Psychometric Evaluation of the Professional Moral Courage (PMC) Scale in a Nurse Executive Population

Joanne Connor
This research was completed as part of the degree requirements for the Nursing Department at Molloy College.

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Molloy College

The Division of Nursing

PhD in Nursing Program

Psychometric Evaluation of the Professional Moral Courage (PMC) Scale in a Nurse Executive Population

a dissertation

by

JOANNE CONNOR

Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy

November 29, 2017
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The dissertation of JOANNE CONNOR
Entitled Psychometric Evaluation of the Professional Moral Courage (PMC) Scale in a Nurse Executive Population
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

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ABSTRACT

Statement of the Problem

The nurse executive must navigate a health care environment with competing priorities and conflicting pressures. The rapid changes and economic demands in healthcare present challenges and ethical dilemmas for the nurse executive. The nurse executive is to be professionally and morally responsible to meet the expectation of the role in accordance with ethical standards of the nursing profession. Professional moral courage is the attribute necessary to influence decisions and actions when advocating for the nurse and the patient, while benefiting the organization. Subsequently, the ability to accurately assess this characteristic is an imperative. The Professional Moral Courage (PMC) scale is a tool designed to measure the construct of moral courage as a managerial competency. The purpose of this study was to validate the PMC scale for use in the nurse executive population.

Method

This was a non-experimental methodological study. The sample consisted of 478 nurse executives. The participants all: (a) held a title of Chief Nursing Officer (CNO) or Chief Nurse Executive (CNE); (b) were employed in a healthcare organization; and (c) were members of the American Organization of Nurse Executives (AONE). The psychometric validation of the PMC scale included evaluating reliability, convergent validity, hypothesis testing, and factor analysis. The three instruments used in this study were: (1) the Professional Moral Courage (PMC) scale, to assess and quantify the
construct of moral courage in the nurse executive population; (2) the Values in Action-Inventory of Strengths (VIA-IS) scale, specifically the bravery items, to determine if the character strength of bravery is convergent with professional moral courage; and (3) the Marlowe-Crowne Social Desirability scale, to evaluate the potential influence of social desirability on PMC scale responses.

Results

The psychometric analyses supported the validity and reliability of the PMC scale in the nurse executive population. Correlational analysis for convergent validity concluded convergence between the PMC and VIA-IS bravery items. The hypothesis that the more years of experience working as a nurse executive, the higher the level of moral courage, was supported. Confirmatory factor analysis findings suggest the internal structure of the PMC scale and measurement of the underlying construct, professional moral courage, is acceptable. The model is an acceptable fit for the data and the PMC scores were not influenced by socially desirable responses.

Conclusion

The Professional Moral Courage scale was psychometrically validated within the nurse executive population and this study strengthened the construct of professional moral courage as a recognized competency.
Dedication

This dissertation is dedicated to my husband, Rich, who had been extremely supportive of me through my professional and doctoral journey. His countless sacrifices, unconditional love, and unwavering patience have given me the strength to persevere and reach this goal. Thank you for always being there for me.

To my son, Richard, who encouraged and cheered me on, and has been a huge source of motivation for me. Thank you for being a wonderful son and for making me proud every day.
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Table of Contents

ABSTRACT ...................................................................................................................... i
DEDICATION .................................................................................................................. iii
ACKNOWLEDGEMENT ................................................................................................. iv
TABLE OF CONTENTS ............................................................................................... v
LIST OF TABLES .......................................................................................................... viii
LIST OF FIGURES ........................................................................................................ ix
CHAPTER 1 INTRODUCTION ..................................................................................... 1
  Statement of the Problem ............................................................................................. 2
  Purpose and Research Question ................................................................................. 9
  Significance of the Study ........................................................................................... 11
  Summary .................................................................................................................... 12
CHAPTER 2 LITERATURE REVIEW .......................................................................... 13
  Nurse Executive Role ................................................................................................ 14
  Ethics in Nursing Leadership ..................................................................................... 16
  Education .................................................................................................................. 20
  Experience ............................................................................................................... 23
  Courage ..................................................................................................................... 25
  Moral Courage ......................................................................................................... 26
  Professional Moral Courage ...................................................................................... 28
  Professional Moral Courage in Nursing ................................................................. 31
Measurement of Moral Courage......................................................... 33
Summary............................................................................................. 35

CHAPTER 3 METHODS........................................................................... 37
Participants.......................................................................................... 37
Sample.................................................................................................. 37
Instruments........................................................................................... 38
Human Subject Protection...................................................................... 45
Data Collection Procedures................................................................... 45
Research Design................................................................................... 47
Data Analysis Procedure....................................................................... 50
Summary............................................................................................... 50

CHAPTER 4 FINDINGS.............................................................................. 51
Sample .................................................................................................. 51
Reliability............................................................................................... 57
Convergent Validity................................................................................ 59
Hypothesis Testing................................................................................... 60
Factor Analysis......................................................................................... 61
Social Desirability................................................................................... 66
Summary............................................................................................... 67

CHAPTER 5 DISCUSSION and RECOMMENDATIONS............................ 68
Study Summary...................................................................................... 68
Discussion.............................................................................................. 71
Limitations.............................................................................................. 76
Implications…………………………………………………………………… 76
Recommendations……………………………………………………………… 78
Conclusion……………………………………………………………………… 78
REFERENCES………………………………………………………………… 80
APPENDICES…………………………………………………………………… 88
A. Professional Moral Courage (PMC) Scale .......................... 88
B. Permission to use the Professional Moral Courage Scale ............ 90
C. VIA Survey Bravery Items .......................... 91
D. Permission to use the Bravery Subset of items ...................... 92
E. Marlowe-Crowne (M-C) Short Form .......................... 93
F. Permission to use the M-C Short Form .......................... 94
G. Institutional Review Board Human Subject Research Evaluation form .......................... 97
H. American Organization of Nurse Executive (AONE) Membership List .................. 98
Rental Agreement
I. AONE Membership Research Participation Agreement............... 100
AONE e-news and AONE Working for You (AWFY) newsletter
J. Survey Participant Cover Letter .................................. 101
K. Professional Moral Courage Questionnaire ........................ 102
List of Tables

Table 1 Sample Characteristics .................................................. 52
Table 2 Sample Experience and Education .................................... 53
Table 3 Organization Type/Bed Size, Number of Employees ............... 55
Table 4 Magnet® Designation Status ............................................ 56
Table 5 Region of the Organizations ............................................ 56
Table 6 Scale Statistics/Internal Consistency ................................. 58
Table 7 PMC Subscale Internal Consistency .................................. 59
Table 8 Correlation: PMC Scale and VIA IS Bravery Sub-scale ........... 60
Table 9 Hypothesis Testing/Correlation ....................................... 61
Table 10 PMC Scale: Standardized Factor Loadings ....................... 63
Table 11 PMC Scale: Confirmatory Factor Analysis ......................... 66
List of Figures

Figure 1 Hypothesized Model of the PMC scale........................................62
CHAPTER 1
INTRODUCTION

The health care industry is experiencing the effects of intense reformation within which change is occurring at a rapid pace. Health care organizations are facing lower reimbursement rates and steeper regulatory mandates. Patient acuity and complexity of care have increased, and there are higher expectations for the delivery of safe, high-quality care in an economically fragile environment. Health care reform has required organizational changes to decrease cost and increase value, thus creating a challenge for the nurse executive.

The nurse executive has an enormous amount of responsibility and accountability for how the organization delivers care and for maintaining the balance between quality and cost. Setting priorities and developing strategies to position the nursing department and the overall organization for effective growth is a necessity. The influence of a nurse executive depends upon competence, credibility, and trustworthiness (Edmonson, 2010). Leading a health care organization and redesigning the way it delivers care requires that the nurse executive must have the capacity to act courageously, especially during adversity and despite personal risk (Murray, 2010). In order to ethically fulfill the responsibility and professional obligation to the patient, nurse, and organization, moral courage is a necessary quality.

Frequent changes in the health care system can present challenges in resource allocation decisions that adversely affect the work environment of nurses (Edmonson, 2015). Healthcare is experiencing unprecedented reformation in health policy. As a
result, the health care organization faces increased regulatory requirements, pay for performance mandates, and decrease in reimbursement. The nurse executive must design a care delivery system that serves as a foundation and builds the infrastructure to support the goals of health care reform. However, it requires supporting the work environment in order to empower the nurse to effect positive change and enhance the quality and safety of patient care (LaSala & Bjarnason, 2010). Therefore, it is up to the nurse executive to advocate for appropriate budgets that address regulatory and quality/safety initiatives and evidence-based practice approaches despite competing values and priorities within the organization. This represents a moral challenge for the nurse executive. The nurse executive may face consequences which could include threats to status, career progression, or even employment stability. Moral courage, as well as the strength to persevere, are necessary to engage in the right action in accordance with ethical standards of the nursing profession (Sekerka, Bagozzi, & Charnigo, 2009).

**Statement of the Problem**

Elements of the economic environment in health care, such as pay for performance mandates, decreases in reimbursement, and market competition among health care organizations present challenges which confront health care leaders. Health care organizations need to deliver effective, efficient, and safe patient care, just as the health care industry has increased regulatory requirements and pursues health care reform. The realities of this reform make demands and impose economic conditions that, over the past several years, have forced health care facilities to close, restructure, and
merge. However, change is unavoidable; it is up to the health care leader to position the organization strategically for success.

The rapidly changing health care environment has caused instability and stress in nursing that has led to ethical dilemmas for the nurse executive. The dynamic changes have created an increase in moral and ethical challenges, as economic demands strongly influence management decisions (Sanford, 2006). The paradigm shifts, in the ways organizations deliver care under a different reimbursement structure, confront and test health care organizations and their leadership. To that point, a brief explanation of the reason for health care reform is in order.

The intent of the Patient Protection and Affordable Care Act of the United States is to transform the health care delivery system. The goal is to provide higher quality, safer, affordable, and more accessible health care (Berenson & Zuckerman, 2010). Under this act, the value-based purchasing (VBP) program analyzes organizations’ performance in clinical areas and the overall patient experience to determine payment amounts (Berenson & Zuckerman, 2010). The Institute of Medicine (IOM) report, To Err is Human: Building a Safer Health System (1999) also influenced the health care reform and quality improvement imperatives. This report stimulated unprecedented interest and action to improve quality and safety in health care. The report stated that between 44,000 and 98,000 patient deaths occur annually due to medical errors in hospitals and cost between $17 billion and $29 billion per year in hospitals nationwide (IOM, 1999).

The purpose of this report was to translate knowledge into practice and to focus on how to redesign the health system to foster innovation and improve the delivery of care. In moving toward this goal, the IOM had developed a comprehensive strategy and action plan using six outcomes: safe, efficient, effective, patient-centered, timely, and equitable care (IOM, 2001).

Health care reimbursement, which is driven by pay for performance, emphasizes health promotion and wellness, patient safety and outcomes, and patient satisfaction (Berenson & Zuckerman, 2010). The previous basis of the health care payment system was the maximization of services and volume that provided higher reimbursement, but did not necessarily deliver the most value. Historically, the health care organization has not faced financial penalties for care that resulted in adverse events or poor outcomes. The present system, resulting from health care reform, links care at the bedside to outcomes and this directly impacts the financial performance of an organization. Since the basis of the payment structure is incentives, certain initiatives must be present to maximize reimbursement, such as reducing patient readmissions, decreasing adverse hospital-acquired conditions, decreasing the length of stay, and enhancing the patient experience (Berenson & Zuckerman, 2010).

This reform creates an incredible challenge for the nurse executive while she or he navigates a nursing shortage and high patient acuity in a complex environment. The chief nursing officer is in a position of influence related to her/his scope of responsibility which incorporates every aspect of nursing practice within the health care organization. Therefore, the ability of a nurse executive to plan strategically and to focus on the
elements of the changing health care environment is an imperative; however, it becomes a daunting task in daily operational decision making. Moreover, some consider the nursing department a cost center and not a revenue-producing department for a health care organization, which creates an additional challenge (Sanford, 2011). To overcome this, the nurse executive must gain support from others on the executive team and be able to articulate nursing practices, care models, and resources for quality and value that equate to revenue (Sanford, 2011).

Nevertheless, to meet the expectation of creating a workforce that provides quality care to the patient in a cost-effective manner, the nurse executive must remain morally responsible to the professional nurse and patient by endorsing a broader viewpoint, i.e. ethical leadership (Burkhardt & Nathaniel, 2008). According to Brown, Trevino, and Harrison (2005), ethical leadership is defined as “the demonstration of normatively appropriate conduct through personal actions and interpersonal relationships, and the promotion of such conduct to followers through two-way communication, reinforcement, and decision-making” (p. 120). The ethical dimension of leadership encompasses behavior and influences decision-making. Therefore the presence of ethical leadership is essential in every decision and action taken across the organization. The nurse executive’s moral obligation is to make decisions and lead by example ensuring that the needs of the nurse and the patient are priorities. Nurse executives demonstrate commitment when their decisions and actions focus on the allocation of resources to enable the nurse to practice in an environment that ensures safe quality care for the patient.
The principles and values of the American Nurses Association (ANA) *Code of Ethics for Nurses with Interpretive Statements* (2015) guide nurse executives to support the standards of the nursing profession. The code has nine provisions, with corresponding interpretative statements, summarizing the moral duty and ethical obligations of a nurse in every role. The ANA Code of Ethics, under Provision 6, discusses the professional responsibility of maintaining ethical work environments predicated on moral virtues and the values of the profession. This provision, very specifically, relates to the roles and function of the nurse executive.

Although the ANA *Code of Ethics for Nurses with Interpretive Statements* (2015) acknowledges today’s health care environment as one of providing quality care in a cost-effective manner, the moral directive is for healthy work environments for nurses. The work environment influences a nurse’s ethical professional practice. The code speaks to the commitment to one’s moral character through wisdom, honesty, and courage. As well as defining professional accountability to oneself and others, the Code of Ethics mandates that nurses demonstrate ethical behavior based upon moral principles. The code describes the nurse leader’s role as one of integrity, exhibiting moral behavior congruent with the moral virtues of role modeling, supporting healthy work environments, fostering ethical environments, and encouraging courage to confront challenges (ANA, 2015). The contents of the Code acknowledge nurse leaders’ competing loyalties and multiple obligations; however, the nurse leader is advised to place the patient’s needs first in ways that ultimately result in the right decisions (ANA, 2015). According to Storch, Makaroff,
Pauly, and Newton (2013), ethical leadership for an executive is crucial, not only to support nurses, but also to create positive work environments.

The ANA *Nursing Administration Scope & Standards of Practice* (2009) document defines the nurse administrator broadly:

The nurse administrator is a registered nurse who orchestrates and influences the work of others in a defined environment, most often healthcare focused, to enhance the shared vision of an organization or institution. Due to the dynamism of the healthcare industry, nurse administrators direct a wide array of nursing practice in clinical and non-clinical settings. While nurse administrators are present in many forms and at various levels, certain global themes permeate all roles, including advocacy, leadership, shared vision, knowledge of business practices and processes, mentorship, and dedication to the profession. The goals of the nurse administrator’s efforts are a quality product focused on safety and the requisite infrastructure that seeks to meet the expectations of the nursing profession, the consumer, and society (ANA, 2009, p. 3).

In this document, under the standards of professional performance, the measurement criteria do not incorporate either the level of ethical responsibility of a nurse administrator or the characteristics or personal traits needed to determine the ability to make ethical decisions. However, the nurse executive must have the ability to guide and influence decisions in a health care organization, which is an essential component of moral and ethical action (Storch et al., 2013).
Moral courage is an attribute for the nurse executive that influences decisions and actions to advocate for the nurse and ensure patient safety, while benefiting the organization. Moral courage is a construct that Sekerka and Bagozzi (2007) define as “the ability to use inner principles to do what is good for others, regardless of threats to self, as a matter of practice” (p. 135). To facilitate change requires one to have the courage to act. For that reason, moral courage is a critical component of a nurse executive’s role. As a member of the senior leadership team, it is the nurse executive’s responsibility to create and support the mission, vision, and goals of an organization. In meeting these responsibilities, the nurse executive has the fiduciary responsibility to allocate resources. To effectively assume fiduciary responsibility, one must act to the best of one’s ability in the interests of another, not in self-interest. In a health care organization, the first fiduciary obligation is non-maleficence: “first, do no harm” (Schyve, 2009, p. 3). In addition, building competence, credibility, and trust by demonstrating influence, advocating on behalf of nursing, and having the integrity to take a principled stand are essential (Tomajan, 2012). Nurse executives must create work environments that support moral courage and morally courageous acts by role modeling ethical behavior and providing resources for professional governance structures, ethics committees, and mentoring opportunities (LaSala & Bjarnason, 2010). The challenges and ethical dilemmas a nurse executive experiences require morally courageous behavior and putting ethical principles into action to stand up for what is right (Murray, 2010). A morally courageous nurse executive will oppose work environments that place patient safety at risk because of a cost containment effort (LaSala & Bjarnason, 2010).
The nursing literature discusses moral courage among direct care nurses, but little has been written concerning moral courage in nurse executives (Edmonson, 2015). Moral courage is an important element and the basis for resisting decisions and actions that could place frontline nurses, patients, and/or the organization at risk. Moral courage influences a nurse executive’s role and competency to transform a work environment (Bernard, 2014). Since moral courage is necessary for nurse executives to effectively perform their duties, it is important to be able to accurately assess this characteristic. Therefore, in order to quantify the construct of moral courage, a reliable and valid instrument is necessary.

The Professional Moral Courage (PMC) scale (Appendix A) is a tool designed to measure the construct of moral courage as a managerial competency (Sekerka et al., 2009). The five-dimensional scale was developed through two different methods; a literature review and qualitative analysis of critical incident interviews. The five resulting dimensions identified include moral agency, multiple values, endurance of threats, going beyond compliance, and moral goals (Sekerka et al., 2009). The validity and reliability of the PMC scale were assessed in a sample from leadership within the military population.

