

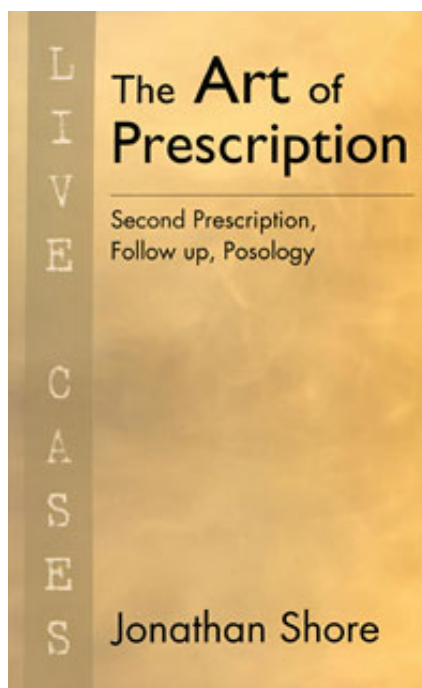
Jonathan Shore

The Art of Prescription - Live Cases

Leseprobe

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von [Jonathan Shore](#)



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INTRODUCTION

DR: This is a part two seminar after a year's break. We will continue where we left off. Some of the audience have met Jonathan from California, who has been involved in homoeopathy for fifteen years. I met him in America and was very impressed by his balanced view of homoeopathy. Although he belongs to the classical school of prescription, he is quite prepared to involve himself in discussion and debate and other ideas. His flexibility extends to his style of care and his style of teaching. I think probably almost all of you have had one of the previews of the videos from last year, just how impressive they were.

JS: What I am going to try and do, is somewhat less dramatic and somewhat more instructive. We are going to try and deal with the evaluation of the action of the remedy and the second prescription (see evaluation, page 288 - 291). So mostly this will be paper cases and not so much an exercise to find the remedy, but to see what has happened after we have given the remedy. Because anyone who has been in practice for a little while realises that finding the remedy is the easiest part. It is once you have found the remedy that your troubles really begin. I will go through and I will give you an idea of how I perceive the various categories of events. Then we will go through the cases one by one and try and see which case illustrates which category of events.

The first prescription is of course **the first remedy which acts**, not the first remedy which you give. You can give ten remedies and not have a first prescription. Of course after your remedy has acted, a decision needs to be made at some point as to whether you need a different remedy and how you will choose what this different remedy might be. So just in passing, I want to make some remarks about the evaluation of acute prescriptions, because these cases you will see here, are chronic cases.

The rhythm of intervention needs to correspond to the rhythm of the disease. In other words: in an acute case you can make a

decision after forty-six hours in many cases, and change the remedy if there is no action. So if you have someone who has an acute bronchitis, pneumonia, a child with pneumonia, a child with severe otitis, cholecystitis, you don't give them the remedy and say: "Call me in two or three days." You expect your remedy to show some action pretty quickly. And you have to evaluate that according to the time of day and the anxiety of the patient. Usually I would say that in acutes which are not really severe, I let them take the remedy every four hours over a twenty-four hour period of time, and I tell them to call me the next day. Because if you tell them that if the remedy has not worked after four hours, they have to call you, they will call you, and they will say: "It hasn't worked!" Unless of course, it is a really clear and dramatic prescription, but most of the time (at least at my level of prescribing) in acute cases, I am satisfied if my remedy turns the case around. A really, really precise prescription in an acute case will work within ten minutes and within an hour or so the person will feel almost completely better. That is a rarity in my personal experience, simply because it is not always easy to find the exact similitum in acute cases, and it is sufficient for me if after they start taking the remedy, instead of declining they begin to turn around and get better. But if they are really sick, the kid is screaming with the otitis, or the person is writhing around with a renal colic or something like that, the remedy has to work very quickly. I mean, in the office, you should see some action.

In chronic disease the situation is of course quite different. The optimum time for evaluation is after a month, and this is by experience. Actually in many cases it could even be longer than a month, but some balance has to be struck between the expectation of the patient and what we consider to be optimal. So a month is good enough, unless of course the person has quite severe asthma or they are on the verge of blowing their peptic ulcer. Then it is needless to say that the way in which you follow the case has to correspond a little more closely to the severity of the condition. But evaluation after one month is really the best time, and often you will see that it is only in the fourth week that people will actually recognise that they are feeling better. Not all the time, but in a

certain significant percentage of cases, it takes a little while before it percolates through to them. If you see them sooner, they will catch you in their trap, in their anxiety and you will prescribe another remedy too soon.

