DOI: 10.1590/1413-81232020251.28342019

Organizational Ethics in Health Settings

Claudia Borges Paraizo (https://orcid.org/0000-0002-0089-3692) [1]
Luc Bégin (https://orcid.org/0000-0001-8339-7637) [2]

Abstract *The article aims to reinforce the importance of organizational ethics for health organizations. As a first step, organizational ethics is differentiated from other areas of applied ethics, which are mobilized by health-related ethical issues. Then, the objects of study and intervention that characterize it are presented. Finally, the article focuses on some core elements of a particularly rich and relevant organizational ethical approach.*
Key words *Organizational Ethics, Health Organizations, Health, Self-regulation, Heteroregulation*

[1] Escola Nacional de Saúde Pública Sérgio Arouca. Fiocruz. R. Leopoldo Bulhões 1480, Manguinhos. 21041-210 Rio de Janeiro RJ Brasil.
cbparaizo@gmail.com
[2] Faculté de Philosophie. Université Laval. Québec QC Canadá.

Introduction

When we associate ethics with health organizations, we often think about issues related to clinical ethics or, more broadly, to all questions, which are sometimes difficult and sensitive, regarding the beginning and the end of the life process, an instance of bioethics. As important as these issues are, they are not the only issues that are relevant in organizations. Like the others, health organizations are environments where workers live, perform variable roles (professionals, managers, administrators, office workers, support, etc.), and face challenges when coordinating the actions of these individuals. They are also forced to experience internal tensions caused by decisions that are sometimes difficult to make, such as resource allocation, service recipients or new situations that require creativity, judgment quality and reflection. These and other similar issues are the subject of study and intervention by an area of applied ethics known as "Organizational Ethics". Next, we will demonstrate the importance of Organizational Ethics for the health environment where it is already relatively well integrated with the health organizations of some countries.

Some examples illustrate initiatives carried out in Quebec and Ontario (provinces of Canada). To understand this interest in health care, it is important to identify its main characteristics and better situate it, since this is not the only domain of applied ethics that can be mobilized by health-related ethical issues. Two main elements characterize the Organizational Ethics. First, it brings to light the organizational dimension of the problems and issues on what it is asked to express itself, which will be explained in the first section of this text. Then, it is recognized by its objects of study and intervention, which are highlighted in the second section. As with many other areas of applied ethics, the objects of study and intervention are viewed by organizational ethics from a variety of approaches that do not always perfectly converge. The third and last section deals with some central elements of a rich and relevant approach.

Ethics and health care: the organizational dimension

The first of these characteristics – foregrounding the organizational dimension – may seem obvious when we talk about "organizational" ethics. However, it is important to understand the extent of this concern and the idea it carries, if one is to correctly weight the relevance of their interest in the health context.

When it comes to ethics, and more specifically related to applied ethics, it is usual to pay special attention to the relationships between individuals, or the structures of society – viewed as a whole – and their effects on individuals. In the first case, one points out about concerns that are at a "micro-level" of analysis: ethics is interested in the actors' actions, their impact on them, as well as the values, rules and norms that constitute these interactions. In the second case, about concerns that are at a "macro-level" of analysis: ethics is concerned with important social issues, such as the legitimacy of certain practices and modes of social organization, fair distribution of resources, rights and freedoms, treatment of vulnerable people, fate of animals and all that is worthy of moral consideration. However, there is another level, which can be described as "medium" or "intermediate": institutions and organizations where there are problems that cannot be satisfied by answers from the "macro" or "micro" points of view.

These distinctions can be envisioned based on the ways through which ethics can be interested in health issues, which are generally addressed by professional ethics and are a good example of the "micro" level, particularly concerned with the privileged relationship and proximity that is established between the care team – doctors, nurses, other health specialists – and the patient. In the words of French philosopher Paul Ricoeur[1], we look at the care pact that unites one and the other. At the heart of professional ethics is the issue of the conditions to be respected, so this relationship will not lead to abuse against vulnerable patients. When taking the codified form, this ethics is accompanied by peer control mechanisms, specifically aiming at respecting the rules of confidentiality and consent to care. But the ultimate reason for this ethics is always the close relationship between the actors in care providing.

