THE CENTRE FOR BIOETHICS
Improving health care through Bioethics

The Centre for Bioethics

Bioethics Bulletin –**Volume 3, Issue 1**

Editorial

Greetings to everyone! We have the topic of this issue as the Professional – patientrelationship. There are many facets to this topic and the articles that follow focus on many of them. Unfortunately by sheer familiarity the word professionalism has all but lost its original meaning and thereby its distinctiveness. Today, the term almost has the opposite meaning! In sport, a professional is one who makes his living from the sport, that is does it for money; whereas an amateur is one who is in it for the joy. We have an article that traces the connection between Hippocratic tradition of Medicine and professionalism which highlights some of the strengths of "profession". Sadly, the Corporate world is increasingly marketing Medicine as a consumer product and the relationship between a doctor and patient as a contract. What can make us go beyond this mindset? Read on to see. What makes profession unique is the relationship. In the articles we are providing you will find numerous qualities illustrated that are important in a physician. As you read you will notice that character traits of a physician are paramount and nothing can replace the place of a virtuous physician in restoring the profession of Medicine to its long held position as the noblest of them all.

Professional –patient relationship

- Dr. Jamila Koshy

A patient planned his words nervously on each visit to the busy doctor. He was aware he would be granted only thirty to forty seconds to give concise information about his status before he was asked to get onto the examination couch.

On the other hand, towards the fag-end of a busy OPD, I noticed a man apparently waiting his turn. However, when I went by an hour later, he was still there. Surprised, I asked him why he had not gone in yet. He replied that he was waiting for everyone to finish, so that he could go in and invite my colleague, who had treated him for years, to his daughter's wedding. He was willing to wait a couple of hours to do that. Such was the strength of his relationship and regard for her!

How, then, should we relate to our patients? Of course, we are taught in medical college, to treat our patients with respect and kindness, but sometimes this is not apparent in doctors' dealings with their patients.

For a healthy and mutually valued relationship, these are some critical areas:

1. Attitude:

- Respecting the patient: Doctors should see the whole patient, as a valued, functioning human being. The patient is more than an infected toenail, an attempted suicide, or an ischio-rectal abscess. Call her by name, greet her politely, enquire about her work, other illnesses and family. This makes the person comfortable, and also makes perfect medical history, but is often sacrificed in the OPD. Needless to say, doctors should maintain physical and sexual boundaries with patients scrupulously.
- While doctors are trained in the area of health and illness, their knowledge is incomplete. They should retain humility about what they know and what they do not know. Assuming a superior, I know-best, God-like air of omnipotence is false and therefore unethical.
- Showing empathy: Doctors need to show understanding of what the patient is going through. A tell-me-your-problem-quickly-don't-waste-my-time, overly business-like attitude will not endear them to their patients. Such patients and families are more likely to create problems and disruptions in the event of unfortunate outcomes.
- Reject the tendency of patients to make you decide: "You tell us what to do, Doctor, we will do that"; "Aap hamare liye Bhagwan hain" (You are like God to us) are not attitudes to encourage. Encourage them, instead, to learn more about the illness, provide information, written, online or oral through medical staff, and to participate in decision-making about the illness and its outcomes. The more they own the decision, the more they will be committed to doing what it takes to get well, and also accept the limitations of treatment.
- Keeping on learning, and not being afraid to show gaps in knowledge: Medical knowledge is always changing and increasing, is never complete, and unless one is pro-active, one can easily lose track of new developments. The doctor should have an active and calm commitment to learning and re-learning in his and allied fields. If despite this, some gaps appear in her knowledge, it should not unduly upset her. If a patient asks about some new drug or technique you do not know, even if it is in your field, be honest and admit it. Look it up, and get back with the information. The patient will only trust you more.

2. Time:

Do we grant our patients enough time to talk? A study showed that physicians routinely interrupted their patients, some 12 to 18 seconds after the patients began their opening speech! While interjecting a short focused question to improve understanding, (but somewhat later than 18 seconds into the history!) is tolerable, the patient should always be allowed to resume stating his concerns. As examination and investigations begin, the patients continue to need the physician's time. Offering treatment options, discussing pros and cons, discussing side-effects – all require time and patience from the treating doctor. There is no short-cut.

