Dr. Russell Malcolm: An Interview

Interviewed by Ronald Whitmont, MD

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The *American Journal of Homeopathic Medicine* is pleased to announce a seminar presented by Dr. Russell Malcolm of the Royal London Homeopathic Hospital. Dr. Malcolm practices as a medical homeopath in Scotland and will be presenting a seminar on the Bowel Nosodes entitled Systems and Symbiosis. The meeting marks a joint venture between the American Institute of Homeopathy, The Homeopathic Medical Society of the State of New York and New York Medical College. It takes place October 23-26, 2008 in Tarrytown, New York. For more information on this conference, please see the calendar at the end of this journal.

The following excerpts are from an interview that took place between Ronald D. Whitmont, MD, (AJHM) and Dr. Russell Malcolm, on June 29, 2007 using SKYPE technology. [quotation marks omitted]

AJHM: Russell, we are all looking forward to having you here with us next year. Can you tell me a little bit about the bowel nosodes and why this seminar will be of interest to us?

Dr. Malcolm: One good reason is that this topic is very self- contained. It has boundaries since there are only ten bowel nosodes of any importance and of those ten, only about eight are in very regular use. So, to start with, the course content is quite clearly defined.

The bowel nosodes, as a group, tend to be underutilized. They are underutilized because prescribers do not have an awareness of the headline indications for these nosodes unless they happen to have received some really good training from someone with experience in using them.

Unfortunately, the bowel nosodes are not often taught well within general homeopathic training programs. Consequently, physicians will encounter many chronic patients with multi-system illness who remain blocked to cure, only because the prescriber does not pick up on the headline indications for the appropriate bowel nosode. If these indications aren't perceived, then the nosodes aren't used appropriately, and practitioners' ability to solve some of these chronic cases will be quite seriously hampered.

I am convinced that a working knowledge of this group of remedies will increase the clinical effectiveness of physicians who learn how to use them.

AJHM: You had mentioned that you've been working on a new repertory of the bowel nosodes. Does this provide something new?

Dr. Malcolm: Yes. The bowel nosodes very rarely appear in standard homeopathic analysis, even with modern computer repertories using search filters. This is one reason why they are under-prescribed, even if they are very strongly indicated in the case. There are many patients whose symptomatology includes clear indications for one of these remedies. In order to select the correct nosode for the case, however, there is little point in repertorizing using a standard neo-Kentian repertory. The bowel nosodes simply get lost among the rest of the remedy data.

I have developed a selective bowel nosode repertory that will allow practitioners to use the keynote symptoms and signs from the case to build up an argument for one of the bowel nosodes.

The data in the repertory has a high reliability. These materials themselves were extensively utilized for over half a century in places like the Royal London Homeopathic Hospital and the Children's Hospital in Glasgow. There were more than 20,000 stool samples analyzed from sick patients. The clinical syndromes, symptoms, diagnoses and investigation results were all collated, along with the clinical outcomes of treatment. A lot of the resulting data has been distilled and indexed in a searchable form.

This has become an important point of reference when weighing the arguments for one of these nosodes in today's patient.

After examining the work of many authors on this subject, I have checked the existing data for consistency and have corrected obvious mistakes and errors. I have also edited the material and structured it in modern repertorial format using a heirarchical style consistent with MacRepertory or Synthesis. Then I have added more rubrics, both from the lesser known literature and from my own cases. Finally, I have added in my own tentative remedy additions from cases that I have seen over the last ten years. The end result is a repertory which is based as reliably as possible on existing literature and from good quality cases. It is structured in a manner that makes it consistent with modern analysis methods.

Dr. Russell Malcolm

AJHM: So, what you are describing is a repertory devoted solely to the bowel nosodes?

Dr. Malcolm: Yes, it is specifically designed around the bowel nosodes. It does not take away the value of doing a classical repertorization in the case, but once one knows what to look for, one will recognize cases that are blocked due to serious bowel dysbiosis, perhaps in patients with obvious gastrointestinal symptoms and problems with background immunity. In this event, one's classical repertorization may not yield a remedy that works completely on its own terms. The case may need to be unblocked by the relevant bowel nosode before the classical simillimum can be employed effectively.

In my teaching, I won't necessarily be starting off with the most complex cases, but I certainly will present a number of cases where the relationship between the nosode and the classically indicated remedy is very important. There are some cases that require one to analyze the case both in terms of a classical repertorization, as well as a very specific 'bowel nosode repertorization'. By the end of the course, participants should have a clear idea of a treatment process that they can apply consistently and effectively in these difficult patients.

