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Ethics in Public Health Management: Principles, Challenges and Impacts On Care

Ética en la Gerencia Pública de la Salud: Principios, Desafíos e Impactos a la Atención

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ABSTRACT

In the field of public health, ethics protects collective needs and serves as a guide for decision-making in crisis situations. It involves defining programs and policies with the support of specialists. The objective was to analyze the fundamental ethical principles that guide public health management, identifying the dilemmas faced by administrators when managing limited resources and ensuring equitable access. The methodology used was quantitative, based on non-experimental, descriptive field research. The population and sample taken for this study were seven (7) doctors and twelve (12) nurses from the Type III "Alberto Adriáni" Zea-Mérida Clinic, Venezuela. And seven (7) doctors and twenty (20) nurses from the Coromoto Type IV Hospital, Nursing Department, Maracaibo, Venezuela. Among the results, the greater ethical adherence of nurses to participation and justice reflects their direct role in daily care, where equity in shifts, supplies, and care times is experienced as a concrete reality. In contrast, doctors tend to emphasize dignity and ethical distribution, possibly because of their responsibility in critical decisions such as triage, treatment prioritization, and allocation of scarce resources. In conclusion, ethical management must also consider the emotional and relational dimension of hospital work. Ethics is not limited to abstract norms, but is expressed in the recognition of others, in empathy for suffering, and in shared responsibility in the face of complex dilemmas.

Keywords: Ethics; Public management; Health; Care.

RESUMEN

En el ámbito de la salud pública, la ética protege las necesidades colectivas y se convierte en guía para la toma de decisiones en contextos de crisis. Implica definir programas y políticas con apoyo de especialistas. Tuvo como objetivo analizar los principios éticos fundamentales que guían la gerencia pública de la salud, identificando los dilemas que enfrentan los administradores al gestionar recursos limitados y garantizar la equidad en el acceso. La metodología utilizada fue de enfoque cuantitativo, se basó en una investigación de campo, no experimental, descriptivo, La población y muestra que se tomó para este estudio fueron siete (7) médicos y doce (12) enfermeras del Consultorio Tipo III "Alberto Adriáni" Zea-Mérida, Venezuela. Y siete (7) médicos y veinte (20) enfermeras del Hospital Coromoto tipo IV, Departamento de enfermería, Maracaibo - Venezuela. Entre los resultados La mayor adhesión ética de las enfermeras en participación y justicia refleja su rol directo en el cuidado cotidiano, donde la equidad en turnos, insumos y tiempos de atención se vive como experiencia concreta. En contraste, los médicos tienden a

destacar la dignidad y la distribución ética, posiblemente por su responsabilidad en decisiones críticas como triage, priorización de tratamientos y asignación de recursos escasos. Como conclusión, la gestión ética también debe considerar la dimensión emocional y relacional del trabajo hospitalario. La ética no se limita normas abstractas, sino que se expresa en el reconocimiento del otro, en la empatía ante el sufrimiento y en la responsabilidad compartida frente a dilemas complejos.

Palabras clave: Ética; Gerencia publica; Salud; Atención.

INTRODUCTION

Ethics in public health management is based on principles such as autonomy, non-maleficence, beneficence, justice, and social responsibility. Complementarily, Paredes et al.[1] point to protection, reciprocity, and responsibility as essential ethical pillars. These principles face complex challenges, including equitable prioritization of access to services, transparency in processes, management of conflicts of interest, and attention to patients' dignity and rights. These aspects have a direct impact on the quality of care, institutional trust, and the efficiency of the health system.

In this context, the central question arises: What are the main ethical dilemmas faced by public health administrators in managing limited resources and ensuring equitable access to services? Evidence shows that one of the most relevant dilemmas is the tension between the universal right to health and the material constraints that require prioritizing specific population groups. Vargas et al.[2] warn that these challenges are increasingly complex and require strategies that ensure the right to health in an equitable, fair, and respectful manner. Added to this are other problems such as transparency in the administration of resources, confidentiality of information, respect for patient dignity, and the management of ethical dilemmas related to treatments, decisions about quality of life, and therapeutic limits. Also included are situations of violence, corruption, and discrimination in the healthcare environment, as well as the need to ensure ethics in the hiring and retention of staff.

The European University[3] also emphasizes the positive impact of ethical conduct in public health management, improving patient satisfaction and loyalty, strengthening institutional trust, and raising service quality. These effects translate into financial benefits and greater management efficiency, contributing to the construction of a more just, equitable, and human-centered system. Consequently, ethics becomes a key element in addressing administrative and social challenges, promoting care that respects fundamental rights and improves the quality of life of populations.

