Voices in Nursing Ethics

Nursing Ethics Chapter Newsletter

Issue 1/August 2026

Stories From The Field

The Nursing Ethics Chapter

Committee Members

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Submission Guidelines

1. Please include your **name**, **current email address**, **your phone number,** and **your designation as a nurse**.
    a. This is to acknowledge your submission; however, if you wish to use a **pseudonym**, you must inform the newsletter editor in your submission. We will include this at the bottom of your submission instead of your actual name.
    b. The contact details **will only be used by the editor** to contact you for clarification (if necessary).
2. Fonts should be Arial, size 12, spacing 1.5 or 2.
3. You can include headings as indicated above in the table under "Structure of Narratives".
4. All submissions must be original work and have not been submitted elsewhere.
    a. The stories should capture **your authentic voice**—imagine you are telling this story to a person—how would you tell your story to him or her?
    b. How is this story meaningful to you?
    c. Why is this story important to you?

Nov to Dec 2026
Being at Someone's Bedside at their End of Life

Jan to March 2027
Role Reversal: When a Nurse Becomes the Patient

Apr to June 2027
Being a Volunteer: When Volunteering Leads
to Asking Difficult Questions of Self

Oct to Dec 2027
Caregiving as a Means of Hope

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From the Desk of the Nursing Ethics Chapter

Welcome to our very first newsletter! We hope that the narratives shared by the seven nurses will both inspire you but also, perhaps, make you little uncomfortable. The discomfort is necessary to help us to be aware of our biases, values, beliefs, and practices and the understanding that decisions are never made in a vacuum. There are always competing needs and wants from various stakeholders, and how these give rise to ethical conundrums.

Each story reflects the tension surrounding making the right decision and taking the right action. This tension is palpable in Rosemary's story. Did she have a choice of not doing anything? On the one hand, the patient and her family refused to go to the hospital; on the other hand, not giving the intravenous Dextrose 50% (as per policy) would have led to a far worse outcome.

Janine also found herself in a situation that was evolving. She *followed* the protocol of breaking bad news but was informed that she did not carry out her duty well. The stories of both nurses illustrate the central of role of power. Questions such as what is power, who has the power, how power is exercised, and who exercises the power are key in ethical decision-making and applies to competing wants. The exercise of power is well demonstrated in Carol's narrative, *A Public Humiliation,* where a nurse was rebuked publicly by a physician. Carol makes an astute observation that ethical practice applies to both patient care and how healthcare professionals interact with one another.

Zheng Yuan's introspection leads him to ask a very important question about care, one that we believe most nurses ask during their professional journey—are we providing the best care to our patients by restricting them in the name of safety? How does a person-centred care truly looks like? The tension is there again—between providing safe care which may be restrictive and enabling the person to live life well on his/her own terms.

Khairunissa faced the same question except this time, the patient was her father. She did not agree with her father's choice but she learned to respect his decision, recognising his right to exercise his autonomy. In her case, the tension emanated from two fronts: first, as a daughter and second, as a nurse. With each role, she had to maintain the corresponding boundaries.

Roshni's and Nur Ba'eyah' narratives illustrate that ethical behaviour is about being aware of one's values, beliefs, and biases. Their stories show that everyday ethics is an act that builds others, practices empathy, shows care, and respects the individual as a person. Nothing more, nothing less.

Each narrative brings its own ethical and personal lessons. We hope these stories will encourage more nurses to come forward and share their human-centred narratives and realise that ethics is not always about problems.

Subadhra Rai
Chair
Nursing Ethics Chapter

The Person Before the Care Plan

A Change in Perspective

Moving from acute care to community care was a humbling experience. The transition taught me how to better provide person-centred care. I came from a clinical setting where the focus was on identifying problems, treating illnesses and preventing complications. As a mental health-trained nurse, I understood dementia clinically. I knew its symptoms, progression and treatment approaches. However, working in the community care sector, especially in a nursing home, made me realise that understanding dementia as a condition was very different from understanding the person living with it.

In our desire to provide the "best and safe care," we sometimes build an elder's life around clinical risks. We may keep someone in bed to prevent a fall, provide texture-modified meals to reduce the risk of choking, restrict favourite foods because of a medical condition or discourage an activity because an accident might happen.

