Busting the myth of 'high' and 'low' potencies: how homochords can improve your potency and dosing outcomes

The last major development in potency and dosing was completed by Hahnemann in Paris, in 1833, with his médicaments à la globule, now commonly known as the LM or Q potencies.

Although selecting the optimum potency and dose is part of a full prescription, along with selecting the curative similimum, I believe that the potential for progress on the topic of potency and dosing has been hindered by the myth of 'high' and 'low' potencies. This myth is determined by two divergent factors - succussion alone, making medicines stronger and more rapid; and dilution alone, making medicines weaker and gentler. Starting with the mother tincture, a medicine is simultaneously made both stronger (with intercurrent succussion) and weaker (with serial dilution). Potentisation is not a singular linear process of making a medicine either just stronger for a 'high potency', or just weaker for a 'low potency'. The evidence showing the therapeutic efficacy of one medicine over a range of differing potencies has been shown instead to be a sine wave, with a regular alternation of similar peaks (maximum efficacy) and troughs (minimum efficacy). Once this non-linear paradox of potentisation is understood, the use of 'homochords' can now be better appreciated.

A homochord is the addition of several different potencies of one remedy put into one dispensing bottle, which has been in clinical use since 1911. Not only can homochords be prepared from the popular Kentian 'ladder' potencies (12C, 30C, 200C, 1M, 10M, 50M, CM, etc.), but also from the Fibonacci series of potencies (1C, 2C, 3C, 5C, 8C, 13C, 21C, 34C, 55C, 89C, 144C, 233C, etc.), or even using the decimal (X or D) and quinquaginta-millesimal (Q or LM) scales.

To finish, I will illustrate the clinical value of homochords with a difficult case.