

The Quantum Homeodynamics Handbook

Foundations, Method, and Research

SECOND EDITION

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Important Medical Disclaimer

This handbook is educational. It sets out Quantum Homeodynamics (QHD), a framework proposed by its author, together with the research that would be needed to test it. It does not diagnose, treat, cure or prevent any disease, and it is not a substitute for assessment and care by a licensed health professional.

No QHD method, modality or device has been shown in controlled research to be effective for any medical condition. Where this book describes sessions, devices or practices, it does so that they can be taught, criticised and studied, not because they have been validated. The author claims no regulatory clearance, approval or certification for any device mentioned here.

Do not delay seeking medical care, and do not stop, reduce or change any prescribed medicine or treatment, because of anything you read in this book. Decisions about medicines belong with the clinician who prescribed them.

If you or someone with you has chest pain, difficulty breathing, signs of a stroke (a drooping face, weakness in an arm or leg, slurred or lost speech), severe bleeding, a severe allergic reaction, a seizure, sudden confusion, thoughts of suicide or self-harm, or any other symptom that feels like an emergency, call your local emergency number or go to the nearest emergency department now. QHD is not emergency care.

The case histories in this book are fictional teaching composites. They are not real patients, and they are not evidence that anything works.

Anyone who studies or practises QHD remains bound by the law, licensing rules and professional standards of their own jurisdiction. Reading this book confers no qualification and no licence to practise.

A Note on Conflict of Interest

I founded Quantum Homeodynamics, and this book is my account of it. That is a conflict of interest, and readers should weigh everything I say in its favour accordingly.

My interests are not only intellectual. My reputation is tied to QHD, and any income I receive from teaching, consulting or services connected with it is a financial interest in the sense that journals use the term. I have tried to limit the effect of these interests in four ways. The framework's own claims are labelled throughout by evidence tier, and none is placed above the tier of an untested hypothesis. The scientific chapters report other researchers' work, including work that undercuts ideas QHD once leaned on, and every reference has been checked against its published record. The research agenda in Book Eight names in advance the results that would oblige me to revise or abandon parts of the framework. And I have left out anything that cannot be substantiated: there are no efficacy figures, trial results, patents or device validations in this book, because none exist to report.

I have also chosen not to list qualifications or affiliations. The framework should be judged on its arguments now and on evidence later, not on the standing of its author.

The framework described here has not been independently evaluated. I would welcome evaluation by researchers with no stake in the outcome, and I would regard a well-conducted study that found nothing as a contribution rather than an attack.

Preface to the Second Edition

The first edition of this handbook was short, about twelve thousand words, and it said what it had to say plainly. The expanded Volume I that followed ran to seventy thousand. Some of that growth was real: citeable definitions, an evidence taxonomy, a research agenda. Much of it was not. When the text was audited, more than eleven thousand words turned out to be paragraphs repeated word for word, one of them forty times. Exercise templates recurred chapter after chapter, and nine “top-up” treatises had been added mainly to reach a length. A book that asks its readers to verify everything had not verified itself. That failure is mine.

This edition is the correction. It is roughly two fifths shorter than Volume I, and no paragraph appears twice. The eight-book architecture remains, because it was sound. The two hundred aphorisms of the Organon have been cut to the strongest hundred and thirty-five, each of which says something the others do not. The teaching cases are fewer and more clearly differentiated. Two new chapters describe quantum biology and bioelectric research as those fields actually stand, separating what is established from what is debated and what is still speculation, and a third sets out, construct by construct, where QHD extrapolates beyond that evidence. A References section now supports the scientific discussion, and every entry has been checked against its published record.

Some things have not changed. QHD remains complementary to conventional medicine and never a replacement for it. Its clinical claims remain hypotheses. The first duty of anyone who practises it is still to recognise emergencies and refer.

I came to these questions through people whose results were normal and whose lives were not: years of fatigue that no abnormal value explained, pain that outlasted the healing of the tissue, sleep that no longer restored. Modern medicine served these people well in many respects and still left gaps in its account of their illness. At the same time I was reading the early literature of

quantum biology, in which physicists and chemists were asking how living systems keep order at scales where quantum effects might matter. I founded QHD in 2024 to bring a disciplined clinical method to the first problem while taking the questions of the second seriously.

What I have produced is a proposal, not a proof. This book is best read as a founder's framework together with a research programme for testing it. If the programme succeeds, later editions will report real evidence. If it fails, I hope the habits it teaches (careful observation, honest speech about uncertainty, fast referral) will outlast the name.

Dr. Abdul Jaleel Kavungal

How to Use This Handbook

The book is written for four kinds of reader: students and practitioners in training, clinicians who want to understand what QHD proposes, researchers who might test it, and sceptics. It is organised in eight books.

Book One sets out the paradigm and the science behind its vocabulary, including a frank account of where QHD goes beyond that science. Book Two is the Organon, a set of numbered principles. Book Three describes the Five-Step Method and specifies the fields in which each step is documented. Book Four covers the modalities and devices and states their evidential status. Book Five teaches case-taking through thirteen fictional composites. Book Six orients students to the problems people commonly bring, with the emphasis on what medicine knows and when to refer. Book Seven covers ethics, formation and the future. Book Eight is the study reference: citeable definitions, the evidence taxonomy, the research agenda, falsification criteria and reporting standards. An appendix of consent language, a glossary, the references and an index follow.

A few conventions run through the text. Claims are classified with the evidence tiers defined in Chapter 55, from T0 (emergency medicine) to T6 (speculation); a tier in square brackets, such as [T4], classifies the statement it follows. Definitions numbered CD-1 to CD-13 are stable and citeable and are collected in Chapter 54. Aphorisms are numbered §1 to §135, and the numbering applies to this edition only. Citations use an author–year style, and the References list only works whose publication details have been checked. Every case is a fictional teaching composite and is labelled as one.

Newcomers should read the Medical Disclaimer, then Book One, the first two groups of aphorisms and Book Three before anything else. Researchers may prefer to start with Chapters 3 to 5 and go straight on to Book Eight. Sceptical clinicians, and I hope there will be many, might begin with Chapter 5, which lists where the framework outruns its evidence, and then read Chapters 55 and 57.

Nothing here makes anyone competent to practise. Competence comes from supervised training within a regulated profession, and this book does not replace it.

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Back matter. Appendix: Sample Consent Language; Glossary; References; Index of Key Terms.

Book One: Paradigm

1. What Quantum Homeodynamics Proposes

Most clinicians know the consultation. A person arrives with a folder of results, all within the reference ranges, and a life that has narrowed over two or three years: tired by early afternoon, sleeping without being restored, wary of any exertion that might cost the next two days. The investigations were necessary, and some of them were reassuring. They did not explain the illness, and they did not tell anyone what to do next.

Quantum Homeodynamics began as an attempt to give such encounters a disciplined structure. It proposes that clinicians attend to how a person's regulatory systems are coordinated over time, and not only to whether individual measurements are normal, and it offers a method for doing so. Its citeable definition (CD-1, given in full with the other twelve in Chapter 54) describes a clinical and educational framework, proposed in 2024, for observing and supporting adaptive coordination in the living human system through a Five-Step Method and a set of resonance-oriented practices, always as a complement to licensed medical care. Two clauses of that definition carry most of the weight. QHD borrows questions and vocabulary from quantum biology and systems physiology without claiming that its clinical methods work through quantum mechanisms. And none of its clinical claims has yet been tested in controlled research.

The name has three parts, and each needs explaining because each can mislead.

Quantum refers to the research field described in Chapter 3, in which physicists, chemists and biologists study cases where quantum effects such as tunnelling, coherence and correlated electron spins do real work inside living things. That field shaped the questions QHD asks: how organisms maintain order far from equilibrium, and how coordination at one scale supports

function at another. It does not supply evidence for QHD's clinical methods. The word is the most contestable part of the name, and I have kept it with some misgiving. If it comes to mislead more than it clarifies, the constructs should be renamed and the method kept.

Homeo- signals affinity with the organism's capacity to regulate and repair itself. It echoes homeostasis, Cannon's (1932) term for the stability of the internal environment, and it acknowledges a debt to older healing traditions that respected that capacity, Hahnemann's among them. It does not make QHD a form of homeopathy; Chapter 8 sets out the difference.

Dynamics is the substantive commitment. Health is not a fixed point to which the body returns but a moving, adaptive order. The word homeodynamics is older than QHD. Physiologists have used it to argue that living regulation is better described as a pattern of changing states than as a single set point (Lloyd et al., 2001), and it also appears in the biofield literature (Rubik, 2002). QHD adopts the idea and adds a clinical method. In practice, dynamics means watching trajectories: whether a person is improving, stalling, oscillating, or crashing after overreach.

QHD's core clinical question follows from these commitments. What is this person's present pattern of coordination and dysregulation, and how might we support the conditions in which their own repair can work better, without delaying any medical care they need? The method answers in five steps (scan, analyse, personalise, deliver and verify), which Book Three describes.

It is worth being precise about the kind of thing QHD is. A validated medical system can show three things. Its measurements measure what they claim to measure. Its interventions produce benefits that exceed their harms when compared fairly with alternatives. Its practitioners can be trained to apply it consistently. QHD cannot yet show any of these. What it offers is a set of definitions, a documented method, an ethical code, and a research agenda designed to find out whether the rest can be earned. Put simply, it is a proposal with a research programme attached.

That position rules certain things out. QHD does not replace emergency care, oncology, the treatment of infection, surgery or any other disease-directed therapy. It does not diagnose disease, and its scans are not a substitute for imaging, laboratory tests or pathology. It offers no universal explanation of chronic illness, and it does not treat the word quantum as a synonym for proven. It uses no diluted substances. It never advises anyone to stop a prescribed medicine.

What remains is modest but, I think, worth testing: a structured way of attending to the whole pattern of a person's regulation, practised under strict rules about honesty and referral, and offered alongside medical care rather than against it.

Questions for study

1. CD-1 says that QHD “borrows questions and vocabulary” from quantum biology. What would have to be shown before it could claim more than that?
2. Name the three things a validated medical system can demonstrate. For each, describe one study that could begin to establish it for QHD.
3. Why might keeping the word *quantum* in the name be a liability as well as an asset?

2. Coherence, Decoherence, and the Discipline of Metaphor

QHD's central terms are borrowed from physics, and that borrowing should be stated openly. In quantum mechanics a system is coherent when the components of its state keep definite phase relationships with one another, which is what makes interference possible. Decoherence is the loss of those relationships as the system becomes entangled with its surroundings, and it is the main reason the everyday world looks classical (Zurek, 2003). In warm, wet, noisy matter decoherence is usually extremely fast. One widely cited estimate for processes in the brain put it at between 10^{-13} and 10^{-20} seconds, set against the thousandths to tenths of a second on which neurons work (Tegmark, 2000).

A patient is not a qubit, and nothing in QHD's clinical use of these words refers to quantum states in the body. QHD uses them as analogies and defines them as clinical working constructs. Coherence (CD-2) means adaptive coordination: subsystems coupled closely enough to work as a whole and loosely enough to change when circumstances change. Decoherence (CD-3) means the persistent loss of that coordination, seen clinically as rigidity, fragmentation, noisy or exhausted regulation, or poor recovery after load. Neither word refers to a quantum state, and neither is ever a diagnosis.

Why borrow physics words at all, when the risk of misunderstanding is so obvious? Partly for historical reasons, since QHD grew out of reading quantum biology. But there is a better reason: the analogy points to something that classical physiology already measures. Heart rate varies from beat to beat, and the pattern of that variation reflects autonomic regulation; standards for measuring it have existed for decades (Task Force, 1996). Many physiological signals show a complex, fractal structure in health that tends to flatten with ageing and disease (Lipsitz & Goldberger, 1992; Goldberger et al., 2002). Organ systems can be studied as networks whose coupling changes with physiological state, for instance between stages of sleep (Bashan et al., 2012). And stress physiology has moved from Cannon's (1932) picture of a stable internal environment towards allostasis, in which the body anticipates demands and adjusts its set points, at a cumulative cost when it must keep doing so (McEwen, 1998; Sterling, 2012).

These literatures suggest three ways in which coordination can fail, and QHD uses them as a clinical vocabulary. Regulation can become too rigid, as when heart rate barely varies or a person can no longer tolerate any change of routine. It can become fragmented, as when sleep, meals and activity drift apart in a shift worker whose rhythms no longer line up. Or it can become noisy and exhausted, as when stress responses fire at small provocations and are slow to settle. None of these descriptions is a diagnosis. Each is a way of asking what, in this person, has lost its ability to adapt.

The metaphor earns its place only under discipline, and three rules apply. First, every coherence statement must be translatable into something observable: nights with five hours of unbroken sleep, days without a post-exertional crash, the time it takes to settle after an argument. A statement that cannot be translated does not belong in a record. Second, coherence language never replaces medical triage; when a coherence account and a red flag point in different directions, the red flag wins. Third, if the metaphor confuses or frightens a particular patient, drop it. The patient needs the plan, not the vocabulary.

Some sentences are therefore acceptable and others are not. “We are using coherence as a working description of how your sleep, energy and stress responses fit together” is acceptable. “Your decoherence caused your cancer”, “the scan shows quantum collapse in your liver” and “your mitochondria have lost their entanglement” are not. They are false as physics, empty as physiology and harmful at the bedside.

On this working model, health is flexible order: physiological, circadian, immune, metabolic and experiential processes staying coordinated while remaining free to change. Illness patterning is the persistent loss of that flexibility. It often coexists with identifiable disease, sometimes precedes it, and sometimes outlasts it. The model is useful to the extent that it directs attention to sleep, load, rhythm, safety and recovery, and dangerous to the extent that it tempts anyone to treat an analogy as a finding.

Questions for study

1. Translate the statement “her regulation has become fragmented” into three observations that could be recorded and checked at follow-up.
2. What does heart-rate variability measure, and why would it be a mistake to treat it as a measure of coherence in the QHD sense without further research?
3. Write one sentence about coherence that you would allow on a consent form and one you would forbid, and explain the difference.

3. Quantum Biology: Established, Debated, Speculative

In one trivial sense all of biology is quantum. The stability of atoms, the shapes of molecules and the colours of pigments all depend on quantum mechanics, and chemistry is its applied form. When researchers speak of quantum biology they mean something narrower: cases in which non-trivial quantum effects, such as tunnelling through energy barriers, coherent superpositions or correlated electron spins, do functional work that classical or semiclassical models would miss (Lambert et al., 2013; Kim et al., 2021). This chapter describes the main cases as the research literature stands. Readers wanting a longer introduction will find a lively popular account in Al-Khalili and McFadden (2014) and a historical one in McFadden and Al-Khalili (2018).

The field is older than its recent visibility suggests. In lectures given in Dublin in 1943, Schrödinger (1944) asked how living things maintain order against the drift towards disorder, and suggested that heredity must be carried by an “aperiodic crystal” stable enough to resist thermal noise. A decade later, Watson and Crick (1953) proposed that spontaneous mutations might arise when a base shifts briefly into a rare tautomeric form and pairs with the wrong partner. Ten years after that, Löwdin (1963) suggested that protons might reach such forms by quantum tunnelling. These ideas stayed largely theoretical for decades. What changed was the arrival of experimental techniques able to test them.

The evidence is best read case by case, because its strength varies enormously.

Tunnelling in enzymes and electron transfer

Tunnelling is the best-established quantum effect in biology. A particle with too little energy to cross a barrier classically has a finite probability of passing through it, and that probability falls steeply as the particle’s mass and the barrier’s width increase. Electrons, being light, tunnel readily, and the chains of redox centres that carry electrons through respiratory and photosynthetic proteins rely on tunnelling between cofactors held at suitable distances by the protein. That picture is now standard biophysics (Gray & Winkler, 2003).

Hydrogen is far heavier, so the evidence that protons, hydride ions and hydrogen atoms tunnel in enzymes was more surprising. It comes mainly from kinetic isotope effects. Replacing hydrogen with deuterium slows a reaction, and classical models set a ceiling on how much. Cha and colleagues (1989) reported isotope effects in an alcohol dehydrogenase that could not be explained without tunnelling. In soybean lipoxygenase the isotope effect is about 81 near room temperature and barely changes with temperature, a pattern consistent with hydrogen transfer that occurs almost entirely by tunnelling (Knapp et al., 2002). Structural and computational work on aromatic amine dehydrogenase described a reaction dominated by proton tunnelling over a distance of about 0.6 ångström (Masgrau et al., 2006).

What is debated is not whether tunnelling occurs but what it means. One school argues that protein motions have been tuned by evolution to bring donor and acceptor close enough for efficient tunnelling, linking protein dynamics directly to catalysis (Klinman & Kohen, 2013). Others argue that the catalytic power of enzymes is explained mainly by the electrostatic preorganisation of the active site, and that appeals to special dynamical effects add little (Kamerlin & Warshel, 2010). Masgrau and colleagues themselves found that in their enzyme a short-range motion sufficed and no long-range coupled motion was needed. Tunnelling in enzymes is established [T1 in biophysical chemistry]; the evolutionary and dynamical story around it is a live research question [T2].

Energy transfer in photosynthesis

Photosynthetic antenna complexes absorb light and pass the excitation energy to reaction centres with near-perfect quantum efficiency (Panitchayangkoon et al., 2010). How they do it became, for about a decade, the most publicised question in quantum biology.

In 2007 Engel and colleagues used two-dimensional electronic spectroscopy on the Fenna–Matthews–Olson (FMO) complex, a pigment-protein from green sulphur bacteria, cooled to 77 K. They observed oscillating signals, or quantum beats, lasting hundreds of femtoseconds, and interpreted them as

evidence of wavelike energy transfer through electronic coherence (Engel et al., 2007). Similar signals were reported in FMO at physiological temperature (Panitchayangkoon et al., 2010) and in antenna proteins from marine algae at ambient temperature (Collini et al., 2010). Theorists suggested why nature might exploit such coherence: in models of FMO, a moderate amount of environmental noise could make transport more efficient than either a perfectly coherent or a fully incoherent process, an effect called environment-assisted transport (Mohseni et al., 2008; Plenio & Huelga, 2008). The story spread far beyond physics, and many writers, including some in integrative medicine, took it as evidence that life in general exploits quantum coherence.

The story did not survive re-examination intact. Duan and colleagues (2017) measured FMO in solution at ambient temperature and found that electronic coherence decayed within about 60 femtoseconds, too quickly to play the proposed role. Using polarisation-controlled spectroscopy and modelling, Thyraug and colleagues (2018) showed that the long-lived beats in FMO were vibrational in origin, and that electronic coherence had dephased within 240 femtoseconds even at 77 K. A review written by many of the field's leading groups concluded that coherences between excitonic states are too short-lived to have any functional significance in photosynthetic energy transfer, and that the long-lived signals come from vibrations set off by the laser pulse (Cao et al., 2020). There was also a problem of principle. The experiments use ultrashort, coherent laser pulses, whereas sunlight is weak, continuous and incoherent, and Brumer and Shapiro (2012) argued that the coherent dynamics seen in the laboratory are not relevant to the natural process.

What remains is still quantum mechanical, but less dramatic. Excitations are shared across several pigments, electronic and vibrational motions mix, and accurate models of energy transfer need quantum theory. The claim that photosynthesis depends on long-lived electronic coherence, however, has been largely withdrawn by the people best placed to judge it [T2, revised]. For QHD this is the most important lesson in the chapter. The coherence metaphor

that QHD adopted was partly inspired by this work, and the science moved on. A framework that builds on young science has to be ready to watch its foundations shift.

The radical-pair compass

Many migratory birds orient by the Earth's magnetic field. Experiments with European robins in the early 1970s showed that their compass responds to the inclination of the field lines rather than to their polarity (Wiltschko & Wiltschko, 1972). In 1978 Schulten and colleagues proposed a mechanism. Light could create a pair of radicals whose unpaired electron spins are correlated, and the rate at which the pair interconverts between spin states, and therefore the yield of its chemical products, could depend on the pair's orientation relative to a weak magnetic field (Schulten et al., 1978). Ritz and colleagues (2000) proposed cryptochrome proteins in the retina as the likely site.

The evidence gathered since is substantial but mostly indirect. Robins became disoriented when exposed to weak oscillating magnetic fields in the radiofrequency range, either broadband from 0.1 to 10 MHz or at a single frequency of 7 MHz, with an effect that depended on the angle between the oscillating field and the Earth's field (Ritz et al., 2004). That kind of sensitivity is expected of spin dynamics but not of iron-based magnetoreceptors. In a series of double-blind experiments, robins housed in unscreened wooden huts on a university campus could not use their magnetic compass. When the huts were screened, which attenuated electromagnetic noise between 50 kHz and 5 MHz by about two orders of magnitude, orientation returned, and deliberately generated noise abolished it again (Engels et al., 2014). At the molecular level, cryptochrome 4 from the European robin showed magnetically sensitive photochemistry in vitro, more so than the same protein from chickens and pigeons, neither of which migrates (Xu et al., 2021).

The radical-pair mechanism is now the leading hypothesis for the avian compass (Hore & Mouritsen, 2016), but it is not proven in the living bird. How the chemical signal reaches the brain is unknown, and why the compass is disrupted by such weak radiofrequency fields is not fully explained. The fruit fly shows how easily evidence in this area can mislead. An influential study reported that cryptochrome was necessary for magnetic responses in *Drosophila* (Gegear et al., 2008), and flies became a common model organism for the question. A later study that tested more than a hundred thousand flies in two behavioural assays, under carefully controlled conditions, found no evidence of magnetically sensitive behaviour and suggested that many of the earlier positive results were false positives (Bassetto et al., 2023). Radical-pair magnetoreception in migratory birds is well supported but incompletely demonstrated [T2]; claims about other species need independent replication.

