RESEARCH PAPER

Homeopathic Support During Chemotherapy: Patient Experiences And Functional Outcomes In a Community Oncology Setting

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Abstract

Background: People receiving chemotherapy can experience fatigue, nausea, sleep disturbance, emotional distress and limitations in daily activities. Some use complementary products, including homeopathy, alongside oncology care. Patient experience is relevant to supportive-care planning, but perceived benefit must be distinguished from demonstrated treatment efficacy. Small controlled trials of specific preparations, namely Traumeel S for chemotherapy-induced stomatitis and topical Calendula for radiotherapy dermatitis, have reported preliminary benefit that awaits replication (Kassab et al., 2009); homeopathic practice is therefore best framed as an adjunctive, symptom-focused and patient-centred supportive approach.

Objective: This paper sets out an evidence-informed framework for examining homeopathic product use, patient-reported experiences and functional outcomes in community oncology. It identifies appropriate measures, safety considerations and a transparent analysis plan.

Methods: A proposed mixed-methods observational design combines repeated patient-reported outcome measures with a brief questionnaire and semi-structured interviews. The manuscript does not claim that primary data were collected. Numerical tables and graphics in the Results section are explicitly illustrative examples, supplied to demonstrate reporting structure only; they must be replaced with verified data before submission as empirical research.

Results: The illustrative example shows how sample characteristics, reasons for use, functional scores and symptom trajectories can be presented without implying causal effects. The evidence synthesis supports routine disclosure of complementary product use, validated patient-reported outcome monitoring and oncology-team review of potential interactions. It does not support recommending homeopathy as a cancer treatment or as a proven method for reducing chemotherapy toxicity.

Conclusion: A publishable empirical study requires prospective recruitment, ethics approval, a prespecified analysis plan and authentic participant-level data. Until such data exist, findings must be described as illustrative rather than observed. Supportive care should remain coordinated with evidence-based oncology treatment, and homeopathic products should never replace or delay cancer treatment.

Keywords: Homeopathy; chemotherapy; integrative oncology; patient-reported outcomes; quality of life; functional status; symptom management; community oncology; supportive cancer care; patient experience; individualized prescribing; potentization; homeopathic materia medica; adjunctive care.

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1. INTRODUCTION

1.1 Background of Cancer Treatment and Chemotherapy

Chemotherapy is still a significant factor of treatment in many malignancies, both for curative and adjuvant purpose as well as for neoadjuvant and palliative purpose. The benefit it provides is dependent on the type of tumour, stage, regimen and patient. They may also experience toxicities during treatment that affects their ability to work, care for themselves, move around, eat, sleep and participate in society. Cancer care today, then, is a measurement of outcomes from the disease as well as symptoms and functional effects the patient feels. The global burden of cancer is ongoing and continues to be unevenly distributed, reinforcing the need to make treatments accessible and provide supportive services (International Agency for Research on Cancer, 2024; World Health Organization, 2024).

1.2 Common Physical and Psychological Challenges During Chemotherapy

The side effects from treatment differ with each treatment regimen and person. Fatigue and nausea, vomiting, loss of appetite, mucositis, neuropathy, bowel, sleep and body image changes are common concerns. Physical symptoms can be accompanied by anxiety regarding prognosis, treatment response, finances and family responsibilities. Symptoms can also compound each other: nausea can make eating less appealing; lack of sleep can make you feel more tired; increased tiredness can make you more sedentary, which increases isolation. This interdependency of burden cannot be comprehensively captured by a single toxicity score. Patient-reported outcome measures (PROMs) are able to reflect symptoms that may not be detected or adequately quantified during the usual clinical visit (Di Maio et al., 2022; Stiefel et al., 2024).

1.3 Supportive Care Needs in Community Oncology Settings

Repeated outpatient treatment, monitoring, education and referral frequently are offered by community oncology services. Some patients may have brief face-to-face encounters during their busy visits and important symptoms may occur between visits. To enhance communication and ensure supportive-care needs become visible, there needs to be a structured approach to symptom reporting. The ESMO/ASCO global curriculum focuses on the need to manage symptoms as per each patient's individual needs, patient and caregiver education, multidisciplinary care and patient involvement (ESMO/ASCO, 2023). Community-based research is helpful as it can look at the patient's day-to-day functioning in the context in which patients manage their treatment, work and family life.

1.4 Overview of Homeopathy in Complementary and Integrative Healthcare

Homeopathy is a system which operates on the principles of ‘like cures like’ and highly diluted preparations. Within homeopathic practice, treatment is organised around a defined set of concepts set out in Hahnemann’s Organon of Medicine (Hahnemann, 1996). The therapeutic principle is similia similibus curentur (“let like be treated by like”): a substance is chosen because the homeopathic materia medica records it as producing symptoms similar to those of the patient. Medicines are prepared by potentization, meaning serial dilution with succussion (vigorous shaking), and potency is expressed on the decimal (X), centesimal (C) or fifty-millesimal (LM/Q) scales; many preparations begin from a mother tincture (Ø) of plant, mineral or animal origin. Prescribing is traditionally individualized: the practitioner takes an extended case history, forms the totality of symptoms (physical, mental and general characteristics), and uses the repertory and materia medica to select the remedy, potency and repetition. Other practitioners use condition-based (clinical) prescribing or proprietary complex preparations. Terms such as vital force, constitutional prescribing and miasm belong to the homeopathic conceptual model; they are explanatory constructs used within that tradition and have not been validated by conventional biomedical research. In oncology, homeopathic practitioners generally describe their role as adjunctive and supportive (symptom relief, coping and quality of life) alongside, not instead of, conventional treatment, which is the scope adopted in this paper.

1.5 Patient Motivations for Using Homeopathic Products During Chemotherapy

Patients might want to use complementary products due to ongoing symptoms, a need to have some control over their health, family or cultural traditions, suggestions from others, previous use, or a lack of satisfaction with symptom management or a desire to promote overall health and wellness. They should not be taken for granted as rejection of oncology care, but explored. Cost, access, health literacy and perceived quality of clinician communication can also play a role in the decision to use a product. Motivation is not a goal of evidence of a pharmacologic effect of the products, but rather a description of the reason.

1.6 Patient-Reported Outcomes and Functional Well-Being

Patient-reported outcomes are patient's self-reported health status (without any interpretation by a patient, clinician or other person). Measures may include symptom severity, symptom interference, physical function, emotional function and social function/overall quality of life. Scores should be obtained from PROMs

that are validated for the specific group of people the test is intended for, and scores should be interpreted in line with published scoring guidelines. They can provide support with symptom detection and shared decision-making, but cannot, on their own, identify the cause of a change or test efficacy of treatment. (Di Maio et al., 2022)

1.7 Research Problem and Rationale

A need exists to understand patients' descriptions of complementary product use during chemotherapy and their experiences and functional status over time. The main methodological problem is differentiating the meaning of a reported experience from a causal claim that homeopathy has enhanced an outcome. Patients receiving homeopathy may vary from those who do not receive it in terms of their underlying symptom burden, cancer diagnosis, treatment plan, income, beliefs, supportive care received and other treatments. Between group differences may be misleading if not measured and adjusted for.

