



The Structure–Function–Symptom Triad: An Integrative Conceptual Framework Linking Human Anatomy, Physiology, Clinical Symptoms and Homoeopathic Interpretation: A Narrative Review with Critical Analysis and Reflections on Individualized Homoeopathic Understanding

“From Anatomical Structure to Physiological Function, From Clinical Expression to Individualized Understanding: Reconnecting the Language of the Human Body with the Individuality of the Patient”

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Abstract

Background: Clinical medicine traditionally distinguishes between anatomical structure, physiological function, pathological change, and the symptoms experienced by patients. In actual clinical practice, however, these dimensions interact continuously. A structural abnormality may alter physiological function, while functional disturbances may produce symptoms without an immediately demonstrable structural lesion. Symptoms may also vary considerably among individuals with apparently similar pathological findings. These observations create a conceptual space for integrating anatomy, physiology, clinical symptomatology, and individualised approaches to patient assessment.

Objective: This narrative review proposes and critically examines a conceptual Structure–Function–Symptom (S–F–S) Triad as a framework for connecting anatomical structure, physiological function, and clinical symptom expression, with particular reflection on its possible relevance to individualised homoeopathic case understanding.

Methods: A narrative literature review was undertaken using relevant biomedical, clinical, and homoeopathic literature addressing anatomy, physiology, symptom perception, biopsychosocial and systems-oriented models of health, clinical reasoning, and individualized homoeopathic treatment. Literature supporting and challenging homoeopathic efficacy was considered to maintain a critical perspective. The framework is conceptual and does not constitute a validated diagnostic or therapeutic model.

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Results and Discussion: The proposed triad consists of three interconnected domains: structure, representing anatomical organization and observable biological substrates; function, representing physiological activity and regulation; and symptom, representing the patient's subjective and clinically observable expression of disturbance. The relationship between these domains is not necessarily linear. Structural abnormalities can produce functional disturbances and symptoms, but symptoms may also occur with limited structural findings. Conversely, similar structural abnormalities can produce different symptom experiences. Contemporary symptom science and biopsychosocial models support the importance of considering biological, psychological, contextual, and patient-reported dimensions together.

Within homoeopathic practice, the framework may provide a conceptual bridge between conventional clinical assessment and individualized symptom interpretation. It may encourage practitioners to understand symptoms in their anatomical and physiological context before considering their individualizing characteristics. However, the framework should not be interpreted as evidence that homoeopathic remedies modify anatomical or physiological processes through mechanisms established by modern biomedical science. Evidence regarding individualized homoeopathy remains heterogeneous and contested, with systematic reviews reporting both positive findings and substantial methodological limitations.

Conclusion The Structure–Function–Symptom Triad may serve as a useful educational and conceptual framework for integrating basic medical sciences with clinical symptom assessment and individualized homoeopathic case analysis. Its principal value lies in promoting structured clinical reasoning rather than replacing established diagnosis or evidence-based medical care. Future research should examine whether the framework improves case documentation, clinical reasoning, symptom characterization, and reproducibility of individualized treatment decisions.

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KEYWORDS: anatomy, physiology, symptoms, clinical reasoning, structure–function relationship, individualised medicine, homoeopathy, individualisation, narrative review, integrative medicine.

1. INTRODUCTION

Medicine is concerned not only with identifying disease but also with understanding how disease, dysfunction, and illness are experienced by individual patients. Anatomy provides knowledge of the body's structural organization, while physiology explains how those structures perform their functions and maintain internal stability. Clinical symptoms represent another level of observation: they describe what patients experience and communicate to the clinician.

The relationship among these domains is often more complex than a simple sequence of **structure** → **dysfunction** → **symptom**. Modern clinical practice demonstrates that symptoms can arise from structural disease, functional disturbance, altered physiological regulation, psychological processes, environmental influences, or combinations of these factors. Symptom experience may therefore demonstrate only a partial correspondence with measurable physiological abnormalities.