Olfaction

How the nose tells one molecule from another is still not fully understood. The dominant view is that olfactory receptors recognise the shape and chemistry of odorant molecules. Turin (1996) revived an older alternative, proposing that receptors detect the vibrational frequencies of odorants through inelastic electron tunnelling, and a physical analysis suggested that such a mechanism was possible in principle (Brookes et al., 2007).

Tests have given mixed results. In psychophysical experiments, human volunteers could not distinguish acetophenone from its deuterated form, whose shape is the same but whose vibrations differ, and the study found no support for the theory's other predictions either (Keller & Vosshall, 2004). Fruit flies, by contrast, distinguished deuterated from ordinary odorants and could be trained to avoid one or the other (Franco et al., 2011). Trained human subjects in a later study again failed to tell the acetophenone isotopes apart but did distinguish deuterated from ordinary musk compounds (Gane et al., 2013). When the human receptor that responds to those musks was tested directly in a cell-based assay, however, it did not discriminate between the isotopes, and its authors judged the vibrational theory implausible (Block et al., 2015). The vibrational theory of olfaction is a contested minority hypothesis [T2].

Tautomers and mutation

The Watson–Crick suggestion about rare tautomers has fared better. High-resolution crystal structures of a DNA polymerase caught a mismatched base pair adopting the shape of a correct pair at the site of incorporation, a shape made possible by the movement of a single proton; this is structural evidence for the rare-tautomer hypothesis (Wang et al., 2011). Using nuclear magnetic resonance, Kimsey and colleagues (2015) showed that G·T and G·U mismatches in DNA and RNA exist fleetingly as Watson–Crick-like pairs, stabilised by rare enol or anionic forms of the bases, with probabilities of roughly one in a thousand to one in a hundred thousand, which is enough to matter for errors in replication and translation. Whether tunnelling, rather than ordinary thermal activation, is the main route into these forms is less clear. An open-quantum-systems model of the guanine–cytosine pair concluded that tunnelling dominates proton transfer and that the canonical and tautomeric forms interconvert far faster than biological processes such as replication (Slocombe et al., 2022). What this means for real mutation rates has yet to be established. Rare tautomers as a source of mismatches are well supported [T1–T2]; the specific contribution of tunnelling is debated [T2].

Speculation at the edges

Some proposals go much further. The best known is the theory of orchestrated objective reduction, which holds that quantum computations in neuronal microtubules underlie consciousness (Hameroff & Penrose, 2014). Most physicists and neuroscientists are sceptical, largely because of decoherence: Tegmark (2000) estimated that any quantum superpositions in the brain would decohere many orders of magnitude faster than neurons fire. The theory is testable in principle and has defenders, but it sits at the speculative end of the field. Used as a clinical explanation, for instance to tell a patient that their anxiety reflects microtubule decoherence, it would be pure speculation [T6].

What this means for a clinical framework

The table summarises the evidence. Its final column matters most.

Phenomenon	Established	Debated	Shown to matter in human chronic illness
Tunnelling in enzymes and electron transfer	Occurs; strong kinetic and structural evidence	The role of protein dynamics; evolutionary tuning	No
Photosynthetic energy transfer	Delocalised excitations; quantum models needed	Largely settled against long-lived electronic coherence	No
Avian magnetic compass	A light-dependent compass disrupted by weak radiofrequency fields	Radical pairs in cryptochrome as the mechanism; the signalling pathway	No
Olfaction	Receptors respond to odorant structure	Any vibrational component	No
Tautomers and mutation	Rare tautomers produce mismatches	The contribution of tunnelling	No
Quantum effects in consciousness	Nothing	Whether any could survive decoherence in the brain	No

Three conclusions follow. First, quantum effects in biology are real but specific. They occur in particular molecules, on particular timescales and under particular conditions, and each has been established or questioned by painstaking experiment. Second, none has been shown to operate at the level of whole-body regulation, still less in the chronic illnesses with which QHD is concerned. Third, the field corrects itself. Its most famous claim was tested by its own proponents and scaled back, and QHD should borrow that habit before it borrows anything else.

QHD therefore takes from quantum biology a set of questions about order, coordination and the limits of classical description, together with an example of scientific self-correction. It takes no mechanism. Anyone who tells a patient that a QHD session works “at the quantum level” is claiming something this literature does not support.

Questions for study

1. Explain in two sentences why a kinetic isotope effect of about 81 is evidence of tunnelling.
2. Trace the photosynthesis story from Engel and colleagues (2007) to Cao and colleagues (2020). What would a responsible popular article have said in 2009, and what should one say now?
3. Why did the fruit-fly results matter for the radical-pair hypothesis, and what does the replication by Bassetto and colleagues (2023) teach about sample size?
4. Choose one row of the table and describe the experiment that would be needed to change its final column from “No” to “Yes”.

4. Light and Voltage: Biophotons, Bioelectricity, and Biomagnetism

Three further bodies of research are often cited, accurately or not, in support of field-based ideas about health. All three describe classical physics at work in living tissue. Each contains established findings, open questions and a penumbra of speculation, and each is routinely overstated in popular writing.

Ultra-weak photon emission

Living cells emit light. The emission is extremely faint: the glow of the human body is roughly a thousand times below what the naked eye can detect, and it can be imaged only with cooled, highly sensitive cameras (Kobayashi et al., 2009). Reviews put its spectral range between about 350 and 1300 nanometres and its intensity at a few to several hundred photons per second per square centimetre during ordinary oxidative metabolism, rising to thousands under oxidative stress (Cifra & Pospíšil, 2014). The mechanism is reasonably well

understood. Reactive oxygen species oxidise lipids and proteins, producing electronically excited molecules that emit photons as they relax (Pospíšil et al., 2014). Ultra-weak photon emission is, in other words, a faint chemiluminescent by-product of oxidative chemistry. Kobayashi and colleagues found that emission from the human body follows a daily rhythm, which they linked to changes in energy metabolism.

The history is more colourful. In 1923 Alexander Gurwitsch reported a “mitogenetic radiation” from living tissue that appeared to stimulate cell division nearby. The claim generated more than seven hundred publications before being largely abandoned after critical studies in the late 1930s, and a modern review concluded that, although some of the physical findings were later confirmed, the biological effect used to detect the radiation remains questionable (Volodyaev & Belousov, 2015). Later, Fritz-Albert Popp and colleagues argued that the emission, which they called biophotons, is coherent and originates in DNA (Popp et al., 1984). Those claims about coherence and a regulatory role have not been established.

The status is therefore as follows. That cells emit ultra-weak light, and that the emission tracks oxidative processes, is established [T1]. Its value as a non-invasive research marker of oxidative stress or metabolic state is a reasonable research question [T2]. The idea that biophotons form a coherent field that organises the body, or that a practitioner can read a person’s state from them, is speculation [T6 in clinical speech]. No clinical diagnostic use has been validated.

Bioelectric signalling

Every living cell maintains a voltage across its membrane, and in nerve and muscle rapid changes in that voltage carry signals; the quantitative description of the nerve impulse by Hodgkin and Huxley (1952) is one of the foundations of physiology. What has become clearer in recent decades is that non-excitabile cells also use steady voltages, and the currents flowing between them, as signals.

When an epithelium is wounded, the break in the layer immediately generates an electric field. Zhao and colleagues (2006) showed that fields of the strength measured in real wounds direct cell migration during healing as a dominant directional cue, acting through identifiable signalling pathways, and that manipulating the wound field changes healing in living tissue. An earlier review summarised how applied and endogenous fields influence cell migration, cell division and the growth of nerves (McCaig et al., 2005).

Developmental bioelectricity goes further. Michael Levin and colleagues have argued that patterns of membrane potential across tissues form a layer of control that helps groups of cells decide what to build (Levin, 2014, 2021). Several experiments in model organisms support the idea. In *Xenopus* tadpoles, a change in membrane voltage driven by a proton pump was necessary and sufficient to induce tail regeneration (Adams et al., 2007), and a brief induced sodium current triggered regeneration at a stage when tadpoles normally cannot regenerate (Tseng et al., 2010). Altering the membrane voltage of embryonic cells produced well-formed ectopic eyes, even far outside the region where eyes normally form (Pai et al., 2012). In planarian flatworms, a brief perturbation of bioelectric networks caused a consistent proportion of regenerating fragments to grow two heads; fragments that looked normal carried a hidden change, because when they were cut again, the same proportion regenerated two heads (Durant et al., 2017).

These are striking findings from careful laboratories. They establish that bioelectric gradients carry patterning information in some developing and regenerating tissues [T1–T2]. How general the principle is, and whether it can be harnessed in human medicine, remain open; Levin (2021) describes a research roadmap, not a clinical practice [T2]. Nothing in this work suggests that an external “resonance” applied to an adult with chronic fatigue reorganises their bioelectric patterns.

It is instructive to see what a conventional route from bioelectric science to treatment looks like. Tracey (2002) described the inflammatory reflex, a neural circuit through which signals in the vagus nerve inhibit the production of inflammatory cytokines. An implanted vagus nerve stimulator later reduced

production of the cytokine TNF and improved disease scores in people with rheumatoid arthritis (Koopman et al., 2016). That study had no control group. The path illustrated there runs from a defined mechanism to a defined device, a measured biomarker and an early uncontrolled study. Any bioelectric claim made for a QHD device would have to follow a path of that kind, and none has.

Biomagnetic fields

Electric currents produce magnetic fields, so the ionic currents of the heart and brain produce measurable magnetic fields outside the body. Baule and McFee (1963) detected the magnetic field of the heart, and Cohen (1968) recorded magnetic fields from the brain's alpha rhythm, the beginning of magnetoencephalography. The fields are tiny beside the Earth's magnetic field, and the brain's signals are weaker than the heart's (Hämäläinen et al., 1993). Measuring them requires superconducting or optically pumped sensors and, usually, a magnetically shielded room, although wearable systems built on optically pumped magnetometers now allow recordings while people move (Boto et al., 2018).

There is an irony here worth noticing. The instruments that detect the body's magnetic fields are quantum devices, but the fields themselves are ordinary classical electromagnetism generated by ions moving through tissue. Nothing in biomagnetism supports the idea that these fields carry regulatory information between organs, still less between people, or that a practitioner's hands can sense them.

Resonance in physiology

The word resonance also has a precise physiological meaning, and it is worth knowing because it can be tested. Heart rate rises and falls with breathing, and the baroreflex, which buffers blood pressure, has its own characteristic delay. When a person breathes at about six breaths a minute, roughly 0.1 hertz, these rhythms reinforce one another and the oscillations of heart rate become very large (Vaschillo et al., 2002). Heart-rate variability biofeedback trains people to breathe at their resonance frequency (Lehrer & Gevirtz, 2014). A meta-

analysis of 24 studies found a large effect on self-reported stress and anxiety compared with control conditions, and its authors noted that more well-controlled studies are needed (Goessl et al., 2017).

This is what a resonance intervention looks like when it can be studied: a named physiological mechanism, a measurable signal, a specified procedure and controlled comparisons. QHD's resonance practices have none of these yet, and heart-rate variability biofeedback is an obvious active comparator for any trial of them (Chapter 56).

What this literature does and does not support

It supports the statements that living tissue produces faint light as a by-product of oxidative chemistry, that bioelectric gradients help to control patterning and wound healing in some tissues, that the heart and brain produce very weak magnetic fields, and that physiological rhythms can resonate in measurable ways. It does not support the existence of a unified field that organises the body, the claim that such a field can be read by a scanner or a hand, or the claim that resonance devices restore it. The next chapter sets out exactly where QHD's language goes beyond the evidence.

Questions for study

1. What is the physical source of ultra-weak photon emission, and what would it take to validate it as a clinical marker of anything?
2. Describe the planarian experiment of Durant and colleagues (2017). Which features of the result make it more than a curiosity, and which limit what it tells us about people?
3. Why does the work on the inflammatory reflex and vagus nerve stimulation make a useful template for evaluating any QHD device?

5. The Biofield as a Working Model, and Where QHD Extrapolates

The word biofield has an institutional history. It was proposed in 1992 by an ad hoc committee of complementary-medicine practitioners and researchers convened by the newly created Office of Alternative Medicine at the United States National Institutes of Health, which defined it as “a massless field, not necessarily electromagnetic, that surrounds and permeates living bodies and affects the body” (Rubik et al., 2015). Proponents have since offered biophysical interpretations of the idea (Rubik, 2002), and a review of clinical studies of biofield therapies described the evidence as nascent and the methodological problems as considerable (Jain et al., 2015).

QHD uses the word differently and more narrowly. In this edition’s definition (CD-6), the biofield is an umbrella term for the measurable, classical field phenomena of the living body (bioelectric potentials and currents, biomagnetic fields and ultra-weak photon emission) taken together with the physiological rhythms they accompany. QHD posits no massless or non-physical field. The term organises questions about whole-body coordination; it does not name a single measured quantity, and it licenses no claim to detect disease.

This definition is deliberately more restrictive than the 1992 one. A field that is massless and “not necessarily electromagnetic” cannot be measured by any known instrument and therefore cannot be tested. The components listed in CD-6 can each be measured, and Chapter 4 described what is known about them. What has not been shown is that they combine into anything that deserves a single name, or that a clinician can learn from them anything that careful history-taking and examination would miss.

Two tested claims close to QHD’s territory should be known by every student. In a blinded experiment, 21 experienced practitioners of Therapeutic Touch, who believed they could feel a “human energy field” with their hands, were asked which of their hands was near the investigator’s hand. They chose correctly in 123 of 280 trials, 44 per cent, close to the 50 per cent expected by chance (Rosa et al., 1998). A systematic review and meta-analysis of randomised trials of static magnets for pain found no significant benefit over

placebo or weak-magnet controls, although for osteoarthritis the evidence was too thin to exclude one (Pittler et al., 2007). Neither study tested QHD. Both tested the kind of claim QHD could easily drift into making, and both found nothing.

Against this background, the extent of QHD's extrapolation can be stated plainly. The table lists each QHD construct, what it borrows, what the evidence shows, and the tier at which QHD may speak about it.

QHD construct	What it borrows	What the evidence shows	Permitted speech
Coherence and decoherence (CD-2, CD-3)	Physics vocabulary; research on heart-rate variability, complexity and allostasis	Classical coordination is measurable; the QHD construct itself is unvalidated	Working model [T3]
Quantum signature (CD-4)	The idea of a characteristic pattern	Nothing is measured; it is a structured written formulation	Documentation convention [T3]
Biofield (CD-6)	Bioelectricity, biomagnetism, photon emission	Components measurable; no unified field shown; detection by hand failed when tested	Working model [T3]
Scan with device adjunct (CD-12)	Biophysical measurement	No QHD device has published evidence of validity	Structured intake [T4]; device readings exploratory only
Resonance therapy and emitters (CD-7, CD-11)	Resonance in physics and physiology	No evidence of effects beyond those of a calm, structured encounter	Hypothesis [T4]
Entanglement assistance (CD-9)	Quantum entanglement	Entanglement cannot carry signals; none has been shown between people	Relational metaphor only [T3]; literal use [T6]
Distance therapy (CD-10)	Remote care	Coaching and relational support have ordinary explanations; no physical remote effect shown	Remote coaching [T4]; literal remote effects [T6]

The widest gap lies between the first column and the third. QHD's vocabulary moves from specific quantum effects in particular molecules, established by exacting experiments, to statements about whole persons in clinics, where no such effect has been sought, let alone found. Nothing in Chapters 3 and 4 licenses that move. QHD's clinical claims therefore stand or fall on clinical evidence of their own, and at present there is none.

That conclusion does not make the framework worthless. A structured method of attention, strict rules about speech and referral, and hypotheses stated precisely enough to be tested are all contributions. It does mean that anyone who presents QHD as quantum medicine in the sense of a proven technology is misrepresenting it, and this book gives them no support. The research agenda in Book Eight is designed to narrow the gap, beginning with the most tractable questions: whether the constructs can be applied reliably, whether the method is safe, and whether the modalities do anything that an attention-matched comparison does not.

Questions for study

1. Compare the 1992 definition of the biofield with CD-6. Which is easier to test, and why does that matter?
2. What features of the Therapeutic Touch experiment made its result convincing? Design an equivalent test for any perceptual claim made in QHD training.
3. Pick one row of the extrapolation table and write the sentence you would use to explain its final column to a patient.

6. Chronic Illness and the Limits of a Chemical-Only Frame

Molecular medicine is one of humanity's great achievements, and QHD has no quarrel with it. Its limits are narrower than its critics claim and more real than its enthusiasts admit. Engel (1977) made the essential argument half a century ago: a model of disease built only on biochemical deviation cannot account for why people with similar lesions experience very different illnesses, or why

some people are ill without any lesion that current tests can find. His biopsychosocial model did not reject biology. It insisted that biology is not the whole of illness.

The clinical science of chronic illness has since borne him out in specific ways. Pain is now defined as an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage (Raja et al., 2020), a definition that deliberately allows for pain without detectable damage. Central sensitisation, an amplification of signalling within the central nervous system, helps to explain pain that persists after tissue has healed (Woolf, 2011). In myalgic encephalomyelitis/chronic fatigue syndrome, a worsening of symptoms after even modest exertion, called post-exertional malaise, is a defining feature (Institute of Medicine, 2015). Persistent illness after COVID-19 involves several organ systems and a range of possible mechanisms that are still being worked out (Davis et al., 2023). Irritable bowel syndrome and related conditions are now classed as disorders of gut–brain interaction (Drossman, 2016).

Common to these conditions are feedback loops that cross the boundaries between bodily systems. Poor sleep lowers pain thresholds, and pain fragments sleep. Fear of relapse reduces activity; inactivity makes the next exertion harder; overactivity on a good day produces the crash that confirms the fear. A prescription may correctly target one node of such a loop while the loop carries on. This is not an argument against prescriptions. It is an argument for additional ways of working that attend to rhythm, load, pacing, safety and relationship over time.

An admission is due here. Much of what QHD calls coherence support is what good clinicians in primary care, rehabilitation and pain medicine already do. QHD's claim to be distinctive rests on two things: the Five-Step structure, which can be tested as a method of documentation and follow-up, and the resonance modalities, which can be tested as interventions. Neither has yet been tested.

A second admission concerns context. The meaning a person attaches to a treatment, and the relationship within which it is given, can change how they feel (Moerman & Jonas, 2002). In a randomised trial in irritable bowel syndrome, placebo acupuncture delivered by a warm, attentive and confident practitioner produced more improvement than the same placebo delivered briefly and neutrally, and both did better than a waiting list (Kaptchuk et al., 2008). A Cochrane review concluded that placebo interventions in general do not have important clinical effects, although they can influence patient-reported outcomes, especially pain and nausea, to an extent that varies widely between trials (Hróbjartsson & Gøtzsche, 2010). Whatever benefit patients report from QHD sessions may come, wholly or in part, from these ordinary sources. That would not make the benefit unreal. It would make any claim that it comes from a quantum or field mechanism false.

QHD therefore occupies a difficult middle position. It honours pathology when pathology is present, attends to pattern when the pattern exceeds any single lesion, and supports coordination without taking the patient away from necessary care. Students should practise saying two sentences together until they sound natural: your physician's work matters, and so does the pattern of your life.

Questions for study

1. Draw the loop linking sleep, pain, fear and activity for a person with persistent back pain. Where might a conventional treatment act, and where might a pacing plan act?
2. What does the trial by Kaptchuk and colleagues (2008) imply for the design of any study of QHD sessions?

7. QHD and Conventional Medicine

QHD is complementary, and the word has a precise meaning in this book: QHD is offered alongside licensed medical care, never instead of it, and it never undermines that care. The stakes are not abstract. In a study of people in the United States with curable breast, prostate, lung or colorectal cancer, those

who chose alternative medicine as their only treatment had about two and a half times the hazard of death of matched patients who received conventional treatment (Johnson et al., 2018). The study was observational and cannot prove cause, but no responsible framework can ignore it.

A shared triage hierarchy keeps the relationship clear, and every student should be able to recite it:

1. A life-threatening emergency goes to emergency services.
2. A possibly serious undiagnosed illness goes to medical evaluation.
3. Known disease continues under disease-directed care from licensed clinicians.
4. Adjunctive QHD support may then be offered, within the practitioner's scope.
5. Self-care and supports for meaning follow, collaboratively and without coercion.

A practitioner who reverses this order, for income or for ideology, has left the framework.

Conventional medicine does things that QHD cannot and should not attempt. It diagnoses structural and infectious disease, stabilises acute illness, operates, prescribes and adjusts medicines, and runs the population programmes, such as vaccination, that prevent disease on a large scale. QHD practitioners should encourage appropriate medical evaluation, respect medicines, refer urgently when red flags appear, and speak of medicine without contempt. Using the word “allopathy” as an insult helps no patient.

Patients arrive carrying many maps: a rheumatologist's letter, a physiotherapist's plan, advice from a podcast, a grandmother's remedy, a therapist's formulation. The practitioner's job is not to burn the other maps but to prevent navigational chaos. That means asking which frameworks the person already trusts, identifying contradictions that affect safety (above all, pressure to stop medicines), translating QHD into the person's own language rather than recruiting them into a sect, and keeping a written care map of who

is responsible for what. The care map is revised whenever a new diagnosis appears. Without one, pluralism turns to fog, and fog is where avoidable harm hides.

Communication with other clinicians should be brief, specific and modest. A model letter:

Thank you for your continuing care of Ms R. With her agreement I am offering adjunctive support sessions within the Quantum Homeodynamics framework, focused on sleep timing and activity pacing. I am not changing her medicines, and I am not treating her diagnosed condition. Her own goal is to walk for ten minutes without a crash the following day. I will refer back promptly if red flags appear, and I would welcome your advice on any medical constraints.

A letter claiming that QHD has detected something the physician's tests "missed" should never be written.

