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The Place of Solidarity in Public Health Ethics

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ABSTRACT

When we consider the literature that has been produced exploring approaches to public health ethics, it is rare to find any mention of solidarity. One obvious conclusion is that solidarity is a meaningless or superfluous consideration. We suggest that this is not the right conclusion to draw, and that we must first understand what solidarity is and then consider what difference it might make to thinking about issues in public health ethics. In this paper we, first, outline some of the existing approaches to public health ethics and suggest that they often involve a set of questionable assumptions about the nature of social relations as well as a clear commitment to particular values. A failure of imagination in relation to solidarity is not, however, an argument against taking the concept seriously. Second, we propose a particular account of solidarity, suggest reasons why it is important for thinking about ethical issues in public health, and suggest how it relates to other relevant values. We argue that it is essential to engage with the issue of where we ought to place solidarity within our debates and frameworks for public health ethics.

Key Words: solidarity, public health, ethics, justice, frameworks

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> *No man is an island, entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friend's or of thine own were; any man's death diminishes me, because I am involved in mankind, and therefore never send to know for whom the bell tolls; it tolls for thee.*
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> John Donne[1]

INTRODUCTION

Over the last ten years or so, there has been a dramatic rise in the number of publications exploring the ethical issues that arise in public health policy and practice. However, when we consider this literature, it is rare to find any mention of solidarity. We find this surprising and think this fact requires some explanation. In this paper we, first, outline some of the various approaches that have been taken as a means of discussing ethical issues in public health and seek to argue that much of this work, despite the use of different methods and theoretical underpinnings, is remarkably similar in its explicit and implicit adoption of a particular set of values that appear to be motivating them. We suggest that such accounts have not so much rejected solidarity as just not considered it adequately. Even when it is explicitly rejected, it is for arbitrary, rather than considered, reasons. In the second section, we do some more positive work and propose, briefly, an account of solidarity and suggest that it has a vital place to play in arguments about the nature of public health ethics. We end by outlining an alternative to the apparently dominant ideas in the field and suggest how taking solidarity seriously is one element in a richer and deeper approach to public health ethics.

SOLIDARITY: VISIBLE IN ITS ABSENCE

There has been a growing body of work, particularly over the last ten to fifteen years, outlining and exploring different frameworks for thinking about public health ethics. However, one striking feature of much of this work is the absence of any mention of solidarity. What are we to make of this? There seem to be a number of options. First, is this a sign that it is thought to be a *superfluous* value, and so we can exclude it from our thinking and any list of relevant ethical considerations? On this view, it might be that solidarity is considered to be captured by some other value or set of values

(solidarity is what we might term a 'non-basic value'). Second, solidarity might be *rejected* as a value. This could be for various reasons. Perhaps solidarity has been considered as a possible relevant consideration, and then rejected because it is not considered to be a real or an important value, or perhaps because it is considered to be unclear what we mean if we talk of 'solidarity'? Third, and, perhaps, most likely, solidarity has just been a *tacit* value. It has just not been given adequate consideration before, because it has not been part of mainstream discussions in normative ethics, bioethics and public health ethics. In the rest of this section of the paper we attempt to explore which of these explanations are most influential. However, whatever the reason for solidarity's absence, the fact of its absence should be noted.

A good starting point to see that solidarity is largely absent from discussions of public health ethics is to consider some of the more substantive, book-length works in the literature that has emerged in recent years. For example, what is probably the leading textbook on public health ethics and law produced by Larry Gostin[2] doesn't contain a single reference to solidarity. Madison Powers and Ruth Faden,[3] somewhat surprisingly, make no mention of solidarity despite their interest in social justice. Stephen Holland,[4] in his textbook on public health ethics, says nothing about solidarity, and John Coggon,[5] in his otherwise excellent book-length discussion of public health law and ethics, explores some related concepts such as public, community and the common good, but pays little attention to solidarity. In one of the many overviews of the literature, produced by Faden and Shabaya[6] in the influential *Stanford Encyclopedia of Philosophy*, solidarity is not even mentioned, never mind discussed.

