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HOMOEO SPIRIT

QUARTERLY BULLETIN

VOL : 3 (SEPTEMBER) YEAR 2025

THE OBJECTIVE OF THIS INSTITUTIONAL BULLETIN IS :

- To provide regular updates and propagate information about the accomplishments of all the faculty members and students.
- To share significant information regarding the exceptional services rendered by the corresponding departments.
- To keep everyone in this institution well informed and engaged with the objective to maintain motivation and raise morale.
- This bulletin is for internal circulation and for educative purpose only.

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JAWAHARLAL NEHRU HOMOEOPATHIC MEDICAL COLLEGE
PARUL UNIVERSITY CAMPUS, AT & PO LIMDA, TA: WAGHODIYA,
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02

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EDITORIAL

It gives us immense satisfaction to present this edition of Homoeo Spirit, documenting the activities and achievements of Jawaharlal Nehru Homoeopathic Medical College for the months of June, July, and August 2025.

This quarter witnessed the successful organization of various workshops and symposiums, which contributed significantly to the academic growth and clinical skills of our students. These platforms provided opportunities for meaningful exchange of knowledge and reinforced a culture of continuous learning within the institution.

The college also observed important occasions such as World Environment Day, World Yoga Day and Doctors' Day, celebrated with due zeal and purpose. These events not only emphasized environmental consciousness and professional values but also reflected the holistic development nurtured on campus.

On the academic front, several PG Scholars added to the institution's scholarly reputation by securing publications in esteemed journals, thereby strengthening the culture of research and evidence-based practice. Additionally, the outstanding performance of our final year students, who attained the first, second, and third ranks in their final examinations, stands as a testimony to their dedication and the consistent academic guidance imparted by the faculty.

The hospital unit of our institution continued its active contribution by conducting numerous medical camps and extending quality healthcare services to the community. These initiatives not only provided accessible treatment but also offered valuable clinical exposure to our students, bridging the gap between theory and practice.

The progress achieved during this period emphasizes the combined efforts of students, faculty, and administration, and highlights the unwavering support provided by the Management in fostering a dynamic and progressive academic environment.

With these milestones, the college continues to move forward in its mission of excellence in homoeopathic education and healthcare.

"Be Here, Be Vibrant"

Clinical Tips for Evaluating a Patient with Neurological Deficit, and Correlating with Underlying Miasm

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Introduction

Neurological deficits—manifesting as weakness, sensory loss, paralysis, coordination problems, altered mental functions, cranial nerve palsies, etc.—demand a careful, structured clinical evaluation in any medical system. In homeopathy, beyond the conventional neurology workup, one also seeks to understand the deeper dynamic disturbance (miasm) driving the chronicity. This article outlines practical steps to evaluate a neurologic patient, and then considerations on how to correlate findings with miasmatic theory (per Hahnemann's laws and later developments). The aim is to bridge the empirical–anatomical side with the dynamic–energetic side of homeopathic practice.

Clinical Tips for Evaluating a Patient with Neurological Deficit, and Correlating with Underlying Miasm

Part I: **Clinical Evaluation of a Neurological Deficit — Key Steps**
A rigorous neurologic evaluation helps you localize the lesion, characterize pathogenesis, assess prognosis, and also gather data that later may integrate into the homeopathic totality. Below is a suggested structured approach.

1. **History Taking (Detailed Anamnesis)**

1. Onset & Temporal pattern

o Was onset acute, subacute, or chronic (progressive/insidious)?

o Temporal evolution: sudden, stepwise, remitting, relapsing, progressive.

2. **Mode of onset / precipitating event**

o Trauma, infection, vascular event, toxin, metabolic derangement.

o Any preceding "prodromal" symptoms (e.g. paresthesias, aura, viral prodrome).

3. **Progression & fluctuations**

o Stable, worsening, fluctuating; any diurnal or positional variation.

4. **Symptom quality & modalities**

o Motor: weakness, spasticity, flaccidity, fasciculation, cramps.

o Sensory: numbness, tingling, pain, hyperesthesia, anesthesia.

o Autonomic: bladder, bowel, sweating, orthostasis.

o Cerebellar signs: ataxia, tremor, dysmetria.

o Cranial nerves: diplopia, facial weakness, dysphagia, hearing, etc.

o Higher functions: speech, memory, cognition, mood.

5. **Associated systemic symptoms**

o Constitutional (fever, weight loss), headaches, seizures.

o Infections, endocrinopathies, toxins, metabolic issues.

6. **Past history and predisposition**

o Vascular risk factors, autoimmune disease, family history, toxins.

o Previous episodes or neurological complaints.

o Emotional/mental history, constitutional tendencies.

