BIOETHICS LINKS

CENTRE OF BIOMEDICAL ETHICS AND CULTURE, SIUT

VOLUME 17 ISSUE 2

DECEMBER 2021

Attributed to Dasavanta. Amr, Disguised as Mazmahil the Surgeon, Practices Quackery on the Sorcerers of Antali, ca. 1570. Opaque watercolor and gold on cotton, mounted on paper, 31 x 25 in. (78.7 x 63.5cm). Brooklyn Museum, Caroline H. Polhemus Fund, 24.49
(Photo: Brooklyn Museum, 24.49_detail_IMLS_SL2.jpg)

Editor's Note

The December 2021 edition of *Bioethics Links* comes to you with a fresh, new format designed by artist and CBEC's Media Associate, Shaheen Jaffrani. Also going live in December is CBEC's new webpage, *BioethicsLinks Online*, a repository for newsletter content and more.

The lead article by Dominique Martin is a reflective narrative about the evolution of her approach to teaching ethics to medical students in Australia. Connected to the theme of ethics education, Farid bin Masood comments in Urdu (English version available online) on the importance of teaching bioethics in a language that reflects local values and culture and CBEC intern, Daliya Rizvi writes about her internship experience.

A perspective piece by SIUT intensivist, Fakhir Haidri, provides an account of the decision to allow family members into SIUT's COVID ICU at the start of the pandemic. In her review of Kazuo Ishiguro's novel, *Klara and the Sun*, Sualeha Shekhani describes the themes of justice and personhood woven into the narrative. Also included are brief reports on selected CBEC events including two talks by Dr. Moazam related to precision medicine - at the International Conference on Clinical Ethics & Consultation (ICCEC), Cape Town and at the Postgraduate Medical Education (PGME) Conference, Aga Khan University Hospital, Karachi - and an overview of two bioethics pedagogy workshops conducted at the end of 2021.

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REFLECTION ON THE EVOLUTION OF MY ATTITUDES AND APPROACH TO TEACHING "MEDICAL ETHICS"

Dominique Martin
Associate Professor in Bioethics and Professionalism, School of Medicine, Deakin University, Australia

As an undergraduate, I studied medicine and arts, majoring in philosophy and English at the University of Melbourne, Australia. After thoroughly enjoying my year of medical internship, I returned to university to complete an honours year in philosophy in the hope this would help me to decide whether to continue a career in medicine or pursue my passion for philosophy. After what felt like a lifetime of indecision as I struggled to balance the competing demands of my interests in the humanities and sciences, it was a relief to discover certainty within my heart during this honours year; I loved medicine, but a life of intellectual inquiry was the one for me.

Embarking on a PhD in applied ethics, and mindful of the limited job opportunities in this field, I nevertheless swore early on that no matter what, I'd never resort to "teaching ethics to medical students." No doubt, I was influenced by the dismal "ethics" classes which I had experienced as a medical student, and the type of impoverished ethics teaching that I characterise as "pseudoethics." My own intellectual snobbery was also influential; philosophical ethics seemed an obviously superior field to that of "medical ethics". I felt that nothing could be less personally rewarding and less professionally impactful than summarising "the four principles" for a crowd of students who would rather be learning "real medicine." I write this narrative in the hope of prompting reflection by others who may be in a similar position, and hesitant to invest time – if not their career – in ethics, for fear of such a desperate fate.

15 years later, I have the privilege and joy of leading one of the most robust ethics, law and professionalism programs for medical students in Australia. Over the past decade, I've had to navigate my own biases about ethics, medicine and teaching, as well as external challenges impacting my teaching plans and objectives, while striving to design, develop and deliver effective and appealing ethics curricula for medical students. If there's one thing I've learned, it's that there is no single formula that will guarantee success in teaching ethics to medical students; everyone must tailor their curriculum to their unique context. Even when you feel confident that you have a reliable learning activity or assessment task, cultural shifts between student cohorts, staff changes, or a pandemic can necessitate significant alterations to your curriculum and approach to teaching.

Early on in my teaching career, I worried most about *what* to teach medical students about ethics. It seemed irresponsible to leave out discussion of the grounding ethical theories, great thought experiments and ongoing debates about seminal issues, and indeed impossible to teach anything worth teaching without these components. All too soon, I began to understand the appeal – and hence the ubiquity – of the "four principles" approach to medical ethics teaching. Principlism is more easily distilled into a one hour "introduction to ethics" class and can be more readily applied in analysis of cases by students than a similarly abbreviated account of virtue ethics, for example.

However, when I joined Deakin University in 2016 and discovered a much more spacious ethics curriculum, I realised more time was useful, but not the solution to all my ethics teaching challenges. I began to focus more on *how* to teach, and how to design curricula in which teaching could have an impact. In particular, I worried how best to engage and retain the interest of medical students in the ethics program. For some medical students, ethics can seem a distraction from precious study time as they anxiously cram scientific knowledge and prioritise clinical skills development.

