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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