R. Hayes über das General Analysis

Beim Treffen der International Hahnemannnian Association 1938 hielt Royal Hayes einen Vortrag über Boger´s Kartenrepertorium. Die 1939 herausgegebene Veröffentlichung und die daran anschliessende Diskussion über Repertorisation an sich und über Boger´s Repertorium im Speziellen wird im Folgenden vollständig abgedruckt:

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REPERTORIES: BOGER'S ESPECIALLY

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Boger's Synoptic Key in the form of cards and accompanying General Analysis in my opinion is by far the best of repertories. lt seems strange, that it has not come into popular use. lt has been mentioned in the literature only casually. Some writer in the Paciflc Coast Journal mentioned it a year ago or so as his preference, but that is the only instance of its use known to me. I have shown its operation to three or four; they nodded and went their way. I had a short illustrative account in the Homoeo-pathic Recorder for February, 1933 (of which a few reprints remain) and the writer was prepared to follow this with a series of case illustrations showing various ways to use it, but as for some reason only the first was published the project was abandoned. I recall, however, that Boger himself was much pleased with what had been worked out and said that it had suggested to him still further ways to manipulate this repertory. This flexibility according to the peculiarities of problems is one of the main features of the invention.

But before discussing this repertory especially I would like to talk about repertorization in relation to our materia medica in general. Certainly we use repertories less as we become more acquainted with the pathways through the materia medica, those pathways with verifications and signs by which we have been guided before, and those trails which we recognize as guiding in their nature, that is, beholden to the individual remedy whether used before or not. In one way or another one must ultimately make one´s own path through the materia medica forest and this should be accomplished as steadily and rapidly as possible. lt seems to me that present methods of training are not as thorough or as extensive as they might be. If we could have less „science" and more medicine I think it would be better. The pursuit of materia medica is, or should be, a life work in itself. Contrary to the common conception or practice, at least, it is the vortex of medicine, an intensive art, directed to and with great possibilities of cure. What about other arts requiring close application? lt takes five years or more for a talented student of music to play the finer works and fifteen, more or less, to qualify for the public platform. There are almost as fine nuances in materia medica as in music. And the performances today? Well, it's time to be going along with our subject.

The study of materia medica should be intensive, and in accord with the principles of prescribing and the higher physiology and pathology, that is, the balance, imbalance and direction of forces. With the exception of us few antiquated numerals in the homoeopathic camp these are almost entirely ignored.

In practice a lively pursuance of the quest will pull one away from any tendency toward routinism, sending one along new paths through the unknown, through which, even today with our boasted skill, we have made but little more than a clearing. lt is safe to say that the powers of homoeopathic materia medica hold as great possibilities

for improvement of the race in its present status of being as any influence that has ever been revealed. And it is an enterprise in which if the medical profession were coordinated every physician would be making „great discoveries“, not the noisy kind that comes and goes suddenly like Belladonna pains, but adding to his own art, and to durable therapeutic knowledge; and to an extent that we can hardly realize even with our present semblance of efficiency. How many suspect, for instance, that Podophyllum is a very potent remedy for certain injuries of the spine? or that 11 p. m. is a very strong, a primary indication for Silica? All careful prescribers uncover uses that their fellows have not known. There are great un-known resources even in our familiar remedies.

I mention this to emphasize the recognized fact that the possibilities of materia medica knowledge and especially of the paths that traverse its fastnesses are above considerations of repertorization. The reason that materia medica is paramount is that a homoeopathic remedy is an entity, at once a unit and a representation of sick individuals, having identity, form, proportion, intensities, relations, all the dynamic qualities that are the replica of sentient beings. Provings, when understood, unmask this truth.
This being so, the dependence on repertorization or emphasizing it at the expense of thorough and everlasting study (discovery might be the better word) of remedies is the wrong approach to its understanding; and although it sometimes seems unavoidable it is the wrong approach to the patient’s remedy.

Students are always being told, and rightly so, to study and compare remedies after the repertorial choice has been made. But the writer believes and it is true in his experience that the freshness and continuity of remedy personality, its essential part, is liable to be lost or faded after going through the repertorial headache. Although many useful points may be acquired with observant use of rubrics one is not so likely to erect any life-like personal complex from them even with the best care in attaching values to the remedy notations. Qualities, relations and intensities are not so naturally associated in the repertory; they are more arbitrary and fragmentary and easily may become offset from the picture; therefore, off the patient’s center of gravity.

