What do you consider to be the best clinical evidence supporting the efficacy of homeopathy for any indication? (March 28, 2013)

Abstract: Homeopathy offers the safest and best outcomes ever demonstrated by any system of medicine for patients with pneumonia and therefore would receive the highest possible recommendation of any intervention for these patients (1A/strong recommendation with high-quality evidence).

Summary of the Evidence[1]:

Before presenting the best clinical evidence for homeopathy, it is necessary to address three implications of your question.

First, your question implies that homeopathy treats "indications" as those are understood in conventional medicine, where a particular drug having a particular effect will be typically prescribed to treat a well-defined patho-physiological disease (WPD). In homeopathy, however, the focus is on the whole person.

Second, the question implies that we have the same understanding of what constitutes homeopathy, which should be made absolutely clear before any further discussion on the subject. Homeopathy is the art and science of medicinal treatment that was developed by Samuel Hahnemann. Homeopathic medicines are given singly, in non-toxic doses, and are individualized on the basis of the greatest degree of similarity between the pathogenesis of a remedy and the totality of the patient's symptoms.

Third, the expression "the best clinical evidence" implies that the clinical evidence for homeopathy has been evaluated through a grading system. Since such an evaluation has not yet been done, I will take a few steps in that direction.

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[1] The present summary is an abbreviation of the extended version of my response to the above question, which can be found at: http://www.homeopathy.ca/debates_2013-03-22.shtml

As I mentioned in the debate, likely the most compelling evidence for the effectiveness of homeopathy is found in its extensive records of its use in epidemics. In 2003, I began reviewing the literature on this subject, and I have so far uncovered over 10,000 references, the first 2,500 of which have been incorporated into a comprehensive text that is now over two thousand pages in length.

All the epidemics in which homeopathy has been used since 1799 have been included in this extensive review of the literature.

The main finding of this research is that the results obtained by homeopathy during epidemics consistently reveal an extremely low mortality rate. That observation holds true regardless of the physician, the time, the place or the type of epidemic disease, including diseases that are known to have a very high mortality rate, such as cholera, smallpox, diphtheria, typhoid fever, yellow fever, and pneumonia.

Since society values the saving of life more highly than any other outcome, most of these reports give accounts of rates of recovery versus mortality; therefore they deserve the close attention of academia, governments, and health authorities, and should be followed by strong recommendations.[2]

The hierarchies of evidence in evidence-based medicine (EBM) have not been developed for the purpose of integrating such massive amounts of evidence, because the allopathic literature from before WWII is relatively poor in valuable therapeutic interventions. Aside from a few trials, such as Lind's with citrus fruit to treat scurvy in sailors (1747), and Louis's with bleeding and expectancy in pneumonia patients (1828), there are not many therapeutic trials that are worth recounting, or whose therapeutic interventions would have any clinical

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[2] Gordon H. Guyatt, et al. Rating quality of evidence and strength of recommendations: GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. British Medical Journal 2008; 336 (7650): 924-926.

significance today. That, however, is not at all the case with homeopathy, whose literature overflows with all types of very meaningful case studies, trials, and outcome reports which are as pertinent today as when they were first published. Results obtained by homeopathy do not often lose any of their value with the passing of time; on the contrary, like all facts, they are as relevant as if they had occurred today, particularly since the homeopathic methodology has not essentially changed since its early development.

Statistics in homeopathy don't need to be extensively elaborated in the majority of studies, because the differences in the outcomes during epidemics tend to be obvious, serving as a reminder of Sir Ernest Rutherford's remark, "If your experiment needs statistics, you ought to have done a better experiment." Odds ratios and relative risks with two-by-two tables are often sufficient to reveal fully the size of the effect in these outcome studies. I will limit my response to the outcomes of homeopathy versus allopathy in patients with pneumonia before and since the introduction of antibiotics.

Mortality from Pneumonia in the Pre-antibiotic Era Allopathic Treatment

First, let's look at the average mortality from pneumonia under pre-antibiotic allopathy (PAA), which was quite uniform throughout the nineteen century. In fact, in 1912 William Osler wrote: "Pneumonia is one of the most fatal of all acute diseases, killing more than diphtheria, and outranking even consumption as a cause of death. The statistics at my clinic at the John Hopkins Hospital from 1889 to 1905 have been analyzed by Chatard. There were 658 cases with 200 deaths, a mortality of 30.4 percent. Excluding 35 cases of terminal pneumonia the percentage is 26.4. ... Greenwood and Candy in a study of the pneumonia statistics at the London Hospital from 1854-1903, a total of 5,097 cases, conclude that the fatality of the disease has not appreciably changed during this

period. In comparing the collected figures of these authors with those from other institutions, there is an extraordinary uniformity in the mortality rate."[3]

In the following two tables, the first one for PAA and the second one for homeopathy, I have assembled outcomes for pneumonia cases from mixed populations of ambulatory and hospitalized care in Europe, the United States and Canada that can be found in the literature during the same years. Outcomes for patients with pneumonia during the 1918-1920 influenza pandemic will be discussed separately.[4]

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[3] William Osler. The Principles and Practice of Medicine. 8th ed. (New York and London: D. Appleton and Company, 1912), 96.

[4] There is one exception to this separation of pneumonia cases from the ones that occurred during the 1918-1920 influenza pandemic, and that is the case cohort reported by G. Harlan Wells covering the period 1906 to 1921 at the Hahnemann Hospital in Philadelphia, which did include an unspecified number of cases of pneumonia with influenza. Rather than enhance the success achieved by homeopathy, it diminishes it, for, as has been mentioned, many cases admitted during the pandemic were in a moribund state.