The traditional biomedical model has been highly successful in explaining many diseases through structural and physiological mechanisms. Nevertheless, Engel argued that a purely biomedical model was insufficient for understanding the complete experience of illness and proposed a biopsychosocial perspective incorporating biological, psychological, and social dimensions.

This broader perspective raises an important question for homoeopathic education and clinical reasoning: **Can anatomical and physiological knowledge provide a stronger**

foundation for interpreting the individual symptom picture used in homoeopathic case analysis?

The present article proposes a conceptual answer through the Structure–Function–Symptom Triad.

The triad does not claim to establish a new biological mechanism of homoeopathy. Rather, it attempts to organize clinical thinking around three fundamental questions:

1. **What structure is involved?**
2. **What function is altered?**
3. **How does the disturbance present as a symptom in this individual?**

This approach may be particularly useful in undergraduate and postgraduate education because it encourages practitioners to move from isolated symptom collection toward clinically contextualized symptom understanding.

2. Conceptual Background

2.1 Anatomy as the Structural Foundation

Anatomy describes the organization of the human body at macroscopic and microscopic levels. Clinical anatomy connects structural knowledge with physical examination, imaging, surgery, and diagnosis. Modern anatomical teaching increasingly emphasizes the clinical relevance of structures rather than treating anatomy as an isolated descriptive discipline.

For clinical reasoning, anatomical knowledge helps answer questions such as:

- Which organ or tissue is involved?

- Which anatomical region corresponds to the complaint?
 - Which structures could produce the observed symptom?
 - Are the symptoms anatomically plausible?
 - Could a structural lesion explain the clinical presentation?
- Thus, anatomy provides the **structural context** for symptom interpretation.

3. Physiology as the Functional Dimension

Physiology explains how organs and systems operate and how they interact to maintain homeostasis. Contemporary physiology is inherently integrative: cardiovascular, respiratory, renal, endocrine, nervous, and immune functions cannot be understood completely as isolated systems.

Guyton and Hall's approach to physiology emphasizes the relationship between cellular mechanisms, organ systems, regulation, and maintenance of homeostasis.

A patient may have:

- normal anatomy with altered function,
- abnormal anatomy with preserved function,
- structural disease producing secondary functional disturbance,
- or interacting structural and functional abnormalities.

Therefore, a clinical symptom cannot always be understood solely by identifying a structure.

4. Symptoms as Clinical Expressions of Disturbance

A symptom is not simply a biological measurement. It is an experienced phenomenon reported by the patient and interpreted within a clinical context.

Pain, fatigue, dizziness, breathlessness, nausea, weakness, sleep disturbance, and bowel complaints may have multiple biological and psychological determinants. The relationship between subjective symptoms and objective physiological dysfunction can vary substantially among individuals.

This has important implications for clinical reasoning.

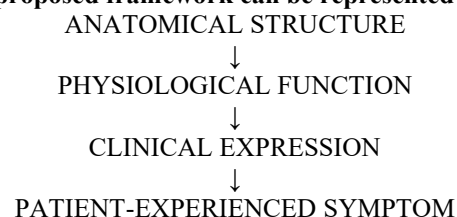
For example, two patients may have apparently similar structural findings but report substantially different experiences. Conversely, a patient may experience significant symptoms despite limited objective structural abnormalities.

Therefore:

Structure does not completely determine function, and function does not completely determine symptom experience.

This observation forms the conceptual basis of the proposed triad.

