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Homeopathy in emergency medicine

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Homöopathie in der Notfall- und Intensivmedizin

Zusammenfassung. *Grundlagen:* Die Anwendung der Homöopathie bei kritisch kranken Patienten wird nur selten berichtet. Wir beschreiben unsere Erfahrungen bei der homöopathischen Behandlung solcher Patienten in der Notfallaufnahme, den Bettenstationen und Intensivstationen konventioneller Spitäler in Österreich und Israel.

Methodik: Wir beschreiben eine Serie von Fallberichten von Patienten, die in der Notfallaufnahme wegen Katastrophenfällen behandelt worden sind, zwei Fallberichte bemerkenswerter Heilungen an der Intensivstation, sowie zwei randomisierte klinische Studien, die die Effektivität der Homöopathie bei septischen und intubierten Patienten zeigen.

Ergebnisse: Eine Fallstudie dokumentiert günstige Ergebnisse bei der homöopathischen Behandlung von Patienten in der Notfallaufnahme- und der Normalstation nach Katastrophenfällen. Weiters beschreiben zwei Fallberichte bemerkenswerte homöopathische Heilungen bei fortgeschrittenen tödlichen Erkrankungen. In zwei randomisierten klinischen Studien zeigte sich die Homöopathie im Vergleich zu Plazebo als effektiver bezüglich der Verbesserung des Langzeitüberlebens von Patienten mit schwerster Sepsis sowie bei der Beschleunigung der Extubation von Intensivpatienten.

Schlussfolgerungen: Unser Bericht lässt vermuten, dass die Homöopathie auch bei kritisch kranken Patienten sinnvoll ist. Wir diskutieren die dabei angetroffenen Hindernisse, einschließlich des Mangels an Werkzeugen für eine erfolgreiche homöopathische Verschreibung bei solchen Situationen, des Misstrauens und der fehlenden Kooperation seitens der Patienten und konventionell tätiger Kollegen sowie der supprimierenden Wirkungsweise begleitender konventioneller Therapien. Wir regen die Entwicklung von Algorithmen und anderer Werkzeuge zur Beschleunigung homöopathischer Verschreibungen bei kritisch kranken Patienten an und diskutieren die Wichtigkeit, Ärzte und Medizinstudenten mit Homöopathie bekannt zu machen um die Kommunikation und Kooperation zwischen diesen komplementären Zweigen der Medizin zu verbessern.

Schlüsselwörter: Komplementärmedizin, Intensivmedizin, Notfallmedizin.

Summary. *Background:* Use of homeopathy is not frequently reported in critically ill patients. We describe our experience treating such patients homeopathically in the emergency room, on the wards, and in the intensive care unit of conventional hospitals in Austria and Israel.

Methods: We describe a case series of patients treated in the ER for multiple casualty incidents, two cases reports of remarkable cures in the ICU, and two RCT's demonstrating the efficacy of homeopathy in septic and intubated patients.

Results: A case series documents favorable results in homeopathic treatment of patients in the ER and wards after multiple casualty incidents. Two case reports narrate remarkable homeopathic cures to imminently terminal illnesses. Finally, homeopathy was demonstrated effective as compared with placebo in improving long term survival in severely ill septic patients and in hastening extubation ICU patients.

Conclusions: Our report suggests that homeopathy may be applicable even for critically ill patients. We discuss the obstacles encountered, including a dearth of tools for successful homeopathic prescription in these situations, suspicion and lack of cooperation by patients and conventional colleagues, and the highly suppressive nature of concomitant conventional therapies. We suggest the development of algorithms and other tools to aid rapid homeopathic prescription in critical care patients, and discuss the importance of familiarizing physicians and medical students with homeopathy in order to facilitate communication and cooperation between these complementary branches of medicine.

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Key words: CAM, intensive care, emergency medicine.