At the other end of the continuum, at the macro level, we will find the considerations related to public health at the heart of the reflection and ethical intervention. The ethics will focus particularly on justice issues regarding the distribution of health care, the equitable treatment of several categories of the population, the conditions to be respected in biomedical research, etc. This is, in general, the level of politics and the major social debates on health and access to care.

Between these two levels, towards the center of this continuum, with the "micro" and "macro"

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levels at the extremes, is the "median" level of ethical concern, which is specific to institutions and organizations. In our healthcare systems, the hospital is the most obvious example of this level, but not the only one. There are health organizations in Quebec called "Local Community Service Centers" (CLSCs) that offer services focused on health prevention, rehabilitation and reintegration. The peculiarity of these places of practice is that ethical questions arise that cannot find satisfactory answers in the reflections carried out at the other two levels. In hospital settings, some of these issues will be addressed by clinical ethics, and others through organizational ethics.

For instance, clinical ethics particularly analyses the decision-making problems that may arise at the clinic, at the bedside, in daily practice. The existence of clinical ethics committees in certain hospital settings illustrates this median level. It is in fact an instituted structure that is relevant only because it responds to the needs inside an organization (here, the hospital). To leave in the hands of physicians who treat patients only decision-making issues with ethical implications would be the same as leaving entirely to the discretion of each physician the resolution of the raised questions. Can we practice some form of contention in relation to this patient? To what extent do you respect treatment demands by the family for patients unable to consent on their own? How to address the question related to the sexual needs of young patients who need lifelong hospitalization due to severe disabling conditions? It can be observed that such issues are of interest to the hospital as an organization.

Hospital administrators and managers may choose another type of effective coordination of care practices with ethical implications rather than allowing each of their physicians' full discretion on these issues. Clinical ethics committees respond, among others, to this type of need by providing a consulting and training structure, participating in the development of guidelines and policies to improve control of litigious practices, i.e., those that originate a variety of views from the diversity of concerned parties (doctors, nurses, legal advisers, patient representatives, ethicists, administrators). Therefore, these committees are organizational mechanisms designed to help resolving clinical ethical issues by which the hospital recognizes responsibility as an organization.

Although it operates at an organizational dimension, the hospital always places itself within the clinical ethics issues, which is different from organizational ethics. At the same "median" level", there are themes that go far beyond clinical ethics, and require ethical, organizational attention. The distinction may seem subtle: it is, however, significant. In the first case, an organizational dimension is added to clinical ethics, which is considered important (or not) whenever it is decided (or not) to create an organizational mechanism (the ethics committee) that allows taking this dimension into account. In the second case, ethical problems arise from the beginning as organizational problems. This is the case, for instance, of conflicts of interest that may be related to hospital administrators. These are issues of ethical concern only because these conflicts involve relationships that may affect the integrity of the organization's established contracts. The same is true with issues related to the organizational environment, employees' psychological distress, conditions that facilitate or not the ethical decision-making by employees, etc. These are ethical issues that only make sense because they are related to organizational practices.

We then observe a first characteristic of organizational ethics: situated at a "median" level of ethical concern – the level of institutions and organizations – which differs from both proximity ethics (for example, professional ethics) and global ethics, those related on issues that affect public health or the justice of health systems. Closer to clinical ethics, it focuses on its concerns about the organizational dimension of the issues it is called upon to concentrate on. In fact, it does not exist except by the reality of this dimension. Such a distinction is even more evident when one looks more closely at the second element that characterizes organizational ethics within health settings: its objects of study and intervention.