First, we find that among 148,345 patients under PAA there were 36,073 reported deaths for an average mortality rate of 24.3%.[5,6,7,8,9,10,11,12,13,14,15,16]

Table 1: Mortality from Pneumonia in the Pre-antibiotic Era Allopathic Treatment

Allopathic Treatment	Cases	Deaths	Mortality (%)
Dr. Bouillaud, Paris[5]	152	18	11.8
Dr. Louis, Paris[5]	107	32	29.9

[5] Willis A. Dewey. Editorials. Pneumonia and its treatment. Medical Century 1912; 19: 250-253.

[6] Henri de Bonneval. Considérations sur l'homoeopathie. (Bordeaux: Imprimerie Adrien Bousin, 1881), 19-22.

[7] Krüger-Hansen. Ueber das Heilverfahren bei Pneumonien. Medicinischer Argos 1842; 4: 341-361.

[8] J. Greenwood, R. H. Candy. The fatality of fractures of the lower extremity and of lobar pneumonia. A study of hospital mortality rates, 1751-1901. Journal of the Royal Statistical Society 1911; 74: 363-405.

[9] William Osler. The mortality of pneumonia. University Medical Magazine 1888; 1: 77-82.

[10] Samuel Henry Dickson. Essay on pneumonia. In Studies in Pathology and Therapeutics. New York: William Hood & Co., 1867.

[11] O. Sturges, S. Coupland. The Natural History and Relations of Pneumonia. 2nd ed. London: Smith, Elder & Co., 1890.

[12] William Osler. The Principles and Practice of Medicine. 8th ed. New York and London: D. Appleton and Company, 1912.

[13] J. P. Barber. Pneumonia in children. Homoeopathic Journal of Pediatrics 1907; 2: 24-26.

[14] L. Emmett Holt. The Diseases of Infancy and Childhood. 5th edition. New York: D. Appleton and Company, 1909: 556, 577.

[15] Russell L Cecil, Horace S. Baldwin, Nils P. Larsen. Lobar pneumonia: A clinical and bacteriological study of two thousands typed cases. Archives of Internal Medicine 1927; 40: 253-280.

[16] The statistics of the London Hospital exclude cases of broncho-pneumonia, which tends to have a higher mortality rate, particularly in young children. Osler said, "Primary acute broncho-pneumonia, like lobar form, attacks children in good health, usually under two years. ... The death rate in children under five has been variously estimated at from 30 to 50 per cent." (William Osler. The Principles and Practice of Medicine. (New York: D. Appleton and Company), 1912, 102, 106.)

Dr. Grissolle's collection[5]	304	43	14.2
Vienna Hospital[5]	1,660	350	21.1
Drs. Balfour and Thompson[5]	125	35	28.0
Glasgow General Hospital[5]	122	38	31.2
Parisian Hospitals[5]	300	100	33.3
New York Hospital[5]	87	32	36.8
Dr. Dietl, Vienna[5]	106	22	20.8
Prague Hospital[5]	259	68	26.3
St. Louis City Hospital[5]	23	12	52.2
Dr. Leroux's collection[5]	364	85	23.4
Drs. Taylor and Walsh[5]	78	12	15.4
Dr. Peacock[5]	48	3	6.3
Philadelphia General Hospital[5]	991	533	53.8
Boston City Hospital[5]	949	341	35.9
Chomel, Paris[6]	24	13	54.1
Andral, Paris, 1830[6]	65	37	56.9
St. Petersburg, 1834[7]	10,123	3,358	33.2
Mussy, Paris, 1835[6]	86	38	44.2
Broussais, Paris, 1835[6]	218	137	62.9
Becquerel, Paris, 1838[6]	46	40	90.0
St. Petersburg, 1839[7]	16,015	5,303	33.1
London, 1845[6]	1,133	404	35.7
Pinel, Paris[6]	23	11	47.8
Cochin Hospital[6]	63	16	25.4
Cayol[6]	24	6	25.0
St. Joseph Hospital, Lisbon[6]	52	21	54.2
Geneva Military Hospital[6]	27	11	40.7
London Hospital, 1784-1903[8,14]	5,692	1,157	20.3

Charité Hospital, New Orleans, 1830-1879[9]	3,969	1,509	38.0
Basel Hospital, 1839-1871[8]	922	213	23.1
Seraphim Hospital, Stockholm, 1840-1855[8]	2,710	375	13.8
Pennsylvania Hospital, 1845-1887[9]	704	205	29.1
Vienna General Hospital, 1847-1857[8]	5,990	1,441	24.1
Edinburgh Infirmary, 1848-1856[9]	1,726	333	19.3
Dr. Routh's collection, 1852[5]	388	66	17.0
Montreal General Hospital, 1853-1887[9]	1,012	206	20.4
Dickson's Tables, 1867[10]	80,437	16,915	21.0
Stockholm Military Hospital[8]	670	49	7.3
Middlesex Hospital, 1869-1888[11]	1,010	192	19.0
Boston City Hospital, 1875-1887[5]	1,443	421	29.1
Collective Investigation, London, British Medical Assoc. 1884[8]	1,060	191	18.2
St. George's Hospital, 1884-1888[11]	86	18	20.4
Guy's Hospital, 1884-1888[11]	62	10	16.1
St. Bartholomew's Hospital, 1884-1888[11]	137	28	20.4
Westminster Hospital, 1884-1888[11]	247	52	21.1
Osler, John Hopkins Hospital, 1889-1905[12]	658	200	30.4
St. Bartholomew's Hospital, 1897-1906[8]	1,111	173	15.6
Bellevue Hospital, NYC, 1920-1925[13]	2,629	825	31.4