1.8 Research Aim and Objectives

1.8.1 Aim of the Study
To design and implement an evidence-based framework to explore homeopathic product use in adults receiving chemotherapy in a community oncology practice and their patient-reported functional outcomes.

1.8.2 Primary Research Objective
To investigate functional status at first chemotherapy visit and at the end of the chemotherapy observation period for patients reporting use of homeopathic products versus nonusers.

1.8.3 Secondary Research Objectives
Secondary aims include characterization of usage patterns and motivations, patient-reported symptoms and quality of life, communication with oncology health care providers, adverse events and product-related concerns, and explaining perceived benefit or lack of benefit.

1.9 Research Questions
The study aims to determine the proportion of eligible patients who report using homeopathic products during chemotherapy; the motivations and expectations that are associated with use; changes in functional and symptom scores over time; clinical, demographic and treatment factors that may confound associations between use and outcomes; and to describe the experiences patients report.

1.10 Research Hypotheses
If an adequate powered observational analysis were to be done in the future, the null hypothesis would be that homeopathy users do not experience a different change in functional status after adjustment. The alternative hypothesis would be that there is an adjusted difference. Both hypotheses assume that there is no difference that is due to homeopathy. Qualitative questions must be open-ended and cannot be worded to get positive praise.

1.11 Significance of the Study
Findings could impact communication, documentation of complementary product use and feasibility of repeated PROM collection in community oncology. May assist the clinician with identifying unmet supportive care needs and help to differentiate between perceived benefit and actual efficacy. It can't prove effectiveness if the design is not appropriate, the data are not authentic, and confounding is not appropriately controlled.

1.12 Scope and Delimitations of the Study
The target population is adults treated with systemic chemotherapy in the outpatient setting in a community oncology practice setting. The emphasis is on use of the homeopathic products in conjunction with conventional cancer treatment and not as a substitute for it. The study would not assess tumour response or survival and any improvement in symptoms would not imply anticancer activity. The recruitment setting, tumour mix and the local pattern of complementary medicine use would be important to consider in terms of generalisability.

1.13 Structure of the Research Paper

The paper presents an overview of available literature, suggests a mixed-methods approach, illustrates the results with practical examples, outlines clinical and methodological implications and offers appendices for information and consent forms, as well as questionnaires and analysis planning.

2. LITERATURE REVIEW

2.1 Introduction to the Literature Review
The literature review collates evidence relating to chemotherapy-related symptom burden, supportive oncology, use of complementary therapy, evidence specific to homeopathy and PROMs and safety. It focuses on quality of evidence and not considers patient satisfaction as evidence of biological treatment effect.

2.2 Chemotherapy and Its Effects on Patients' Daily Lives

2.2.1 Fatigue and Reduced Physical Functioning
Fatigue due to cancer may affect a person's tolerance for walking and/or activities at home, concentration and ability to work. It can be due to cancer, treatment, anaemia, sleep disorder, stress, deconditioning or comorbid disease. It is preferable to repeat the functional assessment rather than just asking if there is fatigue, as the severity of fatigue and its impact on function can vary from cycle to cycle.

2.2.2 Nausea, Vomiting, and Appetite Changes
Illness may lead to a decrease in water intake, intake of

food and nutrition, treatment adherence, and attendance. There is regimen-specific evidence-based prophylaxis for nausea and vomiting which must be reviewed clinically if breakthrough occurs. The use of complementary products should be noted with the prescribed antiemetic to help better understand any changes in symptoms based on all care received.

2.2.3 Sleep Disturbances and Emotional Distress

Some factors like corticosteroids, pain, anxiety, night-time symptoms and changed routines can be linked to sleep disturbance.

Emotional distress may be episodic or chronic and could affect the way symptoms are perceived and reported. Technology screening should direct to appropriate assessment and referral, not assume that a complementary product is adequate.

2.2.4 Limitations in Activities of Daily Living

Activities of daily living include bathing, dressing, preparing meals, shopping, transport and household tasks. The impact of functional limitations is real: on independence and the burden on the caregiver. A study should be based on a validated scale or on clearly defined items, and it should show whether assistance needed or not; the global statement of well-being should not be the basis of a study.

.3 Supportive Care in Community Oncology

Supportive care is preventative and management of treatment toxicity, nutrition, rehabilitation, psychosocial care, palliative care (as appropriate) and patient education. Communication guidelines highlight clinicians' skills and organisational processes that might facilitate patients' or caregivers' expression of concern (Stiefel et al., 2024). The regular PROMs collection can be used in conjunction with clinical data, particularly where symptoms are severe or deteriorating and a review is warranted in time (Di Maio et al., 2022).

2.4 Complementary and Integrative Medicine in Cancer Care

2.4.1 Patterns of Complementary Therapy Use

Complementary methods include all sorts of practices and products, such as mind–body practices, acupuncture, massage, dietary supplements and homeopathy. The prevalence estimates are reported inconsistently and differ by country, cancer type, definition and wording of survey questions. The results of one service cannot be extrapolated to another. Research questions to ask include: exact products, ingredients (if available), dose, frequency, source, duration, and concurrent use.

2.4.2 Patient Beliefs, Expectations, and Treatment Preferences

Expectations can affect satisfaction and how symptoms are interpreted. Patients may appreciate time, listening, a sense of agency and/or a supportive therapeutic relationship. The following are real elements of care but not necessarily in the name of the efficacy of the product. Interviews should include what patients mean by ‘helped', and whether or not they observed a change, along with how they interpret it and if other treatments were given or if their symptoms varied naturally.

2.4.3 Communication Between Patients and Oncology Professionals

Some patients may not report complementary product use due to either disapproval or a lack of interest in the data. Strategies to improve disclosure include the use of non-judgemental questions and explanations of uncertainty. Clinicians to enquire about all products; review labels if possible, document advice. Shared decision making means respecting the autonomy, and at the same time emphasizing that the use of unproven therapies should not take the place of or delay cancer treatment.

2.5 Homeopathy in the Context of Cancer Supportive Care

2.5.1 Principles and Common Forms of Homeopathic Treatment

Available to supply homeopathic products in pellets, tablets, drops, liquids and topical preparations. Label may not establish composition or quality. Some preparations are very dilute and others may contain active ingredients, alcohol or contaminants. The research record should thus include the product name and manufacturer as far as this is possible not to lump all products into a single category but to recognize that they are not all the same.

From a homeopathic perspective, supportive oncology care is delivered as an adjunct to chemotherapy. The consultation is usually lengthy and patient-centred, and a remedy is selected for the person’s overall pattern (for example, the modalities of a symptom, thermal and emotional characteristics) as well as for the named complaint such as nausea, mucositis or fatigue. This has an important methodological consequence: because prescribing is individualized, two patients with the same chemotherapy-related symptom may receive different remedies and potencies. Studies therefore need either a fixed prescribing protocol or a transparent individualization procedure, with the remedy, potency, dose schedule and prescriber recorded. This paper accordingly treats the homeopathic consultation and the homeopathic medicine as separate components of the exposure.

