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The Relationship Between Organizational Silence and Intention to Quit Among Nurses in Palestinian Hospitals in the Southern West Bank

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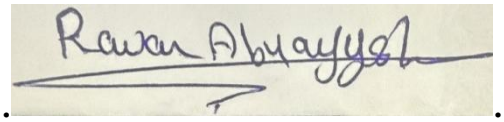
Declaration:

I, Rawan Abuayyash, declare that the thesis entitled: "The Relationship Between Organizational Silence and Intention to Quit Among Nurses in Palestinian Hospitals in the Southern West Bank" is my original work and has not been submitted previously, either in whole or in part, for the award of any degree or diploma at any university or academic institution, whether in Palestine or abroad. I further declare that all sources and references used in this thesis have been properly acknowledged and cited in accordance with academic standards. This thesis was submitted to Al-Quds University – Abu Dis, in partial fulfillment of the requirements for the degree of Master in Nursing Management.

Signature by: ……  **…….**

Rawan Abuayyash

Date: 23/ 8 / 2025

Dedication

I dedicate this work to the enduring memory of my beloved father, whose spirit remains a constant source of strength and inspiration. This achievement is also for my dearest mother, whose unwavering prayers and support have been the guiding light on my academic path. To my brothers and sisters, thank you for your constant presence by my side.

My deepest gratitude is for my dear husband, Mohammad, the cornerstone of my strength, whose steadfast encouragement and support were the reason for the completion of this thesis. This work is also for my beloved children, Leen and Khaled, who are the source of my determination and the true purpose behind every success I pursue. I also extend my sincere thanks to my husband's family for their continuous support and kindness.

Finally, this dedication extends to all my teachers—from my earliest school years to Al-Quds University—who opened the doors of knowledge and instilled in me a passion for learning.

Rawan Abuayyash

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ABSTRACT

Background: Modern healthcare systems face major challenges where transparent communication is essential. Organizational silence (OS), when employees withhold concerns, reduces job satisfaction, increases burnout, and compromises patient safety. Nurses, being central to healthcare delivery, are particularly vulnerable, and silence strongly affects their well-being and intention to quit (ITQ). Little is known about OS in Palestinian hospitals, especially when comparing governmental and non-governmental institutions.

Aim: This study aimed to examine the relationship between OS and ITQ among nurses in these hospitals, considering demographic factors and hospital type.

Method: A quantitative cross-sectional design was used. Data were collected from a convenience sample of 220 nurses across four hospitals. Instruments included a Demographic Questionnaire, a 27-item Organizational Silence Scale (OSS), and a single-item Intention to Leave Work question. OSS reliability was high (Cronbach's alpha = .87 overall). Data analysis involved descriptive and inferential statistics using SPSS ($p<.05$).

Results: Most nurses (70.9%) reported low intention to leave, while 53.2% experienced moderate OS and 25% reported high OS. The highest silence dimension was lack of top management support. Demographic factors such as age, sex, marital status, years of experience, hospital sector (**non-governmental** higher OS), and income influenced OS and ITQ. A small negative correlation indicated that higher OS was slightly associated with lower intention to quit.

Conclusion: Although most nurses intended to stay, many experienced moderate to high OS, particularly regarding leadership support and communication. The inverse relationship between OS and ITQ suggests that dissatisfaction is often internalized due to job security concerns and limited employment options in Palestinian hospitals.

Implications and Recommendations: The findings highlight the need for targeted interventions to reduce OS. Hospitals should enhance communication between leaders and staff, establish anonymous feedback systems, and foster psychological safety. National standards for workplace communication with anti-retaliation policies should be developed. Training in ethical leadership and organizational justice is essential to improve nurse retention and patient care quality.

Keywords: Organizational silence, intention to quit, nurses, Palestinian hospitals, Southern West Bank, **governmental** hospitals, **non-governmental** hospitals.

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List of Acronyms

OS	Organizational Silence
ITQ	Intention to Quit
WHO	World Health Organization
UN	United Nations
OSS	Organizational Silence Scale
SET	Social Exchange Theory
OJT	Organizational Justice Theory
ICU	Intensive Care Unit
ANOVA	Analysis of Variance
M	Mean
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences
UN	United Nations

Chapter One

Introduction

This thesis explores two crucial phenomena impacting the healthcare work environment: organizational silence and the intention to quit, with a specific focus on nursing staff within Palestinian hospitals. It aims to establish a comprehensive foundation for the study by addressing its significance, objectives, research questions, hypotheses, and essential concepts, which collectively underpin the investigation.

This chapter provide an overview of the research background, followed by a discussion of the problem statement, rationale, and importance of the study. It then elaborates on the study's aims, objectives, research questions, and hypotheses, along with theoretical and operational definitions of the core variables being examined. The chapter concludes with a concise summary of its contents.

1.1 Background

Modern healthcare systems face numerous challenges that significantly influence the quality, safety, and efficiency of care delivery. These challenges include resource limitations, increasing patient demands, evolving regulatory requirements, and mounting pressures to improve outcomes while managing costs (Atalla et al., 2022). Within this complex and dynamic context, transparent communication and effective information exchange are vital for enhancing organizational performance and ensuring patient welfare. However, organizational silence presents a serious obstacle—this phenomenon occurs when employees, either intentionally or unintentionally, refrain from sharing thoughts, concerns, or critical information with their superiors (Özdemir & Çelik, 2016). Organizational silence can vary in intensity from subtle reluctance to deliberate avoidance of communication (Parlar Kılıç et al., 2021; Diab & Mohamed, 2020). Its underlying causes are multifaceted, arising from personal factors such as fear of reprisal or low self-confidence, as well as organizational issues like fear-driven cultures, distrustful environments, ineffective communication mechanisms, or perceptions of passive leadership (Yalçınsoy, 2017; Zou et al., 2025) The ramifications of organizational silence are significant. On an individual level, it contributes to reduced job satisfaction, increased stress

levels, and burnout. At an organizational level, it inhibits innovation, disrupts decision-making processes, and compromises patient safety (Kim & Song, 2024; Zou et al., 2025). Nurses play a pivotal role in healthcare organizations due to their direct involvement in patient care and their intimate understanding of hospital operations (Sakr et al., 2023). Their active participation in communication and decision-making processes is essential for enhancing patient outcomes and institutional effectiveness. Yet studies reveal that nurses often experience higher levels of organizational silence compared to other healthcare professionals (El Abdou et al., 2023; Zou et al., 2025). This tendency may stem from nursing-specific challenges or broader workplace norms within healthcare settings (Al-Rousan et al., 2018). When nurses are unable or unwilling to express their concerns due to organizational silence, the consequences extend beyond workplace morale. Patient care quality and safety are compromised, along with nurses' personal well-being and their intention to quit (ITQ). ITQ refers to a deliberate consideration of leaving one's current job within a certain timeframe (Mobley, 1977; Ulupınar & Erden, 2024). As a precursor to actual turnover, this intention poses a significant challenge for healthcare systems globally by worsening staffing shortages, increasing workloads for remaining employees, and elevating recruitment and training expenses. Emerging research underscores a strong link between organizational silence and heightened turnover intentions among nursing staff. For example, a study conducted in Greek hospitals following the COVID-19 pandemic illustrated how organizational silence negatively impacted job performance and engagement, ultimately leading to increased turnover intentions (Yağar & Dökme Yağar, 2023). The findings highlighted how silenced employees experience reduced morale and feelings of being undervalued. Similarly, research from Taiwanese hospitals demonstrated that organizational silence diminished employee engagement while amplifying feelings of insignificance—factors directly contributing to higher turnover rates (Chen & Chou, 2022). Furthermore, evidence suggests that organizational silence operates through mediators. A study in Turkish hospitals revealed that organizational silence fostered cynicism within organizations, which in turn weakened employee engagement and heightened turnover intentions (Özdemir & Kılıç, 2017). This indicates that suppressed communication creates distrust and disillusionment among employees, eventually leading them to leave their positions.

Research in Jordanian hospitals has revealed that insufficient administrative support significantly contributes to organizational silence, which, in turn, heightens nurses' intentions to leave their positions. These findings point to a critical connection: the suppression of open communication—whether through direct actions or psychological effects like cynicism and feelings of undervaluation—serves as a powerful catalyst for nurses opting to quit their jobs.

Organizational silence extends beyond communication issues, undermining both individual capabilities and overall well-being among nurses. El Abdou, Hassan, and Badran (2023) reported a notable inverse relationship between organizational silence and nurses' self-efficacy, finding that increased workplace silence correlates with diminished confidence in personal abilities. This aligns with broader research linking silence in healthcare environments to impaired communication channels and reductions in professional performance and mental

health. The reluctance to speak up, often fueled by fear of retaliation or a perceived lack of value assigned to their input, negatively impacts nurses' job satisfaction and performance outcomes.

Addressing organizational silence requires robust interventions, particularly in leadership and organizational culture. Studies indicate that ethical leadership plays an essential role in reducing silence by promoting fairness, transparency, and integrity in decision-making processes (She et al., 2023). Diab and Mohamed (2020) corroborated this, emphasizing that organizational justice—key to ethical leadership—can cultivate trust and openness, encouraging nurses to share their ideas and concerns without hesitation. A supportive organizational culture is also imperative; open and inclusive environments not only mitigate silence but enhance organizational commitment among staff (Han, 2022). Conversely, non-supportive cultures tend to drive nurses into silence as a defensive response to challenging work conditions or concerns about patient care (Erigüç and Özer, 2014).

Beyond the traditional dynamics of organizational culture, other factors can play a role in countering silence. Diab and Mohamed (2020) observed an inverse relationship between workplace spirituality and organizational silence; nurses with higher levels of spiritual fulfillment were more likely to communicate openly. This highlights the need for workplaces to address the emotional and spiritual dimensions of healthcare professionals' experiences. Furthermore, organizational silence detracts from organizational learning by stifling knowledge exchange. Research by Atalla et al. (2022) and Sakr et al. (2023) consistently shows that silent environments restrict collective learning opportunities, hindering both healthcare delivery efficiency and the professional development of nurses.

The Southern West Bank of Palestine, particularly Bethlehem and Hebron, offers a unique setting for studying these phenomena within nursing as it combines distinct socio-political challenges alongside specific healthcare system issues (WHO, 2023; UN, 2025) and hospital dynamics that influence communication patterns and job satisfaction. While organizational silence and nurses' intentions to leave have been examined globally (Zou et al., 2025; Çaylak et al., 2024), there remains a significant gap in research focused on Palestinian hospitals in this region (Sakr et al., 2023; Atalla et al., 2022). Additionally, exploring differences in these dynamics between Governmental and Non- Governmental healthcare institutions in Palestine presents an important yet understudied avenue for further investigation. This study seeks to address a crucial gap by examining the relationship between organizational silence and nurses' intention to quit their roles in Palestinian hospitals located in the Southern West Bank. The research will assess the prevalence of organizational silence and the inclination to leave the profession, while also analyzing how various dimensions of organizational silence may impact nurses' decisions to consider quitting. By including both Governmental and Non-Governmental hospital settings, the study aims to deliver comparative insights into these dynamics across diverse healthcare environments. Ultimately, it strives to provide actionable recommendations for improving nurse retention, cultivating more open communication cultures, and enhancing patient care quality within Palestinian hospitals.

1.2 Problem Statement

Despite the well-recognized impact of organizational silence (OS) on nurses' well-being and organizational performance, research on this phenomenon in Palestinian hospitals remains limited. OS, where employees withhold concerns or feedback, affects up to 40–50% of nurses in various settings and is associated with low job satisfaction, increased stress and burnout, and a higher intention to quit (ITQ). At the organizational level, it reduces innovation, impairs teamwork, and compromises patient safety. In Palestine, these challenges may be intensified by limited healthcare resources, unique organizational structures, and socio-political constraints. Furthermore, no study has examined the relationship between OS and ITQ among nurses, nor compared its prevalence between governmental and non-governmental hospitals. Addressing this gap is essential for developing evidence-based strategies to improve communication, reduce turnover, and enhance the quality of care. Therefore, this study aims to assess the levels of OS and ITQ among nurses, compare them across governmental and non-governmental hospitals in Bethlehem and Hebron, and explore the relationship between the two, providing baseline data to guide future interventions that support nurse retention and strengthen healthcare system performance.

1.3 Justification/Significance of the Study

This study provides valuable insights into organizational silence (OS) and intention to quit (ITQ) among nurses, directly reflecting the findings from Chapter Four. The results showed that the majority of nurses reported low ITQ, yet over half experienced moderate organizational silence, particularly in areas related to top management support and lack of communication. Demographic factors such as age, sex, marital status, years of experience, hospital sector, and income significantly influenced OS levels, while marital status impacted ITQ. These patterns highlight the practical need to understand how OS manifests in Palestinian hospitals and its subtle relationship with nurses' departure intentions.

By examining OS and ITQ together, this study contributes theoretically by refining existing models on workplace silence and turnover intentions, integrating demographic and institutional variables. Practically, the findings inform interventions targeting communication gaps, leadership support, and psychological safety. For instance, strategies such as establishing direct feedback channels, fostering supportive leadership, and implementing anti-retaliation policies can help reduce OS and enhance nurse retention. Furthermore, the study offers baseline data for future research, curriculum development in nursing education, and evidence-based policymaking, aiming to improve both employee well-being and patient care quality in governmental and non-governmental hospitals in Bethlehem and Hebron.

1.4 Purpose of the study

The main purpose of this study was to examine the relationship between organizational silence (OS) and intention to quit (ITQ) among nurses in governmental and non-governmental hospitals in southern Palestine.

