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Nurses' Lived Experiences of Moral Courage Inhibitors: A Qualitative Descriptive Study

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Abstract

Introduction: Moral courage (MC) has been characterized among the vital strategies, adopted by nurses, for dealing with moral distress; even though there are some factors hindering the development of this behavior in clinical settings.

Objective: The present study accordingly aimed to shed light on Iranian nurses' lived experiences regarding MC inhibitors.

Methods: This qualitative descriptive study was fulfilled, using conventional content analysis. For this purpose, the participants comprised of 15 nurses were recruited purposively from teaching hospitals in Iran. As well, in-depth, individual semi-structured interviews in a face-to-face mode were held for data collection. The data were further analyzed by Graneheim and Lundman's method.

Results: The analysis of the interviews revealed some MC inhibitors, including the individual factors (viz., personality traits, fear of job loss, poor scientific/practical skills, lack of ethical knowledge, and phobia of unpleasant experience recurrence), and the organizational ones (namely, no reward system, lack of power at work and physician dominance, inadequate organizational support, and suppressive environment).

Conclusion: The study findings demonstrated that the MC inhibitors in the nursing practice could be split into two general themes, that is, the individual and organizational ones. Accordingly, organizations could motivate nurses to make ethical decisions courageously, using supporting strategies, such as giving importance to nurses and empowering them, applying appropriate evaluation criteria, and appreciating ethical performance in these frontline healthcare workers.

Keywords

concept analysis, moral courage, nursing, research, qualitative research

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Introduction

Given the nature of the nursing profession, nurses are often drawn against a wide variety of ethical challenges, including moral distress (MD), among the major ones. In general, MD can be assumed as an emotional or mental pain and even a sense of unhappiness, in which a person, despite having the basic knowledge and ability to judge morality, makes moral mistakes, attributable to the real or mental limitations ahead (Morley, 2018). In this respect, much pressure on employees by their affiliated organizations, the lack of facilities and manpower, inability to make the right decisions, carrying out orders by force, the unneeded actions of health team members, and end-of-life care can significantly contribute to the MD occurrence (De Brasi et al., 2021; Henrich et al., 2016). The important thing is that the path is often clear in MD, but the ability to implement the solutions is somehow blocked (Gallagher, 2011). If nurses adhere to their moral beliefs, they can thus take voluntary moral actions to protect patient rights, even if they go through problems, stress, and threats, which has been termed in the related literature as moral courage (MC) (Brown, 2015; Ko &

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Wang, 2011; Savel & Munro, 2015), representing a pure and prominent characteristic of human beings. The MC antecedents also include model orientation, model acceptance, rationalism, individual excellence, academic/professional qualifications, spiritual beliefs, organizational support, organizational repression, and internal/external personal barriers (Sadooghiasl et al., 2018).

Limited MC together with long-term MD can thus result in the development of some negative feelings toward self and the source of crime, which can be an organization, a physician, peers, a patient, or families, and cause low self-esteem, burnout, and job dissatisfaction. Moreover, inadequate MC may give rise to the neglect of even well-defined moral virtues (Ko & Wang, 2011). Quite the opposite, high MC in nurses can be respected as a strategy to reduce MD, thereby improving patient safety and care quality (Brown, 2015; De Brasi et al., 2021; Gallagher, 2011; Henrich et al., 2016; Morley, 2018).

Even if strong spiritual beliefs, considering the Iranian culture, are one of the MC facilitators in most nurses to respect for patient rights and divest oneself of MD, there are sometimes factors hindering the development of this behavior.

Literature Review

In Iran, nurses undergo many problems, typically when it is required to demonstrate MC. There is also no devotion to ethical issues, such as MC, in the nursing curriculum, particularly at the undergraduate level, and most of the content is focused on the principles of nursing ethics. As well, no ethics committees exist to support these frontline healthcare workers in Iranian hospitals, so there is no proper platform to demonstrate MC. In this line, some MC inhibitors, such as organizational failure, deterrent personal identity, defeated professional identity, and lack of support resources have been accordingly recognized in previous research in Iran (Rakhshan et al., 2021). Nevertheless, the factors hindering MC have not been mentioned comprehensively in other surveys in this context, and thus have failed to fill the gaps considering that the samples have been different from those recruited in the present study or the research methods have been quantitative or based on conceptual analysis (Ebadi et al., 2020; Hanifi et al., 2019; Khajevandi et al., 2020; Namadi et al., 2019; Sadooghiasl et al., 2018). Hence, the evidence highlights the existing gap and the need to methodically determine the MC inhibitors in nurses.