**Purpose and Research Question**

The purpose of this study is to validate the PMC scale for use in the nurse executive population. For the purpose of this study, the nurse executive is defined as either a Chief Nursing Officer (CNO) with responsibility for one institution or a Chief Nursing Executive (CNE), who oversees a group of health care organizations within a
larger health care system. These roles encompass establishing the vision for nursing practice, fiscal management, ensuring quality of care, compliance, and contributing to the growth of the organization (AONE, 2015). Additionally, the CNE oversees performance across an enterprise, advocating for broad strategies for the delivery of care, and creating alignment between member hospitals, which relate to the corporate mission, vision, values, and philosophy (Clark, 2012).

The nurse executive must navigate a health care environment fraught with conflicting pressures. Despite the variations in structure and responsibilities of nurse executives across healthcare organizations, the role generally incorporates facilitating change, maintaining a professional practice environment, and assisting to set the future direction for the organization (Clark, 2012). The nurse executive’s work environment is complex, fast paced, and within a context of competing paradigms. The shift to health care as a business combined with the moral imperative to enhance patient safety can create conflicting priorities. The nurse executive possesses strong moral obligations to the patients, staff, and the organization, which are delineated by mission and vision (LaSala & Bjarnason, 2010). The role of a nurse executive requires moral courage that provides her or him with the capacity to take action during adversity and persevere in the face of challenges.

Consequently, the assumption that the PMC scale is appropriate to measure moral courage in the nurse executive population is plausible. However, the reliability and validity of the PMC scale has not been empirically tested in this population, so further
psychometric evaluation is warranted. Therefore, the research question is: Is the PMC scale valid and reliable in a nurse executive population?

**Significance of the Study**

The efforts and actions of a nurse executive leading change in a health care organization depend upon having the ability to display moral courage. Moral courage and acting with moral conviction when facing significant issues can turn challenge into opportunity (Bjarnason & LaSala, 2011). The opportunity is to be true to one’s beliefs, convictions, and ethical principles (Clancy, 2003). This is evident when the nurse executive stands her or his ground in a situation that requires a decision, whether it is about patient safety or the nurse’s practice environment.

When a nurse executive lacks moral courage, the result may be risk avoidance and failure to act (Edmonson, 2010). The consequence is the creation of undesirable practice environments for nurses, unfavorable patient outcomes, and possible unethical behavior in an organization. Furthermore, this affects the personal and professional well-being of the nurse executive; the inability to act can cause moral distress and a moral residue characterized as regret, anger, and frustration (Edmonson, 2010). As a result, the nurse executive may experience low self-esteem, job dissatisfaction, and poor productivity for the organization (Edmonson, 2010). Therefore, the nurse executive should possess the competency and capability to demonstrate moral courage. Establishing a measure provides the information that determines if the nurse executive needs or does not need assistance in developing moral courage.
Validating the PMC scale will provide evidence of a psychometrically valid and reliable tool to measure moral courage as a competency in the nurse executive population. Future use of the PMC scale can set the expectation of practicing with ethical and moral standards and serve as a method of evaluation for professional development.

Summary

The nurse executive holds a vital position in a health care organization and has significant influence over the clinical, fiscal, and administrative outcomes of the organization (Caroselli, 2010). Given the current and future changes in health care, highly competent nurse executives who demonstrate moral courage are a necessity. The PMC scale is an instrument that measures the construct of moral courage (Sekerka et al., 2009), which has not yet been validated in the nurse executive population. The psychometric testing of the PMC scale in the population of nurse executives can provide a valuable measure of moral courage to be used to facilitate professional development and support moral courage as a recognized competency.
CHAPTER 2
LITERATURE REVIEW

Nurse executives today are faced with a myriad of organizational challenges as a result of a changing health care environment. Moral courage is an essential quality in the nurse executive’s role. This literature review examines the concept of moral courage to gain a better understanding of its importance in the nurse executive population. The purpose of this study is to psychometrically test the Professional Moral Courage (PMC) scale developed by Sekerka, Bagozzi, and Charnigo (2009) and to validate its use in the nurse executive population.

The chapter includes a review of the literature on moral courage in the nurse executive population in the context of health care organizations. This review is categorized in the following sections: (a) the nurse executive’s role; (b) ethics in nursing leadership; (c) education; (d) experience; (e) courage; (f) moral courage; (g) professional moral courage; (h) professional moral courage in nursing; and (i) measurement of professional moral courage.

The literature confirmed a gap in the field regarding the construct of moral courage in the nurse executive population. The review focused on the concept of moral courage, mostly obtained from philosophy, psychology, and business perspectives. The nursing literature on moral courage mainly addressed the direct care nurse; it was much more limited in the context of nursing leadership (Edmonson, 2010). Overall, the literature lacks empirically-based studies of moral courage in executive leadership. The review revealed that courage is an element necessary for ethical behavior even though it is an ambiguous and subjective concept and lacks a standard definition (Chapa & Stringer, 2013).
Nurse Executive’s Role

The nurse executive titles under study include the Chief Nursing Officer (CNO) and Chief Nursing Executive (CNE), depending on the organization. The nurse executive is defined as “the highest-level nurse in a healthcare organization who has oversight responsibility and promotes professional nursing practice and standards in a consistent manner across all clinical settings” (Hader, 2009, p.34).

The CNO/CNE assumes a necessary leadership role in a healthcare organization and is mandated by the accrediting body (The Joint Commission [TJC], 2016). TJC’s primary focus is ensuring high quality and safe care to patients (TJC, 2016). The nurse executive role is recognized in both the “Leadership” and “Nursing” chapters of standards in TJC’s 2016 Comprehensive Accreditation Manual for Hospitals. The first standard in the “Nursing” chapter sets the expectation that the nurse executive directs the delivery of nursing care, and particularly at a senior leadership level, is involved in the hospital’s decision-making structures and processes (TJC, 2016).

The nurse executive’s role has expanded in response to the complexities and evolving changes in health care (Kingston, 2013). Generally, the CNO functions at an entity level and the CNE at the system level. The entity CNO has accountability for the operations and performance of one organization and the CNE oversees performance across a multi-facility health care system and is primarily accountable for strategies across many organizations (Clark, 2012; Kingston, 2013). Both the CNO and CNE roles require business acumen, as they are responsible for developing the strategic vision and direction of organizations (Bernard, 2014). The nurse executive creates the framework for a professional practice environment that includes effective interpersonal communication, collaboration, education and research, and promoting a culture of
quality and patient safety (Bernard, 2014; Hader, 2009).

Briefly, according to the American Nurses Association (ANA) Nursing Administration: Scope and Standards of Practice (2009), the role of the nurse administrator is defined as “multifaceted and requires broad-level thinking” (p. 3). Additionally,

The nurse administrator is nimble in understanding and balancing business duties and obligations with the ongoing commitment to nursing. The dichotomy can cause tension or even conflicts of interest, as nurse administrators seek to enhance quality nursing practice in organizations with values that may not always reflect those of nursing. However, even as corporate employees, administrators must act as registered nurses first by upholding the values of nursing and advocating for those values to the utmost extent possible (p. 3).

The role of the nurse executive is to advocate through direct action to ensure appropriate resource allocation and positive practice environments (Tomajan, 2012). In doing so, the nurse executive involves staff in decisions and supports nurse autonomy in innovative initiatives to advance practice in an organization (ANA, 2009; Tomajan, 2012).

The nurse executive’s influence is built upon competency. The American Organization of Nurse Executives (AONE) posits that leadership competency is an element that promotes the strategic imperative to sustain an organization (AONE, 2015). AONE’s primary focus is executive development, and it has established competencies in order to prepare the nurse executive for the demands in healthcare. The AONE Nurse Executive Competency Model includes specific behaviors and skills common to nurses in executive roles; the components are communication and relationship building, knowledge of the health care environment, leadership, professionalism, and business skills (AONE, 2015). The professionalism competency
emphasizes ethics and is defined as: “(a) uphold ethical principles and corporate compliance standards; (b) hold self and staff accountable to comply with ethical standards of practice; (c) discuss, resolve and learn from ethical dilemmas” (AONE, 2015, p. 9). The Healthcare Leadership Alliance’s model was used to develop the AONE competencies (Healthcare Leadership Alliance, 2005). The Healthcare Leadership Alliance involved members of the AONE, American College of Healthcare Executives, Healthcare Financial Management Association, Healthcare Information and Management Systems Society, and Medical Group Management Association (Batchellar, 2010).

As a member of a hospital executive team, the nurse executive has a critical responsibility in the delivery of efficient, safe, and effective health care in an organization (O’Luanaigh & Hughes, 2016). O’Luanaigh & Hughes (2016) describe the nurse executive in a health care organization as a person who: “(a) influences at the highest organizational level; (b) provides advice and work across multiple areas relating to the health-care business-patient experience; (c) understands and translates systems, budgets, strategy and models of care; (d) applies critical thinking skills, varied expertise, knowledge, and extraordinary interpersonal capabilities” (p. 133). Summarizing the nurse executive’s role, O’Luanaigh and Hughes (2016) affirm that the demonstration of leadership is through: “(a) professional governance; (b) quality improvement; (c) transformation and change; and (d) shared governance” (p. 134).

Ethics in Nursing Leadership

The challenge for a nurse executive is balancing clinical and organizational demands as well as ethical issues while meeting the requirements of the rapidly changing healthcare system. The nursing department directs the largest workforce in a hospital, leaving the nurse executive as one of the most valuable assets leading change across the organization. The vital role and moral
responsibility of the nurse executive is to assist the organization with the required changes, as well as to provide leadership behaviors and to take action to retain nurses and keep the patients safe.

The nurse executive faces significant challenges in obtaining the appropriate resources and maintaining a positive practice environment. The allocation of resources, particularly nurse staffing, is a priority. A sufficient number and skill mix of competent nurses to care for patients is the goal. Similarly, it is vital to establish a nurse’s practice environment and achieve high nurse satisfaction, minimize nurse turnover, and deliver safe quality care to the patient. Wolf and Greenhouse, (2006) reference the Institute of Medicine (IOM) report *Keeping Patients Safe: Transforming the Work Environment of Nurses* (2004) and emphasize “the work environment of nurses, the largest segment of the nation’s health care work force, needs to be substantially transformed to better protect patients from healthcare errors” (p. 458). The report quotes Donald M. Steinwachs, chair of the committee on the work environment for nurses and patient safety and chair of the Department of Health Policy and Management, Bloomberg School of Public Health, Johns Hopkins University, in asserting “creating work environments that reduce errors and increase patient safety will require fundamental changes on how nurses work, how they are deployed, and how the very culture of the organization understands and acts on safety” (Wolf & Greenhouse, 2006, p. 458).

The role of the nurse executive is to be an advocate (Bjarnason & LaSala, 2011). However, the nurse executive often has to make decisions between equally unsatisfactory choices. For that reason, Bjarnason and LaSala (2011) suggest that ethical practices, values, and principles must remain the foundation in decision-making. They propose the nurse executive: (a) develop a clear organizational mission, vision, and values; (b) establish a professional practice
model as a framework that depicts how nurses practice, collaborate, communicate, and develop professionally; (c) promote structural empowerment; (d) implement a professional governance model for decision-making; (e) effectively communicate by using assertive communication to invoke the chain of command and escalate as warranted; and (f) create a just culture environment of incentive rather than punish error reporting (Bjarnason, & LaSala, 2011).

Although the code of ethics and ethical principles guide behavior, LaSala and Bjarnason (2010) argue the code is “not enough for promoting morally courageous action and nurses need moral ideals to transcend individual obligations and the moral commitment they make to their patients and co-workers” (p. 2). Edmonson (2010) posits moral and ethical values as the core to decision-making, and provide the individual with a moral compass. Edmonson explains “the concept of the moral compass in healthcare is based on four guiding points: (a) integrity, (b) responsibility, (c) compassion, and (d) forgiveness” (p. 33). He noted that, in a leadership context, the ability to visualize this compass creates a sense of direction toward an inspired vision. “Healthcare organizations guided by leaders with a strong moral compass operate within a framework of humility and intellectual curiosity that is grounded in doing the right thing” (Edmonson, 2013, p. 33).

The history of nursing has noteworthy implications for the nurse executive. Nursing has been (and sometimes still is) considered subservient to medicine which has prevented nurse autonomy (Numminen, Repo, & Leino-Kilpi, 2016). Medicine, a largely male profession, tends to dominate nursing, predominantly a female profession, resulting in oppressive behaviors from doctors. These behaviors lead to conflict and affect a nurse’s work environment (Duffy, 1995; Farrell, 2001; Fletcher, 2006). Farrell (2001) asserts the conflict is rooted in the dominant role of
the physician and subservient role of the nurse. Consequently acting in a courageous manner can lead to conflict and moral distress (Edmonson, 2010).

Edmonson (2010) cautions moral distress can lead to burn out, disengagement, and lack of focus, negative health effects, and lower job satisfaction, and retention. Negative situations are more likely to occur in an unsupported or punishing organization that creates a culture of fear to act (Gallagher, 2010; Lachman, 2009). According to Edmonson (2010), moral distress was framed by Jameton (1984) as:

Arising when one knows the morally right thing to do, but cannot, due to organizational constraints. Moral Distress is described as the initial dimension and the reactive dimension. The initial moral distress is the distress nurses experience when they are faced with interpersonal value conflicts. It is experienced as feelings of frustration, anxiety, anger, and the inability to act. Reactive moral distress is the distress nurses experience when they do not act upon the initial distressing situation to bring to resolution. These acute manifestations of moral distress if not acted upon and resolved, lead to moral residue, or the additional development over time of regret, anger, and frustration (p. 2).

Moral distress has been recognized as a “significant issue with negative consequences for nurses” indicating the need for moral courage as an empowering way to address this issue (Numminen et al., 2016, p. 11). The nurse executive as the professional nurse’s advocate influences decisions and actions across the organization. In addition, the nurse executive has a responsibility in preparing nurses to advocate for themselves (Tomajan, 2012).
The education of the nurse executive contributes to increasing the ability to influence the practice and behavior of nurses in a healthcare organization. Overcoming challenges and dilemmas and fulfilling the nurse executive’s role require advanced education. The nurse executive is the only leadership position with mandates by an accrediting body, the Joint Commission (TJC). The TJC (2016) incorporates the educational requirements for a CNO/CNE to be “a post-graduate degree in nursing or a related field; or the knowledge and skills associated with an advanced degree; or a written plan to obtain these qualifications” (p. NR 1).

The complex paradigm for delivering patient care reinforces the need for appropriate preparation of a nurse executive. The IOM Future of Nursing (2011) report identified the growing need for nurses prepared with advanced professional degrees and education, calling for an increase in the number of nurses holding graduate and doctoral degrees (IOM, 2011). Their recommendations supported lifelong learning and the critical need for advancing education for nurse leaders.

Doctoral preparation is becoming the standard for the Chief Nursing Officer (CNO) and Chief Nurse Executive (CNE) (Caroselli, 2010). However, there has been indecisiveness regarding which doctorate is the best for the nurse executive, the Doctor of Philosophy (PhD) or Doctor of Nursing Practice (DNP). The American Organization of Nurse Executives (AONE) (2010) has released a position statement regarding the preparation of nurse leaders which was developed by a multidisciplinary committee comprised of members representing AONE, the American College of Physician Executives, and the Health Financial Management Association. The committee’s recommendation is that a nurse leader be minimally prepared with a Bachelor’s degree to a Master’s degree in nursing; but also recommended that nurse executive leaders obtain
doctoral education (AONE, 2010). In addition, the Council on Graduate Education for Administration for Nursing (CGEAN) (2011) released a position statement focusing on the advancement of nursing administration through higher education to achieve the goal of leading healthcare in delivering quality, safe, cost effective care. CGEAN endorsed the educational preparation of the CNO to be at a doctoral level, either the Doctor of Philosophy (PhD) or Doctor of Nursing Practice (DNP), to expand knowledge and enhance practice and outcomes (CGEAN, 2011).

The American Association of Colleges of Nursing (AACN) Board of Directors formed the Practice Doctorate in Nursing task force in 2002 to “examine trends in practice-focused doctoral education and make recommendations about the need for and nature of such programs in nursing” (AACN, 2006). The AACN Practice Doctorate in Nursing Task Force developed the content and the curricular elements that must be present in programs that offer the DNP degree. “The task force members included representatives from universities that already offered or were planning to offer the practice doctorate, from universities that offered only the research doctorate in nursing, from a specialty professional organization, and from nursing service administration” (p. 4).


These reports highlight the human errors and financial burden caused by fragmentation and system failures in health care. In addition, the IOM calls for dramatic restructuring of all health professionals’ education. Among the recommendations resulting from these
reports are that health care organizations and groups promote health care that is safe, effective, client-centered, timely, efficient, and equitable; that health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement, and informatics; and, that the best prepared senior level nurses should be in key leadership positions and participating in executive decisions (p. 5).

The AACN (2006) asserts that the PhD, a research degree, and the DNP, a practice-focused degree, are doctoral programs in nursing, both terminal degrees, and “complementary, alternative approaches to the highest level of educational preparation in nursing” (p. 3).

Therefore attaining advanced education prepares and provides the nurse executive with the skill set necessary to lead successfully in this healthcare environment. Edmonson (2010) suggests that education beyond a baccalaureate level and participation in a professional organization enhance conflict resolution, negotiation, and communication skills necessary in a leadership position. Leach and McFarland (2014) surveyed 155 nurse executives (66% Masters degree, 22% Doctorate degree, and 12% Baccalaureate degree) in a cross-sectional, descriptive study in an attempt to identify professional development and knowledge topics that would meet the expectations of a leadership role. The top three professional development topics reported were: (a) leading translation of evidence into management and clinical decision-making; (b) innovation in nursing; and (c) leading in matrix organizations. The knowledge topics highlighted included: (a) healthcare reform; (b) changes in reimbursement and workforce changes; and (c) human factors.