This has happened to me. I remember a case from many years ago, where I gave this woman, *Natrum muriaticum*. I was supposed to see her after two or three weeks, but something happened and I only managed to see her after a month. She came and she told me that after the remedy, starting right away she had a headache, every day for three weeks, and on the twenty-first day the headache disappeared and she felt better than she had in a very long time. Now I know at that level of my experience, if I had seen this woman at nineteen days, I would have changed the remedy, because I would have thought: "Oh my God, I have done something wrong; now she has this bad headache, I messed things up." So be aware of this. Give your remedy time.

The first question that we need to face, is: what is it that is being evaluated? We are evaluating our prescription; exactly what are we trying to evaluate? If you think about this for a while, you might arrive at the conclusion that what we are trying to measure is the degree to which the vitality of the organism has been stimulated or aroused. Because in the final analysis this is all that we are trying to do with our remedies. We are trying to arouse, stimulate the organism's own mechanisms of defence. I think it is very important to understand the idea, that I regard the human organism as an intelligent being, which has far greater capacities for knowledge and intelligent action than I have in my mind. When we make a judgement with our minds about what the body should or should not do, we are imposing the menial onto the master; that is the wrong direction of the hierarchy. So we have to be very cognisant, very careful to understand, that our only job in a way is to give the organism more capacity to do what it already knows how to do. And we use these words; we say: "We stimulate the vitality." For those who don't buy "vitality," we say: "We stimulate the immune system." Everybody knows what the immune system is these days, so we have got to use this word. But whatever it is, we are evoking a response from the healthy part. This is the idea.

The degree of possibility of stimulation or arousal depends upon two factors, broadly speaking:

One: is the accuracy of the prescription itself.

Two: is the inherent limitations of the organism, because what doesn't exist, can't be stimulated.

You will understand the principle of resonance; if you stand next to a piano and you play your violin and you play a certain note, the corresponding piano string will vibrate. If you don't play the note, you are not going to get any corresponding vibration, and if the string is not there, you can play till you are blue in the face. Both these factors have to come into correspondence.

At the end of the first interview, we should be able to form a definite preliminary evaluation of the state of the vitality of the organism, or to put it in different words, of the prognosis. We need to be able to make for ourselves a prognosis. What do we expect to happen in this case? Of course in the beginning most of the time we are wrong. But if we ask this question each time we see a case, sooner or later we gather sufficient data so that we can become more precise. And in a way it is our job to become more precise.

The evaluation of the state of the vitality is based upon the following factors:

1. The clarity of the remedy image. This is a very important thing. No matter how sick the patient may appear, if the remedy image is very clear, it means that this person has a strong vital force. You understand why. Someone can have very severe symptoms, but the remedies are organic patterns and if the organism, despite severe illness, is able to maintain a clear and coherent pattern, if the vitality of the organism is not confused, it means the vitality is strong.

AD: Sometimes you get the feeling with a patient: this is a clear picture, but you don't know what picture it is.

JS: That is the area of the accuracy of the prescription.

AD: ... there is a wholeness about the case ...

JS: Yes, I would go along with that, provided that one knows enough homoeopathy. Because you may think it is very clear, but maybe it is really quite a confused picture, you see. And this has

happened; I have seen cases which I thought had such good symptoms, that it was possible to find a remedy and I tried a long time. Vithoukaskas saw the case and he said: "Oh, God, you'll never find a remedy for this case." But generally speaking you can make your prognosis, if you can see the remedy clearly. Then you are really justified, yes.

AD: Are you talking about clear modalities, clear pictures of symptoms?

JS: Yes, because unless you have clear modalities, you will never find the remedy, unless you happen to be lucky. So homoeopathic symptoms usually consist of clear modalities and other factors. I am saying that you can see clearly that this is the remedy and the clearer you can say that with confidence, the better the prognosis, because the right remedy always cures. So that is the first thing, the clarity of the remedy image and the integrity of the vitality.

2. The depth of the pathology. You have to consider the centre of gravity of the illness (is it mental, emotional or physical) and the degree of organic change or end-organ damage. So of course, if you have someone who has no kidneys, and you see a clear remedy image, you know you will be able to palliate this person very well for a while, but you are never going to regrow their renal function if they really have no kidneys. So the depth of organic pathology is an important consideration in the prognosis as is the depth of the illness. If someone has severe long-standing mental illness, which they have been treating with many, many psychoactive medications, the chances are that you will not see a clear remedy image. If you have a case like that, and the remedy is very clear, you know you will cure this person. But most often you get a case and you think that you know the remedy, but it is not so clear. And then you see that the degree of illness of the patient is very deep, don't tell them: "By next month you will be fine," This is not your expectation, for yourself, and don't give the patient that expectation.

