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# Moral Distress and Moral Courage among Nurses Working in Selected Oncology Wards, BMTU and OPD

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**Abstract:** ***Background: Nurses working in Oncology settings frequently encounter ethically challenging situations that may lead to moral distress. Moral courage enables Nurses to act in accordance with ethical principles despite potential adverse consequences. Understanding the relationship between moral distress and moral courage is essential for improving ethical Nursing practice. Objectives: To assess moral distress, moral courage, to correlate moral distress and moral courage and to determine the association of moral distress and moral courage with selected demographic variables among Oncology Nurses. Methods: A descriptive study was conducted among 82 Nurses working in selected Oncology wards, Bone Marrow Transplant Unit, and Haematology OPD of a tertiary care hospital in South India. Moral distress was assessed using the Moral Distress Scale–Revised (MDS-R) and moral courage was measured using the Nurses' Moral Courage Scale (NMCS). Data were analysed using descriptive statistics, Spearman's rank correlation, and Chi-square tests. Results: The mean moral distress score was 41.94 ± 13.31, indicating a moderate level of moral distress. The mean moral courage score was 86.80 ± 10.56, indicating a high level of moral courage. Spearman's rank correlation showed a weak positive correlation between moral distress and moral courage, which was not statistically significant (ρ = 0.091, p = 0.417). Selected demographic variables showed varying associations with moral distress and moral courage. Conclusion: Nurses experienced moderate moral distress despite demonstrating high moral courage. Moral distress and moral courage were found to be independent constructs, highlighting the need for organizational strategies to support ethical Nursing practice.***

**Keywords:** Moral distress, Moral courage, Oncology Nurses, Ethics, Nursing

## 1. Introduction

Oncology Nurses care for patients with cancers, critically and terminally ill and often end up providing end-of-life care. Palliative care and caring for death and dying are part of their professional life. Many a times, such patients create a deep emotional impact in Nurses. Ethical challenges are inherent in Nursing practice. Oncology Nurses go through an experience of not able to help the patients, feel constrained and powerless, especially when life support is continued even when it may not be in the best interests of the patient, unable to communicate to the patients and family about prognosis and end-of-life care when patients ask Nurses' opinion on this regard, loss of motivation to provide comprehensive care when a patient is terminally ill, inappropriate use of health care resources, considering non-escalation of treatment as abstaining from the treatment, value conflict, etc. Such circumstances risk the Nurses to develop Moral distress unless they have sound Moral courage. Persistent moral distress has been associated with burnout, emotional exhaustion, job dissatisfaction, and attrition from the Nursing profession. Acknowledging and addressing moral distress is essential to preserve Moral integrity as it threatens our core values (AACN, 2021).

Moral courage refers to the willingness and ability to act according to ethical values despite fear of negative consequences. Moral courage is inversely proportional to Moral distress. Moral courage is explained by Savel and Munro in their article (*Am J Crit Care*, July, 2015) as *"feeling fear and acting anyway"*. It enables Nurses to advocate for patients, voice ethical concerns and uphold professional integrity. It encourages the Nurse to follow right course of action in times of ethical dilemma.

While moral courage is considered a protective attribute, its relationship with moral distress remains unclear. In the Indian context, limited empirical evidence exists examining both moral distress and moral courage among Oncology Nurses. Therefore, this study aimed to assess moral distress, moral courage, and their relationship among Nurses working in Oncology settings.

## 2. Review of Literature

### *Moral Distress among Nurses*

Moral distress has been widely documented among Nurses across various clinical settings. Hamric et al. (2012) identified moral distress as a response to ethical constraints that prevent Nurses from acting in accordance with their moral judgment. Studies conducted in Oncology and critical care settings have reported moderate to high levels of moral distress related to futile treatment, inadequate communication, and hierarchical decision-making. Indian studies have similarly reported moral distress among Nurses, particularly in relation to end-of-life care, family demands and physician dominance.

Ranjan et al. (2015) studied moral distress among Indian ICU Nurses and found moderate to high moral distress related to end-of-life care, inadequate staffing, and hierarchical decision-making, emphasizing the need for ethical support systems in Indian hospitals.

