Leadership and Organizational Climate in Hospitals: A Narrative Review of Mediators, Moderators, and Methodological Designs

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Abstract
Hospital organizational climate plays a particularly important role in healthcare institutions, given their labor-intensive nature. It correlates with staff satisfaction, retention, and well-being, as well as patient safety. Leadership, in turn, ranks among its most extensively studied antecedents. However, researchers have yet to synthesize the mechanisms underlying the relationship between these two constructs and the conditions that shape it within an integrated framework. This study aims to synthesize the evidence on the relationship between leadership styles and organizational climate in hospitals. The review examines the mediators, moderators, theoretical frameworks, and methodological designs employed to investigate this relationship. To achieve this objective, we conducted a narrative review of the literature indexed in Scopus. The findings indicate that transformational, supportive, participative, authentic, and servant leadership correlate with more favorable organizational climates. Conversely, laissez-faire, authoritarian, and toxic leadership associate with deteriorating organizational climates. Transactional leadership, however, yields mixed results. The most frequently reported mediators include communication, perceived organizational support, organizational justice, empowerment and autonomy, psychological safety, and burnout. Meanwhile, the moderators most frequently identified in the literature include organizational culture, unit-level subclimates, hospital size, resource availability, and hierarchical rigidity. Nevertheless, researchers have formally tested these moderating effects only in a limited number of studies. Cross-sectional, single-source designs predominate, with researchers relying primarily on regression analysis or structural equation modeling (SEM). Overall, the evidence supports an association between leadership and organizational climate, mediated by everyday working conditions and shaped by the hospital context. Further research should prioritize longitudinal and multilevel designs, explicit tests of moderation and moderated mediation, and empirical studies conducted in Latin American hospitals.

Keywords: Leadership; organizational climate; hospitals; mediation; moderation; nursing; multilevel analysis.

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Introduction

Hospitals, constitute highly complex organizations because they deliver a wide range of services involving highly specialized processes and activities. These services span multiple departments, require diverse professional expertise, and vary considerably in nature. Moreover, hospitals operate under conditions of considerable urgency and uncertainty, face substantial risks with potentially severe consequences in the event of errors, rely on advanced and costly technologies, comply with stringent regulatory requirements and legal and ethical obligations, and accommodate multiple stakeholders with competing interests. Within these institutions, rigid hierarchical structures coexist with interprofessional teams, heavy workloads, and constant demands for patient safety. In this context, organizational climate refers to employees' shared perceptions of the policies, practices, and procedures that the organization rewards and supports (Schneider et al., 2013). Organizational climate has emerged as a relevant indicator of institutional performance, given its documented associations with nursing staff retention intentions (Mrayyan, 2008), occupational injuries and near misses (Clarke et al., 2002), and patient safety outcomes (Weng et al., 2017).

Among the antecedents of organizational climate, leadership occupies a central position. Systematic reviews in nursing consistently indicate that people-oriented and relationship-focused leadership styles correlate with more favorable work environments. By contrast, task-oriented, passive, and destructive leadership styles associate with less favorable climates (Cummings et al., 2010, 2018; Specchia et al., 2021). In Latin America, studies conducted in Peru, Mexico, and Chile have documented associations between leadership and organizational climate in healthcare institutions (Ansoleaga et al., 2025; Castillo Saavedra et al., 2019; Hernández et al., 2021). Nevertheless, regional research output remains limited and predominantly descriptive.

The literature reviewed reveals three major research gaps. First, existing studies provide limited integration of the underlying mechanisms, leaving unclear why leadership influences organizational climate. Proposed mediators remain scattered across studies grounded in different theoretical frameworks. Second, evidence remains insufficient regarding the conditions under which leadership exerts stronger or weaker effects. Researchers frequently treat variables such as organizational culture, hospital size, and resource availability as descriptive contextual factors rather than statistically tested moderators. Third, the role of organizational climate remains ambiguous. Some studies conceptualize climate as an outcome of leadership, whereas others position it as a mediator linking leadership to outcomes such as job satisfaction, patient safety, and staff retention. This conceptual ambiguity hinders the accumulation of consistent empirical evidence.