One study described the transformational leadership practices of CNOs in Magnet®-designated organizations, suggesting a difference in leadership effectiveness with doctoral
preparation. The researchers surveyed 384 Magnet® CNOs with a response rate of 58.4%. The Leadership Practices Inventory (LPI) instrument was used to measure 5 leadership practices: enabling others to act, encouraging the heart, inspiring a shared vision, challenges to process, and modeling the way (Clavelle, Drenkard, Tullai-McGuinness & Fitzpatrick, 2012). The CNOs with a doctoral degree scored higher than those with a master’s degree for inspiring a shared vision and empowering the staff to seek new ways to change and improve (Clavelle et al., 2012). The study revealed the CNOs with doctoral degrees demonstrated higher levels of transformational leadership skills to support leadership practice. The authors connected higher educational and experience levels to an increase in effectiveness of the CNO’s role.

**Experience**

The nurse executive’s work experience enhances competency and confidence that promotes the ability to act when faced with ethical dilemmas and challenges (Murray, 2010). Murray asserts that acquiring experience supports courageous acts at all levels in nursing. Experience is an antecedent of moral courage, both in life and professional practice, and is necessary to endure morally difficult situations (Numminen et al., 2016). Those authors emphasize that training gained through experience becomes an unconscious habit of reflection upon one’s values and morals behind decisions. Experience adds to an individual’s confidence and consequently their level of courage (Numminen et al., 2016).

Goud (2005) postulates that belief and trust in one’s capability, which often arises from experience, is an important determinant for developing and maintaining courage. Confidence counters fear and risks and enhances the strength to persevere when facing significant challenges (Goud, 2005).
In a meta-interpretation of six qualitative studies, Finfgeld (1999) linked courage and experience of threats to wellbeing amongst individuals with long term health issues. The author asserts that becoming courageous is a dynamic process and that courage continues to develop over one’s lifetime as perceived threats are managed. Finfgeld (1999) states courage is promoted and maintained by the interaction of intra and inter-personal factors. Self-confidence as an intrapersonal factor allows the ongoing use of courage to transform threats into manageable challenges which then leads to decisiveness and courageous action (Finfgeld, 1999).

Murray (2010) suggests that individuals responding to ethical dilemmas depend upon previous work experience, individual traits, ethical values, and knowledge of ethical principles. Kidder (2005) concurs and posits that maturity and experience (self-regulation) influence the individual’s ability to manage ambiguity and endure hardship. The individual’s character, past experience, and competency promote willingness to accept risk and manage uncertainty that leads toward morally courageous actions (Kidder, 2005). He defines the aspect of maturity as it relates to moral courage within seven checkpoints: “(1) assess the situation; (2) scan for values; (3) stand for conscience; (4) contemplate the dangers; (5) endure the hardship; (6) avoid the pitfalls; (7) develop moral courage” (p. 17). Kidder (2005) explains the bundled elements to endure hardship include experience, character, faith and intuition. He highlights that experience is a necessity and is validated by asking the questions: “can I rely on what I’ve done in the past, taking it as a predictor of what I can do in the future? And, have I been there, done that enough to have confidence in my background, training, talents, skills, and abilities?” (p. 173).

Therefore, past work experiences enhance a nurse executive’s practice and ultimately enhance the ability to demonstrate courage and moral courage. The CNO/CNE’s years of
experience combine expertise and skills and together establish the necessary confidence to
overcome fear, remain true to convictions, and have courage to make a stand (Clancy, 2003).

**Courage**

Courage involves persevering through adversity and the resilience to resist others, even
during apprehension, uncertainty, or anxiety (Pianalto, 2012; Sekerka et al., 2009). In an attempt
to define courage, from a positive psychology perspective, Rate, Clarke, Lindsay, and Sternberg
(2007) cite 29 different definitions and argue that the study of courage involves subjective
experiences and individual traits. Rate et al. (2007) derived a definition of courage as: “(a) a
willful, intentional act; (b) executed after mindful deliberation; (c) involving objective
substantial risk to the actor; (d) primarily motivated to bring about a noble good or worthy end;
(e) despite, perhaps, the presence of the emotion of fear” (p. 95).

Hannah, Sweeney and Lester (2007) propose courage as a subjective experience which
combines intrapersonal positive traits to establish a courageous mindset. The courageous
mindset increases personal resources to reduce fear, and overcomes residual fear to promote
courageous action (p. 131). This general model has not been empirically tested; however,
building a courageous mindset occurs through experiences and learning, essentially “acquiring
meta-knowledge about oneself which can be accessed in future performance situations” (Hannah
et al., 2007, p.34).

Goud (2005) explored a model for courage. He defined courage as “the energizing
catalyst for choosing growth over safety needs and allowing one to effectively act under
conditions of danger, fear, and risk” (p. 103). Goud (2005) cited the works of Aristotle, Maslow,
and many others from an array of disciplines as influential contributors to three primary
dimensions of courage: (a) fear (danger, risk); (b) appropriate action; and (c) purpose. The three
dimensions correspond to his three recommendations for developing courage, specifically: (a) instilling confidence and trust in one’s abilities; (b) recognizing a purpose; and (c) managing fears. He argues that acting in the face of fear is not enough; one must have a higher purpose affirming or securing a value beyond one’s self-interests in order to perform a courageous act (Goud, 2005).

Courage is connected to one’s values and has ethical significance. LaSala and Bjarnason (2010) assert that to act courageously draws upon the ethical principle of beneficence (doing good for others) in addition to the individual’s own motivation predicated on personal and professional values and standards.

**Moral Courage**

“Moral courage is considered to be the pinnacle of ethical behavior; it requires a steadfast commitment to fundamental ethical principles despite personal risk, such as threat to reputation, shame, emotional anxiety, isolation from colleagues, retaliation, and loss of employment” (Murray, 2010, p. 2). Moral courage and the general definition of courage coexist within the focus of this study as professional moral courage in the leadership (management) context.

For the purpose of this study, the term moral courage is conceptually defined as “the ability to use inner principles to do what is good for others, regardless to threat to self, as a matter of practice” (Sekerka & Bagozzi, 2007, p. 135). Lachman, Murray, Iseminger, and Ganske (2012) also hold a similar view that “moral courage is the willingness to stand up for and act according to one’s ethical beliefs when moral principles are threatened, regardless of the perceived or actual risk” (p. 1). Lachman (2010) further defines moral courage as “the individual’s capacity to overcome fear and stand up for her or his core values and ethical obligations” (p. 10).
Clancy (2003) described moral courage as the inherent ability to confront fear and respond to ethical situations, categorizing it as ethical fitness. “Ethically fit leaders have developed a deep sense of conviction for moral values and, when tested, ethically fit leaders instantly and intuitively know the difference between right and wrong” (Clancy, 2003, p. 130). The element to overcome fear is confidence to stand up and act for what is right and enhance the capability to make ethical decisions (Clancy, 2003; Day, 2007).

From a philosophical perspective, Pianalto (2012) argues that moral courage involves “acting with one’s convictions despite risk, retaliation, or punishment” (p. 1). He distinguishes moral courage from physical courage and explains moral courage as a substantive virtue and important to one’s action in the face of adversity. Pianalto posits “the truly morally courageous person will resist the objectification of others, even those who oppose in values and action” (p. 2). Linking moral courage to integrity, Pianalto suggests moral courage involves commitment and a sense of moral responsibility to “one’s values in deliberation and action” (p. 6). Pianalto’s view is that a morally courageous person stands up for one’s own moral values, and that integrity and self-respect are necessary for morally courageous action. Pianalto’s assertion supports the association of a leader’s confidence and moral courage.

Kidder (2005) asserts that moral courage requires moral strength and the will to stand up for principles and values, recognize risk, and endure hardship. Moral courage is an ethical commitment set by one’s core values and driven by principles and the willingness to act. Kidder (2005) posited that the harder decisions are not right versus wrong, but instead right versus right, and the determination of the rightness. The greatest test of moral courage is when the individual takes action for or against an issue and stands up to those who disagree with the action. However, the awareness and assessment of the risk and danger influence moral courage. The
assessment of the risk is essential to determine the outcome (Kidder, 2005). Kidder points out that exhibiting moral courage based on an underassessment of the risk results in pointless self-sacrifice and imprudence. Individuals accepting moral risk are tolerant of ambiguity, exposure, and loss. Kidder (2005) describes the six conditions required for morally courageous actions as: honesty, responsibility, respectfulness, fairness, compassion, and courage. Moral courage is the commitment to moral principles, an awareness of the danger, and endurance of that danger (Kidder, 2005). Osswald, Greitemeyer, Fischer, and Frey (2007) argue “before a person can act with moral courage, s/he has to perceive an incident as a situation of moral courage; s/he has to take responsibility and has to feel competent to act” (p. 159).


Professional Moral Courage

Sekerca et al. (2009) introduced the concept of professional moral courage (PMC) and defined it as a managerial competency within the workplace. Sekerca and Bagozzi (2007) define moral courage as “the ability to use inner principles to do what is good for others, regardless of threats to self, as a matter of practice” (p. 135). Adding professionalism to moral courage, they define professional as “professionalism in management, involving understanding formal, informal, stated, and expected standards of ethical conduct” (Sekerca et al., 2009, p. 566). Sekerca et al. (2009) suggest that the moral person who demonstrates moral behavior represents the presence of principles and standards that lead to the right behavior guided by character and conscience to assist in decision-making. Professional moral courage is a management virtue and
an attribute that motivates and enables individuals to undertake the right course of action, given the ethics of their profession (Sekerka et al., 2009). Professional moral courage as a managerial competency is defined as an “underlying characteristic that may be a motive, trait, skill, aspect of one’s self-image or social role, or a body of knowledge” which the person uses to accomplish the job (Sekerka et al., 2009, p. 567). Competency in practice enhances the ability to display moral courage and exhibit moral strength. Character development and moral strength are antecedents of the ability to act or respond to daily ethical challenges. Sekerka et al. (2009) emphasize that organizations expect managers to proceed with professional moral courage as part of their role.

Extending the work of Sekerka et al. (2009) and Sekerka and Bagozzi (2007), Harbour and Kisfalvi (2014) describe many approaches to moral courage, studying managerial courage as it relates to professional moral courage from a business ethics and executive leadership perspective. Managerial courage is a virtue embedded in the focus on character, mindset, attitude, action, or competency. They assert, “Managerial courage has been mostly contextualized in organizations exploring courageous behaviors based upon strong, ethically principled standards, both individually and in a collective group” (p. 496). Harbour and Kisfalvi (2014) explored managerial courage in the organizational literature to understand courage from a strategic decision-making viewpoint. Their review examined examples of courageous action both collectively and individually. The example used for collective managerial courage was Quinn and Worline’s (2008) research, based upon the counterattack against hijackers on September 11, 2001. The study used narratives of passengers aboard United Air Lines Flight 93 obtained from books, news articles by investigative reporters, and government documents inclusive of interviews, archival records, observations, and trace records (Quinn & Worline, 2008). The collective approach relates to courageous action within an organization. The
passengers were able to manage emotions, rely on network connections, develop certainty about the circumstances and formulate an appropriate response by having a collective identity, fueling each person’s capacity to engage in courageous action (Quinn & Worline, 2008). The courageous action of an individual within an organization is demonstrated by having a voice, speaking up when encountering wrongdoing and decision-making pertaining to a vision or direction of an organization as demonstrated in the Harbour and Kisfalvi (2014) study.

Harbour and Kisfalvi (2014) explored the perceptions and experiences of five general managers (GMs) undertaking a business merger at the executive level. The focus was on risky strategic decision making. The purpose was to understand and obtain different perspectives of how the executives involved in strategic decision-making displayed managerial courage even with inherent personal risk in the interest of an organization. The aim was to assess the perception of managerial courage demonstrated by the GM during the merger and observed by others; in this study, the project manager and the chairman or vice-chairman of the Board (Harbour & Kisfalvi, 2014). The qualitative analysis of the five mergers yielded 57 critical moments that structured around “intensity of risk” and “level of courage shown and identified three important elements in managerial courage: “degree of emotional intensity, control of emotions, and moral judgment.” The two categories of the critical moments consisted of “courage to act” and “courage to be.” The major findings were that the common view of managerial courage was moral action and suggested that resilience through adversity and “competency and self-confidence are necessary elements in moral courage” (Harbour & Kisfalvi, 2014, p. 510). The two types of managerial moral courage, “courage to act” and “courage to be” were strongly linked to the emotional experiences of the GMs.

Based on these results, Harbour and Kisfalvi (2014) proposed an exploratory conceptual
model of managerial moral courage which consists of four elements. The four elements represent a courageous act in the context of a managerial decision. “The managerial decision and subsequent action (a) are seen to be undertaken for the benefit of the organization, the community or the greater good (as opposed to simple self-interest), and involve (b) a risk or difficulty for the manager that (c) results in noticeable negative emotional intensity (d) which the manager must then control in order to remain focused on the initial purpose” (p. 511).

In an attempt to develop a conceptual model for moral courage, Hannah and Avolio (2010) expanded the work of James Rest’s theoretical four-component model of moral development as a process of ethical decision-making. Briefly, Rest, Narvaez, Bebeau, and Thoma (1999) discuss Rest’s model which includes four psychological processes: (a) moral sensitivity (the ability to recognize a situation as moral); (b) moral judgment (reasoning through the possible choices and potential consequences); (c) moral motivation/intention (to choose the moral decision); and (d) moral courage /action (the individual’s behavior). The conceptual model explored an individual’s development of judgment about moral issues and how these judgments result in actual intentions and behavior. The expanded model focused on a leader’s character, adding ethical awareness and decision-making as well as moral conation (moral motivation and moral action). The new construct developed was called moral potency. Moral potency involves three components: (a) moral courage; (b) moral efficacy (confidence); and (c) moral ownership (feel responsible to act) as critical factors and mutually supporting the development of leaders who will take moral action in the face of adversity and persevere through challenges (Hannah & Avolio, 2010).

Professional Moral Courage in Nursing

Lachman (2010) posits that moral courage in nursing involves the willingness to speak
out and do what is right and to put principles into action despite the consequences. Lachman (2010) advocated the following framework to actualize moral courage as a strategy in challenging situations in the form of an acronym, CODE.

“C” represents the courage (moral courage), the willingness to overcome fear and stand up for core values. The “O” reminds the nurse of their obligation to adhere to the American Nurses Association Code of Ethics for Nurses, which delineates nurses’ ethical responsibilities in a variety of circumstances. The “D” is for danger management, with a focus on developing cognitive strategies and overcoming risk aversion. Because moral courage is essentially an act, the “E” reflects the expression and action component, assertiveness and negotiation strategies (p. 1).

Moral courage, asserted Lachman (2010), is “an individual’s capacity to overcome fear and stand up for her or his core values and ethical obligations” (p. 10). Lachman (2010) asked these questions: “What is the right thing to do? What do I need to handle my fear? What action do I need to take to maintain my integrity?” (p. 2). Lachman referenced the American Nurses Association (ANA) Code of Ethics for Nurses with Interpretive Statements (2001) as an approach to support and contribute to a leader’s moral courage.

The concept analysis conducted by Numminen et al. (2016) attempts to clarify the concept of moral courage in the context of nursing, arguing that it remains ambiguous. The concept analysis comprised various nursing studies and manifested seven core characteristics: “(a) true presence; (b) moral integrity; (c) responsibility; (d) honesty; (e) advocacy; (f) commitment and perseverance; and (g) personal risk” (p. 5). The authors distinguished core characteristics between two contexts, “being a courageous nurse” and “acting as a courageous nurse.” Although related to daily practice of a nurse, the characteristics also apply to leadership.
Numminen, Repo, and Leino-Kilpi (2016) found that the courageous nurse with true presence is willing to enter into interpersonal relationships, recognizes vulnerability, and endures uncertainty, while maintaining openness and responsiveness to a need. The nurse who acts with courage focuses on values, has authenticity, is willing to take risks, and displays integrity. These attributes enhance her or his behavior to do what is right and good and incorporates advocacy to assure professional responsibility and accountability. In addition, the nurse does not lose control or act impulsively. The courageous leader must have integrity and flexibility and be emotionally intelligent, open-minded, and be trustworthy as well. Accordingly, the nurse or leader who acts with conviction demonstrates moral courage (Numminen et al., 2016).

**Measurement of Professional Moral Courage**

Professional moral courage is an essential component of ethical behavior and determines the capacity of one’s response to challenges. Presently, the ability to act with moral courage in the nurse executive population has not been measured. Existing instruments that purport to measure moral courage were reviewed with the goal of selecting the most appropriate measure for the nurse executive population. Ultimately, the Professional Moral Courage (PMC) scale by Sekerka et al. (2009) was considered to be the most fitting to measure professional moral courage in the nurse executive population.

Two other instruments were considered for measuring moral courage. One was proposed by Woodard (2004) which measured the role of courage as a result of the willingness to take action, and the fear experienced while taking action. Woodard and Pury (2007) later reanalyzed the scale only using the “willingness to act” scores (Woodard & Pury, 2007). The other scale was Martin’s (2010) Moral Competency Inventory (MCI) scale, with an underlying assumption of moral competency and moral intelligence in the context of integrity and responsibility.
Woodard (2004) developed a courage scale, the Personal Perspective Survey (PPS). The scale consisted of 108 situation-based questions measuring the relationship of courage and hardiness to physical illness using the theoretical base of fear (Woodard & Purdy, 2007). Woodard (2004) defined courage as “the ability to act for a meaningful (noble, good, or practical) cause, despite experiencing the fear associated with perceived threat exceeding the available resources” (Woodard, 2004, p. 174). Woodard and Purdy (2007) reanalyzed the scale using only the “willingness to act” scores and psychometrically differentiated courage into four dimensions: (1) work/employment; (2) patriotic/religion based; (3) independent/family based; and (4) social/moral.