8. Hahnemann, Homeopathy, and Other Traditions

Samuel Hahnemann published the first edition of his *Organon* in 1810. He revised it through five editions in his lifetime and completed a sixth in 1842, the year before his death; that edition was not published until 1921 (Hahnemann, 1810/1982). Whatever one concludes about homeopathic remedies, a question this book does not attempt to settle, the *Organon* is a remarkable document of clinical method. It insists that the physician observe the whole patient without prejudice, record what is actually seen and reported, individualise treatment, and regard the art of healing as an ethical calling. Its numbered paragraphs made principles memorable and citeable.

QHD owes Hahnemann a precise debt, and it is a debt of form and attitude rather than of doctrine. The *Organon* of QHD in Book Two borrows his numbered format, and its first aphorism deliberately echoes his first

paragraph, which names restoring the sick to health as the physician’s highest calling. QHD also inherits his demand that the practitioner see clearly before acting.

QHD is not homeopathy, and blurring the two would be unfair to both. The differences are material:

	Classical homeopathy	Quantum Homeodynamics
Core tool	Potentised, highly diluted substances matched to the totality of symptoms	A structured method of assessment and follow-up, with resonance-oriented sessions as untested adjuncts
Explanatory ideas	Vital force, the principle of similars, potency	Adaptive coordination as a working model; the biofield as an umbrella for measurable phenomena
Relationship to Hahnemann	Direct lineage of doctrine and practice	Borrowed form and observational attitude; different methods and claims
Medicinal substances	Central	None used

Students who describe QHD as “the new homeopathy” misrepresent both traditions. Students who sneer at Hahnemann without having read him fail as scholars. Read him, compare, and say clearly which framework you are using.

The same courtesy extends to the other traditions patients bring, among them Ayurveda, Chinese medicine, osteopathy and Indigenous healing practices. Each carries insights about pattern, terrain and relationship, and each has its own debates about evidence. QHD does not absorb them, borrow their authority or pass judgement on them. It asks practitioners to be literate enough to talk respectfully with patients who hold them, and honest about which framework they themselves are using, so that no patient is confused by borrowed authority.

Questions for study

1. What exactly does QHD borrow from the *Organon*, and what does it decline to borrow?
2. A patient asks whether QHD is “a kind of homeopathy”. Write a two-sentence answer that is accurate and respectful.

9. A Clinician’s Epistemology

Hahnemann’s most durable demand was that the physician see, and observation of that kind is an ethical act. It includes what is said and what is left unsaid: the pause before a question about money, the joke that deflects a question about sleep. It includes time: worse at night, after exertion, after conflict, in the week before a period, since an infection. It includes relationships: who comes to the appointment, who answers for the patient, who has disappeared from the story. It includes environment, such as shift work, light at night, damp housing or caregiving without respite. And it includes meaning: what the illness has taken, and what the person still loves. It excludes the practitioner’s favourite theory projected onto every case, and any display of a device reading designed to impress.

Good observation is only a start. Chronic care is conducted under uncertainty, and the clinician’s relationship to that uncertainty is itself a clinical variable, because patients borrow it. Catastrophising clinicians produce frightened patients; dismissive clinicians produce abandoned ones. Five tools help:

- A hypothesis board, listing the three most plausible explanations for the pattern without committing to the first.
- A pre-mortem, asking before a plan begins why it might have failed six weeks from now.
- Decision thresholds, agreed in advance, stating what findings would lead to referral and what would justify continuing.
- Second opinions, welcomed rather than resented, with help for the patient in preparing their questions.

- Time-limited trials, treating each plan as a small experiment with a start, an end, a measure and a stopping rule.

The discipline that matters most is the discipline of speech. A practitioner should be able to sort every statement they make into one of six kinds and say which kind it is. This is established physiology. This is emerging laboratory science. This is our working analogy. This is a hypothesis we will check. This is one person's story. This is something we will not say. Book Eight turns these kinds of speech into the evidence taxonomy, tiers T0 to T6, but the habit starts here, and it is more scientific than any number of confident references to quantum physics.

Finally, a framework that claims to be scientific must be able to say what would count against it. Popper (1959) made falsifiability the mark of a scientific theory, and although philosophers of science have since complicated his account, the clinical point stands: a working model that cannot name the result that would refute it has become a creed. Chapter 57 lists in advance the findings that would oblige QHD to revise or abandon its constructs, its method and its modalities.

The practitioner who cannot say “I do not know” is dangerous. So is the one who says it and stops there. The mature position is to say what is known, what is not, and how we will find out.

Questions for study

1. Take a case you have observed or read about and sort ten statements made about it into the six kinds of speech.
2. Conduct a pre-mortem on a plan of your choice. What did it reveal that the original plan missed?

Book Two: The Organon

10. On the Form of an Organon

An aphorism is a principle short enough to remember under pressure. Hahnemann set out his method in numbered paragraphs, and the form has lasted because it does something a textbook chapter cannot: it gives a practitioner a sentence to reach for when a patient is crying, a relative is angry, a vendor is persuasive, or the practitioner is simply tired. The aphorisms that follow are written for those moments.

They are principles, not statutes. Some pull against others, and the tension is deliberate. §17 asks practitioners to believe suffering when the instruments are quiet, and §18 asks them to seek medical evaluation all the same. Where a tension needs working out, a short commentary follows the aphorism. Commentaries are few, and they appear only where they add something the aphorism cannot say for itself.

This edition keeps 135 aphorisms from the 200 of Volume I. About a third are new or substantially rewritten, and the rest have been tightened. Duplicates were merged, and the closing sequence of exhortations that ended Volume I's Organon has been cut, because a principle repeated ten times in different words becomes wallpaper. The numbering has changed, so anyone citing an aphorism should give the edition as well as the number.

The best way to study the Organon is slowly. Read one group aloud with colleagues, choose a single aphorism as the focus for a week of practice, and note the moment in that week when it was hardest to keep. The aphorisms fail when they are used as ornaments on a clinic wall. They succeed when they change what someone does under financial or emotional pressure.

11. The Calling (§1–§12)

§1. The physician's first calling, as Hahnemann wrote, is to restore the sick to health. QHD adds a condition he would have accepted: to do so without deceiving them.

Commentary. The echo of the *Organon*'s opening paragraph is intentional and is the only place where this *Organon* quotes its model so directly. The added condition carries the weight of the whole book. A cure achieved by deception would still be a violation, and a failure to cure, honestly reported, is not.

§2. Health is not only the absence of a named disease. It is the capacity to adapt, to repair, and to take part in one's own life.

§3. First do no harm, remembering that harm arrives by four doors: a wrong action, a missed referral, false hope and needless fear.

§4. Work with the body's own repair. We can sometimes improve the conditions for healing; we cannot command it.

§5. A practitioner who cannot say "I do not know" is dangerous to the people who trust them.

§6. Enthusiasm is not evidence, and warmth is not a treatment plan.

§7. QHD is complementary. Never teach a patient to despise the medicine that may one day save their life.

§8. In an emergency, the right modality is the nearest competent emergency service.

§9. When commerce and honesty conflict, choose honesty. When novelty and safety conflict, choose safety. When being right and the patient's good conflict, choose the patient.

Commentary. These three rules settle most dilemmas a practitioner will meet, and they are ordered by how often they are tested. The first is tested daily in pricing, packages and marketing. The second is tested whenever a new device

or technique arrives. The third is the hardest, because being right feels like serving the patient; it usually becomes visible only in supervision.

§10. The patient owns their body and their decisions. Our role is counsel and care within our scope.

§11. Hope should be realistic, and realistic hope is still hope.

§12. Measure a practice by one question: did it reduce suffering without deceiving anyone?

12. Seeing the Person (§13–§28)

§13. Observe before you intervene, and listen for longer than you speak.

§14. The case is not a list of symptoms. It is the pattern that binds them across time.

§15. Time words organise a case better than organ names: at night, after meals, since the infection, before a period, after the argument.

§16. Record what the patient said in the words they used. “I disappear at three o’clock” will guide a plan better than “fatigue, moderate”.

§17. Pain, fatigue and fear are real when the instruments are quiet.

§18. A quiet instrument is not a licence for an exotic explanation. Believe the suffering and still seek the medical evaluation it may need.

Commentary. §17 and §18 are a pair, and each is dangerous without the other. Practitioners drawn to QHD often come from the experience of seeing patients dismissed, and they hold §17 fiercely. The risk is that they then treat normal results as confirmation of a hidden “field” problem and stop looking for disease. A good record shows both aphorisms at work: the patient’s account taken seriously and written down in their words, and the medical questions that remain open listed with a plan for answering them.

§19. Two people with the same diagnosis may need different support, and two people with different diagnoses may need the same.

§20. The map of disease names is indispensable. The living person is the territory.

§21. Silence in the consulting room can be diagnostic. What a person fears to say may organise the whole case.

§22. Notice who came with the patient, who speaks for them, and who has disappeared from their story.

§23. The nervous system's sense of safety is a clinical variable, and it is set in the first minutes of an encounter.

§24. Sleep is a coherence practice the body already knows. Do not neglect it in favour of exotic tools.

§25. Breath, movement, food, light, relationship and meaningful work are not beneath a quantum practice. They are its ground floor.

§26. Loneliness dysregulates as surely as a poor diet. Ask about connection.

§27. Poverty, unsafe work and discrimination are loads, not lifestyle choices. Name them without blaming the person who carries them.

§28. Cultural humility is a clinical skill. Ask which metaphors help or harm in this person's world before offering your own.

13. Models and Their Limits (§29–§44)

§29. Coherence is QHD's working name for adaptive coordination, and decoherence its working name for the persistent loss of it. Both are borrowed words, used by analogy.

Commentary. Why keep borrowed words that invite misunderstanding? Because they point at something real (the coordination of rhythms, responses and recovery) and because a shared vocabulary makes a method teachable.

The price of keeping them is constant translation. Every time the words are used with a patient, a colleague or a researcher, the practitioner should be able to say, in ordinary language, what observation they stand for.

§30. Do not confuse a useful model with a finished fact.

§31. A metaphor that has stopped helping a patient should be dropped, not defended.

§32. The quantum signature is a written formulation of a person's present pattern. It is not a measurement, and it is never a moral score.

§33. Dysregulation is not a spiritual failure. Shame has no therapeutic frequency.

§34. The biofield is a working model. Teach it as one.

§35. Quantum effects demonstrated in an enzyme, a bacterial antenna or a robin's retina have not been demonstrated in your patient's fatigue.

Commentary. This is the extrapolation rule, and Chapter 5 sets out why it matters. The effects described in Chapter 3 were each established in a specific molecule, under specific conditions, with instruments designed for the purpose. None of that work transfers automatically to a clinical claim about a whole person. A practitioner who cites photosynthesis or bird navigation in a consultation should say, in the same breath, that nothing comparable has been shown in human illness.

§36. Study quantum biology as a young, self-correcting science, not as scripture. Its most publicised claim, long-lived coherence in photosynthesis, has already been revised by its own researchers.

§37. Entanglement does not carry signals, intentions or healing between people. Language that implies otherwise misleads.

§38. Physics vocabulary used to end a question rather than to open one is decoration.

§39. When evidence is thin, make the claim shorter, not the words longer.

§40. Measure what you can, and be candid about what you cannot yet measure.

§41. The beauty of a theory never outweighs the safety of a person.

§42. Harmony means adaptive flexibility, not conformity. Do not pathologise difference in bodies, genders, cultures or neurotypes in the name of balance.

§43. Borrowed words carry borrowed authority. Saying “quantum” does not transfer the credibility of physics to a clinical claim.

§44. If QHD one day dissolves into better science under better names, keep the habits of honesty and let the brand go.

14. Safety, Scope, and Referral (§45–§64)

§45. Refer when red flags appear: sudden or severe symptoms, progressive neurological change, chest pain, breathlessness, unexplained weight loss, bleeding, high fever with systemic illness, thoughts of suicide, and anything beyond your competence.

§46. Referral is not failure. It is fidelity to the patient’s life.

§47. Unusual, severe, progressive or systemic: when any of these words fits, the medical pathway comes first.

§48. Do not diagnose what your licence and training do not allow you to diagnose.

§49. Do not treat what you have not adequately assessed.

§50. Never advise a patient to stop or change a prescribed medicine. That conversation belongs with the prescriber.

Commentary. This rule admits no exceptions, even when the practitioner is also licensed to prescribe, because within a QHD session the practitioner is not acting as the prescriber and has not taken responsibility for the medicine.

Patients often ask. The right response acknowledges the question, explains the rule without embarrassment, and offers to help the patient prepare for the conversation with the person who can answer it.

§51. QHD replaces no vaccine, antibiotic, insulin, chemotherapy, antidepressant, anticoagulant or other essential therapy.

§52. Disease-directed cancer treatment belongs to oncology. Any QHD role is supportive, adjunctive and known to the oncologist.

§53. A psychiatric crisis belongs to crisis services. Settling practices never replace a safety plan.

§54. A systemic infection is not a field problem.

§55. With children, consent has at least two audiences, and medical partnership tightens rather than loosens.

§56. In pregnancy and after birth, medical care has primacy. QHD, if present at all, is supportive.

§57. With older people, count the medicines, ask about falls, and refer liberally.

§58. Dizziness on standing may be trivial or dangerous. Fainting, chest pain or neurological signs send the person to medicine before any harmonisation.

§59. Snoring, witnessed pauses in breathing and daytime sleepiness are referral prompts, not openings for another session.

§60. A distance session with a person who reports chest pain ends at once, and the conversation turns to their local emergency service.

§61. Remote care multiplies uncertainty. Multiply honesty in proportion.

§62. A local emergency plan is part of remote consent, not optional paperwork.

§63. Addiction is not cured by resonance language. Coordinate with specialist care.

§64. The caregiver's exhaustion belongs in the case, and the caregiver may need a referral of their own.

15. Method (§65–§86)

§65. The five steps are a discipline: scan, analyse, personalise, deliver, verify.

§66. Scanning begins with hospitality. Devices, if used at all, come after the person has been heard.

§67. Screen for red flags before anything else, and date the screen in the record.

§68. Ask for the patient's own theory of their illness, and correct it only where it is dangerous.

§69. Analyse in written layers: safety, function, pattern, load, resources, hypotheses. Analysis kept in the head invents confidence.

§70. A signature analysis that names no uncertainties is theatre.

§71. Write down at least one rival explanation, especially the one you would prefer not to consider.

§72. A harmonic profile is a hypothesis for support, not a verdict of destiny.

§73. Priorities should be few enough to verify. Three is usually plenty.

§74. Non-priorities stated aloud prevent scope creep sold as depth.

§75. Two home practices are better than seven. If the plan exceeds the patient's bandwidth, the plan is wrong.

§76. Profiles expire. Date them, number them and revise them.

§77. Agree the stop rules before the first session, not in the middle of a hopeful one.

§78. Deliver with consent, clarity and a freely available pause.

§79. Minimal effective intervention comes before maximal complexity.

§80. Sensation during a session is not a biomarker. Feeling nothing is permitted; feeling a great deal proves nothing.

Commentary. Patients and practitioners both want signs that something is happening, and tingling, warmth, tears or deep relaxation are easily read as signs of efficacy. They are not. They may reflect expectation, touch, attention or the relief of lying still in a quiet room, and none of those has been shown to predict any outcome. Recording sensations is reasonable; interpreting them as proof is not.

§81. Verify. What is not followed up is not known, and a clinic that skips verification invites superstition.

§82. Choose the verification measures before the intervention, and in the patient's terms.

§83. When progress plateaus, simplify before you escalate.

§84. Change one major variable at a time when you can, and keep a log of everything that changed when you cannot.

Commentary. Real lives do not respect experimental design. In the same month a patient may start physiotherapy, change an antidepressant on their doctor's advice, begin a sleep assessment and attend weekly QHD sessions. If they then improve, crediting the sessions would be cheap. A dated change log in the record lets the practitioner, and later a researcher, see what else happened, and it encourages the plain speech the situation calls for: several things changed, and we cannot know which mattered most.

§85. Repeating an ineffective plan is inertia, not loyalty.

§86. Plan the ending near the beginning. A good discharge is a clinical success.

16. Instruments and Modalities (§87–§98)

§87. Technology is a servant. When the device becomes the master, the practitioner has left the art.

§88. Before a device is switched on, say what its job is and name at least three things it cannot do.

§89. No QHD scanner detects cancer, infection or heart disease. Never let a patient believe otherwise.

§90. When a device reading conflicts with medical findings, medicine leads and the reading waits.

§91. A colourful printout that frightens someone is a harm, not a service.

§92. Never stage public demonstrations of scans.

§93. Do not claim approvals, certifications or validation that a device does not have.

§94. Log every device incident and near miss, and review the log.

§95. Touch requires active, specific and revisable consent. Offer a chaperone and a no-contact alternative.

§96. Stop at the first sign of freezing or distress, not only at the word “stop”.

§97. The relational skills taught under the name of entanglement assistance are worth keeping as relational skills.

§98. A vendor may teach the buttons. A vendor may not write your consent form or your outcome claims.

17. Money, Speech, and Power (§99–§112)

§99. Guarantees are marketing. Medicine deals in probabilities, uncertainty and care.

§100. If you cannot describe the risks, limits and alternatives, you are not ready to ask for consent.

§101. Consent is continuous. Refresh it whenever the plan, the modality or the setting changes.

§102. A consent the patient cannot explain back was a brochure, not a boundary.

§103. Fees must never coerce. A package that cannot be exited is not a care plan.

Commentary. Economic design reveals ethics in advance of any slogan. A clinic that sells blocks of sessions should publish how unused sessions are refunded, should never tie the offer to anxiety raised during an assessment, and should expect a proportion of patients to stop early because the plan did not suit them. A falling rate of early exits can mean the service is improving, or that leaving has become harder. Only the second should worry anyone, and only honest records can tell them apart.

§104. Never tie a discount to fear raised by a scan.

§105. Do not sell care with talk of toxins, collapsing fields or fatal decoherence.

§106. Testimonials are not methods sections.

§107. If a sentence could not survive an ethics seminar, delete it before it reaches a website.

§108. Titles do not create competence. Competence earns titles.

§109. When a patient does not improve, reassess the method, the referral and the fit before anyone mentions the patient’s “block”.

§110. When a patient improves, many things helped. Credit them honestly, including the medicine, the physiotherapist or the new relationship that had nothing to do with your sessions.

§111. Apology after error is a clinical skill, not a brand risk.

§112. Warmth can accompany a clear no. A warm yes to a dangerous plan is not kindness.

18. Evidence and Research (§113–§126)

§113. Classify every public claim by evidence tier before you make it. If you cannot classify it, do not make it.

§114. Never invent a percentage, a citation, a patent or a trial.

§115. Anecdote instructs curiosity. It does not establish efficacy.

§116. A case series can suggest a hypothesis. It cannot license an indication.

§117. A working model that cannot say what would count against it has become a creed.

Commentary. This aphorism is the reason Chapter 57 exists. Popper’s (1959) criterion is a demanding one, and much respectable science meets it only loosely, but the clinical form is simple. Before a study begins, the people who favour a hypothesis should write down the result that would lead them to give it up, and then honour what they wrote.

§118. Null results are data. A field that hides them will learn to hide other things.

§119. Choose outcomes that the patient owns, and count the harms you would rather not see.

§120. Distinguish a plausible mechanism from a demonstrated clinical effect. Most failed treatments had a plausible mechanism.

§121. Register the question before collecting the data, and fix the analysis before seeing the results.

§122. Expectation and relationship change how people feel. Study them; do not take metaphysical credit for them.

§123. A method is ready for study only when another trained person could follow its written description.

§124. Independent critique of a founder's framework is a service to it.

§125. Keep the people who stand to gain from a result away from the analysis of it.

§126. Publish uncertainty as readily as success.

19. Formation and Community (§127–§135)

§127. The beginner memorises the steps, the journeyman applies them, and the master knows when to set a tool down.

§128. Train in foundations before advanced claims, and in supervised practice before any claim of mastery.

§129. Supervision is where ego meets reality. Attend it, and bring the cases you are least proud of.

§130. Peer review of notes is worth more than peer admiration of charisma.

§131. Burnout in the practitioner harms the patient. Protect your own sleep and caseload as you would a patient's.

§132. Community among practitioners exists to raise standards, not market share.

§133. Correct the public record when QHD is misrepresented, including by its enthusiastic friends.

§134. An academy that punishes doubt or makes leaving costly has become a cult. Keep the exits open.

Commentary. The markers of a cult are easy to list and hard to see from inside: unreviewable authority, secret teachings, special status sold for money, and a heavy social price for departure. The protection is structural. Teaching should rotate among several people, standards should be written and public, complaints should have somewhere to go, and anyone who leaves should be able to do so without losing their friends or their reputation.

§135. Close each day with the question that opens care: how can I help this person live a little more coherently, without pretending to own the mystery of life?

Questions for study

1. Find two aphorisms that pull against each other, other than §17 and §18, and describe a clinical situation in which both apply.
2. Choose one aphorism from Chapter 17 and write the clinic policy it implies, including how you would audit whether the policy is followed.
3. Which aphorism would be hardest for you to keep when you were tired or short of money? What would help?
4. Rewrite §35 for a patient who has read about quantum biology online and believes it explains their illness.

Book Three: Method

20. The Five Steps and the Rules That Cross Them

The Five-Step Method is the operational core of QHD. It is a workflow for disciplined support, written precisely enough to be taught, audited and studied. It is not a validated protocol and it produces no cures. Its status is that of an educational and operational framework whose clinical value is a hypothesis [T4].

Step	Core question	Main output	Record module
1. Scan	What is present now?	A structured intake, including a dated red-flag screen	M1
2. Analyse	What pattern organises this case?	Signature hypotheses, uncertainties and rival explanations	M2
3. Personalise	What support fits this person now?	A dated, versioned harmonic profile	M3
4. Deliver	What is done today, and how is it received?	A session record	M4
5. Verify	What changed, and what happens next?	A verification note and a decision	M5

A sixth module, M0, covers consent and context and runs across all five steps. Chapter 27 specifies the fields of every module.

