

DNA — MODEL UNITED NATIONS SPECIAL COMMITTEE

THE GREAT HOMOEOPATHY ASSEMBLY

OFFICIAL BACKGROUND GUIDE & DELEGATE HANDBOOK

Agenda: Standardized Approach to Case Taking in Homoeopathy

1. Introduction to the Committee & Topic

The Great Homoeopathy Assembly is a flagship academic and diplomatic simulation conceived under the DNA Initiative. Unlike conventional Model United Nations committees that represent sovereign nation-states, this assembly convenes delegates representing the foremost stalwarts, pioneers, and philosophical schools of Homoeopathy. Each delegate or diplomatic team is assigned a specific homoeopathic master and is mandated to debate, defend, and negotiate based strictly upon the published works, clinical methodologies, and philosophical tenets of their assigned pioneer.

1.1 Committee Mandate & Strategic Purpose

The central mandate of the Assembly is to address the historical and contemporary fragmentation in homoeopathic clinical methodology—the topic this time being **Approach to Case Taking**. Across two centuries of practice, divergent paradigms have emerged: from Von Boenninghausen’s complete symptom framework (Location, Sensation, Modality, Concomitant) to Kent’s rigid hierarchy of mental generals; from Hughes’s pathological and physiological drug-matching to Vijaykar’s embryological genetic constitutional method; and from Vithoulkas’s defense mechanism levels to Sankaran’s vital sensation methodology.

The primary objective of this committee is to negotiate and adopt a landmark **Working Resolution** that synthesizes an authoritative, standardized, and universally applicable Case Taking Proforma. This resolution must harmonize classic Hahnemannian organon directives with modern clinical realities without compromising the foundational principles of homoeopathic individualization.

1.2 Expectations & Evaluation Criteria for Delegates

Delegates will be evaluated rigorously by the Executive Board based on the following criteria:

- **Philosophical Fidelity:** Delegates must strictly adhere to the philosophical stance, posology, repertorial preferences, and case-taking methodologies of their assigned pioneer, irrespective of their personal clinical biases.
- **Command of Source Material:** Every assertion, counter-argument, and motion made during formal committee proceedings must be grounded in verified, authentic homoeopathic literature (e.g., Organon of Medicine, Chronic Diseases, Lesser Writings, specialized treatises).

- **Diplomatic Articulation & Persuasion:** Delegates must exhibit high oratorical caliber, formal parliamentary etiquette, structured speech delivery, and constructive negotiation skills.
- **Rigorous Counter-Debate:** Delegates must critically challenge opposing methodological paradigms (e.g., challenging pure mental prescribing from a pathological standpoint, or challenging low-potency repetition from a high-potency single-dose standpoint) using textual evidence.
- **Resolution Drafting Leadership:** Active participation in unmoderated caucuses to draft comprehensive, legally sound operative clauses that form an actionable standardized case-taking framework.

2. Model UN Procedures & Rules of Procedure (ROP)

To ensure structured, equitable, and rigorous parliamentary debate, The Great Homoeopathy Assembly operates under the formal Model United Nations Rules of Procedure, adapted specifically for philosophical and medical diplomacy.

2.1 Structure of Debate

Committee proceedings flow through three distinct modes of debate:

1. **General Speakers List (GSL):** The default state of committee debate. The GSL remains open throughout the entire conference. Delegates deliver broad policy statements setting forth their stalwart's core philosophy on case taking, overarching critiques of opposing paradigms, and vision for standardization. Speaking time is typically set at 60 to 90 seconds.
2. **Moderated Caucus:** A temporary suspension of the GSL to focus specifically on a narrow sub-topic (e.g., 'Eliciting Mental Generals vs. Physical Modalities'). Proposed by a motion raised by a delegate, specifying total duration, individual speaking time, and topic. Debate is rapid, interactive, and targeted.
3. **Unmoderated Caucus:** A temporary suspension of formal debate allowing delegates to move freely around the chamber, form bloc alliances, collaborate with opposing stalwarts, and draft Working Papers and Draft Resolutions.

2.2 Key Points & Parliamentary Motions

Motion / Point	Type / Requirement	Purpose & Application
Point of Personal Privilege	Interrupts speaker (if audio/room issue)	Raised when a delegate experiences physical discomfort or cannot hear the speaker.
Point of Order	Cannot interrupt speaker	Raised when there is an error in parliamentary procedure by the Executive Board or a delegate.
Point of Parliamentary Inquiry	Cannot interrupt speaker	Raised to ask the Executive Board a question regarding committee rules or procedure.
Motion for a Moderated Caucus	Simple Majority vote	Suspends GSL for focused debate on a specific sub-topic

		(specify total time, speaking time, topic).
Motion for an Unmoderated Caucus	Simple Majority vote	Suspends formal debate for informal negotiations, bloc forming, and resolution drafting.
Motion to Introduce Working Paper / Resolution	Executive Board approval	Formally presents a drafted document to the committee for floor discussion.
Motion to Closure of Debate	2/3 Majority vote	Ends all debate on the agenda item and moves directly into voting procedure on resolutions.

3. Speech Formats & Delegate Templates

To assist delegates in delivering structured, impactful speeches, the following standardized templates are provided for both the General Speakers List (GSL) and Moderated Caucuses.

