# A STANDARDIZED CASE RECORD FORM

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Every homoeopathic physician claims that he cures. Does he? A scientific mind is curious to know. It seeks to examine evidence. Does it exist? Perhaps. Is it adequate for the purpose of scientific examination? Who is to judge and by what standard? Every physician is a standard by himself. He has acted on the basis of his appreciation of a phenomenon and the actions have produced result. The patient has been relieved of the complaints for which he had applied to the physician. What other evidence is needed to justify that the action has been right?

A rational mind is not happy at the above argument. It demands reason behind every action. It desires to know the basis on which the action is designed. It also seeks to know the method and technique involved so that, it becomes possible to repeat those actions and find out whether it results in similar experiences. It sets a standard independent of the experimenter and verifies the results whether they conform to that standard. It accepts only those actions that are confirmed by that standard.

What makes the repetition of action possible? It is the knowledge of the methodology. Every action is designed to achieve a specific purpose. The standard determines the direction of the action and returns a judgment whether it served to achieve the set purpose. The methodology permits a certain amount of flexibility within the parameters set by the standard as long as it achieves the pre-determined purpose. The methodology gets refined through usage over and over again. This process in respect of the methodology by which consistent results are made possible is standadization.

Why do we standardize? A methodology, like a language, when standardized becomes an effective medium for exchanging experiences meaningfully. Unless experiences are shared knowledge does not grow. Science believes in the concept of collective wisdom. Scientific research is an expression of this concept. Standardization thus becomes an integral part of all meaningful scientific aetivity.

Science demands standardization at every stage of the scientific activity beginning from the methods and teehniques of observation to the recording of data. its subsequent analysis, synthesis, interpretation and the interrelationship it has to the ultimate concept.

Homoeopathy is both a science and an art. The science provides the art two standards, a therapeutic standard in *similia similibus curantur* which determines the choice of remedy and a standard of cure, which determines the direction of the curative process. The art conforms with the standards through its expression. Any activity that fails to estahlish this two way relationship

falls outside the scope of scientific Homoeopathy and consequently of scientific research.

Once these basic concepts are conceded, they provide an impartial observer a vantage point for surveying the national scene in respect of the so-called scientific research in the field of Homoeopathy.

The story of homoeopathic research in India takes us back to 1956, when soon after the constitution of the Homoeopathic Advisory Committee, a number of sub-committees were formed to advise on the various aspects of development of Homoeopathy including one on homoeopathic research. It goes on record that a large sum of money earmarked for research was spent. On what research? Where is the evidence of that research? Is it susceptible to verification by the standards described above? What is the outcome of that activity and in what manner has it contributed to the science? These are some of the queries that come to the mind.

December 1978 saw the divorce between the Indian systems of Medicine and Homoeopathy, the two partners in the Central Council of Research. Homoeopathy was granted an independent status. Under its auspices a Scientific Advisory Committee was constituted to guide and supervise research activities in the field. Various centres were allotted different research projects, record their observations and send them for scrutiny by the Scientific Advisory Committee. But alas! the recording and reporting was so deviant and sub-standard that it failed to convey any meaning. The methods followed by the different centres was so much variant that the experiences of one centre could not be communicated to the other. Learning from this experience, it was decided to adopt a standardized method of recording the observations by each centre and the urgent need for designing a Standardized Case Record Form found favour with the members of the Committee.

A search began for a standardized case record form. The Institute of Clinical Research, Bombay which has already a form designed for the purpose and which it has been using for quite some years successfully, came forward with a suggestion that the form it is using may be given a trial. The proposal found acceptance amongst the members of Scientific Advisory Committee and it was decided to hold a workshop in Bombay in the month of May 1979 to examine the feasibility of adopting the ICR Standardized Case Record Form for recording and reporting the observations by the different research centres carrying the research activity. Standardized Case Record Form, case material and a write-up on the manner of filling the form were circulated to all centres for study in advance by the Project Officers and the staff attached to them. The workshop was poorly attended and none of the centres had worked on the material supplied to them. Taking into account the peculiar requirements of each centre a revised version of the original case record form was designed by the I.C.R. to the Scientific Advisory Committee. In a meeting of the Committee held in September the case record form came in for sharp criticism by the Project Officers who held the view that the

form was not suitable for the research purposes.

The foregoing facts raise a number of issues of vital importance.

(1) What is the basis for deciding whether a case record form is suitable for the purpose of recording a case in Homoeopathy?

(2) Why were the Project Officers conspicuously absent from the workshop where an important issue was being discussed?