Seven rules cross all five steps. Consent is obtained before assessment and before any intervention, and refreshed whenever anything changes. Red flags are screened at intake and at every later visit. Records are written in plain language, with QHD terms added only where they help and never in place of

ordinary description. No outcome is guaranteed. One major change is made at a time where possible, and a dated change log is kept where it is not. A care map names every clinician involved and what each is responsible for. And whenever a person deteriorates or stalls without explanation, the fit of the whole plan is reconsidered, beginning with the question of whether they need medical review.

For teaching clinics and researchers, each step is also described in five operational terms: its inputs (the information and consents needed to begin), its procedures (what a trained person does), its outputs (what is filed), its exclusions (when not to proceed) and its speech constraints (what may and may not be said). This makes training fidelity checkable and gives exploratory research consistent data. It implies nothing about whether following the method helps anyone, which is precisely the question that research must answer.

21. Step One: Scan

In QHD a scan (CD-12) is a structured intake. It may include readings from a device, but those readings are optional and exploratory, and the scan is never a substitute for imaging, laboratory tests or pathology. The name is historical, and practitioners should explain it to patients in exactly these terms.

The first minutes of an encounter teach a person's nervous system whether the room is safe, so scanning begins with hospitality: a chair that does not face a glaring window, a glass of water, a pace of speech that allows pauses, and a question about sensory preferences before any lights, sounds or scents are introduced. Consent follows, with a plain account of what QHD is and is not. Then comes the part that must never be skipped, a screen for red flags, recorded with its date.

The narrative history comes next: onset, course, what makes things better or worse, and what has already been investigated and by whom. It is followed by a review of regulation across the domains that matter most in chronic complaints: sleep, energy and the response to exertion, pain, digestion, mood and threat responses, menstrual or hormonal patterns where relevant,

cognition, and autonomic clues such as palpitations or dizziness on standing. The practitioner then asks about the person's life (work, caregiving, money, belonging) and, gently and only with permission, about any history of trauma. Two questions close the intake. What is your own theory of what is happening? And what would a better month look like, in practical terms?

The patient's theory deserves particular respect. It often holds the most important information in the case, and correcting it too early teaches the patient not to share. It should be corrected only if acting on it would be dangerous, for instance if the theory is that a medicine is poisoning them and they are about to stop taking it.

If a device is used, the practitioner explains beforehand what it can and cannot do (Chapter 33), records the reading as an exploratory adjunct, and avoids theatrical interpretation. Deferring a device reading is often the right choice, especially for someone who is frightened of what it might show. A practitioner might say: "I sometimes use a device as part of the assessment. It does not replace your doctor's tests, it cannot detect disease, and I won't use it to frighten you. If you would rather we did without it today, that is completely fine."

The scan stops, and medical or emergency care takes over, if any of the following appears: chest pain, severe breathlessness, signs of stroke, fainting with worrying features, thoughts of suicide with a plan, uncontrolled bleeding, severe abdominal pain, an emergency in pregnancy, rapidly progressing neurological symptoms, or high fever with signs of systemic illness.

The characteristic failure of this step is confirmation scanning, which means noticing only what fits the modality the practitioner already intends to use. The remedy is structure. A practitioner who completes every domain of the review, including those that seem irrelevant, will be surprised more often and mistaken less often.

22. Step Two: Analyse the Signature

The second step turns observations into a structured understanding of the case, which QHD calls the quantum signature (CD-4). Despite the name, nothing is measured. The signature is a written formulation of how a person's regulation appears to be organised at present: the dominant symptom complexes, their timing, triggers and relievers, the loads the person carries and the hypothesised points of dysregulation, set out without any pretence of a microscopic account of quantum states.

Analysis proceeds in six written layers. Writing them down matters, because analysis kept in the head invents confidence.

1. *Safety*. Is medical triage complete, and what questions are still open?
2. *Function*. What can the person do today, and what have they lost?
3. *Pattern*. What organises the flares: when, after what, and relieved by what?
4. *Load*. Which burdens are stacked, such as infection, sleep debt, grief, overwork, pain, caregiving or money?
5. *Resources*. What still restores the person, even a little?
6. *Hypotheses*. Which kinds of support are plausible and least likely to cause harm?

A brief illustration shows why the order matters. A man in his fifties describes waking at three in the morning without being able to sleep again, followed by irritable, foggy days and an evening tightness in his chest that he puts down to stress. The safety layer is not complete: chest tightness in a man of his age needs medical assessment before anyone calls it stress, and the analysis says so first. The function, pattern and load layers can still be written, but the hypotheses remain provisional until the medical question has been answered.

Three further outputs complete the step. An uncertainty list names what is not known. At least one rival explanation is written down, especially the one the practitioner would prefer not to consider, such as sleep apnoea behind the fatigue, depression behind the withdrawal, or a medicine's side effect behind the dizziness. And the goal of being "more coherent" is translated into two or

three observable behaviours that the person cares about: reading to a child at bedtime without falling asleep, perhaps, or walking to the shops and back without paying for it the next day.

The characteristic failure here is the single dramatic narrative that flatters the modality (“it is all decoherence in the gut field”) while the rival explanations go unexamined. A related problem is reliability. If three trained practitioners reading the same intake produce three incompatible signatures with no shared priorities, then either the construct or the training is not yet fit for use. That is an empirical question, and Chapter 56 describes how to study it.

23. Step Three: The Harmonic Profile

The harmonic profile (CD-5) is the plan. It is personalised, revisable and dated, and it is a hypothesis for support rather than a verdict of destiny. A good profile fits on one page and is written in language the patient could repeat to a friend. It contains:

- up to three priorities;
- explicit non-priorities for this phase, stated aloud;
- the medical anchors, meaning who continues to provide which care;
- the proposed sessions, if any, with the reason for each;
- no more than two home practices to begin with;
- a hypothesis about how often to meet, and a review date;
- stop rules and referral triggers, agreed in advance;
- the measures by which the plan will be judged;
- a version number and a date.

Non-priorities deserve emphasis. Naming what the plan will not address (“this phase is not about diet”, “we are not treating your arthritis”) disappoints magical expectations early rather than after money has changed hands, and protects the plan from scope creep dressed up as depth.

A filled profile for a fictional composite shows the form:

Profile v1, 12 March. Priorities: (1) unbroken sleep; (2) pacing activity to avoid crashes; (3) quicker recovery from stress spikes. Not this phase: detox programmes; exercise challenges; new supplements. Medical anchors: continues with her general practitioner, who has requested a sleep assessment (date awaited). Sessions: four weekly Quantum Resonance Therapy sessions [T4 hypothesis], then review. Home practices: ten minutes of outdoor light before nine in the morning; an activity ceiling agreed together, set at a level she can manage on a bad day. Stop or refer if: chest pain, fainting, unexplained weight loss, a mood crisis. Measures: nights with at least five hours of unbroken sleep, from a diary; a 0 to 10 rating of next-day crash after her Thursday teaching. Review: 9 April.

What is absent matters as much as what is present. There is no promise of cure, no percentage and no change to any medicine. Before the plan starts, the patient should be able to say back, in their own words, what it is, what it is not, and how they will know whether it is helping.

24. Step Four: Deliver

Delivery is the part of the method that patients see, and the part most easily turned into theatre. Its inputs are the shared profile, a refreshed consent if anything has changed, a check of any device's safety and cleanliness, and the person's preferences about light, sound, scent and touch.

The principles are simple to state. The person may pause or stop at any moment without explaining why. The simplest intervention likely to help comes first, and complexity is added only for a documented reason. Home practices and medical care continue alongside sessions, so that no one comes to believe the device is doing the work. The practitioner describes what a session may feel like (often nothing much, sometimes relaxation or emotion, occasionally discomfort) and makes clear that none of these experiences

signals success or failure. The room is designed for calm, not awe. Swelling music, dramatic lighting and scripts that peak just before payment are not spiritually advanced; they are behaviourally obvious.

The session record notes the modality, the duration, how it was tolerated, what the person reported immediately afterwards, any adverse experience and how it was handled, and which home practices were confirmed.

Three failures recur. The first is escalation driven by the practitioner's need for a story: more intensity or more sessions because nothing dramatic has happened. The second is touch without active, specific consent. The third, and the most dangerous, is continuing a remote session after a red flag has appeared. If someone reports chest pain on a video call, the therapeutic agenda ends at that moment and the conversation turns to their local emergency service.

25. Step Five: Verify

Verification (CD-13) is follow-up judged against measures and time windows agreed in advance. Without it every story can be spun. With it some stories end, and ending them is ethical.

Different questions belong to different windows. In the first three days the question is tolerance: how the person slept that night, and whether anything unsettling followed. Over one to three weeks it is movement towards the functional goals. Between four and twelve weeks it is whether the profile still fits at all. Beyond that it is maintenance and graduation. A plan that promises a season's change in an hour has failed verification before it begins.

The difference between poor and useful verification is clearest side by side. "How do you feel about the sessions?" invites politeness, whereas "On your crash scale, what happened the day after the Thursday you planned?" gathers data. The practitioner's sense that the room "felt clearer" is not a measure; the patient's sleep diary is. Counting only the people who came back overstates success; a record of everyone who started, including those lost to follow-up, does not.

The change log described in §84 is consulted before any conclusion is drawn. If a new medicine, a new physiotherapy programme or a new relationship began in the same weeks as the sessions, the accurate summary is that several things changed and it is impossible to say which mattered most.

Plateaus are common. After early gains progress often stalls, and the temptation is to add sessions, devices or intensity. The better sequence is to simplify first: check that the measures still fit the goals, look for new loads or new medical problems, ask whether the plan has done what it can, and discuss graduation. Escalation comes last, and it is justified in writing.

Graduation begins near the start. The aim is a person who can maintain what helped without depending on the practitioner, who holds a written summary of what did and did not help, and who knows they can return without guilt if their goals change. Dropping out is data too, and the reasons should be recorded without pressure to stay.

26. Sessions, Records, and Supervision

Clinics vary, but defaults help. A first visit might take ninety minutes, weighted heavily towards consent, triage and the scan, with any delivery deferred until the medical picture is clear. A return visit might take an hour: a brief update of the scan, a check that the signature still fits, the session itself, and ten minutes to integrate and plan. A verification visit is shorter and begins with the measures, not the modality. A remote visit starts by confirming the person's location and local emergency plan, and keeps its ambitions modest. Open-ended sessions that run until something happens create dependency and blur verification.

A QHD record should allow a competent colleague who does not share the practitioner's vocabulary to continue care safely. It includes consent and scope, dated red-flag screens, the care map, the patient's goals in their own words, signature hypotheses labelled as hypotheses, dated profile versions with a change log, session reports, adverse events and referrals. It excludes humiliating remarks, diagnoses beyond the practitioner's scope and anything resembling marketing. Supervisors can audit records against ten questions,

scoring each 0, 1 or 2. Is the language plain? Is the red-flag screen complete and dated? Are the goals recorded verbatim? Are hypotheses labelled? Are uncertainties stated? Is the care map current? Are profiles versioned? Are adverse events recorded candidly? Are referrals documented with reasons? Is the record free of mystical or promotional language? A record that would embarrass its author in an ethics seminar needs rewriting, not better adjectives.

Supervision is where the method is kept honest. It catches overclaiming early, rehearses referral under pressure, reviews records, helps practitioners grieve when patients do not improve, and watches for burnout and eroding boundaries. It also names the characteristic ways in which practitioners fool themselves:

- confirmation scanning, or seeing only what fits the intended modality;
- package captivity, or reading early departures as the patient's resistance rather than a misfit or a sales problem;
- physics costume, or using quantum vocabulary to end a conversation;
- miracle harvesting, or publicising successes and burying nulls;
- triage inversion, or treating a red flag as a coherence story;
- omniscience creep, or gradually losing the ability to say "I do not know";
- sensory coercion, or treating one kind of calm room as right for everyone;
- the vanities of credit and blame, or taking all the credit for improvement and giving the patient all the blame for its absence.

The repairs are unglamorous: pre-mortems, a mandatory line for uncertainty in every profile, open acceptance of second opinions, incident reviews without humiliation, and a lighter caseload when a practitioner is depleted.

Ending well is a skill in its own right. It includes a frank summary of what helped and what did not, written suggestions for maintenance, a list of other services for needs outside QHD's scope, an invitation to return that carries no guilt, and gratitude that does not claim ownership of the person's resilience.

27. The Five-Step Record: Operational Documentation Fields

This chapter specifies the fields in which the Five-Step Method is documented. They serve two purposes: consistent records in teaching clinics, and consistent data in exploratory research, where they can form the basis of a case report form. They are proposed, not validated. No study has yet tested whether they are completed reliably or whether different practitioners code them consistently, and Chapter 56 treats that as an early research priority.

Dates are recorded as year-month-day. “R” marks a required field and “O” an optional one. Free-text fields should quote the patient where possible, and coded fields use the options listed. Adverse events are graded as mild (noticed, needing no action), moderate (needing extra support or a change of plan) or severe (needing urgent medical care); every severe event triggers a review on the same day.

M0. Consent and context

ID	Field	Format	Req.	Notes
M0.1	Consent version and date	Text; date	R	Refreshed whenever plan, modality or setting changes
M0.2	Teach-back completed	Yes/No; free text	R	Patient restates what QHD is and is not, the emergency rule and the medication rule
M0.3	Setting	In person / remote	R	Remote visits also require M0.4
M0.4	Local emergency plan	Location; nearest emergency service; local number	R if remote	Confirmed at the start of every remote visit
M0.5	Decision-makers present	Free text	R	Guardians for minors; interpreter details if used
M0.6	Care map	Clinicians and their responsibilities	R	Updated when any diagnosis or treatment changes
M0.7	Research consent and conflicts	Yes/No; free text	R in research	Includes any founder or vendor involvement

M1. Scan

ID	Field	Format	Req.	Notes
M1.1	Red-flag screen	None / present, urgent referral / present, routine referral	R	Dated, with details in free text
M1.2	Chief concerns	Verbatim free text	R	The patient's own words
M1.3	Timeline	Onset, course, modifiers	R	Include infections, injuries and life events
M1.4	Prior evaluations	As reported by the patient	R	Recorded, not interpreted
M1.5	Medicines and supplements	List	R	Recorded only; never altered by QHD
M1.6	Regulatory review	Sleep, energy and exertion, pain, digestion, mood and threat, cycles, cognition, autonomic	R	Each domain noted as reviewed, even if unremarkable
M1.7	Life context	Work, caregiving, money, belonging, trauma (by choice)	R	Trauma history only with permission
M1.8	Patient's own theory	Free text	R	Corrected only if acting on it would be dangerous

ID	Field	Format	Req.	Notes
M1.9	Goals	Two or three functional goals, verbatim	R	Basis of the measures in M3.9
M1.10	Device adjunct	Device, settings, reading	O	Exploratory, never diagnostic; may be deferred

M2. Signature

ID	Field	Format	Req.	Notes
M2.1	Safety layer	Triage complete / open questions	R	Urgent open questions block delivery
M2.2	Function layer	Free text	R	What the person can and cannot do now
M2.3	Pattern layer	Free text	R	Timing, triggers, relievers
M2.4	Load layer	List	R	Stacked burdens
M2.5	Resource layer	List	R	What still restores
M2.6	Hypotheses	Numbered list, each labelled as a hypothesis	R	Tier stated, normally T3 or T4
M2.7	Uncertainties	List	R	At least one entry
M2.8	Rival explanations	List	R	At least one entry, naming who will assess it

M3. Harmonic profile

ID	Field	Format	Req.	Notes
M3.1	Version and date	vN; date	R	New version for any substantive change
M3.2	Priorities	Up to three	R	
M3.3	Non-priorities	List	R	Stated aloud to the patient
M3.4	Medical anchors	Linked to M0.6	R	
M3.5	Proposed sessions	Modality, rationale, frequency	O	Tier stated for each
M3.6	Home practices	No more than two at first	R	
M3.7	Stop and referral rules	List	R	Agreed before the first session
M3.8	Review date	Date	R	
M3.9	Measures	Patient-owned measures with baseline values	R	Chosen before any delivery

M4. Delivery

ID	Field	Format	Req.	Notes
M4.1	Consent refreshed	Yes / No / not needed	R	
M4.2	Modality and parameters	Free text; device settings if any	R	Enough detail for replication
M4.3	Duration	Minutes	R	
M4.4	Tolerance	Good / some discomfort / stopped	R	Reason recorded if stopped
M4.5	Immediate report	Verbatim free text	O	Sensations recorded, not interpreted
M4.6	Adverse event	None / mild / moderate / severe	R	Severe triggers same-day review
M4.7	Deviations from profile	Free text	R	Including any added complexity and the reason
M4.8	Home practices confirmed	List	R	

M5. Verification

ID	Field	Format	Req.	Notes
M5.1	Window	0–72 hours / 1–3 weeks / 4– 12 weeks / later	R	
M5.2	Measures	Values against the M3.9 baselines	R	
M5.3	Change log reviewed	Yes/No; changes listed	R	Medicines, therapies, life events
M5.4	Adverse events since last visit	None / mild / moderate / severe	R	
M5.5	Home practices completed	Which, and how often	R	Reduce ambition before blaming adherence
M5.6	Decision	Continue / revise / refer / pause / graduate	R	Reason in free text
M5.7	Referrals made	To whom, why, how urgently	R if any	
M5.8	Tier self-check	Highest tier of claim made to the patient this visit	R	Any claim about QHD above T4 is an error
M5.9	Lost to follow- up	Date of last contact; reason if known	R when applicable	Never omitted from summaries

The fields deliberately include nothing resembling a composite “coherence score”. Any such index would imply a validated measurement that does not exist. A research group wishing to explore one should label it exploratory and

should not use it as a primary outcome until it has been validated (Chapter 56).

Questions for study

1. Complete modules M1 to M3 for the first teaching composite in Chapter 37, using only the information given. Which fields could you not complete, and what does that tell you?
2. Why is M5.9 required? Describe how leaving it out would bias a clinic's summary of its results.
3. Propose one field you think is missing and justify it in terms of safety or research value.

Book Four: Modalities and Technology

28. The Evidential Status of QHD Modalities

No QHD modality has been evaluated in a controlled trial. Every claim that a modality helps is a hypothesis [T4], and practitioners may describe the modalities only in those terms. This book describes them so that they can be taught consistently, criticised precisely and, eventually, tested.

A modality cannot be tested until it can be described well enough for someone else to deliver it. The TIDieR checklist, developed to improve the reporting of interventions in trials, asks for a brief name, the rationale, the materials and procedures, who delivers the intervention and with what training, how, where, when and how much, any tailoring or modification, and how fidelity was assessed (Hoffmann et al., 2014). The chapters that follow are a first step towards such descriptions rather than a completed one. Before any trial, each modality needs a written manual that answers every TIDieR item, including the exact settings of any device.

A second difficulty is that calm, attentive encounters can change what people report, whatever else a session contains (Chapter 6). A trial comparing a QHD session with no session might therefore find a difference even if the modality itself did nothing. The meaningful comparisons are with a sham procedure that looks and feels the same, with an attention-matched control, or with an established active intervention such as heart-rate variability biofeedback (Chapter 56). Until such comparisons have been made, nobody, the author included, knows whether the modalities do anything beyond the encounter in which they are embedded.

29. Quantum Resonance Therapy

Quantum Resonance Therapy (QRT, CD-7) is a structured session in which resonance-oriented stimuli, delivered through Quantum Resonance Emitters (Chapter 34), through practitioner-guided protocols or through both, are offered in support of the priorities in a person's harmonic profile. A typical session follows the architecture described in Chapter 26: arrival and settling, a check that the profile's priorities still fit, the delivery itself, and a period of integration in which home practices are confirmed and the next step agreed.

Here I need to be specific. The word resonance has a precise meaning in physics and a measurable one in physiology (Chapter 4), but QRT has not been shown to engage either. I cannot tell readers what, physically, a QRT session does beyond the ordinary effects of a calm, attentive and structured encounter. That is the first question a trial would need to answer, and until it is answered QRT must be described to patients as a supportive session whose specific effects are unknown [T4].

Several practical rules follow. Someone who is medically unstable, in acute psychiatric crisis or in need of urgent conventional treatment is not offered QRT until that has been dealt with. QRT is not described as replacing a prescription or as clearing anything permanently, and a lack of sensation is not read as a failure on the patient's part. And a practitioner should be able to explain QRT to a doctor in two sentences without using the words quantum, field or energy. A fair comparison is the structured hour of a school of psychotherapy: a format for applying principles, which by itself says nothing about whether the principles are sound.

30. Biofield Harmonisation

Biofield Harmonisation (CD-8) comprises hands-on or near-field practices, as taught in QHD training, intended to help a person settle when their arousal is high or when they report physical unease. It always requires consent and clear boundaries.

The Therapeutic Touch experiment described in Chapter 5 shapes how this modality may be presented. When experienced practitioners were tested, they could not detect another person's hand above their own at better than chance (Rosa et al., 1998). QHD practitioners should therefore make no claim to perceive, read or rebalance a field. What remains defensible is modest: a consented, trauma-informed settling practice that may help some people feel calmer, through touch, attention, predictability and rest, none of which needs anything exotic to explain it.

Touch is never trivial, because the practitioner holds power. Consent must be active (asked for, not assumed), specific (which areas, what kind of contact) and revisable at any moment. A no-contact alternative and a chaperone should be offered routinely, with no implication that either party is distrusted. The practitioner stops at the first sign of freezing or distress, not only when the person says stop, and then checks in without making the person feel they have failed. Tears are not “a release of decoherence”. They are tears, and the right response is attention and, if needed, referral to the counsellor already on the care map. The record notes which areas were approached, the words of consent used, the response and any after-effects. Being trauma-informed does not make a practitioner a trauma therapist, and knowing where that line lies is part of the training.