This narrative review aims to synthesize the evidence on the relationship between leadership styles and organizational climate in hospitals. Accordingly, it addresses four research questions:

Which leadership styles correlate with which types of organizational climate?

Which variables mediate this relationship, and which theoretical frameworks underpin these mediation mechanisms?

Which variables moderate this relationship?

Which research designs and methods have researchers employed to investigate this relationship, and which approaches would prove most suitable for future research?

Conceptual Theoretical Framework

Organizational Climate: Definition and Levels

Organizational climate refers to the set of shared perceptions regarding the work environment, particularly employees' perceptions of what the organization expects, supports, and rewards. It differs from organizational culture, which encompasses the deeper underlying assumptions and values that shape these practices (Schneider et al., 2013). Although closely related, these two constructs remain conceptually distinct and cannot be used interchangeably. Organizational culture generally provides a more stable context within which employees develop their perceptions of organizational climate.

In hospitals, researchers rarely measure organizational climate as a unidimensional construct. The most widely used instruments assess several dimensions, including leadership and management support, interpersonal relationships, participation, communication, autonomy, and teamwork (Bustamante-Ubilla et al., 2016; Segredo Pérez, 2017; Sein Myint et al., 2022). Researchers also distinguish between general organizational climates and specific climates, such as safety climate, ethical climate, and team climate, each of which reflects a different referent or domain (Maffoni et al., 2021; Ouwens et al., 2008; Zohar et al., 2007).

Theoretical Frameworks Explaining the Relationship Between Leadership and Organizational Climate

Organizational Climate Theory posits that leaders constitute the primary source of signals regarding which organizational practices receive recognition and support. Through their everyday behaviors, leaders shape employees' shared perceptions of the work environment (Schneider et al., 2013). From this perspective, leaders act as custodians of organizational norms by filtering and reinterpreting institutional policies within their respective units (Zohar & Luria, 2010).

Social Exchange Theory, in turn, proposes that employees respond reciprocally when they perceive fair treatment, organizational support, and consideration. Such reciprocity manifests through greater trust, commitment, and more favorable perceptions of the work environment (Eisenberger et al., 1986). This theoretical framework helps explain why ethical, supportive, and servant leadership can foster a more favorable organizational climate.

The Job Demands–Resources (JD-R) Model conceptualizes leadership as a job resource that buffers the effects of job demands, reduces exhaustion, and promotes work engagement. A recent systematic review in nursing supports this interpretation (Montenegro Méndez et al., 2025). This framework proves particularly useful when the proposed causal mechanisms involve burnout, workload, or employee autonomy.

Transformational Leadership Theory represents the most widely used framework in hospital-based studies (Spinelli, 2006). It proposes that leaders inspire their followers, stimulate them intellectually, and provide individualized consideration, thereby fostering trust and satisfaction (Podsakoff et al., 1990). These leadership behaviors contribute to more favorable work environments, which subsequently influence outcomes such as patient safety and staff retention (Merrill, 2015).

Leader–Member Exchange (LMX) Theory and Psychological Safety Theory shift the analytical focus from general leadership styles to the quality of dyadic relationships between leaders and their followers and employees' perceptions of whether they can express themselves and take interpersonal risks without fear of negative consequences. These frameworks prove particularly relevant when researchers examine patient safety outcomes (Ma et al., 2021).

Finally, Implementation and Change Leadership Theory emphasizes how leadership shapes a specific climate that facilitates the adoption and implementation of evidence-based practices (Gifford et al., 2017).

A robust explanation of the relationship between leadership and organizational climate tends to integrate Organizational Climate Theory, Social Exchange Theory, and the Job Demands–Resources Model. The first explains what leaders communicate through their behaviors, namely, signals regarding organizational priorities. The second explains why employees respond to these signals through reciprocal behaviors and attitudes. The third clarifies the working conditions through which leadership effects materialize, particularly the balance between available job resources and existing demands.

Method

This study employed a narrative literature review, an approach suitable for integrating heterogeneous evidence across research designs, populations, and theoretical frameworks. We conducted the literature search in Scopus in August 2026. The search strategy combined Spanish and English terms, including liderazgo/leadership, clima organizacional/organizational climate, hospital, enfermería/nursing, mediación/mediation, and moderación/moderation.

