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Preventive lipostasis: spawning lipochondria

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Preventive lipostasis, ie lowering/controlling the various lipid levels to protect the coronaries from atherosclerosis, is firmly entrenched in modern therapeutics, to the point of being an almost knee-jerk prescription to every cardiac patient, a genurflexopathy of some sort. Enforced lipostasis through dietary measures and drugs has spawned a new syndrome characterised by an obsession with lowering the levels of lipids with the much-celebrated statins and by a fanatical abstinence from fats, and as a by-product, it has robbed cuisines of the joys of fat. Alex Comfort, better known for his best-selling *The joys of sex*, had penned another mini-classic, *The anxiety makers – the curious preoccupation of the medical profession*. The new syndrome has been named lipochondria, the sound of which harmonises well with that of the well-recognised hypochondria. A reassessment of lipostasis, lipophobia and lipochondria seems overdue.

For over 50 years now, the syndrome of lipochondria has been making increasing inroads into the minds of the public and physicians. It is characterised by an obsession on the part of all people – regardless of age, whether heterosexual or bisexual, whether lay or learned – with the cholesterol and lipids circulating silently, innocently and helpfully in our blood. Cholesterol and lipids are classified into good or bad and heavy or light; and their levels are measured regularly and chased to extinction, or to an assumed normal value, with the help of one dietary do not after another and one statin after another. All this in the name of primary/secondary prevention of coronary artery disease and heart attack. Lipochondria is a malady spawned and pampered by medicos, the media and manufacturers, not just of tests or drugs, but of low- or no-cholesterol food and beverages, a trillion-dollar-worth industry.

Lipochondria reeks of counterintuitiveness and counterproductiveness. Anatomical and/or physiological facts do not justify the logic of lipophobia. The relentless efforts to lower the levels of lipids and indiscriminate prescription of statins produce a plethora of side-effects. Lipophobia has been discussed, documented and disseminated so extensively and repetitiously as to be an article of faith. To question it is to court trouble and invite sneers. Lipophobes, a term which

can be used for those who support lipochondria, heavily outnumber the opponents of lipochondria, who may be called lipophiles.

The mother-event of lipophobia (1) took place in 1913, when the Russian pathologist, Anitschkow, overfed rabbits with a cholesterol-rich diet. Lipid streaks were found in the rabbits' aortic intima at post-mortem.

Post-Anitschkow, there was no looking back for lipophobia, lipodisdain and lipochondria. The thought-leaders in the field, wryly called the cholesterol mafia (2), have progressively lowered the acceptable, normal levels of cholesterol and lipids to the point that the only good cholesterol is almost no cholesterol. The progressive succession of official reductions in levels has crossed the dozen mark (2), each reduction highlighted by cacophony and a media blitz.

Current Medical Diagnosis and Treatment (3), Lange, USA is an annually revised and expanded tome, the 50th edition of which came out in 2011. Its 34th edition (1995) contains a chapter titled "Lipid disorders" by Browner, whose unusual candour is not seen in subsequent editions. We present a few excerpts from the chapter, punctuating, starting with the very first paragraph.

1. *A major problem for clinicians is that current therapies for high blood cholesterol do not reduce total mortality, in part because their use has been associated with an unexplained increase in deaths from non-cardiovascular causes.*
2. *There is no "normal" range for serum lipids.*
3. *As with most primary prevention interventions, however, large numbers of healthy patients (!) need to be treated to prevent a single event: for cholesterol lowering, it may be necessary to treatment (sic) more than 600 patients for several years to prevent a single coronary death or five or six non-fatal coronary events. (Over six years an aggregate of 3 million meals need to be killjoyed for a doubtful statistical gain!)*
4. *Beneficial effects on the risk of coronary heart disease have been seen with bile acid binding resins and with gemfibrozil; the evidences for benefit from dietary reduction of cholesterol*

is less clear. On the contrary, pooling the results of the primary prevention trials indicates that the use of cholesterol lowering therapies has been associated with statistically significant increases in deaths from cancer (by 43%) and from injuries and violence (by 76%). These adverse effects remain unexplained, but they should not be ignored.

5. Most patients with high cholesterol levels have no specific signs or symptoms.

Ray Strand has sounded the alarm bells in *Death by prescription* (4): "Contrary to popular belief, researchers have found that more than half of the patients who have heart attacks in this country (USA) have normal cholesterol levels."

