cbec SIUT Pakistan

Volume 17 Issue 1 June 2021

Centre of Biomedical Ethics and Culture

Bioethics Links

In this edition, Farid bin Masood discusses changing conceptions of death and questions whether a long life is the same as a good life. James Dwyer, Daryl Pullman, Ikram Burney and Shehzad Shamim comment on the nuances of an end of life clinical case. Fifty-five word stories by some of our newest alumni - the fruits of a humanities and bioethics session with Marcia Childress - appear on different pages of the newsletter. Alumnus, Murtaza Dhrolia, provides a summary of his recent article on COVID-19 vaccine placebo trials. Also included is a farewell page celebrating the graduation of PGD (Class of 2020) students who stuck with us through the pandemic affected program and the transition to online learning.

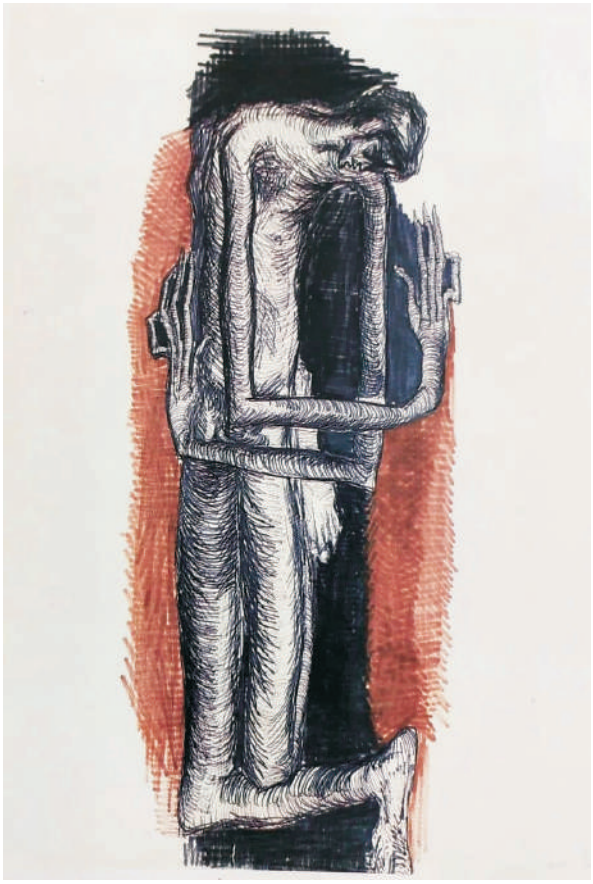
How to Die

Farid bin Masood*

"It takes the whole of life to learn how to live, and - what will perhaps make you wonder more - it takes the whole of life to learn how to die."

Seneca, 65 CE

The quest to defy death is as old as humanity itself, perhaps older. In the Abrahamic scriptures, including the Quran, the first human, Adam, is deceived by Iblis (Satan) into eating the forbidden fruit of paradise to acquire immortality (Quran 20:120). The avoidance of death and the quest to prolong life is a pattern repeatedly woven into the tapestry of human stories. In a Greek myth, Eos, the goddess of dawn, asks Zeus to grant her lover Tithonus (the prince of Troy) immortality but forgets to mention eternal youth along with it. A tragic end follows when Tithonus reaches a "hateful old age," getting to a point where he is not able to even lift his limbs. Finally, Eos locks him into a chamber where he babbles endlessly. In another Greek myth, the Cumaean Sibyl (a Greek priestess) asks the god Apollo for a thousand-year life, but forgets to mention enduring youth. In the end, she too becomes the "prey of a long old age" and shrinks until she is confined to a jar, whispering, "I wish to die." *Continued on page 8*



Drawing (1960s) by Pakistani artist, Sadequain - Retrieved from *The Saga of Sadequain*, Volume II, Sadequain Foundation, 2012

*Farid bin Masood, Part-time Faculty, Centre of Biomedical Ethics and Culture, SIUT, Karachi

The case narrative in this section is based on an actual clinical event at a tertiary care hospital in Karachi. We invited commentaries on the case from four scholars from different parts of the world. Their commentaries dwell on the many facets of the narrative, ranging from the ethical to the practical, and provide unique insights based on their own backgrounds and experiences.