3. Communication and information:

The patient must be seen as an active participant in the healing process, more so in these days of easy access to information. It is the physician's duty to keep communicating and giving precise, easy-to-understand information about the illness, (minus all medical jargon; an easy way is to imagine explaining the illness to a school student), its consequences, treatment options, side-effects, length of treatment and so on.

- Breaking news of a dangerous or poor-prognosis illness needs to be done with sensitivity and privacy. Call the patient apart (ask if he wants his family along) not rushing it, allowing time to let the diagnosis sink in, and answering any questions they may have, not at one sitting, but often in several, or many sittings.

- "Informed consent" should not mean a form hastily signed, (as "consent le liya?" sometimes refers to!) but the actual transfer of information, and an active participation of the patient or his family, in terms of understanding the treatment options, its chances of success or failure, and so on.

- Some tricky issues are: information should ideally be given to the patient, and not the family, till the family dynamics are understood clearly, unless the patient is not in a condition to understand or respond to the information. Special care needs to be taken in providing information to newly-wed spouses and new in-laws, as family disputes can easily arise over whether the illness was concealed prior to marriage and so on. If however, the patient requests that the doctor talk to the family members as well, answering their queries, the doctor is free to go ahead.

4. Being truthful and hopeful, together:

If the chances of success of surgery are only 50%, say so; but also say that for your part, you and your team will do your best to see that the patient will be among the 50% whose surgery is successful. Enumerate the reasons why; perhaps your equipment, your team's competence. Give the factors against a good result too: perhaps the patient's history, biochemical parameters. Then leave it to the patient to decide and do not push.

5. Confidentiality:

particularly in fields where detailed history is essential, maintaining patient confidentiality is vital. This would hold even when the patient has been brought against his will by the family for treatment. The family is bound to ask "What did he say? What happened? Why is he behaving in this way?" and so on, but the doctor has to keep what has been shared confidential, while getting the family to understand what their part in the recovery will be.

6. Money and fees:

This is probably the most contentious of issues between patients and the medical establishment. Patients sometimes persist in thinking they have been over- charged, and view with suspicion tests they are asked to do, cross-consultations they are asked to get, hospitalisation, its time and duration. It must be admitted that there are many times the medical profession is to blame.

- Ignorance: many doctors do not know the comparative prices of drugs, and maybe prescribing the costliest. I can remember being horrified when I realised why some patients were non-compliant – I had prescribed a prohibitively expensive, though useful drug.
- Callousness – we don't care about the patient's whole life, his income, his children's education; we just prescribe the latest drug, or ask for a battery of tests. Deliberate - as when hospitals ask if the patient has insurance or government cover: a sure-fire consequence is a flood of investigations and procedures.
- Hospital policy: some hospitals set targets for doctors on admissions, income, 'returns'.What are the solutions? How does one manage the money question in an ethical and just way that meets legitimate needs without draining all the patients' resources?

- Perhaps most important is to see the medical profession as also, a vocation, a calling, a strong inclination, for some even a divine summons to the field. No one should enter without this sense of vocation.
- While charging a reasonable fee is acceptable and necessary, at no point would they take recourse to underhand means to inflate bills – whether increasing the length of stay at the hospital, carrying out unnecessary tests or procedures and so on.
- At the same time, working for a fair and reasonable salary for medical and hospital staff across the board is necessary.
- Perhaps this would entail cutting costs in fancy infrastructure, finding simple solutions and procedures fit for the Indian context, cheaper drugs, and so on.
- Since often patient fees themselves cannot cover medical establishment costs, specially in the poorer areas, the role of government and private philanthropic agencies assumes great importance. The government sector in particular has hemorrhaged a great many competent doctors to the private field, as well as overseas. More young doctors and nurses could consider working for the government where they would have a reasonable, steady salary with the privilege of working for the poorest sections. Similarly, private charitable hospitals have a role to play in subsidising medical costs for the poor, while giving reasonable wages to their employees.

