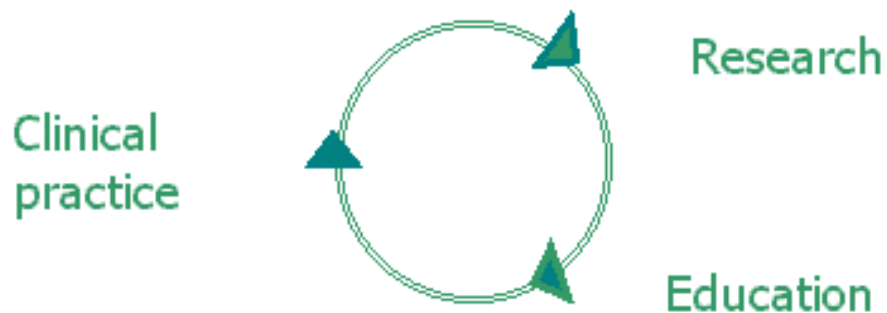


The Development of The GHHOS, The IDCCIM Action Research, & The PC-HICOM Project.

**Developing A Scale Relating Outcome To Impact On Daily Living,
Modelled On Daily Clinical Care And Piloted In An Action Research
Cycle In NHS General Practice.**

Interim Report February 2003



By:

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Introductory comments

This report presents the background development of the GHHOS scale (Glasgow Homoeopathic Hospital Outcome Scale – pronounced ‘ghos’); describes the current version and explains how to use it; and then illustrates its use with data from a primary care evaluation study.

Subsequent to this interim report, results from a further formal validation study of the GHHOS will follow, and at that time elements of this general review will be prepared for formal publication. Consideration will then be given to a formal launching of the scale, perhaps with a new name.

The ideas and data in this report grew from the challenge of measuring easily and quickly the treatment outcome of ordinary busy clinical care *in a way that reflects the patients’ experience of the usefulness of the treatment in relation to their daily lives*. The resultant measurement scale has come into wider use than originally envisaged, and so, besides presenting the results of the project, this document aims to assist those who may wish to use the scale in their clinical work or research. In other words, the report is for a general audience, including clinicians, health researchers, managers, commentators, and everybody who is interested in integrated medicine and/or outcome measures.

In recent years, several outcome scales have been developed and these tend to focus on different characteristics of health and/or care. It is important to keep in mind that any measurement scale can only give a simplified version of what goes on and cannot capture and represent every aspect that influence daily clinical care. The two key characteristics of the GHHOS are that it:

1. Is modelled on how patients and doctors already assess care in daily busy practice, and therefore it can be used to quickly and flexibly reflect and communicate this process,
2. Links outcome to the deterioration or improvement of the experience of daily living.

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1.

Background to the GHHOS & the IDCCIM action research cycle.

The Search for Evidence and the Evidence Mosaic

Will this treatment help? Is it safe? These questions remain the bedrock of care for patients, carers and policy makers alike. Without the reference point of the final clinical results in patients, the argument over evidence or best practice can become detached from reality, and attached to theoretical, academic or political agendas. The search for evidence is made all the more difficult by the fact that proof is a complex of scientific, cultural and personal factors. In truth, in medicine we build 'Evidence Mosaics' for any one approach to care – its shape, content and degree of detail determined as much by who is asking the question and why, as by any abstract notion of science^{1,2}

This challenge was brought into focus with calls for evidence for so-called complementary and alternative medicine (CAM) approaches. Take homeopathy: by the late 1990's, Health Care purchasers in the UK, using the same evidence base, were coming to radically different conclusions in regard to homeopathy, some increasing and some reducing their purchasing, with both actions, said to be based on evidence. Some were satisfied by the balance of evidence in favour of homeopathy being more than a placebo produced by meta-analysis of the 180 controlled trials up to that point^{3,4,5,6}, others dismissing these results as 'no scientific evidence whatsoever'.

The study model and its background

So the project evolved from the need to come at the evidence problem from another angle apart from the academic, focussed trials we conducted^{7,8,9} and a different set of questions came into focus. What is happening in daily practice? How do you know if the accepted educational wisdom and current clinical norms are working for patients and carers. How could you measure that?

The scale that evolved could be used in controlled trial but its origins lay in day-to-day care. The first version was designed as part of the RCCM/MRC Research Fellowship exploring CAM and holism in Glasgow University 1987-90¹⁰ to help judge the value or otherwise of experimental clinics integrating orthodox and CAM approaches. From the outset, the idea was to respect and mirror the dialogue that takes place between a carer and a patient when they are considering if the approach that had been used had been helpful. Every intervention involves a patient and carer

¹ Reilly D, Taylor M (1993) The Evidence Profile. Developing Integrated Medicine. *Complementary Therapies in Medicine*. Vol. 1 Suppl. 1:11-12.

² Reilly D, Fitter M (1998) The Evidence Mosaic. In *Textbook of Complementary and Alternative Medicine*.

³ Boissel JP et. al (1996) Critical Literature Review on the Effectiveness of Homoeopathy. *Commissioners of the European Union Community Homoeopathic Research Group Report*. Chap 11: 195-210.

⁴ Cucherat M, Haugh MC, Gooch M, and JP Boissel (2000) Evidence of clinical efficacy of homeopathy: A meta-analysis of clinical trials. *European Journal of Clinical Pharmacology*. S6: 27-33.

⁵ Linde K, Clausius N, Ramirez G, Melchart D, Eitel F, Hedges LV, and WB Jonas (1997) Are the clinical effects of homeopathy placebo effects? A meta-analysis of placebo controlled trials. *The Lancet*, 350(20): 834-843.

⁶ Kleijnen J, Knipschild P, and G ter Riet (1991) Clinical trial of homeopathy. *British Medical Journal*, 302: 316-323.

⁷ Taylor MA, Reilly D, Llewellyn-Jones H, McSharry C, and TC Aitchison (2000) Randomised controlled trial of homoeopathy versus placebo in perennial allergic rhinitis with overview of four trial series. *British Medical Journal*, 321: 471-476.

⁸ Reilly TA, Taylor MA, McSharry C, and T Aitchison (1986) Is Homoeopathy a placebo response? Controlled trial of homoeopathic potency, with pollen in hayfever as model. *The Lancet*, 18: 881-886.

⁹ Reilly D, Taylor MA, Beattie NGM, Campbell JH, McSharry C, Aitchison TC, Carter R, and RD Stevenson (1994) Is evidence for homoeopathy reproducible? *The Lancet* 344:1601-1606.

¹⁰ Reilly D, Taylor M (1993) The Evidence Profile. Developing Integrated Medicine. *Complementary Therapies in Medicine*. Vol. 1 Suppl. 1:1-50.

trying an approach and then asking themselves if it worked – be it an antibiotic, operation or a herb:

Doctor: Well, was there any effect from what we did?
Patient: Yes I think it helped...
Doctor: Yes but was it a useful effect? Can you give me an example?
Patient: Yes it was really useful, I was able to get about more and go to the shops.
Doctor: Really? And is that a major change, a really marked benefit, or is it less than that?
Patient: No this is really marked, it's the best thing I have ever had for the problem, but I'm not saying it has cured it or anything, I mean I still have the problem, but I could live with it now.

While the scale can be used without this dialogue being used (using the written guidance), the essence of this exploration of whether the intervention worked is buried in the design. The next section of the report gives a more detailed description of the dialogue.

The first versions of the scale did not adequately allow for the occurrences of adverse effects of the intervention. The next versions did incorporate this possibility and these versions were developed as part of the IDCCIM (International Data Collection Centres for Integrative Medicine, pronounced ID-SIM) action research cycle, which lasted from 1995 to 1998. During this time IDCCIM was an international evidence based action research programme with the aim to assess and improve care, and as such formed a framework under which several research projects (including the project of which the results are presented in part three of this report) were conducted. IDCCIM had links with similar action research projects abroad like the ongoing IIPCOS¹¹ (International Integrative Primary Care Outcomes Study) that evaluate the effectiveness of homeopathy in primary care with study centres in Germany and the USA.

The IDCCIM research cycle in turn was based on an earlier cycle over 12 years from 1983-1995 of retrospective assessment of clinical practice stemming from ADHOM's Foundation of Homoeopathy postgraduate education course. Over this time, 20% of Scotland's GPs completed the basic training¹². That course began with a group of experts establishing by consensus the best current practice for targeted primary care applications of homoeopathy. Then a cycle of retrospective outcome tracking of prescriptions was used to see if the educational targets yielded reliable clinical results during each subsequent annual education course. In 1995, IDCCIM then began a prospective tracking of the clinical results, which in turn were used to inform and improve teaching and so subsequently the results of care.

The underlying philosophy of IDCCIM was a model which links research with learning with clinical care, in a growing cycle of enquiry, discovery, verification, and refutation. In this way, the collective experience of both patients and practitioners are fed back into the cycle.

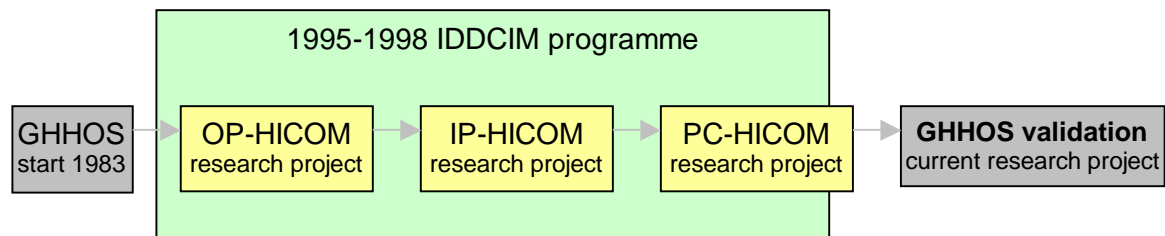


¹¹ Heger M, Riley DS, Haidvogel M, Gordon D, Herrick N, Wolschner U, and A Thurneyssen (2001) IIPCOS - An international project to investigate the effectiveness of homeopathy in primary care. *HomInt R&D NewsLetter* 2:3-19.