A Balancing Act

Nida Wahid Bashir*

Mr. Hashmi, aged 65, was brought into the emergency department (ER) of a private hospital in Karachi after a fall and loss of consciousness. By the time he was brought to the ER, he had regained partial consciousness but was unable to talk coherently. Mr. Hashmi was admitted into the intensive care unit (ICU) of the hospital. He was diagnosed to have experienced a brain hemorrhage for which he underwent an emergency CT scan. The attending neurosurgeon, Dr. Salman, told the family that based on his clinical findings and the CT scan images, Mr. Hashmi did not require immediate surgical intervention but needed to be closely observed.

Mr. Hashmi was married and had two children. His daughter, Rabia, and son, Jabbar, were living with his wife and him in Karachi. As the oldest sibling, Jabbar was the main bread earner in the family. He made the arrangements for taking his father to the hospital and was bearing all the expenses for his treatment.

On the day following his admission, Mr. Hashmi's condition seemed to improve and he was shifted to the ward but still kept under close observation. Three days later, he deteriorated with a significant drop in his level of consciousness. Dr. Salman, the neurosurgeon, reviewed his earlier decision and decided to operate upon Mr. Hashmi. However, the patient did not improve after surgery. He was able to breathe spontaneously but unable to move or talk. Dr. Salman counselled the family about Mr. Hashmi's poor prognosis, and suggested a no-code status for the patient - meaning that in case of further deterioration, nothing would be done to resuscitate the patient.

The family was conflicted. Jabbar recalled that his father always said that God had created a cure for all illnesses and as a Muslim he believed it was his duty to seek treatment. Jabbar felt that going 'no-code' would be a betrayal of his father's wishes and insisted that Mr. Hashmi should be kept full code and provided every possible chance to recover. Mrs. Hashmi and Rabia were distressed as they felt that further measures to keep Mr. Hashmi alive would only cause him suffering. Rabia believed strongly that her father would not want extraordinary measures to keep him alive.

"Gateway to nowhere" - Photograph by Aamir Jafarey, Islamabad, 2021

*Nida Wahid Bashir, Associate Faculty, Centre of Biomedical Ethics and Culture, SIUT, Karachi

Commentary 1

James Dwyer*

To begin, I want to comment on what we should expect from studying ethics. Some people expect too much. They expect that ethics will provide an algorithm or theory that produces the right answer when it is applied mechanically to the facts of the particular situation. They may even hope that studying ethics will relieve them of the responsibility to judge and act in a complex world. Other people expect too little. They are convinced in advance, by unexamined ideologies, that ethical judgements are just opinions and that no one opinion is better than any other. They even may view ethical discussion as a way of disguising power.

I believe that the study and practice of ethics can provide habits, tools, and perspectives that can help us in our medical work and everyday lives. Ethical perspectives can help us to identify morally salient features that we need to consider and discuss with other people. Good discussions can help us to recognize complex webs of relationships, adjust disparate and conflicting concerns, find better responses to particular situations, and take responsibility for fallible judgments and actions.

So, what is morally salient in this situation? I begin with the conflict. This conflict is about the father's wishes, the role of religion, and the nature of suffering. This conflict may also be about money, gender, sibling order, and authority. We learn that the son is the "main bread earner," financially responsible for the treatment at the private hospital, and the oldest sibling. There seems to be an implicit belief, at least on the son's part, that those characteristics give him some authority to speak for his father. The unpaid labor of the wife and daughter is left out. Since I don't think that money, gender, and sibling order are morally salient in this case, I think that Dr. Salman should avoid legitimizing them.

One promising idea is to organize an in-person meeting (respecting pandemic protocols) that gives voice to all the relevant people, including all the family members. Dr. Salman can represent neurosurgery, but he should also involve nursing, palliative care, and social work. Because this meeting needs to address questions of religion, he should involve a religious authority to provide some context and interpretation. I've been struck over the years by how many putatively religious people insist on doing everything possible. To me, that response seems deeply irreligious. So, it would be good to hear from someone who studies Islam and guides people in their faith.