Each decision may be clinically justified. However, when such decisions define an elder's entire day, the person may be physically safe but gradually lose their autonomy, identity and sense of meaning in life. I began to ask myself, "If we remove every risks but also remove what makes life meaningful, are we truly providing the 'best and safe care'?"

Lessons Beyond Clinical Care

After having worked in the community care sector for a few years, I have learnt to first ask our elders what mattered to them most before formulating care plans.

Who was this person before moving into the nursing home? What life roles, relationships and experiences shaped her or his identity? What brought him or her comfort, security, joy, and meaning in life? What might she or he be communicating through their behaviours? What does she or he still hopes to do?

These questions have changed the way I approached care now. Instead of fitting the elder person's care into our routines, I have begun thinking how our care could better support the elder's preferred way of living and desire for ageing well. Clinical knowledge remains essential, but it should help us create more possibilities—not simply justify restrictions on the elder person's life.

The Nurse I Became

In nursing school, I learnt to address physical, psychological, social and spiritual needs through a comprehensive nursing care plan. In acute care practice, the focus often remains on addressing the clinical needs and identified risks. Working in community care helped me to see how these various modalities could be adapted to provide a person-centred care that augmented their capacity rather than restrict them.

I began to ask myself, "If we remove every risks but also remove what makes life meaningful, are we truly providing the 'best and safe care'?"

Today, I believe the elder must be at the centre of the care. The care plan should reflect not only diagnoses and clinical risks, but also the elder's life stories, strengths, and aspirations. Good care is not merely doing everything for an elder. It means preserving what the elder can still do, supporting meaningful choices, and enabling him or her to have meaningful connections to live life well.

My nursing knowledge now guides me differently. Previously, I knew how to care for a person with dementia as a clinical condition. Today, I am learning how to care for the person with the disease as a human being. There is a subtle difference. I know that beneath the disease label, there is still a person who wants to live with joy, hope and dignity.

Ng Zheng Yuan
Nurse Manager
St. Luke's ElderCare Residence @ Jelapang

Reflection Through the Ethical Lens

Zheng Yuan's narrative illustrates the fine balance that nurses have to maintain daily in their care work—how do you honour the wishes of patients/residents without compromising their safety?

He also raised an important point about the extent to which we rely on planning and ensuring that SoPs are followed, and at the same time, these processes have the potential to miss the human being at the centre.

Therefore, the question arises how do we integrate the "ethics of care" in our care work? How could we ensure that we take into account the individual's values, beliefs, needs, and aspirations in our care work and make it part of our care conversation? More important, how could nurses, being in a privileged position of listening to the human stories, ensure that care does not become dehumanised?

These questions are more important now than ever before as care work increasingly moves towards integrating machines and digitalisation.

End-of-Life Reflection: Respecting My Father's Choices

My father was diagnosed with congestive heart failure (CHF) which was complicated by Stage 5 chronic kidney disease requiring renal replacement therapy. Peritoneal dialysis (PD) was recommended as a suitable option and as a renal-trained nurse, I understood the rationale behind this recommendation. I knew that haemodialysis (HD) carried risks of intradialytic hypotension and could potentially precipitate further episodes of angina or myocardial infarction. However, my father firmly rejected PD and insisted on HD.

This was one of the most challenging situations I faced because at that moment, my role was that of a daughter, trying to support her father instead of a nurse, although, my nursing knowledge accentuated the challenging feeling. While I disagreed with his decision, I also recognised that he was fully capable of making his own healthcare choices. He was an educated man with a Master of Science in Public Healthcare, and he understood the risks and benefits of treatment and his rights as a patient.

I learnt that respecting autonomy sometimes means accepting decisions that differ from our own professional judgement. It required immense restraint on my part, as I did not want to create conflict with an already unwell father.

My father remained calm and steadfast even when his condition deteriorated. He told me he had no regrets about his care decisions. When palliative care was suggested, he initially rejected the referral, believing that palliative care was only for cancer patients. This highlighted a common misconception and reminded me of the importance of educating patients and families about the role of palliative care in improving quality of life for those with serious chronic illnesses.

Our conversations gradually shifted towards his end-of-life preferences. As a devout Muslim, he expressed his wish for a simple funeral and a prompt burial without unnecessary delays. We discussed various scenarios, including what might happen if he deteriorated in hospital or even at the dialysis centre. During these discussions, he voiced reservations about completing an Advance Medical Directive (AMD), feeling that it was too rigid and did not allow room for future consideration of treatment options.

