HHN Comfort Care Programme - July 2026

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"The body knows how to live, the body knows how to die" Barbara Karnes

These words were mentioned by Denise Straiges, several times throughout these webinars, and never ceased to lose their significance. Denise ran this course, which I had the privilege of attending in July; I also had the opportunity to virtually attend a similar course from 2 years ago.

The Comfort Care Programme - What is it?

The Comfort Care Programme, developed through the Homeopathy Help Network in partnership with the Academy of Homeopathy Education, prepares professional homeopaths and advanced students to offer compassionate, skilled homeopathic support in palliative, hospice, bedside, and end-of-life settings. The programme focuses on the role of homeopathy when cure is no longer the goal and comfort, dignity, symptom relief, and emotional presence become central to care.

Education for the Comfort Care Practitioner Course is provided by the Academy of Homeopathy Education, with training designed for post-graduate professional homeopaths and fourth-year AHE students. The course introduces practitioners to the modern hospice and palliative care landscape, explores cultural shifts around death and dying, and strengthens clinical confidence in applying Materia medica, therapeutics, case management, and ethical decision-making in sensitive care contexts.

Programme focus

- Integrating homeopathy into hospice, palliative, and bedside care.
- Supporting clients and families through serious illness, active dying, and grief.
- Recognising the stages of dying and adapting care accordingly.
- Using homeopathic materia medica and therapeutics for comfort-focused symptom support.
- Applying appropriate case management, communication, legal, and ethical considerations.
- Collaborating respectfully with hospice teams, death doulas, caregivers, and other end-of-life providers.

Programme format and outcomes

The course is delivered through live online teaching, supported by recordings, bonus learning materials, additional webinars, and a private message board for discussion and community connection. On completion, practitioners should be able to describe homeopathy's place within palliative and hospice care, recognise opportunities for interprofessional cooperation, and offer grounded, ethical, person-centred support to clients and grieving families.

Denise states: *"Dying is a journey into the unknown. The cultural support and experience of our recent ancestors has been traded for high tech often depersonalised, institutionalised delivery of care."*

The approach in this course is groundbreaking and essential to humanise what is becoming a mechanical process, far removed from the human touch of our ancestors.

First-hand experience

I had already committed to report on this course, many months ago, knowing how informative and inspiring Denise's work is, and that of HHN. I could never have imagined the significance of the timing, however. Suddenly, at the end of June, my mother-in-law had a life threatening incident, which led to her receiving palliative, then end of life care. Within a month she was gone. I had never witnessed so closely the inevitable decline of someone close to me and the stages involved. Amid volatile emotions, and needing some personal support, I tapped into the course that was run 2 years ago and following her death, caught up with the latest webinars in July. I found the advice and support a wonderful help, enabling myself and my family to understand the stages and to flow with them, the best we could.

I couldn't help but dwell on the fact her death followed the very recent birth of my first grandchild, bringing meaning to the words 'circle of life' and how the sadness associated with losing someone you love can be healed, in part, with the overwhelming love one feels for a newborn. (Does this sound vaguely homeopathic?!) This love does not replace the person who is leaving but reminds you of the vitality and rawness of youth. Dependency is of course the same, with both individuals requiring love, care and attention. The cruelty of death at times however, and the unpleasantness the person unavoidably experiences, requires superhuman reserves, all of which this course helps with, reminding you

that you are not alone. I would liken its content to having an invisible soul sister always by your side, holding you up and making sure you survive and remain as strong as you need to be, your very own comfort blanket.

Before attending the webinars, I thought I knew everything there was to know about helping the transition of a patient, and had confidently recommended arsenicum, thinking how clever and helpful I was being! I now realise that in reality, my knowledge in this sphere was very limited, I can now say without hesitation that this is no longer the case, thanks to first hand exposure of the various scenarios involved in the dying process. Denise stressed many times that "education is key". We need the tools for how to live through one of life's most normal experiences; far too often we are left simply 'winging it'. How are we supposed to know what to do if we have never been taught or guided? There were many allusions to the comparatively new role of the 'death doula'. This makes total sense. We are taught how to cope with the pain and ordeal of giving birth, why not death? We 'know how to live and we know how to die'; shared wisdom, experience and guidance in this field can only be seen as a beautiful gift.

