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What actions promote a positive ethical climate? A critical incident study of nurses' perceptions

Marit Silén, Jönköping University, Sweden

Sofia Kjellström, Jönköping University, Sweden

Lennart Christensson, Jönköping University, Sweden

Birgitta Sidenvall, Jönköping University, Sweden

Mia Svantesson, Centre for Health Care Science, Örebro University Hospital, Sweden;
Karlskoga Community Hospital, Sweden

ABSTRACT

Few qualitative studies explore the phenomenon of positive ethical climate and what actions are perceived as promoting it. Therefore, the aim of this study was to explore and describe actions that acute care ward nurses perceive as promoting a positive ethical climate. The critical incident technique was used. Interviews were conducted with 20 nurses at wards where the ethical climate was considered positive, according to a previous study. Meeting the needs of patients and next of kin in a considerate way, as well as receiving and giving support and information within the work group, promoted a positive ethical climate. Likewise, working as a team with a standard for behaviour within the work group promoted a positive ethical climate. Future research should investigate other conditions that might also promote a positive ethical climate.

Keywords: Critical incident technique, ethical climate, interviews, nurses

INTRODUCTION

The past two decades within healthcare research have seen a growing interest in the concept of ethical climate as well as perceptions about it among healthcare professionals. First studied within business ethics in the late 1980s, it was introduced to describe the impact organizational environment has on unethical behaviour.¹ Theoretically, ethical climate has often been regarded as a certain type of organizational climate,² with a focus on members' perceptions of how things are.³ During recent years, however, Mayer et al.² have drawn attention to the fact that in order to talk about ethical climate as part of the organizational climate certain steps have to be taken in the data analysis to meet the core feature of ethical climate, shared perceptions. This includes aggregating data and ensuring that there is high within-group agreement. If these steps are met and, consequently, the perceptions are shared, ethical climate can be regarded as part of the organizational climate.² To summarize, ethical climate is part of the focus of research on organizational features, but is not necessarily a certain type of organizational climate as examining it requires certain data analysis methods.

A review of the research on ethical climate within healthcare reveals only one published concept analysis study⁴ but several empirical research studies. All have had a quantitative descriptive and/or correlational design, with nurses as typical respondents. Based on Olson's⁴ definition of ethical climate for nurses as 'nurses' perceptions of how such issues [ethical issues] are handled' (p. 90), the Hospital Ethical Climate Survey (HECS)⁵ has been developed. This is the only instrument developed to specifically measure nurses' perceptions of ethical climate. The HECS includes five dimensions: the relationships of nurses with peers, patients, managers, hospital and physicians.⁵ Previous studies have used the HECS or other ethical climate instruments, such as the Ethics Environment Questionnaire (EEQ)⁶ and the Ethical Climate Questionnaire (ECQ).¹ They have been conducted in hospital⁷⁻¹¹ as well as non-hospital settings,⁸ such as long-term care facilities,¹² and have shown that the more positive the ethical climate was perceived to be, the

more likely it was that the nurses intended to stay in their current position.^{7,8} Associations between certain types of ethical climate and intent to leave have also been reported,¹² as well as a relationship between perceived type of ethical climate and job satisfaction.⁹ Recently, it has been shown that the more positive the ethical climate was perceived to be, the lower the reported moral distress was, and the other way round.^{10,11}

Our previous study¹¹ indicates that ethical climate is an important variable in nurses' working environment; the finding regarding the relationship between perceived ethical climate and experience of moral distress especially deserves attention, since this kind of stress has been shown to be one factor that could result in burnout.¹³ However, there is a lack of qualitative studies exploring the phenomenon of positive ethical climate and what is perceived as promoting it. In this study, we chose to focus on one aspect of the phenomenon – actions that promote a positive ethical climate – and the aim was therefore to explore and describe actions related to significant situations acute care ward nurses perceive as promoting a positive ethical climate.

