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Which Culture, Which Choice? Exploring Culture's Influence on Medical Entrepreneurs' Ethical Decision-Making

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ABSTRACT

In North Africa, particularly Tunisia, medical practice operates at the intersection of Arab-Islamic traditions, strong familial obligations, and a bureaucratic healthcare system. This configuration generates a distinctive ethical environment in which medical entrepreneurs must reconcile religious norms, social expectations, patient involvement, and administrative constraints. Such complexity necessitates an in-depth examination of the cultural variables that shape ethical decision-making. This study aims to explore ethical decision-making among medical entrepreneurs by analyzing the influence of culturally embedded factors. A qualitative design was adopted using semi-structured interviews with 21 medical entrepreneurs from diverse medical specialties. Purposive sampling ensured variation in gender, age, specialty, and professional experience. Data were analyzed through reflexive thematic analysis using NVivo 10, following an interpretivist paradigm that enabled the progressive construction of meaning based on participants' narratives. The findings indicate that ethical decision-making is strongly anchored in the Tunisian socio-cultural context. Family background emerged as a central moral reference guiding professional behavior. Ethical practice was found to be culturally relative, challenging universalist ethical models, while religious faith functioned as a system of metaphysical accountability. Additionally, socio-economic precarity was identified as a structural factor that can undermine professional integrity. Ethical decision-making among Tunisian medical entrepreneurs is a contextualized process shaped by the interaction of familial, religious, and socioeconomic factors alongside universal ethical principles. These results highlight the need for culturally sensitive ethical frameworks adapted to resource-constrained healthcare environments.

INTRODUCTION

Ethical decision-making in medicine is often guided by established theoretical frameworks, principles such as autonomy, beneficence, non-maleficence and justice. (Beauchamp & Childress, 2019) or Virtue Ethics. However, the applicability of these predominantly Western models in non-Western, collectivist societies remains contentious. Critics argue that the emphasis on individual autonomy, a cornerstone of Principism, often clashes with communitarian and family-centered values prevalent in many Asian, African, and Middle Eastern cultures (Chattopadhyay & De Vries, 2013; Myser, 2003). In North Africa, and Tunisia specifically, medical practice is situated at the crossroads of Arab-Islamic traditions, strong familial obligations, and a legacy of French-inspired medical bureaucracy. This creates a unique ethical milieu where a physician's decision must navigate religious directives, family expectations regarding truth-telling and patient involvement, and a rigid administrative system. The post-revolutionary period, characterized by political instability and the weakening of public institutions, further compounded by the COVID-19 pandemic, has intensified these ethical challenges. Physicians are increasingly caught between universal ethical principles and the stark realities of local cultural norms and severe resource constraints.

This dissonance creates a significant 'theory-practice' gap that standard ethical models fail to address adequately. While the variables influencing ethical decision-making are well-documented in stable, high-resource contexts (Ford & Richardson, 1994; Rest, 1986), they are poorly understood in environments of chronic crisis and rich cultural pluralism. Therefore, this study moves beyond simply applying existing frameworks to instead investigate the emergent, ground-up variables that inform ethical decisions for Tunisian physician entrepreneurs. The objective is to investigate culturally sensitive variables that reflect the unique moral landscape of the North African context, responding to the urgent need for context-specific ethical analysis in global bioethics.

Recent research has increasingly recognized the importance of cultural context in ethical decision-making processes. Studies in the Middle East and North Africa (MENA) region have highlighted unique cultural factors that influence healthcare delivery and ethical reasoning (Habib et al., 2021; Ben Amor *et al.*, 2025b; Ben Amor *et al.*, 2026). These factors include family involvement in medical decisions, religious considerations, and collectivist cultural values that may differ significantly from Western bioethical frameworks.

Despite the growing importance of ethics in research and practice (Molterer *et al.*, 2020;) and its increasing

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interest among marketing and management researchers (McDevitt et al., 2007; Heyler *et al.*, 2016), marketing and management studies addressing ethics in the healthcare sector generally, and among medical entrepreneurs particularly, remain limited. Recent systematic reviews have identified the need for more comprehensive ethical decision-making models that account for cultural and contextual factors (Georgieva *et al.*, 2024; Wiisak *et al.*, 2024; Ben Amor *et al.*, 2025b;).

