



PROJECT MUSE®

---

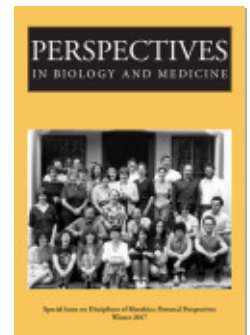
What Nurse Bioethicists Bring to Bioethics: *The Journey of a Nurse Bioethicist*

Connie M. Ulrich

Perspectives in Biology and Medicine, Volume 60, Number 1, Winter 2017,  
pp. 33-46 (Article)

Published by Johns Hopkins University Press

DOI: <https://doi.org/10.1353/pbm.2017.0017>



➔ *For additional information about this article*

<https://muse.jhu.edu/article/669112>

# WHAT NURSE BIOETHICISTS BRING TO BIOETHICS

*the journey of a nurse bioethicist*

---

CONNIE M. ULRICH

**ABSTRACT** Nurses, one of the most trusted professional groups in our society, work with patients and their families at all stages of the illness trajectory. Nurse bioethicists are a small but special subset of the nursing profession and bioethics community, focusing on the moral complexities that arise in clinical care, research, and health policy. This article examines the career trajectory of a nurse bioethicist and the clinical, educational, and research experiences that shaped her career goals. It also addresses the uniqueness of nursing and the ethical challenges that nurse's encounter in their day-to-day interactions with diverse patient populations and calls for distinct conceptual and empirical bioethics inquiry. Training the next generation of nurse bioethicists requires a dialogue with nursing and bioethics scholars on the academic and philosophical skill set and mentorship requirements that will advance and contribute to the broader public good.

I STARTED MY NURSING CAREER AS a pediatric nurse working with children and their families at the Children's Hospital National Medical Center in Washing-

---

School of Nursing and Department of Medical Ethics and Health Policy, University of Pennsylvania. Correspondence: School of Nursing, Room 339 Claire Fagin Hall, 420 Curie Boulevard, Philadelphia, PA 19104.

E-mail: [culrich@nursing.upenn.edu](mailto:culrich@nursing.upenn.edu).

In memory of Dr. Patricia O'Donnell, a social work ethics scholar extraordinaire who lost her battle to cancer, but lived her life to the fullest and shared her goodwill with all those who were fortunate to encounter her.

This work was supported by funding from NCI #R01CA196131; NINR #R21NR010259; and a Fogarty R.25 #2R25TW007693.

*Perspectives in Biology and Medicine*, volume 60, number 1 (winter 2017): 33–46.  
© 2017 by Johns Hopkins University Press

ton, DC. My first position was a staff nurse (or bedside nurse) on a busy surgical floor called 4 Blue. To some degree, and as I reflect on that time, one is never truly prepared as a newly minted nurse or physician for the realities of becoming a clinician. So it was for me. I initially worked a rotational schedule of two weeks of days and two weeks of nights where textbook pediatric cases became everyday experiences. Caring for the most complex of childhood illnesses included patients with osteosarcoma, Wilms tumor, neuroblastoma, short gut syndrome, biliary atresia, failure to thrive, and other diseases, and it tested one's capabilities on a daily basis. It was also the first time that I came face-to-face with the death of children for whom I was their primary care nurse and with the grief and suffering of families that ensued. The loss of a child brings tears to all those involved; there is no exception for nurses or others who also hope for positive outcomes. This work as a pediatric nurse was both demanding and fulfilling. I became part of the fabric of an institution committed to caring for those who were the most vulnerable, and it often evoked a mix of moral emotions. Indeed, there were days when I questioned what was in the best interest of my patients and whether it was within the realm of my position to question.

As I moved on from the surgical unit, I was offered an opportunity to gain didactic and experiential training as an Operating Room (OR) nurse. The technological nature of the OR and the ability to understand the intricate nature of pediatric diseases was remarkable, and interdisciplinary teamwork was paramount. I held many different roles within this practice environment, and every day there was something new to absorb. But then again, as Atul Gawande (2014) reflects in his beautifully written exposition of his life as a physician: "Your competence gives you a secure sense of identity. For a clinician, therefore, nothing is more threatening to who you think you are than a patient with a problem you cannot solve" (8).

In fact, I was able to safely monitor sterile surgical fields, circulate and scrub complex cases while standing for long periods of time and authenticating sponge, needle, and instrument counts, manage multiple stakeholder needs as a clinical manager, and be at the ready for any traumatic injury that might come through the OR doors at any time of the day or night. Nevertheless, ethical questions lingered in my mind. I often wondered how to help myself and my nurse colleagues during difficult times: times when one was alone with a child who died on the OR table and was anxiously waiting for the family in a perioperative room; times when staffing needs were stretched and allocation priorities were questioned; times when interdisciplinary team communication was disruptive; times when parents said their emotional goodbyes to their children as they were whisked off to OR suites hoping, for example, that the tumor was not cancerous or some other life-limiting diagnosis would be not be corroborated; and times when there was a sense of system unfairness for those children who were abused or ravaged by gunfire. I, myself, needed ethics education. Since I became educated as a bio-

ethicist, I have seen and heard the same kinds of things, but I have never thought about them in quite the same way—and for that I am thankful.