(3) Why did not the Project Officers instruct the staff at the centres to work out the material supplied in advance to examine whether the case record form was suitable for their purpose?

(4) In the absence of experimentation how was the conclusion arrived at that the form was not suitable?

(5) Whether pre-judgment was responsible for discarding the available material for the purpose? What place has pre-judgment in the field of research? What place has it in Homoeopathy?

Unless evidence is led by the Project Officers in respect of the above queries in a satisfactory manner it will reflect adversely on their integrity and shake the faith of the profession in them as responsible members of a committee sitting in judgment over the destiny of Homoeopathy in our country. I invite the honourable members of the Scientific Advisory Committee to write their views about standardized approach to research in Homoeopathy: Importance of the standardized case record, and send it for publication in THE HAHNEMANNIAN GLEANINGS, and I, as the Editor of the journal, shall extend all co-operation of publishing them. I plead on behalf of the profession to let it know what the honourable members have in their mind about the subject. The offer is also open to other scientists in the field to write on the need for standardization of methodology in Homoeopathy or, if they have views contrary to it, stating in a clear manner the reasons for their holding the opposite view.

I have the permission of Dr. J. N. Kanjilal to publish his letter on the subject, which he has addressed to the Chairman of the Scientific Advisory Committee of the Central Council of Research in Homoeopathy which is reproduced here. Dr. Kanjilal, incidentally is a member of the above committee and was dismayed at the manner in which the issues were decided by it as is evident from his letter.

306/HMAI/A/79 1st October, 1979

Dr. Jugal Kishore,
Chairman,
Scientific Advisory Committee, C.C.R.H.
Ministry of Health & F.W., Govt. of India.

Dear Sir,

As per the request to me in the last meeting of the S.A.C. held on 19.9.1979 I am sending herewith my review of the Case Taking Form prepared

by the ICR which has been adversely commented upon by some Project Officers.

I think, the case record form which superficially appears to be too big and cumbersome, will be much cleared up, if I present a simple outline of the contents, all of which will be fonnd to be logically related. This is being sent herewith. This should be read in the context of the scheme of symptomatology given on p. 130 of *Principles and Practice of Homoeopathy*, vol. I by Dr. M. L. Dhawale and also plate 19, Atlas, Symposium I.

At the outset we must be very clear about the basic philosophy of this case record form as differing from the usual ones we generally use, with their natural diversities according to our personal attitudes and aptitudes. And we must also admit that none of these diverse case record forms can be accepted as a uniform standard one, necessary for organised and well-conducted research work in the clinical field, which necessitates some standard statistical pro forma.

The principles followed by our usual case record forms are as follows:

(1) We record only the phenomena, facts and data with their environmental modalities as far as we can positively obtain in the case from narration of the patient and his/her attendants, our observations and other investigation reports.

(2) We never try to establish and record any logical (causative, associated, circumstantial) relation amongst the data obtained. We leave this matter to our personal discretion without any written commitment. Naturally in such a situation our conclusions and line of treatment are bound to be different with unassessable results and which later can never be ascertainably related with the basic data.

(3) As our data are not sequentially and concomitantly related, we cannot dependably make a definite plan of treatment with respect to the following very important aspects

(i) Ascertaining the basic line of disorder with their corresponding constitutional remedy.

(ii) Pre-envisaging possible episodal disorders that may occur any time in particular circumstances and keeping prepared for their management and if required treatment with complementary acute remedies.

(iii) Assaying the miasmatic undercurrent of the case and keep prepared for the use of the anti-miasmatic remedy at the opportune moment.

(iv) Foresee the expected result of treatment (in the line of Hering's laws) correctly assess the real progress or otherwise of the case at every point.

The I.C.R. form has only tried to cover up these lacunae, stressing the logical relations amongst the inferences from the available data from the beginning to the end of the form. By filling up this form intelligently and carefully the practitioner can set up a definite plan for the present and future

management and treatment of the case, and scientifically follow up the case with the meticulous attention towards all the morbid conditions of the case from the surface to the deepest planes, as per Hering's laws.

The only risk in this method is that if there enters any error in the logical correlations or inferences, the whole plan may be misdirected at great damage to the interest of cure. So meticulous attention to the course of events occurring in the patient and timely correction of the plan are many times more necessary in this method than the classical method that we follow, where we follow the course of events as they occur with an open mind, without any preconceived plan, and take our steps as dictated by the existing dynamic condition.

