Homeopathic E.R.

by Jo Ketteman MARH

Jo Ketteman was a registered nurse and midwife, before training as a homeopath at the College of Homeopathy. She has been in practice for eleven years. Jo has a busy practice in Chesham, Buckinghamshire and also runs a successful teaching clinic. She has also been a guest lecturer at The Lakeland College in London.

Having a medical background as a qualified nurse and midwife is an extremely useful tool for being a homeopath, as well as for life in general. While I don't go looking for medical emergencies, I have always hoped that I wouldn't panic if something unexpected occurred; that I would 'keep my head' to quote Rudyard Kipling. I have been working as a homeopath for quite some time now, but a few months ago I had an experience which severely tested my mettle. (All names in this article have been changed to protect the identities of the patient, his family and students although all have given pemission for this story to be told.)

It was a lovely day in June, and the final student clinic session of the academic year. The patient was a seven-year-old boy who had previously been seen in clinic, post swine flu, back in January. Since then he had recovered well, but that morning his mother had phoned requesting an appointment for Ryan who had woken that day with a slight temperature and cough.

On arrival at clinic, Ryan looked slightly pale but seemed very cheery. The only observation of note was that, for a hot day, he had his jacket zipped up to the neck. He sat beside his mother as she began to tell Vanessa, their student practitioner, the symptoms. Ryan joined in the discussion and also played with Bridget, his younger sister. After about five minutes, he went to cuddle up to his mother. His breathing suddenly became stertorous – 'loud and difficult, seen in cases of cerebral compression' (Cape & Dobson, 1978) and he began to convulse. (See box on page 27 for a brief description of febrile convulsions.)

One of the students, a trained nurse, swiftly recognised the signs. She and I got Ryan onto his side on the floor and observed his breathing which was, by then, steady and quiet. We assessed his body temperature and pulled up some clothing without disturbing him. We opened the clinic door to lower the room temperature. One of the students suggested that she run to the café next door to get a cloth we could soak in cold water to aid in lowering his temperature. I asked two of the students to take notes so that we would have an accurate record of the situation and any treatment given.

The mother, Patricia, was obviously shaken; she had seen Ryan have a convulsion before when he was very poorly with swine flu, but at that time he had been in hospital. I asked her permission to give him remedies and she was happy to agree. The initial prescription was, of course, *Belladonna* 200 to try to lower his temperature. The remedy was given in pillule form which meant that it could easily be administered into the side of his mouth without any risk to Ryan or the practitioner. Ryan was at this point unconscious and his arms, and particularly his fingers were twitching, but his body was not convulsing and he was not gritting his jaw. We observed the situation but saw no clear response from the first prescription. Ryan was in a state of collapse, so the next obvious remedy seemed to be *Carbo veg 1M*. Following the administration of that prescription, Ryan began to come round slightly. But I was still concerned by his lack of response. We repeated the remedy and he improved again but still his overall state concerned me.

I discussed with Lauren, the student with a nursing background, how long we felt Ryan had been semi-conscious, and we decided that to be safe we should call an ambulance. Patricia agreed, and then one of the students went outside to place the 999 call.

While this was happening, Janet, another student went and sat next to Patricia who was holding on to her three-year-old daughter. Janet explained quietly to Patricia what we were doing, and why we were prescribing certain remedies.

I called out symptoms to the student group as a whole, and asked them to look up rubrics. At this stage Ryan was pale and the twitching was generalised to both hands and fingers. Taking the rubric 'hands, twitching, fingers' (Murphy, 1996) we prescribed *Cuprum met* 1M, and within seconds Ryan's fingers relaxed and he became increasingly alert. We repeated this remedy 3-4 minutes later. This time the response was dramatic. Ryan was fully alert and able to talk to Lauren and his mother. By the time the emergency team arrived, Ryan was sitting up. He was able to answer the paramedic's questions, and walk out to the ambulance for assessment. We presented the paramedic with a list of our prescriptions – his expression was one of bewilderment …

Following assessment for 20 minutes, Ryan was allowed to go home.

To clarify the time scale involved in this episode – it was approximately five minutes before we

Someone having a fit should be put in the recovery position

phoned 999 and then a further ten minutes waiting for the ambulance to arrive. Not long in reality but I can say that at the time it felt considerably longer. Certainly we were all ready for our next patient, one eventful hour after Ryan and his family had initially walked through the door.

Once assured that Ryan and his sister and mother were okay, I felt it was necessary that as a group we had a debriefing session. Seeing someone having a fit can be quite a disturbing experience and, for most of the students, this was the first time they had been that close to a real life emergency. The first thing we did was have a cup of tea and biscuits, to help ground us! We talked through what had happened, what they had seen and how it had left them feeling. Some of the students were quite shaken but appeared better once they shared their anxieties. We talked about keynote prescribing and how important it can be in such situations. There really wasn't time to ponder, we just had to observe and prescribe.

A couple of months on, I look back at this event and have a great sense of pride at how well all the students coped. What was apparent was how well we worked as a team. Lauren took on the main nursing role; Janet supported the family; the student who felt most confident stepped forward to put out the 999 call (a scary experience at the best of times); and together they worked hard at repertorising, coming up with remedies and recording the notes. I hope that I acted in the managing role, co-ordinating our response to the emergency, and supporting the students, Ryan and his family.

I have seen Ryan once since that day. He has recovered fully and seems happy and healthy, as does his sister, who took the whole event in her stride. (She actually sat on her mother's knee singing 'We love you Ryan, we do'!)

The benefit of medical first aid knowledge is really essential in emergency situations; keeping your head helps those around you. I know that taking a first aid course is not a requirement of our training and registration and that a lot of the time it appears to be a nuisance hoop to jump through, but I really would urge you to consider attending. It just might give you the confidence to stay calm in an emergency, which could occur in everyday life as well as in your practice room!

I would like to take this opportunity to say how great it was working with this group of students. Thank you all for coming together so well when needed, and I really hope that the experience, although frightening at the time, will stand you in good stead later in your professional careers.

Febrile convulsions

What are they?
Febrile convulsions are seizures (sometimes known as fits) that occur in a child with a high fever of over 39°C. These most typically occur during the early stages of a viral infection.

What causes them?
The convulsions occur because the electrical systems in the brain have not yet fully matured to cope with the bodily stress of a high temperature.

Who's affected?
Three per cent of children have at least one febrile convulsion. They usually occur between the ages of six months and up to six years of age. They may be a genetic predisposition – up to 20 per cent of relatives will have a seizure disorder including febrile convulsions.

What are the symptoms?
The fits are brief, usually only lasting a few minutes. The child loses consciousness, becomes stiff, stops breathing for up to 30 seconds and can lose control of bladder or bowel. There may be twitching or spasms of both limbs and occasionally the face muscles. The eyes may roll upwards. This stops after a few minutes and the child then regains consciousness.

First Aid response
The aim is to stop the child hurting itself during the seizure but don't hold the child down or put anything in their mouth. Place them on their side, in the recovery position. To bring the temperature down, cool the room, loosen clothing or try a cold application.

NB it is important not to cool the body too quickly as this can also lead to shock.

REFERENCES

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