31. Quantum Entanglement Assistance

Of all QHD's terms, this is the one I would most readily give up, and the reason is physics. Entanglement is a correlation between quantum systems that share a state: measurements on the parts give results correlated more strongly than any classical account allows. It is real, thoroughly tested and central to quantum information science (Nielsen & Chuang, 2010). But entanglement cannot be used to send signals. However far apart the parts are, the statistics of measurements on one of them, taken alone, are unaffected by anything done to the other; the correlation appears only when the results are brought together and compared by ordinary means. Entanglement is also fragile, and in warm, wet, noisy surroundings decoherence destroys it very quickly (Zurek, 2003;

Tegmark, 2000). No study has shown entanglement between the bodies or brains of two people in any sense that could matter clinically, and the physics gives strong reasons to expect that none will.

It follows that no QHD practice transmits anything by entanglement, and no practitioner may say or imply that it does. Quantum Entanglement Assistance (QEA, CD-9), as this edition defines it, is a relational-support format that uses entanglement as a metaphor only. Its practical content is work with two people whose states affect each other: a caregiver whose exhaustion rises and falls with a patient's pain, or a couple whose poor sleep and arguments feed each other. The coupling of people's physiology is itself a respectable subject in classical psychophysiology. Studies of interpersonal autonomic physiology have found that heart rate, skin conductance and other signals can become correlated between people in relationships and interactions, although the literature is fragmented and its methods vary (Palumbo et al., 2017). That is the most QEA's practical content can lean on, and it is enough. Helping two people notice how their states affect each other, and change the pattern, needs no quantum physics at all.

The characteristic abuse of this modality is coercion dressed as physics. "You are entangled, so you both need packages" is not a clinical rationale but a sales technique, and in QHD it is a disciplinary matter. Each person's consent and goals stand alone.

If relational interventions are ever studied under this heading, their outcomes should be relational and functional, measured with the same rigour as any other outcome. Confirmation of the metaphor is not a physics result, and no study should report it as one.

32. Distance Therapy

Distance Therapy (CD-10) is QHD support provided without the practitioner and patient in the same place, usually by video. Its defensible content is the content of good remote care in any discipline: updates to the history, coaching

on pacing, sleep timing and load, consented guided practices, and continuity when travel is impossible. Any claim that a remote protocol acts physically on a person at a distance is speculation [T6], and practitioners must not make it.

Everything that makes in-person care safe becomes harder at a distance (§61). The practitioner verifies the person's identity and location at the start of every session, confirms their local emergency number and nearest emergency service, and records both (Chapter 27, M0.4). The limits of assessment without an examination are stated plainly, and documentation meets the in-person standard. Access matters as well. Remote care can reach people who are disabled or live far from services, but it can also exclude people without bandwidth, privacy or devices, and alternatives should always be offered.

Geography changes thresholds. For someone whose nearest emergency department is ninety minutes away, the point at which a symptom justifies calling for help comes earlier, not later, and the emergency plan should say what to do while help is on its way. If chest pain, fainting or signs of stroke appear during a remote session, the therapeutic agenda ends immediately and the practitioner helps the person reach their local emergency service, staying on the line if that helps.

33. The Biofield Scanner

No QHD scanning device has published evidence of analytical or clinical validity. I say so plainly because patients and practitioners are entitled to know it, and because the temptation to imply otherwise is strong wherever a device produces numbers or colours.

Validating a measuring device is a structured process. A widely used framework for digital measurement tools distinguishes three stages (Goldsack et al., 2020). Verification asks whether the sensor measures what its engineering says it does, accurately and repeatably. Analytical validation asks whether the algorithm that turns raw signals into a metric yields something that corresponds to a defined physiological quantity. Clinical validation asks whether that metric identifies, measures or predicts a meaningful clinical state in the population for which it is intended. A QHD scanner would have to pass

all three stages before any of its readings could inform a clinical decision, and any device marketed with diagnostic claims would also fall under medical-device regulation in most jurisdictions. QHD makes no diagnostic claim for any device, and practitioners must make none.

Until validation exists, the rules are strict. Before switching the device on, the practitioner explains its job and names at least three things it cannot do; one clinic places two cards on the table, headed “Job” and “Not its job”, and asks the patient to read the second aloud. Readings are recorded as exploratory adjuncts, never as findings. If a reading conflicts with medical findings, medicine leads, and QHD care is not escalated on the strength of the reading. A frightened person who wants a scan to settle an argument about a feared disease should usually be offered a medical referral instead. Public demonstrations of scans are forbidden, and readings are health data, stored and protected as such.

In research, device metrics must be declared in advance as exploratory, and they must not be promoted to primary outcomes after the results have been seen (Chapter 56).

34. Resonance Emitters and Technology Stewardship

A Quantum Resonance Emitter (QRE, CD-11) is a class of device used in QHD training to deliver resonance-oriented stimuli during QRT sessions. As with the scanner, no QRE has published evidence of efficacy or validation, no approval or certification is claimed for any, and a QRE is never presented as a substitute for medicines or procedures.

The practical rules are those of any careful clinic. Practitioners train before using a device on their own. They check it for safety and cleanliness before each session, keep early sessions short and conservative, and stop at once if a person reports an unpleasant sensation, settling them and referring if necessary. If a device emits any form of energy, whether light, sound or an electromagnetic field, its output should be documented and kept within the

safety limits that apply where it is used. Marketing language must stay below the evidence ceiling, which at present means describing the device as part of an untested supportive session and nothing more.

Technology enters clinics faster than wisdom, and a few habits of stewardship keep it in its place. Every device has a written statement of its job and its non-jobs. An equipment log records maintenance, cleaning, software versions, incidents and near misses, and someone reviews it. Vendors may train staff to use the controls, but they may not write consent language or set outcome claims, gifts from them above a trivial value are logged, and any research collaboration with a vendor needs independent review of its methods. Data from devices are confidential health data. Experimental firmware or settings stay out of routine care unless an ethics committee has approved their use in a study. Instruments extend attention; they do not absolve conscience.

Questions for study

1. Write a TIDieR-style description of a single QRT session, as far as this book allows. Which items can you not complete?
2. Explain to a sceptical colleague, in under a hundred words, why entanglement cannot be used to send a signal, and what QEA's practical content is instead.
3. A clinic proposes to use a scanner reading as the primary outcome of a small study. Using the three stages described by Goldsack and colleagues (2020), explain why this would be premature.

Book Five: Casecraft

35. Taking a Case

Book Three describes what a scan must collect. This chapter is about how to collect it: the craft of the interview, the language that helps and harms, and the relationship within which a case is taken.

Begin with the person's own words and protect them. The opening question should be open ("What brings you here, and what would you most like to change?"), and the answer should be written down verbatim before anything else. A chief concern recorded as "I disappear at three o'clock" holds information about timing, identity and fear that "afternoon fatigue" throws away.

Follow the clock. Ask when, after what and since when: the hour of the worst symptoms, what they follow, the day they began, the season in which they worsen. A rough sketch of energy across a week, pain across a month or sleep across a fortnight often reveals more than any single description. Perfect data are unnecessary; the direction of change is what matters.

Look for load and resource together. Infection, night shifts, caregiving and debt stacked on one another are not "one root", however elegant a single explanation would be. Resources are clinical data too: a friend who drives the person to appointments, a faith practice that calms without displacing medicine, a dog that gets them outside every morning.

Pattern literacy is the skill QHD most wants to teach, and it is different from diagnosis. Pattern literacy notices timing, triggers, relievers, stacked loads and the limits of a person's energy. Diagnosis assigns disease labels, which a practitioner may do only within their licence, and "quantum diagnoses" that mimic medical authority are forbidden to everyone. A student who can say

“your worst days follow nights of less than five hours’ sleep, and the crash usually comes a day after you overdo it” has done useful work without diagnosing anything.

Language matters. Useful questions include “What would a better month look like in practical terms?”, “What has your doctor already looked at?”, “When did you last have a stretch of days that felt more like you?” and “What should we make sure not to miss today?” Harmful statements include “your field is collapsing”, “only this can help you”, “your doctors have poisoned you” and “I can see your diagnosis in the signature”. When a patient asks “Can you cure me?”, the answer should be memorised: “I can’t honestly promise a cure. I can offer a structured approach alongside your medical care, and we will check together whether it helps with the things that matter to you.”

Three situations recur often enough to rehearse. In the first, a patient says, “If you can’t guarantee results, why should I try?” The practitioner answers that care under uncertainty is still care, and offers a time-limited plan with agreed measures and a promise to stop if it is not helping. In the second, a patient says, “I want to stop my medicine and go natural.” The practitioner says clearly that they will not support stopping a prescribed medicine outside a conversation with the prescriber, offers to help the patient prepare for that conversation, and records the exchange. In the third, a partner interrupts: “Tell her the scan shows she’s toxic.” The practitioner declines the frightening language, asks to hear the patient’s goals in her own words and, if the partner keeps answering for her, arranges part of the consultation in private.

Finally, remember the slope of the relationship. Money, hope, specialised vocabulary and vulnerability give the practitioner power even when the encounter feels collaborative. The response is warmth without the collapse of boundaries, confidence without omniscience, and continuity without captivity. Dual relationships, such as treating friends, employees or partners, erode judgement and should be avoided. Communication norms, including when messages will be answered, belong in the first conversation. When an error happens, whether a missed referral, an overconfident claim or a mistake in the record, it should be acknowledged and corrected promptly.

36. The Case Template

The template below condenses the fields of Chapter 27 onto a single sheet for teaching clinics. It is designed to be printed; researchers should use the full field list.

QHD CASE RECORD

Profile

version ____ Date _____

Practitioner _____ Supervisor present Y/N Setting:
in person / remote

Consent version ____ Teach-back done Y/N Local emergency
plan (if remote) ____

Decision-makers / interpreter

M1 Red-flag screen: none / urgent referral / routine
referral Details _____

Chief concerns, verbatim

Timeline

Prior evaluations, as reported

Medicines and supplements (record only)

Review: sleep __ energy/exertion __ pain __ digestion
__ mood/threat __

cycles __ cognition __ autonomic __

Life context

Patient's own theory

Goals, verbatim

Device adjunct (optional, exploratory)

M2 Safety __ Function __ Pattern __ Load __ Resources __
Hypotheses, labelled with tier

Uncertainties _____ Rival explanations

M3 Priorities (up to 3) _____ Not this phase

Medical anchors _____ Sessions _____

Home (up to 2) ____

Stop or refer if _____ Measures and baselines

Review date _____

M4 Consent refreshed Y/N Modality and parameters

_____ Minutes _____

Tolerance _____ Immediate report _____ Adverse
event: none/mild/mod/sev

Deviations from profile _____ Home practices
confirmed _____

M5 Window _____ Measures against baseline _____

Change log checked Y/N

Adverse events _____ Decision:
continue/revise/refer/pause/graduate

Referrals _____ Highest tier claimed today:
T__

What did I nearly overclaim?

37. Teaching Composites

The thirteen cases in this chapter are fictional teaching composites. None describes a real person, and none is evidence that QHD helps anyone. Where a case describes improvement, the improvement is invented for teaching purposes and is deliberately modest and multifactorial. The cases are built around decisions, the moments when a practitioner must refuse, refer, decline, simplify or stop. Work through them with the fields of Chapter 27 beside you, and notice how often the most useful act in a case has nothing to do with a QHD modality.

The first case follows all five steps in detail. The others concentrate on the decision each is designed to teach.

Composite 1: “I disappear at three o’clock”

Fictional teaching composite; not a real patient and not an outcome claim.

Anna is forty-two and teaches literature at a secondary school. For three years she has collapsed each afternoon, slept badly and felt judged as lazy. Her general practitioner has run investigations that found nothing to explain her symptoms and has mentioned a sleep assessment that has not yet been arranged. She arrives asking whether a quantum scan will “find what the doctors missed”.

Consent and triage. The practitioner explains in plain words what QHD is and is not, including that its scan cannot find disease. Anna can say back that it is not a replacement for her doctor and that nothing is guaranteed. The red-flag screen is negative for emergency features. She mentions mild dizziness on standing, which is recorded for her GP. Because she is frightened of what a device might show, the practitioner suggests deferring any device reading, and she agrees with relief.

Scan. Her chief concern, recorded verbatim, is “I disappear at three o’clock”. The timeline shows a gradual onset after a promotion that doubled her workload, with a clear worsening after a bad chest infection eighteen months ago. She wakes at two most nights and looks at her phone. On good weekends

she catches up on everything and pays for it on Monday. Her resources are a supportive partner and a love of her subject that survives even the worst weeks. Her goal is specific: “to read to my son at bedtime without falling asleep on the sofa”.

Analyse. The six layers are written out. Safety: no emergency features, but the sleep assessment is outstanding and the dizziness needs medical review. Function: about two good hours each morning. Pattern: fragmented sleep, a boom-and-bust cycle around weekends, and a post-exertional crash that seems to have begun after the infection. Load: work, the aftermath of infection, and shame. Resources: her partner and her teaching. The hypotheses, labelled T3 and T4, are that stabilising her sleep timing and pacing her activity might reduce the crashes. The rival explanations written down are sleep apnoea, depression and deconditioning, none of which QHD can judge alone.

Personalise. The profile is the one shown in Chapter 23. Its priorities are unbroken sleep, pacing and quicker recovery from stress, and its non-priorities are detox programmes, exercise challenges and disease-detection scanning. Her GP remains her medical anchor. Four weekly QRT sessions are proposed as an untested supportive adjunct, together with two home practices, morning light and an agreed activity ceiling. The measures are nights with at least five hours of unbroken sleep and a 0 to 10 crash rating after Thursday lessons. The stop rules are listed and a review date is set.

Deliver. The sessions are quiet and unremarkable. In the third, Anna becomes tearful while talking about her son. The practitioner pauses the session, stays with her and, with her agreement, lets the counsellor she already sees know that it has been a hard week. The record notes a mild adverse experience, handled.

Verify. At four weeks her diary shows two more nights a week with five hours of unbroken sleep than at baseline. Her crash ratings improved in two weeks out of four and were unchanged in the others. Meanwhile her GP has arranged the sleep assessment and started a course of iron after a borderline result. The

change log records both. The honest summary is that her sleep has improved modestly, that the crashes have not clearly changed, and that at least three things changed at once, so nobody can say which helped.

The temptation now is to sell her another eight sessions. Instead, the practitioner writes a second version of the profile that keeps the two home practices, reduces sessions to once a fortnight for a month and schedules a conversation about graduation. The plateau is recorded without blame.

What the case teaches. Deferring a device can be the ethical choice. A plateau is not a spiritual failure and not, by itself, a reason to escalate. Verification against measures chosen in advance is what stops a modest, multifactorial improvement from being retold as a miracle. And the care map keeps medicine inside the story: the most consequential events of Anna's month may well have been the sleep referral and the iron.

Composite 2: "Pain means I'm breaking again"

Fictional teaching composite.

Joseph, a warehouse supervisor of fifty, broke his ankle eighteen months ago. His surgeon has told him the fracture has healed, and his physiotherapy started well and then stalled, because every twinge convinces him the bone is giving way. He limps, sleeps badly and has stopped walking his dog. His wife comes to the first appointment and answers most of the questions. He has read about energy healing and asks whether biofield work can "erase the trauma from the tissue".

The case turns on three decisions. The first concerns who is speaking. The practitioner thanks his wife and asks for part of the consultation with Joseph alone, and in that part he says what he could not say in front of her: that he is afraid of losing his job. The second concerns rival explanations. His fear fits the fear-avoidance pattern described in the pain literature (Vlaeyen & Linton, 2000), but before accepting that account the practitioner asks about night pain, numbness, fever and any history of cancer, and records that none is present. The third concerns the physiotherapist. The plan is built around getting Joseph

back to physiotherapy, not around replacing it. Consented harmonisation is offered as a settling adjunct before his physiotherapy sessions, and the practitioner writes to the physiotherapist to say so, promising not to contradict the graded plan.

The profile's non-priorities are explicit: no erasing of trauma from tissue, no talk of bone energy, no advice about painkillers. The measures are the number of steps he walks on the day after physiotherapy without his fear rising above an agreed level, and nights of unbroken sleep. At three weeks his sleep is slightly better and his walking barely changed. The practitioner resists the pull towards more intensive sessions and arranges a joint planning conversation with the physiotherapist instead.

What the case teaches. Partnership matters more than possession of the case. The practitioner's most useful acts may have been the private conversation and the letter, not the harmonisation.

Composite 3: The runner who cannot train

Fictional teaching composite.

Priya was a club runner until a viral illness nine months ago. Since then any sustained exertion, even a long shopping trip, has been followed a day later by exhaustion, aching and a fog that lasts several days. Her doctors have excluded several causes and referred her to a specialist service with a long waiting list. A friend has told her to “push through it”, and she has tried, each attempt followed by a worse crash. She grieves for the athlete she was and is ashamed of being unable to work full time.

The pattern she describes, a worsening of symptoms after exertion with a characteristic delay, is post-exertional malaise. It is a defining feature of myalgic encephalomyelitis/chronic fatigue syndrome (Institute of Medicine, 2015) and is common in persistent illness after viral infection (Davis et al., 2023). The practitioner cannot diagnose either condition but must not ignore the pattern, because it changes what is safe. National guidance in England advises against offering graded exercise therapy, with its fixed incremental

increases in activity, to people with ME/CFS, and recommends instead an individualised approach to energy management that keeps within the person’s limits (National Institute for Health and Care Excellence, 2021).

The critical decision is therefore to refuse the “push through” frame, gently and firmly, and to write it into the profile as a non-priority. The plan centres on pacing: identifying Priya’s current envelope, setting an activity ceiling below it, and recording crashes. Remote sessions are offered in her worst weeks, with her local emergency plan confirmed at the start of each. The practitioner writes to her GP, asking whether the specialist referral can be expedited and noting her dizziness on standing, which needs medical assessment.

At twelve weeks her crashes are less frequent but not gone. She has returned to part-time work from home, and she is still waiting for the specialist.

What the case teaches. Believing a person’s functional loss and respecting the limits it imposes can be more useful than any intervention. Advice that sounds encouraging can harm. A practitioner who knows the relevant guidance can protect a patient from well-meant pressure, including their own.

Composite 4: The caregiver who vanished from her own story

Fictional teaching composite.

Grace, fifty-eight, has cared for four years for her mother, who has advanced heart failure and early dementia. She sleeps in snatches, has twice missed her own breast screening, snaps at her teenage son and cries in the car. She asks for QHD sessions “to keep me going”.

The first task is to notice what the request leaves out. Grace has come to be made more efficient at an impossible job. In the scan she can talk for twenty minutes about her mother’s medicines and cannot name one thing she does for herself. Her first goals are all about her mother. With some patience she names one of her own: an evening walk with a friend she has not seen for a year.

Three referrals come before any session. The practitioner encourages her to rebook her screening and to see her own GP about her sleep and low mood, and asks her directly about thoughts of self-harm, which she denies. The practitioner also gives her information about local respite and carers' support. Because Grace mentions that her mother sometimes becomes frightened and aggressive at night, the practitioner asks whether anyone is at risk, and knows the local safeguarding route should the answer be yes. It is not, but the question is recorded.

The profile is short-term by design, with graduation planned from the first visit. Its priorities are protected sleep on two nights a week, which requires a sibling to cover, one restorative contact a week, and the respite application. Sessions are offered as support while those changes take hold, not as a way of carrying on as before.

What the case teaches. The caregiver's exhaustion belongs in the case formulation (§64). A plan that makes someone better at enduring an unsustainable load, without changing the load, is not care.

Composite 5: Deadline gut, and the result that changed the plan

Fictional teaching composite.

Daniel, a thirty-four-year-old accountant, has had bloating and alternating bowel habits for years, always worse at the end of each financial quarter. A gastroenterologist who investigated him two years ago diagnosed a disorder of gut–brain interaction (Drossman, 2016). He has since tried a series of restrictive diets from the internet, each stricter than the last, and now avoids eating with colleagues. He wants “a quantum reset of my gut”.

The first profile is straightforward. The practitioner declines the language of resets, agrees priorities of regular meals, protected sleep before quarter-end and a gradual return to eating with others, and records the diets as a harm to be undone with his GP's help rather than a solution to be refined. Settling

sessions are offered as an adjunct, with the reminder that context and relationship can themselves improve symptoms in this condition (Kaptchuk et al., 2008), so any improvement cannot be credited to the sessions alone.

At the six-week review Daniel mentions, almost in passing, that he has become breathless on the stairs and that his stools have sometimes been very dark. The practitioner stops the review, explains that these symptoms need prompt medical assessment, and helps him arrange an urgent appointment with his GP that day. Blood tests show iron-deficiency anaemia, and he is referred back to gastroenterology.

The profile is suspended while that happens. When Daniel returns months later, after treatment for a bleeding ulcer, his gut symptoms are much as before, and the plan resumes with his gastroenterologist's knowledge.

What the case teaches. An earlier diagnosis does not protect a person from a new one. Alarm features can appear in the middle of a plan, and a red-flag screen repeated at every visit is what catches them. Stopping a session to arrange urgent care is the method working, not the method failing.

Composite 6: “Scan me for the cancer they missed”

Fictional teaching composite.

Lena, a thirty-nine-year-old graphic designer, arrives with a folder of printouts. Her father died of bowel cancer, and for a year she has been convinced she has it too. Her GP arranged investigations, including a colonoscopy, which found nothing, but Lena distrusts the result. She has read that QHD scanners can “see disease at the energy level” and wants a full scan.

The decision here is to decline the scan. No QHD device can detect cancer (§89), and using one would either frighten her further or offer a reassurance with no basis, which she would soon distrust as well. The practitioner says so kindly, explains why, and asks what would count, for her, as enough investigation. It emerges that no test would; the fear has its own momentum.