This form of I.C.R. superficially appears to be a too big and cumbersome one (like a big card repertory). But as one gets familiar with its contents and principles, the time required for case-taking, and particularly the follow up of the case become many many times shorter. But I like to remind again that this economy of time must be sufficiently over-compensated by faculties of observation and logical correlations and inferences. So I am afraid this case-recording form may not be suitable for a mediocre, who will naturally have to forego the advantage of scientifically foreseeing the course of events that are likely to occur in the case under treatment.

This review of mine is based only on careful study and practical application only on a few cases. For getting a more dependable and objective review you are advised to contact some persons who are more adept in the principles of the ICR and habituated in the use of this form. For this purpose I suggest the following names:

(1) Dr. K. N. Kasad, A. H. Wadia Baug, 310, Parel Tauk Road, Bombay 400 033, (2) Dr. S. Karnad, Gurukripa, 573/4, Parulkar Layout, Nagpur 440 015, (3) Dr. K. P. Muzumdar, Director, N.I.H.

After you obtain a written review from them you should circulate them to all the Project Officers of Clinical Research Units. And then call an extended meeting of the S.A.C. with a view to finalise a suitable standard case recording form for clinical research.

Thanking you,

Yours sincerely,
J. N. Kanjilal

Dr. Kanjilal is a scientist first-to last. He is not a man to compromise where scientific principles are wilfully trampled on. In fact, in his above letter, he calls upon the other members of the sub-committee to logically investigate the evidence in respect of the Standardized Case Record Form brought out by the ICR, Bombay before discarding it as unsuitable for the purpose of research. He reminds them that:

(1) there is a philosophy on which the ICR-Standardized Case Record Form is designed,

(2) the philosophy needs to be perceived and compared with the objective set by the scientific practice of Homoeopathy for recording a case,

(3) it should be next put into practice, which demands a knowledge of the methods and techniques involved in recording a case,

(4) from the record, by a process of logical analysis and synthesis, one needs to evaluate the results and return a judgment whether it serves the purpose for which it is designed.

(5) and finally, if it does, then there should be no objection for accepting it merely because, it involves extra effort on the part of researchers to acquire the requisite competence to use it. The effort cannot be escaped even with another case record designed in its place. Dr. Kanjilal has no objection and, for that matter, no sensible person would ever object to any design of a case record as an alternative to the one proposed by the ICR provided, its utility is not determined only by the ease with which it can be handled, but also by the standard set by the philosophy to reach the purpose equally or in a better manner. Indirectly, he hints at his colleagues in the sub-committee the dangers of prejudgment, the consequences of which they already know as Hahnemannian homoeopaths since, it has been brought out by Hahnemann vividly in the sixth aphorism of the *Organon of Medicine*.

A further fact about the case record by ICR, of which Dr. Kanjilal is aware of, but he is doubtful whether his colleagues have given thought to, is the prefix, 'standardized' added to it. He knows that the ICR Case Record has been in use for many years by several physicians and acting on their suggestions has been revised thrice before it has taken the present shape. That the physicians who have been using it have succeeded in achieving the results for which it has been designed, and of which there is ample evidence available for scientific investigation if one undertakes to carry out, is a further testimony of the reasonable accuracy it permits for achieving the purpose for which it is designed. Though there are many, of whom Dr. Kanjilal is in the knowledge that they are using the ICR Case Record in their practice, he has chosen out of them a handful, whose names he has mentioned in his letter and to whom he has desired that the matter be referred about its utility so that, all can be profited from their experiences as well. Since the list includes the name of the author, he is morally bound to express his opinion about the Case Record which follows.

What is the object set by a homoeopathic physician when he records a case? He studies a diseased man in his totality. For, it is only through the study of the totality of expressions of a diseased individual that he is able to establish the similarity between him and the drug.

A study of man in his totality implies that he is studied from all the different perspectives, especially those attributes of his mind and body that single him out as an individual quite distinct from another. These attributes belong to his traits which he has inherited from his parents as well as those which he has acquired through his interactions with Nature. These evolve