### LEARNING TO BE A BIOETHICIST

Going back to school is never easy, but it is sometimes necessary. As part of my graduate studies, I was able to spend time away from the clinical environment thinking about the delivery and financing of the health-care system by interning on Capitol Hill and for other governmental agencies. This provided me with an insider's view of the legislative process and the wrangling associated with different views on health-care-related issues. The process was slow, and it was drastically different from the day-to-day decision-making activities within the clinical arena that I was accustomed to. But it was well worth the time to observe and participate in legislative activities; it certainly gave me a better sense of the political aspects of health and health care and of the importance of issues to the citizenry. It was a time of managed care, capitation, and worry about spiraling health-care costs and inefficiencies within the system. There was much public fear surrounding health-care reform. To some degree, this story remains true today: the public continues to wrestle with rising insurance premiums and inequities of care. But nursing's voice is often missing from these conversations. As my colleague Christine Grady (2016) stated in her essay in the special issue on nursing and ethics of the *Hastings Center Report*, "nurses are often not at the policy table, or their involvement in policy decisions is largely unrecognized. They are largely absent from the highest decision making levels of health-care policy-making. And they are often relatively overlooked in bioethics discourse" (S6). Thus, much of the early bioethics work that I was interested in was written by medical bioethicists who were leading the dialogue on the ethics of capitation and managed care systems, and on the ethical challenges these systems imposed on the patient-provider relationship. Indeed, this work began to raise ethical questions about divided loyalties and the moral agency of physicians, with some research pointing to the pressures of exaggerating patients' conditions to obtain necessary treatments or using deception to meet one's professional and ethical commitment to one's patients (Freeman et al. 1999; Pellegrino 1997; Wynia et al. 2000).

During this time, there was little research on nursing's views of managed care, although nursing was, is, and will remain a significant part of the health-care system. In particular, it was not clear whether nurse practitioners—advanced practice registered nurses educated and trained to practice autonomously in primary care and other specialty areas—were facing some of the same constraints as their physician counterparts, and what effect, if any, managed care had on their fiduciary relationship with patients. It was also unclear what ethical conflicts these clinicians faced in trying to "do good" within this economic delivery system. I started reading philosophical and empirical works in my doctoral program by early nurse

ethicists, including Mila Aroskar, Ann J. Davis, Sally Gadow, Sara Fry, and Shaké Ketefian. Much of the scholarly work in nursing ethics began by discussing the virtues of the nursing profession (that is, identifying the characteristics of a “good nurse”), as well as questioning the broader role of nursing within the health-care system. As claimed by Ann J. Davis more than 30 years ago, “Neither brains nor compassion is limited to one sex. And those are the ingredients that make a good nurse” (Davis Papers). Discourse also centered on nursing’s advocacy and caring foundations, and on how nursing ethics was similar to, or different from, medical ethics. In fact, some have argued that there is nothing unique about nursing ethics, and that the issues that nurses struggle with are similar to their physician colleagues. This is a plausible argument, but while physicians are usually ordering treatments for their patients, nurses are at the bedside implementing them. As Myra Levine (1977) so artfully put it: “Every nursing relationship begins with an unusual burden of ethical responsibility” (846). Nurses have a professional and moral obligation to care for any and all patients that present for treatment and care, but there are times when one’s personal values can, and do, conflict with professional obligations. Because I was interested in quantifying this type of “ethical burden” within the nursing profession, I relied on early nurse leaders in the measurement of ethics phenomena, such as Shaké Ketefian (University of Michigan School of Nursing) and Ann B. Hamric (Virginia Commonwealth University), who were instrumental in my thinking about how to both conceptualize and operationalize ethics-related phenomena. My dissertation chair, Karen Soeken (University of Maryland School of Nursing), graciously mentored me in methodological rigor, including the psychometrics of measurement and using advanced statistics to more precisely predict ethics-related behaviors and outcomes.

