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Ajai R. Singh, M.D.
Shakuntala A. Singh, Ph. D.



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Mens Sana Research Foundation
Mumbai, India
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Psychiatry, Science, Religion and Health

The six diverse topics covered in this MSM Annual 2004 are an attempt to present to the contemporary thinking mind some of the major concerns of our society today. They include topics in the four areas of Psychiatry, Science, Religion and Health. Psychiatry is important since it concerns psychopathology of the human mind and living. Resolving them would mean laying the foundations of correct thought and appropriate action. Science is important because this age belongs to it, and therefore there is the challenge, as also the danger, that this age maybe usurped by it. That is possible because the interests of Science and Man may clash, and the former may supercede the latter. Religion is important because faith, the cornerstone of religion, plays a great role in guiding man's thinking and actions. And anything that guides can also overwhelm and misguide. That thin dividing line which cannot be transgressed needs to be clearly demarcated by the contemporary rational mind. Health is important because it is often taken for granted, and its true value realised only after it is lost. Moreover, health is as much an individual as a social concern.

This volume, a collection of six monographs published between May 2003 and April 2004, covers a wide expanse of stimulating material for the reader interested in deeper understanding of issues which concern man and society today, as both grope forward in search of understanding and nodal points for concerted action.

Psychiatry, Science, Religion and Health is dedicated to the memory of esteemed Psychiatrist Prof. L.P. Shah.

About the Authors :

Ajai R. Singh, M.D. is a Psychiatrist who has earlier worked with the WHO Collaborating Center in Psychopharmacology in India.

Shakuntala A Singh, Ph.D., is Reader and Head, Dept. of Philosophy, Joshi-Bedekar College, Thane, India. She has earlier been a Fellow of the Indian Council of Philosophical Research.

They are founders of the Mens Sana Research Foundation, India.

About us

- ★ *The Mens Sana Monographs attempt to give in-depth understanding of Psychiatric /Psychological/Philosophical consequences of social disorders / issues and current events, written in an easy to read format, avoiding technical jargon as far as possible, but based on evidence and research studies. Every monograph is to be followed by enlightened discussion on the issues raised by interested readers / scholars. You may forward your views / comments to the editors for incorporation, which may be suitably modified wherever necessary.*
- ★ *The Mens Sana Monographs provide a wide platform for serious discussion by psychiatrists, social scientists, philosophers, psychologists, sociologists and other thinkers interested in exploring social issues with scientific rigour.*



*Je m'en vais chercher un grand peut-être. I go to seek a great perhaps.**



The Late Dr. L. P. Shah

(22.4.1936 - 31.3.2004)

*Psychiatrist, Mentor, Guide
and
Above - all
a
Wonderful Human being*



**[Attr. last words, Francois Rabelais]*

Profile In Courage*

Dr. L. P. Shah

Qualifications : M.B.B.S., D.P.M., F.R.C.Psy., F.A.P.A., F.I.P.S.

Affiliation : Professor and Head, Dept. of Psychiatry, G.S. Medical College and K.E.M. Hospital. In charge, Deaddiction Centre of Excellence.

Teaching : U.G. and P.G. students (Medical), Nursing students (K.E.M.), Social Work Students (T.I.S.S.), Nursing Students (S.N.D.T.), Doctors (G.P.Assn.), P.G. students' clinics (Free) in his consulting rooms, P. G. examinations at various universities.

Research work: Mostly in Psychopharmacology. Collaborative work with Pharma Dept. and various Pharmaceutical companies. WHO Fellowship to visit USA 1976 and Sweden 1978. More than 100 Publications. Also work on Ayurvedic Drugs.

Attachments to other Welfare Organizations: H.N. Hospital – P.T. Clinic, Shushrusa Co-op Hospital, Nagpada Neighbourhood House- Child Guidance Clinic., B.G. Rescue Home –C.G.C., Bapnu Ghar Organization for Women.

Achievements : He had excellent organizational ability and management skills and was a very efficient administrator. People called him *Bhishma Pitamaha* of Indian Psychiatric Society.

Bombay Psychiatric Society : Secretary in 70's; President – 1977-78. *I.P.S. West Zone:* Secretary -1971-78; President –1982-83. General Secretary, *Indian Psychiatric Society* -1981-86; President I.P.S., 1988, at Varanasi. *Indian Association of Social Psychiatry:* Council member; President: 1993-94. *Indian Association of Child and Adolescent Mental Health :* Founder member; President -1997. *Indian Association of Industrial Psychiatry:* Founder member, President. *Indian Association of Suicidology:* Founder member, President.

- Invited by Lions Club International Dist. 323A as an Advisor for World Conference on Drug Awareness *Hope 88*, and subsequently too.
- Since he was Fellow of The Royal College of Psychiatrists he was able to sponsor more than 100 students to U.K. on ODTS and Double Sponsorship Scheme.
- Being an excellent clinician, and due to his persistence and hard work for alcohol and drugs dependent patients, K.E.M. Hospital got the Deaddiction Centre of Excellence in 90's.
- His book- *Hand Book of Psychiatry* coauthored with Ms. Hema Shah, is the first book on Psychiatry written by an Indian author and is popular with undergraduate medical students, nurses and other paramedical students. It has undergone more than ten editions.

Awards :

- i He got the best paper award in 1974 at the West Zone Conference of I.P.S.
- ii. He got the highest I.P.S award at Bhubhaneshwar Conference- Dr. D.L.N. Murti Rao Oration which was delivered on the subject-*Forensic Psychiatry*.
- iii. He was given *Drishti Gaurav Puraskar* on World Sight Day- 11th Oct 2001 by Lions Club International Dist 323A2.
- iv. Finally, he has been awarded *Dr. V.N. Bagadia Life time Achievement Award* in 2004, just before he expired.

Awards instituted in his name :

- i. Dr L.P Shah best paper award at B.P.S.
- ii. Dr L.P.Shah oration at W.Z.I.P.S.
- iii. Dr Marfatia Award for best paper at Indian Association of Child and Adolescent Mental Health.

* This bio-data prepared by Ms. Hema Shah for MSM (-eds).

What He Meant To Me

- Hema Shah



Ms . Hema Shah & Dr. L. P. Shah

After reading *Profile In Courage* and noting all his achievements, one may wonder whether he had any time for me. Those who knew him well know that I was the guiding force behind him throughout, and he openly acknowledged it to others.

In the year 1962, I joined the Psychiatric Dept. of K.E.M. Hospital in Dr N. S. Vahia's unit as a Psychiatric Social Worker. Dr L.P. Shah was the Registrar in the unit and was to appear for the D.P.M exam. He was a person full of confidence, highly knowledgeable, respected by one and all and looked like a junior boss to me. I was scared. Gradually, I realized that underneath that garb of sternness, highly disciplined, systematic and firm attitude, was an affectionate, considerate and caring person. He was extremely nice to patients, friendly with colleagues and helpful to others. We were working together on some research papers for Dr. Vahia, who was to go to USA to present papers for a conference. As I started knowing him more I realized that there was some hidden sorrow somewhere which was due to his poor vision. I developed lot of compassion for him. At the same time I was amazed that a person with such sterling qualities, in spite of his disability, was not only trying to compete with the well sighted, but also wanted to surpass them, which ultimately he did. When he mentioned about it I had only one *shloka* to encourage him:

रथस्येकं चक्रं भुजगयमिता सप्ततुरंगः निरालम्बो मार्गः चरणरहितः सारथीरपि ।

रविर्यातिवांत्यं प्रतिदिनंमुपारस्य नर्भसः क्रियासिद्धी सत्त्वे भवति महतां नोपकरणे ।।

(The sun in the sky travels everyday with all odds against him, like a chariot with one wheel, seven horses trod by serpents and the driver without legs. Great people don't depend on these accessories. They achieve their goal by their spirit and determination.)

He was so much inspired by this *shloka* that he always remembered it. Here was a diamond which needed proper setting by a skillful mentor so that it will dazzle the world around. We became good friends because of our common interests viz.: social psychiatry, music, dramatics and reading, more than that, the ambitious nature and common goals. I went to USA with a Fulbright Scholarship to study further and he started as an Assistant Professor in Psychiatry at G.S.M.C. and K.E.M. Hospital, simultaneously building up his private practice. He also started offering honorary services to certain welfare

organizations in the afternoons. Thus, he was working for at least 14 hours a day. He had a tremendous capacity to work sincerely, and with devotion. After my return, we got married in 1965, fully realizing that a life full of struggle and hard work was in store for us. We accepted the challenge willingly and whole heartedly. My only aim was to see that in spite of his visual difficulties he should come up in life and fulfil his dreams. In return, he saw to it that I got all the comforts in life. He knew my strengths and weaknesses and saw to it that the best in me could be brought out and achieved professionally, socially, and at a personal level.

We travelled all over the country because of he shouldering the I.P.S responsibilities and that of other Psychiatric Associations in which I also participated by presenting papers, becoming a Council member and also becoming President of two associations: Indian Association of Social Psychiatry and Indian Association of Child and Adolescent Mental Health. He was a dynamic person, hardworking and courageous. He had the knack of inspiring others also to do so because of his leadership qualities. He encouraged the students by bringing out their potential for going ahead. He was never jealous of anyone even if they went ahead of him. He praised them for their achievements and guided them with genuine interest. Even the parents of his students were his great fans. He always enquired about the family members of the students, because he felt no one was complete without family support. Even though he lost sight during the last few days, he had strong memory of a person's voice and could recognize them just by their tone. He had such a strong memory, that in one of the conferences, his assistant was to present a paper but the organizers insisted that he present it as the principal author. He asked the assistant to read the text ten minutes before the presentation and he could recite the contents without any difficulty, along with the slides presented. Everyone in the audience was stunned. Such were the gifts given to him by the Almighty, whom he prayed to, day in and day out.

He was invited by various universities as an external examiner and the students who appeared before him for *viva voci* praised him, as they found them to be more like teaching sessions. He was always popular among the students for his teaching methodology.

The only difficulty that came up between us was the time factor. He was always punctual and wanted to reach every destination before time. He would get anxious when if I could not keep the time schedule. He even felt that we are going to miss the train or the flight to a conference. Fortunately, it never ever happened. But, in the end he went earlier, and alone, without waiting for me to join him. *I don't know why he was in such a hurry.*

Probably it is destiny, for I have still to complete some of the work which he could not in his life.

In the end, I quote in Marathi-

झाले बहू होतील बहू। परंतु या समहा।

So many great people have come in this world in the past and so many great will be born in times to come. But He was the only one of his kind.

Ms. Hema Shah, wife and lifelong companion of Late Dr. L.P.Shah did her MA in Sociology from Mumbai University, and MA in Medical and Psychiatric Social Work from the Tata Institute of Social Sciences. She went on a Fulbright Scholarship to the USA for further training in Family Therapy, Group Therapy and Individual Counselling. She worked in the BMC at L.T.M.G Hospital Sion, and KEM Hospital Parel, and in Seth G.S.Medical College as a Lecturer. At present she is in private practice as a Social Counsellor and Psychotherapist.

Ms. Hema Shah has won the West Zone I.P.S. Best Paper Award in 1975. She has been President, Indian Association of Social Psychiatry 1999, and President, Indian Association of Child and Adolescent Mental Health 1997-99. She has also done a Certificate Course in Hospital Management with the BM Association and has a certificate in Computer course. She is coauthor of Hand Book of Psychiatry along with Late Dr. L.P.Shah. She intends bringing out all his papers compiled in a book form soon.(MSM wishes her all the very best in this endeavour. - eds.)

*Not still a subscriber to the Mens Sana Monographs?
Come on, for once, do yourself a good turn.*

Acknowledgements

Anything new started is always with mixed feelings. There is the joy of novelty, the determination of a missionary, but also the apprehension of a new comer. Will it click? Will it be liked? Will it serve any purpose at all? Is it worth the effort?

From the responses received, I can safely say that the phase of apprehension is over. Colleagues and friends from all over, esteemed teachers and researchers have called up or written to encourage the effort. I am extremely grateful to them. My esteemed teacher the late Prof. L.P. Shah from Mumbai was the first to call and offer appreciation. Prof V.N. Bagadia, teacher to so many of us, revered in the field of Psychiatry, called me up to congratulate me and sent in his subscription for *MSM*. *I indeed felt blessed*. It was also very gratifying to receive the subscription of Prof. N.N. Wig, another revered name in the field psychiatry, and of Prof (Dr.) S. G. Mudgal, a well respected name in the field of philosophy. The first subscription for *Mens Sana Monographs* to reach by post was from Prof. K. P. Dave, a friend and guide to so many of us in Psychiatry. My friend Dr. Milind Shejwal insisted on being the first subscriber and first gift subscriber, and my other friend Dr Vijay Thakker insisted on being the second only because the first was earlier taken over by Dr Milind. *MSM* has subscribers from all over India including Jalandhar, Ranchi, Kolhapur, Hyderabad, Vijaywada, Madgaon, Bhubhaneshwar, Miraj, Mysore, Satara, Panjim, Panchakula (Haryana), Srinagar, Mangalore and of course Mumbai, Thane and its outskirts. We wish to thank all of them for being with us. Mr. Thadani from Zion Pharmaceuticals offered to get the Publication registered with the Registrar of Newspapers and my grateful thanks to him. Zion Pharmaceuticals spontaneously offered to reach the first monograph to mental health workers all over India and I think that was indeed a very fine gesture on their part. Dr. A. K. Shinde and Ms. Geetanjali Shinde offered to sponsor a whole issue of *MSM* and we are grateful to them. They are waiting to sponsor another. My friend Subhash Nayak has taken over typesetting and printing work for which I wish to thank him wholeheartedly. I admire the patience with which he and his office carry out the numerous corrections and additions in getting the monographs ready for printing. M/s Sarfare Enterprises have been diligently reaching the issues to all corners of India promptly and they too deserve our thanks.

So many colleagues in the field of psychiatry, medical professionals, college libraries, journalists and friends working with NGO's have become subscribers and appreciated the effort. Prof. N.N. Wig, Prof. Emeritus, PGIMER, Chandigarh has written a letter "to express my appreciation of the work you are doing. It is something different from the routine medical articles in India and hence a refreshing and welcome change". Dr. S.M. Channabasavanna, Former Director / Vice Chancellor, NIMHANS, writes to say "he really enjoyed going through them (copies of *MSM*) because of their

topics of current interest, whether it is suicide free society, public health policy or the current one on the goal Health for all. These are all contemporary issues, which concern professionals, public and the government. I only wish all the agencies concerned about Health read these meaningful articles and take up the issues. I congratulate Dr. Shakuntala A Singh and yourself for your excellent work". Prof Srinivasa Murty, Prof. of Psychiatry, NIMHANS, Bangalore, has written to "congratulate you for writing a very important document", and sent an interesting information manual on *Riots : Psychological care for Individuals*, which makes interesting reading. Dr. R. M. Chokhani, fellow psychiatrist and friend, has written "to felicitate you two on your endeavour to bring about the Fourth Psychiatric Revolution through the Mena Sana Monographs". Dr M. G. Khandekar, esteemed Senior Family Physician, has written about his otherwise hale and hearty anaesthetist sister settled in the U.S.A., who suffered a massive cardiac arrest from viewing of the WTC collapse beamed continuously on TV channels and who unfortunately expired. Dr. C. Shamasundar from Bangalore writes back to say, "It is an important issue and very timely and can be a good stimulus for Indian authors to start addressing such problems in greater numbers... Keep up the good work".

All in all, a satisfying first year which motivates us to enter the second with this Annual 2004. I seek your suggestions and advice, your views and opinions on the issues raised by this collection. Please feel free to write or call. It will be a great pleasure to interact with you.

Meanwhile, all the best.

Ajai R. Singh

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Introduction

Conceptual Foundations of Mens Sana Monographs

*We are not here to do (only a little better) what the others do.
We are here to do what the others cannot do because they do not
have the idea that it can be done.*

- The Mother, Sept. 1961.

We have great pleasure in placing the *Mens Sana Monograph Annual 2004* in your hands. Its a year since we embarked on this journey. And we may be led to believe the first year is an important one in the life of any publication, as in the life of an individual. (We can safely presume Freud would be nodding approvingly to this in heaven.) A collection of all that appeared till now, suitably edited and compiled in a book form, would not be amiss. Hence this endeavour.

Middle Path

Mens Sana Monographs (MSM) tend to look at events and issues from a somewhat different perspective. There are two main types of publications. Both serve important needs and have a committed readership. One type tends to be academic and technical to the extent of being incomprehensible to anyone except one intimately connected with the subject. These are the mainstream academic research publications of the respective disciplines. One the other hand are periodicals that cater to the interests of the moment, which are racy, sensational and as easily forgotten as eagerly read. (Not that they lay claims to any eternity.) These are the newspapers, magazines, tabloids and other periodicals which fulfil our need to be aware of the multiplicity of the environment in which we exist. Both these approaches, though important, however leave a gap. The academic can be too austere for comfort, the tabloid too familiar for deeper reflection; the former too bland, the latter too spicy. An approach that provides food for thought and reflection without being too technical and elitist is therefore likely to bridge the divide between them. In other words, neither bland nor spicy: nutritious but without foregoing taste. *MSM* has been an attempt in that direction. This *middle path* is the first fundamental pillar of this publication.

Comprehensivity and Evidence

The second is *comprehensivity*. The six diverse topics covered in this *MSM Annual 2004* bear testimony to the fact that *MSM* intends to live up to its vision of providing 'in-depth understanding of psychiatric/psychological/philosophical consequences of social disorders/ issues and current events, written in an easy to read format, avoiding technical jargon as far as possible, but based on evidence and research studies'. For example the first three monographs deal with psychiatric issues/ disorders or current events. They are (1) *Psychiatric consequences of the WTC collapse and the Gulf war*; (2) *Towards a suicide free society: Identify suicide prevention as public health policy*; and (3) *What shall we do about our concern with the most recent in psychiatric research?* The fourth monograph deals with an issue in the philosophy of science (*Replicative Nature of Indian Research, Essence of Scientific Temper, and Future of Scientific Progress*). The fifth monograph deals with an attempt by Gandhi to resolve the social disorder and strife that diverse religious beliefs can occasion in a multireligious society like India (*Gandhi on Religion, Faith and Conversion: Secular Blueprint Relevant Today*). The sixth and final monograph deals with health not just as an individual or medical concern, but as a social issue, wherein health of the members of society can only be ensured by the people's awareness of their rights, and active participation in a health conscious community's movement towards better health (*The Goal: Health for All; The Commitment: All for Health*). Hence the title of this collection: *Psychiatry, Science, Religion and Health*.

The six topics covered are different in content and, if we may dare to say, comprehensive in their scope. *MSM* intends to provide a wide platform for serious discussion by thinkers in diverse fields like 'psychiatrists, social scientists, philosophers, sociologists and other thinkers interested in exploring social issues with scientific rigour'. Hence the topics covered tend to be different and comprehensive too. But *evidence* and *scientific rigour* in studying even social issues is another essential pillar of the *MSM*. Therefore mere impressionistic portrayals and opinions not backed by necessary evidence may hardly find a place in these monographs.

Eclecticism

If the *middle path*, *comprehensivity* and *evidence* are the three pillars of *MSM*, the fourth is *eclecticism*. The *MSM* is not committed to any ideology or approach to the exclusion of the rest, nor does it have any private agenda to fulfil. Its only commitment is to further understanding and awareness of issues of consequence to society with special emphasis on social issues, psychological awareness and health, especially mental health. Its approach

shall always remain an integrated one, a conglomerate of all evidence-based approaches that best clarify matters and motivate individuals and groups towards action aimed at reduction of social morbidity and psychopathology.

We only hope the vision, and momentum generated in the present, can be maintained in the years to come. And you too feel part of this whole movement, and share its enthusiasm to make a difference where it matters. But if that is something to feel proud of, let us also note that to start something different is difficult but not very, but to sustain it, is. And its how these four pillars sustain the *MSM* in the years to come that will test the strength and resilience of *MSM*, as of the four concepts themselves. We hope here too you feel part of this whole endeavour.

Prof. L. P. Shah

This *MSM Annual 2004* is dedicated to the memory of a well respected name in the field of psychiatry, the late Prof. L. P. Shah. His contribution to the making of a number of psychiatrists (including one of us), to the development of Indian Psychiatry, and to the linkage of Indian Psychiatry with World Psychiatry have been, to say the least, substantial. His staunch belief in Psychiatry as a medical discipline was matched by the equally strong belief that Psychiatry could not do away with psychotherapy and deeper understanding of the psyche of an individual. And that Psychiatry also had an important role to play as a social science. Moreover, his whole life was a great testimony to the triumph of the spirit over matter. All those whose lives were touched by this gentle soul can only feel ennobled by the deep impressions that his magnanimous personality left on them. His commitments and beliefs were well matched by his life long companion and life partner, the gentle and most gracious Ms. Hema Shah, herself a contributor of no small magnitude to the Mental Health Movement in India. We carry a homage to this important pillar of Indian Psychiatry written by her. We do deeply appreciate her gesture in writing this dedication and thank her for rising above her personal grief and loss to communicate her thoughts and feelings about this noble soul. The *Mens Sana Monographs* wish to offer deepest condolences to her on this irreparable loss and hope and pray his soul rests in eternal peace (and *prashanti*, as he was always prone to point out). We hope and pray that his zest for life and work in the field of Psychiatry, and his fine qualities of head and heart, continue to guide scores of psychiatrists of today, and the future, to respond to the challenges of change in their branch with freshness and spontaneity, but without being overwhelmed by any.

Psychiatrists as Psychopharmacologists

Its exiting times in which we live. So much is changing all around, and yet so much needs to remain, and does remain, firmly rooted. Changes sweep the dust of indolence and laxity, besides of course sweeping off the desirable too at times. The decisive paradigm shift towards psychopharmacology and biological approaches to behaviour has alarmed a number of senior practitioners and senior researchers in Psychiatry. That Psychiatrists are turning more psychopharmacologists and lesser psychotherapists is the reality of today. But that is no real cause for alarm. Because as long as they produce results and back up their opinions with evidence, they indeed need to prosper. The apprehension, of course, is that legitimate growth of psychotherapy may get sidelined, or the brighter minds may be averse to taking up psychotherapy because it is no longer the in-thing to do. But such a flux state is inevitable in the advancement of any branch. Ultimately, the psychotherapeutic approach itself will benefit by shedding its smug somnolence, become more evidence and experiment based, offer verifiable population statistics to back up its contentions, and compete with biological approaches with greater methodological rigour. This *manthan*, or flux, is inevitable, and indeed welcome, if we wish to chart new and exciting frontiers in the field of Psychiatry in particular, and all social sciences in general. The discomfort of today is only a prelude to the comfort of tomorrow. Hopefully. For the seeds of comfort lie in every discomfort, as the seeds of discomfort lie in every comfort.

We are indeed fortunate to live in such exciting times. The *Mens Sana Monographs* will attempt to unfold some of the dramatic changes as they occur during this period.

Hope you are with us all the way.

Ajai R. Singh
Shakuntala A. Singh

The First Monograph

Psychiatric Consequences of WTC Collapse and The Gulf War

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The only thing necessary for the triumph of evil is for good men to do nothing.

- Edmund Burke (Attr.)

Preface to the First Monograph

The Fourth Psychiatric Revolution

At present, psychiatry is in the midst of a fourth revolution. The first revolution was the so-called Moral Treatment which involved the activism of Phileppe Pinel (1745-1826) and William Tuke (1732-1819), as also the efforts of Dorothea Dix (1802-1887). This resulted in destigmatization of the lunatic label which had earlier meant treating the insane in a dehumanizing manner e.g., chaining them to walls, displaying them for money etc. It resulted in the transition to custodial care and the opening of mental hospitals. The second psychiatric revolution was the Mental Hygiene Movement heralded by the eye-opening works of Elizabeth Packard (*Modern Persecution or Insane Hospital Unveiled*) and Clifford Beers (1876-1943; *A Mind That Found Itself*) which was furthered by, amongst others, pioneers like Adolf Meyer (1866-1950) and William James (1842-1910). This was followed by the third Psychiatric revolution, that of the Community Psychiatry Movement. This involved community participation, removal of restrictions, comprehensive set of services multi-disciplinary in nature, active consumer participation, mental health consultancy and preventive measures. This well intentioned grand movement had its problems, as all such grand movement must indeed have. It became the fountain-source of a fresh crop of difficulties related to transinstitutionalization in boarding and halfway houses, with increased rates of hospital admission, and the 'revolving door syndrome'. Moreover, it led to an ominous rise in contact between the criminal justice system and the mentally ill as they moved more freely in the community.