In summary, an ethical and good professional-patient relationship depends on the doctor's treating his profession as a calling, a vocation, not being greedy for money, but fair and honest in all his dealings. She must maintain an attitude of respect, humility, empathy, sharing knowledge and allowing patients' the right to question, participate and decide their treatment. The doctor should give the patient enough time, and maintain a continuous, respectful dialogue, while maintaining onfidentiality with others.

Dr Jamila Koshy is a Psychiatrist who lives and works in Delhi

Professional – patient relationship &truth telling

Dr. Achamma Chandy

Introduction : The Medical Profession is a unique one which has a dignity of its own and has special characteristics which are difficult to find . Since it involves dealing with the quality and longevity of human life, it is brought close to divinity at times. The sense of job satisfaction that a physician gets when he sees his patient resume normal health is immense. Similarly the patient commits his health and life completely into the doctor's hands with absolute trust.

Wisdom from yester years : In the very early century as early as fifth century BCE healing was considered an art or skill and the craftsmen were teachers also. Between the fourth and fourteenth centuries the Church looked favourably on medical healing since its teachings rested on the Gospel of Jesus who himself was described as a miraculous healer of the sick. All the religions had a common thought of being merciful and kind to the sick without expecting anything in return. Buddhism which was perceived in India and China said that three grave illness of mankind are anger, desire and ignorance and these are healed by compassion and meditation. One of the highlights of British Medicine was the book written by Dr. Gregory [1772] who was a Professor of Physics in the University of Edinburgh. His lectures addressed the genius, understanding and temperament that suit a man to be a physician. Dr. Benjamin Rush of Philadelphia was America's preeminent physician at the time of the Revolution. He says the good physician has the virtues of piety and humanity. Dr. Richard .C. Cabot [1868 – 1939] formulated medical ethics in America. He emphasized a very important factor of having good cooperation between physicians and other hospital staff in order to achieve the best patient care.

Expectations of a patient : The personality of a physician should be an embodiment of virtues - kindness, grace, patience, piety to name a few. As far as the decorum of doctors is concerned, it is good to avoid extravagance in manners, attend divine services regularly and be composed, punctual and reasonable. To be approachable at all times is a very difficult trait to have for a physician, but one which makes the doctor- patient relationship very strong. If the physician can be contacted at any time, it means affecting the privacy and family time which is a huge sacrifice.

Competence and empathy in correct proportions makes a perfect physician. A person who is eager to accumulate wealth cannot be a good physician, since at times absolute free treatment would be expected. It is good to educate the patient about his health conditions after establishing a good rapport.

How much should be told to the patient about his medical condition is an important decision for the doctor. Here I would like to elaborate by my personal experience of looking after couples with medical conditions causing infertility. The obstetric history of the wife reveals a first trimester abortion before marriage. Should the husband be told about it? That must be the cause of her blocked fallopian tubes necessitating an Assisted Reproductive Technique in order that they could have a child. In this scenario I have no doubt about my decision. I will never allow the husband to know about this aspect in his wife's obstetric history. If I do, there is a possibility that I would be initiating a divorce. There is a likelihood of the husband being extremely understanding and brushing way the fact that his wife had a relationship before being married to him. Can you take that risk? Certainly not. We have to make decisions according to the circumstances.

Taking the couple through the journey of the treatment of infertility, through all its uncertainties, being available through the long period of treatment is a huge task and responsibility of the physician. According to the educational levels of the couple the investigation and treatment protocols should be explained. This involves long hours of counselling. An infertility specialist has to be a very good counsellor; should have the patience to answer the never ending questions of the couple. Childlessness is a devastating condition in India and a social stigma. The most difficult part of the counselling is when the physician has to tell them that they have to look at other options like adoption to fulfil their dreams to have a family. Desperation, anger, frustration are all the emotions which will happen simultaneously and the physician has to deal with all that. This involves multiple consultations till the couple is able accept the inevitable. We can slowly see them accepting the facts and ready to move on with life. I have found it very useful to pray for my patients asking God to provide them with the peace only He can give.