The meeting should also address Mr. Hashmi's suffering and wishes. Dr. Salman may have missed an opportunity. The day after admission, the patient showed some improvement and was shifted to the ward. That may have been an opportunity to talk to him about his wishes, religious outlook, and concerns about the future. Be that as it may, Dr. Salman and the family now need to address the code status without direct input from the patient. First, Dr. Salman needs to decide if resuscitation is a reasonable medical option in this situation. If so, the code status needs to be addressed in the

The Warrior

Seventeen days old sick baby in his mother's lap. Parents were hopeful, doctors were compassionate. Efforts continued but as days were passing hopes were waning. Doctors and parents were determined. Three uncertain days, a hopeful fourth day. A week later, baby smiling in mother's lap. Neither parents nor doctors: the baby was a real warrior.

Sadaf Aba Umer Kodwavwala (PGD, Class of 2020)

*James Dwyer, Professor of Bioethics and Humanities, Center for Bioethics and Humanities, Upstate Medical University, New York

meeting. Thoughts about suffering, religion, and the future are unavoidable.

To close, I want to comment on a deep cultural pattern that needs to be addressed perhaps by writers and film makers, rather than physicians and bioethicists. In the United States, Taiwan, and Pakistan, I've seen many adult children who are moved by love, gratitude, filial piety, and loyalty to their parents. Although these sentiments and dispositions are laudable, they shouldn't unthinkingly demand every medical intervention that's possible. Sometimes love, gratitude, piety, and loyalty require us not to do everything that's possible, but to do what's best, all things considered. That requires that we focus less on ourselves and more on others.

Distorted

Waris, a good friend I last met 20 years ago. We parted young, ambitious; he, a tall, strong, athletic man with dreams to fulfill. The last picture he sent to me, Covid ICU. This was not him. The skin, bones, hollow sockets staring at me, no more dreams in his eyes. Waris was no more.

Fatema Lanewala (PGD, Class of 2020)

Commentary 2

Shahzad Shamim*

This is a fairly common case scenario of a middle aged gentleman presenting with a hypertensive intracerebral hemorrhage. Pakistan has a relatively higher proportion of these cases, as a subset of stroke, compared to more developed countries. A busy hospital ER in Pakistan would normally receive more than one such patient every day. Some of these patients do reasonably well and do not require surgery. Others do terribly, and are also not candidates for surgery. It is in a very small subset of carefully selected patients that surgery can make a huge difference in patient outcomes. Since the disease is so common, there is enough data available to reliably predict which patient will or will not benefit from surgery. In fact there are smartphone apps that can help clinicians calculate mortality rates in such patients with reasonable accuracy. One would think that with data and technology, surgical indications would be fairly standard all over the world. Yet, the surgical indications and rates appear to vary greatly from region to region, and even within the same region, from hospital to hospital. Although there isn't enough data to draw the same conclusions for hypertensive hemorrhages, in certain developed countries where more than one physician compensation model exists, the rates of surgery for certain surgical pathologies appear to be related to how a physician is compensated for it, a moral hazard in itself.

The case in question is one of those unfortunate clinical situations where the patients themselves are not in a condition to contribute to the decision making and it has to be delegated to the patients' families, along with the physicians looking after them. The decision is easy in cases where surgery will clearly benefit the patient, and in cases where it clearly will not. It is the cases that lie in between these two situations that pose a challenge, and it is these cases where

April 2021 - Nurses attend the last in a series of sessions on *Akhlaq ki ahmiyat* (importance of ethical conduct) conducted in 2020 and 2021 by Ali Lanewala for SIUT's nurses and medical social officers.

*Muhammad Shahzad Shamim, Associate Professor, Section of Neurosurgery, Department of Surgery, Aga Khan Hospital, Karachi

numerous other factors come into play, apart from scientific considerations. An important factor, especially in a country like Pakistan, are the wishes of patients' families. Here, advance directives are usually in the form of a distant conversation between the parent and offspring that may or may not have happened in the presence of witnesses, and may well be taken out of context. Sometimes, the decision is influenced by the family's faith that often supersedes evidence. Often, the decision is influenced by the family's capacity, or willingness to spend money on what may not turn out to be value for their investment. Money, or lack thereof, often trumps both evidence and faith.