The Moral Competency Inventory (MCI) scale measures alignment of one’s moral values and behaviors within three constructs. The three constructs are: (1) moral intelligence; (2) moral competence; and (3) emotional competence. The MCI is based upon Lennick and Kiel’s (2005) moral compass approach, described as one’s innermost beliefs and values that guide thought and action across all cultural barriers (Martin, 2010). The purpose of the MCI is to identify attributes within a moral framework that are to be further developed for leadership, not to identify potential leaders (Martin, 2010). The 10 competencies include: (1) acting consistently with principles, values, and beliefs; (2) telling the truth; (3) standing up for what is right; (4) keeping promises; (5) taking responsibility for personal choice; (6) admitting mistakes and failures; (7) embracing responsibility for serving others; (8) actively caring about others; (9) ability to let go one’s own mistakes; (10) ability to let go of others’ mistakes.

The Personal Perspective Survey and the Moral Competency Inventory scale were not chosen for this study because they did not meet the intent of the concept for the study, professional moral courage. Although the elements of courage and the willingness to act are
measured in the Personal Perspective Survey, the underlying focus of courage is not measuring one’s ability to act nor the extent of moral strength in a professional context. The Moral Competency Inventory primarily identified attributes of moral courage of a leader; however, it was limited in the aspect of professional moral courage in an organizational context. Therefore, the breadth and depth of the Professional Moral Courage (PMC) scale has greater applicability for measuring the construct of moral courage in the nurse executive population.

The Professional Moral Courage scale is an instrument designed to measure the construct of moral courage as a managerial competency (Sekerka et al., 2009). The five-dimensional scale was developed through two different methods: a literature review and qualitative analysis of critical incident interviews. The five dimensions include: (a) moral agency; (b) multiple values; (c) endurance of threats; (d) going beyond compliance; and (e) moral goals (Sekerka et al., 2009). The validity and reliability of the PMC scale were assessed in a sample from the military population. Scale development and its psychometric properties are discussed in Chapter 3.

Summary

The literature supports the need for moral courage in healthcare organizations at all levels of nursing. In a complex and rapidly changing healthcare environment, the nurse executive must have the ability to lead change. The nurse executive role is one of influence and advocacy for the patient, nurse, and organization. The nurse executive has a critical position to drive the delivery of healthcare and support morally courageous action across an organization.

The nurse executive is confronted daily with ethical dilemmas and challenges and navigates a plethora of perspectives and opinions, adversity, and opportunities to ensure positive practice environments and patient safety. Courage is the key virtue to support courageous action.
In addition, moral strength builds moral courage and serves as a determinant for the ability to successfully persevere.

The expectation for a nurse executive is to keep the organization focused on its purpose and commitment at all levels. In doing so, attaining advanced education prepares the nurse executive with the skill set necessary to lead. Additionally, past work experience enhances a nurse executive’s practice and is essential to endure morally difficult situations. Subsequently, advanced education and work experience increase confidence and the ability to demonstrate moral courage to accomplish organizational goals, act as the moral agent for the nurse, and remain centered on the patient.

Professional moral courage as a managerial competency sets the expectation for nurse executive practice. Assessing professional moral courage as an essential quality is an imperative. Measuring professional moral courage of the nurse executive enhances the understanding of this concept and serves as a method of evaluation for existing and future nurse executive professional development.
CHAPTER 3

METHODS

This chapter describes the methodology used to assess the reliability and validity of the 15-item Professional Moral Courage (PMC) scale, in the nurse executive population. The PMC measures moral courage as a managerial competency to address daily ethical challenges inherent in the role of a managerial professional.

Participants

The inclusion criteria were: title of Chief Nursing Officer (CNO) or Chief Nurse Executive (CNE) and membership in the American Organization of Nurse Executives (AONE). The CNO/CNE is an executive with significant responsibility and influence in a healthcare organization. The CNO/CNE interfaces with non-nurse higher executives and has the responsibility to lead and uphold the values of nursing, and advocating for those values in a healthcare organization (ANA, 2015). The exclusion criteria were other titles of the AONE membership such as Director of Nursing, Nurse Manager, Nurse Consultant, Dean and Faculty of undergraduate and graduate nursing programs.

Sample

The study consisted of a psychometric evaluation of the PMC scale, which includes evaluating reliability, convergent validity, hypothesis testing, and factor analysis through Exploratory Factor Analysis (EFA) followed by Confirmatory Factor Analysis (CFA). Although the goal was to have a large sample size to establish generalizability, factor analysis requires a calculation of the number of subjects in relation to the number of measurable variables (Kellar & Kelvin, 2013). According to Waltz, Strickland, and Lenz (2010), the general principle for
sample size is that the larger the sample, the more likely it is to be representative of the population under study. The number of participants should exceed the number of variables; therefore, the ratio of at least 10 subjects for each variable is acceptable and establishes the representativeness of the population (Kellar & Kelvin, 2013). The PMC scale contains fifteen items; therefore, the sample size for the EFA and CFA consisted of a minimum of 150 participants each for a total of 300 participants as an adequate sample size for the study.

Instruments

The three instruments used in this study were: (1) the Professional Moral Courage (PMC) scale, to assess and quantify the construct of moral courage in the nurse executive population (Sekerka et al., 2009); (2) the Values in Action-Inventory of Strengths (VIA-IS) scale, specifically the bravery items, to determine if the character strength of bravery under the virtue of courage is convergent with professional moral courage (Peterson & Seligman, 2004; Peterson & Park, 2009); and (3) the Marlowe-Crowne Social Desirability Form C scale, to evaluate the potential influence of social desirability on PMC scale responses (Reynolds, 1982).

The discussion presented below is related to the article Facing Ethical Challenges in the Workplace: Conceptualizing and Measuring Professional Moral Courage study by Leslie E. Sekerka, Richard P. Bagozzi, and Richard Charnigo (2009). The PMC scale’s underlying concept of moral courage as an essential management competency incorporates certain components contributing to a manager’s ability to respond to ethical challenges. The authors suggest that moral courage is a professional attribute that is essential to fulfill the requirements of a leadership position. The PMC scale design was part of a longitudinal study sponsored by the U.S. Naval Supply Corps aimed at developing ethics education in the military. Sekerka and
colleagues (2009) established initial psychometric validation with participants who were officers (n = 199) in the U.S. Naval Supply Corps; of those 40% had prior enlisted experience. The sample was comprised of 74.7% males and 25.3% females with a mean age of 27.64 (SD = 4.77), and 27.2% with ethnicity other than Caucasian. Sekerka and colleagues (2009) derived the PMC measures through two different methods: a literature review and qualitative analysis of critical incident interviews by two different researchers, and administered twice: before and after an ethics education and training session. The number of participants involved in the qualitative component was not reported nor included in the quantitative section. The only responses used in the analysis were those from the second administration.

Two PMC scales were developed based upon a critical incident qualitative analysis (method A) and analysis of the literature (method B). The items, derived through the critical incident interviews, were grouped into five-dimensions: a) moral agency (the predisposition toward moral behavior and engagement as a moral agent), b) multiple values (the ability to draw on multiple value sets to determine the right action), c) endurance of threats (pursues action and has the will to act despite facing a threat), d) going beyond compliance (considers and applies the rules but goes beyond compliance to do what is right and just), and e) moral goals (completes the action without self-serving interests). Responses were provided on a seven point Likert-type scale, ranging from “never true” to “always true”. Participants were asked to answer the questions in the context of “you at work”. The semantic scoring method is summative; the higher score indicating a greater level of moral courage.

The critical incident qualitative analysis (method A) incorporated interviews with military officers. The officers were asked to describe their response to an ethical challenge at work. The
first scale (method A) used qualitative coding to identify five dimensions and items as well as incorporating statements from the officers. The second scale (method B) was a literature review of courage, moral decision-making, and virtue excellence in organizations, which related the findings to the five previously identified dimensions.

The trait-method-error model of confirmatory factor analysis (CFA) was chosen to minimize any errors, particularly with trait and method variance. The results of the trait-method-error CFA revealed a good fit on all five dimensions. The trait-method-error confirmatory factor analysis model parameter estimates for scale one (method A) yielded high factor loadings of the moral courage dimensions and statistical significance with \( p < 0.001 \). Magnitude of error variance was low and factor loadings for the items derived from method A were: “moral agency 0.80, multiple values 0.85, threat endurance 0.83, beyond compliance 0.88, and moral goal 0.76” (Sekerka et al., 2009, p. 574). Therefore, the PMC scale achieved support for construct validity of the concept, moral courage. As factor loadings were stronger with the tool derived from method A, that version of the PMC scale was used in this study.

Further validation of the PMC scale in the nurse executive population was warranted because the PMC scale was tested in a very different population and sample. Sekerka and colleagues (2009) validated the PMC scale in the military, with mostly white males with a young mean age of 28. The sample proposed in this study will be mostly female, an older group in age, and the majority non-military. Permission was granted to use the PMC scale in this study (Appendix B).

Sekerka and colleagues (2009) suggested that future research should include a different form of convergent validity, so this study used the VIA-IS scale items under the character
strength of bravery. The nurse executive who is brave should be able to demonstrate moral courage when responding to daily ethical challenges or situations. Bravery is defined by Park, Peterson, and Seligman (2004) as “valor, not shrinking from threat, challenge, difficulty, or pain; speaking up for what is right even if there is opposition; acting on convictions even if unpopular; includes physical bravery but is not limited to it” (p. 606). Petersen and Seligman (2004), with a positive psychology focus, developed a classification of character strengths, called the Values in Action- Inventory of Strengths (VIA-IS).

The discussion presented below is related to the “Strengths of Character and Well-being” study by Nansook Park, Christopher Peterson, and Martin E. P. Seligman (2004). The VIA-IS scale is a 240-item, self-report instrument, representing 24 character strengths, specific to six virtues. The six virtues are: wisdom and knowledge, courage, humanity, justice, temperance, and transcendence. The character strengths under the courage virtue include bravery, persistence, integrity, and vitality. The 24 character strength scales, each comprised of 10 items, are 5-point Likert-type scales. Each scale consists of a response range from (1) very much like me through (5) very much unlike me. The response very much like me indicates more character strength, and very much unlike me, less character strength. In the development of the scale the sample consisted of 458,998 U.S. adults. Reliability of all 24 character strengths measured by Cronbach’s alpha coefficient were greater than 0.70. Standard deviations ranged from 0.5 to 0.9 and coefficients of variation ranged from 0.15 to 0.25, indicating acceptable variability. Test-retest correlation resulted in  \( r = .70 \).

The 10 VIA-IS items under the character strength of bravery (Appendix C) come closest to the construct of moral courage. The VIA-IS bravery subset was used to establish convergent
validity in this study. These bravery items include: (1) I have taken frequent stands in the face of strong opposition; (2) I have overcome an emotional problem by facing it head on; (3) I never hesitate to express an unpopular opinion; (4) I must stand up for what I believe even if there are negative results; (5) I call for action while others talk; (6) I always stand up for my beliefs; (7) I always face my fears; (8) I have overcome pain and disappointment; (9) I always speak up in protest when I hear someone say mean things; and (10) I am a brave person. Theoretically the VIA-IS items represent the character strength of bravery under the virtue of courage and converge with the intent of the professional moral courage construct in the PMC scale. Permission was granted by the VIA-IS Institute to use the VIA-IS bravery items in this study (Appendix D).

“Social desirability is a potential concern in interpreting responses to socially-related measures, especially self-report measures” (Waltz et al., 2010, p. 433). Social desirability is defined as the tendency of individuals to project favorable images of themselves during social interaction (Waltz et al., 2010). The PMC scale questions are reflective of socially desirable traits; therefore, the possibility exists that the participants may answer in the context of what should be the behavior instead of the true behavior. The strategy to assess the extent of socially desirable responses was to administer the short form of the Marlowe-Crowne Social Desirability Scale and analyze this construct as a covariate in the measurement process (Waltz et al., 2010).

According to the study conducted by Douglas P. Crowne and David Marlowe in 1960, A New Scale for Social Desirability Independent of Psychopathology, the Marlowe-Crowne Social Desirability Scale (M-C SDS) has been used in the field of personality research and as an adjunct measure to assess the impact of social desirability. The original scale consists of 33 items with a
“true” and “false” format, reduced from 50 after an item analysis (Reynolds, 1982). Crowne and Marlowe (1960) recognized the influence of response distortion upon the ratings of personality test scores so used a different psychometric model in the selection of the items. The selection of the items was from a defined population based upon behaviors that had been culturally approved.

The previously-developed social desirability scale, the Minnesota Multiphasic Personality Inventory (MMPI), was correlated to select items based upon the differentiation between clinically normal and abnormal persons. Similarly, items in the Edwards Social Desirability Scale (SDS) (1957) were drawn from the MMPI and the Manifest Anxiety Scale and based on unanimous agreement of 10 judges who categorized them as socially desirable. Crowne and Marlowe (1960) believed the scale development of both had used statistically deviant procedures and questioned the response clarity, specifically the responses attributable to social desirability. Therefore, upon the development of the Marlowe-Crowne Social Desirability Scale, the items relevant to the pathology content were eliminated, 39 items from Edwards SDS were added, and the scale was submitted to an additional 10 judges. The judges rated the items for the degree of maladjustment implied by the socially undesirable responses. The 5-point scale ranged from (1) extremely well adjusted to (5) extremely maladjusted.

The internal consistency coefficient for the final M-C SDS was 0.88 using the Kuder-Richardson formula. The initial sample consisted of 39 undergraduates taking an abnormal psychology class at Ohio State University with a mean age of 24.4 years with a range of 19-46 years (Crowne & Marlowe, 1960). Additionally, the social desirability scale was administered to thirty-one students on two occasions, one month apart, and the reported test-retest correlation was 0.89.
Reynolds (1982) recognized the low number of social desirability measurements in psychological and social research and desired to develop a short form in an attempt to increase social desirability scale usage. The discussion below is related to William M. Reynolds (1982) research in the article “Development of Reliable and Valid Short Forms of the Marlowe-Crowne Social Desirability Scale.” Through factor analysis Reynolds developed valid and reliable short forms using the 33 item Marlowe-Crowne Social desirability scale. The three short forms consist of the M-C Form A, M-C Form B, and M-C Form C. Reynolds (1982) psychometrically tested the short forms using factor loadings, total scale correlations, and concurrent validations with the Edwards Social Desirability scale. The sample consisted of 608 undergraduate students, 239 male (39.3%) and 369 (60.7%) female with the mean age of 20.54 (SD=4.01) and a range between 17 to 54 years. The initial short form was based upon the factor loading criterion of 0.40 as a minimum level for item inclusion. Using this criterion, 11 items were selected for the first initial short form, M-C Form A. Based upon the factor loadings ranging from 0.40 to 0.54 with a median loading of 0.46, two additional short forms, M-C Form B (12 items) and M-C Form C (13 items) were developed. The analysis continued using these forms and three by Strahan and Gerbasi (1972) labeled as M-C Form XX (20 items), M-C Form X1 (10 items), and M-C Form X2 (10 items).

The 13-item form (M-C Form C) and the 20 item form (M-C Form XX) developed by Strahan and Gerbasi (1972) were found to be the two psychometrically strongest scales. “The M-C Form C revealed a positive correlation of \( r=0.93 \) with the Marlowe-Crowne Standard scale and \( r=0.41 \) with Edwards SDS and demonstrating an acceptable level of reliability” (Reynolds,
Since the M-C Form C is a brief and easy-to-administer social desirability measure, it was used in this study.

The Marlowe-Crowne Social Desirability Form C (Appendix E), is a 13-item scale and is scored using the values assigned $T=1$, $F=2$. However, the scale includes 5 reverse-coded items numbers 5, 7, 9, 10, and 13 which require a reverse scoring. A high score indicates a social desirability response tendency. Permission was granted by William M. Reynolds to use the M-C Form C in this study (Appendix F).

**Human Subject Protection**

Approval to conduct the study was obtained from the Molloy College Institutional Review Board, with exempt status requested (Appendix G). The cover letter included all of the necessary information to meet the required criteria for informed consent. Consent to participate in the study was implicit as the participants agreed to submit a survey in a paper format by mail or electronically. There was no identified risk to the subjects and a benefit is a contribution to the scientific knowledge of the nursing profession.

**Data-Collection Procedures**

Data collection was obtained using participants with the title of Chief Nursing Officer (CNO) or Chief Nurse Executive (CNE), employed in a healthcare organization, and a member of the American Organization of Nurse Executives (AONE). Collecting data through a national professional organization allows for a geographically diverse sample of the population under study. The data collection process began with submission of an *AONE Membership List Rental Agreement* (Appendix H) and an *AONE Membership Access for Research Participation Agreement* (Appendix I). Upon AONE’s approval, the membership list was purchased and a
research summary posted in the AONE’s designated section for research participation opportunities on their electronic platform. The research request for participation also had been advertised through the weekly AONE e-news and the AONE Working For You (AWFY) newsletter.

The AONE membership list included the members’ contact information: name, title, and preferred mailing address. The method to obtain participants consisted of conducting a mailing through the U.S. postal service to all members with the reported title of CNO or CNE, working in a healthcare organization, to their preferred mailing address. The mailing included a cover letter inviting them to take the survey. The cover letter (Appendix J) included the purpose of the study, a summary of the research and its significance, and an assurance of anonymity. In addition, the cover letter provided the researcher’s contact information and offered the option to obtain the results of the study.

The participants had multiple ways to submit the questionnaire. Participants either completed the enclosed paper questionnaire or returned it in the addressed postage paid envelope or submitted electronically. If they opted for electronic submission, participants used the URL provided to type into a web browser with a link to the questionnaire, or directly to a link on the Research Corner section of the AONE website at http://www.aone.org.

To maintain the participant’s anonymity, the returned paper questionnaire and the link provided was set up to have the questionnaire returned anonymously. In addition, to ensure proper identification of eligible participants with the title of CNO and CNE, a clear statement was placed in the cover letter and the heading of the electronic posting in AONE e-news and AONE Working for You (AWFY) newsletter as well as job title as one of the items on the
demographic section of the questionnaire. The heading of the electronic posting in AONE e-news and AONE Working for You (AWFY) newsletter read “Seeking Chief Nurse Officers (CNOs) and Chief Nurse Executives (CNEs) for a study on Moral Courage.”

