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

the abortion law. The author is also in favour of the inclusion of mid-level healthcare providers and those from alternative systems of medicine, arguing that such a step is both ethical and necessary in the face of the high rates of unsafe abortion. While the extension of the gestational limit could trigger ethical debates on eugenic abortions and sex-selective abortions, the author holds 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.

In the 1960s, as the movement for liberalising abortion spread across the West, several nations that were formerly the colonies of European powers began to inquire into the impact of unsafe abortion within their national contexts. During this time, abortion was criminal in India under Sections 312–316 of the Indian Penal Code, which had been passed in 1862 under British rule and inherited unchanged during Independence. In 1966, the Shah Committee, appointed by the government of India to study the sociocultural, medical and legal aspects of abortion in the country, submitted its report, which recommended the legalisation of abortion on compassionate and medical grounds (5). This report was instrumental in shaping the 1971 MTP Act, which led to the liberalisation of abortion under specific circumstances. The recommendations made by the 1965 UN Mission to evaluate India's population policy also shaped the Act (6).

The 1971 MTP Act allows the termination of pregnancies that pose a risk to the life of the woman, affect her physical or emotional well-being, or could lead to the birth of a child with physical or mental disabilities (7). According to its broad definition of well-being, the Act allows women to seek termination of pregnancies resulting from rape or incest, for socioeconomic reasons that render them unable to have a child, or for the failure of contraceptives used by a woman or her husband to limit the size of the family. Under these broad categories, the woman may seek to have an abortion till up to 20 weeks. She may also make the decision to terminate a pregnancy without the influence of her husband and family (except in the case of minors and the mentally ill, both of whom require the consent of one guardian). However, the 1971 MTP Act does not recognise the ability of women to act as autonomous agents within the clinical setting. It primarily offers protection to all doctors carrying out abortions in good faith and within the limits stipulated by the law, empowering them to make the final decision on abortion.

This focus on the medical profession rather than women is partly the result of the fact that the Indian abortion law stemmed from national concern about the growing population and about the high maternal mortality from unsafe abortion. In India, therefore, abortion is located within discourses on family planning and public health, which justifies the 1971 MTP Act's emphasis on the providers of the service. This is in stark contrast to the abortion discourse in the West. In the USA, in particular, the debate on abortion was a part of the public debate on women's equality as individuals (8). Thus, a woman's right to self-determination was recognised at the very outset. In India, the lack of such feminist advocacy for abortion in the 1960s and early 1970s, either because of the lack of such an inclination within the women's movement or the lack of an outright anti-woman opposition to abortion, as seen in the West (9), has led to a situation in which, as Nivedita Menon notes, access to abortion is upheld "through a sanctifying of social norms which are, in fact, antithetical to feminism" (10). So, while the 1971 MTP Act seems liberal from a public health perspective, it can be interpreted as a conservative law from a feminist perspective: the woman's agency is transferred to her healthcare provider and she is made a dependant within the clinic where the abortion is performed.

However, in spite of the focus on public health and the empowerment of providers of abortion, the Abortion Assessment Project, a multicentre survey, estimates that very few abortions in India are performed by trained physicians in approved clinics. Of the 6.4 million abortions performed annually, 3.6 million or 56% are unsafe (11). Deaths from unsafe abortion are estimated to constitute 10%–13% of the total maternal deaths in India (12). These deaths can be attributed to numerous causes, ranging from lack of awareness of the legality of abortion to the lack of affordable services, lack of investment in the public health sector and a providers' base that is not large enough to meet the need for safe abortion (11).

The MTP Amendment Bill 2014 proposes changes that clarify the legal status of medical and surgical abortion, and simultaneously attempt to improve the base of healthcare providers. The changes are based on the findings of a project undertaken by the Population Council between 2006 and 2011. It was found that abortions conducted by trained mid-level healthcare providers are as safe and acceptable as those conducted by physicians (13). While this study was supported by the Federation for Obstetrics and Gynaecological Societies of India, the findings were found inadequate by the Indian Medical Association, which rejected the inclusion of non-allopathic and mid-level healthcare providers in abortion care (2). However, this proposal is also based on the evidence-based recommendations made by the World Health Organization in its updated guidance for safe abortion (14). The evidence is consistent both in the developing and developed countries, with the inclusion of nurses and midwives having improved access to abortion, particularly in remote areas where doctors are not always available (15). Studies from Nepal, a country that is culturally similar to India, show that mid-level healthcare providers are as efficient as doctors at performing first-trimester abortions, if trained appropriately (16). It would be unethical not to train and empower mid-level healthcare providers and those from alternative schools of medicine, given the high rate of unsafe abortions in India and its contribution to maternal deaths, and the evidence suggesting that their inclusion will reduce preventable deaths from unsafe abortion.

The medical community's opposition to the inclusion of these groups is not entirely surprising, considering that it

has enjoyed a monopoly over the field of abortion since liberalisation. Jesani and Iyer draw attention to the power vested in allopathic healthcare providers by the 1971 MTP Act (9), which, along with the non-regulation of the private sector, created a space for the financial exploitation of women seeking abortion. Studies have found that while the overall care provided to patients in the private sector is good, it means an increase in the patient's out-of-pocket expenditure (16). While this also calls for a separate policy to regulate the private sector, the inclusion of trained mid-level healthcare providers will improve access to safe, affordable and legal abortion in the public sector and decrease dependence on the private sector.