3.1 General Speakers List (GSL) Speech Template

The GSL speech should establish the delegate's core identity, state their pioneer's foundational stance on case taking, critique opposing over-simplifications or deviations, and offer a constructive vision for standardized case taking.

3.2 Moderated Caucus Speech Template

A Moderated Caucus speech is concise, highly specific, and directly addresses the motioned sub-topic.

4. Potential Topics for Moderated Caucus

Delegates are encouraged to motion for the following structured sub-topics during committee sessions. Each topic represents a critical fault line in homoeopathic case-taking philosophy:

1. Eliciting the Totality: Mental Generals vs. Physical Modalities

Debate on whether symptom hierarchy must be strictly led by mental/emotional states (Kent, Vijaykar, Sehgal) or by complete physical symptoms and modalities (Boenninghausen, Boger). Delegates must debate how a standardized proforma should weigh conflicting mental and physical indications.

2. Role of Diagnostic Pathology & Objective Investigations in Case Taking

Examining the boundary between diagnostic pathology and homoeopathic prescribing. Stalwarts like Richard Hughes and Stuart Close advocate integrating pathological end-products, whereas Kent and Roberts view gross pathology as mere 'ultimates' that cannot dictate the similimum.

3. Handling Bystanders, Relatives, and Pediatric Anamnesis (§84-89)

Addressing the reliability, pitfalls, and rules for recording information provided by third-party bystanders in pediatric, psychiatric, and comatose cases, as outlined in Dhawale's Standardized Case Record and Organon directives.

4. Acute vs. Chronic Case Taking Methodologies & Miasmatic Investigation

Evaluating the distinct operational rules for acute cases (§99-102: rapid evolution, strike symptoms, genus epidemics) versus chronic miasmatic cases (§103-104: longitudinal history, suppressed miasms, psoric investigation).

5. Modern Innovations vs. Classic Organon Directives (Sensation, Predictive, & Mind Methods)

Debating contemporary developments such as Vijaykar's Genetic Constitutional Method, Sankaran's 7 Levels of Sensation, Sehgal's Present Predominating Mental State, and Vithoulkas's Levels of Health against classical Hahnemannian Aphorisms 83–104.

6. Posology, Potency Selection, and Repetition Rules Derived from Case Structure

Analyzing how the structure of a taken case dictates posology—contrasting single high-potency prescribing (Kent, Vithoulkas) with low/medium potencies (Boenninghausen, Hughes) and 50-millesimal (LM) scales.

7. Standardization of Digital Case Records and Expert Systems in Homoeopathy

Debating the integration of software algorithms, card repertories (Boger, Dhawale), and AI expert systems into clinical case recording without losing the artistic essence of individualization.

5. About Case Taking

Case taking in Homoeopathy is defined as the art of obtaining from the patient the essence of their sufferings or symptoms in their totality through trained observation, structured interviewing, and systematic recording, followed by the selection of the simillimum (§83–104). As expressed by Elizabeth Wright, *"A well-taken case is half cured."* The success of case taking depends upon the mode of interview and the content of the interview.

5.1 Requisites of the Physician & Clinical Environment (§83)

According to Aphorism 83, the physician investigating a case demands:

- **Freedom from prejudice:** Eliminating preconceived theories, personal biases, and premature diagnostic assumptions.
- **Sound senses:** Alert, unimpaired objective observation through sight, hearing, touch, and smell.
- **Attention in observing:** Concentrated, active listening without rushing or interrupting.

- **Fidelity in tracing the picture:** Accurate, uncorrupted recording of the disease image in the exact words of the patient.

The consulting environment requires adequate lighting, proper air circulation, adequate space, strict privacy, and necessary instruments for physical examination to instill confidence and rapport in the patient.

5.2 Operational Rules & Instructions for Case Taking (§84–98)

The Hahnemannian process follows strict operational stages:

- **Aphorism 84 (Patient's Voluntary Narration):** The patient narrates their complaints spontaneously. The physician remains silent, allowing uninhibited speech, and records everything in the patient's exact expressions. Bystanders provide additional observations.
- **Aphorism 85 (Formatting the Record):** Every new symptom or circumstance must begin on a fresh line, leaving ample margin for subsequent completion and qualification.
- **Aphorism 86 (Eliciting More Precise Detail):** After voluntary narration, the physician reads over the recorded symptoms one by one, inquiring into specific location, character of pain, exact time of occurrence, and modalities.
- **Aphorism 87 (Absolute Ban on Leading Questions):** The physician must NEVER ask leading questions (questions framed to elicit a 'yes' or 'no' answer). Leading questions force false answers out of indolence or desire to please, constructing a false disease picture.
- **Aphorism 88–89 (Exploring Neglected Spheres):** General expressions are used to inquire about unmentioned organ systems, physiological functions, or mental dispositions.
- **Aphorism 90 (Physician's Direct Observation):** The physician notes objective signs, facial expressions, demeanor, posture, and physical examination findings.
- **Aphorism 91–93 (Past Drug History & Maintaining Causes):** Distinguishing natural disease symptoms from drug-induced symptoms, and searching out exciting/maintaining causes (*causa occasionalis*).

5.3 Acute vs. Chronic Case Taking & Difficulties

In **acute cases (§99–102)**, symptoms evolve rapidly and strike the senses quickly; fewer questions are needed as the disease picture is self-evident. In epidemic diseases (§100–102), the physician constructs a 'group totality' from multiple affected individuals to ascertain the **Genus Epidemicus** for curative and prophylactic use.