The side-effects of statins (5) as listed in the 33-year-old *Monthly Index of Medical Specialities* (5), are hardly palatable: headache, dizziness, gastrointestinal upsets, asthenia, myalgia, arthralgia, rash, rhabdomyolysis (even of the heart, particularly in the elderly with hypothyroidism or renal insufficiency), hepatitis, jaundice, hepatic failure, abnormalities in laboratory measurements (eg thyroid function, alkaline phosphatase, hypoglycaemia), elevated liver enzymes, cognitive impairment, diabetes, and rarely, immune-mediated necrotising myopathy.

The *Monthly Index of Medical Specialities*, which is updated every month, also has a prefatory "Red alert" on statins: "Additional adverse effects found: recent data suggests a number of additional side-effects of statins. They include depression, sleep disturbances, increased risk of diabetes, and interstitial lung diseases." Statins may or may not help, but they surely wreak havoc on the body.

Nevertheless, in spite of the not so favourable data and the abundance of unfavourable side-effects, the powers that be are bent on pushing humankind into an iatrogenic lipophobic trap. The following summary by Moynihan and Cassels (2), says it all.

"Sales of these drugs have soared in the last decade because the number of people defined as having 'high cholesterol' has grown astronomically. As with many other medical conditions, the definition of what constitutes 'high cholesterol' is regularly revised, and like other conditions, the definition has been broadened in ways that redefine more and more healthy people as sick. Over time, the boundaries that define medical conditions are slowly widened and the pools of potential patients steadily expanded. Sometimes the increase is sudden and dramatic. When a panel of cholesterol experts in the US rewrote the definitions a few years ago, they lowered the levels of cholesterol deemed necessary to qualify for treatment (among other changes), essentially relabeling millions of healthy people as sick, and virtually tripling the numbers who could be targeted with drug therapy." (2).

No wonder Norton Hadler (6), in *The last well person – how to stay well despite the (American) health-care system* (2007), concluded: "The institution of medicine is ethically bankrupt."

To highlight some positive aspects of cholesterol and lipids, we quote a paragraph from *Gray's anatomy* (7). "Myelin is a

relatively lipid-rich membrane and contains 70–80% lipids in PNS and CNS respectively. All classes of lipids have been found. The major lipid species are cholesterol (40 moles %), the commonest single molecule; phospholipids (40–48 moles %); and glycolipids (12–19 moles %). The proportion of cholesterol and glycolipids is particularly high.... Although those lipids are not unique to myelin, they are present in characteristically high proportion."

Cholesterol, the archenemy of the lipochondriacs, is rooted in the famed 32-letter *cyclopentanoperhydrophenanthrene* nucleus and is far from ordinary. "Cholesterol is the precursor of steroid hormones and bile acids and is an essential constituent of cell membranes. It is found only in animals." (8) It is found only in animals, and is essential to all animals. Its complex structure underlies the complex roles it plays in the animal body. Cholesterol and lipids seem to be integral to animal life. JH Hall says, "For membranes to be formed, substances that are not soluble in water must be available.... Thus, the physical integrity of cells everywhere in the body is based mainly on phospholipids, cholesterol, and certain insoluble proteins" (9).

The assumption that coronary patients on statins survive longer is based on statistical evidence, derived from controlled trials and randomised control trials, in which there is no certainty at the individual level, even if there is at the group level. The cocksure attitude arising from the results at the group level is then foisted on individuals. Moreover, whatever gains are made in terms of prevention are nullified by the long list of dietary restrictions, as well as body toxicity.

The long list of the toxic effects of statins makes it clear that while the gain to the coronaries is dubious, the body and the brain incur a heavy loss. Side-effects such as amnesia, depression, psychosis, suicidal tendencies and violence speak of the colossal damage inflicted on the lipid-cholesterol complex that is integral to the central nervous system and peripheral nervous system. It is time to do away with lipochondria.

It should not be very difficult to root out lipophobia, for lipids are but a paper tiger – toothless and clawless. They will not gobble you up. The way out is easy. The literature is replete with critical condemnation of statinology. In the October 22, 2013 issue of the *BMJ* (10), the *crème de la crème* have made climactic statements, such as, "Scientific evidence shows that advice to reduce saturated fats has paradoxically increased our cardiovascular risks.... Never prescribe a statin drug for a loved one."