Considering that the cost of treatment of a stroke patient, and cost of care of a stroke survivor is phenomenal anywhere in the world, and the fact that in a country like Pakistan, this cost has to be borne by the family, it may be debated whether it is indeed justifiable to influence decisions on these factors. With increasing healthcare sophistication and cost, health expenditure is becoming catastrophic with more people being pushed below the poverty line due to healthcare than ever before. 'Making the cure of the disease more grievous than its endurance' has a whole new meaning today.

Another rather unappreciated variable in the equation is how families such as Mr. Hashmi's are counselled. An experienced physician can tell you that given the same statistics, a family can be counselled to opt for or against certain treatment options, including surgery. This probably explains how despite the presence of clear evidence, treatment provided to these patients across centres remains variable. It also suggests that the decision to carry on with a certain treatment option, to a large extent, remains with the treating physician. A widely cited BMJ editorial from 1999 termed the best surgeons as the ones who know when not to operate. Despite the reliance on big data, artificial intelligence and machine learning algorithms, 22 years later the editorial stays quite relevant.

Locked Down and Locked Out from Family

I am on the road, city bound from upcountry where I had whisked my young family away from the virus ravaging Nairobi. My phone rings, my sister says "Hurry up, the president just announced cessation of movement in/out of Nairobi for one month." But it is 3 months before I see my family again.

Timothy Kipkosgei (PGD, Class of 2020)

Commentary 3

Daryl Pullman*

The tragic case of Mr. Hashmi presents a number of ethical challenges. Although the question of what constitutes an appropriate clinical intervention given the evolving situation, is essentially a clinical matter, the question of how best to manage Jabbar's rejection of the recommended way forward creates a number of ethical tensions.

Given the facts of the case as presented, there is no reason to question Dr. Salman's clinical judgement. His initial assessment indicated that watchful waiting was the most appropriate course. When the patient took a turn for the worse more aggressive treatment was initiated. Unfortunately, Mr. Hashmi's condition did not improve. Given Dr. Salman's recommendation of a 'no-code' status, we can assume he suspects irreversible neurological damage. As such, further deterioration is more likely than improvement.

It is not unusual in such a situation for a family caregiver to either resist or outright reject the clinical assessment and recommendations. Nor is it unusual to see disagreement within the family unit about the

*Daryl Pullman, Professor of Medical Ethics, Memorial University of Newfoundland, St. John's, Canada

The Mornings Are Getting Painful Day by Day

The dense, stinky-smoke, the view of the smoke visible in the backyards behind the wards, the ever changing colours of the heaps of tissues, blood and infusion sets.
The neglect goes on unchecked, the galleries are loaded with images where I can see the kids sitting under the smoke collecting death.
This apathy is killing.
Amjad Mahboob (PGD, Class of 2020)

most appropriate course of action. Apparently Mr. Hashmi had not prepared an advance directive, nor does it appear he had taken formal steps to appoint a substitute decision-maker. Nevertheless, by virtue of the fact that Jabbar is the major breadwinner for the family and is covering the financial costs of care for his father, he appears to have assumed this important role. For the sake of this discussion we'll assume that Jabbar has the moral (if not the legal) authority, to speak on his father's behalf.

A classical principlist approach to this apparent impasse might characterize the ethical tension here as between the physician's duty to do no harm and to act beneficently on behalf of his patient, as opposed to the substitute decision-maker's autonomous right to make decisions on behalf of his incompetent father. While such an approach highlights some important ethical considerations in addressing this case, principlism often fails to appreciate the nuances of a complex emotional situation. By way of contrast, a narrative approach invites us to step into the life story of Mr. Hashmi and his family, and to appreciate the situation as the family is experiencing it. A relatively young husband and father has just suffered a catastrophic medical event. This family's entire world has been turned upside down as they struggle to make sense of what is happening. As the son and major provider for the family, Jabbar feels especially responsible. Although he has been providing for the family financially, he must now assume the responsibility of being the spiritual leader of this devout Muslim family as well. It is not surprising then that rather than passively accepting the situation before him, he feels compelled to assert some measure of control over an otherwise uncontrollable situation.