The degree of non-pathological, non-end-organ damage may also be judged by the freedom from limitation or the extent of the

limitation on the freedom of the person's life. So if you have someone who is completely house-bound, because they are terrified to walk out into the street, you understand that this person's life is severely limited and it is going to take a while to bring them back to a normal existence. The degree of the limitation is a very important prognostic indicator.

3. The past medical history, treatments and suppressions,

Of course all these factors have to be weighed in the balance. It is not one of them, it is not the other one of them, but all these. This is how you form for yourself an idea about the case. What is this person's past medical history? Asthma at birth, then severe eczema treated with cortisone for ten years, then the gallbladder was removed, then Xanax for anxiety, and now in front of you. How do you view the prognosis of this patient? Not good.

4. Family history. Very important. Someone comes to you

with mild chronic headaches - not too bad. They just have a headache, it is there, it sort of bothers them, and they have tried many things; it has not helped. They come to you and you think: "Aha, this is not too bad." Mild headache, they are a little fatigued, they don't feel quite the right oomph in their life, and you are going I to do something about it. You look at their family history and you see that their mother was schizophrenic, the grandfather died of diabetes, and on the other side of the family there was tuberculosis, the mother's uncle had cancer and the other brother has something else. You step back from it and you realise that this case is probably going to be one of your most difficult cases. Why?

AD: A blockage in the cure ...

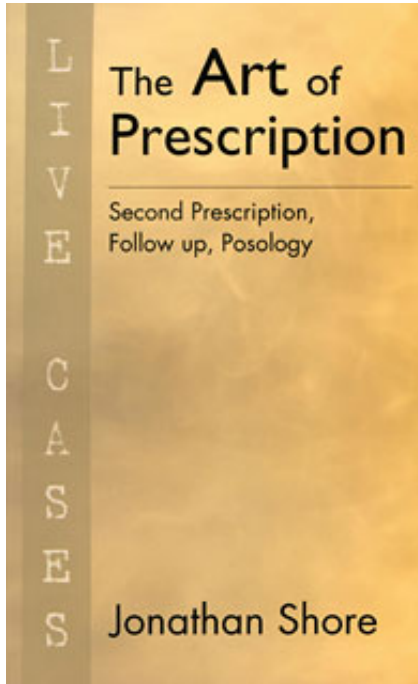
JS: A blockage in the cure, yes. But what you will see is that the symptoms which this person will give you will be vague. "Oh, I just have this headache. Oh, I'm just fatigued; I'm not really ill, I've never been really ill." But the symptoms will be vague, and the family history is bad, and you realise that the roots of this illness go very deep, and the flowers are very nondescript. These are the most difficult cases, because you can't find the remedy. So this sort of case has a very bad prognosis even though they are not that ill, You see the opposite end of the spectrum. Someone who is very ill

and has a clear vitality, a good remedy image and good family history; you cure them. Maybe even insulin-dependent diabetes. And at the other end the person who is not really so ill, just suffers from lack of vitality, and has bad family history. This is a much more difficult case in the end. So it is against the background of this information that the evaluation of the action of a remedy needs to take place. When you are evaluating your prescription (how has it worked, what do I expect, how long do I wait, all these things) this is the information that needs to form the backdrop of the drama.

Having decided **what** is being evaluated, we now have to decide **how** to evaluate; what parameters shall we use to determine the effects of the remedy? And of course symptoms being the main tools of our work, we turn to these. Especially those which reflect the totality of the patient's life, especially those symptoms which reflect the person as a whole. In Kent's terms we may say the generals; do they feel improved in a general way. This general feeling of well-being may be broken down into three main components (in this order):

- 1) Their level of energy.
- 2) The mental-emotional state.
- 3) The chief complaint (s).

1. Their level of energy: for instance, someone comes and he has severe headaches, you prescribe, and he comes back after a month and he says: "It didn't work. I still have my headaches." "That is fine," you say (you don't immediately throw yourself out of the window), "How do you feel?" "It is a funny thing, I am actually getting more work done than I have in years." And you say: "And when you wake up in the morning, you still..." And then he says: "No, no, my energy is pretty good in the day; my energy is good but oh, the headaches." Don't worry, your remedy is acting. On the other hand, if you treat them and they come back to say: "A miracle! A miracle, my headaches are gone." You ask them: "And how do you feel?" They say: "You know this last month (sighing), I mean really, I've been so tired." Watch out, bad news! The general level of energy is the most sensitive general indicator.

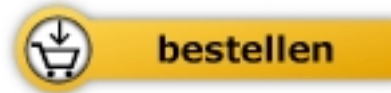


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