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The Amount of Moral Courage and Moral Distress of Nurses and Their Related Factors in Educational and Medical Centers of Zanjan

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Abstract

Background: Ethical challenges are considered an integral part of the nursing profession. In these challenges, despite moral courage, nurses experience moral distress.
Objectives: This study was conducted to determine the amount of moral courage and moral distress of nurses and their related factors in educational and medical centers in the city of Zanjan.
Methods: This descriptive-analytical study was conducted on 256 nurses working in educational hospitals of Zanjan in 2019 through the proportional convenience method. Data collection tools were three questionnaires, including the demographic information questionnaire, Sekerka's Moral Courage Questionnaire, and Corley's Moral Distress Scale. The questionnaires were collected by self-reporting method after distribution and completion by nurses. Data were analyzed using descriptive statistics and independent t-test, one-way analysis of variance (ANOVA), and Pearson correlation coefficient in SPSS software version 22.
***Results*:** Most of the participants were female, married, and design-employed, with a bachelor's degree and a mean age of 32.11± 6.9 years. The mean score of nurses' moral courage was 5.73 ± 0.81 out of 7 points and their mean score of moral distress was 4.48±1.13 out of 7 points. The mean score of moral courage was statistically significantly different from age and work experience ($p<0.05$). The mean scores of moral distress in women, pediatric ward, and individuals with low work experience showed a statistically significant difference ($p<0.05$). The results showed no statistically significant relationship between the score of moral courage and that of moral distress.
Conclusion: According to the results of this study, it is recommended to use less novices and young individuals in stressful wards to reduce moral distress and to have courageous approach in challenging situations.

Keywords: morals, ethics, courage, nurses, Zanjan

Introduction

In the nursing profession, care is a moral commitment considered a dominant approach. Although nurses make many ethical decisions every day in their workplace, in practice, they cannot always behave based on their ethical commitments [1]. These conditions cause a feeling of moral distress in nurses [2]. Moral distress means a person can recognize the right action, but factors such as lack of power to do the action, being judged, weak personality, inappropriate conditions in the workplace such as lack of support from superiors, lack of supportive rules and policies for employees, and stress hinder proper performance in order to promote the individual's professional and personal values and

cause painful feelings, mental imbalance, and disruption in the nurse's professional performance [3,4]. This issue not only causes physical and mental fatigue in nurses but also leads to their lower standards of care [5,6].

Various factors can affect the amount of moral distress. One of these factors is moral courage [7,8]. Nurses need courage in the field of ethics to overcome moral challenges, which is the opposite of moral distress [4]. Moral courage means providing the proper care despite fear [4,6]. Nurses who perform based on moral courage prioritize patients' safety due to their ability to overcome fear and endure to preserve the values [9]. Moral courage greatly affects improving and preserving moral values, improving quality, safe care, shortening hospital stay, reducing costs, and reducing the dissatisfaction of service recipients [10,11]. However, the lack of managerial support and the inadequacy of the moral atmosphere and organizational culture can reduce the sense of courage to do moral things [6]. If nurses are supported by the organization, when faced with moral dilemmas, their moral courage will increase, and they will overcome their moral fear and distress [5,6,12].

Numerous studies have reported the amount of moral distress and moral courage to varying degrees, and that organizational factors, clinical situations, and individual factors have been associated with moral distress [13-15]. The results of some studies have also shown that interpersonal communications and discussion about moral dilemmas increase moral courage, and moral courage is subsequently associated with individual and organizational factors [16-18]. The amount of moral distress and moral courage and their related factors in each society can vary according to the organizational culture and moral atmosphere [7,17,19]. Therefore, this study was conducted to investigate the amount of moral courage and moral distress in nurses and their related factors in educational and medical hospitals of Zanjan.