Organizational Ethics in health environments: objects of study and intervention

Some of the topics of interest to organizational ethics in healthcare settings have already been mentioned in brief. When consulting the legislation and the literature on the issue, it a wide variety of objects of study and intervention is found in this field. It has also been observed the reference to organizational ethics in this environment aimed at achieving various goals and approaches. We will return to this point in the last part of the text, when we indicate the approach that seems particularly of value to us. For now, the objects of study and intervention are speci-

fied, taking as example the Quebec reference in health institutions.

The interest in organizational ethics in the health environment began in the 1990s in the United States. In fact, a first initiative was launched by the American Hospital Association in 1992, aimed more particularly at hospital administrators as an education program. But it was really in 1995 that organizational ethics came to light in health care in this country, when the Commission for Accreditation of Healthcare Organizations decided to add organizational ethics requirements to their accreditation standards[2]. This required hospitals to adopt a code of conduct that addressed issues related to hospital admission, advertising, client billing, hospital relations with the staff and other healthcare providers, such as educational institutions. Other national accreditation bodies have followed the same path, including Canada, since the start of 2000. In Quebec, in 2011, legislation included the obligation to establish a governance committee for all administration boards of health institutions. Therefore, it imposed an organizational ethics mechanism on the organizational charts of all health care and social services institutions in the Canadian province. In addition to some tasks related to the recruitment and training of Administration Board members, the purpose of this committee is to develop governance rules for conducting the institution business, as well as an applicable code of ethics and deontology.

Predictably, when it comes to this type of document, several rules that are understood as a legal set of conducts are confirmed. Non-compliance can lead to a sanction. These rules include the following principles: impartiality when considering proposals for the Administration Board; transparency regarding the other members of this Board about obtained information; confidentiality of information; administrative loyalty and loyalty to the organization mission; prohibition of using the establishment property for their own benefit or that of third parties; prohibition of accepting or offering any type of gifts or benefits; statement declaring all interests of the members and their family members (spouse and children) that may conflict with the internal exercise of the function. Together with the ethical aspect, such codes also emphasize considerations more directly associated with ethics, as demonstrated in the following excerpt:

Article 7. Ethics refers to the values (integrity, impartiality, respect, competence and loyalty) that allow ensuring the public interest. As an administrator, this implies respect for the right to resort, among others, to judgment, honesty, responsibility, loyalty, impartiality and dialogue in the exercise of one's choices and decision-making. Ethics is therefore useful in situations of uncertainty, when there is no rule, when it is unclear or when its observation leads to undesirable consequences[3](p.6).

We will return to this difference between "ethics" and "deontology" and their implications for the approaches proposed in organizational ethics. It is worth emphasizing now that the ethical aspect of these codes refers to values – rather than rules or norms – as well as the judgment capacities of actors in problematic situations that cannot be satisfactorily solved by simply following the rules.

This legal obligation, however, only highlights one facet of the implementation of organizational ethics in Quebec hospitals. It is not limited to the administrative board considerations and the good governance of these institutions. There are several issues that are more broadly related to management and for which organizational ethics is used in a variable way[4]. These management issues are often related to the organization's management fundamentals, referring to the "Mission, Vision, Values" trio. It defines both the purpose of the organization (its purpose and its specificity), a clear picture of the future – of the plans – that guide the organization's decisions, as well as shared beliefs and preferences that contribute to the motivation of decisions and actions within the organization. It is in relation to this trio that one must think about the coherence of the decisions and actions of the organization. Organizational ethics is particularly involved in reiterating this need for coherence and stimulating the coordination of actions of the several publics of interest, so that the organization's values are updated as best as possible, in accordance with its mission.

In terms of management, there are still the so-called areas of vulnerability[5], that is, organizational conditions that weaken the organization, sometimes even threatening the accomplishment of the mission. This is the case, for instance, with public money management – in the case of public hospitals – if transactions with suppliers are not subject to appropriate monitoring and control. In this case, it is the integrity of public markets that is called into question and, consequently, the possibility of the hospital carrying out its mission to the best of its capacity.