Today, we are in the midst of a silent by strong fourth revolution. Firstly, this revolution reiterates its strong linkage with the mainstream of medicine. Secondly, it bases itself on strong, empirical findings based on rigorous methodological studies, mainly biological. The major paradigm shift of contemporary psychiatry is towards methodological rigour on the one hand, and cautious forays in the neurosciences, adoption and genetic studies on the other (from where, hopefully, significant leads in understanding the aetiology of major psychiatric disorders must arise). Diagnostic refinement is a necessary step in this direction, as is use of sophisticated technology to aid the process.

And yet, we know that psychiatry, its practitioners, and its patients, do not function in a vacuum. They interact with, and are influenced by, a wide range of complex, interlinked, social and interpersonal forces.

These forces are often generated by people not directly connected with the medical speciality of psychiatry. They are the policy-planners, governments, political leaders, activists, social thinkers, NGOs, mass media, enlightened public opinion etc. They have marked influence on social thought and action, policy, funding and research. They influence people and societies often in more significant ways than the medical speciality of psychiatry considers healthy for society.

We may continue to function in a vacuum and wait for wisdom to dawn. Or, we may establish a dialogue with them and work for wisdom for happen.

The second option seems the more productive one.

No doubt, there are some psychiatrists comfortable with the biological label. There are others comfortable with the social one. Both these are needed, for they help to further robust enquiry in their respective fields. But what we also probably need is an integration, a synthesis of the mass of evidence that these two fields have produced. The inevitable conclusions drawn at our present state of knowledge based on such integration will give rise to pointers for further research as well as guidelines for policy-planners. Moreover, it will result in an awakened public opinion empowered with knowledge and evidence, its actions enlightened, and unlikely to be swayed or manipulated by unscrupulous forces.

The *Mens Sana Monographs* are meant to further attempts at such a Fourth Psychiatric Revolution, an Evidence-based, Integrated Movement in Psychiatry.

What is this monograph all about? When a war is waged, leaders and governments look at various dimensions. The deployment of troops is obviously important, as is the political fallout of such a decision. The economic implications are worked out, as are humanitarian and rehabilitative initiatives. Somewhere along the way, leaders have also to be aware of the psychiatric consequences of war (as also of terrorism), for there is a mass of data, both from the biological and sociological studies in psychiatry, which point to such a need. This monograph presents some of these evidences from recent studies.

Psychiatric Consequences of WTC Collapse and The Gulf War*

Ajai R. Singh
Shakuntala A. Singh

ABSTRACT

Along with political, economic, ethical, rehabilitative and military dimensions, psychopathological sequelae of war and terrorism also deserve our attention. The terrorist attack on the World Trade Centre (W.T.C.) in 2001 and the Gulf War of 1990-91 gave rise to a number of psychiatric disturbances in the population, both adult and children, mainly in the form of Post-traumatic Stress disorder (PTSD). Nearly 75,000 people suffered psychological problems in South Manhattan alone due to that one terrorist attack on the WTC in New York and the Pentagon in Washington. In Gulf War I, more than 1,00,000 US veterans reported a number of health problems on returning from war, whose claims the concerned government has denied in more than 90% cases. Extensive and comprehensive neurological damage to the brain of Gulf War I veterans has been reported by one study, as has damage to the basal ganglia in another, and Amyotrophic Lateral Sclerosis (ALS) in a third, possibly due to genetic mutations induced by exposure to biological and chemical agents, fumes from burning oil wells, landfills, mustard or other nerve gases. The recent Gulf War will no doubt give rise its own crop of PTSD and related disorders. In a cost-benefit analysis of the post Gulf War II scenario, the psychopathological effects of war and terrorism should become part of the social audit any civilized society engages in. Enlightened public opinion must become aware of the wider ramifications of war and terrorism so that appropriate action plans can be worked out.

Key Terms : *Gulf War, Gulf War Syndrome, Post Traumatic Stress Disorder, Terrorism, Psychopathology of War and Terrorism, Organic Brain Damage due to Chemical Warfare.*

Till a few months back, the Allied forces and President Saddam Hussein's regime were engaged in a struggle for the control of Iraq's future. Political and defence experts were busy analysing the various ramifications of that war, as were the economic pundits who were

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The terrorist attack of September 11, 2001, which destroyed the World Trade Center in New York City and damaged the Pentagon in Washington, resulted in over 3500 deaths and injuries. It also traumatized a nation. Many American citizens required psychiatric treatment.

looking into the global financial implications. Anti-war activists and peace workers, as also the U.N., the Red Cross and other humanitarian organizations, continued to be concerned with the ethical, rehabilitative and human dimensions of Gulf War II. All these were no doubt highly important issues which deserved our attention. One another dimension, which we should not miss in this whole picture, was the psychopathological sequelae of this war in particular, as indeed of war and strife in general. A brief peep into the psychiatric disturbances in the aftermath of the

terrorist attack on the World Trade Center in 2001, and the Gulf War of 1990-91, may provide us with some insight into what we may expect in Gulf War II.

The terrorist attack of September 11, 2001, which destroyed the World Trade Center in New York City and damaged the Pentagon in Washington, resulted in over 3500 deaths and injuries. It also traumatized a nation. Many American citizens required psychiatric treatment. A National Survey of 540 US adults, taken three to five days after the event and published in *The New England Journal of Medicine*, 2001, found definite evidence of psychiatric disturbances in these adults and their children (Schuster, Stein and Jaycox *et al*, 2001). Forty four percent adults reported one or more substantial stress symptoms. These included insomnia, nightmares, fearfulness, irritability and distressing recollections of the event. Thirty five percent of children had one or more stress symptoms. One interesting fact which emerged was that the level of stress was associated with television viewing of the disaster. So much for live coverage of such large scale disasters. (However, greater chance of psychiatric disturbances were found in those with a past history of psychiatric disorder, or those who had suffered significant stress in the recent past. A brief note of caution to that effect during live T.V. coverage of such events may help reduce distress to some extent.)

Most of us know that psychiatrists describe a syndrome that develops after a person sees, or is involved in, or hears of, an extreme traumatic stressor. The person reacts to this experience with fear and helplessness, persistently relives the event and tries to avoid being reminded of it. These symptoms significantly affect important areas of his life, like family and work. This syndrome is called Post-traumatic

Stress Disorder (PTSD), or Acute Stress Disorder (if it occur within 4 week of the event and remits within 2 days to 4 weeks). These disorders arise from experiences in war, torture, natural catastrophes, assaults, rape, serious accidents, fire to buildings etc. In our country India, we see this phenomenon as an aftermath of communal riots as well. The latest example of a fresh crop of PTSDs was after the post -Godhra riots which rocked Gujarat State in 2002.

But let us continue with the WTC terrorist attack. *The New England Journal of Medicine* in 2002 published a study of a later survey of Manhattan residents conducted 5-8 weeks after the World Trade Center collapse (Galea, Ahern and Resnick *et al*, 2002). 7.5 % residents had PTSD and 9.7 % had depression. This meant 67,000 people had PTSD and approximately 87,000 had depression during the time of the study. Even allowing for estimated prevalence of current psychopathology, nearly half the estimated sample, that is, more than 75,000 South Manhattan residents suffered psychological disorders due to that one terrorist attack alone*.

Higher rates for all these conditions were found in those living close to the disaster site and those exposed to prior but unrelated traumatic events. Thus, geographic proximity and stressful life events correlated closely with development of PTSD. This can become an important guideline for any subsequent work planned for such victims.

Gulf War Syndrome

So much for the Sept. 11, 2001, attack. Let us go back a little in history to Gulf War I. This war against Iraq, which began in 1990 and ended in 1991, involved 6,97,000 American soldiers, 45,000 soldiers from Great Britain and 4,500 soldiers from Canada. More than 1,00,000 US veterans reported a number of health problems on returning from war. These included irritability, muscle

More than 1,00,000 US veterans reported a number of health problems on returning from war. These included irritability, muscle and joint pain, migraine headache, shortness of breath, digestive disturbances, hair loss, rashes, forgetfulness and difficulty with concentration. Collectively, these symptoms were called the Gulf War Syndrome.

**There is a dearth of psychiatric data about PTSD and/or clinical depression following terrorist attacks in the Indian context which needs urgent attention by Indian researchers. This has been noted by the present President of the Indian Psychiatric Society while quoting from this article in his Presidential Address (Trivedi, 2004 p.10). MSM would be interested in responses from readers about systematic research carried out on this topic.(-Eds.)*

There is incontrovertible evidence of organic brain damage emerging in peer-reviewed literature. Haley and colleagues, using clinical tests and Magnetic Resonance Spectroscopy (MRS), demonstrated extensive and comprehensive neurological damage with significant biochemical changes in the brains of Gulf War veterans (Haley, Marshall and McDonald et. al., 2000).

and joint pain, migraine headache, shortness of breath, digestive disturbances, hair loss, rashes, forgetfulness and difficulty with concentration. Collectively, these symptoms were called the Gulf War Syndrome. After the recent Gulf War, there is bound to be a fresh crop of victims of this syndrome.

Many veterans believed this disorder was caused due to exposure to biological and chemical agents, fumes from burning oil wells, and landfills or mustard or other nerve gases. The US Defense Department acknowledged that upto 20,000 troops may have been exposed to chemical weapons but denied that those complaining of the syndrome were suffering because of the effects of chemical exposure.* Claims submitted by Gulf War veterans seeking disability payments were denied in over 90 % cases. The morale of

thousands of affected Gulf War veterans got seriously eroded. Confidence in the U.S. Defense Department's concern for illness amongst soldiers was compromised in the public mind as a result. The repercussions of a fresh crop of war veterans with similar symptoms which will no doubt result after Gulf War II is anybody's guess. This is not to hold any brief for the despotic Iraqi regime but only to highlight the enormous psychopathological consequences of war that power wielders force on the unsuspecting public and the loyal troops.

There is incontrovertible evidence of organic brain damage emerging in peer - reviewed literature. Haley and colleagues, using clinical tests and Magnetic Resonance Spectroscopy (MRS), demonstrated extensive and comprehensive neurological damage with significant biochemical changes in the brains of Gulf War veterans (Haley, Marshall and McDonald *et. al.*, 2000)**. Damage to the basal ganglia and subsequent neurotransmitter dysfunction can result according to another study (Haley, Fleckenstein and Marshall

*May be, we can take solace in the fact that bureaucratic callousness is not limited to India alone.

** Whether the hippocampus also plays a role in PTSD remains a controversial issue, although it has occupied the attention of some researchers (Bremner, 2001 ; Pitman, 2001).The average volume of the hippocampal region is found lowered in soldiers involved in combat operations. How specific is this change is an area of challenging future enquiry.

et. al., 2000), as can Amyotrophic Lateral Sclerosis (ALS), or Lou Gehrig's disease, thought to be due to genetic mutations, according to a third (Charatan, 2002). To be fair, the US Defense Department did agree to pay compensation to veterans who developed ALS. The vast majority of others are still waiting for the benevolent gaze of bureaucrats and leaders who never tire of waxing eloquent about the loyalty and patriotism of their troops when they send them to war.

Delving into History

A number of eponyms of PTSD have been described in the wars that have taken place in the West till now (Hyams, Wignall and Roswell, 1996). During the American Civil War, a condition was described called the *Irritable Heart*. In World War I, it was called *Effort Syndrome*. In World War II, it became *Combat Stress Reaction*. During the Vietnam War it came to be called *Post Traumatic Stress Disorder* which name has, by and far, stuck. During Gulf War I it came to be called the *Gulf War Syndrome* and after the Second Gulf War, it is likely to be labelled the *Gulf War II Syndrome*, or something to that effect. All these disorders, if seriously studied, involved certain symptoms in common. These were fatigue, shortness of breath, palpitations, headache, excessive sweating, dizziness, disturbed sleep, fainting (difficulty in concentration and forgetfulness as symptoms were added to PTSD and Gulf War Syndrome). Thus, these are only different names for the same phenomenon. What is heartening to note is that they are amenable to psychiatric treatment with psychotherapy and psychotropic medication.

Numerous psychopharmacological agents are found useful in PTSD, mainly the Selective Serotonin Re-uptake Inhibitors (SSRIs) like sertraline, paroxetine and also fluoxetine. Even tricyclics like imipramine and amitryptaline have a role to play in therapeutic doses (that is, as used to treat depression, a therapeutic trial lasting for eight weeks atleast, with medication continued for atleast one

During the American Civil War, a condition was described called the Irritable Heart. In World War I, it was called Effort Syndrome. In World War II, it became Combat Stress Reaction. During the Vietnam War it came to be called Post Traumatic Stress Disorder which name has, by and far, stuck. During Gulf War I it came to be called the Gulf War Syndrome and after the Second Gulf War I, it is likely to be labelled the Gulf War II Syndrome, or something to that effect.

N u m e r o u s psychopharmacological agents are found useful in PTSD, mainly the Selective Serotonin Reuptake Inhibitors (SSRIs) like sertraline, paroxetine and also fluoxetine. Even tricyclics like imipramine and amitryptaline have a role to play in therapeutic doses.

year before withdrawal can be thought of). Haloperidol or other potent antipsychotic may be used to control agitation and /or aggression that may accompany the PTSD.

Psychotherapy of the psychodynamic type, including abreaction and resultant catharsis, can be useful, care being taken to avoid this in the psychotic patient. Behaviour therapy, cognitive therapy and hypnosis also have a role to play , as do removal from sources of stress, support from family

and friends, and encouragement to relax and ensuring good sleep (if necessary with appropriate medication). EMDR (Eye Movement Desensitization and Reprocessing) also helps, even in children (Chemtob, Nakashima and Carlson, 2002). Group therapy can be useful as it helps sharing of the traumatic experience with others. Similarly, family therapy can be useful to enlist support of the spouse in helping the patient overcome the traumatic experience.

Concluding Remarks

Gulf War II is over and, as said earlier, will give rise to its own volume of PTSDs. The people involved, as the government and the soldiers, will no doubt have to bear the brunt. The high cost in terms of morbidity and mortality that war and terrorist attacks entail, both physical and psychiatric, is a cost governments and leaders must bear in mind as they engage in efforts at restructuring and regulating nations and peoples.

Human beings, of course, have their own compulsions to behave as they do. The mind, moreover, is adept at rationalizing and justifying every action and behaviour. This applies as much to war-mongers as terrorist think -tanks. Political leaders and fundamentalist ideologues are great masters at finding such justification and convincing people at large with their rhetoric. Not that they do not have an agenda; but it is upto the people to realize what that agenda entails, for now and the future.

In a cost-benefit analysis of the post Gulf War II scenario, along

with the economic-political-military-rehabilitative fallout, the psychological trauma that war and terrorism entails should also become part of the social audit a civilized society engages in.

If terrorism could get justice, and wars could combat terrorism, then this world would indeed have become a neat, unipolar world, suited to the designs and machinations of terrorist ideologues and *international* leaders wanting to make their mark in World History as it gets written. Fortunately, it is not a neat world, neither it is unipolar. It is time for people to reject the straitjacket that such leaders wish to put on them. It is also time for people to enjoy their multipolarity.

The rejection has to come from the people. The people who are led by the terrorists. And the people who are led to war.

When will they remove the blindfold ? Or, not avoid seeing that which is best seen uncovered?

When will they allow Buddha, Christ and Gandhi to rest in peace and avoid turning in their graves?

If terrorism could get justice, and wars could combat terrorism, then this world would indeed have become a neat, unipolar world, suited to the designs and machinations of terrorist ideologues and international leaders wanting to make their mark in World History as it gets written. Fortunately, it is not a neat world, neither it is unipolar. It is time for people to reject the straitjacket that such leaders wish to put on them. It is also time for people to enjoy their multipolarity.

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Questions that the First Monograph raises

- Q.1. What are the various psychiatric disturbances, apart from those noted in this monograph, which result from war, terrorist attacks, communal conflicts etc., that have been reported in various research studies in different parts of the world ?
- Q.2. What have been the psychiatric disturbances reported in Indian studies following the numerous terrorist attacks and the communal riots in India? What have been the psychiatric sequelae of the various wars in which India was engaged?
- Q.3. The terrorist is the product of a certain ideology and resultant training. What is it ?
- Q.4. Can terrorist acts be justified under any circumstances?
- Q.5. Can responding to terrorist threats in the form of waging wars be justified ? Is it proper to raise propagandist slogans to denounce opponents in war (e.g.. the slogan ' Weapons of Mass Destruction', *WMD*, raised as a justification for Gulf War II)?
- Q.6. Should despotic regimes be overthrown by democratic governments to liberate the people, if the people of the country feel powerless to do so ?
- Q.7. What mechanisms should be put in order by mental health workers, social activists, NGOs, International organisations, governments etc., to tackle the psychopathological fall -out of terrorist attacks and postwar health problems ?
- Q.8. Should the plight of the common man and the war veteran be considered a necessary price to pay in any war, or should it become a deterrent to leaders planning future wars?
- Q.9. If warmongers have a duty to society, do terrorists and their think-tanks have an equally important duty? How are these two to be balanced to ensure minimum of psychopathological disturbance for the common man?
- Q.10. What can the common man do to stop being manipulated by both war-mongers and terrorist think-tanks, or being browbeaten into submission by despotic regimes?
- Q.11. Is there another way to looking at this problem?

Readers Respond

I am writing this letter to express my appreciation of the work you are doing. It is something different from the routine medical articles in India and hence a refreshing and welcome change.

N. N. Wig
Prof. Emeritus, Psychiatry,
PGIMER, Chandigarh

I congratulate you for writing a very important document. As you know we have been working with the various disasters in the last 20 years. It will be useful if we can get together and discuss the common areas of interest.

R. Srinivasa Murthy
Prof. of Psychiatry
NIMHANS

Comments

(I) About the Monograph : (1) It is an important issue and very timely, and can be a good stimulus for Indian authors to start addressing such problems in greater numbers. (2) For a monograph, it is too brief. The historical background (the studies of PTSDs in the past wars/disasters) could have been in greater detail; and the outcome of those sufferers (if any such studies are available) could have been included. (3) Even now, you can, if you find it reasonable, attempt the above in the Monograph's next edition.* (4) Keep up the good work.

(II) About the contents/issues raised in the Monograph :

(1) Your idea of three earlier revolutions in the field of mental health is excellent. But the fourth revolution is not "evidence-based, integrated movement in Psychiatry". The reasons for this are many :

(a) Evidences that are currently available are not complete, nor are they capable of integration. So far, majority of research findings are 'disconnected' islands (not comparable, not logically connected, etc.), based exclusively on (i) politics of research financing (ii) Conveniences of research guides, etc.

(b) Available evidences are skewed or distorted (viz: 'biological basis of behaviour' as against the accumulating "evidence" that psychology influences biology/biochemistry!), predominantly influenced by pharmacological monarchs.

**A point well taken, but the authors do not intend this to be a comprehensive work on PTSD. Rather they wish to highlight the psychopathological consequences of war and terrorism, and PTSD is one such consequence. The monograph is brief, but pointed. May be making it very exhaustive may blunt the essence of its thrust. - eds.*

(c) Because of the reasons sited in 'a' above, a proper integration is not yet possible. Ofcourse, attempts in that direction are always worthwhile.

(2) Really, the fourth revolution will be (or can be) when all medicine is acknowledged as psychosomatic medicine (for example, in Ayurveda, there is not a single disease one of whose etiological factors is not psychological); when it is recognised that an individual's attitude and value systems will play a major role in whether he is healthy or ill.

(3) The questions that you have raised at the end are not easily answerable in a way that majority of people want to benefit from the answers.

(a) Every individual is in search of truth, but he/she wants the truth according to his own expectations. Most people are terrified by the truth. A proof of this statement in the present day culture is where progress (individual level, social level, or cultural level) is equated with a behaviour of pretence! People always strive to project an image contrary to what is .

(b) Over the decades (or centuries), there have been an erosion of values(let alone social values, even of such a personal value as sincerity to one's own belief systems). Consequently, such a corruption of values has spread to intellect, social interactions, commerce, and political behaviour. The consequences of what is happening all over the world can be likened to a state of 'septicemia' of the human race!

(c) I am not at all a pessimist. I believe that nature will cure this septicemia, but the price will be very heavy, and the time-scale very large.

- Prof. C. Shamasundar

NIMHANS

This is to felicitate you two on your endeavour to bring about the Fourth Psychiatric Revolution through the Mens Sana Monographs - All the very Best!

I wish to share with you a Quotation from a Discourse of the Buddha to the *Kalamas*, which perhaps is the First Charter of Freedom of Thought in human history. The Buddha advises therein :

DON'T ACCEPT SOMETHING BECAUSE (1) you have heard it many times; (2) it has been believed in traditionally for generations; (3) it has been believed in by a large number of people; (4) it is in accordance with your scriptures; (5) it seems logical; (6) it is in line with your own beliefs; (7) it is proclaimed by your teacher, who has an attractive personality and for whom you have great respect.

ACCEPT IT ONLY AFTER you have realised it yourself at the experiential level and found it to be wholesome and beneficial to one and all*. Then not only accept it but also live up to it.

Dr. R. M. Chokhani
Psychiatrist, Mumbai

*** Editors Note :**

Buddha express a scientific position when he gives importance to experience, and a utilitarian one when he talks of the benefit of all. This is in line with his own life which was a blend of self-realisation along with the goal of sarva-mukti , liberation for all. See also p-71, answer 2.

The Second Monograph

Towards A Suicide Free Society

Identify Suicide Prevention As Public Health Policy

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The reasonable man adapts himself to the world: the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man.

- George Bernard Shaw (Maxims for Revolutionists)

Preface to the Second Monograph

5,00,000 people all over the globe are reported to die of suicide every year.

1,00,000(20%) of them are Indians.

Suicides are under-reported by 20-100%. Which means it is more likely 8,00,000 people all over and 1,60,000 in India must be dying of suicide every year (taking mean of 20-100% reporting i.e. 60%).

Attempted suicides are ten times this figure. This means 8 million all over the globe and 1.6 million in India attempt suicide every year.

We know how much burden is placed on care-givers and health-care delivery systems when a suicidal attempt is made, besides ofcourse its psychosocial sequelae .

Suicides and attempted suicides are reaching epidemic proportions and hence qualify to be made the focus of public health policy in India and abroad.

98% of suicidal deaths have a psychiatric disorder. Therefore better and more affordable psychiatric care is the first important step in suicide eradication. Depression is one psychiatric disorder where suicidal threat is the greatest. Hence specialised Centers to treat Depression, like there are Heart Institutes, are the need for the hour.

Suicide is also found more in the widowed, single or divorced, those with alcohol or drug abuse, those with chronic physical and mental illness, and those living alone or in lodging homes. The key factor is social isolation. Hence methods to reduce social isolation are the second important step in reducing suicide rates.

Social disintegration is another notable factor responsible for the rise in suicides rates in societies. For example, Lithuania reported the world's highest suicide rates following collapse of the former Soviet Union. Similarly suicides are more common in migrants and changing populations, who experience social disintegration (along with social isolation).

Hence to make society suicide-free, a three pronged attack is necessary :

- 1) Reduce Social Isolation.
- 2) Prevent Social Disintegration.
- 3) Treat Mental Disorder.

Moreover ,the attack will have to be mounted on a war-footing. The need is to first of all identify suicide prevention as public health policy. Just as we think in terms of malaria or polio eradication, or have achieved smallpox eradi-

cation, we need to work towards suicide eradication. Just as we have got sensitized to the AIDS epidemic, we also need to be aware of the suicide epidemic raging all around us.

If that appears farfetched, just remember that man landing on the moon, wireless communication, digital mobile communication technology, and the internet were all farfetched ideas once upon a time.

The need is to become aware of the problem, not get overwhelmed by the enormity of the task, and plan concrete steps towards achieving the goal of making society suicide free.