Introduction

Homeopathy does not treat life-threatening illnesses. Or so it would appear from a review of the homeopathic literature. In fact, in the modern era, homeopathic experience treating life-threatening diseases is rare. There are several reasons for this. The first is an ethical issue. Homeopathy is largely unproven. For indications for which conventional treatment is available, it would be unethical to delay or withhold treatment while attempting homeopathic intervention. Second is the issue of proximity. The huge majority of homeopaths work in private clinics, far from the centers which care for life-threatening disease, and thus do not come in contact with patients in such a state. Finally there is the issue of experience. Because so few homeopaths have the opportunity to treat these conditions, experience, and the confidence that comes with it, are lacking.

Chronic diseases, tenacious as they may be, permit the luxury of waiting, changing remedies, and waiting again for the salubrious response. Life-threatening conditions leave room for no such luxury. The imperative is "succeed, or (your patient will) perish".

That stated, we would like to present our experience as homeopaths directing units in conventional hospitals, using homeopathy in two different but similarly acute conditions: multiple trauma in the emergency room and intubated patients in the ICU. All the patients received conventional treated as needed, supplemented by homeopathy. We demonstrate how, even in these most extreme of situations, homeopathy proved itself worthy of the occasion.

Homoeopathy in multiple casuality incidents

In the years 2000–2001, as the Israeli-Palestinian conflict intensified, Israel found itself facing repeated attacks of suicide bombers on its civilian heartland. Casualties reached into the hundreds. Hospitals, manned for the daily routine, found themselves swamped within minutes with tens and hundreds of casualties, many critical. A small ER staff found itself dealing with a patient flow worthy of a military battlefield hospital.

In this state of affairs, all available hands were organized into response teams, including the homeopaths of the Center for Integrative Complementary Medicine of the Shaare Zedek Medical Center. We wish to describe our involvement as homeopaths in three multiple-casualty incidents in Jerusalem; two suicide-bombing attacks and a construction disaster [1].

Trauma, particularly in the context of multiple casualties, requires rapid action. Treatment flow-charts are typically used in emergency medicine to facilitate rapid treatment decisions, which will hopefully be appropriate for the majority of patients. Anyone familiar with homeopathy will note that this "one approach for all" approach runs contrary the central homeopathic tenet of individualization. In spite of this, we developed, *ad hoc*, a treatment approach which we hope may be generalizable to acute homeopathic care.

Material and methods

A total of 29 patients were treated in three distinct events. All hospitalized patients were on the orthopedic ward, whereas five patients were treated for anxiety as out-patients. The hospital homoeopaths were recruited within the first 24 hours. Patients were first seen the day after the incidents. Due to the large number of patients awaiting our care, we realized that traditional classical prescribing would be impossible at this stage. We thus opted for a "graded" approach. On the first day, we performed only keynote prescribing using a small number of remedies, in order to offer some aid to all patients. On the second day, because constitutional prescribing was still deemed impractical, "acute" prescribing was continued, however with the addition of "guiding symptoms", and the repertoire of remedies was expanded. On the third day, as some patients were released and the situation stabilized, we began performing individualized prescription. All patients were seen daily, to the degree possible, for up to 10 days. Homeopaths worked in teams of two or three, making "rounds" and taking joint decisions on treatment. These rounds were scheduled so as not to conflict with departmental routines. Rounds lasted 3–5 minutes per patient on the first day and extended to 30–45 minutes on the third. Much of the time on the rounds was spent explaining the homeopathic approach and assuaging the concerns of patients, many of whom had never encountered this technique. Keynote prescribing was performed bedside, typically based upon one or two acute symptoms. After day three, symptoms were collected at bedside, but case analysis was performed in our offices. The directors of the psychiatry and orthopedics departments were invited to join homeopathic rounds. Their presence on the round appropriated credibility and improved patient compliance. When formal case analysis was possible, RADAR software (Archibel Software Products, Belgium) was used. Local pharmacies specializing in homeopathic remedies supplied all remedies free of charge.

Stage one

The first stage of treatment lasted minutes to hours from arrival of the homeopaths to the hospital. Due to the heavy patient load, we decided to prescribe only for pain and anxiety, and to defer treatment of specific complaints to later stages.