In **chronic cases (§103–104)**, symptoms develop slowly over years, requiring painstaking investigation into the fundamental cause (Psora, Sycosis, Syphilis), past history, family diathesis, and lifestyle obstacles. Difficulties arise from patient modesty, habituation to long suffering, suppression by allopathic drugs, and alternating or un-narrated symptoms.

5.4 NEED OF THE TOPIC

The topic of DIIMUN 2026 is the **approach to a case.** The main intention of this topic is to bring a standardisation to how any case is approached. As a newly graduated homoeopathy doctor, when we see our very first patient our minds are crowded with ideas regarding how to approach this patient. As the patient narrates their symptoms, our minds keep wandering whether we stick to LSMC of Boenninghausen or do we give only the mental generals priority like Kent or do we solely prescribe on

their pathology, lab tests or investigations or do we interview and extract their whole personality evolution to workout in Dhawale's method. This whole burden of multiple approaches to a case, each claiming to be the best compared to the other, wears us down. Through this topic, we hope the committee gets to draft a resolution clearly defining which approach works where in the area of case taking to repertorisation, anamnesis, remedy selection, potency selection and followup. This standard when published aspires to be a quick handbook for any homoeopath when a new case arrives to get cured by him.

6. Pioneers & Stalwarts of Homoeopathy

6.1 Baron Carol Von Boenninghausen (1785–1864)

Biography & Historical Context

Baron Clemens Maria Franz von Boenninghausen was a distinguished Dutch-German lawyer, high civil servant, botanist, and homoeopath. Holding a doctorate in jurisprudence, he served as Chief Auditor in the Court of Louis Napoleon and Director of the Botanical Gardens at Münster. Cured of advanced pulmonary tuberculosis in 1828 by Pulsatilla under the care of Dr. A. Weihe, he converted to homoeopathy and became Samuel Hahnemann's most intimate friend, confidant, and intellectual collaborator until Hahnemann's death in 1843.

Case-Taking Methodology & Philosophical Approach

Boenninghausen is regarded as the father of systematic repertorization. To solve the problem of incomplete drug provings, he formulated the **Doctrine of Analogy** and **Grand Generalization** ('what is true of a part is true of the whole man'). He established the classic four-fold complete symptom structure:

- **1. Location:** Anatomical seat, tissue affinity, and side of the body (right/left).
- **2. Sensation:** Quality of pain, distress, or functional alteration.
- **3. Modality:** Modifying conditions of time, posture, temperature, weather, and motion (etiology and aggravations/ameliorations).
- **4. Concomitant:** An apparently unrelated symptom occurring simultaneously before, during, or after the chief complaint.

Boenninghausen emphasized physical generals, general modalities, and concomitants. Mental symptoms were utilized primarily for fine differentiation between competing remedies at the end of analysis. In posology, he favored low and medium potencies (often 30th and 200th) and published extensive studies on relationship of remedies.

The Seven Rubrics of Case Analysis

Böenninghausen categorized these seven questions into specific rubrics to form a complete, individualized image of a disease:

1. **Quis? (Who? / Individual Personality):** Refers to the unique individuality, age, sex, constitution, temperament, and especially the mental and moral state of the patient
2. **Quid? (What? / Nature of Disease):** Refers to the chief complaint, its peculiar character, and the clinical/nosological nature of the ailment
3. **Ubi? (Where? / Seat of Disease):** Identifies the exact anatomical location, organ, or tissue affected by the disease
4. **Quibus Auxiliis? (With what assistance? / Concomitants):** ** Focuses on accompanying or concomitant symptoms that co-exist with the main complaint without an obvious physiological or pathological explanation
5. **Cur? (Why? / Causation):** Explores the etiology or anamnesis—such as exciting causes (exposure to cold, trauma, mental emotions) or fundamental causes (underlying miasms like Psora, Syphilis, or Sycosis)
6. **Quomodo? (How? / Modifying Circumstances):** Examines the modalities, manner, positions, and circumstances that aggravate or ameliorate the patient's condition
7. **Quando? (When? / Time & Periodicity):** Covers the exact time of day, periodicity, or seasonal influences modifying the symptoms

SPECIAL TIP AN EXCLUSIVE SUGGESTION IS TO BE THOROUGH WITH THE CHAPTERS 'concerning the rest and motion' and 'use of high potencies' in Lesser writings to give you an extra edge.

Recommended Source / Book Title	Author / Publication Context
Therapeutic Pocket Book (TPB) & Preface	C. von Boenninghausen (Edited by T.F. Allen / H.A. Roberts)
The Lesser Writings of C.M.F. von Boenninghausen	Compiled by T.L. Bradford / Translated by L.H. Tafel
Systematisch-Alphabetisches Repertorium	C. von Boenninghausen (1833/1835)
Therapeutic Manual for Homoeopathic Physicians	C. von Boenninghausen (1846)

6.2 James Tyler Kent (1849–1916)

Biography & Historical Context

Dr. James Tyler Kent was an eminent American physician born in Woodhull, New York. Graduating from Colgate University (A.M.) and the Eclectic Medical Institute of Cincinnati, he converted to homoeopathy after his wife's severe insomnia was cured by Dr. Phelan using high potencies. Kent served as Dean and Professor of Materia Medica at the Post-Graduate School of Homoeopathics (Philadelphia), Hering Medical College (Chicago), and Hahnemann Medical College (Chicago).

