**ORIGINAL ARTICLE**

# PERCEPTION OF ETHICAL CLIMATE AMONG NURSES IN THE HOSPITAL SETTING

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**Highlights:**

(1) Understand the perception of ethical climate among nurses in the hospital settings. (2) A negative ethical climate is associated with conflicts and weaknesses in patient care, interpersonal relationships, and management. (3) A positive ethical climate is associated with patient advocacy, organizational policies and practices, and professional recognition and appreciation.



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## ABSTRACT

Understanding nurses' perceptions of the ethical climate based on their experiences of moral distress in the face of ethical and moral conflicts encountered in the hospital setting. This is a qualitative, exploratory-descriptive study conducted with 20 nurses working in psychiatry, emergency care, surgical clinic, and obstetric center of a university hospital in southern Brazil. Data collection took place between August and October 2021 through semi-structured interviews. Discursive textual analysis was employed. Two categories emerged: the first, "The ethical climate in the hospital setting" addressed aspects related to weaknesses and conflicts in care, interpersonal relationships, and management based on hierarchical structures; the second, "Moral sensitivity fostering an ethical climate in nursing practice", referred to patient rights advocacy, organizational policies and practices, and professional recognition and appreciation. Moral sensitivity and effective communication are key elements for a positive ethical climate, as they promote an appropriate care environment and contribute to the defense of patient rights.

**Keywords:** Nursing. Ethics. Hospitals. Occupational Health.

## INTRODUCTION

The concept of Moral Distress (MD) has been extensively explored and is constantly evolving, particularly concerning the determination of its causes and manifestations[1]. The first concept of MS addressed in Nursing was proposed by the philosopher Jameton in the United States, characterized when the professional recognizes the correct conduct to be followed but encounters institutional restrictions that prevent them from following this specific course of action[2].

Brazilian authors proposed to expand this definition of MD, defining it as when the professional perceives a moral problem in their daily work, makes their judgment, but is unable to act according to their moral values. Thus, MD is characterized by the impotence to act according to their ethical-moral stance in each situation, due to the occurrence of an

obstruction during ethically correct moral deliberation[3].

Nurses are prone to experiencing MD when faced with morally complex situations or when they feel disappointed with decision-making processes. Consequently, MD can lead to physical and emotional issues for the worker, as well as job disappointment, intent to leave the profession, and a negative impact on the quality of care provided. Furthermore, MD can cause harm not only to the Nursing workforce but also to patient care and the organizational environment[4].

Among the characteristics of the healthcare organizational environment are those that either facilitate or hinder nurses' professional practice[5]. In this context, ethical climate stands out, defined as how individuals perceive the handling of ethical issues within their organizational setting, or whether there are organizational conditions that enable workers to engage in ethical discussions and reflections[6].

Accordingly, when the ethical climate is negative, harmful effects on workers' health, such as MD, become more pronounced. Conversely, a positive ethical climate promotes moral deliberations grounded in values, commitments, and ethically sound principles, supporting conflict resolution. Several studies have demonstrated the impact of a positive ethical climate in healthcare organizations, highlighting it as an important strategy for reducing MD and fostering healthier work environments[5,7-9].

Considering the aspects discussed, this study is justified by the need for a deeper understanding of the relationship between moral distress and the perception of ethical climate in the hospital work environment of nurses, given the lack of Brazilian studies that address these themes together using a qualitative approach[10]. Therefore, this study aims to understand nurses' perceptions of the ethical climate in relation to their experiences of MD when facing ethical and moral conflicts in the hospital setting.

## METHOD

This is a qualitative, exploratory-descriptive study conducted in a university hospital affiliated with the Brazilian Hospital Services Company (*Empresa Brasileira de Serviços Hospitalares* – EBSERH) in the southern region of Brazil. The institution provides high-complexity care, with services offered exclusively through the Brazilian Unified Health

System (*Sistema Único de Saúde* – SUS), and functions as a teaching hospital with activities in education, research, and community outreach.