Arnica montana is considered the homeopathic anti-trauma remedy *par-excellence,* indicated particularly for cases of blunt trauma with hematoma, as also for mental and emotional results of trauma [2]. Thus, all patients first received a single dose of *Arnica montana* 200CH. Additionally, one of four different remedies, tailored to type of anxiety, were added. The considerations in favor of each remedy were made based upon keynotes, as detailed in Table 1. When an anti-anxiety remedy was given, it was delayed by five minutes so as not to interact with the dose of Arnica.

Evaluation of the success of the initial homeopathic treatment was performed 24 hours after the initial prescription (48 hrs after injury). Patients compared their anxiety and pain levels to that prior to homeopathic treatment, according to the following scale: -3 – severe aggravation, -2 – aggravation, -1 – slight aggravation, 0 – no improvement, 1 – slight improvement, 2- significant improvement and 3 – very significant improvement. The patients were also asked whether they thought that the homeopathic remedy improved their condition. Responses are listed in Table 2. All patients hospitalized at the time responded to the questions. Most patients reported lessening of pain (median score = 1, range: –2 to 4, one patient over-enthusiastically marking "4".); 58.8 % felt some degree

Table 1. Anxiety remedies and guiding symptoms

Aconite	**Arsenicum album**	**Opium**	**Ignatia**
Sudden fear/Anxiety	*Weakness*	*Sleep stertorous*	*Sighing*
Fear of death	*Thirst for small volumes*	*Asking for nothing; Not complaining*	*Sensation of a lump in the throat (globus hystericus) or elsewhere*
Restlessness	*Worsening at night*	*Warm perspiration or scant secretion (urine, stool etc.), but with increased perspiration*	Silent grief and brooding
Worsening at night	*Desire for company*	*With drawal*	
Fear of suffocation (following burial in debris)	Restlessness, wish to leave the bed	*Dark red, swollen face*	
Sensitivity to noise	Painlessness/pain starts late after injury	Vertigo during anxiety	
	Fear of being alone. The physician/nurse/somebody should stay with him	Cold drinks improve	
		Small pupils	
Minimal number of symptoms justifying the prescription of the remedy:			
2 Bold + 2 normal or *3 Bold* + 1 normal	*3 Bold* + 2 normal or *4 Bold* + 1 normal	*4 Bold* + 2 normal or *5 Bold*	*2 Bold*

of improvement, and 41.2 % felt that the treatment had either had no effect or had aggravated their pain. 84.6 % of respondents felt an improvement in their degree of anxiety (median score 3, range: 0–4), and 60.8 % felt that homeopathic treatment was helpful overall. All non-responders were patients who had been discharged before evaluation.

Stage two

On the second day, more time was available for each patient, and thus it was possible to enlarge the repertoire of remedies and prescribe more precisely. Additional remedies were added to those used for "fear and anxiety" but case taking remained superficial and limited to keynote symptoms. General and mental symptoms were ignored. The remedies added at this stage were: *Lyssinum, Phosphorus, Cannabis indica*, *Gelsemium sempervirens* and *Kali bromatum*. Pain and anti-trauma remedies were also added to include *Bellis perenis*, *Calendula officinalis* (large wounds), *Hamamelis virginica*, *Carbolicum acidum* (many scratches, with necrotic material [according to Pierre Schmidt]), *Hypericum* (painful wounds), *Staphysagria* (post operative treatment), *Ruta* (sprains, strains, eye injury), *Rhus toxicodendron* (strains, sprains), *Symphytum* (fractures) and *Calcarea phosphorica* (fractures).

Table 2. Reaction to homeopathic treatment of anxiety and pain, and patient evaluation of the cause of the improvement/aggravation

Score (n = 23)	*3*	*2*	*1*	*0*	*-1*	*-2*	*-3*	*No Info*
Pain control	6	0	1	1	5	3	3	4*
Anxiety control	10	0	0	0	2	1	4	6*
Was treatment helpful?			Yes = 14; No = 9					10

* One satisfied patient who scored '4' to express his satisfaction.