As I finished my graduate work, I found an advertisement seeking applications for bioethics fellows at the National Institutes of Health (NIH), and it was an honor to be selected as the first nurse postdoctoral fellow trained in bioethics at this research institution. The bioethics postdoctoral fellowship opened a new world, providing an opportunity for me to learn from bioethics scholars who thoughtfully contemplated diverse issues in bioethics, ranging from the ethics of phase I trials to the ethics of international research and everything in between. The interdisciplinary environment was rich, and dialogue among fellows, faculty, nursing and medical staff, and others was a model of professionalism and respect for diverse thought in the care and ethical protection of research participants. My primary mentors, Christine Grady and Marion Danis (a philosopher with a degree in nursing and physician bioethicist), stewarded me through my fellowship and provided both conceptual and empirical guidance in understanding clinical and research ethics concepts. Importantly, they and other members of the department at the time (Dan Brock, Ezekiel Emanuel, Segun Gbadegesian, Sarah Chandros Hall, Reider K. Lie, Franklin Miller, Gopal Screenivasan, David Wendler, and Benjamin Wilfond) were benevolent advisors who loved their work and showed

it every day. These scholars sought professional and scientific excellence in their fellows through probing bioethics questioning, and through teaching, supporting, and encouraging rigorous clarification of bioethics argumentation in developing the next generation of bioethics scholars.

During my fellowship, I continued my dissertation research on understanding the ethical conflicts in managed care and the views of nurse practitioners and physician assistants (Ulrich et al. 2003, 2006). A national survey pointed to the ethical conflicts experienced by primary care nurse practitioners and physician assistants and how they balanced their obligations to multiple stakeholders, including their patients, practice settings, and third-party payers. Many identified ethical concerns were reported pertaining to insurance constraints, patient demands, conflicts in the nurse-physician relationship, informed consent worries, misunderstandings of patients and families, discrimination of patients, managed care policies and practices that threatened the quality and availability of care, access to care, and resource allocation issues. Empirical bioethics work also started to identify the importance of ethics preparedness, ethics confidence, collegiality, and professional autonomy, and how these characteristics influence perceptions of providing quality care (Ulrich et al. 2014). More work is now needed, as more than 220,000 nurses are licensed as nurse practitioners in the United States, with the majority of these practitioners (83.4%) practicing in primary care (*AANP 2016*). In many cases, nurse practitioners are caring for the most vulnerable in our society: the homeless, the uninsured or underinsured, the very young and the very old, and those transitioning between and among providers and practice settings. They also serve in rural and disadvantaged communities where primary care physician shortages continue to exist. Yet the public is not always aware of their capabilities, and nurse practitioners continue to struggle to gain full practice and prescriptive authority in all 50 states and U.S. territories, despite the fact that their outcomes mirror those of their physician counterparts (Swann et al. 2015). Nurse bioethicists can work with nurse practitioners to identify the unique ethical challenges they face and in support of new educational preparedness models that address the vexing health problems plaguing our society. Moreover, nurse bioethicists can also advocate for improved models of team-based care that include nurse practitioners, working with educational, health-care delivery, and governmental systems to outline the ethical, economic, and societal benefits of enhanced roles in primary care (Macy Foundation 2016).

During my fellowship, I also worked with nursing, bioethics, and social work scholars to empirically delineate the everyday ethical issues that nurses and social workers encountered in their work by examining nurses' and social workers' level of ethics-related stress and their perceptions of the ethical climate of their work environment. First, it was important to quantify the type and frequency of these ethical issues; second, to show how ethics stress can impact one's job satisfaction and retention; and third, to gain a greater sense of how clinicians perceived their

moral atmosphere at work (O'Donnell et al. 2008; Ulrich et al. 2007, 2010). Nurses, in particular, are critical to the health-care infrastructure, yet nursing does not articulate their knowledge and expertise to the public, nor does “the public necessarily become aware of them or know exactly what they do until they become sick” (Meleis 2014). Our study was one of the first to understand the “ethical stress” of nurses and we identified many different types of ethical issues they encountered in daily practice. In our research, we reported on nurses’ sense of powerlessness, fatigue, and frustration when dealing with the everyday ethical issues in clinical practice (Ulrich et al. 2007). Ethical issues included those that affected nurses’ primary commitment to their patients, such as protecting patient’s rights and worries about informed consent, end-of-life and advance care planning, and surrogate decision-making (Ulrich et al. 2010). Interestingly, we also linked the perceptions of the ethical climate of one’s organization to retention. Health-care clinicians want to work in supportive and collegial environments where core values of integrity, civility, respect, and trust in administrative leaders are actualized, and where clinicians are valued for their contributions to patient- and family-centered care. We also reported that approximately 23% of nurses had no ethics education and were therefore less likely to have confidence in their ability to make ethical decisions (Grady et al. 2008). Unfortunately, reports of feeling unqualified and unauthorized to access ethics resources were seen in those who had little or no ethics education. Through empirical bioethics research, we now know that this can lead to personal and professional discord and moral distress within the work environment.