¹² A follow up research in 1993 has shown that these orthodox health carers were claiming that targeted use of homoeopathy was practical and effective in primary care. Reilly DT, Taylor MA. *The Postgraduate Experiment. Complementary Therapies in Medicine* 1993;1 Suppl 1: 29-31.

In practice, individual health care practitioners prospectively tracked the results of their care, we centrally analysed the data, and then the outcomes were fed back to inform better care, better education, and better research, creating an ongoing progression. The results of that study are presented in part 3 of this report.

This diagram shows the development of GHHOS through three projects conducted within the framework of IDCCIM.



The Main Objectives of IDCCIM

Tuning in with the progressive and evaluative nature of the above action research cycle, the main objectives of the project were:

General

1. To contribute to the methodologies for assessing care, and the culture of enquiry by developing a workable measure that reflects outcome linked to impact on the quality of daily experience.
2. To establish, through a simple, but reliable measure the degree of success and safety of outcome in ordinary daily clinical care and to present the obtained results in an accessible way.

Homoeopathy + Integrating Complementary and Orthodox Medicine

3. To pilot the above aims in the context of different forms of homoeopathic care.
4. To contribute to the wider aspirations of a data collection network

Projects within the IDCCIM programme

Three projects were completed within the IDCCIM framework. These projects tracked the outcome in different contexts in the UK National Health Service (NHS). Two projects, namely the IP-ICOM (In Patients – Integrating Complementary and Orthodox medicine) and the OP-HICOM (Out Patients Homoeopathy Integrating Complementary and Orthodox medicine)¹⁴ focus on the inpatients and outpatients of Glasgow Homoeopathic Hospital, which is a Centre for Integrating Complementary and Orthodox Medicine (ICOM). Further details of both studies can be obtained from the ADHOM Academic departments at the Glasgow Homoeopathic Hospital. The third study – PC-HICOM- (Primary Care Homoeopathy Integrating Complementary and Orthodox Medicine) was the largest and will be used to illustrate the project and the GHHOS in Part 3 of this report.

In Part 2 of this report, we will give the current version of the scale with instructions for its use. Please feel free to print out and use this material. However, if you decide to use the scale, we would appreciate it if: you acknowledge the source of the scale; offer a web link to the latest version on the www.adhom.org web site; let us know that you are using the scale; and consider contributing to our validation process.

Overall, the scale has been designed in a way so that it can be used in various contexts, for example:

Context	Study
Primary Care – Acute short lived illness & targeted chronic complaints	PC-HICOM
Outpatients with established, chronic problems	OP-HICOM
Inpatients with complex, usually intractable, problems which are severe enough to require a complex longer term care programme involving in patient multidisciplinary care.	IP-HICOM

Appendix 3 references some other studies that made use of the scale.

¹⁴ Lewith G and D Reilly (1998) Integrating the Complementary, *In NHS Yearbook*. Medical Information, pp 46-48.

2. The Glasgow Homoeopathic Hospital Outcome Scale

Background

The background to the development of the scale, and the projects which have developed it or used the measure are reported in Part 1 of this report.

Characteristics

The scale contributes to the wider debate and development of patient centred outcome measures (such as the MYMOP¹⁵ or EQ-5D¹⁶). Overall, the scale can bring the following strengths:

- ✓ It is simple to use and easy to communicate.
- ✓ It is based on the patient's experience (i.e. patient focussed).
- ✓ It aims to link outcome to the experience of daily living.
- ✓ It models how patients and doctors already assess care in daily busy practice, and it quickly reflects and communicates this process.
- ✓ It allows a comprehensive use in routine clinical practice without disrupting the care process.
- ✓ It allows comparison across different contexts of healthcare in the degree of useful impact achieved by the medical intervention.
- ✓ It establishes a useful shared language, for example, whatever the context if you say a patient experienced '+2' then others know that this was change was at least sufficient to impact on the quality of daily living.
- ✓ It can be used without measuring a previous baseline, capturing the participants views of any change as a snapshot in time.

Some of its weaknesses are:

- ✓ It is a broad-brush measure (and it lacks detail and precision).
- ✓ It is only as good as the participants views, and shares all the strengths and weaknesses of ordinary clinical practice.
- ✓ It focuses only on the participants views of the impact of the care – other issues like 'how?', or 'duration?', 'Why – placebo?', or objective verification – need to be addressed through other approaches.
- ✓ It is subjective, even though anchored in experience of daily living.
- ✓ It can be used without a measured baseline

The contexts in which GHHOS can be used

The scale aims to be a generic and flexible tool so that it can be employed in a wide range of contexts. This means that you have the opportunity to determine the context in which you would like to use the scale. This could be, for example, a time limited study or on-going tracking, and the focus can be on the impact of the patient's well being or on a specific symptom/condition.

The GHHOS has been used in acute prescribing (see the PC-HICOM study in Part 3), as well as in chronic cases with a longer time interval (see the Inpatient audit IP-ICOM (www.adhom.org)). It can be used alone, as in routine tracking in ordinary daily clinical work, or as part of several measurements for deeper research questions - see for example Thompson (2002), Riley et. al (2001), Mercer et al (2001)¹⁷.

¹⁵ Paterson C and N Britten (2000) In pursuit of patient-centred outcomes: A qualitative evaluation of the 'Measure Yourself Medical Outcome Profile'. *Journal of Health Services & Research Policy*, 5(1): 27-36.

¹⁶ Brooks R (1996) EurQol: The current state of play. *Health Policy*, 37: 53-72.

¹⁷ See page 25 of this report to follow up these references.

How the scale works

The scale is used to measure the participants' opinions on the *effects* of the intervention on their daily living. The scale does *not* address the natural progression of the health complaints. The scale was originally modelled on the dialogue that takes place between the health care practitioner (or responsible carer) and the patient when they evaluate whether the treatment intervention has had an impact of any value or not. It is based on the language, used in daily care by health carer and patient. It was modelled on four sequential questions (see box below), which follow this process, leading to a score that reflects the outcome of the assessment dialogue. The four questions can either be asked face-to-face during the consultation, or they can be offered as options of response in a questionnaire. The questions do not need to be asked in a robotic or fixed way, examples can be asked from the patient and if preferred, you can ask the patient to check if the claimed score is justifiable.

1. "Has the treatment caused any improvement or deterioration?"
2. "Is/was this change enough to affect your daily living?"
3. "Is the change very marked, a major effect?"
4. "Is this a complete resolution or disastrous deterioration of the problem?"

Example of the scale in use

The following comes from the questionnaire that is part of the ongoing patient-tracking project conducted at the Glasgow Homoeopathic Hospital. This example illustrates how the four questions lead to a score on the GHHOS. However, it can be presented simply as the descriptive options listed below this 'flow' diagram.

Example of 'FLOW CHART' style, using in this instance a focus on main complaint:

Please, answer the questions by ticking the boxes and then follow either the arrows to the next question or the instructions next to boxes.

Q1 Your main complaint(s)... (please tick boxes)

1a. "Has the care at the Glasgow Homoeopathic Hospital caused any change (improvement or deterioration) in your main complaint(s)?"

- | | | |
|--|--|--|
| <input type="checkbox"/> +1 My main complaint(s) has improved
↓ (please go to 1b) | <input type="checkbox"/> 0 My main complaint(s) has not changed
(please stop) | <input type="checkbox"/> -1 My main complaint(s) has become worse
↓ (please go to 1b) |
|--|--|--|

1b....."Has this change been enough to affect the quality of your daily living?"

- | | | |
|--|--|--|
| <input type="checkbox"/> +2 The quality of my daily living has improved
↓ (please go to 1c) | <input type="checkbox"/> The quality of my daily living has not changed
(please stop) | <input type="checkbox"/> -2 The quality of my daily living has become worse
↓ (please go to 1c) |
|--|--|--|

1c....."Has this change had a major effect on the quality of your daily living?"

- | | | |
|---|---|---|
| <input type="checkbox"/> +3 It was a major improvement
↓ (please go to 1d) | <input type="checkbox"/> No major effect
(please stop) | <input type="checkbox"/> -3 It was a major deterioration
↓ (please go to 1d) |
|---|---|---|

1d."Has this change resulted in a complete resolution or disastrous deterioration of the problem?"