1.5 Objectives of the Study

The specific objectives of this study were to:

- To assess the level of organizational silence among nurses working in Palestinian hospitals in southern Palestine.
- To assess the level of intention to quit among nurses working in Palestinian hospitals in southern Palestine.
- To examine the relationship between organizational silence and intention to quit among nurses.
- To explore whether demographic factors (such as age, gender, years of experience, and educational level) influence the relationship between organizational silence and intention to quit.
- To investigate the impact of hospital type (Governmental vs. Non- Governmental) on the relationship between organizational silence and intention to quit among nurses.

1.6 Main Research Questions

- Is there any correlation between organizational silence and intention to quit among nurses?
- What is the level of organizational silence among nurses in southern Palestine (Bethlehem and Hebron regions)?
- What is the level of intention to quit among nurses in southern Palestine?
- Are there any statistically significant differences in the level of organizational silence among nurses based on their demographic characteristics (e.g., gender, years of experience, educational level)?
- Are there any statistically significant differences in the level of organizational silence among nurses based on the healthcare sector (Governmental vs. Non- Governmental)?
- Are there any statistically significant differences in nurses' intention to quit based on demographic factors (e.g., age, gender, years of experience, educational level)?

1.7 Main Hypotheses

- (H_0): There is no significant correlation between organizational silence and intention to quit among nurses.
- (H_0): There are no statistically significant differences in the level of organizational silence among nurses based on their demographic characteristics (e.g., gender, years of experience, educational level).
- (H_0): There are no statistically significant differences in the level of organizational silence among nurses based on the healthcare sector (Governmental vs. Non- Governmental).
- (H_0): There are no statistically significant differences in nurses' intention to quit based on demographic factors (e.g., age, gender, years of experience, educational level).

Table 1.1(a): Theoretical and Operational Definition.

Terms	Theoretical definition	Operational definition
Organizational Silence	a phenomenon where employees, either consciously or unconsciously, withhold opinions, concerns, or important information from organizational leadership." (Özdemir & Çelik, 2016) environment, and psychological factors. (Tett & Meyer, 1993; Kim & Song, 2024)	Organizational silence will be measured by using tools like the Organizational Silence Scale (OSS), which assesses the level of silence by evaluating (Schechtman, 2008; Brinsfield, 2009).
Age	The number of years a person has lived influences their perspectives, adaptability, and approach to organizational structures. (De Lange, Kooij, & Kooij, 2019)	This will be tested in demographic data in the first part of the questionnaire.
Sex	Biological differences between males and females impact workplace interactions, communication, and leadership dynamics. (Acker, 2020)	This will be tested in demographic data in the first part of the questionnaire (female, male)
Educational Level	Indicates the highest degree attained, affecting cognitive ability, problem-solving skills, and workplace engagement. (McEwan, 2020	This will be tested in demographic data in the first part of the questionnaire (Diploma, Bachelor's, Master's, and PhD)
Period of Experience	The number of years worked in a profession, shaping expertise, confidence, and ability to navigate work-related challenges (Ericsson, Hoffman, Kozbelt, & Williams, 2018)	This will be tested in demographic data in the first part of the questionnaire (Less than 1 year,1 - 5 years,6 - 10 years,11 - 15 years. More than 15 years.
Department	The functional unit within an organization, with each department potentially having different cultures and communication patterns. (Daft & Marcic, 2020)	This will be tested in demographic data in the first part of the questionnaire. Intensive Care Unit (ICU), Emergency, Surgical, Internal Medicine, Pediatrics, Clinics)

Table 1.1(B): Theoretical and Operational Definition.

Terms	Theoretical definition	Operational definition
Healthcare Sector	Distinguishes between governmental (state-funded, bureaucratic) and non-governmental (market-driven, flexible) healthcare settings, influencing work dynamics and communication. (Buchbinder & Shanks, 2021)	This will be tested in demographic data in the first part of the questionnaire (Governmental vs. Non- Governmental)
Income	The financial compensation or earnings an individual receives from their employment, which can be in the form of salary, wages, or other monetary benefits (Jones, 2020)	This will be tested in demographic data in the first part of questioner (Less than 1000 dinars,1000 - 2000 dinars, 2000 - 3000 dinars)
Marital Status	Indicates whether a person is single, married, divorced, or widowed, which may affect their work-life balance and involvement in organizational processes. (Greenhaus, 2021)	This will be tested in demographic data in the first part of the questionnaire. Single Married ،Divorced،Widowed (
Geographical Location	Refers to the region where an individual works, with each location potentially affecting organizational culture, resources, and communication patterns (Bryson & Yeung, 2020)	This will be tested in demographic data in the first part of the questionnaire (Bethlehem and Hebron)

1.8 Summary

The study investigates the level of organizational silence among nurses working in Governmental vs. Non- Governmental hospitals in the southern region of Palestine, specifically in Bethlehem and Hebron. It also examines the relationship between organizational silence and nurses' intention to quit their jobs, considering the influence of demographic characteristics and hospital type. The unique socio-political and healthcare context of the region adds further relevance to this inquiry. A validated Organizational Silence Scale (OSS) and a scale measuring intention to quit will be used for data collection. The findings of this study are expected to provide a deeper understanding of organizational silence and its potential impact on nurses' turnover intentions, thereby informing policies and interventions aimed at enhancing communication, reducing turnover, and strengthening organizational effectiveness within the Palestinian healthcare sector.

Chapter Two

Literature Review

2.1 Introduction

This chapter provides a comprehensive review of the existing academic literature on **organizational silence (OS)** and **intention to quit (ITQ)**, focusing specifically on their relevance to the nursing profession. The review aims to establish a robust theoretical and empirical foundation for the study, clarify the conceptual underpinnings of the variables, and pinpoint the specific research gaps that this study seeks to address, particularly within the unique context of Palestinian hospitals.

Organizational Silence (OS)

Organizational silence (OS) is a well-established concept in organizational behavior, defined as the conscious withholding of important work-related information, ideas, concerns, and feedback by employees from their superiors and colleagues (Morrison & Milliken, 2000). It's not merely a lack of communication but a deliberate choice to remain silent, often driven by a belief that speaking up is futile or carries significant personal risk. This phenomenon is critical in understanding workplace dynamics and has been categorized into three main types:

- **Acquiescent Silence:** Occurs when employees withhold information because they believe their opinion is not important or won't make a difference.
- **Defensive Silence:** Stems from a fear of negative consequences, such as punishment, retaliation, or damage to one's career.

- **Prosocial Silence:** Involves withholding information to protect a colleague or the organization itself, even if that information could be beneficial (Van Dyne et al., 2003).

In healthcare, OS is especially detrimental, as it can directly impact patient safety and the quality of care. For nurses, the act of remaining silent can be a response to perceived risks, such as a lack of managerial support, a fear of being blamed for mistakes, or a sense of hopelessness that their concerns will be addressed. When nurses suppress their voices, it can lead to a host of negative outcomes, including decreased job satisfaction, increased stress, emotional exhaustion, and a breakdown in teamwork and collaboration (Çavuşoğlu & Köse, 2016; Yaşar & Dökme Yaşar, 2023). The suppression of voice within healthcare is a critical issue that must be addressed to ensure a safe and effective working environment.

Intention to Quit (ITQ)

Intention to quit (ITQ) is a key concept in human resource management and organizational psychology, widely considered the most reliable predictor of actual employee turnover (Tett & Meyer, 1993). It is defined as an employee's conscious and deliberate willingness to leave their current organization in the near future. While ITQ is a strong indicator of future behavior, it's a complex variable influenced by a variety of factors, including organizational climate, job satisfaction, perceived workload, leadership style, and feelings of burnout (Hayes et al., 2012).

In the high-stress environment of nursing, ITQ is a persistent challenge. It is often linked to poor working conditions, inadequate staffing levels, a lack of professional recognition, and a general feeling of being undervalued. Nurses with high ITQ are more likely to experience emotional exhaustion, reduced engagement, and a decline in organizational commitment (Flinkman et al., 2010). The link between OS and ITQ is particularly significant: when nurses are silenced, their feelings of frustration and disempowerment grow. This lack of voice can erode their sense of belonging and value within the organization, ultimately leading to a higher likelihood of them choosing to leave.

2.2 Search Strategy

This research employed a methodical and extensive strategy for literature searching, ensuring an unbiased and detailed examination of studies related to organizational silence and nurses' intentions to leave, especially within the setting of hospital nursing in the Southern West Bank.

The following steps were taken in the search strategy:

- **Database Selection:** A range of reputable academic databases were consulted, including PubMed, CINAHL, Scopus, Web of Science, and Google Scholar. These databases were specifically chosen due to their extensive coverage of peer-reviewed literature related to healthcare, nursing, organizational behavior, and management.
- **Keyword Identification:** A detailed list of keywords was developed to encompass both the central themes of the study (e.g., organizational silence, nurse silence, employee voice, turnover intention, intention to quit) and the unique contextual factors of the West Bank (e.g., Bethlehem, Hebron, Palestine, healthcare system).
- **Search String Development:** The keywords were systematically combined using Boolean operators (AND, OR, NOT) to create search strings tailored for each of the selected databases.
- **Inclusion and Exclusion Criteria:** Clear and strict criteria were developed to ensure the inclusion of relevant studies. Inclusion criteria included studies that focused on organizational silence, nursing, employee voice, and intentions to quit in healthcare settings. Exclusion criteria included studies that were not peer-reviewed, did not employ validated measurement tools, or were not in English or easily translatable.
- **Study Selection and Screening:** The search outcomes were first screened by title and abstract. Full-text articles that met the preliminary criteria were then retrieved and critically evaluated for methodological rigor, quality of information, and relevance to the study's aims.
- **Data Extraction and Synthesis:** After determining the eligible studies, relevant data were extracted systematically, focusing on key variables such as organizational silence, demographics, healthcare settings, and intention to quit. A thematic synthesis approach was used to identify recurring themes, patterns, relationships, and significant gaps in the existing literature.

2.3 Theoretical Background

The theoretical literature on organizational silence provides a valuable framework for understanding the dynamics that influence employees' willingness to speak up or remain silent within their organizations. In the context of healthcare, and specifically within nursing, several prominent theories help explain the conditions under which silence is more likely to occur and how it can contribute to a higher intention to quit. These include Social Exchange Theory, Organizational Justice Theory, Social Cognitive Theory, and Sensemaking Theory.

- **Social Exchange Theory (Blau, 1964):** This theory suggests that individuals make decisions based on the perceived benefits and costs associated with their behaviors. In the context of organizational silence, nurses decide whether to speak up or remain silent based on their assessment of potential rewards (e.g., being heard, positive change) and risks (e.g., retaliation, being ignored). When the perceived costs of speaking out outweigh the benefits, silence becomes the logical choice, which can eventually lead to a decision to leave the organization. In the Palestinian healthcare system, where political instability and job insecurity often complicate workplace dynamics, the perception of risk could be amplified, reinforcing silence and driving an intent to leave.
- **Organizational Justice Theory (Greenberg, 1990):** This theory emphasizes the role of fairness in influencing employees' attitudes and behaviors. It highlights three key aspects: **Distributive Justice** (fairness in reward allocation), **Procedural Justice** (fairness in decision-making processes), and **Interactional Justice** (fairness in interpersonal interactions). Nurses who perceive their workplace as fair are more likely to feel empowered to voice concerns. Conversely, those who feel decisions are made unfairly or that their contributions are not valued may choose silence, which is a significant predictor of disengagement, job dissatisfaction, and a higher intention to quit.
- **Social Cognitive Theory (Bandura, 1986):** This theory explains how behaviors are shaped by both individual and environmental factors. In the context of organizational silence, nurses' decisions to speak up or remain silent may be influenced by observing the behavior of their colleagues and superiors. If nurses observe that those who speak up are penalized or ignored, they may choose silence as a self-protective response. This theory emphasizes the critical role of leadership in creating a culture where employees feel supported and confident in voicing their concerns.
- **Sensemaking Theory (Weick, 1995):** This theory focuses on how individuals interpret and make sense of ambiguous or uncertain situations. In situations where the organizational context is unclear or complex, employees may choose silence as a way to cope. For nurses, role ambiguity, unclear expectations, or political instability in the broader environment may lead them to withhold their opinions. This theory is especially relevant to Palestinian hospitals, where political and economic challenges often create complex environments, leading nurses to adopt silence as a coping strategy that can lead to disengagement and a higher intention to quit.

The theoretical frameworks above provide a comprehensive understanding of the factors that influence silence behaviors in healthcare organizations. They collectively offer valuable insights into how individual perceptions of equity, leadership approaches, organizational culture, and the broader socio-political context impact the decision of nurses to either voice their concerns or remain silent. By applying these theories, this study aims to explore the factors contributing to organizational silence in both Governmental vs. Non-Governmental hospitals and investigate its impact on nurses' intention to quit.

2.4 Empirical Review on Organizational Silence and Intention to Quit in Nursing

This section synthesizes the principal empirical findings from a set of studies analyzing **organizational silence (OS)** and its intricate relationships with nurses' **intention to quit (ITQ)**, as well as various influencing and mediating factors. The synthesis is presented thematically to emphasize prominent trends and existing gaps in the literature.

The Direct and Indirect Impact of Organizational Silence on Intention to Quit:

A substantial body of research consistently links organizational silence to heightened turnover intentions among nurses, primarily through its negative effects on their well-being and engagement. Studies by Yağar & Dökme Yağar (2023) in Greek hospitals found a direct negative relationship between OS and job performance and engagement, consequently increasing ITQ. This emphasizes how a silent environment reduces morale and encourages feelings of underappreciation. Likewise, Chen & Chou (2022) observed in Taiwanese hospitals that OS resulted in reduced engagement and increased feelings of being undervalued, contributing significantly to higher ITQ. Beyond direct effects, OS often operates through mediating variables. Özdemir & Kılıç (2017) revealed that OS elevated organizational cynicism in Turkish hospitals, which in turn propelled ITQ. This suggests that when nurses perceive their voices are suppressed, it breeds cynicism, eroding their commitment to the organization. Furthermore, Al-Hussami (2015) in Jordanian hospitals found that a lack of administrative support contributed to OS, which subsequently intensified nurses' ITQ. These findings collectively underscore that the suppression of voice, whether directly or via psychological states like cynicism or feelings of undervaluation, is a potent driver of nurses' desire to leave their positions.

