Measuring nurses' moral courage: an explorative study in Flanders, Belgium

1. Introduction

Moral courage is considered an ethical competence in healthcare and is one of the core virtues in the nursing profession in particular (1–6). Breaking bad news regarding a poor prognosis, speaking up when a colleague appears incompetent, providing care to a contaminated patient or intervening when faced with poor practice are some examples of situations calling for moral courage (4,6). Especially in a time of great stress and uncertainty, such as during the COVID-19 pandemic, resilience and courage appear to be the keys to dealing with these unprecedented challenges (7). Not being able to deliver the best possible care, many nurses feel like they are abandoning their patients. This situation leaves them with the feeling that they are compromising their integrity (8).

A growing number of studies describe how strongly nurses are affected by ethical challenges in care, which has resulted in an increasing interest in the phenomenon of moral distress in nursing (9–11). This concept refers to the feeling nurses experience when they cannot act by their own moral values due to contextual factors (10). This gap between what nurses can do and what they believe they should do causes distress, which can lead to frustration, burn-out and even nurses quitting their job (4,12,13). One of the main concerns during the outbreak of the pandemic was the lack of even the most basic personal protective equipment, hindering nurses in caring for the most vulnerable patients. The shift in focus from 'doing good' to 'preventing harm' prevented tailoring care to patient needs and values, leaving them at risk of developing moral distress (14,15).

To address difficult contextual factors that hinder them from following their ethical values, nurses need moral courage (16). Although attempts have been made to clarify the concept in scientific literature, conceptual clarity is still lacking (17,18). Lachman defined moral courage as the capacity to overcome fear and to stand up for core values. Moral courage is the willingness to speak up and to do that which is right under the influence of opposing forces. It puts principles into action. Moral courage can be the cause of psychological, physical and social harm. An individual who is morally courageous is aware of these risks. Individuals take pride in their actions and have a sense of peace because they stood up for a non-negotiable principle that they deemed right (2).

There is a general expectation that nurses are morally courageous, especially in challenging health care situations, such as during the COVID-19 pandemic. How and to what extent nurses show moral courage when faced with moral distress is, however, hardly been investigated (19). We found two studies supporting the presence of moral courage in the majority of nurses (20,21). A few studies evidenced ethically challenging situations where nurses or nursing students did not have the courage to act according their ethical values or to intervene when faced with poor practice (6,12,13,20). The most

challenging situations, as reported by Kleemola et al. (2020)'s study (7), were related to other caregivers' behaviour or practice. The potential negative consequences of morally courageous behaviour (e.g., fear of reprimand, loss of respect from colleagues) combined with other barriers, such as contextual (e.g., work environment, team support) and personal factors (e.g., educational level, experience), were reported as potential barriers to showing moral courage (12,13,20,21).

To gain better insight into nurses' moral courage and how to support them in complex ethical challenges, more empirical research in this area is needed. Reliable and validated instruments to measure nurses' moral courage are needed to further explore, assess and compare moral courage internationally. Numminen et al. (2018) developed a scale to measure nurses' self-assessed moral courage (21). The scale was named the *'Nurses' Moral Courage Scale'* (or NMCS abbreviated) and was validated in a Finish population of nurses. After its validation, the scale was translated to English to promote its use and the further validation of the scale internationally. A collaborative project involving Belgian and Finish researchers was established to translate the scale from English to Dutch to conduct an exploratory survey on moral courage in Flemish hospitals and use the data for further validation of the NMCS. The study reported in this paper is part of this international project. The main purpose of this study was to (1) translate the NMCS in Dutch and (2) provide a description of nurses' self-assessed level of moral courage with associated socio-demographic factors.

2. Background

Variables used in the NMCS were derived from the concept analysis of Numminen et al. (17) about moral courage in nursing practice. Their analysis was based on empirical studies and revealed seven key attributes that can be used to define what it is to be and to act as a morally courageous nurse: 'true presence', 'moral integrity', 'responsibility', 'honesty', 'commitment and perseverance', 'advocacy', and 'personal sacrifice'.