Phase three

Beginning on day two, as patients were discharged and time became available, we began treatment for specific complaints of the remaining patients (Table 3). Treatment was based upon classical homeopathy. In most cases, high potencies (C30 [10^{-60} of the stem solution], C200 [10^{-400} of the stem solution], 1m [10^{-2000} of the stem solution]) were administered, and were continued for the duration of hospital stay. Patients suffering from fractures were routinely treated with Calcarea phosphorica C6 and Symphytum C4 (3 globules 3 times daily).

Table 3. Distribution of the specific complaints

Specific complaints	*Number*
Nausea	4
Vomiting	3
Vertigo	11
NIDDM	2
IDDN	1
Headache	7
DVT	2
Insomnia	7
Constipation	3
Nightmares	2
Palpitations	2
Premature contractions (pregnancy, 32 weeks)	2
Hemorrhoids	2

Table 4. Self-rating of the effect of the homeopathic treatment on the specific complaints

Response	Evaluation after 3 minutes	Evaluation upon discharge*	
		number of remedies applied	Number of cases
"Helpful"	8	35	18
"Not helpful"	16	33	9
Not clear	4	4	1

* Patients were evaluated upon discharge, including all the patients (hospitalized and not hospitalized).

Patients were asked to evaluate the effect of the remedies of the third stage three minutes after receiving each remedy and upon discharge. Their responses are presented in Table 4. The immediate response to homeopathic treatment was less favorable than the long-term response. At discharge, patients rated the homeopathic treatment successful in 64 % of the specific complaints. Thirty-two percent of patients rated the treatment as unsuccessful. One remarkable improvement in a diabetic patient was the rapid reduction of blood glucose from more than 500 g/dl to 200 g/dl, without anti-diabetic treatment.

Problems encountered and lessons learned

We are not aware of previous reports of use of homeopathy in early stages of a multiple casualty event. The situation is remarkable both for the homeopathic challenges it presents, as well as for the complexity of interacting with the conventional medical professionals at a moment of intense distress. A major problem facing the homeopathic staff was a lack of previous experience or specific guidelines for such a situation. They were in fact called upon to reinvent the wheel in attempting to create a viable treatment scheme.

Early on, the decision was made to perform the homeopathic rounds separately from the conventional rounds. This was done in order not to burden the hospital staff, which was already stretched beyond its limits. This enabled homeopaths to practice freely, without intervention by the conventional staff. On the other hand the homeopaths were not involved in conventional decision-making, and were not notified of important medical developments. The independent homeopathic rounds resulted in separate bedside explanations and in the independent distribution of remedies and monitoring of compliance. We also underestimated the time required for this type of treatment and found ourselves with insufficient time to find the correct remedy.

Compliance was also a problem, as patients were faced with two parallel treatment regimens. Most were unfamiliar with homeopathy, and were not able to fathom the necessity of quixotic homoeopathic case taking, focusing as it does less on immediate problems and more on the patients' general characteristics. Frequently, negative and suspicious attitudes were encountered. The attitude of the conventional hospital staff was often no better. These two groups often fueled each others reservations. A trustful relationship was difficult to establish, even with patients who had had exceptionally favorable responses. Paradoxically, the swiftness of the response even served to augment their suspicion: one patient equated homeopathy with witchcraft.

Over the course of several days trust was indeed established with many of the patients, and a significant percentage of the patients went on to maintain contact with the Center of Integrated Complementary Medicine after discharge. The involvement of the directors of the departments of psychiatry and orthopedics, their presence on homeopathic rounds and their obvious satisfaction with the results did much to help patients overcome initial reservations.

Homeopathy in the intensive care unit

Intensive care medicine has become highly specialized, evolved specifically to cater to the needs of the critically ill. Patients typically present with cardiac, pulmonary, renal or hepatic failure, multi-organ failure or sepsis. Postoperative patients also often require prolonged intensive care stays. The technology of critical care includes drastic medical interventions such as intravenous administration of catecholamines and broad spectrum antibiotics as well as invasive modalities including central venous lines, intubation, tracheostomy and artificial respiration, hemodialysis, intra-aortic balloon pump and venous hemofiltration. Additionally, diagnostic procedures such as right heart catheterization, bronchoscopy, endoscopies, sonography, computer tomography, magnetic resonance tomography are often necessary. Patient survival is often dependent on this armory, though mortality reaches 35 % in spite of it [3]. This situation presents unique challenge for patients, relatives, doctors and nurses.

