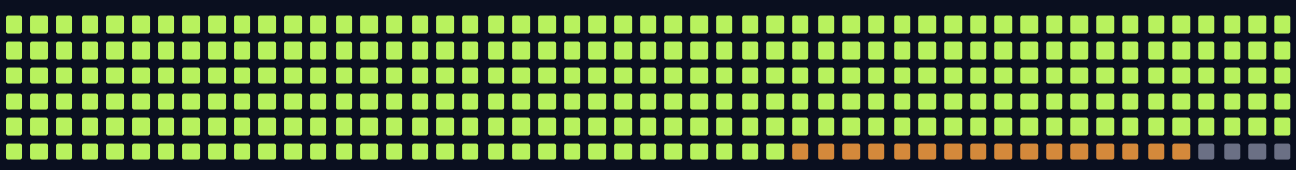
Rubikn

RESEARCH REPORT N° 001
PUBLIC EDITION · NOVEMBER 2026

A DESK STUDY OF SURGEONS AND MEDICAL BRANDS, FROM JORDAN

The Making of a *Surgical Name*

How a surgeon becomes famous and how a medical brand becomes an asset



306 CLAIMS CHECKED AGAINST THEIR SOURCES · **286** CONFIRMED · **16** REFUTED · **4** UNVERIFIED

PUBLISHED BY
Rubikn
Research report series

RESEARCH
September 2026
8 desk studies

CLASSIFICATION
Public edition
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ABOUT THIS REPORT

The Making of a Surgical Name

How a surgeon becomes famous and how a medical brand becomes an asset

SERIES	Rubikn Research Report N° 001 · Public edition
DATE	Research September 2026; public edition November 2026
PUBLISHED BY	Rubikn
SUGGESTED CITATION	Rubikn. (2026). *The making of a surgical name: How a surgeon becomes famous and how a medical brand becomes an asset* (Rubikn Research Report No. 001, public edition). Rubikn.
METHOD	Desk research conducted 16–24 September 2026 in eight studies. Each study examined its question from several distinct analytic perspectives, using sources retrieved online at the time. An independent verification pass then tried to refute the most load-bearing claims against those sources. Synthesis and editorial review followed a protocol designed and supervised by Rubikn. Only public sources were used. No patient data was collected, and no fieldwork has yet taken place.
STATUS	First-pass desk research. Figures are as found in September 2026. Questions that need interviews or a practice's own data are marked as open throughout. They are listed in Appendix F.

NOTES ON THE TEXT

- Numbers in square brackets, such as [12], refer to the numbered References.
- Claims marked **Unverified** could not be settled from a retrievable source. They are reported with that label and are never used as findings.
- Arabic quotations are reproduced verbatim, with English translations.
- Figures are labelled by chapter (Figure 4.2 is the second figure in Chapter 4). Every plotted value appears in a cited source.
- This report is research, not legal or medical advice. Regulatory observations should be confirmed with the Jordan Medical Association.

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ABSTRACT

Abstract

This report presents the first, desk-based phase of a research programme on how a surgeon becomes famous and how a medical brand becomes an asset, with Jordan as the home market: how a surgeon's name becomes known, whose name a practice should carry, and what a medical brand is worth when a practice grows, enters the capital or later looks abroad. The programme completed 7 research streams and a follow-up on platform histories between 16 and 24 September 2026 under a perspective-guided desk-research protocol, adapted in-house: each stream examined its question from methodologically diverse perspectives in separate, independent passes, using sources retrieved online at the time of research, and an independent verification pass re-checked the most load-bearing claims. Of 306 claims formally checked, 286 were confirmed, 16 (5.2%) refuted and 4 left unverified. The evidence indicates that in 12 of the 15 best-documented cases a doctor's first audience was granted by a third party; that patients state a preference for credentials and reviews over popularity; that Jordan's advertising instructions license doctor marketing within a defined list of prohibitions; that medical businesses and name rights transfer, although no transaction reviewed priced a name separately; and that, in every case the study could date, famous institutions' current slogans were codified or adopted after their fame. A surgeon building a name in Jordan faces 3 decisions: brand architecture, category frame and, for a practice outside the capital, the path to Amman. For each, the report sets out what the evidence establishes, what it cannot, and the data, studies and fieldwork required.

Keywords: medical branding; physician fame; brand architecture; medical advertising regulation; Jordan Medical Association; brand equity; healthcare market entry; orthopaedic surgery

THE RESEARCH AT A GLANCE

8 studies, 16–24 September 2026	**52** research perspectives	**306** claims put to independent verification	**720** sources cited across the studies
4,476 searches, fetches and reads	**286** claims confirmed	**16** claims refuted and removed	**9** regulatory regimes compared

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SUMMARY

Executive summary

Purpose

This report presents the first, desk-based phase of a research programme on how a surgeon becomes famous and how a medical brand becomes an asset, with Jordan as the home market. It asks how a surgeon's name becomes known, whose name a practice should carry, what a practice should be known for, what a medical brand is worth, and what travels when a practice outside the capital enters Amman or later looks abroad. The report puts dated, verified evidence under 6 of the programme's 7 strategic questions.

Method

Between 16 and 24 September 2026 the programme completed 7 research streams and a follow-up on platform histories under a perspective-guided desk-research protocol, adapted in-house. Each stream examined its question from 6 to 8 methodologically diverse perspectives, using sources retrieved online at the time of research, and an independent verification pass re-checked about 5 of each perspective's most load-bearing claims. Of 306 claims formally checked, 286 were confirmed, 16 (5.2%) refuted and 4 left unverified. The pass was desk-only, with no fieldwork or patient data; foreign cases are precedents, not predictions (Chapter 2).

Key findings

- Fame is granted before it is built: in 12 of the 15 best-documented cases a producer, editor, publicist, sports agent or institution granted the first audience [1-4]. In Jordan, Osama Al-Odat reached 307,000 Instagram followers by July 2021 [5] (Chapter 4).
- Patients say credentials and reviews outweigh popularity: Saudi respondents (n=1,242) rated qualifications 91.7% and review positivity 91.6% important, against 45.9% for likes [6]. Among 808 US arthroplasty (joint-replacement) patients, referral (44.9%) and word of mouth (18.7%) led first contact, against 8.4% for online advertisements [7] (Chapters 4 and 9).
- Jordan's JMA instructions, in force since 1 February 2025, license doctor marketing within a defined list of prohibitions, including superlatives such as “the first” and “the only” [8]. Enforcement is complaint-driven, and no named, dated advertising decision is public [9-11] (Chapter 3).
- Personal and institutional names have both persisted in the cases studied, a set weighted towards durable survivors; a founder surname can outlive its founder [12, 13]; no retrieved study compares naming architectures, so all 3 routes remain open [14] (Chapter 5).
- A named procedure establishes neither superiority nor exclusivity [15, 16], and the JMA ban on “first” and “only” has no exception for evidence of rarity, so substantiating a claim and publishing it are separate decisions [8] (Chapter 6).
- No portable fee premium for a famous medical name was found [17] and no transaction reviewed priced a name separately [18], although improvements in published US hospital rankings were followed by about 1% more non-emergency Medicare volume per rank position [19] (Chapter 7).
- No case studied shows a current slogan dated before fame [20, 21]; in the case record, the frames that held were structural: a narrowed scope, a patient segment with third-party proof, or scale (Chapter 9).

FIGURE ES.1

2 headline numbers from the first pass

12 of 15
Fame cases with a third-party start

44.9%
First heard of surgeon via referral

Source: 12 of the 15 best-documented fame cases, in which a producer, editor, publicist, sports agent or institution granted the first audience [1, 2]; 808 US arthroplasty (joint-replacement) patients [7].

What the findings mean for the 3 decisions

The report leaves 3 decisions with the reader and makes none; each also depends on inputs that only a surgeon or practice holds and on second-phase fieldwork.

- Brand architecture. The evidence keeps the personal-name, institutional and combined routes open and gives no measured basis for retaining or discarding an existing clinic name [14] (Chapter 5).
- Category frame. Chapter 9 lays out 12 candidate frames and chooses none; any frame must be expressed without superlatives [8], and fit cannot be judged until a surgeon's registered specialties, patient mix, referral routes and verbatim surgery claim are known.
- Amman path. For a practice outside the capital that wants to enter Amman, the question is the incremental value of an owned clinic over lighter forms of presence; break-even depends on receipts, costs and payer terms that the first pass could not observe [22] (Chapter 8).

What happens next

Still to run are 6 desk studies (branding tactics; awareness and mental availability; word of mouth and partnerships; personal brand construction; brand story and message; patient search and booking) and second-phase fieldwork, including a recorded session in which a surgeon states his or her surgery claim. Several measurements can start from a practice's own records, and a written query to the JMA can settle the unit of the Article 8 advertisement licence and whether plain procedure counts are permissible (Chapter 11).

TABLE ES.1

The report at a glance

CHAPTER	QUESTION ANSWERED	HEADLINE FINDING
2 Methodology	How was the evidence produced and checked?	306 load-bearing claims formally checked: 286 confirmed, 16 refuted (5.2%), 4 unverified; 720 distinct source URLs recorded, counted per report with overlap.
3 The regulatory environment	What may a doctor in Jordan and comparable regimes publish, and how are the rules enforced?	The JMA instructions license doctor marketing and prohibit a defined list; 106 complaints of all types and 5 referrals between May 2025 and July 2026; no named, dated advertising decision is public [8, 9, 11].
4 How doctors become famous	Q3: how is fame manufactured for a surgeon?	A third party granted the first audience in 12 of the 15 best-documented cases; video-platform accounts with usable resolution show 1 burst, a long ramp and a plateau [1, 23, 24].
5 Brand architecture	Q1: whose brand?	Founder names and institutional names have both persisted in the cases studied, a set weighted towards durable survivors; name, mark ownership and operator can differ; all 3 routes remain open [12, 14].
6 Distinctiveness and differentiation	Q6: distinctive or different?	The question splits into 5; a named procedure proves neither superiority nor exclusivity; substantiation and publication are separate decisions [8, 15, 16, 25].

CHAPTER	QUESTION ANSWERED	HEADLINE FINDING
7 The medical brand as an economic asset	Q4: how does a medical brand become an asset?	No portable fee premium found; a published US ranking signal was followed by about 1% more non-emergency Medicare volume per rank position; no transaction reviewed priced a name separately [17-19].
8 Market entry	Q5: what travels?	Documented institutional expansions paired a name with local capacity; no name-only return is isolated; Amman's 5,004,600 residents are context, not catchment [26, 27].
9 Brand strategy and articulation	Q2: known for what?	No case studied shows a current slogan dated before fame; among 808 US arthroplasty (joint-replacement) patients, referral (44.9%) and word of mouth (18.7%) led first contact; 12 candidate frames, none chosen [7, 20].
Appendix D Research instruments	How will the surgery claim and Amman sizing be tested?	2 instruments prepared, neither completed; 4 of 7 sizing layers rest on official inputs and 3 are not established or not supplied [22, 28].

Source: Chapters 2 to 9 and Appendix D[1, 7-9, 11, 12, 14-20, 22-28].

PART I

Foundations

01 Introduction

02 Methodology



CHAPTER 01

Introduction

Why this research, what it asks and how the report is organised

1.1 Background: why surgeons' names and medical brands matter

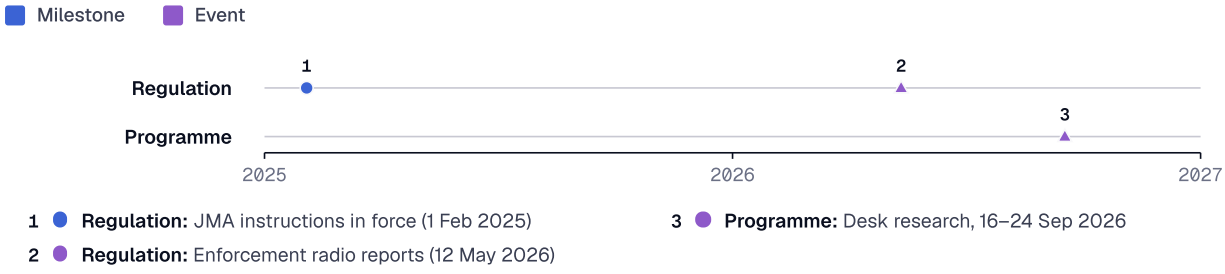
A surgeon's reputation has long travelled by name. Among 808 US arthroplasty (joint-replacement) patients, referral (44.9%) and word of mouth (18.7%) led first contact, against 8.4% for online advertisements [7], and a founder surname can outlive its founder as the name of a practice [12, 13]. Social media has added an audience that can be counted: in Jordan, Osama Al-Odat reached 307,000 Instagram followers by July 2021 [5]. Whether such an audience becomes patients, and whether a name becomes something a practice can grow, move or sell, are separate questions, and they are the subject of this report.

Jordan is the home market for the study. Doctor advertising there is governed by the Jordan Medical Association's instructions, in force since 1 February 2025, which license doctor marketing within a defined list of prohibitions, including superlatives such as “the first” and “the only” [8]; enforcement is complaint-driven, and no named, dated advertising decision is public [9–11]. Amman, with 5,004,600 residents [27], is the capital that a practice elsewhere in the kingdom may wish to enter, and Dubai is among the 8 other regimes whose rules the report reads for a practice that later looks abroad (Chapters 3 and 8).

Nothing about a medical brand was treated as pre-decided: not whether it carries a surgeon's name, an institutional name or both; not what the surgeon is to be known for; and not whether anything working today, such as an established account or clinic name, should survive. The research programme is weighted toward brand questions, with a small direct-response component concerned with how a patient finds and books a surgeon. A claim of uniqueness, such as a surgery no one else performs, is treated as something to test rather than a premise (Chapter 6; Appendix D).

FIGURE 1.1

Dates that frame the report: the rules and the programme



Source: [8, 29, 30]; Chapter 2 (programme dates).

1.2 Objectives

The first pass had a bounded purpose. It was not asked to choose a strategy; it was asked to put dated, sourced and verified evidence under the questions that a strategy must answer, and to separate that evidence from the retold legends that surround famous doctors and famous institutions.

- Make the 7 strategic questions (section 1.3) answerable with cases rather than opinions, drawn from doctors, surgeons, clinics and medical institutions anywhere in the world, including Arabic-language cases.

- Separate documented fact from marketing legend, recording refuted claims as myths retired (Appendix B).
- Read regulation as a research input: how famous doctors have operated inside advertising rules in Jordan and comparable regimes, rather than only what is prohibited (Chapter 3).
- Prepare instruments for the second phase: a surgery-claim test and an Amman sizing worksheet (Appendix D).
- State, for each open decision, what the evidence establishes, what it cannot establish, and what further evidence is needed, without making the decision (Chapters 10 and 11).

> KEY FINDING
>
> The reference library that informed the programme supplied questions and extraction forms only. Every library position the streams tested was supported with limits, reworked, retired, corrected, parked, kept as a hypothesis or escalated; none entered the report as a finding without that test (Chapter 2).

1.3 Research questions

The programme is organised around 7 strategic questions. Each chapter from 3 to 9 exists to put evidence under 1 or more of them. Chapter 10 maps, chapter by chapter, where the evidence is strong, partial or absent.

TABLE 1.1

The 7 strategic questions and the chapters that address them

QUESTION	WORDING	PRIMARY CHAPTER	SUPPORTING CHAPTERS	POSITION AFTER THE FIRST PASS
Q1 Whose brand?	The man, the institution or both, and if both, in what relationship; what the choice cost or earned surgeons later (expansion, succession, sale, a second famous colleague)	5	7, 8, 9	Open decision; all 3 architecture routes remain open
Q2 Known for what?	The category frame, and how famous surgeons chose and changed theirs	9	3, 6	Open decision; 12 candidate frames, none chosen
Q3 How is fame manufactured?	Which engines, gatekeepers and memory assets made surgeons famous, and how long it took	4	3, 9	Pattern established in documented cases; transport to Jordan not established
Q4 How does a medical brand become an asset?	Pricing power, referral captivity, the ability to add surgeons, succession or sale value, survival of a crisis	7	5, 8	Mechanisms documented; a given practice's own economics unknown
Q5 What travels?	From a provincial city to the capital, then abroad: what a surgeon's brand carries and what must be rebuilt	8	3, 5, 7	Open decision; requires a practice's own data and thresholds
Q6 Distinctive or different?	A recognisable signature, a claimed uniqueness or both, and how “the surgery no one else does” has worked for others	6	3, Appendix D	Instrument prepared; a surgeon's verbatim claim required
Q7 How do patients find and book?	What a person with a sore knee does, where the surgeon must appear, and what converts	Study pending	4, 6, 8, 9	Partial evidence only; the patient search and booking study has not run

Source: Research programme plan (strategic questions); Chapters 3 to 9 and Appendix D.

1.4 Scope and exclusions

The first pass was web-only desk research on public sources, retrieved online at the time of research. It covered documented cases worldwide, regulatory texts in Jordan and 8 other regimes (primary where retrievable), official statistics, published studies of patient choice, transaction and annual-report records, and archived platform histories. It did not include fieldwork of any kind or patient data.

TABLE 1.2

Scope of the first pass

WITHIN SCOPE	OUTSIDE SCOPE
Public, web-accessible sources retrieved online between 16 and 24 September 2026	Fieldwork: interviews, observation, surveys, recognition or recall tests
Documented cases of doctors, surgeons, clinics and medical institutions worldwide, including Arabic-language cases	Patient data of any kind
Regulatory texts in Jordan and 8 other regimes, primary where retrievable	Legal, clinical or insurer advice; licensing or eligibility determinations
Research instruments for the second phase	Selection of a brand architecture, category frame or Amman path
What a practice must have in place to keep later moves abroad open	Sizing markets abroad

Source: Chapter 2 (method and limits); Chapter 8 (operating tracks and options abroad).

> LIMIT
>
> Because the pass was desk-only, every finding about patients describes what published studies in other settings report. It does not substitute for the second-phase fieldwork described in Chapter 11.

1.5 Structure of the report

Chapter 2 sets out the method and its limits. Chapter 3 reads the rules that govern doctor marketing in Jordan and in 8 other regimes, because every later chapter operates inside them. Chapters 4 to 7 address fame, brand architecture, differentiation and brand value. Chapters 8 and 9 address market entry and brand strategy. Chapters 10 to 13 synthesise the evidence, set out implications and next steps, consolidate the limitations and conclude. The appendices hold the verification ledger, the retired claims, the contradiction ledger, the research instruments, the glossary, the open questions by chapter and the register of every source retrieved.

TABLE 1.3

Structure of the report

PART	CHAPTERS	CONTENT
Framing	1–2	Introduction; methodology
The rules	3	The regulatory environment in Jordan and 8 other regimes
Fame and brand	4–7	How doctors become famous; brand architecture; distinctiveness and differentiation; the medical brand as an economic asset
Entry and strategy	8–9	Market entry into Amman and beyond; brand strategy and articulation
Synthesis	10–13	Discussion; implications and next steps; limitations; conclusion
Appendices	A–G	Verification ledger; retired claims; contradiction ledger; research instruments; glossary; open questions by chapter; source register

Source: Report chapter map.

CHAPTER 02

Methodology

How the evidence was gathered, checked and graded

CHAPTER SUMMARY

This chapter sets out how the evidence in Chapters 3 to 9 was produced. Seven research streams and one follow-up on platform histories were completed between 16 and 24 September 2026 under a perspective-guided desk-research protocol, adapted in-house: six to eight methodologically diverse perspectives per stream, with a sceptical perspective dedicated to testing popular claims in each of the seven core streams, each perspective researching sources retrieved online at the time of research, and with each perspective's most load-bearing claims (about five per perspective) re-checked in an independent verification pass. Across the programme, 52 perspectives generated 368 research claims and 275 dated history points; independent verification formally checked 306 claims, confirming 286, refuting 16 (5.2%) and leaving 4 unverified, over about 4,476 research actions, with 720 distinct source URLs recorded across the stream ledgers (counted per report, with overlap). The chapter describes the evidence principles, the defence against correlated error, the bounded role of the reference library, the analytical frameworks used by each stream, the verification outcomes and the limits that apply to every finding in this report.

KEY FINDINGS

01 The protocol yielded 368 research claims and 275 dated history points from 52 perspectives across seven streams and a platform-history follow-up; independent verification of 306 load-bearing claims confirmed 286, refuted 16 (5.2%) and left 4 unverified.

02 Verification produced refutation rates from 0% in the architecture, differentiation, asset and market-entry streams to 14.3% in fame (5 of 35) and 17.9% in strategy (7 of 39); the clean streams reflect deliberately bounded claims, not certainty, and their verification passes still corrected dates, fees, ownership shares and denominators.

03 The most consequential single catch recovered a case the programme would otherwise have missed: the claim that no Jordanian orthopaedic surgeon had a documented fame arc was refuted by a dated profile of Osama Al-Odat at 307,000 Instagram followers in July 2021 [5].

04 Verification shifted the regulation stream's answer toward more enforcement and more compliance through its two refutations: two radio reports of 12 May 2026 overturned the claim that Jordan's advertising rules are not visibly enforced [29, 30], and a page footer overturned the claim that a Dubai surgeon's page displays no permit number [31].

05 The correlated-error defence treated agreement between perspectives as a risk signal: where six of seven fame perspectives and five strategy perspectives converged, those claims were verified first and hardest and survived at the source level, with counter-cases recorded and over-reach corrected; the seven regulation perspectives converged on a text each had fetched, and clause-by-clause re-reads found no divergence.

06 Shared sources were disclosed as single sources rather than counted as corroboration; in the strategy stream one study underpinned three perspectives, another four and one institutional page five [7, 32, 33].

07 Where the split is recorded, verification absorbed between about three-quarters of and slightly more than the effort of the perspective passes (161 verification actions against 150 perspective-pass and preflight actions in the asset stream, 128 against 114 in differentiation and 123 against 168 in market entry), within a programme of about 4,476 research actions, counted under two conventions, and 720 distinct source URLs recorded across the stream ledgers (counted per report, with overlap).

08 The reference library of 354 notes in 22 clusters was confined to supplying questions and extraction forms; every library position the streams tested was supported with limits, reworked, retired, corrected, parked or kept as a hypothesis, and none entered the report as a finding.

09 Each stream converted its question into a named analytical instrument, among them the six architecture coding dimensions, the five-question separation and eight-part surgery-claim test for differentiation, the benefit-by-beneficiary asset framework and the four operating tracks for Amman entry, several of them designed for reuse in second-phase fieldwork.

10 Selective verification left 128 of the 368 research claims formally unchecked; they are labelled wherever used, and the whole first pass is desk-only and purposive: no fieldwork or patient data was collected.

2.1 Research design and the questions it serves

This chapter explains how the evidence in Chapters 3 to 9 was produced, checked and graded, so that each finding can be read together with its evidence and its limits. The programme was designed to make strategic questions about building a surgical name answerable, not to answer them in advance. The research was conducted as structured desk research under a fixed verification protocol. Each perspective's most load-bearing claims, about five per perspective and 306 in all, were re-checked in a separate, independent verification pass; claims not selected for checking are labelled 'not independently checked' wherever a chapter uses them.

Every research brief opened with the same non-negotiable frame. It had seven elements, summarised here because they bound what each stream was permitted to conclude.

- Purpose: understand how a surgeon becomes famous and builds a brand that becomes an asset, and how a name built in one city can carry a clinic into the capital and later abroad.
- Proportion: 95% of the programme is brand work; 5% is direct response, meaning how a patient with a sore knee finds and books a surgeon.
- Universal scope: study how doctors, surgeons, clinics and medical institutions anywhere in the world became famous and built brands; prefer cases to opinions; separate documented fact from marketing legend; cite every source.
- Nothing pre-decided: not whether a brand should be the surgeon's name, an institute or both, and not what the surgeon is to be known for.
- The reference library supplies questions and lenses, never findings.
- Regulation is a research input, not a brake.
- Every fact sourced, and a first pass that is web-only, with fieldwork later.

Seven strategic questions follow from that frame. Thirteen research streams were planned to put evidence under them, in four waves beginning with the regulatory environment, the fame record and brand architecture. Table 2.1 maps questions to streams and chapters. At the time of writing, seven streams and one follow-up had been completed. Six further planned streams (branding tactics, awareness and mental availability, word of mouth and partnerships, personal brand construction, brand story and message, and patient search and booking) had not run, so the direct-response question has no chapter yet. Table 2.2 gives the chronology of the completed work.

TABLE 2.1

The strategic questions and where this report addresses them

QUESTION	QUESTION (ABRIDGED FROM THE RESEARCH PLAN)	STREAM	CHAPTER
Q1	Whose brand? The man, the institution, or both, and in what relationship?	Brand architecture	5
Q2	Known for what? The category frame, and how famous surgeons chose and changed theirs	Brand strategy and articulation	9
Q3	How is fame manufactured for a surgeon?	How doctors become famous; platform histories	4
Q4	How does a medical brand become an asset?	The brand as an economic asset	7
Q5	What travels from a provincial city to the capital, then abroad?	Market entry and expansion	8
Q6	Distinctive or different?	Distinctiveness and differentiation	6
Q7	How do patients find and book? (the 5%)	Patient search and booking: planned, not run	Not yet covered
Cross-cutting	How do famous doctors operate inside advertising rules?	Regulation as an input	3

Source: Research plan, version 3 (16 September 2026), strategic questions and stream map.