#CBEContheweb - On November 12, 2021, novelist and counterterrorism professional, Omar Shahid Hamid led a hybrid session on "[W]righting Pakistan" with virtual and face-to-face participants.

With class attendance optional, I soon found little comfort in having curriculum time at the end of semester when many students stayed home to study for exams.

Paying greater attention to the quality of my teaching and learning resources, and focusing more on my broader engagement with students in the program has been valuable in several ways. I soon learned that investing hours of time in fancy slide sets or elaborate learning activities rarely had proportionate benefits in students' satisfaction or achievement of learning outcomes. Instead, I found that taking the time to make curricula easy for students to navigate, clearly and simply communicating assessment expectations, and pre-emptive action to identify and address potential questions or concerns led to better engagement and satisfaction. Students also seemed happy with basic slides and simple case discussions, so long as the key learning points were clear, and the real-world relevance of learning was apparent.

"I now reflect less on what and how I teach, and more on why we teach ethics to medical students"

When considering potential improvements to our program, I now reflect less on what and how I teach, and more on *why* we teach ethics to medical students. Every program will espouse goals of developing ethical and professional medical practitioners, fostering virtuous conduct and attitudes and so on. These are important goals, and a good ethics curriculum can and should play a key role in achieving them. However, so much of the formation of students' characters has already occurred, and their experiences in the clinical environment as students and practitioners will typically exert a stronger influence on their values and behaviours than the classes formally dedicated to ethics. What, then, is the point of our ethics teaching?

What can we provide in our teaching and assessment of ethics that will offer more than the basic conceptual and theoretical knowledge that might be acquired through reading a textbook, and more than the practical application of such knowledge which may be more effectively demonstrated in the clinical setting – assuming of course that preceptors there are suitably competent? This vital question now informs the rationale for my own teaching – why do I teach ethics? – and from this, shapes the content and methods of much of my teaching.

"...educators with specific ethics training and experience are perhaps best equipped to teach at the foundational level."

The "why" will be different for everyone. Personally, I teach in order to equip medical students with what I believe are essential skills they need to practice medicine ethically, and to support ethical decision-making and action by others. These skills comprise critical thinking, reasoning, and the ability to identify ethical considerations and to communicate clearly when discussing ethics. With these skills, students may be more capable of continuing their ethics education and training as independent learners in the clinical environment, and may be less susceptible to the risks of the "hidden curriculum" of medicine.

Regardless of the foundational concepts, principles or issues being explored in a particular class or assessment task, I strive to stimulate engagement with and evaluation of these skills. While these skills may well be taught and learned in the clinical environment, an explicit focus on their development is less likely in that context. Furthermore, these are skills that educators with specific ethics training and experience are perhaps best equipped to teach at the foundational level. This, in short, is an opportunity for my teaching to have a real impact on students, and hence on the individuals and communities they will one day serve as doctors. I also find this way of teaching more aligned with my earlier career aspirations of engaging in and fostering intellectual inquiry.

I occasionally wince when marking student papers that glibly refer to 'the four pillars of ethics' and appear to show that we have, after all, merely taught them psuedoethics. Nevertheless, majority of our students frequently astound me with their insights and the rapid progression of their skills in ethics over the four years of our program. Rather than becoming resigned to teaching ethics to medical students, as I feared when I first obtained an academic job, I have become ever more delighted by this responsibility. Teaching has proven to be an intellectually rewarding experience, and one that I firmly believe has a real and positive impact in the world.

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Attendant caring for patient in SIUT COVID ICU (Photo filtered to protect the identity of the patient)

FAMILY IN THE COVID ICU: A DIFFERENT APPROACH

Fakhir Raza Haidri
Associate Professor, ICU/CCU, Sindh Institute of Urology and Transplantation, Karachi, Pakistan

The COVID-19 pandemic began in February 2020 in Karachi and within a couple of months, the disease had already occupied a large number of beds in ICUs. SIUT, the largest transplant center in Pakistan started a COVID OPD, ward, and intensive care facility for the public as part of the national effort to contain the first wave of COVID. At the same time, the hospital continued to provide care to its own patients.

This variant of COVID was new. The disease process was being understood slowly over time, and treatment was evolving. Most of the medicines being prescribed had not been tested before and were mainly given emergency approvals by drug regulators. But I want to bring up a very different aspect of COVID-19: family involvement in the COVID ICU. In the initial stages of the pandemic, allowing relatives into the COVID ICU was unimaginable. But this is exactly the strategy we adopted at SIUT.

At the start of the first wave of COVID, global standards of care included strict isolation of admitted patients to control disease transmission. COVID-19 guidelines from Pakistan's Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) discouraged the presence of family members, except in the case of paediatric patients. Families were not allowed to visit and the only way to see loved ones admitted with COVID was with a mobile phone. Even dead bodies were handled with great care and funeral gatherings were restricted. In the beginning, doctors were as afraid of COVID as everyone else in the community. We were wearing full-body gowns, masks, eye shields, goggles, foot covers, gloves - even respirators in some instances. We had to write our names on our dresses to identify each other. Attendants were strictly not allowed inside. Nurses were also afraid. And then came a time when nurses started getting COVID. Fear spread like wildfire, and nurses began opting out of ICU duties. Some demanded fewer working hours, and we had to negotiate their timings with them. At the same time, the number of patients was increasing.

