and balancing societal values concerning scientific and medical issues, and that this expertise should be useful to government officials" (p. 129). Claiming that kind of expertise, turning bioethics into MacIntyre's moral fiction of bureaucratic management, is the surest road to irrelevance.

How strange—and unfortunate—then was a petition published by The Hastings Center this March and signed by almost fourteen hundred of, as the Center's website put it, "the nation's most prominent bioethicists and health leaders." The petition noted—quite rightly, I think—the existence of "a large bioethics literature on how to approach triage decisions," and it suggested that bioethicists were well positioned to offer guidance for such choices to health care workers. But it also offered this: "However, as bioethicists and health care leaders we do not prefer to *guide* these decisions. We prefer to *prevent* or *reduce* the need for them." That is, not content to offer the expert knowledge that was truly theirs, they preferred to claim a kind of expertise they do not possess: MacIntyre's moral fiction of managerial expertise.

Thus, they offered recommendations about the manufacture and distribution of medical supplies; about sharing resources with other, poorer countries; about strategies for communicating information about the virus; about government funding to cover needed medical treatment; about provision of sick leave. In short, about all sorts of issues they should certainly address as *citizens* with their fellow citizens when shaping our common life, but on which being a "bioethicist" provides no special expertise.

It is worth asking what a post-pandemic bioethics should look like. It could continue to offer policy advice clothed in the garb of claims to expertise. Perhaps, though, it should return to its roots, focusing less on policy decisions that are the province of all citizens and more on some of the fundamental moral questions that life always presents: Just how important is my survival? Are there other goods that have at least as strong a claim on me? How can we learn to talk about the value of life on a horizontal plane (the natural life cycle) and at the same time of that plane intersected vertically at every moment by our relation to the Eternal? Do we have special, preferential duties to those who share our political community? Or are we just citizens of the world? What virtues do we need if we are to live well in the face of such a pandemic? How might we inculcate them? What do we mean by a "crisis," and how can we recognize one when we actually face it?

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Realigning Pakistan's Bioethics Center during Covid-19

by Farhat Moazam and Aamir Jafarey

Time in the Center of Biomedical Ethics and Culture in Karachi seems to have acquired a new metric, the Pre-Covid-19 Era and the Covid-19 Era. CBEC, part of the Sindh Institute of Urology and Transplantation and a designated WHO (World Health Organization) Collaborative Centre in Bioethics, is the only such center in Pakistan, a country of over 200 million people. In January 2020, we had just completed our intensive on-campus Foundation Module for students from Pakistan and Kenya enrolled in the postgraduate diploma and masters in bioethics programs. The coming months were tightly scheduled with international travel and teaching. Wuhan's Covid-19 lockdown seemed to be someone else's problem.

By February 26, with the first case diagnosed in Karachi, the problem became ours. The schedule was wiped clean. Faculty anxiety mounted about transitioning to a work-from-home system. Video conferencing skills were brushed up on, and active files were transferred to cloud storage.

It became clear that we had to move out of our comfort zone of routine academic teaching, supervision, and research and turn our attention toward the Covid challenges. This became evident during the videoconference debriefing of one student, the only infectious diseases specialist and health planner in a less developed province of the country, who told us that Covid-19 patients were on the rise and that there were insufficient ventilators even for normal times. How should he advise colleagues about the allocation of ventilators if patient numbers surge? Soon after, we received a call from a colleague in Karachi with a similar problem. Of the seven ventilators designated for Covid-19 patients, six were already in use. What criteria should the hospital use to allocate the remaining machine if faced with several eligible patients at once?

Several Covid-19-related guidelines to assist decision-making had emerged from developed countries, but none existed in Pakistan. We need our own guidelines, sensitive to local realities. In addition to addressing the allocation of scarce resources, in a deeply hierarchical society, it was necessary to ensure the protection of lower level members of the health team, including the cleaning staff, security people, and other ancillary staff members. Using the principle of reciprocity, the guidelines emphasized providing them with suitable personal protection equipment and ensuring access to health care.