The practitioner asks gently about her sleep, her mood and how much of each day the worry occupies, and suggests that her GP could offer help with health anxiety, a recognised and treatable problem.

Lena is angry at first, and then relieved that someone has refused to join in. She agrees to see her GP. When she asks whether QHD sessions could help her sleep in the meantime, a short, clearly bounded plan is agreed, with the explicit non-priority “no scans, and no talk of what a scan might show”.

What the case teaches. Declining is sometimes the most helpful act available. A device that cannot answer the question a frightened person is asking should not be switched on, and a practitioner who refuses to feed fear can open the way to help that addresses it.

Composite 7: Ninety minutes from the nearest emergency department

Fictional teaching composite.

Tomás, sixty-one, farms sheep in the hills. His nearest emergency department is ninety minutes away by road, and the internet connection at his house drops in bad weather. With his GP’s knowledge he has sessions by video for sleep and pacing after a long winter of poor health. He has occasional palpitations, which his GP has investigated.

Before the first session the practitioner records his address, the local emergency number, the nearest emergency department and the name of a neighbour who can reach him quickly, and agrees that if the call drops during a session the practitioner will ring his landline. They also agree that, given the distance, he will call for help early rather than late if new symptoms appear.

In the fifth session Tomás mentions a heavy ache in his chest since carrying feed that morning, and says he feels sweaty. The practitioner ends the session’s agenda at once, tells him plainly that this needs emergency assessment, asks him to call the emergency number while the practitioner stays on the video line, and then rings the neighbour. When the video drops, the practitioner rings the landline as agreed. Tomás is taken to hospital and treated for a heart attack.

The record sets out what happened, the times and the advice given. At the next supervision meeting the practitioner reviews whether any earlier sign was missed. None was, but the review is still done.

What the case teaches. A remote emergency plan is worth nothing until it is needed, and then it is worth everything. Every element of this one, from the landline number to the neighbour's name, was agreed in advance, and each was used.

Composite 8: The fifteen-year-old and the football season

Fictional teaching composite.

Maya is fifteen and plays in a competitive football team. For two months she has had headaches and fatigue, and her schoolwork is slipping. Her father wants her “back on the pitch by the play-offs”, and her mother worries that something is seriously wrong. They bring her to a QHD practitioner on the recommendation of a teammate's parent.

Working with a minor means working with at least two audiences (§55). The practitioner begins by clarifying who consents to what, and explains that part of the consultation will be with Maya alone, as is good practice with adolescents. In that part Maya mentions that she was knocked unconscious in a match three months ago and did not tell her coach because she did not want to be dropped. She also says she has been skipping meals to “make weight” for a new position.

Both disclosures change the case. A head injury followed by persistent symptoms needs medical assessment, and return to sport after concussion is guided by established consensus (Patricios et al., 2023), not by the fixture list. Deliberate food restriction in a teenage athlete also needs medical attention. The practitioner explains to Maya that these things must be shared with her parents and her doctor to keep her safe, discusses with her how to do it, and then does it with her in the room. The family is referred to her paediatrician.

No sessions are offered until the medical assessment is done. When the paediatrician later agrees that supportive work on sleep and routine could help, a modest plan is made with the paediatrician's knowledge, and the father's goal of the play-offs is written, with his reluctant agreement, as a non-priority.

What the case teaches. Adult packaging does not fit adolescents. Private time with a young person can surface the information that matters most, and the limits of confidentiality when safety is at stake should be explained at the outset rather than discovered later.

Composite 9: Eleven medicines and a broken night

Fictional teaching composite.

Mr Okafor is eighty-one. He takes eleven medicines prescribed by three different doctors, wakes three or four times a night to pass urine, and dozes in his chair through the afternoon. His daughter wants a “natural reset” and asks whether QHD could replace “some of those pills”.

The answer to the daughter's question is an immediate and courteous no, because medicines are changed only by prescribers (§50). What the practitioner can do is notice. Mr Okafor's list includes more than one medicine with sedating or anticholinergic effects, a group that guidance on prescribing for older adults identifies as potentially inappropriate in many circumstances (American Geriatrics Society, 2023). His daughter also mentions that twice in the past fortnight he has been confused in the evenings, and once did not recognise his grandchildren.

A recent change of that kind in an older person may be delirium, which should be treated as a medical emergency until proved otherwise. The practitioner advises the daughter to contact his GP that day and to seek urgent care if the confusion recurs or worsens. With Mr Okafor's permission, the practitioner also asks in writing whether the GP might review all eleven medicines together.

His GP finds and treats a urinary infection, and a review of his medicines follows. Some weeks later a conservative plan is agreed, with the GP's knowledge, around his surroundings: evening light, a regular bedtime, a clear and lit path to the bathroom to reduce the risk of a fall, and a weekly visit from a friend from his church.

What the case teaches. Complexity rises with age, and conservatism is wisdom. The practitioner's most useful contributions were to refuse the request about medicines, to recognise possible delirium, and to ask the right person for a review.

Composite 10: Sleep during chemotherapy, and a friend's advice

Fictional teaching composite.

Ruth, forty-six, is having chemotherapy after surgery for breast cancer. She sleeps poorly and lies awake with fear on the nights before treatment, and would like help with both. She comes with a close friend, who tells the practitioner within a minute that Ruth "should stop the chemo, because it is poisoning her field, and do quantum treatment instead".

The speed of the response is part of the lesson. Within the first five minutes, and before anything else is discussed, the practitioner says clearly that QHD is not a cancer treatment, that it will not be offered in place of chemotherapy, and that any support will be given alongside her oncology care and with her oncologist's knowledge (§52). The friend is invited to stay and listen or to wait outside; she chooses to wait. Alone, Ruth says she has no intention of stopping treatment but has found the pressure exhausting.

The plan is adjunctive and small: consistent sleep timing, a wind-down routine for the nights before treatment, and a few consented settling sessions timed around her treatment cycles. With her agreement, the practitioner sends a short letter to her oncology team describing what is offered. Her distress is monitored, and the practitioner knows the oncology unit's route to urgent psychological support.

What the case teaches. Refusal delayed reads as negotiable. People who chose alternative treatment alone for curable cancers had a markedly higher hazard of death in an observational study (Johnson et al., 2018), and in this situation the practitioner’s clarity may protect the patient as much as any support offered.

Composite 11: A room without incense

Fictional teaching composite.

Sam, thirty, is autistic and works as a software tester. After a year of heavy workload Sam is exhausted, sleeping badly and signed off work. A previous visit to a wellness clinic ended within ten minutes: the room smelled strongly of incense, a light flickered, and the practitioner kept insisting on eye contact as a sign of “coherence”.

Before the first visit the practitioner sends a short questionnaire about light, sound, scent, touch and preferred ways of communicating. The room is prepared accordingly, with no scent, steady lighting, the fan switched off, written notes available and the option of pausing to write rather than speak. Sam turns a textured object over in their hands throughout, and the practitioner treats it as the regulation tool it is.

In the analysis the practitioner is careful not to equate Sam’s neurotype with dysregulation (§42). The question is not how to make Sam less autistic but what has changed, which in this case is a workload and an open-plan office that overwhelmed Sam’s capacity for months. Medical causes of fatigue are still considered, and Sam’s GP has already checked the basics. The profile focuses on sleep, on recovery time after work, and on adjustments that Sam can request through the employer’s usual routes.

What the case teaches. Harmony means adaptive flexibility, not conformity. Adapting the room is part of the method, and a calm environment for one person can be a hostile one for another.

Composite 12: “Can the sessions replace my medication?”

Fictional teaching composite.

Elena, thirty-seven, has bipolar disorder and has been well for four years on a mood stabiliser prescribed by her psychiatrist. She dislikes the side effects and the blood tests, and after reading online about “frequency healing” she asks whether QHD sessions could replace her medication.

The answer is no, and the reasons are given without condescension. Changing or stopping a psychiatric medicine is a decision for Elena and her psychiatrist, and stopping some mood stabilisers abruptly carries serious risks. The practitioner encourages her to raise the side effects with her psychiatrist, who may be able to adjust her treatment, and offers to help her write down her questions before the appointment.

Elena then asks whether QHD could help with anything at all. Sleep is the obvious candidate, because disrupted sleep can be both an early warning sign and a trigger in bipolar disorder, and protecting it is something her psychiatrist is likely to welcome. With her agreement, the practitioner writes to the psychiatrist describing a plan built around regular sleep and waking times and the early recognition of warning signs, with a shared list of those signs and an agreement about whom Elena will contact if they appear.

Months later Elena has a week of very little sleep and racing thoughts. Following the agreed plan, she contacts her psychiatric team that day, and the practitioner pauses sessions until her psychiatrist advises that they can resume.

What the case teaches. A crisis belongs to crisis services, and a stable illness belongs to the clinicians who stabilised it. A supportive plan built with the psychiatrist, rather than around them, can strengthen the care a person already has.

Composite 13: Two vocabularies and an interpreter

Fictional teaching composite.

Mrs Haddad, fifty-five, moved from abroad two years ago and speaks little of the local language. She has widespread pain, poor sleep and a heaviness she describes, through her son, as “the heart being squeezed by sadness”. Her son is seventeen and usually interprets for her. Her doctors have diagnosed fibromyalgia. Her own understanding, which her family shares, is that the pain came from grief after her husband’s death and the loss of her home.

The first decision is about language. Asking a teenage son to interpret his mother’s account of grief, pain and possibly intimate symptoms is unfair to both of them and risks omissions and errors in consent. The practitioner rebooks the appointment with a qualified professional interpreter, as any clinical service should.

The second decision is about metaphor. “The heart being squeezed” could describe grief, chest pain or both. Through the interpreter, the practitioner asks whether the squeezing comes with exertion, breathlessness or sweating, and is reassured, but records the question and the answer. The next task is to understand Mrs Haddad’s own account of her illness. Rather than replacing it with QHD’s vocabulary of coherence, the practitioner works within it: grief, displacement and the loss of routine are treated as loads, and the plan attends to sleep, gentle daily activity and contact with a community group that speaks her language.

The practitioner is careful neither to present QHD as a truer explanation than hers nor to let hers stand in for her medical care. The record holds both her doctors’ diagnosis and her family’s understanding.

What the case teaches. Cultural humility is a clinical skill (§28). Metaphors do not always travel, and a qualified interpreter is part of safe care rather than an optional extra.

Questions for study

1. In which composites did the most consequential act have nothing to do with a QHD modality? What does that suggest about where QHD’s value, if any, is likely to lie?

2. Rewrite Composite 5 as it might have gone if the red-flag screen had been done only at the first visit.
3. Choose one composite and identify the moment at which a commercially pressured practitioner would be most tempted to go wrong. What would going wrong look like in the record?

Book Six: Clinical Orientation (Educational Only)

38. Help-Seeking Is Not an Indication

People come to complementary practitioners with a recognisable range of problems: persistent pain, fatigue, poor sleep, anxiety, digestive trouble, dizziness, a sense of never having recovered from an infection. Handbooks of integrative care often slide from “people come to us with X” to “we treat X”. This book forbids that slide. The chapters in this Book describe domains of help-seeking, not indications. They exist so that students understand what people are carrying when they arrive, what medicine already knows about it, what must never be claimed, and when to refer.

The chapters share a logic but not a template. Each describes what people report, summarises the relevant clinical science, sketches what QHD support could be (always adjunctive, always a hypothesis at T4), and lists the signs that send a person to medicine first. The guidelines and reviews cited should be read in full; this Book summarises them only so that students know where to look.

The red-flag primer below should be memorised and displayed where practitioners work. Its organising rule is that anything unusual, severe, progressive or systemic goes to medicine first (§47).

- *Heart and lungs*: chest pain or pressure, severe breathlessness, fainting, palpitations with fainting or chest pain, a swollen, painful leg with breathlessness.
- *Nervous system*: sudden weakness or numbness, a drooping face, difficulty speaking, a sudden severe headache, a first seizure, new confusion.
- *Infection and systemic illness*: high fever with a stiff neck, a rash that does not fade under pressure, rapidly spreading redness, shaking chills, unusual

drowsiness.

- *Abdomen and pelvis*: severe abdominal pain, vomiting blood, black or bloody stools, bleeding or severe pain in pregnancy.
- *Mental health*: thoughts of suicide with a plan or intent, psychosis with risk to self or others, inability to care for oneself.
- *Patterns needing prompt rather than emergency assessment*: unexplained weight loss, drenching night sweats, a new lump, a change in bowel habit in middle or later life, persistent hoarseness, difficulty swallowing, new pain in someone with a history of cancer.

This primer does not replace first-aid or emergency training, which every practitioner should hold. It exists because gentle modalities attract people in the middle of a crisis who hope to be spared a trip to hospital. Nobody should be spared that trip when they need it.

39. Persistent Pain

People with persistent pain describe more than pain: broken sleep, fear of movement, the loss of work and identity, and often the experience of being disbelieved. The revised definition of the International Association for the Study of Pain describes pain as an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage, and its accompanying notes stress that pain is always a personal experience shaped to varying degrees by biological, psychological and social factors (Raja et al., 2020). Central sensitisation helps to explain how pain can persist, spread or intensify after tissues have healed (Woolf, 2011), and the fear-avoidance model describes how fear of pain and of re-injury can lead to avoidance, disuse and disability (Vlaeyen & Linton, 2000).

QHD support in this domain, if it is offered at all, is adjunctive: settling practices, attention to sleep, pacing, and a relationship in which the person feels believed, all coordinated with physiotherapy, pain medicine or primary

care. Advice about painkillers lies outside its scope. So does any suggestion that pain is imaginary, “just energy” or purely quantum, and so does any substitute for musculoskeletal or neurological assessment.

Refer, urgently where appropriate, for new pain in someone with a history of cancer; back pain with numbness in the saddle area, new difficulty passing urine or loss of bowel control; pain with fever or unexplained weight loss; pain after significant trauma, especially with neurological signs; and severe, uncontrolled pain with systemic features. Whenever a pain team or physiotherapist is involved, a letter saying what QHD is and is not doing takes five minutes and prevents most conflicts.

40. Fatigue, Post-Exertional Malaise, and Post-Infectious Illness

Fatigue is a common final pathway with many possible contributors, among them anaemia, thyroid disease, diabetes, sleep apnoea, depression, the side effects of medicines, heart and lung disease, infection, cancer and the conditions discussed below. Sorting these out requires licensed clinicians and appropriate tests. QHD practitioners should keep a low threshold for referral and should never offer a metaphysical explanation in place of an investigation.

One pattern deserves particular attention because it changes what is safe. In post-exertional malaise, symptoms worsen after physical, cognitive or emotional effort that would once have been easily tolerated, often after a delay of a day or more, and recovery is slow. An expert committee convened by the Institute of Medicine placed it at the centre of its proposed diagnostic criteria for myalgic encephalomyelitis/chronic fatigue syndrome, together with a substantial loss of function lasting more than six months, unrefreshing sleep, and either cognitive impairment or orthostatic intolerance (Institute of Medicine, 2015). National guidance in England advises against graded exercise therapy for people with ME/CFS and recommends individualised energy management within the person’s limits (National Institute for Health and Care Excellence, 2021). Persistent illness after COVID-19 shares some of these features along with many others, and its mechanisms remain under investigation (Davis et al., 2023).

For QHD, this means pacing rather than pushing. Support concentrates on mapping the person's energy envelope, preventing boom-and-bust cycles, protecting sleep, and measuring progress in crash days avoided rather than in exertion added. Exercise challenges presented as proof of toughness, supplements sold as “quantum energy” and narratives of detoxification have no place here, and neither do miracle timelines. People with these illnesses have often been disbelieved, and being believed, with their limits respected, is itself a form of care.

Refer for suspected anaemia, thyroid or other hormonal disease, sleep apnoea, cardiac or respiratory symptoms, fainting or severe dizziness on standing, unexplained weight loss, and depression that impairs function or comes with thoughts of self-harm. Refer also whenever no licensed clinician has yet considered a diagnosis. The pattern described above is recognisable, but diagnosing it is not a practitioner's task.

Questions for study

1. Why does post-exertional malaise change what it is safe to recommend?
Explain it as you would to a patient's well-meaning friend.
2. List five medical causes of fatigue and, for each, the clue in the history that would prompt you to ask for it to be assessed.

41. Sleep

Sleep is both a symptom and a driver of dysregulation. Poor sleep lowers pain thresholds, clouds thinking, unsettles mood and appetite, and makes every other load heavier, while pain, worry, caregiving, shift work and light at night in turn disrupt sleep. For chronic insomnia in adults, cognitive behavioural therapy for insomnia (CBT-I) is the recommended initial treatment (Qaseem et al., 2016), and practitioners should know how to help people find it. Light is the main signal that sets the body's clock, and timing matters: bright light in the morning and dim light in the evening support the circadian rhythm, whereas bright light late at night disrupts it (Blume et al., 2019).

QHD's contribution is modest and practical: light timing, a consistent schedule, a wind-down routine, the timing of caffeine and, above all, attention to the loads that are destroying the person's sleep rather than a lecture on sleep habits. Lectures that ignore those loads are one reason patients stop telling the truth about their nights. Any QHD session aimed at sleep is an untested adjunct [T4] and never a substitute for CBT-I or for the treatment of a sleep disorder.

Refer when there is loud snoring, witnessed pauses in breathing or gasping at night, or marked daytime sleepiness, all of which suggest sleep apnoea (§59); when insomnia is severe or has collapsed a person's functioning; when sleeplessness accompanies a mood crisis, which in some conditions can herald a relapse; and when unusual behaviour occurs during sleep.

42. Stress, Anxiety, and Threat

People describe stress and anxiety in bodily terms: a jaw clenched all night, a gut that sends them to the toilet before every meeting, a heart that pounds at a phone notification, a startle that will not settle. These are real physiological states, and chronic threat responses shape sleep, pain, digestion and immune function.

Practitioners in this area will meet polyvagal theory, which proposes a hierarchy of autonomic states linked to the evolution of the vagus nerve and has become popular in therapeutic and trauma-informed circles (Porges, 2011). They should know that its physiological premises are contested; a detailed critique argues that each of its five basic premises is either untenable or highly implausible in the light of the available scientific literature (Grossman, 2023). Its clinical language about safety may still be useful, but it should not be taught as established physiology [T3 at most]. By contrast, heart-rate variability biofeedback, a breathing-based method with a clear physiological rationale, has been tested in controlled studies of stress and anxiety, with encouraging if imperfect results (Goessl et al., 2017).

QHD does not replace psychotherapy or psychiatric care, and it does not offer exposure therapy unless the practitioner is separately qualified to provide it. Settling practices, predictable routines and a trauma-informed manner can be offered as adjuncts. Breathwork is optional and never forced, because for some people with a history of trauma being told to attend to their breathing is itself distressing. Anxiety is never described as a moral failing or as “low coherence of character”.

Two referral rules matter most. Chest pain with panic must be medically assessed before anyone calls it panic, because the two can coexist and a practitioner cannot tell them apart. And any thought of suicide with a plan or intent, psychosis with risk, or inability to care for oneself goes to crisis services at once. Settling practices never replace a safety plan (§53).

Questions for study

1. A trainee describes a patient’s state as “dorsal vagal shutdown” in the record. How would you advise them to rewrite it, and why?
2. Why must new chest pain be medically assessed even in someone with a long history of panic attacks?

43. Digestive Complaints

Digestive symptoms isolate people from the tables where belonging happens, and plans for them must not deepen that isolation. Many chronic digestive complaints without structural disease are now understood as disorders of gut-brain interaction, diagnosed by positive criteria rather than by exclusion alone (Drossman, 2016). Stress, sleep, meal timing, alcohol and caffeine can all amplify symptoms, and context matters too: in a trial in irritable bowel syndrome, the warmth and attention of the practitioner delivering a placebo changed how much patients improved (Kaptchuk et al., 2008).

QHD support is adjunctive and practical: regular meals, protected sleep, attention to stress load and, where needed, help in undoing restrictive diets that have become a harm in themselves. Talk of a “quantum gut rewrite” has

no place in it, and neither has the insistence, common in wellness writing, that all digestive symptoms are trauma or that all are food. Gastroenterology remains responsible for the diagnosis.

Alarm features go to medicine promptly: bleeding, black stools, vomiting blood, difficulty swallowing, persistent vomiting, unexplained weight loss, signs of anaemia, a new change in bowel habit in middle or later life, and new symptoms in someone with a family history of bowel cancer. Severe abdominal pain is an emergency. Composite 5 in Chapter 37 shows why these features are screened for at every visit and not only the first.

44. Autonomic and Orthostatic Symptoms

Dizziness on standing, palpitations, fainting or near-fainting, intolerance of heat, and a worsening after meals or exertion are common reasons for seeking help, and fear of these unpredictable sensations often amplifies them. A consensus statement defines orthostatic hypotension, neurally mediated syncope and the postural tachycardia syndrome precisely (Freeman et al., 2011), and European guidelines on syncope set out how to distinguish low-risk from high-risk fainting (Brignole et al., 2018). Fainting during exertion or while lying down, fainting preceded by palpitations, fainting in someone with known heart disease, and a family history of sudden death at a young age are among the features that call for urgent specialist assessment.

QHD must never “harmonise away” a faint. Supportive pacing, attention to fluids and meals on the advice of the person’s clinicians, and work on the fear that follows unpredictable symptoms may be offered as adjuncts within medical care. The stop rules in the profile should be written boldly: fainting, chest pain, breathlessness or neurological symptoms end the session and start a referral.

45. Immune Narratives

Patients often arrive with stories about their immunity: frequent infections, never having recovered from a virus, a sense of being run down, or a self-diagnosis found online. These stories deserve respectful listening and careful

recording, but they do not license invented labels. QHD practitioners do not diagnose immunodeficiency, do not speak of “field purity” as a predictor of infection, and leave decisions about vaccines and antimicrobial treatment with medical and public-health clinicians.

