On Ethical Decision-Making in Healthcare: The Tunisian Post-Revolution Context

***Fourat BEN AMOR[1], Zeineb BEN ZAKOUR[2], Hatem DELLAGI[3], Amel DAKOUMI HAMROUNI[4]**

[1]Higher Institute of Management of Sousse, University of Sousse, Sousse, Tunisia.

[2]Faculty of Economic Sciences and Management of Nabeul, University of Carthage, Nabeul, Tunisia.

[3]Faculty of Economic Sciences and Management of Tunis, University of Tunis Al-Manar, Tunis, Tunisia.

[4]College of Business Administration, Dar Al-Uloom University, Riyadh, Saudi Arabia.

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ABSTRACT

This study examines ethical decision-making among physicians within the evolving Tunisian healthcare context, marked by rising healthcare expenditures, structural transitions, and the disruptive effects of the COVID-19 pandemic. Ethical challenges in medical practice are amplified by the complexity of patient–provider interactions, the urgency of clinical decisions, and the sociocultural environment in which practitioners operate. While international literature provides extensive insights into ethics in marketing and management, empirical research focusing on medical ethics, particularly in North African contexts, remains limited. To address this gap, a qualitative exploratory study was conducted with 11 physicians representing diverse specialties, sectors, and professional backgrounds. Semi-structured interviews were analyzed through thematic content analysis to identify the variables influencing ethical decision-making. The findings reveal that medical ethics is perceived as a set of intrinsic values guiding physicians in navigating dilemmas under time-sensitive and high-stakes conditions. Two overarching categories of determinants emerged. Individual variables include academic background, experience, religiosity, personal values, socioeconomic conditions, emotional states, moral power, and all dimensions of moral intensity. Situational variables encompass professional dynamics such as peer support and interpersonal relationships, organizational resources and culture, and external influences including patients, families, social norms, and the judicial and industrial environments. Several novel factors, particularly personal values, socioeconomic pressures, organizational resource constraints, and judicial influence, highlight the specificity of the Tunisian context. The study contributes a contextualized framework for understanding ethical decision-making among healthcare providers. It offers practical implications for communication strategies, organizational leadership, and ethical governance, while emphasizing the need for future quantitative investigations to validate and extend these findings.

Keywords: Ethics, ethical decision-making, organizational environment, professional environment, external environment, healthcare transformation, medical ethics.

INTRODUCTION

Healthcare has become one of the most economically and socially significant service sectors worldwide, with direct implications for marketing theory and practice. Between 2012 and 2020, nearly one billion individuals devoted more than 10% of their household budget to healthcare expenditures, while over 300 million spent more than 25%, reflecting a substantial and growing financial burden on consumers (WHO, 2022). Globally, healthcare spending now represents approximately 10% of gross domestic product and continues to grow at a rate exceeding overall economic growth. This trend is particularly pronounced in low- and middle-income countries, where healthcare expenditures have increased at a faster pace than in high-income economies (WHO, 2019). Tunisia exemplifies this dynamic, with per capita healthcare spending rising markedly over recent years, highlighting the growing centrality of healthcare services within household consumption and national economies.

From a marketing perspective, these developments reposition healthcare not merely as a public good, but as a high-involvement, high-risk service characterized by intense interactions, strong information asymmetries, and profound ethical implications. The COVID-19 pandemic further accentuated these characteristics by disrupting service delivery systems, amplifying uncertainty, and intensifying consumers' reliance on professional judgment (Diogo & Veiga, 2022). In Tunisia, these effects were compounded by a broader post-2011 political and institutional transformation, often described as a "Healthcare Renaissance," which has reshaped public expectations, trust relationships, and value perceptions in healthcare services. This context raises fundamental questions within marketing scholarships about ethical value creation, trust, and responsibility in service exchanges. Recent research has emphasized that periods of systemic disruption influence consumer ethics and challenge the normative foundations of marketing practice (He & Harris, 2020). These challenges are particularly salient in healthcare services, which represent one of the most complex forms of service delivery due to the intensity of relational interactions, the credence nature of the service, and the asymmetry of expertise between service providers and consumers (Briscoe et al., 2012). In such contexts, ethical dilemmas frequently emerge, and their resolution depends largely on the discretionary decisions of frontline service providers, namely physicians, whose judgments directly affect service outcomes, perceived fairness, and patient trust (Tønnessen et al., 2017).