An ethical perspective of risk analysis[6] – a characteristic of organizational ethics – focuses on the functions, organizational sectors, situa-

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tions, and several factors most associated with such vulnerabilities. From this perspective, one of the objectives of organizational ethics is to propose diagnoses for ethical risks, measures to prevent them, as well as mitigation measures, in case it is not possible to eliminate them. In a hospital, organizational ethics, from the perspective of ethical risks, also focuses on staff management (management-staff relationships, and those between staff categories) and service delivery management (transactions with of all types of customers). Management practices can also leave room for vulnerabilities that affect the achievement of the organization's mission and the updating of its values. This will be the case, for instance, where inequalities in treatment occur, where there are bad relationships between certain staffcategories[7], which are detrimental to quality services, or where economic considerations outweigh the priority that should be given to care (for instance, the readiness to release beds for clients who need more expensive care and, therefore, more profitable for the hospital). According to this same perspective, the interest is broadened for objects as varied as the development of whistleblowing policies (for instance, what rules and procedures should be adopted aiming to facilitate the reporting of irregularities) and the measures to be taken to ensure the safety of information.

It is evident that organizational ethics can be used at different levels of decisions and activities in a hospital. Both in governance and management issues from an ethical risk perspective, it helps develop guidelines and measures (policies, rules, training, processes) that aim to fulfill the organization's mission while respecting the values that ensure the integrity and quality of services expected by the institution[8].

More broadly, however, the role of ethical intervention in organizations aims to develop an organizational culture concerned with ethics, attentive to the ethical dimension of the several situations that can be produced within the hospital institution. This may seem abstract, but it is nevertheless the purpose that gives meaning to all interventions made in the organization in the name of ethics. To lose sight of this goal would be to make this a mere additional control instrument, which unfortunately happens all too often. We will return to this issue in the next section. However, it is worth emphasizing that the best practices related to ethics in health institutions are those that seek to update this objective. The Health Standards Organization (HSO)[9], a hospital accreditation body in Canada, is a good example of good practice in terms of organizational ethics in the Hamilton Health Sciences – a group of hospitals in the Toronto area – that supports a culture and environment that encourage discussions on ethics and decision-making at all levels of the organization. Systems and processes have been developed to facilitate decision-making by the staff – not just doctors – regarding ethics. The consultation service created at these hospitals seeks to enable the staff to adopt decisions, measures and behaviors that are associated with professional and organizational values during difficult decisions.

This is added to what has already been said about the ethical aspect of the ethics and deontology codes that the health institutions' administrative boards and social services of Quebec should adopt. The administrators are called upon to exercise their judgment honestly and responsibly and to be open to dialogue during the exercise of choices and decisions with an ethical dimension. This means that organizational ethics – when well understood – is not limited to a rule-making exercise aimed at imposing personal differences.

Let us now look a little further into the matter of rules, by clarifying the perspective that seems to be a priority for organizations, including health organizations.

Self-Regulation and Shared Values in Health Environments

Health organizations have the peculiarity of dealing with people's lives, although they cannot be considered organizations like others; they are service providers, they are part of a sector of economic activity and incorporate some specific characteristics, and therefore, the ethical principles cited in the first part of this article are required. Organizational ethics encourages overcoming the limits of individuality in favor of the collective dimension, in which each worker is responsible for their practice, making each one of them to participate in the process (working autonomously and with the belonging of their activity).

The several forms of regulation: law, norm, deontology, clinical ethics and ethics, have a complementary role and act as instruments for the development and understanding of the existing ethical relationships in this context. Ethics are always associated with other regulatory forms, showing self-regulatory characteristics[10],

which demands a difficult and constant work of self-control, in order to ensure that the consequences of our actions cannot harm others or the collectivities. This concept of self-regulation is exposed throughout this text. For the moment, it is emphasized that the desirable ethical development to generate an organizational transformation depends on the joint action of normative and ethical applications, so that the plurality and the existence of a reflective environment open to contemporary organizational changes can be disclosed.