over a length of time and are manifested outwardly by the expressions in his structure, form and functions of the mind and body. They characterise the manner in which he has resolved his experiences of the environment that occur to him at every moment of his life. Those experiences and resolutions follow sequentially along the line of cause and effect, where time is the variable factor. They also occur concomitantly at one and the same moment of time, where time is frozen. Man's capacities and capabilities of resolution change with time. For instance, a similar experience may be resolved by him in his childhood in one manner and in adulthood in a totally different manner. These resolutions effected in different phases of life have resulted in different consequences of which, he is the resultant expression at a given moment of time. The environment of man with which he constantly interacts and it results in experiences belongs to either his own worlds of ideas and imagery, or to the situations in which he is placed namely, his family, work and society. Unless he is judged by his behaviour and actions in the above situations he cannot be understood fully with relation to those traits which belong to his mind. The mind-body relationship in the production of diseases is currently getting greater and greater recognition under a fast growing concept of psychosomatic disorders. Even the modern medicine which had set a dichotomy between the disorders that belonged to psyche and soma hitherto, as independent of one another has come to recognise that they are interrelated. Unless all evidence that comes from both the spheres, of mind and body, is examined in its totality in the manner stated above, the totality of man cannot be perceived. Hahnemann's concept of totality is not in variance with this general concept as is evident from his writings in aphorisms 5 and 6 of the *Organon of Medicine* wherein he states:

"Useful to the physician.....In these investigations, the ascertainable physical constitution of the patient (especially when the disease is chronic), his moral and intellectual character, his occupation, mode of living and habits, his social and domestic relations, his age, sexual function etc., are to be taken into consideration.

and further,

"The unprejudiced observer.....takes note of nothing in every individual disease except the changes in the health of the *body and of the mind* which can be perceived externally by means of the senses..... All these perceptible signs represent the disease in its whole extent, that is, together they form the *true* and *only* conceivable *portrait* of the disease."

A totality that falls short of any of the above requirements fails to merit itself being termed a totality in the true sense. Once this standard for a totality is conceded no action that fails to conform to that standard is admissible as scientific. Similiarly, a scientific investigation demands evidence on which the totality is erectetd. Thus it becomes imperative that the

observations are recorded and the record permits a recording of observations made of all the areas referred to above.

It is in the light of what has been derived so far that the ICR Standardized Case Record Form needs to be examined for arriving at a rational conclusion in respect of it.

The ICR Case Record presents a logical sequence of the thinking process of man. The first part of it faithfully records the observations coming from all the different areas. The second part analyses those observations and makes a synthesis of it. The third part permits that synthesis to be compared with the corresponding image of the drug on the basis of the law of similars. This leads to the choice of the remedy. The last part determines the planning and programming of the treatment and its subsequent follow-up. The ultimate result and the summary of the case is then brought to the cover page for ready reference.

The Case Record brings out a beautiful integration of the concepts of symptomatology, Hahnemannian pathology (miasms), clinical pathology and the psychopathology which are the four pillars on which the totality in Homoeopathy is mounted. It also incorporates all the valid concepts that have evolved from Hahnemann down to Roberts. The part of the Case Record that deals with the recording of symptomatology incorporates the concept of a complete symptom of Boenninghausen through the division of each page into the four columns of causation/location, sensation, modalities and concomitance. This concept is not discarded in the chapter on Mind when incorporating Kentian thought, although the columns are discontinued, and follows the same pattern of recording the mental causation, sensations, modalities and concomitance. The logic of sensitivity-sensibility relationship is also adhered to to determine the intellectual state of the patient through connections made from perception to memory, formulation, to consciousness resulting in decision and finally in the performance of action. To those of us that are susceptible to the *Gita*, the same logic of the functioning of mind is illustrated in chapter II, verses 62 and 63 which say:

*Dhyāyato vishayān puṃsah sangasteshūpajāyate*
*sangāt sanjāyate kāmah kāmāt krodhobhijāyate*
*Krodhādbhavati sammoha sammohāt smritivibhramah*
*Smritibhramshādbuddhinasho buddhināshāt praṇashyati*

The above stanzas rendered in English by Swami Chidbhavananda read as under:

"Brooding on the objects of senses, man develops attachment to them; from attachment comes desire; from desire anger sprouts forth. From anger proceeds delusion; from delusion, confused memory; from confused memory the ruin of reason; due to the ruin of reason he perishes."

This psychopathological concept as it evolves further into the realms of miasmatic analysis, the Case Record demonstrates how Roberts with his concept of tubercular miasm walks in to join the company of Boenningbausen

and Kent who are marching forward hand in hand. Unless these subtle points are perceived one is likely to miss how the concept of collective wisdom that was brought out earlier in this paper, finds expression in practice when the ICR designed the Case Record.

In aphorism 5 of the *Organon of Medicine*, Hahnemann brings out the concept of cause and effect and attributes the disease expression in man to three varieties of cause—the fundamental, the maintaining and the exciting. The information leading to the discovery of these causes has its source in the family history, past history and the personal history of the patient. All these, as well as those exciting causes that belong to the factors in time and space to which he is susceptible find a place in the Case Record.

