

Bioethics: A Tale of Unrequited Love and an Amicable Divorce

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Article

Abstract

Even during my basic nursing education, it was evident that ethics could have a role in nursing. What was available at the time was a newly emerging discipline called bioethics. A hybrid field, initially of philosophers and physicians, it offered fresh and clarifying insights, with concepts and vocabulary that had explanatory power. In the United States, the discourse focused on four principles: respect for autonomy, beneficence, nonmaleficence, and distributive justice. However, bioethics had little understanding of or interest in nursing and its literature remained medically-focused, though nurses did take it and wedge it into nursing. Still, bioethics did not address the everyday, relational ethics of nursing that was not problem focused. Bioethics did not take up nursing issues of the corporatization of healthcare that impeded good nursing practice. Nor did bioethics have the interest or expertise to address what constitutes morally good nursing. More importantly, bioethics knew nothing of the 100 years of nursing ethics literature that predates bioethics by a century. It is a fully philosophically informed nursing ethics, with an extensive literature. It also structures nursing ethics by relationships: nurse to family, nurse to other health professionals, nurse to self, nurse to profession, nurse to society, and now nurse to the global human and natural environment. Nursing ethics has a structural warrant and obligation for social and political engagement at the national and global levels, that has no correlate in bioethics. After years of an exceptional education in bioethics, I needed an ethics that was nursing informed, that could address the problems, issues, and barriers to clinical judgment in nursing practice, and barriers to the exercise of good nursing. This article is a chronicle of a long and difficult personal journey into and out of bioethics, and into a vibrant, nursing-focused, challenging, discipline of nursing ethics.

Key Words: nursing ethics, bioethics, Pragmatism, virtue theory, social justice, social ethics, biomedical ethics, medical ethics, relational ethics

Even before nursing school I was an ethics nerd. But then, my experiences as a nurse, from intensive care and a medical-surgical unit, to urban visiting nurse in San Francisco, and backwoods rural home health in South Mississippi, convinced me that I wanted to study ethics in nursing. I wanted an ethics that was native to nursing. There were too many impediments to delivering “good nursing care,” good in the sense of internalizing and expressing the values and aims in patient care and underlying social concerns. I saw structural situations with no good options, and a lack of resources for the most impoverished and in need. That gave me pause again and again. In the 1980s, after many exceptional educational programs, in the emerging field of biomedical ethics, I unexpectedly encountered a vast 100-year literature called *nursing ethics*. Each document was written by nurses, for nurses, and grounded in nursing. Thereafter, I wrestled with *bioethics* and ultimately decided that *nursing ethics* is more in harmony with nursing’s values, goals, concerns, perspectives, and practices than is bioethics.

A clearly articulated field of inquiry, *nursing ethics* is the domain of scholarship and research that explores the nature, scope, and obligations of nursing and the moral limits of nursing responsibilities for the health and wellbeing of all whom nurses serve. *Nursing Ethics* may also refer to a broad scope of the field, from mentorship for ethical comportment, to ethical inquiry, research, and scholarship. All this is found in textbooks, articles, and curricula, and of course the American Nurses Association (ANA) *Code of Ethics for*

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Nurses (2025). I needed to relinquish the bioethics that I had worked so hard and so long to master, for a different marriage that would provide better ethical insight for nursing, and had greater consonance with and explanatory power for nursing. This is the tale of that journey that challenges the dominant paradigm.

The Journey into Bioethics

During my nursing diploma program in the mid-1960s, I found myself attracted to ethics as it could explain and partially address all my nursing concerns. However, the mid-60s nursing literature did not address concerns about or impediments to morally good nursing. At the time my interest in ethics reflected my own bent, and it was certainly not yet “a thing” in nursing. In those years there was no way to pursue this infatuation, except by independent study. After graduation in ‘69, I read medical ethics literature and found a new object of affection in what would transmogrify from *medical ethics* to *biomedical ethics*, then to *bioethics*. Remarkably, in the early 1970s, the literature seemed to be mostly a renewal of early to mid-1900s medical ethics. This was in the face of persistent issues, such as physician paternalism and medical hegemony (Starr, 1982), as well as issues related to technological and scientific advance.