METHOD

This is an exploratory and descriptive study with a qualitative approach according to Flanagan's Critical Incident Technique (CIT).¹⁴ CIT has been described as a systematic, inductive and flexible qualitative research method.¹⁵ It is a methodology for collecting and analysing data with the aim of providing solutions to practical problems.¹⁴ This method focuses on 'pinpointing facts and reducing personal opinions, judgments and generalizations' (p. 1265).¹⁵ The most central concept in the method is that of critical incident, which means real, well-defined and meaningful incidents of human behaviour that positively or negatively affect those involved. The data collection of these incidents is mostly done through semistructured interviews.¹⁴ It has been noted that the use of the term 'critical incident' could be confusing when conducting a CIT study with health professionals.¹⁶ A 'critical incident' may be interpreted by health professionals as

situations involving critically ill patients and crisis events,¹⁷ which is different from what Flanagan regards as ‘critical incidents’.¹⁴ Thus, in this study the term ‘significant situation’ was used with the same meaning as ‘critical incident’. This change of terms is not intended to change the process of the procedure described by Flanagan but instead promotes the recollection of appropriate situations.¹⁶

The process of a CIT study is introduced by stating the general aims of the activity under study,¹⁴ in this case a positive ethical climate. This general aim, based on previous research, might be expressed as the delivery of good care.

Participants

The participants were 20 nurses working at four different wards (three medical and one surgical), at one university hospital and one county hospital in Sweden (Table 1). These nurses, together with nurses from an additional 12 wards, had participated in a previous study¹¹ on perceptions of moral distress and ethical climate, in which they completed the HECS. Based on the HECS scores, the four wards with the highest median scores for ethical climate, that is, the most positive perceived ethical climate, were selected. The median scores at these wards varied between 100 and 105 of a total 130.

Table 1 Demographic characteristics of the participants (n=20)

Variable	n (%)
Sex	
Female	19 (95%)
Age in years	
Median (Q1; Q3)	34.50 (28.50; 40.75)
Experience as a nurse, in years	
Median (Q1; Q3)	7.00 (3.13; 14.00)
Experience at the ward, in years	
Median (Q1; Q3)	6.00 (3.13; 10.00)

After approval from the Regional Ethical Review Board (dnr 2010/289-32), the nurse managers at the four wards were contacted and helped identify potential participants. The inclusion criteria were that the nurse had completed the HECS in the previous study¹¹ and was considered by the nurse manager to be able to provide rich descriptions of significant situations and ways of acting that promote a positive ethical climate at the ward. The respective nurse managers were asked to find five to eight nurses interested in being interviewed. The 28 nurses who expressed an interest in participating were given written information about the study as well as information about what a 'significant situation' is and an example of such a situation. Twenty-three nurses sent in the written consent form, and in the end 20 nurses were interviewed since three changed their mind about participating.

Interviews

Individual semistructured interviews conducted by the first author were carried out at a place adjacent to the respective ward. The main question, emanating from Olson's⁴ definition of ethical climate, was: 'Please tell about a significant situation involving an ethical issue at the ward that you feel you at the ward handled well, so that it promoted a positive ethical climate.' The participants were given the preferential right to define what an ethical issue was. Follow-up questions were asked, and at the end of the interview, the five dimensions of the HECS (the nurses' relationships with peers, patients, managers, hospital and physicians) were presented and the participant was asked if he or she could tell about a significant situation related to each of the dimensions. After the interview, the participant was given information on how to contact the first author if he or she wanted to provide written descriptions of more significant situations, but no one did this.

One test interview was conducted to scrutinize the interview questions, resulting in refinements to the questions' wording. The interviews were tape recorded and lasted 16-50 minutes. They were transcribed verbatim by an experienced secretary.

