LETTERS

Of poor patients and callous doctors

Our country is moving fast towards becoming a developed nation; but are we able to follow the standards of conduct of a developed nation in our government hospitals? I am concerned with the behaviour of medical personnel in government hospitals.

The "hospitality" which the medical personnel of government hospitals provide to their patients is unworthy of mention, to put it politely. A typical scene in a government hospital, amidst the usual chaos: the attending relatives running around frantically, asking for directions, submitting blood samples, and sometimes even hunting for stretchers to transport their patient. After all these efforts, if the patient is lucky enough to get admitted, his real ordeal begins in the wards. There he has to face indifferent and arrogant doctors, nurses and ward boys. Often, if relatives go to the nursing staff regarding medication for the patient, they are packed off after being told to wait for other nursing staff to come to the bedside, but these staff never turn up. Eventually the attendants become frustrated and start creating a scene. Besides this, doctors at government hospitals take their patients for granted, often scolding them instead of explaining. Other common reasons for conflict between the doctor and patient or his relatives are miscommunication to the relatives about the patient's condition, and covering up of any negligence by medical personnel. Since patients going to government hospitals are generally poor, they are unable to raise their voices against practices, unlike in western countries, where the volume of litigation is high and 70% of it is related to poor communication and attitudes of staff (1).

In private hospitals in India the scenario is totally different. Patients are offered the best of care and facilities, and are attended to more promptly. The staff are ready to attend to patients. Medical personnel talk to the patients and their families with due respect. Why do these differences prevail? Are patients coming to government hospitals not human? Don't they need the same tender care and hospitality which patients in private hospitals are getting?

India is still a developing country and 60% of the population is below the poverty line. They are bound to go to the government hospitals. Why can't the medical personnel of government hospitals consider the point of view of the poor patient? Is the pay scale in the private hospitals the incentive or the fear of losing their jobs? The Medical Council of India (MCI) must set up patients' advisory committees which deal with the problems that patients face with the health service. There should be a system by which patients can give feedback on the behaviour of medical personnel. During the recruitment of medical personnel a part of the interview should test their behaviour. Those already working should undergo compulsory training regarding their conduct towards patients and their relatives. If these steps are implemented then surely the situation will improve and government hospitals will become places worthy of treating poor and needy people.

Swati Tandon, *Resident doctor, Pushpanjali Corsslay Hospital, Sector 1, Vaishali, Ghaziabad, Uttar Pradesh 201012 INDIA e-mail: drswatitandon@yahoo.com*

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The ethics of disability language

There has been a gradual evolution of terminology commonly used in health-related or disability-related contexts. Not so long ago, we used the term "normal" thoughtlessly. Looking deeper, what is normal? Two people under the same circumstances behave differently. Who then decides what is "normal"?

When we come to the translation of terms, we encounter greater confusion. The emotions associated with words and terms differ based on experiences. The term "normal" which means "average" is usually translated as either "*sadharan*" or "*samanya*" in many Indian languages. "*Sadharan"* is closer in meaning to the English word "common". *"Samanya"* is probably closer to "normal" or average". But in common parlance, "*sadharan"* is the more popular usage (1).

Language and cultural behaviour have an interdependent relationship. While a cultural context gives rise to language, language in turn, can influence social behaviour. This underscores the importance of using language ethically (2).

When we term someone "handicapped" and look at the translated terms "*vikalaang*" is it the same thing? The word handicap is used in horse racing. The term denoted "equal playing field". The faster horses were weighted down in order to slow them down so that the slower horses would have a better chance. The word "*vikalaang",* used synonymously with handicapped, has a different etymology. "*Vikalaang"* means "imperfect limb" which essentially means "deformed" and not "impediment". The reason for this is that "handicap" in its original meaning has no relevance to India. "*Vikalaang"* on the other hand has reference in the ancient texts and folklore (3).

Now we come to the newer term "disability" which is of fairly simple origin as it is just the opposite of "able". The connotation here is that the disabled person is somehow "not able". This word has no popular equivalent in Indian languages. So while English has changed the word three times already, we have no equivalence. The word *asamarth* is equivalent to "disabled" but somehow this word has not taken root in popular usage. So we continue to equate disability with "crooked limbs". Could this perhaps be the reason why invisible disabilities like mental illness or autism are not part of the public consciousness?

Currently, the popularly used term in English is not "disabled" but "differently abled", although "disability" is still used in scientific parlance. This came about from the realisation that "dis" connotes "inability" which means there is a notion of "normal". "Differently abled" connotes people having different abilities. But doesn't everyone? So are we continuing to label people? Over time will this new term also become pejorative?