7. **Aggravation / amelioration modalities**

o What worsens symptoms (motion, cold, heat, sleep, stress)?

o What relieves (rest, position, sleep, certain remedies)?

(In homeopathy, such modalities are gold in repertorization.)

Clinical Tips for Evaluating a Patient with Neurological Deficit, and Correlating with Underlying Miasm

8.**Concomitant complaints**

o Other chronic complaints (skin, digestion, sleep, mental) may point to overall miasmatic terrain.

2. **Physical & Neurological Examination**

1. General observation

o Gait, posture, muscle bulk, fasciculations, involuntary movements.

2. Mental status / cognitive

o Orientation, attention, memory, language, executive function.

3. Cranial nerve assessment

o Optic (visual fields, acuity), ocular movements, facial nerve, hearing, swallowing etc.

4. Motor system

o Tone, power (graded 0–5), reflexes, pathological reflexes (Babinski, Hoffman).

o Look for upper vs lower motor neuron signs.

5. Sensory system

o Light touch, pinprick, vibration, proprioception, two-point discrimination.

o Map the sensory level.

6. Coordination / cerebellar

o Finger-to-nose, heel-to-shin, rapid alternating movements, dysdiadochokinesia.

7. Gait & balance

o Toe/heel walking, tandem gait, Romberg's sign.

8. Autonomic signs

o Blood pressure changes, pupillary reflexes, sweating, bladder residual.

9. Other systems

o Skin changes (ulcers, tinea), vascular signs, reflex zones elsewhere.

3. **Localization & Differential Diagnosis**

• From the pattern of deficits (motor/sensory, level, UMN/LMN, cranial nerve involvement), localize the lesion (cortex, internal capsule, brainstem, spinal cord, peripheral nerve, neuromuscular junction, muscle).

Clinical Tips for Evaluating a Patient with Neurological Deficit, and Correlating with Underlying Miasm

Construct a differential diagnosis (vascular, demyelinating, infectious, degenerative, neoplastic, metabolic, traumatic).
• Order relevant investigations (MRI, nerve conduction studies, CSF, labs: B12, thyroid, autoimmune markers, etc.)
4. **Severity, Prognostic Factors, and Monitoring Metrics**
• Quantify severity (e.g. MRC grading, scales such as NIHSS for stroke, disability scales).
• Identify red flags or urgent features (progressive weakness, respiratory compromise).
• Plan baseline and followup measurements (strength map, sensory mapping, functional scales).
• Document "before" status accurately — this helps in gauging treatment response over time.
5. **Integration with the Homeopathic Totality Framework** (bridging to miasm)
• While conventional neurology focuses on tissue/structural lesion and pathophysiology, the homeopath also must gather dynamic and constitutional data during the same evaluation:
o Modalities, concomitants, mental–emotional traits, chronology of complaints, and chief complaint's evolution.
o Assess periodicity, symptom shifts, layers of disease history (e.g. earlier less serious complaints).
o Prior remedy responses, aggravations, reaction capacity, and how symptoms shift under stress.

Part II: **Correlating Neurological Deficit with Underlying Miasm** — Theoretical Perspectives & Practical Tips
In homeopathic philosophy, chronic disease is often viewed as governed by miasms (psora, sycosis, syphilis, etc.), which act as predispositional, dynamic disturbances. The neurological manifestation is a local, structural outcome of the deeper dynamic. To prescribe correctly, one must attempt to perceive which miasmatic layer is dominant (or suppressed or in conflict). Below are guidelines, cautions, and illustrative pointers.

Clinical Tips for Evaluating a Patient with Neurological Deficit, and Correlating with Underlying Miasm

1. **Theoretical Basis: Miasms & the Dynamic View of Disease**

• According to Hahnemann's Chronic Diseases, chronic ailments are often expressions of three main miasms: psora, sycosis, syphilis. §204–205. homeopathyplus.com

• In the Organon and later homeopathic thought, structural disease is considered secondary to dynamic derangement of the vital force; structural lesions are manifestations of the deeper dynamic disturbance. homeoint.org+1

• The removal of dynamic disturbance is considered true cure; symptomatic relief or tissue change reversal is secondary. **homeoint.org**

• Later homeopaths and authors have developed extended miasmatic schemes (e.g. Rajan Sankaran's 10 miasms, added classes such as tubercular, cancer, leprosy, etc.). homeopathyschool.com

• The Law of Succession of Forces is a special concept in miasmatic nosode work: Hahnemann observed that prescribing Psorinum leads to next miasms emerging in sequence (Psora → Tubercular → Sycosis → Cancer → Syphilis). homeopathiceducation.com

Thus, when dealing with a neurological case, one must not prescribe simply on the basis of the focal lesion, but weigh the entire constitutional and miasmatic picture.

