# The relationship between ethical climate at work and job satisfaction among nurses in Tehran

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## *Abstract*

***Background:*** *This study aimed to provide an understanding of the relationship between the ethical climate at the workplace and job satisfaction among nurses.*

***Methods:*** *210 nurses working in selected wards in the Tehran University of Medical Sciences were asked to fill out questionnaires on their work environment and level of job satisfaction. The data collection tools included a questionnaire to obtain demographic data, the Olson moral climate questionnaire and Minnesota job satisfaction questionnaire. The data were analysed using SPSS software version 14.*

***Results:*** *We found a significant positive relationship between the ethical climate and the level of job satisfaction among the nurses. Among the demographic variables, the working shift, income level and type of duties allocated had a significant relationship with job satisfaction.*

***Conclusion:*** *Hospital managements should pay attention to the factors influencing job motivation among nurses, including the ethical climate of the work environment.*

## Introduction

Organisations are units of the community that both affect the environment and are affected by it. Organisational ethics is a set of principles that promotes similar behaviours among the organisation's staff, and helps the organisation and staff solve problems caused by conflicts within the system, such as personal tensions and disputes related to job responsibilities (1).

Organisational ethics in healthcare is concerned with issues such as resource allocation (2), funding and setting of priorities (3), safeguarding justice and access to care (4), disclosure of risks and complaints of misconduct (5), and workplace ethics and the ethical climate in the health services (6).

The organisation's ethical climate – also referred to here as moral climate – reflects the organisation's rules and guidelines and their association with ethical consequences (7). It can also be a mediator of moral distress (8,9). Moral distress occurs when a person perceives that the right course of action cannot be implemented because of institutional constraints (10). The ethical climate determines whether decisions are based on ethical criteria, as well as how employees interpret ethical questions (11). Studies have shown that an organisation's ethical climate affects not only the moral attitudes of the organisation's employees, but also their work output (12).

The ethical climate in healthcare settings is defined as "organizational specific conditions that facilitate the discussion on the patients' health problems and their solutions, and provide a framework for ethical decision-making in the clinical environment." Researchers have suggested that the promotion of an ethical climate in the workplace enables employees to better cope with ethical stress and other causes of dissatisfaction, and may increase their level of job satisfaction (8,9).

Employees' job satisfaction has been shown to be reflected in their attitudes towards their work. Those who are satisfied with their work have a positive attitude towards it, while those who are dissatisfied have a negative attitude (13). A positive ethical climate is also associated with high levels of job satisfaction in terms of attitudes to payment, professional progress and colleagues.

Researchers have shown that the organisation can affect the employees' level of job satisfaction by influencing the ethical climate (14).

This study aimed to determine the relationship between the ethical climate at work and job satisfaction among nurses in a university hospital in Tehran.

## Methods

*Population and sample*

The study sample consisted of 210 nurses working in the emergency, surgery and internal medicine wards, and the cardiac care units (CCUs) and intensive care units (ICUs) of the Tehran University of Medical Sciences (TUMS). All were graduates with either BSc or MSc degrees in nursing.

*Sampling technique*

The study used stratified sampling with proportional allocation. The wards were selected according to the number of nurses working there. The sample from each ward was selected randomly (using the lists of nurses working there).

*Instruments*

A demographic form, the Olson moral climate questionnaire (15) and the Minnesota job satisfaction questionnaire (16) were

used to gather data. The moral climate is taken to reflect the ethical climate in professional settings.

The demographic form included questions on age, gender, education, type of employment, level of income, marital status and the current ward assigned.

The Olson moral climate questionnaire, which uses a Likert scale, contains 26 items on the organisation's moral climate. Each question has five options: "almost never" (score=1), "rarely" (score=2), "sometimes" (score=3), "often" (score=4) and "almost always" (score=5). The questions concern five factors, including "communicating level with the colleagues" (items 1, 10, 18 and 23), "patients" (items 2, 6, 11 and 19), "managers" (items 3, 7, 12, 15, 20, 24), "physicians" (items 5, 9, 14, 17, 22 and 26) and "hospital" (items 4, 8, 13,16, 21 and 25). The higher the score, the more positive was the moral climate at work.

The Minnesota job satisfaction questionnaire, which also uses a Likert scale, contains 23 questions on the participants' working conditions. Each question has five options: "very satisfied" (score=5), "satisfied" (score=4), "do not know" (score=3), "dissatisfied" (score=2) and "very dissatisfied" (score=1). The higher the score, the higher is the level of job satisfaction.

