

THE RELATIONSHIP BETWEEN MORAL COURAGE AND PSYCHOLOGICAL EMPOWERMENT AMONG NURSES IN A PUBLIC HOSPITAL, JOHOR BAHRU

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Abstract

Nurses face ethical and quality-of-care issues, but those who show moral courage (MC) can act on their principles. Empowering nurses with psychological empowerment (PE) can help them make better healthcare decisions and perform better as caregivers. This can result in improved patient outcomes and overall quality of care. This study investigated the relationship between MC and PE among 217 nurses at a Johor Bahru public hospital. The outcomes indicated that the nurses demonstrated high levels of MC 78.88 (14.67) and PE 58.73 (9.30). In addition, there was a relationship between MC and PE ($r = 0.54, p < 0.01$), and age ($r = 0.230, p < 0.001$) and work experience ($r = 0.275, p < 0.000$) were found to be significant influences on both variables. The study suggests that psychologically empowering nurses could increase their MC, resulting in increased patient satisfaction and care quality.

Keywords: Moral courage, Psychological empowerment, Nurse(s), Ethic(s)

Introduction

Moral courage (MC) and psychological empowerment (PE) are vital elements of the nursing practice that can influence patient outcomes and the quality of care as a whole. As the backbone of the healthcare system, nurses play a crucial role in providing patients with care and support. However, nurses often face various challenges such as heavy workload, reduced staffing, and increased overtime (1), which can have an adverse impact on their psychological well-being and job performance. In this context, it is essential to investigate the relationship between MC and PE among nurses. One of the fundamental principles of the nursing profession is MC, which serves as a powerful coping mechanism for ethical dilemmas. PE, meanwhile, is a helpful technique for assisting individuals in navigating the psychological pressures of the workplace (2). To ensure quality care and patient safety, collaborate effectively with other healthcare professionals, and advocate for equitable care with healthcare and community organisations, nurses must possess MC (3). Emphasizes that MC is necessary for confronting unethical, unsafe, or discriminatory practices in healthcare settings (4). Numerous prior studies have

documented those moderate rates of MC. The studies found that nurses had moderate levels of understanding of ethics and MC. These findings suggest that nurses may often lack the MC needed to make ethical decisions, which could impact the quality of care they provide to their patients (5-7).

The number of studies that have been conducted on the idea of empowerment in nursing has significantly increased over the past few decades. These studies emphasise that the question of empowerment should be considered when attempting to improve the level of nurses' competence (8). It demonstrated that empowering nurses psychologically increases their potential to influence patient care decisions effectively. Numerous studies indicate that decreased MC and PE among nurses are associated with lower levels of moral distress (9), job satisfaction, and work quality (10). The studies found that nurses had moderate levels of PE (10, 11). These findings suggested that nurses may struggle with managing mental demands and stressors, particularly when caring for acute patients. One study demonstrates a potential correlation between MC and PE among nurses. In their research, they discovered that nurses who reported

higher MC also reported moderate PE (2). Even though previous studies have focused on MC and PE among nurses in other nations, additional research is still required, particularly among Malaysian nurses.

Previous research indicates significant correlations between MC and PE with demographic factors playing a role. Age, experience, position, work shift, employee status, and ethics courses were significantly correlated with MC (12). The studies found that work experience was significantly related to MC (2, 13). However, another study found that other demographic factors were not significant (14). Therefore, this study intends to investigate the relationship between MC and PE with demographic data among nurses in a public hospital in Johor Bahru. The findings of this study perhaps could improve the quality of care provided to patients in Johor Bahru's public hospitals by informing interventions and policies that foster MC and PE among nursing staff.

Materials and Methods

Study design

This study used a cross-sectional survey design to examine the relationship between MC and PE among nurses in a Johor Bahru public hospital. The survey was given out to a representative sample of the nurses working in the hospital, and the data was collected with standardised measures of MC and PE. This was appropriate for this study because it allowed for data collection from a representative sample of nurses at a single point in time.