AJHM: So, you are suggesting that certain cases may require running a parallel repertorization using a bowel nosode repertory?

Dr. Malcolm: Yes. It does not necessarily take a long time to do a search using a bowel nosode repertory because it is much smaller than the standard general repertory. With the data in a searchable form, one can do a bowel nosode repertorization in five or ten minutes. It does not take long to do it, but it can be vital in identifying something which will unblock a case and prepare a patient to respond to a classical simillimum.

AJHM: Does this apply only to cases where there is significant gastrointestinal pathology and bowel dysbiosis or are there cases that require these nosodes that are free of gastrointestinal issues?

Dr. Malcolm: There are times when one has patients who have been quite seriously unwell for a long period of time. They have been subjected to many drugs and to many homeopathic or herbal treatments; they are in 'half-treated' states. There may be a multiplicity of problems: perhaps they are a bit toxic, fatigued, and have some relatively minor gastrointestinal symptoms. Many of these patients require treatment with a bowel nosode, even when the gastrointestinal symptoms are not dominant in the case.

There are also cases where the dysbiosis is not in the bowel but in the airways - patients who are chronically catarrhal, who are host to a disturbed microflora in their airways, and who are open to recurrent infections. They may also have emergent sensitivities to inhaled allergens. The nosodes are of extreme importance in one's strategy for patients in that category.

So, not all patients who require bowel nosodes have their main presenting complaint in the bowel. Some of them will have bowel symptomatology, and in some cases it will be very severe, very obvious, and very dominant in the case. In other cases it is barely expressed by the patients and appears to be of seemingly minor importance in comparison with their other symptoms.

One of the key objectives is to open the practitioner's eyes, so that he can actually perceive those

patients who require one of these medicines at the time of the first interview. It will save a lot of failed prescriptions and a lot of blocked cases if one has an awareness of this particular block to cure early in the process.

AJHM: You're saying that we might be prescribing the correct medicine in a case, based upon a classical analysis, but the case may be blocked because a bowel nosode is required first?

Dr. Malcolm: Yes. We are all taught about obstacles to cure in our homeopathic training, but it often tends to relate to irreconcilable factors at the mental/emotional level, or lifestyle and environmental factors, drugs and steroids, etc. We are all very good at identifying blocks to cure in these external environments. There is much less awareness in the homeopathic community of intrinsic blocks to cure. These are things that are actually 'built into us' at a biological level.

These blocks can be very profound and can generate their own pathological processes. Recognizing these blocks can make a difference between succeeding or failing with your homeopathic treatment. These intrinsic factors are often acquired blocks to cure emerging insidiously after infections, antibiotic treatments, changes in diet, and the prolonged use of certain drugs. Practitioners need to be able to recognize the consequences of these factors if they want to successfully treat these complex chronic cases.

AJHM: How does our knowledge of the bowel nosodes relate to the science of the gastrointestinal microflora?

Dr. Malcolm: The emerging scientific data on human bowel microflora is highly compatible with much of the information already documented in the homeopathic literature. There are many studies that demonstrate the veracity of observations made by clinicians and bacteriologists in the past.

To give you just one example, the bowel nosode Morgan Pure is associated clinically with itching and skin eruptions. The fermentation profile of these patients' stool isolates often shows dominant growth of Morganella morganii. Morganella has been isolated from the bowel of certain fish and modern science indicates that Morganella morganii is one of the most histamine-producing organisms known. It has been experimentally shown to synthesize histamine in appreciable quantities. So, there is a very obvious scientific reason why a patient who is harboring Morganella morganii in the bowel might be prone to itching and skin eruptions.

The original clinical information, which was derived empirically, often has a very good modern scientific basis, which may include a credible model that helps us to describe and explain the observed phenomena. This is just one of many instances where modern science is catching up with the very acute observations in homeopathy.

AJHM: In next year's conference you'll really be teaching three courses: an introductory level course on homeopathy for physicians, an advanced level course on the bowel nosodes for physicians already practicing homeopathy, and a Friday night seminar on "Teacher Training."

Dr. Malcolm: Well, rather than call it a "Teacher Training," it would be nice to look at it as a place where we can all share ideas.

AJHM: Can you tell me more about that?