A few attendants of our patients insisted on staying in the ICU, mainly wives, sisters and children. They wanted to stay with their loved ones for different reasons, the most important being cultural norms which made families duty bound to care for sick kin. Initially, we refused to let family members into the ICU but ultimately, after consultation between infectious disease physicians, intensivists, and the hospital administration, we decided to allow them in. Only family members who were young, healthy and not pregnant were allowed as attendants. In addition to other safety measures set in place, they had to wear complete personal protection equipment (PPE), just as the nurses were wearing.

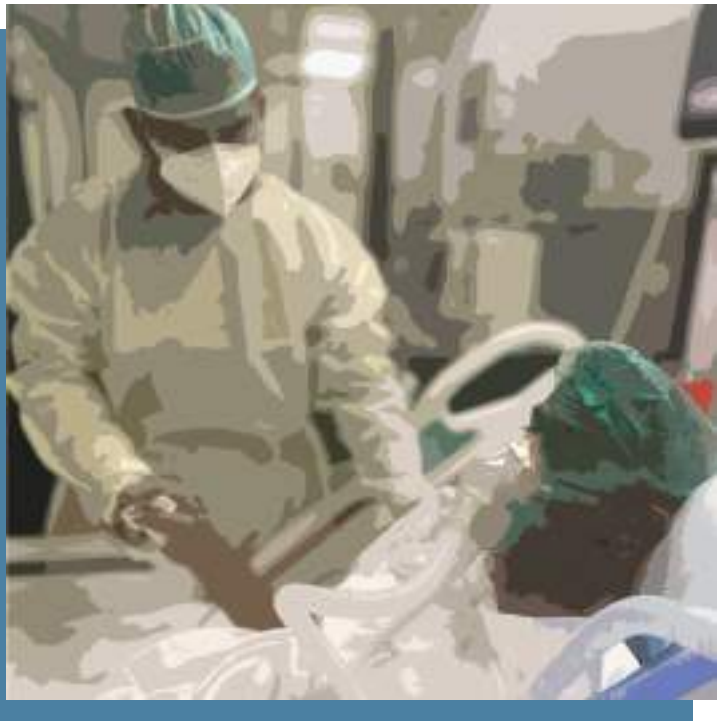
Families strongly wished to be with their sick relatives, but there was also a practical benefit because of the care family members could provide. Short of staff during peak COVID, we found the family helpful at the bedside.

The reason for this allowance was multifactorial. Families strongly wished to be with their sick relatives, but there was also a practical benefit because of the care family members could provide. Short of staff during peak COVID, we found the family helpful at the bedside. We found that pain, agitation and delirium - major concerns in the ICU - were best managed by involving family members. Mobilizing patients out of bed was also a task where the family was helpful. As time progressed and the fear decreased at all levels, we realized that the impact of family involvement in the COVID ICU was tremendous. We began to see miraculous improvement in patients' outcomes.

One of the patients was Mrs. B, a young female from a poor socioeconomic status with a history of psychiatric illness. She came with severe COVID pneumonia, complicated by kidney failure. She received a few sessions of dialysis, but the pneumonia was severe. She underwent a tracheostomy procedure which developed complications. Later, she had massive gastrointestinal bleeding, for which she required surgery and endoscopies. She had severe infections and bedsores. Several times we gave up on her and thought she would not survive even 24 hours. But she did survive. What made her recover and leave the ICU alive was her older sister who cared for her as though she was her mother. She always knew what her sister wanted, and she tried her best to provide it to her.

Then there was Mr. S.A.H, a dialysis-dependent, older man with complicated vascular access. He developed COVID pneumonia and was put on a ventilator. One day, I saw his daughter standing beside him, not doing anything. I asked her why she was not helping her father get better. She took my message positively, and her healing touch made the difference. The father, who was on continuous infusions of different medicines to control delirium and agitation, entirely regained his senses in only three days. The next day he was discharged from the ICU, in his senses and talking.

We admitted Mr. H.A, a doctor who developed COVID pneumonia on top of an already bad chest. He remained



Patient and attendant in SIUT COVID ICU (Photo filtered to protect the identity of the patient)

on BiPAP, the noninvasive breathing support, for a long time. He developed clotting in his lung vessels and was ultimately oxygen dependent. Due to his chest wall deformity, he was not able to sleep on his belly which is the recommended position for COVID patients. His wife devotedly cared for him, day and night, finally stealing her living husband back from the ICU. He remained on oxygen for at least six months before getting back on his feet.

Three problems in the ICU are detrimental to the recovery of patients, independent of the primary illness: pain, agitation, and delirium. Our experience showed that family involvement in the COVID ICU helped with all three problems, helping patients get out of the ICU bed. The ICU is a jail from which patients must be liberated; the family has a definite role in this.