Study setting

This study was conducted in a public hospital in Johor Bahru and involved a sample of 217 registered nurses across multiple wards, including cardiology, general surgery, medical, neurosurgery, obstetrics & gynaecology, orthopaedic, otorhinolaryngology, paediatric wards, and polyclinics. The researchers used a sample of nurses from a single hospital to ensure the findings were specific to the hospital and its nursing staff.

Sample

Purposive sampling was used for the data collection in this study. This technique was chosen as it allowed the researchers to select participants who met specific criteria that were deemed important for the study. To identify potential participants who met these criteria, the researchers collaborated with the hospital's nursing department. Researchers recruited participants by contacting nurses on a list provided by the department who met the study's inclusion criteria. In order to be included in the study, Johor Bahru public hospital registered nurses had to have at least six months of experience in their current ward, be able to read English or Malay and be directly involved in patient care. Nurses in managerial posts and those on extended or sick leave during data collection were excluded.

Sample Size Calculation

The total number of nurses who actively work in the ward in a public hospital setting is 500. Based on this population size, the study's required sample size was calculated using the Raosoft sample size calculator. With a 20% attrition rate, the required sample size is 217 respondents, with an error margin of 5% and a confidence interval of 95%.

Instrument

An instrument for this study was a self-administered questionnaire consisting of three parts. **Part A** is demographic indicators. It consists of the following information: age, gender, employment status, working experience, marital status, education level, and department/unit. **Part B** is the Moral Courage Scale, which measures the MC of nurses (15). The scale consists of 15 items covering five dimensions: moral agency, multiple values, endurance events of threat, going beyond compliance, and moral goals. On a seven-point Likert scale ranging from "never correct" (1) to "always correct" (7), participants evaluate each item. The range of total scores is from 15 to 105, with higher scores indicating greater MC. The MC score is determined by calculating the mean score of items within each dimension and the entire scale. The mean score of each dimension and the total item is considered the MC score, with a higher score indicating a higher level of MC. **Part C** involves using of Spritzer's Psychological Empowerment Scale to evaluate the PE of nurses (16). The instrument consists of a 12-item inventory that evaluates four key areas - competence, impact, self-determination, and meaningfulness. Each area has three corresponding items, rated on a 5-point Likert scale ranging from 1 ("completely disagree") to 5 ("completely agree"). The instrument scores between 12 and 60, with higher scores indicating greater perceived PE. In this study, the MC and PE scales have high internal consistency, with the Cronbach's reliability coefficient being 0.964 and 0.910, respectively.

Data collection

The study was carried out between November 2022 to January 2023. After receiving a list of nurses who met the inclusion criteria from the department, the researchers invited them to participate in the study. Those who agreed to participate in this study were sent a link to self-administered questionnaires via email/WhatsApp. Respondents were required to read the participant information sheet and provide informed consent before answering.

Data analysis

Descriptive statistics were used to present participants' demographic characteristics, including mean scores and standard deviations of MC, PE, and age. Categorical data were presented as frequency (percentage), while the Pearson correlation coefficient was used to analyse numerical data. Independent t-test and One-way ANOVA

were used to determine the relationship between MC and PE with demographic information.

Results

Demographic data

Table 1 shows the demographic characteristics of the study, including age, gender, working experience, marital status, level of education, type of employment, and working department. The mean (SD) age of the respondents' nurses was 31.31 (5.19). Most of the respondents had working experience of 6 to 10 years (38.7%). The majority of the respondents were female (82.0%) and married (66.4%). Further, 96.3% of nurses held a diploma in nursing and were permanent employees. In addition, most respondents (34.6%) were from medical wards, while few reported working in polyclinics (2.8%).

