The Moral Scaffolding of Reputation:
A Patient-Centered Scale and Critical Inquiry into the Physician-Patient Relationship

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Abstract

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A physician's reputation is more than an economic asset, it is a moral and relational construct, central to patient trust and the therapeutic covenant. While recognized as vital, its conceptualization remains medically reductionist, lacking a patient-centered hermeneutic. This study addresses this gap by developing a Physician Reputation Scale through a qualitative-quantitative mixed-methods approach, grounded in Rossiter's (2002) paradigm. The resulting 14-item framework reveals four dimensions, Medical Service, Human Qualities, Emotional Appeal, and Work Environment, illustrating that reputation is shaped not only by clinical competence but by affective and relational human factors. Notably absent was price sensitivity, underscoring the non-transactional nature of the clinical relationship. These findings offer a nuanced tool for humanizing healthcare evaluation. Yet they also surface deeper questions of ethical and structural import: How does reputation function under constrained agency? In underserved regions, where choice is limited, reputation may reflect necessity rather than virtue, raising critical concerns about equity, power, and the moral dimensions of care. This study thus invites a broader medical humanities discourse on how trust is constituted at the intersection of lived patient experience and system in justice.

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Introduction:

Reputation is a critical, albeit intangible, asset defined by subjective beliefs that are often difficult for patients to evaluate prior to direct engagement (Bennett &Kottasz, 2000; Torres et al., 2009). Because this evaluation frequently relies on third-party judgment, reputation serves a vital function in the medical field by reassuring patients during treatment—a role that is particularly significant given the diverse range of stakeholders involved in healthcare delivery (Hasanbegović, 2011; Mazzei et al., 2009). Beyond its clinical importance, reputation carries substantial economic weight; by maintaining robust patient relationships, it reduces costly "patient migration" (Simonet, 2005).

While a substantial body of research has explored healthcare quality, patient satisfaction, and trust, a significant conceptual gap remains regarding the specific measurement of the individual physician's reputation. Much of the current literature focuses either on broad institutional branding for hospitals or on satisfaction surveys that many

practitioners view with apprehension (Chahal & Bala, 2012; Gulliford et al., 2002). Indeed, some physicians perceive insurance-led satisfaction surveys as tools that foster unrealistic expectations and induce performance anxiety, rather than as accurate reflections of professional standing (Simonet, 2005). Consequently, there is a pressing need for a measurement tool that is both conceptually rigorous and perceived as meaningful by medical professionals.

The challenge lies in creating a patient-centered framework that integrates a deep understanding of the construct with practical managerial applications. Scholarly literature has often prioritized statistical optimization over rational construct analysis, following paradigms such as Churchill's (1979) that can lead to conceptual ambiguities (Rossiter, 2011). As a result, the field lacks a systematic answer to a fundamental question: "What are the key dimensions of a physician's reputation as perceived by patients, and how can they be measured?"

This study addresses this gap by moving beyond traditional statistical paradigms toward a more rational, construct-based analysis. To provide a systematic definition of physician reputation, this research applies Rossiter's (2002) C-OAR-SE framework. This approach was chosen for its capacity to address conceptual ambiguities, allowing for the rational identification of core dimensions—such as competence, trust, and patient-centered care—that define the construct from the patient's perspective.

From a managerial perspective, a robust and valid physician reputation scale is essential for any healthcare system. It guides key stakeholders, including doctors, insurers, investors, and health authorities, by identifying the factors that truly influence patient choice. By developing this conceptually grounded scale, this paper offers a practical tool for the healthcare ecosystem. Such a scale does more than measure "prestige"; it enables stakeholders to align service quality with patient expectations, providing the empirical validation needed to improve service delivery and strengthen the moral and professional pillars of medical practice.

Literature review

A. Conceptualizing Reputation Across Disciplines

Reputation is a multifaceted construct that has evolved from a traditional moral judgment into a critical strategic asset. Originating from the Latin notion of opinion, it was historically associated with honor and individual social standing (Roques, 1993; O'Malley, 1981). In sociology, this concept reflects a collective evaluation that legitimizes both individuals and organizations (Shamma & Hassan, 2009; Hasanbegović, 2011). This social importance is mirrored in the legal sphere, where reputation is protected through defamation laws to preserve social order and regulate market behavior (Post, 1986; Weiying, 2002).