Through this research, we attempt to fill a knowledge gap regarding ethical decision-making phenomena, particularly in the case of Tunisian medical entrepreneurs, by investigating cultural factors that may influence their ethical decisions. We tend to examine variables related to the environment in which entrepreneurial physicians operate. This study aims to establish a new research framework based on medical care service providers and their cultural environment.

By adopting both a general approach and addressing a previously understudied cultural context, this work like other researchers, highlights the necessity of universal ethical standards while respecting local beliefs and practices (Benatar, 2002; Tangwa, 2004; Grol-Prokopczyk, 2013). Furthermore, we seek to highlight applicable contributions for medical service providers by identifying variables that may affect their ethical decisions within healthcare institutions. The central research question guiding this study is: What are the cultural themes related to ethical decision-making among medical entrepreneurs?

LITERATURE REVIEW

Defining Ethical Decision-Making

Ethical decision-making is an essential aspect of human behavior, which can influence actions across different fields. It involves systematically evaluating different action possibilities and taking the most suitable one that aligns with the individual's moral principles and values (Yeager, 2015; Devlin & Magill, 2006). This process involves assessing the potential consequences of each choice, considering the impact on different stakeholders, and following certain established ethical standards (Garrido & Nunes, 2026). The complexity of ethical decision-making arises from the need to balance different values that conflict with other interests, which results in uncertain outcomes. Understanding the nuances of ethical decision-making is crucial for promoting responsible conduct and mitigating potential harm in personal, professional, and societal contexts.

The significance of context cannot be overstated in ethical evaluations, as it profoundly shapes perceptions of what is considered right or wrong (Hall & Hall, 2004). Ethical judgment is not made in isolation but is instead influenced by a multitude of factors, including cultural norms (Graham *et al.*, 2016; Wright *et al.*, 1997), social expectations (Sims & Keon, 2000), and situational constraints (Haines & Leonard, 2007). What may be deemed ethical in one context could be viewed as unethical in another, highlighting the importance of considering the specific circumstances surrounding a decision. For instance, business practices that are acceptable in one country may be considered corrupt or exploitative in another, underscoring the need for cultural sensitivity and ethical awareness in global interactions.

Ethical decision-making is a multifaceted phenomenon that operates at multiple levels, encompassing individual, organizational, and societal dimensions (Beu *et al.*, 2003). At the individual level, ethical decisions are influenced by personal values, moral reasoning, and cognitive biases (Fritzsche, 1995). At the organizational level, ethical considerations are shaped by corporate culture, leadership practices, and regulatory frameworks (Davey, 2013). At the societal level, ethical norms are influenced by legal systems, social institutions, and public discourse (Steinberg, 2020). The interplay between these different levels adds complexity to ethical decision-making, requiring a holistic approach that considers the broader implications of individual choices and organizational policies.

Importance of Cultural Context

Culture exerts a profound influence on ethical perceptions and behaviors, shaping the moral frameworks that guide individual and collective actions (Vitell *et al.*, 1993) . Cultural values, beliefs, and norms provide the foundation for ethical judgments, influencing how individuals perceive ethical dilemmas and determine appropriate courses of action (Wright *et al.*, 1997) . These cultural influences are often deeply ingrained and operate at a subconscious level, making it essential to understand the cultural context in which ethical decisions are made.

Cross-cultural studies have consistently revealed significant variations in ethical standards across different societies, highlighting the importance of cultural context in shaping ethical norms (Machery *et al.*, 2005; Wines & Napier, 1992; Graham *et al.*, 2016) . These variations can be observed in areas such as business ethics, medical ethics, and environmental ethics, reflecting the diverse cultural values and priorities that underpin ethical judgments. For instance, attitudes toward bribery, corruption, and nepotism can vary widely across cultures, reflecting differences in social norms and institutional practices (Gelbrich *et al.*, 2016). Similarly, approaches to end-of-life care, patient autonomy, and reproductive rights can differ significantly across cultures (Blank, 2011; Werth *et al.*, 2002).

Understanding cultural nuances is crucial for effective ethical decision-making, particularly in today's increasingly interconnected and globalized world. As businesses expand into new markets and organizations operate across borders, it becomes essential to navigate diverse cultural landscapes and adapt ethical practices to local contexts. This requires developing cultural competence, which involves understanding and respecting different cultural values, norms, and perspectives. It also requires adapting ethical frameworks and decision-making

processes to account for cultural differences, promoting ethical conduct that is both culturally sensitive and globally responsible.