Values are apt to be brought together in the repertorized scheme that have a different relative value in the patient. So, although the warp is there, the woof with its colorings may be disrupted. The repertorized schema is but a cross section and too often, especially with problems not suited to repertory study at all, becomes mere symptomatic hash. When one sees that, he should turn from it, study the reason and seek in the materia medica. There, with skillful reference, ye shall find if thou knowest what of quality to look for.

It seems to me that one may be at times too much influenced (I know that I have been) by the repertory result; that too much dependence on the repertory with its lack of joining symptoms in vital relation and in Kent’s the gross error of excluding concomitants may tend to inhibit remedy acquaintance both in number and quality. Although one must consult the text to differentiate the few remedies that have survived the repertorial test, yet, I think, repertorization is a crude approach toward that significant totality that inheres somewhere in every patient and his remedy. For myself I can say that my best results have been attained by diving into the complex sans mechanism, often making the choice from clues or features not in the repertory. One’s interest in the art of discovering remedy genius should overcome most of the difficulties of size and time met with in the materia medica. I admit though, that in the present low requirements in materia medica the young student may, with repertory use, acquire sooner a tolerable skill in the use of homeopathic medicines. In the face of present unfortunate training possibilities, that would seem to be its best utility excepting, of course, the indispensible indexing. In concluding this part of the subject I would say: Take to repertorization as a confession of failure either to uncover the central and reactible features of patient and remedy or to properly evaluate what is at hand or of a too limited acquaintance with remedies, either numerically or their individual scope or both.

As to Boger’s Repertory, Boger was many years bringing this work to its present state. He added new rubrics with caution and only as his personal work needed them. This made it more practical and guarded against including less pertinent rubrics. No repertory can ever be complete or perfect but Boger did a wonderful job. One would not suppose that a few rubrics like Moistness, Yellow, Discharges ameliorate (suppression), Loose, Relaxation, Inactive, etc. would take the place of so many other

considerations but they do and there is reason behind it.

In this way: Analysis, as I understand it to apply to provings and to patients, is a resolution of the data into the simple elements of the individual complex. This is what Boger's repertory points toward. Compare it with a great part of Kent's, for instance. Chopping up symptoms and regions and laying the pieces up in piles to the extent that Kent did does not help analysis in the philosophical or homoeopathic sense.

Boger made a serious attempt (although in my opinion the object can never become fully realized) by selecting and theoretically consolidating influences or conditions that hold sway over sick individuals, to unite analysis and synthesis in one rubric, usually expressed in one, two or three words. His degree of success in this, as the unavoidable clumsiness of repertory procedure goes, is one of the items that helps to make his repertory superior.

Boger's Repertory is the quickest, usually requiring less than ten, sometimes five minutes for a solution. And it is, in my opinion, the safest in that it is more likely than any other to include the desired remedy in the final group. The best remedy is as likely to be included at the start and less likely to be dropped out on the way.

Another feature, very important, is that judgment must be used in the selection of the first or basic rubrics. This care should be taken at the start. This is where the headwork comes in to save so much time. lt is a practical extension of Boger's idea of synopsis. This has often been practiced before by skillfull repertorists in making a short schema when desirable, but it is especially convenient with Boger's because of his masterly selection of terms for his rubrics (cards).

lt is of especial use with conditions having a paucity of symptoms. With many such problems the best remedy will be run out considerably beyond the others. That remedy, if any in the group, is practically certain to be the right one.

With some problems, if too many cards have been taken out, I eliminate some that can be safely dispensed with, of course in reverse order of their significance. In doing so I watch for the holes in front of a light and when several or a sufficient number for the particular case light through, it is enough. Sometimes I make a separate pile of these lesser values and calculate them separately. Sometimes I make a third pile out of more particular symptoms, especially such as may have been added from Kent´s repertory. Sometimes I estimate the values of these piles separately, at other times I add the first two; or one may add to the basic calculation certain cards only of the lesser groups, according to their merits and the (symptomatic) nature of the patient. In these extended selections one must be careful in admitting values so as not to put false weight on certain features of the problem. To avoid this I sometimes ignore all or some of these extended values as given and mark each one to the lowest degree. When symptoms with their values are taken from Kent's repertory one must be careful about accepting the values as given or false weight may accrue. I often change these values to agree with the patient or with former experience. The schema must be fitted to the patient, not the patient to any repertorial schema.

When the closely competing remedies have missing symptoms it is easier with Boger's repertory to decide to which remedy to give this negative weight. This is because the rubrics of this repertory are so potent.