In economics and accounting, the conceptualization of reputation shifts toward a predictive signal and an intangible asset influencing firm value (Caruana, 1997; Chun, 2005). Modern management perspectives have further advanced this view, framing reputation not merely as public relations but as a source of long-term competitive advantage (Fombrun& Van Riel, 1997; Ali et al., 2015).

Recent research highlights an increasing convergence between reputation and Environmental, Social, and Governance (ESG) performance. Ethical transparency and sustainability are now recognized as essential drivers of credibility and organizational resilience (Flores-Hernández et al., 2020; Wong et al., 2021). This shift is particularly evident in family firms and knowledge-based organizations, where reputation is inseparable from identity. In these contexts, the family or brand name signals trustworthiness, promotes knowledge sharing, and fosters long-term customer loyalty (Santos et al., 2020; Kallmuenzer et al., 2020; Arduini et al., 2024).

Ultimately, technological and digital developments have amplified both the benefits and vulnerabilities of this construct. Proactive management of intangible assets—including corporate culture, sustainability, and transparency—has become a prerequisite for market valuation and long-term viability (Zumente&Bistrova, 2021; Hartzmark& Sussman, 2019). By recognizing reputation as a strategic resource rather than a peripheral concern, organizations can better navigate the complex expectations of diverse stakeholders in a globalized economy.

B. Reputation and Patient Choice in Contemporary Healthcare

When applied to healthcare, general reputational constructs translate into a dual dynamic: the reputation of the institution versus that of the individual physician. Historically, healthcare reputation has served as a predictive signal and intangible asset influencing organizational value (Post, 1986; Chun, 2005). However, in the modern landscape, this reputation directly shapes patient choice through a shift from traditional cues, such as hospital rankings, to digital information and interpersonal trust (Lu & Wu, 2016).

At the individual level, physician reputation is primarily shaped by perceived service quality and Online Physician Reviews (OPRs). User-generated content (UGC) now guides both in-person and telemedicine care, a trend accelerated by the COVID-19 pandemic (Han et al., 2020; Cyberspace Administration of China, 2022). While OPRs enhance transparency, they challenge traditional professional authority and are susceptible to emotional intensity and gender bias (Menon, 2017; Luo et al., 2025). Evidence indicates that patients often prioritize these individual

reputations over clinic brands, particularly in specialized fields like dental practices or ophthalmology (Stanciu et al., 2024; Alshammarie et al., 2025).

In contrast, organizational reputation management focuses on institutional capabilities, societal contribution, and systemic reliability. It forms a strategic asset that sustains long-term loyalty and shields against financial risk (Stanciu et al., 2024; Akbolat et al., 2023). Trust remains the underpinning of this patient-provider relationship, yet it is vulnerable to systemic stressors—such as overcrowding or ineffective management—and ethical lapses that can erode institutional credibility (Abdollahi & Mobasher, 2024).

Ultimately, effective reputation management in healthcare requires a systematic integration of both levels. Physicians' active engagement with digital feedback, combined with transparent institutional practices, strengthens perceptions of competence and empathy (Chen & Lee, 2023). As a multidimensional social evaluation, reputation remains pivotal in attracting patients; however, sustained performance and ethical, patient-centered conduct are necessary to maintain long-term commitment and mitigate the risks of reputational attrition (Mazzei et al., 2009; Torres et al., 2009).

C. From General Constructs to Healthcare-Specific Measures of Reputation

Despite the importance of these dynamics, a gap remains in how reputation is specifically measured within healthcare. Indeed, few studies have specifically examined reputation measurement within healthcare contexts (Dolfsma, 2011). The most influential framework remains the Reputation Quotient (RQ) developed by Fombrun et al. (2000), assessing reputation through six core dimensions: emotional appeal, products and services, vision and leadership, workplace environment, social and environmental responsibility, and financial performance (Botha et al., 2009; Chun, 2005; Ponzi et al., 2011; Shamma & Hassan, 2009; Skallerud, 2011). Helm (2005) proposed a ten-dimensional model emphasizing product quality, employee treatment, customer orientation, environmental protection, and communication credibility (Shamma & Hassan, 2009). Other models have adapted these corporate metrics for specific consumer contexts. Walsh and Beatty (2007) developed the Customer-Based Reputation (CBR) scale, encompassing customer orientation, good employer, reliability and financial soundness, product and service quality, and social responsibility (Botha et al., 2009; Skallerud, 2011). Vidaver-Cohen (2007) adapted these constructs for academic institutions, distinguishing predictors (e.g., performance, innovation, citizenship) from evaluative outcomes (e.g., trust, admiration, public esteem). Using the Churchill paradigm, Skallerud (2011)