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BIOETHICS PEDAGOGY WORKSHOPS, NOVEMBER 11-13, 2021 AND DECEMBER 6-8, 2021

CBEC Report

CBEC has been disseminating bioethics education for the past 17 years but we have never really focused on training people how to actually teach bioethics. This gap was highlighted in the research conducted by our faculty Bushra Shirazi in pursuit of her Masters in Health Professional Education degree. Shirazi was exploring the status of undergraduate bioethics education in medical colleges of Karachi and came to the realization that major impediments in actualizing bioethics education in medical colleges included the paucity of bioethics trained faculty and the challenge of teaching bioethics to different cohorts with different educational requirements.

The question of "how to teach bioethics" became the rationale for two Bioethics Pedagogy (BP) workshops run by CBEC faculty at the end of 2021. Applications were invited from our alumni and others who were involved in teaching bioethics at their institutions. The first BP workshop was offered in Karachi in November 2021 and was designed as a hybrid workshop, with 12 participants from Karachi and 12 online, from Kenya, Cameron, Singapore and from other cities of Pakistan. Based on small group work followed by actual teaching, the workshop provided hands-on practice in the use of videos, cases and interactive lectures to teach bioethics, for both onsite and online participants. Sessions were led by Bushra Shirazi and Shahid Shamim, both surgeons and medical educationists with formal bioethics training.

Beginning with lesson planning, the faculty provided an overview on how and where the three educational tools, videos, cases and interactive lectures, could be used optimally while teaching various bioethics topics. Participants were divided into three online and three onsite groups which worked on different modalities, developing lesson plans and conducting teaching sessions.

Our second BP workshop was organized for 12 selected applicants from Islamabad, Peshawar and Lahore and was an in-person event, designed as a full-time 4 day residential retreat in the picturesque setting of the Margalla hills beyond Islamabad. The retreat format allowed much more time for group work and fostered more effective teamwork. Several changes were brought into the structuring of the event

Bushra Shirazi leading a session on the use of videos at the Bioethics Pedagogy Workshop in Karachi

based on the experiences and feedback from the first BP workshop in Karachi. The retreat format also allowed the faculty opportunities to explore non-conventional modalities of learning. These included a literary gathering after dinner on one of the workshop evenings, with faculty and participants contributing short stories and poetry that connected to ethics. On another evening students participated in a moral game that highlighted factors that influence ethical decision making, such as personal life experiences, social standing, gender, sexuality, and conduct.

Both BP workshops were very well received by the participants, and the faculty was left wondering why we had not initiated them years ago. With the experience of having conducted two BP workshops using different formats, we realize that there is a need for training opportunities which allow participants to engage with different strategies which can work with a variety of audiences - face to face, online and in the hybrid format. Not only can these interventions be a 'stand alone' feature, they can also be integrated on a regular basis into formal academic programs.

Images from CBEC's Bioethics Pedagogy Workshops (clockwise from top left): CBEC faculty and participants during a break in the Islamabad Workshop; a participant leads a workshop session in Karachi; warmly dressed participants in Islamabad engaged in group work; a hybrid session underway in hot and humid Karachi

(From left to right) Drs. Rizwan Khan (Associate Dean PGME), Hameedullah (Chair, Organizing Committee), Farhat Moazam (Keynote speaker and Founding Associate Dean PGME), Khalid Samad & Nadeem Zuberi

THE PRECISION MEDICINE IMPACT: HYPES, HOPES AND HYPERBOLE

Postgraduate Medical Education (PGME) Conference, Aga Khan University Hospital, Karachi, December 17-19, 2021

On December 17, Dr. Farhat Moazam was invited to give the keynote address at the inaugural session of the Aga Khan University Hospital's (AKUH) 25th Postgraduate Medical Education (PGME) Conference. PGME was initiated at AKUH by Dr. Moazam when she was the first Associate Dean at the institution. Under her direction, AKUH hosted its first PGME conference themed around ethics in healthcare, setting a tradition that is now 25 years old. Dr. Moazam's talk at the silver jubilee iteration of the PGME conference dwelt on the potential impact of Precision Medicine on people living in LMICs and the disconnect between Precision Medicine and the actual healthcare needs of most people.

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BOOK REVIEW: *KLARA AND THE SUN* BY KAZUO ISHIGURO

Sualeha Shekhani
Assistant Professor, Centre of Biomedical Ethics and Culture, SIUT, Karachi, Pakistan

"It's not faith that you need but rationality". This sentence touches upon one of the central themes in Kazuo Ishiguro's latest book, *Klara and the Sun.* Released on March 02, 2021 and longlisted for the Booker Prize, this book is an extension of some of the areas that the Nobel Prize winning writer has previously explored.