These seven key attributes were reconstructed as 4 subscales after 3 consecutive principal component analyses. The subscales were named 'compassion and true presence', 'moral responsibility', 'moral integrity' and 'commitment to good care' with Cronbach's alpha values of .81, .81, .82, and .73, respectively, and a Cronbach's alpha value of .93 for the total NMCS score (21). The four subscales are described in detail by Numminen et al. (21).

The questionnaire consists of sociodemographic items and questions assessing moral courage. In the first part, participants are questioned about their age, gender, level of education, period of active employment, experience with healthcare ethics (e.g., participation in ethics projects, acquirement of knowledge base in ethics, self-assessed level of ethical knowledge base) and present work position. The second part of the survey consists of 21 items that estimate moral courage with a five-point Likert scale;

these items form the actual NMCS scale. A score of 1 means “Does not describe me at all”, and a score of 5 means “Describes me very well”. The participant should choose and circle the alternative that describes him/her best. The following item uses a 10-point VAS-scale to assess the participant’s self-perceived moral courage. The next item assesses on a five-point Likert scale how easy it is for participants to act morally courageously when defending their professional ethical values with other actors, professional groups or organizations.

3. Method

3.1. Scale development

Forward-backward translation

The forward translation was performed by two researchers (K.K.; R.C.) who had excellent knowledge of the English language, healthcare terminology and Belgian work conditions. The researchers had conceptual knowledge of ‘moral courage’ and ‘moral distress’ by studying scientific literature on this topic (22).

The initial translation in Dutch was performed by two researchers (K.K.; R.C.) independently. The researchers made a literal translation of the scale. Both translations were reviewed and merged in a first draft. This draft was evaluated several times by the research group, consisting of 3 master’s students in nursing, an expert in nursing sciences and an expert in medical ethics.

The research group evaluated whether the translation was conceptually understood in the Belgian nursing context (conceptual equivalence), correctly reflected the intended English meaning (semantic equivalence), would be accepted by targeted respondents (item equivalence) and had wording, format, instruction and scaling that could be used in the Belgian nursing context (operational equivalence) (23). Questions that could not be resolved by the research group were discussed with the first author of the Finnish NMCS until consensus was reached. The use of words that could imply a socially desirable answer was avoided.

The backward translation was performed by a native English speaker. The translator had no conceptual knowledge of ‘moral courage’ or nursing concepts and was instructed to make a literal translation of the draft. This result was compared with the original English NMCS and analysed by the researchers. Based on this comparison, changes were made to the Dutch draft in concert with the research team.

Pilot study

A pilot study was conducted to check the Dutch NMCS for readability and understandability. The duration of completing the survey was also recorded. Ten nurses were recruited by convenience sampling. The participants were purposefully selected based on age, experience, gender and professional function. The participants were instructed to complete the survey thinking aloud. To simulate the conditions of the survey, no questions were asked by the researchers before the questionnaire was completed. After completing the survey, the researchers conducted a semi-structured interview about the time it took to complete the survey, the fluency of the used language and the difficulty of the items. Last, the participants were asked if they were inclined to give socially desirable answers. The analysis of the results was discussed within the research group.

3.2. Large sample survey of the nurses' moral courage scale

Design, setting and sample

A non-experimental cross-sectional study design was used to survey a convenience sample of nurses working in two hospitals in Flanders from February until April 2019. The target population of the study was registered nurses. In 2018, 3089 registered nurses were working in hospital 1 (an academic setting) and 800 in hospital 2 (a regional setting).

The following eligibility criteria were applied: the participant 1) is a registered nurse, 2) has a sufficient command of the Dutch language to be able to complete the NMCS instrument and 3) works presently in the participating hospitals. Midwives were excluded from this study. Based on statistical power analysis, the required sample size for the study was 350 nurses at the 95% confidence level (24).

Measures, data collection and procedure

Moral courage was explored using 3 scales: the Dutch 21-item NMCS (consisting of 4 subscales), a VAS-scale assessing the participant's self-perceived moral courage and a five-point Likert scale exploring moral courage when defending professional ethical values with other actors, professional groups or organizations. The questionnaire also consisted of eleven items collecting data about the participants' socio-demographic (personal, work and nursing ethic-related) characteristics.