Analysis

The analysis was conducted based on the procedure described by Flanagan.¹⁴ The transcribed interviews were read several times to obtain a sense of the whole. Thereafter, the significant situations were marked in the text, together with the actions the participants perceived as having promoted the handling of the situations in a good way, that is, actions that promoted a positive ethical climate. A total of 78 significant situations were identified in the material, each participant having provided between one and eight. The significant situations involving an ethical issue chiefly concerned life-sustaining treatment situations, patients' behaviours and their wishes regarding care, and the treatment of patients and next of kin (Table 2). The text on significant situations was condensed and the accompanying actions were each assigned a code,¹⁸ whereby a few words indicated their basic content. The codes were then compared, and similar codes were combined to form subcategories. In the next step, the subcategories were compared and grouped into categories, based on similarities. Finally, the categories were grouped into two main areas.

Table 2 Type of significant situations regarding ethical issues (n=78)

Type of situation	n
Life-sustaining treatment situations	13
Patients' behaviours	10
Patients' wishes regarding care	10
Treatment of patients and next of kin	9
Disagreements with next of kin regarding the care of the patient	7
Disagreements and emotional expressions within the work group	7
Obstacles to good care	5
The nurses' state of emotion	3
Life circumstances of patients	2
Life circumstances of colleagues	2
Questioning physicians' standpoint	2
Other	8

The analysis was performed by the first author, with two of the co-authors judging the credibility of the subcategories, categories and main areas. Another of the co-authors acted as co-examiner. The co-examiner received the denominations for the subcategories, categories and main areas and then placed subcategories into categories and categories into main areas. There was full agreement between the first author and the co-examiner on which subcategories/categories should form categories/main areas. However, alterations were made to their labelling.

RESULTS

The results presented here concern the actions the nurses perceived as promoting a positive ethical climate. The two main areas that emerged through the analysis were *Meeting needs* and *Sharing responsibility* (Table 3). The first main area described how different kinds of needs, for patients as well as for next of kin and nurses, were met by the actions of the staff (in the case of patients and next of kin) and by colleagues, managers or external healthcare staff (in the case of the nurses). The second main area described that working as a team meant sharing responsibility among team members. This included taking responsibility for tasks, as well as for discussing things with other team members to solve difficult situations. Moreover, individuals also took responsibility through speaking out, thereby setting a standard for behaviour.

Table 3 Subcategories, categories and main areas regarding what actions the participants perceived as promoting a positive ethical climate

Subcategories	Categories	Main areas
Attending to the psychosocial needs of patients	Giving considerate care	Meeting needs
Complying with the patients' wishes		
Attending to the needs of next of kin		
Supporting each other in the work group	Receiving and giving support	
Receiving external psychosocial support		
Head nurse attending to the staff's working situation		
Using policies and routines as a help	Satisfying the need for information	
Physicians giving reasons for decisions		
Head nurse giving information on delicate matters		
Collaborating interprofessionally	Working as a team	Sharing responsibility
Reaching consensus for care interprofessionally		
Daring to speak out	Setting a standard for behaviour	
Protecting the patients' privacy		

Meeting needs

Giving considerate care

Attending to the psychosocial needs of the patients, together with other professionals, was perceived as promoting a positive ethical climate. This often involved quite simple actions, such as being attentive when a patient needed to talk or calming a patient by just being there. This was the case with a patient who was in an acute confusional state one night:

... one of us who was sitting with this patient, it took maybe one and a half hours before the medicine took effect. And for the medicine to take effect you have to keep it down, so she sat with him and held his hand and sang lullabies and, yes, really took the time for this. (Nurse 7)

It could also involve taking actions with the intention of making patients feel welcome when they arrive at the ward. But attending to the needs of patients could also involve a nurse being present during a conversation between the physician and the patient about treatment and prognosis, so that the nurse could later follow-up with the patient what had been discussed and answer any questions. Attending to the needs of patients meant putting their needs first. This was obvious in a situation when the diagnosis of a serious disease had been delayed and the patient and his family were very disappointed with the healthcare they had received. During a conversation with them the attending physician, nurse and nursing assistant let them get all their disappointment off their chests and did not defend the actions of other health-care staff.