According to most eastern and western scriptures, and in the opinion of the late Eric Ericsson as well, the golden rule of ethical medical practice is to see yourself in your own patients. *Chandogya Upanishad's* "tat twamasi (that art thou)" can be interpreted as: "You are the patient and vice versa". Its clear directive is to do unto the patient as you would be done by, and do not do as you would not be done by. The *Mahabharata* specifically says, "Atmanah pratikulani pareshan na samaacharet (What is not comfortable for you should not be inflicted on

others)." If your near ones cannot have statins, nor should any of your patients.

Lipochondria, lipophobia and statins merit a decent burial.

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MTP Amendment Bill, 2014: towards re-imagining abortion care

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Abstract

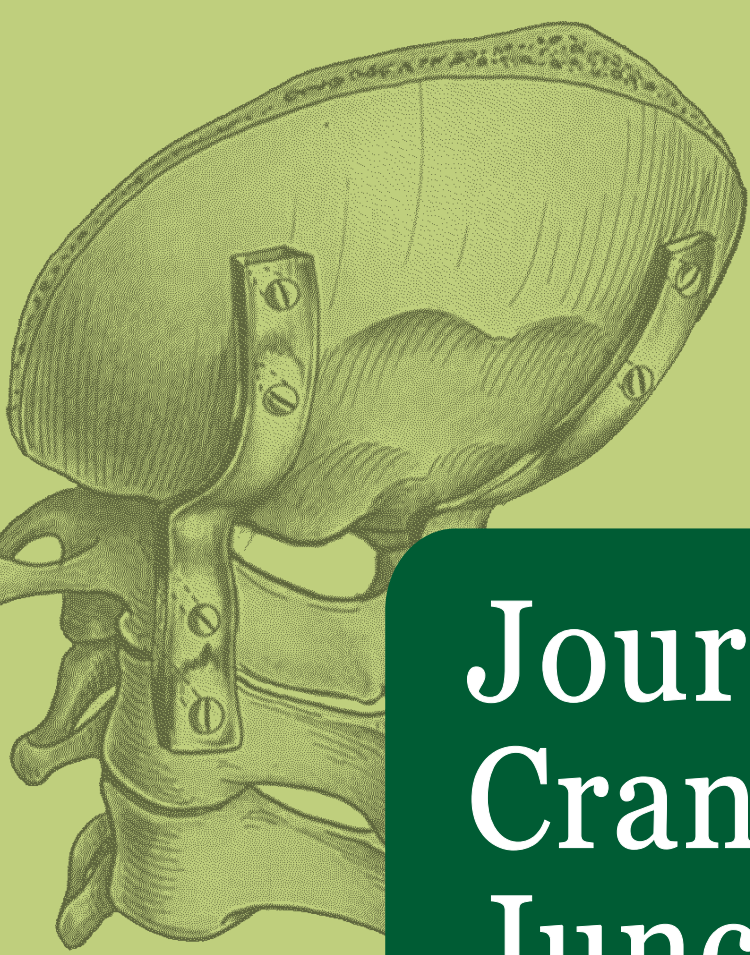
In India, the 1971 Medical Termination of Pregnancy Act, while allowing abortions under a broad range of circumstances, can be considered a conservative law from a feminist perspective. The Act allows healthcare providers rather than women seeking abortion to have the final say on abortion, and creates an environment within which women are made dependent on their healthcare providers. On October 29, 2014, the Ministry of Health and Family Welfare released a draft of the MTP (Amendment) Bill 2014 (1), which proposes changes that could initiate a shift in the focus of the Indian abortion discourse from healthcare providers to women. Such a shift would decrease the vulnerability of women within the clinical setting and free them from subjective interpretations of the law. The Bill also expands the base of healthcare providers by including mid-level and non-allopathic healthcare providers. While the medical community has resisted this inclusion, the author is in favour of it, arguing that in the face of the high rates of unsafe abortion, such a step is both ethical and necessary. Additionally, the clause extending the gestational limit could trigger ethical debates on eugenic abortions and sex-selective abortions. This paper argues that neither of these should be used to limit access to late-trimester termination, and should, instead, be dealt with separately and in a way that enquires into why such pregnancies are considered unwanted.