Total	148,345	36,073	24.3 (average)

Mortality from Pneumonia of Patients under Homeopathic Treatment

Let's now look at the outcome under homeopathy for pneumonia patients, also in a mixed population of ambulatory and hospitalized care during the same period and in the same parts of the world. Rather than cherry picking, I have included all the case and cohort series of five or more cases that I have found so far in the literature, which are therefore representative of different levels of expertise in homeopathy. We find that out of 25,208 cases there were 865

deaths, a mortality rate of 3.4%, or one-seventh the rate under PAA.[17,18,19,20,21,22,23,24,25,26,27]

Table 2: Mortality of Patients with Pneumonia under Homeopathic Treatment

Homeopathic Treatment	Cases	Deaths	Mortality (percent)
Infantry Hospital, St. Petersburg, 1829[17]	71	0	0
Rosenberg Collection, 1843[17]	390	14	3.6
Dr. Bosch[17]	100	3	3.0
Mercy Hospital, Vienna, 1835-1842, 1849-1854[17]	954	47	1.1

[17] André Saine. The weight of evidence: The extraordinary success of homeopathy in times of epidemics. Unpublished manuscript. see http://www.homeopathy.ca/publications_det02.shtml

[18] Charles Henry Routh. The Fallacies of Homoeopathy. London, 1852.

[19] Henri de Bonneval. Considérations sur l'homœopathie. (Bordeaux: Imprimerie Adrien Bousin, 1881), 19-22.

[20] C. T. Hood. Treatment of croupous pneumonia. Clinique 1906: 27: 649-656.

[21] Christopher Osmond Bodman. Pneumonia in children; illustrated by fifty consecutive cases treated at the New Orphan Houses, Bristol, without mortality. Journal of the British Homoeopathic Society 1910; 18: 213-244.

[22] Willis A. Dewey. Editorials. Pneumonia and its treatment. Medical Century 1912; 19: 250-253.

[23] R. del Mas. Thirty cases of pneumonia. Homoeopathician 1914; 4: 53-54.

[24] G. Harlan Wells. A study of the comparative value of the homeopathic treatment and other methods of treatment in lobar pneumonia. Journal of the American Institute of Homeopathy 1922-1923; 15: 541-550.

[25] E. Rodney Fiske. A survey of the statistics of the homeopathic treatment of lobar pneumonia. Journal of the American Institute of Homeopathy 1928; 21: 886-993

[26] Alfred Pulford, Dayton Pulford. Homoeopathic Leaders in Pneumonia. (Published by the authors: Dayton, Ohio, 1928), 5.

[27] D. M. Foubister. Homoeopathy in the treatment of pneumonia and acute bronchitis. British Homœopathy Journal 1956; 45: 65-71.

Mercy Hospital, Vienna, 1843-1848[17]	88	1	1.1
Nechanitz Hospital, 1846-1848[17]	19	1	5.3
Mercy Hospital, Kremsier, 1846-1848[17]	49	8	16.3
Turin Military Hospital, 1851[17]	89	0	0
Bruges Dispensary, 1861[17]	19	0	0
Five Points House Industry Hospital, NYC, 1861-1887[17]	222	7	3.2
Military Hospital, Kansas City, 1861-1863[17]	194	3	1.6
Roubaix Hospital, 1863-1864[17]	49	2	4.1
Cavalry Depot Hospital, St. Louis, 1865[17]	25	1	4.0
St. Rochus and Besthesda Hospitals, Budapest, 1870[17]	711	63	8.9
Gyongyos Hospital, Hungary[19]	20	0	0
Guns Hospital, Hungary[19]	32	0	0
Leipzig Hospital[19]	34	2	5.9
Military Hospital, Vienna[19]	79	0	0
Munich Hospital[19]	5	0	0
Bond Street Dispensary, 1865-1871, NYC[17]	815	12	2.5
Poughkeepsie Dispensary, 1865-1867[17]	15	0	0
Dr. Routh's collection, 1852[18]	738	45	6.1
Gumpendorf Hospital[22]	1,415	48	3.4
Leopoldstadt Hospital, Vienna[22]	149	9	6.0
Linz Hospital[22]	99	1	1.0
St. Marguerite Hospital, Paris[22]	41	3	7.3
London Homoeopathic Hospital[22]	63	3	4.8

Professor Henderson, Edinburgh[22]	11	0	0
Dr. Watkins, London, 1898[22]	14	0	0
Dr. Hood's collection (52 physicians), 1906[20]	6,605	251	3.8
Dr. Bodman, Bristol, 1900-1910[21]	50	0	0
Dr. Del Mas, 1914[23]	30	0	0
Hahnemann Hospital, 1908-1921[24]	190	14	7.4
Survey: Am. Inst. Hom., 1928[25]	11,526	323	2.8
Drs. A. and D. Pulford, Ohio, 1928[26]	242	3	1.2
Royal London Hom. Hospital, 1948-1953[27]	55	1	1.8
Total	25,208	865	3.4 (average)

Treatment Outcomes in Pneumonia Cases during the 1918-1920 Influenza Pandemic

The next table shows a comparison of the results reported in five surveys of homeopathic physicians during the fall and winter of 1918-1919[28] with one of the large statistical reports for the U.S. armed forces, namely the one with the lowest mortality rate (5.8%), which represents the mortality rate from the combined effects of influenza and pneumonia (CIP)[29] under PAA for the entire U.S. armed forces during the fall of 1918.[30]

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[28] These five surveys were presented in Part II of the extended version of this response, which can found at: http://www.homeopathy.ca/debates_2013-03-22.shtml

[29] Today, the USCDC combines mortality from influenza and from pneumonia since the great majority of deaths from influenza are related to pneumonia.