The study participants were nurses from the psychiatry, emergency room, surgical clinic, and obstetric center units, totaling a population of 83 professionals. The selection of these units is justified by a previous quantitative study, related to the same overarching project as the present research, i.e., "Moral distress among hospital nurses: what is its relationship with ethical climate and burnout?", in which a relationship between the mentioned constructs was identified[11,12]. Additionally, nurses from these units presented the lowest and highest average levels of moral distress, respectively.

Thus, the inclusion criteria were being a nurse with at least one month of experience at the institution and working in the units that presented the two lowest and two highest average levels of moral distress namely, psychiatry, emergency room, surgical clinic, and obstetric center. Nurses who were on any type of leave during the data collection period were excluded.

To operate data collection, unit managers were contacted to explain the objectives of the study, its benefits and risks, the data collection period and schedule, and the criteria for participant selection. Additionally, managers were asked to share the invitation to participate in the study with their teams using institutional communication tools such as email and WhatsApp groups. The invitation included the researcher's email and WhatsApp contact information so that interested nurses could reach out directly. Thus, convenience sampling was adopted, allowing all nurses the opportunity to participate in the study.

The number of participants was not defined *a priori*; instead, the sample size was determined based on the coherence between achieving the study objectives and obtaining answers to the research question. Data collection was concluded when data saturation was observed, that is, when responses began to repeat and no new information relevant to the study's objective emerged[13]. In total, 20 nurses voluntarily participated in the study, according to their availability and upon agreeing to the terms of the Informed Consent Form (ICF).

In the approach to participants, the Informed Consent Form (ICF) outlined the risks and benefits of the study. The risks were related to potential fatigue or discomfort when recalling dilemmas experienced in the workplace. If such situations happened, the interview could be temporarily paused or permanently discontinued. The benefits, which were indirect, included contributing to the advancement of nursing knowledge and encouraging reflection

on the topic. It is important to note that no adverse events have happened.

Data collection took place between August and October 2021 and was conducted by two master's students previously trained by the principal investigator. Nurses who expressed interest in participating in response to the WhatsApp and email invitation had their interviews scheduled. The interviews were conducted online via the Google Meet platform, through video calls with audio and visual recording, each lasting an average of 38 minutes. Upon acceptance, the ICF was sent and signed via email.

It is important to note that the online data collection strategy aligns with the guidelines of the National Research Ethics Commission (*Comissão Nacional de Ética em Pesquisa* – CONEP), which issued recommendations for conducting consent procedures and research during the COVID-19 pandemic. Thus, online research using digital platforms is permitted. This approach ensured safety and adhered to prevention and protection protocols for both participants and researchers[14].

For the interviews, a semi-structured script was used, containing both closed and open-ended questions. The closed questions aimed to characterize the participants (age, gender, years since graduation, time working in the field, and whether they held a postgraduate degree) and open-ended questions included (How do you recognize moral distress in your work routine? If you feel comfortable, could you describe situations in which you have experienced or are experiencing moral distress? How do you perceive the moral atmosphere in your work environment? How does your perception of the ethical climate affect your professional practice? And your approach to patient values and rights? How do you perceive the influence of the ethical climate on decision-making in your work process? What are the positive and negative implications of the ethical climate? How do you evaluate interpersonal relationships in your work environment, considering peers, the nursing team, the multidisciplinary team, management, and support services? These questions aimed to understand the perception of the ethical climate in relation to situations involving moral distress in the nurses' daily work.

Data analysis was conducted using discursive textual analysis, a methodology that enables the understanding of participants' phenomena and discourses by mediating the production of meaning through a self-organized process comprising three sequential stages: unitarization, categorization, and communication[15].

In the unitarization step, the interviews were meticulously examined and broken down into meaning units, which consisted of statements related to the phenomenon under investigation. During categorization, relationships were established between these meaning units by comparing and grouping similar elements into intermediate categories, which were then consolidated into two final categories: “The ethical climate in the hospital environment” and “Moral sensitivity fostering the ethical climate in nurses’ practice”. The final stage of the analysis, capturing the emerging news, aimed to clarify the understanding of the investigated phenomenon, enabling the development of new insights into the ethical climate as perceived by nurses and its relationship with moral distress.