….While I disagreed with his decision, I also recognised that he was fully capable of making his own healthcare choices.

One question he repeatedly asked stayed with me—was there a way for him to express his wishes while still retaining the flexibility to choose treatment as his condition changed? This led to me to seek the assistance of an Advance Care Planning (ACP) facilitator. Through ACP, my father was able to explore and communicate the extent of his treatment while maintaining the autonomy that was so important to him. Although ACP is not legally binding, it provided him with a framework for meaningful discussions and ensured that his values, goals and preferences were understood by both his family and the healthcare team.

Reflecting on the experiences with my father, I learnt that end-of-life care is not about persuading patients to choose what we believe is best for them. Instead, it is about supporting them in making informed decisions that align with their values and beliefs. More importantly, I learnt that autonomy, dignity and respect remain fundamental even when we disagree with the choices made.

I realised that my role was not to decide for my father, but to walk alongside with him and to honour the decisions he made until the very end, whether as a daughter or as a nurse.

Khairunnisa Ahmad
Senior Lecturer
Nanyang Polytechnic

Reflection Through the Ethical Lens

Khairunnisa's story shows the ethical dilemma one faces when there are two equally important, but competing roles, to fulfil. In her case, the two roles were that of a daughter and a nurse. Both require her to fulfil different obligations and observe different boundaries.

As a daughter, she has the emotional bond with her father, and therefore, the boundary of a father-daughter to observe. As a nurse, equipped with specialised knowledge in renal care, she needed to respect the professional boundary of the father-as-the-patient. In these two roles, it is easy to overstep the boundaries in the name of obligations and duty.

The question arises how does one balance and maintain a strict boundary between being a daughter and wanting the best for her father and at the same time, as a nurse, knowing that what he has chosen may not be clinically effective or beneficial for him? Is it possible to observe strict boundaries demanded of the two roles? More important, is it relevant or realistic to do so?

These are some ethical dilemma that emerged when the patient is a family and when we have the insider's knowledge of care as a healthcare professional. How could other healthcare professionals recognise this dilemma and assist the family/healthcare professional in his/her difficult journey in caring for their family?

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Five Years as a Clinical Instructor: What My Nursing Students Taught Me

It all began five years ago when I transitioned from being a bedside clinical nurse to a full-time Clinical Instructor (CI). I thought I was prepared for every challenge. I soon discovered that clinical education requires a different set of skills to address the challenges when we least expect them.

I would prepare myself prior to meeting a group of new learners. My preparation include updating and reviewing my clinical knowledge, familiarising myself with the lesson plans and modes of assessment, and building my mental capacity. During an attachment, a CI can feel like a K-pop idol, surrounded by students competing for attention. The difference is that they are not asking for photographs; they are asking for signatures for certification of skills completed. However, the greatest challenge is not the paperwork; it is discovering how students learn.

Thoughtful guidance, honest feedback and human connection matter. Students must feel safe enough to admit, "I am not sure," "I need help," or "I think I made a mistake." This is ethics of care in action.

When I first began my CI position, I was confident that students would remember everything that I had taught them. Unfortunately, reality proved otherwise. Some students would remember every technical steps but forgot to speak to the patients. Others would explain the procedures confidently until it was time to perform them. Absolute silence would ensue.

Not long ago, after I had carefully reviewed with a student how to insert a urinary catheter, the student looked at me blankly and asked, "CI, what am I supposed to do now?" I looked at the student. The student looked at me. Somewhere in the distance, I imagined my carefully delivered instructions crumbling into the abyss. That was when my real education as a CI began.

Initially, I believed that a good CI should have an immediate answer to every question. What is the normal range? *I must know*. Why is this medication given? *I must know*. Where did I put my pen? *That one, unfortunately, I rarely knew*.

The first lesson I learned was never to judge students too quickly. Some enter the clinical area confidently. Others stand quietly with their notebooks, hoping that invisibility would shield them. With patience, guidance and encouragement, the student who once asked, "Can I observe?" may eventually say, "CI, could you assess me on this? I am ready."