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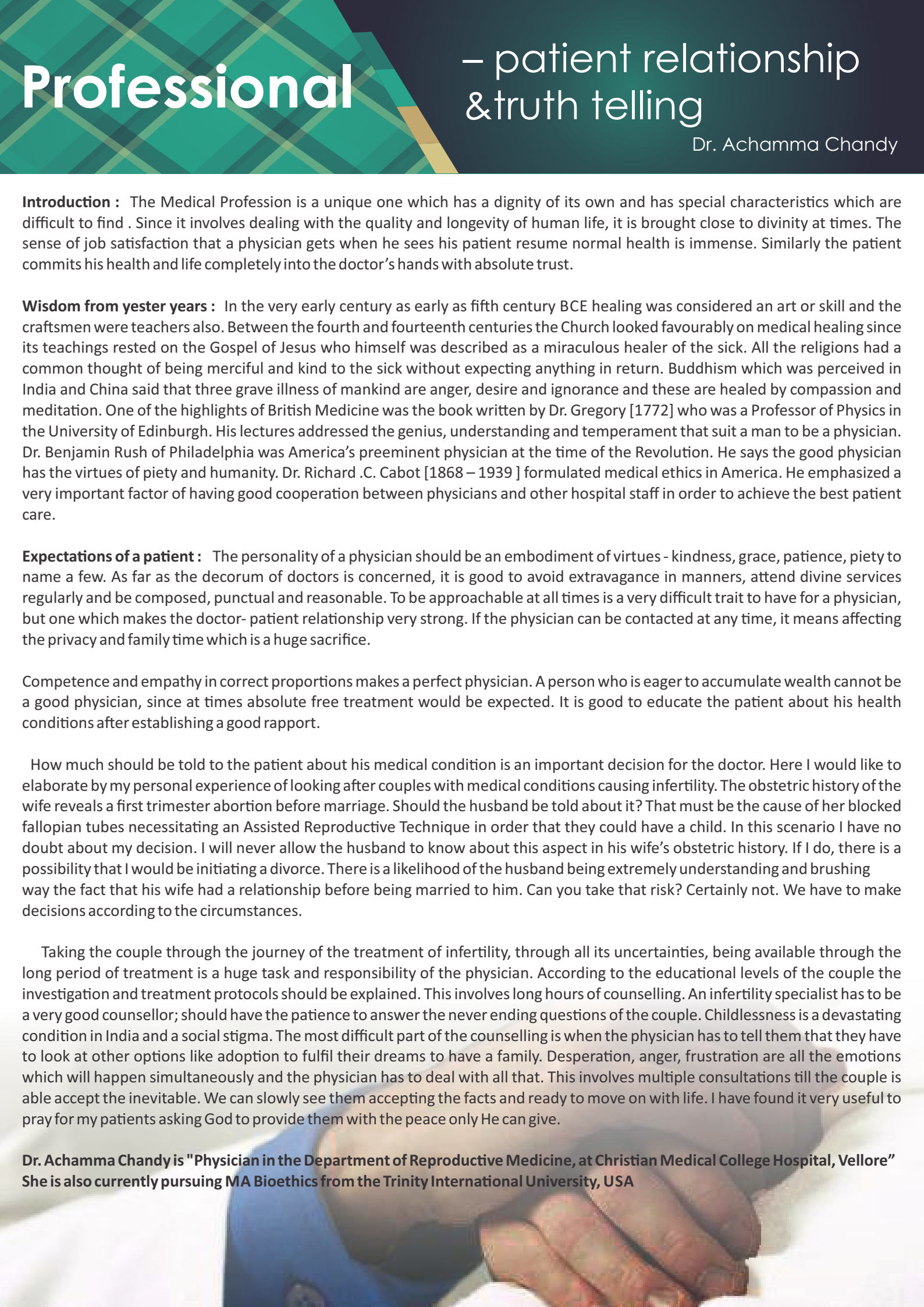


Informed Consent

Mrs xx 24 yrs G1 2 A1, un-booked with 38 weeks of gestation had reported with labour pains to the XN hospital for delivery. Patient delivered immediately. It was decided to include the patient in an ongoing clinical trial. And cord blood was collected for research purposes and APGAR of the baby was noted.