The development of this study followed the recommendations for conducting qualitative research as outlined in the Consolidated Criteria for Reporting Qualitative Research (COREQ). Ethical aspects were respected in accordance with Resolution 466/12. The study was submitted to the local Research Ethics Committee and approved under opinion report number 4.847.212 on July 14, 2021. The nurses’ statements were identified in the study using the codename “Enf,” followed by a sequential number (Enf1 to Enf20), according to the order of the interviews. The data collected are stored on an external hard drive for a period of five years, under the responsibility of the principal investigator, and kept in a locked cabinet in the research group’s office at the university where the study originated. After this period, the interview data will be destroyed and will no longer be available for use.

## RESULTS

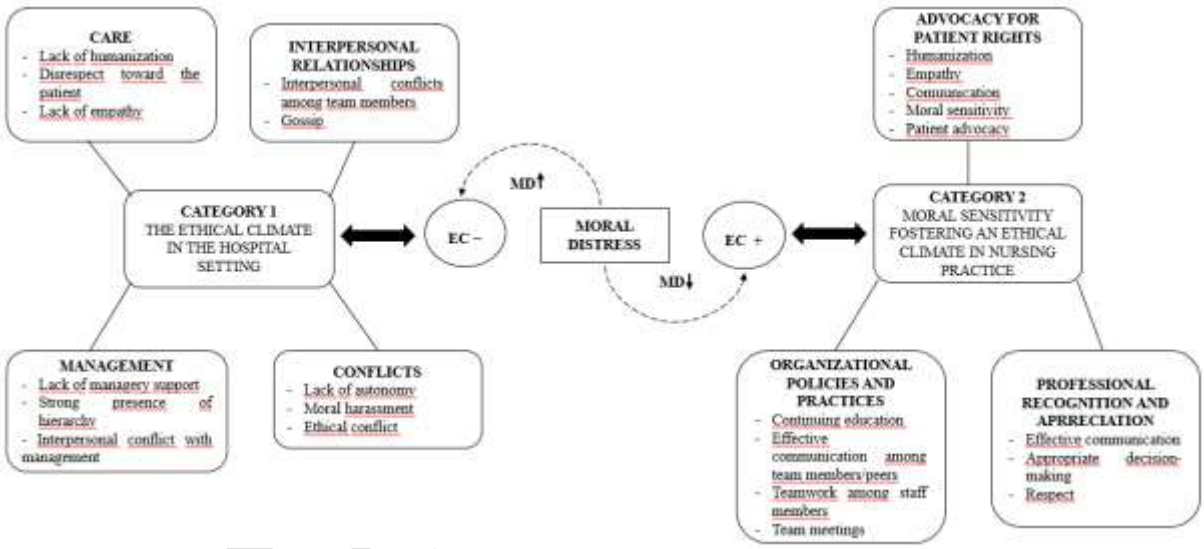
Based on the characteristics of the 20 nurses, their ages ranged from 28 to 61 years, and 16 were female. The length of professional training varied from 6 to 40 years, and professional experience ranged from 5 to 40 years. Regarding their employment status with the institution, 11 had employment contracts under the Consolidation of Labor Laws (CLT), and nine held statutory positions. Among them, ten had completed a specialization course, seven held a master’s degree, and three had a PhD degree. As for their work units, seven worked in the obstetric center, seven in psychiatry, four in the surgical clinic, and two in the emergency room.

Realizou-se o processo de categorização conforme os elementos que configuram o

clima ético[6], ao que emergiu duas categorias: "O clima ético no ambiente hospitalar"; e "Sensibilidade moral favorecendo o clima ético na prática dos enfermeiros". A Figura 1 demonstra os elementos que constituem o processo de categorização do estudo.