TABLE 2.2

Chronology of the completed research

STREAM	FILED	PLANNED WAVE	PERSPECTIVES	CHAPTER
Regulation as an input	16 Sep 2026	1	7	3
How doctors become famous	16 Sep 2026	1	7	4
Platform histories (follow-up)	16 Sep 2026	1 (follow-up)	8 account perspectives plus 1 critic	4
Brand architecture	19 Sep 2026	1	6	5
Distinctive or different	19 Sep 2026	2	6	6
The brand as an asset	19 Sep 2026	2	6	7
Market entry and expansion	19 Sep 2026	2	6	8
Brand strategy and articulation	24 Sep 2026	3	6	9
Six further streams	Not run	3 and 4	Not applicable	Not applicable

Source: Method lines of the eight stream reports; sequence table of the research plan.

2.2 The protocol: perspectives, online retrieval and adversarial verification

Every stream followed one protocol: a perspective-guided desk-research protocol, adapted in-house. Its core idea is that several distinct perspectives interrogate a question against sources retrieved online at the time of research; to this the adaptation adds a mandatory adversarial verification stage and fixed rules for synthesis. Figure 2.1 summarises its six stages.

FIGURE 2.1

The research protocol, stage by stage

01

Question and constraints

One research question, the non-negotiable frame and the stream's hard constraints. Where an obvious, comfortable answer exists, it is named and assigned to a perspective to attack.

02

Perspectives

Six to eight methodologically diverse perspectives, including, in every core stream, a sceptical perspective dedicated to testing popular claims. Each receives a written brief naming concrete sub-questions.

03

Perspective passes

Each perspective searches for and retrieves sources online at the time of research (planned range 8 to 15 lookups) and returns structured claims, each with evidence, at least one retrieved source and a confidence grade.

04

Adversarial verification

A separate verification pass for each perspective selects about five load-bearing claims, loads a cited source for each, runs counter-searches and returns CONFIRMED, REFUTED or UNVERIFIED.

05

Synthesis

Refuted claims become myths retired; unverified claims are labelled; tensions enter a contradiction ledger; evidence is graded; conflicts with earlier documents are named.

06

Ledger

A raw per-claim record, with every URL, verdict and the reasoning behind each verdict, is kept beside each report.

Source: The research protocol specification and the method sections of the eight stream reports.

Three terms are used in a fixed sense in this chapter and throughout the report.

- Perspective: one methodologically distinct line of inquiry within a stream, representing a single way of knowing, such as reading primary legal text or reading filings and accounts, with its own brief, its own online searches and its own structured claims.
- Verification pass: a separate, independent check assigned to one perspective, which selects that perspective's most load-bearing claims, loads a cited source for each, runs counter-searches and returns CONFIRMED, REFUTED or UNVERIFIED.
- Research action: one logged step of the research, mostly an online search or page retrieval, counted by each stream under one of two conventions, so programme totals are approximate (section 2.6).

Questions and perspectives

Each stream opened with one research question. Where the question had an obvious, comfortable answer, the brief named it and gave at least one perspective the explicit task of attacking it; the strategy stream, for example, assigned its sceptical perspective the thesis that famous clinics became famous because they chose a sharp category, a clear positioning statement and a memorable big idea. The protocol's rule is that perspectives are methodologically diverse rather than topically sliced, and that perspectives which would reach for the same sources count as one; where perspectives nevertheless shared a source, the reports disclose it (section 2.3). The platform-history follow-up, which rebuilt histories account by account, is the deliberate exception. Each perspective represents a different way of knowing, from reading primary legal text to reading filings and accounts. Each of the seven core streams included one adversarial sceptical perspective, whose brief is to test which widely repeated practices in the field lack evidence and to separate measured findings from unsupported advice; the platform-history follow-up used a completeness critic instead. Table 2.3 lists the perspectives in each stream.

TABLE 2.3

Perspective sets by stream

STREAM	NUMBER	PERSPECTIVES
Regulation as an input	7	Anglo regulator analyst (UK, Australia, US); Jordan enforcement and practice; JMA text reader; Gulf regulator analyst; ad-library auditor; compliant-fame case analyst; popular-claims sceptic
How doctors become famous	7	Platform-mechanics analyst; case historian; sports-and-procedure fame; Arabic-market reader; economics and cost; broadcast and press insider; popular-claims sceptic
Platform histories	8 plus critic	One perspective per account set: Doctor Mike; Sandra Lee; Dr. Miami; Karan Rajan; Arabic platform-native accounts; Arab orthopaedic comparables; Osama Al-Odat; one baseline account set; plus one completeness critic
Brand architecture	6	History; patient choice; economics; architecture; regional (Jordan); sceptic
Distinctive or different	6	Brand science; patient choice; procedure history; clinical evidence; claims regulation; popular-claims sceptic
The brand as an asset	6	Pricing economics; referral behaviour; transactions and succession; licensing and governance; capacity and measurement; crisis sceptic
Market entry and expansion	6	Economics and sizing; expansion history; Amman competition; regulatory operations; patient geography; popular-claims sceptic
Brand strategy and articulation	6	Archival brand historian; category-frame analyst; decision-unit researcher; regional competitive set; service execution and proof; popular-claims sceptic

Source: Perspective records in each stream's raw claim ledger and method section.

Perspective passes and verification

Each perspective ran its own searches and page fetches and returned structured claims, typically 6 to 10, each carrying its evidence, at least one fetched source with title and URL, and a confidence grade. Several perspectives exceeded the planned 8 to 15 lookups to recover blocked originals or check source versions; the reports retain the actual counts. A separate verification pass was then run for each perspective. It selected the claims on which the most depended, about five per perspective, ran its own counter-evidence searches, loaded at least one cited source per claim to check that the source said what was claimed, and returned one of three verdicts. UNVERIFIED was the default when a source would not load. A refuted claim is counted as a success of the method, not a failure of the perspective.

Synthesis rules

Each stream's synthesis was written centrally and never delegated to a perspective, under five rules. Refuted claims never become findings; they are recorded by name as myths retired, because knowing what failed is part of the value of the work (Appendix B). Unverified claims that must appear are labelled as such and carry no load. Genuine tensions between perspectives enter a contradiction ledger, each with a stated resolution (Appendix C). Evidence is graded in a reliability note from strongest to weakest. Where a finding conflicts with an earlier programme document, such as the research plan, an earlier compliance summary or an earlier stream, the conflict is named and disposed of as resolved, parked or escalated as a decision, never silently overridden.

Perspectives and verdicts: an example

Table 2.4 gives the perspective-level record for the two largest streams. Refutations did not cluster in one weak perspective. In the fame stream, five of seven perspectives each had one checked claim refuted; in the regulation stream, the two refutations fell on the Gulf regulatory perspective and the compliant-fame case perspective; in the strategy stream, five of six perspectives had at least one checked claim refuted, the

sceptical perspective being the exception. Across the seven core streams, whose ledgers all record verdicts by perspective, the sceptical perspectives dedicated to testing popular claims had 1 of 37 checked claims refuted (Figure 2.2); in the regulation and fame streams they had the same refutation count as most other perspectives.

TABLE 2.4

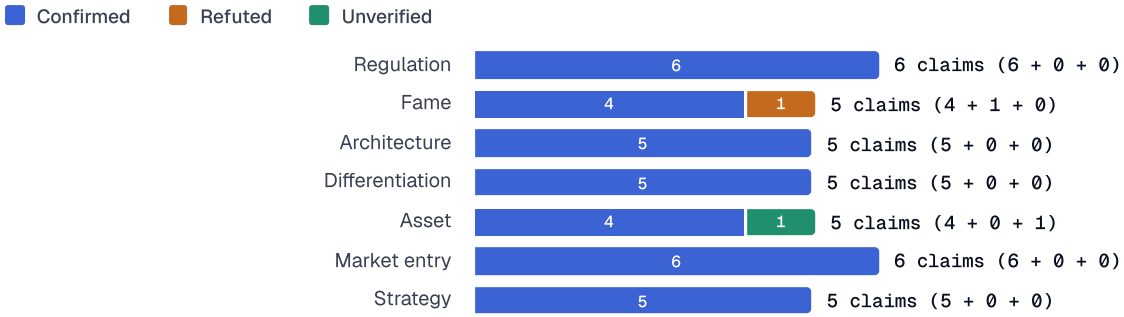
Perspective-level record in the regulation and fame streams

STREAM	PERSPECTIVE	WAY OF KNOWING	CLAIMS	CHECKED	REFUTED
Regulation	JMA text reader	Arabic primary legal texts read clause by clause, cross-read against the 1972 law, the 1989 Medical Constitution and press paraphrases	10	5	0
Regulation	Jordan enforcement and practice	Investigative reporting on what has happened since the instructions took effect on 1 February 2025	10	5	0
Regulation	Gulf regulator analyst	Current primary standards and dated enforcement in Dubai, Abu Dhabi, the UAE, Saudi Arabia, Kuwait and Qatar	10	5	1
Regulation	Anglo regulator analyst	Primary rule texts and dated rulings in the UK, Australia and the United States	10	5	0
Regulation	Ad-library auditor	Observational audit of what is actually advertised in Jordan and Dubai	9	6	0
Regulation	Compliant-fame case analyst	Doctors famous inside restrictive regimes and sanctioned boundary cases, each tested clause by clause	10	5	1
Regulation	Popular-claims sceptic	Widely repeated regulatory claims tested against primary texts and dated enforcement	10	6	0
Fame	Case historian	Dated biographical record of first fame mechanism, gatekeeper, assets, timeline, cost and conversion	10	5	1
Fame	Platform-mechanics analyst	Dated growth records, platform distribution statements and measured audience-to-patient evidence	10	5	1
Fame	Sports-and-procedure fame	Fame built through athletes, team and federation roles and named procedures	10	5	1
Fame	Arabic-market reader	Arabic-language media and regulation in Jordan, the Gulf and Egypt	10	5	0
Fame	Economics and cost	What physician fame converted into and what it cost, with measured evidence preferred	10	5	0
Fame	Broadcast and press insider	How doctors get onto television and into print, and how bookings were assembled	10	5	1
Fame	Popular-claims sceptic	Popular advice on becoming a famous doctor tested against the dated record	12	5	1

Source: Per-perspective claim and verdict records in the regulation and fame streams' raw claim ledgers.

FIGURE 2.2

Sceptical perspectives testing popular claims: verdicts on checked claims, by stream



Source: Per-perspective verdict records in the raw claim ledgers of the seven core streams (37 checked claims; 1 refuted; 1 unverified). The architecture perspective is titled sceptic and the asset perspective crisis sceptic.

Sequencing and the platform-history follow-up

Two sequencing arrangements were used. In the regulation, fame and strategy streams and the platform-history follow-up, each perspective's verification pass began as soon as that perspective's own pass had finished. In the architecture, differentiation, asset and market-entry streams, perspective passes and verification passes were scheduled as capacity allowed; in three of those streams one of the six perspective passes was run centrally, and that pass, like every other, had its own separate verification pass. The differentiation, asset and market-entry drafts also received an independent editorial review. The platform-history follow-up adapted the protocol to time-series evidence: because the first fame pass had taken its account histories from press, the follow-up rebuilt them from archived captures and current pages, with eight account perspectives, eight verification passes and one completeness critic; one verification pass was re-run as a standalone, web-only check. The follow-up recorded 275 dated history points; its verification passes made 154 data re-checks in the run and 26 in the standalone re-run (21 archived points and 5 from current pages), added 31 snapshots and left 48 gaps explicit rather than interpolating them.

2.3 Evidence principles and the correlated-error defence

Five evidence principles recur across the reports. The first, that nothing enters a claim unless it was fetched during the stream, is written into the protocol; the others are practices the reports record, and the last also follows from the programme's web-only frame. Four are summarised in Figure 2.3; all five, with examples, are in Table 2.5.

FIGURE 2.3

Four evidence principles recorded across the programme

PROTOCOL RULE

Fetched, not remembered

Nothing enters a claim unless the page was fetched during that stream. Search snippets guide discovery only.

RECORDED PRACTICE

Verbatim

Quotes, clauses and figures are carried word for word; Arabic stays in Arabic, with a translation.

RECORDED PRACTICE

Negative results need a control

A finding that something does not exist counts only if the search could have found it.

WEB-ONLY FRAME

Public sources, no patient data

Desk research on public sources only; no fieldwork or patient-identifying material.

Source: The research protocol specification, the research plan and the method sections of the stream reports.

Fetched, not remembered. Nothing entered a claim unless its page had been fetched during that stream. Search-result snippets could guide discovery but could not carry a claim; perspectives marked snippet-only material as lower confidence, and material that could not be retrieved was dropped or labelled, never reconstructed from memory.

Verbatim. Quotations, legal clauses and figures were carried word for word, and Arabic stayed in Arabic with a translation. In the regulation stream, five separate verification passes downloaded the Jordan Medical Association's advertising instructions independently and matched the file's checksum [8]. In the strategy stream, intermediate page summaries misreported three items; verification re-read the raw HTML and corrected all three.

Negative results need a control. A finding that something does not exist is only as good as the search that failed to find it. A regulation perspective that reported the Jordanian text as available only in press reproduction had searched rather than fetched, and its negative was superseded by the five perspectives that fetched the file. The strategy stream's claim that no Amman provider publishes volumes was refuted when a verification pass found patient counters in one provider's static HTML [34]. Where searches were bounded, the reports say so, as the asset and architecture streams do for studies of brand decay and of naming.

No interpolation, public sources and no patient data. Time series were built from dated points only, and gaps stayed gaps. No fieldwork or patient-identifying material was collected. Where the best source is private data, such as an account owner's own analytics, the reports name it as an input for later, authorised work rather than approximating it.

TABLE 2.5

Evidence principles and how they were applied

PRINCIPLE	RULE AS APPLIED	EXAMPLE FROM THE PROGRAMME
Fetched, not remembered	A claim needs a page fetched in that stream; snippets guide discovery only and are marked lower confidence	Fame perspectives marked snippet-only items as lower confidence; the asset stream used search snippets for discovery only
Verbatim	Quotes, clauses and figures carried word for word; Arabic kept in Arabic with a translation	Five regulation verification passes matched the JMA file's checksum; three page-summary errors corrected against raw HTML in the strategy stream
Negative results need a control	A result of nothing found counts only if the search could have found a positive; bounded searches are labelled	A searched-not-fetched negative on the JMA text superseded; the claim that no Amman provider publishes volumes refuted
No interpolation	Series use dated points only; gaps stay gaps	48 explicit gaps recorded in the platform histories
Public sources, no patient data	Desk research on public sources; no fieldwork or patient-identifying material	An account owner's own analytics named as a later input rather than approximated

Source: Protocol specification; verification and method sections of the regulation, fame, platform-history, architecture, asset and strategy reports [8, 34].

The correlated-error defence

Multi-perspective research has a characteristic failure: several perspectives can reach the same wrong answer independently because they share a source or a base-rate mistake. The protocol treats this failure as the principal risk of the method and builds three defences against it. First, perspectives are diversified by method rather than by title, so that they do not draw on the same sources. Second, agreement between perspectives is treated as a risk signal rather than as corroboration: claims on which most perspectives converged are verified first and hardest. Third, shared sources are disclosed as one source, not several.

Table 2.6 records how the defence operated. In each stream where perspectives converged, the convergent claim survived at the source level. In the fame stream, verification recorded two counter-cases rather than smoothing them over; in the strategy stream, verification corrected the claim where it over-reached; and in the platform histories, verification added 31 snapshots inside the intervals the perspectives had called bursts; those points cut against rather than for the burst attributions, and two bursts were reclassified as sustained runs. The seven regulation perspectives converged on a text each had fetched, and clause-by-clause re-reads found no divergence. In the strategy stream, one study underpinned three perspectives, another four and one institutional page five; the report discloses each as a single source [7, 32, 33].

TABLE 2.6

Where perspectives converged, and how the convergence was tested

STREAM	WHERE PERSPECTIVES CONVERGED	HOW IT WAS CHECKED	OUTCOME
Fame	Six of seven perspectives: the first fame moment was granted by a third party	Verified first and hardest, case by case, at the source	Survived at source level; two counter-cases (Rajan, Al-Nemr) recorded rather than smoothed over
Regulation	All seven perspectives: the same reading of the Jordanian text	Clause-by-clause re-reads; five independent downloads of the file	Agreement earned: perspectives converged on a document each had fetched and quoted; re-reads found no divergence; one search-based negative superseded
Platform histories	Burst, ramp and plateau shape and platform-native bursts, reached on different platforms, archives and languages	Verification passes added 31 snapshots inside the burst intervals	Shape held; two bursts reclassified as sustained runs
Strategy	Five perspectives: slogans postdate fame	Checked hardest	Survived for Mayo and Cleveland Clinic; corrected where it over-reached, since founder-era creeds existed
Strategy (shared sources)	One study under three perspectives, another under four, one institutional page under five	Disclosed as one source each	Findings resting on them read as single-source
Asset; market entry	Repeated use of the same originals across perspectives	Disclosed in the reliability notes	Not counted as independent corroboration

Source: Verification and reliability notes of the fame, regulation, platform-history, strategy, asset and market-entry reports [7, 32, 33].

> WHAT THIS MEANS FOR THE READER
>
> Where several perspectives within a stream agreed, the agreement was tested rather than assumed. Where a finding rests on one study that several perspectives cited, the chapter concerned says so, and the finding should be read as resting on a single source.

2.4 The role of the reference library

The programme drew on an internal reference library of branding, market-research and behavioural notes. Before the programme was planned, the library was mined note by note, 354 leaf notes in 22 clusters, for the questions, lenses and case types it raises. Its role is bounded by the fifth element of the frame: the library supplies questions and extraction forms, never findings about medicine or about any practice. Where library notes disagree with each other, both sides become research questions; the disagreement over distinctiveness and differentiation examined in Chapter 6 is the clearest example. The third version of the research plan was rewritten on exactly this point after an earlier draft had drawn conclusions from library notes; those conclusions were struck.

Before four streams launched, the relevant notes were read in full (Figure 2.4): 12 for the differentiation stream, 6 for the asset stream, 6 for market entry and 7 for strategy. Provenance was checked rather than assumed. The programme's evidence map of the library classifies every note in the branding-strategy cluster used for Chapter 9 as lacking a traceable primary source, with generic web citations and templates sharing one batch identifier; those notes were therefore used as extraction templates only. In another cluster, one note's citations were found to return repeatedly to the same page, so they could not independently verify its proposition.

FIGURE 2.4

Library notes read in full before launch, by stream



Source: Library-context records prepared before the differentiation, asset and strategy streams; method section of the market-entry report.

The library's positions were then tested as hypotheses. Table 2.7 records what the evidence did to the principal positions the stream reports name. None was adopted as a finding: of the eleven positions listed, one was supported with its limits named, three were reworked, three were retired, one was corrected, two were parked and one was kept as a hypothesis.

TABLE 2.7

Library-derived positions and what the evidence did to them

PRIOR POSITION	STREAM	DISPOSITION
Fame has two engines: reach through gatekeepers, and memorability	Fame	Supported at the level of mechanism; in medicine, memorability attached to face, name and format, and for procedures to the patient's name
Paid follower growth in low-cost geographies builds a following	Fame	Parked as inapplicable: no physician case in the record grew this way
Every point of difference must become a distinctive asset or persona	Differentiation	Retired as an unsupported inference; the converse, that every proven difference is publishable, does not follow either
A surgeon's experience transfers directly to premium pricing	Asset	Retired as evidence for a fee premium
Professional services cannot win on scale; a clinic software system creates captivity	Asset	Reworked as hypotheses: continuity and coordination have evidence; software lock-in is not the demonstrated mechanism
Full-price measures cannot exist because offers are banned	Asset	Corrected: the advertising provisions do not prevent internal measurement of fees
The functional value row is table stakes; the psychological row is the lever	Strategy	Reworked: Amman proof is credentials only, so lawful counts or accreditations would be unoccupied; the measured regional lever is information
For a surgeon the patient is the user, a family member often the decider, referrers and insurers gatekeepers	Strategy	Reworked: two decisions (whether and where; which surgeon); untested in Jordanian elective orthopaedics

PRIOR POSITION	STREAM	DISPOSITION
A big idea must be broad enough to last from a provincial city to the capital and abroad	Strategy	Parked: no case shows a big idea travelling; structure travelled
A strong big idea builds recognition, loyalty and equity	Strategy	Retired as medical evidence; kept as an extraction template
Competitors have a social-media blind spot and scale or captivity advantages	Market entry	Kept as hypotheses, not observed structural facts

Source: Sections on contradictions with earlier documents in the fame, differentiation, asset, market-entry and strategy reports; the programme's evidence map of the library, 15 September 2026.

KEY FINDING

No library position entered this report as a finding. Every position the streams tested was supported with limits, reworked, retired, corrected, parked or kept as a hypothesis, and each disposition is recorded in the stream report that tested it.

2.5 Analytical frameworks by stream

Each stream converted its question into an explicit analytical framework before coding cases. The frameworks share one purpose: to separate things that ordinary brand discussion runs together, so that evidence for one cannot be mistaken for evidence of another. They are coding instruments, not verdicts about any practice, and several were designed to be reused in second-phase fieldwork (Appendix D). Table 2.8 lists the framework each stream used.

TABLE 2.8

Analytical frameworks used by each stream

STREAM	FRAMEWORK	WHAT IT KEEPS APART	CHAPTER
Regulation	Clause-by-clause ledger (permitted, approval, prohibited, mechanics); mechanism-by-regime legality matrix across eight regimes; audit of 26 Jordanian and about 30 Dubai advertisers	What the text says, what is enforced and what is practised	3
Fame	Fixed case-extraction template (first mechanism, gatekeeper, assets owned, timeline, volume, cost, conversion, failure, dated sources); typology of fame engines	The retold origin story and the dated record	4
Platform histories	Dated snapshot series per account; burst, ramp and plateau; platform leadership measured by follower stock, with flow (median views per post over 30 days) recommended as the definition before any strategy relies on it	Audience size and live reach	4
Architecture	Six coding dimensions: name origin, public hierarchy, founder dependence, rights and ownership, operating responsibility, observed outcome; 13 core cases	The name on the door and who owns, operates and depends on it	5
Differentiation	Five-question separation (cue attribution, perceived difference, clinical benefit, scarcity, durability); eight-part surgery-claim test (Appendix D)	Recognisability, perceived difference, clinical benefit and durable advantage	6

STREAM	FRAMEWORK	WHAT IT KEEPS APART	CHAPTER
Asset	Benefit-by-beneficiary framework (six benefits, each with its beneficiary and the evidence that would establish it); seven paired brand and business measures	Trust in a name and transferable economic value	7
Market entry	Four operating tracks (professional status, premises, hospital access, payers); contribution equation with unsupplied inputs left blank	Recognition that travels and access that must be built locally	8
Strategy	Dating rule for slogans; competitor-substitution test; value stack (functional, psychological, monetary) with the proof behind each row; two-decision model (whether and where; which surgeon)	Later codification and the cause of fame; a frame and its proof	9

Source: Method and framework sections of the eight stream reports.

Two of the frameworks are tests rather than descriptions. The strategy stream's dating rule credits a slogan with causing fame only if its first dated record precedes the first dated evidence of fame; no case in that stream qualified. The competitor-substitution test asks whether a positioning statement remains true when another provider's name is swapped in; every statement reconstructed from the sampled Amman materials failed it by construction [34, 35].

The asset stream's benefit-by-beneficiary framework asks, for each possible benefit of a brand, which future benefit survives, who receives it and what must remain in place, so that a patient's trust in a name is not confused with a buyer's ability to acquire it. The market-entry worksheet computes monthly surplus as completed billable units multiplied by retained contribution per unit, less fixed cost and any owner compensation not already counted; every input a practice has not supplied is left blank rather than filled from population or audience figures.

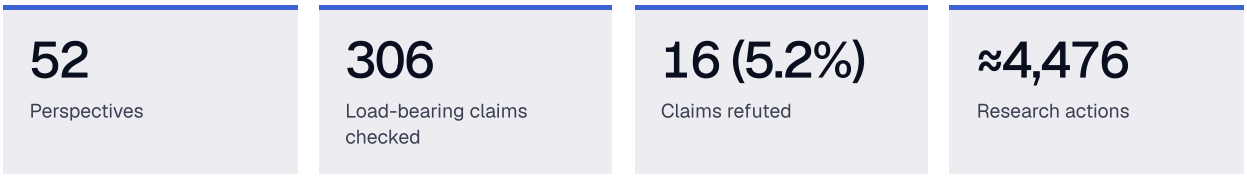
The differentiation stream's surgery-claim test, for a surgeon's claim that a procedure is unique, to be applied once the claim's verbatim wording and supporting evidence are available, is set out in full in Appendix D.