5. The proposed framework can be represented as:

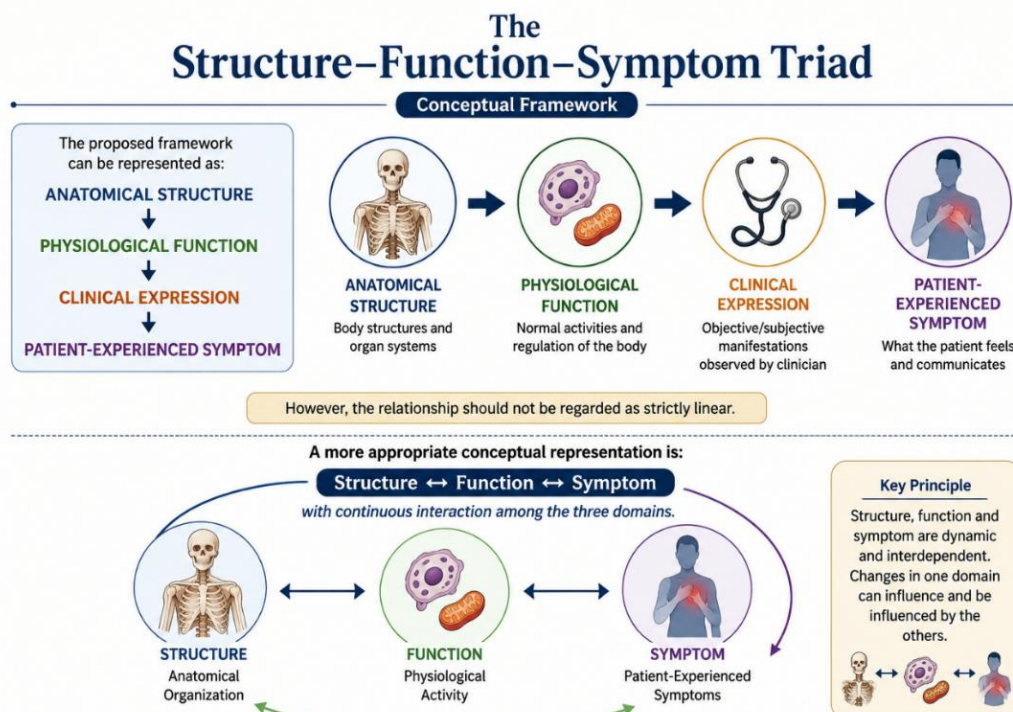


However, the relationship should not be regarded as strictly linear.

A more appropriate conceptual representation is:

Structure ↔ Function ↔ Symptom

with continuous interaction among the three domains



Domain 1: Structure

Includes:

- organs;
- tissues;
- anatomical regions;
- cellular structures;
- vascular and neural structures;
- pathological lesions;
- structural variations.

Domain 2: Function

Includes:

- physiological activity;
- homeostasis;
- regulation;
- neural activity;
- endocrine function;
- circulation;
- respiration;
- digestion;
- elimination;
- immune responses.

Domain 3: Symptom

Includes:

- subjective experience;
- location;
- sensation;
- modality;
- timing;
- causation;
- aggravation and amelioration;
- associated symptoms;
- emotional and behavioural responses;
- functional limitations.

The strength of the framework is therefore not in creating three separate categories but in examining relationships between them.

6. Why the Triad May Be Clinically Relevant

A symptom considered in isolation may provide limited information.

For example:

Headache

is a broad symptom.

A more clinically meaningful analysis asks:

- Where is the pain?
- What anatomical structures could be involved?
- What physiological mechanisms could generate it?
- What is the character of the pain?
- What triggers it?
- What modifies it?
- What associated symptoms occur?
- What objective findings are present?
- What contextual factors influence the experience?

This approach transforms a symptom from a simple complaint into a **structured clinical observation**.

Kroenke's review of common physical symptoms similarly emphasizes that symptom-based clinical encounters require consideration of cause, diagnosis, prognosis, and therapy rather than merely assigning a disease label.

7. Relationship Between Structure and Function

The structure–function relationship is fundamental to medicine. Examples include:

Cardiac system

Structural alteration of a valve may influence blood flow and cardiac workload, subsequently producing symptoms such as dyspnoea, fatigue, or palpitations.

Respiratory system

Changes in airway structure may influence airflow and respiratory mechanics, resulting in cough, wheezing, or breathlessness.

Gastrointestinal system

Structural abnormalities may alter motility, secretion, absorption, or mechanical passage and consequently produce pain, bloating, altered bowel habits, or vomiting.

Musculoskeletal system

Structural changes in joints, muscles, ligaments, or nerves may alter movement and generate pain, stiffness, weakness, or functional limitation.