The current work, which can be regarded as science fiction, provides a glimpse of a dystopian future in which machines potentially replace human beings not merely for technical purposes but also social ones. Machines now possess the emotional capacity to become friends with human children, specifically those who have been genetically engineered to become more intelligent, or as the book terms it, have been 'lifted'. This may seem far-fetched but the phenomenon of being 'lifted' has parallels in contemporary society: Just as better education for children today is connected to socio-economic status and increased opportunities in life, being 'lifted' in Ishiguro's novel signals higher status and a better chance at life.

Klara, a robot engineered to be an Artificial Friend (AF), narrates the story and it is through her worldview that events unfold. Rather like Ishiguro's narrators in other books - a butler in *The Remains of the Day* and a cloned human in *Never Let Me Go* - her narration brings to the fore the perspective of the 'other', making the reader see the world in unfamiliar ways.

"Do you believe in the human heart? I am speaking in the poetic sense....Something that makes each of us special and individual?"

A core aspect of the story is the question of what it means to be a person. AF Klara is purchased from a store as a 'friend' for a human child, Josie. It is through Klara that the reader learns about Josie's strange and mysterious illness, attributed potentially to her being 'lifted'. Through Klara's eyes, we catch a glimpse of the conundrum that Josie's mother experiences as she realizes the adverse consequences of 'lifting' her child, facing the possibility of

Josie dying. But Klara, powered through solar energy, believes that she can save Josie by asking the Sun for magical help. Josie's mother, however, has an additional motive for buying Klara. She wants Klara to learn every aspect of Josie so that when she dies, Klara can replace her in a new robotic body identical to Josie's. This is where Ishiguro points his readers to a difficult question: Is it possible for science and technology to replicate an individual in entirety, to fully capture their true essence? As Josie's father asks, *"Do you believe in the human heart? I am speaking in the poetic sense…Something that makes each of us special and individual?"*

Ishiguro closely connects issues of personhood and humanity to the contemporary fear that machines will replace human beings. A passerby remarks to Klara in a hostile fashion when she accompanies Josie to a mall, *"First they take the jobs. Then they take the seats at the theatre."* Josie's father is also forced to conclude, *"That science has now proved beyond doubt there's nothing so unique about my daughter, nothing there our modern tools can't excavate, copy or transfer."*

Towards the end of the novel, Klara ruminates,*"But however hard I tried, I believe now there would have remained something beyond my reach. It wasn't inside Josie. It was inside those who loved her."* Klara reaches a conclusion about what it means to be human, but questions about her own potential personhood remain.

INTERNSHIP REFLECTION

Daliya Rizvi
High-school student in USA, Daliya describes herself as a “student-scientist” whose interests include scientific research

This past summer, during my break from school in the US, I was fortunate enough to travel to Pakistan and intern at the Sindh Institute of Urology and Transplantation, in the Center of Biomedical Ethics and Culture (CBEC) and the Center for Human Genetics and Molecular Medicine.

At CBEC, I learned about the process of sociological research. I participated in discussions on various topics and worked on creating an updated list of educational films with relevance to bioethics. I was particularly interested in the rights and freedoms available to minor patients, as well as the ethical issues associated with organ transplantation. During my internship, I also led an ethical discussion focused on Richard Selzer’s short story, “Raccoon.” I enjoyed analyzing the many ethical facets of the story with CBEC faculty while uncovering its messages about the physician-patient relationship and about the all-consuming nature of pain.

Although part of my internship was conducted virtually because of a lockdown in Karachi, I was still able to communicate and work as I would have in person. Struggling with certain concepts and asking CBEC faculty questions about their work helped me gain more confidence and improved my communication skills. While interning at CBEC, I began to focus on the importance of bioethics and bioethical education curriculums for young people such as myself. I noticed a lack of materials and resources available to teach bioethics to younger students, and realized the importance of expanding the scope of bioethics discussions to include younger demographics.

Daliya Rizvi discussing her research with Bushra Shirazi which has since been accepted for an oral presentation at the World Congress of Bioethics 2022

Thus, with help from CBEC faculty, I began working on a research project on the perceptions of students in Pakistan and the United States regarding bioethics. Since the lockdown, I have been continuing my research virtually. My goal is to better understand the perceptions and attitudes of young people regarding bioethics while contrasting responses from Pakistan and the United States in order to inform future educational frameworks for teaching younger students about bioethics.

Interning at CBEC has taught me so much about bioethical issues and the gray areas that characterize much of our healthcare system. It has instilled a newfound passion in me for sociology and qualitative research. I am greatly looking forward to completing my research study over the next few months.

CBEC Videos

CBEC’s 12th teaching video, “A Tale of Two Worlds,” is now available for free streaming and downloading. The video was produced as part of dissemination efforts for the World Health Organization (WHO) guidance: "Ethics and vector-borne diseases." It highlights issues of social justice and public health ethics in the context of a dengue epidemic in two communities separated by a creek - one an affluent, gated neighbourhood, the other a slum.