- | | | |
|---|----------------------------------|--|
| <input type="checkbox"/> +4 A complete resolution | <input type="checkbox"/> Neither | <input type="checkbox"/> -4 A disastrous deterioration |
|---|----------------------------------|--|

The last box that is ticked that has a number inside corresponds to the final score on the GHHOS. The GHH outcome scale is defined as follows in the next example of direct 'pick a choice' style:

- +4** Cured/Daily living is back to normal
- +3** Major improvement (that has a major effect on your daily living)
- +2** Moderate improvement (that has an effect on your daily living)
- +1** Slight improvement (but it has no effect on your daily living)
- 0** No change/Unsure whether a change occurred
- 1** Slight deterioration (but it has no effect on your daily living)
- 2** Moderate deterioration (that has an effect on your daily living)
- 3** Major deterioration (that has a major effect on your daily living)
- 4** Disastrous deterioration

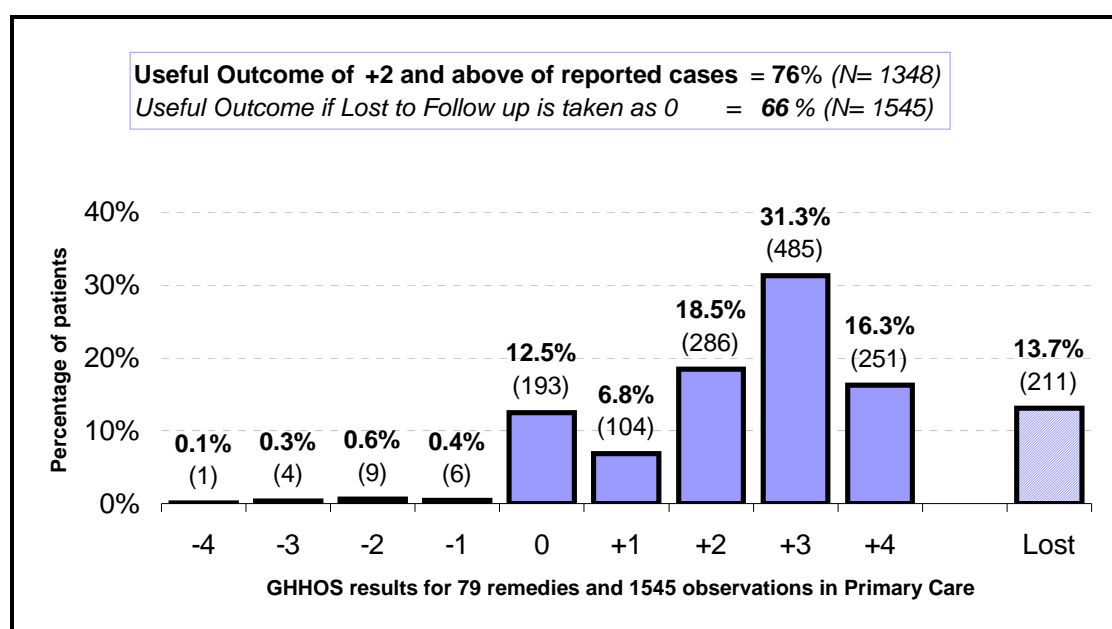
The Threshold score - A simple, direct summary of overall impact

The score of **+2** (i.e. moderate improvement, sufficient to have had an affect on your daily living) is taken as a "threshold", meaning that scores of +2 and above are suggesting that the treatment has had a useful impact on the daily experience and has produced useful success. This score can form the focus of further discussions.

In the examples of the presented results of the GHHOS, we give two percentages on the useful outcome of the study. First, we show only the reported cases and exclude the lost to follow up or missing cases, noted as 'useful outcome of +2 and above of reported cases' above the graph in the box. Second, we give a so-called worse case scenario by which the lost to follow up cases are treated as if it was a treatment failure. This percentage is noted as 'useful outcome if lost to follow up is taken as 0'.

Illustrations of presented results

The results are best presented graphically to allow an intuitive feel and/or immediate 'overall feel' of the results patterns (as the example below shows), perhaps drawing attention to the 'threshold' category of +2 or above. The measure is a general, broad-brush assessment and that is the strength and weakness of the scale. If the enquiry calls for more, then additional more focussed measures will be needed.



Beyond this simple level of descriptive depiction, the use or misuse of statistics or analyses is up to you and not the scale.

Here is another simple example, illustrating the threshold score in use and allow rough comparisons of the percentage of the successful scores between ten different remedies.

The ten most frequently used remedies and the successful outcome by GHHOS.

Remedy	Total number of people who used remedy	% of people who used remedy (N=1549)	% of people with score = +2 (incl. missing cases)	% of people with score = +2 (excl. missing cases)
Arnica	289	18.6	74.1	82.6
Rhus Tox	117	7.6	68.4	77.7
Arg. Nit.	115	7.4	63.7	79.0
Arsenicum Album	93	6.0	64.5	67.4
Pulsatilla	91	5.9	69.3	77.7
Colcynthis	86	5.6	67.5	75.3
Belladonna	76	4.9	65.8	73.5
Gelsemium	76	4.9	65.7	73.5
Aconite	66	4.2	73.8	88.8
Chamomilla	58	3.7	62.0	70.6

NB: It is important to note that validation of the scale is on-going and not yet complete. Please contribute to this if possible.

3. Outcome Study of Primary Care Homoeopathy (PC-HICOM): Piloting the GHHOS

Introduction

This section reports on a prospective tracking of 1655 observations from 1796 clinical cases, using the GHHOS outcome scale, in the context of an introductory post-graduate education course in homoeopathy.

Aims

- ✓ The first objective of this pilot work was to *explore* the effectiveness of homeopathy for simple acute illnesses in routine primary care clinics in the hands of new postgraduate students in an action research cycle.
- ✓ The second objective was to advance the development of a suitable measuring instrument using the GHHOS Scale, which aims to link outcome to the impact on daily living.

Underlying the above aims were the following questions:

Clinical: Were the clinical targets they were being taught resulting in an acceptable level of clinical success and safety?

Educational: Could results be used to improve the teaching and in turn subsequent clinical results?

GHHOS development: Would the outcome measure be flexible enough to meet the needs of different styles of busy clinical practice in different professions, and allow merging and comparison of results across the broad range of diagnostics groups, remedies and health professions involved?

In order to address the above aims and questions, the measurement would need to be flexible, easy to use, and give a broad-brush feel for results, which meaningfully reflected the challenges of daily care.

Methods

Setting

Over three academic years (from 1995 to 1998), observations were made by State Registered Health Professionals who were enrolled on the ADHOM homeopathic postgraduate education course at the Glasgow Homoeopathic Hospital.

Practitioners

During this time, 79 professionals (on average around 40 professionals/year are on the course) volunteered to record the outcome of any prescriptions they made from a variety of clinical targets within the postgraduate course. The educational targets were mostly immediate treatments for common problems that present in everyday primary care: acute conditions such as injuries, infections, allergic reactions and emotional shocks; plus selected chronic problems such as premenstrual tension, rheumatic complaints, and the after effects of previous grief.

The practitioners reflected a mix of modern day health workers, and Table 1 shows the percentage observations made by each group that were included in the analysis. The number of observations per investigator varied considerably across the group ranging from 1 to 220, with a mean of 21.65 ($SD = 36.27$).

Table 1. Representation of professional disciplines and observations

Profession	No. Practitioners (% of total)	Observations (% of total)
Doctor	40 (50.6)	844 (51)
Nurse	11 (13.9)	203 (12.3)
Pharmacist	11 (13.9)	163 (9.8)
Vet + Assistant Vet	4 (5.1)	132 (8)
Physiotherapist	2 (2.5)	207 (12.5)
Dentist	3 (3.8)	42 (2.5)
Midwife	2 (2.5)	24 (1.5)
Health Visitor	1 (1.3)	6 (.4)
Occupational Health Therapist	1 (1.3)	5 (.3)

29 observations were included in the analysis coming from five practitioners whose profession was not recorded.

Outcome Measure – GHHOS

The GHHOS is the only measurement outcome used in the PC-HICOM project. Whether self (or guardian) assessed or in partnership with the practitioner, the scale is based on mirroring four sequential questions that underpin daily clinical practice assessment. Key to the scale is the ‘threshold’ score of +2, and anything at or above this score implies that the intervention can be taken as useful to the patient. The *PC-HICOM* project helped to develop the GHHOS and the background and use of this scale is more fully described in part 1 and 2 of this report.

The GHHOS consists of four sequential questions:

1. “Has the treatment caused any improvement or deterioration?”
If not record as 0.
if YES this puts you at –1 or +1.
2. “Is/was this change enough to affect the quality of your daily living?”
if YES, you have reached –2 or +2
3. “Is the change very marked, a major effect?”
if YES, you have reached –3 or +3
4. “Is this a complete resolution or disastrous deterioration of the problem?”
if YES, you have reached –4 or +4

For each patient that was treated with a homoeopathic remedy one score was noted. This was either done during the follow up consultation or by telephone. Clinical guidelines for the minimum and maximum time frame were supplied and those were determined by the acute or chronic nature of the complaint (e.g. acute infection assess by 1 week, pre-menstrual syndrome 2-3 months). In addition to the outcome score, the investigators also noted their patients’ age, sex, health complaint, the prescribed remedy, and the time between the consultation when the remedy was prescribed and the follow up consultation when the scores were given. An additional Satisfaction Scale (GHHSS) was recorded but as this was not central to the project, and not used consistently, it has been analysed in less detail than the GHHOS.

The investigators recorded their observations on standardised data-collection sheets (see Appendix 1. for an example of this sheet), which they returned to the ADHOM Academic Departments where they were centrally analysed. The results were then fed back to the students and teachers, creating a loop between research, education and clinical practice, aimed at improving clinical care.

Inclusion and exclusion criteria

The project aimed to reflect the actual mix of practice, which was generated by the course. During the data collection there was no selective entry and the practitioners were encouraged to record scores for all patients who they had prescribed a homeopathic remedy. The need was also emphasised to record all patients who did not return and for whom no score could be noted. Any such 'lost to follow up' cases were coded 'L'. Only one homeopathic remedy was to be used, and duplicate use of the same remedy by one patient was excluded in the main analysis.

Results

In total, 1796 cases were returned to the ADHOM Academic Departments and out of these, 1655 observations met the inclusion criteria for the analysis. These observations came from human as well as animal patients. The results of the human patients are presented first.

THE HUMAN PATIENTS

Out of the 1655 observations, 1435 came from human participants, of which 110 people participated twice in the study -and were treated with a different remedy.

Table 2. Crosstabulation of age groups by gender. *N* = 1381, 54 (3.8%) cases are missing.