Among the principles that guide ethical management in public health are autonomy, understood as the respect for patients' right to make informed decisions; non-maleficence, which entails avoiding causing physical or psychological harm; and beneficence, oriented toward patients' overall well-being. The World Health Organization[4] defines ethics in public management as the set of principles that guide managers' actions to make decisions that benefit populations, prioritizing dignity, transparency, and equity. Managers are expected to act with integrity, responsibility, and professionalism, considering both scientific and legal evidence and ethical values such as solidarity and justice.

The Pan American Health Organization[5] also integrates ethics into technical work, influencing

the policies and plans of Member States. For PAHO, ethics is fundamental in decision-making that transcends scientific evidence and laws, focusing on equity, solidarity, and integrity. Management must ensure that actions do not perpetuate inequalities and that they involve communities, respecting their local and cultural perspectives.

In the US context, Thomas et al.[6] point out that ethics in public health administration is based on codes and principles that guide the conduct of professionals to ensure fair and responsible decisions. The American College of Healthcare Executives (ACHE) establishes 39 principles grouped into responsibilities toward the profession, society, and public welfare. Similarly, in 2002, the American Public Health Association (APHA) adopted a code of ethics that addresses challenges in public health, emphasizing social justice and equity.

In Latin America, Venezuela shares the constitutional aspiration for a universal, solidarity-based system. However, various authors warn that the socio-political and economic context exacerbates ethical problems in health management, a situation characterized by difficulty in obtaining medicines, the crisis in hospitals at the national level, and the resurgence of diseases due to lack of compliance with preventive strategies,[7] scarcity of resources, infrastructure limitations, and political pressures that affect the independence of managers. These conditions create ethical dilemmas related to justice and equitable access, affecting the quality and dignity of care. The system's precariousness compromises principles such as beneficence and respect for human dignity, eroding public trust.

Therefore, ethics in public health management in Venezuela is essential to ensure that decisions and policies are responsible, fair, and respectful of human rights. Principles such as social responsibility, community commitment, transparency, and confidentiality are emphasized. However, there remains a gap between the laws that guarantee the right to health and the reality faced by citizens, obliging the state to strengthen mechanisms to ensure equitable, high-quality access. Finally, the main objective of this study was to analyze the fundamental ethical principles that guide public health management, and to identify the dilemmas administrators face in managing limited resources and ensuring equitable access.

METHOD

The methodology used in this study was quantitative, allowing us to work with various elements that can be measured and quantified. Hernández et al.[8] point out that the quantitative approach "uses data collection and analysis to answer questions, test hypotheses, and relies on numerical measurement, counting, and often the use of statistics to establish patterns of behavior in a population accurately."

Taking into account the investigative approach and the desire to solve problems in the same place where they are diagnosed, Palella et al.[9] based their research on fieldwork, referring to "the collection of data directly from the reality where events occur, without manipulating or controlling variables, studying social phenomena in their natural environment." The aim was to describe the ethics of public health management, including its principles, challenges, and impacts on care.

It was also adapted to a non-experimental descriptive design. It is non-experimental because no hypotheses have been proposed, but a set of variables has been defined. Hernández et al.[10] point out that non-experimental research focuses on observing phenomena in their natural environments, without deliberately manipulating variables. It is descriptive because it highlights

the ethical aspects of health management.

Likewise, the set of elements that possess specific characteristics is called the population or universe. The population and sample for this study consisted of seven (7) doctors and twelve (12) nurses from the Type III "Alberto Adriáni" Zea-Mèrida Clinic, Venezuela. And seven (7) doctors and twenty (20) nurses from the Type IV Coromoto Hospital, Nursing Department, Maracaibo, Venezuela.

To collect the data needed to meet the objectives, a survey technique was used, which, according to Arias, provides information from a group or sample of subjects about themselves or in relation to a particular topic.[11] This was done through a questionnaire. In this regard, Palella et al.[9] consider that the questionnaire, both in form and content, should be easy to answer. The questions must be formulated clearly and concisely; they can be closed, open, or semi-open, ensuring that the answer is not ambiguous. The instrument was structured using a Likert scale with the following options: Strongly disagree (SD), Disagree (D), Neutral (N), Agree (A), and Strongly agree (SA). To analyze the questionnaire data, frequency tables were used to calculate the percentages. Descriptive statistics were used to tabulate the data.

In terms of ethical considerations, the research was guided by fundamental principles that guarantee the respect and integrity of all those involved. Informed consent ensures that teachers participate voluntarily and with full knowledge of the objectives and procedures. [12] Confidentiality ensures the protection of the identity of participants and the information collected.

DEVELOPMENT

Venezuela's National Public Health System is organized into three levels of care: primary, secondary, and tertiary, adapted to the needs of users according to the degree of resolution required, whether preventive and curative consultation, hospitalization, or surgical intervention. [13] This design seeks to ensure progressive and orderly access to services, depending on the complexity of health problems. Within this framework, health management plays a fundamental role as a governing and administrative body, responsible for planning, organizing, and supervising the processes that sustain the system's dynamics. One of the essential characteristics of a health manager's profile is ethics, given the level of responsibility and commitment to citizens, whose impact is directly reflected in the health and quality of life of the population.