The Influence of Cultural Variables on Ethical Decision-Making

Ethical decision-making is not a universal process derived from a single set of immutable principles. Rather, it is profoundly shaped by the cultural context in which individuals and organizations operate (Beekun *et al.*, 2005). The literature has provided certain knowledge of different cultural factors influencing ethical decision-making. More precisely, religion (Weaver & Agle, 2002; Vitell *et al.*, 2006), collectivism and individualism, and power distance (Hofstede, 2001), validate their significant impact on influencing ethical norms and behaviors.

Religion serves as a foundational bedrock for ethical systems in many cultures, providing a comprehensive framework that distinguishes right from wrong and prescribes morally acceptable conduct (Weaver & Agle, 2002). Its influence is multifaceted, nurturing personal values, social norms, and institutional practices. Different religious traditions emphasize distinct moral priorities; some may foreground compassion and empathy, while others prioritize justice, fairness, or duty. These varying emphases lead to divergent ethical perspectives and decision-making processes (Vitell *et al.*, 2006). For instance, a religious injunction against usury directly influences financial ethics (Jafri & Margolis, 1999), while several teachings on social responsibility and charity shape attitudes toward philanthropy and corporate citizenship (Brammer *et al.*, 2005). Consequently, religion offers guidance on a wide range of issues (Ben Amor *et al.*, 2025a), from mandates for honesty and integrity in business transactions to imperatives for environmental stewardship.

A second critical cultural variable is the dichotomy between collectivism and individualism. This dimension fundamentally dictates whether an individual's primary ethical responsibility is to the group or to the self (Hofstede, 2001). In collectivist cultures, group harmony, social cohesion, and responsibility to the community are paramount. Individuals define themselves through their group affiliations and are encouraged to make ethical choices that benefit the collective whole, even at a personal cost. Ethical considerations thus revolve around maintaining social harmony, fulfilling obligations, and avoiding actions that cause the group to lose face. In stark contrast, individualistic cultures emphasize personal autonomy, individual rights, and self-reliance. Ethical decisions are often guided by principles that protect individual freedoms, promote personal achievement, and ensure fair competition (Oyserman *et al.*, 2002).

Finally, power distance is defined by the degree to which less powerful members of a society accept and expect unequal power distribution. This variable may exert an influence on ethical judgment (Hofstede, 2001). In high power distance cultures, hierarchical structures are accepted, and authority figures are accorded significant esteem. Ethical decision-making is often guided by obedience to superiors and compliance with established rules and norms. Questioning authority is considered unethical, and the primary ethical concern is to maintain order and respect within the hierarchy (Vitell *et al.*, 1993). Conversely, low power distance cultures promote egalitarianism and are more likely to challenge authority. Ethical judgments are made more independently, with an emphasis on critical thinking, transparency, and accountability. In such cultures, an ethical obligation may be felt to whistleblow or question a superior's directive if it conflicts with the individual's morals. Underpinning these dimensions are deeply ingrained social norms and traditions, which provide the unwritten rules that govern acceptable conduct and create perceptions of right and wrong within a specific cultural context.

MATERIALS AND METHODS

This study employed a qualitative research design, guided by an interpretivist approach, to explore the lived experiences and ethical decision-making processes of physician-entrepreneurs in Tunisia. The following sections detail the philosophical underpinnings, ethical considerations, participant selection, data collection procedures, and analytical strategies employed to ensure the rigor and trustworthiness of the research.

Research Design and Philosophical Positioning

This research is grounded in an interpretivist epistemology, which posits that reality is socially constructed and must be understood through the subjective meanings individuals assign to their experiences (Scotland, 2012; Thanh & Thanh, 2015). Given that ethical values are shaped by societal and personal contexts (Ford & Richardson, 2013; Craft, 2013), an interpretivist stance is appropriate for investigating how physicians interpret and navigate ethical dilemmas within their entrepreneurial practices.

A qualitative methodology was selected as it facilitates a deep, contextual understanding of complex, poorly understood phenomena (Creswell & Poth, 2018). Specifically, semi-structured interviews were chosen to provide a flexible yet focused framework, enabling participants to articulate their experiences, value systems, and deep-seated convictions with freedom (Kallio *et al.*, 2016). This approach is effective for generating rich, narrative data directly from participants' perspectives.

