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*

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
5. Thakur SK .Post-MBBS exit test for doctors in India. *Lancet*. 2010 Dec3;376(9756) :1900-1.
6. Sinha K. Centre considers test for docs to level playing field. The Times of India, Chennai edition [Internet]. 2011Mar 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
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. Chhapia H. Now, MCI to grade medical colleges. *The Times of India* [Internet]. 2011 Mar 18[cited 2013 Jan15]. Available from: 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 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*

References

1. Nizar S. Impact of UNCRPD on the status of persons with disabilities. *Ind J Med Ethics.* 2011Oct-Dec;8(4):223-9.
2. Burns TA. When life is an injury: an economic approach to wrongful life lawsuits. *Duke Law J.* 2003 Feb;52(4):807-39.

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*

References

1. Garbutt JC, West SL, Carey TS, Lohr KN, Crews FT. Pharmacological treatment of alcohol dependence: a review of the evidence. *JAMA* 1999 Apr;281(14):1318–25.
2. Jørgensen CH, Pedersen B, Tønnesen H. The efficacy of disulfiram for the treatment of alcohol use disorder. *Alcohol Clin Exp Res.* 2011Oct;35(10):1749–58.
3. Manjunatha N, Vidyendaran R, Rao MG, Kulkarni GB, Muralidharan K, John JP, Amar BR, Jain S. Subacute vocal cord paralysis, facial palsy and paraesthesias of lower limbs following surreptitious administration of disulfiram. *J Neurol Neurosurg Psychiatry*. 2010 Dec;81(12):1409–10.
4. Gillon R. Medical ethics: four principles plus attention to scope. *BMJ* 1994 Jul 18; 309(8948):184.

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