For the homeopath it is appropriate to ask whether homeopathic treatment is at all feasible in such a situation. Hahnemann gives explicit instructions for case taking [4]. However, in the ICU setting, this is rarely possible since most patients are sedated and many intubated, and therefore unable to answer questions. The homeopath doctor is thus dependent on observation and whatever history can be gleaned from relatives. Symptoms recorded in this manner must be treated with circumspect. Frequently the events leading to admission to the ICU will offer the clue to the simile.

Once the correct remedy has been selected, many obstacles still complicate homeopathic treatment. Family and staff should be informed that homeopathic therapy was given, and be prepared for possible reactions. Initial aggravations are as much a part of these patients responses as of ambulatory patients, and there is tendency on the part of both parties to react medically, risking suppression of the homeopathic reaction. Reactions frequently seen include skin eruptions, mucosal secretions, increased expectoration, diarrhea, leucorrhea, etc.

Administration of remedies is usually by globules under the tongue. This route is feasible even in intubated and unconscious patients. However, globules are liable to be expelled by salivation, and oral hygiene must be avoided for at least 15 minutes afterwards.

Due to the severity of disease, administration may be repeated often, even with high and very high potencies. The clinical signs typically used to assess the homeopathic reaction are often masked by the decreased level of consciousness, and judging success of the prescription may be difficult.

Prescribing homeopathically for such patients is very time-consuming, and busy homeopaths will often find it difficult to dispense with other obligations on short notice. For a single homeopath it is often difficult to perform and to supervise homeopathic therapy at the ICU, alongside his other duties.

In spite of these limitations, we have repeatedly found homeopathic therapy useful and worthwhile in critically ill patients. We wish to present two such cases, and the results of two randomized controlled trials.

Case report 1: Intoxication with amanita phalloides

A 72 years old female patient (H. H.) was admitted to the hospital after ingestion of small baked mushrooms at the end of August 2002. Nine hours after ingestion she suffered from vomiting, diarrhea and intense bowel pain. The mushrooms were identified by the Viennese Botanic Institute as Amanita phalloides. An intravenous infusion of silimarin (Carduus marianus; Legalon®, Madaus, Vienna, Austria) was started. The patient was transferred to the ICU.

On the day after admission the patient suffered ventricular fibrillation and was defibrillated. She lost consciousness, was intubated and put on mechanical ventilation. The patient developed cardiac insufficiency and received IV epinephrine. Epinephrine was replaced by norepinephrine due to tachycardia.

Laboratory testing revealed critical deterioration of liver function: GOT was 450 U/l, GPT 1070 U/l, normotest 40 %. The patient then developed acute renal failure requiring continuous pump-driven veno-venous hemofiltration. Surgeons refused liver transplantation due to the critical state of the patient. Experienced colleagues confirmed the gravidity of the situation, and the relatives were told to expect the patient's imminent demise.

At this stage, homeopathic treatment was initiated. On day 3, the patient received five globules of Arsenicum album C 200 (Remedia Pharmacy, Eisenstadt, Austria). This dose was repeated hourly. On day 5, the liver parameters deteriorated further (GOT 2240 U/l, GPT 6170 U/l., LDH 4800 U/l, normotest 15 %, bilirubine 12,40 mg/dl). Due to the onset of hepatic dystrophy, medication was switched to Phosphor C 200 (Maria Treu Apotheke, Vienna, Austria), according to the same dosage regimen. Shortly thereafter, the patient opened her eyes spontaneously and responded to verbal stimuli. The patient received Helleborus niger C200 (Remedia Apotheke, Eisenstadt) based upon the stuporous mental state.

From this point onward, the course of the disease showed constant improvement. On the 20th day of homeopathic treatment, the patient was hemodynamically stable. Liver functions reached the normal range (GOT 10 U/l, GPT 32 U/l, LDH 209 U/l). The patient was extubated, sat up in bed fully conscious, and was able to eat and drink without support. On day 27 the patient was transferred to the general ward. She was released 34 days after ingestion of the mushrooms, fully recovered by any available measure, except for a hearing impairment. Another woman who ate from the same batch of mushrooms died on day 12.