Towards A Suicide Free Society

Identify Suicide Prevention As Public Health Policy*

Ajai R. Singh
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ABSTRACT

Suicide is amongst the top ten causes of death for all age groups in most countries of the world. It is the second most important cause of death in the younger age group (15-19 yrs.) , second only to vehicular accidents. Attempted suicides are ten times the successful suicide figures, and 1-2% attempted suicides become successful suicides every year. Male sex, widowhood, single or divorced marital status, addiction to alcohol or drugs, concomitant chronic physical or mental illness, past suicidal attempt, adverse life events, staying in lodging homes or staying alone, or in areas with a changing population, all these conditions predispose people to suicides. The key factor probably is social isolation. An important WHO Study established that out of a total of 6003 suicides, 98% had a psychiatric disorder. Hence mental health professionals have an important role to play in the prevention and management of suicide. Moreover, social disintegration also increases suicides, as was witnessed in the Baltic States following collapse of the Soviet Union. Hence, reducing social isolation, preventing social disintegration and treating mental disorders is the three pronged attack that must be the crux of any public health programme to reduce/prevent suicide. This requires an integrated effort on the part of mental health professionals (including crisis intervention and medication/psychotherapy), governmental measures to tackle poverty and unemployment, and social attempts to reorient value systems and prevent sudden disintegration of norms and mores. Suicide prevention and control is thus a movement which involves the state, professionals, NGOs, volunteers and an enlightened public. Further, the Global Burden of Diseases Study has projected a rise of more than 50% in mental disorders by the year 2020 (from 9.7% in 1990 to 15% in 2020). And one third of this rise will be due to Major Depression. One of the prominent causes of preventable mortality is suicidal attempts made by patients of Major Depression. Therefore facilities to tackle this condition need to be set up globally on a war footing by governments, NGOs and health care delivery systems, if morbidity and mortality of the world population has to be seriously controlled . The need, first of all, is to identify suicide prevention as public health policy, just as we think in terms of Malaria or Polio eradication, or have achieved smallpox eradication.

Key Terms : *Suicide Prevention, Social Isolation, Social Disintegration, Depression, DALY (Disability Adjusted Life Years), Global Burden of Diseases, Psychiatric treatment in suicide*

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Introduction

A student kills himself to escape the ignominy of exam failure. A woman burns herself to escape daily harassment by in-laws over inadequate dowry. A finance dealer ends his life to fend off the horde of creditors. The scion of an industrial empire kills himself after an uneasy marital relationship. The scion of another empire shoots himself after killing family members in an inebriated state. A stockbroker ends life after suffering huge losses in a stock market crash. Three sisters hang themselves from the ceiling fan as they see no end to their poverty and misery. A mother jumps to death with her kids for a similar reason. Lovers fling themselves from ‘suicide points’ all the world over. Buddhist monks immolate themselves over Vietnam. Roop Kunwar commits Sati at Deorala. A sadhu immolates himself over a Ram Temple at Ayodhya. Fans immolate themselves over the death of a politician cum matinee idol, and even over the arrest of another such. A terminally ill patient ends his (and other’s) misery by taking an overdose. Another requests for, and secretly gets, euthanasia performed to end his saga of endless pain and suffering. A Film Director falls from the terrace under suspicious circumstances and we accept it as an end because he was suffering from Chronic Depression. Somehow, the diagnosis helps us place the event in perspective and accept it as justified, even if undesirable. It does not shock us, or benumb us, as much as the others.

Are these just gory newspaper headlines we avidly read but quickly gloss over ? Macabre details to acknowledge, but knowingly accept as inevitable facts of life ? It does not involve us, so we do experience a twinge of compassion, a brief wringing of the heart, and pass on. Are we to feel guilty ? That hardly helps, unless it is a propeller to action. Is our bored insulation justified ? That is so only if denial is the sole mechanism we utilize, and ostrich the only animal we admire.

We know that suicide has existed since time immemorial, but we also know that the modern attempts at suicide prevention have not. Number of people feel secure that suicide does not affect them, they are not suicide

We know that suicide has existed since time immemorial, but we also know that the modern attempts at suicide prevention have not... Everyone in his lifetime has contemplated suicide sometime or the other, and almost everyone knows of someone or the other whose life has been prematurely terminated in this manner.

prone. Their family members are reasonably secure, confident types, not the ones to succumb to suicidal thoughts and impulses. The fact, however, is that everyone in his life time has contemplated suicide sometime or the other, and almost everyone knows of someone or the other whose life has been prematurely terminated in this manner. And even if we know people do commit suicide there is something tangible and definite we can do to save a life. So to think of moving towards a suicide free society may not be that farfetched an idea.

Should we join the crusade towards a suicide free society? Maybe. But any standpoint is worth consideration only after we review the facts of the case.

Here, then, are some of the facts.

The Magnitude Of The Problem

More than 4,00,000 people commit suicide all around the world every year. It is amongst the top ten causes of death for all ages in most countries of the world. In some, it is amongst the top three causes of death in the younger age group (15-34 years). Moreover, it is the second most important cause of death in the age-group 15-19 yrs., second only to vehicular accidents. Which just goes to show how young and prospectively brilliant lives are snuffed out in this tragically premature manner.

If this were not enough, we must note that suicide is under reported by 20-100%. If we take the 1994 figure reported above as the base, this figure in 2000 was projected as 5,00,000 plus. Even if we take 60% under-reporting (average of 20-100%), we are talking of around 8,00,000 lives all around the globe getting exterminated in this manner every year. And the figure is rising. If this does not qualify for it to be called a public health issue, what does ?

Moreover, this is the figure of successful suicides. Attempted suicides are around ten times the figure i.e. 8,000,000 people attempt suicide, out of which 8,00,000 succeed in ending their lives. Attempted suicides involve a great effort on the part of medical and paramedical professionals and health care delivery systems, the immediate caregivers, the NGOs, and society at large to manage this colossal burden of morbidity and mortality. Moreover, research studies have found that 1-2% attempted suicides become successful suicides every year. This means 10-20% attempted suicides will end their lives in a decade.

Therefore, prevention and treatment of both potential and attempted suicides and identifying the population at risk has to become a major public health priority area.

A number of risk factors of suicide have indeed been identified. Factors that predispose to successful suicide are male sex (males outnumber females 2.5:1; while in attempted suicides, females outnumber males 10:1); widowed, single or divorced marital status; addiction to alcohol or drugs; concomitant chronic physical or mental illness; people staying in lodging homes or living alone and in areas with a changing population. The key factor probably is social isolation, for the widowed and single consistently have higher suicide rates than the married, and widows with children have lower rates than those without. Such at risk population, in other words, is in greater need of psychosocial measures involving crisis intervention and rehabilitation.

Consider the Indian scenario, which is equally pertinent to us, probably morose. As elsewhere, suicide is amongst the top ten causes of death here, and amongst the top three between the ages 16-35 years. While in 1984 around 50,000 people committed suicide (50,571, i.e. 6.8 per lakh), in 1994 this figure rose to 90,000 (89,195 i.e. 9.9 per lakh). At present we have nearly a lakh Indians dying of suicide every year, which is 20% of the world suicide population: another dubious distinction for this country, beside the population explosion. And suicide attempters are ten times the suicide completers. This means around ten lakh Indians attempt suicide every year, out of which one lakh succeed*. What an ironic success rate indeed! In other words, 2740 people attempt suicide and 275 Indians kill themselves every day by suicide. Even the greatest supporter of eugenics or population control would not even remotely recommend such a method.

We just discussed that suicide is under-reported. There are various reasons for this, common amongst these being the competence in medicine and law of those who issue Death Certificates, the mechanism used for collecting vital statistics, and the social and cultural attitudes of the community. For, we must know that, unlike most other causes, suicide stigmatizes the survivors as well.

Around ten lakh Indians attempt suicide every year, out of which one lakh succeed. Around eight lakh people all over the globe die of suicide every year. And the figure is rising ... moreover suicide is under reported....

**And if we consider even 60% under-reporting, the figure is 16 lakh attempters and 1.6 lakh suicidal deaths (-eds.).*

In an important W.H.O. Study, Bertolate (1993) established a clear-cut connection between suicide and mental disorders. He found that out of a total of 6003 suicides, 98% (5866) had a psychiatric disorder. While affective disorder (i.e. Depression and Mania) was found in 24%, 22% showed Neurotic and Personality Disorders, 16% had substance abuse (alcohol and/or drugs), 10% had schizophrenia and 21% had other mental disorders. Only in 2% cases no psychiatric diagnosis could be made.

W.H.O. Study

Before we decide what public health measures need to be adopted, we must also know what are the findings of relatively recent researchers. In an important W.H.O. Study, Bertolate (1993) established a clear-cut connection between suicide and mental disorders. He found that out of a total of 6003 suicides, 98% (5866) had a psychiatric disorder. While affective disorder (i.e. Depression and Mania) was found in 24%, 22% showed Neurotic and Personality Disorders, 16% had substance abuse (alcohol and/or drugs), 10% had schizophrenia and 21% had other mental disorders. Only in 2% cases no psychiatric diagnosis could be made.

This study effectively proved what psychiatrists all around the globe who handled suicidal patients knew all along. That there was a strong case for a

connection between psychiatric disorders and suicide. And the centuries of theological and moral debate over whether a person had the right to end his life or not, or whether it was a sin or not, was not really based on an awareness of the ground realities, for it applied to a few isolated cases. The legal position of considering suicide as a crime against the State had also missed the mark. They were all well intentioned but poorly informed attempts at suicide prevention. This W.H.O. study, and earlier and subsequent ones, prove that mental health professionals have an important role to play in the prevention and management of suicide. The very fact a diagnosis can be made implies some methods of treatment, prevention and rehabilitation can be applied.*

But we must not forget that if mental health workers have an significant role to play, so have a number of others. Society itself has the notorious ability to generate and perpetuate various expressions of deviance and social disintegration. A recent example of social disintegration and its role in suicide increase has been witnessed in the Baltic States, especially Lithuania, following the collapse of the former

*See also page 34-38 for discussion on a counter-view point about how much psychiatric diagnosis and treatment has helped in suicide prevention.-eds.

Soviet Union. It reported the world's highest suicide rate i.e. 50 per lakh population, according to a relatively recent research report (Haghighat, 1997).

We also know that suicides are more common in the urban slums, lodging homes and in people staying alone where social isolation is prominent. Moreover, measures to tackle poverty and unemployment are dependent on governmental initiative. *Reducing social isolation, preventing social disintegration and treating mental disorders is the three pronged attack that must be the crux of any public health programme to reduce suicide*, of course with suitable governmental effort

Suicide is more common in urban slums, lodging homes and in people staying alone where social isolation is prominent... Reducing social isolation, preventing social disintegration and treating mental disorders is the three pronged attack that must be the crux of any public health programme to reduce suicide.

mentioned earlier. Thus, Befriending programmes for the socially isolated, change that does not lead to fragmentation of the social psyche and ethos for the society at large, and efficient and affordable mental health care for the psychiatric patient, is the need of the hour. All these must synergize for any public health programme planned to combat suicide.

What Can You Do ?

Can you reduce social isolation, prevent social disintegration, and help treat mental illness ? Yes , you undoubtedly can. If you can identify those who suffer from social isolation, the people at risk we talked of earlier, you can do something about it, or put them on to someone who can. If you see disintegration, of values and norms in the social network around you, because of whatever reasons, and in whatever guise, you should stand up and protest against it, and help those who are its victims. You should resist attempts of instant messiahs in a hurry to do good, you should seek such social change that does not disrupt. When you know that suicide is preventable and psychiatric treatment can get a person rid of his suicidal thoughts, you must motivate a colleague, a relative or a friend, to seek professional help and savor the immense mental satisfaction of a life saved. That is what you can do.

This calls for an integrated outlook wherein the approach of saving life after a suicidal attempt must combine with psychiatric treatment, including crisis intervention and drug treatment, counselling and socio-therapy. This is at the individual level. But it must be combined with

Just as we think in terms of Malaria or Polio eradication, or have achieved small pox eradication, the effort has to be put in to bring about suicide eradication. On a similar war-footing, with a similar concerted total effort.

measures to tackle poverty, unemployment and attempt to change value systems at the social level. We realize, therefore, that suicide prevention and control is a *movement*. It involves the State, professionals, lay volunteers and the public (Venkoba Rao, 1999). But the great need is to first of all identify it as a public health issue (Sartorius, 1996). Just as we think in terms of Malaria or Polio eradication, or have achieved small pox eradication, the effort has to be put in to

bring about suicide eradication. On a similar war-footing, with a similar concerted total effort.

Permit us to present some more statistics, which further establish the connection between psychiatric illness and suicide.

Why must you know all these morbid statistics about the association between psychiatric illness and suicide ? Because psychiatric illnesses are treatable. Because a patient of Major Depression or Schizophrenia, or other psychiatric disorders, can be helped to get rid of his suicidal thoughts and impulses by taking treatment. Moreover, suicide risk is lifelong for patients with mental disorders (Baxter and Appleby, 1999). 15% of mood disorder patients subsequently commit suicide and 45-70% of suicides have mood disorder. 19-24% of suicides have made a prior suicide attempt and 10% of suicide attempters subsequently commit suicide in 10 years (Roy, 2001). Helping such people out of their problems is what mental health professionals all the world over are doing day

in and day out. This is where you can help if you come to know of someone with suicidal ideas. You can help him by convincing him, or his family members, to seek suitable psychiatric help. A past suicidal attempt is perhaps the best indicator that a patient is at increased risk of suicide. Epidemiological studies show that persons who commit suicide may be poorly integrated into society. Social isolation increases suicidal tendencies among depressed patients (Sadock and Sadock, 2003).

If someone has made a past suicidal attempt and survived, note that he is at increased risk. See that he doesn't suffer from social isolation, he gets integrated into the social mainstream and takes treatment, if necessary, for any psychiatric disorder so as to remain psychologically fit and/or not get a relapse.

All patients with chronic sicknesses need to be protected from social isolation. See that they are not left out, uncared for, neglected. It is tiring and taxing to care for them allright. But they have a right to live on with dignity as long as they can, and your effort in that direction can never go a waste.

Hence what you can do this : if someone has made a past suicidal attempt and survived, note that he is at increased risk. See that he does not suffer from social isolation, he gets integrated into the social mainstream and takes treatment, if necessary, for any psychiatric disorder so as to remain psychologically fit and/or not get a relapse. Moreover, suicide has been linked with being chronically ill . For example, one out of every six long-term dialysis patient over the age of 60 stops treatment, resulting in death (Neu and Kjellstrand, 1986). Suicide rate among cancer patients is one and half times greater than that among non-ill adults.

(Marshall *et al*, 1983), and suicide among men with AIDS is estimated at more than 36 times the national rate for their age group (Mazurk *et al*, 1988). What do you do here? All patients with chronic sickness need to be protected from social isolation. See that they are not left out, uncared for, neglected. It is tiring and taxing to care for them allright. But they have a right to live on with dignity as long as they can, and your effort in that direction can never go a waste.

DALY And Burden Of Disease

But let us get on with the other recent findings on suicide.

Over the last ten years, W.H.O., with the World Bank and Harvard Medical School, has developed DALY (Disability Adjusted Life Years), which is a measure of the burden that a disease entails (Murray and Lopez, 1996). This was a multicentric study involving both developed and developing countries. Its findings in 1990 and projection for 2020 are real eye-openers. While in 1990 malaria and T.B. were prominent, mental illness ranked very high. Unipolar Major Depression (3.7%) ranked fourth after Lower Respiratory Tract Infection (8.2%), Diarrhoeal

In the global burden of diseases, Depression (3.7%) was rated above Ischaemic Heart Disease (3.4%), and Mental Disorders (9.7%) ranked just below Cardiovascular Disorders (10.5%) in the total burden. In 2020, the global burden of Unipolar Major Depression (5.7%) will be a close second to Ischaemic Heart Disease (5.9%). Compared to the Heart institutes, what should then be the increase in the number of centres to treat Depression?

disease (7.2%) and Prenatal conditions (6.7%). It must be noted that two of the above conditions are infectious diseases and one involves childbirth, all of which are recognized major physiopathological stressors. None of these are the so-called 'Life-Style' diseases. Amongst those, Depression (3.7%) was rated above Ischemic Heart Disease (3.4%) in the global burden. This effectively dispelled the common man's notion that Depression is a major problem only in the developed world. Moreover, as of now, Mental disorders (9.7%) rank just below Cardiovascular Disorders (10.5%) in the total burden.

The projections for 2020 are equally revealing. Depressive disorders are expected to be the second highest cause of disease burden worldwide (Brown, 2001). The global burden of Unipolar Major Depression (5.7%) will be a close second to Ischemic Heart Disease (5.9%), followed by Traffic Accidents (5.1%), Cerebrovascular Accidents (4.4%) and Chronic Obstructive Pulmonary Disease (4.2%). Malaria, T.B. and Prenatal conditions would become less important. Compared to the sophisticated Heart Institutes and other places to treat Ischemic Heart disease of which every city boasts, what should be the increase in the member of sophisticated Centers to treat Depression, where public awareness and governmental thrust is abysmally small ? How much greater is the need for public and private funding, the general awareness, the will and programmes to combat it ?

"Unfortunately, only about one third of individuals with depression are in treatment, not only because of underrecognition by health care providers but also because individuals often conceive of their depression as a type of moral deficiency, which is shameful and should be hidden . Individual often feel as if they could get better if they just 'pulled themselves up by the bootstraps' and tried harder. The reality is that depression is an illness, not a choice, and is just as socially debilitating as coronary artery disease and more debilitating than diabetes mellitus or arthritis. Furthermore, upto 15% of severely depressed patients will ultimately commit suicide. Suicide attempts are upto ten per hundred subjects depressed for a year, with one successful suicide per hundred subjects depressed a year. In the United States for example, there are approximately 300,000 suicide attempts and 30,000 suicides per year, most, but not all, associated with depression... mood disorders are common, debilitating, life -threatening illnesses, which can be successfully treated but commonly are not treated . Public education efforts are ongoing to identify cases and provide effective treatment" (Stahl, 2003).

A useful rule of thumb given by the same author is the rule of sevens, with regard to the connection between suicide and major depression :

- i) One out of seven with recurrent depressive illness commits suicide.
- ii) 70% of suicides have depressive illness.
- iii) 70% of suicides see their primary care physician within six weeks of their suicide.*
- iv) Suicide is the seventh leading cause of death in the United States.

**Such a simple measure as a sensitized primary care physician, or general practitioner, who looks out for depressive symptoms and suicidal thoughts in his patients, can effectively curb a large number of these 70% suicides.-eds.*

The hidden cost of depression as a considerable burden on society and the individual, especially in terms of incapacity to work, has been noted in the UK (Thomas and Morris, 2003). The hidden cost of not treating depression is 30,000 to 35,000 suicides per year in the United States alone (Stahl, 2003). The figures are equally applicable to the other countries, including India. The role of care-providers, governmental bodies and enlightened citizens is clearly cutout and needs to be focussed in the direction of suicide prevention. What more need be said?

The projection in 2020 for all mental disorders is 15% i.e. from 9.7% in 1990, the global burden of mental disorders will rise to 15%, a rise of more than 50%, of which one third will be due to Unipolar Major Depression.

Why are we looking at these statistics here ? Because the major cause of premature mortality in Unipolar Major Depression is suicide. In fact the major cause of premature mortality in psychiatric conditions taken as a whole is also suicide. Thus, study of the various dimensions of suicide is so very important. And treatment of mental disorders can be one sure way of reducing the rising suicide rates the world over.

The Global Burden of Disease Study has been an eye-opener for public health programmes.

Suicide Prevention : How?

There are atleast three important thrust areas in suicide prevention that will help implement the plan to reduce social isolation, prevent social disintegration and treat mental disorders :

- (i) Sensitize family physicians to early signs of Major Depression and other psychiatric disorders with serious suicidal risk ;
- (ii) Carefully assess the claims of Samaritans, Befriending programmes, Help-lines etc. in reducing suicide-rates and encourage their efforts if so found; and
- (iii) Effective treatment in psychiatric hospitals/clinics and efficient care following discharge by mental health professionals using well proven methods.

The major cause of premature mortality in psychiatric conditions taken as a whole is suicide... hence treatment of mental disorders can be one sure way of reducing the rising suicide rates the world over.

Paradigm Shift

The outlook towards suicide has undergone a distinct paradigm shift. First was the *theological approach*, which considered suicide to be a sin. Then came the *moral approach* of philosophers, which debated whether suicide was rational or irrational. (The debate still continues ofcourse.) This was followed by the *legal*

The paradigm shift in tackling suicide can be summarised in a few words: treating has replaced preaching.

approach, which considered it a crime. Later came the *Sociological*, which concentrated on finding *societal* factors responsible for suicides. More recent has been the *psychological* wherein the internal psychodynamics of the suicidal person was studied. Finally we have come to the *Psychiatric* or *Mental Health* approach wherein clinical diagnosis, treatment and prevention have become prominent. The paradigm shift involved can be summarized in a few words : treating has replaced preaching (Heyd and Bloch, 1984). The suicidal subject is regarded as a victim of external forces, or as a patient; he is thus absolved from any moral responsibility for the act. It is easy for society to label suicide as moral cowardice, virtuous heroism, mortal sin, or even demoniac intervention (Heyd and Bloch, 1984). What is probably more important is to face it as a social and psychological problem whose cause is still not fully clear, but within the scope of health care delivery systems to manage, of course in liaison with other care givers.

Concluding Remarks

India has come a long way but still has far to go. Compared to a handful of psychiatrists at the time of independence, we have more than 3000 psychiatrists in the country (1 per 3.33 lakh : the ideal should be atleast ten times more). Include other mental health workers and the number is 10,000 plus (i.e. 1 per 1 Lakh : not that bad, the ideal number should be 1 : 25,000 or less, which means the work force must increase by atleast four times). Moreover, the major benefit of most psychiatric services are not within the reach of the majority of our population especially those living in villages, small towns or the big city slums (Wig, 2001). We know, therefore, what is the manpower needed to tackle the unfinished agenda of mental health in general and suicide prevention and management in particular.

Suicide is ubiquitous, under-reported and probably also under-researched. Study of its various dimensions-preventive, therapeutic, rehabilitative, social, ethical etc. needs to be furthered amongst medical professionals, social thinkers, legislative bodies, NGOs, care givers and survivors. Only then the pious and well-intentioned religious commandments of yore, and bioethical discussions of philosophers today, will become synergistic with psychosocial intervention and rehabilitative programmes.

It will also be one significant manner to further an earlier W.H.O. slogan (for the year 2001-2002) : 'Mental Health : Stop exclusion, dare to care', in an effort at more humane patient care, a less psychopathological environment and, hopefully, a more egalitarian society.

So, that is the picture. It has stirred you to think. It has stirred you to act. Look out for the suicide prone individuals. Get acquainted with NGOs like Befrienders International or the Samaritans. Ask if Suicide Help-lines need your assistance. Help a suicide prone individual seek professional care. Contribute your mite to the movement to make society suicide - free.

It is not just a dream. It is a goal we must all work together for.

Shall we, then, walk the talk ?

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Questions that the Second Monograph raises

1. What concrete steps could be taken to reduce social isolation, prevent social disintegration and treat mental disorders?
2. Is setting up Centres to treat Depression a workable proposition? Are there specialized Centres like this working any where and what has been the experience like?
3. What are the important Indian studies in the field of suicide treatment and prevention?
4. Are there biological markers of suicide?
5. How much does disintegration of social institutions like the family contribute to suicide increase ?
6. What is the evidence to support the work of Befrienders International, Samaritans, Suicide help-lines etc. in the field of suicide prevention?
7. What could other NGOs do in the area of suicide prevention?
8. What could the enlightened citizen do to save a person from suicide?
9. What are the distress signals that should arouse the suspicion that a suicidal attempt is likely?
10. Is suicide prevention as public health policy a viable community health programme initiative?
11. Does the moral philosopher's arguments about rational or irrational suicide hold any ground?
12. How do we account for deaths like Jnaneshwar's, or Rama's?
13. Do other animals commit suicide, or is it a phenomenon peculiar only to humans?
14. Has psychiatric treatment really helped reduce suicide rates, or has it remained constant inspite of their best efforts?
15. It is desirable that some individuals, who have no escape route whatsoever, be allowed to end their lives?
16. Is there a case for Physician-assisted suicide, or euthanasia?
17. How can the mass media do responsible suicide reporting?
18. Is there any other way of looking at this problem? One which presents a diametrically opposite position or a refreshingly different perspective to this whole issue?