Another mentioned aspect of giving considerate care was complying with patients' wishes. This could be seen as a continuum, with totally complying with the patient's wishes at one end point and compromising with the patient's wishes at the other. In some of the situations, the nurses told of patients being near the end of life and having specific wishes, such as being at home as much as possible or insisting on having treatment although this could cause the patient to die sooner than if the treatment had not been given. But complying with a patient's wishes could also mean not giving treatment. This was the case with a patient who, before falling ill, had expressed

that she no longer wanted to live and was now in a state in which she made it clear through signs that this was still what she wanted. However, the physician insisted on further life-sustaining treatment:

that you really talk about it with the next of kin and the patient, and the physician who was responsible and the nurse too. And that we were still able to agree that we could actually remove the drip, that, okay, that's how it can be. That this is her wish. (Nurse 8)

It was sometimes not possible to completely comply with what a patient wanted, but a compromise was sometimes possible. One nurse told of a situation involving a patient who wanted to return home immediately after surgery. However, according to routine the patient was advised to stay at the ward a couple of hours. In this situation, it was possible to reach a compromise with the patient, who was allowed go home but was to return the next day for a check-up.

Considerate care was directed not only at the needs of the patients but also at those of the next of kin. Actions involved, for example, acknowledging what they did for the patient or being attentive to what support they wished to have when the patient was dying. An example of this kind of situation was when a physician had decided to withdraw life-sustaining treatment for a patient and informed the next of kin of this. However, the family had a different cultural background, and the nurse wanted to make sure they had understood the situation and therefore sat down with them and talked about it.

Receiving and giving support

One action that promoted a positive ethical climate was supporting each other in the work group. When there was a tough situation or when a nurse was unsure about what to do, there was always someone else, usually another nurse, to get support from. They sometimes needed concrete advice about what actions to take in a difficult situation, but more often, the most valuable

support was having colleagues to turn to and just say they found a situation hard to cope with. It could involve a patient expressing a death wish, or witnessing a patient in pain when the physician refused to give more medication to alleviate it. Once, there had been a patient for whom the nurses wanted the physicians to decide on a treatment level. However, different physicians were making the rounds, and there was inconsistency in their decisions:

And I know we brought that up at a meeting. And it must've been here at a workplace meeting, I think, both nurses and nursing assistants; unfortunately the physicians don't usually come to those meetings. But we brought it up and discussed it. And we got to the point that we were able to vent a bit, that we thought this was difficult. (Nurse 6)

Receiving support also involved colleagues' acceptance of one's actions, for example sitting down and calming a patient who is worried instead of just giving him/her a tranquilizer. Support was seen as reciprocal; one day a nurse might need to receive support, and the next day, this nurse might be the one giving it. This way of being there for each other is exemplified by a situation in which a patient's state had dramatically worsened. The responsible nurse became paralyzed, however, and another nurse had to take charge. At the same time, as the latter nurse took care of the patient, she made sure a nursing assistant took care of the other nurse. Besides the support offered by colleagues, some nurses also had the possibility to receive external psychosocial support. This was often arranged by the nurse manager.

The nurse manager attended to the staff's working situation by, for example, assigning extra staff when the workload at the ward was heavy. There could also be times when there was a patient whom it was demanding to care for due to conflict between the patient and his or her next of kin. In these cases, the nurse manager could arrange the working schedule in a way that distributed the burden of caring for this patient.

Another source of support was offered by policies and routines, which could help when it was difficult to decide how to act or when motivating one's actions. All wards treated adults only but were sometimes asked to care for children as well:

In those cases we have guidelines because we're not trained to treat children. / .../ And call them and ask if they can admit someone who's under that age; it's really nice to have those guidelines to fall back on. (Nurse 20)

Satisfying the need for information

The nurses' need for information was satisfied by physicians as well as nurse managers. Receiving information from physicians, in the form of reasons for decisions, was important when a nurse did not understand or agree with the course of treatment determined by the physician. This is exemplified by a situation in which a severely ill patient came to the ward. He was given aggressive treatment for his condition, but nurses and nursing assistants could not really understand why:

And then in the end there was a meeting where a treating chief physician, an oncologist, explained the situation, how it was and how they actually believed he would respond to the treatment. / .../ And that communication is very important. Since as a nurse you don't see the whole picture, the medical/ .../. Because then we can in turn explain it to the nursing assistants / .../ You're motivated to keep your efforts up. (Nurse 3)

The nurse manager also provided information on delicate matters, such as a colleague who had had a tragic event in her personal life. In such a case, the nurse manager might gather the group and give them information about what had happened and in what way the ward was supporting this colleague. Also, at times, when there was dissatisfaction within the work group the nurse manager might raise the topic of dissatisfaction and, for example, give positive reasons why she

had made a decision that not everyone was satisfied with. This was the case when a staff member's employment contract had not been prolonged:

But then when you present your argument that it was this way that these possibilities were given, then it dies down. So if you bring things up and don't sweep them under the carpet and are then able to discuss it, everybody doesn't have to agree but then the decision has been explained. (Nurse 13)

Sharing responsibility

Working as a team

Working as a team involved collaborating interprofessionally. This was especially the case when a patient care situation was complex or when there was an emergency situation, for example, cardiac arrest. In the latter situation, the interprofessional collaboration took the form of everyone knowing their place and knowing what to do. But the nurses' perspective, collaboration also meant referring certain issues, such as dissatisfaction with the lack of decisions regarding aggressiveness of treatment, to the physician group. This had resulted in a discussion among all staff at one of the clinics and a way of working whereby the level of patient treatment was decided. Collaborating interprofessionally was possible, owing to less hierarchy among different professions. There was a sense that every member of the staff had responsibility and that collaboration was necessary in order to give good care:

And so we go together to the coronary x-ray and start there with the x-ray and the balloon dilatation. And a physician can't manage this on his own and a nurse can't manage on her own. Instead it's the security in saying yes, come on, let's go and that's us. (Nurse 4)

Nurses also described situations when they had a different opinion than the physicians regarding the appropriate care for the patients. One such situation was when an old, frail man with dementia was admitted to the ward for surgery:

where I can say is it really right to do something, if he codes what do we do then? Where you (nurse and physician) can have this dialogue with each other and can, like, no but you're right about that, we'll let him stop, we won't operate on him. (Nurse 20)

It could also be the case that the nurse and the physician had the same opinion, but that this differed from that of the next of kin. In one such situation, a nurse described how she and the physician collaborated and coordinated their actions to make the next of kin realize that his mother would not benefit from further life-sustaining treatment.

It was sometimes deemed necessary to reach consensus in the work group. This was the case when there were patients or next of kin who had behaviours that were perceived as difficult to handle. One nurse told of a situation involving a man with dementia at the ward who attacked the staff verbally. This situation was discussed among the nurses in order to agree on how to approach this man:

Yes, yes, how should we handle it? Exactly this thing with how much you should mark and how much you should, yeah, not say so much but just be there and do what we're supposed to do and, like, foster the person in question. Because that was surely how we came to the decision that you should put on your armour when you go in and take a few deep breaths and just be friendly in response. (Nurse 18)

Setting a standard for behaviour

One aspect of setting a standard for behaviour was that individuals dared to speak out, either because they felt their responsibility was too heavy or because they felt a colleague was not behaving appropriately. One nurse told of a colleague who sometimes spoke harshly to patients. This nurse had tried to cover up for her colleague in the past but had now chosen a different way of acting:

but now I can confront that person and say now you didn't sound very nice, your voice has to sound nicer. And then she can say, in a thankful way, oh that's good, or yes I'll keep that in mind, and she doesn't sound like that for the rest of the day. And that feels much better for both myself and her, I think. (Nurse 13)

Setting a standard for behaviour was also important in situations when there were patients whose life circumstances might generate gossip. A nurse described how impressed she was with how such a situation was handled by the work group, especially when giving reports:

partly I myself and even many of my colleagues tone it down, I mean if somebody starts saying did you hear this and that, yeah but we don't need to stick our noses into that. You put a lid on it, a lot of us do that in different ways. (Nurse 7)

DISCUSSION

The results showed that the actions the nurses perceived as promoting a positive ethical climate were those that were grounded in either the meeting of needs or the sharing of responsibility.