This topic prompts us to reflect on concepts in healthcare ethics. Ethics, derived from the Greek word ethos, is one of the pillars of philosophy. Socrates (470 BC) was the first to relate goodness and virtue to human morality, while Aristotle systematized ethics as a formal discipline. Bioethics, introduced by Fritz Jahr[14] in 1927 and consolidated by Van Rensselaer Potter in 1970, emerged as a bridge between science and the humanities in response to the dilemmas arising from scientific and technological advances. Subsequently, Beauchamp et al.[15] formulated the four contemporary bioethical principles: autonomy, beneficence (seeking the welfare and protection of others), justice (equitable distribution of resources and opportunities), and non-maleficence (avoiding causing intentional harm).

Medical ethics, understood as the appropriate behavior of the physician towards the patient, has its roots in ancient Greece with Hippocrates and the "Hippocratic Oath." Lara[16] recognizes it as a significant branch of ethics applied to clinical practice. Deontology, on the other hand, refers to the set of moral duties and obligations of professionals, also known as duty theory

or normative ethics (Hardy and Rovelo, Autonomous University of the State of Mexico). In summary, ethics, bioethics, medical ethics, and deontology constitute conceptual frameworks that guide the conduct of healthcare managers and define their level of qualification according to performance.

Ethics is expressed at different levels: metaethics, which investigates the origin of morality; normative ethics, which guides the modification of values to promote the common good; and applied ethics, which addresses specific situations under normative principles and duties. Medical ethics falls within this last level.[17] In public health, ethics protects collective needs. It takes on special relevance in crisis contexts, where scarce resources force the establishment of priorities through programs and collegial decisions.[18]

Ethics in public health

In public health, ethics protects collective needs and serves as a guide for decision-making in crises. When healthcare systems face resource shortages, hospitals must set priorities without deviating from the goals and objectives set by the hospital and the state. This involves defining programs and policies with the support of specialists.

Ethical and moral values directly influence the process of patient care. In professional practice, tensions may arise between individual behavior and interpersonal relationships within healthcare teams. In this context, communication, respect, and the humanization of actions become indicators of job performance.[19] Professional ethics not only regulate the doctor-patient relationship but also interactions among colleagues, resource management, and relationships with the community. Their absence can generate conflicts, mistrust, and a deterioration in the quality of service.

It is important to highlight that ethics in public health management is essential to ensuring that decisions are responsible, fair, and respectful of human rights. Principles such as social responsibility, community commitment, transparency, and confidentiality are emphasized. However, there remains a gap between the laws that guarantee the right to health and the reality faced by citizens, which forces the state to strengthen mechanisms to ensure equitable, high-quality access.

Governance and ethics in health management

This refers to the institutional and practical processes used to direct and regulate the affairs of a society or organization, including government, the state, the market, and civil society. It involves how decisions are made, how resources are managed, and how collective problems are addressed.

Nava, of the Autonomous University of the State of Hidalgo, points out that all human activity faces moral dilemmas that require ethical sensibility to guide management.[20] Kidder, founder of the Global Ethics Institute, defines the ethical dilemma as the choice between two correct options, which requires identifying alternatives that benefit third parties involved.[21]

The 21st century has seen the emergence of the open government paradigm, characterized by transfer, collaboration, and citizen participation in decision-making.[22] This model seeks to create public value above state bureaucracies, develop effective policies, and strengthen accountability. The document Prosperity with Equity: The Challenge of Cooperation in the Americas (Summit of the Americas, 2015) reflects this approach with the support of the European Union.[23]

In Venezuela, the creation of Transparencia Venezuela in 2004, as the national chapter of Transparency International, has promoted conditions and tools to prevent corruption and align the country with international standards.[24] This effort seeks to restore citizen confidence in public institutions and create better living conditions and prosperity.[25]

RESULTS

The instruments used are presented in a systematic and organized manner to ensure clarity and validity of analysis, always in comparative matrices and radar bar charts, which allowed us to identify trends and differences between the groups studied. This tool facilitates data interpretation, revealing patterns of agreement and disagreement regarding the ethical principles evaluated. The combined use of quantitative and visual methods strengthened our understanding of the findings. Knowledge of the findings. This section presents the main perceptions and gaps detected in ethical capital management.