The researchers contacted the nursing department managers of the participating hospitals and explained the purpose of the study. Once permission was granted, the head nurses of the selected departments were invited for an information session. We used a phased approach consisting of 3 stages in which one or two departments were included in the study. Each phase comprised an introduction, survey distribution, collection and analyses of the response rates. The aim of this phased approach was to follow-up on the response rates, adjust promoting measures taken by the researchers and limit the amount of distributed surveys throughout the hospital to prevent nursing inquiry fatigue. We aimed for a response rate of fifty percent. In hospital 1, surveys were handed out in paper format. Surveys in hospital 2 were distributed

digitally. The surveys were accompanied by a letter that ensured the participant that the questionnaire was anonymous.

Specific guidelines were made in consort with hospital management to protect participants' privacy and anonymity and to ease and improve the data-collection process. These guidelines consisted of (1) an information session with head nurses from selected wards to get them interested in the study, (2) instructions for head nurses on how they had to distribute the surveys on their ward and how to promote participation, and (3) instructions for deposit by nurses. Nurses had three weeks to complete their surveys. Data encoding was performed by one researcher and controlled independently by another.

Data analysis

SPSS 25.0 (25) was used to analyse the data. Pairwise deletion was used in case data were missing to maximize power (26). Descriptive statistics, i.e., frequencies, means and standard deviations on items, subscales and the total sample, were used (with 95% confidence intervals).

The differences in moral courage among participants with demographic characteristics were tested using the independent t-test and one-way analysis of variance (ANOVA). Internal consistency reliability was estimated using Cronbach's alpha coefficients, and the minimum value of .7 was regarded as acceptable (27).

Ethical considerations

All measures to conduct research ethically were carefully deliberated throughout the study and were based on the Horizon 2020 program made by the European Commission (28). Permission to translate and use the survey was obtained at the start of the study from the University of Turku, Finland. Ethical approval from the ethics committee of KU Leuven (MP007372) and the participating hospitals were obtained at the start of the study. Participation in the pilot study and the larger sample survey were voluntary and anonymous. Participants were made aware of this information in a letter attached to the survey. The surveys were encoded to ensure participant anonymity, and personal results were not shared with the participating hospitals. Survey results were analysed and stored in an international database hosted by the Finnish University of Turku. Data storage and sharing were performed in accordance with General Data Protection Regulation (GDPR), EU Directive 95/46/EC and other legislation concerning data storage and privacy. Submission of the questionnaire was considered to be informed consent.

4. Results

4.1. Forward-backward translation

During forward-backward translation of the NMCS, changes were made to the demographic questions of the scale; in particular, the employment rate of the participant was added. As the employment rates of nurses in Flanders are rather diverse, the researchers hypothesized that this could be an influencing factor of moral courage in nursing practice. Item 34, an open question, was removed from the survey in consort with the first author of the NMCS given that this question could require considerable time to complete and did not contribute to the goals of this study.

Based on a comparison of the original English NMCS and the backward translation, the researchers found a resemblance of approximately sixty percent based on word count and visual comparison. Twenty percent of the inconsistencies were caused by the use of synonyms of the original words or turning the original sentence around by the translator. This was possibly due to other linguistic rules in the Dutch and English languages. The last twenty percent of the dissimilar words were caused by changes in context.

4.2.Pilot study

A group of 10 nurses were selected to participate in the pilot. The majority of the nurses were less than 30 years old and were female. Seven nurses had a bachelor's degree. One (assistant) head nurse participated in the pilot, and the other nurses were working as ward nurses. Most of the participants (80%) were working full time as nurses. The relevant socio-demographic characteristics of the 10 participants are shown in Table 1.

It took the participants approximately 10 to 15 minutes to complete the survey. Some small grammatical errors were removed from the survey after recommendations from a participant.

None of the participants perceived the survey in general as hard or difficult, although some participants mentioned that the survey required focused attention. None of the participants had a specific background in ethics; they were not familiar with thinking consciously about ethical issues in their working environment. It was noted that participants focused on the examples given with some of the items and did not think at an abstract level. Furthermore, participants noted that some questions were situational, suggesting that scores will depend on the specific condition. They explicitly mentioned the items referring to 'someone else' as opposing person. The participants' answers to the question may be

different if they, for example, imagine that the opposing person is a colleague, a manager or a doctor. However, no examples were removed from the survey to maintain similarity with the original NMCS.