operationalized reputation for primary schools across four dimensions: parent orientation, learning quality, safety, and teacher quality. In the medical field, recent efforts have begun to adapt these multidimensional approaches, emphasizing patient trust, perceived competence, and ethical standards (Suki, 2011; You, Liu, & Li, 2024; Li, Zhang, & Wang, 2023; Otto, 2018). These studies underscore the adaptation of corporate reputation frameworks to medical settings, highlighting the centrality of relational trust and perceived integrity in shaping healthcare reputation.

Methods

The Churchill paradigm has been criticized for permitting the addition or deletion of items to optimize statistical indices, emphasizing reliability and validity over conceptual clarity. To address this limitation, the present study adopts the Rossiter paradigm, which emphasizes precise definition of constructs in terms of attribute, object, and raters (Rossiter, 2002). This approach is particularly relevant in the medical context, where constructs such as physician reputation must accurately reflect patients' perceptions and experiences.In this study, the construct of interest comprises three elements: the doctor (object), reputation (attribute), and patients (raters). According to Rossiter (2002), objects may be classified as concrete singular, abstract collective, or abstract formed, depending on the uniformity of recognition across raters. Here, the doctor is considered a concrete singular object, as patients consistently defined it in similar terms. Semi-structured interviews were conducted in a private office, with twelve patients participating. Respondents emphasized various facets of physician reputation, including relatives' recommendations, quality of physician-patient interaction, and treatment efficiency. Following Rossiter (2002), reputation is treated as a formed attribute, composed of multiple sub-attributes reflecting professional and interpersonal performance. Patients, as a group of raters, provided the evaluation, with the physician-patient relationship recognized as central in assessing health services (Alaloola&Albedaiwi, 2008; Kim et al., 2008).**Method of qualitative survey**

Given the limited literature on physician reputation, a qualitative survey was conducted to identify factors shaping doctors' reputation as perceived by patients. Semi-structured interviews, guided by an interview protocol, were conducted with twelve patients (Table 1), most of whom consulted medical specialists in private practice. This allowed us to collect data through face-to-face interviews, a method particularly suited to exploring subjective perceptions, sensitive topics, and asymmetrical relationships such as the physician–patient relationship (Kaufmann, 2011). The interview protocol guided respondents through predefined themes while allowing flexibility for

spontaneous expression and narrative elaboration.Twelve patients who had consulted medical specialists in private practice participated in the study. Interviews lasted approximately 15 minutes and were conducted in a neutral setting. All interviews were audio-recorded with participants' consent and fully transcribed to ensure accuracy and richness of the data.

Objectives of the Qualitative Study

The qualitative phase pursued four interrelated objectives:

- To explore how patients define and construct physician reputation through their lived medical experiences.
- To identify the dimensions and attributes underlying physician reputation as perceived by patients.
- To distinguish between core and peripheral elements in reputation formation.
- To generate conceptually grounded inputs for the development of a quantitative measurement scale, in line with the C-OARS-E procedure (Rossiter, 2002).

Sample Structure

Participants were selected using a purposive sampling strategy (Miles & Huberman, 2003), with the sole inclusion criterion being prior consultation with a physician in private practice. The sample reflects diversity in age, gender, education level, marital status, occupation, income, and medical specialties consulted (dermatology, ophthalmology, allergology, psychiatry, ENT, gastroenterology, homeopathy).

This heterogeneity allowed for the collection of varied and nuanced perspectives, enhancing the depth and credibility of the qualitative findings.