These examples demonstrate how anatomy and physiology provide an essential clinical foundation before attempting individualized symptom interpretation.

8. Function–Symptom Relationship

The relationship between function and symptom is particularly important because functional disturbance may occur before obvious structural abnormalities become apparent.

Examples include:

- autonomic dysfunction;
- functional gastrointestinal disorders;
- migraine;
- some forms of chronic pain;
- fatigue syndromes;
- functional neurological symptoms.

In such conditions, symptoms may be substantial even when conventional investigations reveal limited structural abnormalities.

Symptom science suggests that the relationship between subjective experience and physiological dysfunction can be influenced by the individual and the surrounding context.

This provides a rationale for studying symptoms as clinically meaningful phenomena without assuming that every symptom must correspond directly to a visible structural lesion.

9. Symptom as an Individualized Clinical Phenomenon

One of the important distinctions between disease-centered and person-centered clinical approaches is the recognition that the same disease can manifest differently in different individuals. For example, patients with the same diagnosis may differ in:

- pain intensity;
- timing;
- associated symptoms;
- emotional response;
- sleep disturbance;
- functional impairment;
- coping mechanisms;
- environmental triggers.

The clinical significance of an individualized symptom therefore depends on both what is experienced and how it is experienced.

This idea is particularly relevant to homeopathic case-taking, in which individualization is traditionally emphasized.

10. Homeopathic Interpretation of the Triad

Homeopathy traditionally emphasizes individualized assessment rather than selecting a remedy solely from the diagnostic label. Hahnemann's *Organon of Medicine* forms the historical foundation of this approach, including attention to the totality of symptoms and individual patient characteristics.

From a conceptual perspective, the proposed triad may help organize this process.

Step 1: Establish the clinical structure

The practitioner first identifies the anatomical region or system involved.

Step 2: Understand the physiological context

The practitioner considers the relevant physiological functions and possible mechanisms of disturbance.

Step 3: Characterize the symptom

The practitioner documents:

- location;
- sensation;
- intensity;
- onset;
- duration;
- periodicity;
- causative factors;
- aggravating factors;
- relieving factors;
- concomitant symptoms.

Step 4: Identify individualizing characteristics

Only after establishing the clinical context can the practitioner examine the characteristics that distinguish one patient's symptom expression from another.

Step 5: Construct the individualized picture

The resulting symptom picture may then be considered within the practitioner's chosen homeopathic methodology.

This sequence may reduce the risk of interpreting symptoms without adequate clinical context.

11. Critical Distinction: Clinical Context Is Not Proof of Therapeutic Mechanism

An important scientific distinction must be maintained.

The fact that anatomy and physiology can help explain a symptom does not establish that a homeopathic medicine can modify the underlying anatomical or physiological abnormality. Likewise, the use of individualized symptom assessment in homeopathy does not itself demonstrate therapeutic efficacy.

This distinction is essential for academic credibility.

Evidence regarding individualized homeopathy remains controversial. A systematic review and meta-analysis of individualized homeopathic treatment reported a pooled effect favouring homeopathy but also emphasized substantial concerns regarding risk of bias and the need for better-quality trials.

Another systematic review examining individualized homeopathy against non-placebo controls found that most included trials had high or uncertain risk of bias and concluded that the available evidence did not permit a decisive conclusion about comparative effectiveness.

Similarly, a systematic review of non-individualized homeopathic treatment reported that the overall quality of evidence was low and that reliable evidence was insufficient for condition-specific conclusions.

These findings support a cautious interpretation.

12. The Placebo Debate and the Importance of Critical Thinking

The scientific literature contains substantial disagreement concerning the clinical effects of homeopathy.

The 1997 meta-analysis by Linde and colleagues reported effects that were statistically different from placebo but also stated that the evidence was insufficient to establish efficacy for any individual clinical condition.

In contrast, the large comparative analysis by Shang and colleagues found that when analyses were restricted to larger and higher-quality trials, the evidence for a specific effect of homeopathic remedies was weak and compatible with placebo explanations.