4.3. Survey

Sample description

A total of 1352 surveys were distributed in the two participating hospitals. In hospital one, 778 nurses received the questionnaire, and 350 surveys were returned, yielding a response rate of 45.4%. In hospital two, 574 nurses received the questionnaire, and 209 surveys were returned, yielding a response rate of 36.3%. In total, 41.3% of the participants returned the survey.

In hospital 1, five major departments were included (oncology, locomotor systems, and internal, thoracic and abdominal medicine), consisting of 38 care units. In hospital 2, three departments were included (internal medicine, geriatrics, psychiatrics; surgery and special care services; and medical-technical services & ambulatory care), consisting of 31 care units.

The participants were predominantly female (84.8%). Most nurses had a bachelor's degree in nursing (73.5%) and were working as ward nurses (87.0%). Approximately half of the participating nurses were working fulltime (52.8%). The majority of participants rated their own ethical knowledge base as good (61.4%), and only 8 participants perceived their ethical knowledge base as '*unsatisfactory*'. Most of the participating nurses acquired their knowledge base in ethics during their professional healthcare education (90.2%) and acquired ethical knowledge during their nursing practice (87.7%). Less than half of the nurses (36%) claimed they had acquired their ethical knowledge through self-study. Further sociodemographic and work-related characteristics are shown in Table 2.

Level of nurses' moral courage

Total scale, subscales and VAS scale

Nurses' mean score of the 21-item NMCS was 3.77 (SD= .54, range: 1.62–5). On the VAS (0–10), the mean of nurses' assessment of their overall level of moral courage was 7.44 (SD= 1.19). The highest single subscale mean score was 4.00 (SD= .58, range: 1.4-5) for 'Compassion and true presence', followed by 'Moral integrity' (mean= 3.78, SD= .59, range: 1.86-5) and 'Moral responsibility (mean= 3.66, SD= .72, range: 1.25-5). The lowest single subscale mean score was 3.61 (SD= .64, range 1.62-5) for 'Commitment to good care'.

The Dutch NMCS had a total Cronbach's alpha of .91. The highest subscale was 'moral integrity' with a Cronbach's alpha of .81 followed by the subscale 'moral responsibility' with a score of .80 and 'compassion and true presence' with a score of .76. The lowest subscale was 'Commitment to good care' with a Cronbach's alpha of .71 (see Table 3).

Item level

The highest single item mean score was 4.46 (SD= .64) with the item *"I admit my own mistakes in care".* The following two highest scores were item *"Regardless of the care situation, I try to encounter each patient as a dignified human being even if…..."* with a score of 4.28 (SD= .72) and item *"I support a suffering patient by being truly present for him/her even if …"* with a score of 4.07 (SD= .80). Both items belong to the subscale 'Compassion and true presence'.

The lowest single item mean score was item *"I am prepared to break prevalent care practices to advocate my patient..."* with a mean score of 3.18 (SD= 1.14). The two items with the lowest scores were *"If I observe evident shortcomings in someone else's…"* with a score of 3.34 (SD= .99) and item *"I adhere to professional ethical principles even if..."* with a mean score of 3.37 (SD= .91).

All but one item ranged from 1 to 5. Item *"I admit my own mistakes in care"* had a range from 2 to 5. Table 4 shows the mean, standard deviation and range of all the items of the NMCS.

Moral courage when defending ethical values with other professional groups or organizations

Participating nurses experienced that acting morally courageously in an ethical conflict in which the opposing actor is a co-worker (mean= 4.02) or a colleague (mean= 3.87) is easiest followed by a situation in which the patient, the head nurse and the patient's next of kin are involved. Nurses found it hardest to act morally courageously when they were in an ethical conflict with a physician (mean=2.93), the healthcare organization (mean= 2.51) or a body outside of the organization (mean= 2.38) as shown in Table 5.

Associations between NMCS and participant socio-demographic variables

As shown in Table 6, statistically significant differences in the total NMCS score ($p<.001$) and three subscale scores were found among the age groups. Older nurses have a higher NMCS score than younger nurses. Similarly, a statistically significant difference is noted based on working experience with more experienced nurses having a higher total NMCS score ($p< .001$) and scoring higher in three subscales.