Dr. Malcolm: Wherever I teach I am struck by the fact that there are a lot of experienced clinicians and teachers already in place. We all have a slightly different clinical background and a slightly different take on homeopathy. Homeopathy often engenders quite strong ideas around the way things should be done or should be taught.

I have been through the stage where I was 'evangelical' about it, and at one time I was quite dogmatic about the structure of training programs. Years of experience have tempered those tendencies – I think that my experience with colleagues internationally has gradually transformed my views on homeopathic education. I have also seen many different curricular designs and have experienced different approaches to the actual training pathways for physicians. It would be arrogant to think that I could show people how to teach and I do not see myself in that role. What I can do is act as a facilitator and a "sounding board" for ideas.

Within a discussion forum, I hope I can help to inform those who are involved in teaching about what is going on internationally and about what happens in other courses. I can provide ideas on the design of learning activities and what considerations informed the creation of the National Homeopathic Training Curriculum in the United Kingdom. I can discuss ways to secure the accreditation of training programs and share my knowledge on quality assurance in adult education, including feedback methods and the management of materials. I can share my views on how a team can collate and develop shared teaching resources.

I also have experience in collaborative projects between different countries and, at various times,

I have had to negotiate on behalf of my teaching team, in London, or at academic board meetings.

There is no doubt that I am mellower and more tolerant of other ideas than I used to be. I am also more aware of the range of possibilities that exist for any given question around teaching delivery.

It is not easy to bring a team together which can design and deliver a course that is coherent and has a thread that runs through it, that is intellectually satisfying and well supported by evidence, that incorporates good quality clinical cases, that draws people in and helps them develop, and also engages participants' own creativity over time. These are big challenges. A good program also fosters collaborative learning, cooperation in the learning process between individuals, and sustainable study groups. These are the factors that any serious committee needs to take into consideration.

That is not to say that all my initiatives have succeeded. My working life has been marked by a succession of successes, partial successes, and ideas that, quite frankly, have never come to fruition. Thankfully, I learned something at each stage, and it may be possible for me to help others find a short-cut around things that have not worked in the past or that others have found difficult to sustain.

I have seen homeopathic education projects start with an extremely ambitious set of ideas and enormous vision. But it is one thing initiating a training program and it is quite another matter sustaining it through both good and bad times. Teams can become divided by differences in perspective and embroiled in tensions around the ownership of materials. These insecurities can be a problem, even in the most talented members of a teaching team. Sustaining and maintaining a teaching team, keeping them enthused, and keeping them creative are challenges for anybody who is trying to get a high quality program off the ground.

Within the potential for each wonderful scheme there are a host of potential pitfalls. My hope for the roundtable discussion, on Friday night, is that it will bring people to some kind of shared perspective on how to identify and overcome the obstacles as soon as they arise. That can make the difference between a good, sustained, long-term development or merely a 'big noise' that just peters out.

AJHM: When did you start teaching?

Dr. Malcolm: By 1992 I had started to teach on the Scottish Faculty course and had also been invited to teach in Eastern Europe following the collapse of communism in the Soviet Bloc.

In 1994, homeopathic education in the UK was also going through a reorganization. The Royal London Homeopathic Hospital was looking for a Director of Education for their new academic unit. I applied for and was accepted in that post. Up to that point the Faculty of Homeopathy had been responsible for all the education in London and the hospital had basically hosted the all the Faculty courses.

I held the post of Director of Education for six years. It was a difficult job because I continued to live in Scotland and commute down to London two or three times a month for meetings, teaching development, communications, and to oversee the administration in the academic office. I also sat on the Academic Board, which at that time was preoccupied with the National Curriculum for Homeopathic Education in the healthcare sector.

That was a very, very busy six years, but I never regretted doing it. When you are dropped straight from the frying pan into the fire, the level of work, commitment and concentration increase manyfold. I found myself working and developing materials well into the night in those early days. I had to edit the materials of my colleagues and arrange for the publication of core texts and workbooks. I also had to cooperate with specialists in adult education, course design and publication. All those initiatives allowed us to develop high quality support materials and design learning activities for students of homeopathy.

I also had to work on methods of continuous assessment and develop what we called the "Fast Track Course," which was partly correspondence learning for international doctors, with additional clinical attachments to the Royal London Homeopathic Hospital.

I had to learn a great deal about a large number of things very quickly and, inevitably, I made a number of mistakes from which I learned some serious lessons. Today, I would not choose to put myself through all that again, but at that time it certainly taught me an enormous amount about the logistics of homeopathic education in a modern medical setting.