The ethical challenge in this complex situation is to assist the family, and Jabbar in particular, in navigating this unfolding crisis situation. While Mrs. Hashmi and Rabia appear to have come to grips with the reality of Mr. Hashmi's situation, Jabbar may need more time. Rather than explaining to him what won't be done (i.e. 'no code') he should hear about what will be done (care and comfort). There are a variety of possible interventions between 'full code' and 'no code'. If Jabbar continues to insist on aggressive intervention, it might be explained that, while not recommended, other interventions could be attempted, but only on a trial basis. For example, should Mr. Hashmi struggle to breathe on his own, he may require a ventilator. Depending on the circumstances, a ventilator might be offered. Whatever the intervention, however, it should be initiated with a therapeutic goal in

"The Cherry Blossom Tree" - Artwork contributed by 9 year old artist, Umme Abeeha Zehra, daughter of PGD alumnus, Asad Jafri

mind and with a clear time frame for assessing whether that goal has been achieved. If there are no measurable improvements within a specified time frame, a particular intervention (including artificial nutrition and hydration) should be either adjusted or withdrawn.

Clearly there is no obligation to provide futile treatment. But 'futility' is a slippery concept, and should be interpreted and applied within a broader context. A narrative approach encourages us to examine the broader social context in which this event is unfolding, and can inform decisions on how best to manage the ethical tensions involved.

Commentary 4

Ikram Burney*

The case is interesting because it epitomizes a common and recurring theme in acute care hospitals, both in Pakistan and elsewhere: a patient is admitted to the hospital and a clinical path is understood, and then the clinical situation and circumstances change, and a conflict surfaces. In this case, 65 year-old Mr. Hashmi was admitted to the ICU with a cerebral bleed and deemed not to require neurosurgical intervention because of "clinical findings and the CT scan images." Over the next few days, however, the surgeon is seen discussing 'futility of care' with the family.

On the surface, there appear to be no gaps in the medical management of this case. There is a common assumption by patients and their families that admission to the hospital implies that treatment will be available and will lead to a positive outcome. However, this is a flawed assumption. For patients who are admitted to hospital ICUs, a limited number get well and are able to actually walk out of the hospital. In Mr. Hashmi's case, the question arises whether the dire nature of the situation was communicated to the family and along with the probability of recovery, the possible chance of the patient not recovering clearly explained.

A common reason for conflicts between the care team and the patient-family complex is a lack of clear communication of the expected outcomes early on. Conflict may occur among clinicians, between the patient and family, between relatives and clinicians - or between the relatives of patients - especially when the patient is incapacitated. The latter is the most challenging situation, as was the case with Mr. Hashmi's family. There are no straightforward solutions to manage such a conflict.

The scenario depicts a conflict within the family but it also hints at a conflict between the surgeon, Dr. Salman, and the patient's son, Jabbar, who have different views about Mr. Hashmi's care. Does Dr. Salman have a responsibility to do more to resolve the differences? In such situations, possible strategies for conflict resolution include repeated discussions, time-limited treatment trials, a second medical opinion, or seeking the help of a hospital ethics committee.

Insofar as the resolution of conflict is concerned, it is important to try whenever possible to reach a conclusion, as opposed to making a judgment. Rational arguments can often be made for either party's approach, as in Mr. Hashmi's case. Arguments can be advanced equally well to support Jabbar's conviction that his father must be kept alive

Homecoming

Having all spent the last five years of our lives running away from home, the demise of our father brought us back. Three estranged siblings. Some genuinely came to pay their respects. Others came armed to fight over the inheritance left by our dear father: the property that sent us packing a few years ago!

Teresia Maina (PGD, Class of 2020)

*Ikram A. Burney, Senior Consultant in Medical Oncology, Department of Medicine, Sultan Qaboos University Hospital, Muscat, Oman

and Rabia's desire not to prolong the suffering. A judgment can neither reflect the complexity of an issue nor does it allow satisfactory resolution of the emotional nature of the conflict.

The best way to manage a conflict in healthcare is to prevent it. Communicating expectations and likely outcomes with the patient and the family at an early stage may prevent conflict, especially when the patient is unable to make rational decisions. In an era of sophisticated scans, genomics, machine learning, and artificial intelligence, it is important to also retain a focus on soft skills such as communication, collaboration, and conflict resolution. Together, these skills form a strong bedrock for the armamentarium in medical practitioners' toolkits.

