Careers in Bioethics: An Interview with James Childress

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ABSTRACT

The following interview with James Childress discusses careers in bioethics, his conception of the principles of biomedical ethics, and other pertinent issues in the field of bioethics.

Keywords: careers in bioethics, James Childress, bioethics careers, bioethics

INTRODUCTION

James F. Childress received his B.A. from Guilford College, his B.D. from Yale Divinity School, and his M.A. and Ph.D. from Yale University. Childress has authored numerous articles and several books in biomedical ethics and in other areas of ethics. His books in biomedical ethics include Principles of Biomedical Ethics (with Tom L. Beauchamp), now in its 7th edition and translated into several languages; Priorities in Biomedical Ethics, Who Should Decide? Paternalism in Health Care, and Practical Reasoning in Bioethics. He is also co-editor of Belmont Revisited: Ethical Principles for Biomedical Research (with Eric Meslin and Harold Shapiro), and Organ Donation: Opportunities for Action (with Catharyn Liverman). Dr. Childress recently retired from the University of Virginia, where he taught for over 40 years. He held the titles of University Professor and John Allen Hollingsworth Professor of Ethics as well as Director of the Institute for Practical Ethics and Public Life. He was also a Professor of Religious Studies, Professor of Public Policy, and Professor of Research in Medical Education in the School of Medicine.

Dr. Childress has been actively involved in several national committees examining ethics and public policy. He was vice chair of the National Task Force on Organ Transplantation, has served on the Board of Directors of the United Network for Organ Sharing (UNOS), the UNOS Ethics Committee, the Recombinant DNA Advisory Committee, the Human Gene Therapy Subcommittee, the Biomedical Ethics Advisory Committee, and several Data and Safety Monitoring Boards for NIH clinical trials. He was a member of the National Bioethics Advisory Commission during the Clinton Administration.

He also chaired the Health Sciences Policy Board of the Institute of Medicine. Dr. Childress is an elected member of the National Academy of Medicine, formerly named the Institute of Medicine, and an elected fellow of the American Academy of Arts and Sciences. In 1990 he was named Professor of the Year in the state of Virginia by the Council for the Advancement and Support of Education; in 2002 he received the University of Virginia's highest honor—the Thomas Jefferson Award; in 2004 he received the Lifetime Achievement Award from the

American Society of Bioethics and Humanities; in 2010 he received the Henry Knowles Beecher Award from the Hastings Center.

He has held a Guggenheim Fellowship, an American Council of Learned Societies Fellowship, and a post-doctoral Liberal Arts Fellowship at Harvard Law School. In 2010, he was the Carey and Ann Maguire Chair in American History and Ethics at the Library of Congress. He has been the Joseph P. Kennedy Sr. Professor of Christian Ethics at the Kennedy Institute of Ethics at Georgetown University (1975-79) and a Visiting Professor at the University of Chicago Divinity School, Princeton University, and a Visiting Scholar at the National Institutes of Health. He remains a fellow at the Hastings Center.

His research currently focuses on two major areas: biomedical ethics, with particular attention to theory and method, religion and bioethics, and public bioethics, and just-war theory and pacifism. He taught both undergraduate courses on biomedical ethics, religion and public policy, as well as graduate seminars on love and justice in Christian ethics, just-war theory and pacifism, and legal and ethical reasoning in public policy.

His esteemed undergraduate lecture, Theology, Ethics & Healthcare drew students from all disciplines as it thoroughly examines the myriad ethical issues surrounding modern medicine. Childress' ability to tease through the most nuanced topics without bias, allowing each student to drawn his or her own conclusions, serves as a testament to his edifying and highly-respected approach to teaching. As a professor at the University of Virginia, when not teaching, Dr. Childress was writing, or contributing to his many committee involvements. He could also be found in his office, generously giving his time to advise budding ethicists on curriculum selections, internship opportunities, and beyond. As University of Virginia Alumni, Dallas and Louisa have had the honor of interacting with Dr. Childress both within the classroom and through extracurricular engagements.

A. On Entering the Field of Biomedical Ethics

D: How did you start your personal journey into bioethics, and how did you become interested in the field?