The course sensitively covers each stage, what can be expected and how to cope, on every level. It was not just a list of homeopathic remedies, rather, a beautiful approach to an inevitable experience, which we all face. I can see why the course was called 'Comfort Care', as it was indeed comforting, helping to soothe unstable emotions. I had never watched anyone die before; it was a humbling, life changing experience. As Denise mentioned, there was an emotional aspect to taking this course, there were times when I could luckily hit the pause button and 'regroup.'

The course ran over two separate days; each being divided into sections. I do not have the space to take each section and discuss, much as I would like to, but will highlight key areas which particularly struck me.

Topics that were covered were:

Day 1

- A situational analysis of death and dying in the US
- Palliative care, Hospice and the hospice e-kit,
- Legalities and 'The 5 wishes'
- Prescribing
- Case taking and terminology
- GI issues, UTI's, wound care

Day 2

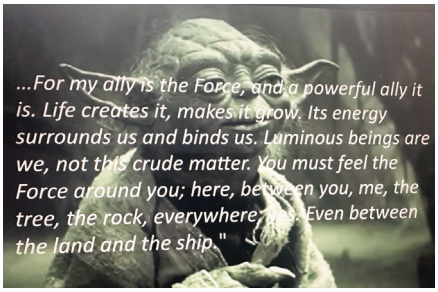
- Reconciling with death,
- Stages. The body knows how to live and die
- Prescribing for pain, agitation, death rattle
- Potency/posology
- Vigil planning and support
- Conducting research
- Taking the work forward

Improve the quality of death care

There is a shifting paradigm arising now, where people are questioning the 'dark side' of keeping patients alive at any cost. I was led to read the book 'Being Mortal' by Atul Gawande, a well-known physician and writer. He invites us to consider the aggressive care that prolongs life for some and its worth. He cites several cases where time may have been given but the quality of life prior to death was poor. One case that will stay with me was of an elderly man, following a terminal diagnosis, who chose to stay at home on his farm, surrounded by his children and grandchildren, animals and wonderful familiarity; he received adequate medical intervention where necessary. He loved this time, referring to it as 'the best time of my life'. He died peacefully amongst those he loved, with his dignity intact. I would recommend everyone to read this book, it covers the limitations of medicine, loss of autonomy, quality versus quantity of life and end of life conversations. In my opinion, it is life changing in its advice and approach to a sensitive subject that needs to be more openly discussed.

Much of the content of the webinars focuses on how we need to break the taboo around death and dying. Many patients do not want heroic interventions at the end of life; the treatment in some hospitals can be aggressive and gruelling. It is also important to consider the spiritual aspect of death and divide it from our mechanistic society.

There is so much we do not know. There is a specific example of divine intervention in the story of the passing of Yogananda, who appeared to transcend earthly pain. He seemed to peacefully transition from life to death. Followers widely cite an unusual mortuary observation following his death, a signed, notarised statement from the director of Forest Lawn Memorial-Park attested that no visible physical disintegration, decay, or mould appeared on his body for twenty days. Mortuary officials described the preservation as an unparalleled case in their professional experience. Regardless of some people's views, the death or rather transition of Yogananda was an extraordinary phenomenon – his disciples view his passing as Maha Samadhi – the conscious and intentional act of a fully enlightened master or yogi leaving their physical body.



The Force

The above image of Yoda's wise words (cited by Denise on several occasions!) sums up the fact we are never truly alone, there is an ever present 'force' which exists. Rather than death, and this being the 'end' of everything, maybe seeing things in relation to a tangible force can help us to understand things better. The key word for many is 'transitioning'. To this end, we must follow the wishes of the patient and create a sacred space should they wish.

The five wishes discussed, developed by Jim Towey who worked with Mother Theresa for 12 years and lived in a hospice she ran for a year, are fundamental to maintain the dignity of a dying person;

- The person I want to make decisions for me when I can't
- The kind of medical treatment I want or don't want
- How comfortable I want to be
- How I want people to treat me
- What I want my loved ones to know.