The Part of Leadership and Organizational Culture in Lessening Organizational Silence:

Competent leadership and a helpful organizational culture are critical in promoting an environment where nurses feel authorized to speak up. She et al. (2023) found that ethical leadership importantly reduces organizational silence among nurses by advocating for transparency and equity in decision-making. This corresponds with findings from Diab & Mohamed (2020), who stressed that organizational justice, a cornerstone of ethical leadership, is vital in reducing silence by cultivating trust and candor. Nurses who see their workplace as fair and just are more likely to voice concerns and ideas instead of remaining silent (Han, 2022; Yang et al., 2022). Supplementing this, organizational culture has a pivotal role. Han (2022) showed that a positive organizational culture, marked by openness and backing, actively lessens organizational silence and concurrently boosts organizational commitment. Conversely, unsupportive organizational

cultures, as found by Erigüç et al. (2014) often compel nurses into silence as a coping mechanism, especially concerning work conditions and patient care.

Workplace Spirituality and Organizational Learning as Protective Factors:

Beyond traditional organizational dynamics, other elements contribute to mitigating organizational silence. Diab and Mohamed (2020) identified an inverse relationship between workplace spirituality and organizational silence, suggesting that nurses who experience a sense of spiritual satisfaction in their work are more prone to engage in open communication. This underscores the significance of cultivating an environment that addresses both the emotional and spiritual well-being of healthcare professionals. Moreover, organizational silence has a profound negative impact on organizational learning. Studies by Ghanem Atalla et al. (2022) and Sakr et al. (2023) consistently showed that silent environments hinder opportunities for knowledge sharing and collective learning among nurses. This communication deficit not only damages the efficiency of healthcare delivery but also limits the professional growth of nurses. These findings are strongly corroborated by Atalla, Elamir, and Abou Zeid (2022), who concluded that fostering a learning-oriented culture and actively reducing silence are critical for improving both individual and organizational performance.

Conclusion of Empirical Review and Research Gap:

Collectively, these studies affirm the pervasive and detrimental impact of organizational silence across diverse nursing contexts, primarily influencing nurses' intention to quit through various direct and indirect pathways. While the literature extensively explores the factors contributing to silence and its consequences, there remains a significant empirical void in understanding these dynamics specifically within Palestinian hospitals. The socio-political and healthcare specificities of this region, coupled with the lack of comparative analysis between Governmental vs. Non- Governmental institutions, necessitate further investigation to develop contextually relevant strategies for fostering open communication, improving nurse retention, and ultimately enhancing the quality of care.

2.5 Linking the Studies and Identifying Research Gaps

The reviewed literature consistently demonstrates that **organizational silence (OS)** negatively affects nurses, resulting in problems like decreased job satisfaction, increased stress, and a higher **intention to quit (ITQ)** (Yaşar & Dökme Yaşar, 2023; Özdemir & Kılıç, 2017; Chen & Chou, 2022). This silence can also prevent hospitals from learning and evolving (Ghanem Atalla et al., 2022; Sakr et al., 2023). Conversely, research suggests that strong ethical leadership and

a positive, supportive workplace culture can help reduce organizational silence (She et al., 2023; Diab & Mohamed, 2020; Han, 2022).

Despite these global insights, there's a significant gap in research when it comes to Palestinian hospitals in the Southern West Bank. While we know about OS and ITQ generally, very little is known about how these two factors interact specifically among nurses in this unique region. The distinct local challenges, like the socio-political setting and limited healthcare resources, mean that findings from other nations might not entirely pertain here.

Specifically, existing studies have not:

- Directly measured both organizational silence and the desire to resign among nurses in Palestinian hospitals in the Southern West Bank.
- Analyzed the specific relationship between these two variables within this specific healthcare context.
- Compared how these issues differ between Governmental vs. Non-Governmental hospitals in the region.

This lack of specific local research makes it hard to develop effective solutions to keep nurses in their jobs and improve healthcare quality in Palestine. Therefore, this study is crucial to fill these specific knowledge gaps and provide much-needed data for the region's healthcare sector.

2.6 Conceptual Framework

This study employs a comprehensive conceptual framework to systematically examine the intricate relationships between **organizational silence (OS)**, **intention to quit (ITQ)**, and various demographic factors among nurses in Governmental vs. Non-Governmental hospitals within Bethlehem and Hebron. The framework is specifically designed to guide the investigation into how OS influences ITQ, and how demographic characteristics might moderate or directly influence both OS and ITQ across these two distinct healthcare settings. The comparative approach aims to provide a nuanced understanding of these dynamics within different institutional contexts.

The study is underpinned by several established theoretical lenses that provide a robust foundation for explaining the hypothesized relationships:

- **Social Exchange Theory (SET):** This theory will be utilized to understand how nurses evaluate the perceived benefits versus costs of speaking up or remaining silent. It helps explain how an imbalance in this exchange, often fostered by organizational silence, can

lead to decreased commitment and an increased intention to quit (Cropanzano & Mitchell) **Organizational Justice Theory (OJT):** This theory is crucial for examining how nurses' perceptions of fairness within the hospital impact their communication behaviors and subsequent decision to remain or leave. A perceived lack of justice can exacerbate organizational silence and contribute to turnover intentions (Colquitt et al., 2001).

- **Social Cognitive Theory (SCT):** SCT will be employed to explain how leadership behaviors and the broader organizational culture influence nurses' decision to voice concerns or remain silent. It also helps understand how these contextual factors shape their overall attitudes towards the organization, including their ITQ (Bandura, 1986).
- **Sensemaking Theory:** This theory is particularly relevant for understanding how nurses in the unique Palestinian context interpret and make sense of their workplace environment. It helps explain how this interpretive process, influenced by local socio-political realities and hospital dynamics, shapes their communication behaviors (e.g., silence) and their subsequent intention to quit (Weick, 1995).

The integrated conceptual framework, therefore, proposes that organizational silence will significantly predict nurses' intention to quit. Furthermore, demographic factors are expected to play a crucial role in shaping these relationships, and their influence will be comparatively examined across Governmental vs. Non-Governmental hospital settings. This holistic framework aims to offer a clear and comprehensive understanding of the complex interplay between individual attributes, organizational communication dynamics, and turnover intentions within the specific healthcare context of the Southern West Bank.

2.7 Study Variables (Operational Definitions of Variables)

This section outlines the key variables explored in this study, specifying their functions as in

dependent, dependent, or control variables inside the research framework.

2.7.1 Dependent Variable

- **Intention to Quit (ITQ):** This is the primary dependent variable, representing nurses' conscious and deliberate inclination to leave their current employment. It will be assessed using a recognized Turnover Intention Scale (e.g., Mobley, 1977), which measures the likelihood of nurses considering resignation.

2.7.2 Independent Variable

- **Organizational Silence (OS):** This is the core independent variable. It refers to the phenomenon where nurses intentionally or unintentionally withhold job-related information, opinions, or concerns from organizational leadership. OS will be measured using a well-established and validated Organizational Silence Scale (e.g., the 27-item scale from Schechtman, 2008), capturing various dimensions such as acquiescent, defensive, and prosocial silence.

- **Demographic Characteristics:**
    - **Age:** Measured in years or categorized into specific age groups.
    - **Sex:** Measured as male or female.
    - **Educational Level:** Categorized based on the highest nursing qualification obtained.
    - **Years of Experience:** Measured as the total number of years working as a registered nurse.
    - **Department/Work Unit:** Categorized by the specific clinical area where the nurse is primarily employed.
    - **Income (JD):** Measured as the monthly income in Jordanian Dinars.
    - **Marital Status:** Categorized as Single, Married, Divorced, or Widowed.
    - **Healthcare Sector:** Categorized as Governmental Hospital or Non-Governmental Hospital.
    - **Geographical Location:** Categorized based on the specific city where the hospital is located (e.g., Bethlehem or Hebron).

Chapter Three

Methodology

3.1 Introduction

This chapter presented the methodological framework used in the current study, which aimed to investigate the relationship between organizational silence and nurses' intention to quit in Governmental Hospital and Non-Governmental hospitals in the Bethlehem and Hebron governorates, located in the southern region of the West Bank, Palestine. It included the research design, study setting and population, sampling procedures, data collection instruments, and the data analysis plan. Furthermore, this chapter explained the ethical considerations taken into account throughout the research process to ensure scientific rigor, reliability, validity, and ethical integrity.

3.2 Research Design

This study employed a cross-sectional quantitative research design, whereby data were collected at a single point in time from nurses working in Governmental Hospital or Non-Governmental hospitals. The main purpose of using a cross-sectional design was to assess the current levels of organizational silence and intention to quit, and to explore the relationship between them, as well as the influence of demographic and contextual variables such as age, years of experience, and type of healthcare institution (Governmental vs. Non-Governmental). The cross-sectional design was deemed appropriate for this study as it provided an efficient and time-effective method for capturing the prevalence and extent of the phenomena under investigation within a specific geographical context. While this design does not establish causality, it allows for the identification of correlations and patterns between variables (Polit &

Beck, 2021). Its key advantages included cost-effectiveness compared to longitudinal designs, which require extended periods of data collection, and its wide applicability in descriptive and correlational studies. Therefore, it was suitable for examining organizational silence behaviors in healthcare settings and for analyzing the factors associated with nurses' intention to quit.

3.3 Study Setting

The study was conducted in four hospitals located in the Bethlehem and Hebron governorates in the Southern West Bank, Palestine.

Governmental Hospitals:

- Princess Alia Governmental Hospital (Hebron)
- Al-Hussein Governmental Hospital (Bethlehem)

Non-Governmental Hospitals:

- Al-Ahli Hospital (Hebron)
- Al-Mizan Specialist Hospital (Hebron)

These hospitals used to ensure a representative sample of both Governmental and Non-governmental health institutions in the area and to capture a range of work environments and organizational relationships within Palestinian health care organizations. For instance, Alia Governmental Hospital in Hebron which is the largest government hospital in Hebron governorate, and Al-Hussein Hospital in Bethlehem, an important governmental hospital providing health care services for the Bethlehem region. Regarding the non-governmental sector, Al-Ahli Hospital and Al-Mizan Hospital in Hebron were chosen because of their perceived ubiquity and large size as the two main non-governmental health centers. This purposive sampling made it possible to ensure a strong comparative analysis between governmental and non-governmental institutions which can sometimes contradict in operational, management and cultural terms. It is important to note that while the original plans included the Arab Society Hospital for Rehabilitation, it was ultimately excluded from the study because it declined to participate in the distribution of questionnaires, citing the sensitive nature of the research topic. This revised selection of hospitals was crucial for gathering a diverse range of experiences and ensuring that the study's results were both practical and relevant within the specified geographical and healthcare context.

Study Population and Sample Target Population:

The target population for this study comprised all nurses currently employed in governmental and non-governmental hospitals located within the Bethlehem and Hebron governorates of the Southern West Bank, Palestine. The focus was placed on nurses working in both governmental

and non-governmental hospital settings, enabling a comparative analysis of organizational silence and intention to quit.

Sampling Frame:

A list of hospitals and their nursing staff was compiled in cooperation with hospital administrations in order to construct a reliable and accurate sampling frame. The total number of nurses in the four hospitals included in the study was as follows:

- **Princess Alia Governmental Hospital** (Hebron) 317 nurses
- **Al-Ahli Hospital** (Hebron) 400 nurses
- **Al-Mizan Specialist Hospital** (Hebron) 150 nurses
- **Al-Hussein Governmental Hospital** (Bethlehem) 170 nurses

This provided a total population of 1,037 nurses from which the sample was drawn.

- **Sampling Technique:**

A convenience sampling technique was used to select participants from the above hospitals. Nurses were approached based on their accessibility and willingness to participate. The sample included nurses from various shifts and units to ensure a diverse representation of the nursing workforce in each hospital.

- **Sample Size:**

The required sample size was calculated using Sample Size Calculator software with a confidence level of 90% and a margin of error of 5%. Based on this calculation, a minimum of 220 nurses was deemed sufficient to meet the study's statistical requirements. Ultimately, 220 questionnaires were distributed and collected from nurses across the four hospitals so the response rate is **100%**.

3.4 Inclusion Criteria

Nurses were to participate in this study if they met **all** of the following criteria:

- **Current Employment**: Currently employed as a nurse in one of the selected governmental or non-governmental hospitals located within the Bethlehem or Hebron governorates of the Southern West Bank, Palestine. This ensures representation from both governmental and non-governmental sectors for comparative purposes.
- **Informed Consent**: Provided informed consent by completing the questionnaire after being fully informed about the study. Participation was voluntary, and participants could withdraw at any time without penalty.
- **English Proficiency**: Possessed adequate proficiency in English to fully understand and accurately complete the study questionnaires.

- **Availability**: Available to complete the study questionnaires within the specified timeframe, ensuring efficient data collection and minimizing potential bias from incomplete or delayed responses.