C: I started teaching at the University of Virginia in 1968, the second year the Department of Religious Studies existed. I was teaching in areas of religion and politics – specifically, courses on civil disobedience, political obligation, just war theory and the like, as well as broader courses. In 1970, during my second year of teaching, the Center for the Study of Science and Technology in Society— which was located in the law school— set up a seminar on artificial and transplantable organs. This was mainly for faculty, but also a few students. They had enough law and medical faculty, but they had no one from the humanities involved. However, it just happened that the chair of that center was a former Yale college classmate of the chair of the Department of Religious Studies. The chair of the center reached out to my departmental chair and said that he needed someone in humanities, preferably someone in ethics, to participate. My departmental chair told me, "I really want you to take part in that." I protested that I was too busy. It was my second year of teaching, and I was teaching three courses a semester, including a large lecture class. However, he persuaded me. It's hard for a junior faculty member to say no to the departmental chair.

That seminar on artificial and transplanted organs was a life-changing event. I wrote a faculty paper for the seminar on "Who Shall Live When Not All Can Live?" which examined different criteria for allocating scarce artificial and transplantable organs, with particular attention to the value of fair equality of opportunity. It was soon accepted for publication in the interdisciplinary journal *Soundings* (Vol. 53, 1970, pp. 339-355). The editors wanted to include a response to the paper, and the head of the nephrology unit at UVA, who was also a member of the seminar, agreed to respond, reflecting some of the debate we had in the seminar. That particular paper ended up getting a lot of attention. Not immediately, but very quickly. It was subsequently published in 25 or so anthologies. But keep in mind: these were the very early days of bioethics. Then four years ago, *Soundings* (Vol.

96, No. 3, 2013) had a retrospective on the piece with five commentators. This paper, my first significant publication, has had a good, long life.

One of the things that really interested me about that seminar was the exchange with medical and legal professionals around topics of fundamental human interest: How can we increase the supply of artificial and transplanted organs? How can we distribute the ones we have in a fair and equitable way? These two questions still persist, and require on-going reflection and resolution in light of important ethical values and technological, professional, and societal changes. I started thinking about these questions with others who were serious and wanted to make a difference in policies and practice, which I really found quite exciting. This led to other interactions with medical and health professionals, including a psychiatrist who was also a member of the seminar. Over the next few years, I published a few articles related to bioethics. The term "bioethics" wasn't even coined until that very year, 1970 — a time still early in the development of the field.

Then, in 1974, Georgetown University invited me to fill the new chair in Protestant ethics, the "Joseph P. Kennedy Professorship in Christian Ethics," located in the Kennedy Institute of Ethics; a Roman Catholic chair was held by Richard McCormick, a Jesuit. Because my little article was getting a fair amount of attention, I was invited to apply for the position. I wasn't particularly interested, because I really loved it at UVA in the new department, which was growing rapidly from the two faculty when I interviewed for the position in 1967.

L: What a neat thing to be a part of.

C: Yes, I was part of something that seemed to be developing very well. I had already become department chair in 1972 at a very early age but, having arrived so early in the department's development, I had been around for several years and had some seniority. Nevertheless, I was finding it difficult to delegate tasks to others, some of whom had been my teachers in graduate school at Yale, and I felt overworked. The research chair at Georgetown had no official obligations. I could teach if I wanted to teach, but there was no requirement to do so. This seemed to be an attractive opportunity that I should at least consider. And my late wife was also interested in the D.C. area. So, I applied. Because I wasn't particularly interested, I had a hell of an interview!

D: We would love to hear more about it.

C: Nothing really hinged on it for me, since I wasn't seeking to leave UVA. And so, I was very relaxed throughout the interview process. When the chair was offered, I did accept it and stayed there for four years. However, a major reason I hesitated at first to accept the chair is that I thought bioethics might be a passing fad and there wouldn't be a lot of interest in it long term; so I wanted to continue my other interests, as well.

I should also add that I do not think of myself as a bioethicist. I'm a person who is interested in ethics and public policy. Public policy goes in several directions. Many of the issues that concern me relate to biomedicine and healthcare, but also to questions of war and peace, among others. I consider these as two subsets of my major interest. I don't do much in clinical bioethics; what I am really focused on is public policy. My first actual experience in public policy related to bioethics came in 1975 on a topic that still hasn't been resolved: compensation for injured research subjects. Building on this experience, I wrote a paper arguing for justice-based compensation for research-related injuries. It still hasn't happened.