Given the learnability of MC, the present study can help develop and strengthen this behavior among nurses in clinical settings and inform policymakers and nursing managers about the main inhibitors.

As MC is a multidimensional and complex concept, shaped by numerous values, cultural/religious beliefs, social context, and passing of time, the present study was conducted considering the context, by tapping a qualitative approach and nurses' lived experiences, to discover the MC inhibitors.

Methods

Design

A qualitative descriptive (QD) research design, used in-depth, individual semistructured interviews in a face-to-face mode, was implemented in the present study. The qualitative approach, recruited in nursing and healthcare research, could thus provide a broad insight into particular phenomena, including MC, and the descriptive methodology could help offer straightforward descriptions of the nurses' lived experiences regarding the MC inhibitors (Doyle et al., 2020; Kim et al., 2017).

Research Question

- What are the MC inhibitors in the nursing practice?

Samples

This QD study was conducted in 2020–21, using conventional content analysis. The study setting was the general wards and the critical care units of teaching hospitals in Iran. The participants also included 15 nurses, recruited by purposive sampling with maximum variation, concerning their gender, workplace, education, work experience, and organizational rank. Table 1 illustrates the participants' characteristics.

Inclusion/Exclusion Criteria

The inclusion criteria were holding bachelor's or higher degrees in nursing, having clinical work experience for more than one year, and showing a willingness to participate in the study. On the other hand, the exclusion criteria involved having less than one year of work experience and being reluctant to contribute to the study.

Data Collection

This study was completed during 9 months, and the data were collected through 17 in-depth, individual semistructured interviews in a face-to-face mode. To note, the interviewer had already taken some courses on qualitative research and had been trained how to conduct interviews. Prior to the study and upon obtaining approval of the Research Ethics Committee, the interviewer introduced herself to the participants, explained the research objectives, acquired their written informed consent, and then assured them of the

Table 1. Demographic Characteristic of the Participants.

Participant	Age	Work experience	Gender	Education level	Unit
1	46	16	Female	BSc	Medical
2	35	14	Male	BSc	Medical
3	32	11	Female	BSc	CCU
4	41	18	Female	BSc	CCU
5	34	13	Female	MSc	ICU
6	35	14	Female	BSc	ICU
7	31	10	Male	BSc	ICU
8	37	16	Female	BSc	Surgical
9	39	18	Female	BSc	Surgical
10	29	9	Female	BSc	Surgical
11	36	16	Female	BSc	ICU
12	29	8	Female	BSc	Emergency
13	34	13	Female	BSc	Emergency
14	30	10	Female	BSc	Emergency
15	35	14	Female	BSc	CCU

BSc = Bachelor of Science; MSc = Master of Science.

confidentiality of personal data. The permission for audio recording and data publication was further reiterated to the participants during the interviews, and they were made sure that their personal information would remain completely confidential and anonymous. After the warm-up phase, the interviews continued on the study subject. First, the following broad question was raised to start the interviews (Table 2), "*Based on your work experience, what factors do hinder your moral courage?*" Then, some probing questions were utilized to more carefully explore the participants' lived experiences; e.g., "*Have you ever encountered with this situation?*" and "*Can you give an example?*." The time and place of the interviews were further arranged based on the participants' preferences in their workplace in a quiet room in the teaching hospitals. The interviews lasted 30–45 min. As well, two participants (no. 6 and 9) were interviewed twice to clarify their answers to some questions. To note, all interviews were held by the first author in a quiet place and were audio-recorded. Furthermore, the data collection continued until theoretical saturation was reached regarding the subthemes extracted.