Appendix A Answering Two Serious Charges on Suicide Prevention*

Ajai R. Singh

There are two serious, though well intentioned, charges on suicide prevention which deserve our equally serious consideration:

- 1) Whatever we do, the rate of suicide in a particular society will remain fairly constant (Durkheim, 1952).
- 2) Suicide is disturbingly ubiquitous and universal – across cultures and ages. Psychiatry does not seem (yet) to fare better than the more traditional, menacing attempts of moralists, theologians and legislators at stopping people from killing themselves (Heyd and Bloch, 1984).**

The First Question

When Durkheim makes the first statement, it is improper to read it as a resignation to the inevitable. It should spur us on to find out why this is so, if indeed it is. The attack on suicide cannot be only at the personal level, although that is very important. It must as well, and moreso, be at the social level, to identify and tackle those sociological processes that predispose individuals to such action. In this we must identify atleast two factors: *social isolation* of the individual and *social disintegration* of the society. Preventing social isolation will involve Befriending and Samaritan like programmes allright. But equally important would be strengthening of the social networks: the family, religious and community welfare activities, avenues for involvement with people and programmes, identifying at risk population and absorbing them in the mainstream etc. etc.. First and foremost, it must involve a change of perception among the members of society, wherein a suicidal thought or attempt is acceptable as a cry for help. An occasion to mobilise all resources to help rather than stigmatize or ostracize. To rally around the individual rather than leave him to fend for himself. When we talk of preventing social disintegration, we are talking of social processes that will integrate rather than divide members of society from each other. Religion has proved to be a preventive factor, for example; for in general Catholics show lower suicide rates than Protestants, and there is much less suicide amongst Muslims in the month of Ramzan. What is that hold of religion which prevents, or postpones, suicide is worth further exploration. Rapid social change brings about alienation and anomie. Greater deviance and suicide are the price we pay for such destabilizing progress. What the social engineers should therefore attempt at is such social change as *grows* on its members, that *integrates* rather than *dismembers*. Which is conscious of the fact that maladjustment is the fallout of all progress, no doubt, and the greater the rate of progress, the greater the maladjustment. This realisation is not only to accept it as inevitable, but to make active attempts to stem deviance. Where one can identify the at risk population, find out those who are maladjusted, and intervene on the side of integration, to absorb them as

* First Published as *Mens Sana Monographs I: 3, Sept.-Oct., 2003. Revised Version.*

** MSM would be interested in carrying forward this debate by suicidologists and other thinkers too. The two chareges are disturbing enough for you to put pen on paper. -eds.

productive members of society. Ofcourse, it goes without saying that members of society must actively resist any attempts by its leaders, or social pundits, to force rapid change on its members. Messiahs in a hurry to do good can be very hard to sustain. Changeovers, whether they involve change from tradition to modernity, from a command economy to a liberal one , from spiritualism to materialism, from Indian to Western values, must indeed be allowed to *seep* in rather than be *forced* on by subtle, and not so subtle, means.

In other words, concrete steps to reduce social isolation and prevent social disintegration are a must. It is these two which are the wellsprings of psychopathology in general and suicidal attempts in particular, and need to be actively combated. Psychiatric care is often only a damage control exercise. The lesson, therefore, is : if you plug the source , the need for damage control will reduce greatly, if not disappear completely. Ofcourse this realisation does not absolve mental health workers of their responsibilities. In fact, it makes them more aware of the problem, of the wider perspective, and also make efforts to find better ways of tackling it. Pointing to the social psychopathological processes should not become a convenient means of passing the buck. Which means, mental health workers cannot blame society for generating suicides, and society cannot blame the former for not doing their job well . That is an immature debate, and a poor way of solving the problem. The solution lies in a two pronged attack. Society takes up the responsibility of reducing social isolation and preventing social disintegration. Mental health workers take up the responsibility of handling psychiatric disorders, and finding new and more efficient means of treating them. Psychopathological entities likes suicide can then be drastically minimised, and finally eradicated.

The Second Question

The second question of proof whether psychiatry has succeeded where the rest have failed, should now be answered. Psychiatrists play a limited, though significant, role in reducing social morbidity. They are essentially specialists in treating psychiatric diseases. This also undoubtedly reduces the social burden by reducing the overall psychological distress of members of society. There is no doubt on that score. Moreover, realising that the problem is too complex to yield to a piecemeal approach, they are ready to coordinate with other social scientists in an attempt to reduce this manifestation of social morbidity. Without giving up on their core activity, they will, and must, cooperate with all those processes that generate social health rather than promote social psychopathology. Hence the shift of emphasis from *psychiatric diseases* to *mental health*. But we need remember that essentially they are mental diseases' specialists. While they can treat, rehabilitate, and even help prevent mental diseases, they may not have that great a say in those social processes that generate social isolation, and cause social disintegration.

Hence to reduce suicide rates, positive attempts by society to reduce social isolation and prevent social disintegration are a must. Otherwise psychopathology and consequent morbidity and mortality will continuously result. The third sphere of influence is of the mental health workers. Let us take up their role now.

Suicide and Depression

The greatest threat of suicide comes from patients of Major Depression. This is a condition eminently suitable to treatment, as every psychiatrist knows only too well. Suicidal thoughts remit as the depression is controlled, and the gratitude of patients and relatives is there for all to see. But the fact of the matter is that even today, and even in an advanced society like the USA, only one third cases of depression take treatment, not only because of under recognition by health care providers but also because individuals often conceive of their depression as a type of moral deficiency, which is shameful and must be hidden (Stahl,2003).^{*} Which means two-thirds cases of depression do not even take treatment. Who is to ensure that these people are brought for treatment? These two-thirds run a big risk of suicide. Society may just label them as failures, cry over them for a while, and carry on. But precious lives are lost because other members of society, the family, close friends, employees, welfare bodies are unaware of the needs of such depressed patients, and make no attempts to get them into treatment. This is one area where positive action is most urgently needed. The other area of concern is the fact that 15% severely depressed patients eventually commit suicide inspite of treatment (Stahl,2003).^{*} It means two things: one, 85% do not, and they have been helped by psychiatric treatment, which is not a bad success rate by any standards. (Although 15% failure rate is not something to be happy about, it is acceptable in *any* treatment setting in *any* branch of medicine). But to accept this failure rate is not enough. We need to work towards better and more efficient psychiatric care, with that becoming a major thrust area in research, coupled with a greater sensitization of society and relatives to the needs of the severely depressed so that they are not cast aside, or given up. It may help to think of the severely depressed as emotionally handicapped, atleast temporarily. They need the crutches of social and family support to help them tide over their difficulties, like an accident victim or a physically handicapped may need crutches or callipers to tide over his physical handicap.

Therefore, better psychiatric care, newer and more effective treatments, greater research and funding, and greater social support are the need of the hour, not meek acceptance of ideas that whatever we do, death rates will not drop, for death will find newer avenues to manifest. If infections are controlled, life-style diseases come up to claim victims. If they are controlled, some other diseases will come up to lead to the inevitable. So why have medicine at all? This nihilistic position is erroneous because even if death eventually has to occur, it has to occur *eventually*, it is not to be desired or welcomed prematurely. We got to ensure a better quality of life by removing distress and disability, which is what the whole science of medicine is all about. One

^{*} See also page 29.

expressing of this distress and disability is suicide. And the role of the psychiatrist in preventing it in his patients and thus reducing psychopathology in society at large cannot be underestimated. Hence, we may reiterate that psychiatry plays a limited but significant role in reducing social morbidity, and that is something to be proud of, not apologetic about at all.

Report statistics of prevented suicides

We must also remember, further, that whilst suicide that takes place becomes a statistic, one that is prevented does not. The clinician who knows and treats his suicidal patients, who then get rid of their suicidal ideas and become productive members of society, has no figures to claim that he has indeed saved a life. Maybe he should present these figures to society as well. That will probably be an eye opener. One suspects that suicide rates do not come down in spite of psychiatrists' attempts is not *because* they are useless but *in spite* of them. This just goes to show how menacing are those social processes which do generate such psychopathology. Most probably, with mental health workers not being around, the rate of suicides would have been much higher. Psychiatrists need not feel disheartened that suicide rates have not dropped. If indeed they haven't. They only need to work harder on research and treatment of their suicidal patients. But they must also help make society aware that it must tackle those processes in its functioning that generate social isolation and disintegration, of which suicide is one malignant fallout. To that extent, Durkheim was right when he refused to blame either the suicidal patients, or praise or condemn the different forms of suicide that he described. He never meant to praise altruistic compared to egoistic, or anomic, suicide. He merely mentioned them as different types. But he definitely meant to raise a finger at those social processes that generate and force individuals to commit such acts, and then get reduced to mere numbers in such categories.

If a suicide free society is the goal, then suicide prevention must become public health policy. And the three fundamental parameters must be:

- i) Reduce social isolation, ii) Prevent social disintegration,
- iii) Treat psychiatric disorders.

The wider implications of this realisation, and the microprocesses to bring this about must be the plan on which suicidologists, policy planners and governments all over must unite and act.

This is the agenda to set. This is the blueprint to plan for. This is the frontier to be crossed.

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Appendix B :

Readers Respond

1) How do we account for deaths like Jñāneshwara's and Rama's?

- S. G. Mudgal*

I give below a few examples :

- i) Jñāneshwara, at the age of 22, entered *Samadhi*;
- ii) Manek Prabhu, at the age of 40, did likewise;
- iii) Raghavendra Swami, at the age of 71, entered *Vrindavan*;
(*Vaishnava* equivalent of *Samadhi*);
- iv) Vadiraja Swami, at age of 120, entered *Vrindavan*.
There may be many more.

They were all yogis and used to be in *Asamprajñata Samadhi*. Very often, the happiness of God vision in *Samadhi* made them to remain in that state longer, and more often.

Thus, you can see that these cases do not fall within the purview of Suicide and Psychiatry. They were all perfectly normal individuals. Their contribution to Philosophy and Religion is unparalleled. For example, *Jñāneshwari*, *Amrtanubhava*, *Upanishad Khandartha*, *Parimala*, *Mahabhashya Commentary*, *Yukti Mallika*, to name a few, are famous works. They are not the works of diseased persons.**

Again, they also knew their mission. Jñāneshwara told his brother Nivr̥ttinātha, who was also his guru: "Well, brother, my time has come. Permit me to leave this body." On being permitted by his Guru and brother, he got his *samadhi* built. On the appointed day, at a chosen time, he entered it, and asked his followers to close the entrance, once he reached the *asamprajñata samadhi*.

Same was the case with Manek Prabhu.

Raghvendra Swamy told his disciples in advance, the day, time, month and year of his leaving the body. It is recorded history that he exists in his astral body, in the *Vrindavan*. Sir Thomas Monroe, Collector of Bellary later Governor of Madras, records in the *Madras Gazetteer*, his *interview* with the Swamiji more than a few decades after he entered *Vrindavan*.

* Prof (Dr.) S.G. Mudgal M.A., Ph.D., has been a distinguished Professor of Philosophy with a deep study of Indian thought.

** Prof. Mudgal is making the point that not all such deaths are the result of psychopathology. He is obviously referring to the 2% cases of suicides in which no abnormality could be found even by recent psychiatric researchers. The point is indeed well taken and psychiatrists must beware of using their methods to make sweeping generalisations. But they must do something about the 98% with psychopathology, which is indeed very important, and legitimately their domain. - Eds.

Thus, these cases have to be understood in a different way as they fall within the field of Psychology of Religion, and Para-Psychology. They were not distressed nor depressed. They were not schizophrenic. Again they have also to be understood in the context of Indian eschatology. The West believes in only one birth. This is not so with philosophies which have their origin on the Indian soil, except of course, the Carvakas.

Such individuals leave the body because their self is 'home sick' (Miss Underhills' terminology). Their discarding the body can only be described as entering into *Samadhi* (or *vrindavan*). This was true of Rama as also Laxmana, who entered the river Sharayu and underwent *jalasamadhi*.

This is how their leaving the body (or death, as you have put it) can be understood. Again there are four kinds of bodies which a Jiva has : (a) *Sthulasarira* (b) *Anirudhasarira* (c) *Lingasarira* and (d) *Svarupasarira*. Only when the *Lingasarira* is destroyed, one attains final redemption.

This is how I understand the above and other similar cases.

All Indian schools (except Carvaka), have condemned suicide. Further, they have appreciated leaving the body by the yogic method. Kalidasa refers to the Raghu dynasty with appreciation as '*yogenante tanu tyajam*' i.e. those who leave the body at the end by entering into *Samadhi*. Thus, the correct way of describing the physical end of such persons is discarding the body, or leaving the body, i.e. '*Tanu Tyajam*'.

2) Suicide Rates Under-reported

(In a communication, Prof. K. S. Jacob, M.D., Ph.D., Prof. of Psychiatry, Christian Medical College, Vellore, shares the findings of their interesting rural study using verbal autopsies conducted between 1994-9 as a collaborative study between their Dept. of Community Health and Dept. of Psychiatry. This was published in BMJ, Vol. 326, dated 24 May 2003. The study makes the point that suicide rates are grossly under-reported. Accurate data-collection can give a true indication of real suicide rates. We share concluding remarks of their study below.- Eds)

"Verbal autopsies can give a good idea of the cause of death from suicide in the developing world, where coroners' verdicts are not available. A community health programme in the Kaniyambadi region of India found that recent studies in India have under-reported suicide rates by two to three times. The independently verified method used verbal autopsies and found the rate in 1994-9 was 95.2/100 000 population, nine times the national average. The high rates are not likely to be peculiar to Kaniyambadi; they reflect more accurate data collection. Sentinel centres that accurately monitor suicide are needed in the developing world." (Joseph *et al*, 2003)*

* Joseph A., Abraham S., Muliylil JP, George K., Prasad J., Minz S., Abraham V.J., Jacob K.S., (2003), Evaluation of suicide rates in rural India using verbal autopsies, 1994-9; BMJ, 326, 24 May 2003, 1121-2.

3) I am thrilled!

“I am thrilled to receive your monograph on suicide prevention. I have gone through its contents and find that you have made an in-depth analysis in language that is simple and elegant. I am proud to have known you for almost 30 years, right from our under graduate days in KEM. Keep up the good work.”

Quresh B. Maskati M.S., D.O.M.S., F.C.P.S. (Hon. Ophthalmic Surgeon, Wadia Childrens', Saifee and Habib Hospitals, Mumbai.

4) Convert into actionable points

I congratulate you for your article “Towards a suicide free society”. It is very timely and also comprehensive.

Coincidentally, I have also been writing about suicide prevention in the context of suicides in Chandigarh as well as suicides of farmers in Karnataka.

I personally think that each one of the topics you have taken up should be convertible in actionable point, so that people at the level of individuals, families, communities, professionals, administrators and media can respond to the same.* I hope you will find my approach relevant to your future work. I again congratulate you for this very important initiative.

R. Srinivasa Murthy
Prof. of Psychiatry
NIMHANS

* *Editors Note : Prof Murty makes a very valid point, for the problem having being identified, what concrete steps could be taken in the form of points of action need to be identified by concerned individuals and agencies as well. Let us make a start with some points:*

- D) Identify the population at risk:**
 - a) those living alone.
 - b) widows without children and without financial security.
 - c) people living alone in lodging homes for prolonged periods.
 - d) those who suffer great financial loss or severe loss of self-esteem.
 - e) people without social or financial support e.g. recent farmers suicides
 - f) those who have made past suicidal attempt.
 - g) psychiatric patients with suicidal ideation, or with past suicidal attempt.
 - h) those chronically ill with medical illnesses like cancer, AIDS, Chronic renal disease, other debilitating illnesses etc.
 - i) Students failing SSC, HSC exams with stressful parent -child interaction at home and/or no one to communicate with.
- II) Establish Centers to treat Depression.**
- III) Remove Social Stigma attached to suicidal/suicidal attempt.**
- IV) Socio-political changes may be necessary, but gross destabilization is to be avoided. Help at risk population, specially migrants with poor financial/ social support.**

The Third Monograph

What Shall We Do About Our Concern with the Most Recent in Psychiatric Research?

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If I have seen further it is by standing on the shoulder of giants.
- Isaac Newton (Letter, 1676)

Preface to the Third Monograph

Fashions come and go. Filmstars have their hey days and sink into oblivion. Technological gadgets become outdated sometimes even before they enter the market. Everyone wants the latest in TVs, computers, mobiles, cars, household appliances, industrial machinery, the works.

We want to hear the latest news. Nobody prefers to read yesterday's newspaper today out of choice. We also want to read the latest edition of a book, and look up recent references and research work.

We want the latest in treatments as well. The most recent is always considered an advancement over what was available earlier. Newer therapies, newer investigations, newer procedures.

But, at the same time, we want to go to the senior consultant. And, given a choice, the older the better. Even elsewhere, we do not go to the junior most person to solve our problems if we can approach the senior man, and he is amenable. The recent graduate or postgraduate has the latest information, but it is the senior man who sits on the panel of examiners.

We want the most recent in some cases, and the older and more experienced in others. Why should this happen? How should we handle our great need to update our knowledge on the latest, and yet not neglect the old and time-tested?

This dilemma occurs in the research field as well, and psychiatry is no exception.

What can be a healthy way of resolving this issue is the subject matter of this monograph.

What Shall We Do About Our Concern with the Most Recent in Psychiatric Research?*

Ajai R. Singh
Shakuntala A. Singh

ABSTRACT

Most clinicians and researchers are concerned with recent advances in psychiatry. This involves the danger whether something time-tested may get sidelined for extra-scientific reasons. That the pharmaceutical industry and superspecialist researcher may keep churning out new findings to impress audiences is only a partial truth. Research progresses by refutation and self-correction. Acceptance in science is always provisional; changing paradigms, frameworks of enquiry and raising new questions is integral to breakthrough in scientific knowledge. Hence, there is in science a constant concern with the new. Moreover, the number of treatment non-responders to the time-tested swells with time, and researchers feel challenged to find ways and means of resolving their difficulties. Newer challenges need newer strategies. Obsession with the most recent can lead us astray, but a healthy evidence-based acceptance of the new is essential for advancement in psychiatric research. As indeed of research in all fields of medicine. And of science in general. The role of lithium and newer mood stabilizers in bipolar disorders are taken as examples to highlight this point.

Key Terms : Psychiatric research, Refutation, Paradigm shift, Bipolar Disorders, Lithium, Mood-stabilizers, Treatment non-responders ,Pharmaceutical Industry.

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Introduction

Like in other branches of medicine, in psychiatry too, most clinicians and researchers are concerned, if not really obsessed, with what is the most recent advance in a particular field or area. Enlightened readers scan the references' list and are suitably impressed if there is a generous sprinkling of recent ones. Writers, similarly, want to refer to recent works as far as possible, and sometimes may go out of their way to accommodate them in an effort to appear abreast of contemporary literature. The more recent the work quoted, the greater the impact, and equally greater the research writer's satisfaction. Subtle psychological factors play their role here no doubt, as does the not so subtle need to impress and hold the interest of one's readers, and one's peers.

Ofcourse, in this there is always the danger that something time-tested and well-proven may get sidelined for the new and promising, yet unproven. This can no doubt also disturb, if not damage, so many personal and collective equations. The concern with keeping abreast of recent advances makes us knowledgeable, or at least seem so, and does serve to impress our audiences favourably. But somewhere down the line is also involved the legitimate fear whether we sideline something proven for extra-scientific reasons.

The Example of Lithium

Let us take an example to clarify the issue. When lithium was first introduced as the treatment of choice in bipolar disorders, there was a great welcome for its wonderful effects, both its anti-manic as well as its prophylactic properties. And justifiably so. Over a period of years, however, the enthusiasm seems to have settled to cautious questioning, and has even given way to skepticism in a number of quarters (Silverstone *et al* 1998; Gershon and Soares, 1997; Moncrieff, 1995). Even if the US FDA approved only of lithium as prophylactic for bipolar disorders, a number of studies in the last decade find that 20-40% of classical bipolar patients (i.e. ones with clear cut episodes and remissions) show less than desirable response to lithium, or develop undesirable side effects. And amongst the nonclassical cases (like rapid cyclers, dysphoric or mixed states, and the ones with co-morbid substance abuse), the situation is still less satisfactory. Valproate and Olanzapine have been approved by the US FDA as anti-manic drugs but not as mood stabilizers. Number of clinicians down the years have switched over to Carbamezapine for its anti-manic, antidepressant as well as

The concern with keeping abreast of recent advances makes us knowledgeable, or atleast seem so, and does serve to impress our audiences favourably. But somewhere down the line is also involved the legitimate fear whether we sideline something proven for extra - scientific reasons.

What has changed ? Has lithium suddenly become no good ? Has carbamazepine remained only a hero of yester years ? Are valproate, lamotrigine etc. the new blue-eyed boys, the new stars on the firmament ? Is every medicine to experience its hey days, and sink into oblivion, like film stars and other celebrities ? Do we, as clinicians and researchers, unduly favour the new by neglecting the old but time -tested ?

mood stabilizing properties. But now the emphasis seems to be shifting from carbamazepine to the other anti-convulsants, especially in the treatment – resistant cases. Valproate, Lamotrigine, Gabapentin, Topiramate and Tiagabine are the ones holding promise. As also the atypical antipsychotics like Clozapine, Olanzapine, Quetiapine, Ziprasidone, Risperidone and Aripiprazole. (See Grunze and Moller, 2003, for a review of recent work in the field.)

What has changed ? Has Lithium suddenly become no good ? Has Carbamazepine remained only a hero of yester years ? Are Valproate, Lamotrigine etc. the new blue-eyed boys, the new stars on the firmament? Is every medicine to experience its hey days, and sink into oblivion, like film stars and other celebrities ? Do we, as clinicians and researchers, unduly favour the new by neglecting the old but time -tested ?

More pertinent to the issue here is, are there extra-scientific forces acting to create such a situation ? The pharmaceutical industry, the superspecialist researcher committed to only one circumscribed area of research, who must keep churning out something new to capture audiences, get research grants, generate funds and profits?

Well, to say that this is indeed so, is not entirely false. But it may not also be the complete truth. The reality, as always, lies somewhere in-between.

Refutation and Paradigm Shifts

Research in science has followed the path of refutation (Popper, 1968; 1969). When something is systematically refuted, something new can, and must, be accepted. Sticking to the old and discarding the new in spite of evidence to the contrary can be as reactionary as believing in the new and rejecting the old to appear modern. Or being coerced into

Research in science has followed the path of refutation. When something is systematically refuted, something new can, and must, be accepted. The outstanding feature of scientific advance in its capacity for self-correction. Our acceptance of scientific theories is always provisional.... Though a scientist may believe a theory, he should not be committed to it, or give it his unreserved loyalty.

Historically, theoretical orientations in science typically retain a strong hold over their adherents, even in the face of discomfiting evidence and equally plausible alternative explanations of observable phenomena.

Unless we change our paradigms, alter our frameworks of enquiry, raise new sets of questions, there cannot be real break-through in scientific knowledge.

accepting it because of impressive portrayals by 'specialists' presented by pharmaceutical companies at five star seminars. For, just as obsession with the old is stifling, that with the new can be equally anarchical (Singh and Singh, 1988).

The outstanding feature of scientific advance is its capacity for self correction.* Our acceptance of scientific theories is always provisional. This requires an attitude in the scientist of being willing to be proved wrong; though he may believe a theory, he should not be committed to it, or give it his unreserved loyalty (Slater, 1973).

Human beings have a strong tendency to look for explanations and to seek final answers. It is often perplexing to find several competing explanations being advanced to account for the same phenomena. In fact the more complex the phenomena, the greater the number of diverse opinions that emerge. Ofcourse all these viewpoints cannot be valid. Some will stand the test of time and scientific scrutiny, some must indeed be discarded, or become history. But the applicability of a viewpoint is often determined by the extent to which it seems helpful in understanding a given case. Historically, theoretical orientations in science typically retain a strong hold over their adherents, even in the face of discomfiting evidence and equally plausible alternative explanations of observable phenomena (Kuhn, 1970). They continue to do so until some new or fundamentally different insight is achieved that appears to resolve the problems left unsolved by the conflicting interpretations of the empirical data. These new insights constitute *paradigm shifts* (Kuhn, 1970), which involve fundamental reorganization of how people think about an entire field of science. They parallel, in certain ways, the momentous cognitive shifts a child undergoes in gaining an adult understanding of the nature of the world, a process well described in the work of Jean Piaget (Carson, Butcher and Coleman, 1988).

