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The Patient's Ethical Perception: Investigating the Role of Religion and Moral Sensitivity

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ABSTRACT: While healthcare ethics has historically been examined through institutional frameworks developed within Western normative traditions, the subjective moral lens through which patients in Muslim-majority societies evaluate physician conduct remains substantially understudied in the Islamic marketing literature. This paper addresses this gap by investigating how patients in Tunisia construct ethical evaluations of clinical encounters through the lenses of Islamic religiosity and moral sensitivity. Drawing on thematic analysis of 23 semi-structured interviews facilitated by ATLAS.ti 9, the study identifies three core themes specific to the Tunisian socio-religious setting: the multidimensionality of patient ethical perception, the operationalization of Islamic religiosity as a moral filter and spiritual anchor, and the role of patient moral sensitivity in detecting gaps between expected and observed physician conduct. Within this particular cultural and religious context, patients evaluate physician morality not through technical expertise alone but through deeply embedded Islamic values of compassion, dignity, and equitable treatment. Islamic religiosity establishes elevated deontological expectations of physician conduct rooted in Islamic moral duty, while moral sensitivity operates as the interpretive capacity that detects discrepancies between those expectations and actual clinical behavior. These findings carry implications specific to patient-centered care design, Islamic health services marketing, and cross-cultural clinical communication within Muslim-majority healthcare contexts.

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1. INTRODUCTION

Healthcare encounters in Muslim-majority societies are shaped by a cultural and spiritual architecture that reaches beyond clinical protocol. Patients in these settings do not approach medical consultations as mere consumers of technical services; they arrive as moral actors whose assessments of physician conduct are filtered through internalized Islamic values, lived ethical sensitivities, and relational expectations that resist reduction to conventional service quality measurements. Despite this reality, the dominant literature on healthcare ethics has largely been constructed within Western normative frameworks that treat patient evaluations as context-neutral assessments of technical competence and procedural adherence (Hunt & Vitell, 1986; Laczniak & Murphy, 2018). The subjective, culturally embedded lens through which Muslim patients construct and communicate ethical judgments about physician behavior has received limited systematic attention in the Islamic marketing literature, and virtually none within the specific socio-religious configuration of North African Muslim-majority healthcare contexts.

This gap carries practical significance. Islamic marketing scholarship has established that religious values function as primary determinants of consumer behavior, service expectations, and ethical standards in Muslim-majority markets (Ben Amor et al., 2026a). In healthcare service encounters, where acute vulnerability, information asymmetry, and elevated emotional stakes define the consumer experience, these religious influences are intensified rather than attenuated. In Tunisia, where Islamic values

are deeply embedded in social identity and where the patient-physician relationship carries significant moral weight, understanding how Islamic religiosity and moral sensitivity shape patient ethical evaluations is directly relevant to the design of healthcare services and to broader questions in Islamic health services marketing.

The Islamic marketing perspective offers a conceptual foundation well suited to this inquiry. The General Theory of Marketing Ethics (Hunt & Vitell, 1986, 2006) establishes that cultural environments are primary external determinants that shape individual value systems, deontological norms, and behavioral expectations. When this framework is applied to a Muslim-majority healthcare context, the implications are specific and tractable: values rooted in Islamic teachings on compassion, equity, and human dignity produce identifiable moral expectations that patients bring to clinical encounters, and deviations from those expectations register as ethical transgressions rather than mere service failures (Ben Amor et al., 2026a; Ben Amor et al., 2026b).

This paper investigates these dynamics through thematic analysis of 23 semi-structured interviews with patients. Two primary questions organize the inquiry. First, how do patients within this Muslim-majority context define and construct ethical medical behavior? Second, in what ways do Islamic religiosity and moral sensitivity shape the criteria and thresholds through which physician conduct is evaluated? The findings are framed as specific to the Tunisian socio-religious environment, where the convergence of Islamic values, North African cultural norms, and a distinctive healthcare infrastructure produces patterns of ethical evaluation that may not generalize directly to other socio-religious settings.

