The patients are attended to without any intervals to get through everyone waiting to be seen.

Randomised Controlled Trials: Homeopathy in the UK and India

Guest Post by Dr. Kushal Banerjee M.D.

Homeopaths often express their reservations about using randomised controlled trials (RCT) for testing the therapeutic effect of homeopathic medicines. Good RCT’s are difficult to design and implement. Yet, trialists labour over them because they are the most rigorous way of determining whether a cause-effect relation exists between an intervention and an outcome[1].
The homeopath’s objection is mainly about the homeopathic process of individualising every prescription. Individualisation, in classical homeopathy [2] means that any homeopathic medicine (usually a single drug) may be selected for any patient of any illness. In other words, the diagnosis or clinical condition of the patient may not alone dictate the prescription. This approach is considered holistic. During an RCT of classical homeopathy, all the participants may get different homeopathic medicines, although they suffer from the same disease. On each follow up, these participants may be given the medicine initially prescribed or a different one depending upon the ‘clinical picture’ as perceived by the homeopath. These are in effect, n of 1 trials for each medicine used in the trial [3]; or severely underpowered arms, incapable of detecting a statistically significant clinical effect.

There are obvious flaws in this design and the complaints of homeopaths are justified. The outcry of objective reviewers and experience observers is conspicuous by its absence. The constant use of evidence generated by such trials for or against homeopathy remains the most astonishing aspect of controversies like the one currently raging in the UK. The vast majority of systematic reviews on homeopathy use data generated from such ‘classical’ homeopathic individualised trials.

Try and picture a trial using conventional medicines with one single condition, no predefined intervention and no restrictions on what medicine may be given, on its repetition or alteration. Should the results of such a trial ever be part of any evidence base?
400 patients per day x 365 for one clinic. Could this be grounds for a good RCT?

This brings us to the other part of the problem. While homeopaths do not encourage RCT’s they are not able to come up with a convincing substitute. If ‘homeopathy’ works, the results of RCT’s should consistently show a therapeutic effect, since individualisation is allegedly the only process of arriving at a homeopathic prescription. If it doesn’t, it can mean either that the process of individualisation is flawed and cannot reliably result in the correct prescription; or homeopathy does not work. In both cases, if homeopathy cannot reliably produce results for a given condition, it shouldn’t be part of a nation’s health services. It is a bit excessive to ask a strained healthcare budget to keep providing a service that has no reliable evidence base, has no means of generating a reliable evidence base and currently has no consistency in its outcomes for any condition.

The process of individualisation insisted upon by homeopaths in the UK and other parts of the world, is not followed by the vast majority of homeopaths.

How is it that a thousand or so medicines known today can never be matched to any disease entity? Symptomatology discovered and listed two centuries ago cannot be evolved to contain clinical conditions known to us today? These medicines can holistically cover every illness of every individual for the rest of time; yet, not a single drug may be used to treat
an illness in an individual?

In India, the country with the highest number of homeopaths and users, busy clinics treat several hundred patients in a day. The practice where I work, for example, has four prescribing doctors and serves an average of four hundred prescriptions a day. There is simply no time for individualisation. In the absence of a good evidence base, homeopaths use observational data to develop treatment regiments to prescribe. There practices are usually extremely successful and devoid of individualisation.

Individualisation has also resulted in homeopathy being considered a complex intervention where the process of case taking itself is thought to be a part of, if not the entire, therapeutic effect [4].

For the hundreds of thousands of Indian homeopaths, using the diagnosis for the prescription is the norm. Patients get an average of five to seven minutes with a homeopath, which is comparable to their interaction with conventional doctors. The placebo effect [5] is non-existent or insignificant. Unfortunately, since these prescriptions are considered ‘unhomeopathic’ and a deviation from ‘the principles of homeopathy’, homeopaths hesitate to publish their data or even acknowledge this practice. Yet, orthopaedic surgeons in India
for example, scribble chits with ‘Symphytum 200ch’ for patients to help with the secondary union of fractures. Dermatologists refer patients to homeopaths for psoriasis, eczema and leucoderma. Nephrologists recommend Berberis Vulgaris for renal calculi. This is homeopathy. It isn’t ‘Indian Homeopathy’: it’s using information that is obvious in your practice to improve efficiency and get through the crowds waiting to see you.

These are the same homeopathic medicines, whose specific utilities have been discovered and have been embraced by conventional doctors. This is the kind of evidence that needs to be created: a deliverable, simple system of medicine where a clinical condition can point to at least a group of medicines.

Unlike the trials of clinical and complex homeopathy [6, 7] where medicines are selected based on symptoms in the archives of the homeopathic ‘materia medica’, the selection of these medicines for trials will carry the additional weight of having been on the prescriptions of thousands of patients for the condition under study.

Homeopaths and policy makers should consider looking beyond the borders of the UK to experience how deeply embedded into health care homeopathy is and the simplicity of its incorporation.

Perpetually contemplating on suitable trial designs, rejecting the established gold standard in medical research while refusing to provide a solution and refusing to accept the validity of serum analyses showing no effect, will leave policy makers of one nation after another with no choice but to remove homeopathy from its health services, as is happening in the UK.

Dr. Kushal Banerjee M.D. – Hom.Consultant Homeopath, Dr. Kalyan Banerjee’s Clinic M. Sc. Student, Evidence Based Health
Dr. Bannerjee’s commentary can be seen in the BMJ, Dr. Amanda Burls has weighed in Homeopathy – The Truth about whether it works as has Dr Amy Price, BMJ and here Homeopathy-Does Evidence Really Matter?

GIVE RESEARCH A CHANCE! If you are interested in funding, collaborating or discussing a methodologically correct RCT with Dr. Bannerjee please respond in the comments section and we will forward your interest on to him.

REFERENCES


7. Shang, A., et al., Are the clinical effects of homoeopathy placebo effects? Comparative study of placebo-controlled trials of homoeopathy and allopathy. The Lancet,