3.5 Exclusion Criteria

Participants were excluded from the study if they met **any** of the following criteria:

- **Health Conditions**: Nurses with significant physical or mental health conditions that could impair their ability to provide accurate and reliable responses (e.g., severe illness or cognitive impairment).
- **Extended Absence**: Nurses who were absent for extended periods or on long leave, as their responses may not reflect the current organizational environment.
- **Inability to Comprehend the Questionnaire**: Any nurse who demonstrated difficulty understanding the questionnaire items, which were available only in English.
- **Educational Level**: Nurses without a diploma or equivalent qualification in nursing, to ensure participants have the necessary professional knowledge and skills.
- **Work Experience**: Nurses with less than three months of experience in the current hospital, as they may not have sufficient exposure to accurately assess the organizational environment.
- **Administrative or Non-Clinical Roles**: Nurses in purely administrative roles or not directly involved in patient care (e.g., department heads or assistants), to ensure responses reflect direct clinical experiences.

3.6 Study Instruments

This study employed the following instruments for data collection:

- **Demographic Questionnaire:** A structured questionnaire collected data on nurses' demographic characteristics, including age, sex, educational level, period of experience, department, healthcare sector (governmental or non-governmental), income (JD), marital status, and geographical location (Bethlehem or Hebron).
- **Organizational Silence Scale (OSS):** The primary instrument for measuring organizational silence was a validated scale adapted from Schechtman (2008) and Brinsfield (2009). This 27-item scale assessed organizational silence across five dimensions:
  - Support of Top Management for Silence (5 items): Assessed the extent to which top management implicitly or explicitly supported silence.

- Lack of Communication Opportunities (6 items): Measured the extent to which communication channels were limited within the organization.
- Support of Supervisor for Silence (5 items): Assessed whether supervisors encouraged or discouraged open communication.
- Official Authority (5 items): Measured the extent to which managers relied on formal authority to influence subordinates.
- Subordinate's Fear of Negative Reactions (6 items): Assessed subordinates' concerns about potential negative consequences of speaking up.

Scoring: Responses were rated using a 3-point Likert scale (1=Disagree, 2=Neutral, 3=Agree). The overall score for the Organizational Silence Scale ranged from 27 to 81. The scores were categorized into levels of organizational silence as follows: the low level ranged from 27 to 45 (representing < 55%), the moderate level ranged from 46 to 63 (representing 55%-77%), and the high level ranged from 64 to 81 (representing >77%). These scores are based on Dyne et al., (2003).

- **Intention to Leave Work Question:** Intention to leave work was assessed using a single item question: "Looking to your career goals, are you going to change your work setting in the coming year?" Participants responded by selecting one of the following options:
    - Very unlikely
    - Unlikely
    - Likely
    - Very likely

3.6.1 Validity of Instruments:

To ensure the appropriateness and interpretability of the data collection instruments within the study's context, the instruments, particularly the Organizational Silence Scale, were critically reviewed for their face and content validity. As the primary scales were adapted from previously validated instruments (Schechtman, 2008; Brinsfield, 2009), their foundational validity was established in prior research. For the purpose of this study and to ensure their relevance and clarity for the target population of Palestinian nurses, the English version of the questionnaire underwent an expert review. A panel of academic experts and clinical professionals, including Dr. Ashraf Abuejheisheh and Dr. Farid Gharib, Dr. Kifah Al-Zabin, were consulted. Their feedback was crucial in assessing the clarity, cultural appropriateness, and comprehensibility of the English phrasing of the items for nurses in the Palestinian healthcare context. Based on their valuable input, any necessary modifications were considered to enhance the face and content

validity of the scales for the local setting, ensuring the instrument was well-understood by the participants.

3.6.2 Reliability Analysis of Organizational Silence Scale:

The reliability analysis of the organizational silence scale and its subscales demonstrated acceptable to good internal consistency. Cronbach's alpha values ranged from .75 to .84 across the five subscales, indicating reliable measurement. The overall organizational silence scale, consisting of 27 items, showed strong internal consistency with a Cronbach's alpha of .87, confirming the reliability of the instrument. As seen in Table 3.1.

3.6.3 Culture Sensitivity and Adaptation in the Palestinian Healthcare Context:

Recognizing the distinctive socio-cultural and linguistic factors within the Palestinian healthcare environment, particular effort was made to ensure the study instruments were both clear and accessible for the target population. To support ethical participation and comprehension, the introductory and informed consent sections of the questionnaire were provided in Arabic. However, the primary survey tools, including the Organizational Silence Scale and the question addressing Intention to Leave Work, were delivered in English. This approach was guided by several critical considerations specific to the nursing profession in Palestine: - **Professional Language**: English is the global standard for advanced education, research, and professional documentation in medicine and nursing. In Palestinian academic institutions, nurses extensively interact with English-language textbooks, clinical guidelines, and scholarly articles throughout their training and ongoing professional development. - **Specialized Terminology**: A substantial portion of medical and nursing terminology is rooted in English, ensuring that nurses are well-versed in using English professional vocabulary. - **Instrument Origin**: The selected scales (Organizational Silence Scale, developed by Schechtman, 2008, and Brinsfield, 2009) were originally created in English-speaking contexts. Administering them in their original language helped preserve their conceptual integrity and avoided potential distortions that could arise during translation.

Table 3.1: Reliability.

Organizational silence subscales	n	Cronbach Alpha
Support of the Top Management of Silence	5	.76
Lack of Communication Opportunities	6	.78
Support of Supervisor for Silence	5	.77
Official Authority	5	.75
Subordinate's Fear of Negative Reactions	6	.84
Organizational silence	**27**	**.87**

3.6.4 Normality tests:

The normality of the data for both key variables was assessed using the Kolmogorov-Smirnov and Shapiro-Wilk tests. These tests revealed that both variables deviated significantly from a normal distribution, as indicated by their respective significance values. Consequently, the findings suggested that the data for both variables were not normally distributed, necessitating the use of non-parametric statistical tests for data analysis. The results of the normality tests are presented in Table (3.2).

Table 3.2: Tests of Normality.

	Kolmogorov-Smirnov			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	df	Sig.
Intention of leave work mean score	.230	220	<.001*	.848	220	<.001*
Organizational silence mean score	.062	220	.039*	.985	220	.017*

*Significant values

3.7 Data Collection Procedure

This section detailed the step-by-step procedures for collecting data, ensuring the ethical and methodological rigor of the research.

- Ethical and administrative approvals were obtained from Al-Quds University, the Ministry of Health, Al-Ahli and Al-Mizan Hospitals before data collection began.
- Meetings were held with nursing directors to secure their approval for conducting the study.
- Explained the study purpose and objectives to the nurses and distributed the questionnaires.
- It was clarified that completing the questionnaire indicated consent to participate in the study.
- Participants were assured that no personal information would be disclosed and that all questionnaires would be kept and disposed of confidentially.
- After collecting the questionnaires, the researcher proceeded with data entry and analysis.
- **Recruitment and Approval**

Nurses were recruited using a Convenience Sampling technique, as detailed in section When the required ethical approvals were obtained, the researcher printed the questionnaires in English and proceeded to the selected hospitals. Appointments were made with the nursing directors or responsible nursing management to obtain their permission for conducting the study within their institutions. After securing administrative permission, the researcher began visiting various departments within the hospitals. The researcher met with eligible nurses, often in groups or individually, during their regular shifts (day and night). The purpose of the study, as outlined in the questionnaire's introductory section, was explained to them, and they were invited to participate and complete the questionnaire. The introductory section of the questionnaire itself stated that their agreement to complete the questionnaire implied their consent to participate in the study. In instances of work overload, the researcher met some nurses individually at appropriate times to prevent work interruption.

- **Informed Consent:**

All potential participants were provided with an information sheet (integrated into the questionnaire's introductory pages) detailing the study's aims, procedures, risks, and benefits, as well as their right to withdraw at any time. Their voluntary completion of the English-only questionnaire was considered as their informed consent to participate in the study.

- **Questionnaire Administration and Collection:**

After participants indicated their informed consent through completion, the English questionnaires (comprising the Demographic Questionnaire, Organizational Silence Scale, and the Intention to Leave Work question) were distributed to the eligible nurses. The researcher was available near the nurses to provide any clarification, explanation, or answer questions regarding the questionnaires and the study. It took each nurse approximately 8 minutes to complete the questionnaire. Once the participants finished filling out the questionnaires, the researcher collected them directly and expressed her thanks and appreciation for their participation and efforts.

- **Data Management:**

All collected data were stored securely, adhering to strict confidentiality and anonymity protocols. Participants' personal information was not collected, ensuring de-identification of data. The data management plan ensured the integrity, accuracy, and security of the data throughout the study. (Specify the software used for data entry, storage, and analysis here if desired).

3.8 Data Cleaning

After data collection, the gathered data were thoroughly checked for completeness, accuracy, and any inconsistencies. Outliers were identified and addressed using appropriate statistical techniques to ensure data quality prior to analysis.

3.9 Data Analysis

All statistical analyses were performed using IBM SPSS Statistics, Version 27. The significance level was set at $p<.05$ (two-tailed) to minimize the risk of Type I error.

The data analysis process included the following steps:

- Descriptive Statistics: Descriptive statistics, including means, standard deviations, frequencies, and percentages, were used to summarize the demographic characteristics of the sample and to describe the distribution of organizational silence and nurses' intention to leave work. This provided an overall understanding of the prevalence and level of these phenomena within different hospital settings.
- Comparison Between governmental and Non-governmental Hospitals: Given the nature of the data and the findings from preliminary assumption checks, Mann-Whitney U tests were utilized to compare the levels of organizational silence and nurses' intention to leave work between nurses working in governmental and Non-governmental hospitals. This analysis determined if there were significant differences in the extent of these variables between the two hospital settings.
- Assessing Relationships: Spearman's rank-order correlation coefficient was used to assess the relationships between organizational silence, nurses' intention to leave work, and demographic characteristics (e.g., age, experience, sex, hospital type). This helped determine whether specific demographic factors were associated with higher or lower levels of organizational silence or intention to leave work within each hospital setting.
- Exploring Group Differences in Demographic Variables:
  - Mann-Whitney U tests were employed to compare differences in organizational silence and intention to leave work between two independent groups (e.g., male vs. female, single vs. married).
  - Kruskal-Wallis H tests were conducted to explore differences in organizational silence and intention to leave work across more than two categories (e.g., different age groups, educational levels, years of experience, departments, and monthly income levels). When significant differences were found, Dunn’s post hoc tests were performed to identify which specific groups differed significantly.

3.10 Ethical Considerations

This study prioritized ethical research practices to ensure the rights and well-being of participants were protected. The following ethical measures were implemented:

- **Ethical Approval:** Ethical approval was obtained from the Ethical Research Committee (REC) at Al-Quds University to ensure adherence to ethical research guidelines and the protection of participants' rights. The application for ethical approval clearly outlined the study's aims, procedures, potential risks and benefits, and measures for safeguarding participant confidentiality and anonymity. This approval also specifically included the method of obtaining informed consent through questionnaire completion after full information disclosure. All data collection procedures complied with the Declaration of Helsinki to conduct research.
- **Informed Consent:** Participants were provided with an information sheet (integrated into the English-only questionnaire's introductory pages) detailing the study's aims, procedures, risks, and benefits, as well as their right to withdraw at any time. Their voluntary completion of the questionnaire was considered as their informed consent to participate in the study.
- **Confidentiality and Anonymity:** All data collected were kept confidential and anonymous. Participants were not identified by name or any personal identifiers. Data were securely stored and de-identified.
- **Data Security:** Data were protected through password protection, encryption, and regular backups. Only authorized personnel had access to the data.
- **Minimizing Risk:** The study involved minimal risk to participants. Any psychological distress caused by answering sensitive questions was minimized through careful questionnaire design and clear instructions. Support services were available for participants who needed assistance.
- **Data Ownership and Sharing:** The data remained the property of Al-Quds University, and access was granted only to authorized personnel. Data sharing followed relevant regulations.

3.11 Summary

This research assessed the level of organizational silence among hospital nurses in Bethlehem and Hebron, Southern West Bank, Palestine, and to investigate its relationship with nurses' intention to leave work, with a focus on comparing governmental and Non-governmental hospitals. Using a cross-sectional design, the study employed a validated Organizational Silence Scale and a single intention to leave work question to measure the prevalence and extent of these phenomena in both hospital types. A convenience sampling method was used to select a representative sample of nurses from both governmental and Non-governmental hospitals. Descriptive statistics, t-tests, correlation, and regression analysis were conducted to examine the levels of organizational silence and intention to leave work, compare them between the two types of hospitals, and assess any demographic factors and the influence of organizational

silence that contributed to intention to leave work. The study provided valuable insights into the prevalence of organizational silence and intention to leave work in different healthcare settings and contributed to the development of strategies for improving communication and organizational effectiveness. Ethical standards were followed to ensure the protection and confidentiality of participants.

Research Timeline

- **Research Start:** September 2024 – Study proposal approved and research plan initiated.
- **Data Collection:** May 1 – May 31, 2025 – Questionnaires distributed and completed by participants.
- **Data Analysis:** June – July 2025 – Data entry, cleaning, and statistical analysis.
- **Thesis Writing / Drafting Chapters:** July – August 2025 – Writing methodology, results, discussion, and literature review.
- **Thesis Defense / Discussion:** August 23, 2025 – Final presentation and defense at Al-Quds University.

Chapter Four

Results

4.1 Introduction

The research findings from this chapter stem from analyzing data obtained from 220 nurses. The study presents descriptive statistics about participant demographics together with their organizational silence levels and their plans to leave their work. The research used Mann-Whitney U tests and Kruskal-Wallis H tests and Spearman correlation tests to analyze key variables for differences and relationships. The study results follow the research objectives to present data patterns and associations in an organized manner.