The questionnaires were designed after a review of the literature, in consultation with colleagues and experts in the field.

*Ethics review*

The research proposal was approved by the ethics committee of the Tehran University of Medical Sciences and permission for the study obtained from the School Research Committee.

*Data collection and analysis*

The researcher handed the questionnaires to the unit heads, who distributed them among the nurses in their units. The participants were provided with information on the goals of the study and assured of the confidentiality of the personal information they would be providing.

The data were analysed using the statistical programme SPSS version 14.

## Results

90% of the respondents were women. The respondents' ages ranged from 22 to 55 years, the average age being 30.8. 61% were below 31 years of age. 207 (98.6%) had a bachelor's degree and 3 (1.4 %) had a master's degree.

Of the 210 nurses, 28.1% worked in the ICU, 26.2% in the surgery ward, 23.3% in the internal medicine ward, 11.9% in the CCU and 10.5% in the emergency ward. Table 1 shows the frequency distribution of the demographic characteristics of the nurses.

Of the 210 nurses, 58.1% described their income as "average", 34.8% as "unfavourable" and 5.7% as "favourable". There are 3 missing values (1.4%).

The mean and standard deviation of the Olson moral climate questionnaire results for the investigated units was 3.36±0.69, and the mean and standard deviation of job satisfaction among the nurses was 3.17±0.63.

Pearson's correlation co-efficient showed a significant positive correlation between the moral climate at work and job satisfaction among the nurses ($r=0.39$, $p\leq0.001$) (Table 5).

The Scheffe test did not show any association between job satisfaction among the nurses and working shift ($p=0.02$) (Table 2).

The one-way analysis of variance test (ANOVA) showed a significant positive association between income level ($p<0.001$) and job satisfaction among the nurses (Table 3).

The Scheffe test showed a significant association between job satisfaction and the type of duties allocated ($p=0.02$) (Table 4).

## Discussion

The study found that the more favourable the ethical climate, the higher the level of job satisfaction reported by the nurses.

Considering the relationship between the ethical climate at work and job attrition, Hart found a significant relationship between a poor ethical climate and job attrition. Factors such as the number of patients, the adequacy of the nursing staff, and supervision of nursing activities also influenced change of job or career (17).

According to Elçi and Alpken, the pursuit of self-interest by employees has a negative influence on work satisfaction, whereas working with the team's interest in mind, social responsibility, and professional codes have been found to have a positive impact (18).

A study by Jaramillo et al found that the ethical climate has a positive effect on a salesperson's satisfaction, which, in turn, leads to a lower employee turnover, greater organisational commitment, and better job performance (19). Olson considers the ethical climate an organisational variable which can be managed and modified in order to improve the work environment.

The ethical climate provides a basis for ethical decision-making in organisations. When healthcare organisations enable their employees to talk to others about difficult issues, such as those faced by nurses in the care of patients, and allow them to feel that they can consult their colleagues, managers or clinicians, they create conditions which promote ethical thinking, ethical dialogue, hope and problem-solving. The work environment affects the behaviour and beliefs of the employees; hence, the work environment must be designed to strengthen relations between nurses and physicians, and to increase job satisfaction (15).

Sumner and colleagues, while investigating why nurses in the USA leave the profession, found that nurses sacrifice their interests for their patients' needs. They may experience

**Table 1**
**Frequency distribution of demographic characteristics of nurses**

| Demographic characteristics | Status | Frequency | Percentage |
|---|---|---|---|
| Marital status | Single | 99 | 47.1 |
| | Married | 109 | 51.9 |
| | Missing | 2 | 1 |
| | Total | 210 | 100 |
| Employment type | Public services | 39 | 18.6 |
| | Contracted | 171 | 81.4 |
| | Total | 210 | 100 |
| Service history (years) | 1–4 | 60 | 28.5 |
| | 5–9 | 66 | 31.4 |
| | 10–14 | 43 | 20.5 |
| | 15< | 29 | 13.9 |
| | Missing | 12 | 5.7 |
| | Total | 210 | 100 |
| Position | Head nurse | 18 | 8.6 |
| | Ward master | 45 | 21.4 |
| | Nurse | 147 | 70 |
| | Total | 210 | 100 |
| Working more than one shift | Yes | 155 | 37.8 |
| | No | 55 | 26.2 |
| | Total | 210 | 100 |
| Working shift | Morning shift | 28 | 13.3 |
| | Afternoon shift | 2 | 1 |
| | Morning and afternoon shift | 22 | 10.5 |
| | Night shift | 13 | 6.2 |
| | Afternoon and night shift | 8 | 3.8 |
| | Rotating shift | 137 | 65.2 |
| | Total | 210 | 100 |

