

COURAGE

# 6Cs and ten commitments: nurses' understanding and use of courage

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## Fiona Barchard

Senior lecturer in adult nursing and programme and curriculum lead, Faculty of Health and Society, University of Northampton, England

## Judith Sixsmith

Professor in public health improvement and implementation, University of Northampton, England

## Sarah Neill

Associate professor in children's nursing, University of Northampton, England

## Clency Meurier

Senior lecturer in adult nursing, University of Northampton, England

## Correspondence

fiona.barchard@northampton.ac.uk

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None declared

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## Abstract

**Aim** This article reports the initial findings of a study that explored nurses' understanding of courage, in the context of the 6Cs and the Leading Change, Adding Value framework. The aim was to explore how nurses' understanding of courage can inform future practice, thus enabling preparation and support for nurses' use of courage in practice settings, and to enhance understanding of their use of it in everyday professional practice.

**Method** The study used unstructured interviews in a grounded-theory approach, in which a theory is constructed by analysing data, underpinned with epistemology of social constructionism, a theory that examines shared assumptions about reality. Twelve qualified nurses were interviewed in depth about their understanding of courage in professional practice. A literature review was also undertaken.

**Results** Nurses discussed their understanding of courage in terms of being in a situation they do not want to be in, speaking up and taking risks.

**Conclusion** Understanding nurses' view of courage and its influence on practice can inform future recruitment and retention policies and practice, thus preparing and supporting nurses in the use of courage in practice settings.

## Keywords

courage, grounded theory, nursing management, the 6Cs, understanding, unstructured interviews

## Introduction

This article outlines the initial results of a constructionist grounded-theory research study of the understanding of courage in the context of nursing. Cummings and Bennett (2012) define courage as the attribute that 'enables us to do the right thing for the people we care for, be bold when we have good ideas, and to speak up when things are wrong'. In the 6Cs, shorthand for the values that underpin healthcare, courage is denoted as an essential nursing attribute (Cummings and Bennett 2012). This is supported in Leading Change, Adding Value (Cummings 2016), the national framework for nursing, midwifery and care staff.

As Cummings (2016) notes, 'we know that compassionate care delivered with courage, commitment and skill is our highest priority', which confirms that courage is important to nursing practice. Yet although there are various studies of the other five Cs, namely commitment (Gould and Fontenla 2006), compassion (Straughair 2012a, 2012b), competence and caring (Rhodes et al

2011) and communication (Kourkouta and Papathanasiou 2014), relatively little work on courage and its role in nursing practice could be found.

## Concept of courage

Grounded theory discourages literature reviews before data collection, to ensure that understanding derives from participants rather than from researchers' preconceptions. However, literature reviews can be useful, for example in writing research proposals (Charmaz 2014), so a preliminary literature review was conducted in 2015 to determine if the subject had been explored.

The library of the University of Northampton, Nelson, CINAHL, Cochrane, EthOS, Medline and Ovid, Google Scholar and the internet were searched for research on courage in nursing. The search terms used were 'courage\*' and 'nursing' in any order in the title or abstract in the past ten years. Articles sought were in English and the field of nursing was not specified. No primary research UK studies were found

but there were three from outside the UK. Two of them were European (Swedish and Danish), namely Lindh et al (2010), who conducted a hermeneutical enquiry into moral strength, and Thorup et al (2012), whose interpretative study explored courage specific to vulnerability, suffering and ethics. The third paper, a hermeneutic research study exploring courage in practice, originated in New Zealand (Spence 2004) and suggests that courage in practice is essential.

Four more discussion and opinion papers that met the search criteria were identified. One of them (Gallagher 2010), which originated in the UK, discussed the concept of moral distress and courage, finding it to be an organisational, political and individual responsibility. The other three papers were sourced from the US. A further 12 papers with only courage in the title and specific to nursing were identified in the same search (ten US, one European and one UK), and were a mix of opinion pieces and discussion articles. The review indicates that courage is seldom mentioned in nursing literature, which supports the observations of Spence (2004) and Murray (2010).

Lindh et al (2010) state that, despite courage being identified as a fundamental component of nursing (Spence 2004, Cummings and Bennett 2012), there is a lack of knowledge about nurses' courage in practice. Writers such as Gallagher (2010), Lachman (2010), LaSala and Bjarnason (2010), Lindh et al (2010) and Thorup et al (2012) identify factors that affect the development of courage. These include constraints within organisational cultures (Gallagher 2010), nurses' characteristics such as resilience (Lindh et al 2010), experience and intuition in providing courageous care (Thorup et al 2012), and supportive working environments (LaSala and Bjarnason 2010).