SCAN QR CODE
to view our latest video:
A TALE OF TWO WORLDS

والی غلطیاں اور غفلت ہے جس کی تدریس میں جذبات کا بہت دخل ہوتا ہے۔ ندا کے مطابق نرسوں اور دیگر پیرا میڈیکل اسٹاف کے لیے دل کی بھڑاس نکالنا، شکایت کرنا، یا جذبات کا اظہار کرنا اردو میں زیادہ آسان ہوتا ہے۔ بہر حال بایوایتھکس کی تعلیم کے لیے کتابیں، مضامین اور دیگر تعلیمی مواد انگریزی زبان میں ہی ہے۔

یہ ہمیں بایوایتھکس کی تعلیم میں حائل ایک اور مسئلے کی طرف لے جاتا ہے۔ اگر ثقافت اور لسانیات کے تناظر سے دیکھا جائے تو بایوایتھکس کے کئی تصورات پاکستان کی سماجی حقیقتوں سے مناسبت نہیں رکھتے۔ کراچی کے دو ہسپتالوں کی انتظار گاہوں میں کیے گئے ایک سروے میں فرحت معظم نے لوگوں سے "ایتھیکل" ڈاکٹر اور "اچھے" ڈاکٹر کی خصوصیات بیان کرنے کا کہا۔ لوگوں کی آسانی کی لیے انہوں نے ایتھیکل کے بجائے "با اخلاق" ڈاکٹر کا لفظ استعمال کیا۔ انگریزی لفظ ایتھیکل کی جگہ اردو لفظ با اخلاق استعمال کرنے کے نتائج بہت حیران کن اور مغربی دنیا میں اس طرح کے مشاہدات سے یکسر مختلف نکلے۔ ان کے جوابات عموماً کلاسیکی اوصافی اخلاقیات (virtue ethics) سے مناسبت رکھتے تھے اور نتیجتاً با اخلاق ڈاکٹر ایک رحمدل اور پدرانہ شفقت رکھنے والے شخص کے طور پر سامنے آیا جو مریضوں کا گھر والوں کی طرح خیال رکھتا ہو۔ ان کے جوابات میں مریض کی باخبر رضامندی (informed consent) کا کوئی تذکرہ نہیں تھا۔ مزید یہ کہ لوگوں کے لیے با اخلاق ڈاکٹر اور اچھے ڈاکٹر میں کوئی فرق نہیں تھا، محض دو لوگوں نے پیشہ ورانہ مہارت کو اچھے ڈاکٹر کی خاصیت کے طور پر ذکر کیا۔

اسی طرح کی ایک مثال ایک ایسے اجتماعی معاشرے میں جہاں لوگوں کی زندگیاں آپس میں ایک دوسرے سے جڑی ہوئی اور ایک دوسرے پر منحصر ہوں وہاں کے طلبہ کو rights کے تصور کی تعلیم دینا ہے۔ لفظ rights کا اردو میں ترجمہ حق یا حقوق کے طور پر کیا جا سکتا ہے لیکن rights کے برعکس کوئی حق مجرد نہیں ہوتا بلکہ ہر حق کسی شخص کی معاشرتی زمہ داری سے جڑا ہوا ہوتا ہے مثلاً بچوں کے حقوق کو اصلاً والدین کی معاشرتی زمہ داریوں کے طور پر دیکھا جاتا ہے۔ زبان اور معانی کی ان پیچیدگیوں کے درمیان ہو سکتا ہے کہ بایوایتھکس کے بنیادی تصورات (autonomy, consent, privacy) وغیرہ ایک طرف بہت بھاری بھر کم اصطلاحات ہوں لیکن بہت سے لوگوں کے لیے یہ محض ناقابلِ فہم الفاظ ہوں۔

ملک میں بایوایتھکس کے فروغ کے لیے ضروری ہے کہ اس کی تدریس مقامی زبان میں کی جائے اور تعلیمی مواد کو بھی اسی زبان میں تیار کیا جائے۔ اس سے بھی زیادہ اہم کام یہ ہے کہ بایوایتھکس مقامی ثقافت میں جڑیں پکڑے اور ان سماجی اور تاریخی عوامل سے مناسبت اختیار کرے جنہوں نے مقامی زبان اور مقامی اخلاقیت کی تشکیل میں اہم کردار ادا کیا ہے۔

Abstract

Our perceptions of the world are influenced by languages we speak which are reciprocally shaped by our context and lived realities. Thus, it is not only difficult to translate a text completely from one language to another, it becomes hard to convey the complete essence of some expressions in another language as some culturally and socially determined understandings of words are not easy to translate. Furthermore, concepts and notions that originate in a specific time and space are imbued with the cultural and social context of that time and space. This is of particular importance when discussing the dissemination and education of bioethics on a global scale. Various notions held as universal principles in bioethics may not be taught easily through literal translation into languages that have evolved in different cultural contexts. The importance of incorporating local language and culture into bioethics teaching in Pakistan is discussed in this essay, using the experiences of the CBEC faculty as examples.