Additionally, each participant had an opportunity to enter into a raffle for an iPad Mini, valued at $500.00. The instructions to enter into the raffle were provided in the cover letter as well as placed at the bottom of the posting on the AONE Research Corner. Raffle participants were advised to send a separate email to the researcher with their name and phone number; the email was not linked to the paper questionnaire or electronic survey.

**Research Design**

This was a non-experimental methodological study. The PMC is an instrument designed to measure moral courage. The research question guides the collection and analysis of the data: Is the PMC scale valid and reliable in a nurse executive population? The purpose of this study was to validate the PMC scale for use in the nurse executive population.

The validation process of the PMC scale includes evaluating reliability, convergent validity, hypothesis testing, and factor analysis.

Internal consistency indicates how well the items on the PMC fit together conceptually (DeVon et al., 2007). The reliability of the PMC scale was estimated with Cronbach’s alpha coefficient for internal consistency. The coefficient alpha of a minimum of 0.7 is determined acceptable for a pilot (Pallant, 2013).

Convergent validity demonstrates if the construct, moral courage, correlates with other validated measures of the construct (Polit & Yang, 2016). The VIA-IS scale’s ten bravery items were used to assess convergent validity. High correlations between the PMC and the VIA-IS
bravery items will support convergent validity. The accepted standard for convergent validity is a Pearson Product Moment correlation of $r \geq .45$ (DeVon et al., 2007).

Testing hypotheses regarding expected difference in groups is an additional method to establish validity of the PMC scale (Waltz, Strickland & Lenz, 2010). In this study, hypothesis testing using the demographics determined whether a hypothesis regarding survey outcome in the nurse executive population is established. The demographic data collected in this study included: title, gender, age in years, total years of experience as a CNO and/or CNE, ethnicity, highest degree in nursing, highest degree in another field, organization bed size (if applicable), number of nursing department employees, the type of organization, ANCC Magnet® designation status, the region in which the organization is located, the location descriptor, and for CNEs, the number of organizations and types of organizations in the system (Appendix K).

The hypotheses tested in this study determined if the educational level and the years of experience as a nurse executive were predictors of the level of moral courage of a nurse executive. The first proposed hypothesis was that the nurse executives who have attained higher educational levels will score higher on the PMC scale than those with less education. The second was that nurse executives who have more years of experience in that role will score higher on the PMC scale than those with less experience.

The first hypothesis tested regarding the educational level of the CNO/CNE was supported by national organizational recommendations and some literature. The prediction was that the nurse executive attaining higher educational levels would display a greater degree of moral courage. The CNO/CNE is an executive level position with decision-making authority in a healthcare organization. The imperative is for the CNO/CNE to influence the environment in
which nurses practice and optimize performance to meet the rapid changes and demands in healthcare.

The second hypothesis tested was the relationship between the CNO/CNE’s years of experience in their leadership role with the level of moral courage. The prediction was that the nurse executive with more years of experience will display higher levels of moral courage. The influence of experience is supported in the theoretical literature, however, the concept of influence as it relates to experience lacks empirical testing. According to Kidder (2005) maturity and experience influence the skills and abilities to persevere and overcome hardships to exercise morally courageous action. In the concept analysis: “Moral Courage in Nursing” by Olivia Numminen, Hanna Repo, and Helena Leino-Kilpi (2016), life and professional experience were recognized as antecedents for moral courage. The experience level of a nurse increases confidence which enhances the ability to voice an opinion or concern. The authors suggest that courageousness requires a commitment to lifelong professional and disciplined training.

Lastly, conduct of, both exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) was planned. EFA is the data-driven technique that determines common factors, while CFA has a theory-driven perspective which defines the factors and how well they fit the data (Waltz et al., 2010). An exploratory factor analysis examines the factor structure and the underlying subscales of the items that define the construct. In addition, using oblique rotations explores the correlations of factors, using the eigen value of > 1.0 as the result criteria. Confirmatory factor analysis follows to test the construct further and validate the extent the model fits the data (DeVon et al., 2007).
Data Analysis Procedure

The data analysis conducted used the statistical software program, SPSS.

The psychometric evaluation of the PMC scale included evaluating reliability, assessed by the Cronbach’s alpha coefficient; convergent validity, using the VIA-IS scale’s ten bravery items; hypothesis testing using the demographics, to determine if the educational level and the years of experience as a nurse executive were predictors of the level of moral courage; the assessment of the influence of social desirability scores, and factor analysis through Exploratory Factor Analysis (EFA) followed by Confirmatory Factor Analysis (CFA).

Summary

This chapter describes the essential components of the methodology of the study and included a plan for psychometric testing. The procedures are inclusive of rationales and discussion of the specific steps in the study, the population and sample, the survey instruments, and the data collection and analysis procedures. The objective of the research design for this study was to assess the psychometric properties of the PMC scale in the nurse executive population.
CHAPTER 4

FINDINGS

This chapter presents the psychometric analysis of the Professional Moral Courage (PMC) Scale in the nurse executive population. Descriptive statistics were used to summarize the characteristics of the sample. The statistical analysis findings have been organized into four sections in order to validate the instrument: reliability, convergent validity, hypothesis testing, and factor analysis. Three instruments were used in this analysis: (1) the Professional Moral Courage (PMC) scale; (2) the Values in Action-Inventory of Strengths (VIA-IS) bravery subscale; and (3) the Marlowe-Crowne (M-C) Social Desirability Form C scale. Reliability was determined by using the Cronbach’s alpha coefficient, and convergent validity and hypothesis testing by using Pearson product-moment correlations. Factor Analysis consisted of conducting a Confirmatory Factor Analysis (CFA) to test the construct and validate how the models fit the data. Maximum likelihood estimates were used in the CFA approach. To identify the model, the variance of the latent variables was set to one.

Correlation analysis was used to assess the extent of social desirability response bias. The findings of the analyses are described both in the narrative and reported in tables.

Sample

The sample consisted of 478 nurse executives. The respondents used one of two methods: a paper questionnaire or an electronic submission through the AONE Research Corner linked to Survey Monkey. The sample was obtained between January 1, 2017 and January 31, 2017. The 1400 mailings through the U.S. postal service generated 300 paper responses (a response rate of 21.4%), and 178 responses were received electronically (yielding an estimated
response rate of 12.7%). The total response rate was estimated at 34.1%. The participants all: (a) held a title of Chief Nursing Officer (CNO) or Chief Nurse Executive (CNE); (b) were employed in a healthcare organization; and (c) were members of the American Organization of Nurse Executives (AONE).

The respondents’ titles were 80.5% CNOs (n=384) and 19.5% CNEs (n=93) of 477 responses was due to one missing data point. Most of the participants were female (90.8%, n=434), and from 45 to 64 years of age (86.9%, n= 415) (see Table 1 for sample characteristics). The respondents reported the following ethnicities: White/Caucasian (94.4%, n= 451), Hispanic or Latino (1.7%, n=8), Asian or Pacific Islander (1.7%, n=8), Black or African American (1.3%, n=6), American Indian or Alaskan Native (1%, n= 5), and prefer not to answer (.6%, n=3).

Table 1

Sample Characteristics

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<td>CNE</td>
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<td>Hispanic or Latino</td>
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Note. *Missing Data

Of the total respondents, 75.9% (n=363) reported 1 to 15 years of nurse executive experience. For the highest degree held, 26.6% of the respondents attained a doctorate in nursing: 6.5% (n=31) the Doctor of Philosophy (PhD) and 20.1% (n=96) the Doctor of Nursing Practice (DNP). The majority held a graduate (Master’s) degree (50.4%, n=241) and some listed a bachelor’s degree in nursing as the highest degree obtained (20.3%, n=97). Those participants whose highest degree held was in another field (41.8%, n=200) reported a graduate (Master’s) degree (35.8%, n=171) in either Business Administration (MBA) or Health/Public Administration (MHA/MPA) (Table 2).

Table 2

Sample Experience and Education

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<td>459</td>
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</table>

Note. *Missing Data.

Most of the respondents work in a hospital (81.71%, n=408). The others work in ambulatory care (1%, n=5); behavioral health (0.6%, n=3); hospice (0.6%, n=3); rehabilitation centers (0.6%, n=3); skilled nursing facilities (0.2%, n=1); sub-acute nursing facilities (0.2%, n=1); and home care agencies (0.2%, n=1) as shown in Table 3. The bed size of the organizations ranged from fewer than 100 beds to over 5,000 beds. The majority of the participants worked in smaller organizations with fewer than 300 beds (53.8%, n=257); the rest worked in medium-sized organizations having between 301 and 499 beds (20.1%, n=96), and larger organizations having between 500 and 5,000 beds (22.0%, n=105). The number of employees reporting to the CNO/CNE in her/his department(s) ranged from fewer than 100 to
over 5,000 employees. More than half of the participants supervised between 500 and 4,999 employees (55.8%, n=267).

Table 3

Organization Type/Bed Size/Number of Employees

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Healthcare Organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td>408</td>
<td>85.4</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td></td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Sub-acute Nursing Facility</td>
<td></td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Home Care Agency</td>
<td></td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td>Rehabilitation Center</td>
<td></td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td></td>
<td>5</td>
<td>1.0</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>51</td>
<td>10.7</td>
</tr>
<tr>
<td>Total*</td>
<td></td>
<td>476</td>
<td>99.6</td>
</tr>
<tr>
<td>Bed Size of the Organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 100 beds</td>
<td></td>
<td>105</td>
<td>22.0</td>
</tr>
<tr>
<td>100-300 beds</td>
<td></td>
<td>152</td>
<td>31.8</td>
</tr>
<tr>
<td>301-499 beds</td>
<td></td>
<td>96</td>
<td>20.1</td>
</tr>
<tr>
<td>500-999 beds</td>
<td></td>
<td>64</td>
<td>13.4</td>
</tr>
<tr>
<td>1,000-4,999 beds</td>
<td></td>
<td>31</td>
<td>6.5</td>
</tr>
<tr>
<td>5,000+ beds</td>
<td></td>
<td>10</td>
<td>2.1</td>
</tr>
<tr>
<td>Not Applicable</td>
<td></td>
<td>15</td>
<td>3.1</td>
</tr>
<tr>
<td>Total*</td>
<td></td>
<td>473</td>
<td>99.0</td>
</tr>
<tr>
<td>Number of Employees in Department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 100 employees</td>
<td></td>
<td>22</td>
<td>4.6</td>
</tr>
<tr>
<td>100-300 employees</td>
<td></td>
<td>87</td>
<td>18.2</td>
</tr>
<tr>
<td>301-499 employees</td>
<td></td>
<td>68</td>
<td>14.2</td>
</tr>
<tr>
<td>500-999 employees</td>
<td></td>
<td>114</td>
<td>23.8</td>
</tr>
<tr>
<td>1,000-4,999 employees</td>
<td></td>
<td>153</td>
<td>32.0</td>
</tr>
<tr>
<td>5,000+ employees</td>
<td></td>
<td>32</td>
<td>6.7</td>
</tr>
<tr>
<td>Total*</td>
<td></td>
<td>476</td>
<td>99.6</td>
</tr>
</tbody>
</table>

Note. *Missing Data.
As shown in table 4, the majority of the CNO/CNEs did not work in ANCC Magnet® designated organizations (55.6%, n=266), although 14.9% of the organizations were in the process of earning Magnet® designation (n=71), and 24.1% (n=115) did hold the designation.

Table 4

*Magnet® Designation Status*

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization</td>
<td>ANCC Magnet® Designated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>115</td>
<td>24.1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>266</td>
<td>55.6</td>
</tr>
<tr>
<td></td>
<td>On the Journey</td>
<td>71</td>
<td>14.9</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>22</td>
<td>4.6</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong>*</td>
<td><strong>474</strong>*</td>
<td><strong>99.2</strong>*</td>
</tr>
</tbody>
</table>

*Note.* *Missing data.*

The respondents represented five geographic regions in the United States: Northeast, Southeast, Midwest, Southwest, and West. As shown in Table 5, the Northeast, Southeast, and Midwest regions provided the largest number of participants. Eleven participants described the organization’s region under “other,” meaning that the organization extended either into all the indicated regions or across the United States. One respondent specified that the organization was international and another indicated global. The participants described their organizations as urban (39.1%, n=187), suburban (34.9%, n=167), and rural (31.4%, n=150).

Table 5

*The Region of the Organization*

<table>
<thead>
<tr>
<th>Region</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>111</td>
<td>23.2</td>
</tr>
<tr>
<td>CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Table 5 cont’d next page*
Table 5 cont’d

<table>
<thead>
<tr>
<th>Region</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southeast</td>
<td>99</td>
<td>20.7</td>
</tr>
<tr>
<td>AL, AR, FL, GA, KY, LA, MS, SC, TN, VA, WV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwest</td>
<td>133</td>
<td>27.8</td>
</tr>
<tr>
<td>IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southwest</td>
<td>51</td>
<td>10.7</td>
</tr>
<tr>
<td>AZ, NM, OK, TX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West</td>
<td>72</td>
<td>15.1</td>
</tr>
<tr>
<td>AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>2.3</td>
</tr>
<tr>
<td>Total*</td>
<td>477*</td>
<td>99.8*</td>
</tr>
</tbody>
</table>

Note. *Missing data (0.2%, n=1)

Reliability

The three instruments used in this study included (a) Professional Moral Courage (PMC) scale; (b) the Values in Action-Inventory of Strengths (VIA-IS) bravery sub-scale; and (c) the Marlowe-Crowne Social Desirability Form C scale. The reliability of each instrument was determined using Cronbach’s alpha coefficient; a value of at least 0.7 is considered acceptable (Polit & Yang, 2016).

As Table 6 shows, the overall PMC scale has good internal consistency, with a Cronbach’s alpha coefficient of 0.853 and a mean score of 96.2 (SD=5.9). The Values in Action-Inventory of Strengths bravery sub-scale was also found to have good internal consistency: it had a Cronbach’s alpha coefficient of 0.785 and a mean score of 17.9 (SD=4.0). The Marlowe-Crowne Social Desirability Form C scale scored lower, with a Cronbach’s alpha
coefficient of 0.609 and a mean score of 22.3 (SD=2.2).

Table 6

Scale Statistics/Internal Consistency

<table>
<thead>
<tr>
<th>Scale</th>
<th># of Items</th>
<th>Mean</th>
<th>Variance</th>
<th>Standard Deviation</th>
<th>Cronbach’s alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMC</td>
<td>15</td>
<td>96.2130</td>
<td>34.965</td>
<td>5.91316</td>
<td>0.853</td>
</tr>
<tr>
<td>VIA-IS Bravery</td>
<td>10</td>
<td>17.9612</td>
<td>16.275</td>
<td>4.03422</td>
<td>0.785</td>
</tr>
<tr>
<td>Marlowe-Crowne</td>
<td>13</td>
<td>22.3534</td>
<td>5.007</td>
<td>2.23753</td>
<td>0.609</td>
</tr>
</tbody>
</table>

Note. The computations are based upon: PMC 96.2% (n=460); VIA-IS bravery sub-scale 97.1% (n=464); Marlowe-Crowne Social Desirability Form C scale 97.1% (n=464).

The PMC sub-scales had acceptable internal consistency overall, although a few scored lower than the acceptable internal consistency of 0.70 (see Table 7). The PMC sub-scales ranged from Moral Agency, with the lowest Cronbach’s alpha (0.328) and Endurance of Threats having the highest Cronbach’s alpha (0.789). However, according to Streiner (2003), interpreting a Cronbach’s alpha to accurately determine an acceptable value is dependent upon the situation and/or population. He asserts that the higher value of Cronbach’s alpha does not always suggest a high internal consistency. Streiner (2003) points out misconceptions about the interpretations of Cronbach’s alpha and cautions interpretation because there are acceptable values of alpha in different situations (p. 99). The three considerations affecting the value of alpha include (1) the number of test items; (2) item interrelatedness; and (3) dimensionality. Based upon these considerations and recognizing the PMC scale is measuring one construct, moral courage, Cronbach’s alpha has been calculated for the entire scale. For that reason, the overall PMC scale (0.853) has acceptable reliability, and is empirically supported.
Table 7

PMC Sub-Scale Internal Consistency

<table>
<thead>
<tr>
<th>PMC Scale/Subscales</th>
<th>Items</th>
<th>Cronbach’s alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moral Agency</td>
<td>3</td>
<td>0.328</td>
</tr>
<tr>
<td>Multiple Values</td>
<td>3</td>
<td>0.607</td>
</tr>
<tr>
<td>Endurance of Threats</td>
<td>3</td>
<td>0.789</td>
</tr>
<tr>
<td>Going Beyond Compliance</td>
<td>3</td>
<td>0.691</td>
</tr>
<tr>
<td>Moral Goal</td>
<td>3</td>
<td>0.628</td>
</tr>
<tr>
<td>Overall Scale</td>
<td>15</td>
<td>0.853</td>
</tr>
</tbody>
</table>

Convergent Validity

Convergent validity identifies the degree to which a construct correlates with other measures of the construct; it is measured by the degree to which there is conceptual convergence (Polit & Yang, 2016). The acceptable validity parameter for convergent validity is a Pearson product correlation coefficient of $r \geq 0.45$. It was hypothesized that scores on the VIA-IS bravery scale would positively correlate with the scores on the PMC scale, which assesses the construct of moral courage. The Pearson product-moment correlation obtained was $r = 0.457$, and it was statistically significant ($p < .001$). Thus, the two scales demonstrated high correlation and the VIA-IS supported convergent validity of the PMC scale (Table 8).

The semantic scoring method of the instruments is summative for both the PMC scale and VIA-IS bravery sub-scales. For the PMC scale, the higher the score, the greater level of moral courage; for the VIA-IS bravery sub-scale, the lower the score, the more character
strength. Taking into consideration the coding differences of the responses, the negative Pearson product-moment correlation “r” value is positive. Therefore, the r value of 0.457 (p= < .001) reveals a statistically significant relationship between the PMC scale and VIA-IS bravery items.

