JUSTMED

DRAWING THE LINE IN MEDICAL ETHICS

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Editor
Jameela George

The Centre for Bioethics
Evangelical Medical Fellowship of India
2016

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Above all, I am immensely grateful to God for enabling TCB to develop Just Med.

Dr. Jameela George
Executive Director
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Abbreviations

1. AID	Artificial Insemination by a Donor
2. AIH	Artificial Insemination by the Husband
3. DoH	Declaration of Helsinki
4. IRBs	Institutional Review Boards
5. IVF	In vitro Fertilization
6. MCI	Medical Council of India
7. PAS	Physician-assisted Suicide
8. PDS	Public Distribution System
9. TCB	The Centre for Bioethics

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Contributors

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Jamila Koshy is a psychiatrist with over two decades of experience. She did her MBBS at Arms Force Medical College and her DPM at Sion Hospital, Mumbai. She is currently in Chennai, consulting at the Kalyani Multi-specialty Hospital and the Apollo Hospital, Vangaram as well as at her own clinic. She is interested in general psychiatry, marital and family problems, and adolescent issues. She also attempts to bring awareness of these issues through writing and involvement at various fora, both church and community based.

Dr. Mitra Dhanaraj is an Obstetrician Gynecologist and sonologist. She did her MBBS at Styanley Medical College, Chennai; MD, DGO at Kasturba Medical College Mangalore and PGDBE from IGNOU. She was HOD Dept. Of OBG at CSI Kalyani Hospital, Director Ethics Bio Lab Pvt. Ltd / Par Bio Sciences Pvt. Ltd, Head Regulatory affairs Norwich Clinical services, Centre head lotus labs, Medical director at-Herbertpur Christian Hospital at Uttrakhand and In charge of CSI Rainy Hospital at Chennai. She has been teaching post graduate medical students for over 15 years and has also been DNB examiner. She has imparted GCP Training at Lotus Labs Pvt. Ltd Chennai and Norwich Clinical Services Bangalore Ethics Bio Lab Pvt. Ltd at Chennai.

Dr. Roopa Verghese did her M.B.B.S. and M. D. Obstetrics and Gynecology from BFUHS, Faridkot, Punjab and Diploma in Emergency Obstetrics management from the University of Karolinska, Sweden. Currently she is pursuing MA Bioethics at Trinity International University, Illinois, USA. She worked as Medical Officer at Christu Mitra Ashram Hospital in Karnataka, Jiwan Jyoti Christian Hospital in U. P and Christa Panthi Ashram Hospital in M. P and as consultant OBGYN at Duncan Hospital, Raxaul. Currently she is the EHA- RCH coordinator and Senior Consultant Obstetrician and Gynecologist at Landour Community Hospital, Mussoorie. She authored a chapter on Endocrinology of Hyperemesis Gravidarium, in the Textbook of Endocrine disorders in Pregnancy and a chapter on Antepartum Management of Gestational Diabetes in Pregnancy, in the Textbook of Diabetes is Pregnancy. She has also compiled the book, “Guidelines for improving Quality of care in Obstetrics Services” for Reproductive and Child Health Services in EHA.

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Foreword

Dr Jameela George,
Executive Director,
The Centre for Bioethics, New Delhi

This Bioethics teaching tool has been developed by The Centre for Bioethics (TCB), in response to a request from EMFI to help in their work with medical students. This has been written in an interactive manner, to facilitate medical students and graduates, to engage with the issues of Bioethics and to enable the facilitator to elicit answers from the participants. The case studies are from real clinical/life experiences. Care has been taken to provide clarity in each module, so that the participants would find it simple to understand and would generate curiosity to explore further, on their own.

The Centre for Bioethics is a registered society with 15 founding institutions. Its intent is to improve health care provision in India through Bioethics. The Vision of The Centre for Bioethics is to have "a fair and equitable society in which individuals, families and communities can be in good health and with dignity regardless of age, gender, religion, education, economic status and ethnicity, through ethical Health care systems in India". The Mission is to build a cadre of ethical Healthcare professionals and ethicists who will provide leadership in the field of Bioethics, and a value based "voice" in influencing the nation.

TCB is engaged primarily in developing teaching aids; teaching & training medical students and graduates through EMFI and CMAI; creating awareness on key issues among youth and pastors and developing Bioethics modules, such as this one. One of the key initiatives has been to enable five doctors from India to do MA in Bioethics in partnership with The Centre for Bioethics and Human Dignity of Trinity International University, Chicago. Currently TCB in partnership with CMC, Vellore is developing curriculum for Post Graduate Diploma in Bioethics (PGDBE). This will be a two year course by distance education.

We trust this tool Just Med will help our young friends to have a sound foundation in medical ethics as they practice medicine.

PREFACE

Dr Manoj C Jacob
General Secretary,
Evangelical Medical Fellowship of India

Medical Science has been rapidly progressing with advancements in technology offering newer options of medical care and treatment. However, especially in India, the ethics and philosophical implications of many of these biological and medical procedures, technologies, and treatments have not been seriously considered.

The curriculum of study prescribed for our medical graduates in majority of the medical colleges does not make any serious effort to look into or address these areas. Moreover, the commercialisation and the conversion of medical care into a multibillion Rupee industry is a matter of concern.

It is in this context that The Centre of Bioethics (TCB), in partnership with the Evangelical Medical Fellowship of India (EMFI) was enabled to develop this teaching material for medical students and young doctors. This has been a long felt need and is kind of a 'dream come true'! It is also in line with EMFI's vision to see *'Christ's transforming presence in Healthcare and the nation through Christ-centred medical professionals'.*

We extend our appreciation to Dr Jameela George for her perseverance and hard work along with her small team of budding bioethicists under training.

This is a start and we trust that it will sensitise our medical graduates to some of the issues involved. As they grapple with the controversial ethical issues emerging from new situations and possibilities brought about by advances in biology and medicine, it will enable them to get a sound biblical perspective. It is our prayer that these modules will facilitate moral discernment and we would see a generation of Christ-centred, ethical medical professionals who can influence the medical policies and practices in our country.

Introduction

Dr. Mathew Santosh Thomas,
Ex-Executive Director
Emmanuel Hospital Association

This set of self and group learning modules on key issues in Bioethics are timely and significant for our Nation. Much thinking and hard work has gone into identifying key and core issues and writing these modules. The format is such that, the reader or the group is challenged to reflect on the issues at hand and find practical applications for the context in which the person is studying or working.

We live in a time when the foundational values that undergirded Healthcare, and which had its roots in a Judeo Christian world view, are being questioned and challenged. In the larger context too, there is an erosion of foundational values, and moral relativism is the fad of the day. This change has affected the approach to ethical clinical practice.

The modules on Foundations and World Views help the reader reflect on his or her own foundations and world view and correlate the same, with globally accepted principles of Bioethics. The section on History, gives the student a glimpse into the past, of Healthcare losing the undergirding values, impacting practice and research. It reveals the basic principles that were set up as boundaries for Healthcare practices. The module also gives the students an opportunity to reflect on these principles against the backdrop of biblical values.

Professionalism and Care are being re-defined in the context of commercialization of Healthcare. From being a profession which was the choice of individuals who wanted to be involved in alleviating pain and suffering, Healthcare is now being chosen for financial and positional gains. The modules on professionalism and care challenge the students to reflect on health and healing from what it was supposed to be – a caring profession, caring for people created in the image of God.

One of the challenges of the transition into commercialization of health care has been that, it has affected the way health care professionals look at work. Work in Healthcare is seen primarily as an opportunity for self-promotion and this adversely affects attitude to work and values which undergird the same. The modules on Work ethics and integrity help the learner look at these issues not only from a set of principles perspective, but also from a personal application perspective.

In our country there are discussions on making abortion more accessible. At the same time, life expectancy is increasing and geriatric care and issues related to end of life care are becoming more relevant. In this context, the modules on Beginning of Life and End of Life, challenge the learner to explore these issues both from a Bio Medical perspective and a Christian value based perspective.

The module on Justice and poor, addresses the issue of health care and accessibility, the inequity in today's systems of Healthcare, and helps the learner reflect on God's heart for the poor.

One needs to approach these modules with a reflective and open mind, so that in addition to acquiring knowledge, these learnings could change the undergirding values on which we build our profession and practice Healthcare.

MODUL

FOUNDATIONS OF BIOETHICS

Dr. Satish Thomas

Introduction to the topic:

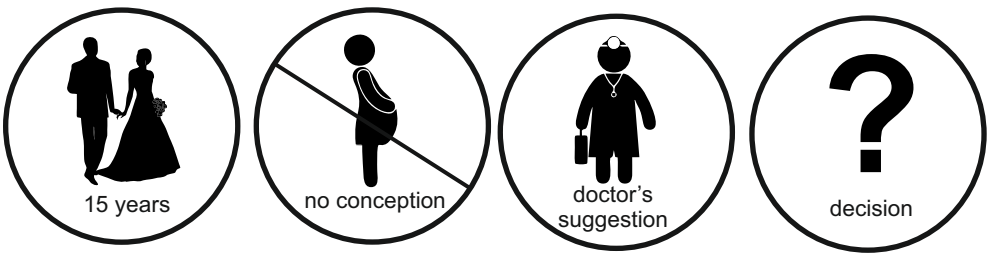
Ethical Standards, Values, and Moral Judgment are said to be the Keys to Ethical behaviour. What is the basis for ethical decision making? How can we decide what is right and wrong in a situation? As Christians, it is easy to say that the Bible provides us with answers sometimes, though not directly. What about those complex dilemmas that modern technological advances pose? It is simplistic to assume that the Bible gives guidance about every situation and ethical predicament , and we could, in some cases, be in danger of taking scripture out of context to justify our position.

There are several frameworks that have been formulated to analyse situations so that a decision can be made on what appears to be the most ethically appropriate course of action in any situation. Of late, one of the most acceptable and widely used is that proposed by Beauchamp & Childress – the 4 principles of autonomy, beneficence, non-malfeasance and justice. Autonomy is the patient's right to self-determination to choose for himself/herself. Beneficence is the principle that the treatment chosen will be in the best interest of the patient. Non malfeasance means to do no harm, or as Hippocratic Oath puts it, "to not make the cure more burdensome than the disease itself". Justice means equality in the distribution of resources and treatment. However, these principles might sometimes be in conflict with each other, and in such situations we might need to see which would be the weightier consideration.

Let us look at a case scenario to see how these frameworks can guide us to make ethical choices.

Case scenario

Sunita and her husband Rahul have been married for 15 years. They have not been able to conceive in spite of extensive treatment and much prayer. The tests reveal that Rahul's sperm count is very low, and so chances of conceiving are minimal, unless they resort to in vitro fertilization. Their gynaecologist, Dr. Kamath, who has more than 2 decades of experience in treating infertile couples, suggests artificial insemination by a donor (AID). He says they are wasting precious time and subjecting themselves to the high possibility of miscarriage and spontaneous abortions if they are willing for artificial insemination only by the husband (AIH). Both Rahul and Sunita are believers in the Lord. Sunita is very uncomfortable with the doctor's suggestion, but Rahul tries to persuade her that use of technology and scientific advancement are from the Lord and that there is nothing wrong with it.



a. Technical Explanation

b. What are the ethical issues in this case/example?

1. _____

2. _____

3. _____

c. Biblical basis:

Scripture portion: _____

What are the Biblical values/ principles?

1. _____

2. _____

d. Personal applications: (with respect to ethical practice)

1. _____

2. _____

3. _____

FACILITATOR'S NOTES

a. Technical input on the topic:

The four main principles used in Medical ethics are Autonomy, Beneficence, Non-malfeasance and Justice.

Autonomy: Autonomy**,** which means 'one who gives oneself one's own law', is a concept found in moral, political, and bioethical philosophy. Within these contexts, it is the capacity of a rational individual to make an informed, un-coerced decision. In medicine, respect for the autonomy of patients is an important goal, though it can conflict with a competing ethical principle, namely beneficence. The principle of autonomy upholds the patient's right to choose what will be done for him or her. Autonomy is the right to self determination. This has become an important consideration following some of the abuses in medical research in the last century. This is in contrast to paternalism, where the doctor decides on behalf of the patient, without taking the wishes of the patient into consideration because he knows what is best for the patient. The principle of autonomy, better referred to as respect for the patient, is now reflected in practices such as informed consent, surrogate decision making, and advance directives. In informed consent, an explanation in detail about any procedure – its indications, details, benefits and harm, is mentioned – so that the patient can make a decision on whether he/she wants it. Advance directive and surrogate decision making are methods to protect the patient's desires when he/she is no longer in a position to make decisions or communicate them.

Beneficence: Beneficence is one of the most important principles to be upheld because, whatever is done, is in the patient's best interests. Beneficence implies consideration of the patient's pain; his/her physical and mental suffering; the risk of disability and death; and quality of life. Most treatments involve some degree of risk or have side-effects, so this principle reminds us to ponder over the possibility of doing harm, especially when you cannot cure. As a principle, it might seem straight forward, but it can create conflict in certain situations such as interests of other family members or the doctor's vested interest and so on. Sometimes the best interest of the patient might not be the treatment of the pure medical condition at any cost.

Non-malfeasance : Non malfeasance is a negative statement asserting the fact that even if we are not able to do good, we must certainly do no harm by any treatment. Any treatment has to weigh the risk-benefit ratio, and we go ahead only if the benefit greatly outweighs the harm.

Justice: Justice is treating each patient fairly and equally. The justice principle holds that patients in similar situations should have access to the same care. This issue can come up in situations where resources are scarce and limited, and choices have to be made between patients. In allocating resources to one group, we should assess the impact of this choice on others. These patients themselves may not be equal in terms of age, disease, prognosis, paying capacity, social status and so on.

In a particular situation, these 4 principles provide a basis for discussion and decision making on the ethical dilemmas that arise. The approach of these four principles helps in fleshing out the requirements of Hippocratic Medicine, so that it becomes more helpful for discussion and deliberation in concrete situations and dilemmas.

b. Ethical issues identified in the case study

An important ethical issue in the given case is the conflict between the autonomy of the wife and that of her husband. The wife is against the concept of AID. The husband on the other hand wants AID. The world-views they both hold have resulted in decisions that are totally contradictory. In this situation, even though one could argue that getting a baby in itself is good and so should be pursued, the process involved has to be thought through.

Are there any permissible limits of technology? If something can be done, is it then ok to do it? An important question that ethics deals with is the “ought” and not the “is”. Modern man believes that if anything is possible, then he has a right to it. However, ethics does not deal with the question of what “is” or what “exists” but whether we “ought” to pursue it - whether it is right.

We have to recognize that the above questions can never be answered in a vacuum that is from an absolutely neutral position. The basic beliefs and underlying assumptions about the nature of the universe, mankind, God, destiny of man and purpose of man, will influence what seems right or wrong about a decision regarding a person. Therefore, a person's beliefs or world-view fundamentally influence his ethical thinking.

How can we learn to think biblically on all matters? Or how do we develop a Christian mind? Romans12:1,2: *Therefore, I urge you brothers, in view of God's mercy, to offer your bodies as living sacrifices, holy and pleasing to God – this is your spiritual act of worship. Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is – His good, pleasing and perfect will*.
2 Corinthians 10:5: *We demolish arguments and every pretension that sets itself up against the knowledge of God, and we take captive every thought to make it obedient to Christ*.

We try and immerse ourselves in the biblical story or narrative. The 4 major themes as they unravel in history are the Creation, the Fall, Redemption and Culmination. We ask the question, 'Where does this puzzle fit in the grand scheme of things'?

In our case scenario we ask the question, what did the original Creator intend? We are only art restorers, not creators when it comes to the human body. The role of medicine is to restore what has been marred by the fall, and if possible, at least comfort and alleviate suffering. We have no right to try and 'improve' on the original Creator's intentions. We cross a boundary when we creatures try to do that. As fellow workers with Christ, we are involved with Him in restoring the effects of the curse.

c. Biblical Basis

Bible and Bioethics principles: All 4 of these principles are biblical to some extent. Autonomy reflects respect for persons, which ultimately can best be grounded in the biblical foundation of *Imago Dei* (man in the image of God). Similarly, beneficence or best interest of the other, finds its highest expression in '*do unto others what you would have them do unto you* (*Luke 6:31*)' or '*you ought to lay down your life for one another* (*John 15:13*)'. Justice is an attribute of God Himself and one of the foundational principles of biblical ethics and practice; a constant and repeating theme of the prophetic messages.