On October 29, 2014 the Ministry of Health and Family Welfare (MOHFW) released a draft of the Medical Termination of Pregnancy (Amendment) Bill (1), which proposes to improve access to abortion through steps that will expand the healthcare providers' base and simultaneously reduce women's dependency on healthcare providers during the process of seeking abortion. The Bill proposes to train and allow non-allopathic and mid-level healthcare providers to perform abortions. It also outlines the methods of abortion more

clearly than the 1971 Medical Termination of Pregnancy Act (1971 MTP Act), recognising medical termination of pregnancy as a separate and legal technique of abortion. While these steps will improve women's access to care for abortion, other changes proposed by the Bill will liberalise the law, making it more inclusive than the 1971 Act. First-trimester abortion will be considered a matter of the woman's choice and a physician's opinion will no longer be required. A woman will require only one physician's opinion in the second trimester. The amendment Bill also explicitly extends abortion care to unmarried women and aims at ensuring privacy for women seeking abortion. The gestational limit for abortion will be extended from 20 to 24 weeks and in addition, abortion will be provided for specific foetal anomalies after this period.

The Bill is to be taken up in the next session of Parliament and could be enacted next year, if passed. To gauge how such an Act would be received, the MOHFW invited comments from stakeholders and the general public until November 10 (1). While the move to extend the gestational limit has been commended, the Bill has received critical reviews from organised bodies within the medical community (2–4) for its proposal to include non-allopathic healthcare practitioners, nurses and auxiliary nurse midwives. The contention of the critics is that including these groups will encourage quackery and put the health of women at risk (2,3).

This paper, however, argues strongly in favour of the proposed changes. Not only does the Bill recognise a woman's right to self-determination and autonomy (although such recognition is limited to the first trimester), it also represents something of a shift in the focus of the abortion law in India from the healthcare provider to the woman undergoing abortion. Such a shift decreases the vulnerability of women within the clinical setting and frees them from subjective interpretations of



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Editorial

Iatrogeny of Alzheimer’s disease: A view point

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Modern Medicine (MM) is held responsible for creating the iatrogenic epidemic of Alzheimer’s disease. All cholesterol-lowering therapeutic agents and dietary deprivation of fat bring about myelin and neuronal damage. Regular intake of aspirin produces microbleedings in the brain. An insult is added to these injuries by vilifying Lady Nicotine that is known to lower the incidence of Parkinsonism and Alzheimer’s disease.

Diseases of Medical Progress (DOMP) is a well-known entity and has been recorded as far back as 1956.^[1] Much water has flown down the Ganges and the overall scene is not very heartening. Dr. Sandeep Jauhar’s latest invective is but a glimpse of the state of iatrogenic MM.^[2] We propose that MM is busy spawning the Alzheimer’s epidemic in countries rich and poor.

Cholesterol, portrayed as the devil to be exorcised among lipids, comprises the cyclopentanoperhydrophenanthrene nucleus and is vital to the body economy *interalia*, hormonally, cellularly, and neurally. Sex hormones and steroids are but a variant of cholesterol. The per second cytopoiesis of four million necessitates cholesterol as the cell-cover. The *Gray’s Anatomy* avers that in the constituents of myelin, “The major lipid species are cholesterol (the most common single molecule), phospholipids, and glycolipids.”^[3] The cholesterol-lowering therapeutic agents are celebrated demeritors and their demyelinating role is waiting to be exposed through some human trials or animal tribulations.

It suffices to say that the gains of the cholesterol-lowering therapeutic agents are hypothetical; the ravages, thereof, are self-evident. The lipid hypothesis inflicts a double whammy by denying the delights of dietary fat and offering the potential poisons in the form of cholesterol-lowering medications. The 1995 (34th) edition of the yearly “Current Medical Diagnosis and Treatment” launches its chapter on “Lipid Disorders” by a *mea culpa*: “A major problem for clinicians is that current therapies for high blood cholesterol do not reduce total mortality, in part because their use has been associated with an unexplained increase in deaths from noncardiovascular causes.”^[4] The text is further candid: “As with most primary prevention interventions, however, large numbers of healthy patients (*sic*) need to be treated to prevent a single event; for cholesterol lowering, it may be necessary to treatment (*sic*) more than 600 patients for several years to prevent a single coronary death or five or six nonfatal coronary events.”^[4] In the subsequent editions of the book, both the above stand deleted *sans* any scientific reasons.