Table 1: Demographic data

Variables	Mean (SD)	n	%
Age	31.31 (5.189)	217	
Work Experience	1-5 year	30.0	65
	6-10 year	38.7	84
	11-15 year	23.0	50
	>16 year	8.3	18
Gender	Male	18.0	39
	Female	82.0	178
Marital Status	Single	30.9	67
	Married	66.4	144
	Widow	2.8	6
Level of Education	Diploma	96.3	209
	Bachelor's Degree	3.2	7
	Master's Degree	1	0.5
Employment status	Permanent	209	96.3
	Contract	8	3.7
Formal position	Medical	75	34.6
	General surgery	20	9.2
	Neurosurgery	29	13.4
	Otorhinolaryngology	10	4.6
	Ophthalmology	11	5.1
	Paediatric	17	7.8
	Cardiology	8	3.7
	Urology	10	4.6
	Obstetrics & Gynaecology	11	5.1
	Orthopaedic	20	9.2
Polyclinic	6	2.8	

Level of moral courage (MC)

MC can be summarized as follows: moral agency, multiple values, an endurance of threat, going beyond compliance,

and moral goals. According to the results, the total mean for MC was 78.88 (14.67) with a minimum score of 21.00 and a maximum score of 105.00. According to the data presented in Table 2, nurses exhibit a significant level of MC. Specifically, the category of "moral goals" had the highest mean (SD) score of 16.46 (3.43), while "going beyond compliance" had the lowest mean score of 15.17 (3.39).

Table 2: Level of moral courage (MC) and its dimensions

Variable	Mean	SD
Moral courage	78.88	14.67
Moral agency	15.71	3.31
Multiple value	15.98	3.32
Endurance of threat	15.48	3.41
Going beyond compliance	15.17	3.39
Moral goal	16.46	3.43

Level of psychological empowerment (PE)

Table 3 displays the PE score. The data presented in the study revealed that nurses had a higher level of PE, with a mean (SD) score of 58.73 (9.30). The scores ranged from a minimum of 28.00 to a maximum of 60.00. The analysis also showed that the category of "Meaning" had the highest mean score of 13.04 (1.75), while "Impact" had the lowest mean score of 10.91 (2.54).

Table 3: Level of psychological empowerment (PE) and its dimensions

Variable	Mean	SD
Psychological empowerment	58.73	9.30
Meaning	13.04	1.75
Competence	12.52	1.86
Self-determination	12.13	1.84
Impact	10.91	2.54

Relationship between moral courage (MC) and psychological empowerment (PE)

Table 4 presents the analysis of the relationship between MC and PE. The findings revealed a statistically significant relationship between PE and MC ($r = 0.54, p < 0.01$). Moreover, a significant relationship was observed between MC and all dimensions of PE ($p < 0.01$).

Table 4: Relationship between moral courage (MC) and its dimensions with psychological empowerment (PE) and its dimensions

Variables	Psychological empowerment		Competence		Self-determination		Impact		Meaning	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
Moral courage	0.54**	0.00	0.49**	0.00	0.44**	0.00	0.47**	0.00	0.35**	0.00
Moral agency	0.45**	0.00	0.47**	0.00	0.37**	0.00	0.39**	0.00	0.29**	0.00
Multiple value	0.52**	0.00	0.43**	0.00	0.43**	0.00	0.49**	0.00	0.33**	0.00
Endurance of threat	0.39**	0.00	0.40**	0.00	0.32**	0.00	0.37**	0.00	0.21**	0.00
Going beyond compliance	0.48**	0.00	0.39**	0.00	0.35**	0.00	0.42**	0.00	0.37**	0.00
Moral goal	0.50**	0.00	0.41**	0.00	0.42**	0.00	0.40**	0.00	0.37**	0.00

**Correlation is significant at the 0.00 level (2-tailed)

Relationship between moral courage (MC) and psychological empowerment (PE) with the nurses’ demographics characteristics