### **THE CONTRIBUTIONS OF NURSE BIOETHICISTS**

Nurse bioethicists have contributed greatly to the bioethics literature on moral distress; this phenomenon was first identified in nursing by a philosopher more than 30 years ago. Moral distress was originally defined as knowing (or thinking one knows) the ethically correct course of action but being precluded from following this course due to institutional constraints (Jameton 1984). These individual, organizational, and system-level constraints may include disagreements surrounding patient- and family-centered treatment goals, particularly at end of life; the lack of policies and guidelines that protect health-care workers in the midst of emerging infectious diseases such as Ebola; and those “layers of vulnerability” (Churchill, Fanning, and Schenck 2013) seen in the day-to-day decisions that patients and their families must make when trying to understand what is in their best interest regarding proposed standard-of-care treatment(s) or research options, among other issues. The study of moral distress has pointed to a serious problem of moral agency and moral compromise for nurses and other members of the health-care team. Indeed, recent evidence suggests that 20% of nurses and 18% of physicians considered leaving their positions imminently due to moral distress

(Whitehead et al. 2015). Unfortunately, each episode of moral distress where one feels morally compromised in some way may lead to what has been termed “moral residue,” or that which remains within us and affects our core being (Epstein and Hamric 2009).

Moral distress is a problem that is not limited solely to U.S.-based nurses, physicians, and other types of health-care providers. In fact, Piers and colleagues (2011) conducted a large international study of clinicians’ (nurses and physicians) perceptions of appropriateness of care in intensive care units (ICU) in Europe and Israel and reported that 27% of their respondents cited inappropriate care with at least one patient. This inappropriateness of care was measured by several statements and patient care scenarios that assessed clinicians’ perceptions of too much or too little care in the ICU, nonadherence of patients, misinformation, and other aspects that affect quality care. From a nursing bioethics perspective, what seemed most troubling was the finding that approximately 31.7% of nurses in Piers’s study rarely or never were present during communication about end-of-life information to family members. It is not clear why this was the case, but patients and families often turn to nurses to address their questions or concerns, especially at end of life. Nurse bioethicists need to encourage their nursing colleagues who are at the bedside to voice their concerns by raising questions and seeking interdisciplinary dialogue. As Bird (1996) observes: “Without people speaking up, a number of potentially beneficial conversations will never take place” (241). The recent report from the Institute of Medicine on *Dying in America* (2015) argues that nurses and physicians are very limited in their ability to discuss end-of-life and palliative care, which ultimately impacts outcomes of care and may lead to ethical conflict. Future bioethics research needs to examine the role of interdisciplinary discourse in mitigating moral distress and whether it affects the decisional conflict that often arises in end-of-life situations.

Finally, normative and empirical work on moral distress also has endeavored to understand this phenomenon in resource-poor countries, principally during the Ebola outbreak in Ghana, Liberia, and Sierra Leone, where we saw extreme suffering, stress, and the death of front-line providers (Ulrich 2014). In 2015, we discussed ethical guidelines for nurses in the event that cardiovascular resuscitation or other aggressive measures might be needed for Ebola victims (Ulrich and Grady 2015). After two U.S. nurses became infected with the virus, there was much concern for the health, safety, and well-being of nurses and other health-care staff who were first-line providers in situations in which the risk of infection was considerable. In my work in Tanzania, for example, where we are training nurses and physicians in bioethics, these professionals want to meet their fiduciary obligations to their patients, but they are limited by the availability of medications, technology, and staff on any given day. As such, nurse bioethicists, philosophers, and empirical researchers continue to conceptualize, clarify, and communicate about the phenomenon of moral distress and its meaning in different cultures and



with different constituents, as well as measure its impact on health professionals' mental, physical, and overall health and well-being within the workplace.

Nurse bioethicists have not only contributed significantly to clinical knowledge but also to our understanding of research and international ethics. For example, Grady has been a leader in the study of financial compensation in research and in the development of ethical payment models for research participants, models that might assist in recruitment and retention while providing a measure of respect for research participants' time and potential burden (Dickert and Grady 1999). She was also the first bioethicist trained as a nurse and philosopher to serve on the Presidential Commission for the Study of Bioethical Issues, under President Barack Obama. In recent federally funded empirical bioethics work, nurse bioethicists have sought to understand aspects of research ethics that specifically focus on the benefits and burdens of research participation, particularly in cancer clinical trials, in which less than 5% of adults participate (Murthy, Krumholz, and Gross 2004). We have developed an instrument to measure benefits and burdens in relationship to retention in cancer clinical trials and are currently conducting a large study to better understand the importance of informed decision-making and the factors that are important to research participants' participation and retention. We have also reported that seriously ill participants' risk-benefit assessment remains problematic, so we have begun to normatively question the amount of information that patient-participants need to know in order to participate in clinical trials (Ulrich et al. 2012, 2016a).