The cards of Boger's and Field's repertories are interchangeable so we may use as much or little of either as desired. But of course, as always, care must be used in appending Kent's or Field's rubrics to Boger's so as not to carry the Kentian faults over into Boger's form and to avoid the undue influence of less essential or less controlling elements in the calculation.

Both Boger's and Field's repertories can be made to cut down their own time one-third or more by indicating the values around the holes as one goes on with its use. This can be done by marking a black circle, for instance, around first value holes, red circles around second value holes and green ink circles around the holes of least value, or small figures at the side of the holes if preferred.

When taking the cards from the pack they will be taken out by the name of the rubric. When replacing them, replace by number. lt works faster and saves time and wear.

Once in a while a problem may be worked out by the book alone (the Synoptic Key, not the General Analysis), especially those which present a very few strong peculiar regional symptoms with little else expressed. But I have seen few such instances.

As the prescriber becomes used to this repertory he will tend to run out the number of rubrics (cards) farther than at first, that is, it will take more cards to cover up all the holes. This shows that the user has gained judgment as to what to use and what to ignore. And it will often be found that the missing notations of closely competing remedies may be found in the materia medica or that the nature of the remedy accords with it, or the opposite, that it is of significant negative value.

The reader may think after reading all this that the less seriously he takes his repertory work, that is, after having become familiar with it, the better he will get along with materia medica; and this is true. Never-theless, Boger's Synoptic Key is a great little work, stamped with the genius of dear old Boger himself. He was a real German, as simple and natural as a child, but in mind and mastery of our philosophy and art, a giant.

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DISCUSSION

DR. HUBBARD: I would like to start the ball rolling by saying that if we were all as intuitive as Dr. Hayes we could follow this suggested method even better than we now can.
This general subject is very dear to my heart and I am interested to hear Dr. Hayes. My temperament works well with the Boger repertory. I suppose choice among repertories is a very individual matter, as all things are in homoeopathy. I shall go home and restudy my Boger cards, which I have and confess to not greatly using. I do agree with him that the older we get (and I am beginning to get old now) the less rigidly we do repertorize the majority of the cases, I think because our knowledge of patients and of remedies becomes deeper and broader, but I was quite struck with his remark that to use some repertory in a case is a confession of failure. In that case I think some of us still fail faithfully and long!
I would be glad to hear an expression of opinion from our members as to just how much they use the repertories, and just what values they find out of them.

DR. GRIMMER: I enjoyed Dr. Hayes' paper very much because it opens up some field for discussion and difference of opinion and we know an honest difference of opinion sometimes does us all good.
I think before we condemn any repertory we ought to know how it is constructed and the background back of it. I must confess that I haven't used Dr. Boger's repertory very much because I was trained to use Dr. Kent's repertory and I was trained to understand how the repertory was built, and unless you know that, unless you know how to follow it after the Hahnemannian manner of taking general groups of symptoms first and then going to particular groups, you can very easily get into a maze. A great many people have opened up the repertory and, without knowing, have thrown it down in disgust, saying they couldn't find head or tail, it was too big, there was too much of it. But if you take your cases carefully and if you learn the relative value of symptoms, you won't find Kent's repertory so hard to handle. You must know the symptoms that are really guiding.
Of course, that is true with any form of prescribing. The best prescribers prescribe on the high-grade symptoms, the mental and moral states, the reaction of the patient to environment, heat and cold, etc., aversions and desires. Take those groups, and you don't have to use so many of them. Three or four general symptoms will frequently lead you to the three or four remedies you want to study more carefully in the materia medica.
The old masters, many of them, would only turn to one or two pages in the repertory, and they had their remedy from study and from a thorough knowledge of the relative value of symptoms. You can take some cases and they will give you page after page of symptoms, and you have no case. That doesn't mean a thing to a prescriber. You can take other cases with three or four symptoms and you have a picture of a sick patient and that is what you must have if you are going to have a repertory.

DR. LEWANDOWSKI: I do not know the origin of Boger's Synoptic Key. However, it stands alone as a short, snappy road to a short repertorization of cases. In spite of

that I have gathered information that in Kent's repertory, with knowledge and wisdom gathered throughout the entire nation, Kent compiled his repertory after making intensive and extensive inquiries. On the other hand, C. M. Boger, from what I learned, practiced in one community and his hook is purely a personal experience, and oftentimes because of that fact may lead one astray from the straight path of correct prescribing.