Later analyses focusing specifically on individualized homeopathy have continued to report potentially positive effects while emphasizing limitations in study quality and heterogeneity.

Therefore, a responsible conceptual framework should not begin with the assumption that homeopathy is either definitively effective or definitively ineffective.

Instead, it should ask:

1. What is the clinical phenomenon?
2. What is already established by biomedical science?
3. What does homeopathic theory propose?
4. What evidence supports that proposition?
5. What evidence challenges it?
6. What remains unknown?
7. What research would provide a stronger answer?

This is the essence of **critical thinking**.

13. Relationship With the Biopsychosocial Model

The Structure–Function–Symptom Triad should not be viewed as a replacement for the biopsychosocial model.

Engel's biopsychosocial model emphasized that illness cannot always be adequately explained using biological variables alone.

The proposed triad is narrower.

It focuses primarily on:

Structure → Function → Symptom

while recognizing that symptom experience can be influenced by psychological, social, behavioural, and environmental factors.

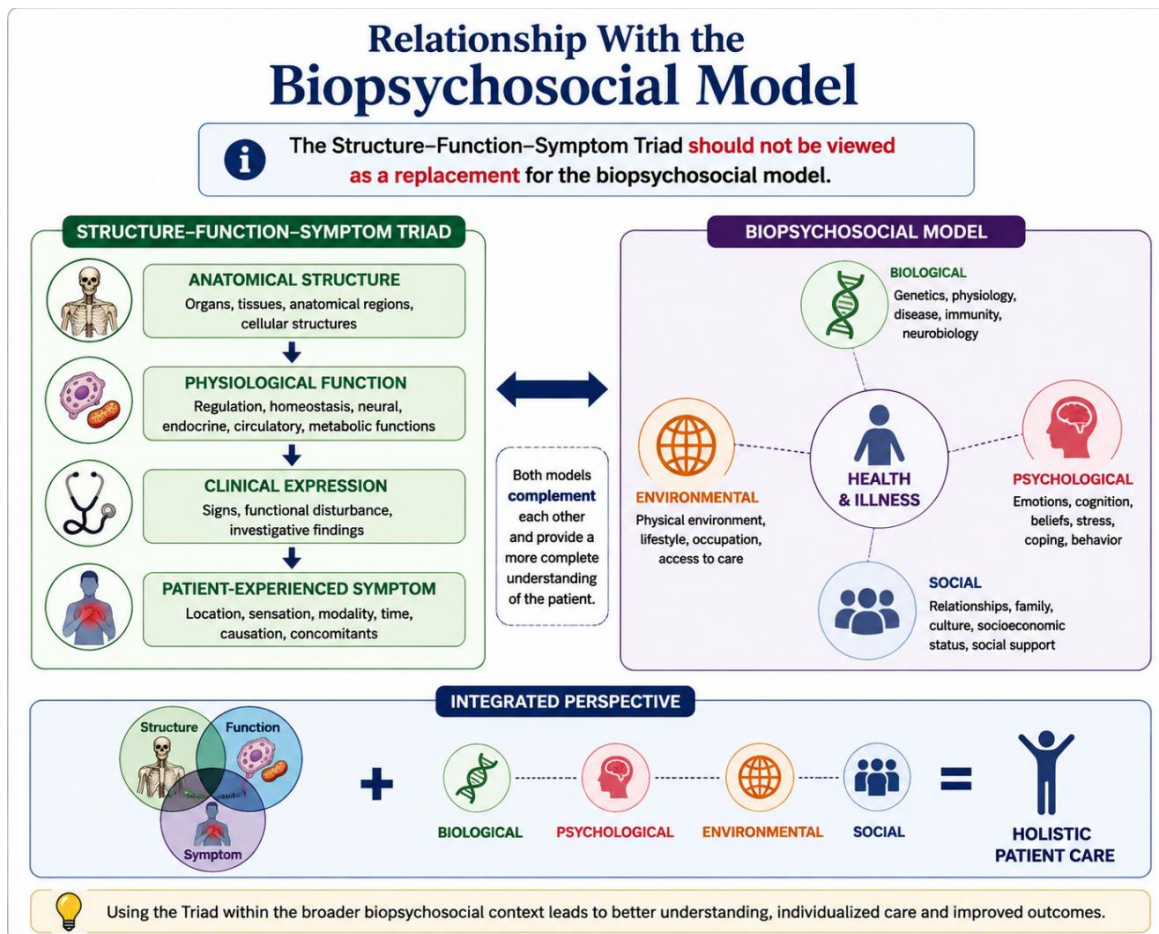
Thus, a possible expanded model is:

STRUCTURE ↔ FUNCTION ↔ SYMPTOM

interacting with:

PERSON ↔ PSYCHOLOGY ↔ ENVIRONMENT ↔ CONTEXT

This broader model may provide a useful conceptual bridge between biomedical assessment and person-centered clinical practice.



14. Educational Application

The proposed triad may have particular value in homoeopathic medical education.

Students frequently learn anatomy, physiology, pathology, materia medica, repertory, and case-taking as separate subjects.

The resulting knowledge may remain compartmentalized.

The triad provides a simple integrating question:

Where is the problem? → What is happening functionally?

→ How is the patient experiencing it?

For example:

Clinical dimension	Question
Structure	Which organ, tissue, or region is involved?
Function	Which physiological function may be altered?
Symptom	How does the patient experience the disturbance?
Clinical correlation	What diagnosis or differential diagnosis should be considered?
Individualization	What characteristics distinguish this patient's presentation?
Homoeopathic interpretation	How may the individualized symptom picture be evaluated within the selected homoeopathic methodology?

Such a framework may improve communication between basic science and clinical subjects.

15. Proposed Clinical Reasoning Sequence

The framework can be operationalized as a six-step reasoning sequence:

S1 – Structural Identification

Identify the anatomical site or system.

S2 – Functional Correlation

Determine the relevant physiological process.

S3 – Symptom Characterization

Describe the symptom precisely.

S4 – Clinical Verification

Consider diagnosis, differential diagnosis, red flags, and appropriate investigations.

S5 – Individualization

Identify patient-specific characteristics.

S6 – Therapeutic Interpretation

Consider appropriate treatment options, including homoeopathic treatment where clinically appropriate and within the scope of evidence and professional practice.

This sequence emphasizes that **individualization should occur after adequate clinical assessment, not instead of it.**

16. Strengths of the Proposed Framework

The framework has several potential strengths.

16.1 Simplicity

The three primary domains are easy for students and practitioners to remember.

16.2 Integration

It connects anatomy, physiology, pathology, clinical medicine, and symptom assessment.

16.3 Patient-centeredness

It recognizes the patient's subjective experience as clinically relevant.

16.4 Compatibility with Clinical Reasoning

It encourages practitioners to establish a biomedical clinical context before interpreting symptoms therapeutically.

16.5 Educational Utility

It may assist students in integrating basic medical sciences with clinical case-taking.

16.6 Research Potential

The framework can generate measurable research questions regarding case documentation, symptom characterization, and treatment decision-making.

17. Limitations and Critical Considerations

The framework has important limitations.

First, the Structure–Function–Symptom Triad is a **new conceptual proposal**, not a validated clinical model.

Second, symptoms are not always direct indicators of anatomical or physiological abnormalities. Symptom perception is influenced by multiple biological and contextual factors.

Third, the framework does not establish the efficacy or mechanism of homoeopathic medicines.

Fourth, individualized homoeopathic research remains heterogeneous, with important methodological limitations reported in systematic reviews.

Fifth, there is a risk that practitioners may retrospectively fit symptoms into a theoretical model. This could introduce confirmation bias.

Finally, the framework must never be used to delay necessary investigation or evidence-based treatment of serious disease.

18. Future Research Directions

The conceptual framework generates several potential research questions.