Table 8

Correlation: PMC Scale and VIA-IS Bravery Sub-Scale

<table>
<thead>
<tr>
<th>Scales</th>
<th>Pearson Correlation</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMC (n=460)</td>
<td>r= -.457*</td>
<td>p= &lt;.001*</td>
</tr>
<tr>
<td>VIA-IS Bravery (n=448)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Correlation is significant at the 0.01 level (2-tailed).

Hypothesis testing

This study utilized a validation approach to test the hypotheses and conclude if the educational level and the years of experience of the CNO/CNE were predictors of the level of moral courage. It was hypothesized that higher educational levels and more years of experience should be associated with greater moral courage, indicated by higher scores on the PMC scale. Hypothesis testing was carried out using a correlational analysis, using the Pearson correlation coefficient to examine the data and test if there is a positive relationship between higher education and experience levels and professional moral courage.

The first hypothesis (which predicted that the nurse executive who attained higher educational levels would score higher on the PMC scale than those with less education) was not supported. The hypothesis was tested by computing a Pearson product moment correlation (r) to test the relationship. The results indicated an r value of -0.041 (p= 0.380), which did not support the notion that the educational level of a nurse executives predicted higher moral courage.
The second hypothesis (which predicted that the nurse executive with more years of experience would display higher levels of moral courage) was supported. The Pearson product moment correlation ($r=0.151$, $p=.001$) supports the notion that the more years of experience a nurse executive has, the higher his or her level of moral courage (see Table 9).

Table 9

*Hypothesis Testing/Correlation*

<table>
<thead>
<tr>
<th>PMC Question</th>
<th>Pearson Correlation</th>
<th>Significance</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many years of experience do you have as a CNO and/or CNE?</td>
<td>$r= 0.151^{**}$</td>
<td>$p= .001^{**}$</td>
<td>458</td>
</tr>
<tr>
<td>What is the highest degree you have received in Nursing?</td>
<td>$r= -0.041$</td>
<td>$p= .380$</td>
<td>459</td>
</tr>
</tbody>
</table>

*Note.** Correlation is significant at the 0.01 level (2-tailed).

**Factor Analysis**

Exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) techniques were proposed as a validation method to examine the factor structure and underlying subscale items that define the construct of professional moral courage. The validation method proposed included a random sample split between the EFA and CFA. However, the low power from the sample size ($n=460$) led to a revision of the approach to conduct only a CFA; this tested the construct and validated the models to fit to the data and prevent a type 2 error. The hypothesized model contains fifteen observed variables on five associated latent constructs of the Professional Moral Courage (PMC) scale (see Figure 1).
The standardized factor loading values for each of the fifteen observed variables include the standard error, significance, and 95% confidence intervals (reported in Table
10). The weakest loading occurred with the latent construct “Moral Agency,” which mapped onto: Q1, “I am the type of person who is unfailing when it comes to doing the right thing at work” (0.282); Q2, “When I do my job, I regularly take additional measures to ensure my actions reduce harm to others” (0.490); and Q3, “My work associates would describe me as someone who is always working to achieve ethical performance making every effort to be honorable in all my actions” (0.431). The strongest loading occurred under the latent construct, “Endurance of Threats,” which mapped onto: Q7, “When I encounter an ethical challenge, I take it with moral action, regardless of how it may pose a negative impact on how others see me” (0.706); Q8, “I hold my ground on moral matters, even if there are opposing social pressures” (0.763); and Q9, “I act morally even if it puts me in an uncomfortable position with my superiors” (0.783). The fifteen observed variable coefficients’ standard errors were strong, with very little variability; each was statistically significant at p < .001, with 95% confidence intervals ranging from 0.189 to 0.834.

Table 10

PMC Scale: Standardized Factor Loadings

<table>
<thead>
<tr>
<th>Factors</th>
<th>Loading</th>
<th>Std. Error</th>
<th>Significance</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMC 1 Moral Agency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1 I am the type of person who is unfailing when it comes to doing the right thing at work.</td>
<td>0.282</td>
<td>0.047</td>
<td>p = &lt;.001</td>
<td>0.189 to 0.375</td>
</tr>
</tbody>
</table>

Table 10 cont’d next page
### Table 10 cont’d

<table>
<thead>
<tr>
<th>Factors</th>
<th>Loading</th>
<th>Std. Error</th>
<th>Significance</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 When I do my job, I regularly take additional measures to ensure my actions reduce harm to others.</td>
<td>0.490</td>
<td>0.047</td>
<td>p= &lt;.001</td>
<td>0.397 to 0.582</td>
</tr>
<tr>
<td>Q3 My work associates would describe me as someone who is always working to achieve ethical performance, making every effort to be honorable in all my actions.</td>
<td>0.431</td>
<td>0.051</td>
<td>p= &lt;.001</td>
<td>0.330 to 0.533</td>
</tr>
<tr>
<td><strong>PMC 2 Multiple Values</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4 I am the type of person who uses a guiding set of principles from the organization as when I make ethical decisions on the job.</td>
<td>0.522</td>
<td>0.043</td>
<td>p= &lt;.001</td>
<td>0.438 to 0.606</td>
</tr>
<tr>
<td>Q5 No matter what, I consider how both my organization’s values and my personal values apply to the situation before making decisions.</td>
<td>0.737</td>
<td>0.037</td>
<td>p= &lt;.001</td>
<td>0.664 to 0.810</td>
</tr>
<tr>
<td>Q6 When making decisions, I often consider how my role in the organization, my boss (supervisor of leader), and my upbringing must be applied to any final action.</td>
<td>0.553</td>
<td>0.042</td>
<td>p= &lt;.001</td>
<td>0.470 to 0.636</td>
</tr>
<tr>
<td><strong>PMC 3 Endurance of Threats</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q7 When I encounter an ethical challenge, I take it with moral action, regardless of how it may pose a negative impact on how others see me.</td>
<td>0.706</td>
<td>0.029</td>
<td>p= &lt;.001</td>
<td>0.647 to 0.765</td>
</tr>
<tr>
<td>Q8 I hold my ground on moral matters, even if there are opposing social pressures.</td>
<td>0.763</td>
<td>0.027</td>
<td>p= &lt;.001</td>
<td>0.710 to 0.816</td>
</tr>
<tr>
<td>Q9 I act morally even if it puts me in an uncomfortable position with my superiors.</td>
<td>0.783</td>
<td>0.026</td>
<td>p= &lt;.001</td>
<td>0.731 to 0.834</td>
</tr>
</tbody>
</table>

*Table 10 cont’d next page*
Table 10 cont’d

<table>
<thead>
<tr>
<th>Factors</th>
<th>Loading</th>
<th>Std. Error</th>
<th>Significance</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PMC 4 Going Beyond Compliance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q10 My coworkers would say that when I do my job I do more than follow the regulations, I do everything I can to ensure actions are morally sound.</td>
<td>0.721</td>
<td>0.029</td>
<td>p = &lt;.001</td>
<td>0.664 to 0.779</td>
</tr>
<tr>
<td>Q11 When I go about my daily tasks I make sure to comply with the rules, but also to look to understand their intent, to ensure that this is being accomplished as well.</td>
<td>0.602</td>
<td>0.036</td>
<td>p = &lt;.001</td>
<td>0.532 to 0.673</td>
</tr>
<tr>
<td>Q12 It is important that I go beyond the legal requirements but seek to accomplish tasks with ethical action as well.</td>
<td>0.633</td>
<td>0.033</td>
<td>p = &lt;.001</td>
<td>0.567 to 0.698</td>
</tr>
<tr>
<td><strong>PMC 5 Moral Goals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q13 It is important for me to use prudential judgment in making decision at work.</td>
<td>0.574</td>
<td>0.038</td>
<td>p = &lt;.001</td>
<td>0.498 to 0.651</td>
</tr>
<tr>
<td>Q14 I think about my motives when achieving the mission, to ensure they are based upon moral ends.</td>
<td>0.703</td>
<td>0.033</td>
<td>p = &lt;.001</td>
<td>0.637 to 0.768</td>
</tr>
<tr>
<td>Q15 I act morally because it is the right thing to do.</td>
<td>0.590</td>
<td>0.038</td>
<td>p = &lt;.001</td>
<td>0.514 to 0.666</td>
</tr>
</tbody>
</table>

Note. LR test of Model vs. saturated: chi² (80) = 167.93, Prob > chi² = 0.001

The chi-square goodness of fit statistic is the most basic index of the goodness of fit estimate for an overall model. The chi-square value is indicative of a good fit if it has a probability of p > .05 (Polit & Yang, 2016). Polit and Yang (2016) emphasize “the chi square is sensitive to sample size and to departures from normality and thus is seldom used as the sole criterion for model fit” (p. 215). The chi square value result p > 0.001 does not indicate a good fit. Therefore, additional fit indices were used to explore different aspects of the analysis and
determine if the hypothesized model was a good fit to the data. Those fit indices include the root mean square error of approximation (RMSEA), which demonstrates how well the model fits the data; ≤ 0.06 indicates a good fit. The Comparative fit index (CFI) and Tucker-Lewis index (TLI) compare the observed correlations with the expected correlations from the proposed model, based on the parameter in the equations; a value of ≥ 0.95 is evidence of a good model fit (Polit & Yang, 2016). As shown in Table 11, the findings consisted of the RMSEA = 0.049 which suggests the model is a good fit on average, and a 90% Confidence Interval (CI), upper-bound for the RMSEA = 0.059 also supports an acceptable fit of the model. The Goodness of Fit Index CFI = 0.953 and the TLI = 0.938 with a coefficient of determination (CD) = 0.979 similarly support the model as an acceptable fit for the data.

Table 11

*PMC Scale: Confirmatory Factor Analysis*

<table>
<thead>
<tr>
<th>Model Fit Indices</th>
<th>Recommended Value for Fit Indices</th>
<th>Value Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-Square</td>
<td>0.05</td>
<td>p &lt; .05</td>
</tr>
<tr>
<td>RMSEA</td>
<td>≤ 0.06</td>
<td>0.049;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90% CI; upper bound= 0.059</td>
</tr>
<tr>
<td>CFI</td>
<td>≥ 0.95</td>
<td>0.953</td>
</tr>
<tr>
<td>TLI</td>
<td>≥ 0.95</td>
<td>0.938; CD = 0.979</td>
</tr>
</tbody>
</table>

**Social Desirability**

The Marlowe-Crowne (MC) Social Desirability Form C scale was administered to determine the extent of social desirability response bias. Social Desirability response bias often
can undermine or distort the interpretation of average score values; it can also restrict variation, which in turn can reduce group differences as well as estimates of effect size and reliability (Polit & Yang, 2016, p. 44). The MC Social desirability Form C scale was used to explore the relationship between the PMC scale and social desirability. The correlation of the PMC scale with MC Social desirability Form C scale was $r = .223$. This correlation suggests no relationship; therefore, social desirable bias did not influence the professional moral courage scores.

**Summary**

This chapter presented the results of the psychometric analysis of the Professional Moral Courage scale in the nurse executive population. The psychometric analyses supported the validity and reliability of the PMC scale. Correlational analysis for convergent validity concluded convergence between the PMC and VIA-IS bravery items. The hypothesis, the more years of experience working as a nurse executive, the higher level of moral courage was supported. Confirmatory factor analysis findings suggested that the internal structure of the PMC scale and measurement of the underlying construct, professional moral courage, is acceptable and the model is an acceptable fit for the data. Lastly, correlation explored the PMC scale scores for social desirability bias and revealed the scores were not influenced by socially desirable responses.
CHAPTER 5
DISCUSSION AND RECOMMENDATIONS

This study sought to psychometrically validate the Professional Moral Courage (PMC) scale for potential use as a method to evaluate moral courage in a nurse executive’s practice. The research question was: Is the PMC scale valid and reliable in a nurse executive population?

The nurse executive’s role is one of influence and advocacy for issues affecting the patient and the nurse as well as those involving the structure, processes, and outcomes of a healthcare organization. The nurse executive has a professional obligation to ensure that the strategic vision and decisions at the executive level foster a positive practice environment for the nurse and the delivery of quality and safe care to the patient. To fulfill this expectation under a complex and changing health care paradigm requires the nurse executive to exhibit moral courage. The challenges and dilemmas faced by nurse executives during health care reform make it an imperative for professional moral courage to be recognized as a competency for nurse executive practice. However, the first step in this recognition is to establish a reliable and valid instrument as a method of evaluation.

This chapter reviews the stated purpose of this research and summarizes applicable study findings. The discussion concludes with implications, limitations of the research, and recommendations for further research.

Study Summary

The purpose of this study was to undertake a psychometric evaluation of the PMC scale in the nurse executive population. The intent of testing the hypothesized model of the PMC scale was to provide a measure to assess the characteristic of professional moral courage and
support it as a competency in nurse executive practice. This study is the first to explore such a measure in the nurse executive population.

The subjects for the study comprised a sample of 478 nurse executive participants from across the United States. The participants were members of the professional organization, American Organization of Nurse Executives (AONE), and were nurses employed as a CNO or CNE in a healthcare organization at the time of the study. The majority of respondents were female, White/Caucasian, CNO/CNEs between 45 and 64 years of age, with 1–15 years of experience as a nurse executive. The doctoral degree (PhD, DNP, and in another field) was cited as the highest educational level obtained by the participants. The DNP was held by twenty percent of those participants. However, most participants reported the master’s degree as the highest-level degree in both nursing and related fields.

The sample demographic characteristics are representative of the nurse executive population. One study conducted by Westphal (2012), *Characteristics of Nurse Leaders in Hospitals in the USA from 1992 to 2008*, described the nurse leader workforce in U.S. hospitals. Westphal (2012), referencing the U.S. Department of Health and Human Services (2010), reported “in 2008, women represented 91.4% of the nurse leaders in US hospitals, a finding similar to the general RN population. The number of men in leadership positions in 2008 (8.6%) was slightly higher than the percentage of men in nursing overall (6.6%)” (p. 936). Likewise, the study sample was 90.8% female. Westphal (2012) found the largest proportion of nurse executives were aged 50 years and older which is comparable to the nurse executive participants in this study; 86.9% were from 45 to 64 years of age. Additionally, Westphal found that nurse leaders holding a master’s or doctoral degree increased from 14.5% in 1992 to 23.2% in 2008.
The sample characteristics for this study revealed the doctorate degree in nursing (26.6%) as the highest degree with approximately half of nurse executives holding a master’s degree in nursing (50.4%). Experience level was not measured.

Eighty five percent of the participants worked in a hospital, and over half of these in smaller organizations with less than 300 beds. Sixty three percent of participants supervised over 500 employees. The majority did not work in an ANCC Magnet® designated organization.

The geographic regions in the United States that provided the largest number of participants were the Northeast, Southeast, and Midwest. The organization locations were distributed among rural, suburban, and urban areas.

The study design employed a fifty-three-question survey structured by four sections and represented the three instruments and demographics. The first section comprised the 15-item PMC scale, developed by Leslie E. Sekerka, Richard P. Bagozzi, and Richard Charnigo (2009). The second section, the 10-item bravery sub-scale, part of the Values in Action-Inventory of Strengths (VIA-IS) developed by Petersen and Seligman (2004), was used to establish convergent validity with professional moral courage. The third section, the 13-item Marlowe-Crowne Social Desirability Form C, psychometrically validated by William M. Reynolds (1982), was used to measure social desirability response tendency. The fourth section provided the demographic information of the participants.

The data collection consisted of 1400 mailings through the U.S. postal service and electronically through a link on the Research Corner section of the AONE website. The two approaches for data collection—a paper mail survey and an electronic platform—produced an
estimated response rate of 34.1% (300 paper surveys and 178 electronic surveys were returned), indicating the importance of professional moral courage among nursing executives.

Some key findings of the study supported the validity and reliability of the PMC scale as a measure for professional moral courage in the nurse executive population. The overall PMC scale had good internal consistency. Convergent validity was established between the character strength of bravery and professional moral courage. The findings also supported the hypothesis that more experience as a nurse executive is associated with higher levels of moral courage. Confirmatory factor analysis (CFA) suggested that the internal structure of the PMC scale and measurement of the underlying construct, professional moral courage, is acceptable. The factor structure and standardized factor loadings for the fifteen observed variables of the PMC scale resulted in the latent construct of “Moral Agency” as the weakest loading and “Endurance of Threats” the strongest loading. In addition, the CFA suggested consistency with the data obtained and the goodness-of-fit estimates suggest the overall model fit is adequate to the data. Lastly, the influence of social desirability response bias due to the subjective nature of the construct did not significantly affect the results.

**Discussion**

This study has psychometrically evaluated the Professional Moral Courage scale in the nurse executive population. The findings of the study suggest that the PMC scale is acceptable as a measure for moral courage in the nurse executive population. The results reported above support prior literature on the importance of professional moral courage in a nurse executive’s practice.
The convergence between the constructs of professional moral courage and bravery exist.

Bravery as a character strength for a nurse executive is consistent with this literature. Sekerka, Bagozzi, and Charnigo (2009) promote the idea that bravery and moral strength support an individual’s ability to act or respond to challenges. Kidder (2005) posits that the absence of bravery results in difficulty managing and overcoming fear, danger, and taking a risk to effectively act. Goud (2005) explored managing and overcoming fear as a model for courage.

According to Lachman (2010), bravery underscores the strategy needed to overcome fear in order to approach a difficult situation or manage conflict. In leadership, bravery as a subset for the virtue of courage is essentially standing up for what is right and the willingness to take risks regardless of the consequence. Moral courage specifically addresses the character of the individual and courage through brave action that evolves from the development of inner character (Day, 2007). In essence, the role of the nurse executive is one of influence and advocacy to ensure positive practice environments for nurses, to assist with required changes within the organization, and promote patient safety. The nurse executive’s commitment and obligation is to have or to gain the ability to exhibit courageous acts through bravery as part of her or his role.