Medical Assistance in Dying (MAID)

More and more these days, in some countries the patient has the ability to end their own life through assisted suicide, this is now a growing, certainly controversial act. Jack Kevorkian, an American physician and activist was known for championing this method. In Canada now for example,

their Medical Assistance in Dying (MAID) program faces intense controversy over its rapid expansion beyond terminal end-of-life care. Critics, human rights advocates, and disability groups argue that the framework lacks sufficient safeguards, risking situations where vulnerable people choose death due to poverty, isolation, or lack of social support. It can be seen at times as a 'quick fix' for problems that with time, could be resolved.

Considering eco-friendly alternatives to burial and cremation

It was discussed how we need to invite conversations on questioning the standard care offered. Cremation for example is not seen as ecologically friendly. 80% of people in the UK are cremated, close on 60% in the US, depending on the area. Out of curiosity here, I investigated further and came up with various eco-friendly alternatives we could consider, such as natural burial sites and the potential of water cremations or Human Composting (terramation) which is natural organic reduction, turning the body into nutrient-rich soil for trees.

Environmental drawbacks of traditional burial

- Embalming chemicals: Toxic formaldehyde leaks into the soil and local groundwater.
- Non-green caskets: Hardwoods and metals demand mining, logging, and heavy manufacturing.
- Concrete vaults: Outer liners prevent the body from returning safely to the earth.
- Cemetery upkeep: Lawnmowers, weed killers, and water use add to the carbon footprint

Environmental drawbacks of cremation

- High energy use: Gas-powered furnaces need extreme heat for hours.
- Carbon emissions: One flame cremation releases hundreds of pounds of carbon dioxide.
- Air pollutants: Vaporised metals like mercury from fillings escape standard filters.

How we die and important remedies to have at hand

Denise spent a lot of time discussing how we die, and the processes involved and at each stage covered appropriate rubrics and remedies. The information here was extensive but she did prioritise. It was stressed that a remedy is not always required. Often simply adjusting the pillows, holding a hand or simply being there can help, we must not feel the pressure to 'do something'. However, the most significant remedies, where they are required, with quick keynotes taking into account the circumstances, are listed in the table.

The most important message discussed was to choose a remedy that has an affinity to what is going on

The processes discussed in the act of dying left me (and I know many others) feeling quite overwhelmed, it was a lot to take in and was close to home; it was all too recent and real. I was very grateful for a little levity when Hyoscyamus was discussed, as Denise mentioned, whilst trying to keep it real, we do not want to die exposing ourselves in a lascivious manner. (This is the polite version!)

Aconite – fear, restlessness, loquacity, >head high, lots more, deer in headlights, blue dry tongue lips etc.

Amyl nitrate – vasodilator, desire for open air

Ant tart – respiration suffocative, cannot release mucous, rattling of mucous

Ars – anguish, despair, inflammation of eyes, petechiae

Aurum – syphilitic rx, <night, want to die, hypertension, bone pains, excruciating, despair. Look at causation. Deep grief, unresolved wishes

Carbo veg – corpse reviver. Air hunger. Want to be fanned, cold breath, sweat, have to sit up to breathe, sepsis, vomiting blood (black vomit) delirium

Lachesis – hormonal. Better discharges, crying etc

Lanchnathes tintora – (Choudary) splitting head pains (cf spigelia)

Medhorrhinum – presentment of death with vomiting

Tarentula cubensis – sepsis, skin, pain

Tarantula Hispanica – terminal agitation, hyperactive (differentiate hyos) do they want to be touched. Destructive violent, desire to kill; often medicated patient. Hispanic incredible- paradoxical reaction, Molly says it needs a lot more attention

Hyoscyamus – Trying to escape. Gestures, fear of poisoning, restlessness. Lasciviousness, rudeness

Latrodectus – toxic, agony before death, chest pains, a lot of drama, anguish, fear of death

Nux – liver affinity. If I could only poop or vomit, when Ars finishes, nux could take over, over sensitivity in nux

Opium – over sensitive to heat. Desire cold air, Oreo daphne in US, as pseudonym. Impaction, itching, formication, maybe good if cannot sleep?