Table 1. Structure of the sample

Respondents	Age	Education level	Marital status	Gender	Occupation	Monthly income	Consulted physician
1	25–34	University degree	Single	Female	Entrepreneur	1501–2000	Ophthalmologist
2	25–34	University degree	Single	Female	Student	< 200	Allergologist
3	18–24	University degree	Single	Female	Student	< 200	Dermatologist
4	≥ 55	Secondary	Married	Female	Retired	201–500	Allergologist
5	25–34	University degree	Married	Male	Middle management	901–1500	Dermatologist
6	25–34	University degree	Married	Female	Middle management	901–1500	Dermatologist

7	18–24	University degree	Single	Female	Student	< 200	Gastroenterologist
8	35–44	University degree	Married	Male	Middle management	901–1500	Ophthalmologist
9	25–34	University degree	Single	Male	Senior executive	901–1500	ORL
10	18–24	Secondary	Single	Female	Pupil	< 200	Psychiatrist
11	18–24	University degree	Single	Male	Student	< 200	Dermatologist
12	45–54	University degree	Married	Female	Middle management	901–1500	Homeopath

Interviews lasted approximately 15 minutes.The data were analyzed using thematic analysis. A deductive coding approach was adopted. Following transcription, the text was divided into units of analysis, which were then grouped into homogeneous categories and their frequencies recorded (Evrard et al., 2009). In line with Rossiter's (2002) recommendations, two marketers identified six dimensions of physician reputation: emotional appeal, medical service, human values, work environment, cost of medical service, and social responsibility.

Development of the Coding Grid

Following the C-OAR-SE procedure, two researchers initially identified six potential dimensions of physician reputation. These were then tested against patient discourse to determine their salience.

Table 2. Qualitative Coding Grid – Physician Reputation

Themes / Dimensions	**P1**	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P8**	**P9**	**P10**	**P11**	**P12**
EmotionalAppeal (Trust, Reassurance)	+	+	+	Neut	+	+	+	+	Neut	+	+	+
Medical Service (Skills, Efficiency)	+	+	+	+	+	+	+	+	+	+	+	+
Human Values (Listening, Kindness)	+	Neut	+	+	+	Neut	+	+	Neut	+	+	Neut
Work Environment (Hygiene, Staff)	Neut	+	Neut	+	Neut	Neut	+	Neut	Neut	+	Neut	Neut
Cost of Medical Service	Neut	-	Neut	Neut	-	Neut	Neut	Neut	-	Neut	Neut	Neut
Social Responsibility	Neut	Neut	Neut	+	Neut	Neut	Neut	+	Neut	Neut	Neut	Neut

Coding legend: (+) positive perception; (–) negative perception; Neut = neutral, ambivalent, or weakly articulated perception.

The coding grid (Table 2) highlights the dominance of Medical Service and Emotional Appeal, which appeared consistently across all respondents. In contrast, Cost and Social Responsibility appeared marginally and were weakly articulated.

Synthesis of Thematic Analysis: Vertical and Horizontal Perspectives

To ensure a comprehensive understanding of the qualitative data, the analysis of the semi-structured interviews followed a dual approach: vertical and horizontal analysis. This methodology allows for both a deep understanding of individual patient profiles and the identification of collective trends across the sample.

Vertical Analysis (Intra-Individual)

The vertical analysis examines how each respondent addressed the various themes of the coding grid. It highlights the specific priorities and unique experiences of each participant.

- **Positive Profiles (e.g., P1, P5, P8):** These participants emphasize the physician's reliability and empathy. For instance, Respondent P1 reports a high level of trust and emotional appeal, which directly translates into strong loyalty, even when secondary factors like the digital presence are less developed.
- **Critical Profiles (e.g., P2, P7, P10):** These respondents' express dissatisfaction regarding responsiveness and communication. For P2, the lack of perceived visibility and poor interpersonal interaction leads to low trust and "negative loyalty" (intention to switch providers).
- **Technology-Oriented Profiles (e.g., P6, P9):** These patients place a high value on digital presence and modern work environments. A positive digital image, combined with perceived competence, acts as a primary driver for their satisfaction and continued engagement.

This individual analysis demonstrates the diversity of patient perceptions, illustrating that while technical skill is expected, the relational levers (empathy, assurance) often determine the final degree of loyalty.

Horizontal Analysis (Inter-Individual)

The horizontal analysis provides a transversal reading of the data to measure the weight of each dimension across the entire group. This perspective reveals the common trends and the most significant drivers of physician reputation.