My students also taught me that knowing is not the same as doing, and doing is not always the same as understanding. Instead of immediately providing answers, I began asking, "What are you observing?" and "What would you do first—and why?" Patients do not arrive with four options and one correct answer. Future nurses must learn to assess, interpret, decide, communicate and act.

Safe and supervised mistakes are powerful lessons. When a student reaches for the wrong item, we remain calm on the outside. Internally, an entire emergency response had been activated. Patient safety must never be compromised, but a gentle "Pause and check again" can sometimes teach more than a lengthy lecture. Thoughtful guidance, honest feedback and human connection matter. Students must feel safe enough to admit, "I am not sure," "I need help," or "I think I made a mistake." This is ethics of care in action.

After five years, I no longer measure successful teaching by how much information or feedback I provide. My success is when I see in students who recognise a deteriorating patient, speak up about unsafe practices, and perform procedures without losing compassion. My students entered the clinical area expecting me to educate them. What they may not have realised is that, for the past five years, they have been educating me too.

Roshni Akhtar DO Roshan Muhammad
Assistant Nurse Clinician.
Ng Teng Fong General Hospital

Reflection Through the Ethical Lens

Ethics of care permeates even in non-clinical work such as teaching and learning. This the gist of Roshni's narrative. Her awareness that teaching and learning does not flow in one way, that is, from the expert to the novice is an act of humility and courage. Ethics of care reminds us to embody these attributes because only then we are able to listen, really listen, to others—their unspoken feelings—fears, hopes, and joy, amidst the noise. This same awareness of the need to listen was also alluded to by both Zheng Yuan and Khairunissa above.

We often consider ethics in the context of patient care or in difficult or complex ethical issues that need to be addressed; however, Roshni's narrative tells us that it is the daily, ordinary interactions, where ethics of care really matters most because if we do it right, the complex, often protracted ethical issues, may not even arise.

Think back in your own area of practice—either in a clinical or a non-clinical, where you practiced the ethics of care (empathy, compassion, kindness, consideration, and relational) that led to a better outcome and averted the emotional pain or anger.

In Roshni's case, the ethics of care was when she recognised that both she and the students have something to teach to each other and they felt safe doing so.

When A Right Action is Not The 'Right Action'

During her scheduled home visit, the nurse found her patient unconscious. The patient had lived with diabetes for many years. When the nurse suggested that the family call the ambulance to have the patient admitted to the hospital, the patient's family declined and informed the nurse that the patient did not wish to be admitted to the hospital. The nurse quickly performed a blood glucose test which showed severe hypoglycaemia. The nurse informed attending physician promptly and was instructed to administer intravenous (IV) Dextrose 50% immediately.

It was to prevent nurses from being in situations where they are compelled to make ethically complex decisions beyond their scope of practice.

The nurse quickly administered the IV Dextrose 50% and the patient regained consciousness, became alert, and was able to ambulate. Although the clinical outcome was favourable, the nurse was subsequently questioned for failing to comply with established protocol. At that time, the policy explicitly prohibited nurses from administering IV Dextrose 50%, even under direct medical instruction.

In response to this incident, IV Dextrose 50% was removed from nurses' care bags. It was to prevent nurses from being in situations where they would be compelled to make ethically complex decisions beyond their scope of practice.

Rosemary
Registered Nurse
Hospital

Reflection Through the Ethical Lens

All of us, at one point or another, have or had to make difficult decisions, where the actions of both decisions would be deemed equally problematic. This was the position which Rosemary found herself. If she had followed the protocol that nurses are not supposed to administer IV Dextrose 50%, the patient outcome would have been dire. However, the counter-argument that following the protocol was necessary to ensure safe practice within the nurse's scope of competency.

On the other hand, going against the protocol and administering the IV Dextrose 50% saved the patient's life and led to a good outcome; however, her action was deemed to be unsafe because she practiced outside her scope of expertise (even though she knew what she was doing and was instructed to do so).

How many of us find ourselves in such a situation as Rosemary—perhaps not as stark but equally difficult, where each action conflicts with professional obligation and ethics. Rosemary faced an ethical dilemma—she had to choose between two course of actions where each action carried some degree of professional ethical violations. The question is, was there a third option for Rosemary to choose in this situation?

What would you have done if you found yourself in a similar situation as Rosemary? Would your answer be as clear as you would hope it would be?

Breaking the News

This event happened many years' ago but it still haunts me to this day. Let me narrate it as it happened.