2.6 Verification outcomes

Across seven streams and the platform-history follow-up, 52 perspectives generated 368 research claims and 275 dated history points. Independent verification formally checked 306 load-bearing claims: 286 were confirmed, 16 refuted and 4 left unverified, a refutation rate of 5.2%. The programme logged about 4,476 research actions and recorded 720 distinct source URLs across the stream ledgers. Both totals are approximate: sources are counted per report with overlap, and research actions follow each stream's own counting convention, as explained later in this section. Figure 2.5 gives the headline numbers, Table 2.9 the full record by stream and Figure 2.6 the verdicts by stream; the per-claim verdicts for all 306 checked claims are listed in Appendix A.

FIGURE 2.5

The programme in four numbers



Source: Programme totals of Table 2.9.

TABLE 2.9

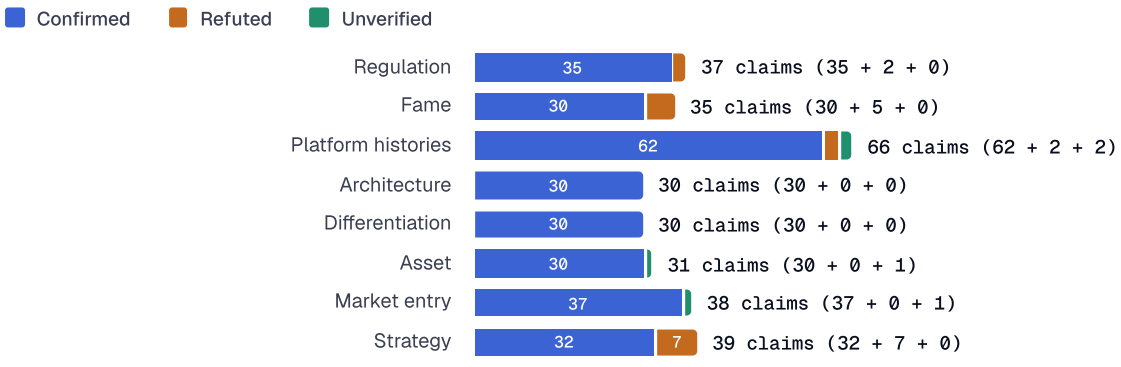
Verification outcomes by stream

STREAM	CHAPTER	PERSPECTIVES	CLAIMS	CHECKED	CONFIRMED	REFUTED	UNVERIFIED	RESEARCH ACTIONS	SOURCE URLS IN LEDGERS
Regulation as an input	3	7	69	37	35	2	0	954	166
How doctors become famous	4	7	72	35	30	5	0	562	237
Platform histories	4	8 perspectives, 8 verification passes, 1 critic	66 perspective claims, from 275 dated points	66	62	2	2	1,336 (excluding the standalone verification re-run)	Per snapshot; not totalled
Brand architecture	5	6	47	30	30	0	0	314	63
Distinctive or different	6	6	38	30	30	0 (1 supporting detail refuted and corrected)	0	246	44
The brand as an asset	7	6	39	31	30	0	1	328	50
Market entry and expansion	8	6	45	38	37	0	1	295	47
Brand strategy and articulation	9	6	58	39	32	7	0	441	113
Programme	All	52	368 research claims; 66 platform-history claims from 275 dated points	306	286	16 (5.2%)	4	≈4,476	720

Source: Method lines and verification notes of the eight stream reports. Sources are distinct URLs counted per report and may overlap; research actions follow each stream's own counting convention. Per-claim verdicts are listed in Appendix A. The asset and market-entry streams also ran three supplementary background checks each, which are excluded from these tallies.

FIGURE 2.6

Verdicts on checked claims, by stream



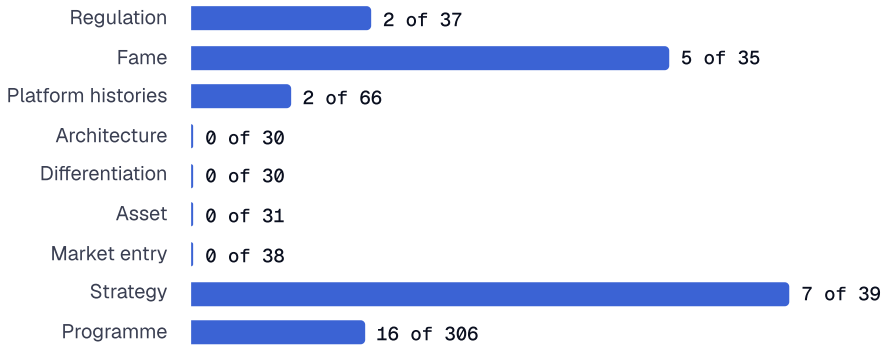
Source: Verdict counts in Table 2.9.

The refutation rate, compared by stream in Figure 2.7, is read as a signal, not a score. Four streams returned no refuted main claim: architecture, differentiation, asset and market entry. Each of those reports states that this means no carefully bounded claim collapsed under checking, which is not certainty. Those streams wrote deliberately narrow claims, such as a dated event, a disclosed contract term or a study's stated sample, and their verification passes still changed the synthesis, correcting a stale opening date, a relabelled fee,

an ownership percentage and a denominator. The streams with the highest rates were strategy, at 17.9% (7 of 39), and fame, at 14.3% (5 of 35). In the fame stream, four of five refutations corrected dates and counts lifted from secondary pages (one of the four, Sandra Lee, corrected a mechanism rather than a date) and one was substantive; in the strategy stream, three were one-sided readings of who decides on surgery, one was a synthesis over-reach and three were detail errors.

FIGURE 2.7

Refutation rate by stream



Source: Computed from the verdict counts in Table 2.9; the fame and strategy reports print these rates as 14% and 18%.

The protocol concentrates checking where the most depends, so not every claim is checked. Of the 368 research claims, 240 were selected for formal verification across the seven core streams; the remaining 128 stay in the ledgers as sourced research material and are labelled where used, for example as not independently checked in Chapter 9. The platform-history follow-up verified all 66 of its perspective claims.

Research actions are not counted identically across streams, and Table 2.10 states each stream's counting convention beside its count. The regulation, fame and strategy streams and the platform-history follow-up count every research action taken in the stream, mostly online lookups (about 900 of 954 in regulation); the platform-history count excludes the standalone verification re-run. The other four streams count individually logged web actions, including failed and repeated retrievals. The two conventions are not strictly comparable, and the programme total is approximate. Where the split between stages is recorded, verification took between about three-quarters of and slightly more than the effort of the perspective passes: 161 verification actions against 150 perspective-pass and preflight actions in the asset stream, 128 against 114 in differentiation, and 123 against 168 in market entry; within the differentiation stream, verification effort exceeded perspective-pass effort for four of the six perspectives.

TABLE 2.10

Research effort by stream: counts, counting conventions and stage splits

STREAM	RESEARCH ACTIONS	UNIT (LOGGED DIFFERENTLY ACROSS STREAMS; NOT STRICTLY COMPARABLE)	PERSPECTIVE PASSES (WITH PREFLIGHT WHERE RECORDED)	VERIFICATION	SUPPLEMENTARY AND EDITORIAL
Regulation as an input	954	All research actions taken in the stream, mostly online lookups (about 900 of 954)	—	—	—
How doctors become famous	562	All research actions taken in the stream, mostly online lookups	—	—	—
Platform histories	1,336	All research actions taken in the stream, mostly online lookups; excludes the standalone verification re-run	—	—	—

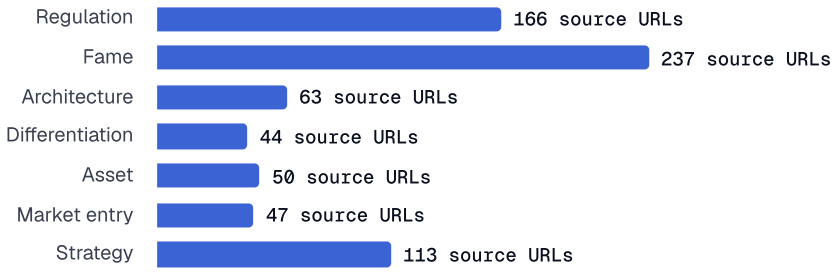
STREAM	RESEARCH ACTIONS	UNIT (LOGGED DIFFERENTLY ACROSS STREAMS; NOT STRICTLY COMPARABLE)	PERSPECTIVE PASSES (WITH PREFLIGHT WHERE RECORDED)	VERIFICATION	SUPPLEMENTARY AND EDITORIAL
Brand architecture	314	Individually logged web actions, including failed and repeated retrievals	—	—	—
Distinctive or different	246	Individually logged web actions, including failed and repeated retrievals	114	128	4 (preflight and supplemental)
The brand as an asset	328	Individually logged web actions, including failed and repeated retrievals	150	161	17 (10 supplementary, 7 editorial)
Market entry and expansion	295	Individually logged web actions, including failed and repeated retrievals	168	123	4 (supplementary source checks)
Brand strategy and articulation	441	All research actions taken in the stream, mostly online lookups	—	—	—
Programme	≈4,476	Two conventions combined; approximate total	—	—	—

Source: Method lines and audit sections of the eight stream reports. Stage splits are shown only where a stream report records them; a dash means no split is given. Differentiation's perspective-pass and verification figures are sums of the per-perspective counts in its report. Because the two counting conventions differ, the programme total is approximate.

Source counts are distinct URLs recorded in each stream's ledger, counted per report and overlapping between reports. They are not independent studies and not the references cited in this report; the References list at the end of the report holds the sources cited. Figure 2.8 gives the counts by stream.

FIGURE 2.8

Distinct source URLs in stream ledgers, not this report's references (see References)



Source: Unique source URLs recorded in each stream's ledger. These are not the references cited in this report; the References list at the end of the report holds the sources cited. The platform-history follow-up records a snapshot URL per data point and gives no total. Counts may overlap between reports, and several reports cite fewer numbered entries than the URLs recorded.

The catches made in verification are the most informative output of that stage, because each names a class of error the chapters would otherwise have carried; Table 2.11 lists them by stream. The single most consequential catch reversed a negative: the fame stream's finding that no Jordanian orthopaedic surgeon had a documented fame arc was refuted by a dated press profile of Osama Al-Odat at 307,000 Instagram followers in July 2021 [5], a case the programme would otherwise have missed. Both regulation-stream refutations moved the answer toward more enforcement and more compliance rather than less [29–31].

TABLE 2.11

What verification caught, by stream

STREAM	VERDICTS OTHER THAN CONFIRMED	WHAT VERIFICATION CAUGHT
Regulation	2 refuted	'Not visibly enforced' was overturned by two radio reports of 12 May 2026 citing referrals for misleading advertising; 'no permit number' was overturned by a page footer carrying a licence-style number valid to 16 September 2025. Also sharpened: a name conflation in an Egyptian strike-off and the framing of a Kuwaiti suspension.
Fame	5 refuted	Four corrected details from secondary pages: a YouTube launch in 2016, not 2017; a key referral in 1985, not 1986; an episode count of 1,681 contradicted by a per-season total of 2,209, and an overstated production credit; and one creator's claimed Instagram-first, press-free rise, a mechanism rather than a date. One was substantive: a Jordanian orthopaedic surgeon with 307,000 Instagram followers in July 2021.
Platform histories	2 refuted, 2 unverified	Framing errors, not number errors: a YouTube channel called dormant had grown from 7.4K to 16.6K subscribers after 2020 and added 28 uploads in a year; an account-existence bound was corrected to its capture date. Five press figures in the fame report were corrected.
Architecture	0 refuted	Distinctions on contract dates, ownership percentages, retirement and current roles: a published Burjeel brand valuation (US$419m, February 2023) does exist, and a 15% pre-IPO stake became 14.4% after listing.
Differentiation	0 refuted; 1 supporting detail refuted	Two open-arm hardware removals in a cited trial were one irritation case and one patient-request case, not two symptomatic removals; demographic wording and construct definitions qualified.
Asset	0 refuted, 1 unverified	A hospital operator's 2024 cost figures could not be re-retrieved and were excluded; a stale project page was superseded by a March 2026 opening announcement; a denominator discrepancy and a study endpoint corrected.
Market entry	0 refuted, 1 unverified	Original records disagree on an overseas branch's opening, April 2016 in the accounts and a November 2015 inauguration release; survey percentages, source rounding and licensing examination requirements qualified.
Strategy	7 refuted	Three one-sided readings of who decides; one synthesis over-reach; three detail errors (an affiliation dated 1949 to 1951, insurers' own terms misread as the official fee schedule, patient counters missed in static HTML).

Source: Verification notes and myths-retired sections of the eight stream reports [3, 5, 29–31, 34, 36–49].

LIMIT

A CONFIRMED verdict means that a bounded claim survived an independent check against its source. It does not validate an institution's self-description, establish causality or show that a foreign case transfers to Jordan. Unverified claims carry no load anywhere in this report.

2.7 Limitations of the method

The method has limits that bound every chapter, and the stream reports state them. The most important is that the first pass was desk research only. No patients, referrers or members of the public were interviewed, no recognition or recall was tested, and no practice's own fees, capacity, referral sources or account analytics were inspected. Several questions a practice most needs answered, such as which name patients remember first, who initiates a referral and how much of a surgeon's demand could transfer to a colleague or a new site, are therefore handed to second-phase fieldwork with instruments prepared, not answered.

Case selection was purposive, not representative. The streams studied cases chosen because they are documented, which skews the record toward successes and, in the fame stream, toward English-language, American and cosmetic-adjacent fame. Patient-choice evidence is mostly stated preference: surveys asking what respondents consider important rather than records of what they chose. The Jordanian survey on which several chapters draw is a gender-preference questionnaire of 1,708 adults, 81.3% of them educated to bachelor's level or higher and 49.7% working or studying in health [50]; no Jordanian study of elective orthopaedic decisions was found. Institutional histories are self-retellings: every origin story in the fame record shortened the timeline and dropped the broker. Foreign cases are precedents, not predictions; no source establishes transport from an American institute or a Gulf hospital group to a surgeon in Jordan.

Some archives and pages were unavailable. The Internet Archive was offline or rate-limiting for roughly a third of the platform-history run, and it was blocked during the strategy stream, so no current tagline could be dated. Several publishers refused retrieval; one Jordanian hospital's official site could not be recovered, and it was excluded from the core architecture comparison; Jordan's advertising committee has no published output. Archives also have a structural blind spot: they begin capturing an account once it is already notable, so the first fame moment sits before the first snapshot in every case. Table 2.12 summarises each limit and how the reports handle it, and Table 2.13 shows how each stream graded its own evidence.

TABLE 2.12

Limitations of the method and how the reports handle them

LIMIT	WHERE IT BITES	HOW THE REPORTS HANDLE IT
Desk-only first pass	No patient, referrer or recognition data; no practice financial, capacity or analytics data	Questions handed to second-phase fieldwork; instruments prepared
Purposive case selection	Cases skew to documented successes and to English-language, US and cosmetic-adjacent fame	Stated in each reliability note; no universal sequence inferred from cases
Stated rather than revealed preference	Most patient-choice evidence is survey-based; no Jordanian study of elective orthopaedic decisions	Designs and samples reported with each finding; Jordan-specific claims marked untested
Institutional self-retelling	Origin stories compress timelines and omit brokers; slogans post-date fame	Dated records preferred; self-descriptions labelled as such
Foreign cases as precedents	Transport to Jordan not established	Conditional implications only; decisions left to each practice
Unavailable archives and pages	Archive outages and blocks; publisher refusals; one hospital site unrecoverable	Failures logged; affected claims narrowed, bracketed or excluded
Archive blind spot	Snapshots begin once an account is notable	Press record used for the first fame moment; archives for later phases
Selective verification	128 of 368 research claims not formally checked	Labelled as not independently checked wherever used
Counting conventions	All research actions in some streams, logged web actions in others; sources overlap across reports	Totals stated as approximate

Source: Reliability, method and limitations sections of the eight stream reports; research plan, part E.

TABLE 2.13

How each stream graded its own evidence

STREAM	STRONGEST EVIDENCE	WEAKEST EVIDENCE
Regulation	Primary texts fetched and re-fetched: the JMA instructions, the DHA standard, the Saudi annex, the GMC guidance, Australian and US legal texts	Jordanian broadcast booking terms; television roles attested only by unsourced encyclopaedia lines; snippet-only totals
Fame	Dated primary and near-primary records re-checked at source; three peer-reviewed patient-choice studies read in full	Search-summary-only pages; platform profile counts; income and waitlist figures from industry blogs
Platform histories	Exact integers read from raw archived pages and re-read to the digit	Snapchat figures; embed-card TikTok counts; bio-site floors; undated snippets
Architecture	Dated issuer disclosures and audited accounts	Causal claims about naming; success-only selection; transport to Jordan
Differentiation	Original clinical comparisons for narrow outcomes; the official JMA text; actual foreign adjudications	Promoter claims of uniqueness; institutional origin stories; a non-official transcription of the Medical Constitution
Asset	Regulator records, issuer filings, audited accounts, administrators' announcements	Provider self-descriptions; private contract terms; founder-exit counterfactuals
Market entry	Official statistical tables with explicit denominators; licensing service cards; statutes read	Interested explanations of commercial success; transport from hospital groups to a solo surgeon
Strategy	Peer-reviewed quantitative studies read in full; institutional pages checked against raw HTML	Vendor and consultant narratives; self-published programme books; ad-library page names without ad text

Source: Reliability notes of the eight stream reports.

> **WHAT THIS MEANS FOR THE READER**
>
> The findings are strongest where they rest on primary texts, filings and dated records, and weakest where they would require knowing how patients in Jordan actually choose. The brand architecture, the category frame and any path into Amman remain decisions for each practice; the local evidence needed to inform them has been specified rather than assumed.

PART II

The evidence

03 The regulatory environment

04 How doctors become famous

05 Brand architecture

06 Distinctiveness and differentiation

07 The medical brand as an economic asset

08 Market entry: the capital and beyond

09 Brand strategy and articulation

CHAPTER 03

The regulatory environment

Permissive text, complaint-driven enforcement and the proof devices that do not travel

EVIDENCE BASE REGULATION	69 Claims generated	37 Put to verification	35 Confirmed	2 Refuted	0 Unverified	166 Sources recorded	954 Research actions

CHAPTER SUMMARY

This chapter reads the rules that govern a Jordanian surgeon's marketing at home and in the markets a practice might later enter. The Jordan Medical Association's advertising instructions, in force since 1 February 2025, are a five-page, thirteen-article text that licenses doctor marketing and prohibits a defined list; they set a 10-dinar website licence, contain no per-post approval, and leave the unit of an "advertisement licence" undefined [8]. Enforcement is complaint-driven and secret: the JMA complaints committee received 106 complaints and referred 5 doctors to the disciplinary council between May 2025 and July 2026, and no named, dated advertising decision is public [9-11]. A comparison of Jordan with eight comparator regimes shows that credentials, institutional roles, education and broadcast are lawful everywhere, while the proof devices are regime-specific: testimonials fail in Australia, Saudi Arabia, Qatar and Kuwait, patient imagery in Saudi Arabia, Qatar and Kuwait, offers in Jordan, and unsubstantiated superlatives in every regime read.

KEY FINDINGS

01 The JMA instructions are a 5-page, 13-article council text in force since 1 February 2025 that license doctor marketing and prohibit a defined list; the file was unchanged from 22 December 2024 when last checked on 16 September 2026 [8].

02 The only fee in the issued text is 10 dinars for a website licence; the September 2024 draft's 50-dinar website fee and 5-dinar per-page fee did not survive, and no per-post approval clause exists [8, 51].

03 Before-and-after images of the same patient are lawful in Jordan with written consent, while intra-procedure imagery, superlatives such as "the first" and "the only", products and sponsors, and unregistered specialties are prohibited [8].

04 The JMA complaints committee received 106 complaints between May 2025 and July 2026, referred 5 doctors and closed 71, with orthopaedic surgery (9) among the top three categories [9].

05 The JMA 2025 annual report records more than 100 complaints and 50 doctors summoned but publishes no advertising count and never mentions the Article 4 advertising committee [10].

06 Of 26 Jordanian physician advertisers audited on 16 September 2026, 10 (38%) showed a text-visible conflict with the instructions (an observation against the text, not a finding of breach; no enforcement action is implied), 14 (54%) ran only permitted content, and none displayed a JMA licence reference [52, 53].

07 Across the regimes read, credentials, education, broadcast, books and institutional roles are lawful everywhere, while testimonials range from a criminal offence in Australia (up to $60,000 for an individual) to lawful with written consent in Dubai [54, 55].

08 Dubai's operative standard remains ST-21 version 1.1 of 2022, re-circulated on 17 August 2026; a separate circular of 23 August 2025 remains unread [56, 57].

09 The sanctioned doctors in 5 jurisdictions share one signature, a camera or promotion that changed clinical behaviour or exposed a patient's identity, while the famous doctors relied on credentials, roles, education and broadcast [58-60].

3.1 The instrument and its standing

The rules that govern a Jordanian doctor's marketing sit in two layers: a professional layer issued by the Jordan Medical Association (JMA) and a state layer administered by the Ministry of Health. The professional layer is one instrument, تعليمات الإعلانات والإعلام الطبي للأطباء (instructions on medical advertising and media for physicians), a five-page, thirteen-article PDF issued by the JMA council under Article 35(ل) of Law 13/1972, which charges the council with determining what physicians may advertise [8, 11]. It is council-level instructions, not a Cabinet regulation, and no Official Gazette issue was found; the JMA posted it on Facebook on 24 December 2024 and Alwakeel reproduced it verbatim the same day [61, 62]. It has been in force since 1 February 2025 (Art. 13), and its server date was still 22 December 2024 when last checked on 16 September 2026. In the independent verification pass, the file was downloaded separately and its checksum matched [8].

FIGURE 3.1

The JMA instructions at a glance

5	13	10 JD	1 Feb 2025
pages	articles	website licence fee (Art. 7)	in force (Art. 13)

Source: Primary text read in full [8].

Article 3 incorporates Articles 5(أ) and 10 of the 1989 Medical Constitution. They carry a blanket ban on self-advertising, save one newspaper announcement of up to a week at opening, relocation or a new specialty, and bar press writing that reads as personal publicity, lending one's name to drug promotion or commercial purposes, and claiming unproven methods. Through Articles 41 and 42, cross-referenced in Article 5(2)(ج), the Constitution also bars charging outside the JMA fee schedule and advertising set times for free treatment [8, 63, 64]. Article 9(ز) of the instructions makes the doctor personally liable for any content on his own site or page, whoever produced it [8].

The state layer

A second layer operates independently of the JMA. Public Health Law 47/2008, Article 5(ب), provides that «لا يجوز لاي شخص القيام باعمال الدعاية والاعلان ... ما لم يحصل على ترخيص لذلك من الوزير» (no person may carry out publicity and advertising without a licence from the Minister), and Article 9 lets the Minister close premises [65]. The 2014 clinic regulation requires the title on a clinic sign to match the Ministry licence (Art. 7(ب)) [66]. No separate Ministry advertising instructions were found [65], and a former head of the JMA professional-conduct committee said in May 2026 that ministry oversight still needs «تطوير وتفعيل أكبر» (greater development and activation) [29].

3.2 The Jordanian text, clause by clause

The instructions do not ban doctor marketing. They license it, attach conditions to some forms of it and prohibit a defined list. The clause ledger in Table 3.1 sets out every operative clause by status.

TABLE 3.1

Clause ledger of the JMA medical advertising instructions

STATUS	CLAUSE	WHAT IT SAYS
Permitted, no approval	5(1)	Name, facility, addresses, hours; university; titles and degrees; specialties granted under law; phone numbers
Permitted, no approval	5(2)	A website; advertising on social media and audiovisual and print media, if the facility and doctor are "duly licensed"
Permitted, no approval	5(2)(د)	Television, radio and press interviews, but not "exploited for direct promotion" of the facility or the doctor
Permitted, no approval	5(2)(هـ)	Scientific information, health-education topics and treated cases, only if scientifically established or published in refereed journals or conferences (a substantiation test, not an approval gate)
Permitted, no approval	9(ح)	Before-and-after photos and video of the same patient, respecting privacy, after the patient's written consent; applies to television programmes and adverts too
Permitted, no approval	Constitution 5(أ)	One newspaper announcement of up to a week at opening, relocation or a new specialty
Committee or council approval	5(2)(ج)	Offers, discounts, free or reduced treatment: banned "subject to the fee schedule and Constitution Arts. 41–42, and provided the committee approves"; Art. 9(هـ) repeats the ban with no proviso
Committee or council approval	9(ب)	Society memberships, honorary certificates, titles, diplomas, courses
Committee or council approval	4(ب)(2)	Free medical days
Committee or council approval	6	Announcing courses, conferences, workshops, unless issued by one of eight listed bodies (Ministry of Health, Royal Medical Services, accredited hospitals, syndicates and their societies, university faculties, accredited e-learning platforms, licensed societies, accrediting councils)
Prohibited	5(2)(و)	«الأول، الأوحد، الأبرع، الوحيد» (the first, the sole, the most skilled, the only) and the like
Prohibited	5(2)(ب), 9(ج), 9(د)	Any drug, therapeutic or cosmetic product, device or sponsoring company, licensed or not
Prohibited	9(أ)	Any certificate or specialty not registered with the Jordan Medical Council
Prohibited	9(ح)	Any image or video of the patient during the surgical or cosmetic procedure
Prohibited	9(هـ)	Instalment plans advertised outside the facility, by any medium
Prohibited	9(و)	Non-Arabic primary language; other languages only as a matching translation strip
Prohibited	5(2)(ز), Constitution 10(أ)	Unregistered "discoveries" or unproven methods
Prohibited	9(ط)	Indecent content
Mechanics	7	Ten dinars for the licence of the facility's or doctor's website

STATUS	CLAUSE	WHAT IT SAYS
Mechanics	8	An "advertisement licence application" requires JMA and pension dues paid and listing in the practising register; a licensed facility; the facility's address and phones on the site or page; the facility's dues paid
Mechanics	4	A seven-member advertising committee (the president or a delegate, two council members, four doctors of five years' standing, two of them from the private-sector committee) that monitors and controls advertising, licenses free days and recommends referrals
Mechanics	12	Violating doctors go to the disciplinary council; violating facilities may be referred to the courts
Mechanics	13	In force from 1 February 2025; no transitional or review clause

Source: Clause numbers are those of the instructions unless marked "Constitution" (the 1989 Medical Constitution, incorporated by Art. 3) [8, 63].