The main findings were the importance of the availability of collegial support and of working as a team for the ethical climate to be perceived as positive.

The general aim of a positive ethical climate has been previously stated to be the delivery of good care. The results of this study could be considered to be in accordance with this aim, either directly or indirectly. Having the ability to meet the needs of patients and next of kin could be described as being directed precisely at the delivery of good care. When the nurses' own needs were met and responsibility was shared, manifesting itself in teamwork and in having a standard for behaviour, this could be regarded as having satisfied the prerequisites for the delivery of good care.

Regarding *Meeting needs*, receiving support from the work group and especially from other nurses was seen as a very important factor for a positive ethical climate. The significance of collegial support in situations characterized by different stressors has also been reported elsewhere.¹⁹ This has been suggested to be either due to a lack of organized support in the workplace or a way of not exposing oneself in a workplace meeting.¹⁹ Some of the nurses had external psychosocial support available, and it was seen as important that the person who functioned as a moderator and adviser during these meetings had no connection to the ward, so that they could see the problem in a new light. This was also pointed out as important in a study evaluating an ethics rounds model.²⁰

As for *Sharing responsibility*, working as a team is one of the actions that promotes a perceived positive ethical climate, according to the nurses interviewed in this study. This teamwork was based on sharing responsibility. In this study, this was demonstrated not only by taking responsibility for one's own professional tasks but also by taking responsibility for coordinating these tasks with those of other professionals. It meant placing one's own actions in a wider perspective, with the desired outcome of providing the best care possible. The sharing of responsibility has also been described by Reeves et al.²¹ as one of the core elements of teamwork.

Although teamwork was perceived as promoting a positive ethical climate, there was room for improvement. It was reported that physicians seldom took part in workplace meetings, which was sometimes considered a pity since the problem often concerned the whole team. If, as has been argued here, working as a team is important in promoting a positive ethical climate, the introduction of interdisciplinary team meetings at which patient care problems are discussed could further strengthen the teamwork. This would also be an opportunity for physicians to give reasons for their decisions, which the nurses considered valuable. Unknown goals regarding patients' treatment, or a vague understanding of the goals, has previously been reported as being

difficult for nurses to cope with,²² but this could largely be prevented through closer interprofessional communication regarding these questions.

As there is a lack of qualitative studies on ethical climate, especially positive ethical climate, this study deepens previous knowledge and contributes knowledge concerning the actions that promote a positive ethical climate. However, a task for future research seems to be to investigate what else contributes to a positive ethical climate, besides actions, and whether ethical climate is something more than the perceptions of how ethical issues are handled. Although the research on what promotes a positive ethical climate is scant, partly parallel findings have been described by Rodney et al.,²³ who have not only used the metaphor of moral horizon to describe the good that nurses strive for but also the currents facilitating navigation towards the moral horizon. Supportive colleagues and the use of professional guidelines were mentioned as some of the facilitating currents.²³ The present findings partly parallel those by Rodney et al.²³ This raises the question of just how giving good care relates to a positive ethical climate. In this study, providing considerate care was described as actions promoting a positive ethical climate but has previously²³ been described as a feature of good care. There seems to be an interconnection between good care and positive ethical climate, but whether a positive ethical climate facilitates the giving of good care or vice versa is a question for future research to investigate.

