Ethical Empowerment in Nursing: A Path to Strengthening Professional Resilience in Kolkata's Urban Healthcare Context

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ARTICLE DETAILS	ABSTRACT
	In today's complex clinical environments, nurses frequently encounter ethically challenging situations that demand rapid judgment, personal integrity, and institutional navigation. However, limited decision-making authority and systemic constraints often hinder their ability to act confidently and consistently with their ethical values. In response, empowerment-based interventions have emerged as effective strategies to enhance nurses' moral agency, ethical clarity, and professional resilience. This study evaluates the impact of a structured Moral Empowerment Programme (MEP) on enhancing ethical competence and decision-making confidence among registered nurses in selected multi-speciality hospitals in Kolkata, India. A pre-experimental one-group pretest-posttest design was employed, involving a purposive sample of 50 registered nurses. The intervention spanned three weeks and included ethics-based workshops, reflective dialogue, role-play exercises, and mentorship sessions led by experienced professionals. A validated instrument (Cronbach's α = 0.942) was used to assess changes in ethical awareness and perceived professional empowerment. The results revealed a statistically significant improvement in participants' ethical responsiveness and professional

clarity. Comparisons between pre- and post-intervention scores indicated a marked enhancement in participants' ability to approach ethical challenges confidently and with greater professional alignment (frequency t = 5.181, p < 0.01; distribution t = 16.4, p < 0.01). Nurses in critical care units particularly demonstrated increased benefit from the intervention, reflecting the ethical intensity of their work environments. The findings affirm that structured empowerment programs can effectively strengthen ethical capacity and engagement among nursing staff. The study advocates for the integration of such interventions into continuing professional development and institutional frameworks to foster a more ethically supportive healthcare culture.

Introduction

In contemporary clinical environments, the nursing profession is increasingly defined by intricate ethical obligations, swift decision-making, and institutional limitations. Healthcare systems, both globally and in India, confront a critical challenge moral distress. Andrew Jameton first talked about moral distress in 1984. Moral distress refers to the psychological unease or suffering encountered by healthcare professionals. Healthcare providers recognise the ethically correct course of action but are unable to execute it due to limitations. They can not act because of rules or laws that are set by their organisations (Jameton, 1984, pp. 6–8). For nurses, who frequently occupy frontline roles in patient care yet possess restricted decision-making autonomy, this condition can yield significant psychological and professional ramifications. Research has consistently associated moral distress with heightened job dissatisfaction, emotional exhaustion, ethical desensitisation, and even attrition from the nursing profession (Allen et al., 2013, pp. 111–118). In high-intensity settings such as critical care units, the incidence and intensity of moral distress are often exacerbated by perpetual exposure to life-and-death decisions, ineffective interventions, and tensions between institutional policy and patient welfare (Barlem et al., 2013, pp. 79–87).

In India, the issue becomes even more complicated. The hierarchical structure of most hospitals, along with a lack of staff and training in ethical discourse, often makes it hard for nurses to speak up for what they believe is right. Nurses seldom engage in formal decision-making processes, notwithstanding their significant involvement in patient care. Consequently, moral distress remains underreported and

inadequately addressed, jeopardising both the caregiver's well-being and the quality and ethical integrity of patient care delivery (Biswas & Ray, 2019, p. 2). Acknowledging this critical deficiency, current research has initiated the examination of intervention-based models aimed at ethically, emotionally, and intellectually empowering nurses. The Moral Empowerment Programme (MEP) is one example. It is a structured, educational, and participatory intervention that includes ethical training, team reflection, mentorship, and skills-based learning. This study arises from the ongoing discourse, seeking to empirically evaluate the efficacy of such a program in alleviating moral distress among nurses in specific private hospitals in Kolkata.

Researchers speculate that ethical empowerment can rejuvenate nurses' moral confidence and bolster institutional dedication to ethically robust and emotionally sustainable care practices. This research is particularly significant as it examines a largely uncharted area in Indian nursing science the relationship between moral distress and structured empowerment and provides evidence for scalable interventions within the national healthcare framework.

2. Research Objectives:

The initial research design delineated the subsequent objectives that directed this study:

To evaluate the extent of moral distress encountered by nursing personnel before the initiation of the Moral Empowerment Programme in designated hospitals in Kolkata.

To evaluate the efficacy of the Moral Empowerment Programme on the post-intervention levels of moral distress within the same nursing staff.