We also searched for specific leadership styles, including transformational, servant, authentic, ethical, toxic, and laissez-faire leadership. The inclusion criteria covered: (1) empirical studies conducted in hospitals or healthcare services that examined leadership and organizational climate or related work environment constructs, such as practice environment, safety climate, and ethical climate; (2) systematic and scoping reviews addressing the topic; and (3) methodological studies examining mediation and moderation testing procedures.

We excluded studies conducted outside the healthcare sector, except for methodological contributions and studies explicitly identified as evidence from non-hospital settings. We organized the evidence thematically into five analytical domains: leadership styles, theoretical frameworks, mediators, moderators, and research designs and measurement instruments.

Results

Leadership Styles and Organizational Climate

Table 1 presents a classification of leadership styles and their associations with organizational climate in hospitals. The findings revealed consistent associations across studies for the following leadership styles: transformational, relational, laissez-faire, authoritarian, and toxic leadership.

Transformational leadership represents the most extensively studied style and demonstrates the strongest positive associations with organizational climate and work environment (Cummings et al., 2018). However, this pattern does not apply exclusively to transformational leadership. Relationship-oriented styles share a common core of support, consideration, communication, and participation, which appears to constitute the underlying active mechanism. This finding suggests that distinctions among leadership style labels may matter less than the specific behaviors leaders demonstrate within their respective units (Cummings et al., 2021).

Table 1. Leadership Styles and Their Associations with Organizational Climate in Hospitals

Leadership style	Association with organizational climate	Main evidence
Transformational	Positive: greater support, participation, and healthier work environments.	Cummings et al. (2010, 2018); Hussain & Khayat (2021); Dunham-Taylor (2000)
Relational, supportive, participative	Positive: open communication and stronger cohesion.	Malloy & Penprase (2010); Hernández-Gracia et al. (2021)
Authentic, ethical, servant	Positive, often mediated by organizational justice, psychological safety, or lower burnout.	Lee et al. (2019); She et al. (2023); Ma et al. (2021)
Paradoxical	Positive association with organizational climate in healthcare services.	Kuleyin et al. (2026)
Transactional	Mixed: positive associations in some studies, but less favorable outcomes than relationship-oriented styles in others.	Richards (2020); Specchia et al. (2021)
Laissez-faire, authoritarian, toxic	Negative: deteriorating organizational climates, higher burnout, and stronger turnover intentions.	Hossny et al. (2023); Tsapnidou et al. (2025); Cooke et al. (2026)

Source: Authors' own elaboration based on the literature reviewed.

At the opposite end of the spectrum, research on toxic leadership in nursing has expanded rapidly. Scoping reviews consistently highlight its detrimental effects on psychological well-being and staff retention (Cooke et al., 2026; Tsapnidou et al., 2025). Hossny et al. (2023) demonstrated that perceptions of organizational climate and toxic leadership behaviors independently correlate with employees' intentions to remain in their organizations.

In the Latin American context, Castillo Saavedra et al. (2019) identified an association between leadership and organizational climate among healthcare workers in a health micro-network in Peru. Hernández-Gracia et al. (2021) documented how communication problems undermine organizational climate in a Mexican public institution. Using a qualitative approach in Chilean hospitals, Ansoleaga et al. (2025) demonstrated how leadership intersects with organizational dimensions and gender inequalities in shaping employees' mental health.

Mediators of the Relationship

A recurring finding across the literature indicates that leadership rarely operates through direct effects alone. Rather, its influence unfolds through intermediate conditions embedded in everyday work practices (Table 2).

Table 2. Mediators Identified in the Relationship Between Leadership and Organizational Climate and Between Leadership and Outcomes in Hospitals