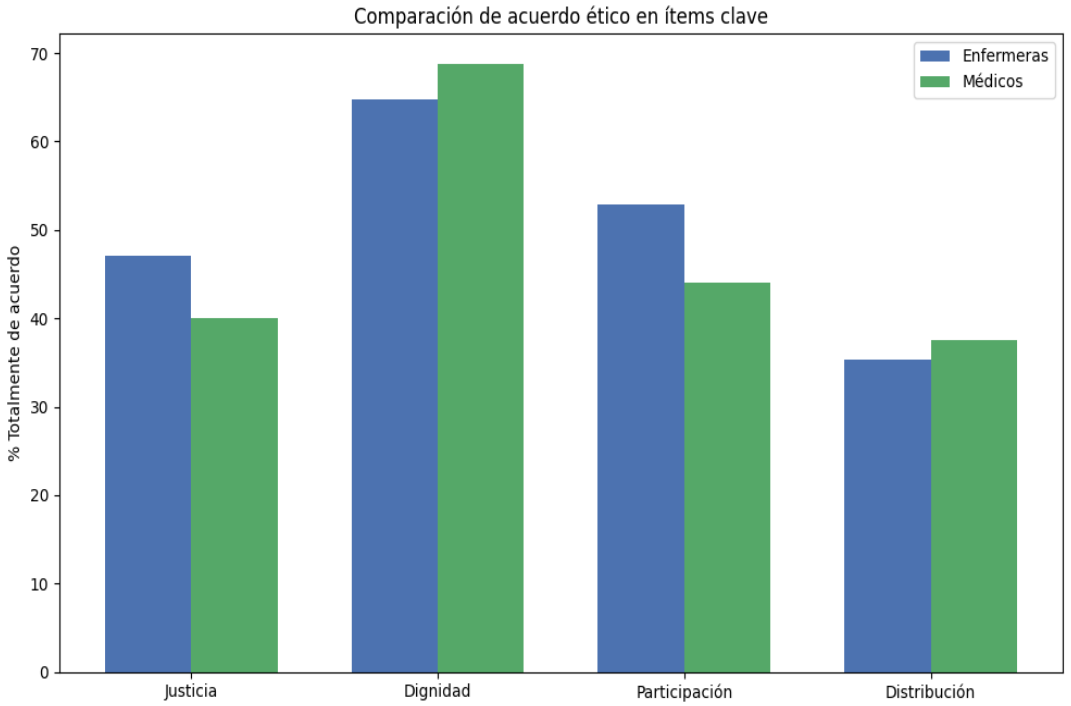

Figure 3.1. Comparison of ethical agreement on key items

This graph shows subtle differences between doctors and nurses regarding justice and equity. Nurses outperform doctors, suggesting that these principles are more firmly rooted in the distribution of shifts, supplies, and direct care. The higher response rate of "strongly agree" among nurses regarding participation indicates that this involvement is not only perceived as valuable but also decisive in correcting certain clinical decisions and improving others. Doctors emphasize dignity and ethical distribution because of their role as advisors between Angel and clinical prioritization, where dignity is ultimately grounded in criteria of risk indication and distributive justice. The closeness of the percentages in ethical distribution suggests converging perceptions, but does not eliminate doubts about traceability and explicit criteria.

Table 3.1. Comparison of ethical agreement between physicians and nurses

Item	Nurses %	Doctors %
Justice and Equity	47,1	40
Dignity as a priority	64,7	68,8
Participation strengthens ethics	52,9	44,1
Ethical distribution of resources	35,3	37,5

Nurses' greater ethical adherence to participation and justice reflects their direct role in daily care, where equity in shifts, supplies, and care times is experienced as a concrete reality. Their involvement in clinical and administrative decisions strengthens their perception of procedural justice. In contrast, physicians emphasize dignity and ethical distribution, possibly because of their responsibility for critical decisions such as triage, treatment prioritization, and allocation of scarce resources. This difference reveals that each interprets and applies ethical principles from their functional position, which opens up opportunities for complementarity in hospital governance.

