Original Article

Explicating the process of moral courage in clinical nurses: a grounded theory study

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Abstract

Moral courage in nurses is the product of a complex process and can be enhanced by identifying the steps through which nurses make morally courageous decisions. This qualitative study aimed to explicate the process of moral courage in clinical nurses and present a descriptive model. The study was conducted in Shahrekord University of Medical Sciences in 2022 using the grounded theory approach. Twenty-one clinical nurses were selected through purposive and theoretical sampling. Data were analyzed using Strauss and Corbin's 2015 approach and data management was supported by MAXQDA software (version 11). The core variable identified was moral excellence. When faced with a misalignment between authority and responsibility, nurses experience ambiguity in ethical decision-making. The nurses in this study employed spirituality, legality, and self-sacrifice strategies, which helped them to manage system expectations. In this model, moral courage ultimately gravitates toward managing system expectations—a deviant mechanism failing to yield positive outcomes due to organizational infrastructures and conditions. Therefore, it is recommended that healthcare organizations address factors contributing to ambiguity in nurses' decision-making, such as lack of operational protocols for ethical decisions, mismatched expectations and responsibilities, and deficiencies in professional autonomy.

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Introduction

The nature of the nursing profession exposes nurses to a variety of challenges. Ethical challenges are a significant concern as they can have various consequences (1). Studies indicate that approximately 67% of nurses experience moral distress (2). Additionally, 15–45% of nurses leave the profession after encountering ethical conflicts, while 25–45% change their workplace within the organization (3, 4). Ethical challenges can negatively impact nurses and, consequently, the quality of care they provide. Therefore, understanding how nurses confront ethical dilemmas is of critical importance (5, 6).

Nursing is fundamentally an ethical profession, and nurses serve as moral agents in the community. To deliver high-quality care, nurses must adhere to ethical principles (7). Upholding values such as commitment and respecting patients' rights requires a strong dedication to ethical standards (6). However, a gap exists between moral decisions and providing care aligned with these principles (7, 8). Moral courage is crucial in bridging this gap as it enables nurses to act ethically despite the mental and systemic barriers in healthcare settings. Moral courage is a tool for overcoming fear during practice and is essential for conscientious and duty-driven performance (8, 9).

Adopting an appropriate ethical approach when confronted with ethical issues requires courage (10). Moral courage is a virtue that enables nurses to remain steadfast in their beliefs and make ethical decisions, leading to ethical actions despite the challenges (11). Moral courage in nurses helps them manage their dissatisfaction in the face of ethical dilemmas and lowers the likelihood of their leaving the profession (12). Furthermore, moral courage positively influences the collaborative atmosphere within healthcare teams while fostering an ethical environment in healthcare organizations (13). As nurses develop moral courage, their self-confidence grows, enabling them to transform ethical intentions into ethical actions with conviction. Moral courage allows nurses to make decisions about patients without fear, ultimately enhancing the quality of care (12).

One of the challenges highlighted in various studies regarding moral courage is the complexity of the concept and the ambiguities surrounding its application (14,15). Hu et al. emphasize that to exhibit moral courage effectively, nurses must clarify and understand all its dimensions (15). Additionally, moral courage involves a complex

process that manifests in various forms during practice (16,17). While it is true that moral courage stems from deep confidence and conviction, further research is necessary to distinguish it from related concepts such as resilienc e and moral efficacy (18). Although these concepts contribute to moral confidence and conviction before ethical action, they only sometimes lead to ethical behavior in practice, due to the fact that moral courage may fail to emerge under certain circumstances (19). As such, demonstrating moral courage remains a vague and challenging phenomenon in existing studies that warrants further investigation to provide greater clarity.

A review of studies in this field reveals limited research on the process and mechanisms of moral courage in nurses. Moreover, it is essential to note that this concept is context-dependent. For instance, Iran is a religious country with unique social conditions and distinct processes of moral courage formation. While insights from studies conducted in other societies can serve as valuable guides for better understanding this phenomenon, there is still need to capture its characteristics fully within the Iranian context. To achieve a comprehensive understanding, the present study aims to examine the formation of moral courage in clinical nurses and develop a descriptive model.