Mediator	**Proposed mechanism**	**Related theoretical framework**	**Evidence**
Organizational or safety climate (as a mediator)	Leadership shapes employees' perceptions of the work environment, which subsequently transmit its effects to safety, commitment, or staff retention.	Organizational Climate Theory	Weng et al. (2017); Liang et al. (2016)
Communication and transparency	Two-way communication fosters trust and promotes stability in organizational climate.	Organizational Climate Theory	Hernández et al. (2021); Vranas et al. (2021)
Perceived organizational support	Support from immediate supervisors translates into a broader perception of institutional support.	Social Exchange Theory	Eisenberger et al. (1986); Mrayyan (2008)
Organizational justice	Fair treatment and equitable decision-making shape employees' perceptions of the work environment.	Social Exchange Theory	She et al. (2023)
Empowerment and autonomy	Increase employees' sense of control and participation in decision-making.	JD-R Model / Transformational Leadership Theory	Choi et al. (2016); De Brún & McAuliffe (2020)
Psychological safety	Enables employees to express themselves without fear and facilitates learning.	Psychological Safety Theory	Ma et al. (2021)
Burnout	Leadership effects operate partly through the reduction or exacerbation of occupational exhaustion.	JD-R Model	Lee et al. (2019); Dai et al. (2025)
Work environment and motivation	Leadership enhances job resources and motivation, thereby improving employee well-being.	JD-R Model	Kohnen et al. (2024); Boamah et al. (2018)

Source: Authors' own elaboration based on the literature reviewed.

Two broad categories of mediators can be distinguished. Relational and justice-related mediators: communication, organizational support, justice, and trust. Social Exchange Theory provides the strongest theoretical explanation for these mechanisms, which show the closest associations with overall organizational climate. For example, She et al. (2023) demonstrated that organizational justice mediates the effect of ethical leadership on organizational silence among nursing staff.

Motivational and resource-related mediators: empowerment, autonomy, psychological safety, and burnout. The Job Demands–Resources (JD-R) Model provides a more suitable explanation for these mechanisms, which predominate when researchers examine employee well-being or retention. Choi et al. (2016) demonstrated that empowerment mediates the relationship between transformational leadership and job satisfaction. Lee et al. (2019) found that the work environment and burnout mediate the effect of authentic leadership on turnover intentions. Similarly, Dai et al. (2025) identified burnout as a mediator linking authentic leadership, organizational climate, and job satisfaction among physicians working in tertiary hospitals.

A critical issue concerns the dual role of organizational climate. In studies such as Weng et al. (2017), climate functions as a mediator between leadership and patient safety. In other studies, researchers conceptualize it as an outcome of leadership. Both positions hold theoretical merit, but they entail different analytical models. When organizational climate functions as the outcome, the proposed causal sequence follows this pattern: leadership, mechanism (e.g., organizational justice or communication), organizational climate. Conversely, when climate functions as the mediator, the sequence becomes: leadership, organizational climate, employee or patient outcomes.

Few studies explicitly justify this conceptual choice, and some incorporate variables that overlap conceptually with the dimensions of organizational climate itself, such as support, communication, and autonomy, within the same analytical model. This practice creates a risk of construct redundancy. Nearly all the empirical evidence on mediation identified in this review relies on cross-sectional designs. One notable exception involves the multicenter longitudinal study by Jing et al. (2026), which examined ethical leadership and presenteeism among nursing staff.

Moderators of the Relationship

The literature suggests that the effect of leadership on organizational climate depends more on the hospital context than on isolated leader characteristics (Table 3).

Table 3. Proposed Moderating Variables and Level of Evidence

Moderator	**Proposed effect**	**Level of evidence**
Organizational culture	A supportive culture and shared values strengthen the effect of leadership, whereas a hierarchical or rigid culture constrains it.	Suggested. Formal tests have been conducted primarily outside hospital settings (Alhadidi & Mofrad, 2026); hospital studies have mainly described culture as a contextual factor (Moreno-Domínguez et al., 2024; Mutonyi et al., 2022).
Unit level and subclimate	Unit leaders filter the hospital-wide climate. The same leadership style may produce different effects across departments.	Moderate (Mrayyan, 2008; Zohar & Luria, 2010; Zohar et al., 2007).
Hospital size	Safety leadership showed a stronger association with learning from adverse events in smaller hospitals.	One study involving a formal moderation test (Ginsburg et al., 2010).

Resources and working conditions	Excessive workloads and resource shortages constrain leaders' ability to foster a positive organizational climate.	Suggested, particularly by implementation studies (Ansheila et al., 2026; Frank et al., 2025).
Hierarchical or bureaucratic structure	Centralization limits the extent to which employees perceive supportive leadership as a facilitating factor.	Suggested (Moreno-Domínguez et al., 2024).
Consensus in leadership perceptions	When team members hold heterogeneous perceptions of their leader, leadership effects become less stable.	One multilevel study (Gatti et al., 2020).

