SAÚDE E PESQUISA
e-ISSN 2176-9206

ORIGINAL ARTICLE

https://doi.org/10.17765/2176-9206.2025v18e12875

NURSES PERCEPTION OF THE ETHICAL CLIMATE IN THE FACE OF THE POSSIBILITY OF DIALOGUE WITH THE TEAM AND MANAGEMENT

PERCEPÇÃO DO CLIMA ÉTICO DE ENFERMEIROS DIANTE DA POSSIBILIDADE DE DIÁLOGO COM EQUIPE E GESTÃO

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Received: 23 June 2024
Accepted: 12 Dec. 2024

ABSTRACT: Aim: To verify the association between the ethical climate and the communication/ dialogue variables of nurses working in the hospital context. Method: A cross-sectional study was carried out between April and June 2019 with nurses from a university hospital in southern Brazil. The collection instruments used were a questionnaire to characterize the participants and variables on communication/dialogue and the Hospital Ethical Climate Survey - Brazilian Version. Descriptive statistics, bivariate analysis, and Poisson regression were used. Results: A significant difference was observed in the ethical climate with the variables institution receptive to dialog, manager receptive to dialog, and nursing receptive to dialog. Conclusion: This study verified the association between the ethical climate and the communication/dialogue variables of nurses working in hospital settings. This finding is important for clinical practice, as it helps to understand what can impact workers' quality of life.
KEYWORDS: Ethics. Professional. Nursing. Working conditions. Hospitals.

RESUMO: Objetivo: verificar a associação entre o clima ético e as variáveis sobre o diálogo de enfermeiros atuantes no contexto hospitalar. Método: estudo quantitativo com delineamento transversal analítico, realizado entre abril e junho de 2019 com enfermeiros de um hospital universitário no sul do Brasil. Utilizou-se como instrumentos de coleta um questionário de caracterização dos participantes/variáveis sobre a comunicação/diálogo e o Hospital Ethical Climate Survey - Versão Brasileira. Foi realizada a análise estatística descritiva, bivariada e regressão de Poisson. Resultados: observou-se uma diferença significativa em relação ao clima ético com as variáveis instituição receptiva ao diálogo, chefia receptiva ao diálogo e Enfermagem receptiva ao diálogo, em que o clima ético positivo apresenta uma prevalência 47% maior naqueles que avaliam que tem diálogo com a chefia. Conclusão: este estudo permitiu verificar a associação entre o clima ético e as variáveis sobre a comunicação/diálogo de enfermeiros atuantes no contexto hospitalar. Esta constatação é importante para a prática clínica, pois auxilia a compreender o que pode impactar na qualidade de vida do trabalhador.
PALAVRAS-CHAVE: Ética profissional. Enfermagem. Condições de trabalho. Hospitais.

INTRODUCTION

The current way of producing work can lead to burnout and psychological distress among health workers. These occurrences seem to affect interprofessional relationships and jeopardize work processes.[1] Internationally, research indicates that one-tenth of nurses worldwide suffer from symptoms of Burnout Syndrome.[2] In Brazil, some studies that have identified the prevalence of Burnout Syndrome in hospital nursing professionals converge with international data, observing medium to high levels.[3-4]

This can result from organizational problems, and interpersonal conflicts, and arise due to unattainable demands that exceed the worker's capabilities.[5] In nursing practice, situations often arise that include interpersonal problems, such as conflicts between professionals, management, and work activity, due to the high demand for care.[6]

Other studies suggest that although nurses feel supported by their colleagues, there can be challenges in interdisciplinary collaboration.[7-8] Therefore, circumstances involving the autonomy of the profession, the organization of work, decision-making, and disagreements arising from patient care can cause professionals to experience conflicts that compromise the provision of care in an ethical manner and with high quality, affecting the ethical climate at work.[9]

Maintaining a positive ethical climate within healthcare institutions is essential for promoting a healthy working environment, which in turn has a direct impact on the quality of care offered to patients.[10] The ethical climate is defined by how professionals perceive the approach to ethical issues in their workplace and can be influenced by the organizational conditions made available for workers to reflect on ethical aspects during their practice.[11]

This perception can be negative or positive. When it is positive, the ethical climate improves worker satisfaction and provides healthier environments, with qualified and safe care.[12-13] Thus, the decision-making process must be based on ethical practice, which requires trust and acceptance of the individual perceptions of each person involved, and is a process based on interdisciplinary discussions that enrich care and bring benefits to the patient.[14]

In this sense, there must be healthy discussions and an exchange of knowledge based on dialogue for subsequent decision-making, to foster a safe climate, welcoming the perceptions of colleagues and patients, which will lead to increased trust between teams, providing understanding, exchange of experiences and values, as well as promoting the health of the worker.[15]