Methods

Qualitative Approach and Research Paradigm

The present study aims to elucidate the process of moral courage in clinical nurses and propose a descriptive model based on the findings. This qualitative study was conducted in 2022 using a grounded theory approach in hospitals affiliated with the Shahrekord University of Medical Sciences. The approach was deemed appropriate, considering moral courage is inherently a process. The research question focuses on understanding the process of moral courage in clinical nurses—an area that has received limited attention in the Iranian healthcare system.

Researcher Characteristics and Reflexivity

Participants were chosen in such a way as to ensure maximum diversity in age, gender, educational background, work unit type, and service years. In order to achieve maximum diversity, participants of both genders were selected from a wide range of ages and levels of education. It was also attempted to include nurses with various years of work experience from different work environments and departments of the hospital.

Context and Sampling Strategy

Clinical nurses were selected purposefully based on the inclusion criteria, which was willingness to

participate and share experiences, a minimum of one year of clinical work, and holding at least a bachelor's degree in nursing. Given that no data were available at first, the sampling began purposefully. After the analysis of the initial interviews, the sampling continued in line with the analysis until theoretical saturation. The clinical experience and the presence of researchers in the clinical environment made it possible to select nurses who were known for exhibiting ethical courage or the courage to deal with ethical problems in the hospital setting. Purposeful sampling began by identifying nurses who met the inclusion criteria and consented to participate in the study. To select more participants, both the researchers' self-knowledge and the introduction of other participants (snowball sampling) were used. Analysis of the interviews guided the study process as well as the choice of participants in order to achieve data and theoretical saturation.

Ethical Issues Pertaining to Human Subjects

This research project was approved by the Ethics Committee of Shahrekord University of Medical Sciences under the ethical code (IR.SKUMS.REC.1401.053). Written informed consent was obtained from participants to begin the study and audio recording. The ethical principles of confidentiality, privacy, and freedom to enter and exit the study were emphasized.

Data collection

Data were collected through in-depth, face-to-face, semi-structured individual interviews. The time and location of the interviews were determined based on the participants' preferences and consent. The interviews were semi-structured, in-depth and individual, and lasted from 35 to 50 minutes, with an average duration of 42 minutes. They were conducted according to the participants' convenience and in the clinical environment, but sometimes phone calls were made to ask additional questions. Each interview began with warm-up questions such as: "Please tell us about your work day," and then the target questions were asked as open-ended questions: "What is your perspective on the process of moral courage?" or "Could you share your experiences of making courageous decisions in ethical situations?" As the interviews progressed, more specific questions were asked to achieve the research objectives. Based on the participants' responses, explanatory and probing questions were posed, for example: "Could you elaborate further?" or "What do you mean by this point you mentioned?" In the course of the study, the interviews were guided by the emerging theory, with the researcher tailoring questions to reflect the

prominent and significant categories that had been identified.

Data Collection Instruments

A total of 21 interviews were conducted, beginning in September 2024 and lasting for 6 months. At the end of 17 interviews, data saturation occurred, with no new data or categories being obtained. The 18th interview was conducted to complete the theory, which is when theoretical saturation was reached, but to ensure data saturation, the interviews continued until 21. Memoing was employed throughout the interpretation and coding process to facilitate the formation of categories and theory development. All interviews were recorded using a digital audio recorder. Data management was supported by MAXQDA software (version 11).

Units of Study

Twenty-one nurses from different places of service were included in the study and interviewed. The participants' ages ranged from 25 to 52 years, and seven were male. In terms of educational qualifications, 13 had a bachelor's degree, 5 a master's, and the rest had Ph.D.'s, and their work experience ranged from 1 to 32 years. The demographic characteristics of the participants are presented in Table 1.