Case-Taking Methodology & Philosophical Approach

Kent championed a Swedenborgian, vitalistic philosophy: "*The mind is the man.*" He asserted that sickness flows from center to circumference—from the innermost (will, intellect, affections) to the outermost (physical tissues and gross pathology). Case taking must prioritize the mental and emotional sphere.

Kent's Hierarchy of Symptoms:

- **1. Mental Generals:** Will and Affection (loves, hates, fears, suicidal impulses) → Intellect and Understanding (delusions, hallucinations, confusion) → Memory disturbances.
- **2. Physical Generals:** Thermic reactions (hot/chilly patient), general modalities (weather, motion, night/day), appetite/cravings/aversions, sleep/dreams, and sexual sphere.
- **3. Characteristic Particulars:** Local symptoms possessing unique, peculiar, or qualified modalities.

Kent rejected Boenninghausen's grand generalization, insisting upon **Limited Generalization** (a symptom must be experienced in more than two locations to be classified as a general). He introduced **Series in Degrees** (ascending centesimal potencies: 30, 200, 1M, 10M, 50M, CM, DM, MM) and formulated the famous **Kent's 12 Observations** for interpreting remedy reactions.

Kent's totality of symptoms

Dr. James Tyler Kent's concept of the totality of Symptoms is built on the principle that disease proceeds from center to circumference the innermost (the man) to the outermost (the physical organs and tissues)

1. General Symptoms (Highest Rank)

General symptoms describe the patient as a whole ("I feel...", "I am...") rather than an isolated organ.

Mental Generals (The Innermost Core):

- **Will and Affections:** Loves, hates, fears, desires, aversions, and suicidal impulses. These rank highest because as the affections are, so is the man.
- **Intellect and Understanding:** Delusions, perversions of reasoning, hallucinations, and loss of memory
- **Physical Generals:**
 - Reactions of the whole organism to physical environment (sensitivity to heat, cold, weather, storms, bathing, motion, time/periodicity)
 - General cravings/aversions for food, sleep/dreams, sexual perversions, and menstrual modalities

2. Particular Symptoms (Lower Rank)

- Refer to specific anatomical parts or organs ("my throat", "my knee")
- Particulars serve to differentiate remedies within a group already selected via Generals
- **Rule:** Strong Generals overrule Particulars, and no Particular symptom can contradict a strongly marked General

3. Common Symptoms (Lowest Value for Prescribing)

- Diagnostic or pathognomonic symptoms common to a disease entity (e.g., fever, debility, constipation, swelling). They assist in disease diagnosis but carry little to no value in selecting the individualizing *simillimum* unless modified by peculiar circumstances or modalities.

Qualitative vs. Quantitative Totality

- **Quantitative (Numerical) Totality:** The unorganized aggregate of all symptoms collected during case taking
- **Qualitative Totality:** The logical synthesis of **strange, rare, and peculiar (characteristic)** symptoms (P-Q-R-S) that portray the patient's unique morbid state.

Recommended Source / Book Title	Author / Publication Context
Repertory of the Homoeopathic Materia Medica	J.T. Kent (1897)
Lectures on Homoeopathic Philosophy	J.T. Kent (1900)
Lectures on Homoeopathic Materia Medica	J.T. Kent (1905)
Lesser Writings, Clinical Cases, New Remedies, Aphorisms and Precepts by Dr. James Tyler Kent	J.T. Kent (1926)

6.3 Herbert Alfred Roberts (1868–1950)

Biography & Historical Context

Dr. Herbert Alfred Roberts was a prominent American homoeopath, military surgeon (World War I), President of the International Hahnemannian Association (IHA), and Chairman of the American Foundation for Homoeopathy. He served as Editor-in-Chief of *The Homoeopathic Recorder* for many years.

Case-Taking Methodology & Philosophical Approach

Roberts played a pivotal role in clarifying Hahnemannian philosophy using precise scientific and dictionary definitions. He viewed disease as a dynamic disturbance of vital energy following natural laws (Newton's Law of Mutual Action, Law of Least Action). In case taking, he emphasized:

- **Thermic Reactions:** Detailed evaluation of the patient's general response to heat, cold, seasons, and weather.

- **Concomitants with Common Modalities:** Roberts demonstrated that a concomitant symptom possessing a modality common to the chief complaint is the most powerful indicator for remedy selection.
- **Functional vs. Structural Pathology:** Strictly separating dynamic functional symptoms (the true disease) from gross tissue end-products ('ultimates').
- **Endocrinology & Miasms:** Correlating miasmatic stigmata with endocrine glandular dysfunction and atomic weight tendencies of remedies.

Recommended Source / Book Title	Author / Publication Context
The Principles and Art of Cure by Homoeopathy	H.A. Roberts (1936)
Sensations As If...	H.A. Roberts (1937)
The Principles and Practicability of Boenninghausen's TPB	H.A. Roberts & A.C. Wilson (1935)
Rheumatic Remedies	H.A. Roberts

6.4 Stuart M. Close (1860–1929)

Biography & Historical Context

Dr. Stuart M. Close was an eminent American homoeopathic philosopher born in Oakfield, Wisconsin. He studied law before entering medical education at the Cooper Medical College and graduating from the New York Homoeopathic Medical College in 1885. He served as Professor of Homoeopathic Philosophy at the New York Homoeopathic Medical College and President of the IHA (1906).