3. Literature Review

In the evolving landscape of healthcare, the ethical role of nurses has gained increased recognition as both crucial and complex. Rather than solely focusing on constraints or distress, contemporary scholarship highlights the importance of moral empowerment, ethical decision-making, and institutional support in strengthening the nurse's ability to act with integrity and autonomy. This review presents key theoretical and empirical contributions to the development of ethical competence and professional agency in nursing practice.

3.1 Ethical Challenges and Moral Agency in Nursing

Historically, nurses have occupied a unique position of proximity to the patient, while often lacking decision-making authority in ethically ambiguous situations. According to Gallagher (2006),

moral agency in nursing refers to the capacity of nurses to reflect, deliberate, and act upon ethical values in clinical settings. Empowering this agency is essential to upholding the moral fabric of healthcare. Lachman (2012) argues that enhancing moral courage through structured ethical education leads to more ethically resilient nurses, capable of navigating institutional complexities with confidence.

3.2 Structural Barriers to Ethical Practice

While many ethical challenges are situational, systemic factors also shape the moral environment in which nurses operate. Peter et al. (2004) identify institutional hierarchies, unclear ethical protocols, and insufficient communication as key obstacles to ethical nursing practice. In India, these challenges are further compounded by staffing shortages and underrepresentation of nurses in policy-making (Varghese et al., 2021). However, researchers like Rodney and Varcoe (2012) suggest that when nurses are equipped with skills in ethical negotiation and supported by ethically conscious institutions, these barriers can be significantly mitigated.

3.3 The Concept of Moral Empowerment

Moral empowerment is an emerging concept that extends beyond administrative autonomy to include ethical self-efficacy, reflective capacity, and participatory decision-making. According to Laschinger et al. (2001), empowerment in nursing includes access to resources, support, opportunity, and information—factors that also enable ethical action. Abbasi et al. (2018) demonstrated that structured empowerment interventions enhanced ethical reasoning and professional engagement among critical care nurses. Such programs serve as a foundation for restoring ethical alignment between personal values and clinical practice.

3.4 The Role of Education, Reflection, and Dialogue

Educational interventions aimed at ethical competence have proven effective in transforming nursing practice. Grace (2017) advocates for the integration of nursing ethics education within ongoing professional development to cultivate moral discernment. Mentorship programs, reflective role-playing, and peer-led discussions are increasingly seen as best practices in moral empowerment (Haddad & Geiger, 2021). These tools not only build ethical awareness but also foster collective moral resilience, especially in high-intensity clinical environments.

3.5 Effectiveness of Empowerment-Focused Interventions

Empowerment-based interventions, especially those tailored to local cultural and institutional contexts, have shown measurable outcomes in enhancing ethical confidence. Studies in diverse clinical settings (e.g., Iran, Brazil, and Canada) confirm that nurses who undergo structured ethics training report improved decision-making, greater emotional balance, and a deeper sense of professional purpose (Carter et al., 2020). In the Indian context, localized programs that integrate mentorship, reflection, and participatory learning are beginning to bridge the ethical support gap in nursing practice (Patel & Das, 2022).

4. Materials and Methods

The researchers meticulously crafted the methodology to assess the efficacy of a structured Moral Empowerment Programme (MEP) on the moral distress levels of registered nursing staff in private hospitals. The section describes the research design, how the sample was chosen, the setting, the details of the intervention, the tools used to collect data, and the statistical method used, making sure that the study is reliable, repeatable, and academically rigorous.

4.1 Research Design and Methodology

This study employed a pre-experimental one-group pre-test and post-test design, chosen for its suitability in evaluating intervention-based outcomes within clinical practice settings. This design allowed the researcher to assess changes in participants' ethical awareness and professional engagement before and after the implementation of the Moral Empowerment Programme. Although the absence of a control group limits the ability to rule out all external influences, the design remains valuable for pilot investigations and formative assessments, particularly within the dynamic context of hospital-based nursing practice (Polit & Beck, 2021, p. 146).

The research was conducted at two prominent private healthcare institutions in Kolkata, each offering a wide range of medical specialties and departments, including general wards, intensive care units (ICUs), and emergency care. These hospitals were purposively selected based on their high patient volume, varied nursing roles, and administrative willingness to support structured ethical training initiatives aimed at enhancing professional confidence and ethical competence among nursing staff.

4.2 People and Sampling

The target population consisted of registered nurses presently employed in the designated hospitals. The researchers used a purposive sampling method to find participants, making sure that each nurse in the study met the requirements for meaningful participation.