Ethical Considerations

Prior to participation, all respondents received a detailed information sheet and provided informed consent. Participants were assured of their right to withdraw at any time without penalty. To ensure confidentiality, all identifying information was removed from transcripts, and participants are referred to by pseudonyms (e.g., P1, P2) throughout this paper.

Participant Selection and Recruitment

A purposive sampling strategy was used to identify participants who could provide rich, information-dense cases relevant to the research question (Palinkas *et al.*, 2015). The inclusion criteria required participants to be (a) licensed healthcare practitioners, (b) practicing in Tunisia, and (c) owners or co-owners of their private medical practice for at least five years. To ensure diversity of perspectives, we sought variation in gender, age, and medical specialties.

Initial participants were identified through professional networks. Snowball sampling was then employed, whereby initial participants were asked to refer colleagues who met the study criteria. Data collection took place between March and June 2024. Recruitment ceased once theoretical saturation was achieved, which occurred after the 21th interview. Saturation was defined as the point at which new interviews yielded no new variables or conceptual developments related to the research questions (Saunders *et al.*, 2018). The final sample consisted of 21 medical entrepreneurs, whose characteristics are presented in Table 1.

Table 1: Sample Characteristics

Participant	Gender	Field of Experience	Age
P1	M	General Medicine	38
P2	F	Dental practice owner	35
P3	M	Radiology center founder	52
P4	M	Gynecology private clinic	45
P5	F	Dermatology clinic	41
P6	M	Private cardiology practice	57
P7	F	Medical laboratory owner	44
P8	M	Orthopedic clinic	49
P9	F	Pediatric clinic	39
P10	M	Ophthalmology clinic	55
P11	F	Aesthetic medicine clinic	36
P12	M	ENT private practice	48
P13	F	Pharmacy owner	54
P14	M	Psychiatry clinic	60
P15	M	Pharmacy owner	64
P16	F	Nutrition & dietetics center	33
P17	M	Urology clinic	51
P18	F	Physiotherapy center	37
P19	M	Nephrology dialysis unit	58
P20	F	Medical laboratory owner	50
P21	M	Multispecialty polyclinic	62

Note: The table presents anonymized and illustrative participant characteristics. The aim is to demonstrate sample heterogeneity rather than statistical representativeness, consistent with qualitative interpretive research principles.

Data Collection

An interview guide was developed based on a review of the literature on medical and business ethics (Craft, 2013; Ford & Richardson, 2013). The guide was structured around two main thematic areas: (a) the definition and understanding of medical ethics in private practice, and (b) the the cultural variables influencing ethical decision-making processes.

The guide was pre-tested with two medical entrepreneurs who were not part of the final sample. This process led to refinements in question wording to reduce jargon and the addition of prompts asking for specific anecdotal examples, which significantly enriched the data collected. All interviews were conducted online via the Google Meet platform and lasted between 43 and 80 minutes. With participants' consent, interviews were audio-recorded. The recordings were transcribed verbatim using a combination of automated transcription software and manual verification to ensure accuracy. The final transcripts constituted the data corpus for analysis.

Data Analysis

The data were managed and analyzed using QSR NVivo 10, employing reflexive thematic analysis in accordance with the six-phase framework proposed by Braun and Clarke (2006, 2019):

1. Familiarization with the data: The lead researcher immersed themselves in the data by repeatedly listening to recordings and reading transcripts while noting initial ideas.
2. Generating initial codes: Systematic, open coding was performed on the entire dataset using NVivo 10 software to identify salient features of the data.
3. Searching for themes: The initial codes were collated and grouped into potential themes.
4. Reviewing themes: The potential themes were checked against the coded data and the entire dataset to ensure they formed a coherent pattern.
5. Defining and naming themes: Each theme was refined and clearly defined, identifying its essence and scope.
6. Producing the report: The analysis was woven into a narrative, supported by vivid, illustrative quotes from the transcripts.

This process was iterative, with codes and themes being continuously refined. A codebook was developed and discussed among the research team to enhance consistency.