Despite the growing recognition of ethics as a central concern in marketing and management research (McDevitt, 2007; Heyler et al., 2016; He & Harris, 2020), empirical studies addressing ethical decision-making in healthcare services from a marketing perspective remain limited. Existing marketing ethics research has predominantly focused on corporate behavior, branding, or consumer responses, while largely overlooking physicians as frontline service employees embedded in complex service ecosystems. Only a small number of studies have explicitly examined ethical decision-making among physicians by conceptualizing them as providers of professional services operating under relational, organizational, and institutional constraints (e.g., Deshpande et al., 2009; Zyung et al., 2020). Yet, recent marketing scholarship increasingly calls for the development of integrative models that account for ethical behavior within service systems, particularly in high-stakes sectors such as healthcare (Abrantes et al., 2022).

Given the non-hypothetical nature of medical services, where decisions have immediate and sometimes irreversible consequences (Kreitmair, 2021), understanding ethical decision-making among physicians is critical not only from a clinical standpoint but also from a marketing and service management perspective. Ethical decisions made by physicians influence perceived service quality, relational trust, patient satisfaction, and ultimately the legitimacy of healthcare institutions. However, existing studies tend to emphasize either individual moral reasoning or abstract ethical principles, without sufficiently accounting for the interaction between individual characteristics and situational factors embedded in the service environment.

In response to these gaps, the present study aims to advance services marketing and marketing ethics research by examining ethical decision-making among physicians, who serve as frontline healthcare service providers within a complex service ecosystem. Adopting a qualitative approach, this research examines how individual characteristics, organizational conditions, and broader systemic constraints collectively influence ethical judgments and actions in clinical service encounters. Accordingly, the study addresses the following research question: How do individual, organizational, and systemic factors influence ethical decision-making among physicians as frontline healthcare service providers? By answering this question in the Tunisian healthcare context, the study contributes a context-sensitive and multilevel framework that enhances understanding of ethical value creation, trust, and professional conduct in high-stakes service environments.

From the Concept of Ethics to Ethical Decision-Making

The Concept of Ethics

To use Reverdy's (1948) terms, ethics represents "*inner aesthetics*." Numerous complementary definitions exist to ensure a better understanding of this notion. A thorough literature review has identified two main categories of definitions. The first apprehend ethics as a process. Indeed, ethics is a continuous process or reflection based on moral principles to perform actions accepted by society (World Medical Association, 2015; Costa, 1998; Gossling, 2003; Pope & Vasquez, 1998; Richard, 2011; Strike & Soltis, 1985). The second category presents

ethics based on the notion of regulation. From this perspective, ethics is treated based on its regulatory nature (Boisvert & Bégin, 2019; Boyer, 2004; Giasson, 2020). Summarizing these perspectives, it is possible to advance that ethics is an active reflection process based on regulation to determine acceptable individual and collective behaviors.

Medical Ethics

According to the World Medical Association (2015), medical ethics is primarily concerned with problems raised by the practice of medicine. It is the application of ethical reasoning to medical decision-making. The modern use of the term medical ethics dates back to 1803 with Thomas Percival's introduction of a document describing the requirements and expectations of health professionals within medical establishments. It was based on his thoughts that the code of ethics was adopted in 1847. Subsequently, medical ethics materialized by universal codes and declarations, notably the Nuremberg Code in 1946. In practice, medical ethics is a critical reflection on "norms or values, good or bad, and what should or should not be done in the context of medical practice" (Gillon, 1985). More precisely, it aims to resolve conflicts between values, law, and concurrent obligations (Ben Amor, 2015).