COVID Eid

Received a call in the morning. "I want to meet my father; he is in your ward for two weeks now and today is Eid." I make arrangements for that. "Can you come after prayers?" "Yes," he says. "Salam and Eid mubarak, Doctor." "I am so sorry dear, you have to wait for the body."

Asadullah Jafri (PGD, Class of 2020)

"How to Die" from page 1

The Roman Stoic philosopher Seneca remarked that it is not only difficult to learn how to live but that "it takes the whole of life to learn how to die." A few thousand years down the road, humans have not yet succeeded in evading death but medical advancements in the last century are pushing back the boundaries, raising new questions about what kind of life is worth living and what it means to die well. In one of Plato's dialogues (The Republic, Book III), Socrates says that Herodicus, regarded as the tutor of the Greek physician Hippocrates, tormented himself as well as others "by the invention of lingering death." Herodicus, who had a chronic disease, spent his life trying to cure himself. Since recovering from that disease was impossible, he used his skills in medicine and therapy to keep himself going till he reached old age. Plato criticizes Herodicus for practicing such coddling medicine and argues that Aesculapius (the god of medicine) did not teach such medical practices - not out of ignorance, but because Aesculapius was concerned about society's functionality. In a well-governed society, according to Plato, there is a function specific to each member of that society, and no one has "leisure to be sick" and doctor himself all his days.

Whether we agree with Plato's rather stern viewpoint about a useful life or not, it is hard to deny that medical advancements that are making it possible to live longer, are changing the ways in which we die. In traditional narratives of death in many societies, an old parent would die in his bed after having distributed inheritance and attended to his responsibilities. Death in a familiar environment, surrounded by loved ones, fulfilled the dying person's psychological and emotional needs without involving many healthcare professionals. Death was deemed imminent and faced with patience and confidence. This was a constant in history across cultures. Prophet Muhammad's (peace be upon him) companion *Continued on page 9*

Experience of Frontliners in COVID Pandemic

Personal protective equipment which was the armor in the battle against COVID-19 provided in limited quantities. COVID positive patients referred from private hospitals to government setup. A COVID positive patient came. Staff and junior doctor refused to attend the patient. I was frightened too but the Oath gave me courage and I attended this patient.

Rabia Jamil (PGD, Class of 2020)

"How to Die" from page 8

Bilal bin Rabah on his deathbed, sang, "Tomorrow we shall meet with our beloved ones, Muhammad (pbuh) and his companions." The Sufi ascetics embraced death gladly. Ibn Qayyim al-Jawziyya explained that death was a way of union with God, saying, "Every lover yearns for the meeting with his beloved."

In fifteenth century Europe, Christian texts titled *Ars moriendi* (the art of dying) were well known. These texts provided guidance on the proper rules and procedures for facing death in the best way. For those who gladly accepted it, death was not only a natural process but also had a spiritual and 'other-worldly' aspect. Dreams and presentiments of death were common, even among ordinary people. French historian, Philippe Ariès, quotes from the history of Europe, the last words of kings, knights, saints, common people - even children - calmly facing death. "I shall not live two days," "I see, and I know that my end has come," "I feel that death is near," "My death is at hand, that's what it is," were common phrases near death.

Despite the fact that people in earlier times prepared themselves for dying well, death did not ask before coming - nor could it be turned away. With the rapid scientific advancement in the last century, death has become less adventitious, at least, in technologically advanced societies where a large cohort of the population dies after going through the regular phases of life (education, marriage, career, and children) and reaching old age. Death no longer seems as unpredictable as before, but something has been lost: The presentiment of death has become rarer.

According to a well-known quote by Ivan Illich, "In every society, the dominant image of death determines the prevalent concept of health." Death in our times has been medicalized. From an inevitable natural phenomenon or a call by God, death has transformed into the effect of an identifiable cause (disease) which it is possible to get the better of. The categorization of death into natural and unnatural/abnormal/accidental supplements this perception. Along with this, the idea of 'savior', formerly invested in the physician's persona, has now materialized in the form of the healthcare institution and we turn to the hospital to save us from death. The resultant medicalization of society elevates the 'power over death' perception to a new level. Death feels optional. Consequently, people spend massive amounts of money on healthcare in the last few days of life. While this does not eliminate death it does create the most rational and normal form of death - a hospitalized death under the supervision of medical experts.

