

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 term 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 expression, 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?

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#### References

1. Pathak, RC. *Bhargava's concise dictionary of the English language (Anglo-Hindi Ed.)* Varanasi: Bhargava Book Depot; 1966.
2. Krauss MR, Chiu C. Language and social behaviour. In: Gilbert TD, editor. *The handbook of social psychology*. 4th ed. Boston: McGraw-Hill; 1998.
3. Karna GN. *United Nations and the rights of disabled persons: a study in Indian perspective*. New Delhi: APH Publishing Corporation; 1999.

#### 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.

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#### References

1. Ministry of Law and Justice, Government of India. The Indian Medical Council (Amendment) Ordinance, 2010 [Internet]. New Delhi: MoLJ. 2010 May 15 [cited 2013 Jan 16]. Available from: <http://www.mciindia.org/tools/announcement/ord0210.pdf>
2. Nagral S. Ketan Desai and the Medical Council of India: the road to perdition? *Indian J Med Ethics*. 2010 Jul-Sep;7(3):134-5.
3. Medical Council of India. About MCI [Internet]. New Delhi: MCI. 2010 [cited 2013 Jan 12]. Available from: <http://www.mciindia.org/AboutMCI/Introduction.aspx> accessed 16.01.2012
4. Times News Network. Mamata's opposition scuttles medical test. The Times Of India [Internet]. 2012 Jan 12 [cited 2013 Jan 15]. Available from: [http://articles.timesofindia.indiatimes.com/2012-01-10/india/30611239\\_1\\_cbse-medical-colleges-examination](http://articles.timesofindia.indiatimes.com/2012-01-10/india/30611239_1_cbse-medical-colleges-examination)
5. Thakur SK. Post-MBBS exit test for doctors in India. *Lancet*. 2010 Dec;376(9756):1900-1.
6. Sinha K. Centre considers test for docs to level playing field. The Times of India, Chennai edition [Internet]. 2011 Mar 3 [cited 2013 Jan 18]. Available from: [http://epaper.timesofindia.com/Repository/getFiles.asp?Style=OliveXLib:LowLevelEntityToPrint\\_TOINew&Type=text/html&Locale=english-skin-custom&Path=TOICH/2011/03/03&ID=Ar01100](http://epaper.timesofindia.com/Repository/getFiles.asp?Style=OliveXLib:LowLevelEntityToPrint_TOINew&Type=text/html&Locale=english-skin-custom&Path=TOICH/2011/03/03&ID=Ar01100)
7. Medical entrance test racket unearthed in AIIMS, five arrested. The Indian Express [Internet]. 2012 Jan 9 [cited 2013 Jan 15]. Available from: <http://www.indianexpress.com/news/medical-entrance-test-racket-unearthed-in-aiims-five-arrested/897625>
8. Chhaphia H. Now, MCI to grade medical colleges. *The Times of India* [Internet]. 2011 Mar 18 [cited 2013 Jan 15]. Available from: [http://articles.timesofindia.indiatimes.com/2011-03-18/india/29144614\\_1\\_medical-colleges-medical-council-naac](http://articles.timesofindia.indiatimes.com/2011-03-18/india/29144614_1_medical-colleges-medical-council-naac)

## 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 fetuses 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.

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