Many other papers used words similar to 'courage', for example 'advocacy', 'moral strength' or 'virtue', but these were not included as the aim was to explore courage as it is named in the 6Cs (Cummings and Bennett 2012).

To truly appreciate what nurses understand by 'courage', we need to ask them. Given the paucity of research (Spence 2004, Lindh et al 2010, Murray 2010), this study aimed to explore nurses' understanding of the concept.

## Study

### Aims

The aims of the study were to explore how nurses' understanding of courage can inform future practice, thus enabling preparation and support for nurses to use

courage in practice settings, and to enhance understanding of adult nurses' use of courage in everyday professional practice.

Three initial themes from analysis of the findings are presented and discussed below, and are applied in the context of Leading Change, Adding Value (Cummings 2016). This nursing framework is designed to enable delivery of the triple aims of the Five Year Forward View (NHS England 2014): better outcomes, better experiences for patients and staff, and better use of resources.

### Methodology

Constructionist grounded theory was used because of constructionism's social, rather than individual, emphasis. Nurses do not work in isolation or with an individual focus (Nursing and Midwifery Council (NMC) 2015a); instead they work in a socially constructed culture, where social processes, historical culture and interactions are evident (Young and Collin 2004, Read 2013). Social constructionism is congruent with grounded theory as an appropriate epistemological model for exploring shared social meaning and understanding (Mills et al 2006). Grounded theory is a structured but flexible methodology, and data are collected with simultaneous and sequential analysis. Charmaz's (2014) approach includes emphasis on action and co-construction of meaning with the participants.

### Method

Adult nurses were recruited from local acute care providers and the community through fliers and self-nomination. There were 12 female participants, and their practice settings and other demographics are shown in Table 1. Most participants had experience of work in community and acute settings.

Adult nurses were recruited as the researcher is undertaking a professional doctorate and her area of practice is adult nursing. Additionally, the Francis report on failings in care at the Mid Staffordshire NHS Foundation Trust (Francis 2013) describes failings in 'courage' that, while not exclusively related to adult nursing, were mostly located in general wards and departments. Unstructured interviews, consistent with constructionist grounded theory (Age 2011), took place in locations chosen by participants and lasted on average one hour. The interviews sought to reveal participants' salient views and what meanings they attached to the word courage (Bowling 2009, Prescott 2009). The opening question was: 'Could you tell me what's your understanding of courage in nursing?'

### Summary

According to the 6Cs: 'Courage enables us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working.'

Data were transcribed and coded, to categorise findings to form theoretical themes, using line-by-line coding, and repeatedly re-examined so that the researcher remained open and receptive to unexpected directions depending on the information (Charmaz 2014). The aim was to analyse rather than simply describe the data (Corbin and Strauss 2008).

During coding, memos, including written explanations, ideas and linkages about the data, helped to strengthen and build categories (Charmaz 1983), enabling movement from description to conceptualisation (Charmaz 2012). NVivo software, which encourages data analysis during collection (Bringer et al 2006, Bazeley 2007, Hutchinson et al 2010), was used. The 12 interviews raised 86 codes related to nurses' understanding and use of courage. The codes were refined into a series of themes, three of which are discussed below.

#### Ethics

Ethical concerns including anonymity, confidentiality, informed consent, withdrawal, briefing and debriefing, and protection from harm, were all addressed, ethical approval was granted, and recommendations were followed. Participants received a comprehensive information sheet detailing their involvement in the study, the potential risks of taking part and how the information would be used. They were reassured that consent was voluntary,

and that they could withdraw at any point before analysis, after which all data would be anonymised. Data held were anonymised, password protected and securely stored. At the request of the university ethics committee, a protocol was devised in case an issue of concern, for example relating to patient or staff safety, was raised during interviews.

#### Findings

The development of a conceptual theory has yet to be completed. Once finalised, it will be published in another article. The three initial themes included here are as follows: being in a situation you do not want to be in, speaking up and taking risks.