Title: Cord blood Vs APGAR to diagnose intra-partum Asphyxia

The objective of the study was to determine the efficacy of cord blood analysis Vs APGAR Score in determining Foetal asphyxia. The sample strength was 50. Patients who delivered vaginally after 38 weeks of gestation were included in the study. The APGAR score was assessed immediately after birth. Cord blood was collected and analysed for acid base status of the foetus. The analysis was done to find out whether Apgar scores correlate well with cord artery pH in cases of intra-partum asphyxia.

Ethical issues

A. IRB approval – whether the study was approved by the internal review board or ethics committee

B. Written Informed consent – whether obtained from the patient?
C. If the data shows abnormality what is the investigators responsibility?
D. Whether compensation is involved for using the tissue.
E. Permission to publish the data of the study

Discussion of ethical issues

A. IRB approval – Ethics committee approval was taken prior to the start of the study
I Updates to IRB may be necessary if required by them.
ii. Final report should be sent to the IRB

B. Written Informed consent – whether obtained from the patient.

1. Un-booked patient VS booked
2. Patient is in labour- not the ideal time to recruit participants for study
3. Not enough time/state of mind of patient in labour to understand
4. Time to explain is not adequate

C. If the data shows abnormality what is the investigators responsibility?

1. Disclosure to the parents –the investigator must discuss with the parents the results of the analysis and inform if there are any problems
2. Should the investigator or hospital bear the expenses? The cost of analyzing the cord blood should be borne by the investigator
3. It will be ethical to treat the infant in case it is needed.

D. Whether compensation is involved for using the tissue.

E. Permission to Publication of the data – Confidentiality –permission must be got from the patient and confidentiality should be maintained.

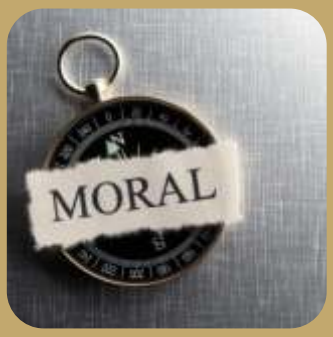
Conclusion:

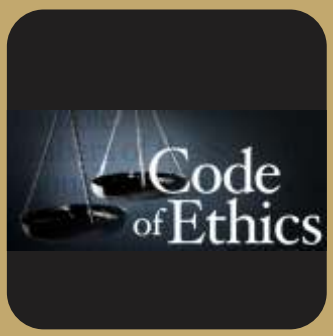
- The study should be one which is beneficial
- Appropriate ethics approval should be obtained
- Written informed consent should be obtained from each participant
- It is the responsibility of the investigator to get informed consent and to meet the cost of testing cord blood
- Compensation need not be given
- The data should be pass word protected and confidentiality should be strictly maintained.

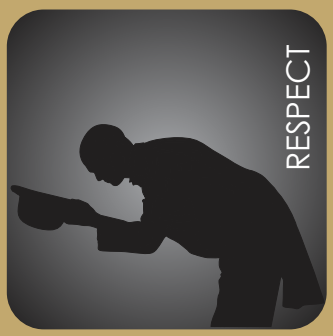
Dr. Mitra Dhanraj has done MD in ObG and PGDBE and is working as Director & Principal Investigator at Par Biosciences and Consultant Obstetrition & Gynecologist at CSI Kalayani Multispecialty Hospital, Chennai

Professionalism in medicine

- Dr. Roopa Jewel







Professionalism in medicine throughout the generations embodies similar fundamental behaviors, such as demonstrating compassion, respect, and humility; adhering to high ethical and moral standards; subordinating personal interest to that of others; and reflecting on actions and decisions. Despite the dynamic nature of the profession itself, the omnipresent need for such traits will define medical professionalism for decades to come. “Just as you want others to do for you, do the same for them” (Luke 6:31). The relationship my patient has with me is central to the practice of healthcare and is essential for the delivery of high-quality health care The doctor–patient relationship forms one of the foundations of contemporary medical ethics. In order to be an effective clinician, a doctor must be able to develop and maintain a professional relationship with both their patients and their colleagues. By being polite, considerate, honest, trustworthy as well as treating each patient with dignity and as an individual, a doctor will be able to effectively communicate with the patient, obtain their trust and subsequently address the individual patient needs.