Many research participants trust their physician to know what is best for them and are more likely to participate in research based on this bond. We don't know, however, if this would be true for nurse researchers, who are serving as principal investigators and who might be conducting similar types of research studies. We have found, however that research nurses (who are not in the investigator role) are central to answering patient-participant's questions, discussing treatment plans with research participants, and showing caring attitudes supportive of participants' research participation activities (Ulrich et al. 2012). Because nurses participate in research as principal investigators, research coordinators obtaining informed consent, co-investigators on a research team, or in monitoring procedures as they occur at the bedside, ethical issues remain. In fact, some research suggests that nurse coordinators often face ethical struggles in balancing their roles as subject advocate, study advocate, and patient advocate (Davis et al. 2002). The nurses' professional *Code of Ethics* speaks solidly to the fact that nurses' primary obligation is to patients (ANA 2015); thus, there will always be an underlying ethical tension between the goals of clinical care and the goals of research.

### THE VALUE OF ETHICS EDUCATION FOR NURSING

In her 1943 book *Ethics for Nurses*, Charlotte Aikens discusses the importance of ethical training for nurses and states that “the attitude of mind” that a nurse holds toward ethical questions has as much, or more, to do with her ultimate success as the quality of the technical training she will receive in the art of nursing (2). Indeed, technical training is foundational to providing beneficent patient care: the use of technology advances and often reexamines our understanding of the human condition, but it also sheds light on the critical gap between what we do to our patients and what we *ought* to do to our patients. At times, the use of innovative technology raises profound ethical questions on issues of survivability, suffering, end of life, personhood, and what it means to protect the best interests of patients and families under our care.

In testimony to the Presidential Commission for the Study of Bioethical Issues (2016), I was able to share my thoughts on the importance of bioethics education for the nursing profession and the values that the nursing profession brings to patients, families, communities, and societies. Nursing bioethics education is not uniform, nor is it valued in the same way at every institution. As discussed with the Commission, I see the goals of bioethics education in nursing as important in the following ways. First, we must stimulate students to “critically reflect upon and question the values, beliefs, and assumptions that they bring to clinical practice in an atmosphere that supports and respects diversity of intellectual thought, cultural paradigms, and respect for persons” (Presidential Commission 2016, 67). Second, we must begin to educate our students to engage in morally relevant conversations that promote the overall societal good and addresses patient advocacy at every level of care delivery, whether it is at the hospital bedside, a primary care office, or a hospice facility. Third, bioethics education can provide nurses with an intellectual foundation that will assist them as they “navigate the competing demands and multiple alliances within the workplace; and, to overcome the sense of ‘being caught in the middle’ between the physician and the patient, the patient and the family, or other parties engaged in challenging ethical issues” (Presidential Commission 2016, 67; see also Hamric 2001). Nurses often feel as though they are caught between multiple stakeholders and pulled in different directions. Nurses are agents for their patients, research participants, and institutions, and should be equal partners with physicians, yet they also have an ethical obligation to maintain their own integrity. Given the structures in which they are employed, it is easy to see how nurses might privately question what the ethically right thing to do is in a particular situation, yet remain passive in addressing that question. Hospitals, for example, are generally hierarchal structures, and ethical tensions can arise between physicians and nurses and others based on perceived power differentials. Nurses, therefore, might feel intimidated or worried about bringing forward ethical issues based on established or accepted norms of behavior within their clinical unit or organization. Poor communication between the professions can lead to misun-

derstandings, disruptive behaviors, and patient safety concerns (Rosenstein and O'Daniel 2008). For those nurses who seek ethics support and consultation for ethical problems, concerns seem to stem around physicians not communicating with families on their goals and preferences (Bartlett and Finder 2016). Yet, “all of us live and work in settings where we can initiate or revive good conversations about issues that matter. Initially, we are not expected in a mechanically efficient way to resolve all conflicts that arise, to institute reforms, or to overcome past injustices. We are, nonetheless, expected to help nudge conversations along” (Bird 1996, 250).