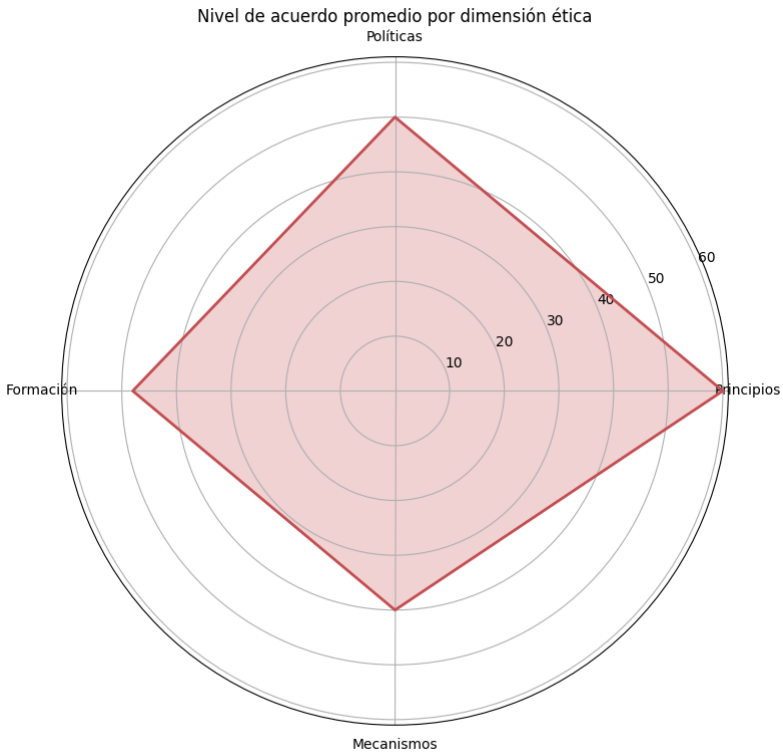

Figure 3.2. Matrix between concept, trend, and identified gap

The radar chart groups the items into four dimensions: a) Ethical principles (justice, dignity, respect): 60 %, leading because they are shared frameworks with high social desirability; their translation into everyday practice seems to be culturally consolidated. b) Institutional policies (clarity, codes, triage): occupy a second level, 50 %, suggesting that documents and

references exist, but with gaps in accessibility, updating, and contextualization by service. Training and professional development: 48 % are close to the sufficiency threshold, but the impact on observable behaviors needs to be measured and linked to performance evaluations and continuous certification. Corrective mechanisms and traceability: 40 % here; doubts arise about their real effectiveness, response times, protection of whistleblowers, and the closing of the cycle with feedback.

Ítem	Concepto Central	Tendencia General	Nivel de Consenso	Brecha Identificada	Implicación Práctica
1	Justicia y equidad en decisiones de gestión	Predomina acuerdo (DA/TDA) en ambos grupos	Alto	Mínimo desacuerdo	Evidenciar casos y protocolos concretos de asignación
2	Dignidad como prioridad frente a objetivos institucionales	Acuerdo muy alto (DA/TDA)	Muy alto	Casi ausencia de neutralidad	Explicitar ponderación de dignidad ante restricciones
3	Respeto y solidaridad guían decisiones	Acuerdo predominante	Alto	Baja neutralidad, nulo desacuerdo	Capital simbólico fuerte para comités de ética
4	Distribución de recursos con criterios éticos explícitos	Alto acuerdo con mayor neutralidad	Medio-Alto	Mayor duda relativa	**ZONA CRÍTICA**: Mejorar explicitación y trazabilidad
5	Gestión de datos respetando confidencialidad	Acuerdo casi unánime (DA/TDA)	Muy alto	Prácticamente nula neutralidad/desacuerdo	Consolidado; auditorías periódicas necesarias
6	Mecanismos efectivos para corregir prácticas poco éticas	Predomina acuerdo con mayor neutralidad	Medio-Alto	Dudas sobre efectividad y consistencia	**FOCO DE MEJORA**: Protocolos, tiempos, protección denunciantes

Source: Prepared based on results using Perplexity
Figure 3.3. Matrix between concept, trend, and identified gap

There is a predominance of alternatives (DA/TDA) in both groups; minimal disagreement. There is a widespread belief that the values of justice/equity are present in management. Nurses show even greater adherence than doctors. Regarding the priority of human dignity

over other institutional objectives, there is very high agreement (DA/TDA) in both groups, with almost no neutrality or disagreement. Dignity is a consensual axis of practice. The principles of respect and solidarity guide decisions in services; the trend is toward agreement, with low neutrality and little or no disagreement. The professional cultures of nursing and medicine converge on respect/solidarity as operational criteria.

Regarding the distribution of resources with explicit ethical criteria affecting nursing, the option is total agreement. The majority perceive ethics in distribution, although with more doubts. Nursing staff show strong support, but a segment is not so sure. In the management of personal data respecting confidentiality and data protection, the option of agreement is almost unanimous (DA/TDA); neutrality and disagreement are practically non-existent. The practice of data recording and management in nursing is perceived as aligned with data protection. And in effective mechanisms to correct unethical practices in nursing, agreement predominates, but with greater neutrality than other items and less unanimity.

Ítem	Concepto Central	Tendencia General	Nivel de Consenso	Brecha Identificada	Implicación Práctica
8	Decisiones éticas de gerencia mejoran calidad y seguridad	Acuerdo fuerte en ambos grupos	Muy alto	Mínima neutralidad	Justifica inversión en gobernanza ética
9	Políticas éticamente fundamentadas favorecen atención centrada en persona	Alto DA/TDA en ambos	Muy alto	Casi nula neutralidad	Alinear políticas con cuidado relacional
10	Claridad de políticas y códigos de conducta	Acuerdo muy alto	Muy alto	Ligera diferencia (más TDA en médicos)	Mantener actualización y difusión específica
11	Formación en ética/bioética aplicada a enfermería	Acuerdo muy alto en ambos grupos	Muy alto	Similares proporciones a ítem 10	Consolidar programas continuos con evaluación
12	Participación de enfermería en decisiones fortalece ética	Acuerdo contundente	Muy alto	Casi nula neutralidad	Institucionalizar participación en comités mixtos
13	Prioridad a pacientes vulnerables ante escasez de recursos	Acuerdo alto	Alto	Distribución similar entre grupos	Traducir a protocolos explícitos de triage ético