Refer promptly for recurrent or unusually severe infections, infections that fail to settle, and any suspicion of a weakened immune system. Refer immediately for signs of sepsis or meningitis: high fever with shaking chills, confusion, a stiff neck, a rash that does not fade under pressure, or rapid deterioration. During epidemics, QHD clinics follow local public-health advice, support convalescence without claiming to own post-infectious care, and never use fear of infection to sell packages.

46. Life Stages and Particular Needs

Some groups need rules of their own.

Children and adolescents. Consent has at least two audiences, the young person and their guardians, and part of any consultation with an adolescent should be private (§55). Partnership with the child’s doctor is required, not optional, and safeguarding concerns follow the local route without delay. Composite 8 shows how much can depend on the private part of the conversation.

Pregnancy and after birth. Obstetric and midwifery care has primacy, and QHD, if present at all, is supportive. Any worrying symptom in pregnancy, such as bleeding, severe pain, reduced fetal movements, a severe headache or disturbed vision, goes to maternity services at once. Low mood and anxiety after birth are common and treatable, and thoughts of self-harm or of harming the baby are an emergency.

Older adults. Medicines multiply, and so do their interactions; published guidance identifies medicines that are potentially inappropriate for older people in many circumstances (American Geriatrics Society, 2023).

Practitioners count the medicines, ask about falls, never suggest stopping anything, and treat new confusion as a medical emergency until proved otherwise. Plans are conservative, and contact with the GP is frequent.

Caregivers. The exhaustion of the people who support a patient belongs in the formulation, and a caregiver may need care of their own (§64). A plan should never simply help someone endure an unsustainable load.

Neurodivergent people. Neurodivergence is not dysregulation. Rooms and routines are adapted to the person's sensory needs: no scent without asking, steady lighting, quiet, no forced eye contact, and a welcome for the tools people use to regulate themselves (§42).

People with serious mental illness. A stable illness belongs to the clinicians who stabilised it. Any QHD support is built with them and is never positioned as an alternative to medication or crisis care (Composite 12).

People in cancer care. Disease-directed treatment belongs to oncology. The danger of alternative treatment used instead of conventional treatment is not hypothetical (Johnson et al., 2018), and any QHD support is adjunctive and known to the oncology team (§52).

Cyclical patterns. Menstrual and hormonal cycles often organise the timing of symptoms, and noticing this is legitimate pattern literacy. Abnormal bleeding, severe pelvic pain and possible pregnancy go to medical care.

Delayed help-seeking. Some people, often but not only men, have learned to ignore their symptoms. Practitioners should make early referral feel normal, particularly for chest pain, breathlessness and urinary or testicular symptoms, and should never praise the stoicism that keeps someone away from a hospital.

Questions for study

1. Choose two groups from this chapter and describe how the consent conversation would differ between them.
2. What would you do if an adolescent asked you to keep a disclosure about self-harm from their parents?

Book Seven: Ethics, Academy, and Future

47. Honesty About Limits

QHD's credibility rests on the sentences its practitioners are willing to say aloud. We do not know whether QHD's modalities help anyone. More research is needed, and until it is done every claim of benefit is a hypothesis. Some people will not improve with our methods. Emergency and disease-directed care save lives that we must never put at risk. The framework was written by its founder, who has an interest in its success. Its working models may prove wrong, and if they do, we will say so.

These sentences are uncomfortable for a clinic's finances and for a practitioner's ego. They are also what distinguishes a research programme from a belief system. The audit of Volume I described in the preface is an example of the discipline applied to QHD itself: when the book was found to have been padded, the right response was to say so in print and correct it, not to defend it.

Honesty about limits also means honesty about what a practitioner does not know in a particular case. "I don't know yet, and here is how we will find out" is worth practising until it can be said calmly. Patients are more reassured by a clinician who can say it than by one who cannot.

48. Consent as a Continuous Practice

Respect for autonomy is one of the central principles of biomedical ethics, and informed consent is its practical expression (Beauchamp & Childress, 2019). In QHD, consent covers what is proposed and why, what it involves, the alternatives (including doing nothing and seeking other care), the uncertainties, stated plainly, the costs, the right to withdraw at any time without penalty, and the rules about emergencies and medicines.

Consent is continuous, not a signature. It is refreshed when a plan changes, when a remote session replaces an in-person one, when a device is added, when touch is proposed, and whenever a package or payment plan is offered. Understanding is checked by teach-back, in which the patient explains in their own words what they have agreed to. In an observational study of primary care for people with diabetes and low health literacy, physicians assessed recall or comprehension of new information in only 12 of 61 visits, but patients whose physicians did so were more likely to have haemoglobin A1c below the group mean (Schillinger et al., 2003). In QHD, five points must come back before consent is complete: what QHD is, what it is not, what to do in an emergency, that medicines are changed only by prescribers, and how progress will be judged.

Some failures of consent are common in complementary care: a single signature followed by silent escalation, consent bundled with a same-day discount, explanations wrapped in jargon no patient could repeat, and remote care without a local emergency plan. Each is a violation, whatever the form says.

A useful training exercise asks students to explain QHD in two minutes to a simulated relative who is openly sceptical, without sneering and without overclaiming, and then to take consent from a simulated patient who remains uncertain. The student passes only if uncertainty, QHD's complementary role and the right to stop are all named.

Questions for study

1. Write the five points of a QHD teach-back in language a twelve-year-old could follow.
2. Which common failure of consent is hardest to detect from the record alone, and how would you audit for it?

49. Money, Marketing, and Public Speech

Economic design reveals ethics before any mission statement does. QHD clinics publish their fees, allow payment per session wherever possible, offer packages only with clear exit terms and refunds for unused sessions, and never link a discount to anxiety raised during an assessment (§103, §104). Income targets that can be met only by overselling are a design fault, and commission on upgrades sold to frightened people is forbidden. Financial pressure does not justify deception. It justifies redesigning the business.

Some kinds of public speech are prohibited outright: predictions of catastrophe drawn from a scan, shaming of people who decline care, conspiracy stories that separate patients from their doctors, invented success rates, invented patents or trials, and slogans such as “doctors are blind”. Testimonials, if used at all, must be accurate and freely given, must not be exchanged for free care without disclosure, and are not evidence (§106).

Two structures help. The first is a review of every public claim by two people before publication, one checking the ethics and one checking the evidence tier, with rejected drafts kept as training material rather than quietly reused. The second is an annual review of the clinic’s own marketing, in which every absolute verb is underlined and every sentence rewritten until it would survive an ethics seminar. If a business cannot survive without deceptive copy, the business needs to change.

Front-desk staff need scripts as much as clinicians do. They explain fees and exit terms, avoid any hint of a guarantee, keep scan results and offers apart, and hand clinical questions to a clinician. They should be thanked in staff meetings when they refuse a sale that would have been wrong.

Public talks should leave people freer than they arrived: clearer about emergencies, clearer about uncertainty, and better able to recognise fear-based marketing, even if they never use QHD. A talk that ends only in a time-limited offer was not education. When journalists call, practitioners lead with QHD’s

complementary role, its untested status and its refusal of invented statistics, and they invite criticism. When an influencer offers publicity in exchange for a claim of cure, the answer is no.

Questions for study

1. Find a real advertisement for a complementary therapy and rewrite it so that it would pass the two-reviewer check. What had to go?

50. Access and Justice

Support that only the wealthy can reach becomes a luxury. QHD cannot solve inequality, but a clinic can take concrete steps: a sliding scale, supervised low-cost student clinics, group sessions for skills that need no device, plain-language materials, qualified interpreters, captioned video, physical access for disabled people (or clear disclosure of its absence, with alternatives), and a permanent ban on the idea, sometimes heard in wellness circles, that poverty reflects “low vibration” (§27). Remote care can widen access, but only if alternatives exist for people without bandwidth, privacy or devices.

Good intentions are not enough. A clinic should choose one access practice each year, measure it (how many reduced-fee places were filled, how many people left because of cost) and report what it found. Talk of justice without that kind of effort is decoration.

51. Error, Incidents, and Correction

Every clinic makes mistakes, and what distinguishes a safe one is how it learns from them. QHD defines adverse events broadly: any worsening temporally associated with a session, emotional distress needing extra support, a fall, a faint, a severe panic, and any emergency referral made during or after a visit. Events are recorded within a day and reviewed weekly. Near misses count too, such as the catastrophic scan interpretation that was almost said, the replacement of care that was almost agreed, or the chest pain that was almost talked through. Reporting is praised, never punished.

Reviews look at systems as well as individuals. If a red flag was missed, was the screen skipped because the schedule was too tight? If an overclaim was made, did the clinic's own materials encourage it? The aim is to fix the conditions that made the error likely, without humiliating the person who made it and without excusing it.

Consider a fictional clinic that grows quickly. A new operations manager introduces automatic offers after every scan, scripted certainty and commission on add-ons. Revenue rises and, more quietly, so do near misses, until a supervisor finds a record in which a red flag was played down so as not to "lose the sale". The ethical path is to stop the marketing, audit the records, retrain or remove staff, rewrite the scripts, accept the loss of income and circulate an internal correction. The unethical path is to call the near miss the patient's non-compliance and carry on growing. Students who discuss this fiction should draft the first email they would send on discovering that record, because courage has a timestamp.

Errors in public materials are corrected in public, and that applies to this book. Future editions will list what has changed and why, and will not silently alter its ethical commitments.

Questions for study

1. Write the email described in the fictional clinic story, addressed to the clinic's owner.

52. The Academy: From Foundations to Mastery

QHD education is organised in four stages, and progress through them is earned by demonstrated competence and conduct, never by payment or speed.

Foundations. Students learn the paradigm, the disclaimer, the evidence taxonomy, the citeable definitions, the Organon's aphorisms on harm, referral and honesty, and basic case-taking using composites. They must be able to write the disclaimer from memory, refuse three tempting overclaims, complete

composite records without mystification, and explain QHD to a sceptical clinician without attacking medicine. The personal outcome is the ability to say “I do not know” without distress.

Advanced. Students deepen their signature analysis, study the modalities and device ethics, and learn research literacy: study design, bias, and the difference between mechanism and outcome. They critique a real published abstract, build profiles with explicit uncertainties, and show that they can classify claims by tier under time pressure.

Clinical. Under supervision, students apply the method with real patients where the law and their own licence permit. Their records are audited, their referral decisions are observed under pressure, and they present at least one case that plateaued or failed, without humiliating the patient or inflating themselves. The personal outcome is choosing the patient’s good over being right (§9).

Mastery. Practitioners teach, revise protocols transparently, contribute to rigorous research, and support colleagues when methods fail. The personal outcome is that titles match competence and that devices hold no charm.

A student’s first ninety days might run as follows. In the first month they read Book One and the Organon twice, copy out the first two groups of aphorisms by hand, and write the disclaimer from memory. In the second they study the Five-Step Method and complete records for composites only. In the third they work through ethics scenarios with peers, observe supervised intakes where possible, and begin reading one real review article a month in a related field, found through their own literature searches. Nobody should see members of the public independently on the strength of reading alone.

The academy itself must be built to resist the dynamics of a cult (§134). That means several teachers rather than one, written standards, a route for complaints, published ethics cases, at least one outside sceptic invited to teach each year, and the freedom to leave without losing friends or reputation.

53. A Practical Vision

I do not hope for a future in which quantum vocabulary conquers medicine. I hope for one in which medicine becomes more complete: fierce in acute care, patient with chronic uncertainty, literate in systems and biophysics, and unwilling to abandon a person when the tests come back normal. QHD is one proposed contribution to that future. It may prove useful, or its useful parts may turn out to be things good clinicians were already doing under other names. Either result would be worth knowing.

What I would like to see is modest: chronic-care teams that include people skilled in pattern, pacing and follow-up; patients unashamed either of seeking complementary help or of trusting mainstream care; device sellers unable to outrun ethics committees with adjectives; education that forms character before charisma; and research funding that follows questions, not only markets. If QHD one day dissolves into better science under better names but leaves behind habits of candour and whole-person attention, I will not mourn the brand.

To the clinician reading this with folded arms: welcome. Folded arms have protected patients from many fads. Notice what QHD refuses, which is hostility to medicine, invented statistics and any role in emergencies. Where quantum biology is contested, we say so. Where clinical claims must meet an evidence bar, we agree that they must, and Book Eight describes how we propose to meet it or fail in the attempt. Where subjective chronic suffering deserves more than dismissal, perhaps we can meet as colleagues. Criticise us where we are vague, and we will try to become more precise.

To the person who picked up this book because they are tired of being tired, or in pain, or frightened by a body that no longer feels like home: please keep your medical team. Be wary of anyone who asks you to trade your doctor for certainty, including anyone who uses this book to do so. Judge QHD practitioners by their honesty when you ask them your hardest questions. You are not a failed machine. You are a person in a hard chapter, and good support, from anyone, is skilled accompaniment rather than a marketplace of miracles.

My thanks go to the clinicians whose insistence on triage runs through every chapter, to the physicists and biologists who tolerate naive questions from outside their fields, to the patients who teach more than any textbook, and to the critics of the previous edition, whose objections made this one better.

Health is not a product to be sold. It is a capacity to be served.

Book Eight: For Researchers and Students

54. Citeable Definitions

This chapter holds the canonical wording of QHD's thirteen citeable definitions, version 2.0, which belongs to this edition. Earlier chapters paraphrase them; anyone quoting a definition should use the wording below and cite it with its number and version, for example "CD-6, v2.0". Future editions will change a definition only by issuing a new version with a published note of what changed.

The main changes from the Volume I wording (v1.0) are these. CD-1 now states that QHD claims no quantum mechanism for its clinical methods and that none of its clinical claims has been tested. CD-6 restricts the biofield to measurable, classical phenomena. CD-9 defines Quantum Entanglement Assistance as a relational format that uses entanglement as a metaphor only. CD-10 limits distance work to history, coaching and guided practice. CD-12 and CD-13 add, respectively, the exploratory status of device readings and the requirement that measures be chosen in advance. The remaining definitions have been tightened without any change of meaning.

CD-1. Quantum Homeodynamics (QHD). A clinical and educational framework, proposed in 2024 by Dr. Abdul Jaleel Kavungal, for observing and supporting adaptive coordination in the living human system through a structured Five-Step Method and a set of resonance-oriented practices. QHD is complementary to licensed medical care and never a substitute for it. It borrows questions and vocabulary from quantum biology and systems physiology; it does not claim that its clinical methods operate through quantum mechanisms, and none of its clinical claims has yet been tested in controlled research.

CD-2. Coherence (clinical working construct). Adaptive coordination among physiological and regulatory processes, such that subsystems are coupled closely enough to function as a whole and loosely enough to change when circumstances change. The term is borrowed from physics by analogy and does not refer to a quantum state.

CD-3. Decoherence (clinical working construct). Persistent loss of adaptive coordination, appearing clinically as rigidity, fragmentation, noisy or exhausted regulation, or impaired recovery after load. The term is analogical and is never a diagnosis.

CD-4. Quantum signature. A structured written formulation of how a person's regulation appears to be organised at present, covering dominant symptom complexes, timing, triggers and relievers, stacked loads, resources, and hypothesised points of dysregulation, each labelled as a hypothesis. Nothing is measured, and the signature is never a moral judgement.

CD-5. Harmonic profile. A personalised, dated and versioned plan that sets out up to three priorities, explicit non-priorities, medical anchors, any proposed sessions with their rationale, no more than two initial home practices, stop and referral rules, pre-specified measures and a review date. It is a hypothesis for support, not a prognosis.

CD-6. Biofield (working model). An umbrella term for the measurable, classical field phenomena of the living body, namely bioelectric potentials and currents, biomagnetic fields and ultra-weak photon emission, considered together with the physiological rhythms they accompany. QHD does not posit a massless or non-physical field. The term organises questions about whole-body coordination; it does not denote a single measured quantity and licenses no claim to detect disease.

CD-7. Quantum Resonance Therapy (QRT). *A structured session in which resonance-oriented stimuli, delivered by Quantum Resonance Emitters, by practitioner-guided protocols or by both, are offered in support of a harmonic profile. Its specific effects, if any, are unknown; it is a supportive practice under study and not a treatment for any disease.*

CD-8. Biofield Harmonisation. *Hands-on or near-field settling practices taught in QHD training, delivered only with active, specific and revisable consent and in a trauma-informed manner. No claim is made that the practitioner perceives or alters a field.*

CD-9. Quantum Entanglement Assistance (QEA). *A relational-support format for two or more people whose states affect one another, using quantum entanglement as a metaphor only. No transmission of any signal, energy or effect by entanglement is claimed.*

CD-10. Distance Therapy. *QHD support provided without shared physical location, limited to history, coaching and consented guided practices, and conditional on a confirmed local emergency plan. No physical effect at a distance is claimed.*

CD-11. Quantum Resonance Emitter (QRE). *A class of device used in QHD training to deliver resonance-oriented stimuli during QRT. No QRE has been validated, approved or shown to be effective, and none substitutes for medicines or procedures.*

CD-12. Scan (QHD). *A structured intake comprising consent, a dated red-flag screen, a narrative history, a review of regulatory domains, the person's life context, their own theory of the illness and their goals, with any device readings recorded as exploratory. It is not imaging, laboratory testing or pathology, and it cannot detect disease.*

CD-13. Verify. *Follow-up evaluation of function, tolerance, adverse events and the fit of the plan, judged against measures and time windows agreed before the intervention, with every person who began care accounted for.*

55. The Evidence Taxonomy

The most damaging errors in a young field are category errors: an anecdote spoken as if it were trial evidence, or a laboratory finding about a molecule spoken as if it were a clinical result. The QHD evidence taxonomy exists to prevent them. It classifies claims, meaning individual statements as they are spoken or written. It does not grade bodies of evidence, and it is no substitute for formal methods such as GRADE, which rate the certainty of evidence about particular outcomes (Guyatt et al., 2008). A claim that reaches T1 here still needs formal appraisal before it can inform a guideline.

Tier	Name	What it covers	Legitimate speech	Illegitimate speech
T0	Emergency and standard medical care	Established acute pathways and standard treatment	“This needs emergency care now.”	“Skip the hospital; we will clear your field.”
T1	Established physiology and biophysics	Well-replicated findings in standard curricula, such as membrane potentials, circadian effects of light, tunnelling in enzymes	Taught with standard sources	Ordinary physiology relabelled as a QHD discovery
T2	Emerging research	Active, unsettled research, such as radical-pair magnetoreception, developmental bioelectricity, photon emission as a biomarker	“Research is exploring this; its clinical relevance is unknown.”	“Birds navigate by quantum effects, so your fatigue is quantum.”
T3	Working model or analogy	QHD’s constructs: coherence, signature, the biofield as an umbrella term	“We use this as a working model to organise questions.”	A model presented as a finding or a diagnosis
T4	Clinical hypothesis	Claims that a QHD method or modality helps, such as “QRT may support sleep”	“This is untested; we will check whether it helps you.”	“A proven treatment for condition X.”

Tier	Name	What it covers	Legitimate speech	Illegitimate speech
T5	Anecdote	Testimonials, individual stories, uncontrolled clinic impressions	“One person’s experience; it raises a question.”	A story marketed as proof; “most of our patients improve”
T6	Speculation or unfalsifiable claim	Claims with no evidential route or no possible test, such as destiny readings or remote quantum healing	Not used in consent, teaching as fact, or marketing	Any clinical or commercial use

Six rules govern assignment.

1. Classify a claim as it is actually spoken, not as its speaker intended it.
2. A compound claim takes the tier of its weakest necessary link. “Quantum coherence in photosynthesis shows that QRT restores cellular coherence” has a revised T2 premise and a T6 conclusion, so the claim is T6.
3. Evidence about mechanism never raises the tier of a clinical claim. A demonstrated mechanism can make a clinical hypothesis more plausible; it cannot make it true.
4. T0 overrides everything. No working model, hypothesis or preference may delay emergency care.
5. When in doubt between two tiers, assign the weaker one.
6. At present no claim that a QHD method or modality works can rise above T4. Any such claim spoken as T1 or T2 is an error.

Worked examples show the rules at work. “Chest pain with sweating needs emergency assessment” is T0. “Morning daylight helps to set the body clock” is T1. “Robin cryptochrome 4 is magnetically sensitive in the test tube” is T2.

“We use coherence to describe how your sleep, energy and stress fit together” is T3. “Four QRT sessions may help your sleep goal, and we will measure it” is T4. “My neighbour felt wonderful after one session” is T5. “Your soul’s entanglement contract caused your illness” is T6. And “studies show resonance therapy works” is not a claim at any tier but a fabrication, since no such studies exist; it must be withdrawn (§114).

Tier laundering is the presentation of a lower-tier claim as though it belonged to a higher one. Its common forms are “studies show” without studies; “quantum-biologically proven” when only a model system was studied; “clinically established” on the strength of testimonials; “doctors now accept” without evidence; and borrowed authority, in which a genuine paper from an adjacent field is cited as though it supported a claim it does not address. Detecting laundering should be routine and unglamorous, like any other safety check.

On this taxonomy, QHD currently draws inspiration from T2, holds its constructs at T3 and its methods and modalities at T4, treats anecdotes as T5, never speaks above T4 about itself, and never allows anything to override T0.

56. A Research Agenda

The agenda is ordered by what must be known first. There is little point in testing whether a modality works if the constructs used to target it cannot be applied reliably, or if the method as practised is unsafe. The order is therefore safety and process, then the reliability of the constructs, then feasibility, then efficacy against appropriate comparators, and last of all mechanism. The Medical Research Council’s framework for complex interventions supports this kind of staged approach, moving through development, feasibility, evaluation and implementation with attention to context and to the theory of how the intervention is meant to work (Skivington et al., 2021).