Head nurses and assistant head nurses scored significantly higher ($p< .001$) on the total NMCS score and all the subscales than ward nurses. There was also a statistically significant difference in the total NMCS score ($p=.002$) and the subscales based on the education level of nurses. Nurses with a higher degree tended to have a higher total NMCS score than lower educated nurses.

No statistically significant difference in total NMCS score was noted between genders. However, male nurses score significantly higher on two subscales: “Moral integrity” ($p = .049$) and “Commitment to good care” ($p = .033$). No statistically significant differences in the total NMCS score were noted between nurses’ employment rates.

Some significant differences in variables related to nursing ethics and the NMCS were observed. Nurses who previously participated in developmental work in ethics had a statistically significant higher score on the total NMCS ($p < .001$) and on all subscales. Nurses who assessed their level of ethical knowledge on the higher end of the Likert scale scored significantly higher on the total NMCS ($p < .001$) and on all subscales.

Nurses who acquired their ethical knowledge by participating in ethics courses ($p < .001$), self-study ($p < .001$) and through their nursing practice exhibited a significantly higher total NMCS score than participants who did not. Nurses who acquired their knowledge base in ethics through their professional healthcare education did not score significantly better on the total NMCS than nurses who did not. Nurses who experienced situations that required moral courage more often had a statistically significantly higher total NMCS and subscale scores ($p < .001$). Last, a moderate positive correlation ($\rho = .582$, $p < .001$) was noted between nurses’ self-assessment of their moral courage (VAS) and total NMCS score.

5. Discussion

This study sought to translate the English NMCS to a Dutch version that is suited for the Flemish nursing context and to provide a description of the nurses' self-assessed level of moral courage in Flanders. The readability and understandability of the Dutch NMCS were positively evaluated. The scale showed a good level of internal consistency for the total scale as well as for all four subscales with Cronbach's alpha values exceeding the recommended acceptable values and approaching the values of the original Finnish survey (21).

According to the findings of this study, the nurses perceived themselves on average as morally courageous (mean NMCS total score= 3.77; VAS scale= 7.44). Items that belonged to the subscale 'Compassion and true presence' were found in the higher tiers of the results. These were items that focused on the direct interpersonal relationship with patients, in which nurses can commit to core values of nursing. These findings lend support to nurses' values-driven ambition, which allows them to truly make a positive difference in care (29). However, it appeared to be more difficult for nurses to be morally courageous if the opponent was a physician, a person in a higher professional position or a body outside the organization.

The results of this study demonstrate that self-perceived moral courage increases by age and experience. A major gap was observable between freshly graduated nurses with less than 5 years of experience and more experienced nurses. In addition, nurses who more frequently experienced situations that require moral courage scored significantly higher in our sample. Similarly, Bickhoff et al. (13) and Escobar-Chua (12,13) described how nursing students lack moral courage due to their novice status, fear of consequence, lack of confidence and experience, and how moral distress drives students to avoid ethical conflicts. Although the position of junior nurses is not the same as that of nursing students, they both lack experience in acting morally courageously and possibly undergo a comparable experience when confronted with situations that provoke moral distress (30–32).
The significantly higher total NMCS scores of head nurses support the importance of age or experience in acting morally courageously. However, their slightly higher location on the hierarchical ladder of the hospital or their leadership competencies may have facilitated them in advocating the patient and thus explain these higher scores (30).

The significant relationship between educational factors and self-assessed moral courage supports Kidder's idea that moral courage can be taught (33). Nurses with a higher degree and nurses who assessed their level of ethical knowledge on the higher end scored significantly higher on the NMCS. The results revealed significant relations for ethical knowledge acquired by participating in ethics courses, by self-study or through nursing practice. It is remarkable that we did not identify a significant relationship between moral courage and ethical knowledge developed through nursing training

programs. The findings also suggested a positive impact of personal interest in nursing ethics on the development of moral courage.