Atul Gawande, in his essay, 'Letting Go', writes that anxiety about death is increasing in modern society. According to Gawande, until the actual declaration of death, there is often a state of denial regarding impending death by both the patient and the family. Possibly, the denial stems from this relatively new, institutionalized image of death as something that can be controlled, circumvented, defeated - or even chosen. As a result, the modern, hospitalized death often follows extraordinary efforts to 'do everything' to prolong life - regardless of the quality of that life. For those who are engaged in healthcare provision, a BMJ editorial asks a thought provoking question: "Would you like to die the way your patients do, doctor?" As Seneca wrote, the question of how to die is perhaps connected to the question of how to live - the other side of the same coin.

Stolen Flowery Moment

"I know my cancer is advanced but COVID-19 has done me worse than missing chemo: the lockdown.
I longed to see her - my niece, the only new girl in the family since me. I may never hold, bless her."
Her pain was palpable, I was empty, there was little I could do to comfort her.
John Weru (MBE student, Class of 2021)

CBEC Graduates PGD Students, Class of 2020

In June 2021, CBEC's 9th batch of PGD (Postgraduate Diploma in Biomedical Ethics) students crossed the finish line. Congratulations to our 10 newest alumni who will now start their 'internship' and implement bioethics teaching projects in their institutions.

January 2020 - Kenyan students on the terrace outside CBEC during Module 1, in pre-COVID days - (From left to right) Teresia Maina, Timothy Kipkosgei, John Weru, Geoffrey Sang and Melba Katindi

No more lunches on the terrace: PGD and MBE students attend a virtual class during the Research Ethics and Public Health Module in October 2020

Shanza Agha
Senior Medical Officer, Obstetrics and Gynaecology
OPD, Civil Hospital, Karachi
Project: "Introducing Basic Concepts of Clinical Ethics to Medical Officers and Paramedics at Dr. Ruth K. M. Pfau Civil Hospital, Karachi"

Syed Asadullah Jafri
Head of Department Anaesthesia
Combined Military Hospital, Karachi
Project: "Introducing Biomedical Ethics to Post-graduate Residents of Surgical Specialities in Combined Military Hospital, Malir"

Rabia Jamil
Senior Registrar, Obstetrics and Gynaecology
Dow University of Health Sciences, Karachi
Project: "Introduction of Bioethics to Obstetrics and Gynaecology House Officers at Dr. Ruth K. M. Pfau Civil Hospital, Karachi"

Melba Katindi
Advocate, High Court of Kenya
Katindi and Company, Nairobi
Project: "Introducing Basic Concepts of Research Ethics to Community Paralegals in Key Populations Organizations in Kenya"

Timothy Kipkosgei Kiplagat
Research Scientist (SERU)
Kenya Medical Research Institute (KEMRI), Nairobi
Project: "Introduction of Research Ethics to KEMRI SERU Ethics Review Committee Members"

Sadaf Aba Umer Kodwavwala
Associate Professor, Paediatric Urology Department
Sindh Institute of Urology and Transplantation, Karachi
Project: "Introduction of Bioethics to Paediatric Urology Team at Sindh Institute of Urology and Transplantation (SIUT), Karachi, Pakistan"

Fatema Ali Lanewala
Assistant Professor, Ophthalmology Department
Sindh Institute of Urology and Transplantation, Karachi
Project: "Introducing Biomedical Ethics to Ophthalmology Residents at Shaheed Mohtarma Benazir Bhutto Institute of Trauma & Dr. Ruth K. M. Pfau Civil Hospital, Karachi "

Amjad Mahboob
Associate Professor
Gajju Khan Medical College, Swabi
Project: "Introduction to Biomedical Ethics for the Undergraduate Students of Pharm.D Program Enrolled at University of Swabi, Khyber Pakhtunkhwa"

May 2021 - Pakistani PGD students at CBEC after more than a year of virtual interaction - (clockwise) Amjad Mahboob, Sadaf Kodwavwala Rabia Jamil, Shanza Agha, Fatema Lanewala and Asad Jafri

Teresia Wamuyu Maina
Part-time Lecturer, Public Health Department
Pwani University, Kilifi County
Project: "Introducing Basics of Biomedical Ethics to Final Year Master's Students in the School of Health Science at Pwani University, Kilifi, Kenya"

Geoffrey K. Ngasura Sang
Research Scientist (SERU),
Kenya Medical Research Institute, Nairobi
Project: "Introducing Concepts of Research Ethics to Research Scientists and Regulatory Staff of the Center for Global Health Research, Kenya Medical Research Institute"

After completion of course work, we carry our MBE students forward through field work and thesis writeup: A metaphor for the struggles the faculty has been experiencing keeping our academic programs on track in Covid stricken times.