Figure 3.**4.** Matrix between concept, trend, and identified gap

Regarding ethical decisions by management improving patient quality and safety, the

agreement option was strong in both groups, with slight neutrality among physicians and minimal neutrality among nurses. Ethically based policies favor person-centered care, with a high trend in DA/TDA in both groups and almost no neutrality. There is a clear connection between ethical policy and a person-centered approach. Regarding the clarity of policies and codes of conduct for nursing care, the agreement trend is very high; slight difference with more TDA in physicians; nurses maintain robust DA/TDA.

Regarding training and professional development in ethics/bioethics applied to nursing, the **trend is** very high agreement in both groups, with proportions similar to item 10. The participation of nursing staff in decisions strengthens ethics, with strong agreement and almost no neutrality. Finally, regarding prioritizing vulnerable patients in the face of resource scarcity, the agreement option is high; nurses are distributed between DA and TDA, and physicians have a higher TDA.

Table 3.2. Priority-area-problem matrix

Priority	Area	Problem	Specific recommendation
Critical	Corrective Measures	Doubts about effectiveness	Audit and reactivate correction protocols; establish SLAs (response times); create whistleblower protection
Critical	Distribution of resources	Lack of explicit criteria	Create a documented ethical decision matrix; communicate criteria at all levels
Critical	Clarity of ethical responsibilities	28,1 % disagree (nurses)	Develop a manual of ethical responsibilities by role; training sessions
Important	Conflicts of interest	88,2 % see negative impact	Identification protocol; conflict registration; mandatory disclosure policy
Important	Nursing involvement	Valued but not systematized	Create joint clinical decision committees; regular meetings; feedback mechanisms
Important	Ethical triage	Principle known, not operationalized	Explicit triage protocol; vulnerability criteria; equity audit
Continuous improvement	Ethical training	Widely supported	Consolidate ongoing programs; evaluate impact on practices; link to performance evaluation

Table 3.2 reveals critical areas in hospital ethical management that require priority intervention. Corrective mechanisms raise doubts about their effectiveness, which requires audits, defined response times, and protection for whistleblowers. The distribution of resources lacks specific criteria, so a documented ethical matrix and cross-functional communication are recommended. Clarity in ethical responsibilities shows a 28,1 % disagreement among nurses, highlighting the need for role-specific manuals and training. In critical areas, conflicts of interest negatively affect 88,2 % of cases, requiring the implementation of identification and disclosure protocols. Nursing participation, although valued, is not systematized. Furthermore, although ethical triage is recognized, it is not applied operationally. Finally, ethical training is widely supported, suggesting the consolidation of ongoing programs and their integration with performance evaluation.

DISCUSSION

The graphs and figures reveal significant patterns in the ethical perceptions of doctors and nurses regarding hospital management. The strong adherence to principles such as justice, dignity, and respect confirms their consolidation as a shared normative framework, as noted by Juve et al.[26], who emphasize that professional ethics is a cross-cutting issue in clinical and administrative decision-making.

In the dimension of justice and equity, nurses exceed physicians by 47,1 % to 40 %, suggesting a more everyday experience of these principles in the distribution of shifts, supplies, and direct care. This functional difference is consistent with Páez Moreno's view, which warns that distributive justice in health must consider the operational proximity of staff in direct patient contact.[27] The perception of equity is not only linked to abstract values, but also to concrete practices such as the allocation of resources and care time.

Regarding respect for dignity as a priority, physicians show greater agreement (68,8 %) than nurses (64,7 %), which may reflect their role in critical decisions, such as triage and treatment prioritization. In this sense, dignity is operationalized through clinical criteria of risk and need, as proposed by contemporary clinical bioethics,[15] where dignity translates into respect for autonomy and the application of proportional and fair treatment.

Both groups value nursing staff's participation in ethical decision-making, but with greater emphasis on nursing (52,9 % versus 44,1 %). This difference reinforces the need to institutionalize participation mechanisms such as joint committees and clinical ethics rounds. According to a study by the University of Barcelona, Juve et al.[26], the active participation of nursing staff in clinical decisions strengthens procedural justice and improves the quality of care.

In terms of the effective distribution of resources, the percentages are close to 35,3 % nurses and 37,5 % doctors, suggesting convergence in perception but not eliminating doubts about traceability and explicit criteria. The lack of a documented ethical framework and cross-cutting communication is identified as a critical problem. Páez Moreno warns that conflicts of interest in the distribution of resources must be regulated by principles of equity and utility, prioritizing the most vulnerable.[27]

The dimension of conflicts of interest shows a negative perception in 82,88 % of cases, which requires protocols for identification, registration, and disclosure. This figure is alarming, as conflicts of interest can compromise equity in care and resource allocation. Paez Moreno argues that transparency in management is a necessary condition for justice in health.[27]

The corrective mechanisms raise doubts about their effectiveness, placing neutrality above other items. This indicates that, although protocols exist, their application is not perceived as effective. The audit recommendation, establishing response times, and protecting whistleblowers address the need to close the ethical cycle through feedback.