Sufficiency of the Bible: As evangelical Christians, we uphold the Bible to be the final word on all matters. And yet, can we go to the Bible for guidance in matters of bioethical controversy? How can a book written in pre-scientific times, in a world technologically primitive and predominantly rural, give us answers to the questions that modern technological advances have thrown up?
The Bible has much to say and enough to guide us in these matters if we approach it in the right manner. If we look to it for ready-made answers, we will be disappointed. For God has not given the Bible as a dictionary of quotations or as a trouble-shooting manual. Instead, the scriptures are a comprehensive revelation of God to mankind that covers the sweep of world history. Rather than turning to the Bible in the hope of finding ‘proof-texts’ which will apply directly to the ethical dilemmas of genetic engineering, stem cell research or in vitro fertilization, we need to immerse ourselves in the Biblical revelation, so that our transformed minds can lead us.

Need for Biblical world view:

We all have our worldviews, the spectacles with which we perceive and interpret all data in the universe. Our worldviews influence our perspectives, thereby influencing our decisions. Not every Christian necessarily has a Christian worldview (*Romans 12:1, 2*). Even the new birth does not ensure that we automatically think scripturally (*2 Corinthians10:5, 1 Corinthians 14:20*). Hence, it is very important to develop a Christian mind or a biblical worldview so that we can see and think about every issue from that perspective. How can we learn to think biblically or formulate a Christian worldview?

The 4 Epochs: As mentioned earlier with reference to the 4 themes or epochs that human history unravels, namely the Creation, the Fall, Redemption and Culmination, any issue considered in the light of this framework will give us a fresh and balanced perspective. As an example let us consider ethical issues related to use of technology. How much of technology is acceptable in tampering with the human body? Can we go to any extent in trying to improve or are there limitations that we ought to impose? In order to think biblically on this issue, it's helpful to look at the 4 grand themes of human history.

Man was created by God in His image, originally good, even 'very good'. Then came the corruption due to the Fall. Since that fateful event in the Garden of Eden, God is at work in restoring man, and indeed the whole of creation, to their original glory. While this work of restoration and reversal continues side by side with sickness and disease and death, it will be consummated (completed) only at the end of the ages. Seen from this perspective, what is the role of a medical intervention? It can be best described as an art restoration. The original masterpiece, created with much love and artistry has been defaced, flawed and contaminated. But through the imperfections, we can still see the outlines of the original masterpiece which inspires a sense of wonder at the underlying design. If a biblical perspective on human beings views them as flawed masterpieces, then our responsibilities are to act as art preservers and restorers.

Art restorers: As coworkers with God in reversing the effects of the Fall, our duty is to protect the flawed masterpieces from further harm, and attempt to restore them in line with the original Artist's intentions. Art restorers are not free to alter or improve the masterpiece as they like, provided they are operating within the constraints fixed by the original Artist. Restorers may then decide to employ highly artificial and invasive technology. As medical professionals faced with mind boggling possibilities led by technological advances, we have to keep asking the basic question, 'does the use of this technology allow the Maker's original intention to be fulfilled, or is it changing the design at a fundamental level'?

d. Possible applications

In an ethical dilemma, the 4 principle approach provides a reasonable basis for thinking through the situation and also in articulating the arguments for a particular course of action. However, the principles can be contradictory in a given case.

In the case scenario under consideration, the Creator's original intention for mankind is the institution of marriage and the sanctity of the conjugal bed. Children were intended to be born within wedlock as a unique product of the love between a man and his wife.

AIH can be seen as a process of reversing the effects of the curse in the Garden of Eden. Technology is used to correct the damages caused by original sin in the physical realm. Sickness and disease came as a result of original sin and the curse. We see God in Christ actively involved in redemptive and restorative work, and this gives us the mandate and the motivation to do all we can to fight disease and suffering. Technology can be seen as arising from the mandate given to man to 'fill the earth and subdue it', and so the use of technology can be an expression of faithful stewardship.

AID crosses a boundary in marriage and in the idea of children born from the union of husband and wife. It is an attempt to redefine original creation, and the relationships within a marriage (spouse and spouse) or within the family (parent and child; sibling and sibling) which may or may not survive the crossing of these boundaries. It opens the door to the possibility of confusion, doubt and regret. However, for childless marriages where AIH has bleak prospects, adoption could be a possible option.

References:

1. Wyatt, John. 1998. *Matters of Life and Death.* Inter-varsity Press: Leicester.
2. Bartholomew C.G; Goheen M.W. 2004. *The Drama of Scripture*. Baker Academic: MI.
3. Rae S.B; Cox M.C. 1999. *Bioethics.* William B Eerdman's Publishing Co: MI.
4. Hester DM, Schonfeld T, eds. 2012. *Guidance for HealthCare Ethics Committees*. Cambridge, UK: Cambridge University Press.
5. Jonsen AR, Siegler M, Winslade WJ. 2010. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine.* 7th ed. New York, NY: McGraw-Hill.
6. Lo B. 2009. *Resolving Ethical Dilemmas: A Guide for Clinicians*. 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins.

MODULE

WORLD VIEWS AND DECISION-MAKING

Dr. Jamila Koshy

Introduction to the topic:

In the medical practice, periodically, the doctor, the patient or his family may be confronted with choices. Sometimes the answer is obvious, (Do I go to school when I have an infectious disease? Answer: No, you stay away till the infective period is over). But often there are subtleties and complexities which make the choice difficult or even painful (Do I go to school when all my class-mates, except one, have had the infectious disease, but my exams are approaching and I cannot afford to miss a particular revision class?). In such cases, how does one decide what to do? This would depend on the worldview held by individuals, and it is important for doctors to understand and work through these issues with patients.

There are a variety of world-views held by people, consciously or unconsciously, which influence their ethical choices. Many of these world-views are secular, and some are faith-based. Of the secular world-views, unaffected by religious beliefs, there are various kinds: Some people think behaviour should be governed by what brings pleasure or reward – philosophers call this hedonism. Never mind how it affects others. Others would desire to act in ways that develop the full potential of their human-ness, perhaps showing love, compassion, and tolerance. Several are bound by duty – act strictly according to their learned social rules of good and evil; the pitfalls are many. Some think behaviour only becomes good or bad depending on the consequences; and some in particular think of acting in such a way that the maximum number of people attain happiness. For some, individual rights is the beacon – they would never imperil others' rights.

For many, faith is their guide - religious beliefs would dictate action. For Christians, the Bible would be their reference point, and opinions on various issues would be influenced by the Bible's take on those issues. There are a variety of other spirituality or faith-based world-views, as one may imagine, ranging from animistic ideas of spiritual forces influencing life, causing good and evil, which need placation, pantheistic ideas of all life being part of the divine to more classically theistic faith-based religions, with their own particular emphases and biases.

How should the Christian doctor navigate this confusing ocean of differing views?

- By learning to understand nuances and shades of grey, and being compassionate and thoughtful as you deal with people.
- By finding common points in whichever worldview the person espouses: pointing out inconsistencies; and encouraging them towards what is nearest to a Christian/ Biblical viewpoint; keeping in mind that several issues are still being debated within the church. It is good to educate oneself and listen carefully to others as they set out their opinions.

Case scenario

A young post-graduate student, aged 24, has a first episode of schizophrenia-hearing voices, fearing attacks from neighbours, behaving in a noticeably distraught manner, refusing to go out, meet strangers, unable to work, eat or take care of her usual chores or study. She is put on medication, and shows good recovery. She goes back to finish college, continuing maintenance medication, on the advice of her doctor.

Six months later, her parents plan to get her married. They ask their doctor whether she should continue medication since she is completely okay', and is to be married soon. They have not told the groom or his family about her illness, brushing it off as 'a little tension', and confide in the doctor that they have also taken her to their pujari, who has performed certain rituals, and assured them that the bad time is now over. After the session, the doctor is uncomfortable since he is sure the girl is still hallucinating occasionally, and also has negative symptoms. When he advices them to continue medication, they are upset, keep pushing him to stop it, as 'she is quite okay now'.

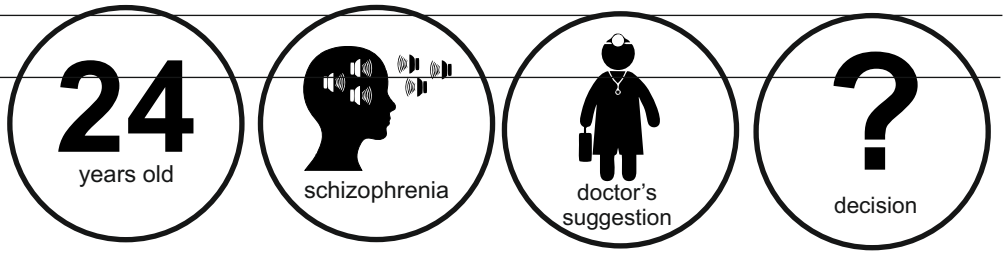
a. Technical Explanation

b. What are the ethical issues in this case/example?

1. _____

2. _____

3. _____



c. Biblical basis:

a. Technical Explanation

Scripture portion: _____

b. What are the ethical issues in this case/example?

1. _____

What are the Biblical values/ principles?

2. _____

1. _____

3. _____

2. _____

c. Biblical basis:

d. Personal applications: (with respect to ethical practice)

1. _____

Scripture portion: _____

2. _____

3. _____

What are the Biblical values/ principles?

1. _____

2. _____

d. Personal applications: (with respect to ethical practice)

1. _____

2. _____

3. _____

FACILITATOR'S NOTES

a. Technical input on the topic:

Schizophrenia occurs in approximately one out of a hundred people, and is usually a long-term illness. Men usually have their first episode in their teens, and women in their twenties. Schizophrenia has the potential to disrupt a person's overall personality – one's thought, perception, mood and behaviour - with positive symptoms such as hallucinations, delusions or disorganised speech and movement, and negative symptoms like lack of motivation, emotional flattening, and social withdrawal.

Treatment has vastly improved over the last few decades, and 25% of patients may recover completely. 25-30% may have minimal or no impairment, but may show another relapse. The remaining patients show a chronic course with impairments of moderate to severe degree. The fortunate 50% may lead fairly normal lives, but the illness still requires maintenance therapy and awareness of the possibility of relapses in 75% of patients. Stoppage of treatment and stress can lead to quicker relapses, both of which often happen at the time of marriage. When the illness strikes later in life, married people who succumb to the illness do better than singles. There are various theories of aetiology, suggesting a multi-factorial causation, including a genetic component of, as yet undefined proportions.

b. Some ethical issues identified:

1. Stoppage of medication in order to persuade everyone that the person has recovered completely and the illness was just a brief glitch, a little anxiety or a minor problem. This is often unconsciously done. The defence mechanisms of denial and minimisation (of the mental illness) come into play to deal with the anxiety of the illness.
2. Discontinuation of treatment because of the belief that the illness was caused by some form of the evil eye being cast on them (*nazar lag gayee*), or by some spiritual forces punishing the patient or the family for something.
3. Seeing the illness and medication as a barrier to marriage, and therefore denying proper treatment to the girl, thereby putting her at risk of relapse in order to conform to society's rules, which demand all girls of a certain age get married.
4. Hiding or minimising a serious illness from the groom and his family, deception and secrecy being frequent, even if no active lies are told.
5. Why should she suffer because of the stigma society attaches to mental illness? After all, with early and regular treatment, she can do almost as well as other girls who are married, and have a family as other young people do.
6. As there is a genetic factor in schizophrenia, the possibility of passing on the illness to the resulting children must be considered as well. The corollary of choosing not to conceive would affect the whole family.

c. Biblical Basis:

1. Do not deceive:

Christian Healthcare professionals should exhibit truthfulness in all areas of their lives. Truthfulness will be visible and will reflect Christ's character. Galatians 6:7: “Do not be deceived, God is not mocked; for whatever a man sows, this he will also reap.” No one should flatter or deceive others because God's people are children who should not lie, who dare not lie, who hate and abhor lying. When we deceive others and cause them to undergo trouble, we are displeasing God who hates deceivers. Also, when we deceive others, we deceive God. We can see this from the example of the life of Ananias and his wife Sapphira who deceived the people of God (Acts 5:1-9). People are not to deceive others, but to live in a way that is beyond criticism, avoiding every form or appearance of evil. It is clear that in the Bible, deceiving others originated from the serpent who deceived Eve by his craftiness in the Garden of Eden (2 Corinthians 11:3; cf. Rev 12:9; Gen 3). Therefore we must not deceive others, as deceiving is the character of Satan.

2. Truthfulness:

Truthfulness is a virtue and truthfulness can build healthy relationships in a person's life. Ephesians 4:25: “So then, putting away falsehood, let all of us speak the truth to our neighbours, for we are members of one another.” Apostle Paul encourages the Ephesian Christians to be truthful to each other, by putting away the lying tongue and by doing good to our neighbours, because we are members of the body of Christ. Proverbs 23:23: reminds us to buy truth, and not to sell it; and to buy wisdom, instruction, and understanding. It is important to live a life of truthfulness which will edify one another.

3. Caring:

John 13:34-35 : “I give you a new commandment, that you love one another. Just as I have loved you, you also should love one another. By this everyone will know that you are my disciples, if you have love for one another.” Loving is the character of God. He cares for us. He left His heavenly abode and came into this world to bear our burdens, take our sinful place and die for our sins. Paul encourages the Galatian Christians to bear one another's burdens, and in this way fulfil the law of Christ (Gal 6:2). Caring for others and bearing each other's burden is fulfilling the law of Christ. Therefore, we have to be kind to one another, tender-hearted, and forgiving each other, just as God has done to us by forgiving our sin, by His death on the cross. He has done all these things, because He cares for us. So we should stretch out our caring hands to those who need our care.

4. Imitating Christ:

Ephesians 5:1-2 – “Therefore be imitators of God, as beloved children, and live in love, as Christ loved us and gave Himself up for us, a fragrant offering and sacrifice to God.” People are to develop virtue by imitating Christ. Apostle Paul encourages the saints in Ephesus to be imitators of God by loving fellow believers, caring for the needy, forgiving those who do not deserve forgiveness, and to show Christ's image to people around. Paul also boldly tells the Corinthian Christians to be imitators of him as he imitates Christ, because he knows that there can be no higher standard than imitating Christ. Likewise, we the children of God ought to be imitators of Christ by being truthful, loving and caring, thus reflecting the character of Christ.

a. Possible applications:

When discussing these issues with the patient and her family, the Christian doctor must make sure she first understands their ethical viewpoint. Also, it will be helpful to know their beliefs about God. Discuss and work towards the biblical ethical viewpoint which may include:

1. Treat both the girl and the groom with respect. Do not imperil their rights - deny her treatment, or deceive him.
2. Accept the illness as part of her life and the family's. Be hopeful of a good outcome, but do not prematurely terminate the treatment.
3. Prayer and respect for God is certainly vital, but medical knowledge is given to humans through the application of their God-given minds, and therefore is not contradictory to trusting God for healing, or carrying out any religious ritual.
4. Accept available treatment willingly and compliantly. The merits of continuing treatment without any irregularity should be stressed.
5. Be just in your dealings with all concerned. Care should be taken not to focus only on the girl, but to see the issue in the context of her family and her possible marriage.
6. Develop the virtues which would come from imitating Christ, including honesty, faithfulness, transparency and patience.
7. Be absolutely honest in dealings with the groom's family.
8. Trust God for the girl's future, even if the other party decides not to go ahead, or she never gets married, that God is still working for her good.
9. If you choose to go ahead without making this fact plain, thinking only of your social duty of getting her married anyhow, or thinking only of her happiness and not others, then be careful of the consequences. Some of such marriages have ended unhappily, with social maelstroms, when the truth was discovered.
10. Applying wisdom in choosing to have or not have children, if she does marry.
    (Adoption is a good option for people unable to have children, but the choice lies with them).

Obviously, the discussion will have to be modified accordingly if the family is not Christian. Since most common people in India have no problem with the concept of God, (even those with a largely animistic, spiritualistic worldview), the Christian doctor could discuss most of the above with them, using their own words for God and faith. For those who do not believe in a personal God, using the principles of honesty, rights, virtues, correct behaviour, 'doing to others as you would have them do to you', could be the way to discuss these issues.

The discussion on these matters may not be possible in a single sitting. However, real concern on the part of the doctor to help the family, if evident, could be helpful to develop trust with the patient and her family. This could be a process in which the facts about the sickness, the prognosis etc., are shared incrementally, but in honesty. This might require more time, but could be rewarding. Thus, during follow up sessions, the family could be enabled to move from their position to a more workable situation.