Three of the permissions bear directly on public visibility. Advertising on social media, television, radio and print is lawful once the facility and doctor are «مرخصين حسب الأصول» (duly licensed) (Art. 5(2)); media appearances are lawful unless used «للترويج المباشر» (for direct promotion) (Art. 5(2)(د)); and consented before-and-after images of the same patient are lawful on social media and television alike (Art. 9(ح)) [8]. Education is governed by a substantiation test rather than an approval gate:

> «عدم الإعلان أو نشر أي معلومات علمية أو مواضيع تثقيفية صحية أو حالات مرضية تم علاجها ما لم تكن مثبتة علميا أو منشورة في مجلات محكّمة أو مؤتمرات علمية محكمة» *(No advertising or publishing of any scientific information, health-education topics or treated cases unless scientifically established or published in refereed journals or refereed scientific conferences.)*
>
> Art. 5(2)(هـ), JMA instructions. One independent extraction reads «ومنشورة» (and published), which would make the test conjunctive; the majority reading is «أو» (or) [8].

Approval is required for four matters: offers and free or reduced treatment (Art. 5(2)(ج)); society memberships, honorary titles, diplomas and courses (Art. 9(ب)); free medical days (Art. 4(ب)(2)); and course or conference announcements outside eight listed bodies (Art. 6). The prohibitions are specific rather than general: superlatives, products and sponsors, unregistered specialties, intra-procedure imagery, instalment advertising outside the clinic, a non-Arabic primary language and unregistered discoveries [8].

FIGURE 3.2

Three tiers of the JMA instructions

PERMITTED

Permitted without approval

Identity and credentials (5(1)); licensed website and social, broadcast and print advertising (5(2)); media appearances without direct promotion (5(2)(د)); substantiated education (5(2)(هـ)); consented before-and-after of the same patient (9(ح)).

COMMITTEE OR COUNCIL

Approval first

Offers and free or reduced treatment (5(2)(ج), contested by 9(هـ)); memberships, honorary titles, diplomas and courses (9(ب)); free medical days (4(ب)(2)); course and conference announcements outside eight listed bodies (Art. 6).

BANNED

Prohibited

Superlatives (5(2)(و)); products, devices and sponsors (5(2)(ب), 9(ج–د)); unregistered specialties (9(أ)); intra-procedure imagery (9(ح)); instalment advertising outside the clinic (9(هـ)); non-Arabic primary language (9(و)); unregistered discoveries (5(2)(ز)).

Source: Summary of the clause ledger in Table 3.1. [8]

What the text leaves open

Three ambiguities are recorded rather than resolved. "Duly licensed" in Article 5(2) may mean the practice licence or an advertising licence. Article 8 is headed «متطلبات تقديم طلب ترخيص إعلان للجنة» (requirements for an advertisement-licence application to the committee), yet never says whether that licence covers a site or each advertisement. And Article 5(2)(ج) makes committee-approved offers arguable while Article 9(هـ) repeats the ban without the proviso; the source study concludes that a strict committee will read Article 9. The text is silent on testimonials, third-party reviews and influencers; paid posts are caught by the Article 2 definitions, which extend to «الانترنت ووسائل التواصل الاجتماعي» (the internet and social media), and by Article 9(ز) [8].

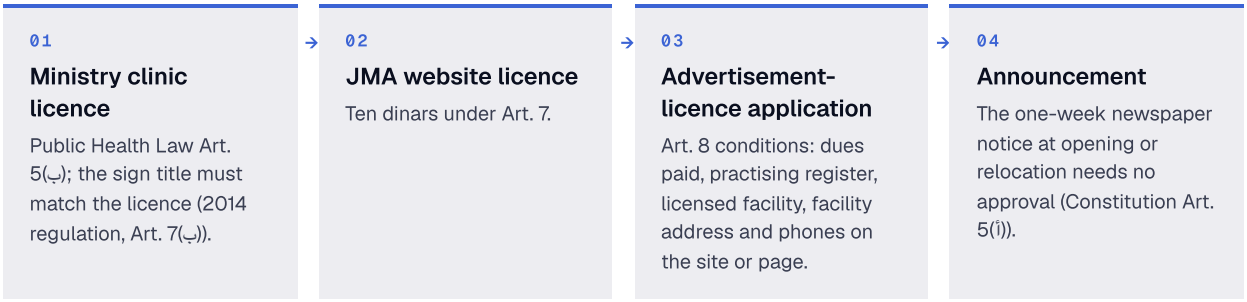
> KEY FINDING
>
> The enacted text is narrower than the paraphrase in circulation. It licenses a website for 10 dinars and defines an advertisement-licence application of undefined unit; it contains no per-post approval, no per-page fee and no review clause. Health education needs substantiation, not approval, and media appearances need no approval [8].

3.3 Mechanics, penalties and the draft-to-final trail

Article 7 sets the only fee: «تستوفي النقابه مبلغ عشرة دنانير مقابل رسم ترخيص موقع المنشأة أو الطبيب الإلكتروني» (the Association collects ten dinars as the licence fee for the facility's or physician's website). Article 8 sets four conditions for an advertisement-licence application, and Article 4 gives a seven-member committee the task of controlling medical advertising «بكافة أشكاله وأنواعه» (in all its forms and kinds), a mandate broad enough for the committee to assert wider scope than the text spells out [8].

FIGURE 3.3

Sequence for announcing a new clinic, as the source study reads the texts



Source: [8, 63, 65, 66]

The penalty route

Article 12 hands enforcement to the disciplinary machinery of the 1972 Law, which a patient or competitor can trigger with a fee-paid written complaint (Art. 48). Hearings are secret and judgments may be published only once final (Art. 50) [11]. The consequence is structural: no body of published case law shows where the line is drawn.

TABLE 3.2

Disciplinary route and sanctions under the JMA Law

STEP	PROVISION	CONTENT
Referral	Instructions Art. 12	Violating doctor to the disciplinary council; violating facility may be referred to the courts
Trigger	Law Art. 48	Council's own knowledge, or a written complaint from a doctor or citizen against a fee
Investigation	Law Art. 49	Three-physician investigation committee
Hearing	Law Art. 50	Secret; judgments unpublished unless final and approved by the council
Interim measure	Law Art. 53	Provisional suspension during proceedings
Sanction	Law Art. 55(أ)	Warning
Sanction	Law Art. 55(ب)	Fine of 100 to 1,000 dinars
Sanction	Law Art. 55(ج)	Bar from candidacy for president or council for up to two terms
Sanction	Law Art. 55(د)	Temporary ban from practice for up to two years
Sanction	Law Art. 55(هـ)	Permanent ban and strike-off, only after a final court conviction
Appeal	Law Arts. 57, 59	Higher Disciplinary Council, then the Administrative Court within 60 days

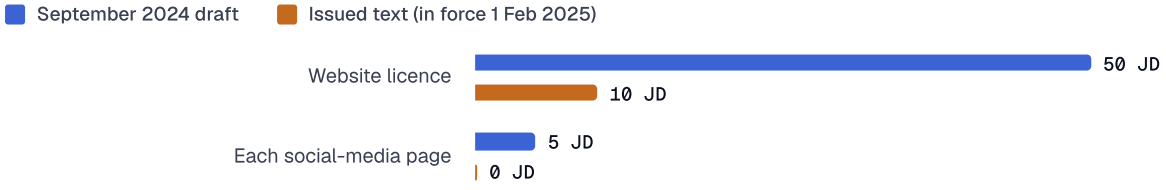
Source: [8, 11]

From draft to final

The September 2024 draft set a 50-dinar website fee plus 5 dinars for every social-media page and routed advertisements to the professional-conduct committee before publication [51, 67, 68]; the issued text cut the website fee to 10 dinars and dropped the per-page fee and the pre-publication routing [8], as Figure 3.4 and Table 3.3 show. The per-post reading still in circulation traces to that draft and to a May 2026 paraphrase by a former head of the JMA professional-conduct committee, who said the instructions «تمنع أي طبيب من إنشاء صفحات أو نشر إعلانات طبية دون ترخيص مسبق» (prevent any doctor from creating pages or publishing medical advertisements without prior licence), words that match no clause [29]. The Dental Association's 2022 regime shows what an explicit per-page system looks like, with approval for any social-media page and a 200-dinar application fee; the verification pass found the JMA text to be a near-verbatim adaptation of it, without that clause [69].

FIGURE 3.4

Licence fees: September 2024 draft versus issued text



Source: The issued text sets no per-page fee (Art. 7 is its only fee); the absence is shown as 0. Draft figures as reported in September 2024 [8, 51, 67].

TABLE 3.3

What changed between the draft and the issued text

ELEMENT	SEPTEMBER 2024 DRAFT	ISSUED TEXT (IN FORCE 1 FEBRUARY 2025)
Website fee	50 dinars	10 dinars (Art. 7)
Social-media pages	5 dinars per page	No per-page fee
Pre-publication review	Advertisements presented to the professional-conduct committee before publication	No per-post approval clause; an Art. 8 application of undefined unit
Reviewing body	Professional-conduct committee (لجنة ضبط المهنة)	New seven-member advertising committee (Art. 4)

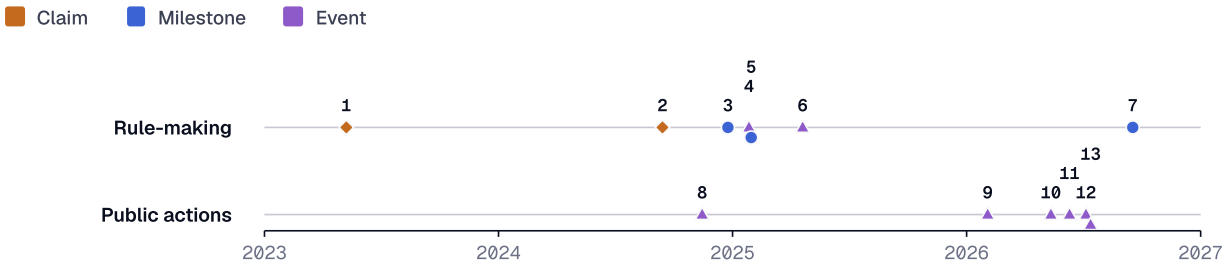
Source: [8, 51, 68]

Review history

On 24 December 2024 the Private Sector Doctors' Assembly rejected the instructions «جملة وتفصيلا» (wholesale), objecting to Articles 5 and 6 [70]. On 25 January 2025 the head of the JMA media committee said the council would apply them for six months and review them if defects appeared, the protests having concerned "two or three" clauses; objectors also argued that the Article 7 fee conflicts with the Press and Publications Law [71]. The council changed in April 2025, when Issa Al-Khashashneh was elected president with 17,200 of 46,000 members eligible to vote [72]. Through 16 September 2026 no amendment, suspension, review outcome or court challenge was found, and a former head of the JMA professional-conduct committee in May 2026 still described the 2024 text as operative [8, 29]. This is absence of evidence after a reasonable search, not proof that no internal decision exists.

FIGURE 3.5

Jordan: rule-making and public actions, 2023 to 2026



1 **Rule-making:** 2023 JMA announces a regulating system
2 **Rule-making:** 2024 Draft: 50 JD plus 5 JD per page
3 **Rule-making:** 2024 Issued; private-sector rejection
4 **Rule-making:** 2025 Six-month run-in announced
5 **Rule-making:** 2025 In force
6 **Rule-making:** 2025 New JMA council elected
7 **Rule-making:** 2026 Text unchanged at last check
8 **Public actions:** 2024 Fee-schedule referral
9 **Public actions:** 2026 Dental: 25 referrals reported
10 **Public actions:** 2026 Advertising-linked fine reported
11 **Public actions:** 2026 Surgeon suspended, clinic closed
12 **Public actions:** 2026 Fake-sticker litigation
13 **Public actions:** 2026 106 complaints reported

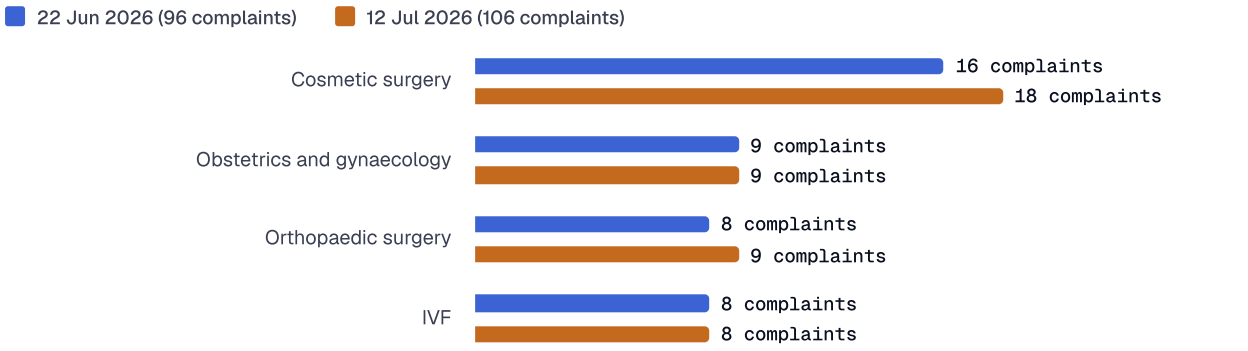
Source: Positions are decimal years derived from the dated sources; the dental referrals are placed at the date they were reported, not the date they were made [8, 9, 51, 68, 70-78].

3.4 Enforcement in Jordan: complaints, reports and the ad record

Enforcement in Jordan is real, complaint-driven and secret. The JMA complaints committee received 106 complaints between May 2025 and July 2026, referred 5 doctors to the disciplinary council, closed 71 files and left 35 pending; orthopaedic surgery tied for second place with 9 complaints, and 9,620 dinars were recovered for overcharged patients [9]. An earlier snapshot of 22 June 2026 recorded 96 complaints, 58 technical committees and 162 consultants [79]. The committee chair attributes most complaints to «هوس التجميل والإعلانات المضللة عبر وسائل التواصل الاجتماعي» (the cosmetic obsession and misleading advertisements on social media), but neither article states the grounds of the five referrals; that they concern care outcomes rather than advertising is an inference, not a reported fact [9, 79].

FIGURE 3.6

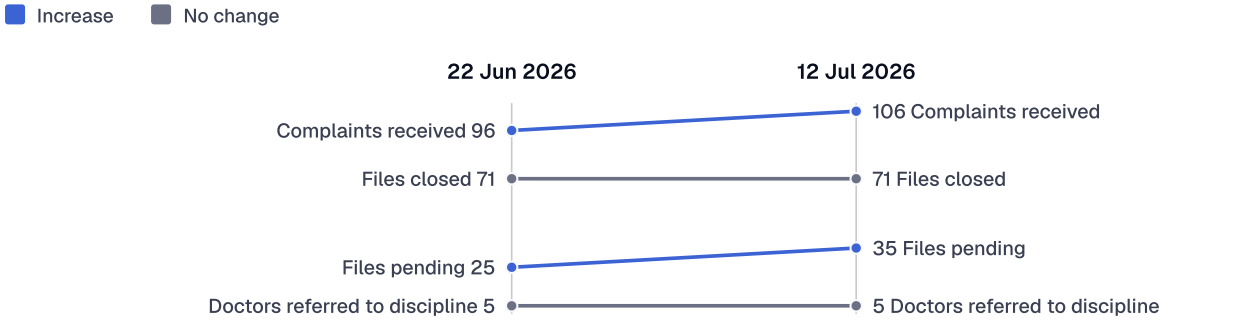
JMA complaints by leading category, two snapshots



Source: The July figures run from May 2025; the June snapshot's start date is not stated [9, 79].

FIGURE 3.7

JMA complaint outcomes, June and July 2026 snapshots



Source: Closed and pending files sum to the complaints received in each snapshot; the sources do not state how the five referrals relate to those two counts [9, 79].

The JMA's 177-page 2025 annual report states that the professional-conduct committee made recommendations ranging from closing files to permanent strike-off and followed up «الدعاية غير المنضبطة» (undisciplined promotion), with Ministry of Health licensing staff in its sessions. It publishes no advertising case count, and the Article 4 advertising committee appears nowhere in it [10].

FIGURE 3.8

The JMA 2025 annual report on professional conduct

30+	100+	50	0
committee meetings	complaints and reports examined	doctors summoned	mentions of the Art. 4 advertising committee

Source: [10]

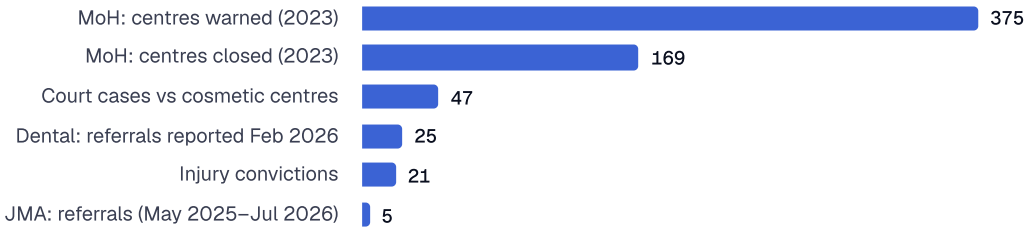
The one advertising-linked sanction described publicly is a fine. After a general practitioner was arrested in May 2026 on unrelated charges, the president of the plastic surgeons' society (جمعية جراحي التجميل) told Roya that the man had run platform advertisements «غير متوافقة مع العادات الأردنية» (inconsistent with Jordanian customs) and had been fined earlier; his clinic was licensed for general practice only, yet he presented himself as a «طبيب تجميل أردني» (Jordanian cosmetic doctor) on an Arab television programme [76, 80]. The account is second-hand, from an interested party, and states neither the date, the instrument nor the body that imposed the fine [76]. A Roya reel of the next day describes the same man as «غير مسجل بالنقابة» (not registered with the syndicate), which, if meant literally, sits awkwardly with a JMA fine [81]. In the same week the JMA spokesman conceded the limits of the syndicate's powers [30]:

> «النقابة لا تمتلك الصلاحيات القانونية الكافية لضبط جميع المخالفات المرتبطة بالإعلانات الطبية» *(The syndicate does not possess sufficient legal powers to control all violations linked to medical advertising.)*
>
> JMA spokesman, Husna FM, 12 May 2026 [30].

Other public actions concern fees, scope and safety rather than a licensed doctor's advertising copy. The much-reported "first referral" of 16 November 2024 concerned the fee schedule and predates the instructions [74]; a surgeon was suspended and his clinic closed pending court cases in June 2026 [77]; and the Dental Association reported in February 2026 that it had referred 25 impersonation cases to the judiciary [75]. The state acts against unlicensed practice and product promotion: 169 centres closed in 2023 and 375 warned; 47 court cases against cosmetic-centre workers and owners between 2017 and mid-2024, with 21 injury convictions and a further 16 unlicensed-practice convictions; and a January 2026 requirement of prior approval before cosmetic products are promoted [82, 83]. An August 2026 press piece called the JMA conduct committee frozen; it names no sources and conflicts with the JMA's own account of more than 30 meetings [10, 84].

FIGURE 3.9

Adjacent enforcement counts in Jordan (none advertising-specific)



Source: Counts cover different bodies, periods and conduct and are shown for scale only. Court cases and injury convictions run from 2017 to mid-2024; a further 16 unlicensed-practice convictions are reported [9, 75, 82].

What practitioners publish

The Meta Ad Library shows Jordanian physicians advertising at scale 19 months into the regime. On 16 September 2026 roughly 2,600 active ads reaching Jordan matched «عيادة» (clinic), about 350 «عظام» (bones) and about 53 «خصم عيادة» (clinic discount); raw totals are polluted by spam, so only the audited samples carry weight [52, 53, 85]. Of 26 physician advertisers read in full, 10 (38%) carried a text-visible conflict with the instructions, 14 (54%) ran only Article 5(1) content plus educational video, and none displayed a JMA licence reference. Ads carrying such conflicts started between November 2025 and September 2026, and 2024-dated ads were still active [52, 53, 85]. The verification pass re-read 3 of the 26 advertisers; the other counts were not independently recounted, and the audit tables (Table 3.4, Table 3.5, Table 3.6) mark them accordingly.

> HOW TO READ THE AUDIT
>
> The audited advertisers are not named in this report; where one must be told apart from another it is referred to by letter (Advertiser A, Advertiser B). Each count records wording observed in ad text and set against the text of the JMA instructions. These are observations, not findings of breach, and no enforcement action against any advertiser is implied.

TABLE 3.4

Audit of 26 Jordanian physician advertisers, 16 September 2026

OBSERVATION AGAINST THE TEXT	ADVERTISERS (OF 26)	SHARE	VERIFICATION
Permitted content only: Art. 5(1) content plus educational video	14	54%	Not independently checked
Text-visible conflict with the instructions	10	38%	Not independently checked
Not classified in the sources	2	—	Remainder of the 26
JMA licence reference displayed	0	—	Not independently checked

Source: Observations against the text of the instructions, not findings of breach; no enforcement action is implied. Advertisers are not named. The licence-reference row overlaps the other rows. Text-only audit; 3 of 26 advertisers re-read in the verification pass, the rest not independently recounted [52, 53, 85].

TABLE 3.5

Conflict types observed among the 10 advertisers with a text-visible conflict

CONFLICT TYPE OBSERVED	CLAUSE OF THE INSTRUCTIONS	ADVERTISERS (OF 10)	VERIFICATION
Named-patient outcomes or guarantees	5(2)(هـ)	7	Not independently checked
Device or product brands	5(2)(ب), 9(د–ج)	6	Not independently checked
Superlatives	5(2)(و)	4	Not independently checked
Discounts or price lists	5(2)(ج), 9(هـ)	3 (plus 1 hashtag)	Not independently checked
Unapproved awards or fellowships	9(ب)	2	Not independently checked

Source: An advertiser can appear in several rows. Observations against the text of the instructions, not findings of breach; no enforcement action is implied. Patient-identifying video appeared in 5 advertisers; written consent cannot be verified from the library [8, 52, 53].

The superlatives observed are of the kind Article 5(2)(و) lists, among them Advertiser A's «الوحيد» (the only one), applied to a named town, and Advertiser B's claim to the best joint quality in the world [52, 53]. An explicit free consultation is rare: only 7 ads reaching Jordan have ever contained «كشفية مجانية» (free consultation), 4 of them non-medical, though the same inducement appears in other wording [52, 86]. Among the 12 orthopaedic and spine advertisers sampled, 8 ran purely educational or credential ads [53].

TABLE 3.6

Ad content of twelve orthopaedic and spine advertisers in the Jordan sample

AD CONTENT	ADVERTISERS (OF 12)	VERIFICATION
Educational or credential ads only	8	Not independently checked
Named-patient outcome videos	3	Not independently checked
Device promotion	1	Not independently checked

Source: From the same Ad Library reading of 16 September 2026; not independently recounted. Observations against the text of the instructions, not findings of breach; advertisers are not named [53].

TABLE 3.7

Jordanian and Dubai advertiser samples compared, 16 September 2026

MEASURE	JORDAN (26 PHYSICIAN ADVERTISERS)	DUBAI (ABOUT 30 HEALTHCARE ADVERTISERS)
Price, discount or free offer	3 clear, plus 1 hashtag (banned in Jordan)	17 (lawful in Dubai)
Absolutes, superlatives or guarantees	4 superlatives; 7 named-patient outcome or guarantee claims	At least 7 using wording the Dubai standard bans
Testimonials or patient videos	Named-patient videos in 5 advertisers; consent not verifiable	6 influencer, celebrity or customer testimonials
Other	6 device or product brands; 2 unapproved awards or fellowships	1 prize draw for free hair transplants
Licence or permit number in ad text	0	0 (the Dubai rule places it on the account, not the ad)

Source: Text-only reading of ad bodies; image and video overlays not inspected. Observations against each rule's text, not findings of breach; no enforcement action is implied. Jordanian counts: 3 of 26 advertisers re-read in the verification pass, the rest not independently recounted [52, 53, 55, 85, 87, 88].