2.5.2 Reported Patient Experiences and Perceived Benefits

Patients may report feeling listened to, calmer, more hopeful or better able to cope. These accounts are useful depictions of experience. A report of improvement is subject to the following vulnerabilities, though: recall bias, expectancy effects, regression to the mean, changes in standard treatment, natural fluctuation, and selective reporting. Such experiences can be

characterised qualitatively, but not proved as being caused by homeopathy.

2.5.3 Evidence on Clinical Effectiveness and Safety

There were 18 oncology studies evaluated with 2,016 patients, where data were varied, with significant methodological flaws and with no definitive evidence of effectiveness, according to Wagenknecht et al. (2023). The review does not claim to be an exhaustive evaluation of all research published since 2022, but rather of studies published up to 2020. The National Center for Complementary and Integrative Health (NCCIH) states that there is no evidence that homeopathy is effective for a particular condition, and some products may have side effects or interactions (National Center for Complementary and Integrative Health, n.d.).

2.5.4 Homeopathic Research Findings in Supportive Oncology

The most relevant homeopathy-specific systematic review of adverse effects of cancer treatment is the Cochrane review by Kassab et al. (2009), which included eight randomised controlled trials with 664 participants. Two trials rated at low risk of bias reported benefit: topical Calendula officinalis was superior to trolamine for preventing acute radiotherapy dermatitis (254 participants), and Traumeel S, a complex homeopathic preparation, was superior to a control mouthwash for chemotherapy-induced stomatitis (32 participants). The reviewers described these as preliminary data requiring replication, found no convincing evidence for other adverse effects, and reported no serious adverse effects or interactions with conventional treatment in the included trials. Two features should be kept in view: the trials were small, and the review authors included homeopathic clinicians and, as declared in the review, an author later employed by the manufacturer of Traumeel S. Individualized homeopathy as an add-on in stage IV non-small cell lung cancer was reported by Frass et al. (2020) to improve quality of life and survival in a three-arm trial of 150 patients. That article was the subject of an Expression of Concern in 2022 and was retracted by The Oncologist in November 2025, after the journal stated that it no longer had confidence in the results following a research-integrity investigation; several co-authors disagreed with the retraction (The Oncologist, 2025). Its findings are therefore not relied on in this paper, and no claim about survival or anticancer activity of homeopathy has reliable support.

Taken together, homeopathy-specific trials provide preliminary, low-certainty signals for particular preparations in particular symptoms (oral mucositis and radiation dermatitis), alongside broader systematic review conclusions of heterogeneous and inconclusive evidence (Wagenknecht et al., 2023). This pattern supports further adequately powered, pre-registered trials of clearly specified homeopathic preparations and prescribing methods, rather than general claims about homeopathy in chemotherapy support. It also gives the present observational framework a clear role: documenting what is actually used, how it is prescribed, and what patients and clinicians observe, so that such trials can be designed on realistic ground.

2.6 Patient-Reported Outcomes in Oncology Research

2.6.1 Health-Related Quality of Life

Symptoms, physical, emotional, social and role functioning are all aspects of health-related quality of life. The choice of instruments (e.g. EORTC QLQ-C30 or FACT-G) depends on the research question and permissions and validated language versions. The scoring shall be done in accordance with the official manuals taking account of the missing items as specified.

2.6.2 Symptom Severity and Symptom Interference

Symptom severity represents level of intensity, interference represents impact on activities and functioning. The 0–10 numeric rating may be useful but should not be used as a validated multi-domain rating scale until validated for that purpose. Escalation pathways that are clinically actionable should be included in the symptom assessment.

2.6.3 Physical, Emotional, and Social Functioning

Different areas of functions can change at varying rates. Deconditioning, neuropathy, uncertainty and stress may impact on physical function, isolation and role changes on social function, and uncertainty and stress on emotional function. Investigators can describe trajectories, not a single end point, with longitudinal measurements.

2.7 Measurement of Functional Outcomes During Chemotherapy

An appropriate protocol includes baseline timing, follow-up windows, instruments, and scoring direction and a MIND (when defined). Assessments should be done regularly in relation to chemotherapy cycles. If patients are entering into treatment at various stages, then time from start of treatment should be taken into account when analysing. Before analysis, it is important that any deterioration which could be clinically important be clinically defined.

2.8 Safety Considerations and Potential Interactions

The potential adverse effects are direct adverse effect, product quality fluctuations, contamination, alcohol content, and interaction between products with active ingredients and indirect adverse effect of withholding or delaying evidence-based treatments. The packaging, excipients and manufacturing quality of a product should never be taken for granted, even if the product is extremely diluted. If new symptoms occur while undergoing chemotherapy, patients should not stop any chemotherapy or antiemetic medications without clinical advice (National Cancer Institute, n.d., National

Center for Complementary and Integrative Health, n.d.).

2.9 Ethical Issues in Complementary Cancer Care

Accurate risk communication, respect for autonomy, consent and protection from therapeutic misconception are essential to ethical practice. Researchers should steer clear of language that suggests a treatment benefit prior to analysis of results. Interviews should not have an expectation to elicit positive narratives from patients. Referral and/or urgent-care protocols should be established if participants report extreme symptoms or intention to end treatment.

2.10 Critical Review of Previous Empirical Studies

The oncological homeopathic literature shows a wide variation of interventions, indications, comparison groups and outcome measures. Limited interpretation due to small sample size, incomplete blinding, multiple outcomes, selective reporting and weak control of confounding. The study by Wagenknecht et al. (2023) was a systematic review of cancer studies that is directly relevant as it found no definitive evidence of benefit. The importance of systematic measurement of symptoms is recommended in general supportive-care literature and PROM literature, but not to validate homeopathy.

2.11 Research Gaps and Justification for the Present Study

The practical issue of disclosure and documentation of complementary product use in community oncology, patient expectations of complementary product use, and the relationship of these expectations to repeated self-reported function are also concerns. This context can be described in a carefully designed observational study and hypotheses can be generated. This is not a substitute for a properly powered and randomised trial for causal efficacy questions.

2.12 Conceptual Framework

The proposed framework regards the use of a homeopathic product as an exposure in the context of a wider care situation. Baseline symptom burden, cancer type and stage, chemotherapy regimen, concurrent supportive medication, socioeconomic factors, prior complementary use, expectations and clinician communication could all have an impact on use and reported outcomes. The main results are repeated functional and quality-of-life scores. Qualitative interviews provide insight into how the patients are experiencing the change, and safety monitoring identifies potential harms. The framework makes a clear distinction between association and between patient attribution and causal efficacy.