Research Question 1

Does structured use of the Structure–Function–Symptom framework improve the completeness of homoeopathic case documentation?

Research Question 2

Does teaching the framework improve students' ability to connect anatomy and physiology with clinical symptoms?

Research Question 3

Does the framework improve inter-rater agreement in symptom characterization?

Research Question 4

Can the framework improve the reproducibility of individualized treatment decisions?

Research Question 5

Can standardized case records distinguish anatomical, physiological, symptomatic, and individualizing information?

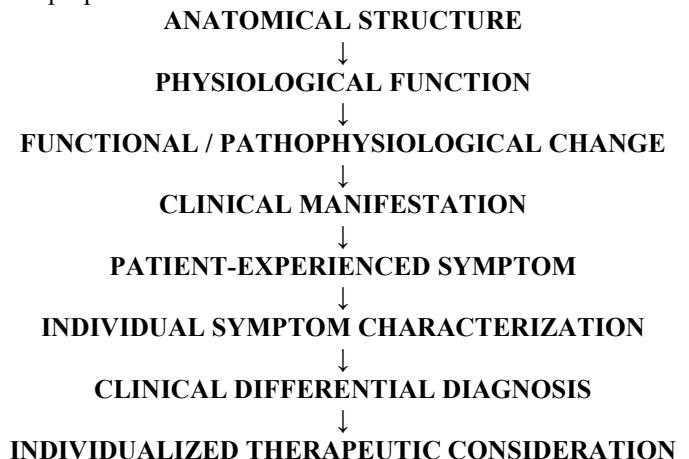
Research Question 6

Can prospective studies determine whether the framework improves clinical reasoning without increasing diagnostic delay?

Future research should ideally use validated assessment instruments, predefined outcomes, transparent case-taking protocols, blinded assessment where feasible, and appropriate statistical methods.

19. Proposed Conceptual Model

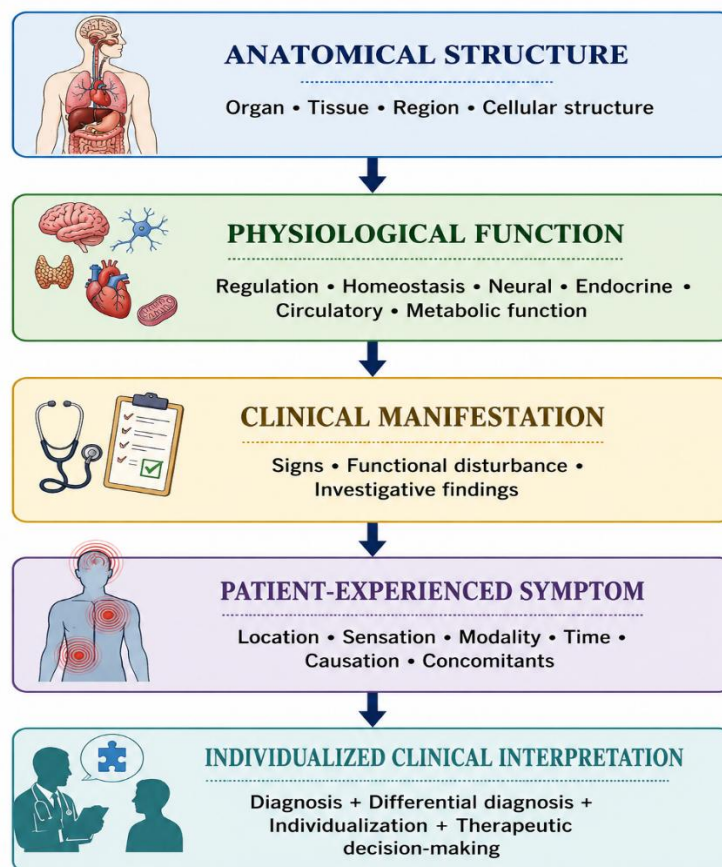
The proposed model can be summarized as follows:



At every stage, the process is influenced by:

Patient factors + psychological factors + environmental factors + social context + previous illness + treatment history.