Full English version of the article is available at:
siut.org/bioethics/cbec-newsletter-bioethics-links/

The Wheel of Fortune, 2014 series Dewar Kahani by Rabbania Shirjeel, photographer based in Lahore, Pakistan

بایو ایتھکس کی بولی

فرید بن مسعود
پارٹ ٹائم فیکلٹی، سی بیک، ایس آئی یو ٹی

گزشتہ سال غربت کے بارے میں فلسفے کا ایک کورس پڑھاتے ہوئے میں نے اپنے طلبہ سے کہا کہ وہ اردو کے ایسے الفاظ کی ایک فہرست بنائیں جنہیں وہ "غریب" کے مترادفات کے طور پر استعمال کرتے ہوں۔ طلبہ کی ان فہرستوں کو یکجا کرتے ہوئے ہم نے 28 الفاظ جمع کیے۔ ایرانی ماہر معاشیات اور غربت کے موضوع کے ماہر ماجد راہنما نے اپنے ایک مضمون میں لکھا ہے کہ ازمنہ وسطی کی لاطینی زبان میں غریب کے لیے 40 کے قریب الفاظ پائے جاتے تھے اور فارسی میں 30 سے زیادہ الفاظ ہیں جب کہ زیادہ تر افریقی زبانوں میں ایسے محض 3 سے 5 الفاظ ہیں۔ یہ فرق ممکنہ طور پر مختلف زمان و مکان میں "غربت" کے بارے میں پائے جانے والے مختلف تصورات پر روشنی ڈالتا ہے۔

لوگ جس طرح دنیا کو دیکھتے اور تصور کرتے ہیں وہ ان کی زبان سے متاثر ہوتا ہے۔ اسی طرح زبان کی تشکیل بھی ان مقامی حالات سے ہوتی ہے جن میں لوگ رہتے ہیں اور ساتھ ہی ساتھ یہ ان کے معاشروں کے نظریہ کائنات اور زندگی کے روزمرہ کے تجربات کی عکاسی کرتی ہے۔ مثلاً ایسکیمو زبانوں میں برف کے لیے تقریباً پچاس الفاظ ہیں جبکہ انگریزی میں اس سے نسبتاً کچھ کم اور اردو میں فقط دو تین الفاظ ہیں۔ زبان محض مادی یا جغرافیائی حالات سے متاثر نہیں ہوتی بلکہ سماجی اور ثقافتی پس منظر سے بھی گہرا تعلق رکھتی ہے۔ زبان کی اس تفہیم کی بنیاد پر ہم یہ اندازہ لگا سکتے ہیں کہ کسی تحریر کا مکمل طور پر ایک زبان سے دوسری زبان میں صرف ترجمہ کرنا ہی مشکل نہیں ہوتا بلکہ کسی زبان کے بعض فقروں کے مکمل معانی کو کسی دوسری زبان میں پوری طرح منتقل کرنا بھی ناممکن ہو جاتا ہے۔ مزید براں ایک خاص زمان و مکان میں پیدا ہونے والی کوئی اصطلاح یا تصور اس زمان و مکان کی خاص سماجی اور ثقافتی خصوصیات سے منتھی ہوتا ہے۔ عالمگیر بایو ایتھکس کے بارے میں گفتگو کرتے ہوئے یہ گذارشات اہمیت کی حامل ہیں۔

1984 میں طبی عمرانیات کی ماہر رینے فاکس نے ایک مضمون "Medical morality is not bioethics" میں لکھا تھا کہ بایو ایتھکس کو ثقافت یا تہذیب سے غیر متعلق یا ماوراء اکائی کے طور پر دیکھنا ایک متعصبانہ مغالطہ ہے۔ انہوں نے لکھا کہ جسے آج بایو ایتھکس کہا جاتا ہے وہ ایک "مغربی اور امریکی" ثقافتی پیداوار ہے نہ کہ ایک "غیر جانبدار اور عالمگیر اصطلاح"۔ پاکستان میں بایو ایتھکس کو "مقامیانے" کی کوششوں کے حوالے سے لکھتے ہوئے فرحت معظم اور عامر جعفری نے اپنے مضمون میں اس بات کی نشاندہی کی ہے کہ اگرچہ طبی اخلاقیات ایک عالمگیر مسئلہ ہے لیکن "بایو ایتھیکس" کی گلوبالائزڈ شکل اپنی طریق اور تصورات دونوں میں "سیکولر، اینگلو امریکی فلسفے کی روایت" سے ماخوذ ہے۔ اگرچہ بایو ایتھکس اب ایک عالمگیر اہمیت حاصل کر چکی ہے، موجودہ بایو ایتھکس کی ترویج کی کوششوں میں دیگر معاشروں کی سماجی حقیقتوں (یعنی ان کے اپنے عقائد، اقدار اور روایات) کو اکثر نظر انداز کیا جاتا رہا ہے۔