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Shana Alexander’s article in *Life Magazine*, “They Decide Who Lives, Who Dies,” brought public attention to the allocation of a dialysis machine to one patient among several candidates, and the committee (sometimes called the “God Squad”) was tasked with making the decision (Alexander, 1962, p. 262). By the early 1970s to early 1980s, medical ethics extended to issues of withholding and withdrawing treatment, specifically ventilators and dialysis; autonomous technology (Winner, 1978); rationing; access to and cost of care; informed consent; and more. At that point, biomedical ethics seemed to be an evolving domain with the potential to go beyond medical practice per se, perhaps even to nursing, but the field itself had not yet done so.

I was fortunate to receive a Joseph P. Kennedy, Jr. Fellowship in Medical Ethics (still *medical ethics*) at Harvard, in 1978. Before, during, and after the fellowship I was exposed to an outstanding and comprehensive education in the emerging principle-focused biomedical ethics, by the men (a significant aspect) who established, developed, and were leaders in the field. At that point, the discipline had not coalesced and specific courses in biomedical ethics were only offered in the annual Georgetown workshop, and in religious colleges and seminaries. Most of my colleagues in the ‘80s were educated in biomedical ethics in these institutions, whether or not they shared the same religious beliefs.

Biomedical ethics did not invite nurse participation.

I admit that I was smitten and I plunged into the relationship with biomedical ethics wholeheartedly, blindly, and without hesitation or reservation, and remained in love for years. The works of philosophers and theologians in the ‘70s and ‘80s, provided new insights, a vocabulary, concepts, and a language to address painful, even tragic, situations that plagued medical practice. Frankly, it revealed a new cognitive amusement park that was challenging and diverting. This relationship was exciting and gratifying until...well...I became disenchanted. Like a bad marriage, I was putting in all the effort to keep the relationship afloat. Biomedical ethics did not invite nurse participation. It seemed to have more concern for justifications for withholding, implementation, or cessation of medical technology (Reiser, 1978) and abortion, than for issues of suffering, or care and compassion, or notions of the patient-as-person (Ramsey, 1970). Aside from its focus on the experiences of white patients, it did not seem concerned for “women’s issues,” such as disproportionate funding for male diseases; the male body as normative for drug testing, symptoms; unconsented episiotomy; the dismissal of women’s clinical concerns such as premenstrual syndrome; and medical sexism/misogyny, and more.

Wanting and Waning

At some point, I realized that though I had loved bioethics, bioethics did not love me. Bioethics articles and eventually the textbooks that emerged did not mention nurses, then and even now into the 2020s. Nurses seemed to be absent in the discourse. A rare bioethics book had one single chapter, among many, that was written by a nurse, or where nurses were mentioned offhand – then and even now. For the most part the bioethics textbooks addressed medical issues such as the Hippocratic Oath, biomedical principlism, the physician-patient relationship, brain death criteria, informed consent and patient coercion, unethical medical experimentation, and the technological treatment issues noted above. Nursing simply did not exist for bioethics, except as represented by nurses themselves who took bioethics back into nursing and then applied it to practice. The bioethics that was being promulgated did not and could not meet my needs as a nurse; it certainly did not reflect nursing input, and it was inadequate to address the moral scope or nature of nursing practice — it did not address the moral concerns of nurses or the moral goals of nursing and was clearly not interested in doing so. Additionally, it approached clinical practice with a problem focus, and did not address the longstanding, well-articulated, diverse structural relationships of nursing: nurse to patient, nurse to colleagues, or nurse to society, etc. Indeed there was never even a mention of nursing’s social contract.