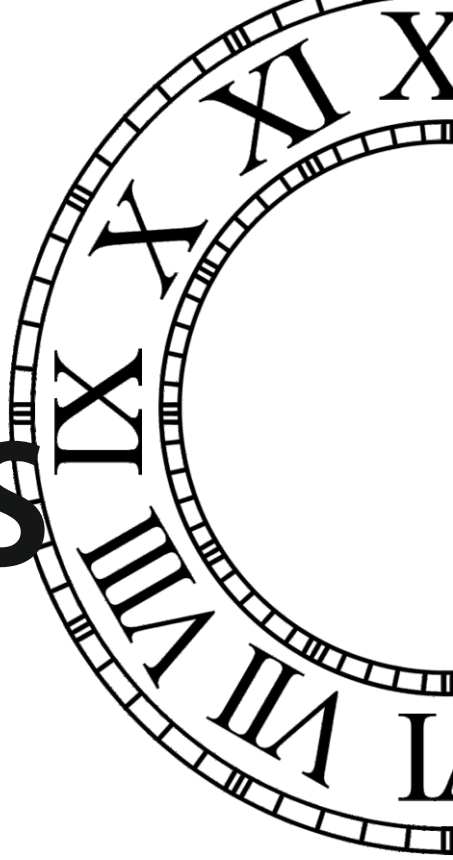
References:

1. *Introduction to ethical studies*, an open source reader http://philosophy.lander.edu/ethics/ethicsbook.pdf.
2. Oxford textbook of Women and mental Health, OUP, 2010.
3. Kaplan and Sadock, *Synopsis of psychiatry*, 11th edition.
4. John Stott and John Wyatt, *Issues facing Christians today*, revised and updated 4th edition. 2006.

MODULE

HISTORY OF BIOETHICS

Dr. Jameela George



Introduction to the topic:

Over the centuries, physicians /healers/medicine men were looked upon by people as those who practice a noble profession. The commitment and integrity with which they treated patients earned their trust. But the Holocaust was a dark period in the history of mankind and modern medicine. Nazi doctors violated the trust placed on doctors by society. Contrary to the common notion that doctors save patients' lives, the experiments conducted by the doctors during World War II were completely unethical.

During the war, German soldiers were exposed to harsh conditions, high altitudes, freezing temperatures etc. So the quest for knowledge to find better ways to manage the German soldiers in these extreme environments was intense. Nazi doctors conducted experiments to ascertain how German military personnel might survive conditions of combat.

About 70 medical research projects were carried out in Nazi concentration camps. Around 200 doctors were posted at the camps. Their job was to select subjects who would participate in these medical experiments initiated by German and Austrian universities and research institutes.

The Jews who arrived by train at Auschwitz were divided into three groups. One group was sent directly to the gas chambers. The second group was used for experimentation and the others were assigned to hard labour. The availability of vulnerable people proved to be the optimum condition for the experiments. Several types of trials such as experiments on twins, head injury tests, Malaria experiments, sterilization and high altitude experiments were conducted. In this session, we will look at the Hypothermia Experiments performed at Dachau concentration camp, presided over by Professor Ernst Holzlohner and Dr. Sigmund Rascher.

Case scenario

During World War II, the German soldiers were ill prepared for the bitter cold. Thousands of German soldiers died of freezing or were debilitated by injuries due to the cold. **The freezing experiments** were divided into two parts. First, to establish how long it would take to lower body temperature to the point of death, and second, how best to resuscitate the frozen victim.

Young healthy Jews or Russians were stripped naked and prepared for the experiment. An insulated probe which measured the drop in body temperature was inserted into the rectum and was held in place by an expandable metal ring. The victim was then placed in a vat of cold water which started to freeze. The second way to freeze victim, was to strap them to a stretcher and place them outside, naked. The extreme winters of Auschwitz made it a natural place for this experiment.

It was learned that most victims lost consciousness and died when their body temperature dropped to 25 degree C. The icy vat method proved to be the fastest way to drop body temperature.

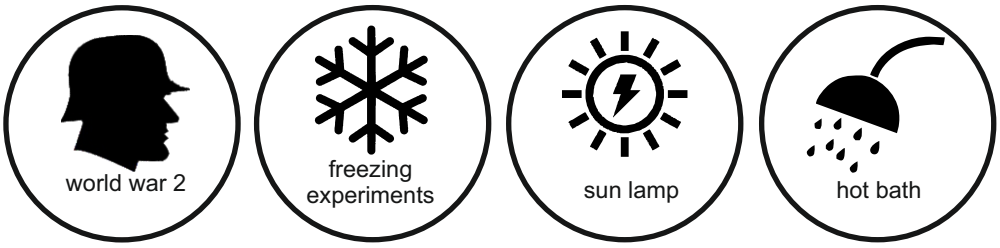
The resuscitation or warming experiments were just as cruel and painful as the freezing experiments.

Sun Lamp: The victims were placed under sun lamps which were so hot that they would burn the skin. One young victim was repeatedly cooled to unconsciousness, then revived with lamps, until he was pouring sweat. He died one evening after several test sessions.

Internal Irrigation: The frozen victim would have water heated to a near blistering temperature forcefully irrigated into the stomach, bladder, and intestines. All victims appeared to have died from the treatment.

Hot Bath: The victim was placed in warm water and the temperature was slowly increased. This method proved to be the best. Many victims died due to shock if they were warmed up too quickly.

[The experiments were conducted under the supervision of Dr. Sigmund Rascherat Birkenau, Dachau and Auschwitz. Dr. Rascher reported directly to Himmler. Dr. Rascher publicized the results of his freezing experiments at the 1942 medical conference entitled '*Medical Problems Arising from Sea and Winter*'].



a. Technical Explanation

b. What are the ethical issues in this case/example?

1. _____

2. _____

3. _____

c. Biblical basis:

Scripture portion: _____

What are the Biblical values/ principles?

1. _____

2. _____

d. Personal applications: (with respect to ethical practice)

1. _____

2. _____

3. _____

FACILITATOR' S NOTES

a. Technical input on the History of Bioethics:

The **Doctors' trial** was the first of 12 trials (Subsequent Nuremberg Trials) for war crimes of German doctors that the U.S authorities held in their occupation zone in Nuremberg, Germany, after the end of World War II. On August 20, 1947, the judges delivered their verdict in the "Doctors' Trial" against Karl Brandt and 22 other doctors who were involved in the human experiments in concentration camps. Following this, over the years, a number of codes, declarations and guidelines have been put forward to protect patients and others who are subjected to clinical research by researchers who are doctors and other Healthcare professionals.

Nuremberg Code 1947
The Nuremberg Code drafted at the end of 'Doctors' trials' has been considered a landmark document in medical and research ethics. It was intended to prevent mistreatment of research subjects as had been practised by Nazi physicians.

Declaration of Helsinki (DoH)1964
The DoH was first adopted at the 1964 WMA General Assembly in Helsinki. Its purpose was to provide guidance to physicians engaged in clinical research, and its main focus was the responsibilities of researchers for the protection of research subjects. The advancement in medical science and the promotion of public health, although recognized as important objectives of medical research, were clearly subordinate to the well-being of individual research subjects.

Belmont Report 1978

The Belmont Report is a report created by the National Commission for the Protection of Human Subjects of Biological and Behavioural Research. The three fundamental ethical principles for using any human subjects for research are Respect for persons, Beneficence and Justice. Applications of these principles to conduct research requires careful consideration of i) informed consent, ii) risks benefit assessment and iii) selection of subjects for research. Today, the Belmont Report continues as an essential reference for institutional review boards (IRBs) that review research proposals involving human subjects.

CIOMS (1982, revised repeatedly)

The Guidelines relate mainly to ethical justification and scientific validity of research, ethical review, informed consent, vulnerability of individuals, groups, communities and populations, women as research subjects, equity regarding burdens and benefits; choice of control in clinical trials, confidentiality, compensation for injury, strengthening of national or local capacity for ethical review, and obligations of sponsors to provide Healthcare services.

Other Guidelines:

- 1980: ICMR - Guidelines and 'Policy Statement on Ethical Considerations involved in research on Human Subjects'.
- 1990s: The Decade of Harmonization.
- 1996: Guidelines of Good Clinical Practice.
- 2000, 2006: ICMR - Ethical Guidelines for Biomedical Research on Human Subjects.

MCI code of Ethics Regulations 2002:

This document gives a detailed account of the duties and responsibilities of the physician in general, duties of physicians to their patients, in consultation, to the public, to the paramedical profession, unethical acts, misconduct, punishment and disciplinary action, and responsibilities of physicians to each other.

b. Ethical issues identified:

Were the research subjects informed and did they consent?

Protecting the autonomy of all people, treating them with dignity and respect, and allowing for informed consent is the responsibility of the principal investigator. The experiments on captives of World War II were far from treating human beings as equals. They were not informed about the research. The unsuspecting people were just assigned to various experiments. They had no choice, but to obey. Informed consent was not obtained from the subjects to be enrolled in the study.

Exploitation of the vulnerable:

The manner in which the Nazi doctors conducted the experiments was horrifying and unethical. The account makes one wonder about the extent of suffering inflicted on the research subjects. The experiments proved that doctors could go to any extent in the pursuit of knowledge or fame. The people were totally deceived. They were forcefully assigned to the various experiments. Vulnerable people were used as a means to develop methods to enable the soldiers survive. Thus, this is a classic example of exploitation of war captives.

Injustice:

It is understandable that when one tries to gain knowledge by doing research, there could be risks. Some risks are predictable, but there could be such that may not be foreseen. So, when great harm such as death takes place, the research ought to be prematurely terminated. However, in the experiment discussed, the end point itself was death. In other words, the study was continued until death occurred. The risk inflicted on the study subjects (death) is not acceptable as proportionate to the benefits – knowledge to enable soldiers to survive. Yes, the desire of the Nazi doctors to find ways of protecting the army was considerate, but not at the cost of gross injustice and severe harm inflicted on the captives to the point of death.

c. Biblical Basis:

Introduction: When God had completed the work of creation and saw all that he had made, it was very good (*Genesis 1: 31*). The *all* includes all of creation, including humankind. He instructed Adam and Eve what they ought to do (*Genesis 1: 28-30*) and what they could eat (*Genesis 2: 16*). He also cautioned them of the consequences of disobedience. Before the Fall, there were perfect relationships between a) God and humankind, b) Man and man c) Humankind and the rest of Creation and d) among the rest of Creation. This harmonious state did not last long.

The Fall: As we read in Genesis 3, humankind chose to disobey God and so resulted the Fall. They acted as if they knew better than God. Being like God was apparently, more attractive than listening to and obeying God. The effect of this disobedience ensured that human identity and all dimensions of human relationships would be marred. The scope of sin was broad. It led to widespread deception, distortion and domination in all forms of human relationships – with God, with one's self (and family), within the community, between others, and with the environment. Thus, the fall has devastating effects not only on Adam and Eve, but also on all humanity and the world.

Effects on relationship with God: The loving relationship between Adam and God was replaced by fear of God and a desire to hide from Him. Innocence and love was replaced with fear and shame (*Genesis 3:7*). Instead of taking responsibility for what he had done, Adam blamed Eve (*Genesis 3:12*). They did not seem to repent or be sorrowful. Consequently, Adam and Eve were sent out of the Garden of Eden (*Genesis 3:23, 24*) – separated from God and altered their relationship with Him.

Effects on human beings: On the physical level, human beings became subject to pain, disease and ageing. A woman's joy in bringing forth new life became mixed with the pangs of childbirth (*Genesis 3:16*). As a result of the fall, all human beings have to experience physical death, resulting in the separation of soul and body. The warning of *Genesis 2:17* was that disobedience would result in death. This means that human life now ends in physical death (*Genesis 3:19*); and beyond that is the prospect of eternal death in terms of punishment by God (*Romans 2:5; Revelation 21:8*).

Effect on the relationship between human beings: The original unity between Adam and Eve was lost: fear, shame and irresponsible behaviour leading to disunity entered their relationship. In other words, they began to experience evil. They were no longer able to be at peace in their nakedness because of lost innocence. They had moved from a state of total love and service towards each other, to one mingled with self-interest and lust. Not wanting to be fully revealed, they made coverings for themselves. As an extension of this, we see conflict, anger, exploitation, scheming, cunningness and the like.

Effect of sin on individuals: The fall (original sin) resulted in a sinful nature among human beings. Though we were created for good works, it became common to see things happening otherwise. The 'original sin' of man, his turning from God-centeredness to self-centredness, meant first and foremost that he no longer looked upon the world and other human beings as precious.

Effects on creation: Paul, writing to the Romans about the Fall, writes in *Romans 8: 20*, "*For the creation was subjected to frustration, not by its own choice, but by the will of the one who subjected it*". Mankind in general, and the whole visible creation lost their original beauty and glory. 'Everything seems perverted from its intended use: the material things are used to further man's rebellion; the heavenly planets and stars give him light by which to work wickedness; the fruits of the earth are sacrificed to his luxury, used without control and as a show off to others; the earth's resources are ransacked for metals, from which arms are made, for public and private murder and revenge; or to gratify his extreme greed, and excite him to fraud, oppression, and war. The animal tribes are subject to pain and death through man's sin, and their sufferings are exceedingly increased by his cruelty, who, instead of a kind master, has become their inhuman butcher and tyrant. Everything is in an unnatural state: the *good* creatures of God *appear evil,* through man's abuse of them; and even the enjoyment originally to be found in them is turned into frustration, bitterness, and disappointment, by his idolatrous love of them, and expectation from them.' (Paraphrased from Benson Commentary)

Conclusion: As a result of the fall, the good creation of God became bent and no longer points at the purpose for which it was created. The impact of the fall was not just on the individual, but on the whole of human society as well. The fall negatively impacted the social, economic, political and religious systems. It brought with it sickness, pain and death. Creation as a whole was cursed by God (*Genesis 3: 14 – 19*). The doctrine of the fall affirms the radical nature of evil. It has made it clear that we or our social institutions cannot be perfected apart from the redeeming work of Jesus Christ and the full coming of the Kingdom of God.

d. Possible applications:

1. How do we show respect to our patients? There exists a power inequality between the doctor and the patient due to disparity caused by knowledge, financial status, position in society, health status, etc. Therefore, it becomes necessary to take additional efforts to treat each patient and his/her attendants with respect, as each one is created in the image of God. Addressing patients appropriately, taking time to listen to their requests/complaints, providing appropriate answers to the questions they might ask, being kind and not being rude, etc., could be some ways of showing respect.

2. Interacting with patients, explaining and engaging with them in the treatment / management plan etc. would be treating them with dignity.

3. In research, it is essential to take informed consent from the patient/guardian before enrolling them for research. The same holds good before performing any intimate examination, procedure/operation, etc.

4. It is important not to inflict harm on patients due to one's own lack of knowledge, incompetence and negligence or quest for research data.

References:

1. Nazi Medical Experiments: https://www.jewishvirtuallibrary.org/jsource/Holocaust/nazi_experiments.html down loaded on 11.5.15
2. Nuremberg Code, The UNITED STATES Holocaust museum memorial museum, [United States Holocaust Memorial Museum note] www.ushmm.org/information/exhibitions/.../nuremberg-code http://en.wikipedia.org/wiki/Belmont_Report
3. Belmont Report at http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html down loaded on 19.5.15
4. Basic Principles of the Belmont at http://www.drexelmed.edu/drexel-pdf/research-clinical/belmont_report.pdfReport.
5. Code of medical ethics, http://www.mciindia.org/
7. Graham Beynon, *An introduction to the Fall and Sin*

MODULE

PROFESSIONALISM

Dr. Roopa Verghese

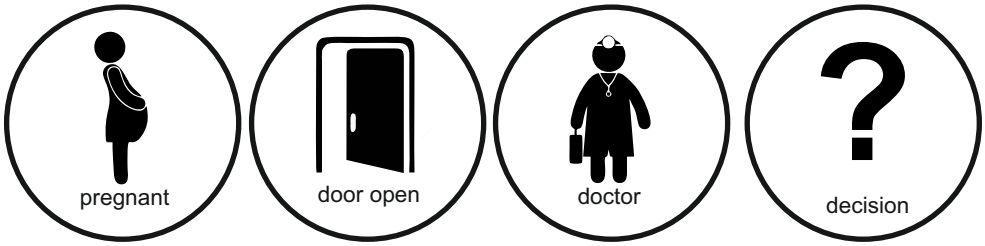
Introduction to the topic:

Professionalism is an essential quality in every worker who displays excellence, skill, and special training in attitude and work. It is good to remember that the opposite of professionalism is “amateurism”, which does not go well with one trained in Medical care! The doctor–patient relationship has been and remains a keystone of care: the medium in which information is gathered, diagnoses and plans are made, compliance is accomplished, healing, patient activation, and support are provided. Since the time of Hippocrates, the relationship between doctors and their patients have received philosophical, sociological, and literary attention. The science of the doctor–patient encounter and relationship can guide decision making in Healthcare plans. Most of the medical encounter is spent in discussions between the practitioner and patient. These discussions function in gathering information, developing and maintaining a therapeutic relationship, and communicating information.