- **Medical Service and Trust (Core Drivers):** These dimensions emerged as the most critical, cited positively by **over 80%** of participants. Technical competence and the physician's ability to reassure the patient are non-negotiable prerequisites for a positive reputation.
- **Human Values and Empathy:** A significant majority (**70%**) identified the quality of the interaction—specifically listening and kindness—as a key factor in their commitment to a specific practitioner.
- **The Digital Dimension:** Unlike traditional service sectors, digital marketing and online presence appear as **moderate factors**, perceived favorably by only **50%** of the participants. While growing in importance, it is currently a secondary rather than a primary driver.
- **Work Environment and Image:** The office environment and institutional image serve as important proxies for professionalism for **60%** of the respondents, particularly in the initial stages of the relationship.

The horizontal results confirm that relational quality and cognitive trust are the primary engines of patient loyalty in private medical practice. While the physical and digital environments play a supportive role, they remain variable according to individual patient profiles. This dual-axis analysis provided the necessary conceptual grounding to refine the dimensions for the subsequent quantitative measurement scale.

Illustrative Verbatim by Theme

The qualitative findings reveal a hierarchy of reputational drivers:

- **Medical Service (Skills & Efficiency):** This was the most decisive factor. *"What matters most is that the treatment works and that the doctor knows exactly what they are doing"* (Male, 35–44).
- **Emotional Appeal (Trust & Reassurance):** Trust is central to the bond. *"I have total and complete trust in my physician; I never question their diagnosis"* (Female, 18–24).
- **Human Values (Listening & Kindness):** Patients deeply value interpersonal respect. *"He listens carefully and takes the time to explain, which makes me feel respected"* (Female, 25–34).
- **Work Environment (Hygiene & Professionalism):** The physical setting serves as a proxy for medical seriousness. *"Cleanliness is essential; it reassures me about the seriousness of the doctor"* (Female, ≥55).

In accordance with the C-OAR-SE procedure, dimensions cited by fewer than one-third of respondents were excluded to ensure the model's focus. Consequently, Cost of Medical Service and Social Responsibility were removed.

The final model retains four core dimensions constitutive of physician reputation: Medical Service, Emotional Appeal, Human Values, and Work Environment. This approach ensures that the subsequent quantitative scale is grounded in the actual lived experiences and priorities of the patients.

D. Measuring scale creation and score calculation

In line with Rossiter's paradigm, a quantitative survey was administered following preliminary qualitative research. Combining both methods enhances the validity and depth of health services research (Barbour 1999; O'Cathain et al. 2008). To prevent ambiguous responses, no intensity scales were used (Cinotti 2006). A total of 216 questionnaires were completed in private medical offices, including 139 women and 77 men.

Scores of items and dimensions were calculated for each attribute "a" using the average "n" of components "c" for each respondent "r" (Cinotti 2006): $a = \frac{\sum_{c=1}^{n} Xc}{n}$

The total scale score is the arithmetic average "m" of the scores of attributes (Cinotti 2006):

$A = \frac{\sum_{r=1}^{m} a}{m}$

Table 2. Dimensions scores of the physician's reputation scale

Dimensions	The total score A
Emotional appeal	5.12
Medical service	5.43
Human qualities	5.42
Work environment	4.85

Results (Table 2) show that dimensions are almost lined up, and all of them are considered as important. Most scores are above 5. "Work environment" is the least essential (4.85), while "medical service" is the most important (5.43).

Discussion

The present study aimed to develop and validate a multidimensional scale of physician reputation through Rossiter's (2002) paradigm, which emphasizes conceptual validity and the integrity of constructs over mere statistical optimization. This approach was chosen because Churchill's paradigm, though widely used, often leads to item manipulation for statistical adequacy at the expense of construct validity (Cinotti 2006). In this framework, the construct of reputation was conceptualized as a formed attribute of a concrete singular object, the physician, as perceived by a group of raters, namely patients.

The qualitative stage, conducted through face-to-face interviews with 13 participants, generated 55 items subsequently refined to 14 across four dimensions. The exclusion of the "cost of medical service" and "workplace"

dimensions reflected participants' limited concern with price or environment, confirming prior findings that consumers are generally insensitive to price variations in health services (Kahn et al. 1997). This aligns with the notion that health care decisions are guided by perceived competence and trust rather than economic calculus.

