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APPROACHES TO SYMPTOM EVALUATION IN KENT, BOENNINGHAUSEN, BOGER AND SYNTHESIS REPERTORIES: A NARRATIVE REVIEW

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ABSTRACT :

Background: Repertorisation is the structural bridge between case-taking and remedy selection; four influential repertories in the development and teaching of homoeopathic repertorisation — Kent's Repertory, Boenninghausen's Therapeutic Pocket Book (TPB), Boger's Synoptic Key, and Schroyens' Synthesis 9.1 — rest on distinct assumptions about which symptoms deserve the most clinical weight.

Objective: To trace the historical and philosophical evolution across these four repertories, with attention to how each author's grading logic shapes the totality that is finally repertorised, and to discuss how these differences may influence the construction and analysis of the repertorial totality.

Methods: A narrative review was conducted using databases like PubMed, Google Scholar etc and homoeopathy-specific sources, searching for English-language literature published up to September 2026 using terms including "repertorisation," "Kent's repertory," "Boenninghausen," "Boger," "Synthesis repertory," and "symptom grading." Classical repertory texts were consulted directly where accessible; peer-reviewed publications reporting prospective or statistical evaluation of repertorial grading were reviewed in full and prioritised where available.

Results: Kent's hierarchy privileges mental and general symptoms as the chief individualising markers; Boenninghausen builds totality from location, sensation, modality and concomitant through the doctrines of analogy and grand generalisation; Boger synthesises Boenninghausen's four-fold symptom with pathological generals and time/tissue-affinity considerations; Synthesis 9.1 retains Kent's structural skeleton while integrating source-verified additions from the other schools. Prospective studies using Bayesian and likelihood-ratio approaches have identified discrepancies between selected Kent repertory entries and empirically derived symptom–remedy associations. These findings raise questions regarding the reliability of the traditional typeface grading system, although the available studies concern selected rubrics and cannot be extrapolated to the repertory as a whole.^{1,2,3}

Conclusion: The four repertories embody differing, historically traceable readings of Hahnemannian totality, and at least one of these readings — Kent's absolute typeface grading — has been empirically questioned in peer-reviewed research; repertory selection based on the characteristics of the presenting case and aware of this evidence, is a matter of clinical judgement rather than mechanical procedure.

Keywords: Repertorisation, Kent's Repertory, Boenninghausen, Boger's Synoptic Key, Synthesis, symptom weighting, likelihood ratio, totality of symptoms

INTRODUCTION

A repertory is often treated, in undergraduate training, as a neutral index — a cross-reference of symptoms to remedies to be searched mechanically once a case is taken. In reality, every repertory encodes a philosophical position on what counts as a symptom worth weighting, and that position was shaped by the personal clinical experience, era, and reading of the *Organon* held by its compiler. This matters directly at the bedside: two competent prescribers working the same case through two different repertories can, and often do, arrive at different short-lists of remedies, not because either has erred, but because the repertories foreground different classes of symptoms. Kent, Boenninghausen, Boger and Schroyens were chosen as the four reference points for this comparison because they trace a historical sequence extending from the nineteenth century to modern repertorial systems. and represent four distinct schools of symptom evaluation: Kent's Generals-hierarchical school, Boenninghausen's four-limbed analogical school (location–sensation–modality–concomitant), Boger's pathological-general school that consciously bridges Boenninghausen and Kent, and Synthesis 9.1 as the

modern, source-verified descendant that attempts to reconcile all three within a single, continuously updated database.^{4,5} A further reason for this selection is that Kent's own grading system — arguably the most influential weighting scheme in the field — has itself become the subject of prospective, peer-reviewed statistical scrutiny in recent decades, giving this comparison an empirical as well as a historical dimension.^{1,2,3} Understanding how these four systems diverge, and where independent research has questioned one of them, has direct bearing on teaching, dissertation-level repertorial methodology, and everyday clinical repertorisation.

METHODS

This is a narrative review; no formal protocol was registered. Literature was identified through searches of databases and homoeopathy-specific sources, using combinations of the terms "repertorisation," "Kent's repertory," "Boenninghausen," "Therapeutic Pocket Book," "Boger," "Synoptic Key," "Synthesis repertory," "symptom grading," and "likelihood ratio," for material published up to September 2026. Classical repertory texts (Kent, Boenninghausen, Boger, Schroyens) were consulted directly where accessible, with secondary historical sources used to supplement or corroborate primary material. Peer-reviewed publications reporting prospective or statistical evaluation of repertorial grading were identified and reviewed in full; other sources were selected for relevance to the historical and structural description of each repertory rather than through a systematic or exhaustive search process.