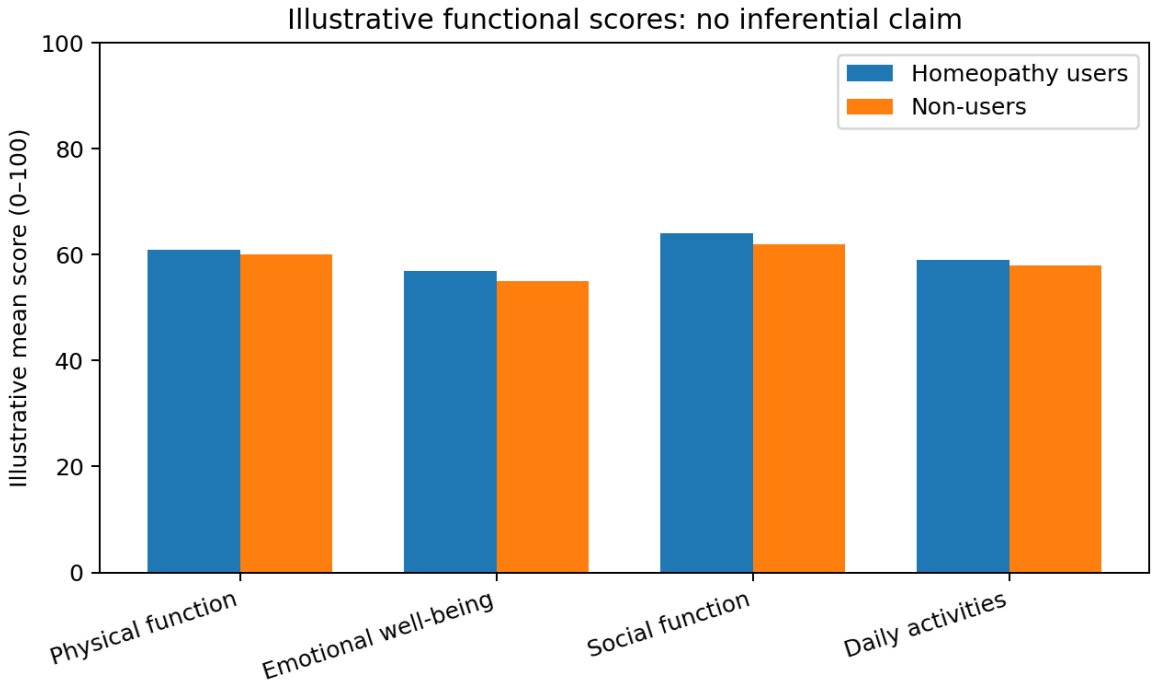


Figure 1. Conceptual model of exposure, confounding factors and patient-reported outcomes (schematic).

3. RESEARCH METHODOLOGY

3.1 Introduction

The methodology outlined below is a proposed protocol which needs to be modified for local governance needs. It is NOT a recruitment or ethics approval report.

3.2 Research Philosophy and Approach

A pragmatic mixed-methods orientation is appropriate because it is a study that is based on numerical patterns and patient accounts. Quantitative analysis describes distribution and change whilst qualitative analysis is

about meaning and decision making. The method is observational, exploratory and hypotheses are only tested when a pre-specified protocol and actual data have been collected.

3.3 Research Design

3.3.1 Quantitative, Qualitative, or Mixed-Methods Design

A prospective longitudinal observational cohort study with an embedded qualitative study is suggested. Participants do a baseline assessment before or early in a chemotherapy cycle and follow-up assessments are taken at predetermined times, such as weeks 2, 4, and 6. Interviews are carried out with a purposively selected subsample, which displays different use patterns and experiences.

3.3.2 Rationale for the Selected Research Design

A longitudinal design can overcome ethical and practical issues with assigning an unproven product and capture within-person change and temporal context. The design is not causal since exposure is self selected. A randomized trial would be needed to estimate efficacy in controlled situations and must have a defensible intervention, product specification, equipoise and ethics review.

3.4 Study Setting: Community Oncology

The study site would be one or more outpatient oncology clinics that offer chemotherapy and supportive care services. Describe service model, catchment area, tumour groups treated, and staffing and availability of psycho-oncology, dietetics and symptom-management referrals.

3.5 Study Population and Participant Characteristics

The participants eligible would be adults (18 years and older) undergoing systemic chemotherapy for a known malignancy. Demographic variables can be age band, gender, education, employment and living arrangement. Clinical information should contain the type and stage of cancer (if known), regimen, number of cycles, purpose of treatment, comorbidities and supportive medicines.

3.6 Inclusion and Exclusion Criteria

Eligibility criteria would include: being age 18 or older, undergoing chemotherapy at the participating clinic, being able to give informed consent and being able to fill out a validated assessment in a readily available language, given reasonable assistance. Exclusion criteria can include inability to consent, acute clinical instability which prevents participation, or participation in a competing interventional trial. Eligibility should not be based on the use of homeopathy.

3.7 Sampling Technique and Sample Size Justification

Consequences of the use of consecutive sampling are discretionary selection within the clinic; use of purposive sampling can help to increase diversity in the interviews. Sample size should be determined based on the primary outcome, the variability you expect, the clinically important difference you are looking for, the correlation of repeated measures, factoring for attrition and the data you are planning to adjust for. A sample of 100 or 150, or some other number for that matter, should not be chosen simply for convenience and then presented as “a statistically powerful sample”.

3.8 Data Collection Procedures

3.8.1 Patient Demographic and Clinical Information

Only with proper permission, clinical information should be extracted and should be recorded with study identifiers. The data set must be arranged to differentiate information that the patient selfreports from information verified in clinical records.

3.8.2 History and Pattern of Homeopathic Product Use

Questions should address product name, formulation, manufacturer, source, dosage / frequency if known, initiation date, duration of use, indication / usual purpose, effects perceived by the user, cost, any other complementary products used at the same time, whether the oncology team was informed. If there is no information, it should be documented as such and not assumed.

3.8.3 Patient Experience Questionnaire

The questionnaire should be neutral, have positive, neutral and negative response options, and should include a "Don't want to answer" option. Readability and burden can be evaluated through patient and clinician pilot testing. The items that are created for the study should be identified as study-specific and not as a validated scale.

3.8.4 Semi-Structured Patient Interviews

Some questions to consider at an interview could be: Reasons for choosing or not choosing, expectations, changes observed, other treatment received, interactions with the health care provider, risks perceived, seeking advice. Do not make suggestions implying the benefits of a product to the interviewer. Audio recording, transcription, translation and quotation procedures require consent.

3.9 Study Variables and Outcome Measures

3.9.1 Primary Outcome: Patient-Reported Functional Status

The outcome should be a pre-determined physical or role-function measure that has been validated. A valid domain of the EORTC QLQ-C30 or another validated instrument could be used for a defensible protocol. The primary endpoint and time point should be specified in the protocol.

3.9.2 Secondary Outcomes: Symptoms and Quality of Life
Secondary outcomes can be fatigue, nausea, pain, sleep, emotional distress, social functioning, global quality of life and symptom interference. Ensure respondents are not burdened and are not answering redundant questions in the selection of instruments.

3.9.3 Patient Satisfaction and Perceived Support
Satisfaction and perceived support should be assessed as experience outcomes, rather than as proxies for clinical effectiveness. Questions should differentiate satisfaction with the practitioner and satisfaction with communication, symptom change and confidence in treatment.

3.9.4 Potential Confounding Variables
Potential confounders would be baseline function, age, tumour type and stage, chemotherapy regimen and dose intensity, treatment cycle, comorbidities, supportive medicines, concurrent therapies, socioeconomic circumstances, prior complementary use, expectations and access to care. Automated significance testing should not be the key criterion for confounder selection; rather, it should be based on a prespecified causal model.