		Age groups (people)						Total
		<1	1-15	16-30	31-45	46-60	61+	
Men	count	44	104	103	145	73	61	530
	row %	8	20	19	27	14	12	100
Women	count	34	102	169	230	171	145	851
	row %	4	12	20	27	20	17	100
Total		78	206	272	375	244	206	1381
		6	15	20	27	18	15	100

There were 530 (38%) men and 851 (62%) women, aged from 0 to 95 with a mean of 35.8 (*SD*= 22). Table 2 (above) shows the age by gender distribution and shows that the proportion of female patients was higher in the older age groups. This is a common finding in primary care. Table 3 (below) summarises the presented complaints, with musculo-skeletal problems being the most common complaint, followed by injury and mental disorders.

Table 3. Crosstabulation of diagnostic group by condition (total number in descending order). *N*=1531, 14(.9%) cases are missing and 110 people participated more than once in the study.

Diagnostic group	Acute	Chronic	Total	
			number	%
Musculoskeletal	196	83	279	18.2
Injury, including operative	266	10	276	18.0
Mental Disorders	220	18	238	15.5
Digestive System	154	24	178	11.6
Respiratory	122	42	164	10.7
Ill defined Conditions*	69	25	94	6.1
Reproductive, pregnancy and perinatal	5	74	79	5.2
Infectious	49	5	54	3.5
Dental	51	1	52	3.4
Skin	40	11	51	3.3
Ear	21	2	23	1.5
Nervous System	20	1	21	1.4
Genito-Urinary	8	4	12	0.8
Cardiovascular	4	-	4	0.3
Peripheral Vascular	2	1	3	0.2
Eye	2	1	3	0.2
Total	1229	302	1531	100

* Including non-specific complaints such as lack of appetite, tiredness.

Missing cases and patient characteristics

Out of the 1545 times that homeopathic remedies were prescribed, 211 (13.7%) cases were reported as lost to follow up, and no score on GHHOS could be obtained. A statistical difference was found between the number of patients been recorded as “lost” (meaning lost to follow up) and the age groups (*Chi-Square* = 25.737, *df* = 6, *p* < .005), indicating that the lost to follow up patients were commonest in the ages between 16 and 30. It is important to note that coding as lost to follow up does not necessarily mean that they did not return for further care, some investigators commented that they may have been seen by another practitioner.

Table 4. Crosstabulation age groups by lost to follow up, N =1489, 56 (4%) missing

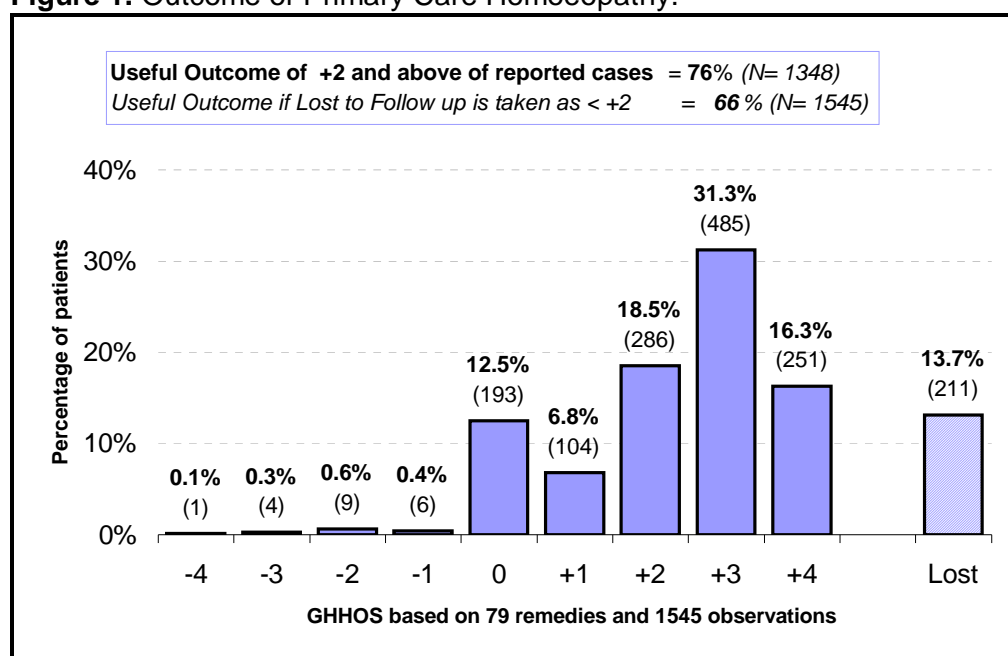
		Age groups (people)					Total
		<16	16-30	31-45	46-60	61+	
Lost to follow up	count	29	59	61	32	21	202
	row %	9	20	15	12	10	14
Not Lost to follow up	count	280	232	354	226	195	1287
	row %	91	80	85	88	90	86
Total		309	291	415	258	216	1489
row %		100	100	100	100	100	100

The following results are based on the cases with follow up data (meaning that a score on the GHHOS has been recorded), but for caution a secondary “worst case analysis” was done assuming the “lost” patients had experienced no benefit.

The Outcome of Care: The GHHOS scores

Overall, the response to the homeopathic treatment as measured by the GHHOS indicates a useful response (i.e. score is +2 or above) for 76% of the observations. A ‘worst case scenario’, where the lost to follow up cases are assumed as treatment failures (scored as 0), is 66% (N= 1549) useful results. There were 20 (1.4%) possible adverse events recorded in the 1545 cases.

Figure 1. Outcome of Primary Care Homoeopathy.



The Outcome in Different Conditions: The GHHOS scores by diagnostic group and condition

A useful outcome (i.e. GHHOS = +2) was achieved for 78% of the acute cases and 69.5% of chronic cases. These figures do not take into account the lost to follow up cases. A breakdown of the GHHOS scores = +2, by diagnostic group and condition – excluding the lost to follow up cases- is presented in Table 5.

Table 5. Crosstabulation of diagnostic group by condition and useful GHHOS outcome score of = 2 on GHHOS. The lost to follow up cases (i.e. cases with no scores on GHHOS) are *not* included. 11 cases are missing.

Diagnostic group	Total	Acute	Acute GHHOS = +2	Chronic	Chronic GHHOS = +2	Total GHHOS = +2	Total GHHOS = +2 %
Injury, including operative	251	242	208	9	7	215	85.7
Musculoskeletal	245	171	130	74	48	178	72.7
Mental Disorders	191	176	142	15	12	154	80.6
Digestive System	162	142	107	20	13	120	74.1
Respiratory	141	104	82	37	27	109	77.3
Ill defined conditions	83	59	42	24	14	56	67.5
Reproductive, pregnancy and perinatal	60	5	3	55	41	44	73.3
Dental	46	45	34	1	1	35	76.1
Infectious	45	43	32	2	1	33	73.3
Skin	43	33	22	10	7	29	67.4
Ear	21	19	11	2	2	13	61.9
Nervous System	17	16	13	1	-	13	76.5
Genito-Urinary	11	7	5	4	3	8	-
Cardiovascular	4	4	2	-	-	2	-
Peripheral Vascular	2	2	1	-	-	1	-
Eye	2	2	1	-	-	1	-
Total	1324	1070	835	254	176	1011	76.3

In Table 6 the lost to follow up cases are included and recorded as 0, with a useful outcome achieved in 68% of the acute cases and 58.5% of the chronic cases.

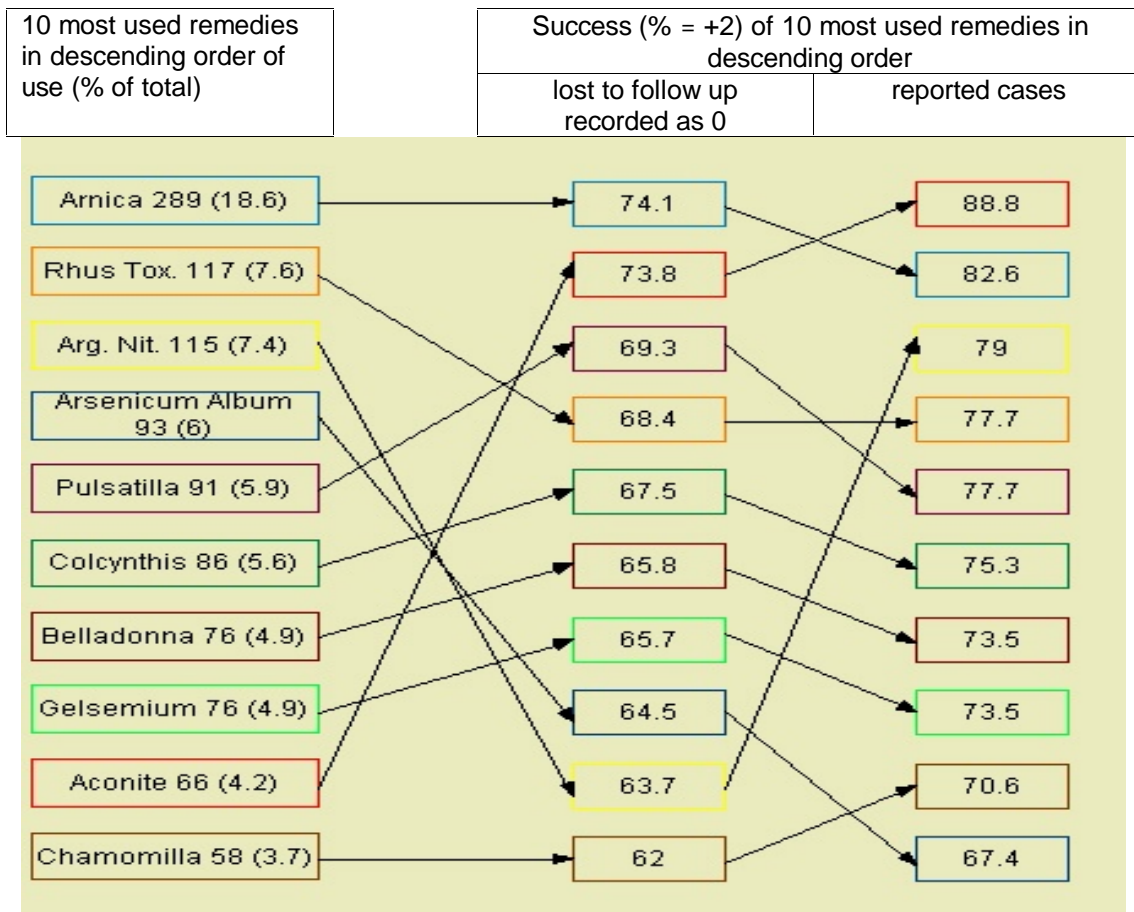
Table 6. Crosstabulation of diagnostic group by condition and useful GHHOS outcome score of = 2 on GHHOS. The lost to follow up cases (i.e. cases with no scores on GHHOS) are included. 14 cases are missing