Table 1. Characteristics of study participants

Characteristics		N
Age (years)	25-33	6
	34-42	7
	43-52	8
Gender	Male	7
	Female	14
Education Level	Bachelor's degree	13
	Masters degree	5
	Ph.D	3
Place of Service	Medical	3
	Surgical	4
	Operating Room	1
	Children	1
	Urban Health Service Centers	2
	Faculty of Nursing	2
	Gynecology and Obstetrics	3
	Emergency	3
	Pre-Hospital Emergency	2
Work Experience (years)	1-10	6
	11-21	10
	22-32	5

Data Processing

In the process of the study, first the interview text was read several times and the coding was done. The initial codes were classified and the subcategories were formed based on semantic similarities and differences. Next, the subcategories were revised considering similarities, merging and the categories. After categorization and data saturation, the interview text was examined in order to extract the main concern. In the next stage, the context that caused the main concern was extracted and formulated as the relationship statement. After that, the study process was extracted, the core variable was identified, and the relationship statement between the context-concern-process were formulated. Different aspects of the process, such as intervening factors and consequences, were also investigated. Finally, the study implementation was organized around the core variable and a theory was formed. The coding process is presented in Table 2 and the data analysis appears in Figure 1.

Table 2. The coding process

Category	Subcategories	Initial Codes	Quotations
Professional assertiveness	Courage in facing challenging situations	Feeling empowered to overcome problems that have arisen	On numerous occasions, challenges have emerged in densely populated environments. In each instance, I have successfully navigated these complexities, leveraging my capacity for effective situational management.
		Not being afraid to express opinions in challenging situations	A critical issue arose involving my colleague, resulting in undue censure directed toward him. Notwithstanding the prevailing sentiment of culpability, I advocated for his defense and articulated a counter-narrative
	Innovation and ability to change	Ability to accept new conditions	Upon appointment of the new head nurse, a series of new demands were introduced. I demonstrated a considerable aptitude for adapting to these emergent conditions with notable celerity.
		A sense of constant forward movement	I tend to avoid monotonous environments and consistently seek out new opportunities and experiences.