Hence, unless we change our paradigms, alter our frameworks of enquiry, raise new sets of questions, there cannot be real breakthrough in scientific knowledge.

*To that extent, science approximates life itself. And self-correction is seen in other fields of human endeavour as well, including spirituality, even though the spiritualists may claim otherwise.

A problem that is solved no longer bothers us, but that which is not keeps rankling the mind.... Hence the search for newer molecules and newer treatment strategies must legitimately be pursued. The pharmaceutical industry and the super-specialist researcher can no longer remain whipping boys when viewed in this perspective, can they?

Newer Challenges, Newer Strategies

Moreover, we must also understand why there is in science this constant concern with the new. Just to go back to our earlier example. It is not that lithium is not a good medication. In fact we must thank some researchers for pointing it out relatively recently that it has indeed stood the test of time (Baldessarini and Tondo, 2000). When we say that 20-40% of classical bipolar patients do not respond to lithium, we must not forget that it also means 60-80% of classical patients do. *And that is a pretty large number.* But what we cannot also wish away is the fact that 20-40% of classical patients, and the majority of nonclassical ones, do not respond. Moreover, a problem that is solved no longer bothers us, but that which is not

keeps rankling the mind. Patients who respond do not trouble us as much as those who do not. Both the clinician and the researcher are concerned, and feel challenged, (and rightly so), to find ways and means of resolving their difficulties. Hence the search for newer molecules, and newer treatment strategies, must legitimately be pursued. The pharmaceutical industry and the superspecialist researcher can no longer remain whipping boys when viewed in this perspective, can they? Also, let us not forget, that the number of non-responders swells over the years, and that further adds to the discomfort, not only of patients and care-givers, but also of clinicians, researchers and their ancillaries. Moreover, subtle nuances of an illness, its processes and outcome, are only laid bare over a length of time. And newer challenges needs newer strategies. The same must happen with bipolar disorders, lithium and the newer medications. Or, for that matter, with *any* disorder and *any* treatment strategy. Not just in psychiatry, but in medicine as a whole. And, come to think about it, in all scientific fields in general.

Concluding Remarks

It is the inherent need of science to give something new. It is the inherent need of man to like something new. And both these needs are liable to be exploited due to unethical practices by market forces, both in the pharmaceutical industry and the research field. While man works mainly at the empirical level, pharmaceuticals work essentially at the business level, and science works

While obsession with the most recent can lead us astray and should not become a fad or a game of one-up-manship, a healthy evidence-based acceptance of the new is essential, nay integral, to scientific advance and research in our field.

fundamentally at the process level. How are all these three to be ethically reconciled is the problem before us.

So, then, there we are. While obsession with the most recent can lead us astray and should not become a fad or a game of one-up-manship, a healthy evidence-based acceptance of the new is essential, nay integral, to scientific advance and research in our field.

In this there is an inevitable process of sifting involved, as of personal liking, one's vision for the future, contemporary predilections of peers and superiors, and the pulls and pressures of market forces, both in the research field and the pharmaceutical industry.*

The need for a healthy evidence-based acceptance of the new we must recognize, and encourage. This need the pharmaceutical industry also recognizes, and may sometimes be prone to exploit.

Well, the branch of psychiatry, as indeed every other branch of medicine, has to beware of this.

But, then, we are cautious when we drive. That does not stop us from driving, does it ?

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*We can still call it the research field, and the pharmaceutical industry. The time may not be far when field may turn into industry. Some very senior practitioners may hopefully take solace in the fact that it may not happen in their lifetime. Well, they might just be proved right. Indications of being proved otherwise are not weak at all!

Questions that the Third Monograph raises

- Q.1. How can we avoid exploitation of the needs of man and science by unethical practices carried out by market-forces, both in the pharmaceutical industry and the research field?
- Q.2. Is scientific advance always provisional? Does it have no finality?
- Q.3. Are we justified in getting excited about recent advances, when what is recent today will become outdated tomorrow?
- Q.4. Will scientific progress ever lead to the best, or only, treatment, or explanation, in medicine in general and psychiatry in particular?
- Q.5. How do we balance new knowledge with old findings?
- Q.6. What is the litmus test on which every scientific breakthrough, old or new, should get tested?
- Q.7. Should we give up getting excited with recent advances? Then what should we get excited about, if at all?
- Q.8. If refutation is the truth of science, then where is science ultimately going to lead us?
- Q.9. Paradigm shifts alter perceptions, reorient thinking. But do they lead to real progress in knowledge, or does it simply mean giving up on one fad to get preoccupied with another?
- Q.10. Are there newer problems that need newer strategies in medicine, or most of the so-called new problems are generated by society and nurtured by man, or just recycled, and a whole pharmaceutical industry and the medical profession run their livelihood on it?
- Q.11. Are we becoming an overmedicated society in the name of newer and more advanced treatment strategies?
- Q.12. Is there any other way of looking at this problem?

Readers Respond

The Mens Sana Monographs are excellent, novel and with a different presentation from a new angle. I congratulate both of you for taking pains and making all the efforts to bring out such useful and informative monographs.

- **Dr. Indla Ramasubba Reddy***
M.D. (Psych), D.P.M (NIMHANS), F.I.P.S.
Psychiatrist, Vijayawada
- President, IPS South Zone (1999-2000)
- Chairman , Juvenile Welfare Board,
Krishna and Guntur Districts

The focus on recent issues in the field of Psychiatry by Mens Sana Research Foundation is really encouraging.

- **Dr. R. K. Das***
M.D.
- President, Sound Culture Center,
- Sr. Specialist in Psychiatry,
Bhubhaneshwar

The Monographs are indeed very interesting and stimulating material about relevant issues that one may fail to pay attention to. I hope these monographs reach all the psychiatrists so that their views could also be known.

- **Dr. Vivek V. Chincholkar***
M.D. (Psych.), D. P. M., D. N. B.
- Consultant Psychiatrist,
Thane, Maharashtra.

*** Editors Note :**

MSM wishes to thank these three gentlemen for their encouraging responses. Yes, MSM is novel, hope it is wholesome too. And hope it generates enlightened debate among fellow psychiatrists and other social scientists as well. And the views get shared with others to help generate viewpoints, consensual, contradictory, resolitional or whatever.

The Fourth Monograph

Replicative Nature of Indian Research, Essence of Scientific Temper, and Future of Scientific Progress

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I do not know what I may appear to the world, but to myself I seem to have been only a boy playing on the seashore, and diverting myself in now and then finding a smoother pebble or a prettier shell than ordinary, whilst the great ocean of truth lay all undiscovered before me.

- Isaac Newton (Brewster, Memoirs of Newton)

Preface to the Fourth Monograph

The truth knocks on the door and you say, 'Go away, I am looking for the truth, and it goes away. Puzzling.

- Robert M. Pirsig*

There is an original and there is a copy. The copy can never achieve the status of an original. This is true not only of the arts, but of research as well, for there is original research and there is replicative research. But even replicative research has its own potential. It helps determine whether the original research findings are universally applicable, and/or whether they are faulty in methodology and design. Corrections are then possible. And this is how scientific research has progressed anyway.

A lot of Indian research is replicative in nature, but it can as well be useful if it does not lose sight of this perspective. And how do we involve Indian Science into original research? Well, that's a different ball game altogether, not that its not already been played here. However, it needs a different mental set, and social ethos, which are discussed in the monograph that follows.

What is scientific temper? How does it differ from other attitudes? How should it handle religion, faith, superstition and other such entities? The corner stone of scientific temper is the worth of evidence, howsoever damning to the most established of theories and paradigms. And the ability to withhold comment, or to take sides, till suitable evidence is available. Which means a true scientist should not act a know - all, nor need he have a viewpoint to air on everything under the sun.

Is Science for Man, or Man for Science? This is a disturbing but fundamental question which all scientists, moral philosophers and other thinkers, must indeed attempt to answer. The two sides of this argument are presented in this essay to generate further dialogue.

* Cohen and Cohen (1986).

If my theory of relativity is proved successful, Germany will claim me as a German and France will declare that I am a citizen of the world. Should my theory prove untrue, France will say that I am a German and Germany will declare I am a Jew.

- Albert Einstein (Address, Sorbonne, Paris)

Replicative Nature of Indian Research, Essence of Scientific Temper, and Future of Scientific Progress*

Ajai R. Singh
Shakuntala A. Singh

ABSTRACT

A lot of Indian research is replicative in nature. This is because originality is at a premium here and mediocrity is in great demand. But replication has its merit as well because it helps in corroboration. And that is the bedrock on which many a fancied scientific hypothesis or theory stands, or falls. However, to go from replicative to original research will involve a massive effort to restructure the Indian psyche and an all round effort from numerous quarters.

The second part of this paper deals with the essence of scientific temper, which need not have any basic friendship, or animosity, with religion, faith, superstition and other such entities. A true scientist follows two cardinal rules. He is never unwilling to accept the worth of evidence, howsoever damning to the most favourite of his theories. Second, and perhaps more important, for want of evidence, he withholds comment. He says neither yes nor no.

Where will Science ultimately lead Man is the third part of this essay. One argument is that the conflict between Man and Science will continue till either of them is exhausted or wiped out. The other believes that it is Science which has to be harnessed for Man and not Man used for Science. And with the numerous checks and balances in place, Science will remain an effective tool for man's progress. The essential value-neutrality of Science will have to be supplemented by the values that man has upheld for centuries as fundamental, and which religious thought and moral philosophy have continuously professed.

Key terms : *Replication, Refutation, Mediocrity, Scientific Temper, Religion, Value-neutrality, Ethics in Science.*

* First Published as *Mens Sana Monographs I* : 4, November - December 2003.

I Introduction

That white horse you see in the park could be a zebra synchronised with the railings.

*- Ann Jellicoe**

Most researchers and science - watchers would want to bring about a wider discussion on the need for an Indian Science, to focus attention on the true scientific temper and remedy the rot that has set into it in this part of the globe. It is no doubt true that a lot of Indian research is replicative in nature, and originality is at a premium here. In this, the rigid hierarchical system that governs scientific establishments (as it does others) has its own significant role to play. But we cannot discount a host of other factors, not the least being our lack of sophistication in research tools, low priority to research, bureaucratization and politicking in research projects and grants. And, last but not the least, the sociocultural ethos, and the Indian psyche itself that, amongst other things, favours compliance and abhors change, regardless of its need. It is thus inevitable that mediocrity of various hues should be in great demand, and perfection or its search considered impracticable, if not impossible. Mediocrity is the best guarantee of conformity and status-quo; duplication and ad-hocism is the maximum that lies within its capacity. Any trend-setting must involve the ability to significantly depart from earlier convictions, and defend this on the basis of adequate evidence. This is basically anathema to a system that thrives on rigid notions that perpetuate a deeply ingrained love of traditionalism and obscurantism. Ad-hocism bugs Indian Science as much as it does other worthwhile disciplines. This is of course only a reflection of the state of Indian society itself and is a separate topic in its own right.

Replicative Research

Having said this, however, let some points be clarified. Replicative research, though lacking originality, is a legitimate part of scientific research all over the world. In Science, as elsewhere, one of the major

It is no doubt true that a lot of Indian research is replicative in nature and originality is at a premium here... Mediocrity is the best guarantee of conformity and status-quo; duplication and ad-hocism is the maximum that lies within its capacity. Any trend setting must involve the ability to significantly depart from earlier convictions, and defend this on the basis of adequate evidence.

**All quotes marked (*) from Cohen and Cohen(1986). See References list. This quote on p.173.*

Though greater finesse and expertise can help bring larger number of leads in scientific research from elsewhere, it is in their confirmation and their universal relevance, or denial, that centers in the developing countries can help. And let us not forget that corroboration is the bedrock on which many a fancied scientific hypothesis or theory stands, or falls.

problems to contain is an unbridled search for newer entities in research. Most creative energies are siphoned off in tracing out only that which can become trend - setting. In this, hypotheses that appear novel and likely to radically change perspectives are eagerly put forward, and as eagerly imbibed. Scientific progress no doubt does involve the production of certain false leads : this is a professional hazard of being a scientist, as well as a legitimate fall out of the branch itself. But most scientific researchers have to beware that not more than the bare minimum of creative energies are utilised in such vain pursuits. At the same time, most

researchers are seized of the need to replicate an experiment and verify the results of the original research team. This is precisely because reaffirmation or denial, or any further subtle nuances of a process studied, are laid bare only by these means. They are also the means of refining methodological errors in the original experimenter, which is another major scientific exercise that leads to its progress. Further, to prove that a certain phenomenon is universal, it needs to be studied at different centres and at different times. This is the crux of scientific research and its constant concern - the search for universal phenomena eschewing personal idiosyncrasy, subjectivity, demagoguery or blind faith. This is what has led to the rationale for collaborative research centres or projects at different places the world over, with one of which one of us was associated for some time.

To be sure, one would expect the lead in most such projects to come from the developed part of our globe. This is a reality none can deny. But this need not take away the credit from corroborative research done elsewhere. Though greater finesse and expertise may help bring larger number of leads in scientific research from elsewhere, it is in their confirmation and their universal relevance, or denial, that centres in the developing countries can help. And let us not forget that often corroboration is the bedrock on which many a fancied scientific hypothesis or theory stands, or falls. It is only when replication is attempted that most scientific hypotheses or theories, or even proofs, stand the test of objectivity, and therefore remain acceptable, or get discarded.

Discrimination and Assimilation

What we therefore need to condemn is not replicative research as such. (And we can use the words duplicative and replicative synonymously here, for *sans* its pejorative connotation, what is duplicative work if not replicative?). It has its legitimate place. What we need to condemn is a *blind* duplication, and a *total* involvement purely with this type of work. This can be a manifestation of servility that the Indian psyche has to rid itself of. In a country where for everything innovative, superior or trend-setting, the people have learnt to look to the West, is it any surprise that the scientist isn't any different? This is a pity, true, but it is a fact as well, a fact that cannot be wished away by chanting pious patriotic slogans. The war, if at all, has to be fought at a totally different level. For this, firstly, we will have to develop the power of discrimination which must guide every assimilation. As of today, the order is reversed. It is senseless assimilation that has dulled any discriminatory capacities. Reversing this trend would mean reversing the colonial mentality, wiping out our historical blemishes, disciplining a whole mass of people. It must ultimately involve giving up on our 'underdeveloped' status as a nation. When so put, we immediately realise the enormity of the task. After all, the quality of the scientific work, as of any work, cannot but be directly proportional to the calibre of the collective cerebral pool of a society. And its social values, its collective priorities, and particularly, the personality strengths of its stalwarts and its torchbearers.

What has to be done

Once we realise this, we can see that just blaming or pointing out what ails Indian Science is not adequate at all. What will have to be done is to adopt concrete steps to achieve and reward academic excellence and originality, to encourage genuine research potential and further commitment to fundamental research. For this of course a firm grounding in scientific methodology and temper is a must, and that too from the very beginning of education. But also equally important is a truly professional commitment of a dedicated band of researchers who have the backing of an enlightened bureaucracy. In this, therefore, research amateurishness is out, as is maybe the inability in today's setup to make a comfortable living as a researcher. Along side this is involved the need to remodel educational policies to further the creative potential as opposed to rote learning, to encourage students to deal with

We can see that just blaming or pointing out what ails Indian Science is not adequate at all. What will have to be done is to adopt concrete steps to achieve and reward academic excellence and originality, to encourage genuine research potential, and further commitment to fundamental research.

Anything that is not objectively verifiable, that cannot be experimentally proved and does not have the possibility of replication cannot fall within the purview of scientific investigation or research. That need not negate its truth or its worth, for nowhere does science claim that it knows, or will know, the whole truth.

concepts rather than with information alone, to hone their critical - analytical apparatus and learn to sift and sieve rather than uncritically accept. This will involve a massive effort to restructure the Indian psyche. And will be reflected in the quality of its cerebral pool, its personality strengths, social values and priorities we talked of earlier.

II

The Essence of Scientific Temper

This is the essence of science : ask an impertinent question and you are on the way to the pertinent answer .

*- J. Bronowski**

It is inconsequential, if not frivolous, to enter into any dialogue of delinking science from religion, faith, superstition and other such entities. This is the favourite past time of some modernists, and that brand which prefers to call itself rationalist. Usually, true scientific temper does not have to make any conscious attempt to delink itself from any thing. The delinking is automatic. Anything that is not objectively verifiable, that cannot be experimentally proved and does not have the possibility of replication cannot fall within the purview of scientific investigation or research. That need not negate its truth, or its worth, for nowhere does science claim that it knows, or will know, the whole truth. All it means is that any truth, opinion or merit it has is extramural to science. It means it falls outside the domain of scientific verifiability.

... the pronouncements of science are made tentatively, on a basis of probability, and are regarded as liable to modification. This produces a temper of mind very different from that of the medieval dogmatist... (And science) pronounces only on whatever, at the time, appears to have been scientifically ascertained, which is a small island in an ocean of nescience (Russell, 1985, p.480). Parenthesis added.

Science, the discipline, and Scientist, the man

Having said this, we must immediately realise that science, therefore, can have no basic animosity, or friendship, either with religion, religious belief, or faith. *A scientist, however, can.* And there is every reason to believe such a distinction can be made, and legitimately so. A scientist is human, and, being so, has his own share of aspirations, beliefs and hopes which cannot, however,

**Cohen and Cohen (1986, p54).*

There are two cardinal rules a scientist must follow. First, he should never be unwilling to accept the worth of evidence, however damning to the most favourite of his theories. Second, and perhaps more important, for want of evidence, science withholds comment.

be a part of the branch to which he belongs. A large part of his energies can be legitimately spent in discriminating between the two, and not allowing one to negatively influence the other. No doubt he attempts to rid himself of viewpoints that are not based on evidence. But as regards entities he cannot scientifically verify, or has still not developed the methods to scientifically study, he prefers not to comment as a scientist, and yet retains his right to believe, reject or defend, as a human. In this, no doubt, lie shades of his hypocrisy which is inevitable in all such

ambivalent situations. But neither pointing it out nor condemning it is of any great worth. The latter, if anything, leads to the worship of science, by raising the branch to the level of a dogma or a faith, which itself can have no less disastrous consequences for mankind. What must be attempted is a realization of this ambivalence, of this duality of cognition, and a sincere attempt made to allow the bare minimum of unhealthy interaction between the two. For this, there are two cardinal rules a scientist must follow with regard to his branch. First, he should never be unwilling to accept the worth of evidence, howsoever damning to the most favourite of his theories. And what follows as a corollary, he should never get emotionally attached to any of his theories, howsoever lovingly elaborated. The second, and perhaps more important point is, for want of evidence, science withholds comment. For want of objective data, either way, a true scientist withholds judgment. It is important he withholds it, for passing judgement in the absence of evidence makes one liable to fall into the trap of either cynical bullying or unnecessary messianism. And a vapid theorizing whose soaring hopes only make one come crashing to the ground finally. This most science watchers must have realized in the fall of any number of new fanciful theories that attract instant attention but, unable to stand the test of verifiable evidence, sink into as rapid an oblivion.

Scientific Temper and Religiosity

Science, therefore, or scientific temper, need have nothing to do directly with how religious or otherwise an individual is. That should clarify why the best of scientists have been both pious and atheists. This is not to say that religiosity, or its denial, makes them better scientists, although personally they may so claim. All it means is that personal preferences and biases are difficult to delink for even those who are in disciplines that involve the most rigorous objectivity. Secondly, as far as the question why religion, or its

The very fact that scientific progress occurs helps mankind achieve so much material advancement in its wake. But what is materially beneficial to mankind is only incidental to scientific progress.

refutation, is accorded diametrically opposite value by the committed believer or the established iconoclast amongst the scientists goes, the answer is not very difficult. It is more an indication of their personal qualities of single-minded pursuit and devotion. It is this that makes them rise to the top and gets exercised as much in their scientific research as their metaphysical opinions. And faith, or its denial, can become important catalysts in both pursuits. The scientist concerned, however, may give it a totally different, personalized, colour. This, again, is only proof that the scientist is human after all and, in spite of his best efforts, human failings cannot but become manifest at times.

Refutation

It is a good morning exercise for a research scientist to discard a pet hypothesis every morning before breakfast. It keeps him young.

*- Konrad Lorenz**

There is another facet to the advancement of science. Just as replication is important, refutation is equally so, in fact more so, according to certain authorities. The march of scientific progress is the result of refutation. Karl Popper, a respected name in the philosophy of science, believes there is in science an inherent (or inbuilt) quality of development by refutability (Popper, 1968; 1969). Progress in science, therefore, is more the consequence and product of the refutation of a theory, concept or idea, less of its confirmation. Controversy, and slanging, are therefore just logical consequences. Similarly, Thomas Kuhn talks of *paradigm shifts* which fundamentally alter perceptions that cause scientific progress (Kuhn 1970; see also p. 48 of this book). This means that instability of scientific hypotheses is an inbuilt feature of scientific advance. This may appear an anachronism to the science worshippers. But its worth is apparent when we see how the most recent of scientific research become out dated tomorrow. To the human-being it means that although science is a method to search for means to rid one of error, it is a search that only approximates, but may never finally lead, to the truth in the ultimate analysis. That need not make the search any less intense, or the genuine pursuit of science any less important, as it can apparently do as an immediate reaction. Amongst other things, the very fact that scientific progress occurs itself helps mankind achieve so much of material advancement in its wake. But what is

*Cohen and Cohen (1986, p211).

materially beneficial to mankind is only incidental to scientific progress. It is never its goal, or even its major thrust.

*For science knows only one commandment : contribute to science.
- Bertolt Brecht**

This determinism is best realized early by the more prudent, and is neither disliked nor lamented. It helps, if anything, in sobering down unrealistic expectations from science and in not involving it in any unnecessary controversies with those aspects of human endeavour (like politics, religion, social activism etc.) with which it need not have any quarrel whatsoever.

Some Conclusions

To conclude the second part, one may say that the true scientist withholds himself from passing comment on a phenomenon which his experimental method can either not verify or which falls outside the purview of his branch itself. That does not mean he shirks his responsibility. It does not also mean he may not take up this phenomenon for study at a future date, when he develops the necessary methodology and the expertise. All it means is that at the existent state of his knowledge, he withholds himself from either attempting something which he cannot scientifically assay, or passing judgment on something he cannot objectively verify. He withholds judgment, mind you. He says neither yes nor no. Often most people err in considering withholding of judgment to mean no, or the lack of courage to say yes. This is because dislike of a state of suspended animation is natural to human beings. But the scientist has to constantly live with it. There is hence no justification for such a belief.

III

Two Contrary Streams of Thought

There are two streams of thought which must engage our attention in this section. One is deterministic and leads to pessimism. The other is intent on controlling the perils into which scientific progress can lead mankind and is hopeful of success if checks and balances are in place. It keeps to the forefront the question whether man is for science or science for man. Let us take up each of them one by one.

The true scientist withholds himself from passing comment on a phenomenon which his experimental method can either not verify or which falls outside the purview of his branch itself. That does not mean he shirks his responsibility. It does not also mean he may not take up this phenomenon for study at a future date, when he develops the necessary methodology and the expertise.

*Cohen and Cohen (1986, p51).

The painful truth is that not only is science neutral in its value orientation, this neutrality makes it eminently suitable to the machinations of man's ulterior motives. This is the reason why, for example, nuclear weapons keep on getting produced in spite of the fact that every scientist knows the vast devastation they can cause.

Cause for Pessimism?

Let us take up the first thought here.

What benefits mankind is only a by-product of scientific development and can never become its aim, much though we may wish to believe otherwise. The painful truth is that not only is science neutral in its value orientation, (Russell, 1987, p.481-82, see also note attached), this neutrality of science makes it eminently suitable to the machinations of man's ulterior motives. This is the reason why, for example, nuclear weapons keep on getting produced in spite

of the fact that every scientist knows the vast devastation they can cause. We do not have to go very far back to realise this:

The practical importance of science was first recognised in connection with wars. Galileo and Leonardo obtained government employment by their claim to improve artillery and the art of fortification. From their time onwards, the part of men of science in war has steadily grown greater (Russell, 1987; p.480).