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By now I had found that my relationship with biomedical ethics was frustrating, vexing, and abrading. It largely dealt with withholding and withdrawing medical interventions, informing patients of medical procedures, not harming patients with futile medical care, not conducting research on patients without their permission, and other medically-oriented topics. As a nurse, I did not order a ventilator, I did not order biopsies and resection, the drug toxicity study was not

mine, and so on.

This ubiquitous form of bioethics focused on four principles, identified by a philosopher, Tom Beauchamp, and theologian, James Childress. Proposed as central in ethics in healthcare settings, the principles were: respect for autonomy, nonmaleficence, beneficence, and distributive justice. These principles were biomedical in nature, that is, driven by medical needs, not inclusive of those of the focus or context of nursing – that of human responses to illness or suffering. There are other sets of principles, such as those of W.D. Ross’ seven principles that include *gratitude*, and *reparations* for when we harm someone (Beauchamp & Childress, 1979; Ross, 1930). If one were to insist upon a principle-based ethics, it seems that some of the principles less frequently mentioned by Beauchamp and Childress are more consonant with nursing.

I had loved bioethics but it had only ever loved me when I filled an empty seat in waning philosophy departments or at biomedical ethics conferences and, even so, it did not offer me a genuine embrace. I began to look elsewhere for an authentic relationship that would meet my needs for interrogating the moral dimensions of nursing, and honor my perspective as one who embraced a nursing identity.

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The Dissertation: The Separation Begins in Earnest

During my doctoral program in ethics in the early 1980s, in my dissertation, I explored the several successive iterations of the ANA Code of Ethics for Nurses with Interpretive Statements (the Code), and the interaction of nursing, society, and the Code in the historical social context of each iteration (Fowler, 1984). Supporting the work was a little used German theory, the *wechselseitige Durchdringung*, “reciprocal interpenetration,” or the “interconnectedness among historical actualities,” (Troeltsch, 1912). It addressed the social conditioning and interaction of (nursing and its) ethics with society, culture, and history.

I began with the Nightingale Pledge, written by Lystra Gretter (1893). It was a nursing-focused interpretation of the Hippocratic Oath, written in 1893 and subsequently revised in order to secure a copyright after it had fallen into the public domain (Fowler, 1987). From there I moved to the 1926 Suggested Code, (ANA, 1926), the 1940 Tentative Code, (ANA, 1940), the first adopted code of 1950 (ANA, 1950), and every successive iteration thereafter through the 1976 Code (ANA, 1976). I graduated before the 1985 revision of the code had been written, though I consulted on its revision. Subsequently I became a

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member, and then chair, of the ANA Committee on Ethics.

The task force for the 1985 Code had attempted to incorporate the biomedical principles and more of *biomedical ethics*, but the principles did not fit well and could not be made to do so. More importantly, even today, the four principles are not mentioned in the ANA Code of Ethics for Nurses (2025), the core moral document for nursing. Support for the patient, and for the autonomy of the nurse’s practice are mentioned, but there is no mention of a principle of respect for autonomy. Nonmaleficence and beneficence are not mentioned and justice as articulated in bioethics is not found in the ANA Code, though it addresses social justice, a related concept. I would come to understand that the Code is an enduring remnant of nursing ethics that points back to our 150 years of ethical discourse and literature. The many iterations of *The Code of Ethics for Nurses* greatly predate the emergence of the discipline of bioethics and the Code is not, and has never been, a bioethics document (Fowler, 1984; Fowler, 2024).

My dissertation described the development of the Code, but in the process, I discovered an astonishing, lavish, voluminous, coherent body of nursing ethics literature actually called “nursing ethics.” It included hundreds of nursing-ethics journal articles starting in 1889; and approximately 100 textbooks and published works on nursing ethics, commencement addresses on ethics, International Council of Nurses (ICN) speeches on ethics, and much more. Since the topic of my dissertation required the exploration of the iterations of the Code, I needed to set that treasure trove aside and proceed with the task at hand. However, I began to question why this literature was unknown both within nursing, but more specifically within bioethics, and why it was not drawn upon. My disaffection with bioethics had begun and I was separating, not yet knowing where I might go. As with most dysfunctional relationships, I feared being alone – or a lone voice — so, I hesitated to move on. Admittedly, bioethics did not notice or care that I had fallen out of love, but I had.