Ethical training is widely supported, but it ranks 48 % in terms of sufficiency, suggesting it should be linked to performance evaluation and continuing certification. The literature recommends that ethics training should be contextualized, evaluated, and related to healthcare quality indicators.[26] Ethical triage is a well-known but not operationalized principle. The absence of explicit protocols and vulnerability criteria limits its application in situations of scarcity.

In summary, the results reveal a shared ethical culture, but with gaps in mechanisms, policies, and training. The differences in perceptions between doctors and nurses reflect their distinct functional roles, creating opportunities for them to complement each other in hospital governance. Institutional ethics cannot depend solely on normative principles, but on operational structures that guarantee its practical application.

CONCLUSIONS

Ethics in hospital management cannot be understood solely as a set of normative principles, but rather as an institutional practice built at the intersection of professional culture and organizational structures. The study's findings reveal not only the degree of adherence to ethical values among doctors and nurses, but also the conditions that facilitate or limit their practical application in real care contexts.

One of the most relevant contributions of the analysis is the identification of areas of convergence and divergence between professional groups. Although both share high levels of agreement on dimensions such as dignity, justice, and confidentiality, differences in participation, traceability, and corrective mechanisms indicate that ethics are not experienced uniformly. This requires rethinking hospital governance models from an inclusive perspective, recognizing the voices of all actors as legitimate sources of ethical deliberation.

Institutional ethics requires more than declarative action: it needs structures to support it. The absence of explicit protocols for triage, resource distribution, and conflict-of-interest resolution demonstrates that ethical principles can remain abstract unless translated into verifiable procedures. In this sense, ethics must be operationalized through decision matrices, equity indicators, and monitoring mechanisms that enable its impact to be evaluated in everyday practice.

Another key aspect is the relationship between ethics and professional training. Although the data support ethics training, the challenge lies in linking it to evaluation, certification, and continuous improvement processes. Ethics cannot be isolated from academic programs; rather, it is a cross-cutting competency that is updated in response to emerging dilemmas, technological transformations, and social demands. This involves designing training itineraries that integrate ethics into clinical decision-making, team management, and patient relations.

Nursing staff's participation is a transformative force. Their direct involvement in care, resource management, and user interactions gives them a privileged perspective on procedural justice. However, this participation is not yet systematized in many contexts. The creation of joint ethics committees, deliberation spaces, and feedback mechanisms can strengthen institutional capacity to make decisions that are more just, contextualized, and sensitive to the realities of care.

Ethical management must also consider the emotional and relational dimensions of hospital work. Ethics is not limited to abstract norms, but is expressed in the recognition of others, in empathy for suffering, and in shared responsibility in the face of complex dilemmas. It is therefore essential to promote an organizational culture that values ethical care as part of professional performance and that offers safe spaces for reflection, support, and conflict resolution.

In contexts of scarcity, such as those faced by Venezuela and other countries in the region,

ethics takes on an even more critical dimension. The allocation of resources, the prioritization of patients, and the management of personal data are high-impact decisions, in which equity, transfer, and the protection of rights must be guaranteed. This requires strengthening regulatory frameworks and institutional capacities to apply ethical criteria under pressure, uncertainty, and vulnerability.

Finally, hospital ethics must be understood as a living system, constantly interacting with social values, public policies, and professional practices. It is not enough to have codes of conduct; they must be known, applied, and reviewed periodically. Ethics must be part of the management system, the design of performance evaluation indicators, and strategic planning.

BIBLIOGRAPHICAL REFERENCES

1. Paredes M, PK, BX. Ética en la salud pública: propuesta sobre los principios fundamentales que guían las responsabilidades éticas del Estado en el contexto de la pandemia por COVID-19. Revista Médica de Chile. 2020;148(10). https://www.revistamedicadechile.cl/index.php/rmedica/article/view/8504

2. Vargas M, VC. Salud pública y ética de la gerencia de la salud. 2023. https://campusvirtual.icap.ac.cr/pluginfile.php/201051/mod_resource/content/1/SALUD%20P%C3%9ABLICA%20Y%20ETICA%20DE%20LA%20GERENCIA%20DE%20LA%20SALUD%20XLV%20%284%29.pdf

3. Universidad Europea. Ética profesional en el sector sanitario. Blog. 2024. https://universidadeuropea.com/blog/etica-profesional/

4. Organización Mundial de la Salud. Ética en la salud pública. Página OMS. 2024. https://www.paho.org/es/etica-salud-publica