Baliga et.al. (2019) reported that Indian Nurses often experience moral distress due to conflicts between

professional judgment and family or physician demands, particularly in Oncology and critical care settings.

Oh & Gastmans (2015, South Korea) highlighted that Nurses experience moral distress when organizational culture limits ethical agency, despite strong moral commitment.

***Moral Courage in Nursing***

Moral courage is considered a core ethical virtue in Nursing. Numminen et al. (2019) reported that Nurses generally demonstrate high moral courage, especially in areas related to compassion, moral responsibilit, and integrity. Asian studies have emphasized that moral courage is strongly influenced by ethical climate, leadership support, and organizational culture rather than individual characteristics alone.

***Relationship between Moral Distress and Moral Courage***

The relationship between moral distress and moral courage is complex. Some studies suggest that moral courage may mitigate moral distress, while others report that organizational barriers limit the ability of morally courageous Nurses to act, resulting in persistent moral distress. These findings suggest that moral distress and moral courage may coexist as distinct constructs.

## 3. Methodology

The study was conducted using descriptive research design and in selected Oncology wards, Bone Marrow Transplant Unit and Haematology Outpatient Department of a tertiary care hospital in South India. A total of 82 Nurses who met the inclusion criteria were recruited using an enumerative sampling technique. Moral distress was assessed using the Moral Distress Scale–Revised (MDS-R) and moral courage was measured with the Nurses' Moral Courage Scale (NMCS). After obtaining ethical clearance and informed consent from participants, data were collected through self-administered questionnaires. Data analysis was performed using SPSS software. Descriptive statistics were used to summarize levels of moral distress and moral courage, Spearman's rank correlation coefficient was used to examine the relationship between the two variables. Associations between moral distress, moral courage, and selected demographic variables were analysed using the chi-square test. Statistical significance was determined at a p value of $< 0.05$.

## 4. Results

A total of 82 Nurses participated in the study. With regard to age, the majority of participants were in the 36–45 years age group (37.8%), followed by >45 years (32.9%) and 25–35 years (26.8%), while only 2.4% were below 25 years of age. The sample was predominantly female (98.8%), with only 1.2% male participants. In terms of educational qualification, 75.6% were GNM-qualified Nurses, and 24.4% held a BSN degree. More than half of the participants were married (57.3%), while 42.7% were unmarried. Regarding Nursing experience, 39% had more than five years of experience, whereas 25.6% had 1–3 years of experience. In Oncology Nursing, 31.7% had more than ten years of experience. Most Nurses (67.1%) reported encountering 1–3 patient deaths per week, and 97.6% reported no close relative with cancer or receiving cancer treatment.

The mean moral distress score was 41.94 ± 13.31, indicating a low to moderate level of moral distress. The mean moral courage score was 86.80 ± 10.56, indicating a high level of moral courage.

Spearman's rank correlation analysis revealed a weak positive correlation between moral distress and moral courage ($\rho = 0.091$), which was not statistically significant ($p = 0.417$). This indicates that moral distress and moral courage were largely independent of each other.

The results also revealed that moral distress is significantly associated with age (p=.009)**,** suggesting that different age groups may experience moral distress differently. Other demographic variables showed no significant association. Moral courage, however, was not significantly associated with any demographic variable, indicating that moral courage is likely independent of age, experience, or death handling.

**Table 1:** Distribution of demographic variables, n=82

| Variable | Category | Frequency | Percentage |
|---|---|---|---|
| Age (Yr.) | <25 | 2 | 2.4 |
| | 25-35 | 22 | 26.8 |
| | 36-45 | 31 | 37.8 |
| | >45 | 27 | 32.9 |
| Gender | Female | 81 | 98.8 |
| | Male | 1 | 1.2 |
| Qualification | BSc. (N) | 20 | 24.4 |
| | GNM | 62 | 75.6 |
| Marital status | Married | 47 | 57.3 |
| | Unmarried | 35 | 42.7 |
| Experience in Nursing | <1yr | 4 | 4.9 |
| | 1-3yr | 21 | 25.6 |
| | 3.1-5yr | 8 | 9.8 |
| | 5.1-10yr | 17 | 20.7 |
| | >5yr | 32 | 39.0 |
| Experience in Oncology Unit | <1yr | 18 | 22.0 |
| | 1-3yr | 15 | 18.3 |
| | 3.1-5yr | 8 | 9.8 |
| | 5.1-10yr | 15 | 18.3 |
| | >10yr | 26 | 31.7 |
| Deaths per week | Nil | 23 | 28.0 |
| | 1-3 | 55 | 67.1 |
| | >3 | 4 | 4.9 |
| Close Relative with cancer or receiving cancer treatment | No | 80 | 97.6 |
| | Yes | 2 | 2.4 |