Since starting in an academic position at the University of Pennsylvania more than 10 years ago, it has been a privilege to work with students, faculty, and staff to discuss the many ethical issues that we face as a discipline and the broader ethical issues that impact national and international populations. I was most fortunate that my previous Dean at the School of Nursing, Afaf Meleis, and Arthur Caplan—Bioethics Center Director at the time of my appointment—were moral visionaries. Both of these leaders saw the value of interdisciplinary moral discourse at a research-intensive environment that included a nurse bioethicist, and they supported, encouraged, and advised me accordingly. Among nurse bioethicists, however, there is much concern about the next generation of nurse bioethics scholars, as well as about the future educational content for nursing students. Although ethics education in nursing is perceived as valuable, there is limited consensus on its academic priority within an already crowded field of nursing educational requirements. Much more discussion is needed about the type of ethics educational courses that would be beneficial at the undergraduate, graduate, and doctoral level and about the outcomes that would follow. We also need more research on partnering with our medical colleagues to address pressing bioethical questions that impact both professions and to closely examine how we close the gap between theoretical-classroom knowledge and the ethical realities that students express from in-house clinical training. With very few nurses trained in bioethics, there is limited mentorship available to help the next generation of nurse bioethicists develop their normative and empirical bioethics portfolio. Additionally, funding remains challenging for bioethics scholarship in general. Science will not come to a halt without bioethics funding, but the ethics of that science will certainly lag behind. Innovative discoveries that push the boundaries of both clinical care and research will require bioethicists to weigh in on the consequences of these breakthroughs for all relevant stakeholders, at both micro and macro levels. Nursing bioethics will continue to evolve in the face of all these issues, focusing on questions of vulnerability in clinical care and research, power structures, justice, transitions in care for an aging society, end of life, and the nature of the patient-provider relationship in differing contexts and societies.

### THE UNIQUENESS OF NURSING

Caring is often evoked as a foundation to nursing and nursing bioethics. When speaking with a critical care nurse manager who recently found her way into nursing following a degree in law, I asked her about the intense nature of critical care and the ethical challenges she encountered within this practice environment. I also asked why she chose nursing. With little effort, she commented: “I love nursing.” In that moment, it made me realize how this “love of nursing” shapes bioethics through the values that the nursing profession brings to patients and their families—integrity, compassion, grit, intellectual rigor, inquisitiveness, and trustworthiness, to name a few. Nurses are moral catalysts within the health-care system: they are dedicated to the beneficent care of their patients as savvy observers and doers of what needs to be done for patients who are acutely, chronically, and seriously ill—whether it is within hospital walls, outpatient clinics, or community settings.

As the largest group of health-care providers in the United States (McMenamin 2015), nurses provide unique insights into the day-to-day assessments of patients’ physiological, emotional, and social care needs; they implement and evaluate the preferences and goals of their patients, families, and communities; and they see, touch, and feel joy and sorrow firsthand. Ethical issues are commonplace in nursing practice, and they are not likely to diminish as we usher in a new era of precision medicine, artificial intelligence, and genome editing, all of which have implications for patient care and the patient-provider relationship. How will we communicate this type of information and the ethical challenges that it will bring, and who will be responsible for that conversation? And while we face these new ethical challenges, it is not likely that the everyday ethical concerns in clinical practice will dissipate. Nursing’s voice needs to be more present in newspaper editorials, op-eds, and other avenues of public discourse, as nurses share their concerns about new technologies, policies, procedures, and emerging and reemerging diseases that impact the care they provide, as well as nurses’ overall mental and physical health. To tackle the complex scientific and medical challenges that lie ahead, new models of collaborative science are needed. It will take “collective intelligence” to resolve the recalcitrant ethical problems that persist (Payne, Callier, and Hertelendy 2004). As Daniel Callahan (2012) reminds us, enduring ethical issues such as genetics, human subjects research, death and dying, and other topics “will be affected by new scientific knowledge, social and medical needs, fresh cadres of researchers and clinicians, and the simple fact that all of them touch at some deep level on ancient and enduring ethical, legal, and political problems, never once and for all solved” (155). Nurse bioethicists should, and must, be part of this conversation.

## CONCLUSION

I am grateful to have learned from, and worked with, excellent and thoughtful nurses, physicians, anesthesiologists, social workers, researchers, bioethics scholars, students, mentors, and others who have helped shape my bioethics path. With all of the hard work, there has been much joy too. It is uncanny how one learns life lessons from patients and families as they are thrust into situations where they must weigh the risks and benefits of proposed treatments or participation in research activities, muddle through the uncertainty of a startling diagnosis, place their immediate trust in health-care providers who are unexpectedly introduced to them during a medical encounter, and, at times, accept undeniable grief and sorrow with both dignity and grace. Nursing's voice in bioethics discourse continues to grow as nurse bioethicists aptly address the day-to-day clinical practice, research, educational, and policy concerns. As philosopher Warren T. Reich (2008) has written: "the global, interdisciplinary, and interprofessional character of the initial ethos of bioethics" was not meant to become medicalized with one profession dominating the conversation (xx). The normative and empirical influence of nurse bioethicists can only serve to enrich the field of bioethics by bringing much depth to understanding the human experience of patients, families, and communities, as well as by bringing conceptual and methodological rigor to the complex individual, organizational, societal, and global health-related problems that solicit answers from the bioethics community. Researching, reflecting, and responding to the ethical questions that shape the greater good of one's society calls for diverse ways of knowing, thinking, and doing, and "good work in ethics requires care and diligence," as well as innovative and rigorous analytics (Callahan 2012, 21). Seeking nurse bioethicists' voices on the many ethical issues that matter to them will lead us to act collaboratively with respect, compassion, and responsibility for the privilege of caring for those who are sick and ailing, and who are partners with us during this difficult period in their lives.