Most medical schools teach students from the beginning, even before they set foot in hospitals, to maintain a professional rapport with patients, uphold patients’ dignity, and respect their privacy. A doctor should act as a positive role model and be a supportive and encouraging influence to others involved in patient care. In order to do the above, a doctor should respect the skills and contributions of others, encourage and support each member, communicate effectively and review each situation regularly. In a successful doctor-patient relationship a professional boundary should exist between doctor and patient. If this boundary is breached, it can undermine the patient's trust in their doctor, may compromise the quality of patient care, as well as the public's trust in the medical profession. To believe passionately in what you do, and never knowingly compromise your standards and values is important. A true professional aims for true excellence, and the money will follow.

Knowing we cannot see inside a person’s heart,it is important to remain humble and guarded when judging the character of others with partial information. A patient must have confidence in the competence of their physician and must feel that they can confide in him or her. For most physicians, the establishment of good rapport with a patient is important. Some medical specialties, such as psychiatry and family medicine, emphasize the physician-patient relationship more than others, such as pathology or radiology. As we develop understanding of our own professional development needs we must not become fixated on Knowing we cannot see inside a person’s heart, it is the outward behaviors at the expense of the inner attitudes and beliefs.

Consider the most fundamental relationship between beliefs, attitudes, and behaviors: beliefs are the causes of our attitudes, which in turn cause our behaviors. The patriarchal nature of health-care delivery produced the sense of “doctor knows best”—doctor as the authority. The better the relationship in terms of mutual respect, knowledge, trust, shared values and perspectives about disease and life, and time available, the better will be the amount and quality of information about the patient's disease transferred in both directions, enhancing accuracy of diagnosis and increasing the patient's knowledge about the disease. Where such a relationship is poor the physician's ability to make a full assessment is compromised and the patient is more likely to distrust the diagnosis and proposed treatment, causing decreased compliance to actually follow the medical advice. In these circumstances and also in cases where there is genuine divergence of medical opinions, a second opinion from another physician may be sought or the patient may choose to go to another physician. Professionalism also insists on respect toward others, explained best by “The Golden Rule.” “For all the law is fulfilled in one word, even in this: ‘You shall love your neighbor as yourself” (Galatians 5:14).

Although some timeworn therapies have persisted for decades, medical knowledge has advanced markedly in the last 50 years. In the past, both available therapies and understanding of disease processes were more limited. Patients were told “No more can be done” more frequently and earlier in the course of disease. The doctor’s role in crisis was support at the bedside, either in hospitals or in patients’ homes. Today’s doctors enjoy unprecedented access to medical knowledge and therapeutic options. The wealth of clinical understanding is more readily available in formal medical education and through online resources, digital pharmacopeias, and pocket references.

Good communication requires listening to the views and questions of the patient, providing information in an accessible way and collaborating to come up with a shared plan. Within the clinical environment, it is also important to work in teams. It is important to understand that judging behavior is the very thing that others will do about us. In fact, there are those who wait in ambush and will pounce unmercifully at the first sign of moral indiscretion. Professionalism in medicine must include its impact on successive generations of physicians. Fifty years ago, doctors acting professionally emphasized medicine as a calling and an ability to act as the authority for patients in crisis at home and in hospitals. Therapeu tic options were limited relative to the modern era, and the laying on of hands was practiced as science and art. Today, doctors balance increasing demands on time and efficiency with the sense of primacy of patient care. The public enjoys dramatically improved access to medical information admittedly of varying degrees of accuracy through the media and the internet. Medical decision-making is being analyzed through lenses of increasing acuity. Now that doctors can do more, they fear repercussions of not doing enough, errors of omission. “Defensive medicine” comprises the practice of treating liability risk as well as the disease at hand; physicians may order additional tests just to reassure patients or may avoid patients at higher risk of bad outcomes.