From the evolutionary aspect also, the Case Record records all events from the intra-uterine development to birth, the neo-natal problems, the developmental landmarks, such as the various milestones, to the toilet training and all problems of infancy, childhood, puberty, adolescence to full manhood. It also takes into account the problems peculiar to the fairer sex coming from the menstrual and child-bearing functions.

There are three sources from which a physician can have knowledge about his patient according to Hahnemann. They are from the patient himself, the friends and relatives of the patient and from the observations a physician makes of him. The last aspect particularly, which is neglected by most case records, that are in vogue, as not necessary for homoeopathic practice, especially at the level of carrying out detailed physical examination of the patient, is set at rest by the ICR Case Record Form. At the same time, it has exploded the misconception about the necessity of obtaining the laboratory help and x-ray diagnosis by drawing correlations between the concepts of clinical pathology and Hahnemannian pathology. The list of clinical investigations recorded throw light on how an emphasis is laid for a detailed physical examination.

A further example of the evolutionary aspect in the Case Record is found in the case analysis part where an effort is made to trace the disease from the constitution of the patient successively through the stages of prodrome, functional and structural changes keeping in tune with the Hahnemannian concept corroborated further by identical concept in modern medicine. Only the terminology is different in the latter as for instance, the functional disorders go by the term patho-physiology while the structural and functional changes together are listed under Histo-pathology of the disease.

All this time the need for a standardized case record form was presented as a problem of homoeopathic practice. But it serves more than one purpose. A well documented case serves as an useful medium for effective homoeopathic education in our institutions. It provides scope for developing each area in different directions to bring home the various concepts, both in the fields of general medicine and Homoeopathy. Besides, it also serves as the only medium through which all meaningful homoeopathic research can be carried out so that the experiences get transmitted and knowledge evolves.

It brings us to the final question whether the ICR Standardized Case

Record Form meets all these requirements. From whichever angle one chooses to view it, it stands out as an unique model of balanced integration of the concepts of evolution, causation, phases and concomitance which, in essence, is the Hahnemannian totality—the objective set for determining an ideal case record form.

No amount of theory can convince a scientific mind, as was brought out earlier, unless supported by evidence. I shall now present a case recorded by me on the ICR Standardized Case Record Form in support of the views expressed in the foregoing pages. I would call upon the members of the Scientific Advisory Committee to follow the case with the aid of the ICR-Standardized Case Record Form, a copy of which they have in their possession.

COVER I

Name: Mrs. SPM. O.P.D. Reg No: Si-12/7-79 Date: 5-7-1979
Index Letter: M

Diagnosis: Diabetes mellitus with cervical spondylosis.
Age: 62 Years Sex: F Status: Married Religion: Hindu Veg.
Spouse: Name: Mr. PM Age: 66 years Occupation: Businessman
Father: X died in pt's childhood. Mother: X died 15 years ago
Siblings: M- X died at 79 20 years ago. F- X died at 75 5 years ago
X Died 30 years back.
Children: M: 34, 32, 30 F: 36, 28, 26
Address: (Recorded) Tel. No (Recorded)
Occupation: Housewife.

COVER II

Case Summary

Not entered since the patient is still under treatment

Present History

*Page 1*

I. Chief complaints

| No. | LOCATION etc. | SENSATION & Pathology | MODALITIES A.F. aggr./amel. | ACCOMPANIMENTS Strict time relation |
|---|---|---|---|---|
| | Since 1 month | throbbing pains | *Aggr.* Lifting a wt. | Formication of parts. |
| | Rt. upper ext. extending to back & rt. scapular region. | Spasmodic<br>Drawing | Lying rt[3]. side.<br>Movement of the limb.<br>Waking from sleep[3]. | Fatigue |
| | | | *Amel.* Warm fomentations<br>Lying down[3] | |

*Page 4*

II. Associated complaints (concomitants)

| | | |
|---|---|---|
| Since 7 years | Stiffness | *Aggr.* Rising from sitting[3] |
| Rt. knee | | *Amel.* Contd. movement. Hom. treatment. |
| 7 to 8 years | Eruptions | *Aggr.* Monsoons[3] |
| back | Itching | sweats |
| Legs | Wet, discharging | *Amel.* Dry Weather[3] |
| Forearms | sticky, watery | Hom treatment. |

*Page 5*

| | | |
|---|---|---|
| Since 7 years | Diabetes Mel. | |
| Pancreas | Frequent urination | *Aggr.* Evenings |
| | Profuse sweating | 4 to 8 P.M. |
| | App-° Thirst-° | |

*Page 7*

III. Patient as a person

1. Appearance: Obese.

*Page 10*

Perspiration: Excessive. Odors: Present Stains: Colour-Yellow Fast[3].