By contrast, solidarity is referred to on a number of occasions in the Nuffield Council of Bioethics (NCoB)' report on public health ethics,[7] but the articulated role of the concept in their approach is limited. They argue that a narrow reading and application of John Stuart Mill's harm principle[8] is inadequate as an approach to public health ethics. Mill's influential principle is often roughly held to say that it is only legitimate for the state to interfere in the autonomous choices of competent individuals where such choices may have harmful consequences for others. Interference on the grounds of protecting an individual or seeking to improve their lives is an insufficient justification for state action. The NCoB, by contrast, argue for government action on other grounds in at least some situations, such as where the provision of a health care system may ensure a framework for adequate equality of access to health care. They suggest that a fuller liberal approach can be supported by what they term a 'stewardship' model. They do not really explain what this view is in any detail and provide little support for it in a theoretical sense. They focus instead on sketching out

what such a model would support in practice.[7] Does it move beyond the 'Millian' paradigm that they critique? There is reason to think that it does not.[9] One way that the NCoB could have sought to justify their approach would have been to make more of the idea of solidarity, but they do not do so. They do appeal to the concept but its role in their view is rather sketchy, and this was perhaps one influence on their part-sponsorship of later work on solidarity by Prainsack and Buyx.[10] Certainly, in the discussion of a number of cases in the NCoB report, solidarity plays no real role, and the suggested policy solutions to the cases that they consider, reinforce the idea that it is liberty considerations that do most of the work.[9]

A second place to look for a role for solidarity is in the attempts to formulate different sets of principles or values as a means of discussing public health ethics, under the influence of the widely cited 'four principles of biomedical ethics': beneficence, non-maleficence, justice and respect for autonomy.[11] Some supporters of the four principles approach insist that this is all that is needed to consider any ethical issue in bioethics, including ethical issues in public health.[12] On this view, presumably, if solidarity has any place at all, it is a 'non-basic value' and can be 'translated' into one or more of the four principles. Perhaps the concept of solidarity is captured by that of beneficence or justice, or some combination of the two? We do not know of any supporters of the four principles that have explicitly argued this point in relation to solidarity. However, if solidarity has any real substantive meaning, as we believe that it does, it is difficult to see how it can be interpreted, understood and applied in terms of the four principles. An alternative approach to public health ethics is to see public health activity as distinctive so that if we wish to approach ethical judgment through using such a framework, then it might be plausible to use a different set of starting values. Over the last few years a number of different frameworks for thinking about public health ethics have been produced, loosely inspired by *the* four principles, but appealing to other elements. Here we outline and discuss just two such representative approaches.

The first is that proposed by Ross Upshur,[13] when he offers a set of four 'principles for the justification of public health interventions' as follows:

1. Harm principle;
2. Least restrictive or coercive means;
3. Reciprocity principle; and
4. Transparency principle.

The second is that produced by James Childress et al. (2002).[14] This account is much more ambitious, in that they are interested in sketching out an account of public health ethics in two parts. The first element seeks to

outline a set of moral considerations 'generally taken to instantiate the goal of public health' as follows:

1. Producing benefits;
2. Avoiding, preventing, removing harms; and
3. Maximising utility.

The second element then offers five 'justificatory conditions' for possible interventions to be used in potentially seeking to achieve such public health goals. These are:

1. Effectiveness;
2. Proportionality;
3. Necessity;
4. Least Infringement; and
5. Public Justification.

There are, of course, many issues to talk about here if we were to focus on each account in any detail, particularly in relation to the nature of the different elements, how the substantive and procedural elements relate to each other, and how they are suppose to be used in practical judgment.[15] However, for our purposes in this paper, the first thing to notice is that neither proposal mentions solidarity explicitly (and, indeed, the concept is not mentioned in either paper). Second, whilst there is some overlap between the features picked out, there are also some significant differences. Upshur explicitly talks of 'principles',[13] where as Childress et al. call them 'considerations'.[14] Perhaps this is important, in the sense that a 'consideration' is less pre-defined than a principle, maybe such a notion will allow us to capture what it is that we want when we talk of solidarity? However, Upshur probably gets closest to the idea of solidarity in his appeal to the 'principle' of reciprocity.[13] Reciprocity requires some mutual, social interaction, which may relate to solidarity, but it is not clear that solidarity is just a sub-set of reciprocity. The three 'goals' outlined by Childress et al. don't obviously relate to solidarity in any obvious way, beyond any possible 'translation' of the concept into benefits/harms as considered above in relation to the four principles. Nothing in the 'justificatory conditions' that they outline suggests any place for solidarity either.[14] What both these frameworks do illustrate is the apparent dominance of ideas about negative liberty in discussions of public health ethics. So, for example, these views appeal to the idea of least restrictive/coercive means and least infringement. This clearly points to the high value that they assign to individual freedom (in the sense of both autonomy and liberty).