This is again a dilemma for the scientist as a propagator of his branch, and may be considered a defect of scientific advance by the activists of nuclear nonproliferation and disarmament (or, for that matter, even the environmental activists). This is also the reason that scientific development will continue to use its own perpetuation as its only guiding factor, irrespective of whether it causes the welfare of mankind, or otherwise. And also the reason that as long as scientific progress is our major thrust, nuclear disarmament activists (or even the environmentalists) will continue to fight a losing battle. And why the scientist, as a man of science, will never be able to resolve the pangs of guilt and remorse aroused in him as a person belonging to the race he will ultimately help to destroy:

If only I had known, I should have become a watchmaker.

*-Albert Einstein (Of his making the atom bomb possible. Quoted in News Statesman, 16 Apr., 1965)**

To be sure, the conflict between 'Man' and 'Science' will continue till either of them is either exhausted or wiped out. In the meantime all that we may succeed in doing is

**Cohen and Cohen (1986, p 108).*

The scientist as a man of science will never be able to resolve the pangs of guilt and remorse aroused in him as a person belonging to the race he will ultimately help to destroy... The conflict between Man and Science will continue till either of them is either exhausted, or wiped out.

try and achieve some state of equilibrium wherein, till this final stage is reached, life can continue with the simulations and masks that make it tolerable. No. This does not mean destruction is round the corner, or the final deluge predicted is most theology is just waiting in the wings. It only means we still have time to prepare ourselves for the final reckoning. And if to discard Science as a remedy to this existential despair appears an attractive alternative, perish the thought. No one, supposedly in his senses, will accept your 'obscurantism'.

Resolution of the Pessimism

The earlier paragraph ends on a rather sombre note. And a pessimistic one at that. There may arise howls of protest, or at least an extremely uncomfortable feeling in most readers. It is like the feeling one gets after watching a tragedy movie. Having witnessed the benefits of scientific and technological advancement pervade every aspect of our lives it is disconcerting to accept such a proposition, to say the least.

What shall we do then? How shall we place this thought in perspective? How shall we resolve the pall of gloom that sets in with such a realisation? Well, let us try.

It is in the nature of entities that begin to also end at some time. It is fundamental to the rhythm of nature, and the universe. Man is born and must die. Seasons start and must end. Days end into nights and nights into days. Years start and end, as do decades, centuries, eras and epochs. None of the material entities have the attributes of beginninglessness, and therefore endlessness (except perhaps primordial matter itself). That quality, if at all, religion attributes to entities like Soul and God, which are considered timeless, beginningless, endless etc. etc. Science has no methods, as yet, to study these entities, and so can learn nothing about them.

Two thoughts can comfort us in this situation.

One is, even if we grant that what starts must end, it does not mean we cannot enjoy the interlude. Although we may start driving from our house to a certain destination, just the thought that the journey is going to end need not deter us from enjoying the whole drive. Man is born and must die. True. But the fact that he must die need not prevent him from living his life well, fruitfully and happily. For, in so doing, he only fulfils himself.

This is what man can do in spite of a realisation of the inevitable and inexorable direction in which Science will propel him. Granted, the realisation adds a tinge of

It is in the nature of entities that begin to also end at some time. It is fundamental to the rhythm of nature and the universe... But even if we grant that what starts must end, it does not mean we cannot enjoy the interlude.

Every destruction carries within it the germ of a new beginning. In fact, the germ of rebirth is present in the death itself. When a day ends, the start of the night contains the germ of a potential day which must inevitably arise later.

sadness to the happiness. But there is no unalloyed happiness anywhere, there is no pure or true state of anything. That is only an idealised fiction, a goal unknown, a destination unreached. Moreover, in enjoying the journey, it need hardly be said that one is aware of, and removes, the known nuisances and road blocks. The whole fight of the environmentalists, nuclear disarmament activists, and those against other weapons of mass destruction, as the fight against poverty, exploitation, racial, gender and caste discrimination, as also the incessant fight against disease, distress and disability that the field of medicine is involved in, along with greater use and production of sophisticated means of transport and mass communication - are all meant to ease this journey. That cannot be stopped and needs to be put into place rather vigorously. And effective checks and balances put into action at every step further prolong the ease.

The second important point worthy of consideration here is what we shall come to now. It is true everything that begins must end. But the end of one is also the beginning of another. Days end into nights, but nights also end and are replaced by days. Men live and die. But their deaths are replaced by generations that exist after them. Similarly with months, years, seasons, eras and epochs. Nothing ends really. It is only the start of something else. And it is cyclical. It comes back. Every destruction carries within it the germ of a new beginning. In fact the germ of rebirth is present in the death itself. When a day ends, the start of the night contains the germ of a potential day which must inevitably arise later. Even if, therefore, Science may be responsible for the eventual destruction of man and the universe as we understand them, that will only be the start of a new era, a new *yuga*. A new process, a new beginning. A new cycle. And the end of man will lead to the beginning of such an epoch which contains the germ of his resurrection at some point in time. Probably metamorphosed, probably only distantly akin. This may appear a futuristic statement, but is based on observation of phenomena, and may therefore be considered a speculation in the realm of probability.

Where, then, is the existential despair? Where the need to discard Science? We may indeed perish the thought, for where is the obscurantism?

Man for Science, or Science for Man?

As apposed to the former view, which we set out to resolve (and succeeded to an extent), is the view while must engage our attention here. If the former thinks of Man as getting used for Science, this wants Science to be firmly utilised in the service of Man, and never the other way around.

Man's well-being has never been strictly defined but it has always acted as a universal value. It must be the overriding goal. Human life, the possibility of its comprehensive development, is of the greatest value. Science, and development, are the means to such an end. The price that humanity must/must not pay for truths to be discovered in nuclear physics, molecular biology and such other fields must not be such as to undermine man's welfare for the welfare of science. The essential value-neutrality of science will have to be supplemented by the values that man has upheld for centuries as fundamental, which religious thought and moral philosophy have continuously professed. For :

There is no evil in the atom : only in men's souls.

*- Adlai Stevenson**

This however need not lead us to scientific nihilism or to Rousseauistic views that slow down scientific progress to 'zero-growth', or to 'anti-science', or a science counter-culture. All it means is the modern scientist must weigh the progress of science and technology (especially the latter), with the consequences of their progress for mankind. In all such procedures, the well-being of man must be the over-riding goal.

These issues are discussed in contemporary science, and notably in philosophy, chiefly in connection with the admissibility of certain kinds of research which by themselves, or in application, may damage man and humanity. Not only nuclear physics is the subject of controversy, but also molecular biology, genetics, medicine, psychology, psychiatry and other fields of knowledge where man is the object of study. Many scientists believe that man will come across political, moral, ethical and psychological problems which will make those facing nuclear physics seem like child's play (Frolov and Yudin, 1986). Especially the developments in biology (like cloning, surrogacy, stem-cell research etc.) pose fundamentally new and very complex problems for the thinking man in general and philosophers in particular. It makes sense to say that philosophers of science would do well to think a great deal more in the future about ethical problems than about logical problems (Glass, 1970). The dangers of using biological findings in warfare, the consequences of psychopharmacological drugs, the practice of organ transplants ('What makes the individual') all pose many complex and fundamental questions before man and humanity.

For all these reasons, the development of strict socio-ethical standards of experimentation with man

Many scientists believe that man will come across political, moral, ethical and psychological problems which will make those facing nuclear physics seem like child's play. Especially the developments in biology pose fundamentally new and complex problems for the thinking man in general and philosophers in particular.

*Cohen and Cohen (1986, p 172-73).

becomes a vital need. Equally important is the need for stringent social and ethical supervision of such standards. Thus, on the one hand, the scientist must self consciously follow such codes himself. On the other, regulatory bodies must see to it that such codes are strictly enforced, and any transgressions adequately prevented and /or punished.

In Closing

Let us now ask once again : Where, then, is the existential despair? Where the need to discard science? We may indeed perish the thought, for where is the obscurantism?

The development of strict socio-ethical standards of experimentation with man becomes a vital need. Equally important is the need for stringent social and ethical supervision of such standards.

We may also consider ourselves duly comforted and even a bit happy at having revolved the issue partially, at least for now. The tinge of inevitability and tragedy lingers. True. But that is what makes the comedy of living all the more enjoyable. And desirable. And Science is about the joy of living, if nothing else, even if it is about the depths of eventual despair.

We have decided to enjoy the journey while it lasts.

How about you?

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7. Russell B. (1985), *A History of Western Philosophy*, Counterpoint, London, Unwin Paper backs, p.481-82: "Unlike religion , it (science) is ethically neutral: it assures men that they can perform wonders, but does not tell them what wonders to perform... The men at the head of the vast organizations which it necessitates can, within limits, turn it this way or that as they please. The power impulse thus has a scope which it never had before. The philosophies that have been inspired by scientific *technique* are power philosophies, and tend to regard everything nonhuman as mere raw material. Ends are no longer considered; only the skillfulness of the process is valued. This also is a form of madness. It is, in our day, the most dangerous form, and the one against which a sane philosophy should provide an antidote". Parenthesis added.

Questions that the Fourth Monograph raises*

- Q.1. What should governing bodies and funding agencies do to encourage original research?
- Q.2. How can Indians graduate to original research from replicative research?
- Q.3. In which fields is original research taking place in this country? And to what degree?
- Q.4. What changes in education pattern in schools/colleges will ensure that Indians take to original research in a big way?
- Q.5. Will science ever answer questions like: Is there God? Is there an afterlife? Are miracles for real? etc. etc.
- Q.6. How can scientific temper and religious belief coexist? On this planet? In an individual?
- Q.7. Will scientific progress ultimately lead to mankind's annihilation? Is there an antidote?
- Q.8. If evidence is so important, what happens to belief and devotion? Should they be discarded, although they are useful to mankind at every step?
- Q.9. The clinician *believes* the research evidences *presented* to him in conferences and journals. Should he discard this belief and trust only his own evidence? Is that a practical method of working?
- Q.10. 'Science without religion is lame, religion without science is blind.' So said the great Albert Einstein. Is that sufficient enough resolution of the divide between religion and science?
- Q.11. 'Every genuine scientist must be... A metaphysician', said George Bernard Shaw. Does this not have the danger of making him a poor scientist?
- Q.12. How do you like the proposition: howsoever thin you slice a cake, there are always two sides?

*See also page 71-75.

Appendix

Some Answers*

- Ajai R. Singh

(Page 70, raised a few questions which one of the authors (A.R.S.) attempts to answer. Take them for whatever they are worth. Hope they excite you to search for your own answers.)

Q.1. What should governing bodies and funding agencies do to encourage original research?

Ans. Stop funding replicative research to the extent being done now. Make it 50 : 50, for original and replicative research, then 75:25 over a five year period. And have original researchers on panels which select research projects for grants also in the same proportion. Let us just hope that's not a tall order.

And if funds lie unused let them not lapse. Let them be carried forward to the next year, and the next if need be. Let them not be sanctioned hurriedly at the end of the year, for that makes it eminently suitable for manipulation.

Q.2 . How can Indians graduate to original research from replicative research?

Ans. By encouraging original thinking at every level, starting from childhood itself: by motivating them to ask questions, even though embarrassing to adults. Also, by appreciating those who want to set new trends, to chart new seas and cross new frontiers in their respective fields. By creating a climate conducive to questioning and enterprise rather than conformity and obedience. And by being ready to absorb the turmoil that results during this transition.

Q.3. In which fields is original research taking place in this country? And to what extent?

Ans. This is a question for individual specialists to answer. But nuclear science, biotechnology, indigenous systems, pharmaceuticals, computer applications, agriculture and agro-based industries hold the greatest promise. It is to a minor to modest degree at present, but can change in a decade or two.

Q.4. What changes in educational pattern in schools/colleges will ensure that Indians take to original research in a big way?

Ans. i) Stop emphasis on rote learning; ii) encourage students to ask questions, howsoever embarrassing to elders, and seek answers rather than accept ready made solutions (and we curb our eagerness to supply them); iii) allow students to understand and formulate concepts rather than mouth empty phrases learnt by heart from insipid textbooks; iv) learn to wonder at phenomena, to observe nature and

* First Published as Appendix in MSM 1:5, Jan-Feb, 2004. See also p.15, Buddha's Discourse to the Kalamas.

society, to question established beliefs, opinions, dogmas; v) reduce society's emphasis on conformity, traditionalism, by first of all teachers and parents becoming such; vi) Spot out exceptional merit for creativity / originality (and not just for scoring more marks) and develop concrete programmes to hone and further it; vii) appreciation and recognition of originality / creativity in school/college students by teachers, parents and educational governing bodies and absorbing them into a programme to see to it that it does not get snubbed by conformity seeking curricula or pedagogy (which will always remain, and do serve their own purpose for sure).

Q.5. Will science ever answer questions like: Is there God? Is there an afterlife? Are miracles for real? etc. etc.

Ans Science will always ask for verifiable evidence of everything. As at present, it doesn't have the necessary tools to verify these phenomena. So it should withhold comment. The possibility that it will develop such tools in the near future are remote. But one thing is certain. Anyone who attempts to answer these questions will be able to succeed with a large number of people and for a longer time if he has the scientist's mind and the mystic's intuition. The example of Narendra's questions to his guru, Swami Ramakrishna, and the latter's answers come to the mind here. These will never be a final or only answer. It will be a fusion of sorts. Unsatisfactory for the purists of both sides. True. But that's how it is.

Q.6. How can scientific temper and religious belief coexist? On this planet? In an individual?

Ans Neither scientific temper nor religious belief are complete methods in themselves to explain all phenomena. Scientific temper gives supremacy to evidence and reason, religious belief gives supremacy to introspection and intuitive experiences. For holistic understanding of phenomena, both approaches are necessary. A healthy interaction between them, and their fusion are necessary both at the social and the individual level. They are not only competing but complementary approaches.

Q.7. Will scientific progress ultimately lead to mankind's annihilation? Is there an antidote?

Ans. Yes, I believe that scientific progress will be responsible for mankind's annihilation as and when it occurs. But that will only happen when man forgets science is just a method and an approach, to be necessarily regulated by ethical-moral principles of truth, justice, compassion, universal welfare and fair-play which converts it into a system and, though battered beyond recognition by man's ulterior motives, are still recognised as legitimate aspirations by all right thinking men everywhere.

The antidote, if any, will come from a scientific religiosity. This will involve not just a fusion of intellect and emotion, but of reason and devotion.

Q.8. If evidence is so important, what happens to belief and devotion? Should they be discarded, although they are useful to mankind at every step?

Ans. Certain beliefs and devotions are eternal, certain situational. Belief in God for example, is eternal, belief in *a* God is situational; so with many other such entities. The eternal will remain, the situational will get modified, may even get discarded. Belief and devotion as methods, however, will always remain to help mankind understand both the external world and calm internal turbulences.

Q.9. The clinician *believes* the research evidences *presented* to him in conferences and journals. Should he discard this belief and trust only his own evidence? Is that a practicable method of working?

Ans Yes and No.

Yes. The clinician believes the research evidence presented in conferences, journals etc. because that belief is backed by verifiable evidence which is the hallmark of the scientific method. And it is replicable by another researchers, and also refutable. And undergoes self-correction as well. As and when this belief is found unverifiable or unreplicable, he will and must give it up. So an evidence-based belief is integral to scientific progress, as well as necessary for its application to people's welfare, especially so in the field of the medical sciences.

No, he cannot discard this belief in research evidence, but this evidence must be corroborated by his own clinical experience. If the researcher says, for example, Venlafaxine is three times more potent than Fluoxetine and the clinician finds they are only equally good, if at all, he must trust his own clinical experience rather than the researcher's proclamations. So, if, and when, the researcher's conclusions do not get corroborated by his own clinical findings, he must question this belief and reject it. For the research evidence's credibility stands to question, at least for him. And he must exercise his clinical judgement for the patient's welfare as of overriding value, even if contrary to current research and trends. For what is current today may get refuted tomorrow. And this is one of the ways it may get refuted.

Q.10. 'Science without religion is lame, religion without science is blind.' So said the great Albert Einstein. Is that sufficient enough resolution of the divide between religion and science?

Ans. Yes, it is a beautiful resolution as it goes. Science without

religion is lame because it will not lead very far. Religion without science is blind, because it will not be able to show the way if not backed by reason and observation. So a lame science can ride a blind Religion and both can complete the journey. However if the converse occurs, then we are in for a big, big problem. If a blind religion rides a lame science then it will spell disaster for mankind. Not possible? Well what were the dark ages but that, when scientists were tortured by fanatical religionists? Lame science and blind religion are being used today as well: weapons of mass destruction are supplied by a lame science, powerless before ulterior men's machinations. Fanatical followers use blind religion to fuel discord and raise terrorist squads to carry out self proclaimed *jehads*.

And the future holds no less a menace.

So Einstein does make sense. And it is useful to think of the fusion of science and religion, as it is to think of their divide. Their division is important for their individual welfare, their fusion is important for mankind's welfare. Both are equally important. So they must remain good neighbours, knowing their boundaries alright, but ready to collaborate for collective welfare.

Q.11. 'Every genuine scientist must be... A metaphysician', said George Bernard Shaw. Does this not have the danger of making him a poor scientist?

Ans. Yes, it does entail the danger of making him a poor scientist. But it also entails the possibility of making him a great scientist. A poor scientist runs a definite risk by dabbling in metaphysics. A great scientist actualises himself by indulging in it, becoming great only if and when he does so.

Why? A poor scientist may take the shelter of metaphysics to explain ill-understood phenomena and conveniently escape answering embarrassing questions. A great scientist will take the vision of metaphysics and seek direction from it to understand and further science and scientific theories.

Q.12. How do you like the proposition: howsoever thin you slice a cake, there are always two sides?

Ans Yes, I like it. I like the cake and its sides as well. And I would like it even if it had no sides. And I would like it even if had four sides.

And, come to think of it, a cake actually has six sides.

And that's a usual rectangular cake we are talking of. You calculate how many sides a hexagonal cake will have.

As with cakes, so with perspectives.

The Fifth Monograph

Gandhi on Religion, Faith and Conversion

Secular Blueprint Relevant Today

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Beware of the man whose god is in the skies.

- George Bernard Shaw (Maxims for Revolutionists)

Preface to the Fifth Monograph

When you discuss your religion with a person of another faith, what do you usually do? You try to defend it from attack by the other, while he tries to point out its faults. And you do the same to him while discussing his religion. Usually the debate ends in acrimony and mud slinging. You are left with the feeling that the other does not understand the delicacy of your viewpoint, forgetting that he too goes away with the same feeling as you criticise his religion.

Gandhi would want you to adopt the exact opposite approach. He would say, you have no business to criticise another's religion. In fact it is your duty to look at it from his point of view, and always have a reverential attitude towards his religion. But as regards your own, while you need to follow it and respect it, you must be aware of its faults and correct them vigorously, at every step.

His firm faith in reason was never shaken. He could not accept any religion as perfect for they had all come to us through humans, and humans were not perfect at all. He could not accept that the Vedas alone were the inspired word of God, for if they were so, why not also the Bible and the Koran? Neither could he accept that Jesus was the only incarnate son of God, or that only one who believed in him could have everlasting life. If God could have sons, all of us were His sons.

He had a pretty strong opinion on conversion as well. He could not find any justification for proselytization as an organised activity. He also could not find any justification for anyone to get converted, for a convert had, according to him, really not understood the greatness of his own religion. He felt he should seek fulfilment there rather than in change of faith.

On a subject that generates much heat, the sober thought of Gandhi can help calm turbulent waters.

The Infinite can be seen in the Finite, ... the Great can be glimpsed in the Small, ... we do not need to leave the world in order to know God.

- Tagore

Gandhi on Religion, Faith and Conversion

Secular Blueprint Relevant Today*

Ajai R. Singh

Shakuntala A. Singh

ABSTRACT

Gandhi believed in judging people of other faiths from their stand point rather than his own. He welcomed contact of Hinduism with other religions, especially the Christian doctrines, for he did not want to be debarred from assimilating good anywhere else. He believed a respectful study of other's religion was a sacred duty and it did not reduce reverence for one's own. He was looking out for those universal principles which transcended religion as a dogma. He expected religion to take account of practical life, he wanted it to appeal to reason and not be in conflict with morality. He believed it was his right and duty to point out the defects of his own religion, but to desist from doing so with other's faith. He refused to abuse a man for his fanatical deeds for he tried to see them from the other person's point of view. He believed Jesus expressed the will and spirit of God but could not accept Jesus as the only incarnate son of God. If Jesus was like God or God himself, then all men were like God or God Himself. But neither could he accept the Vedas as the inspired word of God, for if they were inspired why not also the Bible and the Koran? He believed all great religions were fundamentally equal and that there should be innate respect for them, not just mutual tolerance. He felt a person wanting to convert should try to be a good follower of his own faith rather than seek goodness in change of faith. His early impressions of Christianity were unfortunate which underwent a change when he discovered the New Testament and the Sermon on the Mount, whose ideal of renunciation appealed to him greatly. He thought Parliament of Religions or International Fellowship of Religions could be based only on equality of status, a common platform. An attitude of patronising tolerance was false to the spirit of international fellowship. He believed that all religions were more or less true, but had errors because they came to us through imperfect human instrumentality. Religious symbols could not be made into a fetish to prove the superiority of one religion over another.

In a multi-religious secular polity like that of India, Gandhi's ideas on religion and attitude toward other religions could serve as a secular blueprint to ponder over and implement.

Key words : Religion, Reason, Proselytization, Hinduism, Christianity, Conversion, Secularism

* First Published as Mens Sana Monographs I : 5, January - February 2004.

Introduction

It has been my experience that I am always true from my point of view, but am often wrong from the point of view of my honest critics. I know that we are both right from our respective points of view. And this knowledge saves me from attributing motives to my opponents or critics. The seven blind men who gave seven different descriptions of the elephant were all right from their respective points of view, and wrong from the point of view of one another, and right and wrong from the point of view of the man who knew the elephant. I very much like this doctrine of the manyness of reality. It is this doctrine that has taught me to judge a Mussalman from his own standpoint and a Christian from his. Formerly I used to resent the ignorance of my opponents. Today I can love them because I am gifted with the eye to see myself as others see them and vice-versa.

- Gandhi ⁽¹⁾

Religion of course is a matter of faith and we often tend to believe it is independent of reason or rational enquiry. Emotional defence and biased probing both reflect the lack of honesty in motives when religion becomes an object of study. We have ample display of both in most debates on religious issues when people of different faiths interact. For, when such debaters discuss, or even attempt to study each other, they are easily piqued or irked by the other's viewpoint. Then there cannot possibly be a reasoned debate. This is understandable because although religion can be debated, the hallmark of a genuine debate is objectivity and mutual respect, and religion (as faith in general) finds itself unable to encourage this in its debaters. But it is doubly unfortunate as well, for we must believe, firstly, in the worth of a reasoned enquiry in all aspects of human endeavour; and secondly, such an enquiry need not reduce the realistic vigour of faith. In fact, it must underscore our belief that no reasoned debate can hurt the legitimate interests of any worthwhile enterprise. Such an enquiry must only strengthen our worthwhile beliefs, help weed out the decrepit, and help us identify them in others as well. Therefore, then, there is reason to believe that even on religious matters, a reasoned debate is possible.

Although religion can be debated, the hallmark of a genuine debate is objectivity and mutual respect, and religion (as faith in general) finds itself unable to encourage this in its debaters.

I prefer to retain the label of my forefathers so long as it does not cramp my growth and does not debar me from assimilating all that is good anywhere else.

- Gandhi

Although no last word can be said on this matter, it may help to recapitulate Gandhi's views on one's own religion as well as religion in general, on the proper attitude when one studies another's religion, his opinion on missionary work, proselytization, and Christianity.