As previously discussed, a nurse executive is faced with many challenges and opportunities that primarily surround rapid changes in health care and health care reform. The arrival of value-based reimbursement and the implications of failure to provide quality and safe care, favorable patient experience, and a positive practice environment for the nurse are significant for the nurse executive. Delivering on these expectations in an environment of dwindling reimbursements and greater fiscal responsibility requires advanced knowledge and
leadership experience. This study tested two hypotheses: first, to predict if the nurse executive who attained higher educational levels would score higher on the PMC scale than those with less education; and second, the nurse executive with more years of experience would display higher levels of moral courage.

The first hypothesis, that a higher educational level is associated with higher moral courage was not supported. The study did show that educational differences existed: approximately half of the respondents held a master’s degree in nursing; some held only a bachelor’s degree in nursing; and around one quarter held doctorates. The lack of support for this hypothesis may indicate that although higher education provides the necessary knowledge and skills for a nurse executive to lead through the rapid changes in healthcare; however, assuming the role of a nurse executive still requires personal and professional development.

The hypothesis that more years of experience was associated with higher levels of moral courage was supported. This finding is consistent with Murray (2010), Kidder (2005), and Goud (2005) who have asserted that work and past experiences enhance competency, confidence, and maturity in order to increase moral strength, manage challenges, and gain the ability to courageously act. Numminen, Repo, and Leino-Kilpi (2016) added that past experiences increase an individual’s confidence, and consequently, the level of courage. Building confidence requires experience, both personal and professional. Essentially, self-confidence contributes to the ability to act with moral courage. Since the nurse executive role requires strategy and decision-making to ensure positive nurse practice environments and the delivery of quality care; previous work experience can increase competency and skill levels. This is emphasized in the American Organization of Nurse Executives (AONE) (2015) comprehensive guide for successful
nurse executive practice. The leadership competency in the AONE guide describes the acquisition of experience through a nurse executive’s personal journey. The personal journey contributes to competency and is defined as, “learn from setbacks and failures as well as successes” (AONE, 2015, p. 8). Thus, previous experiences build the moral strength, resilience, and perseverance necessary in nurse executive practice.

Construct validity of the PMC scale was established using confirmatory factor analysis. Confirmatory factor analysis (CFA) evaluated the structure and model fit of the PMC scale. The hypothesized model of the PMC scale is shown schematically in Figure 1. The factor-structure and standardized-factor loadings of the PMC scale showed the latent construct of “Moral Agency” as the weakest loading and “Endurance of Threats” as the strongest loading.

Moral agency represents “a predisposition toward moral behavior and persistence of the will to engage” (Sekerka et al., 2009, p.568). Moral agency had the weakest factor loading, which is not consistent with the original factor analysis of the PMC scale; the moral agency factor loading was 0.80. In this study, the moral agency subscale had the lowest Cronbach’s alpha (0.328) which may explain the weak factor loading since both are based on correlations. Uncertainty and demands in the healthcare system create challenges and stress that can affect the nurse executive’s practice. This may be true because of role pressure and/or an unsupportive organization which could eventually lead to moral distress. Therefore, it is possible that a weak loading for moral agency may suggest that the nurse executive is experiencing moral distress. As Edmonson (2010) asserted, moral distress affects the personal and professional well-being of the nurse executive.

“Professional Moral Courage is reflected in managers who face difficulties both
perceived and real danger and threat, with endurance” (Sekerka et al., 2009, p.569). Endurance of threats as the factor with the strongest loading suggests the nurse executive’s commitment and moral strength to advocate for the principles and values of nursing and ultimately the patient. Moral courage involves the willingness to speak out and the ability to confront and overcome fear (Lachman, 2010; Clancy, 2003; Kidder 2005). Kidder (2005) asserted that trust in one’s ability is an important element of morally courageous decision-making and enduring the hardships of that decision. Kidder (2005) explained that trust in one’s ability emerged from four sources of endurance:

1. Experience, through which we rely on what we’ve done and, by extension, what we can do;
2. Character, encouraging us to trust in who we are rather than what we’ve done, and giving us comfort that the values and virtues we’ve always expressed will be there in the future;
3. Faith, which causes us to trust that whatever we worship as an authority beyond ourselves will sustain us as we move forward; and
4. Intuition, leading us to act according to a gut feeling, with the confidence that if our intuitions have been right in the past they will probably be right in the future (p.151).

Harbour and Kisfalvi (2014) added that resilience through adversity; competence and self-confidence were identified as necessary managerial competencies for decision-making.

The broader PMC scale incorporates latent variables, or sub-scales, and items to represent the construct of professional moral courage. Although each sub-scale is an important component of the construct, the overall PMC scale represents homogeneity and captures the overarching concept of the construct, and what is being assessed. Although the chi square value did not show good model fit, the assumption is this is due to the low power of the study. The additional
fit indices (RMSEA = 0.049; CFI = 0.953; and TLI = 0.938) suggest an acceptable model fit to
the data and support instrument validation. Consequently, the findings from this study were
supportive of the utility of the Professional Moral Courage scale.

**Limitations**

Limitations of the study were the demographic characteristics and sample size. First, the
study findings were limited to AONE nurse executive members. Those nurse executives who are
currently working and not AONE members were not in the sample, and their inclusion could
affect the generalizability of the results. Future studies should consider expanding to those nurse
executives who are not AONE members. Second, despite the adequacy of the sample size for the
factor analysis component of the study (requiring the number of participants exceeding the
number of variables) (Waltz, et al., 2010), the CFA goodness-of-fit testing parameter, chi square,
did not indicate a good fit, suggesting the study may have been underpowered. Although the
return rate was strong, the data collection timeframe and time of the year may have led to limited
response. The month of January is immediately after a holiday season, when work demands are
usually high, and the short period of data collection, one month, may have been contributing
factors. The plan for data collection should be carefully crafted in future studies to maximize the
sample size.

**Implications**

This research study contributes to the literature in nursing leadership and nurse executive
practice. This study evaluated an instrument to measure professional moral courage in the nurse
executive. Prior research in nursing has not focused on the measurement of professional moral
courage. Therefore, this study fills the void in the literature to evaluate a measurement tool that assesses professional moral courage in the nurse executive population.

The demanding role and challenges facing nurse executives reinforce the need for professional moral courage as a necessary attribute in the nurse executive. To evaluate this competency, a method to measure professional moral courage in the nurse executive population is essential. The PMC scale is a tool that advances the evaluation of a nurse executive’s ability and promotes a better understanding of the level of professional moral courage needed at the nurse executive level. The method of evaluation provides a mechanism to assist in identifying deficits in desired behaviors, highlights professional development opportunities to enhance the nurse executive’s ability, and establishes this essential quality as a competency.

The PMC scale can be used in an organization to support decisions and actions, and build resilience. The performance appraisal process, with a self-assessment component, assists in guiding personal growth and professional development. Integrating the PMC scale into the appraisal process could identify needs and assist in establishing educational programs for nurse executives. The evaluation process reinforces expected behavior, promotes feedback, self-monitoring, and encourages reflection for improvement. Depending on the PMC scale results; educational modules can be created based upon the five dimensions of the PMC scales: (a) moral agency; (b) multiple values; (c) endurance of threats; (d) going beyond compliance; and (e) moral goals. By doing so, it is plausible that the education will enhance the nurse executive’s ability to practice with professional moral courage and embody leading by example. In addition, the PMC scale, as a pre-employment tool, has the potential to proactively assess potential
candidates for ability and promote awareness of the expected behaviors in the nurse executive role.

**Recommendations**

Research is necessary for the advancement of the discipline of nursing and nursing leadership. The pursuit of further research in professional moral courage in the nurse executive population and instrument evaluation strengthens this body of knowledge.

Additional research is warranted to support the PMC scale in its evaluative role amongst the nurse executive population. Replicating this study in a larger population across the United States, and not limiting it to professional organization members, would provide the generalizability needed to support the study findings further.

Another recommendation is to pursue modifications of the existing latent variables and items of the PMC scale. Piloting the instrument with nurse executives may be advisable to provide insight into the existing sub-sets and items, increase the sample size to boost power, and revisit exploratory and confirmatory factor analyses.

Continued research in professional moral courage at the nurse executive level further expands nurse executive leadership practice. Accurate evaluation of professional moral courage in the nurse executive population requires measurement. The first attempt to validate an existing instrument, the PMC scale, was conducted, and showed applicability as an initial measure of professional moral courage in the nurse executive population.

**Conclusion**

This study was the initial step in quantifying a nurse executive’s level of professional moral courage. This research project explored validation of a measure for professional moral
courage in nurse executive practice. Use of this survey heightens awareness of and supports professional moral courage as a concept and creates an opportunity to enhance nurse executive practice. Moreover, a valid and reliable measure is essential to guide professional development and educational needs to improve the level and ability of professional moral courage in the nurse executive population.
References


Appendix A

Professional Moral Courage Scale

Evaluate the statements as they pertain to you at work, on a scale from 1 (never true) to 7 (always true).

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Theme 1
_____ 1. I am the type of person who is unfailing when it comes to doing the right thing at work.
_____ 2. When I do my job, I regularly take additional measures to ensure my actions reduce harms to others.
_____ 3. My work associates would describe me as someone who is always working to achieve ethical performance, making every effort to be honorable in all my actions.

Theme 2
_____ 4. I am the type of person who uses a guiding set of principles from the organization as when I make ethical decisions on the job.
_____ 5. No matter what, I consider how both my organization’s values and my personal values apply to the situation before making decisions.
_____ 6. When making decisions, I often consider how my role in the organization, my boss (supervisor or leader), and my upbringing must be applied to any final action.

Theme 3
_____ 7. When I encounter an ethical challenge, I take it on with moral action, regardless of how it may pose a negative impact on how others see me.
_____ 8. I hold my ground on moral matters, even if there are opposing social pressures.*
_____ 9. I act morally even if it puts me in an uncomfortable position with my superiors.*

Theme 4
_____ 10. My coworkers would say that when I do my job I do more than follow the regulations, I do everything I can to ensure actions are morally sound.
_____ 11. When I go about my daily tasks, I make sure to comply with the rules, but also look to understand their intent, to ensure that this is being accomplished as well.
_____ 12. It is important that I go beyond the legal requirements but seek to accomplish tasks with ethical action as well.

Theme 5
_____ 13. It is important for me to use prudential judgment in making decisions at work.
_____ 14. I think about my motives when achieving the mission, to ensure they are based upon moral ends.
_____ 15. I act morally because it is the right thing to do.*

*Indicates updated item from originally published scale, given additional testing (reverse score items removed).
Appendix A (cont’d)

Suggested scoring:

1) For each dimension: Add scores for each dimension (3 questions) and ÷ 3
2) For overall PMC: Add all of the question scores (15 questions) and ÷ 15

Dimensions of PMC: Represented by Five Themes

Theme 1: Moral Agency

A predisposition toward moral behavior and possessing a persistence of will to engage as a moral agent.

Theme 2: Multiple Values

The ability to draw on multiple value sets in moral decision making and to effectively sort out and determine what needs to be exercised, and to hold firm to beliefs despite external concerns or demands.

Theme 3: Endures Threat

Facing an ethical or moral difficulty, both perceived and real danger or threat, with endurance.

Theme 4: Goes Beyond Compliance

One who not only considers the rules, but reflects on their purpose, goes beyond compliance-based measures to consider what is right, just, and appropriate.

Theme 5: Moral Goal

A drive for task accomplishment that includes the use of virtues (e.g., prudence, honesty, and justice) throughout the decision making process to achieve a virtuous outcome.

Appendix B

Permission to use the PMCS from Dr. Sekerka

Certainly! I'll be very interested in reading your results.

Best wishes, Leslie/Prof Sekerka

Leslie E. Sekerka, Ph.D.

Professor of Management
Director, Ethics in Action Research and Education Center
Menlo College, Atherton, CA - USA
650.543.3701
www.menlo.edu
www.sekerkaethicsinaction.com
1000 El Camino Real, Atherton, CA 94027-4301

On Sun, Nov 15, 2015 at 4:35 PM, Joanne Connor <joannecon@optonline.net> wrote:

November 15, 2015
Dear Dr. Sekerka,

I am a doctoral student at Molloy College in Rockville Centre, New York, currently in my dissertation phase for my PhD in nursing under the direction of my dissertation chair, Dr. Ellen Rich. I am studying the construct of moral courage in the nurse executive population and interested in using your instrument, Professional Moral Courage (PMC).

The purpose of my study is to psychometrically evaluate your instrument in the nurse executive population. Nurse executives are challenged to meet the potentially conflicting needs of the patients, staff, and organization on a daily basis. Given the current and future changes in healthcare, specifically in hospitals, having highly competent nurse executives with moral courage is necessary. Validation of your measure in this population would allow it to be used in further study of the construct of professional moral courage for nurse administrators.

I am requesting a copy of and your permission to use the PMC instrument in my study. Thank you for your consideration.

Sincerely,
Joanne Connor, PhDc, MSN, MPA, NEA-BC, CPHQ
Appendix C

VIA Survey ©-240 Bravery Questions
Do Not Distribute. Used with Permission- Joanne Connor

Bravery

I have taken frequent stands in the face of strong opposition.

I have overcome an emotional problem by facing it head on.

I never hesitate to publicly express an unpopular opinion.

I must stand up for what I believe even if there are negative results.

I call for action while others talk.

I always stand up for my beliefs.

I always face my fears.

I have overcome pain and disappointment.

I always speak up in protest when I hear someone say mean things.

I am a brave person.
Appendix D

Permission to use the Bravery Subset of items from the VIA-IS

Research Approval/Agreement Form

Dear Joanne Connor,

In order to provide you with your request for the VIA Survey bravery questions we ask that you confirm your agreement with the following statements:

✓ I agree to keep the information strictly confidential and will not distribute it unless I’m given written permission from VIA.

✓ I agree to use the information for research purposes only.

✓ I understand the VIA Survey was not created and/or tested to measure this subset of the 24 character strengths, and therefore the subset version of the survey cannot be considered a validated measure.

✓ I will limit the application and interpretation of results to that which is provided by VIA and otherwise is scientifically based.

✓ I understand that the VIA Survey is provided free of charge, that I will not charge my research subjects for taking the VIA Survey.

✓ I agree to share my research findings and outcomes with the VIA Institute, (servingvia@uta.edu & via@uta.edu).

✓ I agree to cite the VIA properly, according to the citations noted here:

Citation in text:
“the bravery scale from the 240-item VIA Survey”

Use both of these references for the VIA Inventory of Strengths (VIA-IS):

Use this reference for the VIA Classification:

In signing, I understand and will adhere to ALL of the statements above.

[Signature]

Joanne Connor 1/14/16

Name (printed) Date

[Signature]

Ellen Rich PhD 1/18/16

Advisor Signature Name (printed) Date
Appendix E

Marlowe-Crowne Short Form: M-C Form C
(W. M. Reynolds 1982)

Personal Reaction Inventory

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide how it pertains to you.

Please respond either TRUE (T) or FALSE (F) to each item. Indicate your response by circling the appropriate letter next to the item. Be sure to answer all items.

1. It is sometimes hard for me to go on with my work if I am not encouraged. T F
2. I sometimes feel resentful when I don’t get my way. T F
3. On a few occasions, I have given up doing something because I thought too little of my ability. T F
4. There have been times when I felt like rebelling against people in authority even though I knew they were right. T F
5. No matter who I’m talking to, I’m always a good listener. T F
6. There have been occasions when I took advantage of someone. T F
7. I’m always willing to admit to it when I make a mistake. T F
8. I sometimes try to get even rather than forgive and forget. T F
9. I am always courteous, even to people who are disagreeable. T F
10. I have never been irked when people expressed ideas very different from my own T F
11. There have been times when I was quite jealous of the good fortune of others. T F
12. I am sometimes irritated by people who ask favors of me. T F
13. I have never deliberately said something that hurt someone’s feelings. T F

* To score the MC, assign values of T=1 F=2, then reverse score the following items: 5, 7, 9, 10, 13, where, T=2, F=1. Sum the items. A high score indicates a social desirability response tendency
Appendix F

Permission to use the Marlowe-Crowne Social Desirability Short Form (M-C Form C)

Hello Joanne,

My apology for the delay. Attached is the information you requested. You have my permission to use the scale in your research.

Best regards,

Bill Reynolds

William M. Reynolds, Ph.D.

Professor and Chairperson
Psychology Department
Humboldt State University
Arcata, California 95521
Tel: (707) 826-3162
Fax: (707) 826-4993
email: wr9@humboldt.edu
web page: http://www2.humboldt.edu/psychology/faculty-staff/william-reynolds

On Mon, Feb 15, 2016 at 4:51 AM, Joanne Connor <joannecon@optonline.net> wrote:

February 15, 2016
Dear Dr. Reynolds,

I am a doctoral student at Molloy College in Rockville Centre, New York, currently in my dissertation phase for my PhD in nursing under the direction of my dissertation chair, Dr. Ellen Rich. I am studying the construct of moral courage in the nurse executive population and psychometrically evaluating the Professional Moral Courage (PMC) scale. I am interested in using your instrument the Marlowe-Crowne Social Desirability Short Form (M-C Form C) to provide a social desirability measure for the study.

The purpose of my study is to psychometrically evaluate the PMC scale in the nurse executive population. Nurse executives are challenged to meet the potentially conflicting needs of the patients, staff, and organization on a daily basis. Given the current and future changes in
Appendix F (cont’d)

Permission to use the Marlowe-Crowne Social Desirability Short Form (M-C Form C)

healthcare, specifically in hospitals, having highly competent nurse executives with moral
courage is necessary. Validation of the PMC scale in this population would allow the PMC scale
to be used in further study of the construct of professional moral courage for nurse administrators.

The PMC scale questions are reflective of socially desirable traits, therefore, the possibility
exists that the participants may answer in the context of what should be the behavior instead of
the true behavior. The strategy to assess the extent of socially desirable responses is to use the
Marlowe-Crowne Social Desirability scale.

I am requesting a copy of and your permission to use the Marlowe-Crowne Social Desirability
Short Form (M-C Form C) in my study. Thank you for your consideration.