Case report 2: Massive bleeding at the site of a drainage

A 60-year old patient (I. J.) experienced minor trauma to the lumbar spine upon falling down stairs in 2001. Pain persisted despite a paravertebral injection of lidocaine chlorhydrate.

A paravertebral abscess was suspected and a magnetic resonance tomography demonstrated an irregularly shaped collection of uniform fluid in the paravertebral space. Drainage elicited copious quantities of purely serous fluid, with no suppuration. The patient was admitted to the general ward.

Within five days, thrombocytes decreased sharply from 460,000 to 5,000/mm^3, and the patient developed acute renal failure (serum creatinine ◘ 9.0 mg/dl). The patient experienced epistaxis and a severe headache in the morning. Idiopathic thrombocytopenia was suspected. The thrombocytes fell below 1,000/mm^3, without elevation of LDH or fragmentocytes on blood smear. Hemoglobin decreased from 12.6 to 8.2 mg/dl.

The patient was admitted to the ICU (day 0). The patient received immunoglobulin and thrombocytes rose to 11,000/mm^3, however fell again to 3,000/mm^3. The lumbar drain continued to exude over 1,000 ml of bloody serous liquid per day.

The patient was given 5 globules of Lachesis muta C 200 (Spagyra, Hallein, Austria). Within one hour the spinal discharge ceased. At this point, cortisone therapy (100 mg per os) was commenced. On the next day, there was another bloody drainage of liquid. A second dosage of Lachesis C 200 resulted in an immediate cessation of the bleeding. Three days later, the thrombocyte count increased markedly (to 95,000/mm³) and serum creatinine values decreased to 5.2 mg/dl. Urine production returned to normal. On the next day, the thrombocyte count was 150,000 G/l. The lumbar drain was removed. The patient felt well, was fully mobilized and was transferred to the general ward on day 6. She was released to her home ten days after admission to the ICU.

Randomized clinical studies

In a recent paper [5] we describe the improvement of tracheal secretions in critically ill patients suffering from chronic obstructive pulmonary disease (COPD), using homeopathically prepared potassium dichromate (= Kalium bichromicum). That study was performed with the thought that improvement in tracheal secretions might expedite successful extubation in mechanically respirated patients. Under randomized, double blinded conditions, we were able to demonstrate both a significant decrease in tracheal secretions and shorter time to extubation in patients treated with the homeopathic preparation, and a shorter ICU stay in one of the treatment groups. The study suggests that potentized (diluted and vigorously shaken) potassium dichromate may help to decrease the amount of stringy tracheal secretions in critically ill patients suffering from COPD.

In a second paper, [6] we investigated the effect of homeopathy on long-term outcome in patients critically ill with sepsis. Patients suffering from severe sepsis received homeopathic treatment (n = 35) or placebo

(n = 35). While no significant difference in survival could be found on day 30, survival was significantly higher with verum homeopathy (75.8 % vs. 50.0 %, P = 0.043) on day 180. We concluded that homeopathic treatment may be an useful adjunctive therapeutic measure severely ill septic patients admitted to the intensive care unit.

Problems encountered and lessons learned

Homeopathy is an individualized science which bases remedy choice primarily upon subjective information received directly from the patient. The more alert and communicative the patient is, the more valuable the information. Objective and clinical observation are less valuable, unless unique or peculiar [7]. Since the patients were unconscious, it was impossible to obtain subjective information from them, thus we were left to make our decisions based upon meager clinical clues. Yet, due to the heavy medication our patients were receiving, even the value of the objective and clinical observations was questionable. For example, is the patients bradycardia indicative of his disease state, or simply a side effect of the beta-blocker he is receiving? Ultimately, we were called upon to invoke much historical experience, and guesswork. It will not therefore be surprising that finding the correct remedy was often delayed, to the severe detriment of our patients.