Significant relationships were found between MC and PE in the nurses’ demographic characteristics (Table 5). The results showed a significant relationship between the age of respondents and MC ($r = 0.230, p = 0.001$) and PE ($r = 0.275, p = 0.000$), so MC and PE increased with the increasing respondent age. ANOVA was conducted to compare the MC and PC with demographic data. There was a significant difference of mean MC between the year of experience for the four groups $F(3,213) = 7.250, p < 0.001$. Post hoc test results showed that the mean MC (72.83, SD 13.97) of 1-to-5-year experience is significantly lower than the 6 to 10 years of experience (79.58, SD 14.48). The mean MC (84.96, SD 12.79) of 11 to 15 year of experience is significantly higher than the 1-to-5-year experience

(72.83, SD 13.97), but there were no significant differences between other groups. There was a significant difference of mean PE between the year of experiences $F(3,213) = 8.862, p < 0.001$. Post hoc test results revealed that the mean PE (45.98, SD 6.72) of 1–5-year experience is significantly lower than the 11–15-years experience (51.36, SD 5.59). However, the mean PE (51.36, SD 5.59) of 11–15- years experience (51.36, SD 5.59) is significantly higher than the > 16-year experience (51.11, SD 5.39), 1–5-year experience (45.98, SD 6.72) and 6-10 years of experience (48.43, SD 5.63). There were no significant differences between the other groups. There was a significant difference of mean MC between marital status for the three groups $F(2,214) = 10.008, p < 0.001$. Post hoc tests showed that participants who were widowed had a significantly higher mean PE score (56.17, SD 4.36) than those who were married (46.43, SD 6.87) and single (49.28, SD 5.63).

Table 5: Determining the relationship between moral courage (MC) and psychological empowerment (PE) scores with demographic variables

Variables		Moral courage	Psychological empowerment
Age	<i>r</i>	0.230	0.275
	<i>p</i>	0.001	0.000
Work Experience	1-5 year	Mean (SD) 72.83 (13.97)	45.98 (6.72)
	6-10 year	Mean (SD) 79.58 (14.48)	48.43 (5.63)
	11-15 year	Mean (SD) 84.96 (12.79)	51.36 (5.59)
	>16 year	Mean (SD) 79.55 (15.27)	51.11 (5.39)
	<i>p</i>	<0.001^b	<0.001 ^b
Gender	Male	Mean (SD) 82.05 (14.44)	48.72 (7.08)
	Female	Mean (SD) 78.20 (14.67)	48.43 (6.02)
	<i>p</i>	0.137 ^a	0.795 ^a
Marital Status	Single	Mean (SD) 79.40 (15.69)	49.28 (5.63)
	Married	Mean (SD) 76.73 (12.04)	46.43 (6.87)
	Widow	Mean (SD) 90.67 (10.13)	56.17 (4.36)

Table 5: Determining the relationship between moral courage (MC) and psychological empowerment (PE) scores with demographic variables (continued)

Variables			Moral courage		Psychological empowerment	
		<i>p</i>	0.064 ^b		<0.01 ^b	
Level of Education	Diploma	Mean (SD)	78.55 (14.74)		48.43 (6.19)	
	Bachelor's Degree	Mean (SD)	88.29 (10.23)		50.28 (7.32)	
	Master's Degree	Mean (SD)	-		-	
		<i>p</i>	0.212 ^b		0.737 ^b	
Employment status	Permanent	Mean (SD)	79.11 (14.56)		48.56 (6.00)	
	By contract	Mean (SD)	73.13 (17.38)		46.50 (10.70)	
		<i>p</i>	0.334 ^a		0.011 ^a	
Department	Medical	Mean (SD)	77.24	(15.11)	48.65	(6.71)
	General surgery	Mean (SD)	87.50	(12.57)	48.45	(7.58)
	Neurosurgery	Mean (SD)	78.83	(17.01)	48.52	(4.79)
	Otorhinolaryngology	Mean (SD)	77.20	(13.40)	48.20	(4.21)
	Ophthalmology	Mean (SD)	78.10	(12.19)	47.18	(5.86)
	Pediatric	Mean (SD)	80.41	(8.14)	48.18	(3.97)
	Cardiology	Mean (SD)	78.88	(19.38)	48.25	(4.13)
	Urology	Mean (SD)	84.00	(10.18)	51.90	(7.99)
	Obstetrics & Gynecology	Mean (SD)	73.55	(17.83)	51.18	(6.10)
	Orthopedic	Mean (SD)	76.20	(12.90)	45.75	(7.33)
	Polyclinic	Mean (SD)	81.17	(18.74)	48.83	(2.31)
		<i>p</i>	0.308 ^b		0.478 ^b	