What about the translation of "differently abled" into Indian languages? Though the officially adopted terms is "*vikalachetan*", it has no linguistic or semantic equivalence to the word "differently abled" which, in English, is arguably "positive". "*Vikalachetan*" means "imperfect abilities". So it is no different from "imperfect limb". Why then, do we go through this exercise of coining new terms? Is labelling avoidable? Is labelling, whatever the label may be, ethical? How about "*vibhinnachethana*" (differently abled)? Could the expresson, if adopted, become part of the popular parlance? Would it perhaps encourage us over time to view "disability" as "normal". After all, what is "normal"? How many people must have a certain condition for it to be "normal" or "typical"? India, by sheer numbers, is set to become the capital of many conditions. So eventually will all of them be part of the mainstream?

***Kavitha Raja**, Professor, Department of Physiotherapy, Manipal College of Allied Health Sciences, Manipal University, Manipal 576 104 Karnataka INDIA e-mail:kavitha.raja@manipal.edu*

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After supersession of The Medical Council of India

After the arrest of the then president of the Medical Council of India (MCI) and president elect of the World Medical Association, Dr Ketan Desai, in April 2010, the MCI was superseded by a Board of Governors for one year under the Indian Medical Council (Amendment) Ordinance 2010, notified in The Gazette of India on May 15, 2010 (1). The board had six members and most of them were individuals with good academic standings and records of honest careers (2). The Board's term ended on May 14, 2011 but it was extended for one year. No member of the previous board was retained in the reconstituted board.

Till date the Government is not sure about what to do with the MCI. The standard of medical education in the country is falling each day. This is reflected in the deteriorating healthcare available to the common man. When the MCI was founded in 1956 with the prime aim of maintenance of uniform standards of medical education at all levels (3), Indians had hoped for an improvement in the standard of medical education in the country.

One may argue that one year is too short a time for the board to bring any positive change in a system long plagued by corruption. Unfortunately, no positive efforts have been made in this regard by the board, though it had come up with some bright ideas. To name a few:

1. Combined entrance examination test;
2. Post- MBBS exit test for doctors, before they are allowed to practice;
3. Tests for doctors to level the playing field; with the objective of removing doubts over proficiency of graduates from different medical schools;
4. Grading of medical colleges;
5. Vision 2015.

The idea of holding a common test for entrance into the undergraduate and postgraduate course is good. However, the reservation policy, lack of uniformity among the state boards, and the demand for the test to be held in the regional languages, all present challenges. Also the strong lobby of owners of private medical colleges in the country is putting obstacles in the way of its implementation. The holding of the National Eligibility-cum-Entrance Test (NEET) was postponed to 2013. The Union health ministry has said, "The conduct of the test is a Herculean task which requires great deal of preparation and for paucity of time, it is practically impossible to resolve the issues raised by various state governments and hold the UG-NEET in 2012." (4)

This board has gone on to allege that the majority of medical graduates of India are not fit to practise medicine (5). This statement, coming from an organisation which is supposedly responsible for setting the standards of medical education, is irresponsible.

Further, the statement of a member of the Board, which appeared in *The Times of India* under the heading "Centre considers test for docs to level playing field", smacked of regional bias (6). The proficiency of a doctor cannot be judged only by the Institute from which he has graduated, but from what he eventually delivers to society. This idea of grading the proficiency and quality of doctors based on an examination is ridiculous. We have seen the corruption prevailing in any competitive examination in our country. People may have forgotten Ranjit Don, who was imprisoned for manipulating the common admission test for Indian Institute of Management and common entrance test held by central board of secondary education for admission into medical colleges, but I am sure the recent racket in the AIIMS admission test is fresh in our memory (7).

Regarding the grading of medical colleges, the Board has not made its stand clear on its purpose. The criteria are promising (8) but need some modification

The board came up with the concept of Vision-2015, which can be found on the official website of the MCI. The two basic needs identified are: increasing the number of doctors, and improving the quality of medical education by setting short-term, mid-term and long-term goals. Many factors will have to be taken into consideration in order to be able to meet both the objectives.. The present doctor to population ratio in India is 1:1,700. The members have suggested that this should be brought down to 1:1,000 by 2031. This suggestion has not taken into account the fact that the ratio of doctor to population in urban areas is better than in rural areas. The major steps suggested for improving this ratio are: increasing the number of seats in medical colleges, and opening new medical colleges as public-private partnerships.

At the time of Independence, India had only 23 medical colleges. There are 330 today. More than 70% of the colleges established in the last five years are in the private sector. It is evident that medical education in India is going to be completely in the hands of the private sector in the near future. With the poor state of government medical colleges in the country, the common man is going to suffer.

***Sudhir Kumar Thakur**, Department of Surgery, Saraswathi Institute of Medical Sciences, Hapur, Ghaziabad, UP-245304 INDIA e-mail: thakur_sk@rediffmail.com*

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Disability-selective abortion: denying human rights to make a "perfect world"?