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Nursing Ethics Loved Me for Who I Was

I eventually dug into nursing ethics textbooks, speeches, journal articles, personal correspondence among leaders, commencement addresses and everything I could get my hands on in the pre-internet era. It was slow going having to telephone or write letters to librarians, getting library loans by the United States Postal Service, and photocopying whatever I could. Then it was on to reading, digesting, and reflecting. I was astonished. Here was a deeply philosophically informed literature of virtue ethics combined with the philosophy of Pragmatism. Pragmatism is a philosophy that judges ideas, beliefs, and theories by their practical consequences and usefulness in the real world, over abstract principles, focusing on what works rather than what is ideal theoretically. It largely reflected the work of John Dewey and William James, and contained an explicit rejection of rationalism that is, abstract, absolutist, rationalist principles like those of Beauchamp and Childress. As Grace (2025) notes, pragmatism is neither relativism nor absolutism but sits between them and has particular resonance for nursing.

This relational structure included every health setting and every concern from the individual patient to greater society. Nursing Ethics was and still is structured on the basis of five, now six relationships that include nurse to family, nurse to other health professionals, nurse to self, nurse to nursing profession, nurse to society, and nurse/nursing to the human and natural environment (or integral environment) (Fowler, 1997; Fowler, 2024; HCC, 1889). This relational structure included every health setting and every concern from the individual patient to greater society. It provided a warrant and mandate that nurses be patient focused as well as civically, politically, and globally engaged. The natural environment is clearly called out and included. This literature addressed every role of every nurse in acute moral detail, and the moral trajectory of the profession’s concerns and obligations. Finally, here was an ethics that reflected who I am, what I do as a nurse, wherever I am, and in whatever role I am practicing, for all the concerns I had *as a nurse*. I felt like I was home, with a new love that loved me for who I was.

But there was a lingering question: why did biomedical ethics not acknowledge nursing ethics? The answer is three-fold. First, nursing ethics slipped away from nursing as the educational programs transitioned from hospitals into colleges and universities in the mid-1960s, when biomedical ethics was germinating. Nursing ethics textbooks were not transferred and accessioned by the college libraries, perhaps with the sole exception of Robb’s 1900 *Nursing Ethics: For Hospital and Private Use* (1900). Second, in colleges, ethics education was wrested from the hands of nursing faculty and given to philosophers and theologians who knew nothing of nursing, the role of the nurse, or nursing history. They taught an absolutist, rationalist ethics that did not need to know that the person was a nurse, much less a nurse with a patient. And third, perhaps most significantly nursing ethics had been dismissed as ethics at all by the moral philosophers as early as 1920.

Thomas Verner Moore (1935) regarded the nursing ethics textbooks as works of moral suggestions and moral advice but not works of ethics. He reserved that designation for the ethics-in-nursing textbooks written by priest-theologians, representing Roman Catholic natural-law ethics. In his unwillingness to accept other approaches to ethics, he dismissed John Dewey’s *Ethics*, a philosophical work, not medical ethics, (Dewey & Tufts, 1908) as ethics (Fowler, 2024, p 45). A deeper read of the nursing ethics textbooks would uncover the practice and tradition-based ethics, and prevent their dismissal as moral advice, counsel, or suggestions, instead of as ethics (but Moore did not do this). Without identifying any specific passages in Aikens or Robb, Spalding (1920, p 13-15) outright referred sweepingly to the “false theory of Dewey, Aikens and Robb.” He differed with Dewey on the source of *rights*; saying of Aikens’s book that “very little in the book can be classified under ethics,” and refers to Robb’s book as “practical advice and common sense,” while identifying her as Elizabeth Hampton Robb not Isabel (Spalding, 1920, p 13-15). Beyond this, Moore finds the “ethics of conditionate morality,” that is consequentialist theories such as Mill’s (1859/1978) Utilitarianism (specifically) to be inadequate; and any “ethics of absolute morality” (i.e., duty-based ethics, such as Kant’s (1785/1969) emphasis upon reason) as also inadequate (Fowler, 2024, p 44; Moore, 1950, p 365).

