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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.

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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.

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