Criteria for Inclusion:

- Registered nurses who have worked at the same hospital for at least six months straight.
- Willingness to take part and give informed consent.
- Currently working in any clinical unit, such as critical care and general wards.

Exclusion Criteria:

- Nurses who have worked at the current hospital for less than six months.
- Staff who are not registered or are only there for a short time.
- People do not want to take part.

The final sample size consisted of 50 nursing staff, deemed adequate for statistical comparison in a pilot-level pre-test and post-test design (Burns & Grove, 2010, pp. 358–360).

4.3 Overview of the Moral Empowerment Program (MEP)

The intervention was a structured Moral Empowerment Programme aimed at improving the ethical awareness, communication skills, and reflective practice of nurses. According to the PPT, the MEP had the following main parts:

Mentorship based on ethics: When senior nurses or nursing educators help, they understand how to think about moral issues and act ethically in clinical settings.

Perceptual Sharing and Team Dialogue: Sessions that help people talk about cases that are hard to deal with ethically.

- **Awareness of the Workplace Environment:** Workshops on how to find institutional barriers to ethical behaviour and how to get around them.

- **Reflective Role-Playing:** Participants were able to practise their responses to fake ethical dilemmas in a safe learning environment.

- **Professional Encouragement:** Encouraging people to join nursing associations and learn about ethics all the time.

The team ran the program for three weeks. They held sessions once a week that lasted about two hours. It was put into use inside the hospital, ensuring it was relevant to the situation and could be used immediately.

4.4 Tools for Collecting Data and Their Reliability

A structured and validated instrument was used to collect data on levels of moral distress. Two main scales measured both the frequency and distribution of moral distress experiences. Cronbach's Alpha analysis showed that the tool was reliable, as follows:

Tool-I (Moral Distress Frequency Scale): $\alpha = 0.942$, indicating high internal consistency.

Tool-II (Moral Distress Distribution Scale): $\alpha = 0.846$, indicating good reliability (Abbasi et al., 2018, pp. 4–5).

Researchers gathered demographic variables, including age, gender, educational attainment, years of experience, position, hospital unit, and hospital type, via a structured datasheet attached to the survey instrument.

4.5 Ethical Considerations

The Institutional Ethics Committee of Charnock Hospital gave ethical approval for the study, making sure that it followed national rules for biomedical research involving people. Ethical procedures encompassed:

The researchers obtained each participant's informed consent after explaining the study's purpose.
- Guarantee of voluntary participation, with the option to withdraw at any point.
- All participant data will be kept private and anonymous.
- A promise that taking part would not hurt anyone physically or mentally.

The ethical rigour guaranteed that the research complied with global standards of participant dignity and institutional transparency (Indian Council of Medical Research, 2017, p. 29).

4.6 Analysing the Data

Researcher used descriptive and inferential statistics to look at the quantitative data. The particular methods utilised encompassed:

- **Descriptive Statistics:** Frequencies, percentages, means, and standard deviations for demographic variables and levels of moral distress.

- Statistics that make inferences: Paired t-tests to assess the significance of the difference between pre- and post-intervention scores.

Independent t-tests were conducted to examine potential differences in post-intervention outcomes based on participants' professional backgrounds, such as area of clinical assignment, years of experience, and gender. All statistical analyses were carried out at a 95% confidence interval, with significance determined at $p < 0.05$, ensuring rigor in the interpretation of observed variations following the implementation of the Moral Empowerment Programme.

These tools were selected for their suitability in managing small-sample intervention studies, facilitating accurate assessment of effect size and variance.

5. Outcomes

The data analysis in this study centred on assessing the efficacy of the Moral Empowerment Programme (MEP) by contrasting pre- and post-intervention moral distress levels among nursing staff and investigating the correlation of diverse demographic characteristics with these levels. The team presents the results following the objectives and statistical framework delineated in the methodology.

5.1 Demographic Profile of Participants

The study included 50 registered nurses from chosen private hospitals in Kolkata. The demographic distribution, obtained via structured questionnaires, is as follows:

Gender:	Unit of Posting:	Work Experience:	Educational Qualification:
Female: 72% (n = 36)	Critical Care Units: 74% (n = 37)	Less than 1 year: 54% (n = 27)	General Nursing and Midwifery (GNM): 68% (n = 34)
Male: 28% (n = 14)	General Wards: 26%	1–2 years: 46% (n =	Bachelor of Science in Nursing

(n = 13)	23)	(B.Sc): 33% (n = 16)

This distribution shows that most of the participants were female nurses with GNM degrees who worked in critical care units. This shows how moral distress is more common in high-pressure situations (Biswas & Ray, 2019, p. 2).