A third possible place to look for a discussion of solidarity in an account of public health ethics is to see whether it is mentioned in documents that

are more focused on policy rather than theoretical considerations. Perhaps, surprisingly, it is actually more visible here than in the more theoretical considerations outlined above. A good example of this is in the documents produced by the University of Toronto's Joint Centre for Bioethics (JCB) infectious disease and pandemic ethics framework documents.[16]

The JCB approach proceeds by outlining ten 'substantive values' and five 'procedural values' to take into account in thinking about ethical decision-making in response to a pandemic. The ten substantive values are:

1. Individual liberty;
2. Protection of the public from harm;
3. Proportionality;
4. Privacy;
5. Duty to provide care;
6. Reciprocity;
7. Equity;
8. Trust;
9. Solidarity; and
10. Stewardship.

The five procedural values are:

1. Reasonable;
2. Open and transparent;
3. Inclusive;
4. Responsive; and
5. Accountable.

This is not the place to discuss whether this is a coherent list or whether these are even values (some are clearly obligations, not values). It is solidarity that we are interested in here, and it is noteworthy how this value is outlined in this document. However, when this is considered in more detail, it is clear that solidarity is used in a very particular way. There is a greater focus on the possible policy implications of the application of the concept rather than on what the concept actually means. It is largely used here to motivate the need for taking account of considerations relating to global solidarity in the sense of responding to infectious disease threats in lower income countries, etc. or to invoke the need for collaboration between health care institutions. These are certainly important ends, but it remains somewhat mysterious how solidarity as a concept relates to them, as it is not clear how solidarity is supposed to relate to other relevant considerations. For example, is it okay to restrict freedom somewhat to bring about greater solidarity? Or does such an idea make no sense? Why is solidarity described as though it is something that only exists 'among health care professionals,

services and institutions',[16(p.7)] rather than citizens themselves? We are presented with a list of relevant values and a number of limited scenarios to consider where they are to be discussed, but no account of the status and weight to be attached to each value.

The general lack of clarity about where values come from and what grounds them invites a tendency to 'pick the values' you like, as happened explicitly on the North Carolina Public Health Task Force when formulating their pandemic plan.[17] They started with the JCB list above and then rejected various values including solidarity as effectively being of little relevance in the United States (or at least in the State of North Carolina). Tong, a member of the Task Force, makes the substantive claim that: "… solidarity with fellow citizens is not as important to Americans as being able to chart the course of their own individual lives."[18(p.219)] However, it is not clear that we face the dichotomy that is presented here. At the very least, assuming most or many Americans believe individual choice to be the most important consideration, we might see this very claim as instantiating a kind of solidarity in relation to the status to be accorded to this particular value. The rejection by the Task Force of solidarity is at least partly explained in cultural terms by Tong as follows: "…some Task Force members associated the substantive value of solidarity with unions and/or socialism/communism, [and] the Task Force as a whole decided to forsake this value as too politically charged."[18(p.219)]

This is a curious position to hold. First, simply because a value is associated with a particular historical tradition, that alone does not define its ethical significance. If a committee is discussing options for action to address the potentially difficult decisions to be made when faced by a pandemic, it seems odd to reject a value because it is 'too politically charged'. Much state activity in response to societal threats may be controversial, but this alone hardly counts as a reason not to consider those options. Second, there seems to be a problem in the way that solidarity is understood here. Seeing that solidarity is important, even in a US context, just means that this is something to take into account. The endorsement of a single value such as solidarity does not entail any particular outcome. It does not involve any prior commitment to the status or ranking of particular values, such as the thought that solidarity can be weighed against liberty, or that it will always triumph over it. Tong herself, in the first quotation above, seems to endorse the idea that solidarity is not held to be *as* important as liberty, but seems to miss the fact that this is a claim about the relative weight to be accorded to these two values, not grounds for saying that solidarity is irrelevant or non-existent (even within a US context).