The categorization process was carried out based on the elements that define the ethical climate[6], from which two categories emerged: "The ethical climate in the hospital environment" and "Moral sensitivity fostering the ethical climate in nurses' practice". Figure 1 illustrates the elements that constitute the study's categorization process.

**Figura 1** – Elements that constitute the study's categorizations. Santa Maria, RS, Brazil, 2024.




Source: The authors.

*High moral distress (MD ↑); *Low moral distress (MD ↓); *Negative ethical climate (EC -); *Positive ethical climate (CE +).

### The ethical climate in the hospital environment

In this category, it was found that nurses reported weaknesses in the care provided to patients. They identified factors such as a lack of humanization and empathy, disrespect toward patients, and ethical conflicts regarding treatment choices. These aspects were seen as barriers to delivering qualified and appropriate care.

Nurses reported ethical conflicts that arise, particularly in the obstetric center, related to procedures and treatments. In this unit, obstetric nurses are trained to provide care to

women experiencing low-risk pregnancies. However, in their efforts to ensure appropriate care, they observed a lack of humanization and empathy in the care provided by other team members, as well as disrespect for the rights of the women in labor. They also witnessed unnecessary therapeutic interventions.

[…] the patients who come in for care due to fetal death have no privacy. In cases of miscarriage, it seems like there's no sensitivity to the pain of that patient who is going through an abortion, just because the baby isn't alive. It's really complicated! And **sometimes we** depend on a prescription to administer medication, and that prescription takes longer because it's for an abortion and not for a live baby. (Enf5)

[…] there's evidence that (doctors) insist on ignoring… Like early cord clamping, you know? We know it's unnecessary. Or sometimes we see that the baby is fine, crying, and they already want to take the baby and put it in the crib instead of leaving it with the mother. Or, like, oxytocin during the expulsive phase, why? There's no evidence for that, and it's something that harms the baby. (Enf3)

Another element is interpersonal relationships, which are seen as an ethical issue that hinders the establishment of an adequate organizational environment. According to the nurses, these conflicts occur between different team members, as well as within the nursing team due to unnecessary conversations, or with nursing management due to a lack of autonomy and respect for the professional. Additionally, they reported gossip as a factor that negatively impacts harmonious and ethical coexistence in the organizational environment.

[…] the relationship within the team, the nursing team, with people in general, maybe that's the hardest part for there's this heavy atmosphere. Nowadays, I prefer silence, you know? Because we often can't express our ideas. I tried to share my thoughts, and it was taken personally, as if I were criticizing. (Enf4)

[…] I had some disagreements with my manager. Like, I would take action or follow up on something, and then she'd come in and say, 'oh no,' and just let it slide; or the opposite, she would demand something, and I'd say, 'no, it's not quite like that, let's try to talk to the person, let's try to improve'. (Enf1)

[…] the difficulty is that we have a very conservative medical team, which doesn't allow us to take a step forward. I think that's the biggest obstacle. (Enf6)

[…] there are a lot of staff members, and sometimes a comment pops up here and

there, things that really shouldn't be said. We make little remarks, but we know they're not ethically appropriate. (Enf9)

Nurses also expressed concerns related to management practices based on hierarchy, highlighting issues such as lack of support from immediate supervisors and recurring interpersonal conflicts. The strong presence of hierarchical structures, particularly within nursing leadership, was identified as a contributing factor to these challenges. Such elements may lead to feelings of insecurity when engaging in moral deliberation or cause a sense of powerlessness among professionals, resulting in limited expressiveness from nurses.

[…] one of the situations we often experience is the lack of support from management. We would like to have their backing, but we don't. Sometimes, we're not even listened to, our voices aren't heard, and we receive no support from our own supervisors. (Enf6)

[…] the issue with management is also quite toxic. We experience a significant amount of harassment, as we are never supported. We're excluded from meetings and from decisions regarding protocols. This is something that, at times, can be very discouraging. (Enf3)

Furthermore, the nurses reported elements related to a lack of autonomy and moral harassment in the context of nursing care. When these elements come into conflict with their actions and convictions, they threaten moral integrity, which can impair nurses' decision-making.