The compliant fame channel visible in Jordan is broadcast education, badged by institution: JRTV's live phone-in «ألو دكتور» identifies guests by public hospital and has aired an orthopaedic and joint surgery episode, and Roya's «دنيا يا دنيا» hosts doctors speaking within their specialty. Neither page discloses a paid arrangement; confidence in booking terms is low [89, 90].

> WHAT THIS MEANS FOR A PRACTICE
>
> The sources frame risk conditionally. If risk enters through a complaint, as the Jordanian record indicates [9, 10], the claims that matter most are those that would look bad in a complaint file: outcome promises and specialty overreach. The conduct types with documented regulator attention are promotion outside the registered specialty [29, 76] and intra-operative footage [58, 91]. Chapter 9 takes up how these conditions bear on brand articulation.

3.5 Jordan and eight comparator regimes

Because a name built in Jordan may later travel to other markets (see Chapter 8), the study set Jordan beside eight comparator regimes and read the texts in force and the dated enforcement in each: Dubai, Abu Dhabi, Saudi Arabia, Kuwait, Qatar, the United Kingdom, Australia and the United States (Table 3.8). The Kuwaiti and Qatari instruments were read through law-firm and press reproductions, and the Abu Dhabi entry rests on a single 2023 circular.

TABLE 3.8

Eight comparator regimes: text, permit, enforcement and distinctive rules

REGIME	TEXT IN FORCE	PERMIT	ENFORCEMENT, DATED	DISTINCTIVE RULE
Dubai (DHA)	Standards for Medical Advertisement Content on Social Media, ST-21 v1.1: issued 3 Aug 2022, effective 3 Oct 2022, revision due 3 Aug 2027; re-circulated by CIR-2026-00000144 of 17 Aug 2026; a 23 Aug 2025 circular exists and was not read	Federal MOHAP advertising licence number on the facility's official account (§5.2); 3 working days; one account per institution; medical-director approval for any post naming the facility (§5.3); DHCC approval 14 working days ahead, valid six months	Warnings of disciplinary action (Aug–Sep 2026); no dated case with a primary source found	Explicit acceptable list: fees, insurance and instalment plans, qualifications, teaching posts, affiliations, peer-reviewed publications; banned words include "distinguished, famous, pioneer" (§6.11); before-and-after same person, same lens, unedited, equal-font disclaimer (§9.6); testimonials lawful with written consent; no filming under anaesthesia (§9.7)
Abu Dhabi (DoH)	Healthcare Guidelines for Health Media & Advertising System (text not retrievable); Circular 26/2023	Two trained representatives per facility before ads can be logged on DoH systems; separate business ad permit of AED 5,000	Not found	Training-then-logging gate
Saudi Arabia	Health Professions Practice Law Art. 10(a); MOH Annex 10 (issue 4)	Regional approval for discounts, each up to 60 days, at most three a year	9 Jul 2017 warning on filming surgeries; 10 Nov 2024 referrals over clips and an inpatient video; 18 Jun 2026 proceedings over synchronised promotional posts; 17 and 27 Jun 2026 licence suspensions over exosome promotion	Bans any patient image or testimonial, superlatives such as "the only, the expert, the most", and "guaranteed"; ads must state they are ads, be in Arabic and state total fees
Kuwait	Ministerial Resolution 87/2023; Decision 9/2025 for pharmacies	Licence from the Health Licensing Department before publishing any promotional content	33 clinics closed 30 Apr 2023; 33 facilities referred 31 Oct 2024; 5 closed and 23 referred 26 May 2025; neurosurgeon suspended July 2024	Most closure-prone regime; written consent is not a defence when identity is shown
Qatar	MoPH Circular 1/2021 as amended by 1/2022	Medical director's written approval of ad content	Legal action against 51 advertisements, 15 Oct 2023	No patient pictures, video or personal information; no direct medical advice to followers; discussion within specialty allowed
United Kingdom	GMC Good medical practice 2024; social-media guidance (in force 30 Jan 2024); cosmetic-interventions guidance; CAP Code as applied by the ASA	None; professional-conduct regime; the ASA cannot fine	ASA rulings against Transform (2022), LIFT Aesthetics (2023), MYA (2024), Pall Mall (2024); 4,000+ paid cosmetic ads reviewed in a year	Testimonials lawful with evidence and permission; "leading" needs proof; "experienced" means six years' specialist practice; before-and-after need signed, dated proof
Australia	National Law s133 (criminal offences); Medical Board cosmetic-surgery guidelines (1 Jul 2023); higher-risk non-surgical guidelines (2 Sep 2025)	None	Aronov conditions (29 Nov 2021); Lanzer surrendered registration (Dec 2021); Cosmetic Surgery Enforcement Unit: 520 notifications, 195+ audits, about 8% of completed cases with regulatory action	Any testimonial is an offence ($60,000 individual, $120,000 corporate); no free or discounted surgery for influencers; before-and-after only of own patients with a results-vary warning
United States	FTC Endorsement Guides (16 CFR 255.2) and 2024 fake-reviews rule; HIPAA 45 CFR 164.508; AMA 9.6.1; Texas, California, Florida, New York rules	None federally; state boards	Cadia settlement of $182,000 (30 Sep 2025) for 150 patients' success stories posted without authorisation; Ohio revoked Grawe (12 Jul 2023)	Testimonials lawful, but "results not typical" is insufficient; "board certified" only for ABMS or AOA boards in Texas, California and Florida

Source: Abu Dhabi guideline text was not retrievable; the AED 5,000 figure is a business ad permit reported by the press, not a health-advertising fee [54–60, 91–132].

In Dubai, the circular of 17 August 2026 that the press reported as new rules links the same 2022 version 1.1 standard, and the banned words the press quoted are its §6.11 [55, 56, 133, 134]; a separate circular of 23 August 2025 exists and was not read [57]. The facility's account, not each ad, must show the federal MOHAP licence number [55, 92]. The standard also requires a separate professional account, a separate Dubai account for visiting doctors, and no Dubai patients on international accounts, so a Jordan-built account cannot be reused as it stands [55]. A reported licence fee of AED 1,000 a month or AED 3,000 a year rests on search snippets and is unverified [135], and per-creative approval numbers appear in consultancy guides, not in the standard [136, 137]. Of Jordan, Dubai, the United Kingdom and Australia, Australia is the strictest on proof devices: any testimonial is a criminal offence, and the repeal of that ban was withdrawn in 2022 [54, 138, 139]. In the United States a "results not typical" disclaimer is insufficient, and marketing use of patient information needs a written HIPAA authorisation [123, 125].

FIGURE 3.10

ASA proactive monitoring of paid cosmetic-surgery ads: compliance before and after intervention



Source: More than 4,000 paid Meta ads reviewed, December 2024 to December 2025 [115].

FIGURE 3.11

Australia's cosmetic-surgery enforcement in numbers

520 notifications to the Cosmetic Surgery Enforcement Unit	**195+** audits of practitioners	**about 8%** completed cases ending in regulatory action	**$60,000** maximum individual penalty per advertising offence

Source: A search snippet of Ahpra's 2024/25 annual report cites 3,800+ advertising complaints and 15 completed prosecutions; the primary was not read and the figure is medium confidence [54, 122, 140].

The legality matrix

Figure 3.12 condenses the mechanism-by-regime matrix, and Table 3.9 gives the wording behind each cell. Both set Jordan beside seven of the eight comparators, with Saudi Arabia, Kuwait and Qatar in one column; Abu Dhabi, whose guideline text was not retrievable, has no column. Every cell rests on a text read in the study and, where one exists, a case.

FIGURE 3.12

Legality of fame and proof mechanisms by regime

	Jordan	Dubai	Saudi / Kuwait / Qatar	UK	Australia	US
Credentials and registrations	Permitted, 5(1)	Acceptable, App. 1	Permitted	Permitted; thresholds	If accurate	Permitted; ABMS rule
Memberships, awards, honorary titles	Committee approval, 9(ب)	If recognised	If genuine	Permitted	If accurate	Permitted
Evidence-based education	Established or refereed	Permitted, §6.9	Permitted	Permitted	Outside s133	Permitted
TV, radio, press, podcasts	No direct promotion	Permitted	Permitted	Permitted	Subject to s133	Permitted
Conference, society, teaching roles	Permitted; Art. 6	Acceptable	Permitted	Permitted	Permitted	Permitted
Institutional "firsts"	Unlawful, 5(2)(و)	Grey	Saudi: "the only" banned	If substantiated	If substantiated	Objective evidence
Consented before-and-after	Written consent	Same lens, consent	Banned	Signed, dated proof	Own patients, warning	Comparable; HIPAA
Patient testimonials	Text silent	Written consent	Banned	Evidence, permission	Criminal, s133	HIPAA; typicality
Offers, discounts, free consultation	Banned, 9(هـ)	Fees OK; no trial	Licensed or closure	Deadlines irresponsible	Terms; cosmetic banned	Exact prices
Products, devices, sponsors	Banned, 5(2)(ب)	Disclose benefit	Unapproved banned	Disclose; no POM	Disclose	Disclose
Influencers and paid social	Caught by 9(ز)	Approval, disclosure	Prosecuted; licence	Label as ad	No free surgery	Ad disclosure
Intra-operative or live footage	Banned, 9(ح)	Banned, §9.7	Sanctioned	GMC exposure	Removal order	Consent-based; Grawe revoked

Permitted (accuracy conditions only) · Conditional: approval, consent, proof, disclosure or grey · Banned, criminal or sanctioned · Not applicable or not assessed (see note)

Source: Condensed from the full matrix in Table 3.9. Grey cells: not addressed by the text. Jordan's education cell is graded conditional because Art. 5(2)(هـ) requires the content to be scientifically established or refereed. Third-party reviews, books and language rules appear in the table only [8, 54, 55, 58, 98, 102, 107, 109, 118-120, 123, 125, 130, 141].

TABLE 3.9

Mechanism-by-regime legality matrix (full wording)

MECHANISM	JORDAN (JMA TEXT)	DUBAI (DHA V1.1)	SAUDI / KUWAIT / QATAR	UK (GMC + CAP)	AUSTRALIA	US
Credentials, registrations, university, affiliations	Permitted, 5(1); unregistered specialties banned, 9(i)	Acceptable, App. 1 j, l, m	Permitted; unearned titles banned	Permitted; "specialist" and "experienced" thresholds	Permitted if accurate	Permitted; "board certified" ABMS-tied
Society memberships, awards, honorary titles, diplomas	Committee approval first, 9(ب)	Acceptable if recognised, not framed as superiority	Permitted if genuine	Permitted; honesty	Permitted if accurate	Permitted

MECHANISM	JORDAN (JMA TEXT)	DUBAI (DHA V1.1)	SAUDI / KUWAIT / QATAR	UK (GMC + CAP)	AUSTRALIA	US
Evidence-based education content	Permitted if scientifically established or refereed, 5(2)(هـ)	Permitted, §6.9; must flag study, consensus or opinion	Permitted; Qatar: within specialty, no direct advice to followers	Permitted (Rajan)	Permitted outside s133	Permitted (AMA 9.6.1)
Television, radio, press, podcasts	Permitted unless direct promotion, 5(2)(د)	Permitted; director approval if facility named	Permitted; Saudi: avoid promoting services on air	Permitted (Rajan, BBC)	Permitted subject to s133	Permitted
Conference and society roles; teaching	Permitted; announcing own courses needs council approval unless an accredited body issues them, Art. 6	Acceptable, App. 1 l–m	Permitted	Permitted	Permitted	Permitted
Institutional "firsts"	Unlawful wording, 5(2)(و)	Grey: "first" not on the §6.11 list, but "pioneer", "unprecedented", "the only" banned; contested claims live and unenforced	Saudi: "the only, the expert, the most" banned	Only if substantiated	Only if substantiated	Superiority needs objective evidence (California)
Consented before-and-after of the same patient	Permitted with written consent, no intra-operative imagery, 9(ح)	Permitted: same person, same lens, unedited, equal-font disclaimer, written consent	Banned (Saudi, Qatar, Kuwait)	Permitted with signed, dated proof; representative	Permitted under 2023/2025 rules with results-vary warning, own patients only	Permitted; comparable; results vary; HIPAA authorisation
Patient testimonials	Text silent; treated-case claims must be evidence-based	Permitted with written consent; no cross-profession comparisons	Banned	Permitted with evidence and permission; outcome testimonials can be ruled irresponsible (Pall Mall)	Criminal offence, s133(1)(c)	Permitted with HIPAA authorisation and typicality disclosure
Reviews on third-party platforms	Not addressed; doctor liable only for his own site or page, 9(ز)	Not addressed	Not addressed	Permitted	Not a breach unless linked, reshared or engaged with	Permitted; fake or paid reviews banned (2024 rule)
Offers, discounts, free consultation, instalments	Banned, 9(هـ); committee proviso in 5(2)(ج); Constitution Art. 42 bans set free-treatment times; free days only as committee-licensed events	Fee statements and instalments acceptable; "trial usage" banned; unrealisable time-limited inducements banned	Saudi: prices required, discounts licensed, up to 3 a year; Kuwait: unlicensed price publicity is a closure ground	Time-limited surgery offers ruled irresponsible even with cooling-off (Transform)	Inducements need stated terms; cosmetic time-limited offers and bundles prohibited	Permitted; exact prices (California)
Products, devices, sponsors on the doctor's channels	Banned, 5(2)(ب), 9(د–ج); Constitution 10(هـ)	Material benefit must be disclosed, §6.7	Saudi: unapproved treatments banned (exosome suspensions)	Disclose interests; no prescription-only medicine promotion	Disclose	Disclose (FTC)
Influencers and paid social	Not named; caught by the Art. 2 definitions and personal liability, 9(ز)	Director approval and disclosure, §5.3, §6.7	Saudi: coordinated staff promotion prosecuted (June 2026); Kuwait: pre-approval	Must be labelled an ad; tagging the clinic is insufficient (LIFT)	No free or discounted surgery for influencers	"This is an ad" disclosure

MECHANISM	JORDAN (JMA TEXT)	DUBAI (DHA V1.1)	SAUDI / KUWAIT / QATAR	UK (GMC + CAP)	AUSTRALIA	US
Livestreaming or intra-operative footage	Banned, 9(ج)	Banned, §9.7	Sanctioned (Saudi 2017 warning; Kuwait)	GMC paras 89–90 exposure	Aronov removal order	Grawe revocation
Books	Unrestricted	Unrestricted	Unrestricted	Unrestricted (Rajan)	Unrestricted	Unrestricted
Language	Arabic primary, 9(و)	Not specified	Saudi: Arabic	Not specified	Not specified	Not specified

Source: [8, 54, 55, 58, 60, 63, 98, 100, 102, 107, 109, 111-114, 116, 118-120, 123-125, 127, 130, 141]

Two readings follow. The portable stack is the fame stack: accurate credentials and registrations, training, teaching posts and affiliations, peer-reviewed publications, evidence-based education, topic-led media appearances, books, and conference and society roles are lawful in every regime read, need no consent artefact and have drawn no dated enforcement anywhere. One list is lawful nowhere: fabricated or paid reviews, guaranteed results, unsubstantiated "best" or "unique" claims, identifiable patient imagery without written consent, intra-operative footage for promotion, and marketing cosmetic procedures to minors. Everything in between is regime-specific, and the regime-specific devices are the proof devices: testimonials fail in Australia, Saudi Arabia, Qatar and Kuwait; patient imagery in Saudi Arabia, Qatar and Kuwait; offers in Jordan; unsubstantiated superlatives everywhere [8, 54, 55, 98, 102, 107, 123, 141]. A free consultation is the highest-risk offer type in Jordan, Saudi Arabia and Dubai [8, 55, 98]; no UK ruling on free consultations was found, and CAP treats consultation processes favourably [116, 142]. Chapter 6 considers what this means for distinctiveness.

TABLE 3.10

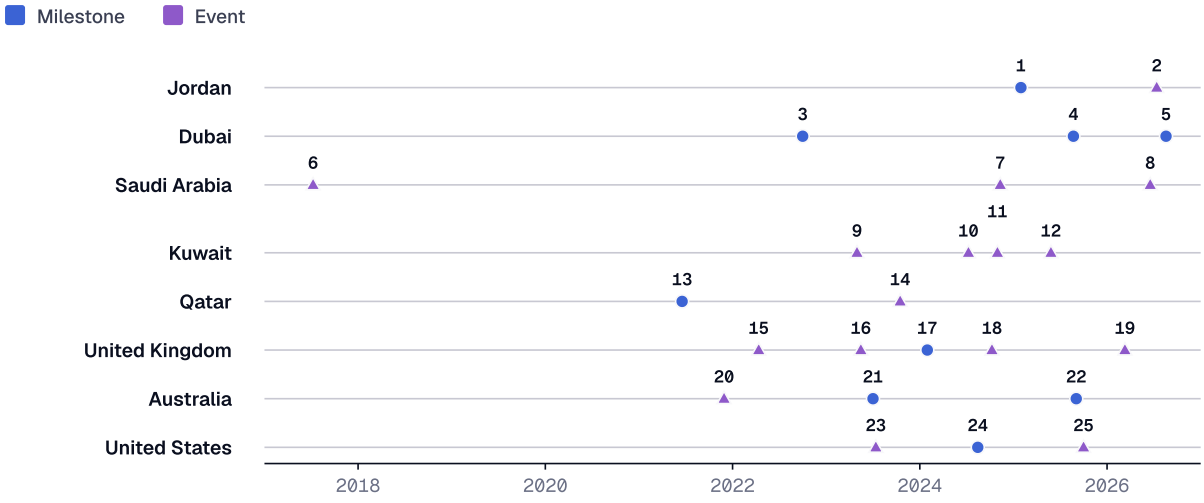
Licensing mechanics compared

	JORDAN	DUBAI	SAUDI ARABIA	KUWAIT
What is licensed	The website (10 JD, Art. 7); an advertisement-licence application of undefined unit (Art. 8)	The facility's advertising account, federally (MOHAP), number displayed on the account; per-post director approval	Discounts and offers, regionally, up to 60 days each, up to 3 a year	Any promotional content, before publishing
Turnaround	Unpublished; no form, register or refusal record found	3 working days (MOHAP); DHCC 14 working days, valid six months	Not stated	Not stated
Who is liable	The doctor personally for his own site or page (9(ز))	The facility for anything filmed on its premises (§5.5); the professional for their account	The practitioner	The facility and the practitioner
Sequence for a new clinic	Ministry clinic licence, then the JMA website licence and Art. 8 application, then any announcement; the one-week newspaper notice needs no approval	Trade licence, medical licence, MOHAP advertising licence, separate Dubai professional account	MOH facility licence; content must state it is an ad	Health Licensing Department licence

Source: [8, 55, 63, 65, 92, 93, 98, 102]

FIGURE 3.13

Dated rule changes and enforcement actions across regimes, 2017 to 2026



1 **Jordan:** 2025 JMA instructions in force
2 **Jordan:** 2026 106 complaints, 5 referrals
3 **Dubai:** 2022 ST-21 v1.1 effective
4 **Dubai:** 2025 Regulations circular (unread)
5 **Dubai:** 2026 Standard re-circulated
6 **Saudi Arabia:** 2017 Warning on filming surgeries
7 **Saudi Arabia:** 2024 Referrals over clips
8 **Saudi Arabia:** 2026 Coordinated posts; exosome suspensions
9 **Kuwait:** 2023 33 clinics closed
10 **Kuwait:** 2024 Neurosurgeon suspended
11 **Kuwait:** 2024 33 facilities referred
12 **Kuwait:** 2025 5 closed, 23 referred
13 **Qatar:** 2021 Social-media circular memo
14 **Qatar:** 2023 Action against 51 ads
15 **United Kingdom:** 2022 ASA: Transform
16 **United Kingdom:** 2023 ASA: LIFT Aesthetics
17 **United Kingdom:** 2024 GMC social-media guidance
18 **United Kingdom:** 2024 ASA: Pall Mall
19 **United Kingdom:** 2026 ASA enforcement report
20 **Australia:** 2021 Aronov conditions
21 **Australia:** 2023 Cosmetic-surgery guidelines
22 **Australia:** 2025 Non-surgical guidelines
23 **United States:** 2023 Grawe licence revoked
24 **United States:** 2024 FTC fake-reviews rule
25 **United States:** 2025 Cadia HIPAA settlement

Source: Positions are decimal years derived from the dated sources. The Saudi actions of 17, 18 and 27 June 2026 are shown as one event; Lanzer's December 2021 surrender and the MYA ruling of July 2024 are omitted for legibility. Abu Dhabi has no row: its guideline text was not retrievable, Circular 26/2023 is omitted, and no enforcement action was found there [8, 9, 55-60, 91, 99-101, 103-105, 107, 108, 110, 112-115, 118-120, 124, 126].

3.6 Fame inside the rules and the sanctioned cases

The famous doctors read in this study grew inside restrictive regimes by monetising credentials, institutional roles, education and broadcast (see Chapter 4). Karan Rajan built more than 11 million followers under the GMC through evidence-based education, then BBC presenting and a bestselling book, with no clinic or product promotion on the pages retrieved [143, 144]. Khaled Al-Nemr and Tariq Al-Habib in Saudi Arabia and Hossam Mowafi in Egypt follow the same pattern, professorships combined with education or broadcast, although some of the broadcast details rest only on Wikipedia [145-147]. Ali Albelooshi in Dubai relies instead on institutional firsts and on society and university roles published on a licensed facility's site; his "first" wording is grey under the Dubai standard and would be unlawful in Jordan [8, 31, 55]. None of the pages retrieved for these doctors shows patient imagery, offers or testimonials [31, 143, 145].

The sanctioned cases share a signature the famous ones lack: the camera or the promotion changed clinical behaviour, or a patient's identity was exposed. In Ohio, Katharine Grawe's licence was permanently revoked on 12 July 2023; the Board had a video of her making two medically unnecessary jabs to explain technique to viewers, three patients had been hospitalised, and she had dismissed two prior warnings [58]. Her own defence conceded that her educational intent had been

> *"executed in a manner that fell below the expectations of a practicing surgeon"*
>
> State Medical Board of Ohio, approved minutes, 12 July 2023 [58].

In Saudi Arabia, two licences were suspended on 17 June 2026 after one doctor received an exosome injection from his brother on camera to vouch for its safety [60], and a practitioner's licence was suspended on 27 June 2026 for promoting exosome injections, the ministry stating that personal experiences do not constitute recognised scientific evidence [101]. In Kuwait, neurosurgeon Hamad Al-Enezi was suspended in July 2024 over a post-operative ward video posted with the patient's written consent, because the patient's identity was shown and the purpose was not scientific [59]. Table 3.11 sets out the remaining cases, including Egypt's March 2026 strike-off for advice outside the doctor's specialty [148].

TABLE 3.11

Famous and sanctioned cases read in the study

DOCTOR	REGIME	MECHANISM OR CONDUCT	OUTCOME
Karan Rajan	UK (GMC)	Evidence-based education; BBC presenting; a number-one Sunday Times bestseller; 11 million+ followers	No clinic or product promotion on the pages retrieved; no sanction found
Khaled Al-Nemr	Saudi Arabia	Professorship; daily health posts; 2025 television appearance	No clinic promotion found; an MBC slot could not be verified
Tariq Al-Habib	Saudi Arabia	Professorship; broadcast opinion; clinic chain	Weekly MBC slot attested only by an unsourced Wikipedia line
Hossam Mowafi	Egypt	Professorship of critical care; three television programmes	Syndicate award attested only by Wikipedia
Ali Albelooshi	Dubai	Institutional firsts; society vice-presidency; university posts on a licensed facility site	No testimonials or before-and-after; "first" claims contested by rivals and unenforced
Katharine Grawe	Ohio, US	Filmed while operating; two medically unnecessary jabs to explain technique; delegated post-operative care	Permanent revocation, 12 July 2023, after patient harm and two ignored warnings
Daniel Aronov	Australia	Social-media cosmetic surgeon, 13 million TikTok followers	Supervised general practice only; cosmetic content removed; no time limit (29 Nov 2021)
Daniel Lanzer	Australia	Clinics subject of a broadcast investigation	Surrendered registration, December 2021
Saudi exosome cases	Saudi Arabia	One doctor received an exosome injection from his brother on camera to vouch for it; exosome promotion	Two licences suspended, 17 June 2026; one practitioner's licence suspended, 27 June 2026
Diya al-Din al-Awadi	Egypt	Anaesthetist posting unproven opinions and advice outside his specialty	Struck off, March 2026; a ministry closure order was reported in a search summary only
Hamad Al-Enezi	Kuwait	Consented post-operative ward video showing the patient	Suspended, July 2024; identity and non-scientific purpose cited

Source: [31, 58-60, 101, 120, 121, 143-148]

FIGURE 3.14

What separates the famous from the sanctioned

FAMOUS

Credentials and institutional roles

Professorships, society offices, hospital affiliations and registrations, stated accurately. Lawful in every regime read.

FAMOUS

Education and broadcast

Topic-led television, evidence-based posts and books, with no clinic promotion inside the segment.

SANCTIONED

Care changed for the camera

Unnecessary steps performed for viewers, on-camera product vouching, delegated care (Grawe, Saudi exosome case).

SANCTIONED

Identity or scope breached

A consented video that showed the patient (Al-Enezi); advice outside the specialty (al-Awadi).