2. LITERATURE REVIEW

2.1 Patient Ethical Perception as a Service Construct

To analyze how patients evaluate a medical provider's conduct, it is necessary to distinguish between formal normative ethics and the descriptive concept of perceived ethical behavior, which captures the subjective moral reality constructed by the patient during clinical interactions (Hunt & Vitell, 1986). This perceived ethical behavior is interpretive by nature, shaped by relational cues, communicative style, and demonstrations of empathy or indifference that the patient observes throughout the encounter. Within the Service-Dominant Logic framework, value and quality emerge through co-creation within specialized social ecosystems (Vargo & Lusch, 2004; Ojasalo & Kauppinen, 2024). Applied to healthcare, this positions the ethical character of a clinical encounter not as an objective property of the physician but as something dynamically constructed through the patient's interpretive engagement during the service interaction.

Service quality research established long ago that consumer assessments depend heavily on relational dimensions rather than on technical outputs alone (Parasuraman et al., 1988). In healthcare, this dynamic is intensified by the patient's exposure to physical and emotional vulnerability. Hall et al. (2001) observe that patients rarely possess the specialized knowledge required to objectively evaluate clinical precision; consequently, they substitute technical metrics with behavioral indicators, assessing the practitioner's honesty, fidelity to patient interests, and relational respect as primary signals of professional reliability. Perceived ethical behavior thus becomes the primary framework through which clinical competence is inferred and trust is extended or withheld. In Muslim-majority healthcare contexts, where the moral obligations of the caregiver are often understood through an Islamic ethical lens, this inferential process carries additional cultural weight that existing service quality models have not systematically addressed.

2.2 Islamic Religiosity and Moral Expectations in Healthcare

Religion constitutes a foundational sociocultural institution that structures individual cognitive schemas, value commitments, and moral expectations across all domains of life, including healthcare service consumption. The General Theory of Marketing Ethics (Hunt & Vitell, 1986, 2006) positions cultural environments, and religious traditions specifically, as primary external determinants of individual ethical evaluations. In Muslim-majority societies, these cultural environments are shaped by Islamic values that assign explicit moral obligations to the care of the sick and the conduct of healers (Ben Amor et al., 2026a; Ben Amor et al., 2026b). Islamic ethics emphasizes the protection of human life, the preservation of dignity, and the unconditional obligation to treat every patient with compassion and fairness. These principles generate specific and elevated moral expectations that Muslim patients carry into clinical encounters, transforming what secular frameworks might classify as service failures into perceived violations of religiously grounded duties.

The distinction introduced by Allport and Ross (1967) between intrinsic and extrinsic religious orientation provides a useful analytical tool for understanding how these values operate at the individual level. Patients with an extrinsic orientation tend to mobilize religious identity primarily for social or instrumental purposes, while those with an intrinsic orientation have internalized their faith as a comprehensive moral framework that governs daily judgments and interpersonal evaluations. When intrinsically oriented Muslim patients assess physician conduct, their Islamic religious schemas function as an active evaluative baseline, generating specific deontological expectations regarding compassion, humility, and equitable treatment that extend well beyond what generic service quality instruments are designed to capture (Hassan & Rahman, 2023; Sulaiman et al., 2021). For such patients, in contexts like Tunisia where intrinsic Islamic religiosity is prevalent, medicine is understood not as an economic service but as a moral calling carrying spiritual accountability, and physician conduct that falls short of Islamic compassion or dignity is interpreted as a breach not only of professional standards but of Islamic moral duty.

The Islamic religious framework also provides an emotional and cognitive anchor during clinical encounters characterized by uncertainty and vulnerability. Muslim patients whose faith incorporates the concept of divine agency in healing may evaluate a physician's acknowledgment of therapeutic limits and expression of spiritual humility as a morally significant signal of integrity. This dynamic suggests that Islamic religiosity does not function as a passive cultural backdrop but as an active interpretive mechanism shaping both the content and the threshold of patient ethical evaluations, a mechanism specific to the socio-religious contexts in which this form of religiosity is practiced.