Case-Taking Methodology & Philosophical Approach

Close interpreted Hahnemannian principles in the light of Baconian inductive logic and contemporary 20th-century biological science. He defined homoeopathy as the "*Science of Vital Dynamics*." His case-taking approach emphasized:

- **Inductive Logic in Anamnesis:** Collecting exact individual facts without theoretical speculation, proceeding systematically from observation to generalization.
- **Psychosomatic & Environmental Factors:** Searching out moral character, domestic relations, emotional stress, occupation, and social environment as maintaining causes.
- **Totality as a Work of Art:** Defining totality not as a numerical aggregate of symptoms, but as a coherent, logically related structure ('a Work of Art').
- **Symptom Completeness:** Analyzing every symptom into Location, Sensation, and Modality.

SPECIAL TIP: Homoeopathic Posology chapter from the genius of homoeopathy will give the delegate good traction.

Recommended Source / Book Title	Author / Publication Context
The Genius of Homoeopathy: Lectures and Essays on Homoeopathic Philosophy	Stuart Close (1924)
The Psychological Point of View in Medicine	Stuart Close (Monograph)
Symptomatology and Examination of the Patient	Stuart Close (Essay Series)

6.5 Cyrus Maxwell Boger (1861–1935)

Biography & Historical Context

Dr. Cyrus Maxwell Boger was a legendary American homoeopath born in western Pennsylvania. Graduating in pharmacy from the Philadelphia College of Pharmacy and in medicine from Hahnemann Medical College of Philadelphia, he practiced for nearly 50 years in Parkersburg, West Virginia. He taught at Pulte Medical College and the American Foundation for Homoeopathy.

Case-Taking Methodology & Philosophical Approach

Boger bridged the Boenninghausen and Kentian schools. He introduced **Pathological Generals** (symptoms depicting tissue-level structural changes across the body, e.g., tendency to fatty degeneration, ulceration, hemorrhage, inflammation). His methodology featured:

- **Tissue Affinity & Anatomical Sphere:** Identifying the primary anatomical tissue seat where symptoms originate.
- **Keynote Prescribing & Synoptic Key:** Extracting the striking, peculiar central symptom around which the case revolves.
- **General Analysis & Card Repertory:** Developing the visual punch-card sorting system for rapid, objective rubric matching based on locations and general modalities.

Recommended Source / Book Title	Author / Publication Context
Boenninghausen's Characteristics and Repertory (BBCR)	C.M. Boger (1905)
A Synoptic Key of the Materia Medica	C.M. Boger (1915)
General Analysis with Card Index	C.M. Boger (1931)
Studies in the Philosophy of Healing	C.M. Boger

6.6 Richard Hughes (1836–1902)

Biography & Historical Context

Dr. Richard Hughes was a prominent British physician born in London. Holding MRCS (Eng) and LRCP (Edin) degrees, he served as Editor of the *British Homoeopathic Journal* and Permanent Secretary of the International Homoeopathic Congress.

Case-Taking Methodology & Philosophical Approach

Hughes represented the **Pathological**. Critical of Hahnemann's later dynamization and miasmatic theories, Hughes viewed Hahnemann primarily as a brilliant experimental pharmacologist. In case taking, Hughes emphasized:

- **Pathological Similarity:** Matching the drug's pathological and tissue-lesion action (derived from toxicology and crude provings) to the patient's pathological diagnosis.
- **Rejection of High-Potency Provings:** Excluding symptoms obtained from attenuations above the 12th centesimal potency in his Cyclopaedia of Drug Pathogenesis.
- **Posology:** Strict preference for low potencies, and triturations (30C and less, rarely 200c)

Recommended Source / Book Title	Author / Publication Context
A Manual of Pharmacodynamics	Richard Hughes (1867)
A Cyclopaedia of Drug Pathogenesis (4 Volumes)	Richard Hughes & J.P. Dake (1886–1891)
The Principles and Practice of Homoeopathy	Richard Hughes (1902)
The Knowledge of the Physician	Richard Hughes (1884)

6.7 Dr. M.L. Dhawale (1927–1987)

Biography & Historical Context

Dr. Mitrachandra Laxman Dhawale was an eminent Indian homoeopath, clinician, and master educator born in Bombay. Son of Dr. L.D. Dhawale, he served as Principal of the Bombay Homoeopathic Medical College and Founder-Director of the Institute of Clinical Research (ICR), Mumbai.

Case-Taking Methodology & Philosophical Approach

Dhawale formulated the **Standardized Case Record System** and the **Conceptual Image Framework**. His methodology integrates Hahnemannian principles with modern medical concepts (psychosomatic medicine, Hans Selye's adaptation syndrome, and systems logic):

- **Cross-Section & Longitudinal Section Study:** Analyzing the patient's current disease state (cross-section) alongside their life-line evolution from birth (longitudinal section).

- **Four-Stage Conceptual Image:** Synthesizing the case into Core (cause/antecedents) → Form (general modalities) → Individuality (mentals, physical generals) → Differentiation (peculiar particulars).
- **Standardized Case Sheet:** Structuring clinical data into history in patient's own words, interrogation additions, physical exam, diagnosis, chronological sequence, case analysis, and repertorial synthesis.