Source: [31, 58–60, 143, 145, 148]

KEY FINDING

The line every regulator drew was clinical conduct, specialty scope, scientific basis and identity. It was never audience size, and never education or credentials [58–60, 148].

3.7 Myths retired and questions left open

Both comfortable answers fail on the texts. Marketing is not impossible in Jordan, since the instructions license websites, social media, broadcast, credentials, consented before-and-after images and evidence-based education. Nor are the rules on paper only, since the JMA runs a live, if secret, disciplinary process and the Ministry closes premises beside it. The accurate statement is permissive text, complaint-driven and secret enforcement, and no public precedent on a licensed doctor's advertising copy [8, 10, 82]. Appendix B lists every retired myth and Appendix C the contradiction ledger; Table 3.12 gives the five that bear most directly on Jordan.

TABLE 3.12

Five myths about the Jordanian rules and what the texts show

MYTH	WHAT THE TEXT OR RECORD SHOWS	BASIS
Jordan requires a licence for every social post	Art. 7 licenses a website for 10 dinars; Art. 8 defines an application without a unit; no per-post clause exists. The reading comes from the dropped 2024 draft and a 2026 paraphrase	Arts. 7, 8
Health-education content needs prior JMA approval	Art. 5(2)(هـ) is a substantiation test, not an approval gate; the approval reading is the objectors' statement of 24 December 2024	Art. 5(2)(هـ)
Doctors are banned from television and awareness programmes	Art. 5(2)(د) bars exploiting appearances for direct promotion; appearances need no approval	Art. 5(2)(د)
Before-and-after is illegal in Jordan	Art. 9(ح) permits it for the same patient with written consent; only intra-procedure imagery is banned	Art. 9(ح)
The rules were suspended or amended after the January 2025 review	A monitored run-in was announced; nothing amended has been published and the file is unchanged	Press record; PDF server date

Source: [8, 29, 51, 70, 71]

Open questions

- The unit of the Article 8 licence, and whether "duly licensed" in Article 5(2) means the practice or an advertising licence; the source study sees a written JMA query as the only route to an answer [8].
- The advertising committee's form, turnaround and refusal record; its output appears nowhere in the 2025 annual report [10].
- Whether committee-approved offers are lawful under Article 5(2)(ج) or barred by Article 9(هـ) [8].
- The content of the DHA circular of 23 August 2025 [57].
- Whether the discount and superlative wording observed in the audit is still in circulation three months later, a low-cost indicator of whether advertising copy draws any committee action [52].

> LIMIT
>
> The research was structured desk research, organised in research streams, and an independent verification pass re-read the load-bearing claims against the retrieved sources: 37 of 69 claims were verified, 35 confirmed and 2 refuted. The Jordanian enforcement record is press-reported and incomplete because hearings are secret, the advertising audit is a one-day, text-only sample, and regimes that announce actions can look harsher than Jordan partly for that reason.

LIMITS OF THIS EVIDENCE

- Jordan's advertising committee has no published output, so licence counts, turnaround and refusals are unknown.
- Disciplinary hearings are secret by law and judgments unpublished unless final; the Jordanian enforcement record is press-reported, second-hand in the one advertising case, and structurally incomplete.
- The advertising audit is a one-day, text-only sample of 26 Jordanian physician advertisers; the verification pass re-read 3 of them, before-and-after imagery inside videos is undercounted, and the sample skews to the Arabic keywords chosen for the audit.
- Raw Meta Ad Library counts are estimates polluted by spam pages; some platform archives were unavailable (one returned no results for Jordan and another supports only advertiser lookup), so no cross-platform keyword sample was possible.
- The Abu Dhabi guideline text was not retrievable; only a 2023 circular was read.
- A DHA circular of 23 August 2025 and a supporting guideline on the 2026 circular page were not read.
- The MOHAP social-media licence fee rests on search snippets and is unverified.
- Jordanian broadcast booking terms rest on channel self-descriptions only.
- The television roles of Al-Habib and Al-Nemr and Mowafi's syndicate award rest on unsourced Wikipedia lines.
- Ahpra's 2024/25 complaint totals come from a search snippet of a tabled report; the Cadia regulator quote is paraphrased in one secondary source.
- The Medical Constitution was read from lawyers' transcriptions, not a JMA-hosted copy; the absence of an Official Gazette issue for the instructions is an inference from instrument type.
- Enforcement pictures over-represent what regulators publish, so Gulf regimes can look harsher than Jordan partly because they announce actions; Arabic searches for the syndicate were dominated by Egyptian and Syrian news, which was excluded.
- Of 69 claims, 37 load-bearing claims were checked in the independent verification pass (35 confirmed, 2 refuted); the remainder rest on the research streams' reading of the sources.

LEFT OPEN

- Is the Article 8 advertisement licence issued per site or per advertisement, and does "duly licensed" in Article 5(2) mean the practice licence or an advertising licence?
- What are the advertising committee's form, turnaround and refusal record, and how many licences has it issued?
- Are committee-approved offers lawful under Article 5(2)(ج), or barred by Article 9(هـ)?
- Has any advertising-specific disciplinary referral been made since 1 February 2025?
- What does the DHA circular of 23 August 2025 add to the ST-21 standard?
- Is the discount and superlative wording observed in the audit still in circulation three months later?
- How will a Jordanian board credential be described in the US, where "board certified" is reserved for ABMS or AOA boards in Texas, California and Florida?
- Does third-party booking-platform wording, such as a listed free consultation, engage the incorporated fee-schedule and free-treatment rules, given that the text addresses only the doctor's own site and page?

CHAPTER 04

How doctors become famous

Gatekeepers, lags, costs and the shape of a doctor's audience curve

EVIDENCE BASE FAME	72 Claims generated	35 Put to verification	30 Confirmed	5 Refuted	0 Unverified	237 Sources recorded	562 Research actions
EVIDENCE BASE PLATFORM HISTORIES	275 Dated points	66 Put to verification	62 Confirmed	2 Refuted	2 Unverified	n/a Sources recorded	1,336 Research actions

CHAPTER SUMMARY

This chapter examines how doctors and surgeons become famous and what the dated record implies for an orthopaedic surgeon in Jordan. It draws on a fame study of the best-documented international and Arabic cases, in which 30 of 35 load-bearing claims were confirmed by independent verification, and on a second-phase study that rebuilt 8 platform histories from 275 dated data points. In 12 of the 15 best-documented cases a third party, not the doctor's own feed, granted the first audience; lags from first exposure to the automatic name ran from months to about 15 years, usually after a decade or more of ordinary practice. Patients say they weigh credentials and reviews above popularity, and the only social-to-volume effect this study found is small. Costs arrived mostly 3 to 10 years after fame and tracked promotion, patient imagery and claims outside specialty rather than audience size. On archived data every video-platform account with usable resolution shows one burst, a long ramp and a plateau; Al-Nemr's X account is the exception, a pure accumulation curve. Later television, books and controversies bought small lifts at most.

KEY FINDINGS

01 In 12 of the 15 best-documented cases a producer, editor, publicist, sports agent or institution granted the first audience; the 2 named counter-cases, Karan Rajan and Khaled Al-Nemr, both sat on institutional titles [1, 2, 143, 149, 150].

02 Lag to the automatic name ran from months (a news event or magazine) through 1–3 years on short-video platforms and ~5 years under a television patron to 10+ years for procedure and athlete fame, usually after about a decade of ordinary practice (Andrews 12 years, Salzhauer 12, Lee ~10) [1, 3, 4, 151].

03 Patients say they weigh credentials and reviews above popularity: Saudi respondents (n=1,242) rated qualifications 91.7% and review positivity 91.6% important against 45.9% for likes, and US sports-medicine patients (n=382) scored board certification 9.12 and team affiliation 4.75 (14th of 19) [6, 152].

04 The only social-to-volume effect this study found is about 7 more prostatectomies a year (~25% on a mean of 27, P=.05) associated with a social-media presence among 195 California urologists, while one 1-star review cut new-patient volume 2.3–2.6% for at least 16 weeks across 1.12 million appointments [153, 154].

05 Costs arrived mostly 3 to 10 years after fame, mostly from peers, regulators, courts and journalists, tracking cosmetic content, out-of-specialty claims, product promotion and patient imagery rather than follower count; Grawe's licence was permanently revoked on 12 July 2023 [120, 155, 156].

06 The largest cash exits of a physician's name found in this study were product companies rather than audiences: Dr. Dennis Gross Skincare sold for $450M in 2024, and Obagi, agreed at $19.75 a share in 2013 (valued by Obagi at about $360M), was resold for $190M in 2017 once detached from its founder [157-159].

07 On 275 dated points, every video-platform account with usable resolution shows 1 platform-native burst, a multi-year ramp and a plateau, with Al-Nemr's X account the exception (pure accumulation); Rajan's TikTok went from 85,393 to 1,400,000 between 6 April and 6 July 2020 and has read 5.4M since June 2025 [23, 24, 160, 161].

08 Television after an account was large bought small, temporary lifts, not steps: +16% in 62 days on Dr. Miami's Instagram around his premiere and +5% in 33 days on Sandra Lee's YouTube around her TLC special, while Rajan's book and Doctor Mike's 2020 controversy left no inflection [162-165].

09 By follower stock a video platform leads Instagram by 1.8 to 7.7 times for the global doctor-creators and the 2 Egyptian platform-native accounts, while Instagram leads for the Arab comparables [166, 167].

10 A Jordanian orthopaedic precedent exists: Osama Al-Odat reached 307,000 Instagram followers by July 2021 on educational content and read 504K on 16 September 2026, plateaued since late 2022 [5, 168].

4.1 The central finding: fame is granted before it is built

On the dated record, doctors did not become famous by posting. They became famous when a gatekeeper handed them an audience, and in 12 of the 15 best-documented cases that gatekeeper was a producer, an editor, a publicist, a sports agent or an institution rather than the doctor's own feed. Mehmet Oz had a 2003 Discovery series and then several dozen Oprah appearances from 2004–06 before his own show launched in September 2009 [1, 169]. Sanjay Gupta was a White House Fellow whom CNN hired in summer 2001; the anthrax coverage weeks later and the 2003 Iraq embed made the name [2]. Doctor Mike had posted on Instagram from early 2012 for more than 3 years before a BuzzFeed writer (August 2015) and the editors of People (November 2015) picked him; his YouTube channel followed in 2016, after the fame rather than before it [36, 170]. Andrew Huberman, a PhD rather than a physician, was placed on the largest podcasts by a publicist he met in 2019, before his own podcast existed in January 2021 [149]. Michael Salzhauer ("Dr. Miami") hired a PR director within a month of starting on Snapchat [171]. James Andrews' fame arrived 12 years into practice, when an agent referred Roger Clemens, operated on in August 1985, whose record 20-strikeout game followed in April 1986 [3, 172].

FIGURE 4.1

Who granted the first audience in the 15 best-documented cases



12 Third-party gatekeeper (80%)

3 Other cases (incl. Rajan, Al-Nemr) (20%)

Source: Case-by-case dating in the fame study [1, 2, 36, 143, 149, 150, 171, 172]. A third-party gatekeeper means a producer, editor, publicist, sports agent or institution. The study names only 2 of the 3 remaining cases.

The exceptions are recorded rather than smoothed over. Karan Rajan grew on TikTok during the 2020 lockdown, and the Saudi cardiologist Khaled Al-Nemr reached 1 million followers on X through daily text posts. Both sat on an institutional title (NHS surgeon and lecturer; university professor), and neither was lifted by a third-party gatekeeper: Rajan's audience came from a breakout video in February 2020 and a lockdown burst, Al-Nemr's from years of accumulation with no burst [23, 143, 150, 173]. Because 6 of 7 independent perspective passes reached the same gatekeeper thesis, and agreement of that kind is where correlated error hides, the independent verification pass tested it hardest, case by case; it survived at source level. The fame study drew on 237 unique sources. Of its 35 load-bearing claims, 30 were confirmed and 5 refuted, a 14% refutation rate, and 4 of the 5 refutations corrected dates and counts lifted from secondary pages.

KEY FINDING

The trigger was external in almost every case, and the doctor's own output was the follow-through that kept the audience. No case in the retrieved record shows posting cadence producing the first fame moment.

TABLE 4.1

The fame engines: a typology from the dated record

ENGINE	HOW THE FIRST AUDIENCE ARRIVED	DATED CASES	LAG TO THE AUTOMATIC NAME
TV patron	A producer or host with an existing audience books the doctor repeatedly	Oz: Discovery 2003; Oprah regular 2004–06; own show September 2009	~5 years
Newsroom hire and news event	An institution hires; a crisis makes the name	Gupta: CNN summer 2001; 9/11 and anthrax within weeks; Iraq 2003	Months
Reality format	A production company with a slot, often with family or franchise adjacency	Nowzaradan: TLC specials, then My 600-lb Life (February 2012), with his son as director and producer; Botched: both surgeons had been married to Real Housewives cast members (per the surgeons' Wikipedia biographies)	Immediate on air; 40 years of practice before
Editorial pick on a platform	A writer or magazine chooses the person; the platform amplifies	Doctor Mike: Instagram from 2012; BuzzFeed August 2015; People November 2015; 1.5M Instagram crossed between 27 November 2015 and 15 March 2016	Months
Format on a platform, then a network	A repeatable visual format grows an audience; television commissions it	Lee: YouTube inflection February–May 2015; SLMD 2017; TLC special January 2018; series July 2018	~3–4 years
Broadcasting the procedure	Operating-room access as content	Salzhauer: Instagram deleted February 2015; Snapchat within days; PR director hired March 2015; WE tv March 2017	~2 years
Publicist-brokered audio	A publicist places the guest on the largest podcasts	Huberman (a PhD, not a physician): publicist from 2019; Rogan July 2020; Huberman Lab January 2021; 4M Instagram by 2023	~2 years
Agent-referred athlete comeback	A sports agent sends a star; the comeback credits the surgeon	Andrews: practice 1973; Clemens via Randy Hendricks, surgery August 1985; 20-strikeout game April 1986	12 years to the trigger, then compounding
Named procedure	A first-of-its-kind operation on a famous patient, named by the press	Jobe: September 1974; "Tommy John surgery" in print March 1980; JBJS paper November 1986; ~40% of MLB pitchers today	10+ years; the name is the patient's
Federation role, then destination clinic	A national-team post, then a resort-town clinic with a research institute	Steadman: US Ski Team physician 1974 or 1976; foundation 1988; Vail 1990	~15 years
Institutional first (Arabic)	A national first inside a state or academic institution; a hospital follows years later	Kilani: first IVF baby in Jordan and the region, 1 May 1987; Farah Hospital 1994. Hanania: first open-heart surgery in Jordan 1970. Yacoub: Harefield 1980; foundation 2008; Aswan 2009 (dates from search summaries, medium confidence)	7–28 years

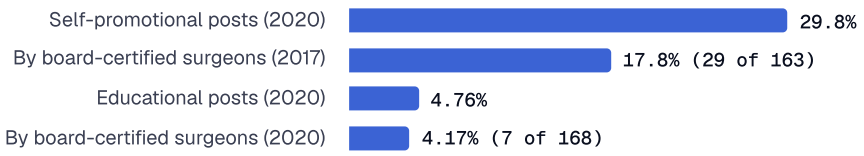
ENGINE	HOW THE FIRST AUDIENCE ARRIVED	DATED CASES	LAG TO THE AUTOMATIC NAME
Professor, then national television (Arabic)	Decades of academic seniority, then a channel owner's slot	Mowafi: Qasr Al-Aini department head 2003–07, vice dean 2007–11, then Al-Nahar, Al-Mehwar and Sada El Balad. Al-Habib: KSU professor, weekly MBC slot (attested only by an unsourced Wikipedia line), Mutmaenna centres in 5 cities	30+ years
Expert voice on X (Arabic)	Daily text posts on one platform, anchored by a title; no burst	Al-Nemr: award 2014; 1,000,000 followers June 2021 (the 7-year span is an inference from the award date)	~7 years of accumulation
Platform-only under strict rules	Educational short video; lockdown timing; no advertising	Rajan: YouTube 2012; first TikTok hit February 2020; 5.4M TikTok; book January 2024; BBC work	8 years from first content; 4 from the burst

Source: Fame-study typology with corrections from the verification pass applied (Doctor Mike's YouTube 2016; Andrews' Clemens surgery 1985 and 12 years; Huberman's publicist 2019; Doctor Mike's 1.5M date from archived captures; Salzhauer's Snapchat start within days of the February 2015 deletion) [1-3, 36, 143, 146, 147, 149-151, 169, 171-191]. The Hollywood Reporter item was seen as a search snippet only; the cited Botched Wikipedia page does not itself carry the Real Housewives connection.

The typology supports 2 readings and rules out a third. It supports that the trigger is external, and that platform-only fame exists but has so far required an institutional anchor and a timing window (Rajan's lockdown; Al-Nemr's professorship). It rules out the reading that a doctor becomes famous by cadence. The platform's own selection runs the other way: of the top Instagram posts under plastic-surgery hashtags in 2020, only 4.17% were by board-certified plastic surgeons and only 4.76% were educational, against 29.8% that were self-promotional [192].

FIGURE 4.2

What the platform surfaced: top Instagram posts under plastic-surgery hashtags



Source: Updated review of plastic-surgery hashtag use on Instagram [192]. Shares of top posts, not patient outcomes; the 2020 update used 22 hashtags. The 2017 value is from the original study (21 hashtags), as reported in the 2020 update.

4.2 The gatekeepers, named

The gatekeepers fall into 6 groups (Table 4.2), of which 2 change how physician exposure should be read. First, some US local-television physician exposure is bought rather than earned: hospitals pay stations for news-style segments featuring their own doctors, with fees undisclosed on air, and Mayo's Medical Edge service (c. 2001) reportedly raised patient preference for Mayo by about 60% in 3 years, with a reported value of more than 10 times its production cost (hospital-reported) [193, 194]. Second, in the United States the team-physician title is largely a hospital purchase, bought through multi-year sponsorship contracts for "official provider" rights [195, 196].

Platforms now act as gatekeepers in their own right. Since 27 October 2022 YouTube has let licensed clinicians apply for health-source panels and health-content shelves in search, a distribution asset tied to the licence and separate from the recommendation algorithm [197]. At verification, however, no Arab country was on the eligible list, and a reach threshold applied [198]. In the Gulf, according to Snap's business lead for

Saudi Arabia, Snapchat reaches more than 90% of Saudis aged 13–34 [199], yet Saudi respondents name Instagram (41.3%) and X (37.6%) well ahead of Snapchat (11.6%) as the places they find doctors [6]. Reach and discovery are different jobs.

TABLE 4.2

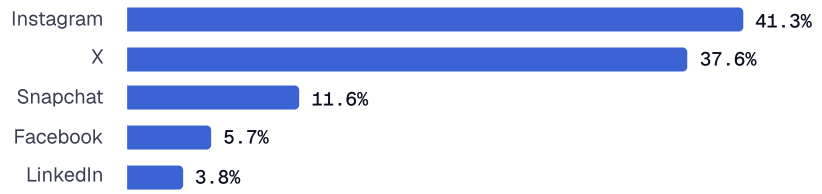
The gatekeepers named in the record

GATEKEEPER TYPE	NAMED EXAMPLES	WHAT THE RECORD ADDS
Television and press	Oprah/Harpo and Discovery (Oz); CNN (Gupta); TLC and Megalomedia (Nowzaradan); Evolution Media (Botched); TLC and Ping Pong Productions (Lee); WE tv and 2C Media (Salzhauer); BuzzFeed and People (Doctor Mike); The New Yorker from 1998 (Gawande)	Gupta's hire was reportedly structured with an Emory neurosurgery post so he could keep operating (medium confidence)
Hospital marketing budgets	US hospitals paying stations for news-style segments; Mayo's Medical Edge (c. 2001)	About 60% higher patient preference in 3 years, with a reported value of more than 10 times production cost (hospital-reported)
Publicists and expert databases	Robert Mohr (Huberman); Salzhauer's PR director, hired in month 1; HARO (shut December 2024, relaunched April 2025), Qwoted, ProfNet	Practitioner "what producers want" lists cite no producer data
Agents, mentors and teams	Randy Hendricks (Clemens to Andrews); Tom Brady to Neal ElAttrache via a mutual friend; the Dodgers and Kerlan-Jobe (Jobe)	The NFL's 2004 rule only bars contracts that force teams to use the sponsor's doctors; the players' union checks board certification only
Platforms	YouTube health-source panels and shelves for licensed clinicians (since 27 October 2022)	Eligibility needs 1,500+ public watch hours in 12 months or 1.5M Shorts views in 90 days; no Arab country listed at verification
Arab television formats	MBC1 Sabah Al Kheir Ya Arab (since 2012); Roya's دنيا يا دنيا (Donya Ya Donya) with a standing طب وصحة (medicine and health) segment; Jordan TV's live call-in ألو دكتور (Allo Doctor); Sada El Balad, Al-Nahar and Al-Mehwar in Egypt	Whether the Jordanian slots are sold as sponsored segments could not be established

Source: [1, 2, 36, 90, 147, 149, 171, 172, 174, 175, 181, 182, 193-198, 200-204]. The Roya item rests on a search summary. The 10-times figure is Mayo executives' own report, relayed by the Association of Health Care Journalists.

FIGURE 4.3

Where Saudi respondents look up or follow doctors



Source: Saudi cross-sectional survey, n=1,242, December 2023 to May 2024 [6]. TikTok was absent from this ranking, although 17.4% named it their most-used platform overall. Stated preference, not observed behaviour.

> **WHAT THIS MEANS FOR A SURGEON IN JORDAN**
>
> Arab television formats with standing doctor segments exist and can be named, including 2 Jordanian ones. Whether their slots are sold, and who books the doctors, is not established; the US record says the question should be asked before a slot is treated as earned exposure.

4.3 Timelines, volume and the compressed origin story

Time from first exposure to being the automatic name split by path: months when a news event or a magazine did the work (Gupta 2001; Doctor Mike 2015); 1 to 3 years on short-video platforms (Rajan, Salzhauer, Lee, Huberman); about 5 years under a television patron (Oz, 2004 to 2009); and 10 years or more for procedure and athlete fame (Jobe 1974 to 1986; Gawande 1998 to 2009; Andrews 1973 to 1985–86 to 2007) [1, 172, 182, 200]. The typology states these lags on different bases, so Table 4.3 names the event each one counts from. Before the trigger there was almost always a decade or more of ordinary practice (Figure 4.4).

TABLE 4.3

Lag to the automatic name, and the event each lag counts from

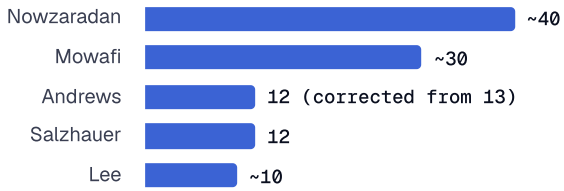
ENGINE	BASE EVENT	LAG	CASE
Reality format	First broadcast: TLC specials, then My 600-lb Life (February 2012)	Immediate on air	Nowzaradan, after 40 years of practice
Newsroom hire and news event	CNN hire, summer 2001	Months	Gupta: anthrax coverage weeks later; Iraq embed 2003
Editorial pick on a platform	BuzzFeed feature (August 2015); People (November 2015)	Months	Doctor Mike: 1.5M Instagram crossed between 27 November 2015 and 15 March 2016
Broadcasting the procedure	Snapchat start, within days of the February 2015 Instagram deletion (PR director hired March 2015)	~2 years	Salzhauer: WE tv, March 2017
Publicist-brokered audio	Publicist's podcast bookings (publicist from 2019; Rogan, July 2020)	~2 years	Huberman, a PhD, not a physician: own podcast January 2021; 4M Instagram by 2023
Format on a platform, then a network	YouTube inflection, February–May 2015	~3–4 years	Sandra Lee: TLC special January 2018; series July 2018
Platform-only under strict rules	TikTok burst, 2020 (first content: YouTube, 2012)	4 years from the burst; 8 from first content	Rajan: book, January 2024
TV patron	Oprah regular from 2004 (Discovery series 2003)	~5 years	Oz: own show, September 2009
Expert voice on X (Arabic)	Award, 2014	~7 years of accumulation (inferred from the award date)	Al-Nemr: 1,000,000 followers, June 2021
Institutional first (Arabic)	First institutional milestone (Kilani: first IVF baby in Jordan, 1987; Yacoub: Harefield, 1980)	7–28 years, to a hospital or foundation	Kilani: Farah Hospital 1994. Yacoub: foundation 2008; Aswan 2009
Named procedure	First operation, September 1974	10+ years; the name is the patient's	Jobe: name in print March 1980; JBJS paper November 1986
Agent-referred athlete comeback	Start of practice, 1973	12 years to the trigger, then compounding	Andrews: Clemens surgery August 1985; 20-strikeout game April 1986
Federation role, then destination clinic	US Ski Team post, 1974 or 1976	~15 years	Steadman: foundation 1988; Vail 1990
Professor, then national television (Arabic)	Academic career (decades of seniority)	30+ years	Mowafi; Al-Habib

Source: Lag column of Table 4.1, with the event each lag counts from [1-3, 36, 143, 146, 147, 149, 150, 169, 171, 172, 174, 177, 178, 180-183, 186, 187, 189, 190]. The bases differ, so the lags are not directly comparable: most run from first exposure; the institutional-first

span runs from the first institutional milestone to a hospital or foundation (Kilani 1987 to 1994; Yacoub 1980 to 2008; dates from search summaries, medium confidence); Andrews' runs from the start of practice to the trigger; Rajan's runs from his 2020 burst to his January 2024 book, while the fame study's timeline groups him with the 1–3-year short-video paths. Years of ordinary practice before each trigger are in Figure 4.4. Values marked + are minimums.