Methods

This descriptive-analytical study was performed on nurses working in hospitals affiliated to Zanjan University of Medical Sciences from December 2019 to February 2020. Three hospitals affiliated to the University of Medical Sciences with 815 nurses working constituted the study population. The participants' properties included having at least 6 months of work experience, rotating shifts, and willingness to participate in the study. Those who worked only in a fixed shift were not included in the study. The present study was part of a large study, in which after a pilot study on 30 nurses with a reliability of 95, d equal to 0.1, and a standard deviation of 0.81 with a ten percent loss, the sample size was calculated 275 people. Sampling was performed as proportionally and conveniently in this way: Considering the number of nurses in each hospital, their share of the total number of sample was determined 275 people using the following formula. The way of apportioning the hospitals' participants was performed according to the $n = \frac{N_1}{N} \times n_1$ formula (n_1= the sample size required in the present study; N = the total number of nurses working in public hospitals of Zanjan; N_1 =the number of nurses in each hospital) so that the number of participants from Ayatollah Mousavi Hospital, Hazrat Vali Asr Hospital, and Shahid Beheshti Hospital was considered 161, 92, and 22 people, respectively.

In this study, three questionnaires were used, including the demographic information, the moral courage, and the moral distress questionnaires. The Sekerka et al.'s Moral Courage Questionnaire was designed in 2009. This questionnaire has 15 questions in 5 dimensions of moral agency (the individual's willingness and readiness to face and do moral work), multiple values (the individual's ability to combine his/her values with the organizational and professional values, prioritizing professional values), endurance of threats (the individual's ability to recognize threats and pressure), going beyond compliance (the individual's pioneering in doing moral work despite the environmental pressures), and moral goals (prioritizing helping and benefiting others over personal interests). Each dimension consists of 3 questions arranged in a 7-point Likert scale (1= "never true" to 7 = "always true"). The mean score of each dimension and then the total mean score were considered the moral courage score. Also, the number 4 was considered the mean score of each dimension and the mean score of total moral courage, and individuals who received a score higher than 4 had high moral courage [20]. In Iran, the psychometric properties of the Moral

Courage Questionnaire were assessed, and its validity and reliability were confirmed by Khoshouei. In Khoshouei et al.'s study, the reliability of the Moral Courage Questionnaire using Cronbach's alpha was reported to be 0.78 [21]. Considering all questions of the questionnaire, Cronbach's alpha was obtained 0.85 in the present study.

The Moral Distress Questionnaire was first designed by Jameton and developed by Corley [22]. In Iran, psychometric properties were assessed, and its validity and reliability were confirmed in this study by Vaziri et al., and the reliability with Cronbach's alpha was reported to be 90%. This questionnaire has been arranged with 30 questions in three dimensions of ignoring the patient (16 questions related to human dignity, personality, respect, patient rights, patient satisfaction, and lack of notification of consent form), patient decision-making power (8 questions related to patient's unconsciousness, lack of patient decision-making power, and obeying the requests of patient's family that are harmful to the patient), and professional-functional competence (6 questions related to professional-functional competence, tests, and unnecessary and incomplete treatments). This questionnaire assesses the severity of moral distress on a 7-point Likert scale (1="does not create tension in me" until 7= "very severe") [23]. In this study, as suggested by Corley, participants were asked not to respond if they had no experience in each of the items raised. Finally, the items left unanswered by the participants were replaced with the questionnaire mean score. The number 3.5 was also considered the cut-off point. Individuals who received a score higher than 3.5 experienced high moral distress [22]. In the present study, the reliability of this tool was obtained 0.94 using Cronbach's alpha. The mean was used to manage the missing data in both questionnaires.

After obtaining the code of ethics, the researcher referred to all three hospitals of Ayatollah Mousavi, Hazrat Vali Asr, and Dr. Beheshti in all three shifts (morning, evening, and night). The questionnaires were provided to the participants in person by the research assistant. The required time was given to the participants to complete the questionnaire. In order to respect the participants' rights, the delivery time of the questionnaire was considered within two weeks after its distribution.