Dr. M.L. Dhawale's Concept of Susceptibility

What is Susceptibility?

Dr. Dhawale defines susceptibility as the **inherent, natural capacity of every living organism to react to stimuli** in its environment. It is the fundamental quality that distinguishes a living being from non-living matter.

Susceptibility in Health vs. Disease

- **In Health:** The body's susceptibility maintains a fine, stable balance (managed by the neuro-endocrine system). The body adapts smoothly to external stresses without producing discomfort.
- **In Disease:** When unfavorable environment or internal stress alters this normal susceptibility, the body loses its balance. Signs and symptoms are simply the outward, visible expressions of how the body's disturbed susceptibility is trying to react and regain balance.

Susceptibility and the Homoeopathic Remedy

- **The Simillimum:** The human organism exhibits its **maximum susceptibility toward the exact similar remedy (*Simillimum*)**. Because the sick person is hyper-sensitive to the similar remedy, giving a crude or massive dose causes a harsh medicinal aggravation. This led Hahnemann to discover potentization and the infinitesimal dose.
- **Cure vs. Suppression:** A true curative remedy (*Simillimum*) satisfies and normalizes the abnormal susceptibility. Suppressive therapies (like strong chemical ointments or heavy sedatives) merely block the outward symptoms without altering susceptibility; as a result, the disease energy is driven deeper into more vital organs.

States of Susceptibility & Clinical Handling

1. **Increased / High Susceptibility:**
 - Found in sensitive, nervous, intellectual, or allergic individuals, as well as in acute fevers.
 - The body reacts quickly and vividly. Dosing requires care so as not to unleash a severe aggravation.
2. **Decreased / Poor Susceptibility:**
 - Found in patients with advanced gross pathological damage, worn-out vitality, severe miasmatic blocks, or those heavily suppressed by long-term steroids, ECT, or tranquilizers.

- The body fails to produce clear, characteristic symptoms, showing a "nondescript" or flat picture.
 - **Handling:** Requires lower potencies, frequent repetitions, or intercurrent remedies/nosodes (like *Sulphur*, *Opium*, *Nux Vomica*, or *Psorinum*) to rouse dormant reactivity.
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Potency Selection (Homoeopathic Posology)

Dr. Dhawale stresses that potency selection is not guesswork; it depends on a careful assessment of **patient susceptibility**, **degree of symptom similarity**, and the **stage of disease**.

Guidelines for Potency Levels:

- **High Potencies (200C, 1M, 10M, and above):**
 - **When to use:** When the remedy shows a **very close, striking similarity** to the patient's complete picture, especially when fine mental and physical general symptoms are clear and well-developed.
 - Indicated in sensitive, vigorous patients with dynamic or functional illness.
- **Medium Potencies (30C, 200C):**
 - **When to use:** Represents the **"middle path of maximum safety and efficiency"**.
 - It is ideal for beginners and sensitive/hysterical subjects where high potencies might risk an intense, uncomfortable aggravation. Dr. Dhawale highlights Kent's view that the 30C potency is neither too low nor too high.
- **Low Potencies (Below 30C, Tinctures, 3x, 6x):**
 - **When to use:** Indicated when susceptibility is low, in advanced structural/pathological organic disease, or when the case presents only common, diagnostic organ symptoms without fine individualizing mental features.
 - Also used in hypersensitive patients who tend to suffer severe medicinal aggravations.
- **Ascending Scale of Potencies (Tyler's Scheme):**
 - In resistant or mental cases where a well-confirmed remedy fails to evoke a reaction, Dhawale recommends giving ascending potencies on consecutive days (e.g., 30C → 200C → 1M) until a reaction is observed, then stopping immediately.

Importance of the LSMC Framework (Location, Sensation, Modality, Concomitant)

In Dr. Dhawale's clinical teaching, **LSMC** refers to the classic Bönninghausenian four-fold structure used to build a complete **Conceptual Image** of a case:

1. **L — Location:** The exact anatomical seat or region affected.
2. **S — Sensation:** The specific feeling or pain experience (e.g., burning, stitching, tearing).

3. **M — Modality:** Modifying circumstances—conditions of aggravation or amelioration (time, temperature, motion, position, weather).
4. **C — Concomitant:** Accompanying symptoms co-existing with the chief complaint that have no direct physiological relation to the main disease.

Why LSMC is Crucial in Dr. Dhawale's Method:

- **Bridges Raw Narrative to Materia Medica:** It takes an unorganized, overwhelming collection of patient complaints and structures it into an orderly "form" or "outline image".
- **Grand Generalization:** Dr. Dhawale emphasizes that when a modality or sensation is shared across both the main complaint and a concomitant (a "singular instance"), it becomes a powerful **General Modality** that overrules minor particular details and points directly to the *Simillimum*.
- **Harmonizes Bönninghausen and Kent:** Dr. Dhawale's model uses **LSMC to establish the structural framework** of the illness (causation, anatomical sphere, and modalities), and then uses **Kentian mental and physical generals** to narrow down and differentiate the final remedy.