4.2 Frequency and Percentages of the Demographic Characteristics of Nurses

The majority of participants were aged 20–29 years, accounting for 43.2% (n = 95). Most were female, comprising 60.5% (n = 133) of the sample. In terms of marital status, the majority were married, representing 68.6% (n = 151). Geographically, most participants were from Hebron at 72.7% (n = 160). Regarding educational level, the highest proportion held a Bachelor's degree, making up 74.1% (n = 163). In terms of experience, 1–5 years was the most common category, with 39.1% (n = 86). The most frequently reported department was the Emergency Department at 19.1% (n = 42). The majority worked in the governmental sector, representing 59.5% (n = 131). Finally, the most common monthly income range was 500–999 JD, reported by 66.8% (n = 147) of the participants. As shown in Table (4.1).

Table 4.1(a): Frequency and Percentages of the Demographic Characteristics of Nurses (n=220).

Demographic Characteristics		**n**	**%**
Age Group (Years)			
	20-29	95	43.2%
	30-39	82	37.3%
	40-49	31	14.0%
	50-59	12	5.5%
Sex			
	Male	87	39.5%
	Female	133	60.5%
Marital Status			
	Single	69	31.4%
	Married	151	68.6%
Geographical Location			
	Bethlehem	60	27.3%
	Hebron	160	72.7%
Educational Level			
	Diploma	38	17.3%
	Bachelor's Degree	163	74.1%
	Higher education (Master and PhD)	19	8.6%
Years of Experience in Healthcare			
	<1 year	17	7.7%
	1-5 years	86	39.1%
	6-10 years	62	28.2%
Department			
	Intensive Care Unit (ICU)	33	15.0%
	Emergency	42	19.1%
	Surgical	26	11.8%
	Medical	30	13.6%
	Pediatrics	17	7.7%
	Hemodialysis	13	5.9%
	Ear, Nose and Throte	7	3.2%
	Operation room	8	3.6%
	Clinics	15	6.8%
	Others	29	13.2%

Table 4.1(b): Frequency and Percentages of the Demographic Characteristics of Nurses (n=220).

Sector			
	Governmental sector	131	59.5%
	Non- Governmental sector	89	40.5%
Monthly income			
	<500 JD	36	16.4%
	500-999 JD	147	66.8%
	1000-1500 JD	28	12.7%
	>1500 JD	9	4.1%

4.3 Intention to Leave Work Among Nurses

The bar chart illustrates the levels of intention to leave work among nurses. The majority of nurses (70.9%) reported a low intention to leave their jobs, while 20.5% indicated a moderate intention. Only a small proportion (8.6%) expressed a high intention to leave. As shown in Fig (4.1).

The analysis of nurses' responses to the question regarding their intention to change their work setting in the coming year revealed varying levels of intention to leave. A total of 38.2% reported being "Unlikely" to leave, while 32.7% indicated they were "Very unlikely," together representing a majority with low intention to leave. Meanwhile, 20.5% of participants stated they were "Likely" to change their work setting, and 8.6% were "Very likely" to do so. The overall mean score was 2.05 (SD = 0.937), placing the group in the **moderate intention to leave** category based on the defined cut-off points (1–2.00 = Low, 2.01–3.00 = Moderate, 3.01–4.00 = High). As shown in Table (4.2).

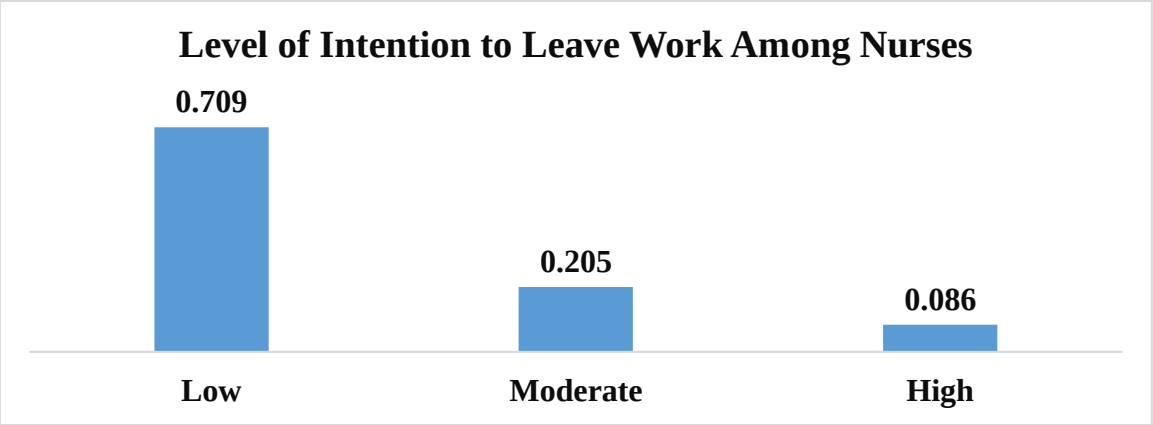

Fig 4.1. Level of Intention to Leave Work Among Nurses.

Table 4.2: Frequency, Percentages and Mean Score for the Intention to Leave Work Among Nurses (n=220).

Item		N	%	Mean	SD	Status
Are you going to change your work setting in the coming year?	Very unlikely	72	32.7%	2.05	.937	Moderate intention to leave
	Unlikely	84	38.2%			
	Likely	45	20.5%			
	Very likely	19	8.6%			

Cut off points as follows; 1-2.00=Low intention, 2.01-3.00=Moderate intention, 3.01-4= High intention Mean score over 4

4.4 Organizational Silence Among Nurses

The chart illustrates the levels of organizational silence among nurses. Over half of the participants (53.2%) reported a moderate level of organizational silence, while 25.0% indicated a high level, and 21.8% experienced low organizational silence. As shown in Fig. (4.2).

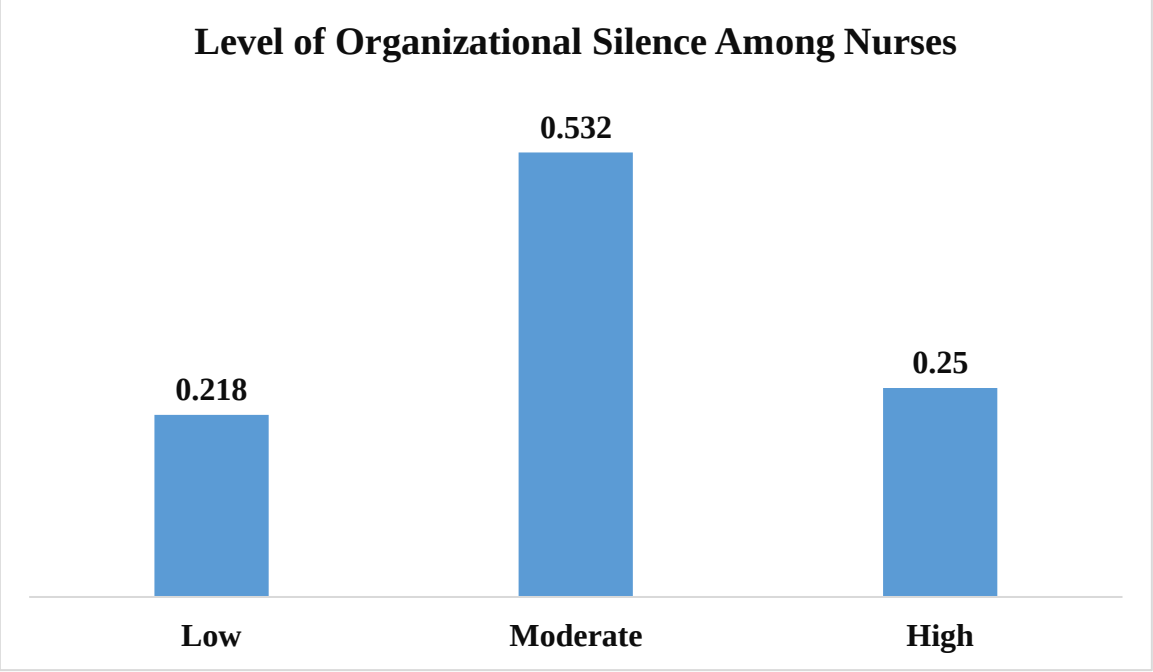

Fig. 4.2. Level of Organizational Silence Among Nurses.

4.5 Organizational Silence Subscales mean score among nurses

The bar chart presents the mean scores of organizational silence subscales among nurses. The highest mean score was observed in the "*Support of the Top Management*" (2.19). This was followed by "*Lack of Communication*" (2.06) and "*Subordinate's Fear of Negative Reactions*" (2.01). The lowest mean scores were found in "*Support of Supervisor*" (1.98) and "*Official Authority*" (1.95), suggesting relatively lower levels of silence in these areas. As shown in Fig. (4.3) .

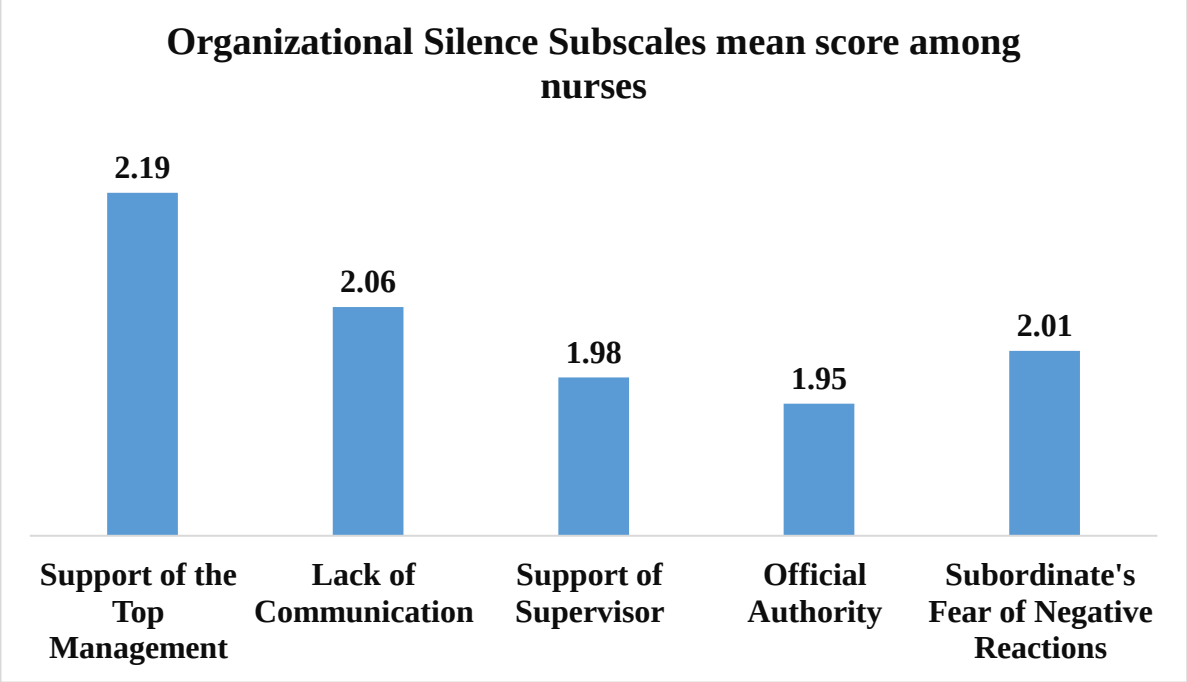

Fig. 4.3 Organizational Silence Subscales mean score among nurses.

The support of the top management of silence indicates a moderate level of organizational silence among nurses across all five items. Individual item means ranged from 2.10 to 2.30, with the highest score related to discomfort when management is involved in personal problems (M = 2.30, SD = 0.800), and the lowest related to management's limited role in implementing instructions (M = 2.10, SD = 0.846). As seen in Table (4.3).

The lack of communication opportunities reflects a moderate level of organizational silence among nurses. All six items scored within the moderate range, with mean values ranging from 1.91 to 2.23. The highest mean (2.23, SD = 0.824) was related to the lack of communication channels between employees and senior management, while the lowest (1.91, SD = 0.853) addressed the absence of information exchange among departments. As shown in Table (4.4).

Table 4.3: Mean Score for the Support of the Top Management of Silence (n=220).

Item	Mean	SD	Status
1. Organization's management believes that its role is limited to the implementation of instructions.	2.10	.846	Moderate
2. The organization is not interested in encouraging employees to express their opinions or suggestions concerning aspects of the work.	2.11	.860	Moderate
3. Management of the organization does not tend to serious discussion of the views and suggestions of employees.	2.22	.798	Moderate
4. Management of the organization does not express gratitude to workers for their opinions and suggestions for useful work.	2.26	.817	Moderate
5. I do not feel comfortable when management of the organization is involved in a problem belonging to me personally.	2.30	.800	Moderate
Total Mean Score (5 items)	**2.19**	**.588**	**Moderate**

Higher mean score means higher organizational silence Cut off point as follow; 1-1.66=low, 1.67-2.33=Moderate, 2.34-3=High. Mean score over 3

Table 4.4: Mean Score for the Lack of Communication Opportunities (n=220).

Item	**Mean**	**SD**	**Status**
1. There is no exchange of information among various departments and divisions within the organization	1.91	.853	Moderate
2. The chances of communication between employees in other departments are not enough	2.04	.854	Moderate
Management of the organization does not notify the staff with the organization's important problems and issues	2.06	.861	Moderate
3. There are not enough channels of communication between employees and senior management of the organization.	2.23	.824	Moderate
4. Management of the organization does not bother to hold meetings to discuss issues and matters relating to work	2.13	.856	Moderate
5. My supervisors at work do not possess the good skills needed for listening to my views and suggestions.	2.05	.845	Moderate
Total Mean Score (6 items)	**2.06**	**.587**	**Moderate**

Higher mean score means higher organizational silence Cut off point as follow; 1-1.66=low, 1.67-2.33=Moderate, 2.34-3=High. Mean score over 3

The support of supervisor for silence showed a moderate level of organizational silence among nurses, with all five items falling within the moderate range. Mean scores ranged from 1.84 to 2.09, with the highest score (M = 2.09, SD = 0.855) reflecting the perception that supervisors

view criticism as a challenge, and the lowest (M = 1.84, SD = 0.848) indicating that supervisors may disregard negative feedback about employee performance. As shown in Table (4.5)

Table 4.5: Mean Score for the Support of Supervisor for Silence (n=220).