B. On Developing the Principles of Biomedical Ethics

D: What led you to exploring the field of medical ethics further?

C: One of my early tasks at Georgetown was to teach in an intensive bioethics course, which had been offered once before I got there. A philosopher at Georgetown, Tom Beauchamp, was also teaching in it, and we had very

different views. In the parlance of the time, he was a rule utilitarian, and I was a rule deontologist. And yet, we found areas of fundamental agreement. I had known Tom at Yale Divinity School, before he pursued his Ph.D. degree in philosophy at Johns Hopkins. I had stayed at Yale to pursue my Ph.D. degree in religious ethics. So, we came to bioethics from different perspectives. We decided that we could develop something that might be of interest in the field, because there were very few methodological discussions at the time. Early contributors to the emerging field in the 1960's were people like Paul Ramsey and John Fletcher. They had already done a lot. I by no means consider myself a pioneer. And there was a lot of work in religious communities on medical ethics: Protestant, Catholic, and Jewish. The background was already there and so I considered myself in the beginning of the next generation of people working in the field. At the time, there were only a few systematic books in medical ethics. Particularly important were those written from religious perspectives by such thinkers as Joseph Fletcher, Paul Ramsey, Jakob Jakobovitz, Gerald Kelly and John Ford among others. I recall only one systematic book looking at medical ethics from a philosophical perspective—Howard Brody wrote a physician-philosopher's book. Most of the books that were available were anthologies, organized around problem areas, such as abortion, euthanasia, allocation of resources. Tom and I wanted to offer something different. Coming from two different ethical theories, we felt we could get agreement about some important principles. We believed it was possible to get more agreement on these principles than on why we affirm them, and more agreement on these principles than on how they apply in practice. In short, we wanted to offer an ethical framework for thinking about biomedicine and health care. Tom and I published the first edition of Principles of Biomedical Ethics in 1979; seven editions have now been published and about a dozen translations into other languages have been published or are being published. At Georgetown, then, I was not forced, but rather led into working more in bioethics.

D: I was curious— you said that you don't consider yourself a bioethicist. Can you elaborate just a little more on that?

C: I don't like the term "bioethics," even though I often use it now for shorthand purposes (as in this interview). The original conception of bioethics, when the term was coined by Rensselaer Potter in 1970, was a very, very broad conception. The term I use most often, when I'm not seeking a shorthand expression, is "biomedical ethics." I have a particular reason for that. I think of biomedical ethics as parallel to business ethics, political ethics, and so forth. But to call the field bioethics— or to identify specific subsets such as neuroethics or genethics— is actually to suggest, by having using the combined words, that this is some kind of independent enterprise. I don't accept that conception. Instead, we should reflect on ethical principles, rules, and values that then get brought into play in the particular problem areas of business, politics, public policy, and biomedicine. So, that's one reason I prefer "biomedical ethics" to "bioethics," even though I know it's a losing battle because shorthand expressions are often useful. Another reason for my reluctance to call myself a bioethicist is that, again, I think of myself more as working on ethics and public policy, with biomedicine and health care being one of the subsets of this dominant interest.

C. Contributions to the Field

D: You talked a little bit about how this a gradual evolution of your career. You also mentioned some of the writings that you've done and the things that you published at the very beginning. What would you consider some of your major successes within your career?

C: There are some publications that I really like, including, among others, that very first little article, Principles of Biomedical Ethics (New York: Oxford University Press, several editions, 1979, 1983, 1989, 1994, 2001, 2009, 2013), and an article on just-war theories (Theological Studies 39, 1979) as well as articles on conscience, organ procurement and allocation, public health ethics, etcetera. So, there are several things that I've done that I really,

really like; I'm particularly proud of those. Others, I think, have been useful. I also believe my work in public policy to be important. I've been heavily involved in public policy over a number of years since that first foray in 1975. It just happens I do most of it in relation to biomedicine and healthcare. I served on President Clinton's National Bioethics Advisory Commission (NBAC) as well as on a number of other governmental committees addressing bioethical issues. Some of these were bioethical in content even if their labels do not indicate this. For example, I served on the human fetal tissue transplantation research panel and I was vice-chair of the federal taskforce on organ transplantation, as well as a number of committees for the Institute of Medicine (now the National Academy of Medicine). I would also consider the undergraduate courses I've taught, including Theology, Ethics, and Medicine, which I have loved teaching, to be a highlight of my career. I have also really enjoyed teaching my graduate seminars. In the spring semester, 2015, I had one of the most interesting seminars I've ever taught on Just War Theory. I had five students from philosophy, five from religious studies, two from politics and international relations, three had military backgrounds, and at least two were pacifists. It was such a rich seminar.