A patient who does not trust or like the practitioner will not efficiently disclose complete information. An anxious patient is unable to clearly comprehend information. The relationship therefore directly determines the quality and completeness of information elicited and understood. It is a major influence on the practitioner and patient satisfaction. It prevents practitioner burnout and turnover, which is the major determinant of compliance. Other important aspects to the relationship include eliciting patients' own explanations of their illness, giving patients information, and involving patients in developing a treatment plan. The doctor–patient relationship is critical for vulnerable patients as they experience a heightened reliance on the physician's competence, skills, and good will. The relationship need not involve a difference in power, but usually does, especially to the degree the patient is vulnerable, or the physician is autocratic. Trust is a fragile state. Deception or other, even minor betrayals, are given weight disproportionate to their occurrence, probably because of the vulnerability of the trusting party.

Case scenario

In the OPD of a small hospital, there was a young pregnant lady who did not want to continue her pregnancy. The senior doctor who had seen her briefly wanted to send her for an urgent appointment for counselling regarding her unwanted pregnancy. However, he asked a young new busy resident to see the patient and to examine her. As the resident was in a hurry, he did not leave the room while the woman was undressing. The examination room had run out of drapes and so he gave the patient a small hand towel to cover her lower abdomen. Then he proceeded to do an internal examination without explaining to the patient what he was about to do. He did not have a chaperone, and when exiting the room, left the examination room door open while the patient was still redressing.



a. Technical Explanation

b. What are the ethical issues in this case/example?

1. _____

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3. _____

c. Biblical basis:

Scripture portion: _____

What are the Biblical values/ principles?

1. _____

2. _____

d. Personal applications: (with respect to ethical practice)

1. _____

2. _____

3. _____

FACILITATOR' S NOTES

a. Technical input on the topic:

Professionalism is a trait that's highly valued in the workforce. It has many attributes, including specialized knowledge, competency, honesty, integrity, respect, accountability, self-regulation and image. Doctor - patient relationships carry an inherent power imbalance, which may place patients in a position of vulnerability. Physicians are responsible for behaving professionally and maintaining appropriate boundaries with patients at all times. It is important to recognize that the lines between appropriate behaviour and boundary crossings are blurred. When the boundaries of the therapeutic relationship are crossed, care givers enter a "grey area" in which the consequences of their action on the patient's well-being may be positive (welcomed supportive touch), neutral (addressing the patient by first name according to his or her request), or negative (holding the patient's hand making her feel uncomfortable and increasing her anxiety). At times, it may be necessary to enter a grey area, but in doing so, there is also a greater risk of harm, exploitation, or other detrimental effects on the patient. Your patients may be from cultures different from your own, and you need to recognize and respect cultural differences. Cultural differences may also influence how professional boundaries are perceived, and so cultural sensitivity may help prevent misunderstandings.

Excessive self-disclosure, giving or accepting inappropriate or elaborate gifts, probing for inappropriate or irrelevant personal information, failing to obtain consent for intimate examinations, or failing to respect a patient's privacy, are all good examples of boundary transgressions and are thought of as intrusive behaviour. The opposite of this could be to keep yourself aloof, and the physician may be labelled under-involved (e.g. formal, cold, distant, dismissive or not empathetic). This can also result in harm and lead to complaints.

In the medical field, the physician should acquire up-to-date knowledge, skills and competence in one's area of function. This is all the more essential because patients are human beings created in the image of God. In the task of restoring a patient's health, utmost care should be exercised to promote health.

b. Ethical issues identified:

1. **Treating the patient with dignity** is of utmost importance. Irrespective of patients' socio economic status, gender or age, each patient and his /her attendant should be treated with dignity. This lady who was trying to do away with her unwanted pregnancy had to subject herself to the required examination. This does not mean that she could be treated in a less respectful or undignified way.

2. **Sanctity of life:** Each person, including the preborn, has intrinsic value. Hence, it is very essential to listen to the issue under consideration. Appropriate counselling should be offered, but not forced on her. While dealing with sensitive issues such as the current one, it is necessary for the doctor to give sufficient time to understand the patient and do the needful.

3. **Informed consent:** For intimate examinations, implied consent should not be assumed. Just because she came to the hospital, it did not mean that she was agreeing to any type of examination. To minimize misunderstandings before the intimate examination, the doctor should adequately and clearly explain to the patient the procedure of the examination, and why it is being performed. Then, with the consent of the patient, the specific examination could be performed.

Privacy: The patient has a right to bodily privacy. It is inappropriate for a male resident or people outside the room to be watching a woman undress and redress in the examination room. Give patients sufficient privacy to undress (and redress). Avoid altering or removing a patient's clothing without express consent. Have a chaperone present during sensitive examinations or procedures. Document any steps taken to minimize a patient's discomfort with an examination or procedure. Any violation of privacy and propriety could be considered as battery, which is punishable by law.

c. Biblical Basis:

1. Our God does all things well. Along with other meanings, this also has the meaning of having done everything in an excellent way. It was 'Good' and 'Very Good'. (*Genesis 1*). His amazing work in creation speaks of one who is thoroughly “professional” or excellent in all that He has done in His infinite wisdom.
   The implication that arises from this is that, created in the 'Image of God', we are to mirror and reflect this excellence in all that we do. Though we are marred by the fall, the standard of excellence is seen through the scriptures as one we are constantly called to aspire to bear. Our practice needs to mirror Him in that excellence, and it is a quality the world needs desperately.

2. A few examples of Professionalism (Excellence) in the Bible.
   It is God who gives the skill. *Exodus 31:6*. In the tabernacle work, “skillful” people are called out, *Exodus 35:10, 25*. Bezalel is spoken of as one filled by God to have characteristics of excellence – 'wisdom in understanding, and in knowledge and in all craftsmanship' (NASB), *Exodus 31:1-5*; 35:30-31: and also to be inventive. In *35:33-35*, God also put it in their hearts to teach and to have skill. In the temple work, we see those who are excellent chosen to do the work. *Proverbs 22:29*: mentions that those who are skilled in work will stand before Kings.
   Joseph and Daniel are singled out and spoken of with great honour as being professional in their work and as having received the promotions with God's help. So professionalism is a characteristic that God would want us to emulate.

3. An important Biblical mandate we have is the commandment, '*Therefore you are to be perfect, as your heavenly Father is perfect*, *Mathew* 5:48. Excellence in our lifestyle, relationship and work is mandated for every follower of Jesus. We are to be salt and light so as to be His representatives or ambassadors. What a privilege to represent the Kingdom of God in our offices, consultation rooms, wards, operation theatres, etc.!

4. We are called to do everything as '*unto the Lord',. Colossians 3:23*. *'Whatever you do, do your work heartily, as for the Lord rather than for men*'. The motivation of doing all our work as unto the Lord releases us to be pursuing excellency. We know that He is watching over all that we do and so the presence of the Lord in our work place is a reminder to be truly professional by being faithful and excellent! We are not working as unto the patient but unto the Lord.

The Biblical understanding that our 'work is also worship' unto the Lord is not fully understood by most. *Romans 12:1-2* teaches us that presenting ourselves to God is our 'spiritual service of worship'. This encompasses all of our workplaces too! All our decisions, procedures, labour in caring for others, takes on a new meaning when we see that it can be presented back to God as our worship.

d. Possible applications:

1. Treat all patients and their attendants with dignity. It is almost considered normal to treat the wealthy, the educated and the influential with dignity, and the poor as belonging to the lower strata of society. So, every effort should be made to uphold the dignity of all, especially the poor and marginalised.

2. Treat colleagues and others in the team with respect. Unity among the Healthcare team is essential for the welfare of patients. If there are differences in opinion about a treatment etc., such matters ought to be discussed privately, and not in front of the patient.

3. Though you may not agree with the decisions of the patients, continue to show concern and care. Patients at times may not seem to accept your suggestions. But this does not permit one to neglect the patient.

4. When there is a need to examine a patient, have a chaperone especially if the patient is of the opposite sex. If a staff is not available, the patient's attendant could be a good substitute.

5. Be kind and polite to everyone, presenting a professional image in your attitude and dress, and showing up for work or meetings fully prepared and on time.

6. In Healthcare, professionalism is a combination of patient centeredness & communication skills; medical knowledge, clinical skills & competence; maintaining appropriate doctor-patient relationship & etiquette. It is not easy to demonstrate such a demanding combination and so such qualities have to be cultivated.

References:

1. Siegler, Mark. "Training doctors for professionalism: some lessons from teaching clinical medical ethics." *The Mount Sinai Journal of Medicine, New York* 69.6 (2002): 404-409.
2. Thompson, Lindsay A., et al. "The intersection of online social networking with medical professionalism." *Journal of general internal medicine* 23.7 (2008): 954-957.
3. Ludmerer, Kenneth M. "Instilling professionalism in medical education." *Jama* 282.9 (1999): 881-882

MODULE

ART OF CARING

Dr. Roopa Verghese

Introduction to the topic:

Practicing medicine ethically and compassionately is complex by its very nature. The task of fine-tuning our own internal code of ethics is a life-long process. Established standards in medical ethics can help working professionals manage any number of thorny issues. For instance, patients are vulnerable by definition, and this can create an imbalance of power in the physician-patient relationship. As advances in medical science continually pose ethical questions, these professional guidelines may seem to address larger moral issues. Healthcare practitioners must continually strive not only to facilitate cure, but to offer care –compassionate care.

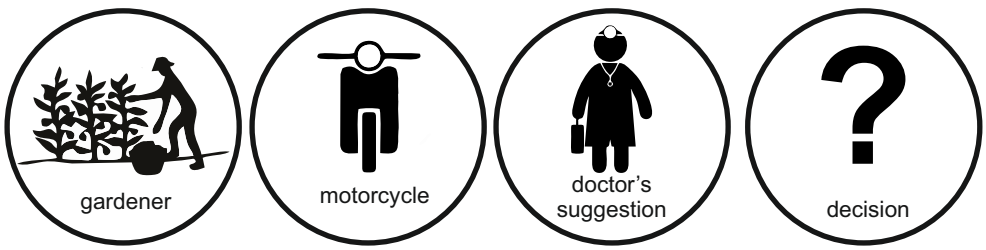
A worried mother may insist on your undivided attention to her child alone, when there are several other patients waiting for you. A compassionate listening ear could give you insights which you could have missed. Perhaps your understanding of the lady that a sibling of this child died earlier could enable you to be caring and patient with her. In the midst of demands of patients, pressure to generate income for the hospital, and other personal concerns, how do you love your neighbors - patients and their attendants?

Case scenario

Our gardener wanted to discuss his wife's illness. She was recently diagnosed to have germ cell cancer of the ovary at a local hospital. Chemotherapy was advised, the cost of which would run from tens of thousands to several lakhs of rupees. He wanted to know what he should do.

The gardener has two small children. He works in a factory. In order to earn a little more, he engaged in gardening. Recently he purchased a motorcycle so that he could reach more customers in the time available in the evenings. He told us that he did not have much savings, but thought that he could raise some funds by selling off his motorcycle. He had discussed his financial situation with the social worker in the public hospital, who told him that he would be eligible for some financial relief, but would still be responsible for the major portion of the cost. The local doctor had told him that his wife could be admitted for treatment when the money was ready.

He now comes to you for advice as he knows that you are a Christian doctor who has been practicing and helping people for several years.



a. Technical Explanation

b. What are the ethical issues in this case/example?

1. _____

2. _____

3. _____

c. Biblical basis:

Scripture portion: _____

What are the Biblical values/ principles?

1. _____

2. _____

d. Personal applications: (with respect to ethical practice)

1. _____

2. _____

3. _____

FACILITATOR' S NOTES

a. Technical explanation of the topic

Cancer, also known as a malignant tumour, is a group of diseases involving abnormal cell growth with the potential to invade or spread to other parts of the body. Not all tumours are cancerous; benign tumours do not spread to other parts of the body. Possible signs and symptoms include: a new lump, abnormal bleeding, a prolonged cough, unexplained weight loss, and a change in bowel movements, among others. While these symptoms may indicate cancer, they may also occur due to other causes. There are over a hundred different known cancers that affect humans. Some of these grow faster than the others. The treatment offered could be surgical removal of the tumour, radio therapy, chemo therapy, or a combination of these, according to the response of the tumour to the treatment.

Cancer is a complex disease. There are several diagnostic and screening tests that are used to detect cancer. While early detection is useful for the patient, needless investigations and false positive results may raise anxiety in the patient and their families unnecessarily. These may lead to severe mental agony and other ill effects on the patient as well.

In order to tackle cancer, one requires an appropriate infrastructural support and evaluation within a multidisciplinary approach by skilled professionals. Cancer care is fraught with several ethical issues. There are dilemmas in diagnosis, extent of patient information, planning treatment and follow up. These issues often concern doctors in their day-to-day practice.

Approaching patients with cancer is not an easy task in clinical practice, because it involves communicating medical information about the diagnosis, prognosis, risks and benefits of treatment, in addition to the possibility of disease progression. In such circumstances, the process of delivering bad news to patients is challenging, difficult and is the sole responsibility of the physician.

Communication of information about prognosis is vital particularly when the prognosis is very poor and the patient would want to avoid thinking about death. Moreover, assimilation of the information given by the physician and how patients experience their disease vary widely from one patient to another. So how one *communicates* the content of the medical information is important. In order to communicate effectively, understanding the pathological, psychosocial, anthropological, and socio-cultural aspects of the disease is essential. In addition to these, giving a listening ear to the patient and his/her attendant will go a long way in caring for the patient.

b. Ethical Issues identified:

Troubled communication between the patient and Healthcare team is more evident while working with patients with advanced cancer as compared to early-stage cancer cases. The aspect that draws the most attention is the vulnerability of the patient to the content of communication. There is a power inequality between the Healthcare team and the patient.

1. Extent of patient information:

Revealing the diagnosis and its outcome to the patient has been an ethical challenge from time immemorial. Once diagnosed, questions arise over the extent of information to be given to the patient regarding the spread and possible outcome of the disease. Some patients may prefer to have the truth in black and white but others may wish to be shielded about the extent of spread of the cancer. Interacting with the patient could help understand to what extent one wants to know about the disease, treatment options etc. While sufficient information has to be given to make informed decisions, one has to be careful not to give too much information at a time.

2. Treatment options:

Many patients may be unwilling to undergo certain treatment modalities. For example, a breast cancer patient may wish to retain her breasts and not lose them to surgery. Some patients may refuse chemotherapy due to the fear of its severe adverse effects like hair loss, nausea and susceptibility to infections. When patients refuse treatment that could be beneficial, or demand that which is futile, a caring attitude of the Healthcare professional could be helpful to enable the patient deal with the situation. Patients have ultimate control over their own bodies. Refusal or acceptance of treatments rests with the patient, even if it is contrary to your professional opinion. The physician's responsibility is to provide patients with the information necessary to make an informed decision, even though the decision they make may not be medically sound. Similarly, use or choice of alternative treatment which could play a supportive role is something that can be tried.

3. Best interest of patient:

Physicians should try to improve each patient's health to the best of their ability, recognizing that what is good for one patient may not be good for another. This means cultivating an awareness of each patient's ability to manage pain, illness, and suffering, and with that, comprehending the impact their decisions may have on the patient's quality of life. In the case under consideration, one has to weigh how to care for this lady without depleting all her resources.

4. End of life issues:

'Do Not Resuscitate' orders and life prolonging interventions are other issues to be considered. One's perception of these could be related to the patient's personality, religion, culture, socioeconomic status, personal, and family life. So, when the prognosis is very poor, it would be appropriate to discuss these in advance with the patient and the family when the patient is in a good frame of mind. This could bring clarity to the patient, his/her family and to the treating doctors.

5. Palliative care:

If the patient wants withdrawal from active treatment which is another major ethical issue, this could be the patient's own choice or due to non-responsiveness of the cancer to therapy. In such situations, palliative care could be offered enabling the patient to be without pain and discomfort. Dying patients usually will not be severely harmed if they become dependent on drugs used in dosages adequate to relieve their pain. Hence, they may take the drugs and need not be concerned about becoming addicted to them. And while it is wrong for dying patients to hasten death deliberately, they need not refuse drugs to relieve their pain, even if they foresee side effects which could shorten life.

Religious and spiritual beliefs and practices are important in the lives of many patients, yet medical students, residents and physicians are often uncertain about whether, when, or how, to address spiritual or religious issues. The training in Medical institutions is limited to diagnosis and treatment of diseases and not on how to relate to the social and/or spiritual side of the patient. Palliative care includes addressing these issues also, so that staff facilitate setting right relationships with their loved ones and their Creator.

c. Biblical Basis:

1. One of the earliest questions God asked man was, "*where is your brother* ?" One of the implications of this encounter was that I am my brother's keeper! Our biblical understanding of 'caring' needs to be underlined by the fact that it is God's will that I care, and I am responsible for my fellow human being.