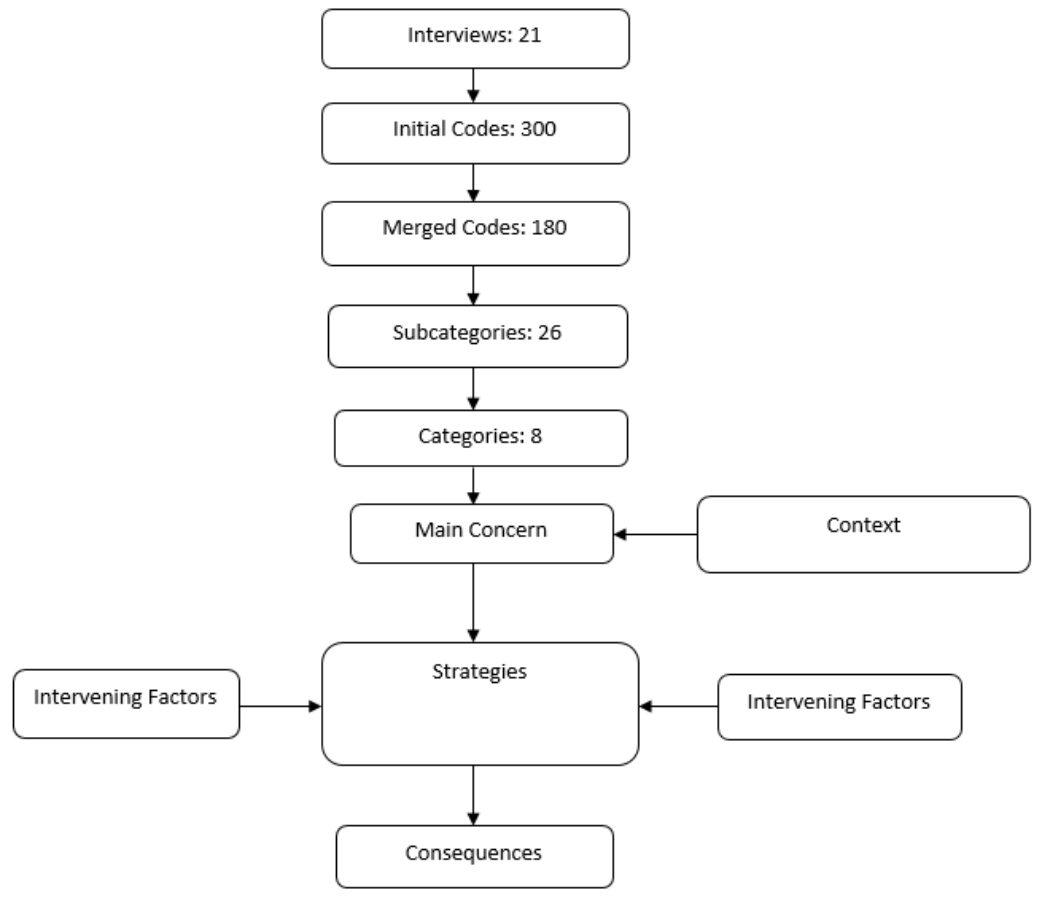

Figure 1. The data analysis process

Data Analysis

Data analysis was conducted concurrently with data collection and followed Corbin and Strauss's 2015 approach (20), which involved:

1) Open coding: Identifying the concepts
2) Developing the concepts according to their properties and dimensions
3) Analyzing the data for context
4) Bringing the process into the analysis
5) Integrating the categories

Techniques to Enhance Trustworthiness

Lincoln and Guba's criteria were applied to assess the accuracy and scientific credibility of the findings (21). The researcher engaged deeply with the research topic and data for an extended period. The interview transcripts and the resulting open codes were shared with the study participants, and the consistency of the extracted ideas was examined in the light of their feedback. The participants' suggestions were then incorporated into the analysis. The full transcripts of the interviews, along with the corresponding codes, concepts, and emerging categories, were sent to

reviewers and colleagues for examination and critique of the coding and analysis process. Throughout the study, the emerging codes, concepts, and categories were repeatedly sent to experts familiar with qualitative research for feedback, and the materials were revised based on their input. Additionally, maximum diversity in sampling was considered, as mentioned above. The study aimed to present all stages of data collection, coding, analysis, and presentation of findings precisely and thoroughly. All phases of the research were documented, copied, and analyzed, ensuring that the research process was auditable and traceable.

Results

Twenty-one face-to-face interviews were held with 21 participants. The results are presented according to the stages outlined by Corbin and Strauss:

1 and 2) Open Coding and Developing the Concepts according to Their Properties and Dimensions):

Analysis of the raw data generated 300 open codes. After merging repeated items, 180 codes were incorporated into the analysis. Classification of these open codes led to 35 subcategories, ultimately organized into nine categories (Table 3).

Table 3. *Categories and subcategories derived from the interviews with participants*

Categories	Subcategories
Spirituality	Spiritual commitment
	Faith in divine supervision
	Adherence to religious instructions
Legality	Respect for rules, regulations, and administrative systems
	Professional responsibility
	Organizational responsibility
Moral excellence	Growth and honor
	Professional pride
	Professional commitment
Self-sacrifice	Sacrifice for others
	Selflessness
	Working without expectations
Ethical commitment	Honesty
	Integrity
	Conscience-based action
	Human dignity
	Respect for values
	Advocacy for rights and justice
Professional assertiveness	Courage in facing challenging situations
	Innovation and ability to change

	Acceptance of responsibility for reforms in professional procedures
	Having a questioning attitude
Professional requirements as barriers	Unquestioning obedience to superiors
	Focusing on fulfilling patient needs in any condition, even if doing so causes harm to staff
	delegating tasks against job descriptions
	Professional commitment as a factor for exploitation of staff
Misalignment between authority and responsibility	Having insufficient professional power despite multiple responsibilities
	Conflict in managing system expectations from nurses
	Inability to make decisions proportionate to power and lack of independence
	Fear of ethical decision-making due to conflict with system interests
	Conflict in fair decision-making between patients and management
Managing system expectations	Inner satisfaction despite existing barriers
	Attention to job descriptions to prevent harm to oneself
	Balancing system demands and their implementation
	Self-Care in performing work

Main Concern: Ambiguity in ethical decision-making

At the end of this phase, the main concern emerged. The most significant issue for clinical nurses was the ambiguity in ethical decision-making. Nurses reported experiencing uncertainty about what decision to make in certain situations.