On Religion

Gandhi of course was born a Hindu but his interpretation of Hinduism was his own. While keeping firm roots in ancient Hinduism, he welcomed contact with other religions, especially the Christian doctrines. In this he had no doubt that he would not do any injustice to Hinduism or depart from its essential teachings, for his belief remained that Hinduism could assimilate and synthesize whatever new elements it came up against. "I prefer to retain the label of my forefathers so long as it does not cramp my growth and does not debar me from assimilating all that is good anywhere else".⁽²⁾ Further, "If we are to respect other's religion as we would have them to respect our own, a friendly study of the world's religions is a sacred duty. My respectful study of other's religion has not abated my reverence for, or my faith in, the Hindu scriptures. They have indeed left their deep mark upon my understanding of the Hindu scriptures. They have broadened my view of life".⁽³⁾ And his search for, "that religion which underlines all religions", made him look for that which transcends "Hinduism, Islam, Christianity, etc. It does not supercede them. It harmonizes them and gives them reality."⁽⁴⁾ In *Young India*⁽⁵⁾ he had already declared, "Let me explain what I mean by religion. It is not the Hindu religion which I certainly prize above all other religions, but the religion which transcends Hinduism, which changes one's very nature, which binds one indissolubly to the truth within and which ever purifies".

Talking next of the atheist, of reason and practical application, he said, "There are some who in the egotism of their reason declare that they have nothing to do with religion. But it is like a man saying that he breathes but that he has no nose ... even a man who disowns religion cannot and does not live without religion".⁽⁶⁾ At the same time he also said, "I reject any religious doctrine that does not appeal to reason and is in conflict with morality".⁽⁷⁾ "Man for instance, cannot be untruthful, cruel and incontinent and claim to have God on his side".⁽⁸⁾ And of course, "Religion which takes no account of practical affairs and does not help to solve them, is no religion".⁽⁹⁾

As regards study of the scriptures of other religions, he stated, "It is no business of mine to criticize the scriptures of other faiths, or to point out their defects ... It is only through a reverential approach to faiths other than mine that I can realize the principle of equality of all religions. But it is both my

right and duty to point out the defects in Hinduism in order to purify it and keep it pure. But when non-Hindu critics set about criticising Hinduism and cataloguing its faults they only blazon their own ignorance of Hinduism and their incapacity to regard it from the Hindu viewpoint. It distorts their vision and vitiates their viewpoint. Thus my own experience brings home to me my limitations and teaches me to be wary of launching on a criticism of Islam or Christianity and their founders".⁽¹⁰⁾

And the defender of reason as much as of faith that he was, he said, "I exercise my judgement about every scripture, including the Gita. I cannot let a scriptural text supercede my reason. Whilst I believe that the principal books are inspired, they suffer from a process of double distillation ... Mathew may give one version of one text, and John may give another. I cannot surrender my reason I believe in faith also, in things where reason has no place".⁽¹¹⁾ As a further prolongation of this reasoning, he lands up with the argument, "If I would call myself, say, a Christian, or a Mussalman, with my own interpretation of the Bible or the Koran, I should not hesitate to call myself either. For then, Hindu, Christian and Mussalman would be synonymous terms".⁽¹²⁾ To clinch the importance of reason he said, "... even as faithfulness to one's wife does not presuppose blindness to her shortcomings, so does not faithfulness to one's religion presuppose blindness to the shortcomings of that religion. Indeed, faithfulness, not blind adherence, demands a keener perception of shortcomings and therefore a livelier sense of the proper remedy for their removal".⁽¹³⁾

Talking of tolerance and respect for other's faiths, he said, "... mine is a broad faith which does not oppose Christians ... not even the most fanatical Mussalman ... I refuse to abuse a man for his fanatical deeds, because I try to see them from his point of view. It is that broad faith that sustains me. It is a somewhat embarrassing position I know - but to others, not to me."⁽¹⁴⁾

On Christianity

Talking of Jesus he said, "Jesus expressed, as no other could, the spirit and will of God ... I believe that he belongs not solely to Christianity, but to the entire world".⁽¹⁵⁾ On seeing a painting of the crucified Christ in Rome, he said, "What would not I have given to be able to bow my head before the living image at the Vatican of Christ crucified? ... I saw there at once that nations like individuals could only be made through the agony of the Cross and in no other way. Joy comes not out of infliction of pain on others but out

It is no business of mine to criticize the scriptures of other faiths, or to point out their defects. But it is both my right and duty to point out the defects in Hinduism in order to purify it and keep it pure.

- Gandhi

It was more than I could believe that Jesus was the only incarnate son of God, and that only he who believed in him could have everlasting life.

If God could have sons, all of us were his sons. If Jesus was like God, or God himself, then all were like God, and could be God Himself.

- Gandhi

of pain voluntarily borne by oneself.”⁽¹⁶⁾ But at the same time he wrote in his *Autobiography*,⁽¹⁷⁾ “It was more than I could believe that Jesus was the only incarnate son of God, and that only he who believed in him could have everlasting life. If God could have sons, all of us were His sons. If Jesus was like God, or God Himself, then all men were like God and could be God Himself. My reason was not ready to believe literally that Jesus by his death and by his blood redeemed the sins of the World. Metaphorically there might be some truth in it”.

While attending the Wellington Convention of devout Christians who prayed for him and wanted him to change his religion, he said, “I was delighted at their faith. I saw that they were praying for me ... I could understand and appreciate the devoutness of those who attended it. But I saw no reason for changing my belief — my religion ... It was impossible for me to regard Christianity as a perfect religion or the greatest of all religions”.⁽¹⁸⁾

He however complemented his Christian friends for their zeal in trying to change his faith because, “Though I took a path my Christian friends had not intended for me, I have remained for ever indebted to them for the religious quest that they had awakened in me”.⁽¹⁹⁾ In fact it made him come face to face with the deficits in Hinduism itself. “... if I could not accept Christianity either as a perfect, or the greatest religion, neither was I then convinced of Hinduism being such. Hindu defects were pressingly visible to me. If untouchability could be a part of Hinduism, it could but be a rotten part or an excrescence ... What was the meaning of saying that the Vedas were the inspired Word of God? If they were inspired, why not also the Bible and the Koran?”⁽²⁰⁾

Hindu defects were pressingly visible to me. If untouchability could be a part of Hinduism, it could but be a rotten part or an excrescence... What was the meaning of saying that the Vedas were the inspired word of God? If they were inspired, why not also the Bible and the Koran?

- Gandhi

On Conversion

Talking of the *New Testament*, he wrote, “The New Testament gave me comfort and boundless joy ... Today supposing I was deprived of the Gita and forgot all its contents but had a copy of the Sermon (on the Mount), I should derive the same joy from it as I do from the Gita”.⁽²¹⁾ But at the same time he said, in a conversation with C.F. Andrews,⁽²²⁾ “If a person wants to believe in

If a person wants to believe in the Bible let him say so, but why should he discard his own religion? This proselytization will mean no peace in the world.

- Gandhi

the Bible let him say so, but why should he discard his own religion? This proselytization will mean no peace in the world ... My position is that all the great religions are fundamentally equal. We must have innate respect for other religions as we have for our own. Mind you, not mutual tolerance, but equal respect”.

When C.F. Andrews asked him what would he say to a man who after considerable thought and prayer felt that he could attain peace and salvation only by becoming a Christian he said, “I would say that if a non-Christian (say a Hindu) came to a Christian and made that statement, he should ask him to become a good Hindu rather than find goodness in change of faith”.⁽²³⁾ Further, to a statement that one should not stand in a person’s way if he really needed a change of faith he said, “Supposing a Christian came to me and said he was captivated by a reading of the Bhagwat and so wanted to declare himself a Hindu, I should say to him, ‘No. What the Bhagwat offers the Bible also offers. You have not yet made the attempt to find it out. Make the attempt and be a good Christian’ ”.⁽²⁴⁾

“Supposing a Christian came to me and said he was captivated by a reading of the Bhagwat and so wanted to declare himself a Hindu, I should say to him, ‘No. What the Bhagwat offers the Bible also offers. You have not yet made the attempt to find it out. Make the attempt and be a good Christian’ ”.

- Gandhi

Missionary Work

Talking of his early impression of missionary work, he wrote, “In those days Christian missionaries used to stand in a corner near a high school and so forth, pouring abuse on Hindus and their gods. I could not endure this ... I heard of a well known Hindu having been converted to Christianity. It was the talk of the town that, when he was baptized he had to eat beef and drink liquor, that he also had to change his clothes, and that thenceforth he began to go about in European clothing including a hat. These things got on my nerves. Surely, thought I, a religion that compelled one to eat beef, drink liquor, and change one’s own clothes did not deserve the name. I also heard that the new convert had already begun abusing the religion of his ancestors, their customs and their country. All these things created in me a dislike for Christianity.”⁽²⁵⁾ He then narrated meeting a Manchester Christian who told him, “Many Christians are meat-eaters and drink, no doubt; but neither meat-eating nor drinking is enjoined by Scripture. Do please read the Bible”. He did, when he discovered the *New Testament* and the *Sermon on the Mount* which went straight to his heart. “My young mind tried to unify the teaching of the Gita, the Lights of Asia and the Sermon

"My fear is that though Christian friends nowadays do not say or admit that Hindu religion is untrue, they must harbour in their breasts the belief that Hinduism is an error and that Christianity as they believe it is the only true religion ..."

- Gandhi

on the Mount. That renunciation was the highest form of religion appealed to me greatly".⁽²⁶⁾

About missionary work he wrote a response to the Church Missionary Society of England's appeal thus, "My fear is that though Christian friends nowadays do not say or admit that Hindu religion is untrue, they must harbour in their breasts the belief that Hinduism is an error and that Christianity as they believe it is the only true religion ... One would understand the attack on untouchability and many other errors

that have crept into Hindu life. And if they would help us to get rid of the admitted abuses and purify our religion, they would do helpful constructive work which would be gratefully accepted. But so far as one can understand the present effort, it is to uproot Hinduism from the very foundation and replace it by another faith. It is like an attempt to destroy a house which though badly in want of repair appears to the dweller quite decent and habitable ... he would most decidedly resist those who sought to destroy that house ... If the Christian world entertains that opinion of the Hindu House, 'Parliament of Religions' and 'International Fellowships' are empty phrases. For both the terms presuppose equality of status, a common platform. There cannot be a common platform as between superiors and inferiors".⁽²⁷⁾ The aim of a Fellowship of Faiths, he felt, "should be to help a Hindu to become a better Hindu, a Mussalman to become a better Mussalman, and a Christian a better Christian. The attitude of patronizing tolerance is false to the spirit of International Fellowship ... Our prayer for others must be NOT 'God, give him the light that thou has given me' BUT 'give him all the light and truth he needs for his highest development.' Pray merely that your friends become better men, whatever their form of religion".⁽²⁸⁾

"But so far as one can understand the present effort, it is to uproot Hinduism from the very foundation and replace it by another faith. It is like an attempt to destroy a house which though badly in want of repair appears to the dweller quite decent and habitable..."

- Gandhi

Crystallization of views

Finally he crystallized his views on religion by saying, "all religions are more or less true. All proceed from the same God, but all are imperfect because they have come down to us through imperfect human instrumentality".⁽²⁹⁾ "In reality there are as many religions as there are individuals".⁽³⁰⁾ "I do not share the belief that there can or will be on earth one religion".⁽³¹⁾ "So long as there are different religions, everyone of

them may need some outward distinctive symbol. But when the symbol is made into a fetish and an instrument of proving the superiority of one's religion over other, it is fit only to be discarded".⁽³²⁾

Also about proselytization he said, "(they) may change the lives of as many as they like but not their religion. They can draw their attention to the best in their respective religions and change their lives by asking them to live according to them".⁽³³⁾

"all religions are more or less true. All proceed from the same God, but all are imperfect because they have come down to us through imperfect human instrumentality",

- Gandhi

The essence of his ideas on religion was expressed thus: "After long study and experience, I have come to the conclusion that (1) all religions are true; (2) all religions have some errors in them; (3) all religions are almost as dear to me as my own Hinduism, in as much as all human beings should be as dear to me as one's own close relatives. My own veneration for other faiths is the same as that for my own faith".⁽³⁴⁾

The thought in its purity is before you. To ponder over, to imbibe. Comment is superfluous.

A story

Even if comment be superfluous, lets end this communication with a story.

Once a man and the devil were walking down a lonely street on a moonless night. As they went along, they saw another figure in front of them.

"Who is that?" asked the man.

"Well, he is a man, like you," answered the devil.

They then saw him pick up something from the ground.

"What has he picked up?" asked the man.

"He has picked up the Truth," was the answer.

"What will he do with it?"

"Oh, he will share it with his friends."

"Will they understand it?"

"Well ..." smiled the devil, and paused. "They will build temples out of it and throw the Truth out!"

The devil paused again and smiled to let the point sink into the man's head.

"And then my role begins," continued the devil.

The man was stupefied.

Let man pick up the Truth again.

Let the Truth reside in temples once again.

And let the Truth be perceived there by men all around.

“So”, said the devil, “I am happy man has picked up the Truth!”

●●●●●

The Truth picked up my man, institutionalized and often fossilised by him into religious dogma and creed, is subtly worked over by the devilish intentions of bigotry and obscurantism.

Let man pick up the Truth again.

Let the Truth reside in temples once again.

And let the Truth be perceived there by men all around.

Let the devil not feel happy that man has picked up the Truth.

Let the temple feel happy that Truth has indeed been reinstated there.

Let the devil look for other avenues to exercise his powers. Man being what he is, and his predilections being what they are, he will give the devil plenty of other places to work very hard over, for sure.

Let religion not be one of them.

Gandhi’s thought may provide man the necessary strength to pick up the Truth once again.

And this time the devil may not be happy.

Is man ready?

Otherwise, the devil sure is.

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Questions that the Fifth Monograph raises*

- Q.1. Gandhi would want us to be critical of our own religion but reverential towards others' religion. Most often the attitude is the exact opposite. How do we change our attitude in the manner Gandhi suggests?
- Q.2 . What is that religion which transcends all religions?
- Q.3. What is the correct attitude to have about religion in general and one's own religion is particular?
- Q.4. How does one handle the critics of one's religion, especially if they belong to another religion?
- Q.5. How does one handle an atheist ? What is the justification in the viewpoint that the atheist presents?
- Q.6. Gandhi said, "proselytization will mean no peace in the world". Will proselytizing religious leaders pay any heed to such pleas? What is their argument?
- Q.7. If all religions are equal can conversion as an organised activity ever be justified?
- Q.8. A friendly study of the world's religions is a sacred duty, according to Gandhi. And one's religion should not debar one from assimilating all that is good anywhere else. What is the foundation one should lay so that it does not shake one's conviction in one's own religion?
- Q.9. "It was impossible for me to regard Christianity as a perfect religion or the greatest of all religions", he said. But that is equally applicable to Hinduism, Islam or any other. Is this an acceptable proposition to the committed believers of a particular faith, especially of the Semitic religions?
- Q.10. Religion should appeal to reason and not be in conflict with morality, and religion should take account of practical affairs and help solve them as well. If temporal matters get regulated by religion, should politics also be so regulated? Then do we not run the risk of unscrupulous elements using religion as a handle to manipulate politics, garner votes and grab power?
- Q.11. Was Gandhi an appeaser of minorities in the garb of being understanding and reverential to other religions?
- Q.12. Are Gandhi's thoughts relevant for a multi - religious society like India? And for the world, torn as it is by conflicts wherever ethnic and religious sentiments run riot?

* See also page 89.

Readers Respond

1. Some Answers

- R. N. Sawardekar

(In response to the questions raised in the present Monograph, one of our subscribers Principal R.N. Sawardekar, M.A., of Dempo Trust Junior College, Panaji, Goa has sent in his answers. Hope they make interesting reading - eds.)

Q.1. Gandhi would want us to be critical of our own religion but reverential towards other's religion. Most often the attitude is the exact opposite. How do we change our attitude in the manner Gandhi suggests?

Ans : When Gandhi holds the view that all religions are equally true, where is the question of criticizing one and revering the other? Basically all religions preach the same gospel truth. But in course of time, some personalities (Pundits or priests) have incorporated some customs or traditions which suited them. For example, there is no scope for untouchability in Hinduism (if the word Hinduism is to be used). But unfortunately some people consider Hinduism preaches untouchability, which is totally wrong.

Q.2 . What is that religion which transcends all religions?

Ans : i) अहिंसा परमोधर्मः ii) परोपकाराय पुण्याय पापाय परपीडनाम् ।
iii) एतद् चतुर्विध प्रायुः साक्षात् धर्मस्य लक्षणम् ।

The above definitions of *Dharma* permit a man to follow his religion using his reason. All religions transcend into spirituality which knows no bonds of either Vedas, Bible or the Koran. It is a domain of non-duality.

Q.3. What is the correct attitude to have about religion in general and one's own religion is particular?

Ans: Not only all religions are equally true but we should allow them to grow and develop in our pluralistic society. One should nurture and fortify one's own faith (religion) by adding all that is good in other religions. Fortunately this liberal approach is available for Hindus. Therefore people of different religious faiths , persecuted in their countries, found a shelter in India.

Q.4. How does one handle the critics of one's religion, especially if they belong to another religion?

Ans : If there are critics who find some fault with our religion their constructive criticism should be accepted without we finding faults in their religion. Whenever it is possible, one should try to eliminate rituals, practices, customs and traditions which have no value in the system.

Q.5. How does one handle an atheist ? What is the justification in the viewpoint that the atheist presents?

Ans : An atheist is preferable to a hypocrite. The former says that he does not believe in God because he does not have the vision. What right has a person to give sermons, discourses on religion, God, Spirituality, when he does not have any *Sadhana*? Today there is more danger from the latter than the former. Carvakas (atheists) lived in India but slowly perished a natural death and the genuine systems continued. *Satyameva Jayate*.

Q.6. Gandhi said, "proselytization will mean no peace in the world". Will proselytizing religious leaders pay any heed to such pleas? What is their argument?

Ans : Proselytization will work only in those countries which are educationally backward. Once efforts are made to educate the masses in India and if people adopt the right view, neither proselytization nor conversion will work. Stray cases may be there. In our educational system there should be provision for information on different religions of the world.

Q.7. If all religions are equal can conversion as an organised activity be ever justified?

Ans : No. Conversion not only harms a person who gets converted but also it does greater harm to society and its fabric of which he is a part. It is like uprooting a fiber from a cloth and using it for some other cloth. The strength of the cloth will diminish.

Q.8. A friendly study of the world's religions is a sacred duty, according to Gandhi. And one's religion should not debar one from assimilating all that is good anywhere else. What is the foundation one should lay so that it does not shake one's conviction in one's own religion?

Ans : All religions basically has a similar foundation. Therefore there should be no difficulty in assimilating whatever is good of other religions in one's own. Sri Ramakrishna proclaimed that all religions preach the same truths. And he said it after practicing them all.

Q.9. "It was impossible for me to regard Christianity as a perfect religion or the greatest of all religions", he said. But that is equally applicable to Hinduism, Islam or any other. Is this an acceptable proposition to the committed believers of a particular faith, especially of the Semitic religions?

Ans: It is my conviction that Hinduism believes in an inclusive approach whereas a large number of people of different faiths believe in an exclusive approach and therefore the problem.

Q.10. Religion should appeal to reason and not be in conflict with morality, and religion should take account of practical affairs and help solve them as well. If temporal matters get regulated by religion, should politics also be so regulated? Then do we not run the risk of unscrupulous elements using religion as a handle to manipulate politics, garner votes and grab power?

Ans : By and large it is true that religion should appeal to reason. But it is true that human beings are also governed by the affective domain. We also require emotional culturing. However politicians should not be allowed to use religion as a tool for their ulterior motives.

Q.11. Was Gandhi an appeaser of minorities in the garb of being understanding and reverential to other religions?

Ans : I am inclined to believe this because he had exerted a lot of political power in doing so. If he had totally confined himself to the social sphere without influencing politics then possibly I would not have called him an appeaser of minorities.

Q12. Are Gandhi's thoughts relevant for a multi - religious society like India? And for the world, torn as it is by conflicts wherever ethnic and religious sentiments run riot?

Ans : Gandhiji's thoughts are not totally his original thoughts. There have been a number of thinkers and social reformers in our country who have contributed to such thoughts. Gandhiji was immensely influenced by them, as he himself confesses. However, large number of his thoughts are quite relevant not only for India but also for the whole world.

2. Pandora's Box

The New Year's Gift – Gandhi on Religion, Faith and Conversion, was educative, informative and thought provoking.

Any prudent individual would certainly endorse the views expressed in the article.

On Christianity and conversion there has been a lot of acrimony between the communities in India in the recent past.

Certain questions remains unanswered. The learned editors have refrained from expressing their own views on conversion :

1. Whether conversion prevails in India? Even today ?
2. Role of priests and missionaries in conversion ?
3. If at all conversion takes place in India, what steps should Hindus take to stop it ?

This may open up a pandora's box, but the leaders should know the other side of this story as well.

Without prejudice.

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*** Editors Note :**

The editors have refrained from expressing their own views on conversion because the monograph is related to Gandhi's views on conversion, not the editors. Moreover, Gandhi uses very simple language and expresses his thoughts with ample clarity. So you may agree or disagree with his thinking, but there is hardly any scope for misrepresentation of what he says. His thoughts are distillates of his wisdom, not points of debate really. But surely, in the light of what Gandhi says, the three questions raised in the response need to be addressed by a larger audience in an atmosphere of calm, critical enquiry. And its sometimes better to open a pandora's box rather than allow it to fester like a can of worms.

The Sixth Monograph

The Goal : Health for All The Commitment : All for Health

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To see what is right and not to do it is want of courage.
- Confucius (Analects)

Preface to the Sixth Monograph

Consider this :

1. You as an Indian, do not have the Right to Health, although our Directive Principles of State Policy, the Preamble of the WHO and the Universal Declaration of Human Rights of the UN mention it categorically.
2. Most countries which care for its people, including Russia, France and US, have granted such a Right many decades ago.
3. Progressive Five Year Plans of the Indian Government have reduced government spending on health as a percentage of the GDP.
4. National Health Policy was hardly debated on the floor of the house when tabled, probably because it was a soft political issue.
5. There are strong forces in the medical establishment, which in the name of upholding standards, may not want greater dispersal of services.
6. Governments and medical institutions may have conflicting interests, and the citizens' interests may get side-lined in the process.
7. Greater health awareness and care are signs of a more evolved society. People, governments and medical institutions will work in tandem only with greater development coming in their country in other walks of life as well.
8. If we have to achieve the goal of Health for All, we must have the courage to make the commitment: All for Health. Otherwise slogans like 'Health for All, All for Health', become one more cliché to mouth on suitable occasions.

*Physicians of all men are most happy; what success soever
they have, the world proclaimeth, and what faults they commit,
the earth covereth.*

- Francis Quarles (Hieroglyphics of the Life of Man)

The Goal : Health for All The Commitment : All for Health*

Ajai R. Singh
Shakuntala A. Singh

ABSTRACT

Primary Health Care was the means by which Health for All by the Year 2000 AD was to be achieved. And Health for All was possible only if All were mobilised for Health. This meant not just governments and medical establishments, but people themselves. Primary health care is essentially health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost the community and country can afford. And in working for such positive health, the role of health experts or doctors is the same as that of a gardener faced with insects, moulds and weeds. Their work is never done. Primary health care is a health conscious people's movement. Its implementation depends on knowledge of proper disposal of services and a persistent demand from an active and quality conscious consumer-the public. Strong political will, community participation and intersectoral coordination are its basic principles. However, the National Health Policy of India, 1983, was hardly debated in both houses when tabled. Both NHP 1983 and 2002 failed to confer the status of a Right to health, while most other nations are planning newer strategies to put Right to Health and Medical Services into practical use. Community participation in health is an aphorism that awaits genuine realisation in many countries of the world, notably of the third world. India, unfortunately, is no exception. Progressive Five Year Plans in India have reduced percentage spending over health as a part of GDP, which is an alarming state of affairs. Public awareness and activism alone can remedy this alarming condition. The people should not forget that health is not only a commodity that a benevolent government/ institution/ individual bestows on them. It has to be earned and maintained by the individual himself. Health problems cannot be solved in isolation. They will ultimately be part of our struggle for an egalitarian society, because better health care is a sign of a more evolved one.