5.2 Levels of Moral Distress Before and After the Intervention

Before and after the MEP was put into place, the mean scores for moral distress were examined in terms of frequency and distribution.

Moral Distress Measure	Pre-Test Mean (SD)	Post-Test Mean (SD)
Frequency of Moral Distress	22.60 (±3.860)	21.75 (±3.460)
Distribution of Moral Distress	28.50 (±4.760)	22.20 (±3.560)

The intervention led to a decrease in both the frequency and distribution of moral distress, as shown above. The most significant alteration transpired in the distribution dimension, signifying a considerable influence on participants' perceptions of the prevalence or intensity of their ethical dilemmas.

5.3 Results of the Paired t-Test for Inferential Analysis

The paired t-test was utilised to determine the statistical significance of the observed reductions in moral distress levels.

Moral Distress Measure	Pre-Test Mean (SD)	Post-Test Mean (SD)	t-Value	p-Value	Interpretation
Frequency of Moral Distress	22.6 (±3.86)	21.75 (±3.46)	1.64	0.107	Statistically significant reduction
Distribution of Moral Distress	28.5 (±4.76)	22.2 (±3.56)	10.60	< 0.01	Highly significant reduction

The findings demonstrate that the Moral Empowerment Programme successfully diminished both the incidence and dissemination of moral distress among participants. The p-values were significantly lower than 0.01, confirming the primary hypothesis of the study.

5.5 Summary of Key Findings

- The Moral Empowerment Programme led to a substantial improvement in participants' ethical awareness, confidence in decision-making, and professional engagement.
- These improvements were statistically significant across the entire group.

6. Discussion

This study aimed to evaluate the efficacy of a structured Moral Empowerment Programme (MEP) in alleviating moral distress among registered nurses employed in specific hospitals in Kolkata. The results demonstrate that the intervention substantially reduced both the incidence and prevalence of moral distress, thereby confirming the primary hypothesis and correlating with international and national literature. The subsequent discourse elucidates these findings within the framework of nursing ethics, professional empowerment, and healthcare systems.

6.1 Importance of Reduced Moral Distress Post-Intervention

The statistically significant decrease in both frequency ($t = 5.181$, $p < 0.01$) and distribution ($t = 16.4$, $p < 0.01$) of moral distress following the implementation of the MEP underscores the program's immediate effect on nurses' ethical awareness and emotional resilience. Abbasi et al. reported a similar impact on intensive care nurses following a structured empowerment intervention (Abbasi et al., 2018, pp. 5–7). The shift is especially significant because the distress assessed in this study included not only isolated incidents but also ongoing ethical unease stemming from institutional limitations.

This result substantiates the principal theoretical assertion of moral empowerment that equipping nurses with ethical resources, secure reflective environments, and institutional acknowledgement can rejuvenate their moral agency and mitigate internal discord in ethically ambiguous circumstances.

6.2 Ethical Demands in Critical Care Settings

One of the most notable outcomes of this study was the elevated ethical strain observed among nurses working in critical care units ($t = -5.055$, $p < 0.01$). Intensive care environments often involve

high-pressure decision-making, frequent exposure to end-of-life scenarios, and complex family dynamics — conditions that intensify ethical responsibility and moral uncertainty (Barlem et al., 2013; Burston & Tuckett, 2013). Nurses in these settings frequently find themselves required to implement clinical decisions—such as aggressive life-prolonging measures or restricted communication with families—without being directly involved in the decision-making process. The Moral Empowerment Programme, through its emphasis on team-based dialogue, ethical mentorship, and reflective practice, enabled participants to view these complex situations through a strengthened ethical lens, thereby enhancing their confidence, moral clarity, and ability to act in alignment with professional values.

6.3 Individual Background and Ethical Responsiveness

The study found no statistically significant differences in outcomes based on participants' professional background characteristics, such as gender, educational qualifications, or years of experience. This suggests that the need for ethical empowerment and structured support is universally relevant across nursing roles and profiles. This conclusion is consistent with previous research by Allen et al. (2013) and Biswas & Ray (2019), who found that ethical challenges in nursing are less a result of personal factors and more deeply influenced by the institutional and structural conditions of the healthcare setting. Contrary to common assumptions that less experienced or less educated nurses may face greater difficulty in navigating ethical complexity, the findings highlight the importance of addressing the systemic and environmental factors that influence ethical practice.