Ensuring Trustworthiness

To ensure the rigor and credibility of the findings, several strategies, aligned with the criteria of Lincoln and Guba (1985), were employed. For credibility, member checking

was conducted by sharing a summary of key findings with five participants to confirm the accuracy of our interpretations (Birt *et al.*, 2016). Moreover, dependability was maintained by documenting all analytical decisions, changes to the codebook, and meeting notes from research team discussions. Also, peer debriefing sessions were held with two qualitative research colleagues not involved in the project to challenge the authors' assumptions and interpretations to ensure confirmability.

RESULTS AND DISCUSSIONS

The thematic content analysis generated a comprehensive framework of cultural variables influencing ethical decision-making among Tunisian physicians. The findings highlight how individual, familial, and societal dimensions intersect with professional and institutional contexts, revealing both universal aspects of medical ethics and culturally specific patterns unique to the Tunisian healthcare environment. Eight key cultural themes emerged from the data.

Personal and Family Background

The analysis identified that a physician-entrepreneur's ethical framework is not formed exclusively through professional training but is profoundly rooted in pre-professional, culturally-mediated socialization. Participants consistently emphasized the enduring influence of their personal and family background, positioning early childhood upbringing as the foundational moral anchor that orients their subsequent professional conduct. This theme reveals that the family unit acts as the primary vessel for the cultural transmission of core ethical principles, which subsequently serve as a stable reference point in navigating the complex and often ambiguous ethical terrain of medical entrepreneurship.

This intergenerational transfer of values was articulated by one participant who stated, "The values and principles acquired since childhood, that is culture and childhood education; that is the most important thing" (P7). This reflection underscores that attributes such as respect, honesty, and responsibility are not merely abstract professional ideals but are first cultivated as personal virtues within the familial context. For these entrepreneurs, ethical reasoning in business is therefore an extension of a deeply ingrained personal identity, rather than a simple adherence to externally imposed codes.

This finding positions the family as a constitutive force in ethical development, preceding and informing professional ethical frameworks. It suggests that for medical entrepreneurs, especially in cultures with strong collectivist orientations, the "moral compass" is calibrated early in life. This early formation provides a resilient, internalized guide that they continually refer to when facing pressures from market forces, investor demands, or regulatory constraints, thereby making their upbringing a primary axis of ethical orientation.

Social Norms and Cultural Context

A central finding of this analysis is the assertion that ethical practice is not an absolute construct but is fundamentally situated within a specific social and cultural context. Participants articulated a clear perspective of cultural relativity, where the ethical valence of a decision is contingent upon local norms and communal expectations. This directly challenges the notion of a one-size-fits-all ethical framework in global medicine, positioning the "cultural landscape" as a powerful, context-specific determinant of what constitutes appropriate professional behavior.

This view was compellingly summarized by one participant who observed, "An ethical dilemma… the first thing is where you live, there are things that are acceptable for you but not for me. And this applies even in medicine..." (P6). This statement is crucial as it explicitly rejects the universality of medical ethics and extends the concept of cultural difference directly into the clinical and entrepreneurial realm. It signifies that entrepreneurs cannot merely transplant a business model or a technology; they must also navigate the complex translation of its ethical dimensions.

For a medical entrepreneur, this creates a defining tension: the need to reconcile their professional training (which often promotes universalist principles) with the particularistic demands of the local culture. A practice deemed ethically sound in one region may be perceived as contentious or unacceptable in another. Therefore, this theme illustrates that ethical decision-making is an exercise in cultural interpretation. The findings indicate that success and ethical integrity in the global health market require a deep sensitivity to this relational dynamic, where actions are judged not against an abstract global standard, but against the backdrop of local societal norms.

Religion and Spiritual Values

Moving beyond socially-constructed norms, the analysis revealed that for many participants, the most profound source of ethical guidance was rooted in religious faith and spiritual values. This theme delineates religion not merely as a cultural artifact but as a system of metaphysical accountability that provides an ultimate foundation for moral reasoning. Participants explicitly linked their professional conduct to divine commandments and spiritual consequences, framing their ethical duties as extending beyond human stakeholders to a higher authority. This imbues their decision-making with a sense of sacred purpose and a powerful, internalized constraint that surpasses secular professional codes.

This was vividly articulated by one participant who stated, "Religion guides us to act with mercy and fairness; as a doctor, I feel accountable not only to the patient but also to God" (P4). This concept of a dual accountability, to both the patient and a divine entity, establishes a uniquely potent ethical framework. It was further reinforced by another participant who explained, "Our faith reminds us that preserving life is sacred, so it shapes the way I make medical decisions" (P9). Here, the religious principle of the sanctity of life is not an abstract concept but a direct and practical shaper of clinical and entrepreneurial

judgment.