Recommended Source / Book Title	Author / Publication Context
Principles and Practice of Homoeopathy (Vol 1)	M.L. Dhawale (1967/1985)
ICR Operational Manual & Perceiving 1	Dr. M.L. Dhawale Memorial Trust / ICR

6.8 Dr. Praful Vijaykar (1852–2021)

Biography & Historical Context

Dr. Praful Vijaykar was a renowned classical homoeopath based in Mumbai, India. Founder of **Predictive Homoeopathy**, he revolutionized modern practice by integrating Hahnemannian organon directives with genetics, embryology, immunology, and biochemistry. His work is largely based on German new medicine theory.

Case-Taking Methodology & Philosophical Approach

Vijaykar formulated the **Genetic Constitutional Method** and the **7 Layers of Suppression** based on embryological germ layer origin (Ectoderm, Mesoderm, Endoderm). Key case-taking features include:

- **Genetic Axis & ATT Parameters:** Case taking focuses on determining the patient's genetic baseline: Action/Attitude, Thermal reaction (Hot/Chilly), and Thirst (ATT).
- **Present Predominating Mental State:** Evaluating the exact genetic mental state during sickness.
- **Direction of Cure & Hering's Law:** Predicting cure by observing disease reversal from deeper embryological layers (e.g., endoderm/mesoderm) to superficial layers (ectoderm/skin).
- **GNM method arriving at conflicts present in the case :** This is adopted for each case approach by Dr vijaykar: Detailed Case Taking - Search for Conflicts - Note the Reactions to those conflicts - Convert them to rubrics - More concerned to Mind Rubrics + One Main Chief Complaint rubric (On the whole the rubrics should reflect the Pathology - Mind Connection)

Special tip: please go through Vitamin Gosian's Videos too (If relevant / preferred) to get more edge.

Recommended Source / Book Title	Author / Publication Context
Predictive Homoeopathy Part 1: Theory of Miasms	Praful Vijaykar
Predictive Homoeopathy Part 2: Theory of Acutes	Praful Vijaykar
Predictive Homoeopathy Part 3: Verifying the Simillimum	Praful Vijaykar
Treasures of Dr. Prafull Vijayakar	Compiled by Günter Lutz

6.9 Prof. George Vithoukas (1932–Present)

Biography & Historical Context

Prof. George Vithoukas is a world-renowned Greek classical homoeopath, recipient of the Right Livelihood Award (Alternative Nobel Prize, 1996), and Director of the International Academy of Classical Homeopathy (IACH) in Alonissos, Greece.

Case-Taking Methodology & Philosophical Approach

Vithoukas developed the **Levels of Health Theory** (12 distinct levels grouped into 4 continuum bands). Case taking evaluates the strength of the organism's Defense Mechanism, genetic predisposition, and clear symptom picture:

- **Essence Prescribing:** Case taking seeks the core emotional/mental essence and keynotes of the patient.
- **Prognosis via Defense Mechanism:** Observing reaction after remedy administration (e.g., appearance of high fever in healthy levels vs. lack of fever in compromised levels).
- **VES (Vithoukas Expert System):** Integrating algorithmic case analysis into classical prescribing.

Recommended Source / Book Title	Author / Publication Context
The Science of Homeopathy	George Vithoukas (1978)
Levels of Health	George Vithoukas (2010)
A New Model for Health and Disease	George Vithoukas
Essence of Materia Medica	George Vithoukas

6.10 The Sehgal Method (Dr. M.L. Sehgal & SSRH)

Biography & Historical Context

Founded by late Dr. M.L. Sehgal in New Delhi, India, and expanded by Dr. Sanjay Sehgal and Dr. Yogesh Sehgal under the **Sehgal's School of Revolutionized Homoeopathy (SSRH)**, this method offers a specialized, mind-oriented approach to case analysis.

Case-Taking Methodology & Philosophical Approach

Known as **Rediscovery of Homoeopathy (ROH)**, the method focuses solely on the **Present, Predominating, and Persisting Mental State (PPP)** of the patient during sickness:

- **Interpretation of Patient's Vernacular:** Translating the patient's exact daily expressions, worries, and complaints into precise Mind Rubrics from Kent's Repertory.
- **Three Mind Rubric Limit:** Prescriptions are made using 3 key mind rubrics reflecting the patient's exact mental state during illness.
- **Focus on Acute & Present State:** Ignoring long past history or miasmatic background, focusing entirely on the active present state.

Recommended Source / Book Title	Author / Publication Context
Rediscovery of Homoeopathy (ROH Series Vol 1–14)	M.L. Sehgal, Sanjay Sehgal & Yogesh Sehgal
Perfect Materia Medica of Mind	Sanjay Sehgal & Yogesh Sehgal
Feeling Version of Mind Rubrics	M.L. Sehgal

6.11 Dr. Rajan Sankaran (1860–Present)

Biography & Historical Context

Dr. Rajan Sankaran is an internationally acclaimed homoeopath based in Mumbai, India. Son of Dr. P. Sankaran, he is the pioneer of the **Sensation Method** and Head of the Homoeopathic Medical Research Development Trust.

Case-Taking Methodology & Philosophical Approach

Sankaran introduced the **7 Levels of Experience** in case taking: Level 1 (Name) → Level 2 (Fact) → Level 3 (Emotion) → Level 4 (Delusion) → Level 5 (Sensation) → Level 6 (Energy) → Level 7 (Blankness/Seventh State). Key case-taking features include:

- **Vital Sensation:** Reaching the non-human specific sensation that connects mind and body at the center of the diseased state.
- **Kingdom Classification:** Categorizing the vital sensation into Plant (sensitivity/reactivity), Mineral (structure/organization), or Animal (survival/victim-aggressor).
- **Non-Verbal Cues:** Observing hand gestures, body language, and spontaneous non-human descriptions during the interview.

