Exploring the Barriers of Moral Courage from Iranian Nurses' Point of View: A Qualitative Study

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Abstract

Background: Nursing is a caring profession. Due to the nature of their, nurses need moral courage to deliver safe nursing care. Research results have reported a low level of moral courage in the majority of nurses. So the current study aimed to explore the barriers to the formation of moral courage nurses who work in hospitals.

Methods: In this qualitative study, conventional content analysis was used to explain the barriers to moral courage in hospital nurses. Data was gathered using in-person, semi-structured in-depth interviews. Interviews were conducted from March to September 2020. Purposeful sampling was used and sampling was continued until data saturation was reached. Data were analyzed using conventional content analysis. Participants were 19 nurses working in hospitals in Iran.

Results: Three main themes extracted including organizational failure, deterrent individual identity, and defeated professional culture as well as six categories and eighteen sub-categories.

Conclusions: The results of this study revealed the barriers to moral courage which were usually overlooked in previous quantitative studies. It appears that the elimination of these barriers is an effective step in the improvement of nurses' competencies and delivered care. The results of this study can be helpful in the development of management programs to identify the factors affecting nurses' moral courage and how to improve it.

Background

Nowadays, advances in medical science have placed nurses in difficult situations in their workplaces that require ethical decision-making. These situations have created an increasing need for discussion and exchange of views on ethical issues and decision-making (Sorokin et al., 2016). Nurses are the principal group of service providers in health care systems (Freund et al., 2015) and have a significant impact on the quality of health care (Oldland et al., 2020). They often face challenging ethical issues in clinical settings (Harrison et al., 2016) and as moral agents, they need moral courage to properly manage ethical problems and have a professional commitment to their patients (Mahdaviseresht et al., 2015).

Moral courage is one of the most important topics in nursing professions and has a long history (Hawkins and Morse, 2014). The concept of moral courage was introduced by Florence Neningel. It is, among all the personal characteristics and competencies, the basic principle for being a good nurse. It is a trait that allows a person to act based on moral principles (Numminen et al., 2019). Moral courage means acting based on moral values. A person who has moral courage, despite the difficulties and dangers, in times of moral challenges and dilemmas, decides and acts constantly, consciously and voluntarily, despite all the negative consequences of her/his decisions (Hamric et al., 2015, Numminen et al., 2019, Numminen et al., 2017). Nurses, based on their profession nature, need moral courage to emphasize humanitarian care and resist doing immoral things (Lindh et al., 2010). Moral courage helps

the nurse to provide acceptable care for the patient, the family, and the community in addition to having the qualities of a good person (Fry et al., 2010).

Moral courage is a trait that leads to a reduction of moral distress (Hoseini et al., 2019, Lachance, 2017, Taraz et al., 2019, Woods, 2014), personal and professional development (Dinndorf-Hogenson, 2015, Lamiani et al., 2017), motivation, acquisition of skills, and maintenance of the body of knowledge in the nurse (Sekerka et al., 2009). In its absence, the provision of nursing care is affected and may lead to immoral behavior (Lamiani et al., 2017). Nurses' courageous decisions to achieve ethical goals can prevent ethical conflicts (Santos et al., 2018). Also, having moral courage in the face of moral challenges can maintain moral frameworks and prevent moral chaos (Lachance, 2017). Murray (2010) states that strengthening moral courage can play an important role in the prevention of the undesirable consequences of moral challenges that typically arise in therapeutic settings (Murray, 2010). However, the findings of most previous studies showed a low level of moral courage in nurses (Aminizadeh et al., 2017, Taghaddosi et al., 2020) and some reported it as moderate (Aminizadeh et al., 2017, Hoseini et al., 2019, Taraz et al., 2019). Studies have shown that personal and professional factors (Suhonen et al., 2011) along with organizational culture and leadership style (Escolar-Chua, 2018) can affect nurses' moral courage. Nurses try to adhere to their moral principles and values in situations such as protecting the patient, giving bad news, caring for an infected patient, and inappropriate care by immoral coworkers. But fear of negative reactions from co-workers, losing a job, widespread emotional reactions, and violence cause them to avoid moral action. As a result, they experience depression, guilt, and anger and they may feel being worthlessness and powerlessness (Gallagher, 2011, Lachman, 2012).