Item	Mean	SD	Status
1. I hesitate to speak freely with my direct manager concerning a problem at work.	2.01	.712	Moderate
2. My direct manager does not care about any negative information about my performance.	1.84	.848	Moderate
3. My direct manager sees any criticism against him a sort of challenging him.	2.09	.855	Moderate
4. My direct manager suspects the source of my information concerning my performance at work	1.93	.841	Moderate
5. My direct manager sees the difference in opinion on the problems of working longer unhelpful	2.07	.871	Moderate
Total Mean Score (5 items)	**1.98**	**.598**	**Moderate**

Higher mean score means higher organizational silence Cut off point as follow; 1-1.66=low, 1.67-2.33=Moderate, 2.34-3=High. Mean score over 3.

The mean scores for official authority indicate a **moderate** level of organizational silence among nurses. All five items scored within the moderate range, with means ranging from 1.73 to 2.14. The highest mean (2.14, SD = 0.849) was related to the perception that managers primarily rely on their official authority to influence subordinates, while the lowest mean (1.73, SD = 0.821) reflected that manager follow laws and regulations when solving subordinate problems. As shown in Table (4.6).

Table 4.6 Mean Score for the Official Authority (n=220).

Item	**Mean**	**SD**	**Status**
1. My direct manager depends mainly on the official authority to influence subordinates	2.14	.849	Moderate
2. My direct manager draws on the method of threatening with punishment to guide the behavior of subordinates	2.00	.884	Moderate
3. My direct manager accepts excuses of subordinates with difficulty when they commit negligence in their work.	2.11	.844	Moderate
4. My direct manager directs the behavior of subordinates through compliance with laws and regulations *	1.78	.844	Moderate
5. My direct manager complies with laws and regulations in force when solving problems of subordinates *	1.73	.821	Moderate
Total Mean Score (5 items)	**1.95**	**.430**	**Moderate**

Higher mean score means higher organizational silence Cut off point as follow; 1-1.66=low, 1.67-2.33=Moderate, 2.34-3=High. Mean score over 3

The subordinate's fear of negative reactions demonstrated a moderate level of organizational silence among nurses, with all six items falling within the moderate range. Mean scores ranged from 1.80 to 2.12, with the highest score (M = 2.12, SD = 0.865) indicating concern that speaking about work problems could harm personal interests, while the lowest (M = 1.80, SD = 0.838) reflected fear of informing managers about organizational problems. The total mean score was 2.01 (SD = 0.648), suggesting that nurses moderately refrain from speaking out due to fear of conflict, damaged relationships, or negative consequences—highlighting a notable barrier to open communication in the workplace. As seen in Table (4.7).

Table 4.7: Mean Score for the Subordinate's Fear of Negative Reactions (n=220).

Item	**Mean**	**SD**	**Status**
1. I feel afraid to inform my direct manager with the problems of work in the organization.	1.80	.838	Moderate
2. I don't tend to talking about the negative working conditions for fear of being held accountable.	2.00	.886	Moderate
3. I prefer to stay silent in order to avoid conflicts or disagreements with superiors.	2.08	.877	Moderate
4. I prefer to stay silent for fear of breaking my relationships with my colleagues.	2.03	.867	Moderate
5. I prefer to stay silent not to be considered a problem-maker.	2.05	.877	Moderate
6. My speaking of work problems could be harmful to my personal interests.	2.12	.865	Moderate
Total Mean Score (6 items)	**2.01**	**.648**	**Moderate**

Higher mean score means higher organizational silence Cut off point as follow; 1-1.66=low, 1.67-2.33=Moderate, 2.34-3=High. Mean score over 3

4.6 Differences Between Demographic Variables in Terms of Intentional to Leave

A Mann–Whitney *U* tests and Kruskal–Wallis *H* tests were conducted to assess the differences in intention to leave work based on demographic characteristics among participants (n = 220). A statistically significant difference was found in intention to leave work based on marital status, (U = 4294.5, Z = –2.202, p = .028), with single participants (Mean Rank = 123.76) reporting higher intention to leave compared to married participants (Mean Rank = 104.44) based on Dunn's post hoc test. No significant differences were observed by age group, (H(3) = 2.133, p = .545); sex, (U = 5132.5, Z = –1.491, p = .136); geographical location, (U = 4432.5, Z = –0.921, p = .357); educational level, (H(2) = 0.201, p = .904); years of experience, (H(3) = 2.519, p = .472); department, (H(9) = 7.941, p = .540); sector, (U = 5357, Z = –1.075, p = .282); or monthly income, (H(3) = 3.461, p = .326). As shown in Table (4.8).

Table 4.8: Differences between demographic variables in terms of intentional to leave work mean score (n=220).

Demographic Characteristics		**n**	**Mean Rank**	**Statistical value**	**P-value**
Age Group (Years)	20-29	95	115.34	H=2.133 DF=3	.545
	30-39	82	102.92		
	40-49	31	112.81		
	50-59	12	118.04		
Sex	Male	87	118.01	U=5132.5 Z=-1.491	.136
	Female	133	105.59		
Marital Status	Single	69	123.76	U=4294.5	.028*
	Married	151	104.44	Z=-2.202	
Geographical Location	Bethlehem	60	104.38	U=4432.5 Z=-.921	.357
	Hebron	160	112.80		
Educational Level	Diploma	38	113.95	H=.201 DF=2	.904
	Bachelor's Degree	163	109.25		
	Higher education (Master and PhD)	18	108.47		
Years of Experience in Healthcare	<1 year	17	124.85	H=2.519 DF=3	.472
	1-5 years	86	115.15		
	6-10 years	62	103.54		
	>10 years	55	106.64		
Department	Intensive Care Unit (ICU)	33	99.53	H=7.941 DF=9	.540
	Emergency	42	113.82		
	Surgical	26	121.10		
	Medical	30	117.78		
	Pediatrics	17	109.71		
	Hemodialysis	13	86.31		
	Ear, Nose and Throat	7	103.36		
	Operation room	8	83.56		
	Clinics	15	104.77		
	Others	29	124.57		
Sector	Governmental sector	131	106.89	U=5357 Z=-1.075	.282
	Non-Governmental sector	89	115.81		
Monthly income	<500 JD	36	127.58	H=3.461 DF=3	.326
	500-999 JD	147	107.38		
	1000-1500 JD	28	106.70		
	>1500 JD	9	104.89		

Mann Whitney U test and Kruskal Wallis H tests

**Significant values*

4.7 Differences Between Demographic Variables in Terms of Organizational Silence

The research findings demonstrated major distinctions in organizational silence mean scores which corresponded to specific demographic characteristics among participants (n=220). A Statistically significant differences were found based on **age group**, (H (3) = 8.719, p = .033), with participants aged 40–49 years (Mean Rank = 136.85) showing higher organizational silence compared to other age groups based on Dunn's post hoc test. A significant difference was also observed by **sex**, (U = 4794, Z = –2.149, p = .032), where females (Mean Rank = 117.95) reported higher silence scores than males (Mean Rank = 99.10). Similarly, **marital status** showed a significant difference, (U = 3545.5, Z = –3.801, p < .001), with married participants (Mean Rank = 121.52) reporting higher silence than single participants (Mean Rank = 86.38). Regarding **years of experience in healthcare**, significant differences were observed, (H (3) = 12.445, p = .006), with the lowest mean rank found among participants with less than 1 year of experience (Mean Rank = 65.56), and the highest among those with 6–10 years (Mean Rank = 125.19). A significant difference was also found based on **sector**, (U = 4719, Z = –2.398, p = .016), with non -Governmental sector employees (Mean Rank = 122.98) reporting more organizational silence than those in the Governmental sector (Mean Rank = 102.02). Additionally, **monthly income** differences were statistically significant, (H (3) = 16.711, p < .001), with participants earning 1000–1500 JD showing the highest mean rank (126.45), and those earning more than 1500 JD the lowest (67.33). Based on Dunn's post hoc test. No statistically significant differences were found in organizational silence by **geographical location**, (U = 4526.5, Z = –0.651, p = .515); **educational level**, (H (2) = 2.271, p = .321); or **department**, (H (9) = 14.539, p = .104). As shown in Table (4.9).

Table 4.9(a): Differences between demographic variables in terms of organizational silence total mean score (n=220).

Demographic Characteristics		**N**	**Mean score**	**Statistical value**	**P-value**
Age Group (Years)	20-29	95	99.14	H=8.719 DF3	.033*
	30-39	82	112.19		
	40-49	31	136.85		
	50-59	12	120.79		
Sex	Male	87	99.10	U=4794 Z=-2.149	.032*
	Female	133	117.95		
Marital Status	Single	69	86.38	U=3545.5 Z=-3.801	<.001*
	Married	151	121.52		
Geographical Location	Bethlehem	60	115.06	U=4526.5 Z=-.651	.515
	Hebron	160	108.79		
Educational Level	Diploma	38	123.39	H=2.271 DF=2	.321
	Bachelor's Degree	163	106.46		
	Higher education (Master and PhD)	18	113.75		
Years of Experience in Healthcare	<1 year	17	65.56	H=12.445 DF=3	.006*
	1-5 years	86	106.08		

	6-10 years	62	125.19		
	>10 years	55	114.75		
Department	Intensive Care Unit (ICU)	33	89.88	H=14.539 DF=9	.104
	Emergency	42	98.38		
	Surgical	26	120.77		
	Medical	30	115.45		
	Pediatrics	17	149.35		
	Hemodialysis	13	129.04		

Demographic Characteristics		N	Mean score	Statistical value	P-value
	Ear, Nose and Throte	7	114.86		
	Operation room	8	87.19		
	Clinics	15	106.27		
	Others	29	113.67		
Sector	Governmental sector	131	102.02	U=4719 Z=-2.398	.016
	Non- Governmental sector	89	122.98		
Monthly income	<500 JD	36	78.94	H=16.711 DF=3	<.001*
	500-999 JD	147	117.83		
	1000-1500 JD	28	126.45		
	>1500 JD	9	67.33		

Mann Whitney U test and Kruskal Wallis H tests
**Significant values*

4.8 The Relationships Between Intentional to Leave Work and Organizational Silence Subscales

The Spearman correlation analysis demonstrated a significant small negative relationship between work departure intentions and total organizational silence ($r = –.153$, $p = .023$) which shows that higher organizational silence levels lead to slightly lower departure intentions. The only subscale that demonstrated a statistically significant negative relationship with intention to leave was lack of communication opportunities ($r = –.133$, $p = .048$) which indicates that restricted communication is weakly linked to decreased departure intentions.

The remaining subscales including support of top management, support of supervisor, official authority and fear of negative reactions did not show significant correlations with intention to leave but displayed weak negative relationships. The subscales demonstrated strong and significant correlations with each other as well as with the total organizational silence score which indicates strong internal consistency within the organizational silence construct.
Table 4.10: The relationships between intentional to leave work and organizational silence subscales (n=220).

Spearman Correlation		(1)	(2)	(3)	(4)	(5)	(6)	(7)
(1) Intention	r							
	P-value	.						
(2) Support of the Top Management of Silence	r	-.127						
	P-value	.059	.					
(3) Lack of Communication Opportunities	r	-.133	.481					
	P-value	**.048***	**<.001***	.				
(4) Support of Supervisor for Silence	r	-.094	.468**	.486				
	P-value	.167	**<.001***	**<.001***	.			
(5) Official Authority	r	-.103	.265	.240	.386			
	P-value	.129	**<.001***	**<.001***	**<.001***	.		
(6) Subordinate's Fear of Negative Reactions	r	-.097	.290	.286	.522	.307		
	P-value	.151	**<.001***	**<.001***	**<.001***	**<.001***	.	
(7) Organizational silence	r	-.153	.689	.716	.818	.551	.715	
	P-value	**.023***	**<.001***	**<.001***	**<.001***	**<.001***	**<.001***	.

r: Correlation Coefficient
**Significant values*

Chapter Five

Discussion

5.1 Introduction

This chapter present the discussion of the results of this study compared to the previous study on the same topic. Moreover, this chapter illustrates some recommendations for policy makers in addition to the strengths and area of improvement.

The study becomes the first research to investigate employee retention patterns in Palestinian hospital settings and specifically in Southern West Bank facilities. The regional socio-political challenges along with restricted healthcare resources make it logical that workforce retention factors exist beyond what global studies reveal. The research indicates workforce stability but also shows the necessity for maintaining ongoing assessment along with organizational initiatives that foster open dialogue and psychological safety and nurse empowerment programs.

Organizational Silence

The research showed that Palestinian nurses experienced moderate organizational silence at 53.2% and high silence at 25.0%. The research indicates that more than three-quarters of the nurses experienced at least moderate voice suppression which shows substantial barriers to open communication and feedback in their organizations. The findings match those of the systematic review done on China, Turkey, and Korea. In several hospitals, this phenomenon was found to be widespread among nurses and related to various negative outcomes such as cynicism, job satisfaction, and turnover intentions (Wen et al., 2025). Lv et al. (2024) found that the nurses in Chinese general hospitals reported moderate to high levels of organizational silence due to fear of retaliation, lack of support, and hierarchical leadership.

