

ADDITIONS

When I started practicing homeopathy (1978), there was an important group of homeopaths who believed no additions should be made to Kent's Repertory. The idea was that the Repertory contained wisely selected information and that additions could only increase the bias of too much information. One would be tempted to believe that this was Kent's vision as well, as he introduced the third edition of his Repertory as follows: "You will find all remedies of any value contained herein. The book is complete." But a conversation has been reported, shortly before his death, where he contradicted his wife who was making the same statement. He confessed to Dr. Frederika Gladwin that "his job was almost done. If it had to continue, his students had to take care of it."

Today there seems to be little doubt as to the necessity of additions. But another problem is emerging: an increasing number of homeopaths is questioning the reliability of those colleagues who suddenly report hundreds if not thousands of additions based on their clinical experience. I believe we should take a resolute stand and treat each other's "fever for additions". Moreover, we should balance it with "fastidiousness about correct additions".

I. THE SOURCES

1. CURRENT ADDITIONS

From which sources have the additions previously been made?

You will find the additions from the Repertories that are primarily used today: Boger's version of Boenninghausen Repertory, Oscar Boericke's Repertory, Phatak's Repertory, etc.

Information from different Materia Medica books has been integrated, especially from the classical authors such as:

- Hahnemann: surprisingly, many of Hahnemann's symptoms seem not to have been integrated into Kent's Repertory
- Kent's Materia Medica (fully integrated on the basis of Dr. Linda Johnston's tremendous work (Los Angeles, USA)
- Hering's Encyclopedia (this source was preferred over copying from the secondary source, Knerr's Repertory, which contains the same material)
- Allen's Encyclopedia (the original book, not the index, which contains many mistakes and omissions as we found with key-word searches using Radar. Whenever possible we have indicated if the information came from Allen's full text or from the Index to his Encyclopedia)
- Roberts "Sensations as if". Although some consider it as a Repertory, it is a full text structured line by line. It takes much time to transcribe it to a correct repertory structure, but the book is being integrated into Kent's Repertory.

- other Materia Medicas have been integrated, although most of them partially, due to the amount of work involved. Worth mentioning: Clarke's Dictionary, William Boericke's Materia Medica, Phatak's Materia Medica, Borland's books, Tyler's Drug Pictures, etc. Special thanks at this level goes to the European homeopaths collaborating under the coordination of Thomas Lowes (Munich, Germany) and to the members of the American rhus-tox study group.

Many other homeopaths have done great jobs on particular remedies taken from different sources, or from research according to their interest. Since Synthesis 5, for example, you will find much more complete pictures of the nosodes: additions from Henry Allen's Nosodes, reviews of carnosinum, psorinum, different strains of tuberculinum and medorrhinum.

An important number of clinical observations from different "living" authorities has been added.

The largest number of additions in this category is derived from George Vithoukas. We have taken great care to make sure that Synthesis is the best reflection of his clinical experience, which is probably the largest in homeopathy to date.

George Vithoukas has gathered a great number of homeopaths in a Clinical Centre in Athens. All consultations are supervised by more experienced homeopaths or by him. Today 34 medical doctors are working in the Centre and Vithoukas estimates to have seen more than 150.000 cases.

Vithoukas himself has not published his additions and the best source so far is Dr. Bill Gray's booklet of notes taken during his stay in Athens (1979).

For the first time, George Vithoukas himself has been writing down his additions for the chapter mind, and these are now integrated in Synthesis. The chapter MIND has now more than 1600 controlled additions from his hand. Many of these additions have been confirmed by other authors.

On his instructions, more additions to other chapters have been added in successive versions of Synthesis. In this version we have also included his indications on changes of degrees (most often a higher degree).

When a remedy has a higher (lower) degree according to Vithoukas, it is followed by a sign: "*merc.3^{vh}*" means that for this rubric, "merc." should be in the third degree instead of the second degree. There are more than 1.000 such instances and one is free to follow this advice or not.

2. FUTURE ADDITIONS

It is misleading to call any Repertory complete. More work will always be needed to further improve the quality and increase the content of Synthesis and it is certain that this job will

never be completely finished. So, as a consequence, all current collaborators and, in fact, anyone is invited to go on with this collaboration.

The most productive contributions are made when everyone does what interests him or her: the remedy he needs, the author she likes, etc. Nevertheless a few suggestions:

- If you plan to undertake a big job, check to see that the work has not been done or started already by someone else.
- In any event it is beneficial to check again encoded additions, as we have done for some earlier additions.
- The priority set by most of our collaborators is to encode all information of the so-called classical authors (Hahnemann, Kent, Allen, Hering, Clarke and Boericke).
- We should continue to give priority to the most reliable information. Written sources and confirmation of existing material will remain the best choice for a long time. It is more valuable to have a confirmation by someone not belonging to the same school as the one whose information is to be confirmed.