2.3 Moral Sensitivity in Clinical Service Encounters

While Islamic religiosity provides the macro-level value architecture that informs patient expectations, moral sensitivity represents the individual psychological capacity required to operationalize those values within specific clinical encounters. Derived from Rest's (1986) Four-Component Model of moral development, moral sensitivity constitutes the initial, essential stage of ethical processing: the capacity to recognize that a specific situation contains moral implications, to identify the available courses of action, and to comprehend how those actions will affect the welfare of those involved (Toti et al., 2021). Without an adequate level of moral sensitivity, individuals remain unable to perceive the ethical dimensions of interpersonal situations, interpreting conflicts or systemic failures through purely practical or technical lenses.

In healthcare service contexts, patient moral sensitivity manifests as an interpretive awareness directed at the physician's behavior, communication choices, and relational style. Schluter et al. (2008) note that moral sensitivity is neither fixed nor purely dispositional; it is shaped by personal history, cultural context, and the structural dynamics of the institutional environment in which encounters take place. A patient with high moral sensitivity attends closely to perceived discrepancies between expected moral standards and actual clinical behavior while observing whether autonomy is respected, whether equity is maintained across patient groups, and whether communicative transparency is practiced. A patient with lower moral sensitivity may overlook subtle ethical violations, focusing instead on technical outcomes or procedural convenience. In a Muslim-majority healthcare context, where the Islamic religious framework heightens the moral stakes of clinical encounters, moral sensitivity functions as the cognitive mechanism through which religiously grounded expectations are translated into concrete evaluations of physician conduct.

3. METHODS

3.1 Research Design and Paradigm

This study adopts an interpretivist epistemological paradigm and a phenomenological qualitative design to examine the lived experiences of Tunisian patients and the subjective meanings they assign to physician conduct in clinical encounters. The interpretivist approach recognizes that social reality is constructed through individual experience and cultural context, and that ethical perception cannot be understood in isolation from the particular socio-religious environment within which it takes shape. By centering the descriptive narratives of participants, this design allows the underlying thematic structures of patient evaluations to emerge from the data, rather than being imposed by pre-existing theoretical categories.

3.2 Sample and Participant Selection

The qualitative sample consisted of 23 participants selected through purposive sampling to ensure richness and diversity in demographic background, clinical history, and religious orientation. The primary inclusion criterion required that participants had engaged in multiple consultations with physicians for chronic or acute medical conditions within the preceding 12 months, ensuring a substantive experiential foundation for reflection. To capture a range of perspectives within the Tunisian context, the sample included variation across age groups (ranging from 22 to 74 years), gender (13 women, 10 men), socioeconomic position, and educational attainment. Sampling continued until theoretical saturation was reached (Guest et al., 2006; Saunders et al., 2018), a point at which subsequent interviews produced no new conceptual codes related to ethical perception, Islamic religiosity, or moral sensitivity. Participant characteristics are presented in Table 1.

Table 1. Sample Characteristics

Part.	Age	Gender	MTU (/10)	Place of Residence	Level of Education
P01	23	Male	4	Nabeul	UUE
P02	20	Male	2	Nabeul	SS
P03	48	Male	4	Tunis	CUE
P04	29	Female	5	Sousse	CUE
P05	28	Female	5	Tunis	UUE
P06	20	Female	2	Sousse	SS

Part.	Age	Gender	MTU (/10)	Place of Residence	Level of Education
P07	24	Male	4	Sousse	CUE
P08	23	Male	5	Nabeul	UUE
P09	22	Female	5	Sousse	CUE
P10	47	Female	7	Nabeul	CUE
P11	33	Female	8	Sousse	CUE
P12	23	Male	3	Nabeul	UUE
P13	47	Male	3	Sousse	CUE
P14	68	Female	1	Mahdia	PS
P15	47	Male	1	Mahdia	SS
P16	28	Male	6	Monastir	CUE
P17	35	Female	9	Monastir	CUE
P18	56	Male	1	Monastir	UUE
P19	19	Female	3	Tunis	UUE
P20	54	Female	3	Tunis	CUE
P21	24	Male	3	Kef	UUE
P22	30	Male	8	Nabeul	SS
P23	24	Female	6	Tunis	CUE

Note. MTU = Medical Terms Understanding; UUE = Uncompleted University Education; CUE = Completed University Education or higher; SS = Secondary School; PS = Primary School.