Sincerely,
Joanne Connor, PhDc, MSN, MPA, NEA-BC, CPHQ
Dear Colleague:

Thank you for your interest in the Marlowe-Crowne Social Desirability – Short Form.

Below please find a copy of the 13-item Marlowe-Crowne Social Desirability Scale – Short Form. This form may be reproduced for use in your research.

To score the MC, assign values of \( T=1 \) \( F=2 \), then reverse score the following items: 5, 7, 9, 10, 13, where, \( T=2 \), \( F=1 \). Sum the items. A high score indicates a social desirability response tendency. To double check your scoring, it is advisable to enter the item data with the rest of your results into the computer and run a reliability analysis checking the item-total scale correlations (all should be positive, with negative typically indicating an error in reverse scoring). Because of the nature of the construct and measure, internal consistency reliability is typically in the low .70s to low .80 range.

This form has been used in quite a few published research studies by other researchers (I do not keep up with who uses it). It has become public domain – you do not need my permission to use the measure. Furthermore, please note that I am not the author of the scale, Crowne and Marlowe are the authors. I simply provided some empirical evidence to suggest that a shortened form of their original 33-item scale was viable as a quick measure of social desirability. You may cite my 1982 article as the source for the short form of this measure.

I wish you well in your research endeavor.

Sincerely,

William M. Reynolds, Ph.D.
Professor

Department of Psychology
Humboldt State University
Arcata, California 95521

Tel: (707) 826-3162
Fax: (707) 826-4993
cmail: William.Reynolds@humboldt.edu
web page: https://www.humboldt.edu/~psych/fs/reynolds/reynolds.htm
Appendix G

Molloy College Institutional Review Board
Human Subject Research Evaluation

Date: November 16, 2016
To: Joanne Connor
From: Kathleen Maurer Smith, Ph.D.
Co-Chair, Molloy College Institutional Review Board
Patricia Eckardt, Ph.D., RN
Co-Chair, Molloy College Institutional Review Board

SUBJECT: MOLOY IRB REVIEW AND DETERMINATION OF EXEMPT STATUS
Study Title: Psychometric Evaluation of the Professional Moral Courage (PMC) Scale in a Nurse Executive Population

Approved: November 16, 2016
Approval No: 10031514-1116

Dear Joanne:

The Institutional Review Board (IRB) of Molloy College has reviewed the above-mentioned research proposal and determined that this proposal is approved by the committee. It is EXEMPT from the requirements of Department of Health and Human Services (DHHS) regulations for the protection of human subjects as defined in 45CFR46.101(b). Please note that as Principal Investigator (PI), it is your responsibility to be CITI Certified and submit the evidence in order to conduct your research.

You may proceed with your research. Please submit a report to the committee at the conclusion of your project.

Changes to the Research: It is the responsibility of the Principal Investigator to inform the Molloy College IRB of any changes to this research. A change in the research may disqualify the project from exempt status.

Sincerely,

Kathleen Maurer Smith
Kathleen Maurer Smith, Ph.D.

Patricia Eckardt, Ph.D., RN
Appendix H

AONE Membership List Rental Agreement

Membership Access Guidelines, Policy and Agreement

Membership Access for Research
Access to AONE membership for research participation is available for the conduct of academic research. Access will be permitted only for those that conform to generally accepted norms and standards for survey research and that impact the role of nurses in executive practice who design, facilitate and manage patient care delivery across the health care continuum.

The following guidelines have been established for accessing AONE membership for research participation. Access to membership may be obtained by mailing list rental or request for research participation through an electronic format: AONE eNews; AONE Working for You (AWFY).

Request for Research Participation: Mailing List Rental Policy
See Mailing List Rental Agreement.

Request for Research Participation: Electronic Format
1. All requests for membership access for research participation must be made in writing using the AONE Membership Access for Research Participation Agreement, accompanied by an executive summary of the research proposal, evidence of IRB approval and a copy of the survey/questionnaire. AONE evaluates each request within 14 business days after receiving the required documents. Any rejection shall specifically state the reason(s). Negotiations for any proposed revisions for membership access can be made between the parties; however, it is understood that AONE has final authority to approve or reject the request.

2. Each request must be accompanied by the request for research participation language that will be used to recruit participants.

3. Requests will be accepted only for purposes appropriate to nursing leadership, and shall not be in conflict with the AONE mission, goals and activities.

4. The researcher is responsible for providing approved language requesting research participation and an active URL directing participants to the survey and or research home page. Study publications must include the following statement: "Participation of AONE members does not indicate AONE review or endorsement of this study."

5. Publishing the request for research participation occurs at the first opportunity after the receipt of approved language and payment.

6. Approved requests are published on a first come first served basis. AONE has the right to limit the number of requests at any one time.

7. AONE will not provide refunds for early withdrawal of request for research participation.

Questions? Contact MT Meadows at mmmeadows@aha.org or 312-422-2807.
Appendix H (cont’d)

AONE Membership List Rental Agreement

<table>
<thead>
<tr>
<th>Cost of List Rental:</th>
<th>Type of File:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Excel file</td>
</tr>
<tr>
<td>Date of proposed mailing:</td>
<td>List Selection:</td>
</tr>
<tr>
<td></td>
<td>Full list</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of organization or company being advertised</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State/Province</th>
<th>Zip/Postal Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telephone</th>
<th>Fax</th>
<th>E-Mail Address</th>
</tr>
</thead>
</table>

The following policies have been established for the rental of the AONE membership list. Please carefully review these policies.

1. All drafts and final versions of the AONE membership files and labels are the sole and exclusive property of AONE.

2. All list rental orders must be made in writing using the AONE membership list rental contract. Each request must be accompanied by a sample of the material to be mailed to AONE members. AONE will review and approve the sample prior to processing the list order.

3. Lists will include only member names and preferred mailing addresses; telephone/fax numbers and e-mail addresses will not be released. Please note that many AONE members use their home address as their preferred mailing address.

4. Requests will be accepted only for purposes appropriate to the nurse executive/director/manager roles and responsibilities, and shall not be in conflict with the AONE mission, goals and activities.

5. The AONE membership list cannot be rented for the purpose of publicizing employment opportunities. Contact AONE's Chicago office at (312) 422-2805 to learn about employment advertising options.

6. Products and educational programs to be marketed must not conflict with AONE offerings. If you have any doubt about this, please contact AONE to discuss your proposed mailing before determining your print quantity and submitting the rental contract. In general, AONE will not rent its membership list for promotions of in-person national education programs scheduled one month before or after an AONE education program or distance education programs scheduled one week before or after an AONE distance education program. However, AONE reserves full discretion to determine when a conflict exists and to deny a mailing list rental request.

7. Rental of the AONE membership list is available for the conduct of both proprietary and nonproprietary research. In both cases, rental will be permitted only for those that conform to generally accepted norms and standards for survey research and that impact the role of nurses in executive practice who design, facilitate and manage patient care delivery across the health care continuum. Proprietary research, that is, for the purpose of informing future products and service development, may not use the AONE name nor associate AONE in any way with the study. A copy of the survey must be provided to AONE in advance for its review and approval. Study results do not have to be shared with AONE. Research that is non-proprietary (i.e., will be shared with the public) must be shared with AONE upon completion of the final report. Non-proprietary study publications must include the following statement: “Participation of AONE members does not indicate AONE review or endorsement of this study.” A rental fee discount is available to graduate students who are conducting thesis or dissertation research; please contact Mary MT Meadows at (312) 422-2807 or HYPERLINK "mailto:mmeadows@aha.org" mmeadows@aha.org for details.

Contact Cristien Bolan | Senior Marketing Specialist | (312) 422-2805 | Email: cbolan@aha.org
Appendix I

AONE Membership Research Participation Agreement
AONE e-news and AONE Working for You (AWFY) newsletter

Placement
Placement of requests for research participation will appear in a designated section of AONE eNews and AWFY, “RESEARCH PARTICIPATION OPPORTUNITIES”. The design and formatting of the research language is the responsibility of the researcher and must meet the parameters of AONE’s electronic newsletter platform.

Pricing:
Members:
$250.00 - Includes published requests in AONE eNews and or AWFY until research closes.

Non-Members:
$500 - Includes published requests in AONE eNews and or AWFY until research closes.

All payments shall be made prior to publication of research participation request.

Indemnification: It is understood that the Researcher is acting as an independent contractor and assumes the entire responsibility for performance under this agreement. AONE, its employees and agents are harmless against all liabilities, claims, causes of action, losses and damages to persons and property, including expenses and attorneys' fees, arising out of or caused by the researcher’s performance, excluding any such liability caused by the sole negligence of AONE, its employees and agents.

Duration: This Agreement will begin on the first publication of the research request and concludes on the last published date. This Agreement may be cancelled by either party in writing within 14 days.

Miscellaneous:
1. This Agreement supersedes all prior agreements, oral or written, and constitutes the entire understanding among both parties.

2. This Agreement shall be governed by the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have executed this AGREEMENT by and between the American Organization of Nurse Executives (AONE), a subsidiary of the American Hospital Association (AHA), an Illinois not-for-profit corporation with principal offices at 155 North Wacker, Chicago, IL 60606.

<table>
<thead>
<tr>
<th>American Organization of Nurse Executives:</th>
<th>Researcher:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Signature</td>
</tr>
<tr>
<td>Title</td>
<td>Title</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
</tr>
</tbody>
</table>
Appendix J

Survey Participant Cover Letter

Dear Nursing Colleague,

Greetings! The intent of this mailing is to ask for your participation as a CNO/CNE in a research project I am conducting as part of my PhD degree in Nursing at Molloy College, Rockville Centre, New York, under the supervision of Dr. Ellen Rich. The title of my research study is “Psychometric Evaluation of the Professional Moral Courage Scale in the Nurse Executive Population.”

The purpose of this research study is to psychometrically evaluate the Professional Moral Courage (PMC) scale in the nurse executive population. Given the current and future changes in healthcare having highly competent nurse executives with moral courage is necessary. Having a valuable measure of moral courage can be used to facilitate professional development and support moral courage as a recognized competency.

Along with this mailing, I have included a paper option and two electronic options, a URL https://www.surveymonkey.com/r/CYX2BLD to type into a web browser as a link to the survey or to access the research participation/AONE foundation website, http://www.aone.org/aone-foundation/research/participation.shtml. Please choose either the electronic or paper option to complete the questionnaire.

Your participation is voluntary and you are free to withdraw your participation from the study at any time. The survey should only take approximately 15 minutes to complete.

This study has been approved by the Institutional Review Board of Molloy College. There are no risks associated with participating in this study. The survey collects no identifying information. Your response will be completely anonymous and not linked to your identity. Completion of the questionnaire implies your consent to participate either in a paper format by mail or electronically.

Your participation is appreciated. Please send your response no later than January 30, 2017. If you have any questions regarding the questionnaire or this research project in general, please contact Joanne Connor at (631) 807-2614 or by email at jconnor@lions.molloy.edu. If you have any questions regarding your rights as a research subject, you may contact Dr. Patricia Eckardt by email at peckardt@molloy.edu or Dr. Maurer-Smith by email at Ksmith@molloy.edu.

I thank you for your willingness and assistance in this effort. To be entered into a raffle for an iPad Mini, valued at $500.00 or if you would like to obtain the results of the study, please send a separate email with your name and phone number to jconnor@lions.molloy.edu.

Sincerely,

Joanne Connor
Joanne Connor MSN, MPA, RN, NEA-BC, CPHQ
Doctoral Candidate, Molloy College
Appendix K

Professional Moral Courage Questionnaire

Instructions: Evaluate the statements as they pertain to you at work, on a scale from 1 (never true) to 7 (always true). Please respond to all of the statements.

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2</td>
<td>3 4</td>
<td>5 6</td>
</tr>
</tbody>
</table>

___ 1. I am the type of person who is unfailing when it comes to doing the right thing at work.

___ 2. When I do my job, I regularly take additional measures to ensure my actions reduce harms to others.

___ 3. My work associates would describe me as someone who is always working to achieve ethical performance, making every effort to be honorable in all my actions.

___ 4. I am the type of person who uses a guiding set of principles from the organization as when I make ethical decisions on the job.

___ 5. No matter what, I consider how both my organization’s values and my personal values apply to the situation before making decisions.

___ 6. When making decisions, I often consider how my role in the organization, my boss (supervisor or leader), and my upbringing must be applied to any final action.

___ 7. When I encounter an ethical challenge, I take it on with moral action, regardless of how it may pose a negative impact on how others see me.

___ 8. I hold my ground on moral matters, even if there are opposing social pressures.

___ 9. I act morally even if it puts me in an uncomfortable position with my superiors.

___ 10. My coworkers would say that when I do my job I do more than follow the regulations, I do everything I can to ensure actions are morally sound.

___ 11. When I go about my daily tasks, I make sure to comply with the rules, but also look to understand their intent, to ensure that this is being accomplished as well.

___ 12. It is important that I go beyond the legal requirements but seek to accomplish tasks with ethical action as well.

___ 13. It is important for me to use prudential judgment in making decisions at work.
Appendix K (cont’d)

_____ 14. I think about my motives when achieving the mission, to ensure they are based upon moral ends.
_____ 15. I act morally because it is the right thing to do.

Evaluate the statements as they pertain to you on a scale from 1 (very much like me) to 5 (very much unlike me). Please respond to all of the statements.

<table>
<thead>
<tr>
<th>Very Much Like Me</th>
<th>Like Me</th>
<th>Neutral</th>
<th>Unlike Me</th>
<th>Very Much Unlike Me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

_____16. I have taken frequent stands in the face of strong opposition.
_____17. I have overcome an emotional problem by facing it head on.
_____18. I never hesitate to publicly express an unpopular opinion.
_____19. I must stand up for what I believe even if there are negative results.
_____20. I call for action while others talk.
_____21. I always stand up for my beliefs.
_____22. I always face my fears.
_____23. I have overcome pain and disappointment.
_____24. I always speak up in protest when I hear someone say mean things.
_____25. I am a brave person.

The statements below concern personal attitudes and traits. Read each item and decide how it pertains to you. Please respond either TRUE (T) or FALSE (F) to each item. Indicate your response by circling the appropriate letter next to the item.

26. It is sometimes hard for me to go on with my work if I am not encouraged. T  F

27. I sometimes feel resentful when I don’t get my way. T  F
Appendix K (cont’d)

28. On a few occasions, I have given up doing something because I thought too little of my ability. T F

29. There have been times when I felt like rebelling against people in authority even though I knew they were right. T F

30. No matter who I’m talking to, I’m always a good listener. T F

31. There have been occasions when I took advantage of someone. T F

32. I’m always willing to admit to it when I make a mistake. T F

33. I sometimes try to get even rather than forgive and forget. T F

34. I am always courteous, even to people who are disagreeable. T F

35. I have never been irked when people expressed ideas very different from my own T F

36. There have been times when I was quite jealous of the good fortune of others. T F

37. I am sometimes irritated by people who ask favors of me. T F

38. I have never deliberately said something that hurt someone’s feelings. T F

39. What is your title?

Chief Nursing Officer (CNO)_______ Chief Nurse Executive (CNE)_______

40. What is your gender?

Female_______ Male _______

41. What is your age?

20 to 24 years______ 25 to 34 years______ 35 to 44 years____ 45 to 54 years ____
55 to 64 years ______ 65 to 74 ________ 75 years or older _______

42. How many years of experience do you have as a CNO and/or CNE?

1-5 years _____ 6-10 years____ 11-15 years____ 16-20 years____ 21-25 years______
26-30 years______31-40 years ______ Over 40 years __________
Appendix K (cont’d)

43. What is your ethnicity?

American Indian or Alaskan Native ______ Asian or Pacific Islander______
Black/African American ______ Hispanic or Latino ______ White/Caucasian______
Prefer not to answer________ Other (please specify) ______________

44. What is the highest degree you have received in Nursing?

Diploma____ Associates ______ Bachelors _______ Graduate (Master’s) ______
Doctor of Philosophy (PhD)_______ Doctor of Nursing Practice (DNP)____
Other (please specify) __________

45. What is the highest degree in another field you have completed?

Associates______ Bachelors__________ Graduate (Master’s)________
Doctorate ___________ None __________ Other (please specify) __________

46. What is the type of healthcare organization?

Hospital________ Skilled Nursing Facility________ Subacute Nursing Facility ______
Home Care Agency __________ Behavioral Health________
Rehabilitation Center______ Hospice ___________ Ambulatory Care________
Other (please specify)____________

47. What is the bed size of the organization?

Less than 100 beds ______ 100-300 beds_______ 301-499 beds_____
500-999 beds______ 1,000-4,999 beds _____ 5,000 + beds______ Not Applicable____

48. What is the Number of employees in your department (s)?

Less than 100_______ 100-300 employees _________ 301-499employees ______
500-999 employees ___________ 1,000-4,999 employees _________
5,000 + employees_____________
Appendix K (cont’d)

49. Is your organization ANCC Magnet® designated?

Yes_______
No_______
On the journey ________________
Other (please specify) ______________

50. What region is your organization located? ________________

Northeast: CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT
Southeast: AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV
Midwest: IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI
Southwest: AZ, NM, OK, TX
West: AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY
Other (please specify) ______________

51. What best describes the area of your healthcare organization(s)? (Please select all that apply)

Rural___________
Urban___________
Suburban_________
Other (please specify) ______________

52. CNEs ONLY:

How many organizations are in the healthcare system? ______________

53. CNEs ONLY: Please indicate the type of organizations that are in the healthcare system? (Please select all that apply).

Hospital_________ Skilled Nursing Facility_______ Subacute Nursing Facility ________
Home Care Agency _______Behavioral Health_______ Rehabilitation Center_____ 
Other (please specify)___________________
Appendix K (cont’d)

Thank you for your time and participating in this important research!

If you would like to receive the results from this study and/or would like to enter into a raffle for an iPad Mini, valued at $500.00, please send a separate email with your name and phone number to jconnor@lions.molloy.edu.

Sincerely,

Joanne Connor
Joanne Connor MSN, MPA, RN, NEA-BC, CPHQ
Doctoral Candidate, Molloy College