MM completes its assault on the sanity of the body by its too hackneyed a jihad against what was once depicted by Herbert Spencer as “divine tobacco,” whose positive contributions to health have been glossed over. Now comes the news that tobacco lowers the incidence of both Parkinson’s and Alzheimer’s diseases.^[5-10]

Winston Churchill, who, so to say, drank like a fish and smoked like a chimney, on his 80th birthday, was photographed by a young journalist who expressed the hope that he be able to photograph the great man the next year as well. “Why not,

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young man," quipped Churchill, "I see nothing wrong with you!" Having said that, he went to bat till a ripe age of 94 years. Mark Twain's health, creativity, humor, and longevity, lay, in his own words, to two strict rules on smoking: To never ever smoke when asleep, and smoke only one cigar at a given time.

Iatrogeny of different kinds are public knowledge. DOMP was conceived *vis-à-vis* MM's antibioticism. Raeburn, writing in "The Lancet" on immunodeficiency in children, warned: "In years to come, the story of antibiotics may rank as Nature's most malicious trick" on mankind.^[11] The current viral epidemics have been ascribed to the monkey slaughter that medical experimenters have indulged into. The Polio Vaccine alone had entailed a "sacrifice" of a million monkeys (Deborah Blum).^[12] The peaceful simian viruses are busy turning to the human apes for a lodgment and humanity is reaping the whirlwind. Cancer chemotherapy itself is known to be a cause for second cancer.^[13,14] Aspirin has been found to cause microbleeds in the brain, only to aggravate the neural damage detailed above.^[15-19] The current epidemic of the fashion and the fad of being Worried Well (WW) — Worried Well — Is a fitting climax to what Alex Comfort, the gerontologist and the sex guru depicted long ago as *The Anxiety Makers* (Panther, London, 1967). Comfort held anxiety-making as a "curious preoccupation of the medical profession."^[20]

Globally, medical Check-up Clinics are alchemically transmutating the well who walk into the clinic into the Worried Well that walk out from there, loaded with investigative prophecies of doom, killjoy proscriptions, and needless, harmful, lifelong preventive prescriptions. Checkup clinics are booming business and booming iatrogeny as well. Through his book titled *Mirage of Health — Utopias, Progress and Biological Change* (1959), René Dubos^[21] and the term "healthism" size up MM's, media's and mankind's obsessive compulsive, almost neurotic tilting at the windmills of preventive checkupism. In the passing, it may be mentioned that "iatrogeny" could etymologically connote doctorpoiesis as well. "The New England Journal of Medicine" long ago suggested replacing "iatrogeny" by "iatrality" and "iatrogenic" by "iatral".^[22]

The Alzheimerogenic iatrality (pardon the neologism) resides in dietary deprivation of the delights of fat, cholesterol-lowering drug-induced myelin and neuronal damage,^[23] the microbleedings in the brain from aspirin and statin^[24] obsession, and last but not the least, in the abjuring of the better side of Lady Nicotine. All the foregoing factors act individually or in consort to promote a faster rate of the apoptosis of cerebral neurons with effects that are too evident to merit elaboration.

MM needs, in all humility, to roll back on its lipid and tobacco hypotheses. Mencken, the celebrated US journalist and social critic, bemoaned the killjoy asceticism of MM *vis-à-vis* the daily delights of life. Dubos, the founder member at Rockefeller Institute, wrote: "In the words of a wise physician, it is part of doctor's function to make it possible for his patients to go on doing the pleasant things that are bad

for them — Smoking too much, eating too much, drinking too much — Without killing themselves any sooner than is necessary."^[20] Mencken declared that "The true physician does not preach repentance; he offers absolution." By the way, Mencken's words are epigraphic to the 2000 edition of *The Concise Oxford Textbook of Medicine*.^[25]

We may end with a doggerel:

Beer and Bacon,
Taken in a mood of cheer
Is superior to the ideal diet
Taken in a mood of fear.

MM's ostensible jihad to save humankind from the perils of a killer disease No. 1, 2, 3, ..., n is laudable as a public rhetoric but, so far has had a very poor outcome. It has been Oceanic Output, zero Outcome (OOOO) — Oceanic Output, zero Outcome. Despite all kinds of statistical scares doled out by MM, human population has been mounting up and up, to threaten to burst the Earth at its seams. So you must conclude that the killerness lies more in the minds of MM, than in reality. In which case, let humanity savor the joys of eating, smoking, drinking, and the bedroom to spread some shivers of joy that are likely to be the best antidote to Alzheimer's and the like.