2. **Practical Tips to Discern Miasmatic Influence in Neurological Cases**

Below is a set of pointers and heuristics (not rigid rules) that experienced homeopaths may use. Use them as aids, not as dogma. Always prioritize the totality, remedy-proving concordance, and individualization.

Clinical Tips for Evaluating a Patient with Neurological Deficit, and Correlating with Underlying Miasm

Clue / Observation	Suggests More Psoric Influence	Suggests More Sycotic Influence	Suggests More Syphilitic (or destructive) Influence
Imaging findings	Minimal structural damage, early lesions, reversible anomalies	Moderate hypertrophy, induration, proliferation, compensatory changes	Marked destruction, necrosis, atrophy, cavitation
Temporal pattern	Long latent period, insidious onset, slow deepening	Periods of remission and exacerbation, proliferations, cystic changes	Progressive deterioration, destructive changes
Lesion character	Functional/irritable affections, demyelination	Tumors, benign growths, hyperplasia, compressive lesions	Ulceration, hemorrhage, necrosis, ischemic infarcts
Aggravation modes	Cold, emotional stress, suppression of skin complaints	Overwork, excess, overuse, suppression, dampness	Suppression, ulceration, traumatic shock, destructive states
Patient constitutional themes	Weakness, hypersensitivity, chronic complaints of skin/allergies, sensitivity to cold	Proliferative tendencies (warts, growths), heart enlargement, nodular changes, swelling	Degeneration, rapid decline, ulceration, hemorrhages
Modality features	Shifting, migrating pains; amelioration by rest, warmth	Symptoms worsen from motion, overexertion; amelioration from constant gentle motion	Better from cold, night aggravations, intense pain with destructive effect
History of suppressed complaints	Frequent history of suppressed skin eruptions, eczema, urticaria	Frequent warts, condylomata, glandular swellings, benign tumors	History of malignant disease, tubercular tendency, fractures, hemorrhages

Some illustrative examples:

- A patient with compressive spinal tumor and gradually evolving paraplegia might exhibit strong sycotic miasm dominance (proliferation, hypertrophy).
- A case of ischemic stroke with areas of infarction, progressive damage, cavitation may hint at syphilitic or destructive tendency (especially if imaging shows necrosis).
- A demyelinating neurological disease (e.g. multiple sclerosis) might show a strong psoric–tubercular overlay, given the remitting–relapsing nature and hypersensitivity features.

3. Approach to Prescribing & Miasmatic Strategy in Neurology

1. **First aim: find the correct *simillimum***
   a. While miasmatic insight is useful, it should not override the main law of similars and totality.
   b. Your constitutional remedy should ideally encompass the neurological symptoms (mental, modalities, etc.) as well as the miasmatic shade.
2. **Consider intercurrent / miasmatic nosodes**
   a. In deeper or resistant cases, after you have stabilized with the constitutional remedy, you may consider intercurrent nosodes (e.g. Tuberculinum, Medorrhinum, Syphilinum) in a sequence following the Law of Succession. homeopathiceducation.com
   b. But use nosodes judiciously, respecting the patient's vital resistance and avoiding "destabilization." HomeopathyBooks.in
3. **Observe Arising & Disappearing Symptoms (Hering's Law of Cure)**
   a. During the course of remedy action, watch for symptom shifts: deeper symptoms re-emerging, older suppressed complaints returning, movement of symptoms from vital organs outward, from head downward, etc. Encyclopedia+1
   b. In neurological cases, improvement may be slower; be patient, observe subtle changes (e.g. slight increase in strength, return of reflex,

improved sensation) before expecting gross structural reversal.

4. Be cautious of aggravations & crisis reactions

- Neurological cases often carry risk if over-antagonistic remedies or too aggressive potency changes are given — sudden aggravation can worsen deficits.
- Monitor frequently, always have fallback (lower potency, pause, antidote) options.

5.**Follow-up & Reassessment**

- At defined intervals, re-examine power, reflexes, sensation, gait, functional status, and correlate with subjective improvements (pain, paresthesia, fatigue).
- Re-evaluate the dynamic totality: if new symptoms arise, a shift in miasmatic dominance may have occurred, requiring re-adjustment of remedy.

6.**Complementary support & integrative care**

- In neurological deficits often structural support (physiotherapy, rehabilitation, nutrition, neurotrophic support) is needed alongside homeopathic therapy.
- The homeopathic remedy may help modulate the underlying vital force, but one should not ignore conventional care when needed.