One nurse shared his experience of this ambiguity as follows:

"I had a patient who was on dialysis and had a malfunctioning fistula. When I informed the patient and the doctor, no one took action.... On one hand, the patient needed dialysis, but on the other hand, it was risky. I didn't know what to do." [Participant No. 3]

3) Analyzing the Data for Context

The results in this phase revealed that the misalignment between authority and responsibility provides the context that creates ambiguity in ethical decision-making. Nurses reported that while they held responsibilities as healthcare providers, they often lacked the authority to act accordingly or were compelled to perform actions contrary to their responsibilities. In such situations, they experienced uncertainty about what decisions to make, and were not sure what would be in their

and the patient's best interest. In this regard, another nurse said:

"The emergency doctor told me to do a certain task. I told him, "This is not my duty." On one hand, it's not my responsibility, and on the other, the patient's life is at risk.... What should I do in a situation like this?" [Participant No. 10]

4) Bringing the Process into the Analysis

The results showed that nurses employ spirituality, legality, and self-sacrifice strategies in situations of ethical decision-making ambiguity. These strategies help nurses manage system expectations. Professional assertiveness and ethical commitment facilitate these strategies, while professional requirements may undermine or distort them.

A) Strategies for Moral Courage

As mentioned above, legality, spirituality, and self-sacrifice are strategies that help nurses manage the system's expectations in cases of ethical decision-making ambiguity. Legality ensures that nurses remain committed to their professional responsibilities under the law, thereby resolving the emerging ambiguities. The spirituality strategy emphasizes a commitment to God and religious principles, which prevents decision-making errors in morally ambiguous situations. Finally, self-sacrifice enables nurses to overcome ambiguities in such conditions through devotion and selflessness, thus allowing them to make ethical decisions.

Here is what one nurse said about his experience regarding the spiritualty strategy:

"A patient's companion insulted me in the ward. I didn't know what to do.... I wanted to respond, but I turned to God and continued caring for the patient... Later, I realized that I had made the right decision in that situation." [Participant No. 14]

Another nurse shared her experience of employing the legal strategy to resolve a case of ethical decision-making ambiguity:

"We had a doctor here who sometimes made unnecessary prescriptions for patients. When I confronted him, he insulted me... I didn't argue and reported the matter to the hospital management and security... and they gave him a warning." [Participant No. 1]

B) Intervening Factors (Professional Assertiveness and Ethical Commitment/Professional Requirements)

Professional courage and ethical commitment are two characteristics that facilitate the strategies used by nurses in morally ambiguous situations. A courageous spirit and personality help nurses navigate difficult situations and challenge existing conditions, ultimately aiding the decision-making process in such circumstances. On the other hand,

professional requirements and organizational constraints, such as expectation of blind obedience and the obligation to perform duties regardless of the circumstances, can disrupt nurses' ethical decision-making strategies.

One nurse stated:

"The head nurse told me that the doctor hadn't arrived, so I had to use a Sheldon for the patient. I refused, saying it wasn't my responsibility. At first, I was threatened, but then they admitted I was right, saying we'd be blamed if something went wrong." [Participant No. 11]

Another nurse told us about a similar experience:

"A patient needed stitches, and the doctor asked us to write that we had used an expensive thread, even though we hadn't. I reported this to the head nurse, who told me it didn't concern us and just to add it. This kind of blind obedience removes our independence in making ethical decisions." [Participant No. 2]

C) Consequences

When faced with ambiguity in ethical decision-making, nurses employ strategies that allow them to manage the system's expectations. This does not necessarily resolve the ambiguities but can help the nurses address the existing uncertainties and may even prevent further issues.