The moderate levels of silence might indicate an organizational environment where nurses sometimes feel heard but still fear negative consequences from speaking up. According to Li et al. (2024), nurses usually refrain from speaking up because they think that their concerns will not be addressed in environments where feedback mechanisms are weak or leadership is authoritarian.

The 25.0% of nurses experiencing high levels of silence is particularly concerning. Research shows that high levels of organizational silence are linked to major problems such as decreased psychological safety, impaired teamwork, and lower patient safety outcomes (Hashemian et al., 2025; Lee et al., 2024). A systematic review by Montgomery et al. (2025) demonstrated that nurses who experience high levels of silence may stop sharing crucial clinical information or hide errors or refuse to participate in improvement programs which puts patient care quality at risk and decreases staff morale (Montgomery et al., 2025). Only 21.8% of participants experienced low levels of organizational silence indicating that few nurses feel completely comfortable and empowered to express themselves freely. This percentage indicates there is a leadership or cultural problem that prevents open communication. El-Gazar et al. (2025) emphasized that transparent, fair, and psychologically safe leadership known as ethical leadership is necessary to reduce silence and foster nurse voice behavior.

The small number of nurses who reported low organizational silence requires targeted interventions to develop an inclusive and communicative work environment. The interventions should include leadership training alongside non-punitive reporting systems and decision-making participation structures. The absence of research comparing hospital environments in Palestine makes it necessary to create interventions that address local socio-cultural and institutional elements of the region.

5.2 Organizational Silence Subscales

The analysis of organizational silence subscales provides essential information about which organizational dimensions lead nurses to remain silent. Nurses reported the highest level of silence or voice suppression through their responses to the “Support of the Top Management” scale. Research by Al-Momani et al. (2023) and Bellack and Dickow (2019). supports this finding because distant top management creates communication barriers which prevent frontline staff from expressing their opinions or concerns. When senior leaders appear distant or uninterested it creates an environment where employees feel their input becomes pointless or dangerous.

The lowest mean scores appeared in “Support of Supervisor” and “Official Authority” because nurses reported fewer obstacles when interacting with their direct supervisors and formal reporting channels. The results might indicate that unit-level leaders maintain close informal relationships with nurses or that department-level support systems protect nurses from

higher-level organizational silence Asif et al. (2023), discovered similar results when they found immediate supervisors served as a connection between staff members and senior leaders. The different organizational silence patterns show that this phenomenon exists independently across hierarchical structures and relational systems. The implementation of targeted interventions requires proper alignment with specific organizational needs. The perception of disconnect that leads to top-level silence can be reduced through initiatives that strengthen top management visibility and establish feedback loops and improve vertical communication. The existing supervisor-level strengths should be used to promote voice behavior and psychological safety and shared decision-making.

The "Subordinate's Fear of Negative Reactions" (M = 2.01) also emerged as a key factor influencing silence. Nurses may withhold input due to concerns about being criticized, ignored, or facing retaliation. This fear can be especially strong in settings where power dynamics are rigid. As noted by Srivastava et al. (2023), fear-based silence can erode trust, stifle innovation, and reduce employee morale. Establishing psychological safety, reinforcing anti-retaliation policies, and training leadership in empathetic communication are vital strategies to address this issue.

The varied levels across subscales highlight that organizational silence is not uniform but influenced by specific relational and structural elements. Tailored interventions are necessary. Strengthening vertical communication, increasing top management engagement, and addressing communication deficiencies and fear of retaliation can help create a more transparent, safe, and responsive workplace culture.

5.3 Demographic Differences in Both Intentions to Leave and Organizational Silence

The research study discovered major population differences between work departure intentions and workplace silence among nurses because personal and social environments shape their workplace perceptions and actions. The research shows that single nurses want to leave their jobs at higher rates than nurses who are married. The results match previous research which demonstrates that single healthcare employees tend to move jobs more often because they have fewer family commitments to their current roles and possibly less organizational dedication (Clendon & Walker, 2017). Single nurses tend to feel more confident about finding superior opportunities because they lack organizational support in stressful work environments. The external responsibilities and economic needs and family support and organizational commitment of married nurses lead to their greater job stability (Clendon & Walker, 2017).

The study found that female nurses displayed higher levels of organizational silence than male nurses. The research findings match existing studies about gender relationships within healthcare facilities. Female nurses tend to hide their opinions because of cultural norms

and power differences and concerns about professional repercussions (El Abdou et al., 2023). The research shows that married nurses tend to remain silent more frequently than single nurses. The need to protect their family financial stability and job security makes married workers more cautious about workplace conflicts. The risk-averse nature of married nurses leads them to avoid expressing concerns because they believe it could damage their professional reputation (El Abdou et al., 2023).

The research findings indicate that marital status and gender interact with organizational culture to determine how employees express themselves at work and their plans to leave their jobs. The findings have significant implications for nurse managers and policymakers because they demonstrate the requirement for individualized interventions. The establishment of psychologically safe environments for female nurses combined with targeted solutions for single staff members regarding career development and inclusion issues can decrease both silence and departure intentions. The observed differences demonstrate the necessity for leadership approaches to maintain equity in their practices. Workforce engagement and retention require organizations to prevent their systems from unintentionally silencing specific groups including women and married employees.

5.4 Intention to Leave Work

The majority of nurses at 70.9% showed a low intention to leave their current jobs indicating stable job retention in this studied setting. The result indicates that supportive leadership alongside workplace cohesion and professional commitment act as buffers that protect nurses from organizational stressors. Nurses working in Palestine's healthcare context choose to stay in their jobs despite dissatisfaction may be due to the economic dependence and job scarcity and cultural norms.

A fact that 20.5% of nurses expressed moderate exit intentions while 8.6% showed high intentions to leave remains significant. The workforce segment identified in this study faces risks despite showing lower departure rates than international research has demonstrated. The Turkish hospital study conducted by Çaylak and Altuntaş (2017) jobs because of organizational silence. The research of Saeidipour et al. (2021) discovered that nurses working in Iran showed higher turnover intentions because organizational silence decreased their workplace engagement and made them feel undervalued.

The current study shows that only 8.6% of nurses reported a high intention to leave, which indicates that although organizational silence may be present, its negative effects are likely reduced by protective factors. These include ethical leadership, which promotes trust and fairness; organizational support, which makes employees feel valued; a positive organizational culture, which encourages openness and communication; and workplace spirituality, which gives employees a sense of purpose and connection. Research supports the idea that these factors

help minimize the impact of organizational silence and strengthen employee commitment (Kim & Song, 2024; Parcham & Ghasemizad, 2017).

The 20.5% of workers showing moderate intention to leave represents an essential discovery. The employees who fall into this category might be on the verge of changing their behavior because of growing dissatisfaction or suppressed communication. According to Çaylak and Altuntaş (2017), organizational silence functions in ways that creates disengagement and cynicism through subtle processes. The workforce stability risk increases when this group remains without intervention because they might evolve into high-risk candidates for turnover.

5.5 Relationship Between Intention to Leave and Organizational Silence

Organizational silence shows a significant negative correlation with work leave intentions which contradicts the general findings in the literature. The research findings contradict typical studies by showing that nurses who experience more organizational silence tend to leave their jobs less often.

The inverse relationship between organizational silence and nurse intention to leave work may occur because nurses choose to internalize their dissatisfaction instead of taking action when they cannot leave their jobs. The economic limitations along with restricted job opportunities and cultural expectations within the Palestinian healthcare system create conditions where nurses tend to remain silent about their dissatisfaction. Nurses choose to hide their voices while tolerating poor working conditions because they want to maintain their job security and fulfill their family obligations which leads them to use passive coping instead of leaving their jobs (El Abdou et al., 2023).

The short-term maintenance of staffing stability through this silence creates major long-term problems for healthcare systems. The suppression of feedback through organizational silence prevents the identification and resolution of systemic problems. The lack of institutional problem resolution because of unaddressed weaknesses results in operational inefficiencies and repeated errors and workforce trust deterioration. The quality of patient care deteriorates because nurses choose not to report unsafe practices and insufficient resources and harmful behaviors. The failure to address clinical concerns through silence creates direct threats to patient safety which leads to more medical errors and poor communication and compromised outcomes.

Nurses who maintain prolonged silence experience emotional exhaustion and moral distress which eventually leads to burnout (Karakachian & Colbert, 2019). The psychological pressure of hiding concerns while dealing with challenging situations creates long-term negative effects on their mental health and job satisfaction and professional identity. The failure to address chronic stress leads to higher risks of employee absence and disengagement and eventual departure from work despite initial low intentions to leave. Healthcare leaders need to address

this issue with immediate strategic support because organizational silence appears to lower turnover intentions but creates hidden threats to system resilience and patient safety and nursing well-being.

The practice of organizational silence functions as a protective mechanism which helps nurses maintain their workplace status through avoiding confrontations that could lead to conflict. When nurses remain silent, they create emotional distance that prevents them from leaving their positions. The distinction between active disengagement (e.g., turnover) and passive disengagement (e.g., silence) is supported by Du Plessis (2021) who shows that passive disengagement can lead to job retention despite employee dissatisfaction.

The research findings differ from multiple studies which demonstrated a positive relationship between silence and employee turnover intentions. The Saeidipour et al. (2021) discovered that nurses who experienced increased organizational silence developed stronger intentions to quit because silence decreased their engagement and lowered their morale. The results indicate that cultural elements together with environmental factors determine how silence impacts employee decisions about staying or leaving their jobs.

5.6 Conclusion

The research evaluated both organizational silence levels and nurse departure intentions together with their demographic variations and connection patterns. The majority of nurses indicated low departure intentions yet a substantial number demonstrated moderate to high organizational silence levels especially regarding top management support and communication deficiencies. The research discovered an inverse relationship between organizational silence and nurse departure intentions because some nurses remain silent instead of leaving their jobs possibly because of job security and limited employment options in particularly of the political conflict in Palestine and the current war that started on October 7, 2023.

Single nurses demonstrated higher intentions to leave their jobs but female nurses along with married nurses displayed more organizational silence. The research demonstrates how personal and social elements shape workplace conduct. The research demonstrates that organizations need to establish open communication channels and practice ethical leadership while creating supportive work environments to decrease silence and maintain nurse retention.

5.7 Strengths and Limitations of the Study

This study is not without limitations. First, it employed a descriptive cross-sectional design and was limited to the southern region of the West Bank in Palestine. Therefore, future research is

recommended to encompass all regions of Palestine for a more comprehensive understanding. Second, data were collected through self-administered questionnaires, which may introduce certain biases such as self-reporting or social desirability bias. Third, some hospitals declined to participate—possibly due to the sensitivity of the topic from the perspective of administrators. We recommend developing strategies to enhance hospital engagement in future research. Additionally, using alternative methodologies such as qualitative or mixed-method designs may provide deeper insights into the issue. Despite these limitations, and to the best of the authors' knowledge, this is the first study conducted in Palestine to investigate this critical issue.

5.8 Recommendations

For hospital administrators

- The establishment of direct communication links between hospital leaders and nursing personnel helps decrease staff perceptions of distance and organizational silence.
- The implementation of anonymous feedback systems through suggestion boxes or digital surveys enables staff to report concerns without facing any negative consequences.

For nurse managers and supervisors

- The creation of psychological safety requires nurse managers to guarantee that employees can share their concerns without facing any form of retaliation or judgment.

For policy-makers and healthcare authorities

- The development of national guidelines should establish workplace communication standards while enforcing zero tolerance for retaliation practices.
- The government should allocate funding to support training initiatives which teach ethical leadership and organizational justice practices in both Governmental and Non-Governmental healthcare facilities.

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Appendix A

- Research Ethical Sub-Committee from AQU
- Ref. No.: RESC/2025-76
- Approval form (Alahli , Almizan ,Alia & Alhussen) hospitals

جامعة القدس
Al-Quds University

كلية المهن الصحية

برنامج ماجستير إدارة التمريض

استبيان بحثي حول العلاقة بين الصمت التنظيمي والنية في ترك العمل لدى الممرضين في المستشفيات الفلسطينية في جنوب الضفة الغربية

عزيزتي/عزيزي الممرض(ة)

تحية طيبة وبعد،
في إطار استكمال متطلبات درجة الماجستير في إدارة التمريض بجامعة القدس - أبو ديس، أقوم بإجراء دراسة تهدف إلى معرفة **العلاقة بين الصمت التنظيمي والنية في ترك العمل لدى الممرضين في المستشفيات الفلسطينية في جنوب الضفة الغربية**

هدف الاستبيان:
يهدف هذا الاستبيان إلى جمع البيانات اللازمة لفهم **العلاقة بين الصمت التنظيمي والنية في ترك العمل :هدف الاستبيان لدى الممرضين في المستشفيات الفلسطينية في جنوب الضفة الغربية**، مما يساهم في تحسين بيئة العمل في المؤسسات الصحية

.

أجزاء الاستبيان:
يتكون الاستبيان من جزأين رئيسيين:

1. المعلومات الديموغرافية.
2. قياس الصمت التنظيمي.

سرية المعلومات:
جميع البيانات التي سيتم جمعها ستُعامل بسرية تامة ولن تُستخدم إلا للأغراض البحث العلمي فقط. لن يتم الكشف عن أي معلومات شخصية، والمشاركة في الاستبيان اختيارية بالكامل.

مدة تعبئة الاستبيان:
يتطلب الاستبيان ما يقارب 10-15 دقيقة من وقتكم الثمين.

مشاركتكم تساهم في تطوير بيئة عمل أفضل وتحسين جودة الرعاية الصحية المقدمة للمرضى.

لأي استفسارات أو توضيحات، يُرجى التواصل معي:
الباحثة: روان عماد أبو عياش
بإشراف: الدكتور أشرف أبو جحيشة
جامعة القدس - أبو ديس

شكرًا لتعاونكم ودعمكم لهذا البحث
يرجى التكرم بقراءة الأسئلة والإجابة عنها بكل موضوعية ودقة

Part 1: Demographic Information

Please fill in the following information by marking or filling in the appropriate option.