Regardless of the time period involved, professionalism imbues medicine. It simply takes different forms over the years. Professionalism was not directly discussed earlier, but it remained a combination of mastery of current medical knowledge enabled by contemporary technology and delivered with compassion, humility, respect, and sensitivity to the needs of patients and their families. Love of the craft, commitment to their patients, competence, compassion, facility in communication—simply put, those qualities that make us not only great doctors, but true professionals.

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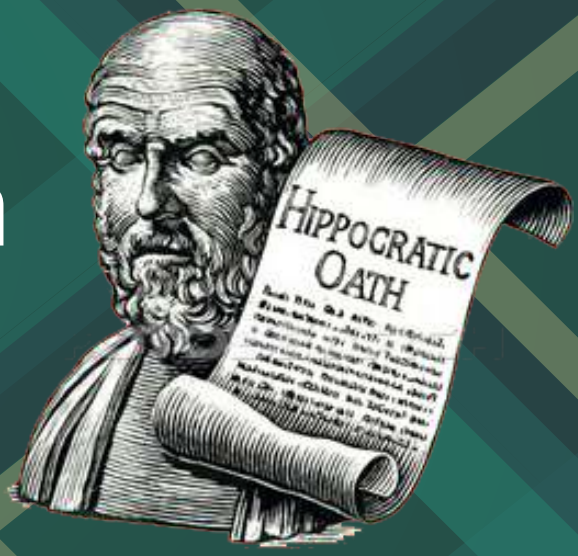
The Role of Hippocratic Oath in the Profession of Medicine



- Dr Satish Thomas

The words profession is one of the most abused terms in modern usage that has lost its meaning. It is helpful for us to dwell on some history so that we understand crucial and distinctive elements that define the discipline of medicine.

Medicine is one of the oldest professions. Historically it was called so because its practitioners "professed" to something. They proclaimed that they would hold themselves to the highest ethical standards of care, compassion and the interests of patients above themselves. This in turn led society to give them the right to regulate themselves and earned Medicine nobility and honor as a profession. It was probably Hippocratic medicine that blazed this trail. However its marriage to Judeo-Christian values of Imago dei and justice later on was what gave Medicine this crucial honor and respect it enjoyed for almost 20 centuries in the Western world.

Hippocratic medicine was counter-cultural in its original setting in ancient Greece in that it stood out against the more permissible lower standards of the day. It was because these physicians were opposed to the prevalent practice and stood for different values that they felt necessary to submit and have allegiance to an oath. There are some characteristic features of the Hippocratic Oath. One, the Hippocratic physician sees his role as a calling. He sees himself as entrusted with this responsibility by the gods and therefore answerable to them. "I swear by Apollo Physician, by Hygeia, by Panaceia, and by all the gods and goddesses, making them witnesses, that I will carry out, according to my ability and judgment, this oath…" In this way we could say that Hippocratic medicine is theistic.

"In purity and holiness I will guard my life and my art." This unity of life and art as one whole gave it one of its greatest strengths – the virtuous character of the physician. The physician recognized that he can do his best for his patients only if he watched not just his craft but also his own life and character…"keeping myself from all intentional wrong-doing and harm, especially from fornication with woman or man, bond or free"

It was obviously a paternalistic system where the physician's values must be accepted by the patient. The paternalistic nature of medicine has drawn much flak in recent times with the abuse of medicine in the last century. So patient's autonomy has become the biggest factor in ethics nowadays. This has been an important factor in casting modern medicine into a contract system or a business proposition. It has moved far away from the Hippocratic tradition where the physician set his ability and judgment at the sole disposal of the patient's interest. This corporatization of medicine has redefined it as a consumer product and now corporate structures market it in such a way as to deliver it in the most attractive way to consumers.