5. Organización Panamericana de la Salud. Ética de la salud pública. OPS/OMS. 2024. https://www.paho.org/es/etica-salud-publica

6. Thomas J, MR. Códigos de ética en salud pública. Enciclopedia Internacional de Salud Pública.

7. González G. La crisis del sistema de salud en Venezuela. Salus. 2018;22(1). https://www.redalyc.org/journal/3759/375956270002/html/

8. Hernández R, FC, BM. Metodología de la investigación. 6.ª ed. México: McGraw-Hill; 2014.

9. Palella S, MF. Metodología de la investigación cuantitativa. 3.ª ed. Caracas: FEDUPEL; 2010.

10. Hernández R, MC. Metodología de la investigación: las rutas cuantitativa, cualitativa y mixta. 1.ª ed. México: McGraw-Hill Educación; 2018. https://bibliotecadigital.uce.edu.ec/s/L-D/item/793

11. Arias F. El proyecto de investigación: introducción a la metodología científica. 6.ª ed. Caracas: Episteme; 2012.

12. Flick U. Introducción a la investigación cualitativa. 5.ª ed. Madrid: Morata; 2015. https://

edmorata.es/wp-content/uploads/2021/02/Flick.-Introduccion-a-la-investigacion-cualitativa_prw.pdf

13. Salazar M. Organización sanitaria de Venezuela. Universidad Rómulo Gallegos; 2025. https://es.scribd.com/document/844133233/organizacion-sanitaria-en-venezuela

14. Garzón F. Fritz Jahr, ¿el padre de la bioética? Revista Latinoamericana de Bioética. 2009;9(2). https://www.redalyc.org/pdf/1270/127020306001.pdf

15. Beauchamp T, Childress J. Principios de ética biomédica. 6.ª ed. New York: Oxford University Press; 2009. https://dialnet.unirioja.es/descarga/articulo/6080122.pdf

16. Hardy A, RJ. Moral, ética y bioética: un punto de vista práctico. Revista Medicina e Investigación. 2015;3(1). https://www.elsevier.es/es-revista-revista-medicina-e-investigacion-353-articulo-moral-etica-bioetica-un-punto-S2214310615000084

17. Ferrer J, Álvarez J. Para fundamentar la bioética: teorías y paradigmas teóricos en la bioética contemporánea. 2.ª ed. Bilbao: Desclée de Brouwer; 2005. https://produccioncientifica.ugr.es/documentos/62d8e375ef8a9e0e42abef27

18. Paredes M, PK, BX. Ética en la salud pública: propuesta sobre los principios fundamentales que guían las responsabilidades éticas del Estado en el contexto de la pandemia por COVID-19. Revista Médica de Chile. 2020;148(10). https://dialnet.unirioja.es/servlet/articulo?codigo=9426999

19. Morales M, MI, RA. Conducta ética del profesional de enfermería en el cuidado directo al paciente hospitalizado: revisión sistemática. Sociedad Venezolana de Farmacología Clínica y Terapéutica. 2021;40(3). https://www.redalyc.org/journal/559/55969712008/55969712008.pdf

20. Nava G, MJ, EJ, DL. Principios de ética, bioética y conocimiento del hombre. 1.ª ed. México: UAEH; 2011. https://www.uaeh.edu.mx/investigacion/productos/4821/libro_principios_de_etica.pdf

21. Villarreal E, VG. Dilemas éticos. Revista Salud Uninorte. 2013;29(1). https://www.redalyc.org/pdf/817/81728689013.pdf

22. Naser A, RA, RD. Desde el gobierno abierto al Estado abierto en América Latina y el Caribe. 1.ª ed. Santiago: CEPAL; 2017. https://www.oidp.net/docs/repo/doc188.pdf

23. Organización de los Estados Americanos. VII Cumbre de las Américas: participación de la sociedad civil y los actores sociales. 2015. http://www.summit-americas.org/cs/pubs/vii_summit_compilation_es.pdf

24. Transparencia Venezuela. Historia. Asociación civil sin fines de lucro. 2004. https://www.alianzaregional.net/transparencia-venezuela/

25. Martínez F, UJ, DFM. Manual de gobierno abierto y lucha contra la corrupción. https://transparenciave.org/wp-content/uploads/2019/04/Manual-de-Gobierno-abierto-2019.pdf

26. Juvé M, Antón F, Escobar B. Práctica profesional ética y participación de las enfermeras en la toma de decisiones clínicas: fortalecimiento de la justicia procesal y la calidad de la atención. Enfermería Clínica. 2023;33(1). doi:10.1016/j.enfcli.2022.11.002

27. Páez MR. Conflicto de interés en la distribución de recursos en salud. Medicina y Ética. 2020;31(3). http://www.scielo.org.mx/scielo.php?script=sci_arttext&pid=S2594-21662020000300627

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