D: Do you choose your major topics or did they choose you?

L: It seemed to happen pretty organically.

C: "Organically" is an interesting way to put it, because certainly the first topic that lured me into the field came from the outside. It was not self-chosen and it came from the outside in more ways than one. I have definitely gravitated towards certain kinds of topics in method and theory and I've probably concentrated the most on organ transplantation—in regard to both procurement and allocation. And more recently I have focused much of my work in public health ethics.

D: From writing that very first publication to going to Georgetown and being there with basically free reign at that time, what really propelled you towards organ transplantation?

C: As I mentioned, the seminar that lured me into bioethics was on artificial and transplanted organs, so even though I wrote mainly on distribution of artificial organs, kidney dialysis in particular, I also paid attention to organ transplantation. I found that just fascinating in terms of the ways we think and feel about the human body and transfer of body parts from both living and deceased individuals. I taught a course on Human Bodies and Parts as Property several times in the 1990s and 2000s dealing with a wide range of uses of human bodies and parts, not only in transplantation, but also in research, education, and other ways, including reproduction (e.g., donor sperm and eggs and surrogacy) and plastinated body exhibits. I'm fascinated by these topics.

L: Do you have a particular piece of work that you think has had the biggest impact on the biomedical ethics field?

C: Well, I again think that Principles of Biomedical Ethics had the biggest influence. I would say the book has had the biggest impact simply because the first edition came out in 1979, it is now in the seventh edition (perhaps there will be one more!), and it has appeared in about a dozen translations into other languages. Our critics play an important role in our willingness to revise the book as we try to take account of their arguments, accept what we find helpful, and offer counterarguments where needed.

D: Are there particular things that you focus on when you're making a new edition, to tweak or change?

C: The way we start with a new edition is to see which one of us has been working on some area, and then that person develops the new draft of that specific part of a chapter or a whole chapter, based on what he's been doing. Our changes grow out of thoughts that we have developed since the previous edition and the ways we've been teaching or writing, as well our efforts to respond to critics. So, that gets the process started and then we go through draft after draft until we get the book that we together like. That's basically it.

D: So, the paths harmonize?

C: Generally, but some differences get hidden in the language. We each have an independent life. This is the only work we really collaborate on. But it has made a strong impact. The late John Arras, whom I miss a great deal,

commented at one point that Principles of Biomedical Ethics was like the "Borg." This is because resistance is futile, "we're going to capture and assimilate." I was always amused by that comment. However, my counter would be that, "No, we actually try to learn from others first and see how we can adjust or refine our position rather than try to 'conquer and assimilate.'"

D: Do you feel like you also learned from Beauchamp, too, when you were both writing this together? That there were some areas where you might find some disagreement and have to find some common place?

C: Of course, we have our differences, and we sometimes paper over them, we sometimes convince the other, we sometimes wear the other out. When we started planning this book, we originally had another co-author, a psychiatrist, Seymour Perlin, working with us but he ended up not being able to continue because of other professional commitments. He was part of our early discussions and put us in contact with his editor at Oxford University Press, Jeffrey House, who had worked with him on a book on suicide. Oxford had not published any books in bioethics by the late '70s. Principles of Biomedical Ethics was its first book in bioethics, and now I can't even read all the books it publishes in this field. One nice thing about starting in 1970 was that I could read everything in a particular area in a day or so. I still probably have the eight or ten articles in a file that I read for "Who Shall Live When Not All Can Live?"— so I had to draw from other areas. For example, I didn't know that Paul Ramsey was working on similar issues at the same time --he built his reflections into his book that came out later in 1970 – Patient as Person: Explorations in Medical Ethics (New Haven, CT: Yale University Press, 1970). But at the time I was drawing from Ramsey's other work on triage on the high seas, that is, throwing some passengers overboard in order to keep a lifeboat afloat. This was another allocation of a scarce resource. I not only worked with the modest literature in bioethics, but I also drew from a variety of other works to try to cast light on this particular area.