The challenges that exist in the health environment demand a permanent look at daily practices and, therefore, the regulations depend on the understanding and recognition that daily life occurs through the interactions, constructions and deconstructions of social associations. Therefore, the coexistence, complementarity and the need for such regulatory practices are emphasized, enabling these practices to be permanently, dynamically and continuously updated.

In Brazil, health practices are conducted with well-defined normative bases. As an example, we mention the deontological codes of professionals who are part of the institutional framework and the standardization of good hospital practices, which seek excellence from certifications that define the existing relationships between organization, customers, suppliers and society. Such normative pictures establish that everyone should act in accordance with the internal norms and policies of the organization, detaining the function of the general set up of behaviors and aiming at guaranteeing the collective order of predictable characteristics.

George Legault[11] differentiates the rule that manifests a "duty" or an "obligation" from an axiological one, which expresses the sharing of values, of which the first is a prescriptive one. The association of established approaches based on rules and values is reinforced by the *Organisation for Economic Co-operation and Development* – OECD[12] as fundamental. The first emphasizes the importance of external controls on the behavior of professionals; the one based on values is supported by the supervision of "internal" control, as it is exercised by the professional over themselves. It aims to stimulate the understanding of values and their applications in daily life, as well as improve the skills in the field of deontological-decision-making[12].

The heteronomous, heteroregulatory behavior, that is, the one that is determined by the norm or by a law, aims at the application of principles and standards imposed on social groups to promote the relationships in the organization. According to Campeau and Jutras[13]:

The updating of ethics, in its heteroregulatory conception, falls under the fulfillment of principles or norms. The behavior adopted by the individual, the action they choose, is a response to a directive from an external authority. This authority guides the individual's conduct by imposing certain limits[13].

Organizational autonomy is based on the reflexive conception of ethics, in which the freedom of judgment of the actors and the dialogue between them regarding issues related to the meaning and purpose of the practices, are valued. New organizational and management forms point to more flexible work processes in which each participant must have autonomy and responsibility for their choices and decisions. For that, it is envisioned that administrative challenges may carry with them the theoretical and methodological need, as well as ethics and politics, as integral parts of the coping with contemporary manifestations and demands. Having autonomy means that the workers are able to determine for themselves what they prefer to do in a specific situation, present in their activity, and generate their own priorities, as long as they do not violate the present rules and interests[14].

Each type of management has its own characteristics, but those with a stronger base directed to norms and rules, and others to values, do stand out. What is relevant in these models corresponds precisely to the guidelines and assertions that are given to ethics. Since all types of management are part of a process of permanent complexity, the distinction of such characteristics is unclear, except in their didactic form.

In an attempt to elucidate the distinction between norms and values, Harbemas[15] points out four characteristics that differentiate them, namely: a) the possibility of the action having a mandatory or teleological character, being that of a mandatory character based on the norms included in the deontological sense that "make its recipients, without exception and in equal measure, have a behavior that fulfills generalized expectations"; b) to the values, which are guided by a teleological sense, that is, they should be understood "as intersubjectively shared preferences". The values "express preferences deemed worthy of being desired in certain collectivities and can be acquired or accomplished through an action directed towards an end"[15].

In order to maintain qualified and inclusive organizational practices, one counts on the pres-

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ence of the moral commitment from all involved in the work process, of transparency mechanisms and the presence of individual and social responsibility. For this purpose, there is an incentive to share values and treatment equity, as part of the purpose of encouraging the act of "living together" in the workplace and encouraging corrective actions to give way to preventive ones, as well as the emergence of new ways of interaction, based on the reflection and unmasking of unacceptable behaviors and customs, thus enabling the change of each individual, leading them to increased respect for themselves and the collective to which they belong[7]. Such measures, based on shared values, are related to what is recognized by empowering control[16], and this refers, for instance, to making professionals recognize the significance of their work and their professions. Empowering control is also about stimulating socialization between professional groups in order to fight personal weaknesses. In a health care organization, unlike others, there is an intense need for commitment to ethical values, as they are organizations that take care of lives and, therefore, it is essential to have a permanent updating of shared values and the reflective exercise.