These accounts demonstrate that religion functions as a superordinate normative force. It provides an unwavering "moral compass" that offers clarity in ethically ambiguous situations, such as those involving profit motives, resource allocation, or innovative yet risky treatments. For the medical entrepreneur, this can create a clear boundary for innovation; a technology or business practice that conflicts with core religious tenets, regardless of its profitability or secular legality, is rendered ethically untenable. Consequently, this theme positions religious belief as a critical lens through which the very goals and methods of medical entrepreneurship are evaluated and legitimized.

Socioeconomic Factors

Complementing the influence of ideational cultural factors, our analysis identified that the material conditions of practice constitute a powerful, and often corrosive, external determinant of ethical behavior. Participants highlighted how macroeconomic instability and inadequate remuneration create an environment of structural precarity that actively tests professional integrity. This theme reveals that ethical decision-making is not conducted in an economic vacuum but is profoundly constrained by the financial vulnerabilities of the practitioner and the healthcare system itself, often pitting survival against principle.

The mechanism of this erosion was starkly illustrated by one participant's candid observation: "The physician's salary first, if the salary is low; he prescribes medications from laboratories that will reward him later..." (P7). This statement is critical as it moves beyond abstract ethical tension to describe a concrete, incentive-driven pathway to misconduct. It demonstrates how financial scarcity can create perverse allegiances, shifting a physician's fiduciary duty away from the patient and towards third-party commercial interests.

For the medical entrepreneur, this socioeconomic landscape presents a dual challenge. First, it is a contextual reality they must navigate, where corruption or kickbacks may be normalized within the local market. Second, and more profoundly, it represents a core entrepreneurial opportunity and ethical responsibility. This finding suggests that a truly ethical venture in such contexts must consciously design its business model, from physician compensation to supplier contracts, to insulate against these systemic pressures. Therefore, socioeconomic factors are not merely background noise; they are active, structural variables that must be explicitly managed to create an ecosystem where ethical decision-making is sustainable and rewarded.

Family Obligations and Responsibilities

The analysis uncovered that the physician's role is not hermetically sealed from other social identities; rather, professional boundaries are often permeable, influenced by deeply held cultural expectations around family responsibility. This theme highlights a clash of moral commitments: the duty to the patient versus the duty to one's family. In cultural contexts where familial roles are central to identity, these personal obligations can directly impinge upon professional time, focus, and judgment, creating a unique form of ethical strain that arises from competing goods, rather than obvious malfeasance.

The quotidian reality of this conflict was illustrated by a participant who provided a relatable example: "Family obligations sometimes impact work. For example, a decision can be poorly made because the doctor wants to leave early, just to pick up his children from school." (P1). This statement is significant because it moves beyond abstract principles to reveal a concrete, mundane scenario where the cultural value of familial care directly compromises the professional standard of thoroughness and undivided attention. The "poorly made" decision is not necessarily malicious but emerges from the negotiation of these competing duties.

For the medical entrepreneur, this presents a critical organizational and leadership challenge. It suggests that an ethical venture must be architecturally designed to acknowledge and accommodate these cultural realities. This could involve implementing flexible scheduling, providing adequate coverage, and fostering a culture that recognizes the legitimacy of family commitments, thereby preventing them from becoming a source of ethical compromise. Therefore, this finding underscores that ethical decision-making is not solely an individual act of will but is also a function of the organizational structures that either mitigate or exacerbate the inherent tension between an individual's multiple cultural roles.

Organizational and Institutional Culture

Extending beyond individual and societal influences, the analysis identified the organizational environment as a potent mediating factor that actively shapes ethical behavior. Participants consistently described the hospital or practice setting not as a neutral container but as a distinct socio-material ecosystem with its own norms, resources, and ethical climate. This institutional culture, variable across different settings, was reported to either enable and reinforce ethical conduct or create perverse incentives that constrain it, effectively acting as a daily moderator of the physician's agency.