4. Limitations, Cautions, and Pitfalls

- A purely structural lesion (e.g. large infarct, spinal cord transection) can impose limitations: homeopathy may improve residual function or symptoms but may not reverse gross necrosis.
- Overemphasis on “which miasm” can distract from matching the remedy to the patient’s total symptom picture.
- Misidentification of miasm can lead to erroneous nosode use, destabilization, or suppression rather than cure.
- Homeopathic outcomes in neurology should be monitored with objective measures, and referral to conventional neurologic care is essential in serious cases.

Clinical Tips for Evaluating a Patient with Neurological Deficit, and Correlating with Underlying Miasm

Case Illustration — Applying the Method

1. **Case Summary**
   - A 45-year-old male presents with progressive right lower limb weakness over 6 months, with foot drop, paraesthesia below knee, mild bladder urgency. No pain.
   - Past history: eczema in childhood; recurring warts on hands; tendency to catch colds.
2. **Neurological Evaluation**
   - Motor: 3/5 dorsiflexion, 4/5 plantar flexion; hyperreflexia on right knee reflex.
   - Sensory: decreased pinprick and vibration from right L4–L5 dermatome.
   - Imaging: MRI shows thickening of nerve root with hypertrophic change but no gross necrosis.
3. **Dynamic / Homeopathic Data**
   - Modalities: symptoms worsen walking, better at rest; aggravated by cold and damp.
   - Mental/emotional: anxious about responsibility, self-sacrificing, suppressed anger.
   - Constitutional: history of warts and skin eruptions suppressed by ointments.
4. **Miasmatic Hypothesis**
   - The hypertrophic nerve root suggests a sycotic tendency (proliferation).
   - The suppressed skin eruptions and wart history also point to sycotic layer.
   - However, the insidious progression and sensitivity indicate underlying psoric structuring.
   - So the dominant miasm may be psoro-sycotic, with sycotic shade stronger.

Clinical Tips for Evaluating a Patient with Neurological Deficit, and Correlating with Underlying Miasm

5. **Remedy Strategy**
    - Choose a constitutional remedy that matches neurology symptoms and totality.
    - After stabilization, consider a sycotic nosode or intercurrent (e.g. Medorrhinum) if indicated, following succession laws.
    - Monitor strength increase, return of reflexes, sensory improvement, and any reappearance of older suppressed symptoms (e.g. eczema) as sign of cure.
6. **Outcomes & Adjustments**
    - Over 6 months, mild improvement in dorsiflexion to 4/5, improved sensation, reduced bladder urgency.
    - Meanwhile, a mild flare of childhood eczema returns (interpreted as dynamic clearing).
    - Based on evolving totality, remedy may be revised or potency escalated, or intercurrent nosode considered.

Conclusion

Evaluating a patient with neurological deficit demands both rigorous clinical–anatomical skill and a nuanced understanding of the homeopathic dynamic framework. While your neurologic assessment helps you localize the lesion, grade severity, and monitor progress, the homeopathic lens invites you to perceive the deeper miasmatic terrain. By gathering multimodal data (modalities, constitutional features, history of suppressed disease, mental and emotional patterns), and applying miasmatic reasoning (with caution and humility), you can better individualize remedy selection and plan miasmatic strategy (constitutional, intercurrent, succession). Always remain tempered by clinical realism: structural damage has limits of reversibility, and integrative support (rehabilitation, nutrition, adjunctive care) is often indispensable.

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Homoeopathic Materia Medica and Repertory — Bridging the Gap for Effective Prescription

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Introduction

In classical homoeopathy, Materia Medica and Repertory are twin pillars that support the art and science of prescribing. The Materia Medica (MM) provides the detailed portrait of each remedy's symptomatology, while the Repertory (R) functions as a reverse-index or "search tool," mapping clinical symptoms to remedies (or remedy parts) that have produced them in provings or clinical use. As John Henry Clarke put it, the Repertory is "an index … in which all remedies having caused any particular symptom may be found." Homeopathy Online

However, these two tools are not always in perfect harmony in practice. Discrepancies, omissions, ambiguities, or conceptual mismatches often hamper the transition from casetaking to the final prescription. The "gap" between Materia Medica and Repertory—if unrecognized—can lead to suboptimal remedy selection, weak justification to the patient, or poor outcomes.

Bridging this gap is thus essential. This article explores why this integration matters, what challenges hinder it, and how evolving curricular innovations (in particular the CBDC framework) can help remedy the disjunction.

Why Bridging Matters: Theoretical and Practical Perspectives

1. From symptom to remedy: closing the deductive loop

A patient presents with a constellation of symptoms. The prescriber must build a **totality** and then ask: which remedy matches best? In practice:

• The repertory helps shortlist remedies by symptom rubrics (e.g. "anxiety with palpitation > worse lying down")

• Then the Materia Medica is consulted to check how fully each remedy covers the entire picture, including modalities, concomitants, concomitant gradations, mental and general symptoms, and "essence."