Data analysis was performed with SPSS software version 22. The Kolmogorov-Smirnov test was used to investigate the normal distribution of the data. The data had a normal distribution. The independent t-test and the analysis of variance (ANOVA) with the least significant difference (LSD) post hoc test were used to evaluate the mean scores of moral distress and moral courage based on demographic variables. The relationships between moral distress and moral courage as well as dimensions were investigated using Pearson correlation coefficient. The significance level was considered less than 0.05.

Results

Out of 275 questionnaires distributed among the participants, 256 were completed and returned to the researcher. Most of the participants in this study were female, married, and design-employed, with a bachelor's degree and a mean age of 32.11± 6.9 years. One hundred and twenty-four (48.4%) nurses participated in ethics courses, and 10 (4%) had a job-quitting history (Table 1).

Table 1: Frequency Distribution of Participants' DemogrAphic Variables

Demographic Variables		Frequency (Percentage)
Gender	Female	225(87.9)
	Male	31(12.1)
Marital status	Single	73 (29.7)
	Married	183(70.3)
Age (year)	23-33	143 (55.8)
	33-43	83 (32.4)
	43-53	30 (11.7)
Education	Bachelor	240 (93.8)
	Higher	16 (6.8)
A history of participating in the ethics workshop	Yes	124 (48.4)
	No	132 (51.6)
Job-quitting history	Yes	10 (3.9)
	No	246 (95.4)
Job status	Employed	115(44.8)
	Design-contractual	141 (55.2)
Work experience	10<	166 (65.62)
	10-20	83 (32.42)
	20-30	7 (32.4)
Place of work	Internal	48 (18.8)
	Surgery	50 (19.5)
	Emergency	39 (15.2)
	Pediatric	26 (10.2)
	ICU	71 (27.7)
	Psychiatrics	22 (8.5)

There was a weak inverse relationship between the score of moral courage and that of moral distress but not statistically significant (r=-0.09, p=0.07). Moreover, the scores of moral distress and its dimensions were not statistically significant associated with the scores of moral courage and its dimensions, and only the dimension of ignoring the patient showed an inverse and statistically significant association with the total score of moral courage (Table 2).

Table 2: Investigating the Relationship Between Moral Courage and Moral Distress and their Dimensions in Nurses

Variable	Dimensions	Moral Agency	Multiple Values	Endurance of Threats	Going Beyond Compliance	Moral Goals	Total Moral Courage	Total Moral Distress	Ignoring the Patient	Patient Decision-Making Power	Professional-Functional Competence
		r	r	r	r	r	r	r	r	r	r
Moral courage	Moral agency	1									
	Multiple values	0.450**	1								
	Endurance of threats	0.386**	0.416**	1							
	Going beyond compliance	0.511**	0.527**	0.608**	1						
	Moral goals	0.397**	0.529**	0.500**	0.610**	1					

	Total Moral courage	0.121	0.004	0.116	0.075	0.067	1				
Moral distress	Total Moral distress	0.027	0.023	0.019	-0.009	0.022	-0.09	1			
	Ignoring the patient	0.005	0.024	-0.015	-0.005	-0.018	-0.103*	0.894**	1		
	Patient decision-making power	0.016	0.035	0.005	0.018	0.010	0.057	0.802**	0.732**	1	
	Professional-functional competence	0.074	0.049	0.008	0.017	0.01	-0.129**	0.778**	0.751**	0.689**	1

***P-value<.05**
****P-value<.001**

The mean score of moral courage was 5.73 ± 0.81 out of 7 points. The maximum mean was related to the dimension of going beyond compliance and the minimum was related to the dimension of multiple values. Also, the mean score of moral distress was 4.48±1.13 out of 7 points. The dimension of patient decision-making power had the lowest, and the dimension of professional-functional competence had the highest mean score (Table 3).