Phos – golden glow of urine. Bleeding, easy haemorrhage, feeling alone, open anus, leaking stool, muttering delirium, picking at things, lascivious mania

Spigelia – trigeminal neuralgia, end of life pain, sharp, shooting, hot wires

Veratrum – often indicated. Cold blue dehydration, icy cold sweat, rudeness, delusions.

Posology

As ever, this is dependent on the patient and presentation of the various symptoms and should be adapted accordingly. Our job is 'to support the lifeforce as it exits the incarnate presence. Letting the spirt go free; to bring peace'. Denise reminded us that death is an acute and at times requires high potency interventions. All the energy is put into the process; 200c, 1M potencies or possibly higher, are often indicated.

Repetition

The advice was to treat like a regular acute, try to "stay ahead of the pain and the remedy". If in a hospital setting, where homeopathy is not accepted, remember that Holy water is.

I loved Denise's analogy that there is "No way out but through". I remember being in labour and thinking, "that's it, I have had enough" but then realising exactly this. We have to do the work to "get to the end point", whether it is birth or death. *The body knows how to live, and the body knows how to die.*

Conventional medicine

I am well known for saying there is a time and a place for pharmaceuticals, and this for sure, is one. From my limited recent experience, I saw how allopathic drugs eased the pain, reduced anxiety and helped to numb the senses, at the very end of life. The drugs used are probably typical to the situation, but when employed judiciously, and with love and care, and ideally integrated with our remedies, transition can be eased, where necessary.

Research

There was much more discussed. Alastair Gray is undertaking research into this subject, both qualitively and quantitively. It is an area which is often a research conundrum. More coming soon!

Molly Punzo, who has been actively involved in this program as an MD is investigating the hospice model and how we can best parallel ourselves with the medical system, where our potential is to shine. They need people to work with us on any potential research in this field.

Overall summary

The Comfort Care Programme positions homeopathy as a gentle, whole-person support for individuals and families navigating profound transitions. By combining specialist education, clinical preparedness, and compassionate collaboration, the programme aims to expand access to supportive homeopathic care at the end of life while preparing practitioners to serve with sensitivity, confidence, and respect

Take aways

There is so much more that could be added to this article, and I personally have learnt a lot about a subject I had never really delved into before. Let us know your thoughts!

For my part, I wrote little notes as the webinars progressed, with 'action' points and things to further investigate. It certainly took me out of my own comfort zone, and I was unquestionably affected and moved by its content; I am not just referring to the recent death, rather the whole subject and the finality of someone ceasing to exist in human form. I have since read endless poems and books on death and dying; I appear to be in a different, maybe a more complete, certainly more educated zone these days, on what can be a very taboo subject. Thanks to Denise and all at HHN for putting this wonderful content together and opening an often difficult conversation. Another course will likely be running soon; we will keep you up to date!

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New words for complementary and alternative medicine from WHO

Definitions of the elements covered by the new terminology adopted by WHO reported on the front cover includes:

Traditional medicine — refers to codified or non-codified systems for healthcare and well-being, comprising practices, skills, knowledge and philosophies originating in different historical and cultural contexts, which are distinct from and pre-date biomedicine, evolving with science for current use from an experience-based origin. It emphasises nature-based remedies and holistic, personalised approaches to restore balance of mind, body and environment. It is tied to cultural/historical origin (e.g., Traditional Chinese Medicine, Ayurveda). TCIM is used in 170 countries, according to a 2019 WHO report. A more recent figure from a WHO meeting report puts documented use even higher, at 88% of WHO Member States (WHO has 194 member states, so that's roughly 170 as well).[3,4]

Complementary medicine — defined by its relationship to a country's mainstream system, not by cultural origin. This refers to additional healthcare practices that are not part of a country's mainstream medicine. Evidence-based complementary medicine has the potential to support mainstream medicine and more comprehensively support people's health and well-being needs.

Integrative medicine — the deliberate blending of biomedicine with traditional/complementary approaches. This is an interdisciplinary and evidence-based approach to health and well-being by using a combination of biomedical and traditional and/or complementary medical knowledge, skills and practices.

References available on request from the Editor