The interpersonal development of professionals plays a fundamental role in health practices, as it makes it possible to recognize elements that strengthen the quality of care, including management support and dialogue between the team, which offer tools for increasing productivity, self-confidence, and worker satisfaction.[16] A study carried out with nursing residents shows that deliberative dialogue contributes to the acquisition of professional skills during training.[17]

The ethical climate comprises an expansion of complex knowledge related to the hospital environment, which is why it is a challenging subject. However, intervening in professional relationships promotes a better connection between staff, managers, and institutions and is of the utmost importance to expand the ethical climate in the workplace.[18] The climate in the work team also refers to the conception of the work team, as it involves the integration and collaboration of all those involved.[19]

Nursing is considered to promote broad and centralized work. Therefore, teamwork contributes to the development of safer care, due to the more communicative, participative, and collaborative climate, centered on the characteristics and particularities of each patient.[20]

In addition, some studies that seek to evaluate the association between ethical climate and other variables, such as moral courage and leadership, can identify factors that contribute to a positive or negative ethical climate.[21-22] However, internationally there is a gap in studies that associate ethical climate with variables on dialog or communication.[8,23] At a national level, research into nurses' perceptions of ethical climate is still incipient, especially among hospital nurses.[7] Furthermore, identifying factors that influence ethical climate, as well as the relationship between these variables, could help to reduce evasion due to change or abandonment of the profession among nursing workers.[23]

Given the above, this study asks "What is the association between nurses' perception of the ethical climate and the possibility of dialog in the hospital context?" and aims to verify the association between nurses' perception of the ethical climate and the possibility of dialog in the hospital context.

METHODOLOGY

This is a quantitative study with an analytical cross-sectional design, involving nurses and verifying the association between the perception of the ethical climate and the variables of the possibility of dialog between nurses working in a university hospital with approximately 400 beds. This location was chosen because it is a reference for high-complexity care and teaching in Rio Grande do Sul.

Data collection took place between April and June 2019 and was carried out by the authors and previously trained members of the research group who had no ties to the participants. Nurses with at least one month's work in care sectors at the research hospital were included. Nurses on leave for any reason during the data collection period were excluded.

Initially, the nurses taking part in the study were approached and invited to take part in the study in their work environment, in all hospital units and shifts, choosing to answer the questionnaire on the spot or hand it to the researcher later in a sealed envelope to maintain confidentiality and avoid bias.

When they were invited, they were given approximately 20 minutes to complete the questionnaires. Participants signed the Free and Informed Consent Term (FICT), signed by the researcher and the participant, two copies of which were given to the researcher and the other to the respondent. Up to three attempts were made to search for the completed instrument on different days in different shifts in the workplace. Those who agreed to take part in the study were given information about the research objectives, benefits, and potential risks, guaranteeing their right to choose whether or not to take part in the study without any negative repercussions.

Convenience sampling was used. The population of this study consisted of 303 nurses. From this total of nurses, a minimum sample was calculated for statistical purposes using a formula for a finite population, with a sampling error of 5% and an estimated percentage of 50%, establishing a minimum of 171 participants.

The data collection instrument consisted of a sociodemographic and work questionnaire, covering sociodemographic variables (gender, age, marital status, and number of children) and work variables (schooling), length of training, whether they had a specialization or residency, length of service at the institution, work sector, shift and whether they had another job; institution receptive to dialog (hospital managers and administrators) management receptive to the dialog (evaluation of dialog with immediate managers in the units or sectors), nursing receptive to dialog (evaluation of dialog established between nurses and nursing staff) and meetings (meetings held periodically in the units).

Continuing education center (whether the participant was aware of the presence of a permanent education center or policies at the institution), ethics committee (if the participant was aware of the

presence of an ethics or bioethics committee at the institution), and the Hospital Ethical Climate Survey - Brazilian Version (HECS-BV). This instrument was adapted and validated for use in Brazil in 2019 and initially developed in the US in 1998 to assess the perception of the ethical climate among nurses in the workplace.[3,17]

The HECS consists of 26 items, organized into five factors: peers (four items: 1, 10, 18, 23) - working relationships between colleagues and help in making decisions about care; patients (four items: 2, 6, 11 and 19) - sharing information that concerns patients' wishes; managers (six items: 3,7,12,15,20 and 24) - the head of each sector and their relationship with the professionals; the hospital (six items: 4, 8, 13, 16, 21, and 25) - the relationship between the health professional and the hospital management about the institution's mission; and the doctors (six items: 5, 9, 14, 17, 22 and 26) - trust and respect between the doctors and the nurses when making decisions about the patient. The items are related to the ethical issues involved in the work environment and in the relationships between nurses and their peers, doctors, patients, and management. The instrument consists of a five-point Likert scale with the following response options: 1= almost never true; 2= rarely true; 3= sometimes true; 4= often true and 5= almost always true.[17]

The data was initially organized in the EpiInfo® program (version 6.4), based on independent double entry to check for possible errors and non-conformities. The analysis was carried out using the Statistical Package for the Social Sciences (SPSS) software version 18.0 for Windows, using descriptive statistics, with absolute and relative frequency distribution for categorical variables, and measures of central tendency and dispersion for quantitative variables.