Table 2. Examples of the Questions Used in the Interviews.

Questions:
1. Please tell us about the ethical challenges you faced in practice.
2. What reaction do you show when you experience moral distress? And why?
3. Please talk about your experience about the situations that required showing moral courage.
4. Based on your work experience, what factors suppress your moral courage?
5. Which factors negatively affected your moral courage based on your experiences?
6. What problems did you face after showing moral courage?
7. How did you feel after you have been suppressed?
8. Tell us about your most unpleasant experiences.

Data Analysis

The data analysis was performed using Graneheim and Lundman's method (2004), namely, conventional content analysis. For this purpose, the authors, who performed the data analysis, immediately listened to each interview several times and transcribed them verbatim. Next, the texts were imported into the MAXQDA 10 software package (ver. 10 R 160410; Udo Kuckartz, Berlin, Germany), for data analysis, along with the coding and extraction of the categories and themes. Two authors (MJ and FN) coded the first interview independently and at the same time, to ensure coding agreement and interrater reliability, indicating 90% agreement between both coders. The conflicts were also resolved by discussion. Besides, the interview transcripts were considered as the units of analysis. The paragraphs, sentences, and words, which were relevant to the study objectives, were also identified, and then considered as the semantic units, which were consequently coded (Table 3). Afterward, the codes were constantly compared with each other and categorized into subthemes in accordance with their similarities. Subsequently, the subthemes were grouped in line with their identical concepts to form the main themes. Finally, all authors reviewed and approved the subthemes and themes extracted.

Trustworthiness

To ensure the trustworthiness of the study findings, four evaluative criteria, including credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1986) were investigated. The credibility was thus met through

continuous interactions with the participants and the data, long-term contact via frequent reviews of the interview transcripts, the corrective views raised by faculty members on the interview process, data analysis and code extraction, as well as the views expressed by some participants and those involved in the interviews. To assess dependability, another external audit was used to find the similarities and differences between the external auditors' understanding of the subjects and those of the researcher. To check the confirmability and transferability criteria, the study phases, including data collection, data analysis, and theme formation, were fully explained to enable the readers to scrutinize them. The study process was also made available to a number of study collaborators to confirm its trustworthiness.

Results

Sample Characteristics

In total, 17 interviews with 15 nurses were organized and completed. The participants' mean age was 34.86 ± 4.64, and their average work experience was 13.33 ± 3.17 years. As well, 13 participants were female, and 14 cases were holding bachelor's degrees (Table 1).

Research Question Results

The analysis of the interviews revealed two themes and nine subthemes as the MC inhibitors, containing individual (five subthemes) and organizational (four subthemes) factors (Table 4).

MC Inhibitors

Individual Factors. The individual factors as the first theme consisted of personality traits, fear of job loss, poor scientific/practical skills, lack of ethical knowledge, and phobia of unpleasant experience recurrence.

Personality traits. Some personality traits, such as no sense of responsibility, shyness, not being sensitive, lack of motivation, and inadequate self-confidence were found to hinder MC. In this regard, one of the participants stated that:

> "I myself do not have self-confidence as much as necessary, because there have been scores of situations where I have thought that my decisions have been right, but I have failed to insist on them." (P12, a female nurse)

Another participant also added that:

> "We had a post-CPR case. My colleague was nursing this patient, but had not attended to him. I saw that the oxygen supply had run out, and the patient had expired. Even though I had told him several times to be more vigilant in caring for patients, he had not done so due to laziness or no sense of duty and commitment. As a whole, he had not minded it." (P2, a male nurse)

Table 4. Factors Inhibit MC.

Themes	Subthemes
Individual barriers	Personality traits
	Fear of job loss
	Inadequate scientific and practical skills
	Lack of moral knowledge
	Fear of repeating unpleasant experiences
Organizational barriers	No reward system
	Lack of power at work and doctor dominance
	No organizational support
	A suppressive environment

MC = moral courage.

Table 3. Examples of Meaning Units, Condensed Meaning Units, and Codes.