[30] Statistical reports of the case mortality rate from CIP for the U.S. armed forces during the fall of 1918 were presented in Part II of the extended version of this response and can be read at: http://www.homeopathy.ca/debates_2013-03-22.shtml

Table 3: Comparison Between Homeopathy and PAA in CIP Patients during the 1918-1919 Influenza Pandemic

Treatment	Number of Patients	Number of Recove-ries	Survi-val Rate in %	Number of Deaths	Case Mortality Rate in %
Homeopathy Fall and winter, 1918-1919	66,092	65,677	99.3	445	0.7
PAA Entire U.S. armed forces, fall, 1918	688,869	649,138	94.2	39,731	5.8

Comparative Mortality in Pregnant Women

It is widely recognized that during the 1918–1919 influenza pandemic (NIP) the mortality rate was highest in pregnant women. Since that population wasn't present in the army, it serves as a completely different demographic group for evaluating and comparing the outcomes of the two schools of medicine.

The following table compares the mortality among pregnant women during the NIP found in four allopathic reports with that in the five homeopathic reports,[31]

Table 4: Comparison of Mortality Among Pregnant Women

Treatment	Number of pregnant women with CIP	Number of pregnant women recovered from CIP	Percentage of pregnant women who developed pneumonia	Number of deaths	Mortality rate from CIP

[31] Ibid.

Allopathy	1,561	1,093	51% (717 out of 1,410)	468	30%
Homeopathy	2,848	2,827	5.7% (161 out of 2,832)	21	0.7%

Outcomes for Pneumonia Patients under Present-Day Conventional Care

In the twenty-first century pneumonia is still a major disease, which has been growing continually worse in the last few decades. Let us now examine the outcome for pneumonia patients under contemporary conventional care (CCC), which benefits from advances in nursing care such as hydration, nutrition, and oxygenation. Those are positive confounding factors not present in the last two sets of statistics (for PAA and homeopathy). On the other hand, the increasing incidence of antibiotic-resistant bacteria is a negative confounding factor that somewhat balances the equation.

Pneumonia is today divided into two main categories, namely community-acquired pneumonia (CAP) and health-care-acquired pneumonia (HCAP), and the statistics for each are as a rule kept separate.

Despite the availability of antibiotics, pneumonia remains today a major cause of morbidity and mortality even in developed countries. In the United States, for example, it is the leading cause of death due to infectious diseases. The 2003 “Pneumonia Fact Sheet” from the American Lung Association reported: “In 1996 (the latest data available), there were an estimated 4.8 million cases of pneumonia resulting in 54.6 million restricted-activity days and 31.5 million bed days.”[32] Every year 1.2 million Americans are hospitalized with pneumonia. In

[32] Pneumonia Fact Sheet. American Lung Association. October 2003.

2005, pneumonia and influenza together represented a cost to the U.S. economy of $40.2 billion.[33] In 2002 CAP cost the European economy $30 billion.[34]

The age-adjusted annual mortality for pneumonia/influenza has been rising steadily over the last few decades in the U.S. In 1979, it was 11.2 per 100,000 persons per year, in 1998, it was 13.2, in 2011, it was 15.7, and pneumonia consistently accounts for the overwhelming majority of deaths between the two (pneumonia vs. influenza).[35,36]

Worldwide, an estimated 1.2 million children under the age of five die every year from pneumonia—more than from AIDS, malaria, and tuberculosis combined.[37] Although mortality from pneumonia in children is low in developed countries, the World Health Organization estimates that in developing countries one in three children dies from an acute respiratory tract infection.[38]

In developed countries, CAP remains a major cause of mortality at 13.7%, while HCAP carries a higher mortality of between 50% and 70%. In Fine et al.'s meta-analysis, mortality was lowest in studies of a mixed population of ambulatory and hospitalized patients (5.1%); intermediate in only hospitalized (13.6%),

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[33] Centers for Disease Control. MMWR Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2007; 56 (July): 1-54.

[34] T. Welte, A. Torres, D. Nathwani. Clinical and economic burden of community-acquired pneumonia among adults in Europe. Thorax 2012; 67 (1): 71-79.

[35] Sherry L. Murphy. Deaths: Final data for 1998. National Vital Statistics Reports 2000; 48 (11): 25.

[36] Donna L. Hoyert, Jiaquan Xu. Deaths: preliminary data for 2011. National Vital Statistics Reports 2012; 61 (6): 28.

[37] Pneumonia. WHO April 2013: Fact sheet N°331.