Source: Authors' own elaboration based on the literature reviewed.

Gatti et al. (2020) found that within-team variability in perceptions of transformational leadership among head nurses correlated with lower job satisfaction. This finding suggests that the perceived level of leadership alone does not determine its effects; consistency in leadership perceptions also matters. Sociodemographic variables, such as sex, age, and length of service, appear in some studies as covariates, but researchers have yet to establish them as central moderators.

The overall assessment remains clear: moderation represents the weakest link in this body of literature. Although several factors emerge as plausible boundary conditions, few hospital-based studies formally test them through interaction terms, multigroup comparisons, or random slopes in multilevel models. Furthermore, some variables may function as either mediators or moderators, depending on the theoretical model. Psychological safety, trust, and organizational support provide examples of such dual roles. Consequently, theoretical justification should precede the selection of the statistical model (Baron & Kenny, 1986).

Research Designs and Analytical Methods

Predominant research designs. Most hospital-based studies rely on cross-sectional surveys that measure leadership, mediators, and organizational climate at a single point in time, typically using a single informant. Researchers generally conduct their analyses through regression with bootstrapping, the PROCESS macro, or structural equation modeling (SEM) (Hayes & Rockwood, 2020; Shrout & Bolger, 2002).

This research design presents two well-documented limitations. Bias in indirect effect estimation. Mediation represents a process that unfolds over time. Consequently, cross-sectional estimates of indirect effects may exhibit substantial bias relative to the underlying longitudinal process (Maxwell & Cole, 2007; Maxwell et al., 2011). Common method variance. When leadership and organizational climate measurements originate from the same questionnaire and the same informant, their associations may become inflated (Dionne et al., 2002; Podsakoff et al., 2003). More robust alternatives. Table 4 summarizes the research designs and analytical approaches recommended for each research question.

Table 4. Recommended Research Designs and Analytical Approaches According to the Research Question

Research question	Recommended design	Analytical approach	References
Does the effect of leadership operate through a mediator?	Longitudinal design with at least three waves (X, M, and Y measured at each wave).	Longitudinal SEM / cross-lagged panel models.	Cole & Maxwell (2003); Mitchell & Maxwell (2013)
Does the mediation effect have a causal interpretation?	Experimental or quasi-experimental design (e.g., leadership training intervention).	Mediation analysis in experimental trials.	Kraemer et al. (2002); Stone-Romero & Rosopa (2010); Podsakoff et al. (2026)
Does the effect vary across groups (categorical moderator)?	Multicenter study with predefined groups (e.g., type of department, public or private sector).	Multigroup SEM with prior measurement invariance testing.	Kang et al. (2022); Villarroel-Nuñez et al. (2026)
Does the effect vary according to a continuous moderator?	Cross-sectional or longitudinal design incorporating moderator measurement.	Latent interactions (LMS method) or hierarchical regression with an interaction term.	Klein & Moosbrugger (2000); Hayes & Rockwood (2020)
Do leadership and organizational climate operate at different levels?	Design involving employees nested within units and hospitals.	Multilevel SEM (MSEM) and hierarchical models with random slopes.	Preacher et al. (2010); Preacher (2011); González-Romá & Hernández (2017, 2023)
Do mediation and moderation operate simultaneously?	Multilevel design, preferably longitudinal.	Moderated mediation (PROCESS or MSEM).	Cheung (2024); Hayes & Rockwood (2020)

Source: Authors' own elaboration based on the literature reviewed.

Several methodological considerations warrant particular attention in hospital settings. When leadership refers to the head of a hospital unit and organizational climate represents a shared property, the resulting data exhibit a nested structure. Conventional hierarchical models may conflate within-group and between-group effects in multilevel mediation analysis (Zhang et al., 2009). Multilevel structural equation modeling (MSEM) allows researchers to disentangle these effects (Preacher et al., 2010). Furthermore, doubly latent approaches account for measurement error and sampling error associated with data aggregation (Morin et al., 2022).