When I came for my shift, I learned that a patient was found unresponsive by the previous shift staff. Despite our best resuscitative efforts, the patient did not regain consciousness and was pronounced dead. Because the collapse was unwitnessed and its cause unknown, the patient's death was classified as a coroner's case.

After the handover from the patient's nurse, I was handed the responsibility of continuing the efforts to contact the patient's next of kin (NOK). It can be imagined that in the midst of resuscitative chaos, and the situation in which it was triggered, I was dealing with a situation in which I had limited information. Eventually, I was able to get hold of the patient's daughter who was the documented NOK in the patient's charts.

…..Following the discussion, the consultant expressed dissatisfaction of being placed in what he described it as an "awkward situation."

….the Nurse Manager informed me that I should have been the one to break the news of the patient's death to his daughter as I was the nurse on duty that day.

However, based on my professional judgment, I felt that it was not appropriate for me to break the news of her father's death to her given the circumstances surrounding his death and my superficial knowledge regarding the event that had unfolded earlier. There was another reason for my reluctance, and this had to do with the well-being of the daughter—she would have many questions which I would not be able to answer them, which I imagined would cause her great emotional distress.

Therefore, I approached the consultant to inform the daughter. The consultant delivered the news with another nurse present, ensuring professional support during the disclosure. Following the discussion, the consultant expressed dissatisfaction of being placed in what he described it as an "awkward situation".

Later that day, I was approached by the Nurse Manager who informed me that I should have been the one to break the news of the patient's death to his daughter as I was the nurse on duty that day.

Janine
Registered Nurse
Hospital

Reflection Through the Ethical Lens

Janine's story is the opposite of Rosemary. Janine followed the protocol of breaking bad news in a hospital. It is the role of the physician in-charge who ought to break the news of death to the next of kin (NOK) and yet, in this case, following the protocol led to Janine being deemed

as not performing her professional duty. Does this mean that the boundary of a nurse's 'professional duty' is fluid? If professional duty is governed by the scope of practice and professional ethics, did Janine's action point to a failure in carrying out her responsibility? These questions require further discussion and analysis in the context of power, duty, and ethics because in healthcare settings, competing narratives on ethics and duty by diverse stakeholders abound.

When seen from the perspective of ethics of care, Janine's actions reflected her empathy, compassion, and a deep understanding of grief surrounding a sudden loss. She knew that there were gaps in her knowledge surrounding the death and would not have been able to answer the grieving daughter's questions. This self-awareness requires moral courage.

What would you have done if you found yourself in a similar situation where you were informed to break a bad news to a patient?

Compassion Over Judgment[1]

I was caring for an adolescent who had been admitted for behavioural and emotional concerns. He appeared withdrawn and hesitant to communicate. Through my consistent engagement and building trust, he gradually opened up about his struggles, including his confusion about his identity and his attraction to the same gender.

At that moment, I became very aware of my role as a nurse and my ethical responsibility. Instead of allowing personal beliefs or societal norms to influence my response, I chose to focus on creating a safe and supportive space for him. I listened actively, acknowledged his feelings, and ensured that he felt respected and accepted. I reminded myself that my priority was not to judge, but to care. This approach helped to preserve his dignity and allowed him to express himself more openly.

On reflection, I realised that ethical nursing practice goes beyond clinical skills. It requires empathy, self-awareness, and the ability to set aside personal biases.

This experience reinforced my belief in person-centred care. Every individual comes with their own unique background, experiences, and identity, and as nurses, we must respect these differences. In a diverse society like Singapore, it is especially important to remain culturally sensitive and uphold professional ethics in all aspects of care.

On reflection, I realised that ethical nursing practice goes beyond clinical skills. It requires empathy, self-awareness, and the ability to set aside personal biases. By choosing to be non-judgmental and supportive, I was able to build trust and contribute positively towards the adolescent's health. This experience is a reminder that I must place the patient, and the person, at the centre at all times.

Nur Ba'eyah Roslin
Secretary
Nursing Ethics Chapter

[1] This narrative was first published in the poster presentation at the ASPAN conference held in Singapore from June 25 to 26, 2026 at Expo Hall. Reprinted with permission.