*^aIndependent t-test

*^bOne-way ANOVA: Post Hoc test was conducted for significant value level $p < 0.05$.

Discussion

The study discovered that the nurses who took part in it demonstrated a considerable amount of MC, which is in line with previous studies that also reported high levels of MC among nurses (2, 5, 14). The high levels of MC among nurses suggest that nursing education programs should continue to prioritize ethical decision-making and provide training on how to navigate moral dilemmas. Furthermore, healthcare organizations should foster a culture that values ethical behaviour and provides resources to support nurses in making difficult ethical decisions. However, previous studies have found that nurses exhibit a moderate level of MC (17, 21). The differences in results could be attributed to workplace conditions, ethics, culture, management, isolation fears, group behaviour, and social acceptance (7). The present study indicates that the highest score for MC was observed in the dimension of "moral goals". This result is consistent with a previous study which also reported high levels of MC in the dimension of "moral goals" (18). In light of the high scores for "moral goals", indicates that nurses are able to identify what is right and appropriate based on their guidance and prudence. By making these judgments, they will be motivated to act in an appropriate manner. Moreover, these findings suggest that

individuals' personal and organizational values influence individuals' "moral behaviour" and ethical decision-making. Furthermore, according to some studies (5, 14), "moral agency" is the dimension in which the greatest amount of MC is exhibited. The dimension with the lowest score in the current study was related to "going beyond compliance". "Multiple values" were associated with the dimension with the lowest score in a previous study (2), whereas another study found that the dimension of MC with the lowest score was "endurance of threat" (7). Nurses who have a low score in "going beyond compliance" may have difficulty dealing with organisational constraints and making ethical decisions. This can potentially affect their inner capabilities and ultimately impact the quality of patient care. It is important for responsible authorities to take note of this issue. Organizations should prioritise moral virtues such as courage and promote a supportive and empowering organisational culture for courageous nurses. Doing so can have positive consequences, such as ensuring that the right decisions are made, appropriate actions are taken, patient safety and comfort are prioritized, and the nursing staff can effectively fulfil their role as caregivers (19).

The study found that the participating nurses demonstrated a significant level of PE, which is consistent with previous

research that also reported high levels of PE among nurses (20). These findings showed that nurses were empowered to act under pressure and act with confidence in their performance and position as professionals. Furthermore, it showed that the administration department created an environment encouraging nursing staff to provide high-quality care and show commitment to their organization. Effective leadership styles and empowering strategies implemented by nursing leaders will improve the nurses' working environment (11). Several studies have reported a moderate level of PE among nurses. A previous found that Chinese nurses experienced moderate PE (10), while a study in Egypt reported similar findings (21). A systematic review found that Iranian nurses were moderately empowered psychologically (22). It was concluded from these studies that nurses' empowerment could have been more moderate, as a lack of encouragement from the organization could affect individuals' empowerment (22). The highest score for PE in the present study was related to meaning, which was parallel to the findings of the previous study, whereas the lowest score was related to impact (23). A high score for nurses' meaning indicates that they feel their work and job activities are valuable and meaningful. Low levels of impact refer to nurses' lack of control and influence over what occurs in their organization. In light of this, nursing managers should be attentive to this issue. The previous study (10) and the present study found that nurses tend to score highest on the "competence" dimension of PE and lowest on the "impact" dimension. However, a previous study found that the highest mean score was associated with "competence" and the lowest mean score was associated with "self-determination," which contradicts the findings of the present study (24). The variation in PE scores among nurses could be influenced by multiple factors, including workload, organizational culture and support, individual characteristics, and cultural and contextual factors. Future research could investigate these factors further in order to gain a deeper comprehension of the determinants of PE among nurses.