D: At the time, were you surprised that Principles of Biomedical Ethics garnered so much attention?

C: Yes, of course.

D: What do you think surprised you about that?

C: Well, I mean, you never know, when you put something out there, what kind of response it will get. Some of the best things I've written haven't received much response. Some of the more modest things have. You just never know, right? Not until it gets out there and strikes a chord—what might be useful and why something takes off and gets a lot of attention, while something else does not. It's all very puzzling. I can look back now and see why, given the fact that, again, so little had been written from a philosophical perspective that tried to offer a systematic framework for thinking about bioethics. So, that was one thing. A second thing is that both Tom and I were contributing to the work of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, which produced the Belmont Report, with its famous principles, during these years. Tom was actually a staff philosopher for the National Commission at the time and worked on the Belmont principles, which still play such an important role in research involving human subjects. "Principles" became part of the air we breathe, as it were. Principles became a helpful way to organize ethical discourse and reflection. Ours were similar, with important differences. Principles have a downside too, because as critics sometimes note, some practitioners engage in a mechanical application of the Four Principles. Two of our critics, Bernie Gert and Dan Clouser, said others were chanting the "mantra" of autonomy, beneficence, non-maleficence, and justice—our four principles—without really grappling with those principles. That can be a problem.

D. Formative Influences

L: Have you had any major influences in your life during your career and was there any work that inspired you or any people in the field or outside the field that really influenced you?

C: There were several indirect formative influences—I use the term "indirect" here because they're not so directly related to biomedical ethics but nevertheless shaped my choices, personal career, and academic life. I come from a Quaker background, but North Carolina Quakerism is a lot like any other Southern Protestant denomination. There are hired ministers, there's programmed worship with music, not what we often think of as the more traditional Quaker silent unprogrammed meeting for worship, with participants speaking out of silence. In college—at Guilford College, a Quaker school—I was further exposed to this tradition, including its critical perspective on a number of social issues, and I found it quite appealing. Also at Guilford College, I worked with several faculty members in a strong department in religious studies. I decided that I would like to teach in religious studies, preferably religious ethics. This led me to Yale Divinity School. At that time, virtually everyone interested in pursuing a Ph.D. degree in religious studies went first to divinity school. At Yale Divinity School I became even more interested in an academic career in religious ethics. Several faculty members there, as well as faculty members in college, were important. But James Gustafson was the biggest influence. He ended up being one of the key figures in the development of modern bioethics or biomedical ethics. He was part of the group with Paul Ramsey and Hans Jonas and others who helped Will Gaylin and Dan Callahan develop the Hastings Center. His influence as a teacher and a scholar was very, very important for me. But then there were many others, including David Little who advised my dissertation on civil disobedience. In divinity school and graduate school, I also learned much from my peers, such as Stanley Hauerwas. And once I started teaching, I continued to learn from colleagues and from students, both undergraduate and graduate students.

L: That is always important to keep in mind.

C: So, yes, I learned from them. Then the various other influences really came in more direct way, especially from working with Tom Beauchamp from whom I have learned so much, through debates, and through interactions with colleagues at the Kennedy Institute of Ethics at Georgetown University where I held a research chair for four years.

L: Along with colleagues, how have your students helped to shape your opinions and beliefs on certain issues?

C: My basic conception of ethics in relation to public policy is that of public justification. Ethics involves critically reflecting on the kinds of reasons we give for the kinds of actions we propose and undertake, whether individually or publicly. I learned a lot through this reflective practice. One of the important people I learned from was Joanne Lynn, a physician-bioethicist, and a fellow at the Hastings Center. She had participated in a summer seminar I taught under the auspices of the National Endowment for the Humanities. We published an article that played an important role in the debate regarding artificial nutrition and hydration. That article really depended a great deal on her work as a very thoughtful physician. I do think dialectically, and I found our interaction to be quite valuable. I should also add, in that regard, I do a lot of team teaching. Probably more than most people. I'm not even sure I can count up the number of team taught courses.