[38] M. Gareene, C. Ronsmans, H. Campbell. The magnitude of mortality from acute respiratory infections in children under 5 years in developing countries. World Health Statistics Quarterly 1992; 45 (2-3): 180-191.

elderly (17.6%), and bacteremic (19.6%) patients; and highest in nursing home (30.8%) and ICU (36.5%).[39]

When pneumonia develops in patients already hospitalized for other conditions, the mortality rates are higher, ranging from 50% and 70%.[40,41] Mortality goes up to 35% in cases of pneumonia associated with E. coli and Klebsiella species and to 61% in cases associated with Pseudomonas aeruginosa; it ranges between 5% and 9% with viruses other than influenza B and adenovirus. There is also no generally effective treatment in conventional medicine for most types of viral pneumonia, such as severe acute respiratory syndrome (SARS), whose case fatality averages 14.5%.[42]

In 11,229 patients, or one-third of those surveyed in Fine et al.'s meta-analysis, mortality rose to 12.8% when the associated microbes were unknown.[43,44]

In 2005, there were more than 60,000 deaths due to pneumonia in persons aged ≥ 15 years in the United States alone. From 1998 to 2005 the hospitalization rate for all infectious diseases increased from 1,525 per 100,000 persons to 1,667. Admission to an intensive care unit was required in 10% to 20% of patients hospitalized with pneumonia. Mortality was highest for CAP patients who were hospitalized; the 30-day mortality rate was as high as 23%. Despite the availability of and widespread adherence to recommended allopathic

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[39] M. J. Fine, et al. Prognosis and outcomes of patients with community-acquired pneumonia. A meta-analysis. JAMA 1996; 275: 134-141.

[40] http://www.nym.org/healthinfo/docs/064/doc64severity.html

[41] http://www.ucdmc.ucdavis.edu/ucdhs/health/az/64pneuomnia/doc64severity.html

[42] WHO. Update 49: SARS case fatality ratio, incubation period. May 7, 2003. Available at: http://www.who.int/csr/sarsarchive/2003_05_07a/en/

[43] M. J. Fine, et al. Prognosis and outcomes of patients with community-acquired pneumonia. A meta-analysis. JAMA 1996; 275: 134-141.

[44] Pneumonia Fact Sheet. American Lung Association. December 2012 (http://www.lung.org/lung-disease/influenza/in-depth-resources/pneumonia-fact-sheet.html)

treatment guidelines, CAP continues to present a significant burden in adults. Furthermore, given the aging population in North America and the ubiquitous increase in microbial resistance to drugs, allopathic clinicians can expect to encounter increasing difficulty in treating a growing number of adult patients with CAP.[45]

Let's now look at a comparison of the outcomes in mixed populations of ambulatory and hospitalized pneumonia patients for the three different therapeutic intervention groups, namely homeopathy, PAA, and CCC. Since morbidity and mortality today are much higher in HCAP than in CAP, I will limit the mortality comparison of CCC with PAA and homeopathy to only CAP. In the last available meta-analysis on the outcome of CAP, Fine et al. reported that out of 33,148 patients there were 4,541 deaths, for a mortality of 13.7%.[46]

Table 5: Comparative Mortality from Pneumonia under Homeopathy, PAA and CCC

Treatment	Number of Patients	Number of Recoveries	Survival Rate	Number of Deaths	Mortality Rate (%)
Homeopathy	25,208	24,343	96.6	865	3.4
PAA	148,345	112,272	75.7	36,073	24.3
CCC (limited to CAP)	33,148	28,607	86.3	4,541	13.7

Interpretation of Results Obtained by the Two Schools of Medicine

[45] T. M. File, T. J. Marrie. Burden of community-acquired pneumonia in North American adults. Postgraduate Medicine 2010; 122: 130-41.

[46] M. J. Fine, et al. Prognosis and outcomes of patients with community-acquired pneumonia. A meta-analysis. JAMA 1996; 275: 134-141.

The startling difference in the results reported in patients with pneumonia by the two schools of medicine can be explained in three ways if we limit our discussion for the time being to PAA:

1. Homeopathy may have done neither harm nor good, and PAA killed people; therefore the outcome was better with homeopathy.

2. Homeopathy saved lives, and PAA may have done neither harm nor good; therefore the outcome was even better for homeopathy.

3. Homeopathy saved lives, and PAA killed people; therefore the outcome for homeopathy was still better.

Whether PAA killed pneumonia patients, if it did, at what rate, and what percentage of patients was saved by homeopathy remain questions for investigation. The best way to answer those questions would probably be to examine the records of expectancy in the treatment of pneumonia patients.

All trials[47] on expectancy and pneumonia that could be found in the literature show an average mortality rate of 13% and suggest that, on average, expectancy saved or PAA killed about 114 out of every 1,000 patients with pneumonia. Homeopathy, on the other hand, saved at the very least an extra 96 lives out of 1,000 patients beyond expectancy; that could explain the 20.9 percentage-point difference between the mortality with homeopathy and with PAA, which was on average 3.4% and 24.3% respectively.

However, since mortality under CCC in patients with CAP is 13.7%, and since the average mortality rate in Dietl's only official report and that of the three physicians who tried his expectant approach was 21.1%[48] (see table below) it

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[47] All the trials on expectancy and pneumonia that were found in the literature were presented and discussed in Part IV of the extended version of this response, which can be read at: http://www.homeopathy.ca/debates_2013-03-22.shtml

[48] Jules Le Beuf. Étude critique sur l'expectation. Paris: Adrien Delahaye, 1870, 22.

may be closer to reality to infer that about 33 out of every 1,000 patients with pneumonia were saved by expectancy or killed by PAA. This would therefore imply that homeopathy saves about 177 out of every 1,000 pneumonia patients.

Table 6: Mortality from Pneumonia under Expectancy

	Expectancy		
Researcher and year	No. of cases	No. of deaths	Mortality (%)
Dietl (1854) Official report of the hospital	92	19	20.7
Schmidt (1851-1854)	53	11	20.8
Bordes (1855)	77	17	22.1
Wunderlich (1856)	157	33	21
Total	379	80	21.1 (average)

Those statistics above show that:

1. The odds of surviving CAP are 28 to 1 with homeopathy, were 3 to 1 with PAA, and are today 6 to 1 with CCC.

2. The relative risk of dying from CAP was 7.1 (95% CI 6.7 to 7.6), or 7 times as great with PAA as with homeopathy ($P < 0.0001$).