FIVE FINGER METHOD

The core philosophy of the method is "5 Fingers. One Remedy." It acts as a 5-coordinate system where five distinct, independent dimensions of a patient's case must converge on the exact same remedy to confirm a prescription:

1. **Superclass:** The overarching thematic pattern or realm of experience (spanning the 6 Superclasses, such as "Limit and Expansion").
2. **Kingdom & Subkingdom/Class:** The natural source origin of the state (Plant, Animal, or Mineral; periodic table rows/columns, botanical families, animal classes).
3. **Miasm:** The depth, pace, desperation, and coping mechanism of the defense mechanism (spanning 10 miasms: Acute, Typhoid, Malaria, Ringworm, Psoric, Sycotic, Tubercular, Leprosy, Cancer, Syphilitic).
4. **Characteristics:** Classical Hahnemannian PQRS symptoms (Peculiar, Rare, Uncommon, Striking — Organon § 153) and characteristic repertorial rubrics.
5. **Keynotes & Source Language:** Confirmation through exact Materia Medica keynotes, patient expressions, gestures, and non-human source qualities/words.

Recommended Source / Book Title	Author / Publication Context
The Spirit of Homoeopathy	Rajan Sankaran (1991)
The Sensation in Homoeopathy	Rajan Sankaran (2004)
Sensation Refined	Rajan Sankaran (2007)
An Insight into Plants (Vol 1–3)	Rajan Sankaran

7. Summary Matrix: Stalwart Comparative Analysis

The following comparative matrix provides delegates with an immediate side-by-side synthesis of all 11 pioneers across primary case focus, diagnostic tools, and posological preferences:

Pioneer / Stalwart	Primary Case Focus	Key Analysis Tool	Posology Preference
Von Boenninghausen	Complete Symptom (Location, Sensation, Modality, Concomitant)	Therapeutic Pocket Book (TPB) / Analogy	30th & 200th Potencies
J.T. Kent	Mental & Emotional Generals (Will, Intellect, Memory)	Kent's Repertory / Series in Degrees	30th to MM Potencies
H.A. Roberts	Thermic Reactions & Concomitants with Common Modalities	Inductive Logic / Organon §83-104	Full Range (30th, 200th, 1M)
Stuart Close	Psychosomatic & Environmental Causes; Vital Dynamics	Baconian Inductive Logic	Flexible Potency Scale

C.M. Boger	Pathological Generals & Tissue Affinity	BBCR / General Analysis Card Index	Low to High Potencies
Richard Hughes	Pathological Tissue Lesions & pathological Action	Manual of Pharmacodynamics	Preferred 30C and less.. Rarely 200
M.L. Dhawale	Conceptual Image (Core, Form, Individuality, Differentiation)	Standardized Case Record System	Medium Range (30th, 200th)
Praful Vijaykar	Genetic Axis & Embryological Germ Layer Origin (ATT)	Predictive Homoeopathy / 7 Layers	Succussed Single Dose
George Vithoulkas	Defense Mechanism & Essence Prescribing	Levels of Health / VES System	Single High Potency
Sehgal Method	Present, Predominating, Persisting Mental State (PPP)	3 Mind Rubrics from Kent's Repertory	Centesimal Scale (30th, 200th)
Rajan Sankaran	Vital Sensation & 7 Levels of Experience	Kingdom Classification & Gestures	Potency linked to Level

8. Guidelines for Resolution Writing & Negotiation

The ultimate objective of The Great Homoeopathy Assembly is the drafting, negotiation, and adoption of a comprehensive Working Resolution on **"Standardized Approach to Case Taking in Homoeopathy."**

8.1 Resolution Structure

A UN-style resolution consists of two main parts:

- **Preambular Clauses:** States the historical context, Organon aphorisms, and philosophical justifications for the resolution (e.g., 'Recalling Aphorisms 83 to 104 of the Organon of Medicine...', 'Reaffirming the cardinal principle of individualization...'). Preambular clauses begin with italicized participle phrases.
- **Operative Clauses:** Sets forth actionable, numbered mandates and recommendations for standardizing case taking (e.g., '1. Recommends the adoption of a unified 4-section Case Proforma...', '2. Urges the integration of thermic and general modalities...'). Operative clauses begin with underlined action verbs.

8.2 Strategic Advice for Delegates during Unmoderated Caucuses

During unmoderated caucuses, delegates should form strategic alliances (blocs) based on shared philosophical perspectives (e.g., the Classical Mental Bloc, the Boenninghausen-Boger Structural Bloc, the Modern Sensation/Genetic Bloc, and the Pathological-Physiological Bloc). Delegates should negotiate

compromise clauses that incorporate multi-layered case evaluation—allowing mental generals, physical modalities, and pathological investigations to coexist in a standardized proforma.

NOTE: This document is just a guide and DOES NOT SERVE AS YOUR ULTIMATE SOURCE FOR MUN PREPARATION. DELEGATES ARE ADVISED TO BE THOROUGH WITH THE ACTUAL REFERENCE SOURCES MENTIONED IN THE DOCUMENT.