All organizations, including the healthcare ones, present a micro view of the company from its mission, vision and values that determine the intended purposes, which are often defined by market demands. The mission defines the organization's action focus, the vision works as a large long-term goal and the values are defined by how the company should behave in the market and in society. The presence of this triad, especially of the values in hospital centers, can promote openness towards a self-regulatory management and should never be used as a control instrument. Rather than highlighting the oppositions between the empowering ethical development of professionals and the adherence of members to the mission and organizational principles, one should reinforce the complementarity between the two, emphasizing the necessity of an interactive approach. This interactive approach is fundamentally based on learning the possibility of viewpoint plurality[17].

The described behaviors, self-regulating and heteroregulatory, can be translated by the presence of two models: that of shared values and the compliance-based one. The first are generated by the reflexive conception of ethics promoted by the appreciation of dialogue on questions related to the purposes and the meaning of the practices; in the second, based on compliance, the ethical conception is, above all, behavioral, in this case taking the form of statements of principles and rules of conduct, which are aimed at reinforcing what must be done and, consequently, what should be avoided. This model, represented by an authoritarian set of rules and welcomed by the command-control regulation is present in the top-down institutional design, where corporate initiatives start from the managers and the processes have a hierarchical structure.

Self-regulation is embodied in the moral subject's ability to act on the values about which they deliberate, favoring, above all, the dialogue. It shows a subjective responsibility that gets updated within the reflection and deliberation focused on a decision or an action that has been taken. In the health environment, there is a need for a space to get the professionals closer together and improve the collective where they are located, considering their inevitability in dealing with emergencies, and their daily coexistence with technoscience, which requires a high level of knowledge and experience. From another point of view, the discomfort generated by decision-making can be mitigated by the protection given by the norm. Therefore, ignoring the complex interactions that exist between the dimensions of actions would be failing to understand the complementarity between these two approaches. In the presence of shared values, workers are empowered to act and to commit to organizational values, as they are embedded in a rich process of pressure and decision-making.

In daily work, the autonomy determined by the self-regulation of ethics, allows the workers to become responsible for their activities and to be able to mobilize certain knowledge included in their daily practice, as well as the development of concern for others. This autonomy occurs as the emergence of competences occurs. Ethically competent workers can recognize the need to reflect on what happens in their activity and to take on a critical behavior about normativity, more specifically about values.

Currently, there is a greater demand for more flexible, team-based organizations, where each worker is responsible for the process of building and transformation. The dialogue is reinforced to the detriment of the command-control binomial, and sociotechnical interactions take place supported by relations between the environment and the worker, assuming characteristics of a complex worker-centered behavior.

Conclusion

The standards of excellence and effectiveness required by health organizations establish the need and importance of the presence of dialogical and reflective spaces, included in professional practice, allowing the opportunity for engagement, vocation and internalization of practices. In the first section, we looked at the case of Hamilton Health Sciences – a group of hospitals in the Toronto area – which is mentioned as an example of good practice and that specifically support the creation of a culture and environment that encourages discussion of ethics and decision-making at all levels of the organization. An ethical management shares, in addition to the commitment to the Law, the ethical attitude and the moral and political responsibility present in the work process, the capacity of each individual to overcome the know-how. In this condition, it should be considered that the workers know how to act in unusual situations. Every creative and creation process is triggered by reflecting on one's own practice. Therefore, it can be said that the collective included in the clinical approaches represent the strength and the differences, the challenges. Integrating organizational ethics into healthcare organizations is a way of improving these organizations, enabling them to more effectively achieve the social goals they aim for, with a more responsible and conscious view of the ethical dimension that pervades their practices and their team goals.