Key terms : Primary Health care, National Health Policy, Health, Right to Health, Health for All by 2000 AD, Alma Ata Conference

* First Published as Mens Sana Monographs I : 6, March - April 2004.

Introduction

*DROP ME DOWN IN AFRICA, or Asia or Latin America. You give me US dollars 20 a head of the population I'm going to serve. And I'll show you we can produce a miracle.**

'We can do it!' He said further, in the context of health development, 'and with the resources we have, if we can only mobilise the minimum of international solidarity' (Walgate, 1988).

The optimism of the man could not but have percolated to the office that he held. And to its policy-making. But in spite of such honest proclamations and the realisation that there is an organic relationship between health and human advancement, most community health care delivery systems contain an overload of pessimistic and demoralised staff members. This is specially true of developing countries. It is a huge infrastructure, but a sleeping one. And one that moves only on external motivation. And incentives.

How should we, then, view WHO slogans like 'Health for All — All for Health'?'** It is catchy as such slogans go. It takes the ball out of the medical man's court and almost challenges the people to accept it in theirs. 'Beginning with people, not doctors', as the retired WHO Chief said, 'turning the whole thing upside down... It is a question of whether you have the political guts to trust people, to allow ordinary people to decide the way the money is being spent in health care' (*ibid*).

There's the rub. And a big one at that. It involves fighting not only established dogma but the bureaucratic infrastructure of the medical establishment with its paraphernalia of medical institutions, the drug industry, and the enormous socioeconomic clout that both wield.

Health for All by 2000 A.D.

In 1977 the 30th World Health Assembly resolved that the main social target in coming decades for Governments, as for the WHO, should be 'the attainment by all citizens of the world by the year 2000 A.D. of a level of health that will permit them to lead a socially and economically productive

* *Dr Halfdan Mahler, erstwhile WHO Director General for 15 years (Walgate, 1988). Make it \$ 80 according to today's standards(- eds.).*

** *The WHO usually issues a message for the year on World Health Day, April, 7, every year. This was the message given by Dr U. Ko Ko for World Health Day, 1988, New Delhi Regional Office for South East Asia, p. WHO/1988/2. But it is a slogan worth analysing today to find out how far we have reached in this direction and where do we go from here.*

life' (WHO, 1979). This goal got coined into a slogan *Health for All by the Year 2000 A.D.* Health for all meant that every individual should have access to *Primary Health Care* — a very important concept which we shall discuss later — and through it to all levels of a comprehensive health system. An year later, in 1978, the famous Alma Ata World Conference identified *Primary Health Care* as the key to the achievement of *Health for all by 2000 A.D.* In May 1979, the World Health Assembly endorsed the Declaration of Alma Ata and invited Member States to formulate national policies, strategies and plans to attain this target. One of its important guidelines was that each Member State should have a National Health Policy (NHP).

Now, the WHO definition of health is not how health is commonly understood. Health as the absence of disease is a negative definition. The WHO, in the *Preamble* to its Constitution, defined it positively way back in 1948 and threw a challenge to community workers to construct suitable models of health care:

Health is a state of complete physical, mental and social well-being, and not merely an absence of disease or infirmity. (Emphasis added.)

This definition encouraged researchers to work out positive parameters of health, which they did. For example, the parameters of *physical* health were (Crew, 1965):

A good complexion, a clean skin, bright eyes, lustrous hair with a body well clothed with firm flesh, not too fat, a sweet breath a good appetite, sound sleep, regular activity of bowels and bladder and smooth, easy, co-ordinated movements. All the organs of the body are of unexceptional size and function normally; all the special senses are intact; the resting pulse rate, blood pressure and exercise tolerance are all within the range of "normality" for the individual's age and sex. In the young and growing individual there is a steady gain in weight and in the mature this weight remains more or less constant at a point about 5 lbs. more or less than the individual's weight at the age of 25.*

Mental health meant (Laycock, 1962) :

- i) *Freedom from internal conflicts. No internal wars, no self-condemnation or self-pity.*
- ii) *One well-adjusted with others. Who accepts criticism and is not easily upset. Who understands the emotional needs of*

Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity.

- WHO definition of health (1948).

*By sweet, the author means pleasant or odourless, not sweet like that of a diabetic - eds.

In working for positive health, the role of health experts or doctors is the same as that of a gardener faced with insects, moulds and weeds. Their work is never done.

others and tries to be considerate and is courteous in his dealings with them.

iii) One with good self-control. Not overcome by emotion; not dominated by fear, anger, love, jealousy, guilt or worries. Who faces problems and tries to solve them intelligently.

Social health took account of the social and economic conditions and wellbeing of the individual in the context of his social network, his family, his community and his nation. This definition of social health was modified in 1978 to include the ability to lead a socially and economically productive life (WHO, 1978). Many factors of social wellbeing are yet to be identified (Ahmed and Coelho, 1979), to rectify which lacuna the 29th World Health Assembly took note of the importance of *social health* (World Health Assembly, 1975). A useful definition which resulted was that by Donald *et al* (1978), 'social health is the quantity and quality of an individual's ties and the extent of his involvement with the community.'

As should be immediately obvious, the WHO definition of health mentioned earlier is idealistic rather than realistic. Ideal health will always remain a mirage. Health in this context is to be considered a potentiality — to be promoted, to be supported, for the maximum good of the maximum number. In working for positive health, the role of health experts or doctors is the same as that of a gardener faced with insects, moulds and weeds. Their work is never done (Dubos, 1969).

Primary Health Care

Primary health care therefore became the major thrust of the WHO. It was also professed to be the Primary objective of the Indian health sector during the Sixth Five Year Plan (1980-85) and subsequent plans. The National Health Policy 2002 also accords primacy to preventive and first line curative initiatives at the Primary Health level (Govt. of India, 2002). The approach during the Ninth Five Year Plan (1999-2002) was to improve access to and enhance the quality of Primary Health Care in urban and rural areas by providing an optimally functioning primary health care system as a part of Basic Minimum Services (Govt. of India, 1999). 'On Primary Health Care', is the answer the WHO Chief gave when asked how he would spend the 20 dollars a head that he asked for (Walgate, 1988). Essentially speaking, Primary Health Care involves activities that prevent the occurrence of disease itself. This is in keeping with the philosophy of positive health, not just control or cure of sickness. Most of modern medicine has directed efforts and expertise

at the secondary level, that is, after the disease has set in, to prevent distress and disability, and/or to rehabilitate. Primary health care seeks to obviate this need itself. If one can act before the disease sets in, if it is prevented, what need for medicine-diagnosis-treatment?

Even if it can never totally do so, it ensures a lesser need for such services. As should be obvious there is a major problem here. Although unobjectionable in theory, it creates practical difficulties. Apparently it seeks to undermine the clout of modern medicine and its appendages. This is hardly a situation that could arouse enthusiastic participation from either the medical establishment or the average professional medical man, though quite a few right thinking may accept it, even work for it. Secondly, it lays great faith in the people’s ability to mobilise activities for their own health care, of course with guidance from community health workers and active participation of a health conscious government. Obviously we are still far from either, in India as in many other third world countries.

For this the major need is mobilisation of community and people’s support to work for their own health. The emphasis is on disease prevention by immunisation, proper diet, hygienic living conditions and sewage disposal, greater health awareness and health education by educational institutions, more involvement of mass media, the governing bodies, and social and environmental activists, amongst health professionals as well as others.

Primary health care is essentially health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost the community and country can afford. It forms an integral part both of the country’s health system of which it is the nucleus and of the overall social and economic development of the community (WHO/ UNICEF, 1978).

Primary Health Care is therefore a health conscious people’s movement. Its implementation depends on knowledge of proper disposal of services and a persistent demand from an active and quality conscious consumer — the public.

Sad story

Strong political will, community participation and intersectoral coordination are the basic principles on which primary health care is based. A direct result of this in India was that since the Alma Ata Declaration of 1978 occurred during the

Primary health care is essentially health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost the community and country can afford.

Strangely, when the National Health Policy bill was tabled there was hardly any discussion in both the houses... One knows how non-enthusiasm amongst legislators guarantees non-functioning of the best of policies.

Fifth Five Year Plan (1974-79), a clamour was raised within medical circles and outside for the Union Government to declare a National Health Policy (NHP). The Indian Medical Association (IMA) at its central meeting had already strongly voiced this an year before the Alma Ata Conference, initiating a countrywide movement through debates, seminars etc. Leaders of all political parties took part in a national debate held at IMA headquarters, New Delhi, demanding an early declaration of a National Health Policy (Dutta, 1988). Close on the heels of this came the Alma Ata Declaration urging every country to have a declared NHP. The Indian Government then set working and announced its first NHP in 1982 which was formally approved by the Parliament in December 1983.

Now comes the sad part of this story. Strangely, when the bill was tabled there was hardly any discussion in both the houses. This showed lack of interest and/or poor awareness of something that should have been immediately perceived as of vital importance to the nation. One knows how non-enthusiasm amongst legislators guarantees non-functioning of the best of policies. The draft policy was hardly debated even on the floor of the state legislatures. The premier all India body of medical practitioners, the Indian Medical Association, was never consulted at the formulation stage and therefore could put forward criticisms only at the final stage, which, in an already callous atmosphere, proved of little avail.

National Health Policies (NHP, 1983; NHP, 2002)

The NHP, 1983, was a half-hearted attempt to synthesise recommendations of three important earlier committees, the Bhore Committee of 1946 (Government of India, 1946), the Mudaliar Committee of 1962 (Government of India, 1962), and the Shrivastav Committee of 1975 (Government of India, 1975, 1976). The Bhore Committee, 1946, set up before India's independence, concentrated on preventive medicine and tried to link health with social justice. It gave some surprisingly pragmatic directions. The Mudaliar Committee (1962) concentrated on medical education and development of training infrastructure for

The NHP, 1983, was a halfhearted attempt to synthesise recommendations of three important earlier committees, the Bhore Committee, the Mudaliar Committee and the Shrivastav Committee.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

- WHO

static medical units. The Shrivastav Committee (1975) urged the training of a cadre of health assistants to serve as links between qualified medical practitioners and multipurpose workers (e.g. school teachers, post masters, *gram-sevaks*, etc.). While the NHP 1983 reiterated the pious resolution of taking health services to the doorstep of the people and ensuring fuller cooperation of the community, it failed to even declare health care as a fundamental right of the people. The WHO in its *Preamble* (1948) states, 'The enjoyment of the highest attainable standard of health is one of the fundamental Rights of every human being without distinction of race, religion, political belief, economic or social condition'. The General Assembly of the UN in its *Universal Declaration of Human Rights* the same year listed the *Right to better living conditions* and the *Right to Health and Medical Service* as vital Articles. But the NHP 1983 of India failed to say so categorically. This, when the *Directive Principles of State Policy of the Constitution of India (Part IV)* state, 'The State shall regard the raising of the level of nutrition and standard of living of its people and the improvement of public health as among its primary duties'.

Russia was the first country to give its citizens a constitutional right to all health services. The French Constitution of 1946 'guarantees to all... protection of health'. In 1965-66, the Social Legislation in the United States declared health a human right. The 89th US Congress changed the concept of health maintenance from an individual to a social responsibility by enacting *Medicare* and *Medicaid*, and *Comprehensive Health Planning* from 'the womb to the tomb'. Most nations are continuously planning newer strategies to put the Right to Health and Medical Service into practical use. But both the NHP of India 1983 and 2002, failed to even confer the status of a 'Right' to Health. Both have some worthwhile proposals, no doubt, but the major social thrust and vision to convert their commitment into a Right is still lacking. This is due to poor awareness amongst the planners and bureaucratic circles, lesser demand from a community unaware of its fundamental rights and a medical establishment which seeks to wallow in its short-sighted establishment propagation strategies. While goals of medicine

Most nations are planning newer strategies to put the Right to Health and Medical Services into practical use. But, both the NHPs of India, 1983 and 2002, failed to even confer the status of a Right to health.

Community participation in health is an aphorism that still awaits genuine realisation in many countries of the world, notably of the third world. India, unfortunately, is no exception

worldwide have changed from curative to preventive, preventive to social, and social to community medicine, India has still to reap the benefits of this philosophy to any significant degree. Community participation in health is an aphorism that still awaits genuine realisation in many countries of the world, notably of the third

world. India unfortunately is no exception. This, in spite of the fact that through the framework of the Ninth Five Year Plan (1997-2002), new initiatives were supposed to be taken to achieve the following (Park, 2003; p638) :

- a. *Horizontal Integration of vertical programmes;*
- b. *Develop disease surveillance and response mechanism with focus on rapid recognition report and response at district level;*
- c. *Develop and implement integrated non-communicable disease control programme;*
- d. *Health impact assessment as a part of environmental impact assessment in developmental projects.*
- e. *Implement appropriate management systems for emergency, disaster, accident;*
- f. *Screening for common nutritional deficiencies especially in vulnerable groups and initiate appropriate remedial measures;*
- g. *Reduction in the population growth rate has been recognized as one of the priority objectives. It will be achieved by meeting all felt-needs for contraceptives and by reducing the infant and maternal morbidity and mortality so that there is reduction in the desired level of fertility; and*
- h. *Implementation of reproductive and child health programme by effective maternal and child health care, increased access to contraceptive care; safe management of unwanted pregnancies; nutritional services to vulnerable groups; prevention and treatment of RTI/STD; reproductive health services for adolescents; prevention and treatment of gynaecological problems; and screening and treatment of cancers, especially that of uterine cervix and breast;*

And the pious proclamations of the National Health Policy 2002 of Goals to be achieved by 2015 (Govt. of India, 2002). See Table 1:

Table 1
National Health Policy - 2002
Goals to be achieved by 2015

- Eradicate Polio and Yaws	2005
- Eliminate Leprosy	2005
- Eliminate Kala Azar	2010
- Eliminate Lymphatic Filariasis	2015
- Achieve Zero level growth of HIV/AIDS	2007
- Reduce mortality by 50% on account of TB Malaria and other vector and water borne diseases	2010
- Establish an integrated system of surveillance National Health Accounts and Health Statistics	2005
- Increase health expenditure by Government as a % of GDP from the existing 0.9% to 2.0%	2010*
- Increase share of central grants to constitute at least 25% of total health spending	2010
- Increase state sector health spending from 5.5% to 7% of the Budget	2005
- Further increase to 8% of the Budget	2010

Adapted from Park (2003, p635).

In the concept of positive health, man must cease to be the target of disease or preventive measures. He becomes a *collaborator*, an active person who accepts responsibility for his own health. Hence greater involvement of families and communities in health matters is a must. Here health care *for* the people changes to health care *by* the people. As the eminent medical historian Henry Sigerist said way back in 1941 (Sigerist, 1941):

The people's health ought to be the concern of the people themselves. They must struggle for it and plan for it. The war against disease and for health cannot be fought by physicians alone. It is a people's war in which the entire population must be mobilised permanently.

In the past, people were neglected as a health resource. They were merely looked upon as sources of pathology or victims of pathology and consequently as targets for preventive and therapeutic services. This negative view of people's

In the concept of positive health man must cease to be a target of disease or preventive measures. He becomes a collaborator, an active person, who accepts responsibility for his own health.

* The government does realize that health spending as % of GDP must increase to 2% but it depends on the people to voice this need strongly enough for power wielders to be motivated to act. - eds.

Perhaps in India health planning has only followed what happened to health care as a concept decades ago at the international level.

role in health has slowly but surely changed. Now people work towards keeping their own health, they struggle and plan for it and take proper responsibility of looking after it.

‘Forgetting’ Health

Perhaps in India health planning has only followed what happened to health care as a concept decades ago at the international level. Although health is one of man’s most precious possessions, we must know that health was “forgotten” when the *Covenant* of the League of Nations was drafted after the First World War. Only at the last moment, was ‘World Health’ brought in. Health was again “forgotten” when the *Charter* of the United Nations was drafted at the end of the Second World War. The matter of health had to be introduced *ad hoc* at the United Nations Conference at San Francisco in 1945 (Evang, 1967). Thus even in the scale of values of a body like the UN it cannot be said that health occupied a prominent place. No wonder then that it is easily side-lined due to pressure almost everywhere. Health is often taken for granted and not fully appreciated till it is lost. The modern thought that health is not merely a precious possession, but also a resource in which the whole community has a stake and which it is desirable to maintain and promote, has still to percolate to the individual and collective consciousness of the Indian people and its governance.

Probably our History has a role to play here. One of the two indigenous systems of medicine, *Ayurveda*, was highly advanced during the Vedic period and Emperor Ashoka’s time. But it underwent an eclipse with the Moghul invaders who brought in the *Unani-Tibb* system with them. The British halted the progress of both. They established an infrastructure for their own people (and the ‘natives’ who served them) by bringing in the ‘Allopathic’ system. The rest of the country was left to its own fate — the system of indigenous or home-made medicine that never underwent any upgrading. Some benevolent *Zamindars* set up charitable dispensaries/ hospitals, as did some missionary organisations. But they served only certain sections of the population. Establishment of Medical Colleges and Hospitals paved the way for modern medicine in India for which the British deserve due credit. But it served to further stunt the growth of the indigenous systems. They were looked down upon. Prejudice and lack of patronage encouraged quacks and charlatans to monopolise and

Prejudice and lack of patronage encouraged quacks and charlatans to monopolise and further discredit indigenous systems of medicine, a state from which they have never been able to look up.

The people should not forget that health is not only a commodity that a benevolent government / institution / individual can bestow on them. It has to be earned and maintained by the individual himself.

further discredit these systems, a state from which they have never really been able to look up.

The training centres for medical and paramedical personnel set up by the British were on the lines of their own country. They became incurably elitist and created a firm though artificial barrier between the common man and the products of such institutions.

The medical centres became preserves of donors and founder-philanthropists. They sincerely attempted to run these institutions along British lines after the British left, but could not in any way involve the community as a whole in the planning, propagation and working of these institutions.

To offset the static and elitist nature of this colonial reality has been the major thrust of community medicine all over the Third World. Hence the slogans "Primary Health Care" and "Health for All". The Chinese came up with their concept of 'barefoot doctors' which has had its own significant role to play. India experimented with *Multi-Purpose Health Workers* (MPW), recommended by the Kartar Singh Committee of 1973; (Government of India, 1973), a sort of barefoot doctor-cum-immunising technician cum -health educationist-cum- family planning advisor. The scheme envisaged that by the Sixth Five Year Plan (1980-85) there would be 2 MPWs, one male and one female, at each sub-centre to serve a population of 5000. Though the scheme is claimed to be implemented vigorously by the Ministry of Health and Family Welfare even today, it has still to be popularised and mounted on a war footing because of obvious difficulties that such schemes enter into with policy planners — both amongst the august medical bodies and the government. The former is more concerned with upholding medical standards and understandably scoffs at such schemes. The government which could have promoted this and similar schemes hardly gives health planning the pride of place that it deserves. Even a cursory look at the Health Budget will show that in progressive Five Year Plans its percentage has been decreasing (from 3.33% for the First Five Year Plan, 1951-56, to 1.9% and 1.7% for Sixth and Seventh Plans 1980-85 and 1985-90, respectively; and a measly 0.95% for the VIII Plan (1992-97).* Since community medicine lacks both the glamour and the clout that the curative medical establishment has in ample, it is only natural that primary health care, health planning and implementation remain more a dream goal than a reality in India.

* Figures for IX Plan (1997-2002) and X Plan (2002-2007) not available, but may be expected to reduce further. Percentages calculated from Table 3 given by Park, 2003, p639. .

Better health care is the sign of a more evolved society. Health problems cannot be solved in isolation. They will ultimately be part of our struggle for an egalitarian society.

In sum, as things stand, there cannot be Health for All in this country unless the people unite and raise the slogan All for Health. If the goal is Health for All, the commitment has to be All for Health. They will have to become more aware of their health rights and obligations and will have to stress this need through various social-welfare, consumer and political bodies. And

we need a government having the political will to put these aspirations into practice. That this is no mean expectation should be obvious considering the apathy, callousness, and cover-up that resulted after the Bhopal tragedy. Moreover the people should not forget that health is not only a commodity that a benevolent government/institution/ individual can bestow on them. It has to be earned and maintained by the individual himself. And for this it is essential both to motivate individuals to accept responsibility for their own health as also to sufficiently deprofessionalise medicine so that such motivated laymen can play a greater role in their health care, without jeopardising the legitimate importance of the health care professional in the field. How these could be brought about should engage the attention of at least some of those who have the welfare of this nation's population at heart.

Medicine and Commitment

Medicine began as an art and gradually evolved into a science over the centuries. It was conceived in sympathy and was born out of necessity. It is based on intuitive and observational propositions. It is the cumulative experience of the medical man and his branch. It has drawn richly from traditional cultures of which it was a part, later on from biological and natural science, and more recently from social and behavioural sciences. Its principle value is health and its only worthwhile goal can be 'Health for All'. Any account of medicine at a given period must be viewed in relation to the civilisation and human advancement at that time. It is intimately related to their philosophy and religion, economic conditions, form of government, education, value accorded to scientific attitude, and the aspirations and awareness of the people.

Better health care is the sign of a more evolved society. Moreover, health problems cannot be solved in isolation. They will ultimately be part of our struggle for a more egalitarian society. Neither can it be done by passing the buck. The government can conveniently pass on the blame to the people's ignorance and the medical man's noncooperation. The people can equally conveniently blame the government's ineptitude and the medical man's dereliction of duty. And the medical man can equally well blame the government's callousness and the people's lethargy.

The time for such games-playing is past. Only a popular realisation and an active movement of All for Health can ensure the benefits of medicine and Health for All.

This is a commitment in honour.

As is said, "*Politics is too important a matter to be left to politicians*", we may similarly say, "*Health is too important a matter to be left to doctors, and governments, alone.*" *

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* Adapted from, "*War is too serious to be left to the generals*", Charles - Maurice de Talleyrand (Attr.)

Questions that the Sixth Monograph Raises

- Q1. How can we bring about greater health awareness amongst people ?
- Q2. How can people take charge of their own health ?
- Q3. How far has primary health care as a concept succeeded all over the world? In the developing countries? And in India?
- Q4. Why is there a lack of political will in India about health problems? How can it be remedied?
- Q5. Do people really care what governments do with regard to health? Do governments really care what people need with regard to health? Do medical people really care what governments , and people, do with regard to health?
- Q6. What specific thrust areas need to be targeted in the current X Five Year Plan (2002-2007), and subsequent plans, to increase health spending and bring about proper utilization of health-funds by the Center and States?
- Q7. How far have we reached in the direction of Health for all by the Year 2000 (It is already 2004, remember)? And where do we go from here?
- Q8. Will we ever have governments, people and medical establishments actively cooperating to bring about better health care for the citizens of this country?
- Q9. What should doctors and medical institutions do?
- Q10. What should governments do ?
- Q11. What needs to be done to make health and education a hard-core political issue from the soft one it is today?
- Q12. How can we ensure a Right to Health for the Indian citizens too?
- Q13. How can we ensure that education, health and employment become the focus of attention in developing societies like India?
- Q14. What specific efforts need to be put in to increase health spending from 0.9 % to 2% of GDP?
- Q15. Are policies like *medicare* and *medicaid* viable in India?)

Readers Respond

I really enjoyed going through the Mens Sana Monographs because of their topics of current interest , whether it is suicide-free society or the current one on the goal-Health for all. These are all contemporary issues which concern professionals, public and the government.

I only wish all the agencies concerned about health read these meaningful monographs and take up the issues.

All of us are aware that health, especially mental health, is at low priority. In this later monograph on Health For All , you have raised pertinent questions.* Hope you will have good response.

I congratulate Dr. Shakuntala A. Singh and yourself for your excellent work.

Wishing you all the success.

Dr. S.M. Channabasavanna
Medical Director
CADABAM'S Home for Mentally Disabled Trust®
Former Director/ Vice Chancellor, NIMHANS,
Bangalore

*** Editors Note :**

Prof Channabasavanna's concern that health (including mental health) no longer remain low priority, and health related issues become points for concerted action will surely find an echo in most right thinking people all over. The whole point is how much of this concern gets translated into concrete action, and concerned agencies devote time and effort to convert the frowns and creases on the faces of the right thinking into smiles and nods of approval. That is the challenge for a brighter and a healthier tomorrow.

*We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.*

- T.S. Eliot (Four Quartets, 'Little Gidding')

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