2. In *Genesis 9:6*, we are given the reason why we are not to take life, 'for in the image of God He made man'. This has to form the basis of our decision making in critical areas of care. When we look at the commandment that forbids murder (*Genesis 20:13*), we have to see this in a much larger framework of not just negating life, but to be involved in all actions that affirm life and promote it to its maximum. Those who do not see a purpose and value in human life also have no motivation to save them or care for them. This addresses issues like palliative care, euthanasia, abortion, etc. Mother Teresa is an example of one who saw an intrinsic value in caring because the biblical message challenged her to do so.

3. The many Old Testament injunctions to take care of the poor, alien, widows and orphans express commands to take care of the vulnerable in society who needs our special care. The laws of the Sabbath year and Jubilee are all expressions of the heart of God for the suffering (*Leviticus 19:9-10; 23:22.*) Our God is concerned and cares, and He demands that His people express that same concern too.

4. The prophets speak even more deeply about caring for our fellow beings. *Amos 5:15, 24* and *Micah 6:8-9* are two representative passages among many, where God castigates the people of Israel for their lack of concern and care for others. In fact, many of the prophetic passages reduce one's spirituality to the way one treats one's fellow beings. This is a yardstick to measure the condition of the inner heart.

5. The incarnation is a prime reason we are to be involved in care. In 'God becoming flesh', we have the motivation to be involved in ameliorating the suffering and pain of others. If He came to take away our sorrows and diseases, then we are called to do the same.

6. In the life of Jesus, our model, we see that he had 'compassion on the people' and acted on it. The sacrificial love demonstrated to us by Jesus on the cross, is the greatest biblical motive for us to care. *John 13: 14* clearly demonstrates to us that we are called to wash one another's feet and care for one another.

7. The Christian church, true to its calling, has been faithful in the past in this field. Long before the medical profession became something to be aspired for in society, the followers of Jesus were involved in this great service, because they understood it to be a central part of the calling. So, in periods when there was no monetary value in this amazing field of service, we find scores of witnesses who have laid down their lives in caring, and continue to do so.

d. Possible applications:

1. Maintaining a patient's autonomy in the decisions on treatment is important. We need to help them out with the fear of the unknown by enabling them to meet people who have undergone the same. This will help them make decisions.

2. Most ethical issues need to be resolved using a high degree of sensitivity and very good communication skills on the part of the Healthcare team.

3. Medical treatment can be very costly. "Cost" can mean the use of scarce resources of patients or their families, of particular treatment systems, or of societies at large. At each level, choices must be made, and at some point at which it becomes clearly unfair to others to accept or to continue treatment, the issue of cost can be taken as reasonable factor to limit it.

4. Some medical treatment can be too damaging to one's bodily self and functioning. For example, a woman who hopes to have a child might not consent to a recommended hysterectomy. Again, a cancer patient might refuse chemotherapy because of its side effects on various bodily functions.

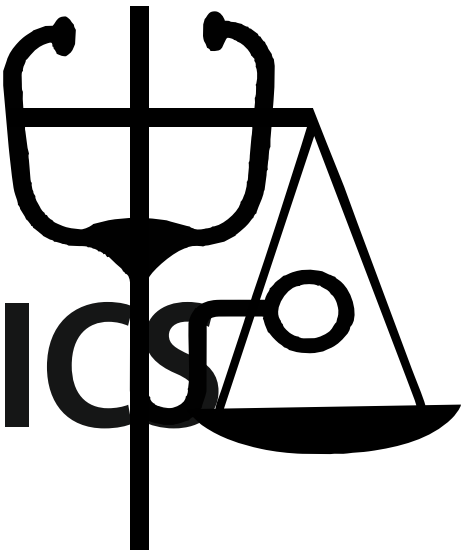
5. Medical treatment can be painful. Courageous patients patiently endure some pain, but reasonably draw a line. Palliative care could be offered when cure is not foreseeable.

References:

1. Orr, Robert D., and Wayne Shelton. "*A process and format for clinical ethics consultation*." (2009). Pellegrino, Edmund D. "*For the patient's good: The restoration of beneficence in health care*." (1988). *Biomedical ethics*. Boston: McGraw-Hill, 2001.

2. Oden, Thomas C. *Should Treatment Be Terminated? Moral Guidelines for Christian Families and Pastors* (New York: Harper and Row, 1976).

MODULE



WORK ETHICS

Dr. Mitra Dhanraj

Introduction to the topic:

The importance of a medical student evolving into a physician with values crucial for humanity cannot be over emphasized. Healthcare is an ethically driven science. Hard work and diligence play a major role in a medical student becoming a care giver with high moral ideals and good academic standards, as one would be responsible for human life and human dignity. The objective of this module is to enable students understand work ethics.

"*Work ethic is a value, based on hard work and diligence*"- Wikipedia. Work ethic is a set of moral principles an employee uses in his job. It also includes a person's attitudes, feelings and beliefs about work. People who possess a strong work ethic embody certain principles that guide their work behavior, leading them to produce high-quality work consistently and without the prodding that some individuals require to stay on track. A strong work ethic - one that encompasses a positive and productive approach to work - is favored in the work force.

Students will have to train themselves and understand that certain aspects of work ethics such as honesty, accountability, dependability, discipline and diligence would help them manage life saving situations in the future by their very act. As a medical student a great opportunity, resource and time are given. What are you going to do with them?

Case scenarios:

Example 1

A medical officer is posted in the casualty. At about midday, his friend whom he has not seen for some time comes, and both of them go out for lunch. The doctor informs the nurse that he is going to see some patients in the ward.

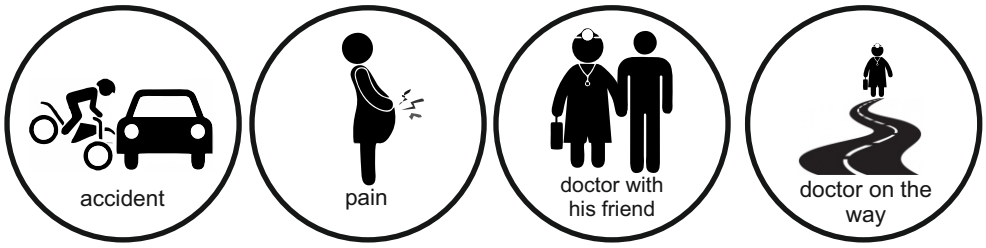
A person who has been in a Road Traffic Accident has been brought in bleeding. Immediately the nurse calls the doctor, who informs her that he is busy with another patient in the ward, whereas in reality, he is with his friend. By the time he returns, the patient's condition has deteriorated.

Example 2

A patient is in labour. The day duty hours of the doctor in the labour room is from 8 am to 4 pm. At 8:30 am, the night duty doctor called the day duty doctor to find out at what time she would come. The day duty doctor replied that she was on the way to the labour room and that the night duty doctor could leave. In reality, the day duty doctor had not yet reached the hospital.

Suddenly the baby of a lady in labour had difficulty and needed to be delivered immediately. The doctors not being present had resulted in serious complications to the baby.

Even though what is mentioned here is a hypothetical scenario it happens so often and we see a lot of incidences reported. There is a duty roster displayed on the notice board month after month, but often there are no doctors in the casualty.



a. Technical Explanation

b. What are the ethical issues in this case/example?

1. _____

2. _____

3. _____

c. Biblical basis:

Scripture portion: _____

What are the Biblical values/ principles?

1. _____

2. _____

d. Personal applications: (with respect to ethical practice)

1. _____

2. _____

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FACILITATOR' S NOTES

a. Technical input on the topic:

Various codes and guidelines are available to promote high standards of work ethics among Health care professionals. The medical code of ethics evolved from the Hippocrates Oath of the 5th century. Oddly enough, it starts with the responsibility of the medical student. The responsibility may be different, but they do have a duty towards patients.

Declaration of Geneva of the World Medical Association: (adopted 1948, amended 1966 and 1983) states, "*I solemnly pledge myself to consecrate my life to the service of Humanity*".

The Medical Council of India (MCI) Code of ethics regulation was published in Gazette in the year 2002 and was amended in 2009, where every doctor is required to sign a declaration. In these declarations, every doctor is required to sign that they will maintain high levels of work ethics which is based on respect to patients, peers and teachers, work with honesty and integrity, take responsibility and work with diligence and discipline for the community to achieve the goal, which is the well being of humanity.

General Medical Council (U.K) and the Medical Schools Council developed guidance for Medical students on professional values.

These guidance include:

1. Developing the skills and behaviour necessary for the provision of good clinical care,
2. Ensuring a commitment to maintaining knowledge and skills on a life-long basis,
3. Engaging constructively with teaching, training, assessing and appraising,
4. Developing the skills necessary to develop and maintain strong professional relationships with patients,
5. Being able to work effectively and constructively with colleagues inside and outside of Healthcare,
6. Acting with honesty and integrity.

b. Ethical issues identified

In the first example, we find that the doctor concerned lacked a sense of responsibility, had wrong priorities and was dishonest. In the second case also, it appears that the doctor on day duty was dishonest. The concept of team work did not exist. The night duty doctor should have stayed back and taken care of the situation until the arrival of the day duty doctor. We see a lack of responsibility and accountability, lack of punctuality and dishonesty.

The behavior of doctors in both the examples, point to the fact that the patients were not treated with dignity and respect. Their way of functioning did not favor the best interest of the patients. Lack of commitment to the task was very evident. Moreover, there was lack of respect for peers and authority. In both the cases, quality of Healthcare was poor because of lack of work ethics.

c. Biblical Basis:

What is Christian work ethic?

1. God instituted work: *Genesis 2:15*

"*The Lord God took the man and put him in the Garden of Eden to work it and take care of it*". God gives a task to Adam - the responsibility of taking care of the garden of Eden, and expects him to work hard on it. Work was instituted before the fall. God is at work. The creation story gives us a vivid picture of how God created everything one by one.

The character of God is the basis of Christian work ethics.

- **Holiness** = Integrity
- **Justice** = Fairness
- **Love** = Compassion

- Holiness – Being honest, accountable to teachers and authorities, and understand that they are being trained for the welfare of the community with certain sacrifices.
- Justice – Being fair in all dealings with patients, not taking more interest in some patients and neglecting others. Being impartial in administering limited resources.
- Love – Compassion, Empathy – feeling that comes from putting oneself in another's place. Self-sacrifice – be willing to give up our rights out of respect and concern for the welfare of others.

2. Accountability: *Matthew: 25: 14-30 & Luke 19: 12-28*

The word accountability means to be held accountable, liable, answerable, or be held responsible for what a person has been given. In these two passages, we find Jesus giving an example of a master entrusting his servants with opportunity, time and resources. Two were good stewards and used their talents wisely while the third was a poor steward.

We are accountable to God and stewards of the gifts He has given us. "Obey in everything those who are your earthly masters, not by way of eye-service, as people-pleasers, but with sincerity of heart, fearing the Lord", Colossians 3:22. In other words, don't just start looking busy when the boss is watching, but even when he isn't, for God is always watching.

3. Hard work and diligence: *Ecclesiastes 9:10*

"*Whatever your hand finds to do, do it with all your might*." *Colossians 3:23-24* "*Whatever you do, work heartily, as for the Lord and not for men, knowing that from the Lord you will receive the inheritance as your reward. You are serving the Lord Jesus Christ*."

In essence, this is Christian work ethic. We are commanded to put forth our best efforts, to work from our heart and soul. Our work flows out of our gratefulness to Him. We work for God and not just for our employer. Ultimately, God will reward us, if not in this life, surely in the life to come. Wherever God has placed us, it is a holy vocation and not just a job.

d. Possible applications:

1. Discipline

In the Indian scenario, students come straight out of school. Most of them experience freedom from parental pressures and discover new kinds of social life. As a result, there could be conflicts between social and academic demands. So it becomes necessary to be disciplined in:

- Preparing a personal academic schedule.
- Being on time for classes and clinics.
- Planning time with peers and teachers for discussions.
- Planning for rest and relaxation.

2. Hard work and diligence:

Till the day you entered into medical college, it was only a dream. What you did not bargain for is the hardest period of your life. It involves early rising to run to the hospital for classes and rounds, late nights of non-stop preparation for assessments, no time for favorite TV shows, sports or to relax in a restaurant. As a Health care professional, it is a life time of hard work and commitment.

3. Punctuality:

Punctuality is a form of reverence that respects another's time and one that acts quickly when God and others call on us. This shows that you care and respect others. It is realizing that time is important; the time of others is valuable. Lateness, tardiness, hindering others and procrastination are not acceptable.

Medical students and young doctors should remind themselves that punctuality is important during the time of learning. Healthcare is team work. Better results are obtained when there is a good team. Tardiness and lack of punctuality will affect the team, and at times it may lead to poor or undesirable outcomes for our patients. Every effort should be made to exercise self discipline in order to be on time.

4. Honesty and integrity:

Among students there is a trend to take 'bit' during the examination. It is tempting to take a few short cuts. 'This one time I will party and take my friend's help'- but these will add up and you may lose your focus. When a student lacks commitment and is not focused, the stress and pressure of being a medical student can result in various problems such as drug or alcohol abuse, absenteeism etc. Commitment to God and to the career are crucial elements to stay focused to be a successful student and doctor. There are no short cuts to becoming an efficient doctor. Honesty and integrity have to be inculcated.

5. Dependability:

How dependable are you? To what extent can you be trusted with your responsibilities? Carrying out responsibilities to the best of one’s ability in a timely manner will make one dependable. This could mean going the extra mile. To become responsible persons, students must learn to develop the trust of patients. Students should aim to develop trust also among co-workers, as team work is important when treating patients. Students should learn to develop a good rapport with their co-workers, teachers and peers, to effectively function as care givers. An important component to develop trust is to learn to communicate well with patients and colleagues. They should also learn professional boundaries.

6. Accountability

Students should understand the fact that each health care giver is accountable for their patients' safety. Each of us is given 'patients' and the responsibility of taking care of them. We need to be disciplined in planning for the best outcome and work hard towards reaching the target.

Students should bear in mind that there are limits to their competence, training and skills. They should be humble enough to acknowledge the expertise and experience of teachers, be courageous to accept one's ignorance and inexperience, and ask for help so that they learn more. Do not experiment on patients.

Accountability is not only in patient care, but also for reading, attending clinics, preparation and submission of assessments on time. We are not only accountable to authorities or superiors, but every Christian doctor is also accountable to Jesus, who is our role model.

References:

1. *The Bible*
2. Amelia Jenkins, *5 Factors That Demonstrate a Strong Work Ethic* Demand Media
3. Erin Schreiner, *Five Characteristics of a Good Work Ethic* Demand Media
   http://smallbusiness.chron.com/five-characteristics-good-work-ethic-10382.html
4. *The Character of Punctuality* By Dr. Richard J. Krejcir
5. 5http://www.apttoteach.org/Theology/Humanity/pdf/403_Work_ethics.pdf
6. http://www.gotquestions.org/Christian-work-ethic.html
7. http://bma.org.uk/practical-support-at-work/ethics/medical-students-ethics-tool-kit
8. http://www.gotquestions.org/Christian-work-ethic
9. http://bible.knowing-jesus.com/topics/ethics
10. www.cehat.org/rthc
11. Jack Well, *Top 7 Bible Verses About Work, Work Ethic or Employment May 8, 2014*
12. Jack Wellman, *Top 7 Bible Verses About Accountability August 16, 2014*

MODULE

INTEGRITY IN HEALTHCARE

Dr. Sedevi Angami

Introduction to the topic:

There was a time when those who provided Healthcare were viewed as belonging to a noble profession. Unfortunately, it no more stands true . Today's Healthcare scenario in the country is a very complex one. Healthcare is now considered an industry that is recession proof. Health tourism has come to stay. The era of consumerism and disposables have led to medical treatment becoming a commodity, and patients or 'clients' are viewed as part of the profit making business of Healthcare.

More investigations to meet targets, referrals to diagnostic centres or hospitals to acquire commissions, organ trade, unnecessary surgeries, capitation fees cloaked as donations for medical college seats, false certificates to realise insurance money, foreign trips to exotic places sponsored by the pharma industry and abortion clinics, are just some of the practices that have become commonplace and often accepted by the medical profession.

Trust in the medical profession is at an all-time low. This has led to litigation by patients and relatives and in turn, the practice of defensive medicine by physicians to protect themselves, thereby hurting the poor and vulnerable the most.