If the repertory leads to remedies that lack depth in Materia Medica (or have contradictory aspects), the prescriber may end up compromising. A more synchronized repertory–Materia Medica mapping leads to more confident and precise prescribing.

2. Resolving ambiguities and lacunae

• **Missing or weak rubrics**: Some rare or peculiar symptoms may not be present in the repertory. Unless the materia medica notes are deeply internalized, the prescriber may ignore them or force-fit them into a generic rubric.

• **Conflicting rubrics**: A remedy may appear in multiple rubrics in different grades; without crosschecking the detailed Materia Medica context, the remedy may be over- or under-ranked.

• Modalities and context: A rubric might indicate "> cold air," but the Materia Medica may specify that this only applies under certain internal conditions (e.g. in the evening, when fatigued). The interplay of context is not always captured in a repertory heading.
Thus, the gap can lead to mechanical, superficial prescription rather than analytical and holistic prescribing.

3. **Educational gaps:** rote learning versus integrative thinking
In many educational settings, students learn Materia Medica (remedy profiles) and Repertory (rubrics) as separate silos. They are drilled in memorization or rubric lookups without enough guided practice in integrating both into dynamic case solving. Consequently:
• The student may become "repertorizationdriven" (focusing heavily on the rubrics) or "bookdriven" (looking up in materia medica), but not truly integrating both in the clinical moment.
• Inexperience in seeing how the repertory can mislead (e.g. via rubric weighting, omissions) may reduce critical evaluation.
Bridging the gap in training helps inculcate the habit of cross-checking, evaluating deviations, and resolving mismatches—skills essential for nuance in prescribing.

4. **Increasing complexity and modern demands**
As homoeopathy evolves, new provings, rare remedies, complex multi-morbid cases, and comorbid conventional diagnoses appear more frequently. Prescribers need flexibility:
• A rigid repertory may not yet include a newly proved symptom; the practitioner must infer from materia medica or crossremedy comparisons.
• In complex cases, ranking by a pure repertory score may mislead; deeper knowledge of remedy profiles is needed.
Hence, bridging ensures that the prescriber is not overly dependent on mechanical repertory scores but uses them as guiding tools backed by deep remedy understanding.

Homoeopathic Materia Medica and Repertory — Bridging the Gap for Effective Prescription

Challenges in Bridging the Gap

Several obstacles exist in fully integrating Materia Medica and Repertory in education and practice:

1. **Historical divergence**

Repertories have grown over many authors and editions; rubrics and gradations differ (e.g. Kent, Boger, Boenninghausen). Meanwhile, newer Materia Medica works and clinical observations may not align directly with older repertory structures.

2. **Volume and complexity**

The sheer size of materia medica and repertories can overwhelm learners. Students may resort to superficial shortcuts rather than deep crosschecking.

3. **Inconsistent rubric quality or referencing**

Some repertory rubrics are inadequately referenced or lack crossreferences. Mismatches in rubric naming (e.g. phrasing differences) may lead to overlooked entries.

4. **Lack of guided pedagogy or mentorship**

Without guided demonstration and critical case discussions, students may not internalize the integrative method. Teachers less acquainted with bridging techniques may reinforce compartmentalization.

5. **Limited curricular emphasis**

In many curricula, the study of materia medica and repertory may be scheduled separately, without overlapping or integrative assessments or exercises.

Strategies for Effective Bridging

To surmount these challenges, the following strategies can help:

• **Case-based teaching with integrative drills**: Present real or simulated cases; students must repertorize, then cross-check remedy profiles, discuss mismatches, and justify final selection.

Rubrictoremedy mapping exercises: Frequent drills where a rubric is given and students must list and annotate remedies from MM context.

• **Shadowing and mentorship:** Experienced homeopaths verbalizing their thought process in matching repertory entries with MM insights.
• **Dynamic repertory updates:** Encouraging additions of new rubrics or crossreferences based on new provings or clinical observations.
• S**oftware tools with links**: Using repertory–materia medica software that links rubric entries to remedy profiles and case references can ease exploration and feedback.
• **Integrated assessments**: Exams or quizzes that require students to traverse from rubric to remedy to justification, not just rubric scoring.
Over time, such strategies cultivate intuition and confidence in bridging the two domains, improving prescribing accuracy and patient outcomes.