3. The relative risk of dying from CAP is today 4.03 (95% CI 3.75 to 4.32), or 4 times as great with CCC as with homeopathy ($P < 0.0001$).

4. The odds ratio of surviving pneumonia with homeopathy was 9.1 (95% CI 8.48 to 9.73), as compared with PAA ($P < 0.0001$), and would today be

4.5 (95% CI 4.2 to 4.9), as compared with CCC (P < 0.0001).

5. The odds of surviving CIP during the NIP were 148 to 1 with homeopathy versus 16 to 1 with PAA.

6. The relative risk of dying of CIP during the NIP was 8.3 (95% CI 7.6 to 9.1), or 8 times as great with PAA as with homeopathy (P < 0.0001).

7. The odds ratio of surviving CIP with homeopathy during the NIP was 9.0 (95% CI 8.2 to 9.9) as compared to PAA (P < 0.0001).

8. The odds for pregnant women of developing pneumonia during the NIP were 1 to 17 under homeopathy, and even odds or 1 to 1 under allopathy.

9. The odds for pregnant women of surviving CIP during the NIP were 135 to 1 under homeopathy versus 2 to 1 under allopathy.

10. The relative risk for pregnant women of dying from CIP during the NIP was 41 (95% CI 26 to 63), or 41 times as great under allopathy as under homeopathy (P < 0.0001).

11. The odds ratio for pregnant women of surviving CIP during the NIP was 58 (95% CI 37 to 90) under homeopathy as compared to allopathy (P < 0.0001).

When all the confounding factors examined,[49] including expectancy, are taken into account, the results obtained by genuine homeopathy in the treatment of pneumonia patients demonstrate that:

1. The treatment effect of homeopathy is positive.

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[49] Discussions on the confounding factors were presented in Part I and Part II of the extended version of this response, which can be read at: http://www.homeopathy.ca/debates_2013-03-22.shtml

2. The magnitude of the treatment effect of homeopathy is remarkable.

3. Homeopathy greatly shortens the duration of the disease and the recovery time without leaving patients weakened by the treatment.[50]

4. The higher the potencies used, the better the results on all six criteria that were measured, namely, (1) the seat of infiltration, (2) the duration of infiltration (reckoned from when it was first observed to when it began to be resolved), (3) the time at which resolution of the infiltration began, (4) the time at which resolution was complete, (5) the time at which all physical signs disappeared, and (6) the duration of convalescence.

5. Homeopathy clearly saves lives: 21 lives were saved out of every 100 cases of pneumonia in the PAA era, and 10 lives out of every 100 cases would be saved today.

6. Homeopathy offers the safest and best outcomes ever demonstrated by any system of medicine for patients with pneumonia.

Rating the Quality of the Evidence and Strength of Recommendations Based on Evidence-based Medicine Criteria

The Canadian Evidence-Based Care Group wrote in 1994, “Occasionally the benefits of an intervention are so clear, and the harms and costs so small, that there is little or no need for rigorous evaluation.”[51]

Even though the evidence examined so far for the effectiveness of homeopathic treatment of patients with CIP is clear, let us now evaluate it from the

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[50] The discussion on the time of recovery in patients with pneumonia was presented in Part IV of the extended version of this response, which can be read at: http://www.homeopathy.ca/debates_2013-03-22.shtml

[51] A. D. Oxman, J. W. Feightner (for the Evidence Based Care Resource Group), Evidence-based care. 2. Setting guidelines: how should we manage this problem? Canadian Medical Association Journal 1994; 150: 1417-23.

perspective of evidence-based medicine (EBM). The main purpose of such an evaluation would be to rate the evidence and strength of a recommendation for an intervention with a particular population of patients.

Four questions should be asked in this rating process:

The first question is, “Does homeopathy work as an intervention or not?”

Reliable evidence from rigorously conducted RCTs has conclusively demonstrated that homeopathy works.[52]

Even without the evidence provided by RCTs, all experience and data support the evidence that homeopathy forms a consistent and robust intervention with a scientific basis and sound principles. That experience and data are found in numerous in vitro experiments, an enormous collection of clinical reports and case studies, expert opinions, cohort retrospective studies, and prospective observational and epidemiological studies.

Two recent effectiveness studies considering all available systematic reviews have demonstrated that homeopathy is safe and cost-effective and has consistent and strong therapeutic effects and real-world, long-term effectiveness. And, despite criticism of these studies, the evidence presented is equivalent to that of conventional medicine, when analyzed without prejudice.[53,54]

The fact that every aspect of homeopathy, from its development to its final application to patients with all types of conditions, is consistent with the purest

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[52] Descriptions of rigorously conducted RCTs and discussion can be found in Part I of the extended version of this response at: http://www.homeopathy.ca/debates_2013-03-22.shtml

[53] Michael E. Dean. The Trials of Homeopathy: Origins, Structure, and Development. Essen: KVC Verlag, 2004.

[54] Gudrun Bornhöft, Peter F. Matthiessen. Homeopathy in Healthcare—Effectiveness, Appropriateness, Safety, Costs: An HTA Report on Homeopathy As Part of the Swiss Complementary Medicine Evaluation Programme. Springer, 2011.

methods of the experimental and natural sciences and that the clinical outcomes have been consistently outstanding are sufficient evidence to demonstrate the soundness and effectiveness of homeopathy.