Reflection Through the Ethical Lens

Nur Ba'eyah's care towards the youth reflects the foundation of a mindful practice. She is present to the youth's struggles of self-identity and at the same time, she is also aware of her own values, beliefs, and assumptions that could potentially become barriers to listening to the person in front of her. This is the basis of ethical care. Ethical care acknowledges the person at the centre and treats that individual with fairness, respect, and honesty regardless of who they are and where they come from.

When we are honest with ourselves that our own beliefs and assumptions may be flawed or potentially biased, we are able to provide care that is compassionate, empathetic, and respectful. At the end of the day, ethics is about treating a person with integrity, kindness, and with regard. Nur Ba'eyah's approach towards the youth reflected that ethical care.

The question that we all have to ask is, what would we do if we have a patient whose values and beliefs clashed with our own personal perspectives? Would we still be able to provide care that is person-centred?

A Public Humiliation[2]

A physician called a nurse "stupid" in front of the staff and patients. Although a high-pressure clinical environment can trigger stress, this disparaging remark breached professional ethics and undermined the interprofessional collaborative care.

The nurse appeared distressed and humiliated. The disparaging remark had a ripple effect—it undermined her confidence, brought to question her clinical judgment, and eroded patient's trust in her. That single rebuke was insidious: it created a quiet mistrust among the various health professionals and a simmering hostility in the workplace.

What can we learn from this? That a single, thoughtless remark, borne out of frustration does not stop at one point but takes on a life of its own which, if not corrected, (here, the physician should have apologised publicly to the nurse), becomes the poison that permeates into everything. It creates fear, anger, and distrust among colleagues.

Ethical practice is reflected not only in how we care for patients, but also in how we treat one another.

All healthcare professionals deserve to be treated with respect and kindness and has the right to work in a safe environment. Ethical practice is reflected not only in how we care for patients, but also in how we treat one another. Respectful communication strengthens teamwork, safeguards patient care, and builds a positive healthcare culture.

Carol Loi
Assistant Secretary
Nursing Ethics Chapter

[2] This narrative was first published in the poster presentation at the ASPAN conference held in Singapore from June 25 to 26, 2026 at Expo Hall. Reprinted with permission.

Reflection Through the Ethical Lens

There is a substantial body of literature that deals with ethical care and behaviour towards patients and their families, and these are needed of course. But what we often do not discuss openly or extensively is the unethical behaviour of colleagues towards one another.

Unethical behaviour could be put-downs in the form of jokes (this is most insidious of all) or as advise for growth in the form sarcasm or as in this narrative, an outright nasty rebuke by a physician to a nurse. To be sure, these various examples of unethical behaviour are not only concentrated in the physician population. These unethical and unprofessional behaviour are found when there is a power disparity between the person who wields the power and the individual who has little or no power at all.

If we read Carol's story carefully, there is another hidden narrative embedded in it, and that is, what is the role of those who are observing the put-down? Do they have an ethical duty to speak up, and state unequivocally, that this type of behaviour is unwarranted? When we remain silent, we are implicitly agreeing to the unethical behaviour—that the put downs or the rebuke or the jokes, or the inappropriate words, touch, or glance are acceptable. Silence makes us all complicit to the unethical professional behaviour.

Events

Local

Nursing Ethics Chapter
Narrative Ethics Workshop
MWS Bethany Nursing Home
August 26, 2026
1300 to 1500 hrs.

International

Carol Carfang Nursing and Healthcare Ethics Conference
Advancing Ethical Practice: Exploring the Gray Areas
February 24 to 26, 2027 in Clearwater, Florida
https://www.duq.edu/academics/colleges-and-schools/nursing/events/carfang-nursing-and-healthcare-ethics-conference/index.php

Ethics of Caring
Strengthening Connections: Embracing Humanity
In Healthcare
April 8 and 9, 2027 in Los Angeles
https://ethicsofcaring.org/

International Conference on Medical Humanities
The social, historical, and cultural dimensions of health.
March 14 to 14, 2027 in London (Hybrid)
https://medhumconf.lcir.co.uk/

Next Submission to *Voices in Nursing Ethics*

- **Issue**: Nov to Dec 2026
- **Theme**: *Being at Someone's Bedside at their End of Life.*
- **Submission deadline**: November 30, 2026.
- **Word limit**: 300 to 400 words
- **Email submission to**: nursingethicschapter@gmail.com