And finally: the most reliable symptoms are found when you use the source in **the original language**.

II. THE CRITERIA TO MAKE AN ADDITION

1. CONFIDENCE IN ADDITIONS

Not all homeopaths agree with each other's additions or criteria to make additions.

In the book, the only way to solve this is to clearly indicate the source, permitting each one to make his decision⁴.

But there are some perspectives. To the presence of any remedy a confidence level will be given based on homeopathic criteria allowing one to select only the most confident additions at any stage.

The lowest level of confidence means that it is a one-time addition from just anyone. If other homeopaths start making the same observation and reporting the same addition, the confidence in this information will increase. A confidence level of 2 may appear if the remedy belongs to the original Repertory of Kent, or if the information is supported by at least three different authors, etc.

The confidence level is NOT reflected in the degrees of the remedies. It is entirely possible that different authorities confirm that a symptom is sometimes, but not often, found for a remedy: in this case the confidence level will increase, but not its degree.

⁴ For those who use the Radar-program an ingenious technology has been designed allowing you to select or deselect the authors you want to work with. Any combination of authors, more precisely: of sources, can be selected or unselected!

At first this tool will only be usable by those working with the computer, as we have yet to imagine how this information can be translated to the printed form. Our only reasonable solution now seems to be to accept everybody's additions with consideration, provided they have been added with caution and precision. There is no selection that would please everybody. Can we refuse to take additions from the Latin-American schools ? Or include only their additions ? Not everybody would be pleased.

We are toolmakers and Synthesis is like a violin. We can make it sound very charming, but we cannot define which music will be played on it: Mozart, a bohemian rhapsody or a cacophony.

2. LITERATURE VERSUS WORDS

"Verba volant, scripta manent"⁵: it is common-sense that what is written has more scientific value than what is told. Our first attention goes to the integration of written information.

Another point of attention has unfortunately proved to be the following. When homeopath X quotes an addition from colleague Y, he should be sure that Y has been quoting from his own experience.

The most relevant question when additions are proposed is: "From whom?". If there is no reassuring answer to this question, we are better off with no addition at all.

3. PROVINGS VERSUS CLINICAL EXPERIENCE

A proving has always been the primary source of homeopathic information. As most provings are supervised by more experienced homeopaths and are, in fact, a scientific study, the results tend to be more reliable. The rules to extract useful symptoms from a proving have sufficiently been laid down, but nevertheless, quoting Jeremy Sherr, "good supervision is the key to a good proving".⁶

It is different with clinical information since homeopaths are so different. One homeopath mentions with some reluctance one new addition after ten years of practice, while another one shouts with joy at his ten additions within his first year of practice.

I do not want to dictate rules, but I believe that the general concern is that one should have at least ten years of full time homeopathic practice before "offering" additions to the community.

Even more experienced homeopaths agree that the additions purely on clinical experience should be integrated with caution. That is why we added the additions from living "authors"

⁵ Words fly, writings remain

⁶ Jeremy Sherr and his colleagues (Northampton, England) made very well organized provings of scorpion, hydrogen, chocolate and others.

in the first degree in Synthesis, unless they get confirmation, which may affect a higher degree.

Then finally: when do symptoms of a cured case become possible additions?

There is a difference in the attitude to be taken towards acute or chronic cases.

A **chronic case** can yield additions if:

- the reaction to the remedy is clear-cut, which means
 - no interference from positive circumstances
 - no mix up with other remedies or therapies
 - the reaction to the remedy is spectacular and repeated. A strong reaction to one dose is not sufficient proof of the remedy's action: we must have placebo-awareness. If the same symptoms disappear a second and a third time, we feel already more confident about the causative agent.
 - the duration of action should clearly exceed the possible placebo effect, e.g. from a "nice conversation"
- It might take several years before you can decide whether a chronic case is "good enough" to use for additions.

An **acute case** can yield additions if:

- the reaction is clear-cut (see above)
- the reaction to the remedy is spectacular and carries the patient to a prompt cure (no further remedies nor therapy needed)
- the speed of onset of improvement should be considered. In a full hit acute case, useful for additions, this should be within 24, preferentially 12 hours after the dose. Be aware that some acute cases get better on their own, if you wait long enough. We should prefer to consider only the very spectacular cases.

In both acute and chronic cases, placebo-awareness is a key. For this reason homeopaths were advised by Dr. Jacques Imberechts (Brussels, Belgium) to first prescribe a placebo.

III. PROCEDURE FOR ADDITIONS

Once the symptom and remedy to be added are firm, one has to search in the existing Repertory to see if the symptom already exists. It is very important to invest time in this procedure, otherwise many too similar rubrics are created. You should also be aware that the Repertory is a summary of the homeopathic information and so is its language. I refer you to the section on the language of the Repertory where you can find "Preferred words, expressions and spelling".