#### Being in a situation you do not want to be in

Several participants exhibited courage by staying in a situation they did not like. This involved emotional factors, such as facing their fears, going into the unknown or feeling out of their comfort zone, and practical knowledge such as when to take themselves out of a situation.

P7 talked about dealing with distressing emotional situations in acute settings: '...it's a situation you don't want to be in, that you wouldn't have chosen to be in, so yeah, I think that's courage definitely', while P10 spoke in general terms about her understanding of courage in the community: 'I guess, perhaps being out of your comfort zone from your every day to day, sort of work.'

P9, also a community nurse, spoke of the personal-safety aspect of courage and how she faced situations and stayed in them, but also knew when to remove herself: 'Yes, so, so it's courage in the, the true sense of bravery, as in I need to save myself, from, from the situation as it were.'

These participants described various situations they had had to stay in, when they would have rather not, including dealing with challenging families or patients, managing unexpected deaths, and walking into unknown situations, such as when starting to work with new patients in the community. Most participants had not considered these as courageous acts until they were asked to reflect on them, after which they agreed with the sentiment expressed by P7: 'Actually lots of things that we do were courageous but we don't really think of it like that.'

This theme suggests that nurses are prepared to face discomfort, stay in situations when they are needed, and will face their fears, even though it is difficult and may require them to tolerate personal discomfort.

TABLE 1. Demographics

Participant	Age range	Range of years' experience	Practice setting
P1	53-59	30-35	Acute
P2	32-38	10-15	Community
P3	53-59	30-35	Community
P4	46-52	25-30	Community
P5	53-59	30-35	Acute
P6	46-52	10-15	Acute
P7	25-31	5-10	Acute
P8	46-52	25-30	Acute
P9	46-52	25-30	Community
P10	46-52	25-30	Community
P11	32-38	0-5	Acute
P12	46-52	30-35	Community

As P6 noted: 'You don't necessarily always feel comfortable in what you're doing... it is, again, it's facing those fears.'

Nurses might need support to face these situations for the benefit of their patients.

### Speaking up and keeping quiet

Despite the NMC's (2015a) expectation that nurses will challenge and question changes in the traditional hierarchy of the NHS, and a proposed new style of leadership (King's Fund 2012), participants found that it can be difficult to speak up and to have a voice. P3 and P4, both community nurses with more than 30 years' experience, said: 'It's having the courage to have a voice', and '... having the courage to say "No" to them'. Both were relating their experiences of challenging authority or hierarchical processes if they thought something was wrong.

P2 had a similar experience in an acute setting when two departments were being combined: 'Nobody had the courage to speak up; everybody accepted what happened, why it happened; nobody had the courage to challenge it and, if they did challenge it, nobody had the courage to, to back them up and say we can't do this anymore.'

These findings show that even experienced nurses can find speaking up difficult and challenging, so implications for practice include considering how nurses are educated and developed to find their voices.

### Taking risks

Participants suggested that being courageous could be considered as taking risks, and these risks could include losing their registration, opening themselves up to emotional distress, and being placed in the difficult position of having to 'fight' for something they believed in. Despite the post-Francis climate, there were only infrequent mentions of aggression and whistleblowing.

P10, a community nurse with 25 years' experience, said: 'I think it's, it's perhaps, being very brave, taking risks, being out of comfort zone, prepared to take risks', in the context of having difficult conversations with patients or their families. P4 related both nursing and personal aspects to risk taking as follows: '... but, at the end of the day, I couldn't leave him so I did (treated the patient), but I put my job on the line then; I put my registration on the line', when talking about treating a patient when she was not sure she should do so.

She also said, as she recalled a patient who she felt emotionally distressed about 20 years after caring for them: 'I don't

know; is compassion connected to courage? I suppose courage in letting yourself feel'.

These comments suggest a complex interplay of different facets in relation to risk, including bravery, physical and psychological risk, and fear of losing their registration. Some interpreted risk differently, for example as being exposed to emotional pain when practising compassion.

Overall, this theme has depth and complexity, and implications for practice include supporting nurses to manage the risks they face.

### Discussion

The themes described above indicate something of nurses' understanding of courage. Finding the courage to stay in a difficult situation is challenging, and this notion of courage is evident in the work of Gallagher (2010) and Edmonson (2010). Gallagher (2010) notes that moral distress affects nurses' health and ability to provide care, which in turn affects job satisfaction, while Edmonson (2010) suggests that distress leads to burnout, desensitisation, and disengagement.