In a family-centric society in which three or more generations often live

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under one roof, input from multiple colleagues involved in management of Covid-19 patients revealed that our colleagues' greatest anxiety was fear of infecting elderly parents and others living with them. Clauses included in the guidelines prioritize medical treatment of infected first-degree relatives of those working on the front lines, a recommendation not found in other guidelines. Indemnification for medical decisions made during the pandemic was included to remove fear of reprisals.

The final document, "COVID-19 Pandemic: Guidelines for Ethical Healthcare Decision-Making in Pakistan" was posted on the center's website (http://www.siut.org/bioethics/) on April 15.

One of the distance-learning components of CBEC programs involves students posting on a blog news items, academic articles, and personal and professional experiences that raise ethical issues. The blog is an important tool to initiate discussions among students in which faculty members also participate. By March, blog postings and discussions had converted almost entirely into matters related to Covid-19. The discussions were shaped by local socioeconomic and political contexts and, in some cases, existing community values and religious beliefs.

A student working in a major Karachi hospital posted that an acutely ill patient had died in the emergency room soon after arrival. Suspecting Covid, doctors informed relatives that, per government regulations, they were required to take a nasopharyngeal sample postmortem, and if it was positive, the burial would have to follow operating procedures put in place for Covid-related deaths and use government-appointed services. Enraged, the family refused, saying, "You are accusing us of carrying a *gandi beemari* ["dirty disease"]. . . . You want to hurt a dead man further by taking sample? We are . . . clean Muslims and pray five times a day. You cannot stop us from taking his body for final respects and burial."

As the pandemic tightened its grip and the government-enforced lockdown took hold, everybody had a Covid story to tell, from the common man on the street hit hard economically to doctors facing unprecedented personal and professional challenges.

A staff member related to one of us that information about members of an extended family who tested positive and were quarantined in their house somehow made its way into social media. "We were inundated with comments from people we did not know blaming us for endangering lives of others, we received veiled threats, like lepers in olden times," a member of the family described. "We have never experienced *badnaami* ["loss of good name"] like this before."

Wishing to provide an avenue for sharing such experiences, CBEC initiated a #HumansOfCovid series on its official Facebook page. Narratives began to emerge challenging the feasibility of enforcing international recommendations in an impoverished, family-centered society in which one daily wage earner can be responsible for many lives, where one apartment can house three generations of a family, and where prayers are considered communal rather than solitary activities.

Stories we received reveal how the pandemic, instead of producing the much touted "coming together," can in fact serve to illuminate widening fault lines within the social fabric of a country. South Asia has a community of transgender individuals, called *khawaja seras*, who are marginalized and make a living either as sex workers or by begging on the streets. A CBEC colleague posted her conversation with a *khwaja sera* in which the latter said disdainfully that social distancing was of no relevance to her community, adding poignantly, "We have been treated like a virus all our lives."

Many men in Karachi are daily wage earners who have moved to the city from different parts of the country. With the cessation of public transportation, a bus conductor told a staff member, "I cannot meet my wife's eyes when I go back home empty-handed . . . without groceries." A vendor who sells vegetables from a cart in the neighborhood said, "We have always been poor. [With the lockdown,] I will not have customers. Who will help us? Imran Khan [the prime minister]?"

Physicians shared anxieties about situations they had never imagined facing. One young doctor said he had "never imagined there would be a time when as a clinician I would experience this feeling, a soldier walking through a minefield [but] fearful of the unknown, but bound by duty, filled with love for the nation." Female physicians expressed concerns for themselves but especially for their children: "My two-year-old son does not understand why I no longer hug him when I get home." Another shared a colleague's distress when both she and her physician husband were posted for Covid duties. The colleague wondered about the lack of options for her nine-year-old son if both she and her husband died. Several worried about infecting elderly parents living with them.

The pandemic may have pushed us out of our comfort zone but, adapting to new realities, we are contributing to Pakistan wherever we can. Our students remain our prime responsibility, and we are still struggling with how to reconfigure educational strategies until the world returns to a semblance of normality.

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