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Ethics tries handling inner conflicts scientifically/spiritually

MANU KOTHARI, LOPA MEHTA

"Ethic: from **ethos**, character, L **ethos**, adopted by English especially in sense of 'character and spirit of a people'. Intimately akin to Gr **ethos**, custom, Skt. **sva-dha** one's own doing or action; **sva** self (cf suicide) + **dha** to self." (1)

"Sva-dha: self-position, self-power, inherent power, custom, rule, ease, comfort, according to one's habit or pleasure, spontaneously, willingly, easily, freely, undisturbedly, wantonly, sportively." (2)

Words reveal their meanings to those who establish intimacy with them, as the bride unveils her face only to the beloved one.

The Rig Veda 10.71.4

The above etymological preamble is inspired by Aldous Huxley's lament in *The perennial philosophy* (3) that humankind is indifferent to the genuine meaning of terms. For example, the word "love" is used to describe two characters embracing rapturously on the screen, as well as the concern felt by Buddha, Christ or Gandhi for the whole of humankind. This confusion regarding the use of words arises from "the lack of a suitable vocabulary and an adequate frame of reference, and the absence of any strong and sustained desire to invent these necessary instruments of thought. Many thoughts are unthinkable apart from an appropriate vocabulary and a frame of reference." (3). Unless "Ethics" is eusematically analysed and synthesised, much of our effort to be ethical is likely to be unproductive.

The Oxford companion to philosophy (4) gives 23 subsets of "ethics", among which are ethical naturalism/objectivism/relativism/subjectivism. However, through all these subsets runs the underlying refrain of "transactional" because ethics pertains to the interaction between two or more people, the encounter between a patient and a physician being one such. At the very outset, we may cite Swami Dayananda Saraswati (5), considered by many to be the guru of *Vedanta*. His *panchreston*, golden rule or *mahamantra* on ethics is "Do unto others what you would have them do unto you and do NOT do unto others what you would not like." This is an echo of what the *Bhagwad Geeta*, the Jewish *Talmud* and Eric Ericsson (6) preach. The whole essence of medical ethics may be summed up as the physician's readiness to put himself/herself in the position

of the patient. Would a physician question himself/herself as to whether he/she would have his/her treating physician act rude, hurried or dismissive, or overcharge, or diagnose/treat "pragmatically"; and so on?

Park and Lees (7), after an extensive survey of breast cancer, concluded that many a breast cancer was pragmatically diagnosed and treated with the idea that the breast, however normal, was better off in the theatre bucket than on a woman's body. Bloodgood (8), in a retrospective study at Johns Hopkins, discovered that as many as 35% of breast cancers were diagnosed for the heck of it, the breasts having been histologically normal. People who are thoroughly asymptomatic and at peace with their "blocked" coronaries meet much the same fate when their coronaries are prophylactically bypassed and/or angioplasty and stenting is performed (9), with the invasive coronaryologists claiming that they have been snatched from the jaws of imminent death. *Doing better and feeling worse: health in the United States* (10) is a 1977 Rockefeller Foundation tome that details how the USA, which spent an average of \$8–10 billion a year on health in the 1970's, is now spending \$5 billion a day, with doctors and the establishment "doing better" and the patients "feeling worse". Wildavsky (10), a New York physician, states that medical science is helpful in just 1 out of 10 maladies.

How come, despite Norman Cousins having officially chaired humanities at Stanford and Sunil Pandya having laid the foundation for the current *IJME*, Medical Ethics has taken a nosedive, regardless of *IJME*, and the global movement towards some ethical sense? How come Norton Hadler (11), in *The last well person – how to stay well despite the health-care system* concludes that "the institution of medicine is ethically bankrupt." Ethics, ethics everywhere, a note which hardly a medical soul is ready to sing.

Why has the game gone colossally awry, both nationally and globally? Has medical ethics metamorphosed into some new mammonic avatar, designed more to serve the establishment and the shareholder than the patient? Words remain true to themselves and do not change; however, our attitude to them does. It is our attitude that we must question to find a way out.