*Page 11*

2. Digestion:

Aversions (A) & Cravings (C) C-Ice Cream[3], C-Acids, Pickles[2], C-Sweets[2], C-Salt[3], C-Butter Milk & Curds[3], C-Rice[3].

*Page 12*

Coffee- twice daily with saccharine.

Thirst:

3. Eliminations: Stool—hard if she observes fast, otherwise normal.

*Page 13*

4. Menstrual Function:

H/O Menses—duration 8 days, regular, cycle-30 days.

Flow—Black

Clots Stains-Fast

*Page 14*

Climacteric: 10 years back

*Page 16*

5. Sexual Function.

6. Pregnancy, Labour, Puerperium.

*Page 17*

Abortions Natural—one of 3 months.

*Page 18*

Delivery: F.T.N.D.—6.

*Page 19*

Birth weight: Each child 5 to 6 lbs.

*Page 21*

Developmental Landmarks & Problems:

*Page 23*

B. The Mental State

(Not recorded)

*Page 36*

Sleep: Excessive. H/O amel. siesta.

*Page 37*

Dreams: Robbers.

*Page 38*

Life Situation

An orthodox mother (lived with her) liked to be attended all the time by daughter.

A joint family—6 children, husband's brother and sister's children, father-in-law, mother-in-law.

Orthodoxy prevented help (coming) from servants.

Slogged singly to provide for all.

Resigned when angry. But seldom she was annoyed.

*Page 41* C. Reactions- Physical Factors

1. Time: .....

*Page 42*

2. Position & Motion:

Lying on right side aggr. pain shoulder.

*Page 43* Swing aggr.

3. Meteorological: Temperature-Hot aggr. Sun aggr. — Sweats. Winter-amel.

*Page 44* Change: Weather- aggr. = slight/cold for a day.

Wind—Breeze: amel. Fan: amel. Air, open: amel.

Uncovering amel.

Clothes: Light, in all seasons.

*Page 45*

Bath: Tepid.

$C^2H^3$

*Page 48*

Perspiration: D—aggr.

*Page 58* Past History

*Page 59* Diabetes mellitus: Patient, Brothers 1 & 2, Sisters 1, 2 & 3.

*Page 60* Ischaemic Heart Disease: Father, Paternal Uncle, Brother.

*Page 61* Typhoid: Patient—when 15 years old.

*Page 62* Physical Examination

B.P.—140/78 mm. Hg.

anaemia—2 plus Nails-*

skin: Hairy growth on chin and lips—2 plus.

*Page 64* Investigations

*Page 65* P.P.B.S.—200 mgms % on 19.6.79.

X-ray—Cervical Spine: Marginal Sclerosis with Osteophytes. Restricted mobility in mid-cervical spine in flexion and extension.

Opinion—Cervical spondylosis

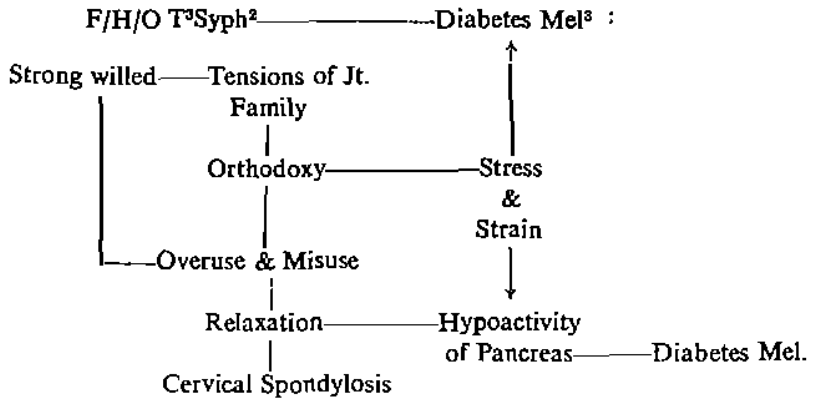
*Page 68* to *Page 75* Miasmatic Expression

| | PSORA | SYCOSIS | TUBERCLE | SYPHILIS |
|---|---|---|---|---|
| Pre-dispositions | | Eczema P | Diabetes mel[3] F | I.H.D. F |
| Type | Will ↑ 3 I<br>Possessive<br>Accommodative<br>E<br>Obese<br>Dark skin<br>P | Hairy growth on chin and upper lip P | | |
| Prodrome | Stress & strain of a large jt. family<br>Strong willed<br>Activity-3 plus. | | Strong diabetic history in family. | |
| Functional Phase | Excessively fond of rice and sweets<br>Also, salt.<br>Desires cold drinks and food.<br>Obesity.<br>Unmindful of own health. | | | |