L: Oh, that must be very fun.

D: What do you find that's valuable about team teaching?

C: It is an approach to a class that depends in part on the other person's views. And I gain a lot of insight from the other person. And, as in the seminar I took part in on artificial and transplanted organs, what I find so fascinating and illuminating is the interaction, the dialogue, and the exchange.

D: That's wonderful.

C: It fits well with part of what I find in the public policy context, where we're trying to develop a consensus statement or come as close to a consensus as possible on important matters. It's a willingness to say "I don't

think that I have to have the answer, so let's together see if we can come up with an answer that's justifiable given the range of values at stake."

D: So, in this, it's affecting everyone's life. It's public policy. I can only imagine some of the very long debates or at least discussions that were had.

C: Yes, definitely.

E. Future Directions

D: Returning back to the field and your own goals, what do you see yourself focusing on next? Do you have any plans for, for instance, an issue you might want to tackle or anything?

C: Well, I'm finishing a long overdue book on Public Bioethics, which includes several articles I've previously produced or published, along with several new chapters as well. And, again, Tom Beauchamp and I may do another edition. But the next thing I want to do after Public Bioethics is a book on Just War Theory. I published a book on civil disobedience and public obligation and another on moral responsibility in conflicts. So, I've already published some materials related to this topic, but I want to pick up the 1978 article on just-war theories as well as some other articles I have written since then and rework those into a book, and, here again, respond to critics, because that one article has also been subject to a fair amount of criticism. I'll try to straighten the critics out as best as I can!

D: Big plans, as always.

F. Current Developments Within Bioethics

L: Now we wanted to move into more about the field and your thoughts on certain topics.

D: Of course, a lot has happened since the beginning. But, specifically, in terms of the whole scope of the field, how do you think bioethics has changed over the scope of your career?

C: It's changed a lot in terms of expansion. And obviously, it got started in part because of the expanding questions that couldn't be handled well in existing frameworks. After all, medical ethics has been around a long time. Nursing ethics is not so young, either. And religious traditions have long reflected on these topics. So, why in the '60s and early '70s did bioethics develop as an area of critical reflection? Well, in part because there were new questions that had to be addressed. I think that's what was occurring in research, in developments in genetics and reproductive technology, and in organ and tissue transplantation, for example. The 1968 Harvard statement on determination of death was developed in part because of the need to be able to determine death for purposes of deceased organ donation before the organs deteriorate. We needed a way to determine death that would allow us to take the organs, with consent, in a timely way. And we had to consider the patients whose hearts were still beating because of the attached machinery. These were issues that, again, expanded the field and that expansion hasn't stopped. And so, that's where I was mistaken back in the 1970's—bioethics was not a passing fad. I didn't fully appreciate that there would continue to be new pressing issues that would require attention. For example, the last version of my Theology, Ethics and Medicine course had to be revised, because I had to discuss the new and promising gene editing techniques. Topics such as human genetic engineering continue to develop. To take another example, we thought that brain death issues were settled. They aren't; in some ways they've unraveled. Things fall apart, new things develop, and so on.

Expansion in a second sense has also occurred. The global scale or scope of bioethics has become very important in a variety of different ways through concerns about human rights and global justice. The interest in global public health is a good example—what happens in South Korea, for instance, doesn't stay in South Korea.

Expansion also occurs in devoting more attention to certain topics or areas over time. Even though I've always been interested in public policy, more attention is now paid to the public policy implications of bioethics, beyond the clinical implications. I think we have seen a broadening out to public policy combined with attention to the larger sociocultural context of bioethics, which brings into play the work of sociologists and anthropologists and others. And I think that's been a part of broadening the field.

So, those are some of the kinds of changes that I think are important. I think it is also important to recognize that bioethics has been, in many ways, limited by its origin in the U.S. with its strong individualistic thrust. In the U.S. context, for several reasons, respect for autonomy tends to be particularly emphasized. You can see why it's important, but the U.S. also tends to give it a very individualistic cast that looks very different if you're approaching this from most other countries in the world, even the U.K., with which we share a lot. I think we need more attention to community and relationships, especially relational autonomy as emphasized by feminist thinkers.