A caution applies throughout. In fields where the prior probability of a true effect is low, expected effects are small and analytic flexibility is high, most positive findings are likely to be false (Ioannidis, 2005). QHD fits that description. Studies should therefore be preregistered (Nosek et al., 2018),

with analysis plans fixed before the data are seen, because undisclosed flexibility in data collection and analysis can make almost any result look significant (Simmons et al., 2011).

Nine designs make up the agenda.

A. Safety and process audit. The aim is to learn whether QHD care as practised delays medical care, changes medicine use or causes harm. Teaching clinics audit, prospectively, their red-flag screening, referral decisions and the time taken to refer, adverse events, medication changes as reported by patients, markers of dependency (sessions without progress), and the quality of teach-back. This design cannot show benefit. It comes first because it tests the claims QHD makes most emphatically: that it is safe and complementary.

B. Reliability of the constructs. Several trained practitioners independently analyse the same recorded or simulated intakes and select priorities from a structured list. Agreement is measured with a chance-corrected statistic such as Cohen's kappa (Cohen, 1960), against a threshold fixed in advance (Chapter 57). The design can show whether the constructs are teachable. It cannot show that they help anyone.

C. Prospective descriptive series. Consecutive patients are enrolled and followed at fixed windows on pre-specified, patient-owned measures, with every loss to follow-up accounted for; individual cases that are reported follow the CARE guideline (Gagnier et al., 2013). The series describes who seeks care, what their profiles contain and what harms occur. Without a comparison group it cannot show efficacy.

D. Series of n-of-1 trials. Within individual patients, periods with and without a specific component, such as QRT sessions, alternate in random order, with washout periods where appropriate. The approach was first proposed for clinical practice by Guyatt and colleagues (1986) and is described in detail in a user's guide from the Agency for Healthcare Research and Quality (Kravitz & Duan, 2014); results are reported using the CONSORT extension for n-of-1

trials (Vohra et al., 2015). The design suits stable chronic conditions and interventions whose effects come and go quickly. Blinding is difficult without a credible sham.

E. Feasibility and pilot study. A small study establishes whether a full trial is possible: rates of recruitment, acceptability, adherence and retention, the credibility of a sham, and the variability of outcomes needed to calculate a sample size. It is not a test of efficacy and should not be reported as one.

F. Sham-controlled trial of a modality. Participants receive active or sham sessions (for example, a QRE that operates normally or one that looks, sounds and is scripted identically but emits nothing), delivered by practitioners following the same protocol. Outcome assessors are blinded, practitioners are blinded if possible, and both expectation and the success of blinding are measured. This is the decisive test of whether a modality has specific effects.

G. Pragmatic randomised trial of the QHD package. This design asks whether adding QHD support to usual care improves outcomes that matter to patients in ordinary settings. The comparator might be usual care alone, usual care with an attention-matched control, or usual care with an established active intervention such as heart-rate variability biofeedback (Goessl et al., 2017). The PRECIS-2 tool helps to match such a trial's design to its purpose (Loudon et al., 2015). A positive result against usual care alone would not show that the resonance components matter; it would show only that the package helps, possibly through entirely ordinary means.

H. Device validation. Before any device reading is used as an outcome, the device passes through verification, analytical validation and clinical validation (Goldsack et al., 2020).

I. Qualitative and ethics research. Interviews with patients and practitioners, audits of clinic advertising before and after training, and observation of referral under pressure can show whether consent is understood, whether expectations are realistic and whether the ethical rules in this book are followed. This work is often more urgent than another device study.

Outcomes should be patient-owned and measured with validated instruments where possible. The PROMIS item banks provide standardised, calibrated measures of physical, mental and social health, including physical function, fatigue, the interference caused by pain, and sleep disturbance (Cella et al., 2010), and the Pittsburgh Sleep Quality Index is a long-established self-report measure of sleep quality (Buysse et al., 1989). Individual goals, such as those recorded in field M1.9, can be used alongside standard measures but not instead of them. Every study records adverse events, referrals and changes in medicines. No invented “coherence score” should serve as a primary outcome.

Because context, relationship and expectation can shift patient-reported outcomes (Kaptchuk & Miller, 2015; Hróbjartsson & Gøtzsche, 2010), studies of QHD must measure expectation at baseline, blind the people who assess outcomes, test whether participants can guess their allocation, and prefer comparators that match the attention and ritual of a QHD session. A study that finds QHD sessions better than a waiting list has learned very little.

A worked outline shows how these principles combine in a pilot of design F. *Population:* adults with chronic insomnia who have completed or declined CBT-I and remain under the care of their GP. *Exclusions:* untreated sleep apnoea, active psychiatric crisis, pregnancy, and any implanted electronic device. *Intervention:* four weekly QRT sessions with an active QRE. *Comparator:* four weekly sessions with a sham QRE, identical in appearance, sound and script. *Primary outcome:* change in Pittsburgh Sleep Quality Index score at eight weeks. *Secondary outcomes:* sleep-diary measures, PROMIS sleep disturbance, adverse events, a blinding index and baseline expectation. *Aims:* to establish the feasibility of recruitment and blinding and to estimate variability, not to test efficacy. *Conduct:* registration before enrolment, a protocol published in line with SPIRIT 2025 (Chan et al., 2025), analysis by statisticians independent of QHD, and publication whatever the result.

57. Falsification Criteria

This chapter sets out, in advance, the results that would oblige me, and anyone teaching QHD, to revise, suspend or abandon parts of the framework. Falsification here means rational retreat, not humiliation. Each criterion names a finding, the design that could produce it (Chapter 56), and its consequence.

F1. Construct reliability. If, after structured training, agreement between practitioners on the priorities of a signature falls below a threshold fixed in advance (a kappa of 0.4, for example) in a well-conducted study of design B, the signature construct will be simplified and retested. If agreement remains low after revision, the construct will be abandoned as a clinical tool.

F2. Distinctiveness. If audits show that harmonic profiles reduce in practice to generic advice about sleep and pacing, with no operational content specific to QHD, the QHD vocabulary will be withdrawn from the method, which would then be taught simply as a structure for documentation and follow-up.

F3. Specific effects of a modality. If adequately powered, preregistered, sham-controlled trials of design F find no meaningful difference between active and sham QRT on their primary patient-owned outcomes, the hypothesis that QRT has specific effects will be withdrawn, and QRT will no longer be offered as a therapeutic modality outside research. The same rule applies to Biofield Harmonisation and to any device.

F4. Safety. If audits of design A, or any trial, show that QHD care is associated with delayed medical care, inappropriate changes to medicines, or harms greater than those of comparators, the practices concerned will be suspended at once and redesigned before any resumption.

F5. Devices. If a device fails verification or analytical validation (design H), its readings will be removed from all clinical conversations and records, and it will not be used as an outcome measure.

F6. Language and coercion. If entanglement or other physics language is found to be associated with coercion, refusal of medicines or financial pressure, it will be removed from teaching and practice altogether.

F7. Value of the package. If pragmatic trials of design G show no benefit of the QHD package over an attention-matched control, the claim that QHD adds anything beyond good supportive care will be withdrawn.

Two kinds of evidence count for nothing, in either direction. Testimonials and practitioners' convictions can neither falsify these hypotheses nor confirm them. Small, unregistered or uncontrolled studies can raise questions but cannot settle them.

I commit to publishing, or making openly available, the results of any study conducted under the QHD name, whatever they show, and to revising this book accordingly. If any of the criteria above is met, the next edition will say so on its first page.

58. Reporting Standards

Every study of QHD should meet a minimum reporting standard:

1. Registration before enrolment, with the registry identifier in every report.
2. For trials, a published protocol following SPIRIT 2025 (Chan et al., 2025).
3. Reporting of randomised trials according to CONSORT 2025 (Hopewell et al., 2025), and of n-of-1 trials according to the CENT extension (Vohra et al., 2015).
4. A full description of every intervention and comparator using the TIDieR checklist (Hoffmann et al., 2014), including device settings and practitioner scripts.
5. Case reports following the CARE guideline (Gagnier et al., 2013), with consent for publication and removal of identifying details.
6. All harms, all null results, all deviations from protocol and all losses to follow-up.
7. A statement of QHD's complementary role and of the usual care that participants received.
8. A declaration of every conflict of interest, including any involvement of the founder or of device vendors, and a statement of who analysed the data.

9. Conclusions labelled by evidence tier, with no claim stronger than the design supports.
10. No invented citations, percentages or claims of validation, and data shared wherever consent and privacy allow.

Posters and conference presentations follow the same standard in miniature. They say that QHD is a proposed framework and that the intervention was adjunctive, describe the sample, show the missing data and the nulls, state the limitations and invent nothing. If a poster needs embellishment to be accepted somewhere, it is better not to present it there.

59. Limitations, Conflict of Interest, and How to Cite This Book

Researchers and students may adapt the following limitations statement:

Quantum Homeodynamics (QHD) is a framework proposed by its founder. The second edition of its handbook provides definitions, an Organon of principles, a documented Five-Step Method, an evidence taxonomy and a research agenda with falsification criteria. It reports no efficacy estimates for any QHD method or modality because none exist, does not replace licensed care, and describes QHD's clinical claims as untested hypotheses. Any empirical study of QHD methods should be adjunctive, ethically approved, preregistered and fully reported, including null results.

This handbook is written by the founder of the framework it describes. Researchers who use its definitions or methods should say so, and should prefer study teams in which the data are analysed by people with no stake in QHD.

The book should be cited as: Kavungal, A. J. (2026). *The Quantum Homeodynamics Handbook: Foundations, Method, and Research* (2nd ed.). Definitions are cited by number and version (for example, CD-6, v2.0), aphorisms by number and edition (§35, 2nd ed.), and tiers by the taxonomy in Chapter 55.

Cite it for its proposed definitions, its principles, the operational description of the Five-Step Method, the evidence taxonomy, its ethical constraints, and its research designs and falsification criteria. Do not cite it for evidence that any QHD method works, for disease cures, for claims of quantum effects in clinical practice, or for the accuracy of any device, because it contains no such evidence. An accurate citation reads: “Kavungal (2026) presents QHD as a proposed framework and classifies its clinical claims as untested hypotheses.” An inaccurate one reads: “Kavungal showed that resonance therapy relieves chronic fatigue.” The second sentence is false to this text.

60. Using This Book in a Course

The book can support a twelve-week seminar:

1. The disclaimer, conflict of interest, and what QHD is and is not (front matter and Chapter 1).
2. Coherence as a working model and the discipline of metaphor (Chapter 2).
3. Quantum biology, case by case (Chapter 3).
4. Bioelectricity, biophotons and biomagnetism, and where QHD extrapolates (Chapters 4 and 5).
5. The evidence taxonomy, with drills in classifying claims (Chapter 55).
6. The Organon, concentrating on Chapters 11, 14 and 18.
7. The Five-Step Method and its documentation fields (Book Three).
8. Modalities, devices and validation (Book Four).
9. Casecraft with the teaching composites (Book Five).
10. Clinical orientation and the practice of referral (Book Six).
11. The research agenda and falsification criteria (Chapters 56 and 57).
12. The ethics of marketing and access, with student presentations that rewrite a real advertisement in tier-honest language (Chapters 49 and 50).

By the end, students should be able to state CD-1 to CD-13 accurately; classify any claim by tier and justify the classification; complete a Five-Step record for a composite; refuse a request to replace medical care; write a letter

to a physician; design a study that could falsify a hypothesis they favour; and explain what quantum biology has and has not shown.

Suitable assessments include a closed-book test of the definitions, a timed station on classifying claims, an audit of a composite record against the ten questions in Chapter 26, an observed referral with a standardised patient who demands certainty, and a short study protocol containing no invented citations. Eloquence without honesty fails. A plain-spoken student who refers correctly passes.

Appendix: Sample Consent Language

This template is a starting point for education and must be adapted to local law with qualified legal and clinical advice. It is not legal advice.

Consent to adjunctive Quantum Homeodynamics support

What QHD is. A proposed framework for supportive care. It uses a structured method of assessment, planning and follow-up, and it may include sessions such as Quantum Resonance Therapy. It is offered alongside your usual medical care.

What QHD is not. It is not emergency care, not a replacement for your doctors or your treatment, not a diagnosis and not a cure. None of its methods, sessions or devices has been shown in controlled research to work for any condition, and no device we use can detect disease.

What we will do. We will take a detailed history, including questions that check for symptoms needing medical attention. We will agree a written plan with you that has a small number of priorities. We will offer sessions only if you want them, and on dates we agree we will review whether the plan is helping, using measures we choose together.

Uncertainty. You may feel better, feel no different or feel temporarily worse. We cannot know in advance, and we will not promise results.

Possible discomforts. Tiredness, emotional upset, or frustration if the plan does not help. If anything worries you, tell us. We will stop and, if needed, help you get medical advice.

Alternatives. Continuing your usual care alone, other supportive approaches, waiting, or seeking a second opinion.

Emergencies. If you develop chest pain, trouble breathing, signs of a stroke, severe bleeding, thoughts of suicide or any other emergency, call [local emergency number] at once. For remote sessions we will confirm where you

are and your local emergency number at the start of every session.

Medicines. We will never ask you to stop or change a prescribed medicine. Please discuss any change with the person who prescribed it.

Your information. We keep your records confidential, except where the law requires us to share information to prevent serious harm.

Fees. [Insert fees, package terms and the refund policy for unused sessions.] You will never be offered a discount because of anything found during an assessment.

Your choices. You may refuse any part of this, pause, or stop at any time, without giving a reason.

Before signing, please tell us in your own words what QHD is, what it is not, what you would do in an emergency, and how we will know whether it is helping.

Patient or guardian: ____ *Practitioner:* ____ Date: _____

Glossary

Terms are defined as this book uses them. Where a citeable definition exists, its number is given; the canonical wording is in Chapter 54.

Adaptive coordination. The capacity of physiological subsystems to work together while remaining free to change; the core of QHD's clinical construct of coherence (CD-2).

Adverse event. Any worsening temporally associated with QHD care, including emotional distress needing extra support, falls, faints and emergency referrals. Graded mild, moderate or severe (Chapter 27).

Allostasis. Regulation that anticipates demands by adjusting physiological set points; allostatic load is the cumulative cost of doing so repeatedly (Chapter 2).

Analytical validation. The stage of device evaluation that asks whether an algorithm turns raw signals into a metric corresponding to a defined physiological quantity (Chapter 33).

Biofield. In QHD, an umbrella term for the body's measurable classical field phenomena and associated rhythms; a working model, not a single measured quantity (CD-6).

Biofield Harmonisation. Consented, trauma-informed hands-on or near-field settling practices; no claim to perceive or alter a field (CD-8).

Bioelectric signalling. The use of membrane voltages and ionic currents as signals, including by non-excitable cells during development, regeneration and wound healing (Chapter 4).

Biomagnetism. The very weak magnetic fields produced by electrical activity in the heart and brain, measurable with sensitive instruments (Chapter 4).

Care map. A written list of every clinician involved in a person's care and what each is responsible for.

Central sensitisation. Amplification of pain signalling within the central nervous system, which can sustain pain after tissues have healed (Chapter 39).

Change log. A dated record of every major change in a person's treatment or circumstances, consulted before attributing any improvement (§84).

Clinical validation. The stage of device evaluation that asks whether a metric identifies, measures or predicts a meaningful clinical state in its intended population (Chapter 33).

Coherence (physics). Definite phase relationships among the components of a quantum state, which make interference possible.

Coherence (QHD). A clinical working construct meaning adaptive coordination; borrowed from physics by analogy (CD-2).

Complementary. Offered alongside licensed medical care, never instead of it, and never undermining it.

Cryptochrome. A family of light-sensitive flavoproteins; in the retina of migratory birds, the proposed site of the radical-pair compass (Chapter 3).

Decoherence (physics). The loss of quantum phase relationships through interaction with the environment, usually very rapid in warm, wet matter.

Decoherence (QHD). A clinical working construct meaning persistent loss of adaptive coordination; never a diagnosis (CD-3).

Delirium. An acute disturbance of attention and awareness, common in unwell older people; a medical emergency until proved otherwise.

Disorders of gut–brain interaction. The current classification of many chronic digestive conditions without structural disease, such as irritable bowel syndrome (Chapter 43).

Distance Therapy. Remote QHD support limited to history, coaching and guided practices, conditional on a local emergency plan (CD-10).

Entanglement. A correlation between quantum systems that share a state, stronger than any classical correlation; it cannot be used to send signals (Chapter 31).

Environment-assisted transport. The theoretical finding that moderate environmental noise can make energy transfer in some quantum networks more efficient (Chapter 3).

Evidence taxonomy. QHD's classification of claims into tiers from T0 (emergency care) to T6 (speculation) (Chapter 55).

Exciton. An electronic excitation that can be shared across several pigment molecules, as in photosynthetic antenna complexes.

Falsification criteria. Results named in advance that would oblige QHD to revise, suspend or abandon a construct, method or modality (Chapter 57).

Fear-avoidance. A pattern in which fear of pain or re-injury leads to avoidance, disuse and disability (Chapter 39).

Fenna–Matthews–Olson (FMO) complex. A pigment-protein from green sulphur bacteria, the model system in which long-lived quantum beats were first reported and later reinterpreted (Chapter 3).

Five-Step Method. Scan, analyse, personalise, deliver and verify: QHD's operational framework, currently an untested hypothesis (Book Three).

Graduation. A planned transition from regular sessions to self-maintenance, begun near the start of care.

Harmonic profile. QHD's personalised, dated and versioned plan (CD-5).

Heart-rate variability (HRV). Beat-to-beat variation in heart rate, reflecting autonomic regulation.

HRV biofeedback. Training people to breathe at their resonance frequency, around six breaths a minute, to maximise heart-rate oscillations (Chapter 4).

Homeodynamics. The idea that living regulation is a pattern of changing states rather than a fixed set point; the term predates QHD (Chapter 1).

Homeostasis. Cannon's term for the relative stability of the body's internal environment.

Kinetic isotope effect. The change in reaction rate when an atom is replaced by a heavier isotope; unusually large effects indicate tunnelling (Chapter 3).

Medical anchor. The clinician who remains responsible for a given part of a person's medical care, named in every profile.

N-of-1 trial. A randomised, usually multiple-crossover comparison of treatments within a single patient (Chapter 56).

No-signalling. The principle that operations on one part of an entangled system cannot change the measurement statistics of another part, so no message can be sent by entanglement.

Non-priorities. Issues deliberately excluded from the current phase of a plan and stated aloud to the patient.

Pacing. Managing activity within a person's current energy envelope to avoid boom-and-bust cycles.

Pattern literacy. Noticing timing, triggers, relievers, loads and limits without assigning disease labels.

Placebo and context effects. Changes in how people feel that arise from the meaning, ritual and relationship surrounding a treatment rather than from its specific action (Chapter 6).

Post-exertional malaise. A worsening of symptoms after exertion, often delayed, with slow recovery; a defining feature of ME/CFS (Chapter 40).

Pre-mortem. Asking, before a plan begins, why it might fail.

Preregistration. Recording a study's question, design and analysis plan publicly before data are collected.

Quantum biology. The study of cases in which non-trivial quantum effects do functional work in living systems (Chapter 3).

Quantum Entanglement Assistance (QEA). A relational-support format using entanglement as a metaphor only (CD-9).

Quantum Homeodynamics (QHD). The framework described in this book (CD-1).

Quantum Resonance Emitter (QRE). A device class used in QRT; none has been validated (CD-11).

Quantum Resonance Therapy (QRT). A structured supportive session whose specific effects, if any, are unknown (CD-7).

Quantum signature. A structured written formulation of a person's present pattern; nothing is measured (CD-4).

Radical pair. Two molecules each carrying an unpaired electron, whose correlated spins can make chemical yields sensitive to weak magnetic fields (Chapter 3).

Red flag. A symptom or sign that requires medical or emergency assessment before anything else (Chapter 38).

Referral fidelity. Referring whenever the criteria say to refer, including under social or financial pressure.

Regulatory reserve. The capacity a person has left to adapt without crashing; the reason ambitious plans often fail.

Rival explanation. An alternative account of a pattern, written down to guard against premature certainty.

Scan (QHD). A structured intake, with optional exploratory device readings; not imaging and unable to detect disease (CD-12).

Sham control. A procedure that looks and feels like the intervention but lacks its supposed active component.

Stop rules. Conditions, agreed before care begins, under which a session or plan is paused or ended.

Tautomer. One of two or more forms of a molecule that differ in the position of a proton; rare tautomers of DNA bases can cause mismatches (Chapter 3).

Teach-back. Asking a person to explain in their own words what they have agreed to, as a check on consent (Chapter 48).

Teaching composite. A fictional case built for teaching; never evidence and never a real patient.

Tier laundering. Presenting a claim from a weaker evidence tier as though it belonged to a stronger one (Chapter 55).

Triage hierarchy. The order of priority from emergency care, through medical evaluation and disease-directed care, to adjunctive QHD support and self-care (Chapter 7).

Tunnelling. The passage of a particle through an energy barrier it could not cross classically; well established for electrons and hydrogen in enzymes.

Ultra-weak photon emission (UPE). Faint light emitted by living cells as a by-product of oxidative chemistry; sometimes called biophotons (Chapter 4).

Verification (device). The stage of device evaluation that asks whether a sensor measures what its engineering says it does (Chapter 33).

Verify (QHD). Follow-up judged against measures and time windows agreed in advance (CD-13).

Working model. An explanatory frame held provisionally, used to organise questions, and revised or dropped as evidence requires.

References

Every work listed here was checked against its published record. Journal articles were checked against their Crossref records and, where indexed, against PubMed; books, reports and guidelines were checked against publisher, library or official catalogue records. DOIs are taken from Crossref. Titles are reproduced as published. Up to six authors are listed, followed by “et al.” where there are more. The verification notes that accompany this manuscript record how each entry was checked.

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