Diagnostic group	Total	Acute	Acute GHHOS = +2	Chronic	Chronic GHHOS = +2	Total GHHOS = +2	Total GHHOS = +2 %
Musculoskeletal	279	196	130	83	48	178	63.8
Injury, including operative	276	266	208	10	7	215	77.9
Mental Disorders	238	220	142	18	12	154	64.7
Digestive System	178	154	107	24	13	120	67.4
Respiratory	164	122	82	42	27	109	66.6
Ill defined conditions	94	69	42	25	14	56	59.6
Reproductive, pregnancy and perinatal	79	5	3	74	41	44	55.7
Infectious	54	49	32	5	1	33	61.1
Dental	52	51	34	1	1	35	67.3
Skin	51	40	22	11	7	29	56.9
Ear	23	21	11	2	2	13	56.5
Nervous System	21	20	13	1	-	13	61.9
Genito-Urinary	12	8	5	4	3	8	-
Cardiovascular	4	4	2	-	-	-	-
Peripheral Vascular	3	2	1	1	-	1	-
Eye	3	2	1	1	-	1	-
Total	1531	1229	835	302	176	1011	66.0

The most frequent prescribed remedies

In total 79 different remedies were assessed. A list of all the remedies and its use can be found in Appendix 4. The ten most frequently used remedies made up 69% of the total prescribed remedies to people. Their individual performance is shown graphically in Appendix 2 and their relative performance will be shown in the picture below.

The remedies that were more frequently than others did not necessarily have better outcome scores (Kruskal-Wallis, $Chi-square= 14.355$, $df= 9$, $p= ns$). The lack of association can also be seen from the following figure, which also gives a sense of the process that the teachers and students used to identify areas of poorer performance (like Arsenicum Album) or those worthy of greater emphasis (like Aconite).



The Satisfaction with Care

In total, 1171 GHPSS scores were recorded. The satisfaction and the outcome scores (GHPSS and GHHOS) are correlated in a highly positively way ($r= + .930$, $p< .005$). This could indicate that both scales measure a similar response, or that satisfaction is highly linked to the success of treatment. No further analysis was conducted including the GHPSS.

VETERINARY RESULTS

Out of the 1655 observations, 110 came from animal patients, of which 13 observations came from animals who took more than once part in the study, while using a different remedy. 40 (42%) are male and 55 (58%) are female (2 cases are missing).

Table 7 shows the areas of the presented complaints for which homeopathic remedies were prescribed. Most homeopathic remedies were prescribed for acute cases and digestive system problem was the most common complaint, followed by injury and skin problems.

Table 7. Crosstabulation of diagnostic group by condition. $N=110$ (13 animals participated more than once in the study with a different remedy), total number is in descending order.

Diagnostic group	Acute	Chronic	Total	
			number	%
Digestive System	22	2	24	21.8
Skin	11	5	16	14.5
Ill defined Conditions	8	5	13	11.8
Injury, including operative	13	-	13	11.8
Infectious	8	-	8	7.3
Mental Disorders	8	-	8	7.3
Eye	5	3	8	7.3
Musculoskeletal	4	3	7	6.4
Reproductive, pregnancy and perinatal	6	-	6	5.5
Ear	2	-	2	1.8
Respiratory	1	1	2	1.8
Dental	2	-	2	1.8
Nervous System	-	1	1	0.9
Total	90	20	110	100

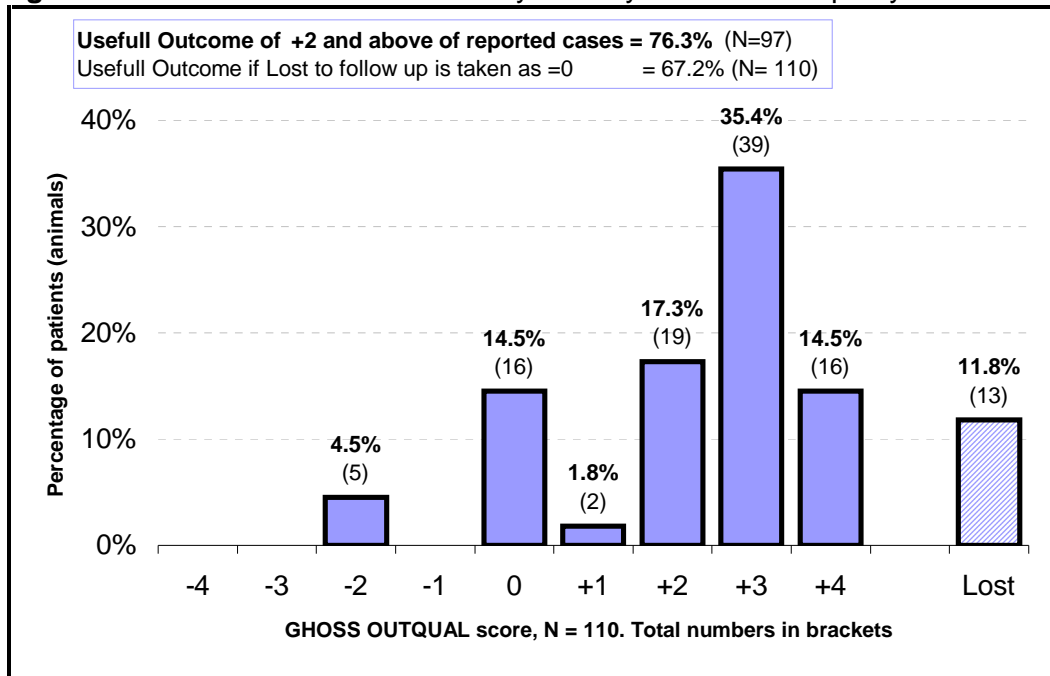
The GHOSS and animal characteristics

Overall, there was a small difference between the genders and the GHH outcome score, indicating that male animals have slightly higher scores (Mann Whitney $Z = -1.815$, $p = .07$, $N = 95$).

A summary of Veterinary Treatment Outcome

Overall, the response of the animal patients to the homeopathic treatment as assessed by the GHHOS suggests a successful score (i.e. score is +2 or above) of 67% and a 4.5% of adverse outcome. The percentage of adverse effects is low, but higher than in the case of the human patients, and the odds ratio indicates that it was 3.6 (Mantel-Haenszel, $p < .05$) more likely for the veterinary practitioners to record an animal as experiencing an adverse effect than for a human. The distribution of the outcome scores is presented in figure 3.

Figure 3. Overall Outcome of Veterinary Primary Care Homoeopathy



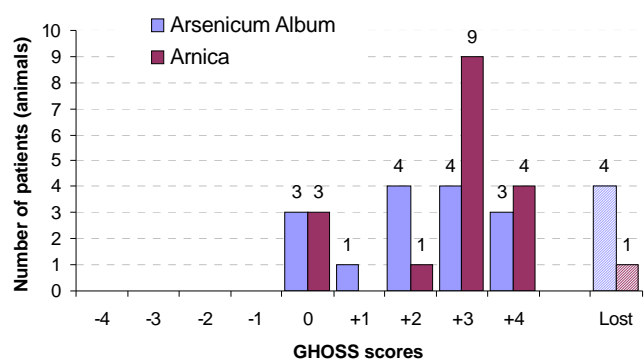
The Outcome of Care: The GHHOS scores by condition

The useful GHHOS scores (= +2) were calculated for the acute and chronic conditions. If the lost to follow up cases were not taken into account, a useful outcome (i.e. GHHOS = +2) was achieved for 79% (64 out of 81) of the acute cases and 62.5% (10 out of 16) of chronic cases. If the lost to follow up cases are included and recorded as 0, then a useful outcome was achieved for 71% (64 out of 90) of the acute cases and for 50% (10 out of 20) of the chronic cases.

The prescribed veterinary remedies

In total 34 different remedies were used and assessed by the carers of the animals. The spectrum of the prescribed remedies can be found in Appendix 5. Arnica was the most frequent prescribed remedy (17.3%), which was also the case for the human patients (namely 18.7%). The use and outcome of the two most frequently prescribed remedies (34% of remedies prescribed to animals), namely Arnica (19 cases) and Arsenicum Album (18 cases) are shown in figure 4. The next most commonly used remedies were Aconite (9 cases), Hepar Sulphuris (6 cases), and Argentum Nitricum (6 cases).

Figure 4. GHHOS distribution of Arnica and Arsenicum Alb.



Satisfaction with the Treatment

In 76 cases, a score on the GHPSS was noted, and these scores were highly correlated with the GHH outcome scores ($r = + .973$, $p < .005$, $N = 76$).

Discussion

The PC-HICOM study used the GHHOS measure, which aims to link the outcome of the treatment to the impact on the experience of daily living, to attempt to ask if simple primary care homeopathy, applied by conventional health care workers in the context of their normal practice, was clinically useful and safe.