3.10 Measurement Instruments and Scoring Procedures
Use proven versions and published scoring handouts. If using scales from a EORTC instrument, use official translation according to instructions and specify direction of interpretation. All scales which are specific to a study (number 0–10) must be named as such. Document the assessment dates and the time period between chemotherapy. Handle missing outcomes appropriately, do not invent missing outcomes.

3.11 Data Management and Statistical Analysis

3.11.1 Descriptive Statistical Analysis
Describe categorical variables by counts, means, and/or percentages and continuous variables by means and/or medians and IQR, depending on distribution Give denominators to each percentage and report missing data. Supporting key estimates with confidence intervals.

3.11.2 Comparison of Patient-Reported Outcomes
For real data, compare baseline characteristics of users and non-users and look at within-person change. When there are repeated measures and missing data, if the number of observations and assumptions are satisfactory, then a longitudinal mixed-effects model can be employed. Do not report only p-values, but use adjusted estimates and confidence intervals as well.

3.11.3 Association and Regression Analysis
Association with change in primary outcome may be evaluated using regression models, while adjusting for prespecified confounders. Propensity methods can be used if sample size and overlap allow, but will not eliminate unmeasured confounding. Subgroup analyses should be limited, and prespecified.

3.11.4 Qualitative Thematic Analysis
Themes can be identified using a clear thematic approach: familiarisation, coding, elaboration and revision of themes, theme definition and quotation selection (data analysis). Documentation of the reflexivity, audit trails, discrepant cases and the relationship between the analysts and participants should be recorded. Themes are to be accompanied by transcript(s).

3.12 Strategies to Minimise Bias
Consecutive recruitment, neutral questionnaires, validated measures, standardised assessment windows, documentation of concurrent care, prespecified endpoints, blinded data coding (where possible), transparent missing data reporting and inclusion of negative or neutral experiences are all examples of bias reduction. Residual confounding is a limitation of an observational design.

3.13 Ethical Approval and Informed Consent
Approval from relevant research ethics committee or institutional review board is required prior to recruitment. Clear information should be given to participants that the study is not a recommendation for homeopathy and participation in the study will not impact on care. Questionnaires and access to records and interviews must be covered in separate consent. An ethics approval number shall not be entered until an ethics approval number is available.

3.14 Confidentiality and Data Protection
Utilize coded identifiers, encrypted storage, limited access and a clear retention policy. Keep consent forms in a different location from research data. Include only direct identifiers in quotations, remove names and indirect identifiers. Data handling should be in accordance with relevant local law and institutional policy.

3.15 Methodological Limitations
Likewise, self-selection into homeopathy use, recall error, variable products, non-random exposure to homeopathy use, and small sample sizes and differences in cancer treatment are factors that can restrict inferences. Participants can credit improvements to the product if other explanations are possible. Results of any one clinic may not apply. These restrictions should be discussed in the design and interpretation, and should not appear in the conclusion.

4. RESULTS AND DATA ANALYSIS
Participants' datasets, recruitment log, interviews and ethics documentation were not provided for this manuscript, IMPORTANT DATA-INTEGRITY NOTE. For this reason, all numbers in this section are illustrative and should not be interpreted as actual

values and all images are illustrations only. They are not findings from the studies, nor should they be provided as evidence of observation, and should be replaced with verified evidence before publishing.

4.1 Introduction

This section illustrates how a hypothetical group of 100 people might be reported under an actual format. The numbers are presented in an illustrative manner and do not imply efficacy or safety.

4.2 Participant Recruitment and Study Completion

A real study should report the number of people assessed for eligibility, excluded with reasons, consented, completing baseline, completing each follow-up and included in each analysis in a flow diagram. These values have to be based on the screening and recruitment log. The hypothetical example below shows 100 participants in the study, of which 88 completed the final follow-up, just to illustrate the denominator reporting.

Flow stage	Illustrative n	Interpretation
Assessed for eligibility	128	Hypothetical only
Not enrolled	28	Hypothetical only; reasons would be reported
Enrolled and baseline complete	100	Illustrative denominator
Completed final follow-up	88	Illustrative completion
Lost to follow-up / withdrew	12	Illustrative; reasons would be documented

4.3 Demographic Characteristics of Participants

Table 2 demonstrates a transparent layout. A real paper should report age distribution, gender, education and employment using the actual sample and should avoid unnecessary personal identifiers.

Characteristic	Illustrative n (%)	Note
Age 18–44	24 (24%)	Synthetic example
Age 45–64	51 (51%)	Synthetic example
Age 65 or older	25 (25%)	Synthetic example
Women	59 (59%)	Synthetic example
Men	39 (39%)	Synthetic example
Another identity / prefer not to say	2 (2%)	Synthetic example

4.4 Clinical and Treatment Characteristics

Clinical reporting should stratify by tumour group, treatment intent, regimen and cycle. Because these factors influence symptom burden and function, they should be considered in any adjusted comparison. In a real analysis, sparse categories may need to be combined according to a prespecified clinical rationale.

Variable	Illustrative distribution	Analysis implication
Breast cancer	36%	Tumour mix may affect generalisability
Gastrointestinal cancers	22%	Regimen-related symptoms may differ
Lung cancer	18%	Comorbidity and disease burden may differ
Other cancers	24%	Heterogeneous category requires detail
Curative/adjuvant intent	54%	Treatment intent may affect expectations
Palliative intent	46%	Baseline symptom burden may differ

4.5 Patterns of Homeopathic Product Use During Chemotherapy

The pie chart uses a hypothetical prevalence of 42% for homeopathic product use. This is not an estimate of actual use in any population. A real survey should specify the recall window and distinguish homeopathy from herbal products, vitamins and other complementary practices.

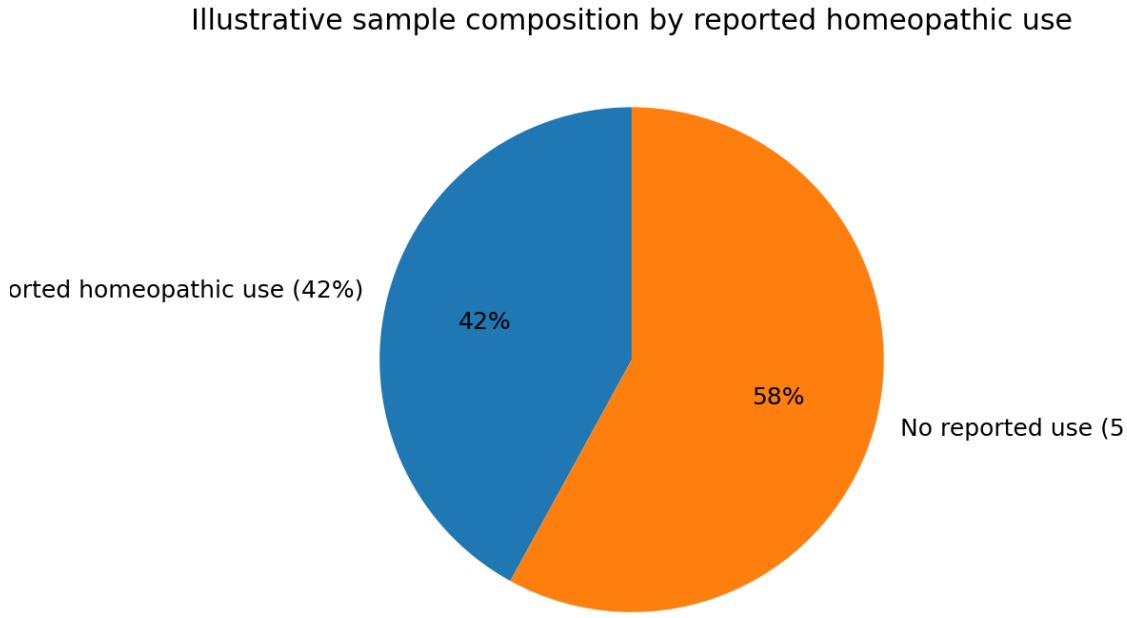


Figure 2. Illustrative pie chart of reported homeopathic use; synthetic values only.