[…] many times, you see what's wrong and feel powerless, you have no way to act because you have no voice. You recognize the mistake, you identify it, but you can't change it. And that's extremely exhausting! (Enf6)

[…] but what affects me the most is when someone comes and undoes something I've done right in front of everyone, you know? In front of the team, the technicians. It's like I don't solve anything, I don't do anything, I'm not even there. There was no need for that. And that's what causes the most distress, you keep dwelling on it. (Enf12)

**Moral sensitivity fostering the ethical climate in nurses' practice**

In this category, nurses act with the premise of defending patients' rights, which, when done ethically, supports their moral deliberation in favor of benevolence. However, it is essential that the relationships between patients, families, and nursing staff be grounded in

humanized care, empathy, and strengthening dialogue. These elements promote care that meets patients' needs and, through effective communication, enable the identification of organizational conflicts and their resolution with greater skill.

[…] I must do my best, I always try, at the very least, to convey confidence to the patient, so they feel comfortable and welcomed. I always try to talk a lot; I'm very much someone who speaks, talks, and gives advice. (Enf2)

[…] the physician's first choice is often an invasive procedure, rather than treating the symptom itself. I believe we should look at the patient not only from a physical perspective but also consider the subjective aspects and put ourselves in their place – 'let's first try to calm the symptoms'. If that doesn't work, then we move on to other procedures. (Enf13)

Moreover, moral sensitivity and patient advocacy are also elements that contribute to the defense of patients' rights. It was found that moral sensitivity enabled the recognition of ethical dilemmas and strengthened professionals' autonomy, while patient advocacy helped promote care based on the patient's wishes and rights.

[…] we try to do things the best way possible to act ethically, responsibly, and respectfully. Of course, there are extreme situations where things may not happen exactly as they should, but we always strive to act in that way. (Enf20)

[…] I've always sought to learn and study legislation, both nursing-related and beyond, to avoid doing anything inappropriate. I make sure to guide the patient and their family about their rights, because sometimes they're hospitalized for days, and no one takes any action. So, I go there and provide orientation about their rights. (Enf8)

Additionally, nurses express that appropriate organizational policies and care practices are fundamental elements in fostering ethically positive environments that support moral deliberations. The highlighted elements include the availability of continuing education, which allows professionals to stay updated and consequently improve the quality of care provided; effective communication among team members through regular meetings; and moral deliberations discussed collectively, grounded in ethical principles.

[...] we have training meetings every month, not only involving management, but also including discussions about situations that need to be addressed to improve the quality of our work. (Enf17)

[…] we have team meetings that we participate in, and meetings with management

when there are work-related matters to address. We also have training sessions and service evaluations. (Enf19)

[…] we have an Ethics Committee within the University Hospital. And the strength of it is that all ethical issues are discussed in a group, as a team. We discuss certain matters to ponder on them or not, to report what happened, what the demand is, what the distress is – we work together, as a team. (Enf15)

Finally, nurses state that professional appreciation and recognition through effective communication is essential for creating healthy, safe, and high-quality organizational environments. Effective communication was present during decision-making processes, carried out in a precise, appropriate, and respectful manner, with the purpose of valuing the professional competence of team members.

[…] there are some difficulties in the workplace, so we try to solve them as we gather the team, discuss what can be improved, and try to resolve things in the best possible way, without affecting the patient or the emotional well-being of any colleague. We try to communicate and resolve things as best we can. (Enf13)

[…] working with competent people who are by my side, both subordinates and superiors. I feel good! I can ask questions; I can try to change some things. (Enf15)

[…] we have freedom of communication, and freedom to act within nursing activities. I feel very calm and confident to act as needed, ensuring that the work is done in the best possible way, that the patient's needs are fully met, and that they are treated with respect. (Enf20)

## DISCUSSION

Health work is dynamic, complex, and characterized by challenges that lead nurses to face various ethical dilemmas[1]. In this context, the workplace environment includes the ethical climate, which is considered a type of organizational climate in which workers share their ethical perceptions of the environment they are part of. Such perceptions can influence moral issues, beliefs, and behaviors among workers[16].