Ethical Decision-Making

While general and medical ethics are foundational, the process of ethical decision-making is crucial, defined as "the process by which individuals determine whether an action is right or wrong based on their moral references" (Carlson et al., 2009). Traditional literature frames ethical decision-making as a combination of individual moral development (Rest, 1986), moral intensity components (Jones, 1991), and situational factors (Ferrell & Gresham, 1985; Hunt & Vitell, 1986). These traditional cognitive rational models viewed decision-making as conscious and controlled.

However, recent developments in literature have significantly expanded this view. Researchers have increasingly integrated unconscious and uncontrolled variables, such as emotions and affect, into the ethical decision-making process (Heyler et al., 2016; Li et al., 2020). The post-2020 healthcare landscape, profoundly shaped by the COVID-19 pandemic, has introduced new layers of complexity. The pandemic forced physicians to navigate unprecedented ethical dilemmas regarding resource allocation, triage, and duty of care under risk, often in environments characterized by high moral distress.

A critical emerging factor in this modern context is the dynamic of trust and communication between provider and patient. Recent research highlights that the patient-physician relationship is foundational to ethical outcomes. Trust is a pivotal element in how patients perceive communication and its influence on ethical decision-making (Ben Amor et al., 2025a). Effective communication is not merely a clinical tool but an ethical imperative that shapes the trust necessary for shared decision-making (Ben Amor et al., 2025a). Furthermore, the cultural and religious context cannot be overlooked, especially in the MENA region. The interplay between religious beliefs and market/service interactions is profound. In their extensive review, Religious underpinnings significantly influence consumer (patient) expectations and provider behaviors. This suggests that ethical decision-making in the Tunisian context must account for these deep-seated cultural and religious variables (Ben Amor et al., 2025b).

Additionally, the organizational climate has been identified as a determinant factor. Silverman et al. (2022) emphasize that the ethical decision-making climate within healthcare institutions directly correlates with moral distress levels among professionals. When the organizational environment supports ethical deliberation, physicians are better equipped to handle high-intensity moral situations.

Consequently, the variables influencing ethical decision-making can be categorized into:

- **Individual variables:** Individual profile (McDevitt et al., 2007; Abrantes et al., 2022), moral intensity (Jones, 1991), moral power (Heyler et al., 2016), and emotions (Li et al., 2020).
- **Situational variables:** Organizational environment (Treviño et al., 2003; Silverman et al., 2022), professional environment (Treviño, 1986), and external environment (McDevitt, 2007; Ben Amor et al., 2025b).

RESEARCH METHODOLOGY

This study seeks to develop an understanding of ethical decision-making among Tunisian medical service providers. In other words, we aim to identify both the individual and situational variables involved in physicians' ethical decision-making, which are therefore essential to the process of ethical deliberation.

To achieve this, an exploratory qualitative study was conducted using individual semi-structured interviews with physicians, following an interview guide provided in the appendix. This methodological choice appeared most appropriate, as this type of interview allows direct contact with the interviewee, leading to a deeper understanding of their experience. Moreover, it provides access to explanations deeply embedded in participants' minds—elements that are rarely expressed in group settings or through standard questionnaires (Auger-Aubin et al., 2021). Semi-structured questions also make it possible to organize respondents' thoughts thematically while offering flexibility in their answers, enabling them to express their values, beliefs, representations, and underlying convictions. As noted by Quivy and Campenhoudt (1995), "the semi-structured interview is neither completely open nor strictly controlled by numerous precise questions. A grid of themes is used, with relatively open guiding questions." To test the interview guide and ensure more effective management of the interviews, a pre-test was conducted with a resident, a physician, and a clinical research associate. This pre-test allowed us to identify and correct imperfections by adding, removing, or modifying questions.

Since the purpose of qualitative research is to ensure richness, depth, and content quality rather than a statistically representative sample, the physicians were selected to maximize diversity in gender, age, sector, and specialty. The final sample consists of 11 physicians, whose characteristics appear in Table 1. The number of interviewees followed the saturation principle, whereby data collection ends once new information ceases to emerge and responses become repetitive. Interview durations ranged from 43 minutes to 1 hour and 20 minutes. Ethical standards regarding confidentiality and the use of personal data were strictly observed.