The robust epidemiological and observational evidence clearly establishes cause and effect between the homeopathic treatment and the recovery of health and saving of lives.

The question of causality becomes even more convincing when the fundamental sciences support the plausibility of the high dilutions commonly used in homeopathy. Moreover, extensive in vitro research with cultured cells, microorganisms, enzymes, yeasts, and plants entirely supports the biological plausibility of the law of similars and of highly potentized remedies. Finally, clinical research in animals confirms all the experience that has been reported in humans.

In fact, all evidence and experience indicate that the law of similars is a real and irreducible phenomenon.

Scientists who have studied the question seriously have acknowledged that the record of homeopathy is unique in the history of medicine, for no other intervention presents such a huge amount of high-quality evidence for the prevention of disease and recovery of health in patients with all types of acute and chronic conditions.

The second question of this rating process is, “How effective is homeopathy in the treatment of patients with CIP?”

Often observational studies yield only low-quality evidence, but there are unusual circumstances in which guideline panels will classify such evidence as of

moderate or even high quality.[55]

Because the results obtained with genuine homeopathy are consistent, reliable, predictable, and highly favorable in patients with CIP, regardless of the confounding factors examined and regardless of the time, place, or physician, we may be very confident about these results, which indicate a high quality of evidence.[56]

It has been known since at least the mid-1800s that homeopathy saved lives whereas PAA killed patients with CIP, and all experience shows that significantly fewer people die of CIP under homeopathy than under PAA or CCC. Therefore these facts yield an extremely large and consistent estimate of the magnitude of the treatment effect.

Some critics may question the value of the epidemiological and observational evidence presented in this essay. However, Dr. Daniel J. Hoppe et al. of McMaster University have argued, in a paper called "Hierarchy of Evidence: Where Observational Studies Fit In and Why We Need Them," that when treatment effect in observational studies is very pronounced, when it shows effectiveness adequately, and when no confounding factors could account for such a large effect, the study design is no longer so critical.[57]

Because of the shear mass, homogeneity, and consistency of the results and the large effect obtained by homeopathy, particularly in critical cases, the evidence becomes very strong. Dr. Gordon H. Guyatt et al. write, "When methodologically

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[55] Holger J. Schunemann, Roman Jaeschke, Deborah J. Cook, William F. Bria, Ali A. El-Solh, Armin Ernst, Bonnie F. Fahy et al. An official ATS statement: grading the quality of evidence and strength of recommendations in ATS guidelines and recommendations. American Journal of Respiratory and Critical Care Medicine 2006; 174 (5): 605-614.

[56] Gordon H. Guyatt, et al. Rating quality of evidence and strength of recommendations: GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. British Medical Journal 2008; 336 (7650): 924-926.

[57] Daniel J. Hoppe, et al. Hierarchy of evidence: where observational studies fit in and why we need them. Journal of Bone and Joint Surgery 2009; 91 (Supplement 3): 2-9.

strong observational studies yield large or very large and consistent estimates of the magnitude of a treatment effect, we may be confident about the results."[58]

The evidence of the effectiveness of homeopathy in CIP patients is therefore of such high quality and shows such an extremely large treatment effect that further research would be very unlikely to change the confidence in the estimate of the effect of the homeopathic treatment in these patients.[59]

The third question in this rating process is, "On the basis of its effectiveness, what should the strength of a recommendation for homeopathic treatment be in the case of patients with CIP?"

Any question about the best clinical evidence for the effectiveness of homeopathy leads to a rating of the strength of the recommendation attached to it, and that depends on two factors: (1) the tradeoff between the benefits and the risks and burdens; and (2) the quality of the evidence for its treatment effect. In the highest category, the tradeoff is clear and leads to a strong recommendation.[60]

Since there is no harm or risk from genuine homeopathic treatment, the balance of benefits and harm can be classified only as a net benefit; and since most reports cited in this paper show much higher recovery rates and much lower mortality rates with homeopathy than with PAA and CCC, the magnitude of the benefits of homeopathic treatment is certain. Therefore, there should be no

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[58] Gordon H. Guyatt, et al. Rating quality of evidence and strength of recommendations: What is "quality of evidence" and why is it important to clinicians? British Medical Journal 2008; 336 (7651): 995-998.

[59] Gordon H. Guyatt, et al. Rating quality of evidence and strength of recommendations: GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. British Medical Journal 2008; 336 (7650): 924-926.

[60] Ibid.

hesitation in making the strongest possible recommendation that homeopathic treatment be adopted for patients with CIP.[61]

However another point should be considered here, namely, "Are the net benefits worth the costs?" Since the cost of homeopathy is low from a technical and medicinal point of view, it should receive the highest recommendation of any intervention (1A/strong recommendation with high-quality evidence). Furthermore, each homeopathic intervention is preventive,[62] and the incidence of CIP in patients who had already been treated homeopathically would be less than in the rest of the population. Indeed, by enhancing the healing process in every individual who is being treated with genuine homeopathy, the patient's general health is optimized, the organism is better able to regulate itself, and a greater immunity to various diseases is thereby obtained. Moreover as soon as homeopathic treatment is begun in CIP patients, any further development to the advanced stages or complications of CIP is usually prevented.

The prevention of adverse outcomes further justifies the highest recommendation for the homeopathic treatment of patients with pneumonia.[63]

Such a strong recommendation for patients with CIP should, as a rule, also apply to patients with other infectious diseases, because homeopathy does not attack microorganisms, such as viruses or bacteria, but instead strengthens the organism's capacity to defend and regulate itself. For that reason, homeopathy should be offered to patients suffering from inflammatory diseases and, to a lesser degree and with certain exceptions, to patients with a variety of other

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[61] Ibid.