Ethicality is judgmental and the judge resides in the very person whose words and actions are to be judged. Objective ethics asks the compassionate "right brain" to question what the proactive "left brain" does. As Monier-Williams (2) says while expanding on *sva-dha*, this occurs from within, is voluntary, spontaneous and sportive, without any external guide or pressure. The right brain commands: "Treat the patient exactly as you would choose to be treated." However, if this judge has been bought over by the powers that be, there are no pricks of conscience, no hard pillow at night, and no regrets whatsoever.

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Hitler and Stalin ordered genocides with a nonchalant self-righteousness and Goebbels and Beria followed suit, almost with smug delight. Much the same way, a modern medico does not have any pangs of conscience, and hence the mayhem keeps growing exponentially.

Bertrand Russell (12) bemoaned that the modern educational system teaches how to do, but not how to think or reflect. It breeds a knee-jerk response to a finding or any assumed or actual pathology, executing genu-reflexopathy on a numbing scale. The medical curricula are overloaded with catalogues of facts and taught by shallow faculty. At conferences and in the accompanying press releases, there is perpetual talk of “modern trends, recent advances, progress” and so on. Conferences are not convened to ponder over regression in medicine. Journals, too, do not discuss this issue. Science from *scientia* (13) is to know and not to do, while technique is all about doing and provides its purveyors with a cocksureness that could never doubt itself when it comes to doing. Statistics then becomes its able helper: “The cardiovascular surgery community speaks of benefit to the patients who have multiple blockages in multiple vessels, but the basis for that claim is marginal. It derives from a reanalysis of the data from the classic trials a secondary analysis’ that is an indefensible statistical manoeuvre.” as Hadler puts it (11). Hadler also cites James Mills who referred to such revision as “data torturing” and explained: “If you torture your data long enough, they will tell you whatever you want to hear.” (14). Hadler may sound pessimistic, but the Russian proverb (15) comes to his rescue in declaring that a pessimist is a well-informed optimist.

In its ostensible pursuit of technological excellence, modern medicine has quashed the last vestiges of scepticism, which is the birth right of the evaluating and questioning right brain. The Gottingen University oath prescribed to a new entrant – “You are here not to worship what is known, but to question it” – has been consigned to history. Mephistopheles is having the last laugh at the expense of Dr Faustus, who is not an ethical moron but has willy-nilly chosen the path of ethical bankruptcy to effectively snuff out any questioning by the right brain.

We thus have the paradox of a not-too-remote Oslerean past when ethics was not talked about but practised fairly well, and the current scenario of conferences, courses, journals, books and soon curricula and examinations on ethics, but hardly any ethics in practice. “The fault, dear Brutus, is not in our stars, but in ourselves.” (Julius Caesar, Act I, Sc 2:140-1). We are forgetting our faults.

Subjective ethics, or the violation thereof, is best illustrated by the way a modern socialite eats and drinks. As Desmond Morris says in *Manwatching* (16), “Here, there is enough food for those who are not hungry, and enough drinks for those who are not thirsty.” At a party, a hotel, or at home when you have been over served and a gentle inner whisper of satiation urges you to stop any more import, the urge gets overruled to spawn the science of bariatrics. Much of global starvation is not because

of the unavailability of food and water but maldistribution and overindulgence. Through evolutionary deprivation, our bodies have learnt to do with ten morsels less, but we still have to evolve the physiology to manage a single morsel more. And that pampers much of the science of gastroenterology, obesity and the consequences thereof.

Ethics is essentially a solo journey, self-willed, voluntary, joyful and pursued entirely in enlightened self-interest. You do not want your reasoning, compassionate, unselfish and uncompromising right brain to pull you up in the dead of night or in solitude. Pasteur (17) aphorised that chance favours a prepared mind. Ethics emanates from an evolved mind, an entity, alas, fast withering. But when genuinely pursued, Ethics tries handling inner conflicts scientifically and spiritually. It is scientific on the basis of the right and left brain dichotomy; and spiritual from *Chandogya Upanisad's Tat Twam Asi* [That art thou]. The patient is no one but your own alter self, obliged by heredity (or herd-ity) to bear the cross on your behalf as most diseases are primarily causeless and secondarily herdistic. Acute lymphocytic leukaemia (ALL), for example, has the fixed incidence of 1 in 33,000 year after year, generation after generation, race after race and country after country (18).