Table 3: Mean and Standard Deviation of Moral Courage and Moral Distress and their Dimensions in Nurses

Variable	Dimensions	Mean ± Standard Deviation
Moral courage	Moral agency	93.0±5.86
	Multiple values	1.05±5.51
	Endurance of threats	1.05±5.69
	Going beyond compliance	0.98±5.86
	Moral goals	0.97±5.81
	Total Moral courage	0.81±5.73
Moral distress	Ignoring the patient	4.69±1.22
	Patient decision-making power	4.61±1.14
	Professional-functional competence	4.76±1.13
	Total Moral distress	4.48±1.13

The findings of ANOVA test in Table 4 showed that the mean of age variables and work experience were statistically significant different from that of moral courage (p<0.05). The LSD post hoc test showed that nurses with less than 10 years of service had less moral courage than those with more than 20 years of service (P=0.011). Nurses under 33 years of age had less moral courage than those aged 33-43 (P=0.008) and 43-53 (P=0.032). However, there was no statistically significant difference between the variables of marriage, education, a history of participating in the ethics workshop, a job-quitting history, job status, and the place of work with moral courage.

The results of ANOVA showed that the mean score of moral distress was statistically significant in terms of place of work and work experience (p<0.05) (Table 4). The LSD post hoc test showed that the mean score of moral distress in pediatric-neonatal-neonatal intensive care unit (NICU) wards' nurses was significantly higher compared to that of nurses in internal medicine (P=0.004), surgery (P=0.028), and emergency (P=0.048) wards, and in nurses with less than 10 years of service experience compared to nurses with 10-20 years of service (P=0.02). However, moral distress has no statistically significant difference from the variables of gender, age, marriage,

education, a history of participating in ethics workshops, a history of job-quitting, and job status. The independent t-test also showed that the mean score of moral distress was higher in women than men, which was statistically significant (P = 0.032) (Table 4).

Table 4: Comparing the Mean Scores of Moral Courage and Moral Distress Based on Place of Work, Age, and Work Experience in Nurses

Variable		Mean and Standard Deviation of Moral Courage	Mean and Standard Deviation of Moral Distress
ward	Internal	5.71±0.77	4.26±1.18
	Surgery	5.67±1.06	4.40±1.36
	Emergency	5.85±0.85	4.48±1.19
	Pediatrics	6.15±0.56	5.10±1.07
	Psychiatrics	6.09±0.69	4.82±0.93
	ICU,CCU, Dialysis	5.75±0.85	4.69±1.26
	*F=0.76, p=0.883		F=1/4 , p=0/034
Age	23-33	5.66±0. 88	4.52±1.15
	34-43	5.95±0.84	4.74±1.36
	44-53	6.13±0.57	4.77±0.98
	F=5.09 , p=0.007		F=1.82 , p=0.163
Work experience	<10	5.69±0.86	4.47±1.16
	10-20	5.70±0.94	4.69±1.30
	20-30	6.28±0.58	4.29±1.82
	F=1.44 , P=0.042		F=2.92, p=0.05

***one-way ANOVA**

Table 5: Comparing the Mean Scores of Moral Courage and Moral Distress Based on Gender in Nurses

Variable		Mean and Standard Deviation of Moral Courage	Mean and Standard Deviation of Moral Distress
Gender	Male	5.49±0.85	4.39±0.91
	Female	5.82±0.85	4.57±1.25
	*t=-2.04, p=0.683		t=-0.79, p=0.032

***Independent T-test**

Discussion

The present study aimed to determine the amount of nurses' moral courage and moral distress and their related factors in educational and medical centers of the city of Zanjan. The results showed that the moral courage of nurses was higher than the average and in a desirable condition. The score of moral distress was also higher than the average. In this study, the mean score of moral courage was significantly higher at age and higher work experience. The mean score of moral distress was significantly higher in female nurses, pediatric-neonatal-NICU wards' nurses, and those with less work experience. There was also a weak inverse relationship between moral courage and moral distress, but not statistically significant. The present study showed that moral courage in nurses was higher than average and in a desirable condition. In line with the findings of the present study, Khodaveisi et al.'s study indicated high moral courage in nurses of educational hospitals in western Iran [24]. Moral courage was reported at a moderate level in Safarpour and Mohammadi's studies [14,25]. Different outcomes may be due to the fact that nurses tend to be honest in practice, but mental and real barriers such as differences in the care environment, managerial constraints, managerial support, organizational support, ethical atmosphere, organizational culture, fear of rejection, and losing the job force them to act differently in the incidence of courageous