AJHM: Are the teaching models different in homeopathic education compared with orthodox training?

Dr. Malcolm: Well (taking aside the different clinical content for a moment) most of our work involves postgraduate education which is different from teaching undergraduates. A good course has to be designed to work synergistically within the lifestyles of practicing physicians.

The curriculum has to allow you to accommodate their clinical experience and allow them to evolve within their own clinical settings, using the informa-

tion that you give them. So, the courses have to be designed in a way that allows their clinical practice to benefit meaningfully from the homeopathic teaching and training.

In a lot of undergraduate education you can design the curriculum and dovetail it into the training plan that exists across other departments. In post-graduate training, you have to allow your doctors the opportunity to develop at their own rates. Success depends more on supporting their particular learning pathway rather than trying to get them to fit into a strict training model that you are delivering; it needs more flexibility.

It also needs more modularity. It must be constantly rechecked. You must check the content for its relevance to clinical practice. I also think you have to support your arguments in a slightly different way from undergraduate learning. In undergraduate learning a lot of things can be based at a theoretical level, but at postgraduate level, most of what you have to say has to have direct clinical relevance and a greater evidential basis. There is also greater diversity of clinical opinion in the post-graduate medical community and you may have to overcome a variety of preconceived ideas.

There is also much more room for debate about course content at the post-graduate level. The huge number of possibilities concerning what should or should not be, in a homeopathic training course, can create enormous difficulties and tensions in a teaching team.

The other vital issues - course delivery, scheduling,, resourcing, materials, accreditation, quality assurance, course marketing and sustainable development - all need to be proactively planned for rather than tacked-on to the teaching.

AJHM: Where are you currently teaching?

Dr. Malcolm: I am teaching regularly at the Royal London Homoeopathic Hospital - everything from Part One, which is our first introduction to homeopathy, right up to our new Post-Membership level course. This 'fourth year' course involves collaborative learning, research projects in virtual teams and case-based learning days, where advanced methodologies and the integrative aspects of homeopathy are discussed.

In the course of my own working life I have seen thousands of patients, both within the National Health Service (NHS) Homeopathic Clinics and in my own practice. When I started out, these busy NHS clinics would run from 9 o'clock in the morning and frequently overrun well into the evening. There was a high patient demand and lots of new patient referrals.

For me this was a heuristic "baptism by fire." I quickly had to learn to become clinically effective in a very difficult group of patients. I had to learn about materia medica, prescribing models, analysis techniques, etiologies, obstacles to cure and management issues, such as the timing of reviews and sequential treatment – all 'on the job' so to speak.

After literally thousands of patient-hours, I felt I really had quite a lot to say about homeopathic treatment methods for a very wide range of conditions. I am grateful to have gone through that process when I was still young enough to have the energy for it.

AJHM: Are you still teaching internationally?

Dr. Malcolm: Yes, I have taught in many parts of Europe and I also teach in some of the Faculty's international courses from time to time. The Faculty run accredited courses in Moscow, Lisbon, and in a number of other parts of the world. They have international teaching and examination links with countries like South Africa and India. It can be an interesting challenge encountering different audiences from different medical traditions and working in different cultural settings.

International teachers need to be quite sensitive to the indigenous training programs, as well as the local prescribing culture and regional medical politics. It is also important to be aware of the clinical demands placed on local doctors who can be faced with a different spectrum of illness from what we encounter at home.

I once went to Portugal with the intention of teaching *Carcinosinum*. When I arrived, I discovered that they are not actually allowed to prescribe *Carcinosinum* in Portugal! It was not legally registered as a medicine. I had to re-organize a significant amount of my program and teach other things.

When I first taught in Bucharest, I went fully armed with multimedia teaching materials only to discover that in those very early days, after the revolution, they did not have access to digital projectors or indeed any projector at all! The vast majority did not have their own materia medica texts or repertories at that time. That was the last time I taught with blackboard and chalk!

AJHM: Can you tell us a bit about your first introduction to homeopathy?

Dr. Malcolm: I graduated in medicine in 1983 and originally embarked on a career in general practice, doing hospital rotations and the kind of work that would be required for a professional life in primary care. As it happened, I was studying arts with the Open University at the same time, partly to keep

me sane during those long nights on-call when you want to have something to take your mind off work when things are quiet.