This is with reference to the article on the impact of UNCRPD on the status of persons with disabilities by Smitha Nizar (1). I appreciate the author's take on the controversial issue of disability-selective abortions. The article discusses the ethical dilemmas of using medical technologies to terminate foetuses diagnosed with disabilities. It also highlights the paradigm shift from the perspective of looking at people with disability as needing charity and welfare to one which recognises their rights and empowerment.

The central argument of the article revolves around the "sanctity of human life" without discrimination. Healthcare professionals are ethically bound to use healthcare interventions to promote the health of human beings equally. The author builds on this idea and asks whether it is justified to sanction the use of advanced medical technologies to deny persons with disability the right to life with dignity and hence devalue their birth.

Current policy permits disability-selective abortion if prenatal genetic testing identifies a foetus with disability. However, the author points out that genetic test are not fool proof. The increasing acceptance of disability-selective abortions highlights the fact that social attitudes have not changed much; we consider disability as undesirable, and the lives of people with disability as not worth living.

The author also points out that when a disabled child is born because prenatal testing for disability was not done – or the doctor has not informed the parents of the test results so that they can make an informed choice – the parents or the child may claim damages for "wrongful life" or "wrongful birth". This would disregard the dignity of the disabled child. The claim for "wrongful life" will expect the infant plaintiff to say: "not that he/she should have been born without defects but that he/she should not have been born at all."(2). The issue can become even more complicated: What if the foetus was conceived through donor eggs, or the foetal disability followed the pregnant woman's exposure to nuclear contamination, or a natural disaster? In such scenarios whom will the law hold responsible?

The author rightly states that we must view disability-selective abortion in the light of the "right to life of the foetus" as well as the duty to prevent discrimination on the basis of disability, and not only from the perspective of women's right to reproductive choice. We must strengthen our health policies and make them more inclusive towards people with disabilities, rather than eliminating those considered "imperfect" or "abnormal". We must invest in research into methods to reduce further disability, and to maximise the potential of persons with disability, rather than preventing their birth.

***Kiran Gupta,** M Sc in Disaster Management, Jamsetji Tata Centre for Disaster Management Tata Institute of Social Sciences, VN Purav Marg, Deonar,Mumbai 400 088 INDIA e-mail: kiran_2050k@yahoo.co.in*

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Surreptitious use of disulfiram

Disulfiram is one of the most important drugs used in the management of alcohol use disorders (1). It is of significance as a treatment modality especially in low and middle income countries like India, as it is a cheaper pharmacological option compared to other medications like naltrexone and acamprosate. The efficacy of disulfiram has been documented in meta-analysis (2). The medication acts as a deterrent agent, due to precipitation of a disulfiram ethanol reaction (DER) when alcohol is consumed. The medication is typically started after taking informed consent and requires regular supervision, which is fairly possible in the usual family setting in India.

However, surreptitious administration of disulfiram by family members to unsuspecting patients has also been a matter of concern (3). In practice, many of us have come across women giving disulfiram to alcohol abusing husbands without their knowledge and precipitating DER in them. Usually, the distraught family members of alcohol abusers approach a physician in the patient's absence. Disulfiram, commonly referred to as '*reaction ki dawai*' (medication causing reaction), is thereafter given to the patient surreptitiously mixed with food or fluids. The patient starts to have a DER after consuming alcohol and quits alcohol use in many cases. Giving disulfiram in such a manner may possibly help some alcohol-dependent patients, especially those who are poorly motivated to quit drinking. However, at times, the patient then drinks larger amounts of alcohol to numb the discomforting DER symptoms, leading to severe reaction and possibly a fatal outcome. Thus, there is a potential risk of overenthusiastic family members causing grave harm to the patient in the hope of 'helping'. Apart from DER, chronic administration of disulfiram can also cause other drug related side effects.

Such surreptitious administration of disulfiram raises a few questions. Could prescribing in such a manner be considered ethical, especially when the patient is always too inebriated or unmotivated to co-operate with treatment? From a utilitarian perspective, the ends justify the means, i.e. since surreptitious administering of disulfiram helps in quitting alcohol, it serves the purpose and is justified. From a Kantian (deontological) perspective, some forms of conduct are obligatory irrespective of the consequences. Under such principles, stealthy efforts to help patients in potentially dangerous ways are better avoided, so that faith in the medical profession is maintained. Following the four tenets of medical ethics (4), prescribing disulfiram to unwitting patients severely compromises the autonomy of the patient. However, sometimes schizophrenic patients are admitted against their will to prevent harm to themselves and others. The therapist may be acting in a beneficent and non-maleficent manner, but not according the patient's wishes. Following similar logic, should perpetually inebriated patients be afforded 'help' at least temporarily, especially when they harm others (recurrent fights, drunken driving) or themselves (drinking despite having liver impairment and haematemesis)? It must be recognised that giving patients possibly harmful treatment without their knowledge is a form of coercion which may lead to subsequent distrust and resentment towards doctors and undermine the efforts of the medical profession. It seems a better option to assess the capacity of the patients to consent, and resort to other means of treatment like motivational interviewing when they refuse such treatment outright. Also, efforts must be made to regulate supply to prevent administration of disulfiram to unwitting patients.