The ethical climate was evaluated based on the average of the factors and classified as positive or negative based on the average of 3.5. Normality was confirmed using the Kolmogorov-Smirnov test. Bivariate analysis was carried out using the Chi-square test. Poisson regression was then used. Variables with $p<0.20$ in the bivariate analysis were included in the crude analysis, then variables with $p<0.15$ were included in the adjusted regression analysis. Variables that remained in the model with $p<0.05$ were considered significant.

This study was assessed and approved by the local Human Research Ethics Committee under approval number 2.764.702 and CAEE 92702318.9.0000.5346. All participants were informed about the objectives of the research and the confidentiality of the data and signed the FICT. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) tool was used to describe the method.[25].

RESULTS

Of the 269 nurses who took part, 88.1% (n=237) were female and 69.1% (n=186) were over 35 years old. The majority, 75.1% (n=202), were married with a partner and 72.9% (n=196) had children. Concerning schooling, 58.4% (n=157) had specializations or residencies and 69.9% (n=188) had been trained for more than 10 years. In addition, 69.5% (n=187) had been working at the institution for more than four years, and 39.4% (n=106) were working a mixed shift, i.e. two different shifts on the same monthly schedule. As for the work sector, 20.1% (n=54) worked in the adult or pediatric Intensive Care Unit. Only 8.2% (n=22) of the participants had another job.

Table 1 shows the results of the bivariate analysis, which sought to assess the association between the ethical climate among hospital nurses and the possibility of dialog with staff and management.

Table 1 - Bivariate analysis of the ethical climate in nursing workers in relation to the variables. Brazil. 2024. (N=296)

VARIABLE	ETHICAL CLIMATE - n(%)		
	Negative	Positive	p-value
Ethics committee			0.076
Yes	51 (31.5%)	111 (68.5%)	
No	45 (42.1%)	62 (57.9%)	
Continuing education center			
Yes	51 (31.5%)	111 (68.5%)	0.769
No	45 (42.1%)	62 (57.9%)	
Institution receptive to dialog			
Yes	21 (21.4%)	77 (78.6%)	
No	17 (65.4%)	9 (34.6%)	**<0.001**
Sometimes	58 (40%)	87 (60%)	
Management receptive to dialog			
Yes	43 (23%)	144 (77%)	**<0.001**
No	13 (86.7%)	2 (13.3%)	
Sometimes	40 (59.7%)	27 (40.3%)	
Nursing receptive to dialog			
Yes	43 (24.4%)	133 (75.6%)	**<0.001**
No	2 (66.7%)	1 (33.3%)	
Sometimes	51 (56.7%)	39 (43.3%)	
Meetings			
Yes	90 (35%)	167 (65%)	0.187
No	6 (54.5%)	5 (45.5%)	

Source: Survey data (2024). Caption: n = sample used.

There was a significant difference (p<0.001) concerning the ethical climate with the variables institution receptive to dialog, management receptive to dialog, and nursing receptive to dialog.

Table 2 shows the regression analysis in the multivariable model, considering p<0.20 for insertion in the crude analysis and p<0.15 for insertion in the adjusted analysis, keeping the variables associated with p<0.05.

Table 2. Crude and adjusted regression analysis of the ethical climate in nursing workers in relation to the variables. Brazil, 2024 (n=296).

VARIABLE	ETHICAL CLIMATE – n/ (%)					
	PRb	IC (95%)	p-value	APR 1	CI (95%)	p-value
Institution receptive to dialog						
Yes	1.327	1.149-1.531	<0.01	1.100	0.944-1.281	0.223
Sometimes	1.189	1.028-1.374	0.019	1.069	0.922-1.240	0.375
No	1			1		
Management receptive to dialog						
Yes	1.562	1.337-1.825	<0.01	1.479	1.239-1.766	<0.001
Sometimes	1.238	1.041-1.472	0.016	1.198	0.995-1.443	0.057
No	1			1		
Nurses receptive to dialog						
Yes	1.317	0.881-1.968	0.179			
Sometimes	1.075	0.716-1.614	0.727			
No	1					
Meetings						
Yes	1.134	0.924-1.393	0.229			
No	1					
Ethics committee						
Yes	1.067	0.992-1.148	0.081	1.033	0.967-1.105	0.336
No	1			1		

Source: Survey data (2024). Key: N = sample used; PRb = Prevalence Ratio; CI = Confidence Interval; APR1 = adjusted prevalence ratio - institution receptive to dialog + manager receptive to dialog + ethics committee.