We do not wish to run down the current ethicists’ movement, which must continue. However, until such time as our educational system is truly humanised, the bankrupt right brain of the average medico will have no chance or capacity to question the deeds and misdeeds of the left brain. The few who dare to listen to the silent whisper (“the voice from within”, also called God or Spirit) of ethics are assured a soft pillow, a clear conscience, a regretless autumn of life.

Ethics at a mass level is too thoroughly, incorrigibly relativistic to assume a “*the.. then*” verity. In a way, it is mob rule as the sheer momentum of numbers outweighs the nuances and niceties of thought and fairness. The following is a case in point:

In 1933, the German government enacted one of the most comprehensive animal protection legislations in the world, the first in a series of laws to protect animals. “In the moral hierarchies born and bred in Nazi minds, there was no conflict between care for animals and genocide of Jews, since, in the Nazi reading, Jews were subhuman beings, lower than most animal species, comparable to vermin.” as Brinda Karat writes (19). How the exalted nation of Goethe, Wagner and Max Mueller could fall prey to the machinations of a maniac will remain a historic riddle. But at that time, each Jew exterminated ethically meant a ‘vermin’ squashed. The absence of conflict left no opportunity for the right brain to question the left, and that caused genocide on an epic scale.

Much the same dynamics could account for the massive erosion of conscience that ought to have plagued modern medicine, but has manifestly failed to do so. Nobel laureate Burnet concluded his brilliant *Genes, dreams and realities* (20) with despair: “The great pharmaceutical houses of the mid-twentieth century may come to feature in history as examples both of the productivity of science applied to industry and the

evil inherent in the technological momentum of a competitive industrial society." Add to that a recent *Selling sickness: how the world's biggest pharmaceutical companies are turning us all into patients* (21) and you only shudder at the fall. Today, textbooks, medical journals, conferences and workshops are in one way or another promoted by industrial might. It has the semblance of organisational décor and scientific probity. It is a mass movement, wherein the vital, ethical conflict, a strictly personal journey has poor weightage. An average medical mindset must change to usher in an ethical renaissance, much desired in medical practice.

It is high time we accepted honest therapeutic bankruptcy, as urged by Asher (22, 23), rather than indulging in ostentatious therapeutic nonsense, and cultivated healthy skepticism at every stage of medical practice. It is neither worth ignoring heresy in the pursuit of science, nor doing things merely to conform for fear of being left out. An understanding of this should become integral to medical *weltanschauung*. Only then would there be a healthy dialectic between the right brain and the left brain, the very heart of that difficult but lofty exercise called ethics.

Among the first mentions of this dilemma is Duryodhan's lament in the *Mahabharata*: "Janami dharmam, na ca me pravrut, Janami adharmam na ca me nivrut (I know what I should do, but I cannot. I know what I should not, but I cannot withdraw from doing it)." (Prapanna Gita, 57-8) Many a conscientious medico, beset by social, financial and peer pressures, faces such a dilemma and ends up compromising on ethics. That is the reality.

A moot question that would plague every ethicist is whether ethics was violated in the Nazi concentration camps, in the Stalinist Gulags, in Rwanda Burundi, in Guantanamo Bay, in the Talibanistic jihadists stoning an adulteress to death, and in one genocide after another at our own doorsteps. Eusemantics – the right connotation of a word – demands that the term "ethics" be not invoked in any of the foregoing, since the perpetrators of the crimes were fully convinced of the righteousness of their actions, and did not suffer from any prick of conscience or did not question themselves, and hence, there was no dilemma. What they did was inhuman, indecent, cruel, immoral and unprofessional, but ethics had no role to play.

Is ethics at stake when a squiggle of the ECG needle lands an unsuspecting person into the whirlpool of cardiology or when a marginal rise in PSA in an asymptomatic person becomes the cause of a radical cystoprostatectomy (24)? Such dilemmas

do bother some evolved medical minds day in and day out. Alas, the medical community in general is carried away by the mentality of doing. Ethics has no snowball's chance in hell until the Jungian *Community unconscious* (25) decides to evolve for the better. In the modern progressive pervasiveness of *I-me-mine*, ethics must get short shrift. Poignantly, ethics begins with one's own self and there it ends. Tragically, that began in the *Mahabharata*, with Duryodhan and rules the roost even today.

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