Historical Background: Two Founding Schools

By the latter half of the nineteenth century, repertory construction had already split into two broad philosophical camps: a "Puritan" school that reproduced provers' symptoms verbatim without synthesis, and Boenninghausen's own school, which actively recombined and generalised symptom elements.⁴ James Tyler Kent inherited and reworked ideas from both currents. He is recorded as having initially favoured the layout of Lippe's repertory but found it clinically inadequate in scope, and it was this dissatisfaction that led him to build a substantially larger and more systematically graded work.⁶ Kent's *Repertory of the Homoeopathic Materia Medica* was first published in 1897, with fuller editions following through his lifetime.⁷

Kent's Repertory: Mentals as the Apex of the Hierarchy

Kent's repertorial philosophy cannot be separated from his broader homoeopathic philosophy, in which the mental and emotional plane is treated as closest to the vital, immaterial economy of the patient, and therefore as the most individualising layer of disease expression. Kent graded symptoms into three tiers of typographical emphasis — bold, italic and ordinary Roman type — corresponding to the frequency and intensity with which a remedy produced a given symptom in provings and clinical verification.⁸ Within his case-analysis hierarchy, mental generals rank first, followed by physical generals (the patient's reaction "as a whole" to heat, cold, time, position and similar influences), and only then particulars localised to specific body parts.⁹ Kent cautioned that grading must be read in combination with other rubrics rather than mechanically, since an over-literal count of grades can eliminate the correct remedy.¹⁰

This absolute, typeface-based grading system has, however, drawn direct empirical challenge in peer-reviewed literature. Rutten and colleagues reported that Kent's typeface method provided an insufficiently reliable representation of symptom–remedy relationships and proposed likelihood-ratio methods as an alternative approach.¹ A follow-up prospective study by the same group, evaluating six repertory rubrics against 4,072 real prescriptions, found that the calculated results diverged from the existing grading in roughly half of the entries examined, though the authors cautioned this could not be generalised to the whole repertory from such a limited sample.² A separate prospective evaluation of eight "physical general" rubrics from Kent's Repertory — thermal reactions and food desires/aversions — conducted across more than 2,000 clinical encounters in West Bengal, India, similarly found discrepancies between Kent's ascribed grading and observed outcomes, with some remedies appearing over-weighted relative to their clinical frequency and others under-represented.³ These findings do not invalidate Kent's structural contribution, but they do indicate that his central weighting mechanism has not gone unchallenged by prospective, data-based research.

Boenninghausen's Therapeutic Pocket Book: The Four-Limbed Symptom and Grand Generalisation

Clemens Maria Franz von Boenninghausen took a markedly different route. Rather than ranking categories of symptoms against one another, he focused on the internal completeness of each individual symptom, holding that a fully described symptom requires four elements: location, sensation, modality, and concomitant.¹² Because case records are frequently incomplete in one or more of these elements, Boenninghausen developed the doctrine of analogy — using the known modality or sensation pattern of one body part to fill in a missing element elsewhere in the same patient — and, building on this, the doctrine of grand generalisation, in which modalities and concomitants recurring across the whole case, rather than confined to one particular, are elevated to the rank of generals.¹³ He further emphasised concomitant symptoms — accompanying complaints with no obvious pathological link to the chief complaint, which patients and physicians alike tend to overlook, but which he considered clinically decisive precisely because of their peculiarity.¹³ His *Therapeutic Pocket Book*, first published in 1846, did not privilege mental symptoms over physical ones; instead, it distributed emphasis fairly evenly across modality and concomitant relationships, so that rubrics familiar from Kent's *Mind* chapter are structured quite differently, or absent altogether, in Boenninghausen's original text.¹⁴ Later editorial revisions, including those of T.F. Allen and subsequently H.A. Roberts and Annie C. Wilson, retained this four-fold analytical scaffold.¹⁴

Boger's Synoptic Key: Integration of Generals, Modalities, Time and Pathological Features