3.3 Data Collection and Interview Protocol

Data collection was conducted through semi-structured, face-to-face interviews, which maintained a consistent thematic structure while allowing participants space for meaningful narrative elaboration. An interview guide was developed and pilot-tested with two patients prior to data collection to verify clarity and alignment with the research objectives. Opening questions invited participants to describe significant healthcare interactions; subsequent questions explored their definitions of morally acceptable and unacceptable physician behavior, the role of their Islamic faith and personal values in these evaluations, and their responses to perceived ethical conflicts in care. Interviews were conducted in private, neutral settings to ensure confidentiality and averaged approximately 65 minutes in duration. All interactions were recorded with explicit participant consent and transcribed verbatim.

3.4 Data Analysis and Coding Process

Transcripts were analyzed using the six-step thematic analysis framework of Braun and Clarke (2006), facilitated by ATLAS.ti 9 for systematic data management and auditability. The process began with immersive reading of all transcripts to establish familiarity with the data, followed by line-by-line open coding to capture initial meanings and recurring concepts. These codes were progressively clustered into sub-themes and iteratively refined into overarching themes directly responsive to the research questions. The coding architecture was continuously cross-referenced against the original participant narratives to ensure that the final thematic map remained firmly grounded in authentic participant expressions rather than in theoretical pre-conceptions.

3.5 Ethical Considerations

Given the sensitivity of discussing personal health histories and deeply held religious convictions, strict ethical protocols were enforced throughout the research process. Prior to each interview, participants received a written disclosure outlining the study's purpose, the voluntary nature of participation, and their unconditional right to withdraw at any stage without consequence. Signed informed consent was obtained from all participants. Anonymity was guaranteed through the removal of all identifying information during transcription, with participants assigned alphanumeric identifiers (P01 through P23), and all institutional names and specific geographic details were excluded from the final data set.

4. RESULTS

The thematic analysis generated three themes from the interview data, each reflecting a distinct dimension of how patients in this Tunisian Muslim-majority sample construct and communicate ethical evaluations of physician conduct. These themes are reported below with supporting verbatim extracts; analytical observations accompanying each extract are specific to the cultural and religious context of the participants.

Theme 1: The Multidimensional Nature of Patient Ethical Perception

The analysis reveals that patient ethical perception operates as a complex, multidimensional construct that extends well beyond assessments of technical clinical competence. Participants consistently indicated that technical mastery constitutes a baseline expectation rather than a differentiating ethical criterion. Instead, ethical evaluations among this sample are organized around three relational and humanistic dimensions: the preservation of human dignity, communicative transparency, and transactional fairness. Ethical transgressions, in the accounts of these patients, occur primarily when physicians reduce the suffering individual to a clinical file or a financial transaction, abandoning the relational obligations that define an encounter as morally acceptable.

> *"I do not expect my doctor to be a miracle worker, but I do expect them to look me in the eye and see a human being, not just a clinical file or a disease to be managed. When they rush you out, talking only to their computer screen, it feels like a violation of basic human dignity. That, to me, is an ethical failure."*
> *(P04)*

Communicative transparency emerged as a central criterion of perceived physician morality within this sample. The willingness to explain diagnoses clearly, to acknowledge clinical uncertainty, and to respect the patient's right to information was interpreted as evidence of moral respect for patient autonomy. Conversely, the strategic withholding of information, the deployment of technical jargon as a barrier to understanding, or the adoption of an authoritarian communication style were perceived as significant ethical violations by this participant.

> *"An ethical doctor does not hide behind complicated medical terms. They respect your right to know the truth about your own body. When they explain options clearly and listen to your fears, they are showing moral respect for you as a person."*
> *(P11)*

Theme 2: Islamic Religiosity as an Evaluative Lens

Islamic religiosity functions in these narratives as a foundational interpretive schema through which patients construct ethical expectations and evaluate physician conduct. For participants demonstrating strong intrinsic Islamic religiosity, faith is not a peripheral identity marker but a comprehensive worldview that defines what the medical profession should morally represent. In the specific context studied here, two mechanisms through which this lens operates are particularly evident: first, the framing of compassionate care as a divine obligation rooted in Islamic moral duty rather than a professional choice; and second, the introduction of a spiritual dimension into the patient's interpretation of clinical uncertainty and medical limitation. Within this sample, the medical profession is widely understood as a trust granted by God, which generates ethical expectations that are substantially more demanding than those derived from secular service frameworks.