While on the one hand, it is important to expand the healthcare providers' base, on the other hand, it is also important to empower women within the healthcare provider–patient relationship. The current law, in choosing to protect doctors acting in good faith, forces women to justify their abortions (17). It also makes them dependent on the doctor's interpretation of the law (9). This is particularly true of women who are not explicitly covered by the 1971 MTP Act, for example, unmarried women or sex workers. In a society in which sexual agency outside the marital relationship is severely criticised, the lack of certainty of access to abortion services renders women vulnerable to exploitation. The amendment bill, by recognising the need of unmarried women to seek abortion, specifically removes this barrier. In addition, the clause ensuring privacy increases the chances of women opting for legal abortions. By requiring doctors to provide abortions on request during the first trimester, it allows women to demand abortions without having to justify their needs. This choice will also empower married women, who, because of the lack of gender equality within marital relationships, are forced to endure sexual violence and then undergo an abortion to limit the size of their family (18). Several of these women have repeated abortions, and doing away with the barrier of a physician's opinion and providing them access to mid-level healthcare providers within their community, as well as wider access to safe and less expensive techniques, such as medical abortion, will improve their access to abortion and also decrease the risk of complications. The Abortion Assessment Project also revealed that doctors in public sector hospitals sometimes refuse to perform abortions unless women undergo sterilisation concurrently (11). The 1971 MTP Act does not include such a clause and such coercion is illegal, but with doctors acting as the final gatekeepers of abortion, it becomes hard for women to negotiate this barrier. The new amendment could give women the agency to demand abortion without facing such coercion.

The extension of the gestational age is likely to engender ethical debates, as it did when Niketa Mehta's plea for an abortion at 24 weeks was discussed in the Bombay High Court in 2008 (19). While the court denied her plea, the National Commission for Women reviewed the case and in 2013, recommended that abortion be allowed up to 24 weeks, keeping in view that modern medical technology can detect some foetal anomalies only after the 20th week (20). While it is important to acknowledge the concerns about eugenic abortions, it can also be argued that it is unethical for a society to prevent individual women from accessing abortions, since it is the woman and her family and not the society that is expected to provide for the physical, emotional and mental well-being of the child. Similarly, sex-selective abortion should not become a deterrent factor in the extension of the gestational age. While second-trimester abortions are assumed to be the result of sex determination, there is no real evidence to suggest such a connection in the majority of cases (21). Moreover, stronger enforcement of the PCPNDT Act, which prevents the use of medical technology for sex determination (22), should remove the opportunity for sex-selection without restricting access to abortion in the second trimester.

Even if Parliament passes the Bill without any changes, the government still has the responsibility of ensuring its proper implementation so that its promising results are realised. The Abortion Assessment Project has found that a large number of unsafe abortions are caused by a lack of knowledge of the 1971 MTP Act (11). The amendment Bill has the potential to improve access to abortion and also allow women to gain some control over their sexuality, fertility and reproduction, but this is possible only if women are made aware of the proposed changes. The government will also have to take up the enormous task of training the mid-level and non-allopathic doctors. While the Bill provides a means to begin this process, it is unfortunately not very clear on where, how and by whom these new healthcare providers should be trained. In the absence of a clear directive on training, the clause recommending the inclusion of mid-level and alternative healthcare providers could easily remain unimplemented. While the medical community might perceive this Bill as a threat because it would disempower them within the doctor–patient setting as well as expand the healthcare providers' base, it is their ethical duty to consider the possible impact of the Bill on reducing unsafe abortions and empowering women. Notwithstanding the fact that it is the ethical duty of medical bodies to identify policy changes that might endanger women's life, their fears with regard to mid-level healthcare providers are misplaced because of the wealth of evidence from around the world. This Bill proposes to bring about significant changes in the scenario of abortion care, and at the same time, marks a step towards a more women-centric, rights-based abortion law in India.

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# Indiscriminate disposal of museum specimens – a case report


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## *Abstract*

*The human body and its parts and organs are invariably used in medical teaching institutions for academic purposes. Legal provisions for the preservation of such specimens are made in anatomy Acts across the country. However, after they have been used, the specimens are not disposed of in a proper manner. This is a public menace and forces the authorities concerned to carry out unnecessary investigations. We report a case in which the bodies of two foetuses that were brought for medico-legal autopsy were later found to be formalin-preserved "museum specimens" that had been used for anatomical study. We wish to emphasise the need for guidelines for the proper disposal of anatomical museum specimens.*


## Introduction

Understanding the human body and its pathology is best achieved through anatomical dissections and the study of museum specimens. Hence, most medical teaching institutions integrate the study of museum specimens with regular training. For this purpose, body parts or organ specimens are retrieved or procured as per the legal provisions. When the specimens have been damaged or are no longer needed, they should be disposed of properly and not just dumped in the garbage. We report a case in which the bodies of two foetuses that were brought for medico-legal autopsy were later found to be formalin-preserved "museum specimens" that had been used for academic purposes in the department of anatomy of a medical teaching Institute.

## Case report

The police received information that the bodies of two foetuses had been found lying in a heap of garbage in an open field. Suspecting foul play, the police recovered the bodies and referred them for medico-legal autopsy. The following were the external findings.

**Case 1:** This was the body of a male foetus, measuring 25 cm in length and weighing 295 g. The umbilical cord and placenta were intact. The length of the umbilical cord was 40 cm, the placenta weighed 110 g and there was no congenital deformity.

**Case 2:** This was the body of a female foetus, measuring 25 cm in length and weighing 190 g. The umbilical cord was intact