Ethical courage is an essential issue in nurses' behavior, as its impact may be seen in the quality of care provided by them (Numminen et al., 2017). Despite the studies conducted, a lack of moral courage is common among nurses and should be enhanced by developing courage and adherence to ethical principles in them (Mohammadi et al., 2014). But its promotion requires the identification of relevant factors (Watson, 2003). Limited studies have been conducted to identify barriers to the formation of moral courage in nurses. Studies on moral courage have often examined this concept through assumptions and in the form of quantitative studies. However, the use of quantitative approaches to identify individuals' beliefs and values about phenomena that are somehow related to human interactions do not have the necessary flexibility and depth (Grove and Gray, 2018). In this regard, qualitative research is mainly used to identify human emotions and perceptions (LoBiondo-Wood et al., 2017). Qualitative research provides an opportunity to answer questions centered on social experience. They are based on the assumption that acquiring knowledge about human beings is impossible without describing and explaining their beliefs and perceptions in their cultural and social contexts (Speziale et al., 2011). Therefore, the use of qualitative methods gives depth and richness to the findings that are not comparable to quantitative research methods (Polit and Beck, 2017). Considering the importance of moral courage and the need to promote it in the nurses along with the need to recognize its formation's barriers in the culture and context of the nursing, the present study was conducted to explain the barriers to moral courage formation of nurses working in hospitals in Iran. Current study aimed to explore the barriers to the formation of moral courage in nurses who work in hospitals.

Methods

The study was conducted using a descriptive exploratory qualitative design with a conventional content analysis approach.

Participant & Research Context

Participants in the study were 19 nurses working in different wards of hospitals in Iran. They were selected by purposive sampling method and invited to participate in the study. Inclusion criteria included at least one year of work experience and willingness to participate in the study.

Data collection

To discover the obstacles to the formation of moral courage in nurses, a qualitative research approach with a conventional content analysis method was used. Individual in-depth Semi-structured interviews were the data collection method which was conducted via Skype or telephone and if they want to communicate face to face with safety protocols. The time of the interview was determined by the agreement of the participants. The second author (N.M.) who has a background in nursing and is interested in ethical issues, arranged and conducted all the interviews.

For this purpose, according to inclusion criteria, the researcher informed the participants 3 days prior to the interview, and if desired, the time and place of the interview was determined by them, and the day before the interview, the necessary coordination was made with them. to maintain Participants safety and convenience and to freely express their experiences and thoughts, interview was done in their house, and in the case of face-to-face interviews in staff room in hospital.

All interviews were recorded with the participants' permission and then transcribed line by line. Interviews last between 35 and 50 minutes. Interview questions included the following:

In the workplace, how will you behave when your professional principles are violated?

In your opinion, what is the moral courage in nursing?

What are the obstacles to having moral courage in nursing?

What prevents you from making moral decisions?

They were followed by specific and follow-up questions such as "Can you explain more?", "What do you mean?", "Explain what you mean by an example you're your personal experience?", "Why? And how? The questions were asked to achieve the objectives of the research and based on the answers of the participants to clarify the details of their answers. The interviews continued until the data saturation was achieved and no new data was obtained.

Data analysis

Data were analyzed using the conventional content analysis approach of Granheim and Landman (Graneheim and Lundman, 2004). First, after each interview, the entire text of the interview was transcribed. In the next step, to get a general understanding of the content, the whole text was read several times. Then the meaning units were determined and the initial codes were extracted. The codes were then classified based on their similarities and differences, and finally, the latent content of the data was extracted.

Rigor

Prolonged engagement with the phenomenon and devoting sufficient time to data collection and continuous review were methods used to increase credibility. From the beginning, the researcher established a good relationship with the participants to collect data. To ensure the accuracy of the findings and their relevance to the transcripts, some of the interviews were checked with the codes and categories by 3 professors of nursing (Peer - debriefing). They were experts in qualitative research and nursing. Interviews and codes were also presented to four study participants, who stated that the findings were consistent with their understanding and interpretation. The researcher reduced the likelihood of bias in collecting, analyzing, and coding of participants' statements and improved credibility by limiting the literature review at the beginning of the study. To achieve the dependability, all stages of the work were independently examined by external observers (qualitative researchers), and then the results were compared with each other. To increase the confirmability, all steps of data collection and analysis were described and explained step by step, which was done through step-by-step repetition and auditing. While qualitative studies cannot have transferability, the researcher tried to provide information about the selection of participants, data collection, and work process along with clear descriptions of the data and research data and selection of participants to be used by other researchers in similar situations (Lincoln and Guba, 1985).

Results

Participants in the study were 19 nurses working in hospitals in different provinces of Iran. The majority of participants were women and married. Among them, three had a master's degree, one had an Associate degree, one was a Ph.D. student and the rest had a bachelor's degree. Their age range was between 25–49 years and they had 1–25 years of work experience. Table 1 shows the demographic characteristics of the participants.