L: When you first entered the bioethics field, you mentioned organ transplantation and dialysis were the big issues that seemed to be the most pressing— the ones that need to be addressed at that time. Were there any others?

C: There were a lot of other issues related to behavior modification and emerging mental health issues that led to de-institutionalization in the '70s—so huge changes were occurring, for better or worse. To take another example, in 1973, the end-stage renal disease program was anticipated to be the first step in the direction of the universal health care in the U.S. But it turned out to be an aberration because the estimates were just wrong, and the costs were much higher than anticipated. We're still struggling and failing to provide universal access to health care.

D: Speaking a little bit about that, during that era, there were obviously some technological changes, too, that were really driving some of those issues. And technology is always changing. Going off of that, what technologies now do you really think are going to change the way that this dialogue goes? What might change the face of medicine or nursing?

C: What's going to change or what has the potential for blowing everything up is gene editing.

L: Yes, you mentioned that earlier, why do you think that?

C: In an on-going effort to make sure that genetic interventions didn't pose too much risk, scientists, ethicists, and others developed a set of distinctions that are still important. One is between somatic cell gene therapy and germ line intervention. Somatic cell alterations remain in a particular person's body; they are not passed on to others while the germ line alterations can be passed onto offspring and future generations. The other distinction is between therapy and enhancement, specifically between gene therapy and genetic enhancement. Gene editing certainly threatens the first set of distinctions, and it will probably be difficult to restrict it to therapeutic interventions, in part because the lines are not totally clear. So, gene editing is potentially transformative but also risky. Several committees and forums have addressed—and will continue to address—these topics. It's exciting, but also troubling.

L: That was actually our next question— as medicine and healthcare become more global, what do you think will be one of the really emergent issues in global ethics? I know we had Ebola in 2015, but it's interesting how the media can sort of hype something up— and then now it's not as talked about anymore. But do you foresee anything in the future?

C: No doubt there will be terrifying things to keep us anxious and active. But I think large questions about global justice are here as well. They include how we think about not only protecting ourselves from infectious diseases that might emerge and put us at risk, but also how we think about this in a global community that requires attention to health needs and threats in other countries. How can we meet broad needs on a global scale? I think those are critical questions. I don't have an easy way to address them. I think the work of Thomas Pogge points us in an important direction, by pushing us to ask what have we done to create these desperate circumstances. This framework will generate a greater obligation to try to meet needs in the global context—there are ways in which we've contributed to global problems that increase our responsibility. It's much easier to state that point than to say exactly how we should go about addressing it.

L: Is there a particular biomedical ethics issue that you feel has been under addressed by the field, specifically, or that remains the most unresolved?

C: At different times, I think it's been easier (and I've been guilty of this too) to concentrate on some "hot button topics," and not to attend as much to, say, public health infrastructure or to health equity in the U.S. or globally. For example, we don't yet have equitable access to healthcare in the United States despite Obamacare. And obviously, some of these issues have become so technical that bioethicists need to know more economics, for example, than I and most bioethicists know. I think that having people in the field who can work in different areas, but also can engage in collaborative partnerships with others to address some of these complex policies is more practical. Moreover, we find it difficult to develop a good, deliberative, and public way to deal with complex issues like gene editing. So, I think we still have a long way to go on a lot of topics.

L: To follow up, what challenges loom largest for the field right now as a whole—whether it's funding or people's differing opinions and the difficulty with coming to a consensus?

C: I'd say I've been amazed, as you probably have, too, by some of the changes that have occurred. Socially and culturally we've moved in new directions in recent years—for example, on gay marriage. And look how far we've moved, say, on physician-assisted suicide; almost every year, a new state is added to the list of states accepting it. So, it's fascinating from a sociological and anthropological standpoint to step back and consider how these changes occur over time.

D: Speaking a little bit more about the future of biomedical ethics, what do you anticipate the field looking like in the next five or ten years? Can you anticipate that at all? And do you have any caveats about looking towards the future?

C: Remember, I predicted bioethics wouldn't be around long. You probably shouldn't ask me for predictions. I'm an unreliable predictor!

D: But now you have more experience, so at least your knowledge-base to make any prediction might be more informed.