To reduce common method bias, researchers should obtain measurements from different sources or at different time points (Dionne et al., 2002). For example, staff members could assess leadership, a separate subsample within each unit could provide data for aggregating organizational climate scores, and administrative records could supply outcome measures. Measuring each variable at a different wave (X at T1, M at T2, and Y at T3) does not, by itself, resolve the biases associated with cross-sectional mediation analysis (Mitchell & Maxwell, 2013). Indirect effects. Researchers should estimate indirect effects using bootstrap confidence intervals or confidence intervals based on the distribution of the product rather than relying on the causal steps approach (MacKinnon et al., 2004; Shrout & Bolger, 2002). Mixed-methods approaches can provide a deeper understanding of the underlying mechanisms, although researchers have rarely employed them in leadership studies (Stentz et al., 2012).

Hospital climate measurement relies primarily on multidimensional questionnaires. The most widely used instruments include:

- Nursing Work Index and its Practice Environment Scale (PES-NWI) version, which assess the nursing practice environment (Choi et al., 2004; Clarke et al., 2002; van Bogaert et al., 2009).
- Hospital Survey on Patient Safety Culture and safety climate scales, whose psychometric properties vary considerably across studies (Al Salem et al., 2018).
- Hospital Ethical Climate Survey (Maffoni et al., 2021).
- Team Climate Inventory (Ouwens et al., 2008).
- Perceived Organizational Climate Scale (Sein Myint et al., 2022).
- COMEt questionnaire, designed for hospital units (Saillour-Glénisson et al., 2016).

Within the Ibero-American context, researchers have developed locally adapted instruments for highly complex hospitals in Chile (Bustamante-Ubilla et al., 2016) and for the public healthcare sector in Cuba (Segredo Pérez et al., 2015; Segredo Pérez, 2017). Instrument selection should align with the type of climate conceptualized in the theoretical framework (general, safety, ethical, or team climate) and with the intended level of analysis.

Based on the literature synthesis, we propose an integrative model of multilevel moderated mediation (Figure 1).

The proposed model advances five hypotheses:

H1. Relationship-oriented leadership styles positively correlate with unit climate, whereas passive and destructive leadership styles negatively correlate with it.

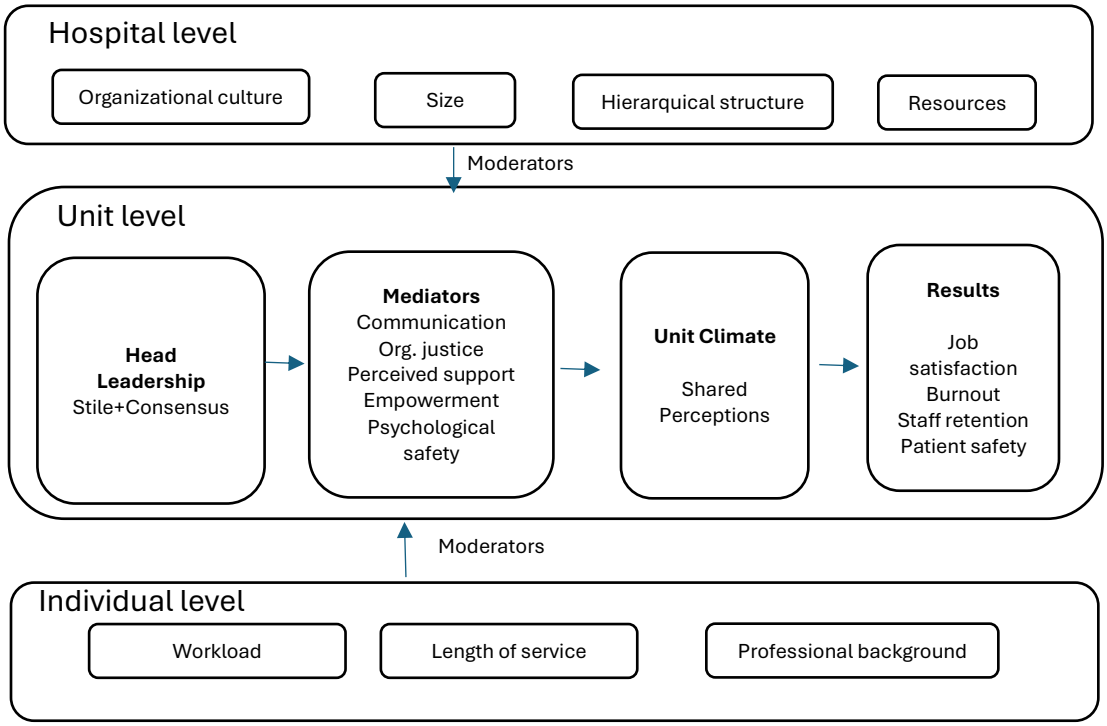
H2. This association operates through relational mechanisms (communication, organizational justice, and support) and motivational mechanisms (empowerment, psychological safety, and reduced burnout).