Table 1
Demographic characteristic of participants.

participant	Gender	Age	Work experience	Marital status	Educational Status	Department Or ward
1	Female	36	12	Married	BSc	ICU
2	Female	35	13	Married	Associate degree	Endoscopy
3	Male	25	2	Single	BSc	Internal
4	Female	41	15	Single	Phd student	ICU
5	Female	38	15	Single	BSc	Neurosurgery
6	Male	45	22	Married	MSc	ENT
7	Female	25	1	Married	BSc	General surgery
8	Female	40	14	Single	BSc	Liver transplantation
9	Male	40	15	Married	BSc	P ICU
10	Female	44	18	Single	MSc	CCU
11	Male	32	6	Single	BSc	Infectious
12	Female	38	12	Married	BSc	Emergency
13	Female	35	12	Married	BSc	Dialysis
14	Female	40	10	Single	BSc	Emergency
15	Female	24	4	Single	BSc	T.ICU
16	Female	49	25	Single	MSc	Thalassemia
17	Male	44	15	Married	BSc	Cardiac
18	Female	36	12	Married	BSc	Internal
19	Male	45	20	Married	BSc	Orthopedic

From the data analysis, three themes were extracted: organizational failure, deterrent individual identity, and defeated professional culture. Also, 1120 codes, six categories and eighteen sub-categories emerged (Table 2).

Table 2
Main themes, category and sub-category of the barriers of moral courage

Themes	Categories	Sub-Categories
Organizational Failure	Repressive environment	Unethical climate
		Inadequate training
		Defective communication
		Lack of powerful role models
	Mismanagement	Aimless assessment and evaluation
		Unsupportive managers
Deterrent personal identity	Individual Characteristics barrier	job interest lack of
		Lack of job motivation
		Moral silence
		low self-esteem
	Job conservation	Fear of outcomes
		being self-centered
		job insecurity
Defeated professional identity	Physician paternalism	Doctors who think they know everything
		The concentration of power in medicine
	damage Professional identity	Professional dependency
		Professional Powerless
		Defective professional status

1. Organizational Failure

Organizational Failure was formed based on two subcategories: Repressive environment and Mismanagement.

1.1. Repressive environment

In this study, the Repressive environment was interpreted by the Unethical climate, inadequate training, Defective communication, and Lack of powerful role models.

The Unethical climate was one of the issues mentioned by the participants. Participant 5:

We are working in an environment that does not pay much attention to the ethics and ethical aspects of practice.

Inadequate training and lack of familiarity with ethical concepts and issues were among the nurses' concerns. The majority of nurses stated that they are not very familiar with ethical concepts.

I can say that in all the years that I have worked here, I have not had an in-service training class that is related to ethics or especially moral courage, and this is not a good thing at all.

Inadequate and inefficient communication between nurses and physicians, nurses with nursing managers, and other staff and lack of cooperation and coordination among health team members were mentioned as another barrier to moral courage among nurses.

When I see an immoral act by a doctor, I have to be silent and not say anything because if I say something, he/she will scream at me.

The lack of brave nurses and role models was another barrier to moral courage that was raised by nurses. (Participant 11)

Now that I think about it, we do not have brave or courageous nurses who can be a role model and we can learn from them

1.2. Mismanagement

This category had two sub-categories including Aimless assessment and evaluation and Unsupportive managers. It was another barrier to nurses' moral courage.

Participant 10 said:

"The evaluations are only based on documents. It means that whatever you have recorded is acceptable, even if it is a lie. In this case, you will try to just do recording instead of caring"

Nurses believed that they needed support to be able to demonstrate their abilities. From the participants' point of view, having a supportive manager is an important factor in strengthening their moral courage. On the other hand, if people who do work morally are not supported, they will be isolated.

I work in the Intensive care unit and most of the time I have to decide and act based on that. If I make a wrong decision, the managers will not support me. (Participant 9)

2. Deterrent personal identity

This theme is derived from two categories; Individual Characteristics barrier and Job conservation.

2.1. Individual Characteristics barrier:

Some of the participants explained the lack of courage by the existence of some personal characteristics that hinder their courage. They mentioned lack of job interest, lack of job motivation, moral silence, and low of self-confidence as important factors in this regard.

From the participants' point of view, interest in the profession is one of the most important factors in the development of moral courage.

".... I was not interested in this profession from the beginning, so I am not looking for morality and immorality in my actions ..." (Participant 12).