Given the fact that solidarity is largely missing from so many discussions of public health ethics, and where it is present its role is apparently marginal to say the least, we need to explain why this is the case. To give an adequate answer would require an extensive sociological analysis of recent bioethics. All we can do here is reflect on the implications and effects of its absence. There is little evidence that solidarity has been explicitly considered and then been held to be *superfluous* or that it has been *rejected* as irrelevant (except in the Tong case,[18] although even here a solidarity-based explanation might be given for the rejection). It looks far more likely that it has just, largely, not been considered explicitly at all. It is a *tacit* value and it is almost certainly the case that this substantive absence reflects some deep-seated assumptions in recent bioethics, perhaps due to the idea that issues in public health ethics can be, largely, tackled using the resources developed in medical ethics where solidarity has traditionally had no place.

WHAT IS SOLIDARITY?

In considering whether we need to incorporate the idea of solidarity into thinking about pubic health ethics, we must first have a clear idea about what the concept means. There has been recent interest in thinking about how solidarity may be relevant to bioethics, including in public health ethics. For example, in 2012 the journal *Bioethics* had a special issue with a focus on solidarity.[19] Prainsack and Buyx recently published a substantive piece of work on the concept and application of solidarity within bioethics,[10] and bioethicists such as Ruud ter Meurlen has produced a series of papers about how solidarity can help explain and justify various health practices within a health care system where resources are pooled and shared, such as in Europe.[20] What this means is that it is impossible to give an uncontroversial definition of solidarity. In this section, we will briefly consider Prainsack and Buyx's account, chosen because it is highly likely to be influential due to the involvement of the NCoB, and suggest some reasons for thinking it is inadequate, before turning to a brief outline of our own preferred account of the concept.

Prainsack and Buyx's account of solidarity contains some good points, but ultimately seems to miss the central idea of solidarity. It also has some odd features, such as the idea that solidarity is built up from the individual level and that 'costs' are a necessary condition for solidarity. According to Prainsack and Buyx, solidarity signifies: "shared practices reflecting a collective commitment to carry 'costs' (financial, social, emotional, or otherwise) to assist others."[10(p.46)] This 'working definition' is extended and

expanded through the development of three so-called 'tiers' of solidarity. The first tier or level is concerned with the inter-personal where solidarity is held to comprise of: "manifestations of the willingness to carry costs to assist others with whom a person recognizes sameness or similarity in at least one relevant respect."[10(p.47)]

The second level concerns: "manifestations of a collective commitment to carry costs to assist others who are linked by means of a shared situation or cause."[10(p.48)]

At the third level, these commitments are further institutionalized in contractual or legal norms. An example given of 'tier 3 solidarity' is a welfare state, where presumably various shared values—such as a collective ideal of organizing appropriate care for disabled or diseased individuals—are backed up and solidified in legal rules, specifying and possibly enforcing rights and obligations of citizens. Prainsack and Buyx hold that 'higher' levels of solidarity are only possible on the basis of sufficiently strong 'lower' levels. Hence contractual or legal requirements (level 3) to share burdens of joint protection should not be called 'solidarity' if they are not based upon prior collective commitments and values (level 2). Level 2 solidarity in turn would not be possible without prior individual willingness to assist others in need (level 1).[10]

Although it does make sense to distinguish these practices and levels of institutionalization, it seems to us that level 2 is the real heart of solidarity, and this should be the focus of attention. Indeed, it is unclear why the first level—the basis for other levels—is to be seen as 'solidarity' at all. An example given in the text of solidarity at this level is of bone marrow donation.[10] Why call the willingness and practice of one person to assist one or more other persons 'solidarity' and not perhaps altruism or beneficence? Indeed, the basic account of solidarity given by Prainsack and Buyx already involves a joint or collective commitment to bear costs as a means of helping or protecting others—which goes further than the one-person-to-one-other relationships that the authors envision at the first level. This suggests that even on their own 'bare-bone' account of solidarity some idea of a group in which people share common commitments towards others in that group is necessary, but it is unclear how this can happen at the inter-personal level. Indeed, the idea of a 'shared practice' is dropped from the tier 1 account. It looks as though there is a confusion here between solidarity (represented by tier 2) and other forms of mutual relations.