> *"Medicine is a sacred duty blessed by God. A doctor is an instrument of divine healing on this earth. Therefore, they must practice with absolute selflessness, profound humility, and deep compassion. When a doctor acts out of greed, vanity, or indifference, they are not just violating a professional code: they are violating a sacred trust."*
> *(P17)*

The Islamic religious schema also provides an emotional anchor that supports patients through clinical uncertainty. When physicians acknowledged the limits of medical knowledge and expressed an alignment with spiritual hope, highly religious participants interpreted this as a morally affirming signal of integrity and Islamic humility. Within this sample, the physician's recognition of divine agency in the healing process was not perceived as a retreat from professional competence but as an expression of Islamic moral character consistent with the shared faith context of patient and provider.

> *"When my doctor said, 'We will do everything scientifically possible, and we will pray for the best outcome,' it gave me immense peace. It showed me that he had the humility to recognize a higher power. That combination of science and spiritual humility represents the highest level of medical ethics."*
> *(P09)*

Theme 3: Patient Moral Sensitivity and Discrepancy Detection

Moral sensitivity manifests in these accounts as an active cognitive mechanism that enables patients to recognize, interpret, and respond to the ethical dimensions embedded in clinical encounters. Participants with high moral sensitivity demonstrated close attentiveness to subtle behavioral details in physician conduct, interpreting the physician's treatment of nursing staff, management of time with elderly patients, and consistency of respect across socioeconomic differences as meaningful ethical indicators. This capacity for discrepancy detection, the identification of mismatches between expected Islamic moral ideals and observed physician

behavior, is particularly prominent in participants who combine strong intrinsic Islamic religiosity with high personal moral sensitivity, a combination that appears especially prevalent in this sample.

> *"I notice the small choices a doctor makes. I observe how they speak to the nursing staff, whether they show patience to the elderly patient waiting in the hallway, and whether they treat everyone with equal respect regardless of their appearance. These minor actions reveal their true moral character far better than any official credentials on the wall."*
> *(P21)*

When moral sensitivity detects an ethical mismatch, it triggers a comprehensive re-evaluation of the entire clinical relationship. Participants who identified persistent ethical discrepancies in physician conduct reported internal experiences of distress, alienation, and a progressive erosion of trust. For several participants in this sample, this re-evaluation resulted in the termination of the clinical relationship, a withdrawal they described not as a consumer complaint but as a moral act consistent with their personal values and Islamic principles.

> *"The doctor was technically accurate, but his complete indifference to my anxiety felt profoundly cold and unethical. He spoke to me like a broken machine that needed a minor adjustment. My internal sense of right and wrong told me that this was not a safe environment for healing, so I chose never to return to his clinic."*
> *(P02)*

5. DISCUSSION

The findings generated from this Tunisian Muslim-majority sample offer several theoretical and practical contributions, advancing understanding of the cultural and religious architecture through which patient ethical evaluations are constructed in Islamic healthcare contexts. Three observations merit detailed discussion, each carrying implications conditioned by the socio-religious specificity of the context studied.

First, within the sample examined here, patient ethical perception operates through a relational and humanistic register that assigns far greater moral weight to the preservation of dignity, communicative transparency, and equitable treatment than to technical clinical outcomes alone. This finding is consistent with service research demonstrating that soft, relational dimensions drive perceived service integrity and long-term institutional trust (Hall et al., 2001; Ostrom et al., 2015; Zeithaml et al., 1988). However, in the specific cultural and religious context of this study, these relational dimensions acquire a distinctly Islamic coloring: dignity is understood through the lens of Islamic principles regarding the sanctity of the human person, transparency reflects the Islamic commitment to honest dealing, and fairness echoes the Islamic imperative of equitable treatment regardless of social standing. This contextual recoloring suggests that the standard relational dimensions captured by models such as SERVQUAL (Parasuraman et al., 1988), while conceptually relevant, require substantial cultural recontextualization before they can meaningfully capture patient ethical perceptions in Muslim-majority healthcare markets. Whether this recoloring operates similarly in Muslim-majority societies with different cultural traditions remains a question that comparative Islamic marketing research has yet to resolve.