FIGURE 4.4

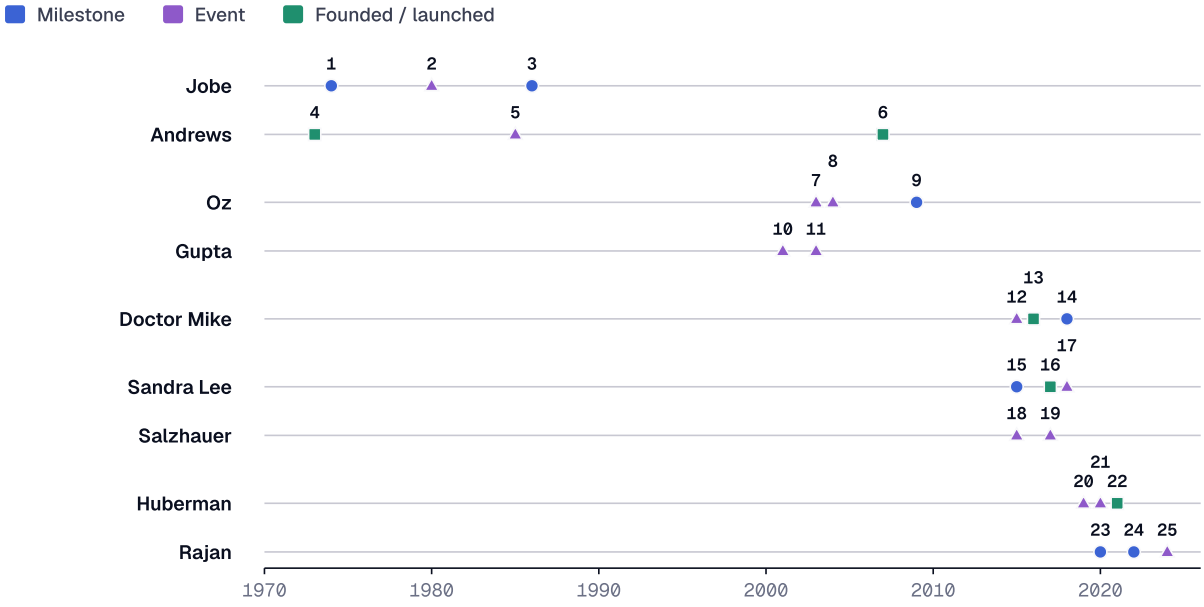
Years of ordinary practice before the fame trigger



Source: [3, 4, 147, 151, 171, 174, 179, 205]. Salzhauer's 12 years run from his 2003 practice founding; Lee's ~10 from the Upland office she described in 2019 as 15 years old. The fame study gives Andrews 13 years; the verification pass dated the Clemens surgery to August 1985, which makes it 12. Mowafi's figure is decades of academic seniority before television.

FIGURE 4.5

Dated fame paths: first exposure, then the owned channel, show or institution



1 **Jobe:** 1974 First operation
2 **Jobe:** 1980 Name in print
3 **Jobe:** 1986 JBJS paper
4 **Andrews:** 1973 Practice begins
5 **Andrews:** 1985 Clemens surgery
6 **Andrews:** 2007 Andrews Institute
7 **Oz:** 2003 Discovery series
8 **Oz:** 2004 Oprah regular
9 **Oz:** 2009 Own show
10 **Gupta:** 2001 CNN hire
11 **Gupta:** 2003 Iraq embed
12 **Doctor Mike:** 2015 BuzzFeed, People
13 **Doctor Mike:** 2016 YouTube channel
14 **Doctor Mike:** 2018 YouTube burst
15 **Sandra Lee:** 2015 YouTube inflection
16 **Sandra Lee:** 2017 SLMD
17 **Sandra Lee:** 2018 TLC series
18 **Salzhauer:** 2015 Snapchat, PR hire
19 **Salzhauer:** 2017 WE tv
20 **Huberman:** 2019 Publicist
21 **Huberman:** 2020 Rogan
22 **Huberman:** 2021 Own podcast
23 **Rajan:** 2020 TikTok burst
24 **Rajan:** 2022 YouTube burst
25 **Rajan:** 2024 Book

Source: [1-3, 24, 36, 143, 149, 169-172, 179-183, 206-209]. Rajan's and Lee's first inflections came on their own channels; what set off Lee's is contested (Appendix C).

Volume, where the record gives it, was institution-enabled rather than solo (Table 4.4). Al-Nemr's is the only Arabic accumulation curve with dates: roughly 28 posts a day for 7 years on one platform [161].

TABLE 4.4

Volume behind the fame, where the record gives it

CASE	VOLUME	ENABLING STRUCTURE
Oz	Roughly 11 network appearances a year for 5 years, plus a book and a daily radio show	A network patron
Salzhauer	~20 live-streamed surgeries a week; ~200,000 daily Snapchat views by September 2015	2 social-media staff and a PR director
Nowzaradan	Continuous television seasons; 60–80 patients a day	A production company
Al-Nemr	~28 posts a day for 7 years on X	A professorship
Rajan	299 TikTok videos (6 April 2020), 748 (6 July) and 1,035 (16 October); 3,233 by June 2026, flat at 5.4M	NHS post and lockdown timing
Sandra Lee	~4 Instagram posts a day through 2016; ~2 a day in the 2018–19 slowdown	Instagram run as a clip feed for the YouTube catalogue
Abol Atta	82 videos in a 78-day run (~1 a day)	No press or television anywhere in the record

Source: [23, 24, 161, 169, 171, 205, 210-216]. The 2 social-media staff are reported by NBC 6 South Florida (April 2015). Posting-rate figures for Al-Nemr, Rajan, Lee and Abol Atta come from the platform-history study's reading of archived post counts.

Origin stories compress and omit. In every case examined, the told version shortened the timeline and dropped the broker (Table 4.5). The working rule the fame study draws is direct: when benchmarking against a famous doctor's own account, add 1 to 3 years and a named intermediary.

TABLE 4.5

The told origin story against the dated record

CASE	THE TOLD VERSION	THE DATED RECORD
Jobe	"One in a hundred" odds	A private estimate near 90%
Nowzaradan	"It just happened"	A Cooley fellowship (1976), prior TLC specials and a son working as director and producer
Sandra Lee	A 2014 start	A 2010 channel with heavy posting only from 2015; the archived curve shows YouTube inflecting first (February–May 2015); what set off the inflection is undated
Huberman	A friend asked what good he would do	Introduced to a publicist in 2019
Salzhauer	"My daughter suggested Snapchat"	A 2008 book, a 2012 video that drew an ethics investigation, an app, and a PR hire in month 1
Doctor Mike	The Wikipedia biography	Omits the November 2020 episode entirely

Source: [4, 36, 149, 171, 174, 179, 180, 182, 184, 205].

4.4 What famous doctors own, and what patients say they weigh

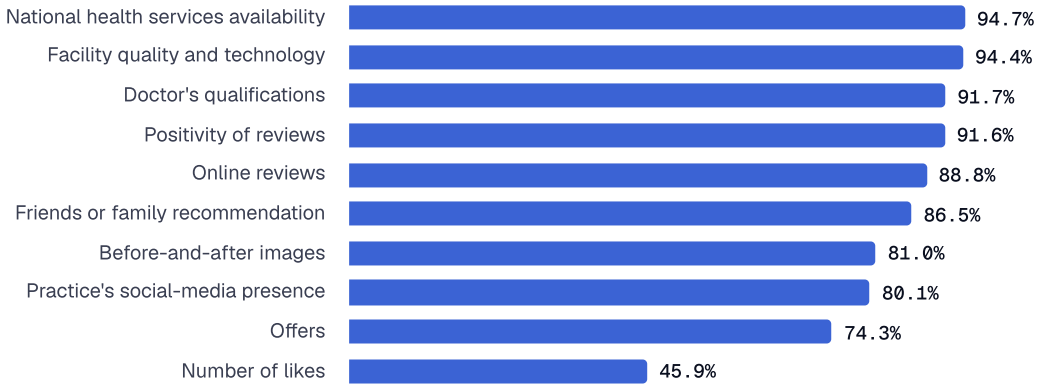
The face and the name carry the platform cases (Doctor Mike, Lee, Salzhauer, Rajan). A format carries Lee (extraction) and Rajan (myth-correction); a phrase carries Atul Gawande ("checklist") [200]; a persona carries Mowafi (a religious-medical elder) [147]. A procedure, by contrast, carries the patient's name. "Tommy John surgery" was coined by sportswriters (Houston Chronicle, 26 March 1980), 5.5 years after the operation and 6 years before Jobe published; Jobe remains an insiders' name [182, 183]. When a procedure diffuses, the public name migrates to the highest-volume operator: from Andrews to Keith Meister after 2023 (a Dallas Morning News characterisation, seen only as search-result text), through a technique variant with 300+ "hybrid" procedures since 2018 [217, 218]. Brand-named elective procedures reach the press fastest and draw formal society opposition: Bunionplasty (trademarks filed 2017–18 by Silvatec Medical; 10 celebrity-hook HuffPost columns in 16 months) and "Cinderella surgery" (national coverage and a rebuke from AOFAS and APMA in 2010; an ACFAS position statement in November 2023) [219-222].

Patient surveys point the same way. In a US sports-medicine practice (n=382), board certification scored 9.12 out of 10 and being "well-known for a specific expertise" 8.27, while online reviews ranked 10th (5.98), primary-care referral 13th (5.61) and professional-team affiliation 14th of 19 criteria (4.75); television, internet and radio advertising came last at about 2.2 [152]. In Saudi Arabia (n=1,242), qualifications (91.7%) and positive reviews (91.6%) outranked before-and-after images (81%), while the number of likes was rated important by 45.9% [6]. The gap between traditional factors and social presence is roughly 6 to 15 points, not the 20 to 50 first reported, because 80.1% rated the practice's social-media presence important; the direction holds.

> *Traditional factors remained more decisive than promotional content.*
>
> Authors' conclusion, Saudi cross-sectional study, n=1,242 [6].

FIGURE 4.6

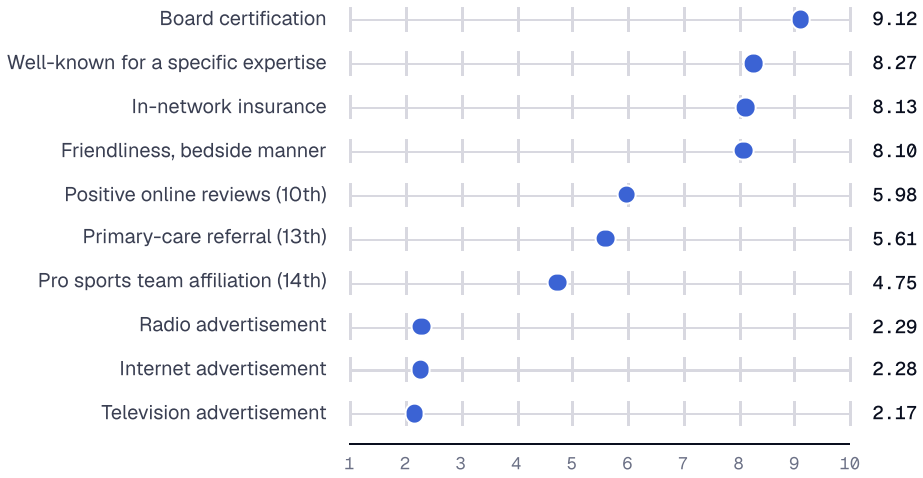
What Saudi respondents rate as important when choosing a provider (n=1,242)



Source: Healthcare (Basel), survey December 2023 to May 2024 [6]. Factors combine the study's practice-choice and doctor-account items. Sample of active social-media users; stated preference.

FIGURE 4.7

What US sports-medicine patients weigh in choosing a surgeon (mean, 1–10 scale)



Source: Orthopaedic Journal of Sports Medicine, 2017; mean importance on a 1–10 scale; 382 responses from 1,077 patients (35%) of 3 physicians in one urban private practice [152]. Bracketed ranks are out of 19 criteria. The study did not measure social media.

Does fame bring patients? No study retrieved for this research links follower counts to patient volume or revenue; a 16-study systematic review in plastic surgery (Level 3 evidence) reports only that following associates with first-page Google placement [223]. The only social-to-volume effect this study found comes from 195 California urologists (2014 data): a social-media presence was associated with about 7 more prostatectomies a year, roughly 25% on a mean of 27, at P=.05, in a cross-sectional design that cannot separate cause from adoption [153]. The one large reputation-to-volume dataset found concerns reviews: across 1.12 million new-patient appointments, a single 1-star review cut new-patient volume by 2.3–2.6% for at least 16 weeks [154]. On a Chinese internet hospital (800 physicians, 275,641 paid consultations), senior title, doctorate, scientific output and profile richness predicted volume; no study of television appearances against volume was found [224]. The outliers are self-pay cosmetic: Salzhauer's "booked two years in advance" is journalist-observed and self-reported [225].

FIGURE 4.8

The measured link between visibility and volume is small

+7 a year
prostatectomies associated with social presence

2.3–2.6%
volume drop after one 1-star review

45.9%
Saudis rating likes important

4.75 / 10
US score for pro-team affiliation

Source: About 7 more prostatectomies a year (~25% on a mean of 27; P=.05; cross-sectional); a 2.3–2.6% new-patient drop lasting at least 16 weeks; likes against 91.7% for qualifications; team affiliation ranked 14th of 19 [6, 152-154].

LIMIT

All patient-choice evidence here is stated preference or cross-sectional. The Saudi survey samples active social-media users; the US survey is one urban private practice with a 35% response rate. No Jordan- or Egypt-specific study of physician fame and patient choice was found, so any claim about conversion in Jordan carries no local evidence.

4.5 The costs of fame, and what it converted into

Costs arrived mostly 3 to 10 years after fame, and they came mostly from peers, regulators, courts and journalists rather than from patients, although Grawe's 2022 suspension followed patient complaints (Table 4.6; Figure 4.9) [226]. That window has 2 exceptions: Salzhauer's 2012 ethics investigation preceded his 2015 fame, and Andrews' 2005 bypass came 19 years after the 1986 comeback [171, 172]. The costs tracked 4 features, not follower count: cosmetic or elective content, claims outside specialty, product promotion, and patient imagery or identity. Credentials protected none of the doctors once claims went outside specialty: Daniel Lanzer was a specialist dermatologist, Oz a vice-chair of surgery, and Diya al-Din al-Awadi a licensed anaesthesiologist [121, 156].

TABLE 4.6

The documented costs of fame

COST	CASE	TRIGGER AND OUTCOME
Evidence audit and legislative summons	Oz	BMJ audit of 40 episodes: 46% of recommendations supported, 15% contradicted, 39% without evidence; Senate subcommittee hearing 17 June 2014; 10 physicians' letter to Columbia, April 2015; moved to professor emeritus in 2018 because he "no longer sees patients"
Professional-body ethics action	Salzhauer	2012 music video led to an ASPS ethics investigation (this preceded his 2015 fame); Instagram account (89,500 followers) deleted in 2015 for surgical imagery
Licence revocation	Grawe (~825K TikTok)	Board warning 2018 on social-media use; suspension November 2022 after patient complaints; permanent revocation 12 July 2023 for livestreaming and answering viewers during surgery; 3 patients severely harmed
Regulator conditions after one broadcast	Aronov (13M TikTok) and Lanzer	ABC Four Corners, late October 2021; AHPRA bars Aronov from all cosmetic surgery and orders posts deleted (29 November 2021); Lanzer surrenders registration (2 December 2021)
Homicide charge	"Dr. Bumbum" (more than 600K Instagram)	Patient death; arrested July 2018
Strike-off and erasure	Diya al-Din al-Awadi (Egypt, anaesthetist)	Advice outside specialty, including stopping insulin; syndicate decision 17 February 2026; expulsion 10 March; clinic closure order 256; licence revoked; died April 2026; publication of his videos banned 3 May 2026
Suspension at the height of visibility	Al-Enezi (Kuwait)	A consented post-operative ward video that showed the patient's face; MOH suspension July 2024. The line drawn was patient identity and non-scientific purpose, not filming or consent
Libel	Jessen (UK)	£125,000 damages plus costs for one tweet (2021); the GMC reportedly declined to act (secondary listings only)
Hypocrisy exposure	Doctor Mike	Maskless boat party, 12 November 2020, while advocating masks; apology reportedly posted on a side channel (weakly sourced); growth continued
The practice itself	Oz, Lee, Attia	No patients since 2018 (Oz); filming rare cases "cuts into time with regular patients" (Lee); practice invitation-only and closed to new patients (Attia)
The body	Andrews	Up to 50 surgeries a week; heart attack and quadruple bypass, January 2005

Source: [58, 120, 121, 151, 155, 156, 171, 172, 226-239]. The Senate hearing date is corrected by verification to 17 June 2014. The GMC and side-channel details do not appear on the pages cited here.

FIGURE 4.9

When the costs arrived



Source: Dates as in Table 4.6 [120, 155, 156, 171, 172, 227-231, 234, 235, 237]. Salzhauer's 2012 investigation preceded his 2015 fame and is shown for completeness; Andrews' 2005 bypass came 19 years after his 1986 trigger.

Fame converted into media properties and products far more often than into a fuller practice (Table 4.7). Surgical institutions came rarely and never alone. The Andrews Institute (Gulf Breeze, 2007) was built by Baptist Health Care "largely on the reputation of Dr. Andrews", with the pro golfer and patient Jerry Pate helping to secure private and state funding; by 2017 it had 127,000 sq ft, 30+ orthopaedic providers and 6,000+ surgeries a year [206, 240]. Kerlan-Jobe (1965) and the Steadman Clinic (1990) predate their founders' wider fame and were its base rather than its product [182, 186]. Yacoub's first institutional fame dates from Harefield (1980); a foundation funded by public donation followed 28 years later (2008), with the Aswan Heart Centre in 2009 [190, 241].

TABLE 4.7

What fame converted into

CASE	CONVERTED INTO	NOTE
Oz	A daily syndicated show (September 2009 to January 2022), then politics	Episode counts conflict: 1,681 in Newsweek, 2,209 in Wikipedia; Harpo produced seasons 1–8 only
Sandra Lee	SLMD skincare (2017), a TLC series (2018), merchandise	She reports modest YouTube income and minimal television pay
Salzhauer	WE tv (2017), a 2020 documentary, CMO of an AI venture that raised $17.5M in 2025	The one case where the surgeon attributes a practice backlog to social media
Nowzaradan	Books (2017, 2019), a 2025 spin-off	Continuous seasons

CASE	CONVERTED INTO	NOTE
Huberman	Scicomm Media (2021), a premium tier	A PhD, not a physician
Rajan	A book (January 2024) and BBC work	Still an NHS surgeon
Andrews	The Andrews Institute (2007), with a hospital partner	Built on his reputation; a patient helped secure funding
Yacoub	A foundation (2008) and the Aswan Heart Centre (2009)	Foundation 28 years after first institutional fame (Harefield 1980)
Al-Habib	Mutmaenna centres in Riyadh, Qassim, Kuwait, Bahrain and Muscat, and a channel	Founding dates undocumented
Al-Nemr	No clinic or product in the record	Directory pages list private-practice profiles and consulting

Source: [1, 143, 146, 149-151, 174, 189, 190, 206, 225, 238, 242, 243].

The largest cash exits of a physician's name found in this study were product companies, not audiences. Dr. Dennis Gross Skincare, founded in 2000 by a practising dermatologist, sold to Shiseido for $450M in February 2024 [157, 244]. Obagi Medical agreed to be acquired by Valeant at $19.75 a share (valued by Obagi at about $360M; The Globe and Mail reports about $344M paid), on about $120M of 2012 revenue [158, 159, 245]; Valeant raised the price to $24.00 a share in April 2013, the price at which the deal closed [246]. Obagi was resold for $190M in 2017, once detached from its founder and its physician-dispensed channel [159]. Neither company was born of an audience.

FIGURE 4.10

The largest cash exits of a physician's name found in this study



Source: [157, 159, 244]. The Obagi bar is the 2013 purchase price as reported by The Globe and Mail. Obagi's own release valued the $19.75 first offer at approximately $360M [158, 245]; the deal closed after Valeant raised its offer to $24.00 a share in April 2013 [246], roughly $435–440M as computed in the verification pass, not charted because it is a derived figure.

KEY FINDING

A physician-named brand is an asset to the extent it is transferable without the physician. Obagi was resold for $190M in 2017 once detached from its founder and its physician-dispensed channel (see Chapter 7).

4.6 The Arabic record, and fame inside advertising rules

The documented Arabic paths are institution-then-television, the expert voice on X, club and federation appointment, "first in the region" technology positioning (Albelooshi; growth mechanism untestable), clinic-shot treatment clips on TikTok (El Masri), and institutional firsts that later became hospitals (Table 4.8). A Jordanian orthopaedic precedent exists and was nearly missed. The first research pass concluded that no Jordanian orthopaedic surgeon had a documented fame arc; the verification pass refuted this with a dated Jordan News profile (24 July 2021) of Osama Al-Odat, orthopaedic and trauma surgeon, at 307,000 Instagram followers, built on educational fracture, first-aid and myth-busting videos and live collaborations with other doctors [5]. He is Amman-based, and on 16 September 2026 read 504K on Instagram and 206.5K

on TikTok, plateaued since late 2022 [168, 247]. Jordan's largest physician-branded audience found is a dentist, Shadi Al-Sheikh (more than 2M on Facebook, 700K on Instagram), built on lectures and education (a search-summary source) [248].

The regional record has 2 further features that matter. The club post is not automatically a route to fame in Jordan: when a national-team player was injured in December 2025, an outside orthopaedic surgeon was named in national press for commenting on the injury while the team doctor went unnamed [249, 250]. And the Arab surgeon-to-the-stars role is held abroad: Gulf footballers go to Ramon Cugat in Barcelona, and Aspetar (2007) was staffed globally because Qatar's athletes had been travelling to Europe and the United States [251, 252]. The largest Arabic "Dr" audiences are not clinical evidence: Kuwait's "Doctora Khaloud", ranked first in the Arab world on Snapchat in May 2024, publishes lifestyle content under a medical title (a reported 9M+ Instagram count rests on search summaries only) [253], and Egypt's Karim Ali built a multi-million YouTube community by translating foreign doctors' content, with credentials contested [254].

TABLE 4.8

Arabic fame paths on the dated record

PATH	CASE	DATED RECORD	EVIDENCE STRENGTH
Professor, then national television	Hossam Mowafi (Egypt)	Head of internal medicine, Qasr Al-Aini 2003–07; vice dean 2007–11; programmes on 3 channels; syndicate "best medical media doctor" award	Arabic Wikipedia; award medium confidence (Arabic Wikipedia only)
Professor, then television	Jaber Al-Qahtani (Saudi Arabia)	Weekly Al-Riyadh herbal column from ~1999; weekly Al-Ekhbariya programme from ~2003; 4-volume encyclopedia 2008	Arabic Wikipedia
Professor, television and clinics	Tariq Al-Habib (Saudi Arabia)	KSU professor; weekly MBC slot; 10 books; 5-city clinic chain and a channel	MBC slot attested only by an unsourced Wikipedia line
Expert voice on X	Khaled Al-Nemr (Saudi Arabia)	Award 2014; "most interactive medical accounts" 2020; 1,000,000 followers June 2021	Press and archived captures
Institutional first, then institution	Zaid Al-Kilani (Jordan)	First IVF baby in Jordan and the region, 1987; Farah Hospital 1994	Search summaries; medium confidence
Club and federation appointment	Ahmed Abou Abla (Egypt)	National-team medical head from March 2015; 100 international matches by June 2024; U-20 medical head and orthopaedic PhD, July 2025	Press (search summaries)
"First in the region" technology	Ali Albelooshi (Dubai)	Press waves: 2018 first robotic knee; 2023 "1,500 surgeries"; 2025 first robotic hip. A third-party list gave 546K; the live page read 915,679 on 16 September 2026	Claim-led positioning; growth mechanism untestable (no history)
Clinic-shot treatment clips (TikTok)	Ahmad El Masri (Lebanon)	3 clinic-shot TikToks above 8M; burst June–August 2025. A third-party list gave 415K; the live page read 599,104 on 16 September 2026	Archived captures; no press or television in the record
Gulf Snapchat on credentials	Anwar Al Hammadi (Dubai); Saud Al-Shehri	~591–597K and ~325K Snapchat subscribers	Presence only; no press profile of conversion
Educational video	Osama Al-Odat (Jordan, Amman)	307,000 Instagram July 2021; 504K Instagram and 206.5K TikTok, 16 September 2026	Press and live pages

Source: [5, 146, 147, 150, 161, 168, 187, 247, 255-267]. The 546K and 415K counts are undated third-party figures, corrected by the platform-history study; the "first in the region" reading is retired for El Masri (Appendix B).