Our colleagues were sceptical of our efforts, and viewed homeopathy as far removed from the task as hand, particularly in the ICU. In spite of this scepticism, some of the nurses took interest and were supportive of our efforts. All staff members were duly impressed by the striking improvement in the woman poisoned by Amanita phalloides.

Discussion

We are not the only authors to observe the usefulness of homeopathy in critically ill patients [8–10]. However, our experience is unique in its integration in the conventional hospital setting and in its performance in conjunction with conventional personnel and technology. We describe several case reports, a case series and two RCTs supporting the contention that homeopathy may be efficacious in critically ill patients, even in hospital emergency and intensive care wards. In the emergency room, more than sixty percent of the patients reported improvement in anxiety and pain following homeopathic treatment. At discharge, 67 % of patients regarded their treatment as successful. In addition to the impressive success rate, we were also encouraged by the speed of reaction. Eight patients reported improvement within three minutes of administration of the remedy.

In the ICU, homeopathic Kali bichromaticum significantly decreased tracheal secretions, shortened time to extubation, and shortened ICU stay in one treatment group. A second ICU trial found improved long term survival in severely ill septic patients treated with classical homeopathy as compared with placebo. While the ICU RCTs were scientifically rigorous, we stress that the objectives of the emergency room account were to report impressions and experiences from a unique pioneering event, and can not be regarded as scientific proof of principle.

In addition to the readily anticipated difficulties facing homeopathic prescribing in such dramatic circumstances, our work was hindered by an unexpected source; the suspicion and initial lack of cooperation of patients *and* medical staff. We would hope that ongoing collaboration between homeopaths and conventional physicians will melt away such barriers, and that patients will become accustomed to meeting homeopaths within the hospital walls.

Purists of classical homeopathy may take issue with the methods of prescription employed in this study, as with the concomitant employment of "suppressive" conventional modalities. We freely admit to these limitations, however draw attention to the fact that, at least in western nations, one is unlikely to encounter such patients in a purely homeopathic environment. It may also be noted that we attempted to correct for this shortcoming by improving our prescriptive technique as time and conditions allowed. We thus feel that we utilize the only realistic opportunity to treat such patients homeopathically, albeit imperfectly.

We believe this report carries two important ramifications. First, we would like to see our staged approach to treatment of acute, critical and multiple injury cases improved and expanded upon. In a break with the traditional homeopathic search for the "similimum", we propose a layered approach which provides for treatment within severe limitations, and improves the prescriptive technique as conditions allow. At the early stages, minimal time and homeopathic knowledge would be necessary to prescribe. Acute care algorithms could even be formulated for use by non-homeopathic personnel. Ultimately, we would like to see the development of a repertory of peculiar clinical and objective symptoms with corresponding remedies in order to facilitate accurate critical care prescription. This would no doubt require a collective and enduring effort of all those involved in treating such patients.

Second, we hope to be establishing a framework for the integration of homeopathy and western medicine into a united therapeutic package. Since no western homeopath can expect to treat such patients single-handedly, our model offers an opportunity for patients to benefit from the best that both methods have to offer. We encourage open academic discussion of this therapeutic integration within both the homeopathic and conventional communities, as well as further rigorous trials to corroborate our findings. In conjunction with this aspiration, we feel it imperative to familiarize medical students with the principles and practice of homeopathy, is order to facilitate future communication and collaboration.

Our results raise obvious questions as to the mechanism involved. As is widely known, homeopathy employs highly diluted substances, frequently beyond Avogadro's number. While the mechanism remains obscure, we believe that homeopathy exerts its effect at the level of the constitution, empowering the organism to overcome even seemingly irreversible damage. We are convinced that our observations cannot be attributed to the placebo effect, as our patients were frequently unconscious or se-

dated. We did not observe any deleterious effects of homeopathic treatment.

We present our experience with homeopathy in the conventional hospital setting, in critically ill patients and multiple casualty incidents. Homeopathy appeared effective in these circumstances, and leads us to suggest homeopathic algorithms for acute care as well as an integrated "conventional + homeopathic" package for critically ill patients. We discuss the limitations of our approach, but hope to have demonstrated that such efforts appear well worth the effort, despite the formidable challenges.

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