"No" to Placebo Controlled Trials of Covid-19 Vaccines

Murtaza Dhrolia*

Recently, the WHO Ad Hoc Expert Group proposed that it is ethical to continue placebo-controlled Covid-19 vaccine trials in countries where vaccines are not available because placebo control trials are cheaper than non-inferiority trials which cost more to arrive at the same results. They further suggest that since participants would receive the local standard of care they would not actually be left worse off.

In an article published in the *Indian Journal of Medical Ethics*, the authors (Murtaza Dhrolia and Aasim Ahmad) contend that the main reason for limited vaccine supplies in developing countries is hoarding instigated by "vaccine nationalism" and economic bullying by rich countries. Instead of rectifying this global injustice, the WHO Group is opening the door for exploitation. The authors argue that cost efficiency should not be a reason to use a placebo and non-inferiority trials would minimize morbidity and mortality while providing reliable results. Justifying placebo-controlled trials for Covid-19 vaccines by using a "standard of care" unfairly thrust upon developing countries *Continued on page 12*

CBEC welcomes two new members to the family

Farid bin Masood (MA) with a background in philosophy and sociology has joined as Faculty (Part time), increasing the strength of the social sciences at the Centre.

Sundus Rasheed (BSc) has joined as Outreach Associate (Part time) and brings with her a rich experience from communication sciences as an educator and a media person.

*Murtaza Dhrolia, Associate Professor/Consultant Nephrologist, The Kidney Centre Postgraduate Training Institute, Karachi

Humanities and Bioethics with Marcia Childress March 6, 2021

Saint Sebastian Interceding for the Plague Stricken (Josse Lieferinx, 1497), used in the humanities session with Dr. Marcia Childress

In March 2021, Marcia Childress, Associate Professor of Medical Education (Medical Humanities), University of Virginia, conducted an online humanities and bioethics session for PGD and MBE students which involved a fascinating discussion on the depiction of epidemics in art. Another novel aspect of the session was a stimulating pre-session exercise: writing 55 word stories. Students were surprised at their ability to encapsulate ideas, experiences and feelings within 55 words, resulting in stories that were powerful and deeply personal.

"No to Placebo-controlled..." from page 11

is unethical. The Declaration of Helsinki also states, "While the primary purpose of medical research is to generate new knowledge, this goal can never take precedence over the rights and interests of individual research subjects."

The recommendations given by the WHO Ad Hoc Expert Group are likely to increase significantly the burden of Covid-19 vaccine research on impoverished populations of developing countries. These need to be debated and stopped.

National Bioethics Committee's Position on Placebo Controlled Covid-19 Vaccine Related Trials

Saima P. Iqbal, Chairperson, REC - NBC

National Bioethics Committee (NBC), Pakistan, a federally appointed body, is entrusted with ethical review of clinical trials and other applicable human subject research. NBC permitted the use of a placebo arm in Covid-19 vaccine trials in Pakistan when such research initially began in 2020, and no vaccines were available. With the efforts of the National Command and Operations Center, several vaccines are now available across Pakistan with Emergency Use Authorization. NBC therefore believes there can be no ethical justification to permit continued use of placebo in new Covid-19 vaccine trials. New interventions must be tested against an active control arm (non-inferiority design), using an already available vaccine to ensure participants are not exposed to easily avoidable harm.

Centre of Biomedical Ethics and Culture
Sindh Institute of Urology and Transplantation
7th Floor, Transplant Tower, Yaqoob Khan Road Near Civil Hospital, Karachi 74200, Pakistan.
Phone:(92 21) 9921 6957
Email: cbec.siut@gmail.com www.siut.org/bioethics
Facebook: https://www.facebook.com/cbec.siut/