The palpable difference between institutions was captured by a participant who noted, "From one hospital to another it changes, the culture differs, the means differ..." (P10). This concise observation is profoundly important; it posits that "culture" is not monolithic but exists in pluralistic, organizational forms. The coupling of "culture" with "means" (resources) is particularly acute, suggesting that ethical practice is a product of both intangible values and tangible, material enablement. A culture of cutting corners can be fostered by a lack of resources, just as a culture of excellence can be sustained

by strong leadership and adequate funding.

For the medical entrepreneur, this is perhaps the most actionable domain of ethical influence. Unlike broad societal norms or deeply personal beliefs, institutional culture is something they have significant power to design and build from the ground up. These findings mandate that ethical entrepreneurship involves the conscious architecting of an ethical organizational infrastructure, from formal codes of conduct and transparent reporting structures to resource allocation, hiring practices, and leadership modeling. Therefore, the venture itself becomes a meso-level cultural project, designed to consistently nurture the ethical decision-making of every individual within it, effectively operating as a bulwark against external pressures and internal frailties.

Community and Patient-Centered Expectations

A defining theme that emerged challenges the predominantly Western, individualistic model of patient autonomy. In its place, participants described a process of negotiated consent, where ethical decisions are co-constructed through a dynamic interplay between medical expertise, patient desires, and familial input. This reflects a profound collectivist orientation, where the individual patient is often situated within a network of relationships, and a decision is deemed ethical precisely because it incorporates this broader communal perspective.

This principle was explicitly articulated by a participant who stated, "The ethical decision is a decision based not only on the physician's reasoning or what he really wants but also on what the patient wants." (P2). While this acknowledges patient desire, the cultural context suggests "what the patient wants" is itself shaped by familial and community expectations. This moves beyond simple consent to a more complex, relational model of autonomy. The ethical act is not merely informing the patient but facilitating a consensus within the patient's relational unit.

For the medical entrepreneur, this has significant operational and design implications. It suggests that services, technologies, and business models that prioritize hyper-individualized, direct-to-consumer care may encounter cultural resistance. Instead, ethical and commercially viable ventures must design for communitarian engagement. This could involve creating platforms that facilitate family communication around health decisions, developing educational materials aimed at the entire family unit, or structuring clinical spaces to accommodate group consultations. Therefore, this finding posits that "patient-centeredness" in such a cultural context must be expanded to "community-and-patient-centeredness," making the understanding of these relational dynamics a critical component of both ethical and business success.

Professional Confidentiality in Family-Oriented Contexts

The analysis revealed a critical paradox wherein the very cultural values that foster deep community trust simultaneously create the conditions for challenging the Western bioethical principle of strict, individual patient confidentiality. Participants described operating within a system where professional boundaries are frequently softened by personal relationships, creating a complex environment where confidentiality is not a rigid rule but a fluid concept negotiated within relationships.

This tension was palpable in the account of one physician who explained, "The relationship between doctor and patient necessarily influences things… I have a patient whose relationship with him is not professional, like he is family..." (P10). This statement is profound; it illustrates how a culturally-prized, high-trust relationship ("like he is family") directly complicates the adherence to a core tenet of professional codes of conduct. The physician is caught between two competing ethical imperatives: to uphold a universal standard of confidentiality versus to honor a cultural norm of relational transparency and familial inclusion.

For the medical entrepreneur, this paradox represents a significant design and operational challenge. It suggests that a venture which inflexibly imposes a strict, Western model of data privacy may be perceived as cold, distrustful, and culturally incongruent. Conversely, one that is too lax may violate fundamental ethical principles. The solution lies in developing culturally informed frameworks for confidentiality. This could involve creating tiered consent processes that explicitly allow patients to designate which family members can receive information, developing secure digital platforms for family-involved care coordination (with patient permission), or training staff in the ethical navigation of these relational dynamics. Therefore, this finding concludes that in such contexts, confidentiality must be re-imagined not as a wall of secrecy, but as a dynamic process of authorized information sharing, designed to respect both the individual's rights and the cultural reality of the family as a unit of care.

CONCLUSION

This qualitative study set out to investigate the cultural factors that influence ethical decision-making among medical entrepreneurs in Tunisia. Our findings reveal that this process is not a straightforward application of universal ethical principles but a deeply contextualized, multi-layered negotiation. Tunisian physician-entrepreneurs navigate a complex moral landscape where their professional judgment is continuously shaped and tested by an interplay of pre-professional moral anchors, potent cultural and religious norms, and constraining socioeconomic structures. The discussion that follows interprets these findings in relation to the existing literature, highlights the theoretical and practical implications, acknowledges the study's limitations, and suggests directions for future research.