Is there a way out of this spiralling trap that we have let ourselves into?

Case scenario:

Dr Shyam has been practicing medicine in a private clinic in a small city for the last 5 years. He has been frequented by medical representatives almost daily to introduce their products. They usually give him a lot of reading material and some gifts. Of late, they have been offering him free trips to professional conferences. These conferences are organised by famous clinicians and are very useful for updating his knowledge. They also translate into better care for some of his patients. Since he does not get much time to update himself on current practices and does not have an institution to back him up, he is grateful to avail of this opportunity.

He feels that there is nothing wrong in accepting these offers since his patients are helped by the added knowledge and he is not hurting anybody in the process. All his colleagues are alright with the practice.

Of late, he is inclined to demand more from medical representatives as he hears of his colleagues receiving laptops, fridges and microwave ovens from pharmaceuticals, for prescribing their products. Considering the number of years invested in studying medicine, he compares himself to other professionals and those much less qualified, but earning a lot more than him. He feels this is an opportunity to become financially equal with his colleagues

He is at peace with his conscience and considers himself a law abiding citizen of the country.

a. Technical Explanation

b. What are the ethical issues in this case/example?

1. _____

2. _____

3. _____

c. Biblical basis:

Scripture portion: _____

What are the Biblical values/ principles?

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2. _____

d. Personal applications: (with respect to ethical practice)

1. _____

2. _____

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FACILITATOR'S NOTES

a. Technical input on the topic:

The roles of physicians have evolved over time. The Pythagoreans of ancient Greece had a heightened sense of duty and nobility as they practiced medicine. Hippocrates, the most famous physician of ancient times, introduced the oath which outlined the practice of medicine in relationship to God, patients, colleagues and teachers. Physicians were to live a life of purity and holiness before God, exercise propriety towards to patients and the opposite sex, respect their teachers, never do harm, take life or perform an abortion, and consider the practice of medicine a sacred art, to be guarded with honour.

This code of medical ethics has been revised, modified or even expanded several times over. The Medical Council of India has its own version of the code of ethics, which leaves out portions of the original code that was felt irrelevant or controversial. It is still a useful standard to refer to.

Ancient India had the Charaka and Susruta Samhita treatises on medicine and surgery. According to this, a physician's work (treatment) could bring about healing to the physical body and mental condition of a patient. Also it could enhance spirituality from the existing status to greater heights.

The Charaka Samhita has an oath that consists of striving relentlessly to relieve the suffering of a patient, even at the expense of the physician's comfort. It spoke of propriety in entering patients' homes, reverential examination of women, diligent study of the art of healing; politeness, gentleness, modesty and truthfulness in behavior. It also had some aspects of passive Euthanasia, like not attempting to treat patients who had fatal diseases.

Proper communication was stressed upon. They were also encouraged to maintain confidentiality. Where it differed from the Judeo-Christian tradition was that enemies of the king or outlaws were not to be treated. The work of a physician fulfilled three main purposes of life as revealed in the Upanishads; religious duty, attainment of pleasure and achievement of wealth. The Indian physician was encouraged to live a life of asceticism and have a teacher student relationship akin to a father – son relationship.

Ancient China too had its share of Ethical medicine in the form of Confucianism and Taoism, where physicians were exhorted to practice their art conscientiously, politely, compassionately, without seeking profit or personal gain and without discrimination.

A physician was once considered a family friend who would visit patients in their homes, a counselor to the family on issues beyond medicine, attend family functions, becoming an integral part of the family unit.

In the recent past, technology has been introduced between the patient and the physician while the divine presence has been pushed to the side-lines and invoked only whenever everything fails, almost as an afterthought. Pushing God away has also removed from the scene the only truly objective and absolute standard of morality by which we can judge our actions and decisions.

Consumerism has created an entirely new world-view whereby everything we interact with; be it humans, materials or structures, are considered commodities to be used and has a price to its head.

In this bewildering scenario, we are now faced with the task of reconstructing an ethical world-view of practicing medicine that needs to draw from our ancient heritage but most importantly from biblical principles, our final and absolute measure.

b. Ethical issues identified:

One would assume that as physicians relate with patients and practice their art, they follow a hidden law within their hearts a code of conduct or a value system that they firmly believe to be true, practical and profitable for growth. This becomes the framework from which all that relates to us is perceived and acted upon. Depending upon which school of ethics theory we prefer, Dr Shyam could justify his actions from a list of possible frameworks.

The self-interest theory or ethical egoism is a consequentialist concept whereby a person is encouraged to pursue his/her own interest as long as the consequences are good for the person. Much of what we consider as unethical practice arises from this concept.

A more elevated form is of Utilitarianism - one which states, 'a person ought to act so as to produce the greatest balance of good over evil, everyone considered'. This is situation dependent and requires a tremendous amount of calculation in order to maximize utility.

Deontology is an approach to ethics that focuses on the rightness or wrongness of actions themselves. It judges the morality of an action based on the action's adherence to a rule or rules.It emphasizes the Golden rule – 'Do unto others as you would have them do unto you'.

Moral reasoning involves using reasoning to individually or collectively figure out morally, what one ought to do. Religious ethics emphasizes a set of rules or principles that are given by God through a book or other means, whereby solutions to various problems can be derived.

Today's world is one of moral relativism, which claims that there are no absolute morals. So, whatever one finds practical and functional is valid, as long as it does not interfere or cause too much of harm to another person's interests. It stems from the understanding that there are no real foundations for morality, and that every generation must carve out its own rules, depending upon the place and manner they are raised.

c. Biblical Basis:

1. Integrity is linked to being truthful. The root meaning has to do with 'wholeness', something whole and not broken. It has the idea of fullness and being true to itself/ oneself. Biblical witness throughout the scriptures calls upon the people of God to be a true reflection of God, who is 'Holy'. Be ye Holy as I am Holy is a biblical command which sets the moral standard for a Christian.

   Integrity is revealed when one takes full responsibility for his/her actions. Integrity means being

   incorruptible. It is an important principle in Healthcare practice. Pretending to be truthful shows lack of integrity. Jesus addressed such as 'hypocrites'. Our words and our lives should not be different, but should be identical.

2. The Ten Commandments call us to not give false witness. This implies that we are to be truthful witnesses, bearers of truth in all that we say, do, and live by. We are to reflect God our Father, in whose image we are created and for whose glory we exist.

3. The amazing examples of those who walked with God in the Old Testament talk to us of those who walked in integrity. The Scriptures do not hide their weaknesses and failures but commends those who walked with integrity. e.g. Job, David (*1 Kings 9:4-5*).

4. The book of Proverbs has many verses addressing this subject. *Proverbs 2:20-21*; *11:3; 20:7; 28:18*. Proverbs declares that wisdom will lead us to live with integrity and has its rewards. The foolish ones will walk in their own way and will be destroyed. The person who walks in integrity can live with a clear conscience and without fear. The one who does not walk in integrity will be exposed. *11:3*.

5. The example of Jesus is our basis for a truthful life. He is the best example of wholeness/integrity and one who lived a truthful life. In fact 'He is the Truth' *John 14:6*, and when we are called to be people of integrity, we are being called to be followers of Jesus - those who walk in His footsteps.

6. To be able to walk in integrity, God has bestowed us with a conscience. 1 *Peter 3:16* exhorts us to keep a clear conscience, implying that it will help us walk in the right way.

7. *Ephesians 4:15* has the phrase 'speaking the truth in love'. This phrase in Greek actually translates 'truthing in love'! We are to be truthful in our words, actions, thoughts, decisions, work, etc. But we also have to do it in love. There has to be wholeness, a balance in the way we walk as people of integrity. It is not just a dry assent to truth or a legalistic approach to telling the truth. It has to be covered with love and understanding. This is so true of medical practice where everything is not so easy to handle and decide. Being disciples of integrity means we are to be those who handle the truth in an understanding way, concerned about the well- being of the patient and maintaining a balance in all of it.

d. Possible applications:

1. The Healthcare industry has a way of justifying its actions. We need to be first aware of the deceitfulness of our hearts when we get involved with the process of interacting with complex scenarios that it throws our way (*Jer. 17:9-10*).

2. As temptations come our way, we need to be single minded – seek first the kingdom of God and His righteousness (*Matt 6:33*), realising that whatever looks like gain is actually worthless compared to the affirmation of Christ. Our treasure will need to be defined, for there our heart's desire exists (*Matt 6:21*) and the motives that determine our actions.

3. As a body of believing Christians, we need to support each other, especially those who are weak and not condemn those who fall. We should rather develop alternative mechanisms within Christian Institutions, to ensure that a viable alternative is provided to our members to be self-sufficient in academic knowledge and skills. A pooling and sharing of resources is required in the Christian medical world.

4. Capacity building by the corporate body of Christians is essential to empower physicians to understand the dynamics of the degeneration that is eating into our ethical foundations.

5. Being the salt and light of the world will involve bringing to light the corrupt practices of our profession, showing the long term impact of such practices, actively engaging with our professional society and appealing to its conscience.

6. The alternative of Christ centred medicine needs to be emphasized as a workable counterculture.

References:

1. Jonsen, A. R. *A Short History of Medical Ethics,* 2000. Oxford University Press

2. Degrazia, David, Mappes A Thomas, Brand- Ballard Jeffrey. *Biomedical Ethics (Seventh Edition)* 2011, Mcgraw Hill.

3. Deontological ethics - https://en.wikipedia.org/wiki/Deontological_ethics The basics of philosophy, http://www.philosophybasics.com/branch_deontology.html

MODULE

BEGINNING OF LIFE

Dr. Achamma Chandy & Dr. Jameela George

Introduction to the topic:

In India it is estimated that there are 50-60,00,000 abortions performed each year. The actual figures are not known. Though abortion was practised for ages, it was legalised in India in 1972. There are 12,510 approved MTP centres. In addition to these, there are thousands more said to be functional. Female foeticide is rampant, causing skewed child sex ratio. The fact is that each abortion involves the destruction of a human life. Unfortunately, in the present century, many a times, abortion is considered an escape route. An abortion could cause physical, mental and spiritual consequences. But, many a time, it is done without giving serious thought to the fact that a child that is formed is prevented from being born.

In the last twenty years, Reproductive Medicine has made stunning progress in treating infertility. A variety of new, expensive and sophisticated techniques now enable couples to procreate. Infertility physicians have given the 'gift of life' to couples who had essentially given up hope of having a child of their own. However, the processes involve techniques such as embryo reduction, cryo-preservation of embryos etc., which are matters of concern.

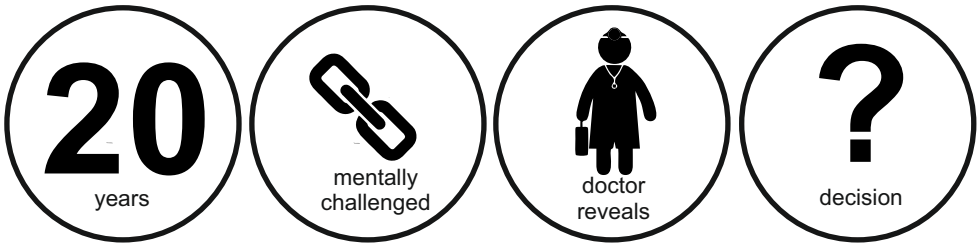
In November of 1998, scientists reported that they had successfully isolated and cultured human embryonic stem cells. Embryonic stem cell research is a burning issue in infertility centres, where couples who have completed families have excess embryos cryo-preserved in the laboratory. Embryonic stem cell research has resulted in intense debate between those who approve of it and those who oppose it. Though this kind of research could result in treatment of specific diseases, because it is necessary to destroy the embryo, such research is unethical, regardless of its benefits.

Finding a way out of an unwanted pregnancy, enabling an infertile couple to have their dream child or providing treatment for parkinsonism, for example, are good in themselves. But destroying embryos to attain the above-mentioned is unethical.

For our discussion, let us consider just one case on abortion.

Case Scenario:

Mallika, a twenty year old girl, living with her parents, was mentally challenged. She could look after her personal needs to a certain extent, but her intellectual level was that of a ten year old. Her mother's brother, who was a frequent visitor to the house took advantage of a situation when the girl was alone in the house and sexually abused her. She could not explain the incident very well to her parents, and so they came to know only when the mother noticed that she was not getting her menstrual cycles. The mother took her to a doctor who told her that her daughter was five months pregnant, and it would be dangerous for the girl to go through a termination at that stage of pregnancy. The mother hearing this was devastated.



a. Technical Explanation

b. What are the ethical issues in this case/example?

1. _____

2. _____

3. _____

c. Biblical basis:

Scripture portion: _____

What are the Biblical values/ principles?

1. _____

2. _____

d. Personal applications: (with respect to ethical practice)

1. _____

2. _____

3. _____

FACILITATOR'S NOTES

a. Technical input on the topic:

Abortion, is the wilful termination of pregnancy with chemical, surgical or non-surgical methods. Abortion, which existed for ages was legalised in India with the introduction of 'The Medical Termination of Pregnancy Act' in 1971.

Medical Termination of Pregnancy is permitted for the following reasons of opinion, formed in good faith, that:

(a) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to physical or mental health; or,

(b) there is a substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Medical Termination of Pregnancy is done up to 20 weeks or 5 months of gestation. The only absolute indication for an abortion is when the mother's physical life is endangered.

Abortion for genetic anomaly of the foetus is an inappropriate use of the genetic testing technology because in many cases, the degree of deformity that the child will experience is difficult to predict. This assumes that the tests are entirely accurate and there is a causal link between the defective gene and the inherited disease. For example, there are varying degrees of abnormality with Downs Syndrome - a chromosomal abnormality with challenges in all modalities, but can lead reasonably normal lives. The decision to end a pregnancy on the basis of genetic deformity alone is no different from eliminating adults simply because they are handicapped.

Assisted Reproductive Technologies: These involve manipulation of the gametes, sperm and egg, in order to produce a good quality embryo which is inserted into the female reproductive tract to achieve a pregnancy. These techniques range from simple intra uterine insemination either with husband's or donor's sperms, or to more complicated ones such as in vitro fertilisation (IVF). In IVF the sperm and egg are united in a well-equipped laboratory which functions like a human body. This interferes with the natural conception by the union of man and wife which was intended by our Creator. In this process embryo reduction may be necessary. Also the excess embryos could be cryo-preserved.

Embryo Research: This is done in human embryonic (pluripotent) stem cells, from which all (more than 200) kinds of tissues in the human body originate. In order to harvest embryonic stem cells, it becomes necessary to destroy the embryo.

Moral status of Embryo: The moral status of an embryo is a highly debatable issue.
When does human life begin? Is it at conception? At implantation? When the heart starts to beat at 21 days? When the embryo takes on a human form? When the unborn is viable? When does a new member of Homo sapiens come into existence?

Various philosophers have stated self consciousness, potential for self-consciousness, sentience, viability, similarity etc., as the stage at which the pre born should be accorded personhood and thereby, right to life.

b. Ethical issues identified in the case study:

a. **Exploitation:** In this case, it is very obvious that the girl with mental disability was sexually exploited by her uncle. Such sexual exploitation is not limited, but it happens in other situations where there is an authority/power difference between the two under consideration. A teacher could take advantage of his position and exploit his students. For fear of being taken out of the school, the student may be reluctant to inform her parents. Similarly, employers exploit employees, and the employee for fear of losing the job, would continue in an exploited situation.

b. **Autonomy of the pregnant girl:** Though this pregnant girl is 20 years old, her mental faculty is not competent to make an informed decision. In such a situation the parent or guardian of the individual holds the right to make decisions on behalf of and in the best interest of the person.This is also true in the case of minors.

c. **Bodily privacy:** The bodily privacy of the girl has been violated by her uncle. The harm rendered has physical, mental and spiritual consequences. Also it has a bearing on her family.

d. **Why punish the baby for the sin of the uncle?** In this situation, the unacceptable behaviour of the uncle has resulted in pregnancy. Is it ethical to destroy the foetus for the sinful behaviour of the uncle?

e. **The Medical Termination of Pregnancy Act** permits abortion until 20 weeks of pregnancy. Currently, efforts are made by gynaecologists to raise this to 24 weeks. Whatever the upper limit is, is it ethical to destroy a living human life? The mother's womb is the safest place for the growing baby. How ethical is it to invade that territory and to kill the baby?

c. Biblical Basis of Sanctity of life:

Why Is Human Life Sacred?

Human life is sacred because God created man in His image.
The Bible says, God created man in his own image, in the image of God He created him; male and female he created them *Genesis 1:27*. This fact establishes the value God places on human beings and serves as the basis for the sanctity of human life.

Human life is sacred because God declared mankind to be very good.
God saw all that he had made, and it was very good *Genesis 1:31*. This all-encompassing declaration of the goodness of God's creation included the making of man.