A nurse stated:

"I was supposed to send someone else on duty, but because the head nurse had given them time off, I was told I had to go instead. At first, I protested according to the rules, and the supervisor told me I didn't have to go. But then I decided to go for the sake of the hospital and the patient. I thought, if I can help, I will, even though I didn't approve of the head nurse's wrong decision." [Participant No. 18]

5) Integrating the Categories

Identifying the Core Variable

Analysis of the interviews and findings revealed that in morally ambiguous situations, nurses' main concern was how to manage their uncertainty. In order to do so, they used legality, spirituality, and self-sacrifice to balance system expectations. A deeper examination indicated that nurses used these approaches to make the best ethical decision possible. In other words, applying legality, spirituality, and self-sacrifice is aimed at moral excellence in decision-making, allowing nurses to make the best decision under the circumstances and manage the system's expectations. Consequently, moral excellence is placed above these strategies and is considered the core variable.

One nurse stated:

"To avoid criticism, the head nurse tried to put a staff member's blame on a newly hired nurse, and even convinced the doctor to go along with it. At

first, I remained silent, but then I realized I couldn't let that injustice happen. I pulled the doctor aside and explained the situation. This eventually led to the head nurse being replaced. In that moment, I acted according to my conscience." [Participant No. 19]

Given that the concept of moral excellence is positioned above each of these strategies, the storyline can be outlined as follows:

When faced with a misalignment between authority and responsibility, nurses experience ambiguity in ethical decision-making. In these situations, they rely on three strategies—legality, spirituality, and self-sacrifice—to resolve the ambiguity. These strategies are facilitated by professional assertiveness and ethical commitment but hindered by professional requirements. Ultimately, these strategies lead to managing the system's expectations.

Considering the position of each strategy relative to the concept of moral excellence in decision-making and the way they interact with one another, moral excellence in decision-making was selected as the core variable, with other variables aligning around it. The components of the model are shown in Figure 2.