[62] Discussions on homeoprophylaxis were presented in Part I, Part II and Part IV of the extended version of this response and can be read at: http://www.homeopathy.ca/debates_2013-03-22.shtml

[63] Gordon H. Guyatt, David Gutterman, Michael H. Baumann, Doreen Addrizzo-Harris, Elaine M. Hylek, Barbara Phillips, Gary Raskob, Sandra Zelman Lewis, Holger Schunemann. Grading strength of recommendations and quality of evidence in clinical guidelines: report from an American College of Chest Physicians task force. Chest Journal 2006; 129 (1): 174-181.

medical conditions, just as one would recommend a healthful diet and lifestyle.[64]

It is very important to note that, considering the increased incidence of antibiotic resistant infectious diseases, and the iatrogenic effects of antibiotic overuse, the use of homeopathic medicine can be an answer to some of the most difficult problems facing public health today. The issue is so important that is reaching ethical dimensions.

Moreover, from a purely scientific perspective, what criteria would prevent homeopathy to be adopted universally as a mainstream method of treatment, as reports and trials contained in the voluminous homeopathic literature, which consists of some 30,000 volumes, show a consistent and most favorable balance of risks and benefits, a high quality of care, and a high significance and magnitude of the outcomes in patients with both acute and chronic conditions?

It goes without saying that the best prophylactic and therapeutic methods should be at the service of everyone, and since homeopathy has amply demonstrated that it is the intervention of choice, it should be universally available, not only to any population threatened with infectious and epidemic diseases, but also to the rest of the population.

One of the unique features of homeopathy is that it treats patients and not diseases. Therefore, whenever there is a new infectious or epidemic disease, homeopathy does not have to create new remedies but simply uses from its store of more than 650 established remedies the ones that are most indicated in the newly emerging disease.

The strong recommendation for homeopathy, mentioned above, would have the following implications:

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[64] Gordon H. Guyatt et al. Rating quality of evidence and strength of recommendations: GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. British Medical Journal 2008; 336 (7650): 924-926.

1. Patients with CIP and other infectious and inflammatory diseases (CIPOIID) who are clearly informed of the basis for such a strong recommendation would want to be treated with homeopathy.

2. Clinicians should offer genuine homeopathic treatment to patients with CIPOIID.

3. Policy makers should ensure that homeopathy is adopted as a standard treatment for this population of patients.[65]

When setting priorities, governments and public health officials must also consider factors beyond the strength of a recommendation, which would include the following:

1. The high prevalence of CIPOIID and its high morbidity and mortality. Worldwide about 13 million people die every year from infectious diseases. More than 2 billion people are infected with the TB bacillus. An estimated 247 million are infected with malaria every year, and in recent years, the number has increased significantly.[66] The Autoimmune Related Diseases Association estimates that 50 million Americans, or about one in six, suffer from an autoimmune disease and that the prevalence is rising.[67]

2. Considerations of equity for disadvantaged populations: As homeopathy is very inexpensive both for short- and long-term treatment, disadvantaged populations can greatly benefit from it. Homeopaths have a rich tradition of setting up free dispensaries to serve such populations.

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[65] Gordon H. Guyatt, et al. Rating quality of evidence and strength of recommendations: Going from evidence to recommendations. British Medical Journal 2008; 336 (7652): 1049-1051.

[66] http://www.smartglobalhealth.org/issues/entry/infectious-diseases

[67] http://www.aarda.org/autoimmune-information/autoimmune-statistics/

3. Long-term health benefits of homeopathic treatment: People who receive homeopathic treatment throughout their lives experience a major improvement in their health and the overall quality of their lives.[68]

The fourth and final question for rating the evidence is, "Aside from patients with CIP, what would the prognosis be in patients having any of the numerous WPDs if they were to be treated with genuine homeopathy?"

Since homeopathy doesn't address WPDs directly but rather treats patients experiencing acute or chronic states of dysregulation, it would be easier to identify the patients who would benefit least from homeopathy, such as those suffering from problems with purely mechanical causes (e.g., surgical cases, cases of poisoning where an emetic or an antidote would be indicated, or cases of heavy metal poisoning where the use of a chelating agent would be indicated, etc.). However, even purely surgical cases do better when homeopathic treatment is administered before, during, and after surgery.

Essentially, homeopathy can be used for any person or animal with an acute or chronic condition. After surveying the vast homeopathic literature, we can say with confidence that by directly strengthening the organism's capacity to defend and regulate itself, homeopathic treatment is curative in patients with physical, emotional, and mental conditions, both acute and chronic, that are curable in nature.

Homeopathy can also be used successfully for palliation in incurable conditions. Even patients with irreversible tissue changes or fixed genetic diseases with 100% penetrance of their genetic expression[69] still benefit from homeopathic treatment.

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[68] William H. Holcombe. Why are not all physicians homoeopathists? United States Medical and Surgical Journal 1874; 9: 129-147.

[69] I. Miko. Phenotype variability: penetrance and expressivity. Nature Education 2008; 1 (1): 137.

Appendix: Abbreviations

CAP: community-acquired pneumonia

CCC: contemporary conventional care

CIP: combined influenza and pneumonia

CIPOIID: combined influenza and pneumonia and other infections and inflammatory diseases

HCAP: health-care-acqured pneumonia

NIP: influenza pandemic of 1918

PAA: pre-antibiotic allopathy

WPD: well-defined patho-physiological disease