C: There is no such thing as bioethics or biomedical ethics— as you know, there are many different approaches, and many people are doing many different kinds of things under this rubric. So, a lot depends on which area one is looking at. I worry that too many entering the field are engaged in a kind of scholastic endeavor of working out further what has been done before or critiquing it. I'm more interested in how fresh perspectives come into the field. So, that's one reason I'm interested in a lot of what's happening in anthropology, for example. Different kinds of perspectives are important to keep the field fresh. I am also concerned, especially, that people narrow in on bioethics too quickly as their area of concentration. They may not get enough breadth or depth in some other areas that actually may be the ones that will shape bioethics in the future. So, that's, I guess, a sort of cautionary note.

D: On that note, what do you think makes a thorough ethicist? What sort of aspects are they considering?

C: Those of us who came into the field when I did, did not come in as bioethicists. We came in from other areas. I'd like to keep those areas fertile and add other neglected perspectives. So, that would be one of my major concerns. But I also think familiarity with the traditions of philosophical and religious reflection and with the legal context is very important. And obviously we need attention to the biological sciences and medicine and health care to be able to address bioethical issues. If bioethicists are not scientists or medical professionals, then they need to choose a few scientific or medical areas where they can gain enough competence to be able to really contribute to the discussion. There are some areas I won't lecture on in a public lecture, because I'm not sufficiently grounded to be able to avoid major misunderstandings of the problems.

D: Following up with that, when you were talking about lecturing in class, what do you think makes a good teacher of bioethics?

C: I think passion for the area can generate enthusiasm on the part of students. For instance, my course Theology, Ethics, and Medicine is aimed at creating informed citizens. Changes are occurring in education that require the teaching profession to be much more interactive than it was years ago. And so the challenge in my course has been to build in weekly film sessions and to plan the weekly discussion sections focused on cases so that even though there are two lectures a week, we can keep the course as interactive as possible. I also think that familiarity with traditions of ethical reflection, specifically in the biomedical arena, but also more broadly, is important for effective teaching.

L: Regarding what you mentioned before about new perspectives coming into the field, though it's a very diverse field, what voices do you think, if any, are not sufficiently represented today in the biomedical ethics field? And who do we need to bring in to help contribute?

C: While there is some minority participation, bioethics is a heavily white field. So, that's one fundamental issue: diversity needs to be addressed. Over time, the field has done a much better job incorporating women and women's voices than it did at the beginning. But that's in part because, insofar as physicians are contributing to bioethics, many more women are now in medicine. Yet, this is not happening to the same extent in relation to minorities.

L: Have you seen any other specific professional groups that haven't been brought in that might serve to enhance the field?

A: I like the fact that nursing students have been about 10% of my undergraduate course on bioethics. This has been important for pedagogical reasons. .

L: Since Dallas and I are both going into the healthcare, we are interested to hear if you have any advice, specifically, for medical or nursing students at the beginning years of their practice.

C: Since the demands are so heavy now on the individuals going through training, my advice is to try to keep alive the reflective and imaginative dimensions. Consider a study out of the University of Pennsylvania about how medical students thought about pelvic exams in medical training and the kind of consent needed for those exams. This study showed that the students' ethical judgments about these matters were worse after their third year than they were in their first two years of medical school.

D: In conclusion, what legacy, if any, do you want to leave in biomedical ethics?

C: I think the late Paul Ramsey, whose book The Patient as Person in 1970 was very important in the further development of medical ethics, said it best when he described writing as contributing to a conversation. So I hope I've contributed to a conversation that will continue, and I look forward to following that conversation. I hope that the students I've worked with--undergraduates, graduate students, and postgraduates—will want to contribute to that conversation too. I think there are few easy answers and in many cases no answers at all. But we have to continue to discuss and think together and try to come up with responses that appear to be justifiable

in the particular circumstances. And so we contribute to the conversation... that's what I consider most important.

D: Well, you definitely have two people in this room who feel that your class and the environment that you and Professor Arras created at the University of Virginia, the bioethics culture, has been amazing, and definitely impacted a lot of people.

C: Good. We miss John, though.

D: Yes.

L: We do.

D: Well, we covered a lot of ground.

D: And I can just say that we are very honored to have been able to talk with you about this and thank you so much for contributing to this conversation.