**Table 2**
**Statistical indicators of job satisfaction based on work shifts and results of analysis of variance (ANOVA) among nurses**

| Work shifts | No. of nurses according to work shift | Mean job satisfaction levels (± SD) | ANOVA |
|---|---|---|---|
| Morning shift (0730–1400 hrs.) | 28 | 3.44±0.69 | p=0.02* |
| Afternoon shift (1330–1930 hrs.) | 2 | 3.02±0.95 | |
| Morning and afternoon shift (0800–1930 hrs.) | 22 | 3.16±0.55 | |
| Night shift (1900–0800 hrs.) | 13 | 3.13±0.59 | |
| Evening and night shift (1330–0800 hrs) | 8 | 3.68±0.42 | |
| Rotating shift | 137 | 3.09±0.62 | |
| Total | 210 | 3.17±0.63 | |

p<0.05*=significant

**Table 3**
**Statistical indicators of job satisfaction based on income level and the results of ANOVA among nurses**

| Income level | No. of nurses according to income level | Mean job satisfaction levels (± SD) | ANOVA |
|---|---|---|---|
| Favourable | 12 | 4.14±0.61 | p<0.001* |
| Average | 122 | 3.24±0.52 | |
| Unfavourable | 73 | 2.89±0.62 | |
| Missing | 3 | - | |
| Total | 210 | 3.17±0.63 | |

p<0.05*=significant

**Table 4**
**Statistical indicators of job satisfaction based on type of duty allocation and the results of ANOVA among nurses**

| Type of duty allocation in the ward | No. of nurses according to duty allocation | Mean job satisfaction levels (± SD) | ANOVA |
|---|---|---|---|
| Functional | 46 | 2.95±0.59 | p=0.02* |
| Case method | 143 | 3.22±0.65 | |
| Team work | 21 | 3.28±0.47 | |
| Missing | 3 | - | |
| Total | 210 | 3.17±0.63 | |

p<0.05*=significant

**Table 5**
**Pearson's correlation between the moral climate at work and job satisfaction among nurses**

| Variable | Moral climate |
|---|---|
| Job satisfaction | r=0.39 |
| | p=0.001* |

* Correlation significant at 0.05 level (2-tailed)

**Table 6**
**Statistical indicators of moral climate based on work shifts and the results of ANOVA among nurses**

| Work shifts | No. of nurses according to work shift | Mean moral climate levels (± SD) | ANOVA |
|---|---|---|---|
| Morning shift (7:30 h–14 h) | 28 | 3.44±0.56 | p=0.36 |
| Afternoon shift (13:30 h–19:30 h) | 2 | 4.15±1.19 | |
| Morning and afternoon shift (8:00 h–19:30 h) | 22 | 3.38±0.79 | |
| Night shift (19:00 h–8:00 h) | 13 | 3.07±0.77 | |
| Evening and night shift (13:30 h–8:00 h) | 8 | 3.47±0.61 | |
| Rotating shift | 137 | 3.35±0.68 | |
| Total | 210 | 3.36±0.69 | |

**Table 7**
**Statistical indicators of moral climate based on income level and the results of ANOVA among nurses**

| Income level | No. of nurses according to income level | Mean moral climate levels (± SD) | ANOVA |
|---|---|---|---|
| Favourable | 12 | 3.87±0.81 | p<0.03* |
| Average | 122 | 3.32±0.60 | |
| Unfavourable | 73 | 3.34±0.79 | |
| Missing | 3 | - | |
| Total | 210 | 3.36±0.69 | |

p<0.05*=significant

**Table 8**
**Statistical indicators of moral climate based on type of duty allocation and the results of ANOVA among nurses**

| Type of duty allocation in the ward | No. of nurses according to duty allocation | Mean moral climate levels (± SD) | ANOVA |
|---|---|---|---|
| Functional | 46 | 3.25±0.79 | p=0.38 |
| Case method | 143 | 3.41±0.68 | |
| Team work | 21 | 3.30±0.45 | |
| Missing | 3 | - | |
| Total | 210 | 3.36±0.69 | |

frustration and moral tension when they are unable to meet their patients' needs and also their own (20).

Among the demographic variables, the income level and type of duties allocated to the nurses had a significant statistical relationship with job satisfaction.