Meaning units	Condensed meaning units	Codes
"In the environment where I work, most of the colleagues and the head of the ward are mostly silent in front of unethical actions and prefer their own interests to the interests of the patient, and it is very difficult for me to show moral courage in such an environment".	Silence of most nurses in front of unethical actions and prefer their own interests to the interests of the patient	Seeing the silence of most colleagues, Seeing the priority of their interests in nurses
"Unfortunately, we are deprived of the support of the authorities and in many cases we are alone in defending the rights of the patient, which makes me and many other colleagues cover everything and remain silent."	Being alone and deprived of the support of the authorities in defense of the patient's rights	Being alone in defense of the patient's rights, Being deprived of the support of the authorities
"I myself do not have the enough self-confidence, there have been situations where I thought my decision was right, but I could not insist on it"	Lack of enough self-confidence and lack of persistence in your decisions	Inadequate self-confidence, Hesitation in decision making, Inability to stand on the right decisions

Fear of job loss. In the present study, the participants' lived experiences showed that the fear of job loss in the current unfavorable economic conditions, caused by their nonpermanent employment, had prevented the MC manifestation. In this respect, one of the nurses asserted that:

> "By distraction, I injected potassium chloride instead of metronidazole for the patient and he expired. At that moment, many thoughts boggled my mind, and made me not to say that I have given the wrong medicine. For example, the thought that if I speak about it, I will be fired or lose my job." (P6, a female nurse)

Moreover, another nurse said that:

> "I used to work as a part-time nurse for a hospital. I was afraid to file complaints and show courage because I might lose my job." (P8, a female nurse)

Poor scientific/practical skills. As evidenced, scientific and practical skills are among the main requirements for nursing practice. The study participants noted that nurses with great professional competence could be more committed to ethical and professional values, and courageously defend them. The participants also stated that lacking some abilities in their professions could reduce their self-confidence and make them remain silent in front of challenging situations. In this line, one of the participants stated that:

> "Inadequate knowledge and experience catch the eye many times. When you see mistakes, you do not have the necessary confidence to report or discuss it." (P10, a female nurse)

Lack of ethical knowledge. One of the main reasons for the poor performance of nurses in the field of ethical issues was their lack of knowledge and insufficient training, as affirmed by the study participants. Accordingly, the notion that being a nurse enables a person to behave ethically without receiving any training is completely unfounded. For example, one of the participants believed that:

> "We did not get any education about ethical issues or moral courage during our studies or in the workplace, so you may keep silent many times because you think that is the best thing to do." (P13, a female nurse)

Phobia of unpleasant experience recurrence. The participants' lived experiences indicated that they had been frequently subjected to horizontal violence by their colleagues, negative views from them, blaming and misbehavior from the authorities when they had stood up for patient rights or had been on the opposite side of the physicians, nursing managers, or other nurses. As a result, they had repeatedly suppressed MC in support of patient rights. For example, one of the nurses stated that:

> "Getting involved in justice-seeking issues is in fact a kind of preoccupation. It costs a fortune, and it is not even easy to talk about such things. Actually, I cannot bear all these problems when protecting patient rights." (P12, a female nurse)

In this sense, one of the participants declared that:

> "As errors or incompetence in novice nurses are more highlighted, the likelihood of admitting mistakes and demonstrating courageous behaviors in many situations that require MC is downgraded." (P12, a female nurse)

Organizational Factors. No reward system, lack of power at work and physician dominance, inadequate organizational support, and suppressive environment were the subthemes extracted as the organizational factors and the second category of the themes.