Many times I have repertorized a case with exactly the same symptoms both from Kent's and C. M. Boger's, and found a big variance. In many cases I have found Boger omit a drug which was in very bold type in Kent's. I am led to believe that what I have heard is probably correct, that C.M. Boger has confined most of his information to his own community and did not seek beyond the confines of his practice to compile bis Synoptic Key. However, in spite of that, I do hold a great distinction for what the repertory stands for. In view of that fact I am oftentimes afraid to depend on it entirely, without at least substantiating it by a larger repertory.

DR. ROBERTS: Dr. Boger's repertory is good if you know how to use it. I have used it some; I have it in my office along with about sixty other repertories, and Boger's repertory to me is not as valuable as some of the other repertories.

Repertorization means the finding of the unusual symptom and getting the valuation of the symptom, because you realize we don't need to repertorize a great many of our cases, but chronic cases particularly require it - a few acute cases need checking up by the repertory. We have in Boger's repertory a compilation of remedies of highest rank from Kent's, from Boenninghausen's, and from some of the other repertories, taking about twelve of the most important remedies in each of those, those that have shown the largest relative values. That is all right so far as you are going, but they omit those remedies of lesser value in that rubric.

Doctor, I have talked to Dr. Boger myself about it several times, and I said I thought he was making a mistake, that he didn't include the remedies that are less frequently used, not valued as much as the others, for when I come to the point where I repertorize a case I want to know the whole materia medica in a repertorization, and the only way you can get it is to take an unabridged dictionary, if I might so express it, not an abridged one, because some of those remedies will come through with only one of the lowest valuations, one of the second valuations, and when you get through you have skipped, perhaps, the very thing that you want because you have skipped that one low valuation and your sum total doesn't work up. That is my objection, primarily, to Boger's repertory.

I do believe that all repertories are good in their place. We are all really waiting for the right kind. Sometimes some cases are more applicable to one repertory than they are to others. Once in a while I get a case that I repertorize by Kent. You may say that is natural, because most everybody in this room probably uses Kent exclusively, but I don't.

The most absolutely sure repertory in this world is Boenninghausen's. As has been said, it is nearly fool proof. You get symptomatic and numerical totality. Not only do you get absolute totality, but you are going to get evaluation along with it. Boenninghausen was the first one to evaluate remedies, and his valuation in five different evaluations is a very valuable thing for us to follow up.

I think we all tend to rely on some repertory, and everyone has his own ideas of how he can work best.

DR. FARRINGTON: I am one of those who does not depend exclusively on Kent. If the symptoms of the case are sufficiently characteristic, I usually use Kent because I can repertorize my case more quickly.

Like Dr. Grimmer, I was brought up with Kent's repertory. I started to subscribe for it and took it as it came out. When the symptoms are more or less common I turn to Boger or Boenninghausen. I think Dr. Roberts is right, that Boger's repertory is somewhat limited and does not contain remedies which, in the unusual case, you may need. Especially is that true of the Synoptic Key itself. If you want to work out some cases with that, or even at the bedside if you undertake to refer to a rubric to refresh your mind, very often you will find the remedy that you know ought to be there and you think the patient ought to have is lacking. The last edition is much better in that respect than the earlier one.

I don't agree with the essayist that you admit failure when you refer to your repertory; when you consider the enormous amount of symptoms that are involved and the long list of remedies, the long intricacies and various phases, any one of which may be the one you need, I don't think you are admitting failure at all. I think you are simply admitting that you are human. lt is impossible for any mind to grasp the entire materia

medica, just as much as it is impossible for any human mind to be able to enumerate the various phases of sickness in the various constitutions that will come to him for him to prescribe for them.
I don't believe that Boger's repertory is fool-proof and I don't believe that Boenninghausen's is, either. In other words, we may not all be fools but, as I say, we are human.
Take for instance Boenninghausen. He deals in generalities, but when you come to a remedy that has two general phases, as for instance where part of the symptoms are worse by motion and part of the symptoms are relieved by motion, unless you watch yourself you are going to be led astray. I understand that if you know how to use Boenninghausen you can get around that.
I wish I could remember some of the things my father said regarding Boenninghausen years ago. lt is quite an extensive review and some of these days I am going to look it up if I ever write on repertory, and give some of his suggestions. One is on this matter of the bi-phasic qualities of remedy. I think probably Dr. Roberts would like to get up and answer me on that question. I see him looking at me. For the beginner, and those not quite well up on repertorization, I think it is a fact.
The older men didn't have any repertories. As he says, Boenninghausen was the first one that evaluated the various symptoms as to their importance. They, in my estimation, depended more on experience in their own practice and the impressions on their minds of remedy individuality, and prescribed not so much on the symptoms as the almost intangible thing that they saw in a patient. Moreover, most of them were provers themselves. They had felt the action of the remedy in their very tissues, and they understood remedies a great deal better than we do. We can not go back to those days very weIl and we don't have to, but among the three thousand remedies we have in the pharmacy and the millions of symptoms we have to deal with we have got to use a repertory some time.