Cyrus Maxwell Boger developed a repertorial approach that incorporated important elements of the Boenninghausen tradition while also engaging with the broader Kentian repertorial framework. His approach drew substantially on Boenninghausen's work, particularly through his development of Boger-Boenninghausen's Characteristics and Repertory (BBCR), and was subsequently expressed in his more condensed *A Synoptic Key of the Materia Medica*.²⁰ Boger accepted Boenninghausen's four-fold symptom structure but added two further dimensions treated only implicitly by Boenninghausen: tissue affinity and the time dimension of symptoms, alongside a formal category of pathological generals — generalisations drawn from the

pathological process itself when expressed consistently across the case.¹⁸ Boger also revised the chapter on Concordance describing relationships between remedies.¹⁷ Structurally, the Synoptic Key arranges its repertory section by time, modality, generalities and then regional/particular symptoms, an ordering that itself signals Boger's view that temporal pattern and modality deserve earlier consideration than localised particulars.¹⁹ Boger explicitly invoked Hahnemann's Aphorism 153 (on the primacy of striking, singular, uncommon and peculiar symptoms) as the philosophical anchor connecting his own synthetic method back to Boenninghausen and, ultimately, to Hahnemann.¹⁵ In this sense Boger positioned his own work as a reconciling path, retaining Kent's respect for the mental state in final differentiation while insisting that physical and pathological generals deserve comparable weight rather than automatic subordination.¹⁶

Synthesis 9.1: A Kent-derived repertory incorporating material from multiple repertorial and Materia Medica sources.

Frederik Schroyens' *Repertorium Homoeopathicum Syntheticum*, familiarly Synthesis, represents an important modern development in computer-assisted repertorisation. Synthesis began in 1987 as the underlying database for the RADAR software project, developed at the University of Namur under Jean Fichet, and was subsequently published as the printed counterpart to that database.²¹ It is explicitly based on the sixth American edition of Kent's Repertory, retaining Kent's chapter structure and grading logic of mental-general primacy, while substantially expanding content by integrating source-annotated material from Boenninghausen's Therapeutic Pocket Book, Boger's BBCR, Boericke's and Phatak's repertories, and Hering's and Allen's materia medica encyclopaedias, contributed by an international editorial collaboration.²² Successive editions through the 1990s progressively expanded the rubric base, and Synthesis 9.1 became a standard print and examination reference edition before further expanded digital editions followed.²¹ Synthesis incorporates corrections and additions from multiple repertorial and materia medica sources, with source information provided for many of the incorporated entries.²³ Philosophically, Synthesis 9.1 does not introduce a new theory of symptom weighting; it inherits Kent's hierarchy of mental-general-particular but dilutes its historical narrowness by making Boenninghausen's and Boger's categories of modality, concomitant and pathological general far more richly represented within the same Kentian rubric structure than in Kent's own original text.²⁴

COMPARATIVE ANALYSIS OF SYMPTOM WEIGHTING

Read side by side, the four works can be understood as four different answers to the same underlying question Hahnemann left partly open in the *Organon*: which symptoms individualise a case most reliably? In the classical Kentian framework, mental symptoms are accorded prominent importance, followed by physical generals and particulars within the broader hierarchy of case analysis.⁸ Boenninghausen's answer is structural rather than categorical: no single class of symptom is inherently superior, but a symptom is only usable once complete across all four components, and modalities/concomitants earn general status only when they recur across the whole case rather than by virtue of being mental.¹¹ Boger's answer is a deliberate synthesis, accepting Boenninghausen's completeness test as the basic unit of analysis while adding pathological generals and tissue/time affinity as further legitimate axes of generalisation.¹⁷ Synthesis 9.1 adjoining these philosophies rather than resolving them: because it retains Kent's mental-first chapter architecture while embedding Boenninghausen- and Boger-derived, source-tagged rubrics throughout, Synthesis 9.1 therefore contains rubrics originating from different repertorial traditions within a predominantly Kent-derived organisational structure.⁵

Table 1. Comparative characteristics of symptom evaluation in four repertories

Feature	Kent	Boenninghausen	Boger	Synthesis 9.1
Principal analytical emphasis	Mental and physical generals, followed by particulars	Complete symptom and relationships among its components	Generals, modalities, time, causation, pathological features and characteristic symptoms	Kent-derived structure with material from multiple sources
Role of modalities	Important, particularly as generals	Central to symptom completion and generalisation	Highly prominent	Broadly represented
Concomitants	Used for individualisation	Major component of the complete symptom	Important in case analysis	Represented extensively
Pathological information	Relatively less central to classical Kentian hierarchy	Considered within totality	Given greater analytical importance	Incorporated within expanded rubric structure
Time	Used as a modality/general	Used as modality	Strongly emphasised	Represented through expanded rubric structure
Overall analytical orientation	Hierarchical	Relational/analogical	Synthetic/analytical	Integrative, Kent-derived