The Role of CBDCBased PG Curriculum in Strengthening Bridging

In India, the National Commission for Homoeopathy (NCH), through its Homoeopathy Education Board, is implementing a Competency Based Dynamic Curriculum (CBDC)across undergraduate and postgraduate levels. National Commission for Homoeopathy+2National Commission for Homoeopathy

This curriculum shift is explicitly intended to move away from rote, content-heavy teaching toward skill, attitude, and competency development, making education more experiential, integrated, and outcome-focused. Homoeopathic Journal

Why CBDC is relevant to bridging the MM–Repertory gap

• Competency orientation: Under CBDC, students are expected not only to know materia medica and repertory content, but to apply and synthesize them in real clinical scenarios. This naturally incentivizes bridging.

• Dynamic curriculum: The term "dynamic" implies that the curriculum can evolve as new knowledge emerges (new provings, updated repertories), addressing one key limitation of static syllabi.
• Entrustable Professional Activities (EPAs): At PG level, EPAs (core tasks that a homoeopath must reliably perform) may include "selecting remedy using integrated repertory-materia medica reasoning." ACS Publisher
• Integrated assessment design: CBDC often mandates assessments that are casebased and competencyoriented, which can test bridging ability rather than isolated recall.
• Faculty development and training: As part of CBDC rollout, NCH is organizing training programs for faculty to adopt new pedagogical methods (integrative teaching, case-based learning) in homoeopathy colleges.
• Regulation and oversight: The NCH mandates that the curriculum at PG and undergraduate levels be aligned with CBDC philosophy, thus pushing institutions to reorient their course designs and teaching methods. National Commission for Homoeopathy+2National Commission for Homoeopathy

Conclusion

Bridging the gap between Homoeopathic Materia Medica and Repertory is critical for prescribing precision, practitioner confidence, and patient benefit. Mere mastery of two separate tools is insufficient; what matters is the capacity to navigate, synthesize and resolvediscrepancies between the repertory indices and deep remedy profiles.

The shift toward a Competency Based Dynamic Curriculum (CBDC) under the National Commission for Homoeopathy offers a timely and structural opportunity to embed bridging as a core competency in PG (and UG) training. With proper design, assessment, and faculty development, CBDC can help produce homeopaths who are not merely users of repertories or reciters of Materia medica, but thoughtful integrators, capable of nuanced, individualized prescribing.

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GALLERY

Date: 7 JUNE, 2025
Jawaharlal Nehru Homoeopathic college students celebrate World Environment Day at Bapod Garden, Vadodara

GALLERY

On the Occasion of World Environment Day, Students of Jawaharlal Nehru Homoeopathic Medical College showcased their artistic flair and environmental awareness through a collage-making competition.