Second, Islamic religiosity functions as a primary evaluative framework in ways that both confirm and extend existing conceptual tools. The General Theory of Marketing Ethics (Hunt & Vitell, 1986, 2006) positions cultural and religious environments as external determinants of ethical evaluation, and Allport and Ross's (1967) framework of intrinsic religiosity provides a mechanism for understanding individual variation in how these environments operate. The present findings confirm both frameworks while introducing a healthcare-specific dynamic that neither was designed to address: for intrinsically religious Tunisian Muslim patients, the medical profession carries the moral weight of a divinely sanctioned trust, and physician conduct that falls short of Islamic compassion or humility is interpreted as a violation of that trust rather than as a service shortfall. This finding aligns with prior research demonstrating the influence of Islamic values on ethical expectations in commercial and organizational contexts within Muslim-majority societies (Ben Amor et al., 2026a; Ben Amor et al., 2026b; Hassan & Rahman, 2023; Sulaiman et al., 2021), while extending those insights to the emotionally and spiritually intensified domain of healthcare service encounters. It is important to note that these dynamics are specific to the Tunisian socio-religious configuration and should not be interpreted as representative of Islamic religiosity in all Muslim-majority societies.

Third, the operationalization of moral sensitivity as an active discrepancy detection mechanism extends Rest's (1986) Four-Component Model beyond its original institutional focus on the moral reasoning of professionals. In this study, moral sensitivity functions not on the provider side of the clinical encounter but on the consumer side, positioning patients as moral agents who continuously monitor and evaluate the ethical character of physician behavior. Patients with high moral sensitivity, particularly those combining strong Islamic religiosity with acute relational attentiveness, engage in real-time ethical monitoring that draws on behavioral cues invisible to conventional service quality instruments. This finding aligns with the interpretations of Toti et al. (2021) and Schluter et al. (2008), who emphasize the role of moral sensitivity in generating ethical awareness, while demonstrating that this capacity is shaped and amplified by the specific Islamic cultural context within which patients evaluate care. The extent to

which this mechanism is mediated by religiosity is a question that quantitative investigation within and beyond the Tunisian context could usefully address.

These findings carry practical implications that are conditioned by their contextual origins. For healthcare providers operating in Muslim-majority North African markets, they indicate that technical clinical excellence alone cannot guarantee a patient's perception of ethical care. Physicians in these markets must cultivate relational competence consistent with Islamic ethical expectations, practicing communicative transparency and demonstrating explicit respect for patient dignity as expressions of Islamic moral duty rather than as optional professional courtesies. For medical education programs in Muslim-majority contexts, these insights suggest that training protocols need to move beyond abstract normative codes to incorporate experiential training in cross-cultural and Islamic ethical communication. Healthcare administrators designing service systems in these contexts must further recognize that institutional pressures for procedural efficiency risk generating systematic ethical dissatisfaction among patient populations for whom Islamic values constitute primary evaluative criteria (Alanazi et al., 2024; Mohamed, 2023). The applicability of these recommendations in Muslim-majority contexts with different cultural traditions or institutional configurations should be empirically assessed rather than assumed.

6. CONCLUSION

This study investigated the subjective moral architecture of healthcare service encounters by examining how Tunisian patients construct ethical evaluations of physician conduct through the lenses of Islamic religiosity and moral sensitivity. Moving away from normative Western frameworks, the qualitative investigation prioritized the lived experiences of participants, demonstrating that, within this Muslim-majority context, assessments of physician morality rest on relational, humanistic, and Islamic values rather than technical clinical performance alone. Technical competence functions as a minimum threshold; the ethical core of the clinical encounter, as experienced by these patients, resides in the preservation of human dignity, communicative transparency, and relational empathy, all anchored in an Islamic moral framework that assigns sacred obligations to the healer.