This has implications for the retention of nurses who may need support, for example through guided reflection or clinical supervision (Rolfe 2002), to enable them to continue to face these challenges. Revalidation supports reflective practice, and could enhance retention if nurses use it to unpick some of the difficulties they face (NMC 2015b).

Speaking out revealed that nurses need courage to find their voice on a daily basis. This is also identified by Lindh et al (2010)'s review of research on courage, which found that remaining true to convictions is a struggle for nurses who may face losing their jobs if they speak out, and Lachman (2010), who suggests that nurses usually know what to say but may not do so because they fear embarrassment or punishment. This is supported by Gallagher (2010), while Francis (2013) notes that staff could be discouraged from speaking out by fear and bullying. The final theme was risk. Lindh et al (2010) also found that courage was related to nurses' willingness to expose themselves to risk, while Gallagher (2010) suggests that organisational, individual or cultural factors can influence this, and proposes that organisations need to embrace moral courage.

The findings should be considered in the context of recruitment using value-based interviewing (Health Education England 2016). They imply that healthcare services need to recruit people who are willing to challenge

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and take risks, and offer relevant development opportunities throughout professionals' careers to enhance retention.

The ten commitments in *Leading Change, Adding Value* (Cummings 2016) support the desire to deliver care of the highest standard, which requires courage, yet the evidence suggests that nurses still find this challenging. This study shows that courage is crucial to realisation of the ten commitments. For example, commitment 3, that 'we will work with individuals, families and communities to equip them to make informed choices and manage their own health', and 5, that 'we will work in partnership with individuals, their families, carers and others important to them', are echoed by P1: 'Everything being a test of courage for the best patient outcome.' Meanwhile, P3 and P4 spoke of their difficulty in finding their voices to achieve these commitments.

Commitment 6, that 'we will actively respond to what matters most to our staff and colleagues', implies that nurses need courage to find their voices, as does commitment 9, that 'we will have the right staff in the right

places and at the right time'. Finally, and crucially, commitment 8 states that 'we will have the right education, training and development to enhance our skills, knowledge and understanding'. P9 noted: 'Courage is very closely linked to confidence, isn't it, and experience; that, if you are confident in your knowledge and you're confident in what you think is right, then you have the courage to shout about it.'

Peate's (2015) article, entitled *Without courage the other Cs will crumble*, is supported by the notion that courage enables other virtues (Walston 2004). This study suggests that even experienced nurses can find using courage demanding, and this should inform recruitment and retention policies. Not only do we require recruitment of nurses who can challenge and take risks, we need to retain them by ensuring there are adequate preparation, training, support and opportunities to enable them to reflect on using courage in practice. As Lachman (2010) notes, courage is far from redundant, and is still relevant today as nurses encounter numerous situations that call for it.

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## Limitations

All the participants were female nurses working with adults, so findings and conclusions could be gender- or field-specific. The nature of the study means it was limited in terms of time and participant numbers, so it might be difficult to realise true theoretical saturation (Charmaz 2014).

Among other limitations, the researcher inevitably brought herself into the interviews (Charmaz 2014), while race, culture and gender influence what is said and how it is said, and consequently what is found and written about. Additionally, researchers and participants belong to 'other identities' such as nurse, teacher or researcher, and these factors influence conclusions.

To increase the reliability and authenticity of findings, the study procedures are made clear and are repeatable. Reflexivity is central to the analysis, and to improve credibility an audit trail of detailed analysis articulates emergent theoretical concepts (Gasson 2004).

It would be interesting to compare results with male nurse participants, and nurses from other disciplines and settings, to see if their

experiences are similar. This study involved a mix of acute and community nurses, but findings are presented as one. Future studies could explore these settings separately.

## Conclusion

The examples described in this article of how nurses confront and remain in difficult situations, speak out even when they fear the consequences (Francis 2013) and take risks are just some of the challenges they face in using courage.

Only the initial coding for the research themes presented in this article is complete, which means that at a conceptual level emergent theory has yet to be explored with further theoretical sampling. However, the implications for practice are becoming clear. Nursing can benefit by considering courage at the point of recruitment, and nurses can benefit from education, support and reflection that begin at recruitment and continue through revalidation and lifelong learning. This could help retain nurses in a profession of which they are immensely proud, but which can be challenging and have a personal cost.

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