In addition to personal and educational factors, contextual factors also appeared to play a part in acting morally courageously, as assessed by the nurses. Nurses' difficulties committing to good care, acting in accordance with their ethical principles and taking responsibilities in situations transcending the individual relationship with the patient illustrate the impact of the context on nurses' behaviour. These findings confirm the results of Dierckx de Casterlé et al.'s meta-analysis (34), suggesting a strong tendency among nurses to conformist reasoning and acting in ethically sensitive situations. Not surprisingly, the lowest item score in our study was "I am prepared to break prevalent care practices to advocate my patient…". The findings of this study urge us to find ways to encourage nurses to go beyond conventional practice. Nurses should be stimulated through education and their professional environment to reflect critically and creatively when confronted with ethically sensitive challenges and to determine how to turn their ethical commitment into action despite the challenging context. This finding emphasizes the need to enlarge the focus in education beyond the nurse-patient relationship, helping nurses to show courage in situations related to third party or other contextual factors, which seem now to inhibit nurses' courageous action. As Gastmans (2002) proposed, particular consideration should be given to the contextual embeddedness of ethical practice, implying that educational programs need to focus on the context in which nurses must manifest their moral courage (35).

In the same vein, the importance of an ethical work environment should be acknowledged. There should be room for open dialogue within the multidisciplinary team, unrestrained from the hierarchical structure (19). A culture is needed in which nurses are encouraged to keep developing their level of moral courage so that they are able to cope better with ethical conflicts and moral distress (13). The creation of this type of culture requires ethical leaders who able to create an environment in which it can be morally justified to question prevalent care practices and bring divergent views or concerns up for discussion. A major challenge of the leader is to involve the entire team, not only nurses, and lead them to understand and commit to a care culture that not only tolerates but also appreciates moral courage.

Strengths and limitations

A stepped approach was used while conducting this study, providing the opportunity to regularly analyse and evaluate the data collection process. During phase 1 of the data collection, a lower response rate than the response rate goal of 50% was observed. The researchers used a more personal approach to the eligible nurses during the second and third phases of the data collection. This feature led to an increase in the response rates of the three remaining departments, resulting in an overall response rate of 41.3.

The external generalizability of the findings may be limited given that only two hospitals participated in this study. In addition, it was decided in concert with hospital management not to include critical care and psychiatric units in hospital 1 due to possible nurses' inquiry fatigue. However, the study succeeded in reaching a large variation of nursing specializations in the two participating hospitals, covering an interesting mix of care environments that may enhance the generalizability of the findings.

The use of convenience sampling and the difference in response rate between departments could be considered a limitation. In one of the departments, a response rate of 28% was reported, which could lead to non-response bias. Using convenience sampling, the distribution of the participants in the departments may not reflect the entire population. Quota sampling could have provided a solution for this issue. The social desirability response bias related to self-assessment instruments should also be acknowledged, although participants in the pilot denied being affected by this factor (36).

The readability and understandability of the Dutch NMCS as well as its level of internal consistency were positively evaluated. Yet we did not perform a test-retest to assess its stability during the time, which is a limitation of the study.

Implications and further research

The data from this study can be used to help validate the English NMCS from which the Dutch scale was derived and enable future international research. More research is recommended to further validate the Dutch NMCS in larger nursing populations. As with any self-perceived scale, this scale measures what a person thinks she/he would do and not what this person actually does. There is a need for in-depth qualitative research to better understand what it means to be morally courageous in challenging ethical situations and which factors may inhibit or support nurses to act courageously in these situations. The aftermath of the Covid-19 pandemic could be an opportunity to gain insight into the phenomenon of moral courage through lived experiences.

6. Conclusion

This study followed a forward-backward translation process to translate the English version of the NMCS into Dutch while taking into account the Flemish nursing context. Additionally, a pilot study was conducted to evaluate the readability and understandability of the scale. This resulted in an equilibrium between a conceptual and semantic translation of the NMCS. Nurses perceived themselves as morally courageous, especially when they were in a direct interpersonal relationship with their patients. Acting courageously in ethical dilemmas that involve third parties appeared to be more

challenging. Further exploration of the concept supported the idea that moral courage is a personal characteristic but also suggested the important role of education and ethical leadership in developing moral courage.

7. Declaration of Conflicting Interests

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

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