

In my remaining time, then, I would like to address, very briefly, one question that I believe is important to the future of bioethics.

This question has to do with the boundaries of our field, in particular how this boundary question is expressed in language- and even more particularly how the term bioethics relates to the many other terms that people in our world use to describe or label what that they do.

Think about the terms you use to describe what you do. How many of you use the term “bioethics,” and how many of you use another term, either in addition, or as alternative to, bioethics?

Not surprising that so many of us do not use only the term bioethics. There are LOTS of other terms to choose from. Consider the following:

- Medical ethics
- Nursing ethics
- Dental ethics
- Clinical ethics
- Consulting clinical ethics
- Organizational health ethics
- Research ethics
- Public health ethics
- Population health ethics
- Gen-ethics
- Neuroethics

You might have noticed that these terms have in common that all of them denote or specify a subject matter of inquiry or practice: genetics, public health, medicine, nursing, health care organization and so on. It is this kind of term that I want to focus on in particular.

There are at least two stances to take on the relationship of such terms to bioethics. One is to view these terms as naming fields that are in important respects different from bioethics- under this view, neuroethics or population health ethics or clinical ethics is not bioethics, rather they are *outside* of and different from bioethics in important intellectual and practical ways. This view assumes, among other things, that bioethics can be given meaning and content in ways that exclude the meaning and content given to these other fields.

The other stance is to view these terms as naming specific areas of specialty or focus *within* bioethics. So understood, bioethics is the generic or broader term, and population health ethics, neuroethics or clinical ethics are specific areas of inquiries or practice within the broader, parent designation of bioethics.

I have a strong preference for the second stance. I do not have time here to develop all the reasons that stand behind that preference, but let me give you three good reasons-- one conceptual, one strategic and one methodological.

First, the conceptual reason. Unlike some, I do not see bioethics as having a distinctive domain-- some particular set of methods or set of principles or mode of inquiry that is unique to bioethics; these would have to be methods or principles or modes of inquiry that cannot be found in or are not relevant to, for example, neuroethics or population health ethics or clinical ethics. Put another way, I reject the view that bioethics can be given meaning and content in ways that exclude the meaning and content given to these other areas. I do not deny, of course, that neuroethics and clinical ethics can differ from each other in meaning and content but only that bioethics is a different kind of concept.

At this point, some might respond that I am working with a stipulative definition of bioethics that by its very structure makes my conceptual point. If bioethics is defined broadly enough, as something like the ethics of health care, the ethics of the health of populations, and the ethics of biomedical science than of course it would subsume narrower areas like nursing ethics, neuroethics and so.

Well, even if this critique of the conceptual point is correct, and I am not conceding that it is, there is an important, strategic reason to stipulate bioethics in this broad way. Bioethics is still a young player in the academy, in the social institutions of health and science, and in public discourse and policy. We need a firm identity, firmer than we have now, as one field if we are to succeed over the long haul in each of these domains.

In the academy, resources, influence and power, and thus sustainability, are, to a large extent, a function of size and of a clear niche in the academic organism. Local academic culture varies of course, but building internal recognition for bioethics as a field- a field substantial enough to have sub-fields and areas of specialty expertise- can be critical for presence and influence, and especially for the successful advancement of academic careers.

The same can be said within the social institutions of health and science. Building a positive identity for what people in our field do in and about these institutions is an ongoing task- a task that is strategically advanced, I believe, by building the identity for bioethics more broadly.

Finally with regard to public discourse and the public policy, I suspect that if we had polling data from the US, or around the world for that matter, on people's views about bioethics, we would find that many if not most people, including many sophisticated people, people in positions of power and influence, haven't a clue about what bioethics is, what people in our world do, and what expertise and value added we bring. Assuming we value having the wider world understand what we do, than, as a strategic matter, there is efficiency in working together to

build public recognition of a parent concept like bioethics, from which an understanding of cognate sub-fields can flow more easily.

Finally, there is the methodological reason. If there is a defining feature of modern bioethics it is as being an interdisciplinary (or at least multidisciplinary) field. At Hopkins, for example, the Berman Institute is often touted for having successfully broken down the traditional disciplinary and divisional silos of academic organization. But, as my wonderful colleagues at the BI have pointed out to me, there is another kind of silo-ing that we are in risk of reifying – not a silo-ing by discipline but by areas of specialty and focus. At the Berman Institute, we self-organize naturally, if not perfectly, by interest- predominantly around public health ethics, research ethics, clinical ethics and the ethics of science. We are now beginning to recognize the importance of not letting this self-organization stand in the way of the kind of innovative work that can occur when people who work in different sub-fields of bioethics think together about an issue. EXAMPLE- discontinue vaccine program – marginal benefit for new country where investment will do much more good- clinical ethics- etc

In summary, I have provided three reasons- one conceptual, one strategic and one methodological, in defense of the view that bioethics should be employed as the term for our broad field, one that is inclusive of multiple subfields and specialties. Close, with two caveats.

First, I am not here suggesting that all areas of inquiry or practice with which bioethics has commerce are subfields of bioethics- Bioethics, like my other love- public health- has some boundaries. Fields like business ethics, animal ethics and environmental ethics share overlapping interests and territory with bioethics, but the relationship here is not a nested model but rather a model of overlapping circles, as in a venn diagram.

Second, I also do not mean to suggest that all programs or services in our field need to be called bioethics programs, far from it. There are often good reasons to use sub-field names. Having a program in neuroethics or research ethics or clinical ethics can be important. Just as it can be important to have specialty meetings, specialty professional organizations and specialty journals in bioethics.

But specialty or sub-field organization is not inconsistent with remaining connected to the broader label of bioethics and the colleagues globally that are captured by it. There is strength in numbers. There is strength in connecting dots between seemingly disparate questions and challenges. And there is strength in unity.

There is strength in bioethics.

Thank you again for this extraordinary honor.