EMPIRICAL AND STATISTICAL SCRUTINY OF REPERTORIAL WEIGHTING

Beyond historical and philosophical comparison, a body of peer-reviewed research has attempted to test repertorial grading against observed clinical data rather than accepting it on authority. Rutten and colleagues argued that absolute grading by typeface theoretically leads every well-used remedy toward appearing eventually in every rubric, since entries accumulate whenever a patient who responds to a medicine happens to show the symptom,

without correction for how common that symptom is in the general population; they proposed likelihood-ratio methods as a statistically sounder alternative.¹ Their prospective assessment of over 4,000 patient encounters against six existing repertory rubrics found around half of the compared entries did not correspond with the calculated likelihood ratios.² Building on this, a subsequent prospective Indian study applying the same likelihood-ratio approach to Kent's physical-general rubrics for thermal reaction and food desires/aversions, across several thousand clinical encounters, similarly reported discrepancies with Kent's existing gradings.³ These studies provide empirical evidence that the traditional grading of selected Kent repertory rubrics may not consistently correspond with likelihood-ratio estimates. Comparable prospective quantitative evaluations of Boenninghausen- and Boger-derived repertorial grading are limited; therefore, the available evidence does not permit conclusions regarding the relative empirical reliability of the four repertorial systems.

IMPLICATIONS FOR CASE ANALYSIS

Because these philosophical and empirical differences are not merely academic, documented comparative exercises illustrate how repertory choice can shift the final remedy short-list. A recent retrospective comparison of 20 chronic cases reported differences in the repertorial ranking obtained through Kent's Repertory and Boger-Boenninghausen's Characteristics and Repertory. The authors proposed that repertorial methodology may be adapted according to the characteristics of the case; however, the small retrospective sample limits the generalisability of these observations.²⁵ A separate case-based comparative study applying Boenninghausen's, Kent's and Boger's methodologies to the same clinical case similarly found that while the three frameworks emphasised different symptom classes during analysis, they nonetheless converged on compatible therapeutic conclusions in that particular instance, suggesting that divergence in method does not always translate into divergence in outcome, but that it can.²⁶

DISCUSSION

The four repertories represent different approaches to symptom organisation and evaluation. Kent emphasises mental and general symptoms within a hierarchical framework, while Boenninghausen focuses on the complete symptom and its component relationships. Boger incorporates additional emphasis on modalities, time, generals and pathological features, whereas Synthesis 9.1 retains a predominantly Kent-derived structure while incorporating material from multiple sources.

Prospective studies have identified discrepancies between traditional Kentian grading and likelihood-ratio estimates in selected rubrics.^{1–3} However, these studies examined only specific Kent rubrics and cannot be generalised to the entire repertory. Comparative case studies have also demonstrated differences in repertorial analysis and remedy ranking, although their small or case-based designs limit generalisability.^{25,26}

Therefore, the available evidence is insufficient to establish the superiority or relative empirical reliability of one repertorial system over another.

CONCLUSION

Kent's Repertory, Boenninghausen's Therapeutic Pocket Book, Boger's Synoptic Key, and Synthesis 9.1 each grew from a different idea of which symptoms matter most: Kent ranks mental symptoms first, Boenninghausen looks for complete four-part symptoms, Boger blends this with disease patterns, and Synthesis brings all three together under Kent's structure. Case comparisons and published research both show this difference can change which remedy a case points to, and that Kent's grading system has been questioned by data-based studies. Knowing this history helps a prescriber choose, or combine, repertories based on the case, instead of simply relying on one out of habit. Choosing the right repertory, is therefore as much a clinical skill as knowing the remedies themselves.

LIMITATIONS AND RECOMMENDATIONS

This review relies mainly on secondary and web-based sources for the older repertories, since the original texts predate indexed journals, and the peer-reviewed statistical literature identified in this review has primarily evaluated selected aspects of Kent's grading system, while comparable quantitative evaluations of Boenninghausen- and Boger-derived repertorial systems appear limited. Future work should apply similar likelihood-ratio or outcome-based studies to Boenninghausen's and Boger's rubrics, and test all four repertories on the same set of real cases to see how often they actually lead to different remedies.

CONFLICT OF INTEREST

None declared.

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