The participants reported that on average, across a range of conditions, 76% of the homeopathic prescriptions produced a useful impact (score of = +2). In other words, overall homeopathy 'worked' usefully. These positive results were shown across the spectrum of age and gender, conditions treated, and clinical discipline. Parallel effects in humans and animals were noted.

Additionally, the outcomes on the GHHOS showed that the safety profile was good. Twenty possible adverse events were reported out of the 1545 treatments (1.4%), though on enquiry, many of these suggest that treatment failures were being recorded inaccurately and this made us change the scale instructions.

Turning for a moment to the GHHOS scale, the methods used here have innovative elements. Its key potential value lies firstly in the way it mirrors the normal dialogue health care participants use to assess outcome, and secondly, the linking of that outcome to its value to the patients daily life (the 'threshold' result). GHHOS also met the aims of being simple, and quick, and able to be used in the course of routine normal care without disruption - allowing success in the study's aim of gathered results from actual busy clinical practice without disrupting that care. In turn, this allowed us to build a useful picture of overall outcome and safety of primary care homeopathy, anchored in clinical reality.

This particular study was further strengthened by the separate but interwoven context of the action research cycle we used, allowing education and clinical practice to immediately inform one another. The data format fitted in well with this, facilitating the participants in a practical re-testing of the traditional clinical claims of homeopathy in different ages and conditions. For example, the most frequently used medicines were not necessarily the most successful or vice versa, and so on route some poorly performing clinical targets were dropped from the education course if redesigned teaching still resulted in poor outcome. Thus, the results began to 'even out' between the targets in the later years. In the early years, for example, Rhus Toxicodendron was scoring around 40% at +2 or above for musculo-skeletal conditions, but by the close of this study this result had improved to the average performance of other prescriptions.

This study concentrated on overall success and relative performance of different drugs. This emphasis does not allow much useful comment on specific diagnoses and other studies using the GHHOS, like Richardson (2001), have focussed on certain types of complaints. Continuing to build the database over time would usefully evolve this process.

Returning to the actual results: what can be made of the useful clinical success demonstrated? There are strengths and weaknesses in the context and methods. The range of data gathered accurately reflected the clinical practice resulting from the educational courses. This is what people are actually doing, and these are the results. There was no artificial narrowing of view or selection bias. However, such 'real world' relevance carries with it all the challenge, uncertainty, bias and errors of daily care - whatever the mode of treatment. These were conventional practitioners who routinely dispensing powerful, expensive and potentially dangerous conventional drugs, and then decided if they had worked. So, this study has the advantage of

using that experience and yardstick to judge their homoeopathic prescriptions. Presumably, both set of impressions are equally relevant. Certainly, it would be a strange form of evidence that discounted carers' and patients' views at the end of the evidence chain.

Of course, evidence of effectiveness says little or nothing about cause. The complex mix of context, attribution, placebo, and random effects, along with the natural course of events in illness and human caring, can produce strong results before any 'specific' effects (or lack of it) is added. A good worker might still produce results with a blunt tool. If the placebo controlled trial tests whether or not a therapeutic chisel is as sharp as it claims - then tracking ordinary outcome in daily care looks at what has been created when the sculptors, chisels and the living stone come together. The GHHOS scale appeared to perform well against the role it was presented with. Formal validation studies seem indicated and these are currently underway.

In the debate about homoeopathy, the reader must place this data beside the placebo controlled RCTs of homoeopathy and judge the picture that emerges. If we had shown poor results then that debate would be sterile, but this work suggests the debate is not in vain – there are useful clinical results to be explained when homoeopathy is used integrated into conventional health care.

Acknowledgment

We would like to thank the many participant patients and health carers, the teachers on the course. Thanks also to the funders: the initial development phase of the GHHOS took part within the RCCM/MRC funded Fellowship in the Glasgow University Department of Medicine; later research support came from Lothian legacy to Glasgow Homoeopathic Hospital; the resources of ADHOM and its parent charity AdHominem. The funding for this full data analysis and report came from The Homoeopathic Research Committee and British Homeopathic Association.

Appendix 1. Data collection sheet used in PC-HICOM project

Prescriber's Name	
Course Year	

<p>Glasgow Homoeopathic Hospital Outcome Scale (GHHOS)</p> <p>+4 Cured/Back to normal +3 Major improvement +2 Moderate improvement, affecting daily living +1 Slight improvement, no effect on daily living 0 No change/Unsure -1 Slight deterioration, no effect on daily living -2 Moderate deterioration, affecting daily living -3 Major deterioration -4 Disastrous deterioration</p>
--

<p>USING THE SCALE</p> <p>Ask the patient the following questions in sequence:</p> <p>1. <i>“Has the treatment caused any improvement or deterioration?”</i> if NOT record as 0. If YES this puts you at +1 or -1.</p> <p>2. <i>“Is/was this change enough to affect the quality of your daily life?”</i> if YES you’ve reached +2 or -2.</p> <p>3. <i>“Is the change very marked, a major effect?”</i> if YES you’ve reached +3 or -3.</p> <p>4. <i>“Is this a complete resolution or disastrous deterioration of the problem?”</i> if YES you’ve reached +4 or -4.</p>

N.B. For scientific validity you must include “lost to follow-up” subjects. If a patient is “lost to follow-up” please write the word **LOST** in box 9.

1. Confidential Data	2. Patient I.D.	3. Sex	4. DoB	5. Date of 1 st Consultat.	6. Presenting Complaint	7. Rx Used	8.Rx Potency/ Dosage	9. Follow-up Date	10. GHHOS score	11. Comments

The completion of the attached form is largely self evident so these notes are only intended to serve as a general guideline.

- | | |
|------------------------------------|--|
| Prescriber's Name | This should be completed with the practitioner's name. |
| Course Year | This should indicate which year of the course prescriber is currently on. |
| 1. Confidential Data | This column is intended for the practitioner's own use and is intended to contain information of a confidential nature such as the patient' name. This information should be blanked out on the copy returned to The Academic Departments. |
| 2. Patient I.D. | This is the unique label by which the patient may be identified without the use of their name. This could be their CHI number, where available, or a concatenation of DoB and Initials i.e. <i>Robert Duncan 03/10/52 would be shown as 031052RD</i> |
| 3. Sex | M = male F = female |
| 4. DoB | Date of birth i.e. 03/10/52 |
| 5. Date of 1st Consultation | This is the date of the first consultation with the patient for the complaint being reported on. |
| 6. Presenting Complaint | This is a short description of the patient's complaint and symptoms |
| 7. Rx Used | This is the name of the remedy or intervention chosen. |
| 8. Rx Potency/ Dosage | This is a description of strength and frequency of the remedy being administered. |
| 9. Follow-up Date | This is the date of the follow-up consultation. |
| 10. GHHOS Score | Simply record the appropriate GHHOS score in the given range of -4 to +4 as detailed on the data collection form. |
| 11. Comments | Any additional specific information or general comments should be noted here. |

Appendix 2. Visual presentations of the GHOS distribution of the ten most frequently used remedies

Figure 1. ARNICA, N = 289

Main clinical indication (including Lost to follow up):

Acute 263 (91%); Chronic 26 (9%)

Injury 214 (74%); Musculoskeletal 56 (19.4%); Dental 11 (3.8%)

Useful outcome of +2 and above of total = **74%** (N = 289)

Useful outcome of +2 and above of reported cases = **83%** (N=259)

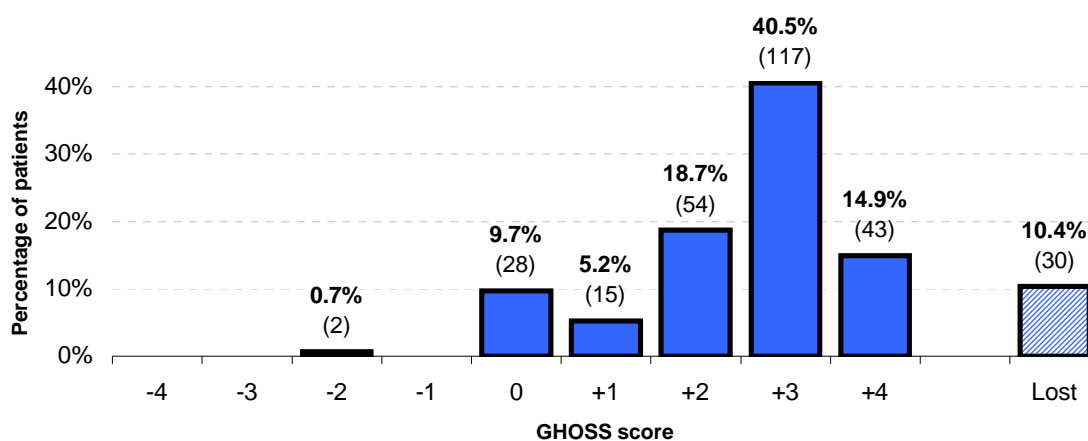


Figure 2. RHUS TOX. N = 177

Main clinical indication (including Lost to follow up):

Acute 74 (63%); Chronic 43 (37%)

Musculoskeletal 95 (81%); Injury 19 (16%)

Useful outcome of +2 and above of total = **78%** (N = 103)

Useful outcome of +2 and above of reported cases = **68%** (N=117)