Human life is created with dignity: The two phrases 'in Our image' and 'in Our likeness' are parallel expressions. The divine image is something that God impresses on humans and what defines our identity. It sets us apart from other created beings. The dignity of human beings resides not in what you can do, but in what you are.

Human life is sacred because God creates every life.
'*For you created my inmost being; you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place. When I was woven together in the depths of the earth, your eyes saw my unformed body. All the days ordained for me were written in your book before one of them came to b*e' *Psalm 139:13–16*.

Human life is sacred because God prohibits the taking of innocent human life.
The Sixth Commandment simply says, '*You shall not murder'*. By this command, God prohibits the taking of human life, which strengthens the sanctity of human life.

Human life is sacred because God cherishes us and has a purpose for every moment of our lives.
'Before I formed you in the womb I knew you, before you were born I set you apart; I appointed you as a prophet to the nations', Jeremiah 1:5.

Human life is sacred because God's creativity begins at conception: God's involvement with human beings in the womb, whatever else it implies, is linked to protection, because of their vulnerability and because they bear the mark of God's creative hand. Since God's creativity begins at conception, it would seem that, in particular, embryos and foetuses merit protection since they are most vulnerable in the womb.

Are all human beings valuable?

Our value to God remains the same, no matter what differences there are among us in sex, age, skin colour, ethnic background, religion, language, nationality, level of intelligence, social status and class, or other factors. Every human life is made in the image of God and therefore must be respected, treated with dignity, protected, preserved, nurtured, and developed - not disrespected, disregarded, devalued, cast aside, diminished, discarded, or killed. All human beings are valuable.

d. Possible applications:

1. When patients request for abortion, make every effort to explain to the patients and their attendants the fact that it is appropriate to preserve life in the womb as far as possible.

2. Giving a child for adoption may be a better option than to destroy the pre-born.

3. When the physical health of the pregnant lady is in grave danger, one will need to terminate the pregnancy, fully aware of the fact that the foetus will not survive if it is below the stage of viability.

4. Counselling: This has to be a pre requisite for infertile couples who intend to embark on assisted reproductive technologies. This should preferably be done by trained counsellors.

References:

1. David Degrazia et al, *Biomedical ethics*
2. Rae, M. S. B., & Cox, M. P. M. (1999). *Bioethics: A Christian Approach in a Pluralistic Age*. Grand Rapids, Mich: Wm. B. Eerdmans Publishing Co.
3. John Kilner et al, *Biotechnology and the Human Good*
4. Orr, R. D. (2009). *Medical Ethics and the Faith Factor: a Handbook for Clergy and Health-care Professionals* (1 edition). Grand Rapids, Mich: William B Eerdmans Publishing Co.
5. The Bible

MODULE

JUSTICE AND THE POOR

Dr. Sedevi Angami

Introduction to the topic:

Equitable distribution of Healthcare to all in society has always been a major concern. In the midst of increasing inflation, limited resources and cuts in health financing, the poor seem to be getting more and more marginalised in their access to Healthcare. Systematic corruption also ensures that only a trickle of what is allocated to Healthcare actually reaches the beneficiaries.

The rise of the corporate health sector has brought in state of the art Healthcare facilities to those who can afford it or are covered by insurance. Much of the country's health policies are now being influenced by these big players. Health is now considered a commodity, just like any other trade product. The lure of big money, academics and the rat race of competition ensures that many bright and competent doctors get absorbed in the cities, leaving very few to work in the rural areas.

Technology comes at a cost. As technology explodes onto the scene, the need to keep up and use all that it offers, creates great tension between its power to diagnose or treat more diseases, versus the added cost to be borne by the poor.

The new culture of litigation has caused more physicians to practice defensive medicine and investigate more, just in case they are sued for missing diagnosis. The poor again stand to lose the most.

The public sector in most states has been accused of being inefficient, unaccountable and even incompetent in many areas of medicine. The wealthy do not used public sector facilities. The poor have no choice. When there are conscientious people in charge of the public health system, the poor benefit.

As the divide between the 'haves' and 'have nots' increases, we seem to be plunging into a dangerous and explosive situation of distrust, selfish desire and a compartmentalized world. This divide in India also relates to various regions whereby the southern states appear to have developed fairly comprehensive and efficient services, with insurance cover for even the poor, while the north and north-eastern states continue to languish with lack of resources for the same. Mass migration to earn better and avail of health services affects better developed states.

Can we think of another model whereby even the poor can access a reasonable level of Healthcare commensurate with their ability to cope with, without losing their dignity?

Case scenario

Raju works as a landless daily wage labourer in a village earning just Rs 250 per day for about half the month. He is the sole breadwinner for his family. He has 5 children, one of whom is disabled with polio. He has two cows that he milks. He sells the milk to support his family.

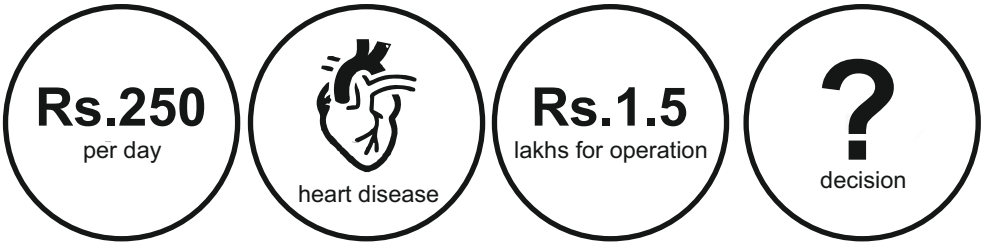
Raju's 12 year old daughter Sita, who was doing well in school, had recently developed breathlessness while walking. A doctor in the nearby town, advised a number of investigations which cost him Rs.5000. She was diagnosed with rheumatic heart disease with severe mitral regurgitation.

Sita was advised to have a valve replacement, that would cost rupees 1.5 lakhs. Raju would need to stay in the city for about 15 days during the surgery. Postoperatively, she will need anticoagulants for the rest of her life. The local Government hospital does not provide these facilities except for basic primary health services.

The nearby money lender lends money at the rate of 10% per month. Many of his friends who borrowed money from the money lender have now become bonded labourers to the landlord. He has heard that there is a possibility of getting some money from the prime minister's relief fund for the heart surgery. However, it involves paying the Village Chairman a sum in order to access the local MP, who will then recommend his case to the PM's office.

He has the option of selling his wife's ornaments. The cows might fetch him some more money to pay just for the cost of the artificial heart valve. However, if he does this, he will have no more milk for his little baby, and his other children may have to stop going to school since there will be no more money for their fees and books.

Raju is in a fix and cannot decide what takes priority.



a. Technical Explanation

b. What are the ethical issues in this case/example?

1. _____

2. _____

3. _____

c. Biblical basis:

Scripture portion: _____

What are the Biblical values/ principles?

1. _____

2. _____

d. Personal applications: (with respect to ethical practice)

1. _____

2. _____

3. _____

FACILITATOR'S NOTES

a. Technical input on the topic:

There is a stark relationship between poverty and ill health. In the poorest countries, life expectancy is just 49 years and one in ten children do not reach their first birthday. In high income countries, the average life span is 77 years and the infant mortality rate is six per 1000 live births.

Poverty creates ill health because it forces people to live in unsafe environments without decent shelter, clean water or adequate sanitation. Hunger and malnutrition make people vulnerable to disease. Poverty creates illiteracy, increases health risks, denies people access to health services, immunization, and affordable medicines. This exposes them to exploitation.

When the poor fall sick or die, the family often loses a much needed bread winner and throws them into a spiral of further poverty from which it is difficult to recover. Healthcare costs arise from acute illness, chronic illness, accidents and hospitalization. According to a World Bank study, the most important cause for pushing people under the poverty line was hospitalization. For a large number of the poor, the cost of hospitalization ranged from 300 to 900 per cent of their monthly income. Direct costs of hospitalization come from drugs, investigations, procedures and services. Indirect costs during hospitalization come from transport, additional food costs and loss of income. Hospitalization leads to loss of control and autonomy over their lives. Dignity can also be lost as a result of invasion on their bodies.

Access to Healthcare can be compromised because of the distance needed to travel to a centre, the affordability of the services, and the attitude of the staff who relate with the poor. The poor often do not have a voice and are easily trampled upon. Some feel they are treated in a sub human manner in Healthcare institutions. Therefore, they resort to alternative and traditional medicine and quacks, who often take advantage of their situation, with disastrous results.

Safe drinking water is a luxury for the poor. It prevents many water borne diseases and resultant hospitalization, yet may be difficult to access. The poor are often forced to occupy unsafe housing – either in terms of location near garbage heaps, or the physical construction is unsafe and contributes to ill health.

Disability amongst the poor is often inadequately addressed. They are often forgotten or the process of applying for disability payments can be so daunting that they are left unutilized.

Women are inadequately represented in their access to Healthcare, and often left out of decision making, despite the fact that they have to shoulder most of the sustenance of their families. They are therefore a vulnerable group and need special attention.

The elderly amongst the poor are even more isolated. There is very little support mechanism for this group especially in the cities because of urban lifestyles. No social support mechanism exists to help them when they need it.

Increasing inflation has made even the most basic essential food items go beyond the reach of the poor. They may be trained to identify good and hygienic food, but do not have the resources, to buy them. Food security in the country varies again by way of region, with the South having access to highly subsidized food and grain through an efficient public distribution systems (PDS) whereas the PDS, maybe non-existent in other states.

Alcoholism is rampant amongst the poor, who seek temporary reprieve to their pain of poverty. This further leads to crime and poor use of scarce resources for the family.

Poor people cannot be treated as a homogenous group. Gender, caste, age, and ethnicity affect health and their perception to health or ill health as well as access to the services provided. The poor have a right to participate in the planning of processes that affect their lives. Strategies are required to involve the poor and their representatives in the design, implementation, monitoring and evaluation of programs and policies that affect health.

b. Ethical issues identified:

Every human being is created equal at conception and endowed with the same body features, sun and natural environment. We are all created in the image of God and so have the right of dignity that comes with this image. However the circumstances differ. People do not have access to the same facilities and privileges depending upon their family background, location and upbringing. This is further complicated by issues of race, caste and creed.

According to the Libertarian concept of justice, a person is entitled to own what she through her own labor has appropriately acquired. The rich do not have a responsibility to the poor in this model. It is a selfish and individualistic world view. It assumes that each person is born and endowed with particular gifts, talents, virtues and favorable circumstances without any defects or handicaps which would hinder their personal or socio-economic growth. It does not allow for the unfortunate circumstance that can befall anybody, that can cause us to go into a spiral of hardship and inequality.

Under the concept of the social contract that we are involved with our governing administration, the nation has some rights over our earnings in the form of taxes. In our country, the government does try to implement all these measures to some extent through various schemes like NREGA, Public distribution system, housing for the poor, old age pension etc. although corruption and dishonesty frustrates much of the efforts. Corporate social responsibility is a new measure that has been introduced by the government to ensure that corporates which earn more than a certain amount in profits every year are forced to give back a certain proportion of these earnings to society in the form of some social venture. This is in line with the Liberal concept of justice whereby those who have more than enough ought to help those in need.

The socialist concept of social equality involves equitable sharing or redistribution of resources and material goods. Governments have the right to intervene and even infringe upon individual rights in order to level the playing field. This sounds a laudable move if only the people in charge have unlimited sense of fair play and are just by nature. The failure of the communist experiment appears to justify the Libertarian concept.

The truth possibly lies in a mixture of all the above-mentioned concepts. In the area of health, this is a vital and foundational aspect of our opportunity for growth. If you do not have health, you cannot compete in the complex and unequal world we live in, let alone survive. It is therefore the responsibility of the Government to provide at least the minimum level of universal Healthcare to its people. Defining entitlement to universal Healthcare and what constitutes basic necessary health care can be complex with the introduction of multiple variables like new technology and drugs that can range from cheap to phenomenal cost.

In this scenario, we need much humility, compassion, innovation and wisdom to proactively be involved in providing for healthcare to the poor. We will also need to wisely engage with the government, Corporates and network with multiple agencies to channel resources to those who need it most.

As Christians, we will need to actively engage with the Word of God and review our understanding of justice and develop ways of genuinely engaging with the poor through practical applications of the Word.

c. Biblical Basis:

The Scripture is explicit about the importance of the poor in our midst both in the OT and the NT. We are commanded to always mind and help the poor. *Deuteronomy 15:7-11* states that we should not be hard hearted and tight fisted, but to be generous and open handed to the poor.

1. Justice is caring for the vulnerable:

Justice is to treat people equally regardless of race or social status. It is also giving people what is due to them, whether punishment or protection or care. *Isaiah 1:17* encourages us to 'learn to do good; seek justice, correct oppression, defend the cause of the fatherless, plead for the cause of the widow'. It highlights the cause of widows, orphans, immigrants and the poor – the quartet of the vulnerable. In Healthcare, it could mean patients with no health insurance, the poor who cannot afford the much needed treatment, and those unable to access health care due to various reasons.

2. Justice reflects God's character:

Justice flows from God's heart. *Amos 5:24*, "*But let justice roll on like a river, righteousness like a never failing stream*". God is concerned about the neglected in communities. *Psalm 68*: *5* states that God is "*father of the fatherless and defender/protector of widows*". God identifies with the powerless. He takes up their cause and so should we.

3. Justice is developing right relationships:

On a daily basis, a person needs to conduct all relationships - with fellow students, teachers, patients etc., with fairness, generosity and equity. In *Matthew 25:34-46*, we find a description of how the Lord, when He returns, will appreciate one's relationship and attitude towards the poor and reward them, but will punish those who neglect them. According to *Psalms 41:1-2*, the person who considers the poor is called blessed. *Proverbs 14:31* indicates that God is the maker of the poor and has a major interest in their welfare, and so should we. How we relate to the poor indicates our relationship with God.
All these years, the New Testament church had an important program of looking after the poor. The poor are given for our transformation. They need us, but we need them more for our transformation. They reflect what we truly are, and they help us grow spiritually and understand the God we serve.

d. Possible applications:

1. Understand the poor

In order to help the poor, we must first understand them. We always have the poor with us, but it is not as simple as giving charity and concessions. Concessions often come with the loss of dignity. How can the poor receive what should be considered their right to receive help, without losing their dignity?

In order to understand them, we would need to be with them and ask many questions. This involves time, compassion and patience. Dr AK Tharien of Christian Fellowship Hospital Oddanchatram, decided to live like them in order to identify with the poor. The missionaries of Charity follow a similar strategy of Spartan living. Some live with the poor in order to understand them better.

2. Empower the poor

The poor have capacity and potential to grow, learn and take control of their lives. They may need facilitation and a helping hand at times to reach this stage. This may come in the form of improving their means of livelihood through information, education, training, self-help groups, cooperatives, financing, educational subsidies, scholarships and other capacity building activities. The poor can actually be very creative, as evidenced by the experiments of Grameen Bank and scores of other initiatives, when they learn to support each other.

3. Appropriate technology suited to the poor

Not every new gadget that enters the medical world is essential for promoting health. Hospitals and concerned individuals need to justify the entry of new technology in relation to the possible impact in escalation of health costs and overall benefit to the poor.

4. Prevention

A large number of illnesses can be prevented through better hygiene, immunization, sanitation, better health practices and education. We must try our best to prevent hospitalization since once this occurs, it is almost impossible to extract the poor from the trap and vortex of debt and poverty. We also need to prevent things from getting worse by judicious use of investigations, and prescribing only the most essential drugs. We need to keep ‘In patient’ stay to the minimum, develop methods to estimate the exact cost of treatment and disease burden to the patient and create awareness among the entire Healthcare team about its impact on the patient.

5. Response of the church

The church is a great vehicle to reach needed resources to the poor, at their doorsteps. Churches can educate themselves on social needs by linking up with professional NGOs, hospitals, community outreach groups, etc., and provide manpower, finances and information to reach out to the poor.

6. At the macro level

We will need to fight for the rights of the poor to receive what is due to them, help frame pro poor policies, involve them in planning for their well being, and ensure that health schemes are implemented in letter and spirit.