H3. Unit climate, in turn, mediates the effect of leadership on employee and patient outcomes, thereby establishing a serial mediation process.

H4. The indirect effect of leadership becomes stronger in supportive organizational cultures, smaller hospitals, less centralized structures, and settings with sufficient resources. This hypothesis therefore proposes a higher-level moderated mediation model.

H5. The effect of leadership becomes stronger when team members reach a higher level of consensus regarding their leader's behaviors.

Figure 1. Integrative Model of the Relationship Between Leadership and Organizational Climate in Hospitals



Discussion

This review confirms a strong consensus: people-oriented leadership correlates with more favorable organizational climates in hospitals (Cummings et al., 2018; Specchia et al., 2021). However, it also reveals that current knowledge regarding how and under what conditions this relationship unfolds remains considerably less robust.

The literature has identified an extensive range of mediators, yet researchers rarely integrate the underlying theoretical frameworks. We propose understanding this relationship as a chain of complementary mechanisms involving three theoretical perspectives. Organizational Climate Theory explains how leaders transmit signals about organizational priorities. Social Exchange Theory accounts for employees' reciprocal responses to those signals. The Job Demands–Resources (JD-R) Model clarifies the working conditions through which leadership effects materialize. Furthermore, future studies should explicitly state whether they conceptualize organizational climate as an outcome or as a mediator and avoid incorporating mediators that overlap with the dimensions of the climate measurement instrument.

The predominance of cross-sectional, single-source designs constrains causal inference. Mediation estimates derived from these designs may exhibit substantial bias (Maxwell & Cole, 2007). Moderation, in turn, has received more inferential attention than formal empirical testing. The methodological research agenda therefore remains clear: longitudinal designs involving at

least three waves; multicenter samples with employees nested within hospital units; explicit justification for aggregating organizational climate measures; separation of data sources; formal interaction tests using multigroup SEM, latent interactions, or random slopes; and, whenever feasible, evaluations of leadership development interventions incorporating mediation analyses.

The available evidence originates predominantly from Asia, the Middle East, Europe, and North America. Existing Latin American studies remain largely descriptive and correlational (Castillo Saavedra et al., 2019; Hernández-Gracia et al., 2021). Healthcare systems across the region often exhibit fragmentation, a high proportion of temporary employment arrangements, and pronounced professional hierarchies. These conditions could function precisely as the moderators identified in this review, making Latin America a particularly relevant setting in which to test them.

As this study adopts a narrative review approach, we did not apply a systematic selection protocol or conduct a formal quality assessment; consequently, selection bias cannot be ruled out. Heterogeneity in measurement instruments and conceptualizations of organizational climate also prevented us from quantifying effect magnitudes. Some proposed moderators rely on evidence from non-hospital settings or a single study and should therefore be interpreted as hypotheses requiring further empirical validation.

Conclusions

Leadership represents a consistent antecedent of organizational climate in hospitals. Its influence operates primarily through everyday working conditions, including communication, organizational justice, support, empowerment, psychological safety, and occupational exhaustion. The strength of this influence also appears to depend on the organizational context, particularly organizational culture, unit-level characteristics, hospital size, resource availability, and organizational structure.

Evidence concerning mediators remains extensive but predominantly cross-sectional, whereas research on moderators remains at an early stage. Future studies should adopt longitudinal and multilevel designs, formally test moderated mediation, and expand empirical research to Latin American hospitals. From a hospital management perspective, these findings suggest that leadership development initiatives should go hand in hand with structural changes that enable effective leadership to translate into a more favorable organizational climate.

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