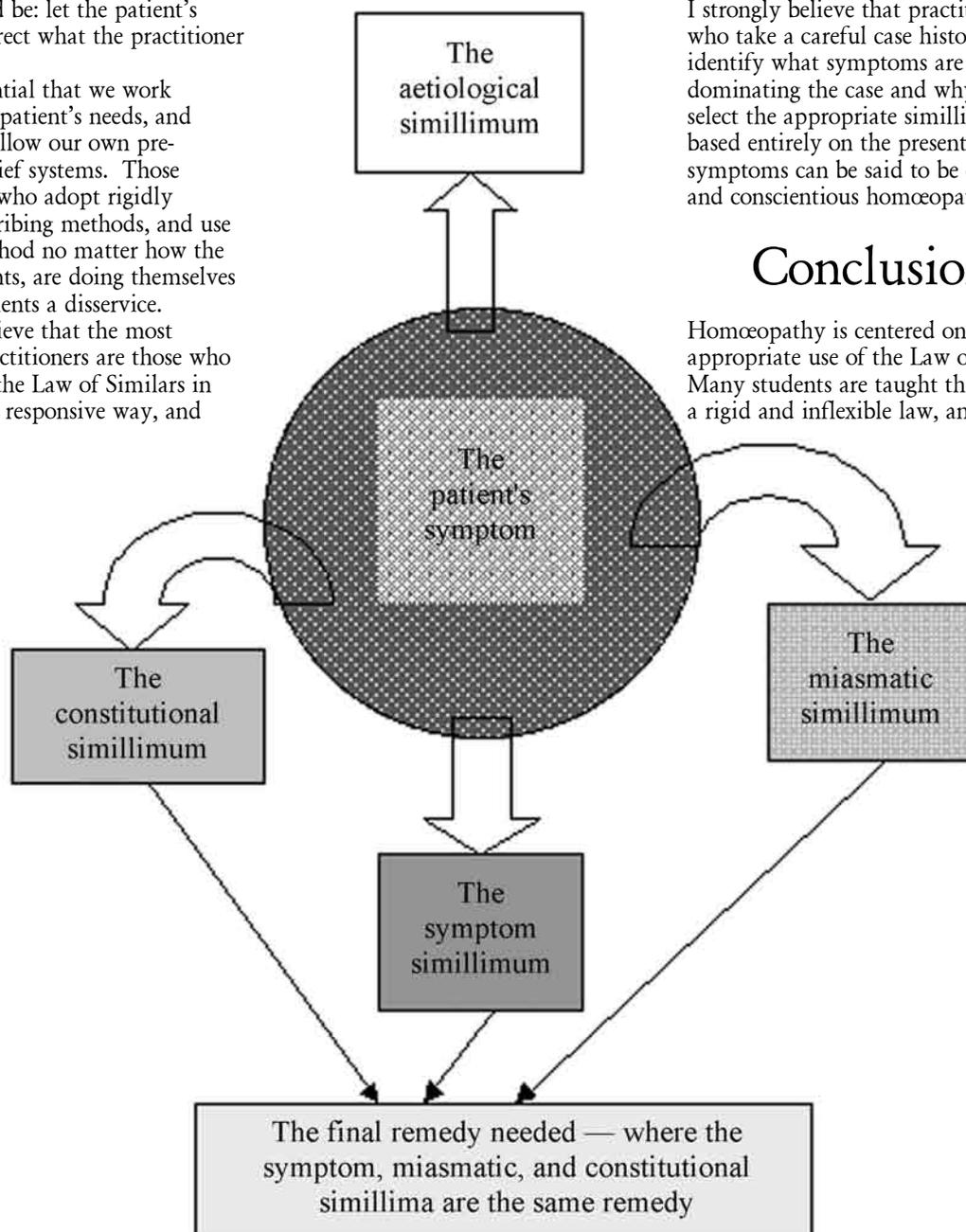
who change the way they approach each case solely according to each patient's needs. And every person is unique, so practitioners need to have at their disposal a variety of analytical techniques, and to be prepared to prescribe any remedy in any potency and frequency—the final decision being made solely in response to their patient's needs. So the most appropriate simillimum will depend on the case; in one, the aetiological simillimum will be the most needed because the symptoms dominating the case significantly relate to the prior trauma. In another case, the miasmatic simillimum will be indicated, because the active miasm is

producing the dominant symptoms. In other cases, the constitutional simillimum will be the goal. I believe that the patient's healing journey will be seen to be near the end when a single remedy is at once the symptom simillimum, the miasmatic simillimum, and the constitutional simillimum. This can only occur when all significant aetiological "layers" have been removed. We see this happen in generally healthy children who have not suffered major traumas, and in adults who have been prepared to work with the practitioner for sufficient time to deal with all their major traumas. This is simply represented in the following diagram.

I strongly believe that practitioners who take a careful case history; identify what symptoms are dominating the case and why; and select the appropriate simillimum based entirely on the presenting symptoms can be said to be competent and conscientious homœopaths.

Conclusions

Homœopathy is centered on the appropriate use of the Law of Similars. Many students are taught that this is a rigid and inflexible law, and that



application of the law in practice is similarly rigid and inflexible. I believe that the Law of Similars is very forgiving, and that it allows great flexibility in remedy selection. For a practitioner to be properly called a homœopath, though, he or she must first employ care in case-taking, and then use the Law of Similars to select the required simillimum. The selected remedy must then be prescribed correctly, taking into account the individual patient's needs, i.e. the strength of his or her vital force, the presence or not of significant pathology, and so on. The individualisation in case-taking, case analysis, and remedy selection and administration required to satisfy each patient's unique needs remains the key to being a successful homœopath.

Isaac Golden has been a homœopathic practitioner since 1984. He was president of the Victorian branch of the A.H.A. from 1992 to 1998, and in March 1999 was awarded the Association's Distinguished Service Award.

Isaac has been teaching homœopathy since 1988. He founded the Australasian College of Hahnemannian Homœopathy in 1990, which offers an RTO/Austudy accredited Advanced Diploma of Homœopathy.

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