## REFERENCES

### *Archives*

Anne J. Davis Papers. Barbara Bates Center for the Study of the History of Nursing, University of Pennsylvania. [http://hdl.library.upenn.edu/1017/d/ead/upenn\\_bates\\_PUNMC165](http://hdl.library.upenn.edu/1017/d/ead/upenn_bates_PUNMC165).

### *Publications*

Aikens, C. 1943. *Ethics for Nurses*. 5th ed. Philadelphia: W. B. Saunders.  
American Association of Nurse Practitioners (AANP). 2016. "NP Fact Sheet." <https://www.aanp.org/all-about-nps/np-fact-sheet>.

- American Nurses Association (ANA). 2015. *Code of Ethics for Nurses with Interpretive Statements*. <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses>.
- Bartlett, V. L., and S. G. Finder. 2016. "Lessons Learned from Nurses Requests for Ethics Consultation: Why Did They Call and What Did They Value?" *Nurs Ethics* 1–17.
- Bird, F. B. 1996. *The Muted Conscience: Moral Silence and the Practice of Ethics in Business*. Westport, CT: Quorum Books.
- Callahan, D. 2012. *In Search of the Good: A Life in Bioethics*. Cambridge: MIT Press.
- Churchill, L. R., J. B. Fanning, and D. Schenck. 2013. *What Patients Teach: The Everyday Ethics of Health Care*. New York: Oxford University Press.
- Davis, A. M., et al. 2002. "The Invisible Hand in Clinical Research: The Study Coordinator's Critical Role in Human Subjects Protection." *J Law Med Ethics* 30 (3): 411–19.
- Dickert, N., and C. Grady. 1999. "What's the Price of a Research Subject? Approaches to Payment for Research Participation." *N Engl J Med* 341 (3): 198–203.
- Epstein, E. G., and A. B. Hamric. 2009. "Moral Distress, Moral Residue, and the Crescendo Effect." *J Clin Ethics* 20 (4): 330–42.
- Freeman, V. G., et al. 1999. "Lying for Patients: Physician Deception of Third-Party Payers." *Arch Intern Med* 159 (19): 2263–70.
- Gawande, A. 2014. *Being Mortal: Medicine and What Matters*. New York: Metropolitan Books.
- Grady, C. 2016. "Cultivating Synergy in Nursing, Bioethics, and Policy." *Hastings Cent Rep* 46 (suppl. 1): S5–S8. doi:10.1002/hast.623.
- Grady, C., et al. 2008. "Does Ethics Education Influence the Moral Action of Practicing Nurses and Social Workers?" *Am J Bioeth* 8 (4): 4–11.
- Hamric, A. B. 2001. "Reflections on Being in the Middle." *Nurs Outlook* 49 (6): 254–57.
- Jameton, A. 1984. *Nursing Practice: The Ethical Issues*. Englewood Cliffs: Prentice-Hall.
- Institute of Medicine (IOM). 2015. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. Washington, DC: National Academies Press.
- Levine, M. 1977. "Nursing Ethics and the Ethical Nurse." *Am J Nurs* 77 (5): 845–49.
- Macy Foundation. 2016. "Registered Nurses: Partners in Transforming Primary Care. Recommendations from the Macy Foundation Conference on Preparing Registered Nurses for Enhanced Roles in Primary Care," June 15–18. New York: Josiah Macy Jr. Foundation. [http://macyfoundation.org/docs/macy\\_pubs/2016\\_Conference\\_Summary\\_FINAL.pdf](http://macyfoundation.org/docs/macy_pubs/2016_Conference_Summary_FINAL.pdf).
- Meleis, A. 2014. "Afaf Meleis, Doctora Honoris Causa por laUA." Cecova TV. Filmed Feb. 19. YouTube video. Posted Feb. 19. <https://www.youtube.com/watch?v=og3InyXCzXM>.
- McMenamin, P. 2015. "ANA-Voice of 3.4 Million Nurses and Growing." ANA Community, Sept. 29. <http://www.ananursespace.org/blogs/peter-mcmenamin/2015/06/29/ana?ssope=1>.
- Murthy, V. H., H. M. Krumholz, and C. P. Gross. 2004. "Participation in Cancer Clinical Trials: Race-, Sex-, and Age-Based Disparities." *JAMA* 291 (22): 2720–26.
- O'Donnell, P., et al. 2008. "Predictors of Ethical Stress, Moral Action, and Job Satisfaction of Health Care Social Workers." *Soc Work Health Care* 46 (3): 29–51.
- Payne, P. W., S. L. Callier, and A. J. Hertelendy. 2014. "Towards 'Collaborative Ethics' for Translational Medical Research Teams." *J Transl Med Epidemiol* 2 (2): 1034. <https://www.jscimedcentral.com/TranslationalMedicine/translationalmedicine-sp1d-collaboration-science-translational-medicine-1034.pdf>.