Lack of job motivation is another emerged sub-category.

"The job and working conditions are so bad that we have no incentive to do a better job at all" (Participant 18).

Based on the participants' point of view, moral silence is a phenomenon in which nurses refuse to comment on issues for various reasons and remain silent.

"Most nurses are not characteristically brave and prefer to remain silent when they are in a position to express their moral opinions" (Participant 6).

From the participants' point of view, the Self-belief is actually the level of self-importance and self-belief. This view determines how one feels about himself/herself compared to others. Self-confidence is a part of human nature. Since nurses in the treatment environment are in close contact with doctors, it seems that they believe that they are less than doctors and have lost faith in their competencies.

"Many times, I wanted to say something or do something, but I was worried about making a mistake, so I did not do it" (Participant 14)

2.2 Job conservation

Some occupational, organizational, and individual issues lead nurses to be risk-averse and cautious and not to interfere in the others work. Fear of outcomes, being self-centered and job insecurity were sub-categories of Job conservation.

Fear of consequence is one of the effective factors in not being brave. Nurses stated that fear of hearing bad things, fear of fighting, and also fear of rejection are obstacles to their moral courage.

"Once we were changing the patient's position, I told the service staff not to put the patient to bed and lift him. He raised his voice so loudly that I regretted it" (Participant 13)

Being self-centered was another concept extracted from the participants' interviews.

"Nurses who talk and act boldly when they see something immoral and act courageously are labeled as self-centered" (Contributor 19).

Job insecurity was another concept that participating nurses repeatedly referred to.

"I am a contract nurse. If I want to say something, they throw me out. So, I prefer to see and suffocate and not talk" (Participant 4)

3. Defeated professional identity

From the participants' point of view, the prevailing professional culture in the hospital is not in favor of the nurses. While nurses have an important role in the care and treatment of patients, but the dominance in the treatment system is not in their favor.

Physician paternalism and damaged professional identity were the main categories of this theme.

3.1. Physician paternalism

Physician paternalism includes two sub-categories: Doctors who think they know everything and the concentration of power in medicine.

According to nurses, the culture of their work environment is such that doctors think only they have science and knowledge and academic literacy.

"Whenever nurses want to say something or in immoral situations, we want to share our opinion, doctors said you do not know what you are talking about, I am a doctor and I know what is right and what is wrong" (Participant 5)

The nurses also acknowledged that in the hospital environment, doctors have absolute power and no one has the right to protest.

"Once a problem was happened for a patient. The doctor and I argued about it. I was right, but he told me that you should do everything I say and I should say who should do what" (Participant 11).

3.2. Damaged Professional identity

Professional identity is a type of social identity that includes gaining a deep insight into professional performance and creating professional ideals and values. Participants expressed that their professional identity is damaged in the hospital environment. Professional dependency, professional powerless and defective professional status were mentioned as the causes.

Professional dependency in nursing means that nurses in many organizations work in a dominated environment and this reduces their ability to develop capabilities due to lack of independence and high dependence.

"I really cannot make a decision alone because I have no independence and I have to get permission from a doctor for anything" (Participant 18)

Professional powerless is another sub-category of distorted professional identity. Participant 12 said, *"We have practically no power in the hospital we are nobody"*

In line with the Damaged Professional identity, study participants stated that one of the most important factors in the development of moral courage is the attention of physicians, managers, and others to their professional status. They acknowledged that the nursing profession should be respected. They also stated that nursing is a very important and fundamental part of the health system and we can be successful in treatment when other professions see nursing as a valuable profession.

"We have virtually no place in the hospital, we have to do a series of low-level jobs, which degrades our profession" (Participant 2)

Discussion

This study aimed to explain the barriers to moral courage in nurses. The findings of the present study showed that organizational inadequacy, deterrent individual identity, and defeated professional culture are the barriers of moral courage. Organizational strategies play a prominent role in the ethical performance of the nurse. Organizational failure means that the organization failed in performing some functions or achieving some goals (Habersang et al., 2019). One of the important goals of hospitals is patient satisfaction, which is achieved through the observance of ethical aspects of practice. In this study, the organization played a deterrent role in moral courage. Therefore, it fails to achieve the goal, which is the implementation of moral decisions. According to Rest theory, moral courage is one of the components of professional ethics. The results of a qualitative study conducted to identify the factors affecting the professional ethics of Iranian nurses reported Organizational Precondition, Support Systems, Education, and Cultural Development as effective factors on professional ethics (Dehghani et al., 2015). The results of previous studies indicate that organizational barriers such as lack of sufficient time, lack of support from officials and managers, and organizational rules make the implementation of ethical decisions difficult or even impossible for nurses (Atashzadeh Shoorideh et al., 2011, Dos Santos et al., 2018, Mousazadeh et al., 2019b). Moral courage is essential for compassionate care (Curtis, 2013). In a qualitative study, nurses' experiences showed that organizations do not support compassionate care (Valizadeh et al., 2015). The repressive environment, ignoring the ethical aspects of practice, the unethical climate of the organization, and the organizational culture prevent the formation of nurses' moral courage (Sadooghiasl et al., 2016).