In contrast to many writers on this topic, we hold solidarity to be a deep and enmeshed concept, a value that supports and structures the way we in fact do and ought to see other kinds of moral considerations. This means that we

do not see solidarity as being something that should just be added to any list of values as the JCB[16] does. This is because there are different types of values, and we do not believe that solidarity is on the same 'level' as beneficence or liberty. It is, therefore, no surprise that it cannot be weighed against them. We see solidarity, rather like concepts such as community and trust, as necessarily involving both normative and descriptive components, and as being essential requirements for the very possibility of ethical decision-making.

Rather than giving a definition in terms of necessary and sufficient conditions, we prefer to describe a number of aspects to this extremely rich concept. We suggest there are four dimensions to solidarity: one foundational and three relational. Our approach uses different propositional 'forms' to express these different aspects. The foundational aspect of solidarity can be captured by the fundamental idea of 'standing up beside'. The key thought here is that solidarity requires a public action. The act itself is to be seen and understood in a particular way, it is a positive identification with another and their position, whether individual or group, driven by sympathy and understanding. The action itself has meaning but also purpose in that it is orientated towards improving or correcting past or present disadvantage or injustice. Certainly such acts may increase one's vulnerability to negative outcomes (criticism, arrest, violence), but we do not think, as do Prainsack and Buyx,[10] that 'costs' are a necessary requirement for solidarity. It is also important to see that although the act of 'standing up beside' seems to imply that all of the meaning and value comes from the action of the one 'standing up', this should not be taken to mean that this is a unidirectional relationship. The individual, group, organisation that is the recipient, may also 'contribute' to the relationship, as it is one of mutuality. What is important is that one party does not act out of expectation of benefit from the other, but out of moral concern for that Other. Mutual self-interest may motivate certain kinds of solidarity, such as when a group is threatened by a joint harm (e.g., pandemic, a flood, etc.), but again this is not a necessary condition for an act of solidarity.

Central to our account is the idea of solidarity as a relational concept. The semantics of solidarity are complex, and in an attempt to capture the different elements, we suggest that there are three different ways to express this relational aspect: 'standing up for', 'standing up with', and 'standing up as'. 'Standing up for' contains within it the idea of representing, advocating for, acting or speaking on behalf of the Other. This way of thinking may capture certain intuitions about solidarity, where the party acts to protect an Other that is disadvantaged or unable to articulate their needs in some way. Solidarity as 'standing up for' enables some form of protection, perhaps as

a means to promote the return of this party back to a state where they can achieve their full potential. The second relational dimension is that of 'standing up with'. The key idea that we seek to capture here is that of equality between the parties, a firm mutuality, that arises from the acceptance that as social creatures we need to always be open to the possibility of, and to the value that comes from, being open to other ways of thinking and living. The third relational dimension is that of 'standing up as'. This contains the strongest degree of affiliation with the Other. However, it does not require the eradication of individuality and difference. Indeed, a plausible way of seeing this element in action is to see it at work not just in the grounded biological nature of human vulnerability, but also in a shared polity or culture that requires a shared commitment to equal respect, civil discourse and tolerance of difference and disagreement. Solidarity is not just something that we reserve for those whom we agree with. It entails a shared space where we listen to and learn from each other. We have said much more about these different elements elsewhere.[21]

AN ALTERNATIVE ACCOUNT OF PUBLIC HEALTH ETHICS

It is certainly striking that so much discussion of issues in public health ethics is focused around the kind of values we see in discussions of medical ethics such as a focus on individual autonomy and concerns about state paternalism. This approach carries with it the danger of just assuming certain kinds of metaphysical and normative views about society. For example, it often seems to be accepted that we should begin our ethical consideration with self-interested individuals and we then have to provide reasons why we ought to take others into account. Societies and communities are presumed to be mere aggregations of individuals. Values are seen as items that can be chosen by individuals depending upon whether they are considered relevant to them. Such values are not viewed in any kind of historical or cultural context, nor are they seen as things that predate or stand in some external relation to them as individuals. The focus is firmly on prudential reasons as the core of normative considerations, and an implicit or explicit commitment to negative liberty as the key to ethical thinking. There may be some consideration of something like public goods in an economist's sense, but they are clearly seen as rare, 'paradoxical' and of marginal interest to discussions in ethics.