Collaborations

C Paraizo and L Bégin equally participated in all stages of the creation of this manuscript.

References

1. Ricoeur P. *Le juste 2*. Paris: Editions Esprit; 2001.
2. Hall RT. *Organizational Ethics in Healthcare. Encyclopedia of Bioethics* [página na Internet]. 2004 [acessado 2014 Maio 3]. Disponível em: https://www.encyclopedia.com/science/encyclopedias-almanacs-transcripts-and-maps/organizational-ethics-healthcare
3. Institut Universitaire de Cardiologie et de Pneumologie du Québec (IUCPQ). *Code d'éthique et de déontologie des administrateurs du conseil d'administration*. Québec: IUCPQ; 2018.
4. Biller-Andorno M, Lenk C, Leititis J. Ethics. EBM and hospital management. *J Med Ethics* 2004; 30:136-140.
5. Roux-Dufort C. La vulnérabilité organisationnelle à la loupe: entre fragilité et ignorance. *Télescope* 2010; 16(2):1-21.
6. Boisvert Y. Par-delà le scandale! Comprendre les vulnérabilités organisationnelles à la base des crises et trouver des stratégies pour mieux gérer les risques éthiques. *Éthique Publique* [periódico na Internet]. 2016 [acessado 2019 Maio 5]; 18(2):[cerca de 36 p.]. Disponível em: https://journals.openedition.org/ethiquepublique/2795
7. Silva DS, Gibson JL, Sibbald R, Connolly E, Singer PA. Clinical ethicists' perspectives on organisational ethics in healthcare organisations. *J Med Ethics* 2008; 34:320-323.
8. Carney M. Influence of organizational culture on quality healthcare delivery. *Int J Health Care Qual Assur* 2011; 24(7):523-539.
9. Health Standards Organisation (HSO). *Offrir des services éthiques intégrés aux plans clinique et organisationnel* [página na Internet]. 2019 [acessado 2019 Maio 15]. Disponível em: https://healthstandards.org/fr/pratique-exemplaire/offrir-des-services-ethiques-integres-aux-plans-clinique-et-organisationnel/
10. Boisvert Y. Argumentation et demonstration de ma conception autorégulatoire de l'éthique. *Ethica* 2007; 16(2):51-71.
11. Legault G.Autorégulation et hétérorégulation: un concept interdisciplinaire. *Ethica* 2007; 16(2):27-50.
12. Organisation de Coopération et de Développement Économiques (OECD), Direction de la Governance publique et du développement Territorial, Comité de la Governance Publique. *Vers un cadre pour l'intégrité solide: Instruments, processus et conditions de mise en oeuvre*. Paris: OECD; 2009.
13. Campeau L, Jutras M. Deux conceptions régulatoires de l'éthique. *Ethica* 2007; 16(2):166-193.
14. Paraizo CB. *A ética organizacional como uma perspectiva inclusiva* [tese]. Rio de Janeiro: PPGBIOS Fundação Oswaldo Cruz; 2017.
15. Habermas J. *Direito e Democracia: entre a factilidade e validade, vol. 1*. Rio de Janeiro: Tempo Brasileiro; 1997.
16. Bégin L, Langlois L. La construction d'un dispositif éthique: l'expérience d'une tension problématique. *Pyramides* [periódico na Internet]. 2011 [acessado 2018 Jul 3]; 22(2):115-136. Disponível em: http://journals.openedition.org/pyramides/907
17. Boitte P, Cobbaut JP. Pour une conduite réflexive de la recherche clinique à partir d'une conception contextuelle et pragmatique de la Bioéthique, Bioethica. *Forum* 2009; 2(2): 81-83.

Article submitted 13/04/2019
Approved 20/08/2019
Final version presented 27/09/2019