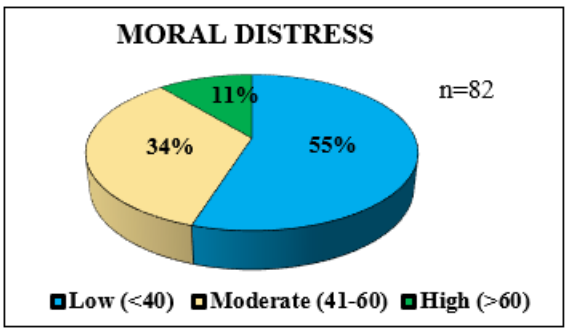


**Figure 1:** Moral distress level among Oncology Nurses

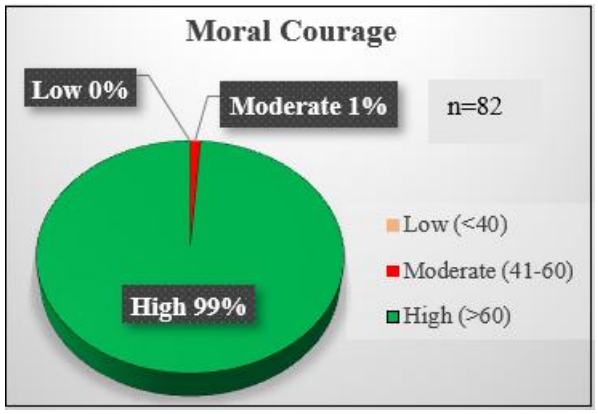


**Figure 1:** Moral courage level among Oncology Nurses

## 5. Discussion

The findings of the present study indicate that nurses working in oncology settings experience low to moderate levels of moral distress. This finding is consistent with the study conducted by Zare-Kaseb et al. (2025), which reported moderate moral distress among oncology nurses in Iran, highlighting that ethical challenges are prevalent in oncology settings and that nurses routinely encounter morally distressing situations. Furthermore, the study by Amin et al. (2025) revealed that moral distress is a significant psychological barrier that weakens the positive impact of patient-centred communication on oncology nurses' ability to deliver competent palliative care. This finding supports the results of the current study, which suggest that ethical challenges related to end-of-life care, communication barriers, and organizational constraints may contribute to moral distress among nurses.

The present study also revealed that, despite experiencing moral distress, nurses demonstrated high levels of moral courage, suggesting a strong ethical commitment and professional integrity. This finding is mirrored in the study by Yildirim et al. (2025), which reported that palliative care nurses exhibit high levels of moral courage, associated with ethical adherence even when facing challenging, complex, and emotionally taxing care situations. However, the absence of a significant relationship between moral distress and moral courage in the current study indicates that moral courage alone may not be sufficient to reduce moral distress. This finding is consistent with the conclusions of Rushton et al. (2017), who emphasized that interventions focused solely on enhancing individual moral resilience or moral courage are insufficient to mitigate moral distress. Their study further suggests that effective reduction of moral distress requires comprehensive system-level interventions, in addition to fostering individual moral courage.

## 6. Conclusion

The study concludes that Oncology Nurses experience low to moderate moral distress and high moral courage. Moral distress and moral courage were not significantly correlated, suggesting that organizational and structural factors play a critical role in shaping ethical Nursing practice.

## 7. Limitations

The study was limited to a single tertiary care hospital, which may limit generalizability. The use of self-reported measures may have response bias.

## 8. Recommendations

Future studies should include larger, multi-centre samples and explore organizational strategies to reduce moral distress. Nursing administrators should promote and provide supportive ethical practice and decision making.

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