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The extensive and replete nursing ethics that I encountered, able to satisfy the mind, heart, and soul of nursing in its fullness, was dismissed, discarded, rejected, suppressed, and lost. I needed to know more, and more, and more — and the deeper I dug the more convinced I became that bioethics, ignorant and dismissive of nursing, could never meet the demands of nursing practice and was inconsistent with nursing perspectives, values, identity and practice. With some fear and trembling I had turned away from bioethics. I acknowledge that having been wedded to bioethics for so long, I was loathe to give it up, and it was not easy to leave, especially when simultaneously adventuring into a novel yet agèd domain of ethics. However, the more immersed I became in nursing ethics, the more I felt that when I was teaching bioethics, I was teaching error by failing to recognize and teach the existence and content of nursing ethics. I had a horrible feeling of betrayal — that I was betraying nursing ethics, nursing, and my students. To quote a formal phrase in the older literature “My learned colleague has fallen into error.” I had.

A Firm and Widening Separation

Bioethics (in the United States) was based on a set of rationalist principles, first enshrined in Beauchamp and Childress's (1979) book *Principles of Biomedical Ethics*, and in the *Belmont Report*, (The National Commission for the Protection of Human Subjects, 1979) and had become the *lingua franca* of hospital ethics committees, medical philosophers, physicians, and bioethicists. Nurses certainly needed to know the language and concepts of bioethics. Yet, in the prevailing principlist approach, principles were shorn of the theories behind them and homogenized as a supposed “common morality.” The principles were problematic. At times they were used independently of laying eyes on the patient; they were sometimes used as if an algorithm or decision tree; they were mistakenly thought to provide guidance, though they do not unless they are already weighted by one’s own bias or culture; and they provided no way to arbitrate between and among the principles

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I was also concerned that, shorn of the theories that had generated them, principles devolved into individualistic interpretations, at odds with the theories behind them. For example, in practice autonomy as *rational self legislation* in Kant (1785) and Mill’s (1859) *autonomy of will* versus *autonomy of action*, which conflicts with Kant’s view, became a problematic “respect for patient choices” devoid of the original nuances of the theories behind them, and more reflective of American law and culture — not ethics. In addition, most students in bioethics were reading secondary sources, and not reading foundational ethics works themselves, and not, for example taking note of the conflict between Kant and Mill. I had difficulty accepting what I knew were theoretical conflicts.

However, and above all, the principles were not sensitive to nursing aims, roles or practice, and worked better in the service of medical treatment decision making. Bioethics was a principle-based, problem-centered, dilemma, and conflict-focused ethics, grounded in Eurocentric abstract, rationalist theories. My understanding of nursing emerges from and is grounded in theories of virtue, relationship, care and the philosophy of Pragmatism.

Noted British philosopher, the remarkable Mary Midgley (n.d., circa 1950s), maintained that rationalist ethics was an ethics of unmarried, privileged, academic males, who could give themselves completely to a life of concentration and abstract thought “withdrawn from the influences around him;” it could not address the world of one who had borne, suckled, or reared children, or was married, (Midgley, n.d., circa 1950s). Midgley, like nursing, counts the embodied, subjective, interdependent, relational, nature of human life as central to morality.