- **Age: _____ (Years)**

- **sex:**

  ☐ Male ☐ Female

- **Marital Status:**

  ☐ Single ☐ Married ☐ Divorced ☐ Widowed

- **Geographical Location:**

  ☐ Bethlehem ☐ Hebron

- **Educational Level:**

  ☐ Diploma ☐ Bachelor's Degree ☐ Master's Degree ☐ PhD

- **Years of Experience in the Healthcare Sector:**

  ☐ Less than 1 year ☐ 1 - 5 years ☐ 6 - 10 years ☐ More than 10 years

- **Department You Work In:**

  ☐ Intensive Care Unit (ICU) ☐ Emergency ☐ Surgical ☐ Internal Medicine

  ☐ Pediatrics ☐ Clinics ☐ Other (Please specify): _____

- **Do you work in the public or private healthcare sector?**

  ☐ Public sector ☐ Private sector

- **Monthly Income (in JD or USD):**

  ☐ Less than 500 JD / 700 USD ☐ 500 - 1000 JD / 700 - 1400 USD

  ☐ 1000 - 1500 JD / 1400 - 2100 USD ☐ More than 1500 JD / 2100 USD

- **Looking to your career goals, are you going to change your work setting in the coming year?"**

  ☐ Very unlikely ☐ Unlikely

  ☐ Likely ☐ Very likely

Part 2: Organizational Silence Scale

For each item below, please indicate your level of agreement using the following scale:

1 = Disagree 2 = Neutral 3 = Agree

Support of the Top Management of Silence

Item	1	2	3
1. Organization's management believes that its role is limited to the implementation of instructions.			

2. The organization is not interested in encouraging employees to express their opinions or suggestions concerning aspects of the work.			
3. Management of the organization does not tend to serious discussion of the views and suggestions of employees.			
4. Management of the organization does not express gratitude to workers for their opinions and suggestions for useful work.			
5. I do not feel comfortable when management of the organization is involved in a problem belonging to me personally.			

Lack of Communication Opportunities

Item	**1**	**2**	**3**
1. There is no exchange of information among various departments and divisions within the organization.			
2. The chances of communication between employees in other departments are not enough.			
3. Management of the organization does not notify the staff with the organization's important problems and issues.			
4. There are not enough channels of communication between employees and senior management of the organization.			

5. Management of the organization does not bother to hold meetings to discuss issues and matters relating to work.			
6. My supervisors at work do not possess the good skills needed for listening to my views and suggestions.			

Support of Supervisor for Silence

Item	**1**	**2**	**3**
1. I hesitate to speak freely with my direct manager concerning a problem at work.			
2. My direct manager does not care about any negative information about my performance.			
3. My direct manager sees any criticism against him a sort of challenging him.			
4. My direct manager suspects the source of my information concerning my performance at work.			
5. My direct manager sees the difference in opinion on the problems of working longer unhelpful.			

Official Authority

Item	**1**	**2**	**3**
1. My direct manager depends mainly on the official authority to influence subordinates.			

2. My direct manager draws on the method of threatening with punishment to guide the behavior of subordinates.			
3. My direct manager accepts excuses of subordinates with difficulty when they commit negligence in their work.			
4. My direct manager directs the behavior of subordinates through compliance with laws and regulations.			
5. My direct manager complies with laws and regulations in force when solving problems of subordinates.			

Subordinate's Fear of Negative Reactions

Item	**1**	**2**	**3**
1. I feel afraid to inform my direct manager with the problems of work in the organization.			
2. I don’t tend to talking about the negative working conditions for fear of being held accountable.			
3. I prefer to stay silent in order to avoid conflicts or disagreements with superiors.			
4. I prefer to stay silent for fear of breaking my relationships with my colleagues.			
5. I prefer to stay silent not to be considered a problem-maker.			
6. My speaking of work problems could be harmful to my personal interests.			

---------- Forwarded message ---------
From: **Loai Aburayyan** <loai@ppu.edu>
Date: Sun, May 4, 2025, 19:06
Subject: Re: Fw: تسهيل مهمة جمع المعلومات
To: iman jado <al_iman2007@yahoo.com>, <salam.khatib@staff.alquds.edu>

السلام عليكم
أتمنى ان تكونو بصحة جيدة

لا مانع من جمع البيانات الخاصة بالطالبة روان عماد ابو عياش في مستشفى الميزان.

بالتوفيق

دائرة التعليم المستمر - مستشفى الميزان

Lo'ai Sa'di Abu-Rayyan.
BSN, MSN, PHD candidate.

Palestine Polytechnic University
Nursing Department

On Sun, 4 May 2025 at 17:18, iman jado <al_iman2007@yahoo.com> wrote:

حضرة الدكتورة سالم الخطيب المحترمة
منسقة برنامج الماجستير / دائرة التمريض
تحية طيبة ،

بالإشارة إلى كتابكم الكريم المتعلق بتسهيل مهمة طالبة الماجستير "روان عماد محمد أبو عياش"، رقمها الجامعي (2312627)، من برنامج ماجستير إدارة التمريض / كلية المهن الصحية / جامعة القدس، بهدف جمع البيانات اللازمة لدراستها المعنونة:

"العلاقة بين الصمت التنظيمي والنية لترك العمل بين المرضين في المستشفيات الفلسطينية – جنوب الضفة الغربية"

وبإشراف الدكتور أشرف أبو جحيشة، خلال الفترة الممتدة من 10/5/2025 وحتى 31/5/2025،

نود إعلامكم بأنه تمت الموافقة على جمع البيانات في مستشفى الأهلي – الخليل، وذلك ضمن المعايير التالية:

- عدم جمع البيانات من قسمي الطوارئ والعناية المكثفة، التزامًا بسياسات المستشفى لخصوصية بيئة العمل في تلك الأقسام.
- ضرورة التنسيق المسبق مع مدير التمريض السيد باسم السعافين على الرقم (0599552871) قبل البدء بتوزيع الاستبانات، لضمان تنظيم العملية وسلاسة العمل داخل الأقسام المعنية.
- الالتزام التام بأخلاقيات البحث العلمي، مع احترام خصوصية المشاركين، وضمان سرية المعلومات، وعدم استخدامها إلا لأغراض الدراسة.

مع تمنياتنا للطالبة روان بالتوفيق في بحثها، ولكم جزيل الشكر على تعاونكم الأكاديمي المثمر.

وتفضلوا بقبول فائق الاحترام والتقدير،
مراد عمرو

مراد عمرو– مستشار تطوير الجودة ومكافحة العدوى،
منسق تدريب وأبحاث طلاب الجامعات

Murad Y. Amro, BSN, SON, HCQP, MPH
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State of Palestine
Ministry of Health
Education in Health and Scientific
Research Unit

دولة فلسطين
وزارة الصحة
وحدة التعليم الصحي
والبحث العلمي

Ref.: ....
Date:..................

الرقم: ٢٠٢٥/١٢٤٤/٢٦٢
التاريخ: ٢٠٢٥/٥/١١

الأخ مدير عام الادارة العامة للمستشفيات المحترم،،،

تحية واحترام...

<u>الموضــوع: تسهيل مهمة بحث</u>

يرجى تسهيل مهمة **الطالبة: روان عماد محمد ابو عياش– ماجستير ادارة التمريض/ جامعة القدس**، وباشراف د. اشرف ابو جحيشة، في عمل بحث بعنوان:

" العلاقة بين الصمت التنظيمي والنية في ترك العمل لدى الممرضين في المستشفيات الفلسطينية في جنوب الضفة الغربية "

من خلال السماح للطالبة بجمع معلومات عن طريق تعبئة استبانة الدراسة من قبل كادر التمريض بعد اخذ موافقتهم، وذلك في:

– مستشفى عاليه – مستشفى بيت جالا

على ان يتم الالتزام باساليب واخلاقيات البحث العلمي، وعدم التعرض للمعلومات التعريفية للمشاركين.
على ان يتم تزويد الوزارة بنسخة PDF من نتائج البحث، التعهد بعدم النشر لحين الحصول على موافقة الوزارة على نتائج البحث.

مع الاحترام...

د. عبد الله القواسمي
رئيس وحدة التعليم الصحي والبحث العلمي

نسخة: منسقة برنامج الماجستير/ دائرة التمريض المحترمة/ جامعة القدس

Telfax.:09-2333901 scientificresearch.dep@gmail.com تلفاكس: 09-2333901

Al Quds University
Faculty of Health Professions
Jerusalem –Abu Dis

جامعة القدس
كلية المهن الصحية
القدس – أبو ديس

Research Ethics Subcommittee of Faculty of Health Professions
Letter of approval

May 2, 2025
Ref. No.: RESC/2025-76

Dear Applicants, (**Dr. Ashraf Abuejheisheh, Ms. Rawan Abuayyash**)

Program: **MSc Nursing Department**

The Research Ethics subcommittee of the Faculty of Health Professions has recently reviewed your proposal entitled (**The Relationship Between Organizational Silence and Intention to Quit Among Nurses in Palestinian Hospitals in the Southern West Bank**) submitted by (**Dr. Ashraf Abuejheisheh**). Your proposal is deemed to meet the requirements of research ethics at Al-Quds University, but further assessment is required by the Central Research Ethics Committee of Al-Quds University. We wish you all best for the conduct of the project.

Hussein ALMasri, PhD

Hussein ALMasri

Associate Professor of Medical Imaging
Research Ethics Subcommittee Chair
Faculty of Health Professions

CC: File
CC: Committee members

العنوان: العلاقة بين الصمت التنظيمي ونية ترك العمل لدى الممرضين في المستشفيات الفلسطينية في جنوب الضفة الغربية

إعداد: روان أبو عياش
إشراف : د. أشرف أبو جيشة
المشرف المشارك : د. كفاح زبن

الملخص:

الخلفية :تواجه أنظمة الرعاية الصحية الحديثة تحديات كبيرة تتطلب تواصلًا شفافًا. يُعد **الصمت التنظيمي،** الذي يحدث عندما يمتنع الموظفون عن التعبير عن مخاوفهم، عاملًا يقلل من الرضا الوظيفي ويزيد من الإرهاق ويؤثر على سلامة المرضى. الممرضون، الذين يشكلون حجر الزاوية في تقديم الرعاية الصحية، معرضون بشكل خاص لهذه الظاهرة، حيث يؤثر الصمت بشكل كبير على رفاهيتهم و**نية تركهم للعمل** .لا يزال هناك القليل من المعرفة حول الصمت التنظيمي في المستشفيات الفلسطينية، خاصة عند المقارنة بين المؤسسات الحكومية وغير الحكومية.

الهدف :هدفت هذه الدراسة إلى فحص العلاقة بين الصمت التنظيمي ونية ترك العمل لدى الممرضين في هذه المستشفيات، مع الأخذ في الاعتبار العوامل الديموغرافية ونوع المستشفى.

المنهجية :تم استخدام تصميم كمي مقطعي. تم جمع البيانات من عينة مريحة قوامها 220 ممرضًا وممرضة من أربعة مستشفيات. اشتملت أدوات الدراسة على استبيان الخصائص الديموغرافية، ومقياس الصمت التنظيمي المكون من 27 بندًا، وسؤال واحد حول نية ترك العمل. أظهر مقياس الصمت التنظيمي موثوقية عالية (ألفا كرونباخ = 0.87 إجمالًا). شمل تحليل البيانات الإحصاءات الوصفية والاستدلالية باستخدام برنامج SPSS ($p < 0.05$).

النتائج :أظهرت غالبية الممرضين (70.9%) نية منخفضة لترك العمل، بينما عانى 53.2% من صمت تنظيمي متوسط و25% أبلغوا عن صمت تنظيمي مرتفع. كان أعلى بعد للصمت هو **نقص دعم الإدارة العليا** .أثرت العوامل الديموغرافية مثل العمر، الجنس، الحالة الاجتماعية، سنوات الخبرة، نوع المستشفى (المستشفيات غير الحكومية أظهرت صمتًا تنظيميًا أعلى)، والدخل على كل من الصمت التنظيمي ونية

ترك العمل. أشارت علاقة سلبية صغيرة إلى أن ارتفاع الصمت التنظيمي ارتبط بشكل طفيف بانخفاض نية ترك العمل.

الخلاصة :على الرغم من أن معظم الممرضين كانوا ينوون البقاء في وظائفهم، إلا أن العديد منهم عانوا من صمت تنظيمي متوسط إلى مرتفع، خاصة فيما يتعلق بدعم القيادة والتواصل. تشير العلاقة العكسية بين الصمت التنظيمي ونية ترك العمل إلى أن عدم الرضا غالبًا ما يتم استيعابه داخليًا بسبب مخاوف تتعلق بالأمان الوظيفي ومحدودية خيارات التوظيف في المستشفيات الفلسطينية.

الآثار والتوصيات :تسلط النتائج الضوء على الحاجة إلى تدخلات هادفة للحد من الصمت التنظيمي. يجب على المستشفيات تعزيز التواصل بين القادة والموظفين، وإنشاء أنظمة ملاحظات مجهولة، وتعزيز الأمان النفسي. يجب تطوير معايير وطنية للتواصل في مكان العمل مع سياسات لمكافحة الانتقام. التدريب على القيادة الأخلاقية والعدالة التنظيمية ضروري لتحسين استبقاء الممرضين وجودة رعاية المرضى.

الكلمات المفتاحية :الصمت التنظيمي، نية ترك العمل، الممرضون، المستشفيات الفلسطينية، جنوب الضفة الغربية، المستشفيات الحكومية، المستشفيات غير الحكومية.

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