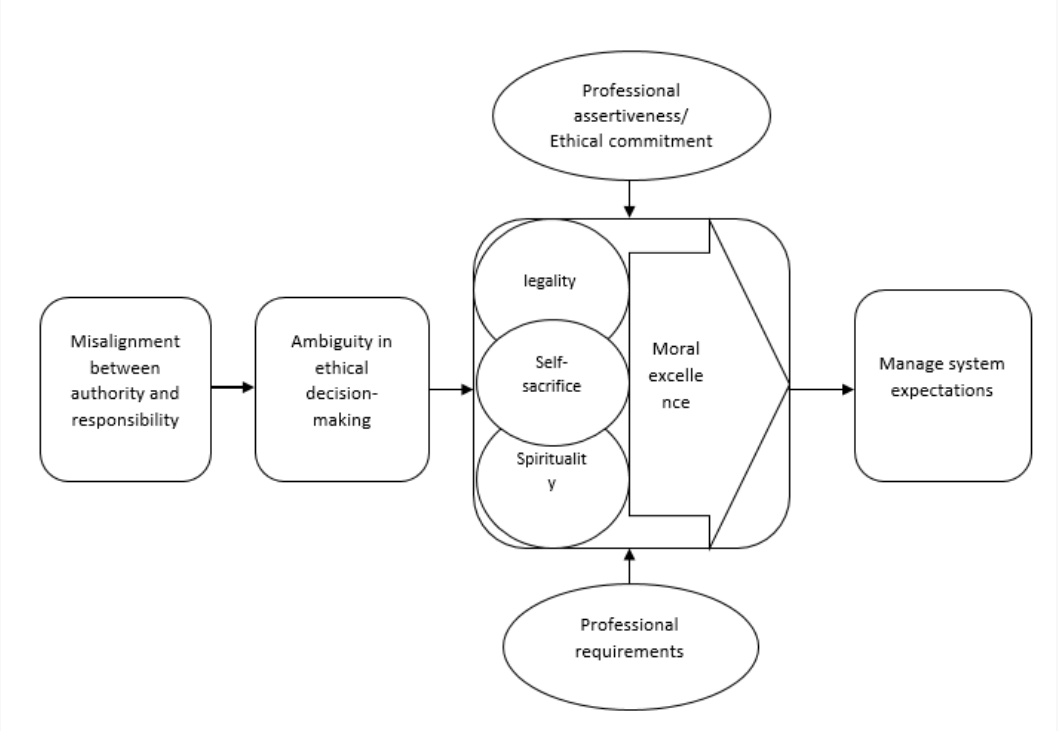

Figure 2. The process of moral courage in clinical nurses

Discussion

The present study aimed to explicate the process of moral courage in clinical nurses and present a descriptive model.

Hannah et al. developed a subjective experience model of courage that proposes three concepts: followers (moral courage), environment-leader-ethics, and prosocial behavior. The study indicated that organizational leaders can influence the ethical behavior of individuals in the environment. This environment, in turn, can directly impact the moral courage of followers, and moral courage can then affect the ethical conditions of leaders themselves (22).

In analyzing this study, it should be noted that their model emphasizes the ethical relationship between leaders and followers, and states that managers can create an environment conducive to moral courage by focusing on the work atmosphere. In contrast, in our model, legal requirements and systems are only considered intervening factors in moral courage. Moreover, Hannah et al.'s model highlights fear as a motivating variable for courage, while in our study, ambiguity in decision-making is identified as the critical challenge to the moral courage process, which presents a different conceptualization of the issue.

Schilpzand et al. investigated workplace courage and proposed a two-dimensional model. They suggest that employees engage in courageous actions when facing workplace challenges such as errors or power abuses. This process involves two stages: first, assessing personal responsibility, and second, evaluating the potential social costs (23).

There are similarities between this model and the model in our study, for instance they both highlight organizational factors and challenges as the starting point for the process. However, the processes and strategies in the two models differ. Schilpzand's model presents a general framework for courage with a strong emphasis on the cognitive dimension. In contrast, our model focuses more on ethical considerations, framing courage within a moral decision-making context.

White proposed a conceptual model of moral courage for leaders in Myanmar's human rights-focused civil society organizations. The study revealed that moral motivation relates to moral courage, mediated by political, social, and psychological factors through active knowledge processes. Findings suggest that moral courage can

drive political and social change, and by emphasizing ethical principles and acknowledging potential challenges, leaders can be supported in their missions and contributions to civil society development (24).

The model presented by White differs from ours in terms of process, but contains certain similar concepts. In both models, recognizing injustice can serve as the starting point for the moral courage process. The moral principles discussed in White's model, for example commitment and the application of the ethical tenets, share commonalities with the concepts in our model.

In the study by Sekerka and Comer, a model was presented in which employees with moral courage facilitated ethical actions. This model emphasizes organizational and managerial perceptual responses as factors influencing moral courage (25). Analysis of the results showed that this model focuses more on individual characteristics such as perseverance, planning, and ethical effectiveness as critical factors influencing moral courage. In contrast, our model identifies personal and organizational factors as intervening elements.

Mohammad Zaheri et al. investigated the link between toxic management and organizational silence, mediated by moral courage among employees in public universities in Hamedan. Their findings indicate that negative managerial traits, including autocratic leadership and narcissism, diminish moral courage, thereby increasing organizational silence. The study defines moral courage as a moral agency involving capacity, diverse values, threat tolerance, and ethical objectives (26).

It should be noted that in Mohammad Zaheri's study, several factors, including the negative traits of ineffective managers, contribute to fostering silence in employees and organizations, acting as deterrents to moral courage. Conceptually, this is in line with the findings of our study, where various organizational obstacles make the moral courage process more ambiguous. In both models, individuals use similar strategies, navigating toward moral courage despite the challenges posed by these barriers.

Alvandi and Mohammad Zaheri validated a model of moral courage in Iranian public sector managers, indicating that individual, organizational, professional, and managerial factors, influenced by environmental elements, affect moral courage. The model posits moral courage as a behavioral competency enabling managers to act on their beliefs despite threats and pressures (27).