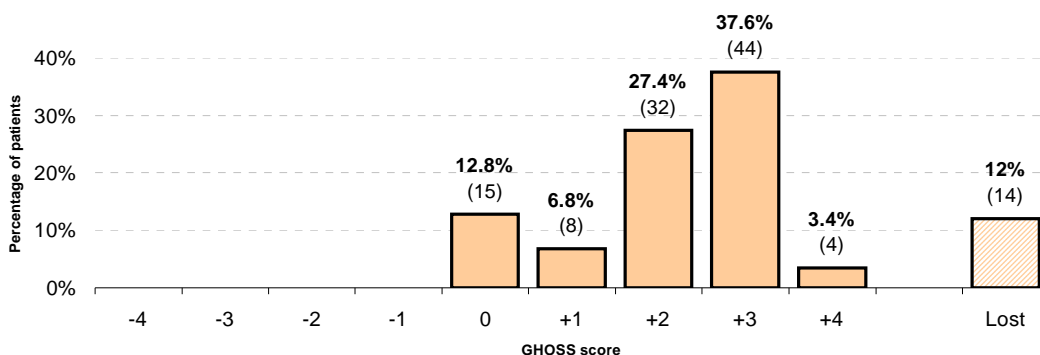


Figure 3. ARGENTUM NITRICUM N = 113

Main clinical indication (including Lost to follow up):

Acute 110 (96%); Chronic 5 (4.3%)

Mental disorders 102 (89%); Digestive systems 6 (5%)

Useful outcome of +2 and above of total = **79%** (N = 91)

Useful outcome of +2 and above of reported cases = **64%** (N=115)

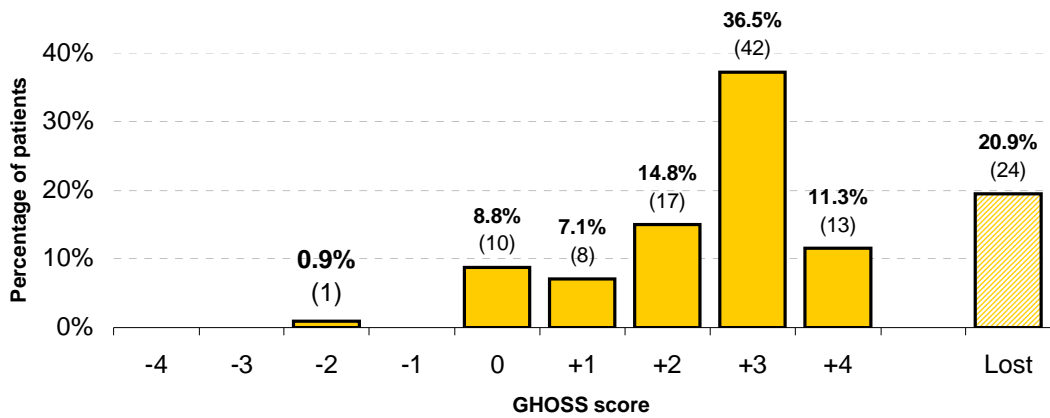


Figure 4. ARSENICUM ALBUM. N = 93

Main clinical indication (including Lost to follow up):

Acute 86 (92%); Chronic 7 (7.5%)

Digestive systems 71 (76%); Mental disorders 10 (11%)

Useful outcome of +2 and above of total = **67%** (N = 89)

Useful outcome of +2 and above of reported cases = **64%** (N= 93)

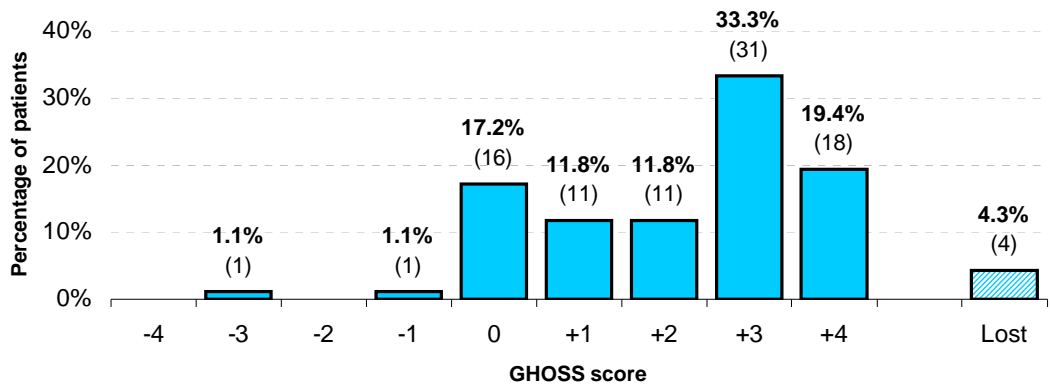


Figure 5. PULSATILLA N= 91,

Main clinical indication (including Lost to follow up):

Acute 51 (56%); Chronic 40 (44%)

Respiratory 60 (69%); Reproductive, Pregnancy 8 (8.8%); Ear 5 (5.5%)

Useful outcome of +2 and above of total = **77%** (N = 81)
Useful outcome of +2 and above of reported cases = **70%** (N= 91)

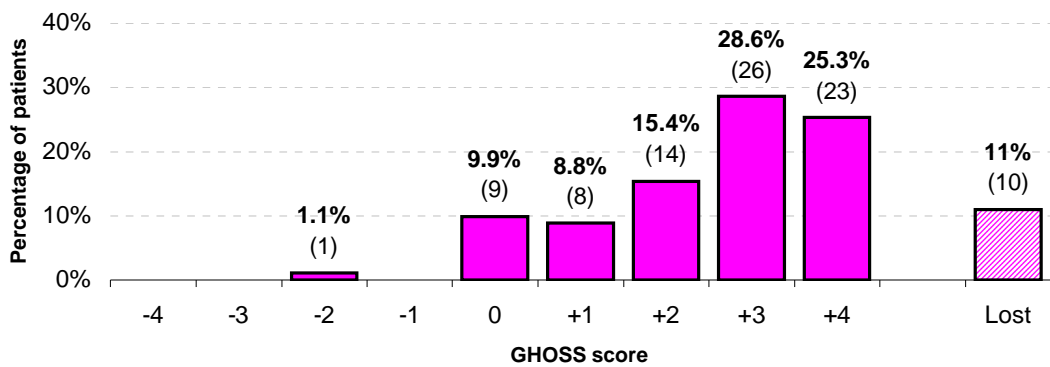


Figure 6. COLOCYNTHIS. N= 86

Main clinical indication (including Lost to follow up):

Acute 75 (87%); Chronic 10 (12%)

Digestive system 69 (80%); Musculoskeletal 10 (12%)

Useful outcome of +2 and above of total = **75%** (N = 77)
Useful outcome of +2 and above of reported cases = **67%** (N= 86)

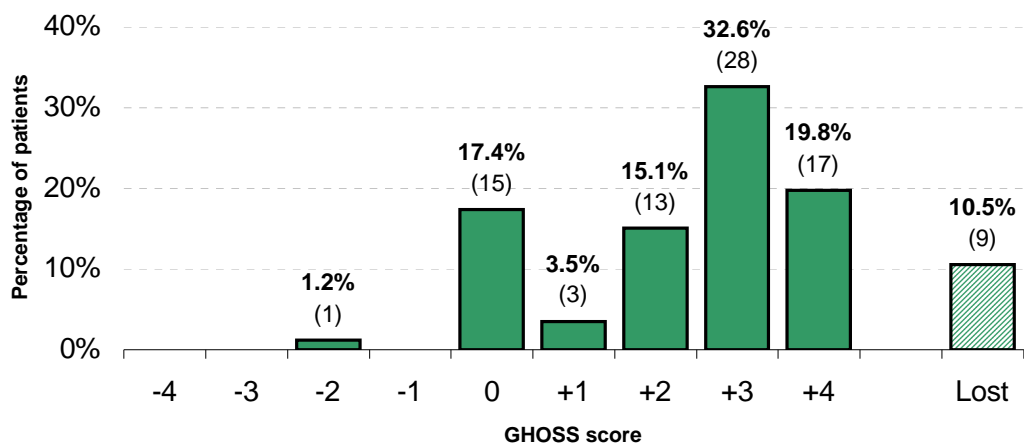


Figure 7. BELLADONNA. N = 76

Main clinical indication (including Lost to follow up):

Acute 71 (93%); Chronic 3 (4%)

Respiratory 19 (25%); Infectious 19 (25%); Ear 15 (20%);

Defined conditions 11 (14.5%)

Useful outcome of +2 and above of total = **74%** (N = 68)

Useful outcome of +2 and above of reported cases = **66%** (N= 76)

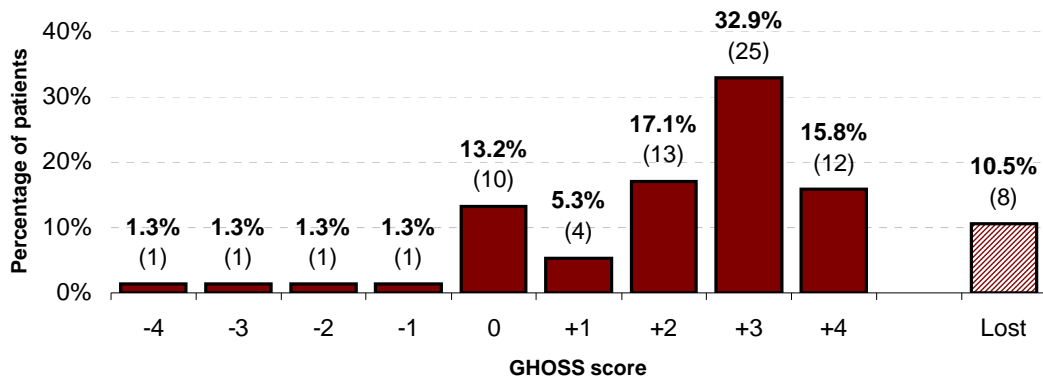


Figure 8. GELSEMIUM. N = 76

Main clinical indication (including Lost to follow up):

Acute 65 (85.5%); Chronic 11 (14.5%)

Defined conditions 26 (34%); Infectious 21 (28%);