Islamic religiosity emerged as the primary interpretive lens shaping patient ethical evaluations within the context examined here, establishing deontological expectations of compassion and humility that substantially exceed what secular professional codes define as adequate care. Moral sensitivity, in turn, operates as the cognitive mechanism through which these religiously grounded expectations are applied to real-time clinical observations, enabling patients to detect ethical discrepancies that conventional service quality instruments would not register. These two constructs operate in combination: the Islamic religious framework raises the moral threshold, while moral sensitivity provides the perceptual acuity required to detect deviations from it.

Several limitations of this study should be acknowledged. The qualitative design and purposive sampling strategy are intended to achieve conceptual depth and theoretical saturation rather than statistical representativeness across Muslim-majority populations. The specific expressions of the Islamic religiosity lens identified here reflect the particular religious traditions, cultural norms, and healthcare conditions of Tunisia and may differ in other Muslim-majority societies, a limitation that underscores the need for cross-cultural comparative research within the Islamic marketing domain (Ermasova, 2021; Khaoula et al., 2023). Longitudinal research designs could further examine how moral sensitivity and Islamic ethical expectations evolve as patients navigate chronic illness and extended clinical relationships. Quantitative replication would contribute to understanding which findings reflect locally specific dynamics and which may generalize more broadly across Muslim-majority healthcare contexts.

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Appendix A: Codebook (Themes and Coding Structure)

Main Theme	Sub-theme	Operational Definition	Grounded Codes
Patient Perception Ethical	Preservation of Dignity	Actions reflecting respect for patient personhood and bodily autonomy.	Dignity_Respect, Anti_Paternalism
Patient Perception Ethical	Communicative Transparency	Willingness to explain conditions without deceptive opacity or dense jargon.	Clear_Info, Jargon_Avoidance
Patient Perception Ethical	Transactional Fairness	Equity in patient treatment across varying socioeconomic boundaries.	Equity_Care, Price_Fairness
The Islamic Religiosity Lens	Divine Mandate of Care	Viewing clinical practice as a sacred calling governed by Islamic moral accountability.	Sacred_Trust, Compassion_Mandate
The Islamic Religiosity Lens	Spiritual Humility	Physician recognition of trans-human healing factors and therapeutic limits consistent with Islamic values.	Humility_Faith, Fate_Healing
Patient Sensitivity Moral	Discrepancy Detection	Capacity to perceive mismatches between expected Islamic moral ideals and observed clinical conduct.	Ideal_Gap, Small_Cue_Awareness
Patient Sensitivity Moral	Vulnerability Response	Emotional and cognitive reaction to perceived structural imbalances in care.	Anxiety_Response, Alienation_Feel

Appendix B: Verbatim Examples by Theme

Theme Reference	ID	Core Verbatim Statement	Analytical Note
Ethical Perception	P04	When they rush you out, talking only to their computer screen, it feels like a violation of basic human dignity.	Highlights the negative evaluation of transactional distance and absence of relational engagement.
Ethical Perception	P11	An ethical doctor does not hide behind complicated medical terms. They respect your right to know.	Links communicative transparency directly with ethical integrity and epistemic respect.
Islamic Religiosity	P17	A doctor is an instrument of divine healing... When a doctor acts out of greed, they violate a sacred trust.	Illustrates internalized Islamic faith forming an elevated baseline of deontological obligations.

Theme Reference	ID	Core Verbatim Statement	Analytical Note
Islamic Religiosity	P09	When my doctor said "We will do everything... and pray for the best outcome," it gave me immense peace.	Demonstrates alignment between Islamic spiritual schemas and the physician's acknowledgment of divine agency.
Moral Sensitivity	P21	I notice the small choices... I observe how they speak to the nursing staff... These minor actions reveal character.	Shows moral sensitivity operating as an active mechanism for micro-interaction ethical monitoring.
Moral Sensitivity	P02	His complete indifference to my anxiety felt profoundly cold and unethical... I chose never to return.	Connects discrepancy detection with relationship termination as a moral act.