Given the adjusted regression analysis, only the variable manager receptive to dialog remained associated with the model, where the positive ethical climate was 47% more prevalent among those who said they had dialog with their manager.

DISCUSSION

In the results presented, the significant association between a positive ethical climate and receptiveness to dialog on the part of the manager indicates that effective communication and leadership support are associated with the establishment of an ethical and healthy environment. The literature corroborates this idea by indicating that leaders who promote open and honest dialog with their teams contribute to strengthening the ethical commitment and well-being of professionals.[25-26]

In addition, a positive ethical climate is essential for effective health promotion and disease prevention strategies, as it influences job satisfaction, perceived support in the workplace, and commitment among health professionals.[9] Thus, an alignment of purposes between institutions and managers provides workers with an open space for dialogue and effective communication, to promote a healthier working environment.

However, an international study that sought to understand how nursing managers perceive their role in supporting ethical care found that managers tended to perceive ethics as a 'personal issue' and that it depended on individual commitment. In other words, they did not distinguish their own responsibility for supporting and dialoguing with employees about ethical care.[27]

Thus, the workplace is a challenging environment where conflicts need to be minimized to provide a positive climate of cooperation between staff and their superiors. But to transform the ethical climate of a healthcare institution, nursing managers also need to be supported, both to understand and to fulfill their responsibilities to promote the ethical conduct of their teams. This is because management is a mediator, meaning that the greater the managerial support, the greater the positive ethical climate.[27-28]

This is corroborated by a mixed study carried out in the south of Brazil with nurses from university hospitals, in which semi-structured interviews showed that the perception of the ethical climate was positive when it was related to the position of manager, even in a scenario of adversity arising from the work environment.[29] Other studies carried out in Brazil reiterate the above by verifying that managers should provide guidance to employees through the use of information and communication technologies, workshops, and advice.[30]

Furthermore, this study found, in a bivariate analysis, that nurses have a positive perception of the ethical climate when the nursing team is receptive to dialog. A previous study in the same context found that good relationships between health professionals enhance care, i.e. receptiveness to dialogue favors interpersonal relationships to ensure better quality of care.[30]

Nevertheless, a descriptive correlational study carried out with 156 nurses in three Iranian hospitals found that the variable “communication with peers” had the highest mean score on the translated Hospital Ethical Climate Survey, which corroborates our findings.[20] In addition to these data, a study carried out with hospital nurses and the HECS-BV in Brazil also obtained the highest score for communication between peers among the five assessment variables.[7]

However, for effective communication between teams, managers, and management to be feasible, the work environment must provide adequate space for active listening, promoting opportunities for the dissemination of knowledge with educational practices, favorable locations for

meetings and continuing education activities, or providing adequate tools for use at different times of care.[30]

This, in addition to a positive ethical climate, can promote the health of nursing workers, since a negative ethical climate has been shown in several studies to be associated with moral distress, job dissatisfaction, and turnover.[31-33] It is therefore important to emphasize that an institution that cares about its workers, as well as management that offers support to improve the ethical environment, programs approaches that promote communication and conflict management, engaging employees in the unit's deliberations through regular meetings and demonstrating participatory leadership as a method of managing services.[30]

4.1 LIMITATIONS OF THE STUDY

One limitation is that the study may not be generalizable to other populations, contexts, or conditions, given that it was carried out in just one hospital. Therefore, it is suggested that further studies on the subject be carried out and disseminated, as well as educational activities to strengthen the ethical climate among nursing professionals.

4.2 PRACTICAL IMPLICATIONS

The research shows that a positive ethical environment is more prevalent when there is an open dialog between managers and nurses. It is, therefore, essential for healthcare institutions to encourage dialog, active listening, and the implementation of technological tools to facilitate communication and discussion on ethical issues, improve problem-solving, and promote health and a healthy working environment.

Holding regular meetings to discuss ethical and management issues can strengthen the ethical climate and promote a more collaborative working environment. This highlights the importance of organizational support, where professionals' contributions are valued and concern for their well-being is real, which is essential for a positive ethical climate.

These implications aim not only to improve the ethical environment but also the quality of work and the satisfaction of health professionals.

CONCLUSION

This study made it possible to verify the association between the ethical climate and the dialog variables of nurses working in hospital settings. Institution, management, and nurses receptive to dialog were the variables with the greatest impact. This finding is important for clinical practice, as it helps us to understand what can have an impact on health promotion and quality of life for workers.

It is suggested that topics related to the ethical climate be included in the training of nursing students, which could help future professionals deal better with ethical issues in the workplace. Finally, it is recommended that tools using information and communication technologies, and discussion forums on ethical issues, policies, and institutional processes be introduced to improve the resolution of institutional ethical problems.

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