DR. DIXON: I haven't arrived at the stage where I can do without the repertory. I may when I grow up. I hope so.
Our discussion here points significantly to the fact that we are individuals and pick our own best instrument to help us out of our troubles. I don't think it was a significant statement at all of Dr. Roberts when he said he used Boenninghausen because it was fool-proof. That man is no fool, and I agree with Dr. Farrington when he says he doesn't think it is fool-proof. We can all make mistakes, and I guess we all do, and probably I am a Kent man because I had intensive training in Kent. I suspect that Dr. Roberts is Boenninghausen because he spent his life with Boenninghausen and he has it at his elbow all the while, and more power to him!
But what I want to stress is the fact that I can't do good work without a repertory right at my elbow, and if we would all use it on practically every case I am not afraid but what we would raise our standards above what they are - any man's, I don't care how intuitive he may be, if he tries to practice medicine without it.
Take the well-known characteristics of remedies, like the 3:00 a. m. aggravation of Kali carbonicurn. If we have a 3:00 a. m. aggravation all materia men think of Kali carbonicum. They don't think of the other remedies in the rubric of Kent's. There are twenty-one, I think, and although that may be an outstanding symptom of the individual case you are working up, yet it isn't every time that Kali carbonicum is going to come out your remedy. lt may be some obscure remedy in that rubric that I myself wouldn't think of if I didn't refresh rny knowledge by going to the repertory.

DR. ROBERTS: I wish to correct Dr. Farrington to this extent: Samuel Hahnemann used Boenninghausen, the first edition. There have been seven of them, and another one coming along, so they did have access to repertories and used them.

DR. KAPLOWE: I don't know very much about Boger or Kent. I have used Boenninghausen, naturally, because Dr. Roberts taught me how. That is about the only method I use. I feel that his repertory is based on deductions and facts and is perhaps one of the greatest generalizations we have in, shall I say, the world. lt is based, of course, on the concept that an aggravation in one part of the body, or a condition which will aggravate one symptom, is liable to aggravate the entire being. That may be wrong in some cases, but in most cases it is right. There may be a

confusion sometimes as, for example, Dr. Farrington said, the aggravation by heat, let us say, of the headache, but you will find that the whole man, the whole individual, may be aggravated by heat too. However, if you find that the entire man as a unit is aggravated by heat, he feels worse in general, but his headache is better, then he is aggravated by heat.

DR. FARRINGTON: I am not talking about particular symptoms..

DR. KAPLOWE. I don't know whether I made the last point clear but I should say that if the entire man as a unit is made worse by heat but his headache is not, or let's say it is ameliorated by cold, I would consider the effect of the modality on the whole man. Some day, Dr. Hayes, I will come up and learn how to use Boger. I would like to do that.

DR. HAYES: lt seems that everybody here seems to feel the need of using a repertory, and each one seems to have a favorite. There are about forty points that came up that I would like to discuss. lt may be worse than repertorizing a case to try to remember them and go through them. I can't do it.
I heard a couple of words used here twice that I don't like to hear applied to a prescriber, and they are the words „intuitive" or „intuition". lt seems to smack of something clairvoyant, and I don't think there is anything of that sort in the case of prescribing without a repertory and getting the right remedy. If we accept the word ,,intuition", though, as being a quality, I would say that it is simply the knack of observing, of forming a judgement on small evidence and forming it correctly and consciously. Some people might arrive at that conclusion unconsciously, but that would seem to be because they did not observe the processes of their own minds, so I think we might well study ourselves and then we won't be so enthusiastic, perhaps.
I notice that when Kent's repertory is attacked a little bit there is always a comeback among a whole lot of workers. There are a whole lot of people who seem to be tied to it and I don't know whether they have anything else to use or not.
One doctor spoke of Kent's repertorization being based on a wide practice. How about Boger? Boger had an immense practice and a practice with all kinds of illnesses. I know that personally because I have been in his office and know about his practice. Basing it on country-wide experience, so-called, is just a little fantastic.
Another thing, if this repertory is based on country-wide practice then also was Lee's, because Kent took Lee's, so Lee's must have been based on country-wide practice.