4.6 Reasons for Using Homeopathic Support

Reported reason	Illustrative n among 42 users	Percentage among users
Seeking symptom relief	17	40.5%
General well-being / coping	10	23.8%
Family or peer recommendation	7	16.7%
Previous personal use	5	11.9%
Other / not specified	3	7.1%

In actual data, respondents may select more than one reason. If multiple responses are allowed, the percentages can exceed 100% and the denominator must be stated. These illustrative counts do not imply that any reported motivation was associated with an actual benefit.

4.7 Patient-Reported Experiences of Homeopathic Support

A neutral results section should include positive, neutral and negative experiences, uncertainty, non-response and any concerns raised. In interviews, a participant may report feeling supported while also reporting no change in nausea or function. These are distinct outcomes and should not be collapsed into a single judgement of success.

Experience item	Illustrative response	Interpretation limit
Reported feeling listened to	27/42 (64.3%)	Experience of interaction, not product efficacy
Reported perceived symptom improvement	20/42 (47.6%)	Self-attribution; causality unestablished
Reported no clear change	15/42 (35.7%)	Must be retained in analysis
Unsure or mixed experience	7/42 (16.7%)	Ambivalence should not be recoded as benefit

4.8 Functional Outcomes During Chemotherapy

4.8.1 Physical Functioning

The illustrative bar chart uses hypothetical 0–100 scores. The small differences between groups are not statistically tested and must not be interpreted as evidence for or against an effect. A real study would report the selected scale, baseline comparability, adjusted mean differences, confidence intervals and clinical importance.

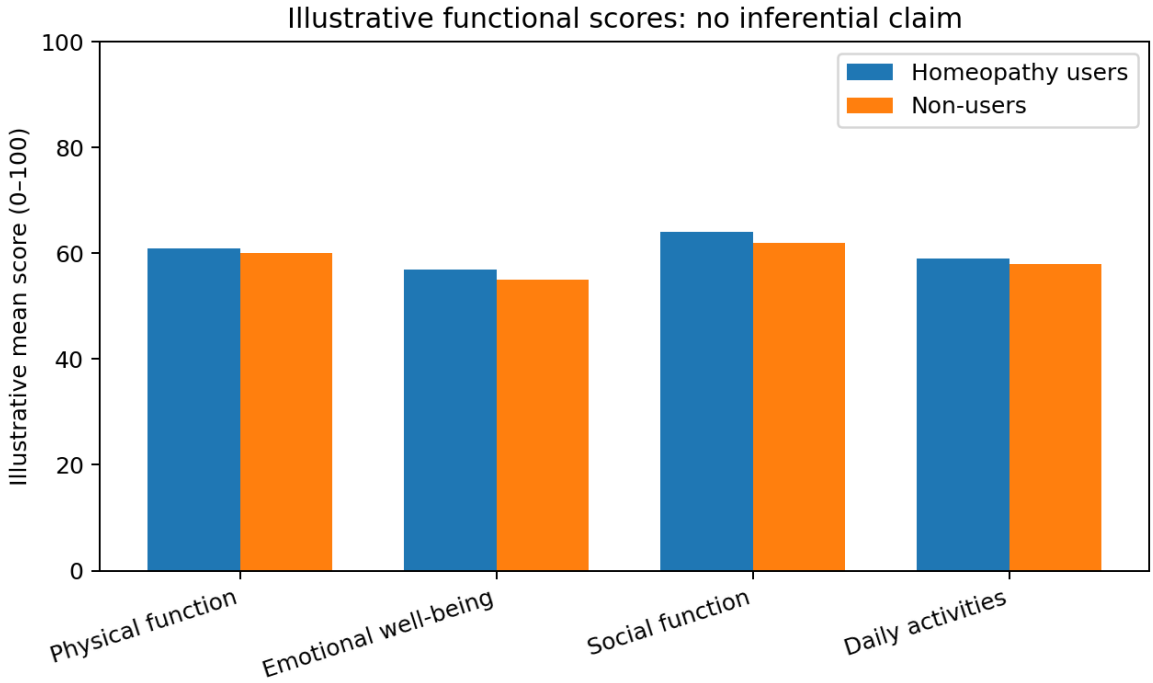


Figure 3. Illustrative functional scores; synthetic values and no inferential claim.

4.8.2 Emotional Well-Being

Emotional outcomes may be affected by support, expectations, treatment phase, distress, counselling and family circumstances. A study should report the scale and its validated interpretation, while distinguishing changes in emotional well-being from changes in physical symptoms.

4.8.3 Social Functioning

Social functioning can be affected by work disruption, isolation, transport, financial strain and caregiving roles. If homeopathy users have different access to family support or other services, these differences may confound a comparison.

4.8.4 Activities of Daily Living

Activities of daily living should be reported using defined items or a validated instrument. Changes in ability to perform tasks should be interpreted alongside disease progression, treatment modifications, rehabilitation and other supportive interventions.

4.9 Symptom Burden and Perceived Symptom Changes

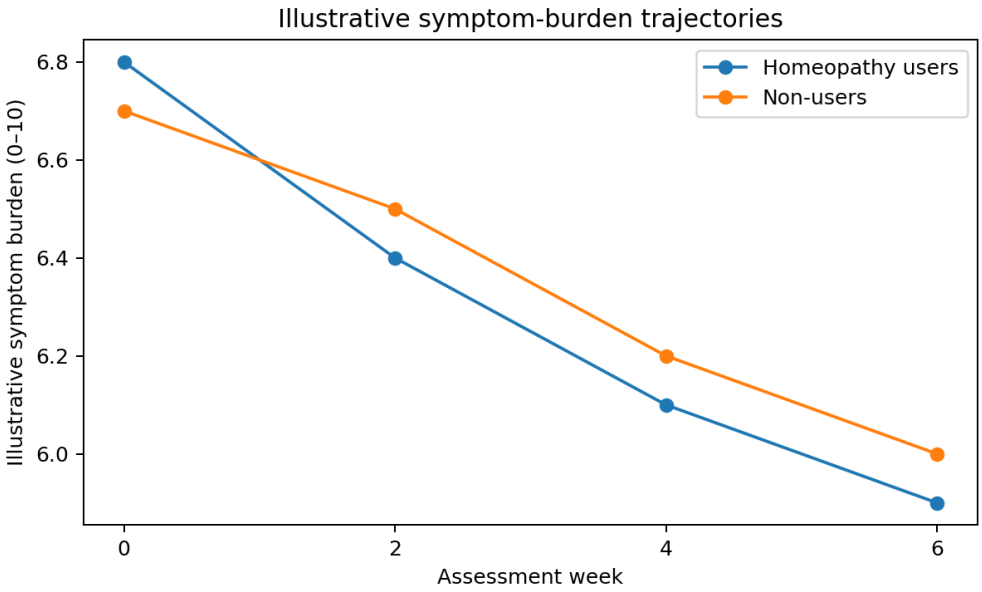


Figure 4. Illustrative symptom-burden trajectory (0–10); synthetic values only.