The third standout feature of the Hippocratic oath was the primary value it placed on sanctity of life. Against the widespread practice of abortion it stood its ground not to apply a pessary. The pledge not to give poison though asked to do so sounds like distant echoes in history against the pressure to perform euthanasia. The motto "first do no harm" was again an expression of upholding the preciousness of human life. In contrast to this is the professional nature of the Hippocratic tradition where the physician committed himself to uphold certain values, most notably his sense of holy calling, personal integrity and the sanctity of human life entrusted to him. This oath was taken before new recruits signed up, so that only those willing to uphold those values would be admitted. The values were more important than the practice of the trade. Unfortunately the oaths have now become just lip-service at the graduation ceremony. We would do well to recover this essence of Hippocratic tradition. In a way we live in similar times. The general standards of ethical values in the practice of Medicine are falling steeply. The general public's mistrust of the medical practitioners is very high. All around us are signs of decay and decadence of a discipline that once upheld lofty values. It was precisely in such an environment that the Hippocratic physicians felt that they need to commit to an oath and stand apart in stark contrast to the majority way. At a time in history when Medicine has become so commercialized and corporatized into a marketing product that makes good business, we can ask ourselves the question whether it is time to revisit the true spirit of the Hippocratic Oath especially when it is seen through the eyes of the Judeo- Christian faith.

Dr Satish Thomas is Professor of Ophthalmology at CMC Ludhiana

What is beyond a contract?

- Dr Jameela George

Contract seems to be the current way of functioning – contracts in jobs, contract in business, contract in legal cases, contract in renting houses and contract even in marriages. In the original sense of the word, contract is an agreement with specific terms between two or more persons in which there is a promise to do something in return for a valuable benefit known as consideration.

Contract is a matter –of – fact type of agreement. When one is hired on contract for a job, the individual is expected to deliver what he/she has agreed to, for an assured sum of money. The only things that matter are the deliverables and the exchange of money, for example, from the employer to the employee. Neither the employer nor the employee is obliged to go beyond - to show empathy, concern etc.

In taking care of patients, there is an unwritten contract between the treating doctor and the patient. The patient pays a fee and expects in return to be treated. There is an obligation on the part of the doctor to treat the patient. Is that all or is there something more than that?

As a student when I visited a Mission Hospital, this is what I found. A junior doctor who was working in that resource limited Hospital was conducting a delivery. (In those days specialists were rare). The delivery went on well, but then the patient was bleeding profusely. The young doctor was over whelmed with the post partum hemorrhage. Suddenly I saw a number of doctors rushing to the labor room. When I enquired, I found that she had sent word to the other doctors in the OPD, who were seeing patients though it was well beyond OPD hours. As a team they worked together. They resuscitated the patient, stabilized her, did all that was required and went back to the OPD. What was quite obvious is that the lives of those doctors were vocation- a divine call to God's service.

How ought one work as a health care professional? Isn't it ethical to approach treating patients as a vocation? If so, what does it entail? The first and foremost is perhaps to accept each patient as one created in the image of God and that each one has intrinsic value. So he/she has to be respected and treated with dignity. Secondly, primacy of patient welfare – keeping the best interest of patients, doing whatever is feasible in the given context. Thirdly, equitable allocation of finite resources, depending on the health needs and not on the paying capacity of the patients.

May we be more than contract professionals. Let us be men and women who have been called to be His hands and feet touching not only the bodies healing their diseases, but more so imprinting God's love in their hearts.

What is beyond a contract? Vocation - a divine call to God's service

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Aims & Objectives of TCB

1. To be a Christian voice on ethical issues based on Biblical values

2. To analyze, interpret and engage with the existing and emerging bioethical issues pertaining to health care and research

4. To promote ethical medical practice

3. To facilitate upholding the sanctity of life and dignity of humans in medical practice and research

5. To build leadership in the field of Bioethics, in the areas of Medical education, Medical practice and Medical research

Prayer support:

TCB needs constant prayer support of churches and individuals alike for the success of its mission and we request all our like-minded believers to kindly uphold us in prayers for God's leading and wisdom. We will appreciate you being in touch with us through face book, website, email or post.

We are glad to let you know that TCB has obtained 12A recently.
''' Donations to continue the work of TCB are very welcome.

Please send your contributions towards the work of TCB to the following Bank account:

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