- Medical Service Dimension (Figure 1)Among the four dimensions, *medical service* emerged as the most significant. Physician skills, treatment quality, and diagnostic accuracy, rational attributes, were prioritized, even though most respondents were women, a group often described in the literature as relying on emotional rather than rational criteria (Naidu 2009). This divergence invites reflection on the evolving nature of the patient–physician relationship in contemporary medicine. As Deshwal et al. (2014) argue, the physician's core understanding of disease and healing remains central to this relationship, yet modern patients increasingly assert their evaluative agency. The relatively low importance given to punctuality and availability may reflect an enduring hierarchical structure in which physicians maintain epistemic authority and patients adopt a deferential stance (Ladeira et al. 2011). Quantitative results also differed from qualitative findings, suggesting that while efficiency dominates patients' discourse, cognitive evaluations of skill and performance gain salience when quantified.

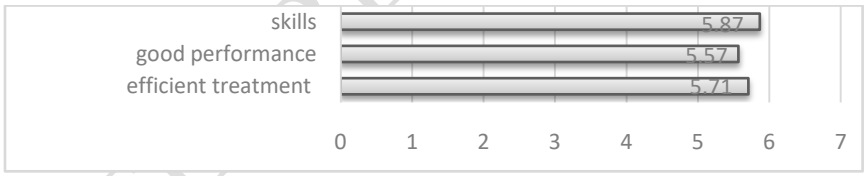

Fig.1score of items forming the medical service dimension

- Humanvalues (Figure 2) obtained average scores between 5.02 and 6.69, emphasizing listening skills as most relevant and generosity as least important. Listening is repeatedly highlighted in literature as essential for the patient experience and the ethical practice of medicine (Deshwal et al. 2014).

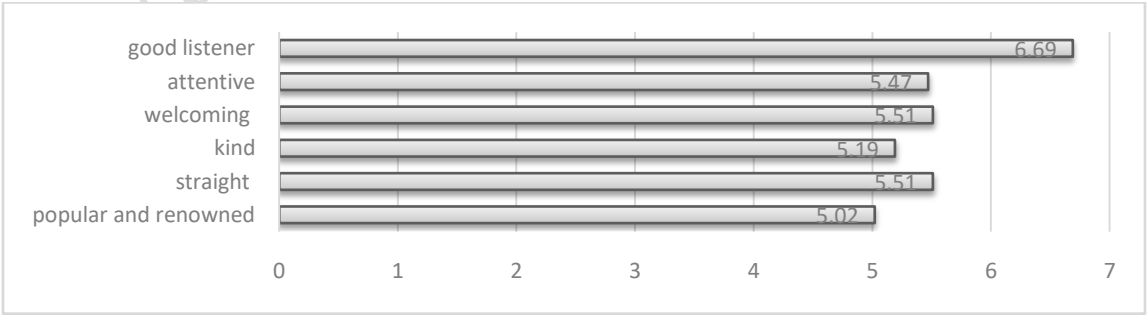

Fig.2score of items forming human values dimension

- Similarly, emotional appeal (Figure 3), comprising trust and professionalism, showed high average scores (6.93 and 6.1, respectively). Trust, as Ribbink et al. (2004) and Akingbola and van den Berg (2015) note, is a cornerstone of long-term relationships and directly influences perceptions of treatment effectiveness. Yet, trust here appears closely tied to professionalism and authority, consistent with Sanyal and Datta's (2011) observation that physicians' epistemic monopoly shapes asymmetrical but necessary relations of dependence.

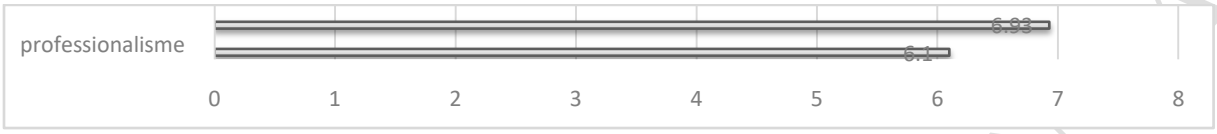

Fig.3score of the items forming emotional appeal dimension

- The work environment dimension, though least weighted, retained relevance through the item "cleanliness of the office." This echoes broader cultural expectations of hygiene and safety in medical spaces, which, though rarely verbalized as core to reputation, remain symbolically linked to competence and moral rectitude.