All interviews were transcribed manually and automatically using AI-based transcription software to optimize the transcription process and minimize human error.

Table 1: Characteristics of the Sample

Interview	Age	Experience	Specialty	Establishment
In1	30	7 years	Ophthalmologist	Private
In2	25	1 year	Radiologist	Public
In3	48	18 years	Dentist	Public
In4	49	24 years	Forensic Doctor	Public
In5	68	40 years	Dentist	Private
In6	82	33 years	General Practitioner	Public
In7	60	17 years	Physiologist	Public
In8	51	5 years	Intensive Care	Private
In9	30	5 years	Intensive Care	Public
In10	30	5 years	Ophthalmologist	Public
In11	30	5 years	Cardiovascular Surgeon	Public

RESULTS ANALYSIS

This study examined how Tunisian physicians perceive and navigate ethical decision-making in clinical practice. The thematic analysis revealed four overarching domains: conceptualizations of medical ethics, ethical dilemmas encountered in clinical settings, individual determinants influencing ethical decisions, and situational determinants shaping their reasoning and actions.

Participants expressed diverse and sometimes conflicting interpretations of what constitutes medical ethics. For some, ethics reflected a set of professional virtues that guide the physician's moral character and interactions with patients. As one participant explained, "Ethics means respecting the patient and being human above all" (R1). Others adopted a more normative perspective, viewing ethics through the lens of legal and deontological

compliance—"We follow the code… We must do what the law and the deontology require" (R7). A third group conceptualized ethics as a contextual and dynamic reasoning process that depends on the particularities of each clinical situation, noting that "Ethics depends on each situation; you have to think quickly according to the context" (R12). Overall, these perspectives indicate that ethical decision-making relies heavily on rapid, context-driven judgment rather than on the application of abstract principles.

Physicians described a wide range of ethical dilemmas that recur in daily medical practice. Decisions related to the limitation or withdrawal of futile care were described as particularly distressing, with one respondent stating, "There are cases where we know that prolonging care is useless. It is very difficult" (R4). Medication shortages further complicated ethical practice, leading some physicians to make improvised decisions they considered morally problematic, as reflected in the statement, "Sometimes we do not have the medication… We have to improvise, and that is not ethical" (R15). Systemic pressure and patient flow, especially in emergency settings, created ethically charged environments in which rapid decisions were often unavoidable: "We work under pressure… you must make a quick decision even if it is not the most ethical one" (R18). Communication challenges were also evident, with several physicians acknowledging that time constraints often prevented adequate dialogue with patients: "We do not always have the time to explain. It is not ideal but it is the reality" (R22). Maintaining confidentiality was another difficulty, particularly in crowded or resource-limited settings, where "Medical secrecy is difficult to respect when everyone wants to know" (R29). Additional tensions arose from interactions with pharmaceutical companies—"Pharmaceutical companies sometimes push… We must remain vigilant not to deviate" (R17)—as well as from dealing with vulnerable patients who heightened the emotional burden of decisions: "When the patient is vulnerable, the decision becomes morally heavier" (R35).

Individual determinants also played a central role in shaping ethical decision-making. Participants noted that academic training and clinical experience mattered, but many emphasized the role of personal upbringing and family values, as illustrated by the statement, "Training matters, but it is mostly the values you received at home" (R11). Socioeconomic conditions were also cited as influencing ethical behaviour, sometimes in subtle and unintended ways: "The living conditions of the doctor matter… sometimes we are influenced despite ourselves" (R31). Emotional experiences—including fear, empathy, stress, and frustration—significantly affected physicians' ethical sensitivity and judgement. One respondent noted, "The fear of making a mistake greatly influences our choices" (R20). Moral intensity further conditioned their decisions, as severe consequences prompted more cautious deliberation, expressed in the statement, "When the consequences are serious, you weigh every word and every gesture" (R14). Moral power, or the perceived ability to act autonomously, also varied with seniority, with younger physicians reporting limited authority to implement the decisions they deemed ethically appropriate: "When you are young, you do not always have the power to do what you think is right" (R26).