Nursing ethics is grounded in a structural set of relationships, with those of nurse to patient/family and nurse to other health professionals grounded in relationship itself. It is informed by the philosophy of Pragmatism, a philosophy that evaluates truth, meaning, and the value of ideas based on their usefulness in real world situations and relationships. Pragmatism has a particular fit and resonance with nursing and its way of knowing the patient (Grace, 2025). Nursing ethics is also firmly grounded in a virtue ethics, or moral character, tied to the norms and values of the cumulative tradition and community of nursing. The evidence for this assertion is found in early nursing ethics textbooks, journal articles, National League for Nursing ethics curricular requirements and more. In virtue ethics, the good intrinsic to nursing – compassion, caring, respect, attentiveness, responsiveness, attunement, i.e., what we are to *instantiate*, manifest as nurses, that is, to express or represent in practice as the patient situation calls for — carries normative weight (Anderson, 2023; Edgell, 1929; Fowler, 2024).

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Having embraced the identity of “nurse,” incorporating the normative values, virtues and ends, ideals, and aspirations of the community of nursing, I longed for an ethics that would be a full expression of nursing values and concerns and could and would explore *good nursing*, and guide *good nursing practice*. Nursing ethics, then provided me with a domain of research and scholarship for exploring the nature, scope, values, obligations, limits, and extent of nursing responsibilities for the health and wellbeing of all whom nursing serves — or would serve were impediments ameliorated. Clearly, I needed to relinquish bioethics, however much I had invested in it and had once blindly embraced it. I had become estranged.

An Amicable Divorce from Bioethics

Nursing ethics is an everyday ethics, is a way of exploring nursing, a way-of-being in nursing, and a way of being a nurse that feels like “home.” There is no need to shoehorn in a foreign ethics, trying to make it fit when it does not. As a norm, nursing ethics seeks to maintain relationships and to prevent relational rupture that produces dilemmas and conflicts. As Midgley (n.d., circa 1950s) observed, and nursing knows, persons are embodied, subjective, interdependent, and relational. The nature of human life is central to morality. Nursing ethics expects nurses to show compassion for this patient or nudge that patient, by normatively being *observant, attuned* and *responsive* to the needs of that specific individual, in that moment, under changing circumstances. This is not an absolutist four-principles, bioethics, or decisional ethics; it is a relational, responsive ethics. It is virtue ethics that expresses the normative values and virtues of the community and tradition of nursing; it is nursing ethics.

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More often than not, nurses are successful and have no need for problem-focused and decisional ethics. But on occasion, we do. There is a place in nursing ethics, a corner in nursing ethics, where a problem-focused biomedical ethics is complementary and should be accommodated. It is also necessary to do so in view of the hold that dilemma-focused ethics has on hospital ethics committees and physicians, and nurses need to be able to do linguistic code-switching. Still, bioethics, without nursing’s relational structure, does not reach into society and the global

human and natural spheres in the way that nursing ethics normatively authorizes and expects of nurses and nursing. Unlike nursing, bioethics does not include a social ethics, consisting of social criticism and social change, as a structural element of its ethics, and remains focused on distributive justice, the allocation of medical resources, rather than social justice. Because of its relational structure, nursing ethics is intrinsically and coherently more inclusive and extensive than is bioethics. Our ethics is authentically present at the bedside and in the world.

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These differences between nursing ethics and bioethics are profound. There are some mutual concerns of course, where hands can be joined, as expected by Code provision eight (ANA, 2025). But nursing ethics is a century older than bioethics; bioethics is at best a distant cousin, and certainly, not by any means the parent discipline of nursing ethics. In an appreciative and amicable departure, and with sadness, I have left bioethics for an ethics that is native to nursing, arising from its own soil, an ethics that cares about good nursing, and cares about what nursing cares about; an ethics that is ours to explore, guide, inform, or chasten us, but an ethics that knows us, an ethics that is us. Let us reclaim the wisdom of nursing ethics, and its identity in nursing. Come, join me.

Table. Suggested Readings for Nursing Ethics

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NOTE: Book contains source materials including NLN ethics curricular requirements 1915—1930s, transcriptions of early chapters, articles, and ICN speeches on nursing ethics.

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