This should be viewed as a **conceptual map rather than a proven causal pathway.**

Figure 1. Proposed Structure–Function–Symptom Triad**Author Contributions**

Author 1 – Dr. Harinath Singh: - BHMS, MD Homoeopathy (Paediatrics), PGDMCH.

Conceptualization and Scientific Framework

- Conceived the Structure–Function–Symptom Triad.
- Developed the central research concept and conceptual framework.
- Contributed to the literature review and interpretation of relevant anatomical, physiological, clinical, and homoeopathic literature.
- Contributed to critical analysis of the relationship between biomedical science and individualized homoeopathic interpretation.
- Drafted the initial manuscript.
- Developed the conceptual model and figures.
- Participated in revision and finalization of the manuscript.

Author 2 – Dr. Vikas Kumar Pandey: - BHMS, MD Homoeopathy (Organon of Medicine) **Literature Review, Critical Analysis and Manuscript Review**

- Contributed to the literature search and identification of relevant scientific and homoeopathic literature.
- Reviewed the conceptual framework from a clinical and academic perspective.
- Contributed to critical appraisal of the available evidence.

- Assisted in interpretation and synthesis of the literature.
- Critically reviewed the manuscript for intellectual and academic content.
- Contributed to revisions and refinement of the final manuscript.
- Approved the final version for submission.

Joint Contribution

Both authors contributed substantially to the conception, development, critical analysis, revision, and final approval of the manuscript and agree to be accountable for the integrity and accuracy of the work.

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Conflict of Interest

The authors declare that they have no conflict of interest related to this manuscript.

Ethical Considerations

This article is a narrative and conceptual review of previously published literature and does not involve human participants,

animal experimentation, patient-identifiable information, or collection of primary clinical data. Therefore, formal ethical approval was not required.

Data Availability Statement

No original dataset was generated or analyzed for this narrative review. The article is based on information available from published scientific and academic literature cited in the manuscript.

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20. DISCUSSION

The central proposition of this review is that clinical symptoms should ideally be understood at more than one level.

The anatomical level answers where a disturbance may be located.

The physiological level asks what function may be altered.

The symptomatic level asks how the disturbance is experienced and expressed by the patient.

Homeopathic case analysis traditionally places considerable importance on individualized symptom characteristics. However, individualized interpretation may become clinically stronger when preceded by sound knowledge of anatomy, physiology, pathology, differential diagnosis, and patient safety. In this sense, the proposed triad does not attempt to create a competing model of medicine. Rather, it proposes an educational bridge between basic medical science and individualized clinical observation.

The framework is also consistent with contemporary recognition that symptom experience is complex. The relationship between physiological processes and subjective symptoms is not always direct, and broader models of illness have emphasized interactions between biological, psychological, and social factors.

For homeopathy, this creates an opportunity as well as a responsibility.

The opportunity is to improve the scientific quality of case documentation and individualized clinical reasoning.

The responsibility is to distinguish clearly between:

- historical homeopathic concepts;
- clinical observations;
- biomedical mechanisms;
- hypotheses;
- and empirically established evidence.

Such distinctions are essential if homeopathic research is to develop in a scientifically credible direction.

21. CONCLUSION

The **Structure–Function–Symptom Triad** is proposed as an integrative conceptual framework linking anatomical structure, physiological function, and clinical symptom expression.

Its central proposition is simple:

A symptom should be understood not merely as an isolated complaint, but in relation to the structure involved, the function affected, and the individual manner in which the disturbance is experienced.

For homeopathic education and practice, the framework may provide a useful sequence for integrating basic medical sciences with individualized case understanding.

However, the framework should not be interpreted as proof of homeopathic efficacy or as a substitute for established diagnostic methods. Current evidence concerning individualized homeopathy remains mixed and methodologically limited, requiring further rigorous investigation.

The principal contribution of the proposed model is therefore conceptual and educational: to encourage clinicians to move from structure, through function, toward symptom—while maintaining critical clinical reasoning, diagnostic responsibility, and scientific humility.

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