Finally, situational determinants significantly shaped ethical decision-making. Organizational constraints—including limited resources, inadequate workflows, and weak administrative structures—were frequently cited as barriers, with one respondent noting, "The problem is not the willingness, it is the organization that blocks us" (R33). External environmental factors such as health policies, insurance procedures, and market shortages imposed additional limits on physicians' ethical options, as reflected in the remark, "Reimbursement rules complicate everything… this affects our decisions" (R24). Professional norms and hierarchical structures also had a strong influence, particularly in settings where decisions were shaped by senior physicians' preferences, sometimes overriding individual ethical judgment. As one participant reported, "Sometimes we think differently, but we follow the head of the department" (R8).

DISCUSSION OF RESULTS

This study contributes to the marketing literature by conceptualizing ethical decision-making in healthcare services as a multilevel process shaped by the interaction of individual, organizational, and sociocultural determinants. While ethical decision-making has been widely examined in marketing and business contexts, particularly in relation to consumer trust, service quality, and professional conduct, empirical insights from healthcare services in emerging economies remain limited. By focusing on physicians as frontline service providers, this research extends services marketing theory by demonstrating how ethical behavior is co-produced under conditions of emotional labor, organizational constraints, and systemic pressures.

At the individual level, the findings highlight the role of personal values, professional experience, emotions, and perceived moral autonomy in shaping ethical judgments. These results align with marketing ethics research emphasizing moral philosophy, individual values, and ethical sensitivity as antecedents of ethical decision-making (Hunt & Vitell, 1986; Ferrell et al., 2019). The strong influence of emotions such as stress, fear, and empathy supports recent work in services marketing that positions frontline employees' emotional labor as a critical driver of ethical and service-related outcomes (Bolton et al., 2018). In healthcare marketing, where service encounters are high in credence attributes and emotional intensity, ethical decisions become inseparable from relational and experiential dimensions of service delivery.

However, individual ethical intentions were frequently constrained by organizational-level factors, including time pressure, resource scarcity, performance demands, and hierarchical structures. This finding resonates with marketing studies showing that organizational culture, control systems, and managerial pressure significantly shape ethical behavior among service employees (Trevino et al., 2014). In highly institutionalized service contexts such as healthcare, organizational constraints not only limit available choices but also redefine what is perceived as ethically acceptable behavior. Junior physicians' reduced moral power mirrors findings in services marketing where role ambiguity and power asymmetry weaken employees' capacity to enact ethical service behaviors, even when ethical awareness is high.

At the sociocultural and systemic level, national health policies, reimbursement mechanisms, and medication availability influenced service delivery decisions and ethical trade-offs. From a marketing perspective, these macro-level factors shape the service ecosystem in which value is created and delivered. Recent service-dominant logic literature emphasizes that value co-creation is embedded within institutional arrangements and resource integration mechanisms that extend beyond firm-level control (Vargo & Lusch, 2016). The ethical dilemmas identified in this study—particularly those related to access, fairness, and transparency—reflect tensions within the healthcare service ecosystem, where institutional constraints directly affect perceived service equity and trust.

Crucially, the findings demonstrate that ethical dilemmas emerge most intensely at the intersection of these three levels. High moral intensity situations—such as caring for vulnerable patients under severe time and resource constraints—simultaneously increased ethical sensitivity while reducing ethical agency. This interaction helps explain inconsistencies observed in marketing ethics research between ethical intentions and actual behavior (Ferrell et al., 2019). In healthcare services, where consumers rely heavily on professional expertise and trust, such discrepancies may have significant implications for perceived service quality, relational trust, and institutional legitimacy.