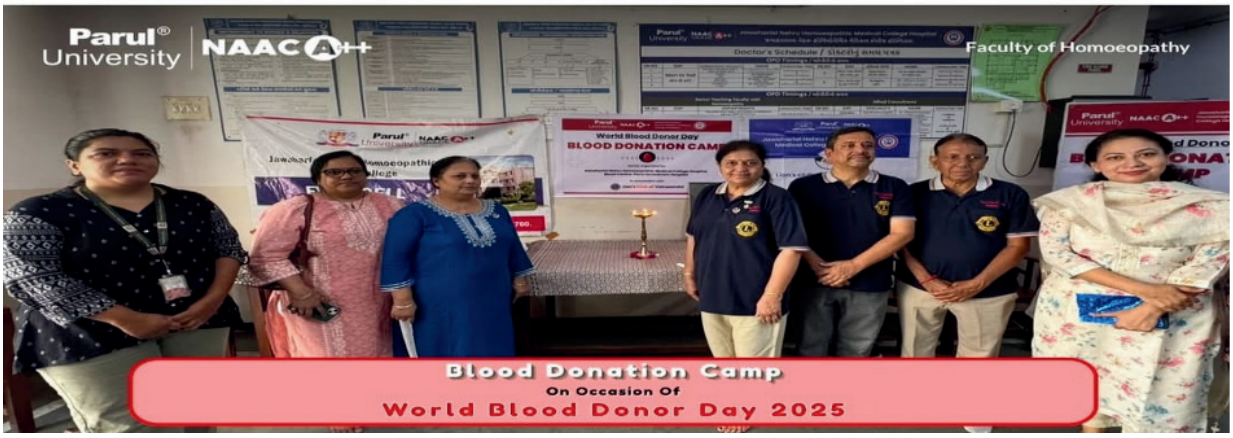
GALLERY

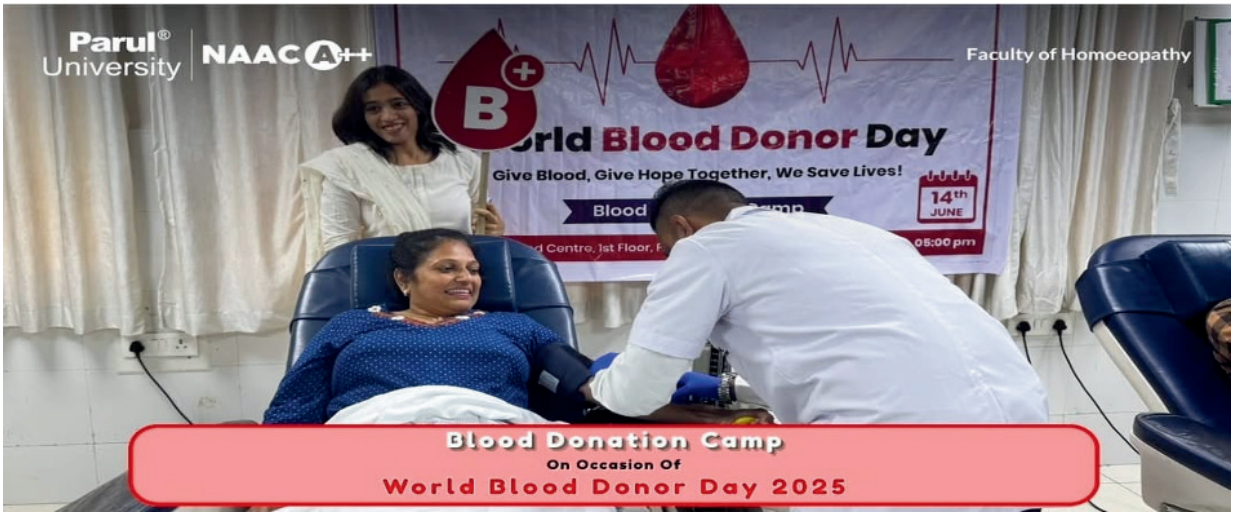
Date: 10 June,2025
Article published in Journal of Emerging Technologies and Innovative Research (JETIR)
Topic: A Comprehensive review of hypersomnia and it's homoeopathic management through murphy's repertory

GALLERY

Date: 15 June

On World Blood Donor Day, the campus of Jawaharlal Nehru Homoeopathic Medical College and Hospital came with purpose and empathy during the Blood Donation camp.

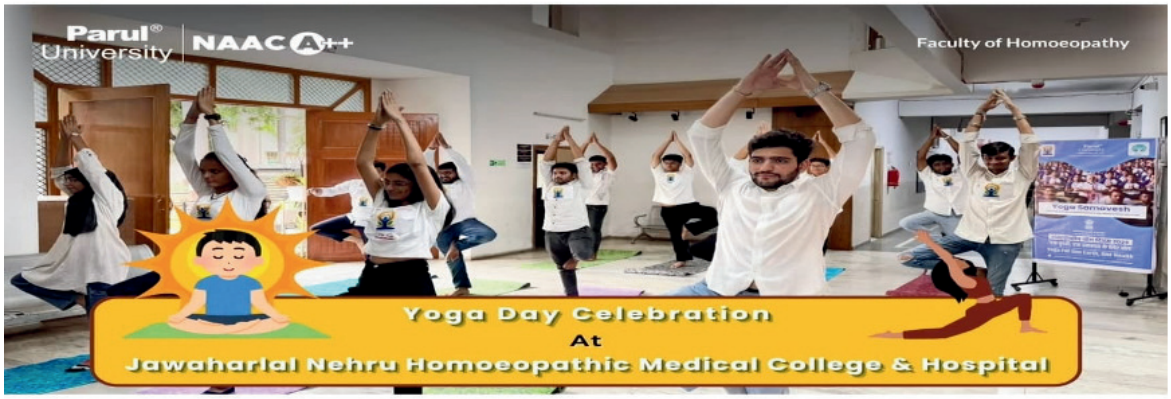




GALLERY

Date: 21 June,2025

On the Occasion of International Yoga Day, Yoga Sangam Event organized by Jawaharlal Nehru Homoeopathic Medical College in collaboration with Morarji Desai National Institute of Yoga, Ministry of AYUSH.



GALLERY

Date: 21 June,2025.
Jawaharlal Nehru Homoeopathic Medical College ,in collaboration with Morarji Desai National institute of Yoga, Ministry of AYUSH organized a Beach cleaning Drive and Yoga Session at a Government School in Daman.

GALLERY

Date: 2 July,2025.
A glimpse into the engaging and insightful presentations by 2nd year student of JNHMC, showcasing their growing understanding of Homoeopathic remedies with confidence through Materia Medica Symposium.