behaviors or suppress them to be safe from the consequences [6,26,27]. The analysis of the dimensions of moral courage showed that the dimension of going beyond compliance had the highest and the dimension of multiple values had the lowest score, which in Namadi and Mahdavi seresht's studies, the highest and lowest scores belonged to the dimensions of moral agency and multiple values, respectively [27,28]. The high score of the dimension of going beyond compliance in the present study indicates that nurses perform ethical work despite the environmental pressures, which will be to the benefit of the patient.

In our study, nurses' moral distress was higher than average. In line with the results of the present study, the severity of moral distress has been reported above average in previous studies [29-31]. In Aminizadeh et al.'s study, the mean score of moral distress was reported to be moderate [32]. Different results can be due to differences in hospital environment conditions, workload, governing rules, and nurses' level of knowledge and response in the face of moral distress. In our study, also, the most common cause of distress in nurses was related to the dimension of professional-functional competence. However, in Vaziri's study, ignoring the patient was the most common cause of nurses' moral distress, which is not consistent with the present study [23]. Working with inexperienced nurses and performing unnecessary and even incomplete tests and treatments due to the educational nature of hospitals can be the reasons for the different results.

In the present study, nurses with older age and more work experience had higher mean score of moral courage. In this regard, the findings of previous studies showed that with increasing age and work experience, moral courage increases in nurses [6,25,27]. Contrary to our results, in Moosavi and Safarpour's studies, no difference was observed between moral courage with age and work experience [11,14]. It seems that having work experience leads to improving professional skills, increasing knowledge about patient rights, more awareness of the workplace, and observing courageous behaviors, consequently strengthening moral courage in them [33]. In the present study, the mean score of moral distress was higher in nurses of pediatric-neonatal-NICU wards. Consistent with the results of our study, nurses in the pediatric-NICU wards experienced the greatest amount of distress based on Vaziri and Borhani's studies [31,34]. The reason for the high level of distress in nurses working in such wards can be attributed to the existence of special conditions such as parents' constant presence and expectations, vulnerability of children, and specific medical and treatment orders. Also, in the present study, moral distress was higher in individuals with less than 10 years of work experience and female nurses. In Mohammadi et al.'s study, it was shown that experienced and female nurses had less distress [25]. In Safarpour et al.'s study, the amount of moral distress was shown to be higher in experienced and female nurses [14]. Experienced nurses seem to benefit from more appropriate adaptive strategies due to facing numerous ethical challenges during their service. On the other hand, in the present study, the number of female participants was higher; considering that the level of emotions is higher in women than in men, it can explain the high level of moral distress in them.

The results of the present study showed that there was no statistically significant relationship between moral courage and moral distress. Contrary to the results of our study, Mohammadi and Aminizadeh's studies showed a significant reduction in the amount of moral distress followed by an increase in moral courage [25,32]. Perhaps the reason for different results can be found in the research community that the two mentioned studies were conducted merely on nurses in the intensive care unit (ICU), but in the current study, nurses from different wards participated. One of the limitations of the present study was the small number of male nurses compared to female nurses, which affected the generalizability of the results. Self-report in questionnaire-dependent studies is influenced by participants' honesty and mood emotional states. In this study, an attempt was made to increase the data validity by allocating sufficient time to the participants to answer the questionnaires and keep the questionnaires anonymous.

Conclusion

According to the results of this study, with increasing age and work experience, moral courage increases and, conversely, the amount of

moral distress decreases. Therefore, it is recommended that nursing managers benefit from experienced nurses in stressful and challenging wards, such as pediatric, neonatal, and NICU wards, in various work shifts so that with the presence of experienced nurses along with novice and younger nurses, ethical challenges are well managed in clinical situations, and novice nurses are less morally distressed and learn the courage in the face of wrong behaviors.

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Conflict of interest
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