From a theoretical standpoint, this study advances marketing ethics research by integrating multilevel dynamics into ethical decision-making models, which have traditionally emphasized individual cognition and moral philosophy. By incorporating organizational and ecosystem-level constraints, the findings support calls for more context-sensitive and system-oriented approaches in services marketing ethics. Practically, the results suggest that improving ethical behavior in healthcare services requires interventions beyond individual ethics training. Organizational policies, leadership practices, and system-level reforms must align to support ethical service delivery and sustain consumer trust. Overall, this study positions ethical decision-making as a core component of healthcare service marketing, influencing patient trust, perceived service fairness, and relational value. Recognizing ethical decision-making as a systemic and relational process provides a more realistic and actionable foundation for both marketing theory and healthcare service management.

CONCLUSION

This study explored how physicians in Tunisia perceive and navigate ethical decision-making in clinical practice. The findings demonstrate that ethical judgment is shaped by an interplay of professional values, contextual constraints, and individual lived experiences. Physicians conceptualize ethics in diverse ways, ranging from virtue-based and deontological approaches to situational reasoning, which reflects the multidimensional nature of ethical deliberation in real clinical environments. The study also highlights several recurrent ethical dilemmas, including medication shortages, time pressures, patient vulnerability, and systemic limitations that frequently challenge the implementation of ethical principles.

Moreover, personal factors such as upbringing, clinical experience, emotional states, and socioeconomic conditions further contribute to the complexity of ethical behavior. Finally, organizational, professional, and external environments substantially influence ethical choices, often acting as structural barriers to ideal ethical practice. Overall, the findings suggest that ethical decision-making in the Tunisian healthcare context is less a function of insufficient ethical knowledge than of complex contextual realities. Enhancing ethical practice, therefore, requires a systemic approach—one that integrates institutional support, improved resource availability, organizational reforms, and sustained professional development. Strengthening interprofessional communication and promoting a culture of shared ethical responsibility may further help align clinical decisions with ethical standards.

Significantly, this study brought to light new variables: the provider's personal values, socioeconomic situation, organizational resources, the judicial system, patient/family influence, and industry influence. These results establish a new research framework for medical service providers in Tunisia. Practically, these variables can inform operational marketing, specifically communication strategies that focus on human aspects, respect for cultural specificity (Ben Amor et al., 2025b), and ethical commitment. Strategically, executive leadership should reflect a culture of ethical values (Silverman et al., 2022).

LIMITATIONS AND FUTURE RESEARCH

Despite its contributions, this study has several limitations that should be acknowledged. First, the qualitative design and sample size, although adequate for thematic saturation, limit the generalizability of the findings to all physicians in Tunisia or other healthcare systems. The perspectives reflect the experiences of the sampled practitioners and may not capture the full diversity of ethical challenges across specialties, regions, or institutional types. Second, data were based on self-reported perceptions, which may be subject to recall bias or social desirability bias, particularly given the sensitivity of ethical topics. Third, the study did not include observations of real-time clinical interactions; consequently, the analysis reflects perceived rather than directly observed ethical behavior. Fourth, although the study highlights the importance of structural and systemic factors, it does not quantitatively measure their relative impact, which limits the ability to compare the weight of individual versus contextual determinants. Finally, the research was conducted within a specific national healthcare system, and contextual specificities may limit the transferability of the findings to other sociocultural and institutional environments.

Future Research Directions

Future research could build on these findings in several ways. First, quantitative studies could assess the prevalence and relative weight of the identified determinants to provide a more precise understanding of how individual, organizational, and systemic factors shape ethical decision-making. Second, a mixed-methods design, including direct observations, ethnographic approaches, or simulated scenarios, could complement self-reported data and capture ethical decision processes as they unfold in real time. Third, comparative studies across regions or countries with differing healthcare infrastructures could help determine which ethical challenges are context-specific and which reflect universal patterns in medical practice. Fourth, further investigation into the role of emotions, moral intensity, and moral power could enrich theoretical models of clinical ethics by integrating psychological and sociocultural perspectives. Finally, intervention-based research, such as training programs, ethics rounds, or organizational policy reforms, could evaluate which strategies most effectively foster ethical behavior and support physicians in morally complex environments.

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