GALLERY

Date: 3 July,2025.
Our talented PG scholars from Jawaharlal Nehru Homoeopathic Medical College have made us proud by securing 1st place in poster presentation and 3rd place in Podium Presentation at the State-Level PG Poster Competition organized by Dr.V.H Dave Homoeopathic Medical College.

GALLERY

Date: 7 July,2025.
On the Occasion of International Doctors Day celebration organized by Jawaharlal Nehru Homoeopathic Medical College, in association with Lions Club Viswamitri,to, to, to facilitate the dedicated doctors who continue to serve with compassion and commitment.

GALLERY

Date: 9 July,2025

On the Occasion of Doctors Day 2025, Jawaharlal Nehru Homoeopathic Medical College organized an enriching workshop by Dr. Ravi Singh, filled with clinical insights and practical Wisdom.

GALLERY

Date: 14 July,2025.
A Heartfelt Celebration of Guru Purnima at Jawaharlal Nehru homoeopathic medical college honouring the guiding lights who shape minds and inspire lives.

GALLERY

Date: 19 July,2025.
An Engaging and Insightful Research Workshop Session by Dr. Prashant Tamboli, guiding students through the art of effectively communicating research and using various research designs in Homoeopathy.

GALLERY

Date: 10 August, 2025.
Pharmacy Symposium conducted with great enthusiasm by the 1st BHMS students of Jawaharlal Nehru Homoeopathic Medical College, under the guidance of the Department of Pharmacy.

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GALLERY

Date: 27 August,2025.
In fond remembrance of our visionary founder Dr. Jayesh K. Patel, Jawaharlal Homoeopathic Medical College held a Reverence Ceremony to honour his life, values, and everlasting legacy.

GALLERY

Date: 29 August,2025.
Academic excellence unlocked! Congratulations to the brilliant minds of Jawaharlal Nehru Homoeopathic Medical College who secured a rank amongst the University Top 03 students in 4th BHMS End Year Examination.

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GALLERY

Date: August 25, 2025

Poorav Desai, the Dean of the Faculty of Homoeopathy, has been invited as a speaker for a seminar commemorating 25 glorious years of excellence during the Silver Jubilee Celebration. This event is organized by C. N. Kothari Homoeopathic Medical College and R. C. Vyara in collaboration with the HMAI - Vyara Unit.

MEDICAL CAMP

Month	No. of camps	Total Beneficiaries
Jun 2025	3	240
Jul 2025	10	726
Aug 2025	8	780

MEDICAL CAMP

MEDICAL CAMP

HOSPITAL DATA

JNHMC OPD					
Month	**Medicine OPD**	**Paediatrics OPD**	**Ob/G OPD**	**Surgery OPD**	**Peripheral OPD**
Jun 2025	2783	927	1056	1107	1862
Jul 2025	2992	941	1194	1247	2319
Aug 2025	2535	769	984	1065	2176

JNHMCH IPD				
Month	**Medicine IPD**	**Paediatric IPD**	**Ob/G IPD**	**Surgery IPD**
Jun 2025	1033	104	220	273
Jul 2025	1015	126	245	297
Aug 2025	953	107	229	218

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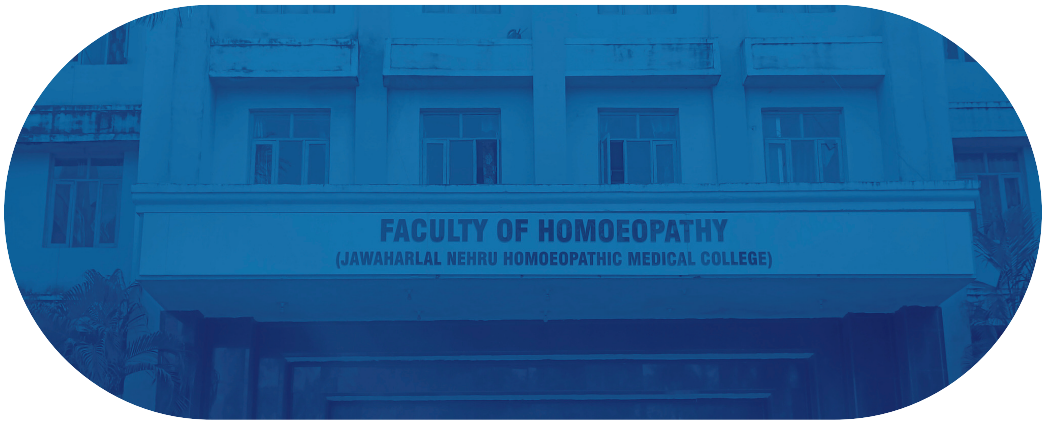

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