No reward system. Rewarding represents the behavior to enhance the positive practices by nurses and encourage them, but the data indicated that no reward system and the inadequate appreciation of positive behaviors like MC could make the nurses unmotivated. In this regard, one of the participants stated that:

> "I have never been encouraged to have high moral courage, but I have faced many problems, which reduce motivation and moral courage." (P11, a female nurse)

Lack of power at work and physician dominance. This subtheme referred to nursing being overshadowed by physicians and the fact that the so-called importance of nurses' roles in care decision-making was very low. In this line, the participants' lived experiences showed that the physicians working in hospitals were like rulers in the current situation because they were assumed as the only individuals in charge of making the main decisions about patients. Even if they would make wrong decisions in some cases, they did not allow nurses as professionals to contribute and have a say. In most situations, this could inhibit MC. In this line, one of the participants asserted that:

> "I told the physician that the patient had a platelet count lower than normal and that in cases where the platelets were below 50,000, we should not do muscle injections, but the physician was upset that I noted this. After that, I did not dare to advise physicians, because our profession has not given us enough strength and there is the dominance of physicians. The principle is to work in a hospital, as a team and inter-professionally, but some physicians are so arrogant that

> they do not accept the advice of others at all." (P5, a female nurse)

Inadequate organizational support. According to the participants' lived experiences, the lack of support from authorities, organization, and supporting committee could make them remain silent in challenging situations that would require MC. One of the participants stated that:

> "Unfortunately, we are deprived of the support of the authorities, and we are left unaided in defending patient rights in many cases, which makes me and many other colleagues cover everything and stay behind." (P12, a female nurse)

Suppressive environment. The working atmosphere is one of the most important factors shaping MC in organizations in accordance with their context and culture. As detected in some participants' lived experiences, exhibiting MC in the workplace could be influenced by ethical workplace culture, colleagues' behavior, and ethical priorities in the organization. In this regard, one of the participants said that:

> "In my workplace, most colleagues and the ward head are more or less silent in front of unethical issues and prefer their own interests to those of patients. It seems demanding for me to show moral courage in such an environment." (P7, a male nurse)

Discussion

The study findings demonstrated that a series of factors could inhibit MC, containing the individual and organizational ones. Unwillingness, no sense of responsibility, shyness, lack of sensitivity, as well as inadequate motivation and self-confidence were thus among the personality traits extracted from the lived experiences of most participants, which could hinder the development of MC. In their study, Numminen et al. (2017) had similarly identified seven key personality traits, that is, real presence, moral integrity, responsibility, support, commitment, perseverance, and personal risk, whose absence could inhibit MC in the nursing practice. As well, Rakhshan et al. (2021) had acknowledged that personality traits, such as lack of interest in one's profession, no job motivation, moral silence, inadequate self-confidence, and self-centeredness could be among the barriers to MC formation.

The participants' lived experiences in the present study also illustrated that the fear of losing one's job had intensified many times more than ever before due to the uncertain economic conditions in Iran, following the international sanctions and the subsequent job insecurity. This fear had even made the nurses refuse to show MC in many situations so as not to face the challenge of job loss. It should be noted that the fear of job loss is stronger, especially among part-time employees. In this line, one survey in Iran had established that the fear of one's behavioral consequences and job insecurity could hinder the growth of MC (Rakhshan et al., 2021).

In this study, the participants additionally reiterated that not having enough work experience and knowledge had led to the loss of their self-confidence, thereby acting as an inhibitor to MC. Various investigations had also mentioned professional competence as a factor in increasing nurses' self-confidence and, in parallel, their MC (Khoshmehr et al., 2020; Numminen et al., 2019). Besides, Murray (2010) had found that MC would be boosted as knowledge and work experience (namely, professional competence) had elevated in nurses. In their study, Sekerka and Bagozzi (2007) had correspondingly concluded that MC could be obtained and strengthened by broadening experience and competence. Thus, individuals with high experience and history were probably not without fear and apprehension, but they could overcome risks and negative consequences, with a stronger heart and knowledge, due to their experiences gained over the years of service.

Lack of ethical knowledge was also another factor that could inhibit MC. In Iran, two units of ethics course had been included in the undergraduate nursing curriculum after 2016, but they had mostly reflected ethical codes and had failed to cover many ethical issues, so nurses might enter their workplace without acquiring sufficient ethical knowledge. In the word of Numminen et al. (2019), nurses with high ethical knowledge have significantly higher MC, which suggests that personal interest in ethics may have a positive effect on the development of this behavior, which is in line with the Aristotelian conception that virtues can be acquired through practice and commitment (Thomson et al., 2004). Another MC inhibitor was the phobia of unpleasant experience recurrence. In this vein, other studies had also revealed that the fear of reprisals could make someone not to act when witnessing poor practice (Bickhoff et al., 2017; Gunther, 2011).