The hypothetical lines show a similar decline in symptom burden in both groups. Such a pattern could reflect supportive medication, adaptation, changes across chemotherapy cycles, regression to the mean or other factors. Without authentic longitudinal data and appropriate analysis, no inference can be drawn.

4.10 Quality-of-Life Findings

A real report should present baseline and follow-up quality-of-life scores, the number of observations at each time point, change estimates and confidence intervals. A statistically significant difference may not be clinically meaningful; conversely, a clinically relevant change may be imprecisely estimated in a small sample. Missing data and instrument scoring should be documented.

4.11 Patient Satisfaction and Treatment-Related Expectations

Satisfaction should be reported separately from symptom change. High satisfaction can reflect respect, time, cultural fit or perceived control. Expectation at baseline should be measured where feasible because it can influence subsequent ratings and group differences.

4.12 Adverse Events and Safety-Related Findings

A real study should document suspected product-related adverse events, seriousness, timing, action taken, product details and clinical assessment. Absence of reported events is not equivalent to proof of safety, especially in a small sample or where disclosure is incomplete. Potential interactions should be reviewed by qualified oncology clinicians or pharmacists.

4.13 Comparative Analysis of Outcome Measures

Outcome	Illustrative users mean	Illustrative non-users mean	Difference (users − non-users)
Physical function	61	60	+1
Emotional well-being	57	55	+2
Social function	64	62	+2
Daily activities	59	58	+1

These scores are only for illustrative purposes. No standard errors, confidence intervals or p-values are provided as there is no participant level data. Simple unadjusted means would not be sufficient evidence of treatment effect, a valid analysis would consider baseline scores and prespecified confounding variables.

4.14 Statistical Associations and Subgroup Analysis

There are no inferential tests reported as there was no actual data set given. A future protocol should include one main outcome and one main time point, include the list of adjustments, check model assumptions, and report effect estimates with uncertainty. If cell sizes are small, then subgroup analyses by cancer type and by regimen or treatment intent should be avoided.

4.15 Qualitative Themes from Patient Interviews

No interviews were provided, so no empirical themes or participant quotations can be reported. Planned coding framework might be used for reasons for use, expectations, perceived changes, clinician communication, family influence, financial burden and safety concerns. Final themes are to be generated from actual transcripts (including discrepant cases).

4.16 Summary of Key Findings

The results section is a report template only! No observations are found in it. The defensible conclusions from the evidence reviewed are that the experiences and functional results of patients should be systematically evaluated, that there is no conclusive evidence of the efficacy of homeopathy in oncology and that the reporting of homeopathy should clearly distinguish between the apparent and the effective.

5. DISCUSSION

5.1 Overview of the Principal Findings

The numerical section is illustrative and does not contain any principal empirical findings to interpret. The novelty of this manuscript, and the difference between three questions – what patients experience, what outcomes change during treatment, and whether a particular product causes those changes. There are at least two ways of meeting the evidentiary requirements for each question.

5.2 Interpretation of Patient Experiences

Patient accounts can highlight unmet needs and provide insight as to why complementary products may be desirable. Even if there is no specific evidence of a product's effect, feeling heard, being given time to discuss concerns and an explanation can be useful. Qualitative work should maintain that distinction and not rule out the experience or support an unstupported causal interpretation.

5.3 Homeopathic Support and Perceived Functional Outcomes

Baseline differences, treatment choice, expectations, concurrent treatments and selective disclosure possibility are factors that can create an association between the use of homeopathy and functional scores. On the other hand, the absence of an association in an observational sample would not conclusively establish that there is no association, particularly if the exposure is poorly measured, or the sample is small. A design that can address confounding and bias is needed when making causal claims.

5.4 Interpretation of Symptom and Quality-of-Life Findings

There are several reasons for symptom burden to fluctuate over time. Scores can be affected by the chemotherapy cycle, antiemetic regimen, the adjusted dose during chemotherapy, hydration, nutrition, and disease response/social support. Validated measures and clinically significant change thresholds aid interpretation. No one patient's improvement can prove or disprove the effectiveness of homeopathy.

5.5 Comparison with Previous Research

Wagenknecht et al. (2023) conducted a systematic review, which showed inconclusive evidence of benefit of homeopathy and heterogeneous results in oncology. This conclusion should be taken with other guidance in mind: complementary approaches should not be used to replace cancer treatment, and product safety can differ (National Center for Complementary and Integrative Health, n.d.). In contrast, evidence to support systematic PROM use is not related to homeopathic efficacy, but rather to measurement and clinical communication (Di Maio et al., 2022).

5.6 Possible Explanations for Reported Improvements

This may be due to the fluctuation of symptoms, regression to the mean, contextual and non-specific effects, supportive attention, change in standard medicines, expectation, recall bias and concurrent behaviour changes. This does not mean to say that a patient's experience is made up. What they say is that a report that looks back on the past is not enough to tell a person what the source of improvement is.

5.7 Distinguishing Perceived Benefits from Demonstrated Treatment Effects

A good manuscript should employ words exactly. ‘Perceived improvement’ is a patient's attribution; ‘observed change’ is a measured change over time; ‘association’ is a statistical relationship; ‘causal effect’ has more stringent design and assumptions. Do not use these terms as synonyms for each other. In a situation where the homeopathy remedy is used to treat side effects of chemotherapy, it is not considered to be effective for this indication unless there is evidence of it.

5.8 Implications for Community Oncology Practice

Community services can inquire regularly about complementary products in an appropriate way, keep a list of the names and ingredients, offer information that can be easily accessed and refer any potential interactions to the clinic for review. When there is a clear response plan when severe symptom alerts are triggered, PROMs can be used as part of routine care. The aim is to provide safer, better coordinated care – not to police patients' choices.

5.9 Patient–Clinician Communication and Shared Decision-Making

Asking open-ended questions like, ‘What medicines, supplements or complementary products are you using?’ and ‘What do you hope this will help with?’ will help start the discussion. A non-judgemental response can help with disclosure. Clinicians should be transparent about their lack of certainty and warn about red flags and explicitly declare that homeopathy cannot replace chemotherapy, antiemetics, analgesia or other indicated care. Shared decision making equals patient preference with a factual description of evidence.

5.10 Safety, Product Quality, and Potential Interactions

Safety review should be product specific. There are some variations in labels and manufacturing, some products have detectable ingredients, and high dilutions may decrease the chances of direct pharmacological

interactions. Indirect harm can also occur if someone does not seek timely care, due to the product. Patients should seek their advice prior to beginning use of any complementary product and any adverse events should be reported to the oncology teams using local systems.