It can be concluded that although Alvandi's model is quantitative, the variables presented in both

models are similar. Organizational factors contribute to the ambiguity in ethical decision-making among managers, who act based on inner characteristics such as self-sacrifice and legality in practicing moral courage. Professional and organizational factors can either facilitate or hinder strategies for applying moral courage in dealing with such situations.

In the study by Paknejad et al., the design and development of a model for fostering moral courage in employees of the Islamic Republic of Iran Railways were explored. The results indicated that individual, environmental, professional, managerial, and organizational dimensions significantly contribute to developing moral courage among employees (28). Factors such as spiritual strength and trust in God were highlighted in the individual dimension, which is aligned with our study's spirituality-based strategy. Work and legal requirements were also emphasized in the professional dimension, corresponding to our model's legality-based strategy.

Chowkase et al., proposed a process-based model of courage, conceptualizing it as a deliberate process initiated by a trigger involving both individuals and situations. The decision to act courageously hinges on alignment with key elements including intention, consultation, risk management, noble intention, and contextual impact, leading to consequences that shape individual experiences and complete a feedback loop (29).

The results of this model do not directly support our model. However, one of the elements of courage in their model might align with the self-sacrifice strategy identified in our research.

Analysis of this model highlights that clinical nurses experience a lack of independence and coordination stemming from resource limitations and inadequate macro-management policies. Health systems often place expectations on nurses that exceed their job descriptions, creating a conflict between their responsibilities and the need to comply with the system. Consequently, nurses tend to manage these expectations through selflessness and sacrifice. A significant limitation of this model is its failure to address the role of individual factors in the development of moral courage. Furthermore, while the study guidelines emphasize legality, nurses often face challenges due to the discrepancy between legal job descriptions and their actual clinical practice. Legality without flexibility can prevent nurses from respecting patient rights. Ultimately, this model cautiously outlines the process of moral courage, presenting a moderate corrective

approach focused on managing existing conditions rather than resolving underlying issues.

One limitation of this study is that the results of qualitative studies cannot be generalized and there is a need to conduct further research in other parts of the country. Another limitation is due to the fact that nurses may avoid expressing their negative experiences in the field of ethics. Therefore, in this study, the interviews were conducted in an impartial and indirect manner so that the nurses could freely express their moral experiences.

Conclusion

The present study aimed to explore the process of moral courage in clinical nurses and propose a descriptive model. In terms of the practical application of the results, it is recommended that healthcare organizations address the underlying conditions that cause ambiguity in nurses' decision-making. In this regard, there is a need to develop ethical decision-making guidelines for many clinical and care situations. Moral standards must be clearly defined in various conditions, and managers and system leaders should design appropriate execution strategies. Also, nurses' professional expectations should align with their responsibilities. While job descriptions are generally defined in clinical team workflows, individuals often have a tendency to overlook this in practice. Regarding professional requirements as a barrier, it should be emphasized that nurses' professional autonomy should be promoted so they are not compelled to follow their superiors without question. Educating nurses about harmful situations during care can reduce the risk of harm and protect them. Finally, it should be noted that the process of courage in this model moves toward managing the system's expectations, which is a type of deviation mechanism, and due to inadequate organizational infrastructure and conditions, achieving positive outcomes is not always possible. Furthermore, senior managers should develop comprehensive plans to enhance the nursing student curriculum with special emphasis on ethical principles. Ethical instruction should prioritize operational solutions applicable to diverse scenarios. Articulating executive protocols for ethical decision-making in various contexts and devising strategies to improve the ethical decision-making process and operationalize ethical decisions requiring moral courage can mitigate numerous ethical challenges.

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Authors' Contributions

SD: Conceptualization. MR: Investigation, data analysis, and writing the original draft. SS: Writing the review, editing, and supervision. SM: Investigation and data analysis.

Conflict of Interests

The authors declare no conflict of interests.

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