If a rubric exists which comes close to the meaning of the symptom to be added, we should not create a new symptom.

1. ADDITION OF A REMEDY

If the rubric exists, only the remedy must be added to it. The only problem is the degree.

These are the rules we used:

- the remedy is not yet present in the rubric:
 - addition from a living author: add in first degree
 - addition from literature:
 - classical author⁷ or author respected by you: add in degree as he proposes
 - lesser known author: add in first degree
- the remedy is already present in the rubric:
 - if there is difference of opinion about the degree, preference should be given to the proposal of the "classical or respected author".If classical authors contradict between them, either the majority is followed, or the highest degree is taken.

The way we have transcribed the meaning of two, three, four or even five different degrees in the Materia Medica to the four degrees as used in the Repertory is described in the Appendix (Degrees in the Repertory for additions from the Materia Medica).

Synthesis uses four degrees according to Dr. Pierre Schmidt, and has a few more remedies in the fourth degree if they met the criteria set for this degree.

2. ADDITION OF A SYMPTOM

The symptom to be added should first be transcribed into Repertorial language as explained in "Editing the symptoms". The following proposed rules for adding new symptoms are in part inspired by the rules Dean Crothers (Seattle, USA) and his collaborators have used⁸.

- a new rubric is not added unless it expresses something characteristic of the remedy
- The most important rule is this: the **addition is made to the most specific rubric**, not to the more general rubric(s).
Say the symptom to be added is: "eye - pain - stitching - coughing, on". The more different modalities exist together, the more this symptom is specific. And we should maintain the specificity of this information. This symptom does not allow us to add the same remedy to the rubrics "eye - pain - stitching" neither to "eye - pain - coughing, on".

⁷ As "classical authors" are considered: A (Allen Timothy); AL (Allen Henry); ALJ (Allen James Henry); B (Boenninghausen); BG (Boger); BR (Boericke William); BRO (Boericke Oscar); C (Clarke); H (Hahnemann); HR (Hering); J (Jahr); K (Kent); KR (Knerr) and NH (Nash). This choice might be different for you, it serves only as an indication.

⁸ Dean Crothers: "A Semi-Automated Method for Making Additions to Kent's Repertory" in "Proceedings of the 42nd Congress of the LIGA" (1987)

Boenninghausen did add the remedies to the more general rubrics on this basis and this is one of the main differences with Kent's approach. As homeopathy is individualizing, we should not exchange the more individualized information for general, more vague symptoms without reason.

If it appears clearly from the proving or from the case that specificity is important, we should not hesitate to create a new rubric, even if a similar symptom or part of the symptom is already reported. In our example: the coughing causes real stitching, not just any type of pain, so we add to "pain - stitching- coughing".

- a remedy can be added to a more general rubric

1: if several more specific subrubrics, common to the same more general superrubric, indicate this.

In the previous example: there is stitching pain in the eye also from sneezing, while stooping, on motion, etc.: we can add the remedy to "eye - pain - stitching" even if this last symptom was not mentioned as such by any prover.

Another example: a case reports fear of thunder. No matter how strong this fear of thunder may be, no matter how many cases with the same remedy report fear of thunder: the remedy cannot be added to the main rubric "fear". Only when various fears are also reported, can the remedy be added as well to "fear", even if no one said: "I am afraid".

2: if the symptom expresses the superrubric and there is no clear modality
E.g.: add remedy to fear, if there are no modalities of the fear known.

- if a modality itself is modified, then the modality closest to the core of the symptom will be preferred, except when there is an indication that both modifications are important.

E.g.: if the symptom is "drawing stitching pain", we say that "drawing" modifies "stitching", and we add the remedy to "stitching". If the symptom is "drawing, stitching pain" or even stronger "drawing and stitching pain", we have to add the remedy to both rubrics (to "pain - drawing" and to "pain - stitching").

- a number of modalities are taken into consideration only if they are really essential. "Backache in the morning" is relevant only if there is little or no backache at other times, in the afternoon, etc.; when the backache returns, it is again in the morning. If it is occurring at different times of the day, the "time modality" is less relevant because the backache has to occur anyway at a certain time of the day. The question is: "Is it noteworthy that the backache appears in the morning?"

The same caution should be taken with modalities of "sides", "localizations", and maybe some other modalities. When adding symptoms, the question we should put to ourselves most often is: "**Is it noteworthy that ...?**"

- a longer symptom should be split into meaningful bits.

When Hering mentions that bromium has "a cough which is aggravated from exercise and on entering a warm room", we should not try and squeeze this information into one rubric (which is what Kent did: "cough - loose - exercise and warm room agg."). In the perspective of more additions, we should build a consistent structure and, therefore, add bromium to "cough - loose - exercise" and to "cough - loose - warm room - going to a warm room".

Only if there is a connection between the two modalities, should they remain together, one modality being a subrubric of the other.