| | | | | |
|---|---|---|---|---|
| | 6 p.g.s.- | | | 1 abortion. |
| Structural phase | | Rheumatic joints. Allergic dermatitis. | Diabetes mel. Cervical spondylosis. | |
| Cause | Physical strain-overuse & misuse of structure. | | T[3] | Syph[2] |
| Aggr. | Sweating hot weather. Swing. Sun. Change of weather. | Rising from seated posture. Monsoons. | Lying on painful side. Hanging the limb. Waking from sleep. Evening 4 P.M. to 8 P.M. | |
| Amel. | Drafts. | Continued movement. | Lying down. | |
| Sensations & Complaints in general: Pathological generals, Sleep and Dreams. | Metabolic disturbance | Rheumatic jts. Allergy. | Glandular activity Prolapse disc. Relaxation.[3] | |
| | Cravings: Ice-cream Salt[3] Sweets[2] Pickles[2] Dreams of Robbers. | | | |
| Mental State | Strong willed. Accommodative. | | | |
| Characteristic particulars. | H/O Menses black[3] clotted. Stains difficult to wash. Sweats: Stain[3] yellow fast offensive | | | |

## EVOLUTIONARY TOTALITY: FLOW CHART

*Page 76*




*Cervical Spondylosis*
Throbbing, drawing pains.
Rt. upper extremity.
Aggr. lying rt. side.
Waking in the morning.
Hanging the limb.
Amel. lying down.

*Diabetes Mel*
Frequent urination.
Aggr. Evenings
4 to 8 P.M.

Aggr. Swinging
Damp Weather
$C^2H^3$
Sweats stain yellow
H/O Black, clotted menses, stain fast.
Craving: Sweets.
Salt.
Pickles.
Ice-Cream.
Hairy growth.

*Page 77*

Swinging motion aggr.
Damp weather aggr.
Warmth in genl. aggr.
Sweats stain yellow.

*Chronic :*

Magnesium mur. — Menses black, stain fast.
Desires sweets, salt, ice-cream.

D/D Magnesium sulph. — Hairy growth on chin, upper lips.

*Intercurrent :*
Medorrhinum — Relaxation.
Diabetes mellitus.

*Pages 79 to 80* — Repertorial totality & Repertorial representation (not used since the case was studied through non-repertorial approach.)

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*Constitutional*— Magnesium mur. 30, 4 hourly S.O.S.
*Acute*— None. No acute complaints.
*Intercurrent*— Medorrhinum 1000, 1 dose HS.

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5.7.79—Mag. mur. 30, 4 hourly S.O.S.

| *Diet* | *Other Measures* |
|---|---|
| Diabetic diet: | (i) Physiotherapy |
| High protein | (ii) Is on DBI 50 mgm 1 BD to continue until hom. drug action established. |
| Low carbohydrate | |
| Low-fat | |
| Curd—half litre | (iii) Becozym c̄ vitamin C, 1 tab. daily. |
| Skimmed milk—half litre. | |

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| *Date* | *Symptom Changes* | *Comments* | *Prescription* |
|---|---|---|---|
| 7.7.79 | Better until yesterday, relapse today. | | Mag. mur. 200, 4 p. 1 *HS* daily S.O.S. |
| 11.7.79 | Better, could sleep, bowels not clear, appetite diminished. | | Medorrhinum 1000, 1 p. HS. |
| 16.7.79 | Pains better, stiffness knees less. | | Placebos. |
| 20.7.79 | Pains status quo. | | Mag. mur. 200, 4 p, 1 HS. daily. |
| 24.7.79 | Pains better. | | Placebos. |
| 28.7.79 | Pains further better, dry itching on forearms. | | Placebos. |
| 1.8.79 | Pains present although less severe. | | Mag. mur. 1000, 1 p, HS. |
| 6.8.79 | Pains amel. itching c̄ discharge. | | Placebos. |
| 13.8.79 | Pains better, itching continues. | | Placebos. |
| 21.8.79 | Pains aggr. physical exertion. | | Mag. mur. 1000, 1 p, HS. |
| 28.8.79 | Pains, eruptions both better. | | Placebos. |
| 5.9.79 | Pains better 60%, eruptions aggr. | | Mag. mur. 1000, 1 p, HS. |
| 12.9.79 | Pains less, itching continues. | | Placebos. |
| 19.9.79 | as above | | Placebos. |
| 26.9.79 | Pains continue, itching present. | | Adv. post meal blood sugar. Mag. mur. 1000, 1 p, HS. |
| 3.10.79 | Post meal B.S.: 300 mgms % Parallel urine sugar: 1 to 2% | | Mag. mur. 1000, 4 p, 1 HS. daily. |