The other category of MC inhibitors was organizational factors, including no reward system, lack of power at work and physician dominance, inadequate organizational support, and suppressive environment, which could hinder the development of this behavior. In Iran, some factors such as physician dominance (Mousazadeh et al., 2019), no autonomy in the workplace, lack of power at work, loss of self-confidence, and duality of respect and value had further prevailed in the professional culture of the nursing community (Rakhshan et al., 2021) that could moderate the ability of nurses to make decisions and show moral behaviors. This could damage ethics and make things worse. Other studies have further underlined the role of the surrounding environment and the supporting organization in the emergence of moral behaviors (Burston & Tuckett, 2013;

Nejadsarvari et al., 2015). One survey had accordingly revealed that organizational culture, such as hospital managers' inattention to ethical aspects and punishment after moral actions, could lead to moral neutralization (Hakimi et al., 2020). Besides, a suppressive environment could prevent MC development in nurses by ignoring the ethical aspects and lacking professional power (Sadooghiasl et al., 2018).

Therefore, nurses and healthcare organizations should take some effective measures to reduce the existing barriers by designing and implementing various interventions.

Strengths and Limitations

Discovering the MC inhibitors, using a qualitative approach and the lived experiences of clinical nurses, was one of the strengths of the present study. However, one of the main limitations addressed was the mere use of in-depth, individual semistructured interviews in a face-to-face mode to collect the data, so it is suggested to conduct more studies based on triangulation. Purposive sampling was further practiced with regard to the qualitative nature of the study, and there was much attempt to meet maximum variation in the study samples, but the number of male participants and age diversity was small, which is typically one of the uncontrollable limitations related to the qualitative approach. Of note, this approach was implemented due to its ability to share the valuable lived experiences of the participants. Another limitation of the study was the influence of people's religious beliefs on MC, which could affect their experiences of this behavior, and then restrict the generalizability of the results, which was uncontrollable. One other limitation was associated with generalizing the results, which is often related to the qualitative nature of the study and the discovery of the experiences of a specific group of nurses with their own background. Accordingly, it is recommended to conduct similar studies in other contexts with a larger sample size to make the results more generalizable. Moreover, it is suggested to design interventions and examine their effects on MC among nurses based on the study results.

Implications for Practice

The results of the present study can help nursing managers and policymakers know more about MC inhibitors and deal with them. Furthermore, educational policymakers can expand the content of the ethics curriculum based on the existing gap, so that students and nurses can graduate with high ethical knowledge, and hospital administrators can strengthen MC in nurses by forming support committees, designing efficient reward and promotion systems, creating an ethical atmosphere in the organization, and holding moral retraining courses.

Conclusion

According to the study findings, most nurses are facing some challenges associated with moral issues, on a daily basis, that demand appropriate reactions and decisions, but there are some individual and organizational factors that suppress MC development among them. Being aware of the existing inhibitors along with planning and implementing interventions to reduce them and encourage MC can thus relieve MD in nurses.

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Author Contribution

All authors read and approved the final manuscript. Study conception and design: (A.Sh, F.N, M.J); Data collection (A.Sh, F.N); Data analysis and interpretation: (A.Sh, F.N, M.J); Drafting of the article: (A.Sh, F.N, M.J); and Critical revision of the article: (A.Sh, F.N, M.J).

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethics Approval and Consent to Participate

The Ethics Committee of Urmia University of Medical Sciences (ethics code: IR.UMSU.REC.1397.258), Iran, approved this study and it has followed ethical principles and standards at all stages of the study in accordance with the provisions of the Helsinki Declaration of 1995 (revised version of Edinburgh 14 in 2000). Participants were informed that participation in the study would be voluntary and study data would be managed confidentially. Prior to the beginning of the interviews, the researcher obtained their written informed consent and assured them that the personal data would be regarded as strictly confidential. Permission for audio recording and data publication was reiterated to participants during interviews.

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