A cornerstone finding of this study is the profound influence of a physician's personal and family

background, which acts as the "primary moral anchor." This underscores that ethical frameworks are not solely acquired during professional training but are deeply embedded through early cultural socialization. This finding aligns with virtue ethics, which emphasizes character and moral education as the foundation of ethical action (Beauchamp & Childress, 2019). In the Tunisian context, a collectivist society, the family unit is the primary vessel for transmitting values such as respect, honesty, and responsibility. This creates a resilient, internalized compass that physicians rely upon when facing ambiguous ethical terrain in their entrepreneurial practice, a phenomenon less emphasized in the individualistic contexts where many Western bioethical models were developed (Hofstede, 2001; Oyserman *et al.*, 2002).

Our analysis strongly supports the notion that ethical practice is culturally relative. Participants explicitly rejected a one-size-fits-all model, asserting that the ethical valence of a decision is contingent on local norms. This finding directly challenges the predominance of principism, particularly its emphasis on individual autonomy, and resonates with critiques from global bioethics (Chattopadhyay & De Vries, 2013; Myser, 2003). The observed practices of negotiated consent and the challenges to professional confidentiality vividly illustrate this. The physician-patient relationship often expands to a physician-family-community dynamic, reflecting a collectivist orientation where autonomy is relational rather than individual. This necessitates a redefinition of "patient-centered care" in such contexts to mean "community-and-patient-centered care," a crucial consideration for both ethical theory and the design of effective healthcare services.

Beyond its role as a cultural backdrop, religious faith emerged as a potent, independent system of metaphysical accountability. For many participants, religious directives provided a superordinate normative framework that surpassed secular codes. This aligns with existing literature on the influence of religion on ethical decision-making (Weaver & Agle, 2002; Vitell *et al.*, 2006), but our study specifies its function in the medical entrepreneurial context: it imbues decisions with a sacred purpose and establishes a powerful internal constraint. The concept of dual accountability, to both the patient and a divine entity, creates a uniquely resilient ethical boundary, particularly when entrepreneurial opportunities (e.g., certain profitable procedures or business partnerships) conflict with religious tenets.

Perhaps the most stark finding is the identification of socioeconomic precarity as a critical structural factor that can actively erode professional integrity. This moves the discussion of ethics from the realm of individual virtue to the realm of profitability. The pressure of a "low revenue" creating incentives for kickbacks, as described by a participant, is a clear example of how material conditions can create perverse allegiances. This finding is consistent with studies highlighting how resource constraints challenge healthcare ethics in developing nations (Habib et al., 2021). It underscores that ethical failure cannot be understood solely as a personal moral shortfall but must also be seen as a potential consequence of a flawed system. For the medical entrepreneur, this presents both a challenge to navigate and a core ethical responsibility to design business models that insulate against these systemic pressures.

Limitations of the Study

Several limitations should be acknowledged in this study. While appropriate for qualitative research and determined by saturation principles, the sample size of 21 physicians limits statistical generalizability. Furthermore, the focus on Tunisian physician entrepreneurs may limit transferability to other cultural contexts, even within the MENA region, where cultural practices and healthcare systems may differ significantly.

Also, data collection after the COVID-19 pandemic may have influenced responses, particularly regarding organizational resources and external pressures. The findings may not fully represent ethical decision-making under normal circumstances. Moreover, a significant number of potential interviewees declined participation due to confidentiality concerns, potentially limiting the diversity of perspectives captured. medical entrepreneurs willing to discuss ethical dilemmas may differ systematically from those who declined participation. And finally, the use of Arabic and French during interviews, with subsequent translation to English for publication, may have resulted in some loss of nuance or cultural specificity in the reported findings.

Future Research Directions

Several avenues for future research emerge from this study. Large-scale quantitative studies could test the relationships between identified variables and ethical decision-making outcomes across diverse entrepreneurial healthcare settings. Nonetheless, the themes emerged from this study in this study should be tested in other MENA countries to determine its broader applicability and identify region-specific variations. However, longitudinal studies could examine how ethical decision-making variables evolve throughout medical entrepreneurs" careers, from projrct launch through business development. And finally, comparative studies across MENA countries could identify common themes and country-specific variations in ethical decision-making.

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