The ethical climate can be assessed as either positive or negative, depending on workers' perceptions and their cyclical relationship with elements of the organizational

climate, ethical expressiveness, and worker health[16]. It is also understood that the particularities nurses experience in care delivery may lead to a crisis of values, with real and harmful consequences, and ethical implications for all involved, ultimately affecting the quality of care provided to patients[1].

In this way, the fragility of care provided to patients was observed, especially in the obstetric center, related to care for women in labor, where nurses face barriers stemming from power relations and organizational structures. This aspect may result from nursing care centered on medical hegemony and interventionism. As a result, when experiencing a lack of quality, safety, and interventionist practices in care, nurses feel powerless in their moral actions, leading to moral distress[17].

A study that evaluated the patient safety culture in this same population identified the importance of communication for fostering a safety culture and reducing the reasons for care omissions. It was observed that the more available professionals are for communication, the lower the likelihood of care being omitted. An institution that is open to dialogue about safety offers professionals the freedom to identify and prevent problems that could result in missed or delayed care[18].

When experiencing moral distress, nurses tend to reduce the quality of care provided and fail to meet patients' basic physical needs. Providing high-quality care that considers patients' vulnerabilities and real needs is a core principle of nursing practice. It is also understood that offering comprehensive care is a patient's right and an ethical responsibility of nurses. Therefore, nursing care must be grounded in ethical principles to protect patients from complications and unnecessary interventions[19].

In this context, the code of ethics and the law governing professional nursing practice are important elements that support moral deliberation, as they provide a rationale based on ethical and bioethical principles of the profession. This rationale goes beyond intuition and uncertainty, offering guidance to professionals when facing difficulties in solving problems and ethical dilemmas. It is understood that the legal foundations of the profession guide nurses' actions in care delivery, enabling them to act ethically and safely, with respect for human dignity, ensuring quality care, and contributing to the development of responsible actions and the exercise of autonomy[20].

Furthermore, when interpersonal relationships among different team members are

conflictual, they can contribute to a tense and uncomfortable work environment, inhibiting interactions, generating stress, and compromising nursing care. In addition, when these workplace relationships are structured in a rigid and hierarchical manner, dominated by power dynamics, they can lead to consequences such as illness and the development of psychological problems among nurses[21].

In healthcare work environments where interpersonal relationships are fragile, autonomy is difficult to maintain, and dialogue is lacking, the ethical climate is perceived negatively, causing harm to workers' health, such as moral distress[9]. This affects the organizational climate, leading to ethical conflicts and reduced ethical expressiveness among nurses, becoming obstacles to problem-solving and the development of ethical-moral competencies[9,22].

It was identified that, in addition to nurses having limited space to voice concerns and receiving little managerial support, there are everyday work situations that generate apprehension. Nurses are often silenced and blocked when attempting to express work-related concerns, which contributes to experiences of moral distress and disruptions in their sense of identity, resulting in their invisibility[1]. Furthermore, the lack of autonomy among nurses also stems from interpersonal conflicts between professional categories, combined with the lack of visibility of nursing work, which is reflected in fragmented care practices that are routine, mechanical, and repetitive[17].

Signs of conflict involving situations of moral harassment were also identified. Moral harassment is understood as a form of psychological violence that occurs subtly, usually intentionally, in a repetitive and prolonged manner, with the intent to humiliate and socially exclude a person from the work environment. Consequently, this practice in the workplace generates emotional disorders that can impact quality of life, reduce work performance, and diminish the sense of pleasure in work[23].