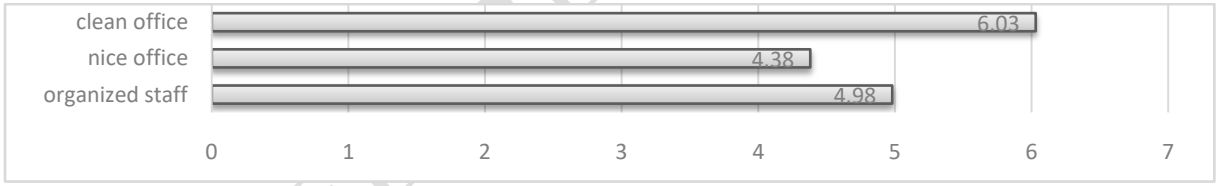

Fig. 4 score of the items forming work environment dimension

Taken together, the dominance of rational over emotional dimensions in this study challenges gendered assumptions about patient perception (Naidu 2009; Badri et al. 2009). While female patients constituted 64% of the sample and might be expected to emphasize empathy or affective qualities, their responses privileged technical mastery and treatment efficiency. This inversion may be rooted in the sociocultural context of health care, where competence remains the ultimate assurance of care and survival. As Ladeira et al. (2011) suggest, patients' emotional evaluations are often mediated by an implicit trust in biomedical authority.Finally, patients considered the *cost of service* less important, reaffirming the relative inelasticity of demand in health care (Ladeira et al. 2011). The ranking of "medical service" above "emotional appeal" and "human values" thus reflects both structural and symbolic dimensions of medical reputation: structural, in that the physician remains a figure of authority and knowledge; and

symbolic, in that technical excellence embodies moral and professional virtue. Physician reputation emerges as a multidimensional construct where competence, trust, and relational ethics interact. Beyond numerical scores, these findings invite a humanistic reading of how patients make sense of authority, vulnerability, and care. The medical encounter remains a site of negotiation, between rational evaluation and emotional reliance, between trust in expertise and the desire to be heard, thereby reaffirming the importance of integrating social and humanistic inquiry into the study of medical reputation.

Conclusion

Organizational reputation constitutes a major intangible asset, representing up to 63% of a company's market value (Boistel, 2014). Consequently, nearly one-third of Fortune Global 500 communication managers view it as a strategic priority due to its capacity to generate trust and commitment among stakeholders (Boistel, 2014; Morgan-Thomas &Veloutsou, 2013). In the specific context of healthcare, however, this reputation is primarily anchored in the physician–patient relationship—the foundational moral and service-oriented bond (Hadwich et al., 2010). While institutional reputation remains relevant for hospitals and clinics (Chahal & Bala, 2012), this research emphasizes the interpersonal and ethical dynamics that specifically define the individual physician's standing.

A significant gap exists in literature regarding the measurement of this individual-level reputation. Existing tools, such as the Reputation Quotient (Fombrun et al., 2000) or the Customer-Based Reputation scale (Walsh & Beatty, 2007), were designed for large corporate entities or academic institutions and are ill-suited for the nuanced context of professional medical services. To address this, the present study developed a physician-specific reputation scale using a mix of qualitative and quantitative methods. Following semi-structured interviews and refinement, a 14-item scale emerged, grouped into four core dimensions: medical service, human qualities, emotional appeal, and work environment.

Interestingly, factors such as price sensitivity, which are prominent in general corporate models, proved less significant in this medical framework. This suggests that patients are less responsive to cost variations when evaluating professional standing, prioritizing instead a construct shaped as much by relational empathy as by technical competence (Kahn et al., 1997).

Despite these findings, certain limitations remain. The sample size and the lack of differentiation by medical specialty suggest that future research should integrate socio-demographic variables—such as age, gender, education, and health status—to examine their influence on reputational perception. Moreover, geographical and cultural factors deserve particular attention. Patients in large urban centers, where individualism and freedom of choice

prevail, may evaluate physicians differently from those in rural regions, where collectivist values and limited access often characterize care.

In regions where finding a specialist is a matter of difficulty, physician reputation may result less from comparison and more from necessity. This inequality of access raises broader ethical questions central to the medical humanities: how structural factors, patient agency, and cultural norms intersect to shape the moral perception of the physician and the trust placed in medical expertise.

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