پاکستان میں بایو ایتھکس کے فروغ میں حائل مسائل میں سے ایک وہ زبان ہے جس میں اس کی تعلیم و ترویج ہوتی ہے۔ پاکستانی میں مختلف مقامی زبانیں بولی جاتی ہیں لیکن عموماً سب سے زیادہ بولی اور سمجھے جانے والی زبان اردو ہے۔ اگرچہ پاکستان میں اعلیٰ تعلیم کے لیے اکثر انگریزی زبان استعمال کی جاتی ہے جو پاکستان کی دو سرکاری زبانوں میں سے ایک ہے لیکن پاکستانیوں کی ایک بہت چھوٹی سی اقلیت ہی باقاعدہ انگریزی میں بات چیت کرنے کے قابل ہے۔ بہت سے مضامین خاص کر سائنسی مضامین انگریزی زبان میں پڑھانا نسبتاً آسان ہے کیونکہ ان کی تعلیم محض معلومات کی منتقلی یا کسی ہنر کے سکھانے پر مشتمل ہوتی ہے۔ البتہ بایو ایتھکس کی تعلیم صرف معلومات کی فراہمی تک محدود نہیں بلکہ اس میں گفتگو، بحث و مباحثہ اور استدلال بھی شامل ہوتا ہے۔

سی بیک (CBEC) کے ایسوسی ایٹ فیکلٹی ممبر علی لین والا سمجھتے ہیں کہ لوگوں کے لیے ایسی زبان میں اپنے خیالات کا اظہار بہت مشکل ہوتا ہے جو ان کی روزمرہ کی گفتگو میں استعمال نہ ہوتی ہو۔ انہوں نے ہم سے اپنے تعلیمی سیشنز کے دوران ملی جلی اردو اور انگریزی زبان استعمال کرنے کا ذکر کیا جس سے طلبہ کے لیے مباحثے میں حصہ لینا بہت آسان ہو گیا اور ساتھ ساتھ اس نے خود ان کے تدریسی تجربے کو یکسر تبدیل کر دیا ہے۔ سی بیک کی ایک اور ایسوسی ایٹ فیکلٹی ممبر ندا واحد بشیر کا موضوع طبی معاملات میں ہونے

Gendering the alphabet *- An enquiry into the linguistic tendencies of Urdu and the aesthetics of its script by Ammara Jabbar, multidisciplinary visual artist and writer based in Karachi, Pakistan: 'Alif' (ا) and 'choti yeh' (ی) are the general denominators of masculinity and femininity in Urdu and other local languages. In the written script, 'alif' stands tall and unchanging while 'choti yeh's' curved, vessel-like shape changes its form depending on its placement within a word.*

"QUO VADIS, PRECISION MEDICINE? THROUGH THE LENS OF A LMIC PHYSICIAN"

International Conference on Clinical Ethics & Consultation (ICCEC), Cape Town, South Africa, November 30-December 03, 2021

On December 02, 2021, Dr. Farhat Moazam gave a virtual talk on the growing push towards Precision Medicine as the dominant paradigm for biomedical research and the "standard of care" for medical practice in the future. Dr. Moazam's talk was part of the 16th Annual International Conference on Clinical Ethics & Consultation (ICCEC), held from November 30 to December 03, in Cape Town, South Africa with the overarching theme 'Beyond Borders: exploring new frontiers'.

The keys to making Precision Medicine a reality are the availability of Big Data and a focus on pharmacogenetics by the pharmaceutical industry. Dr. Moazam pointed out that two-thirds of the world's population lives in low-to-middle income countries (LMICs) which are already being tapped as sites for Big Data, including the genetic data that Precision Medicine depends on. This carries grave ethical implications for LMICs: In addition to threats to privacy and the risk of exploitation in genetic research, pharmaceutical funding will flow towards costly targeted drugs for small groups of patients and specific diseases, ignoring global health issues such as child and maternal mortality and vaccines for common diseases.

At the end of her talk, Dr. Moazam commented on the tension between Precision Medicine and the United Nations' Sustainable Development Goals (SGDs) which were agreed upon by 193 states in 2015 and which emphasize solidarity among nations. Following the talk, a large number of questions were addressed to Dr. Moazam by participants. Responding to one participant, she noted that people in LMICs often failed to look critically at scientific developments that came from high income countries or to recognize that their close-knit cultures had a lot to offer to the world. Instead, there was often an uncritical adoption of technology that remained inaccessible to most people and failed to address public health issues on the ground.

ANNUAL MEETING OF EASTERN MEDITERRANEAN RESEARCH ETHICS REVIEW COMMITTEE, DECEMBER 11-14, 2021

CBEC faculty member Aamir Jafarey attended the World Health Organization's (WHO) Eastern Mediterranean Research Ethics (EMR) Review Committee meeting in Cairo in December 2021. He presented a pilot situation analysis of ethics governance systems in Pakistan, a project commissioned by a request from the EMR Office. The main take-home message of this report was that Pakistan requires a comprehensive mapping of all institutional ethics review committees, as well as their registration with a central authority like the National Bioethics Committee.

The EMR Region of WHO now has three Bioethics Collaborating Centres, in Karachi, Tehran and Beirut, with CBEC being the oldest. Another outcome of the meeting was to develop a network within the three centres so that they could utilize each other's strengths.

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