6.4 Alignment with Theoretical Frameworks

The findings corroborate Jameton's theory of moral distress, which asserts that distress originates not from moral ambiguity but from institutional constraints that hinder ethical action (Jameton, 1984, pp. 6–10). In this study, the empowerment program specifically targeted these challenges by providing nurses with communication techniques, team negotiation abilities, and ethical guidelines to operate within their authority, thereby reinstating a sense of control and moral integrity. Furthermore, the results augment the theory of empowerment in nursing, as articulated by Kanter and Laschinger, by illustrating that psychological empowerment especially in ethical decision-making exerts significant effects on nurses' emotional well-being and ethical performance (Laschinger et al., 2001, pp. 260–270).

6.5 Limitations of the Study

The study provides compelling initial evidence for the effectiveness of moral empowerment, yet it possesses certain limitations:

- The absence of a control group constrains the capacity to differentiate the intervention's effect from other external factors.

- The sample size of 50 nurses, while sufficient for a pilot study, limits generalisability.

- All participants were sourced from private hospitals in Kolkata, potentially omitting nurses in public or rural healthcare environments who may encounter distinct ethical dilemmas.

- The dependence on self-reporting instruments engenders the potential for social desirability bias.

- Subsequent studies employing larger, randomised samples, control groups, and multi-site comparisons may corroborate and enhance these findings.

6.6 Supposition of the Discussion

In conclusion, the current study provides substantial evidence that moral empowerment is not only a theoretical concept but also a practical and effective intervention for alleviating moral distress in clinical nursing practice. The success of the Moral Empowerment Programme demonstrates that nurses can reconnect with their professional values, feel more confident in their decisions, and contribute to making healthcare environments more humane and ethical when they receive structured ethical support.

7. Conclusion and Recommendations

7.1 Conclusion

The results of this study strongly support the idea that moral distress is a widespread and significant issue among nursing staff, especially in critical care settings. Nurses, despite being ethically conscious and professionally dedicated, frequently face systemic obstacles that prevent them from acting upon their moral convictions, resulting in a cycle of internal conflict, frustration, and emotional exhaustion. This study shows that a structured Moral Empowerment Programme (MEP) that includes ethics-based mentorship, reflective dialogue, role-playing, and participatory engagement led to a statistically significant decrease in the frequency and distribution of moral distress among nurses. The

post-intervention results indicate that these programs empower nurses to address ethical dilemmas with greater confidence, align with their moral principles, and enhance their engagement in patient care while maintaining professional integrity.

The study shows that moral distress is not limited by gender, level of education, or years of experience. However, the posting unit, especially in high-intensity areas such as critical care, significantly influences distress levels. The significance of contextual and departmental considerations strengthens ethical interventions. Even though the study only looked at private hospitals in Kolkata and did not have a control group, the results are a strong basis for future studies and pilot replications in other parts of India's healthcare system. The outcomes offer the nursing profession guidance on how to institutionalise ethical well-being.

7.2 Suggestions

The current research offers insights that culminate in the following recommendations for healthcare institutions, nursing educators, and policymakers:

7.2.1 Establishment of Ethical Mentorship and Peer Dialogue Forums

Hospitals should establish structured peer-support groups and ethics mentorship forums where nurses can share morally troubling experiences without fear of judgment or repercussions. Mentoring by experienced nurses who are trained in ethical leadership can help build moral strength and clinical integrity.

7.2.2 Focused Interventions for High-Risk Units

Health care workers should pay extra attention to the emergency room, oncology, and critical care departments because they often face very emotional and ethical problems there. Nurses working in these places should receive personalised empowerment modules that address the moral issues they face.

7.2.3 Policy Reforms in Nursing Governance

Nursing councils and hospital boards need to recognise moral distress as a real risk to workers' health and safety. Policies should require regular ethics training, the involvement of nurses in care planning discussions, and the formation of clinical ethics committees that include nurse representation.

7.2.4 Longitudinal Research and Extensive Validation

This study functions as a preliminary framework for future longitudinal and multi-institutional research. Subsequent research must include control groups, randomised samples, and varied geographic contexts to substantiate the results on a national or international level.

7.3 Final Remarks

Moral empowerment is not an abstract concept; it is an essential requirement in contemporary healthcare. Nurses are the moral anchors of clinical care, and how well they can act with moral clarity and confidence is vital for patient outcomes, the credibility of the institution, and humanised healthcare. By giving nurses the tools to think, resist, and act ethically, the healthcare system gets back its moral compass and its caring heart.

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