Since the sampling of wards for this study was based on the results of a previous study¹¹ in which perceptions of ethical climate were investigated using the HECS, it is of interest to compare the dimensions of the HECS with the results of this study. The HECS has five dimensions describing nurses' relationships with peers, patients, managers, hospital and physicians. The present study deepens the knowledge about actions that are perceived as promoting a positive ethical climate. All dimensions of the HECS can be traced in the results of this study. Actions concerning the relationship with peers, physicians and patients were mentioned most frequently

and spontaneously, that is, without being suggested by the interviewer as dimensions of significant situations. Actions associated with the relationship with the hospital were rarely mentioned. Actions concerning the relationship with next of kin, for example, attending to their needs, were perceived as important for a positive ethical climate. This indicates that it may be valuable to include this dimension when investigating perceptions of ethical climate.

Comparisons can also be made with other instruments measuring ethical climate or ethical environment and the results from the present study. The ECQ¹ is largely concerned with the law, standards, codes and rules of the company, and how employees act in relation to them. The actions and attitudes described are directed at 'the company' or 'people', and it is difficult to judge whom they refer to. Does, for example, 'people' refer to colleagues or the immediate manager?¹ The EEQ⁶ is largely concerned with the ethics infrastructure of an organization, for example, support in ethical issues and the availability of engaging in ethics deliberation activities.⁶ Compared with these instruments, this study contributes results that are close to practice and reflect the day-to-day practice of nurses. In this case, organizational policies seem to be less important than relationships with colleagues and the treatment of patients and next of kin. The research on ethical climate in health-care settings is still relatively young and scant, and there is a need for further studies that deepen the knowledge concerning this phenomenon within health care, on the one hand, and are concerned with how this research relates to the wider research field of ethical climate, on the other.

Methodological considerations

The results of this study have their starting point in the 78 significant situations told about by nurses in interviews. Usually, more than 100 significant situations are recommended in order to be able to perform an adequate analysis²⁴; however, it is possible to have 50 to 100 significant situations if the investigated activity is relatively simple.¹⁴ It could be discussed whether the

activity under study here is simple, but the aim is well defined and the number of significant situations collected was therefore considered adequate.

The research tradition within CIT is to identify participants through strategic sampling in order to ensure maximum variation.^{25,26} However, previous research on ethical climate has not been able to present any clear evidence that perceptions of ethical climate differ because of demographic characteristics. Therefore, an intensity sampling technique²⁷ was used. The nurses who had participated in the previous study on ethical climate, and who were considered to be able to provide descriptions of significant situations and ways of acting that promote a positive ethical climate at the ward, were asked to participate. Although an intensity purposeful sampling technique was used, there was good distribution among the participants regarding age as well as experience as a nurse and working experience at the ward. The sampling was based on the fact that the median score for ethical climate at the selected wards indicated a positive ethical climate. Four wards, those with the highest median scores, were chosen since this was considered that adequate for the recruitment of a sufficient number of nurses to provide the necessary number of significant situations.

In this study the co-authors judged the credibility of the analysis, and one also acted as co-examiner, which strengthens the credibility of the analysis. The quotations from the interviews also make it possible to judge the accuracy of the analysis.

CIT involves the interpretation of data to a lesser degree than many other qualitative methods, and it is possible that the full potential of the data in this study has not been utilized, that is, that there is room for interpretation on a deeper level. However, the strength of using the CIT approach is that the presented results can easily be used in practice, for instance, as a basis for

improving the handling of ethical problems and therefore also the ethical climate, and this focus on practical relevance is in line with the aim of CIT.

CONCLUSION

To the best of our knowledge, this is the first study in which nurses have been asked to provide descriptions of what they perceive as promoting a positive ethical climate. The results of this study could serve as a basis for work groups at acute care wards that want to improve their ethical climate, but there is a limited amount of research on ethical climate. In future research, it is recommended that the perspectives of other professional groups besides nurses be investigated regarding actions perceived as promoting a positive ethical climate. The research focus should also be broadened to capture aspects besides the actions perceived as promoting a positive ethical climate. These could include working conditions such as staffing, as well as internal dispositions of employees such as moral sensitivity and knowledge in different forms, which might be of importance in the creation and sustainment of a positive ethical climate.

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CONFLICT OF INTEREST STATEMENT

The authors declare that there is no conflict of interest.

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