Siddharth Sarkar, *Senior Resident, Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh INDIA 160 015, e-mail sidsarkar22@gmail.com*

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What's in a name? Anomalies in medical degrees

Of the many medical degrees available in our country, this letter focuses on the anomaly in two medical degrees (MD/DM), both of which expand into Doctor of Medicine, according to the Medical Council of India(MCI)(1). . The MCI offers DM/MCh and the National Board of Examinations offers DNB (super-specialty), both as super-specialty medical courses. The MD courses are available in three and two years for MBBS and post-diploma candidates, respectively. The duration of the DM is six, five or three years; six or five years for candidates with an MBBS, and three years for MD candidates. In this way, the MD and DM are at lower and higher levels, respectively, in the medical hierarchy.

I would like raise some questions: How can the same degree have two different abbreviations? How can the same degree course have different durations and occupy different positions in the hierarchy? Is it ethically and legally correct to have one degree with two abbreviations?

The second dimension is the magic of the term "super" in "super-specialties". In ordinary language, the term "super" denotes "something extra" or "something extraordinary". The use of the term "super" is become fashionable for commercial use, as in "super-market" "super-model", and "super-specialty hospital" in the health care industry. Probably there is no technical significance behind in the term "super" in any of these

Indian industries, However, it is gaining importance day-by-day in the area of Indian medical education.

In the history of Indian medical education, MBBS is the basic medical degree, where basic doctors are expected to treat common medical conditions irrespective of so-called specialty areas. As the list of complex diseases grew beyond the scope of basic doctors, the "broader-specialty" (MD/MS) developed to treat complex diseases with specialised skills such as MD-General Medicine focusing on non-operative intervention of all major organ system of the body, MS-General Surgery focus on operative interventions of the body,

In terms of public health, the general public does not get extra-ordinary treatment for any disease. For example, the treatment of gastritis by a specialist of general medicine and a gastroenterologist is not unusually different for a common man. In other words, a so-called "extra-ordinarily skilled specialised doctor" gives ordinary treatment to an illness of the common man. In these circumstances, "super" in super-specialty gives a false impression of extra-ordinary treatment to the common man.

In view of the state of public health, the question inevitably arises: Can India afford to have commercialisation in the name of super-specialties when it is struggling to give universal access to primary health care? How difficult it is for a medical student to enter a post-graduate specialty (2) will have some bearing on the so-called "super-specialty medical courses".

In an era where many industries add the term "super" to their products for commercial purposes, medical courses coloured with the term super- as "super-specialty medical courses"; with different boards and named as DM/MCh despite the fact that expansion of MD and DM according to the MCI is "Doctor of Medicine" [MD for broader-specialty and DM for super-specialty]. This anomaly also exists in MS/MCh, i.e. both having the same literal meaning for MS (Master of Surgery) and MCh (abbreviation for *"Magister Chirurgiae",* a Latin name for the English form of "Master of Surgery") (http://en.wikipedia.org/wiki/Master_of_Surgery).

Unfortunately, MCI, the regulatory body of medical education, frequently uses "super-specialties" for DM and MCh courses on its website (http://www.mciindia.org/RulesandRegulations/PGMedicalEducationRegulations2000.aspx). In the same way, National Board of Examinations (NBE) also developed super-specialty DNB courses. In this way, both these nodal agencies of medical education of country legalised the term 'super' in "super-specialty" which is heading towards a new low in commercialisation of medical education in the coming decades.

It is high time the MCI clarified these doubts about the two abbreviations (MD, DM) for one medical degree (Doctor of Medicine) and how it can rank at different levels in the hierarchy.

Secondly, Government of India should consider abandoning fancy and commercial names in so-called super-specialty medical courses by abandoning the term "super" and renaming it as "sub-specialty". At the end, there is need to revamp the hierarchy of medical courses (3) with lowest and highest degree, probably MD at lower and DM at higher in hierarchy to fit the exact meaning of expansions. Otherwise, it will not be surprise to see terms like "hyper-specialty medical courses", "hi-tech medical courses" etc in coming years.

N Manjunatha*, Assistant Professor of Psychiatry,Department of Psychiatry, MS Ramaiah Medical College, Bangalore - 560054 INDIA e-mail: manjunatha.adc@gmail.com*

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