Mental disorder 11 (14.5%); Respiratory 11 (14.5%)

Useful outcome of +2 and above of total = **74%** (N = 68)

Useful outcome of +2 and above of reported cases = **66%** (N= 76)

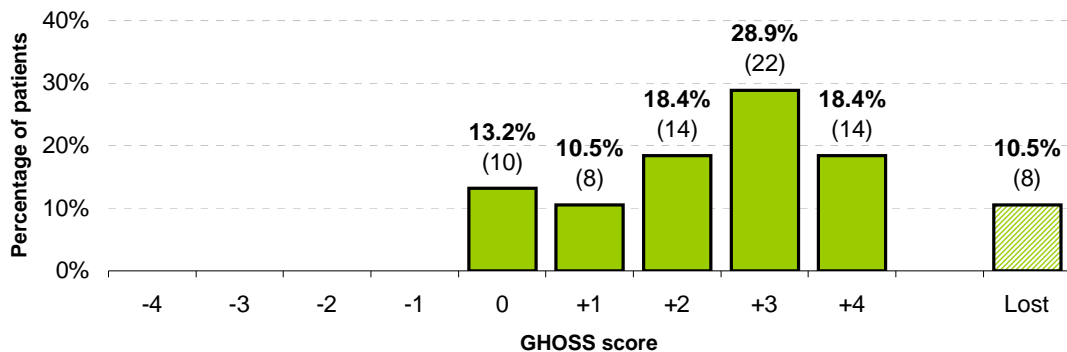


Figure 9. ACONITE. N = 65

Main clinical indication (including Lost to follow up):
 Acute 56 (85%); Chronic 8 (12%)
 Mental disorder 32 (48.5%); Respiratory 13 (20%);
 Defined conditions 6 (9%)

Useful outcome of +2 and above of total	= 89% (N = 54)
Useful outcome of +2 and above of reported cases	= 74% (N= 65)

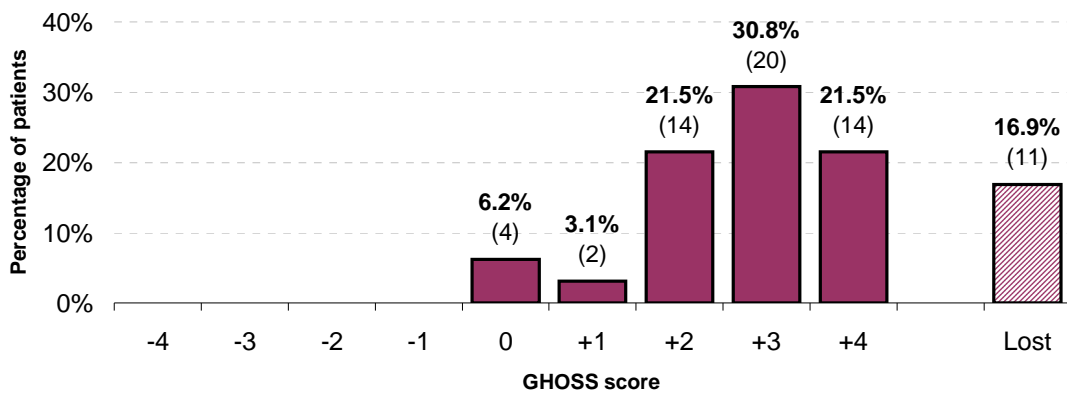
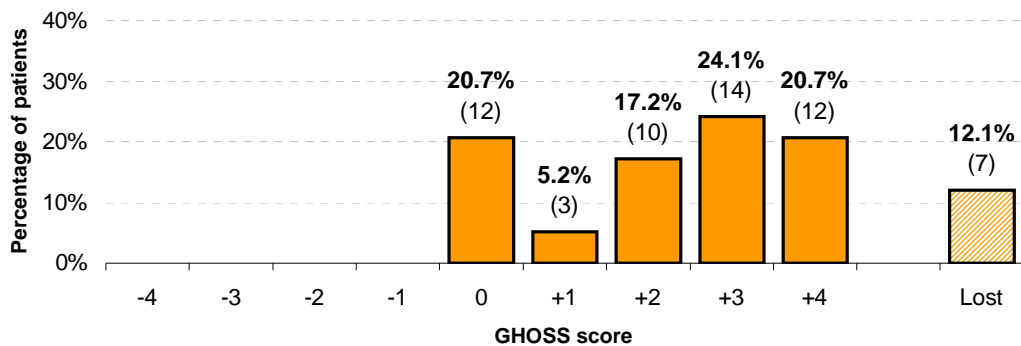


Figure 10. CHAMOMILLA. N = 58

Main clinical indication (including Lost to follow up):
 Acute 56 (95%); Chronic 1 (2%)
 Dental 41 (69.5%); Defined condition 6 (10.2%)

Useful outcome of +2 and above of total	= 71% (N = 51)
Useful outcome of +2 and above of reported cases	= 62% (N= 58)



Appendix 3. References of GHHOS

1) Studies that used GHHOS

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2) Articles that refer to GHHOS

Edwards RA (1996) International integrative primary care outcomes study (IIPCOS) A new concept for effectiveness studies of homeopathy. *Hom Int RD News* (1): 3-12.

Heger M (1998) Prospective documentation in homeopathic practice. *Hom Int RD News* 2.

Long A, Mercer G, Hughes K (2000) Developing a tool to measure holistic practice: a missing dimension in outcomes measurement within complementary therapies. *Complementary Therapies in Medicine*. 8: 26-31.

Van Berckel-Smith J. (1996) Systematic data-collection in daily practice. *Homoeopathic Links*. Autumn 9(3): 165.

Smith JB (1996) Data collection in daily practice. *Homeopathic Links*. 9(3): 165

Steinbekk A (1999) Data collection in Homeopathic Practice – a proposal for an international standard. *Hom Int RD News* (2): 3-33.

3) Article that used an outcome measure very similar to GHHOS

Clover A (2000) Patient benefit survey: Tunbridge Wells Homoeopathic Hospital. *British Homeopathic Journal*. 89: 68-72

Appendix 4. The homeopathic remedies used for people
(Remedy in descending order of use)

Remedy	Frequency	Percent	Remedy	Frequency	Percent
Arnica	289	18.7	Mixed mould/ grasses	4	.3
Rhus. Tox.	117	7.6	Carbo. Veg.	3	.2
Arg. Nit.	115	7.4	Opium	3	.2
Arsenicum Album	93	6.0	Symphytum	3	.2
Pulsatilla	91	5.9	Graphites	3	.2
Colocynthis	86	5.6	Antimonium Crud.	2	.1
Belladonna	76	4.9	Borax	2	.1
Gelsemium	76	4.9	Conium	2	.1
Aconite	66	4.3	Kali. Bic.	2	.1
Chamomilla	59	3.8	Ledum	2	.1
Sepia	53	3.4	Ranunculis Bulbosus	2	.1
Cuprum	42	2.7	Sarsparilla	2	.1
Hypericum	31	2.0	TB	2	.1
Ignatia	31	2.0	Ambrosia	2	.1
Nat. Mur.	29	1.9	Dolichos	2	.1
Hepar. Sulph.	23	1.5	Sabadilla	2	.1
Ruta	20	1.3	Calc. Phos.	1	.1
Combination	19	1.2	Calendula	1	.1
Lachesis	17	1.1	Camphor	1	.1
Thuja	16	1.0	Drosera	1	.1
Sulphur	13	.8	Ferrum. Phos.	1	.1
Bryonia	12	.8	Hydrastis	1	.1
Cuprum Met	10	.6	Plantage Tincture	1	.1
House Dust Mite	9	.6	Robinia	1	.1
Phosphorous	9	.6	Tuberculinum	1	.1
Lycopodium	8	.5	Carcinos	1	.1
Nux Vomica	8	.5	Catuiground tabs	1	.1
Calc. Carb.	7	.5	Draphoegnina	1	.1
Cantharis	7	.5	Dulcamara	1	.1
Silicea	7	.5	Equisetum	1	.1
Apis	6	.4	influenza vaccine	1	.1
Euphrasia	6	.4	Meper Sulp.	1	.1
Phytolacca	6	.4	Mystica Sebifora	1	.1
Merc. Sol.	5	.3	Nadrum	1	.1
Causticum	5	.3	Arsenicum		
Hypercal	4	.3	Secafa Comitium	1	.1
Ipecac	4	.3	Stramonium	1	.1
Staphisagria	4	.3	Rumex Crispus	1	.1
			Paeonia Ointment	1	.1
			Total	1545	100.0

**Appendix 5. The homeopathic remedies used for animals
(Remedy in descending order of use)**

Remedy	Frequency of use	Percent of total
Arnica	19	17.3
Arsenicum Album	18	16.4
Aconite	9	8.2
Arg. Nit.	6	5.5
Hepar. Sulph.	6	5.5
Belladonna	5	4.5
Calc. Phos.	4	3.6
Pulsatilla	4	3.6
Silicea	4	3.6
Caulophyllum	3	2.7
Ignatia	3	2.7
Urtica	3	2.7
Apis	2	1.8
Bacillinum	2	1.8
Chamomilla	2	1.8
Rhus. Tox.	2	1.8
Bryonia	1	.9
Calc. Carb.	1	.9
Calendula	1	.9
Cantharis	1	.9
Colocynthis	1	.9
Conium Plumbum	1	.9
Gelsemium	1	.9
House Dust Mite	1	.9
Kali. Bic.	1	.9
Lycopodium	1	.9
Merc. Sol.	1	.9
Nux Vomica	1	.9
Phosphorous	1	.9
Respiratory nosode	1	.9
Sulphur	1	.9
Symphytum	1	.9
Thuja	1	.9
Travel sickness pills	1	.9
Total	110	100.0