- Pellegrino, E. D. 1997. "Managed Care at the Bedside: How Do We Look in the Moral Mirror?" *Kennedy Inst Ethics J* 7 (4): 321–30.
- Piers, R.D., et al. 2011. APPROPRIATUS Study Group of the Ethics Section of the ESICM. "Perceptions of Appropriateness of Care Among European and Israeli Intensive Care Unit Nurses and Physicians." *JAMA* 306 (24): 2694–2703.
- Presidential Commission for the Study of Bioethical Issues. 2016. *Bioethics for Every Generation: Deliberation and Education in the Health, Science, and Technology*. Washington, DC: Presidential Commission for the Study of Bioethical Issues. [http://bioethics.gov/sites/default/files/PCSBI\\_Bioethics-Deliberation\\_0.pdf](http://bioethics.gov/sites/default/files/PCSBI_Bioethics-Deliberation_0.pdf).
- Reich, W.T. 2008. Foreword. "The Legacy of Nursing Ethics." In *Nursing and Health Care Ethics: A Legacy and a Vision*, ed. W.J. E. Pinch and A. M. Haddad, xix–xx. Silver Spring, MD: American Nurses Association.
- Rosenstein, A. H., and M. O'Daniel. 2008. "A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety." *Jt Comm J Qual Patient Saf* 34 (8): 464–71. [http://www.mc.vanderbilt.edu/root/pdfs/nursing/ppb\\_article\\_on\\_disruptive.pdf](http://www.mc.vanderbilt.edu/root/pdfs/nursing/ppb_article_on_disruptive.pdf).
- Swann, M., et al. 2015. "Quality of Primary Care by Advanced Practice Nurses: A Systematic Review." *Int J Qual Health Care* 27 (5): 396–404.
- Ulrich, C. 2014. "Ebola is Causing Moral Distress Among African Healthcare Workers." *BMJ* 349: g6672.
- Ulrich, C. 2015. "Goals of and Approaches to Bioethics Education." Presentation to the Presidential Commission for the Study of Bioethical Issues, May 27. <http://bioethics.gov/node/4945>.
- Ulrich, C. M., and C. Grady. 2015. "Cardiopulmonary Resuscitation for Ebola Patients: Ethical Considerations." *Nurs Outlook* 63 (1): 16–18. doi:10.1016/j.outlook.2014.11.011.
- Ulrich, C., K. Soeken, and N. Miller. 2003. "Ethical Conflict Associated with Managed Care: Views of Nurse Practitioners." *Nurs Res* 52 (3): 168–75.
- Ulrich, C., et al. 2006. "Ethical Conflict in Nurse Practitioners and Physician Assistants in Managed Care." *Nurs Res* 55: 391–401.
- Ulrich, C. M., et al. 2007. "Ethical Climate, Ethics Stress, and the Job Satisfaction of Nurses and Social Workers in the United States." *Soc Sci Med* 65 (8): 1708–19.
- Ulrich, C. M., et al. 2010. "Everyday Ethics: Ethical Issues and Stress in Nursing Practice." *J Adv Nurs* 66 (11): 2510–19.
- Ulrich, C. M., et al. 2012. "Developing a Model of the Benefits and Burdens of Research Participation in Cancer Clinical Trials." *Am J Bioeth* 3 (2): 10–23.
- Ulrich, C. M., et al. 2014. "The Impact of Ethics and Work-related Factors on Nurse Practitioners' and Physician Assistants' Views on Quality of Primary Healthcare in the United States." *App Nurs Res* 27 (3): 152–56. doi:10.1016/j.apnr.2014.01.001.
- Ulrich, C. M., et al. 2016a. "Cancer Clinical Trial Participants' Assessment of Risk and Benefit." *Am J Bioeth* 7 (1): 8–16.
- Ulrich, C., et al. 2016b. "Nurses at the Table: Nursing, Ethics, and Health Policy." *Hastings Cent Rep* 46 (suppl. 1): S5–S8. doi:10.1002/hast.623.
- Whitehead, P. B., et al. 2015. "Moral Distress Among Healthcare Professionals: Report of an Institution-Wide Survey." *J Nurs Sch* 47 (2): 117–25.
- Wynia, M., et al. 2000. "Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and Hard Place." *JAMA* 283 (14): 1858–65.