As will now be clear, we are keen to argue for a different kind of approach to thinking about public health ethics from that which is dominant within the field. We believe it is mistaken to begin an analysis of ethical

considerations at the level of the individual, and then seek to argue 'up from' that individual to that of a social group. Our approach, broadly speaking, derives from a long tradition of ethical and political thought, going back at least to Aristotle. It can also be seem in more recent literature, such as the first generation of writers interested in exploring ethical issues in public health, as in the work of Dan Beauchamp.[22] This general approach begins with a particular conception of the nature of public health, one that deems it odd not to approach public health through a consideration of what we might term socially-embedded concepts such as solidarity, trust and community. These terms are not just to be added to the list of ethical issues, values or principles but are, rather, to be seen as providing the very grounds for the possibility of other moral commitments. On this view, obligations arise out of, and require fulfillment within, the space of mutual recognition and respect that is dependent upon concepts such as solidarity.

Indeed, solidarity does not impose direct obligations, in a way parallel to that which is seen in much traditional ethics. For example, if I accept I have an obligation of beneficence, I am under some duty to act in a particular way: to bring about a (specific) benefit to a person, perhaps because I promised to do so; or they stand in a particular relationship to me (they are my child); or they require some assistance because they are in need. Instead, we believe that seeing the value and place of solidarity implies a different approach to ethics: one that requires us to see and accept the essentially social nature of the ethical. This means that solidarity is not something that can 'trump' other values in a way that, say, welfare may take priority over liberty. Rather, it requires us to see that solidarity arises from the nature of humans as biological and social creatures. It is a constitutive concept, not a voluntarist one. It is part of a challenge to the dominant model of social life that is just so often assumed in much of bioethics.

Solidarity can be seen to be at work in a number of areas of public health. Just as the pursuit of individual ends often requires various social features to be in place to allow for the possibility of such achievements, the pursuit of individual choice is often only possible where collective capacity allows it to occur. Public health is dominated by clear cases where solidarity can be seen as being at work, such as where health care systems share responding to risks and sick individuals are cared for at the time of need; where children are protected from infection through routine childhood vaccination policies; where heath policies are constructed to monitor and address health inequities in a population; where food, air and water quality are monitored and legislation is put in place to ensure consumers are protected; etc. These examples make it clear that solidarity is and ought to be at the heart of ethical thinking about public health. It does not only come

into existence or prove relevant at times of grave 'threats' to a nation state, such as when a major pandemic hits the population.

Solidarity is an important concept for future thinking in relation to the policy and practice of public health for a number of reasons, but one of the most important is the fact that research is showing that the structural conditions that undermine (or sustain) solidarity among social groups are related to key indicators of health and well-being. Much public health activity is focused on identifying and acting to remove or reduce health inequities. Creating and maintaining solidarity has a clear role to play in contributing to this aim. Solidarity is an important concept for an analysis of public health ethics because it supplies an essential component to the answer to two fundamental questions: Why be moral? and What does it mean to be moral? Solidarity is formed through the combined cognitive and affective recognition of human interdependencies. This recognition provides the reasonable motivation for ethical conduct, and it is one perspective from which to offer richer and deeper interpretations of the substantive requirements imposed by the principles that have been at the heart of more mainstream bioethics such as autonomy, beneficence, equal dignity and respect, and justice.

CONCLUSIONS

In talking about solidarity we seek to re-orientate public health ethics away from the tendency of many discussions to begin with the individual (and their rights and liberties). To focus on individuals, then requires a solution to the 'problem' of how to account for the fact that we are to hold the interests and vulnerabilities of others to be of central importance to us. Instead, taking solidarity seriously allows us to see different factors such as the distribution of health and disease as being of joint and common concern. If I am healthy and you are sick, the appropriate response is not one merely of pity or even sympathy by me towards you, but rather seeing that there is a connection between us. Solidarity allows us to see that your condition is actually inextricably related to my condition. This is not merely because your condition might be a threat to me (due, for example, to contagion) but because our health states are interdependent in a far richer way. The culture and society within which we live influences, shapes and controls the determinants of health to a degree to which it makes no sense to begin an analysis of health with individuals, with 'you' and 'me'. We should start with us. Solidarity is a complex concept that seeks to capture this idea and the grounding of practices out of which moral principles themselves arise, and are produced and reproduced over time.

Acronyms List:
NCoB = Nuffield Council of Bioethics
JCB = University of Toronto's Joint Centre for Bioethics

Conflicts of Interest: None declared.

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