Despite this, participants recognize that by advocating for patients' rights, they are acting ethically and improving nurse-patient relationships. Therefore, actions grounded in humanized care, empathy, and the strengthening of dialogue are necessary for comprehensive care. It is observed that nurses' moral sensitivity contributes to empathetic and holistic care, ensuring the rights, privacy, and autonomy of both the patient and the professional[24].

Empathy and dialogue are essential elements for the development of nurses' moral

sensitivity, serving as facilitators in the perception and deliberation of ethical issues faced. Moral sensitivity enables the recognition of ethical problems, promoting the establishment of actions based on clarifying patients' doubts, concerns, and distress, ensuring their rights, respect, and privacy, and thus minimizing conflicts arising from such dilemmas[24].

In addition, effective dialogue nurse-patient-family supports the practice of advocacy, enabling nurses to ensure patients' rights and exercise their autonomy in decision-making. Patient advocacy in situations of ethical conflict can bring relief to nurses; however, it is essential that they recognize when patients need an advocate, understand the patients' interests, and determine what actions should be taken to preserve, represent, or protect them. Thus, when advocating for the patient, the nurse must inform and empower them, while respecting their rights and ensuring safe and private care[25].

Regarding appropriate organizational policies and practices, as well as professional recognition and appreciation, participants reported the importance of effective communication within the work team. In this context, dialogue is a tool capable of minimizing conflicts and contributing to the development of participatory and democratic leadership that fosters workers' autonomy. Dialogue enables workers to express themselves within their micro workspaces, which promotes the appreciation of all team members[26].

Similarly, meetings have proven to be a positive factor for nurses' moral practice, serving as a strategy for conflict resolution and facilitating decision-making. By holding meetings, nurses create space for discussing conduct, which reflects in quality care and strengthens interpersonal relationships. Meetings are a moment to share issues related to the work process, without judgment and with a focus on valuing team members' performance. Additionally, they can promote workers' mental health by minimizing occupational stressors through effective communication[25,26].

Given the above, improving the ethical environment in the workplace provides greater security for nurses in decision-making. The ethical climate must be favorable in the work setting, as healthcare teams are constantly faced with diverse ethical dilemmas. Moreover, an ethical work environment influences nurses' job satisfaction, and therefore, it is essential that healthcare organizations develop strategies to foster a supportive ethical climate in the workplace[7].

## FINAL CONSIDERATIONS

This study enabled the understanding that moral distress becomes more evident when the perception of the ethical climate is negative in the face of problematic situations, which are associated with conflicts and weaknesses in care, interpersonal relationships, and management. From the perspective of elements that suggest a positive ethical climate, moral sensitivity is triggered to foster an appropriate care environment, as well as the defense of patients' rights, which results in improved quality of care and proves to be a favorable factor for the worker, the patient, and the institution.

It is recommended that nurses hold meetings, as discussing work-related situations strengthens effective communication among team members and facilitates decision-making. Another key factor is the need to find strategies to improve ethical education and moral sensitivity in the workplace, whether through meetings or continuing education, to create spaces that allow for discussion and reflection on ethical and moral issues, with the aim of improving organizational policies in the work environment.

It is important to highlight that, as this is a qualitative study conducted with a specific sample of nurses working in psychiatry, emergency care, surgical clinic, and obstetric center of a hospital institution in the southern region of Brazil, the results cannot be generalized. Another limiting factor is the scarcity of Brazilian studies on the ethical climate in nursing, which prevents comparisons between the research findings and the lived experiences of nurses in different national contexts.



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| **Ariel Siqueira Lemos:** | Data acquisition. |
| **Camila Antunez Villagran:** | Study conception and design; Data acquisition. |
| **Taís Carpes Lanes:** | Study conception and design. |
| **Valdecir Zavarese da Costa:** | Data analysis and interpretation; Intellectual review of the manuscript. |
| **Graziele de Lima Dalmolin:** | Study conception and design; Data analysis and interpretation; Manuscript drafting; Intellectual review of the manuscript. |
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**PERCEPTION OF ETHICAL CLIMATE AMONG NURSES IN THE HOSPITAL SETTING**

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