There was a significantly positive association between the nurses' income level and the level of job satisfaction. This result is consistent with other studies. Manookyan et al found that nurses' income was directly related to their job satisfaction (21). Studies also show that the best indicator of job satisfaction is the individual perception of the level of respect and compensation the organisation offers to acknowledge individual worth and merit (22).

As for the type of work allocation among the nurses, those who worked in a team had a higher level of job satisfaction than those who worked individually. This suggests that there is a synergy in team work (23).

## Conclusion

The results of our study indicate that hospital managements should pay more attention to the factors that motivate nurses and give them job satisfaction. Valuing the nursing profession, allowing scope for job diversification, and maintaining a respectful relationship with nurses all make nursing more productive and provide nurses with opportunities to improve their performance. The direct relationship between the ethical climate of the workplace and the job satisfaction of the nurses covered by this study highlights the necessity of considering measures that might strengthen the ethical climate. One way of promoting the ethical climate of the nurses' workplace and increasing their job satisfaction is to establish a code of nursing ethics, disseminate the provisions of the code, and monitor and evaluate its implementation.

### *Data-sharing statement*

*Two more articles were captured from the thesis (24), but these have been published only in the Persian language. An article entitled "The relationship between the moral climate at work and the job satisfaction of Iranian nurses" has been published in an Iranian journal (Medical Ethics) and its abstract is not in English (25). Another article entitled "Relationship between moral distress and job satisfaction among nurses of Tehran University of Medical Sciences hospitals" has been published in Hayat and its abstract is in English (1).*

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# "It all changed after Apollo": healthcare myths and their making in contemporary India

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## Introduction

In the shadow of recent proposals for universal healthcare in India, discussions regarding the impact of private medical care on Indians' health have taken on a greater urgency. However, our collective attempts to evaluate the effects of India's growing private medical sector have been seriously hampered due to a lack of reliable or comprehensive data regarding (i) the size of the private healthcare sector, and (ii) its patterns of growth, particularly since the 1980s. As we formulate and assess practical strategies for a sustainable healthcare future for India in the absence of reliable statistical data, historians' tools for understanding the recent career of healthcare in the country merit consideration.

To that end, in this article, I examine myths and myth-making as central to the rise and consolidation of Apollo Hospitals, first in Chennai and later as a key player in India's recent healthcare history. Using face-to-face interviews with more than 20 prominent Chennai physicians as well as published sources, I investigate not only the myths surrounding Apollo and its founder, but also the manner in which these stories are regularly circulated within the wider medical community. The case of Apollo is instructive for two reasons: a) Apollo is seen widely as representing the new chapter in the history of healthcare in India; and b) Apollo merits attention on its own, as a case study, to illustrate how corporate hospitals established after it "manage" their own success story and thereby shape the perceptions of the common man and professionals alike. In short, I argue that the most important successes of Apollo Hospitals have been in image management. Given that much of Apollo's "success story" is based on assumptions and assertions that crumble under even the most basic historical scrutiny, we would be wise to regard the corporates' claims of economic promise and therapeutic efficiency with some scepticism.

## Apollo and the invention of the "corporate hospital" in India

At the risk of stating the obvious, the rise and spread of the Apollo Group of Hospitals from the 1980s matters because it is widely seen to represent the beginning of a new chapter in the history of healthcare in India: the rise of the corporate hospital alongside the unfolding of liberalisation in the country. Apollo's story has been told and retold among physicians, journalists, politicians, bureaucrats, and members of the general public. In this story, the career of Apollo Hospitals appears to be nothing short of miraculous: Apollo, in particular, and India's healthcare sector more generally, figure simultaneously both as the cause *and* effect of the country's recent economic successes. Yet, as this essay argues, this legendary status depends on accepting a set of assertions that are at best, debatable and at worst, mere myth. Not only are these stories debatable, they are also dangerous, because they obscure a set of broader historical processes that both precede and go beyond any results that can be attributed to one man or one hospital. In the light of this generally confused state of affairs, it would be useful to begin with a chronological account, both of the establishment and early history of Apollo (particularly in Chennai), as well as of the broader context – in terms of the regional and national provision of healthcare – in which Apollo emerged.

In 1980, Dr Pratap Reddy, founder and chairman of Apollo Hospitals Group, announced that he had acquired a plot of land for the first Apollo hospital, Apollo Hospitals Chennai, on the centrally located Greams Road. At the time, the *Times of India* reported that this was the first of a new chain of large hospitals (1). This development was significant for three reasons. First, the Chennai hospital would be the first private limited hospital in India. Second, in order to move ahead with the financing, Reddy had been given permission to build a private hospital of a capacity of over 30 beds. Until then, the law permitted