The present study found a good relationship between MC, PE, and its dimensions, resulting in nurses having enhanced MC due to increased PE. This was in line with the results of a previous study, which discovered a direct relationship between PE and its dimensions (2). The finding that there is a good correlation between MC and PE is significant because it suggests that nurses who feel more psychologically empowered are more likely to exhibit greater MC in their professional practice. This can have important implications for patient care and safety, as nurses who are more morally courageous are more likely to speak up about concerns and advocate for their patients, even in challenging situations. To summarize, the significant relationship found between MC and PE among nurses has significant implications for nursing practice and patient care. More research is necessary to fully comprehend the underlying factors that contribute to this correlation and to design interventions that can promote the development of MC and PE in nurses.

The study found that age and work experience were significantly associated with both MC and PE. As a result, registered nurses who are older have a greater tendency to work in environments that are less challenging, and they also tend to avoid high levels of stress (6, 13, 25). Furthermore, it shows that nurses have the ability to control their emotions and follow ethical guidelines. The findings of this study suggest that years of experience and marital status may be factors influencing MC and PE scores. The study found that age and work experience were significantly associated with both MC and PE among nurses. This suggests that nurses who are older and more experienced may have more confidence in their ability to make ethical decisions and feel empowered in their work. A higher PE score was found among widows in the present study. The findings of the present study indicate that there is an imbalance in the marital status of the respondents, with only six of them being widows. Married respondents constitute the largest percentage of respondents. Widowed had higher PE scores than married nurses, but the small number of widows in the study may have influenced the results. A previous study found no significant correlation between marital status and PE (2). The participants in the current study may have been from a different country or cultural background, which could have influenced their perceptions of PE and how it relates to marital status.

Conclusion

In conclusion, the study found that nurses possess high levels of MC and PE. Nursing education programs should continue to emphasize ethical decision-making and provide guidance on navigating moral dilemmas. The relationship between PE and MC suggests that nurses who feel more empowered are more likely to demonstrate greater MC in their professional practice, which has significant implications for patient care and safety. Age and work experience were identified as significant factors in this association. This study contributes novelty by highlighting the relationship between MC and PE, the study can inform strategies to foster a supportive environment for nurses, enhance patient care, and optimize the overall functioning of the healthcare system. More research is required to better comprehend these factors and develop interventions to promote nurses' MC and PE. Nursing managers and organisations should implement strategies to increase nurses' participation in decision-making, alter the management style in clinical wards, and cultivate a supportive organisational culture in order to boost nurses' cognitive abilities. It is essential to provide the necessary conditions for nurses to be psychologically empowered, resulting in better nursing care. This study is limited to a single setting and employed a cross-sectional design with non-probability sampling. It is important to recognize that the non-probability sample may not fully represent the entire population. Therefore, a larger study involving nurses from different hospitals is needed to obtain for more comprehensive understanding. Furthermore, the use of a mixed-methods approach could provide deeper

insights into the strong relationship between MC, PE, and nurses' experiences.

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Conflict of interests

The authors declare that there are no conflicts of interest.

Ethical consideration

Approval was received from the Research Ethics Committee Universiti Teknologi MARA (REC) UITM (FERC/FSK/MR/2021/0182) and Medical Research Ethics Committee (MREC) via the National Medical Research Registry (NMRR) (NMRR ID-22-02086-M2D (IIR) and compiled with the Declaration of Helsinki.

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