References:

1. Degrazia, David, Mappes A Thomas, Brand- Ballard Jeffrey. *Biomedical Ethics (Seventh Edition)* 2011, Mcgraw Hill
2. David M. Dror, Olga Van Putten-Rademaker, Ruth Koren. Cost of illness: Evidence from a study in five resource poor locations in India. *Indian J Med res 127*, April 2008: 347-361
3. Dying for change: Poor people's experience of health and ill health, WHO and World Bank. http://www.who.int/hdp/publications/dying_change.pdf

MODULE

END OF LIFE CARE

Dr. Ashita Singh

Introduction to the topic:

Death is the most dreaded enemy of human kind. As doctors and medical students, most of our training is focussed on preventing, or at least delaying, death as much as possible. We are taught to fight death with every available resource to the bitter end. When we are faced with a patient who has an incurable disease, we are often at a loss regarding how to go about handling the situation. As long as there is something we can do towards cure, we feel strong. But when there is little hope for physical cure, we feel a sense of defeat. Often in these situations, the patient is left in the dark about the diagnosis till the very end, because the family feels he/she won't be able to handle it. Furthermore, even if the patient is aware of the diagnosis, death is not something that we as professionals feel comfortable discussing openly with someone who is facing it .

Care of patients at the end of life is a unique challenge for medical professionals. There are many issues to be considered in ensuring optimal care for those who are dying. The five year SUPPORT study conducted in the United States that was designed to track the experience of dying in the hospital setting revealed, that, training in care of the dying has not kept up with changes in technology. This leads to prolonged futile, painful and expensive treatments, mainly resulting from a lack of prior discussions between patients and their families, and treating physicians. This is likely to be the case in many urban centres in our country as well. On the other extreme, particulary among the poor, those with terminal illness may be completely neglected, with no attempts at improving quality of life towards the end. The onus for initiating the conversation towards improving care for the dying lies with us as physicians. Let us consider the scenario given below as we try to address some of these issues from an ethical (universal) and a biblical perspective.

Case scenario:

Mr Kumar is suffering from end-stage lung cancer. He agreed for palliative chemotherapy, but had often expressed that he did not want to be kept alive on a machine when he deteriorated beyond the scope of non-ICU care. He said he was ready to meet his maker. He was on home oxygen, and required help for his activities of daily living. This morning, he deteriorated suddenly, and was rushed to the hospital, where he was immediately intubated and put on a ventilator. After initial stabilisation, the doctors told the family that there was not much hope for his recovery to the previous baseline level.

Mrs Kumar defers the decisions to be made to her three sons. Mr Kumar's sons are divided in their feelings about the situation. One of them wants everything to be done to try and save his father's life. The other wants to end his misery by giving him a lethal injection. The third recognises the fact that his father did not want prolonged ventilator support, but is unsure whether it would be right to remove it, now that he is already intubated. Finances are not an issue as everything is covered by insurance.

a. Technical Explanation

b. What are the ethical issues in this case/example?

1. _____

2. _____

3. _____

c. Biblical basis:

Scripture portion: _____

What are the Biblical values/ principles?

1. _____

2. _____

d. Personal applications: (with respect to ethical practice)

1. _____

2. _____

3. _____

FACILITATOR' S NOTES

a. Technical input on the topic:

When considering end of life care, it is important to distinguish between euthanasia and assisted suicide on the one hand, and withholding or withdrawing life supports on the other. While the former is illegal (in our country), and contradictory to the Christian faith, the latter is often reasonable, and compatible with the Christian faith. While euthanasia involves an active step (eg. delivering a drug in a lethal dose) with the *intent* of causing death, withholding or withdrawing life-sustaining treatment involves avoiding or removing burdensome and futile interventions where death is inevitable. This distinction is widely recognized and endorsed by medical and legal professions. However, it is often poorly articulated even in medical circles, leading to confusion, and often unnecessary guilt among both professionals and families of those who are terminally ill.

It is also widely accepted that there is no ethical distinction between withholding and withdrawing life sustaining treatment. Although subjectively it seems more difficult to *withdraw* a treatment that has been initiated (such as ventilator support) rather than to not initiate (*withhold*) it in the first place, the two decisions have equal status ethically. (In fact, in doubtful situations where prognosis of an acute deterioration cannot be judged immediately, recommendations are to initiate treatment till prognosis can be determined so that the best chance is given, and then withdraw if a poor prognosis is confirmed.)

Euthanasia or good death is the practice of intentionally ending a life in order to relieve pain and suffering. It is also defined as a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering. Euthanasia is categorized in different ways, and can be voluntary, non-voluntary, or involuntary. Those who are against euthanasia may argue for the sanctity of life, while proponents of euthanasia rights emphasize alleviating suffering, and preserving bodily integrity, self-determination, and personal autonomy.

Assisted suicide is suicide committed with the aid of another person, sometimes a physician. The term is often used interchangeably with **physician-assisted suicide** (PAS), which involves a doctor 'knowingly and intentionally providing a person with the knowledge or means or both, required to commit suicide, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs'.

Futile medical care is the continued provision of medical care or treatment to a patient when there is no reasonable hope of a cure or benefit. This may be in the form of a surgeon operating on a terminal cancer patient even when the surgery will not alleviate suffering.

Withholding is 'not starting', whereas **withdrawing** is 'stopping/discontinuing a life sustaining treatment'. Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, artificial nutrition and hydration. There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

b. Ethical issues identified:

1. Whose wish takes priority?
Respect for persons embodied in the principle of autonomy requires that wishes of the patients be honoured. If the patient has lost decision making capacity, a surrogate decision maker should make a decision based on substituted judgment (which means making a decision based on what the patient would have wanted in the present circumstances).

2. What is the legal status of euthanasia in India?
Euthanasia is illegal in India

3. Would it be ethically permissible to consider removing the ventilator for Mr Kumar?
Yes, it would be ethically permissible to consider removing ventilator support for Mr Kumar in the light of the terminal nature of his illness and the poor prognosis. This decision has the same ethical standing as a decision not to intubate Mr Kumar would have.

4. Would it have been better not to intubate Mr Kumar in the first place?
If there had been an open discussion regarding end of life care for Mr Kumar between him and his family before-hand, a plan for optimal comfort and limitation of attempts at curative treatment could have been made well in advance. This would have prepared everyone for deterioration, and with a plan for reasonable end of life care that focused on comfort. Sometimes we feel obligated to use a technology if it is available, but that may not always be the right/best thing to do.

However, when life sustaining treatment needs to be initiated for a patient who is terminally ill, the treating team (including the doctors, nurses, counsellors /social workers, chaplains) should take effort and time to clarify the prognosis and options with the family in a family conference, allowing freedom for expressions of grief, confusion, bitterness and anger, in a secure and non-judgmental environment. Often, this also helps address and resolve differences between family members regarding the care of their loved one, bringing everyone together with the common goal of optimal care through a reasonable plan, mediated and supported by the treating team. This may often take more than one meeting, but it is important for all concerned to be at peace about the collective decision, as much as possible, before it is carried out.

c. Biblical Basis/Principles:

1. Sanctity of life- preciousness of human life, command not to take life

Throughout Scripture, human life is treated as a sacred gift from God. The preciousness and dignity of human life is grounded in the creation of human beings in the image of God (*Hebrews 2:6-8*); with sanctions against taking innocent human life (*Genesis 9: 5-6*; Exodus *20:13; Deuteronomy 5:17*). The respect for, and protection of innocent human life is accepted as a fundamental moral principle in almost every culture. There is also a significant emphasis in the Mosaic law on the obligation to protect the most vulnerable in society (*Leviticus 19:9-10; Deuteronomy 24:19-22; Ruth 2:1-3*). These are the primary reasons for ensuring proper care for the dying, and why euthanasia as an alternative is problematic.

2.Death-an inevitable reality as a result of the fall

Death is a universal part of the human experience on earth as God reminds Adam (*Genesis 3:19*). The apostle Paul clearly states that death entered the world through Adam (*Romans 5:12, 1 Corinthians 15:21-22*), implying that this was not part of God's original plan. But once sin entered the world, death became a normal part of everyday life.

3. Death-a conquered enemy through the cross

Although there are hints at resurrection and after life in the Old Testament (*Psalm 16:10-11; 17: 14-15*), the New Testament is abundantly clear that after life is a reality and the grave is not a person's final destination (*John 11: 25-26; 5:24; Luke 14:14; Matthew 22:31; Philippians 3:10-11, 20; Colossians 3:1-4; 1 Timothy 1:16*). The most powerful description of death as a conquered enemy and the hope of eternal life can be found in *1 Corinthians 15:29-57*, referring to Christ's victory over death with his own death and resurrection.

4. Hope of eternity that changes a Christian's perspective on death

There is no denying the fact that death is associated with inevitable loss, pain and grief, which are not to be minimised. This is a reflection of a temporary victory of sin. However, for one who has put his/her faith in Christ, has lived a full life and is deteriorating, death is not something to be feared, since it provides a passage way into an eternity with God. If this is true, then death need not be resisted at every turn, with every aggressive treatment to forestall inevitable death—unless of course, the prognosis and hope for restoration to health and function is good. Thus, for those who have faith in Christ, a desire for continuation of this life can be overcome by an acceptance of death as a doorstep into a much more desirable eternity. This hope of eternity is available to all who believe, even in the last moments of their lives.

d. Possible applications:

1. View each person as precious, created in the image of God, as an eternal being.

2. Take every opportunity to share this hope of eternity, especially as an urgent matter with those who are terminally ill.

3. In an environment of trust and openness, initiate a discussion on end of life care for those with terminal illnesses, if they are inclined. This must not be rushed, and must be done with sensitivity and care. Suggest gently that when cure of the terminal illness is not possible, focus may shift from prolongation of life, to comfort and relief of pain. Some patients may make a considered choice not to be told the details of their illness, and defer all treatment decisions to someone in the family, and this may be honoured. Others may want to know, and should be given all the relevant information and options while clarifying doubts. They should be assured of continued and focussed care, despite inability to cure the illness, making special efforts to communicate that they will not be abandoned. They may remain in denial about the prognosis for quite long, and this should be addressed gently but consistently. Care can be coordinated through a multidisciplinary approach, according to available resources.

4. If during these discussions, a definite plan is reached (such as not for intubation or resuscitation), record this in the chart for future reference.

References:

1. Connors AF, Jr, Dawson NV, Desbiens NA, & et al. (1995). A controlled trial to improve care for seriously iii hospitalized patients: The study to understand prognoses and preferences for outcomes and risks of treatments (support). *JAMA*, *274*(20), 1591–1598. http://doi.org/10.1001/jama.1995.03530200027032
2. Jonsen, A. R., Siegler, M., & Winslade, W. J. (2010). *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, Seventh Edition* (7th edition). New York: McGraw-Hill Medical.
3. Orr, R. D. (2009). *Medical Ethics and the Faith Factor: a Handbook for Clergy and Health-care Professionals* (1 edition). Grand Rapids, Mich: William B Eerdmans Publishing Co.
4. Rae, M. S. B., & Cox, M. P. M. (1999). *Bioethics: A Christian Approach in a Pluralistic Age*. Grand Rapids, Mich: Wm. B. Eerdmans Publishing Co.

Annexure

Possible questions for discussion

Module 1. Foundations of Bioethics

What is the real issue discussed by the couple?
Whose decision should be followed? Why?
What are the technologies available for the treatment of infertility?
Are there any permissible limits of technology? Is it O.K to do whatever can be done?
What biblical principles will you consider to determine if available techniques/technologies could be used or not?

Module 2. World views & Decision making

What are the apprehensions in marrying one with mental illness?
Why is it not appropriate to hide the fact that the girl has mental illness?
Why was her medication stopped? What does that indicate?
What is the degree of disclosure you would recommend? Why?
How do you handle patients with a world view that is different from that of yours?

Module 3. History of Bioethics

What is wrong with the concept of this research?
What is your opinion regarding the methods used?
How were the research participants treated?
Why is it essential to get one's consent to be enrolled in research?
Why is it wrong to subject research subjects to great risks/harm in research?
Who are the vulnerable among your patients? What special care should be taken when you deal with them?
What application would you draw from this discussion for your practice?

Module 4. Professionalism

What should be your attitude towards a pregnant lady wanting abortion? Why?
What are the ways in which you could treat her with dignity?
How do you discuss sensitive issues in a crowded OPD?
How do you ensure privacy for the patient during consultation/ intimate examination?
What is informed consent? What will you inform the patient/relative to get informed consent?

Module 5. Art of caring

Would you give the gardener all the information that we could find out about this disease? Would you let him then make up his own mind?
Should you explain that the prognosis for this disease is very poor?
What if he misunderstood our description of statistical odds and decides on no treatment at all?
Or what will be his plight if he becomes penniless pursuing the possibility of a cure?
How does one convey the uncertainty in medical treatment and outcome?
Or should we discuss the options ourselves and tell him to follow a course of action that is right in our opinion?
How do you continue to provide care even if cure is not possible?

Module 6. Work ethics

Comment on the behavior of the casualty doctor. What is his attitude towards work, leisure etc.?
In both the cases, what are the basic issues?
In both the cases, what are the qualities missing in the doctors?
How were the patients treated? How can one improve it?
What should one do to uphold the best interest of patients?

Module 7: Integrity in Health care

What are your views about pharma sponsored trips and conferences?
How much money is too much money?
What are the factors that shape your values/desires/longings?
What do you think can bring satisfaction and contentment to one's life?
Is your conscience dependable? Why? Why not?
In an era of moral relativism, what values are integral to Healthcare provision?

Module 8: Beginning of life

What should be your attitude towards Malika and her mother?
How do you deal with unintended/unwanted pregnancy?
What are your views about the preborn?
If the preborn is a human life, can that be destroyed?
What are your views about abortion?

Module 9. Justice and the poor

Is everybody morally equal? Does the life of each person matter?
Should everyone have equal access to Healthcare, regardless of their ability to pay?
Does not society have the responsibility to look after its most vulnerable and weakest members?
Should each person's health need become a matter of societal concern?
Should the rich be held accountable and required to take responsibility for the poor amongst them?
Considering that private sector health costs are phenomenal and exploitative at times, should taxation be increased in these areas and more resources be allocated to the public sector
(which has a poor record of accountability and efficiency)?

Module 10. End of life care

Whose wish takes priority?
What is the legal status of euthanasia, in India?
Would it be ethically permissible to consider removing the ventilator for Mr. Kumar?
Would it have been better not to incubate Mr. Kumar in the first place?

"In an environment where ethical considerations are at a premium and ethical practices are an exception rather than the rule, a Christian approach to Bioethics is essential. In this context, the modules produced by The Centre for Bioethics provide a strong Christian perspective and will go a long way in teaching Bioethics to medical students and graduates and in sensitizing them to its principles".

Dr. Sunil Anand, Executive Director, TLM Trust India

"In the past, all physicians were bound by the Hippocratic Oath. Currently, practices and beliefs are governed by humanistic thinking and individualized opinion, and Ethics in the practice of Medicine seems to have become negotiable. Whether it is medical research, education or clinical practice, we are confronted by situations that challenge us to think about what is right. From conception to the end of life there are questions for which we are seeking answers. From a Christian standpoint, these issues are doubly important to practice within the framework of biblical values. Christian approach to Bioethics is a budding science in India, yet has great significance in its impact on the practice of Christian doctors.
The topics covered in Just Med are relevant and serve as a good primer towards more in-depth study of this science. I commend Dr. Jameela George for being the prime mover in this endeavor and hope that many will benefit through this. The efforts of Christian Medical College Vellore (CMC) and The Centre for Bioethics (TCB) towards imparting Bioethics training is laudable".

Dr. Sunil Chandy, Director, CMC Vellore.

"Teaching Bioethics to medical students and graduates is the need of the hour in today's world which is run on a blurred and self- centered value system. It is important to hold on to the biblical values and to ensure that we practice what we believe. The modules give a clear process of facilitating medical students and graduates in the implementation of ethical Healthcare. We appreciate and applaud this effort of The Centre for Bioethics & EMFI.CMAI, in partnership with The Centre of Bioethics is developing similar modules for all Healthcare professionals to influence and contribute effectively to the practice of ethical Healthcare system of the country."

Dr.Bimal Charles, General Secretary, CMAI.

"The ten modules presented in this book are ten broad themes that lay the foundations and offer a scaffolding for sound thinking when bedside or office decisions are required in clinical or public health practice. They are represented in a self-directed learning structure with a clinical scenario for personal reflection. The facilitator's notes provided are deep and brief enough to expand the horizon of thinking. The references to the biblical teachings on each theme gives reasons to go beyond the secularist's view of ethics. It brings in the dimension of making all of us aware of the sacredness inherent to every decision making and the reverence with which we are to approach human life which is created by God in His own image.

Let me comment the modules to the Healthcare professionals and complement The Centre for Bioethics for publishing them. We are grateful to the authors and to Dr. Jameela George for giving leadership to this project. The initiative of the Evangelical Medical Fellowship of India to facilitate this learning process is highly commendable. Well done Dr. Manoj Jacob".

Dr. M.C. Mathew, Professor & HOD of Developmental Pediatrics, MOSC Medical College, Kerala.

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equipping and building disciples
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