| | | |
|---|---|---|
| 10.10.79 | Pains joints continue, itching present. | Medorrhinum 10M, 1 p HS. |
| 17.10.79 | Pains better, itching better. | Placebos. |
| 31.10.79 | No complaints. | Placebos. |
| 7.11.79 | No Pains, no skin compl. | Placebos. |
| 14.11.79 | as above | Medorrhinum 10M, 1 p HS. |
| 22.11.79 | Pains knees aggr. rising from seat. | Mag. mur. 1000, 1 p, HS. |
| 28.11.79 | Pains better slightly. | Mag. mur. 1000, 1 p, HS. |
| 29.11.79 | Fever, dullness[3], constipation, no chill. | Bryonia 200, 1 p ÷ 8, 4 hourly.<br>Adv. post meal B. S. after recovery. |
| 5.12.70 | Post meal Blood sugar: 172 mgms %<br>acute compl. amel.<br>Pains knees present. | Mag. mur. 1000, 1 p, HS.<br>Cut down DBI to OD |
| 12.12.79 | Extracted a tooth and took antibiotics.<br>Pain in rt. shoulder. | Medorrhinum 10M, 1 p HS. |

(The case continues to be under treatment)

One objection to the use of ICR Case Record Form appears to be its size. The objection is valid if the case record were to be used like a questionnaire, which it is not. It doesn't need a knowledgeable physician to fill a questionnaire. A skilled clerk can as well do that job. A case is said to be recorded when all the salient points for making a totality are perceived. It is not that the recorder runs from cover to cover filling each page in its most minute detail. One could, in fact, not predict how a case proceeds in an interview situation. It requires practice and skill on the part of the physician to post the entries correctly and in their right place as the interview proceeds. It pre-supposes that he is in the knowledge of the different areas of the Case Record, which he can acquire first through the understanding of the philosophy and later through practice by the actual handling of the case record form. Unfortunately, this is the only aspect that cannot be demonstrated through this write-up. It can be shown only in an actual interview session to those susceptible to learn it, and the author is ready and willing to arrange such demonstration for the willing members of the sub-committee/Project Officers of the Central Council of Research.

One objection in respect of the case presented above could be that no mental symptoms are recorded. A physician's purpose and so, his responsibility is to the cure, and once he has in possession sufficient evidence that will permit him to perceive and erect a totality, and once he is able to plan

and programme the treatment on the basis of the material in his possession, it is needless for him to exercise the freedom given to him by the situation to wander about the personal life of his patient. A close scrutiny of it becomes essential to him only where he suspects that the mind of the patient has an overhearing influence on the disease he is suffering from or when the record of physical symptoms alone cannot determine the final choice of the remedy unless the mental traits are known. All these aspects he has to judge before the patient disappears from the scene during the interview session.

The last word about the case above is still not said. A material of the above order can be utilized in a classroom to bring out the concepts in respect of the following areas to the student:

1. Psycho-pathology:
   (a) Masochism
   (b) Repression
2. General medicine:
   (a) Obesity
   (b) Diabetes mellitus
   (c) Cervical spondylosis
   (d) Psycho-somatic disorders
3. Hahnemannian pathology:
   (a) Evolution of miasms
   (b) Tubercular miasm
4. Homoeopathic therapeutics:
   (a) Choice of the remedies: chronic, intercurrent
   (b) Homoeopathic posology
   (c) Ancillary treatment

Homoeopathic Materia Mediea:

(a) Study of drugs: Medorrhinum, Magnesium muriaticum

Homoeopathic philosophy:

(a) Concept of totality
(b) Susceptibility
(c) Hering's law of cure.

It shows how much of potentiality each well documented case has of educational value.

Finally, cases such as the above, where reason can be given for every action that is taken, can be compared and evaluated in terms of the limits and limitations of homoeopathic therapeutics in the treatment of diabetes mellitus, or such other diseases that have been distributed to the various research centres for controlled research. The physical facilities that get attached to those centres should be able to exploit them fully to bring out those aspects of the disease and its curability with greater clarity than what an out-patient clinic where the above case was treated can, with its own limitations.

*Aude Sapere.*