Working in hospital medicine and obstetrics there was always quite a lot of critical care work. There came a point, when I was nearing graduation in my arts degree, when I wanted a quieter job, something a little less acute. One day I picked up a copy of the British Medical Journal and, by chance, saw a job advertisement for a junior medical resident at the Glasgow Homeopathic Hospital. This was a surprise because I did not know that such posts existed in the state sector. I sent in my job application, admittedly for all the wrong reasons - there was an air-call pager and a reasonable piano in the doctors quarters. Looking back, I think I rather bluffed my way through my interview with Hamish Boyd, who was the medical director at that time. I got the job, however, and arrived at the Glasgow Homeopathic Hospital (GHH) as a resident in February 1986.

Although I began the job with a great deal of skepticism, I soon began to re-evaluate everything that I thought I knew about medicine. A few weeks into the job I witnessed treatment results that I found inexplicable (in terms of what I had been taught at medical school).

In the 1980s, the senior staff of the GHH were really very elderly, but they were also very wise, very patient-centered, and very experienced. Watching them interact with patients made the biggest impression on me. Clearly they still had something very valid to teach me about what good medicine was.

When I saw my senior colleagues at work, my own consciousness started to change. I gradually realized what could be achieved with homeopathy, and I was motivated to go into the wonderful faculty library at the hospital. There I embarked on what has turned out to be a process of life-long learning.

After I finished my first term, I stayed on at the GHH for another year, which was longer than I had originally intended. Then I went back into general hospital work to finish my orthodox medical rotation. Ultimately, in 1989, it was time to make the final decision around where my career was going. I was at a real fork in the road, but I finally made the decision to go into homeopathy.

AJHM: What happened then?

Dr. Malcolm: I had passed my membership exam for the Faculty of Homeopathy in 1987, and so I was eligible to work within the outpatient clinics of the UK Homeopathic Hospitals, which were pretty busy with referrals from Primary Care all over Scotland. New vacancies at GHH came up every so often. I started off with just one clinic a week and then I took up other sessions as they became available. To keep a roof over my head, I also did emergency services work and other things within the orthodox sector. It was over a period of two or three years that I was gradually able to rely substantially on the homeopathic work for income. I also worked in the Milestone House AIDS hospice in Edinburgh which was newly opened. I was appointed as a specialist in complementary care and I worked there, part time, for three or four years. Staffing at GHH hit a crisis in 1992 and I acted as a locum consultant for almost two years. That was a steep learning curve.

AJHM: It sounds like you are bringing a lot of clinical and educational experience with you to the New York seminar.

Dr. Malcolm: I see each course as a unique challenge. Although I have taught this particular topic in many different countries as well as extensively here in the United Kingdom, I am not complacent about the material or the topic. I just put the material through a revision for teaching it in Germany six weeks ago and I am even now still working on new cases and incorporating information from my own clinic. The material is constantly in evolution.

It is hard to get balanced information from other sources because the best literature on the subject is scattered across many journals, contained in relatively small papers in various languages. Quite a lot of the data on the nosodes is obscure and difficult to obtain in the general literature. Some serious misconceptions have been perpetuated into recent books on the subject.

It has taken a lot of energy and effort to search through the papers in the British Homeopathic Library, including journal articles, smaller case reports, and then to look at the modern microbiology and micro-ecology of the bowel as it is presented in the literature of the biological sciences. This new material has been reconciled with information from the last century. The end result, I hope, is a responsible synthesis of science and medical empiricism.

This is not only a course for physicians, but also for the person who is seeking some good scientific infrastructure for the more creative aspects of classical homeopathy. The course is a true integration of both the rational side of scientific medicine and the creative and flexible side of homeopathy. I am aware that a course cannot really be all things to all people; however, I have been very sensitive to the feedback I have had from participants over the years. I use it every time to update the materials and to improve them. I anticipate doing that again, after teaching in the United States.

I see the course as being a scientific integration

of new knowledge with old knowledge; finding the bridges, and finding the connections between the two. There is a lot of fascination in this, and it creates a degree of security in the people who are using the bowel nosodes to understand that they are not pulled out of some kind of virtual space. They are not purely abstract materials. They are based on high quality clinical observations with parallels in modern science. This information should help people feel secure about their work with these materials.

About the interviewer: About the Author: Ronald Whitmont, M.D. maintains a private practice in classical homeopathy in Amenia, New York. He is board-certified in internal medicine. Dr. Whitmont serves as Vice President of the Homeopathic Medical Society of the State of New York. AJH

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