In addition to the organization as an external factor, internal factors and deterrent individual identity are other barriers to moral courage identified in the present study. The nurses who participated in the study stated that lack of interest in the profession, lack of job motivation, moral silence, lack of self-confidence, self-centeredness, fear of consequences, and lack of job security obstruct the development of moral courage. In this regard, the results of Ebrahim Abadi's study showed that job insecurity is a barrier to courageous behaviors (Ebrahim Abadi et al., 2020). Escolar-Chua stated that stress and anxiety reduce

courageous behaviors in nurses (Escolar-Chua, 2016). Murray reported that fear of social isolation and a sense of rejection in the organization as factors affecting nurses' moral courage (Murray, 2010).

Another factor that hinders the nurse's moral courage is the culture of the defeated profession. Professional culture is a set of cultural values and practices that are embedded in the culture of organizations (Bloor and Dawson, 1994). Medicalism (Adib Hajbaghery and Salsali, 2005, Mousazadeh et al., 2019a), lack of professional independence, lack of professional power, insufficient self-confidence, and the duality of respect and value (Valizadeh et al., 2015) are dominant in the professional culture of the Iranian nursing community is the existence of. Lack of power reduces the nurse's ability to make decisions and implement ethical measures (Parker, 2007). Sadoughi (2016) in a qualitative study reported the lack of professional power and medical power as obstacles to moral courage (Sadooghiasl et al., 2016) The results of some previous studies are in line with the present study, the lack of professional independence, lack of professional power, and the status of defective professions have been identified as distorted professional identities. The results of a qualitative study showed that impaired professional identity is a deterrent to moral care learning and reduces the nurse's motivation for quality care (Baraz-Pordanjani et al., 2014).

Conclusion

The results of this study showed that the barriers to having morals and courage in nurses including inadequacy, organizational, and defeated professional culture and individual identity were deterrents. Barriers to moral courage can be divided into two general categories: external and internal barriers. It considered the environment of deterrence, mismanagement, medicalism, distorted professional identity as external barriers, and the individual characteristics of deterrent and occupational conservatism as internal. The organization can encourage nurses to courageously implement their ethical decisions by applying supportive strategies such as giving importance and power to the nurse, using the correct evaluation criteria, and appreciating the ethical performance of nurses.

Recommendation

In the present study, the barriers to ethical courage from the perspective of employed nurses were explained, which was an important part of the findings related to managers. Therefore, it is suggested that in future research, the barriers to moral courage be examined from the perspective of managerial nurses. Also, since nurses' perceptions of the barriers to moral courage can vary from community to community, it is suggested that similar research be conducted in different nursing communities.

Limitations

However, the findings of the present study help explain the barriers to nurses' moral courage. But it has its limitations. For example, due to the Covid-19 epidemic, it was not possible to conduct face-to-face interviews, observations, or focus groups to generate data.

Abbreviations

CCU: coronary care unit; ICU: intensive care unit; PICU: pediatric intensive care unit. TICU: Trauma Intensive Care Unit

Declarations

Ethics approval and consent to participate

The Ethics Committee of Mazandaran University of Medical Sciences approved the project (IR.MAZUMS.REC.1399.8064). before each interview, the purpose of the study was explained to the participants. The researcher assures them that the information is confidential. Informed written consent was obtained from them for participation in the study and recording of their voices. They were told that they could leave the study whenever they wished. The time of the interview was determined based on the participants' desire. Their anonymity was preserved in all stages of the research.

Consent to publish

Not applicable.

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing Interests

There are no known conflicts of interest for any of the authors of this manuscript which would interfere with the integrity of this research.

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Authors' Contributions

NM and MR made substantial contributions to conception and design, made analysis and data interpretation, drafting the manuscript, and revising it critically for important intellectual content. HH and FH made data acquisition, drafting the manuscript, and revising it critically for important intellectual content. All authors read and approved the final manuscript.

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