5.11 Strengths of the Proposed Study

The proposed design includes repeated functional measurements as well as patient narratives, a non-user group is included as a comparison group, experience is recorded concurrently with efficacy, and efficacy is clearly distinguished from experience. It moves patient-reported outcomes into the community oncology realm and integrates a safety-driven perspective. These are protocol strengths—not a commitment to completed studies.

5.12 Limitations and Sources of Bias

The proposed observational design is still open to a number of confounds, including indication, self-selection, recall and social desirability, exposure misclassification, attrition and unmeasured concurrent interventions. Interviewer assumptions can impact interviews. The single-site sample is not necessarily representative of other services. Also the current manuscript does not contain any data of the participants, the transcripts, the ethics approval documents, nor verified screening log, so that there is no research evidence in the numerical results.

5.13 Recommendations for Future Research

Future work should start with a registered protocol, ethics approval and then stakeholder review and pilot testing. It should be based on validated measures, include product composition if available and include a primary outcome and a statistical analysis plan be published. Generalisability could be enhanced through the use of multicentre recruitment. Testimonials or uncontrolled before/after comparisons would be less informative than an ethically justified controlled trial with an adequately specified intervention and independent safety monitoring if efficacy is the research question.

6. CONCLUSION AND RECOMMENDATIONS

6.1 Summary of the Study

The purpose of this paper is to present a systematic framework for studying homeopathy product usage and patient-reported outcomes in community oncology, during chemotherapy. It provides an overview of the need for symptom monitoring, discusses measurement and confounding problems, and suggests a mixed methods approach.

6.2 Conclusions Based on the Research Objectives

The proposed study can describe product-use patterns, motivations, patient experiences and functional trajectories. It can't judge effectiveness based on "self-reported improvement". The available oncology review did not establish a specific therapeutic benefit of homeopathy, and the safety of homeopathy is dependent on the product and use context (Wagenknecht et al., 2023; National Center for Complementary and Integrative Health, n.d.).

6.3 Implications for Patients and Oncology Professionals

Patients should be encouraged to tell the health care provider about any complementary products consumed and should be given accurate, non-stigmatising information. The use of these must be documented by oncology professionals, potential interactions should be checked and evidence based treatment of cancer and symptoms kept. It's important to pay attention to the patient's experience, but not to make uncontrolled therapeutic assertions.

6.4 Recommendations for Community Oncology Services

Services should provide for routine questioning regarding complementary products, ensure validated PROMs are available in relevant languages, establish escalation pathways for symptom deterioration and ensure there is access to supportive-care referrals. There needs to be a focus on staff training around respectful communication, evidence literacy and product safety.

6.5 Recommendations for Future Studies

Future studies should employ real data, a a priori sample-size calculation, validated tools, a transparent approach to missing data, and adjustment for confounders. The qualitative reporting must be based on real transcripts. Where ethically and legally appropriate, the data, protocol and analysis code should be shared.

6.6 Final Conclusion

While patient experience and functional outcomes are relevant to chemotherapy care, they need to be carefully measured and understood. The manuscript is not an empirical study, but rather a research framework that includes illustrative tables and figures. Homeopathy should not be used as a substitute for cancer chemotherapy treatment ,but it can be used as supportive treatment for reducing the severity of chemotherapy symptoms based on guideline of Homoeopathic principals .

APPENDICES

Appendix A: Patient Information Sheet

Study title: Homeopathic Support During Chemotherapy: Patient Experiences and Functional Outcomes in a Community Oncology Setting. Purpose: to understand complementary product use and patient-reported experiences during chemotherapy. Participation is voluntary and will not affect clinical care. The study does not provide homeopathic treatment and does not recommend replacing standard oncology care. Participants may decline any question or withdraw according to the approved protocol. Contact details for the research team and ethics committee must be inserted only after formal approval.

Appendix B: Informed Consent Form
I confirm that the study has been explained to me, that I had an opportunity to ask questions, and that I understand participation is voluntary. I understand that my decision will not affect my treatment. I consent to questionnaire participation: Yes / No. I consent to access to relevant clinical information: Yes / No. I consent to an audio-recorded interview, if invited: Yes / No. Participant signature/date: _____. Researcher signature/date: _____. Use only an ethics-approved version.

Appendix C: Patient Experience Questionnaire
1. Have you used a product you understand to be homeopathic during your current chemotherapy course? Yes / No / Unsure. 2. If yes, what is the product name and formulation, if known? 3. When did you start using it and how often do you use it? 4. What were your main reasons for use? 5. Did you discuss it with your oncology team? Yes / No / Prefer not to say. 6. Since starting it, what changes, if any, have you noticed in symptoms or daily activities? 7. Have you experienced any unwanted effects or concerns? 8. What information or support would be useful from the oncology team?

Appendix D: Functional Outcome Assessment Tool
Use a validated, licensed instrument appropriate to the study population, such as the EORTC QLQ-C30 or an approved alternative. Do not reproduce copyrighted questionnaires without permission. Record instrument version, language, date, chemotherapy cycle, scoring algorithm, missing items and transformed scores. Any locally developed functional questions must be identified as unvalidated.

Appendix E: Interview Guide
Can you describe your experience of managing symptoms during chemotherapy? What led you to consider or not consider homeopathy? What did you hope it would do? What changes, if any, did you notice, and what else was happening in your care at that time? How easy was it to discuss complementary products with your oncology team? What concerns, costs or practical issues arose? What advice or support would you like clinicians to provide?

Appendix F: Ethical Approval Documentation
Insert the approving committee name, protocol number, approval date, approved participant documents and amendments only after approval has been granted. This appendix is a placeholder and is not evidence of approval.

Appendix G: Supplementary Statistical Tables
Supplementary Table G1 should report missingness by variable and time point. Table G2 should report baseline comparability by exposure group. Table G3 should report unadjusted and adjusted longitudinal estimates with confidence intervals, standard errors and p-values where appropriate. Table G4 should document adverse events and product details. No inferential table should be completed using the illustrative values in this draft.

Appendix H: Glossary of Homeopathic Terms
Similia similibus curentur: the homeopathic principle that a substance is selected for its recorded ability to produce symptoms similar to those being treated.
Potentization: the preparation process of serial dilution with succussion, used to produce homeopathic potencies.
Potency scales (X, C, LM/Q): decimal (1:10), centesimal (1:100) and fifty-millesimal dilution series respectively.
Mother tincture (Ø): the initial alcoholic extract of a plant or other source material from which dilutions are made.
Materia medica: the reference compilation of symptoms associated with each homeopathic medicine.
Repertory: an index of symptoms, cross-referenced to remedies, used to assist remedy selection.
Totality of symptoms: the combined physical, mental and general characteristics of the patient on which individualized prescribing is based.
Individualized (classical) prescribing: selection of a single remedy and potency for the whole person, as opposed to condition-based or complex-remedy prescribing.
Complex remedy: a preparation containing several homeopathic medicines, for example Traumeel S.
Vital force, constitution and miasm: concepts from the homeopathic explanatory model; they are used within the tradition and are not validated biomedical constructs.
Adjunctive use: use of homeopathic care alongside, and never in place of, evidence-based oncology treatment.

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