Measured regional evidence is thin. Beyond the Saudi study in Section 4.4, a second Saudi study (Jeddah, 2025) rates social media's influence on physician choice as strong for 26% and moderate for 47.8% of respondents, a finding available only as a search summary [268]. Regulation shaped every Arabic case without stopping the lawful ones; enforcement tracked promotion, patient imagery, superlatives and specialty scope, never audience size (Table 4.9). The same Egyptian syndicate code produced a media award for Mowafi (attested by Arabic Wikipedia only) and expulsion for al-Awadi [147, 156, 269], and Al-Nemr reached 1 million followers inside Saudi rules on educational posts [91, 150]. Karan Rajan built his TikTok audience under the UK's General Medical Council by never advertising, and the one UK cost in the record (Jessen) arrived through libel, not the regulator [143, 235]. The clause-level treatment of the Jordanian instructions is in Chapter 3.

TABLE 4.9

Where enforcement drew the line, by jurisdiction

JURISDICTION	RULE IN BRIEF	ENFORCEMENT OR OUTCOME IN THE RECORD
Jordan	JMA instructions issued 24 December 2024, in force 1 February 2025: no superlatives ("the first / the only / the finest"), discounts, product or sponsor promotion, or patient images during procedures; websites and social accounts registered with the JMA (10 JD)	The Private Sector Doctors' Assembly objected publicly; the JMA said it would apply the instructions for 6 months and then review them; no reported enforcement case under them (see Chapter 3)
Egypt	Medical Ethics Code bans self-promotion (Art. 10); media appearances only without workplace, contact details or credentials (Art. 19)	Award for Mowafi; expulsion for al-Awadi; draft rules (May 2026) with penalties from warning to deregistration
Saudi Arabia	MOH warning of 9 July 2017: no surgical or cosmetic imagery, no discounts, no commercial-style publicity; fines SAR 10,000–100,000	2026 proceedings over synchronised promotional posts, while stating that announcing a move of practice is a legitimate right
Dubai	DHA social-media standard (v1.1, 2022): medical-director approval; banned words such as "the best", "miraculous", "100%"; unedited before-and-after with a disclaimer	Reported enforcement from September 2026
Kuwait	MOH rules (January 2025): prior authorisation for health advertising, including influencer accounts; "legend" and "celebrity expert" banned; a health-product advertising regime that reaches physician and influencer accounts	Al-Enezi suspension turned on an identifiable patient, not on filming

Source: [62, 70, 91, 133, 147, 156, 234, 269-272]. Jordan's instructions are confirmed in force on paper only. Kuwait's decision is framed around pharmacies and health-product sales under pharmacy-profession law. Regulation detail is in Chapter 3.

> WHAT THIS MEANS FOR A SURGEON IN JORDAN
>
> The regional enforcement record never turned on audience size, across the 4 jurisdictions with enforcement cases and in Jordan's written rules. On the sources, the conditions that preceded sanctions were promotion, superlatives, patient imagery or identity, and claims outside specialty; an educational orthopaedic account of the kind Al-Odat built reached 307,000 Instagram followers in Jordan by July 2021, before the current Jordanian instructions took effect.

4.7 Platform histories: one burst, a long ramp, then a plateau

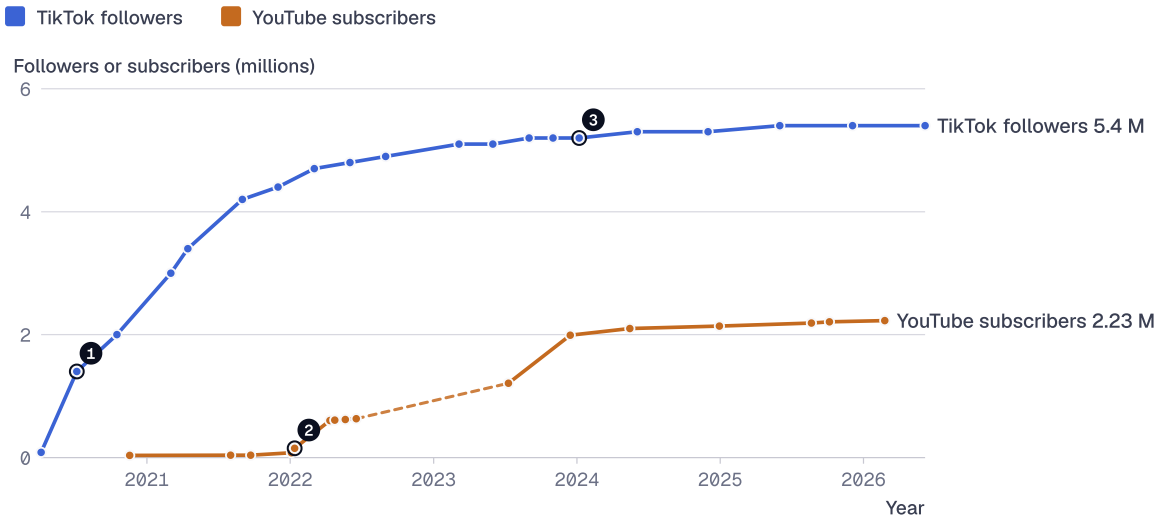
A second-phase study rebuilt 8 of the fame study's press-based account histories from primary snapshots: 275 dated points, most read from Internet Archive captures of the account's own page or from the live page on 16 September 2026, with a minority from dated press and third-party statistics pages. Of 66 claims, 62 were confirmed, 2 refuted and 2 left unverified, and in 154 individual data checks every re-read count

matched to the digit or to the rounding the page exposes. On this data, every video-platform account with usable resolution follows one shape: a single burst window of weeks to months, then a multi-year ramp, then a plateau (Table 4.10). Al-Nemr's X account is the exception, a pure accumulation curve.

Karan Rajan's TikTok went from 85,393 on 6 April 2020 to 1,400,000 on 6 July 2020, during lockdown and while his video count rose from 299 to 748, and has read 5.4M since June 2025 [23, 24, 160]. Doctor Mike's YouTube went from 857,797 on 18 April 2018 to 2,225,023 on 1 October 2018; the steepest part of the burst followed within days of a reaction video to the series The Good Doctor, uploaded on 15 April 2018, and growth before that upload is unobserved [273, 274]. Sandra Lee's YouTube grew about 21-fold in 6 months of 2015, from 14,318 in February to 301,641 in August, in the months she retitled the channel "Dr. Pimple Popper", 2.5 years before television [275, 276]. Khaled Al-Nemr's X, the exception, accumulated: 4,405 followers in July 2012, 832,175 in April 2019 and 1,029,286 in October 2021, on roughly 28 posts a day [161, 277, 278].

FIGURE 4.11

Karan Rajan: TikTok burst in lockdown, YouTube burst 20 months later, then plateaus



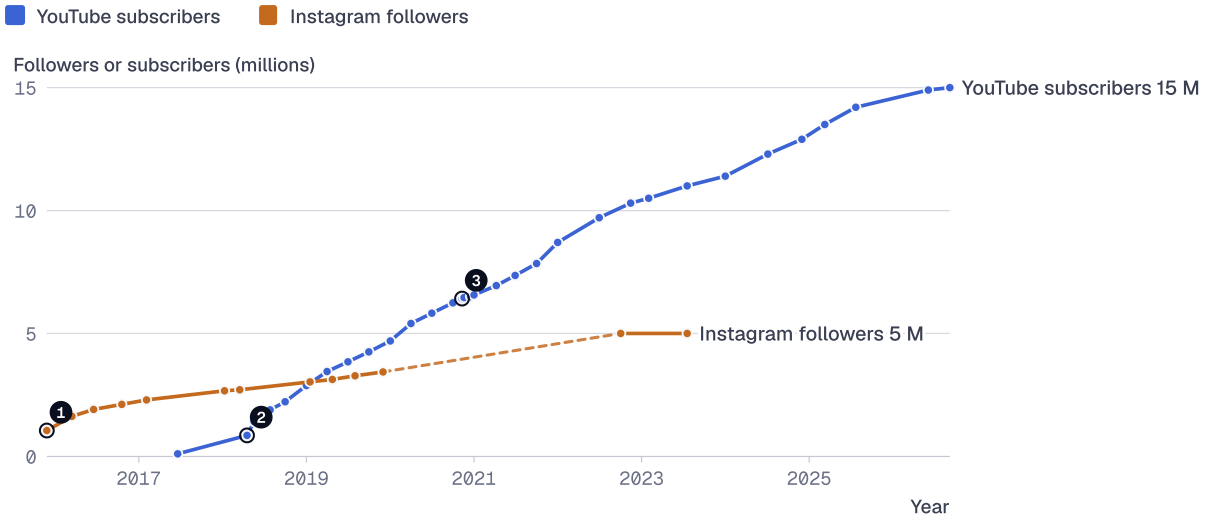
1 85,393 to 1.4M, April to July 2020
2 YouTube burst, January to April 2022
3 Book, January 2024: no inflection

Dashed segments join observations more than a year apart; there is no data between them.

Source: Internet Archive captures of the TikTok profile and YouTube channel, April 2020 to June 2026, as recorded in the platform-history study; representative captures cited, the full series is in that study [23, 24, 164, 209, 212, 279]; live reading [160]. 36 dated observations are plotted (20 TikTok, 16 YouTube); lines join observations and show nothing between them, and segments spanning more than a year are drawn dashed. Nothing is interpolated; points the verification pass did not retrieve again (TikTok 2.8M and 5M; YouTube 84.7K, 129K, 634K and 1M) are omitted. Platform rounding applies after 2019.

FIGURE 4.12

Doctor Mike: Instagram first, a 2018 YouTube burst, no dent from the 2020 controversy



1 10 days after People: 1,051,110

2 857,797 on 18 Apr, 3 days after the Good Doctor reaction

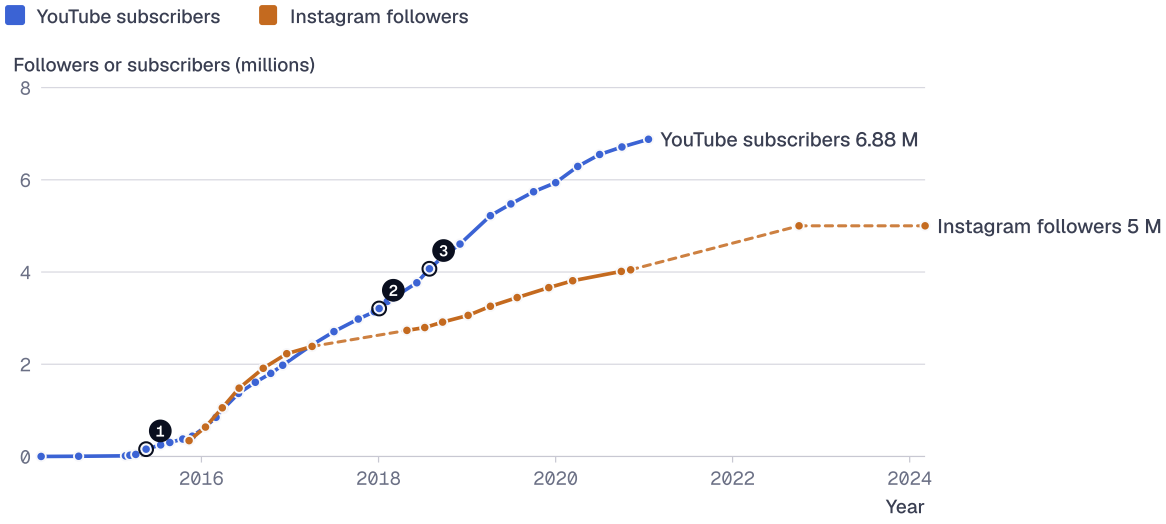
3 Nov 2020 controversy: no dent

Dashed segments join observations more than a year apart; there is no data between them.

Source: Internet Archive captures of the Instagram profile (November 2015 to July 2023) and YouTube channel (June 2017 to September 2026); representative captures cited, the full series is in the platform-history study [165, 177, 178, 207, 273, 274, 280, 281]. 46 dated observations are plotted (33 YouTube, 13 Instagram); lines join observations and show nothing between them, and segments spanning more than a year are drawn dashed. Instagram captures from 2020 to 2022 are login walls, so the dashed Instagram segment across that gap carries no data; post-2022 Instagram values are platform-rounded (5M).

FIGURE 4.13

Sandra Lee: the YouTube inflection came in 2015, long before television



1 YouTube inflection, Feb–May 2015

2 TLC special, January 2018: +5%

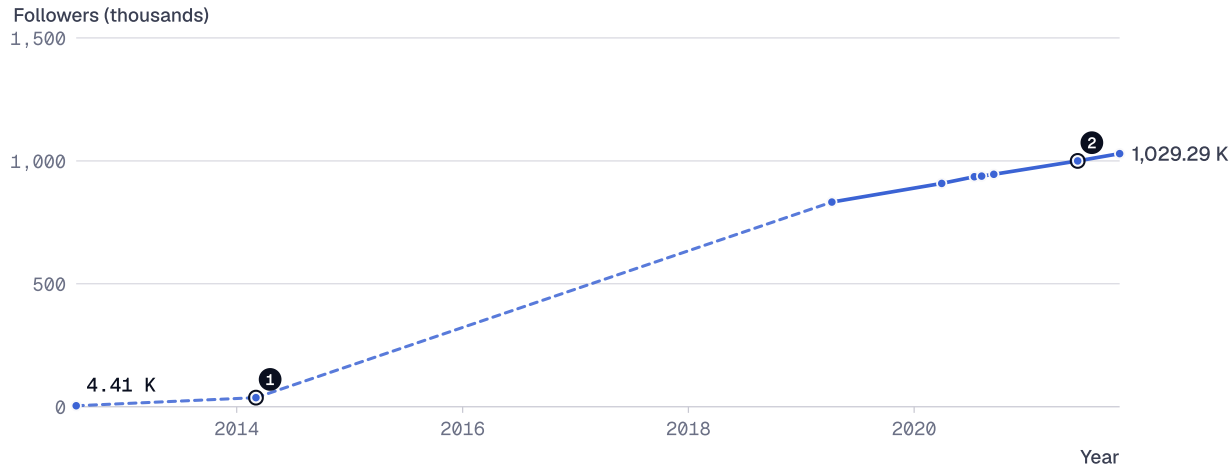
3 TLC series premiered 11 July 2018: pace unchanged

Dashed segments join observations more than a year apart; there is no data between them.

Source: Internet Archive captures of the YouTube channel (March 2014 to January 2021) and Instagram profile (November 2015 to March 2024); representative captures cited, the full series is in the platform-history study [163, 180, 213, 214, 275, 276, 282]; television dates [181]. 55 dated observations are plotted (36 YouTube, 19 Instagram); lines join observations and show nothing between them, and segments spanning more than a year are drawn dashed, including the Instagram segment across the unobserved 2020–2022 gap. YouTube values after 2021 could not be attributed cleanly and are not shown; live YouTube 9.13M and Instagram 5M [283, 284].

FIGURE 4.14

Khaled Al-Nemr: pure accumulation on X, then a flat million



1 37,400 in March 2014 (press)

2 1 million, June 2021 (press)

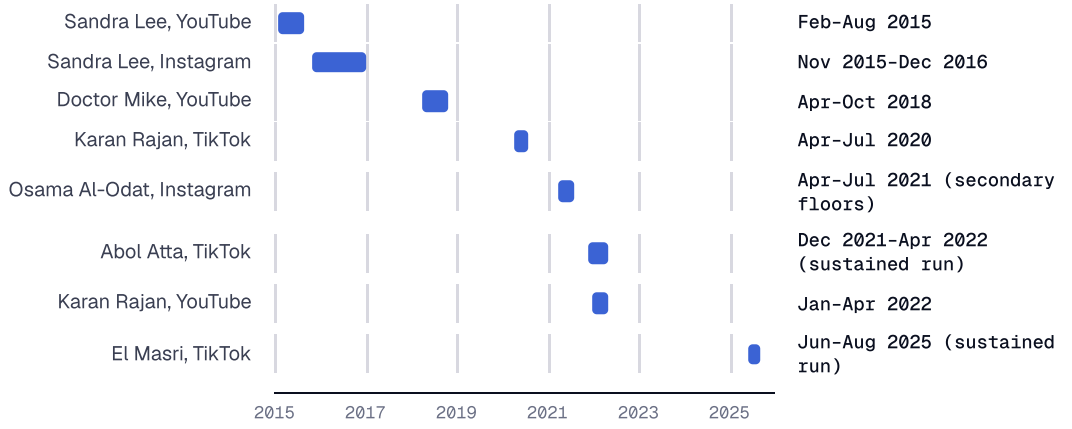
Dashed segments join observations more than a year apart; there is no data between them.

Source: Internet Archive captures of the X (Twitter) profile [161, 277, 278]; press points [150, 285]. 9 dated observations are plotted, 7 from archived captures and 2 from press; lines join observations and show nothing between them, and segments spanning more than a year are drawn dashed. The 2014 to 2019 climb is unobserved, so the dashed segment across it carries no data. The live page reads "1M".

The measurable bursts were platform-native, a cluster of videos catching the algorithm, not television, press or a book. What the archives cannot show is the first fame moment. Doctor Mike's earliest Instagram capture, 10 days after the People feature, already reads 1,051,110, and the press story's "100K to 1.5M within weeks" does not hold as dated: 1.5M was crossed between 27 November 2015 and 15 March 2016 [177, 178]. Archives begin crawling an account once it is notable, so the gatekeeper moment in Section 4.1 sits before the first snapshot in every case. The 2 records describe different phases rather than conflict: a gatekeeper grants the first audience; the platform's algorithm, fed by volume, produces the large measurable bursts later; broadcasts after that point buy small lifts.

FIGURE 4.15

Burst windows by account and platform



Source: Burst windows as dated in the platform-history study, from archived captures [5, 23, 24, 209, 213, 214, 216, 264, 265, 273-276, 279, 286, 287]. Several windows are bracketed rather than dated because the archive was offline for part of the collection.

TABLE 4.10

Bursts or accumulation: the dated primary points

ACCOUNT AND PLATFORM	BURST WINDOW	BEFORE AND AFTER (DATED POINTS)	THEN
Doctor Mike, YouTube	April–October 2018	107,245 (20 June 2017); 857,797 (18 April 2018); 1,418,804 (19 May 2018); 2,225,023 (1 October 2018); ~30K a day at peak	Ramp to 15M (September 2026); no later burst
Doctor Mike, Instagram	November 2015 (no earlier point)	1,051,110 (27 November 2015); 1,628,792 (15 March 2016)	+0.4–0.5M a year to 3.44M (2019), 5M (2022–23), 6M (2026)
Sandra Lee, YouTube	February–August 2015	14,318 (21 February); 56,188 (20 April); 157,148 (18 May); 301,641 (23 August); ~21× in 6 months	1,038,887 (April 2016); 1,977,901 (December 2016); 9.13M (2026)
Sandra Lee, Instagram	November 2015–December 2016	341,750 (11 November 2015); 1,055,110 (27 March 2016); 2,229,366 (19 December 2016)	Slows; 4,048,115 (November 2020); "5M" (2022, 2024, live)
Dr. Miami, Instagram	None after the 2015 relaunch	180,198 (12 July 2015); 480,745 (14 December 2016): ~50K a quarter	1,594,281 (1 November 2020); 1.4M live (net decline)
Karan Rajan, TikTok	April–July 2020	85,393 (6 April 2020); 1,400,000 (6 July 2020); 2,000,000 (16 October 2020)	4.4M (December 2021); 5M (December 2022); 5.4M (June 2025 to live)
Karan Rajan, YouTube	January–April 2022	41.1K (22 September 2021); 79.1K (4 January 2022); 152K (12 January); 604K (12 April)	1M (April 2023); 1.99M (December 2023); 2.24M live

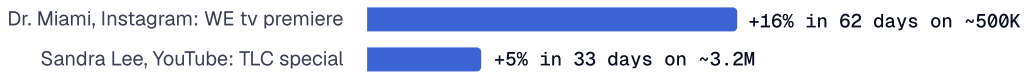
ACCOUNT AND PLATFORM	BURST WINDOW	BEFORE AND AFTER (DATED POINTS)	THEN
Abol Atta, TikTok	December 2021–April 2022 (sustained run)	575,000 (14 December 2021); 657,400 (6 February); 743,900 (18 February); 1,100,000 (25 April); ~1 video a day	1.7M (October 2022); 3.9M (November 2024); 4.5M live
El Masri, TikTok	June–August 2025 (sustained run)	184,800 (14 June 2025); 247,100 (7 August); 253,800 (26 August)	~299,790 (16 September 2026, mirror)
Al-Odat, Instagram	Spring–summer 2021 (secondary floors)	At least 190,000 (17 April 2021); 307,000 (24 July 2021, press); at least 410,000 (7 December 2022)	504K live; at most 94K added in 45 months
Al-Nemr, X	None: pure accumulation	4,405 (31 July 2012); 37,400 (March 2014, press); 832,175 (10 April 2019); 1,029,286 (27 October 2021)	"1M" live; flat for 5 years

Source: Representative captures cited; the full series is in the platform-history study [5, 23, 24, 160, 161, 166-168, 177, 178, 180, 207, 209, 211, 213-216, 264-266, 273-280, 282, 283, 285-295]. Points added in the verification pass inside the Abol Atta and El Masri windows showed sustained runs rather than single steps. Reliability by account: strong (Doctor Mike, Sandra Lee; Karan Rajan on its separate verification); moderate (Dr. Miami, Abol Atta, Desoki, Al-Nemr, El Masri, Albelooshi); weak by construction (Al-Odat).

External events after an account was large gave small, temporary lifts, never steps. Dr. Miami's WE tv series order (July 2016) left no step [290, 296]; the premiere on 31 March 2017 coincided with his fastest Instagram window, +82,696 in 62 days (about +16% on a half-million base, roughly 1,330 a day against about 450 before), after which a steady ramp resumed at about 680 a day to September 2018 [162, 208, 297, 298]. Sandra Lee's audience was already 35% of today's YouTube and about half of today's Instagram when her TLC special aired in January 2018; it added about 5% in 33 days on a 3.2M base, and the series that followed did not change her slope [163, 181, 283]. Rajan's January 2024 book left no inflection on TikTok, and his YouTube slowed after it [164]. Doctor Mike's November 2020 controversy left no dent in a curve read every few days [165].

FIGURE 4.16

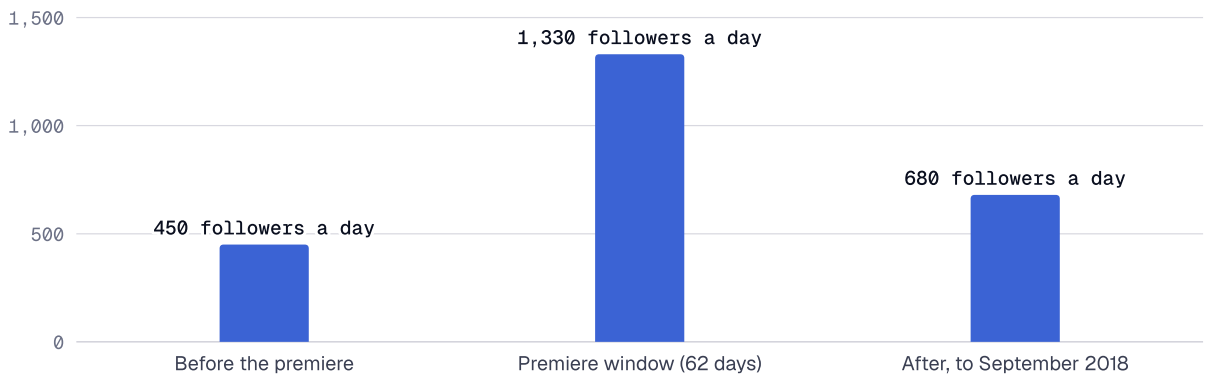
Television lifts once the account was already large



Source: Growth over the window around each broadcast, from archived captures [162, 163, 297]. The 2 bars are on different platforms. Rajan's book and Doctor Mike's controversy produced no measurable change and are not charted as values [164, 165].

FIGURE 4.17

Dr. Miami's Instagram gain per day around the WE tv premiere



Source: Archived Instagram captures, December 2016 to September 2018 [162, 290, 297, 298]; premiere date [208]. Approximate daily rates as stated in the platform-history study; the verification pass computed about 938 a day for September 2018 to October 2019.

Volume rode with the burst and fell with the plateau: Rajan's video count rose from 299 in April 2020 to 1,035 in October 2020, and he now sits flat at 5.4M on 3,233 videos; Sandra Lee ran about 4 Instagram posts a day through 2016 and about 2 a day through the 2018–19 slowdown [23, 211-214]. Audiences were built by a handful of outlier videos rather than the routine feed. The counter-case is Mohamed Desoki, who posts weekly and grew on 3 mega-viral videos in 1 month [299].

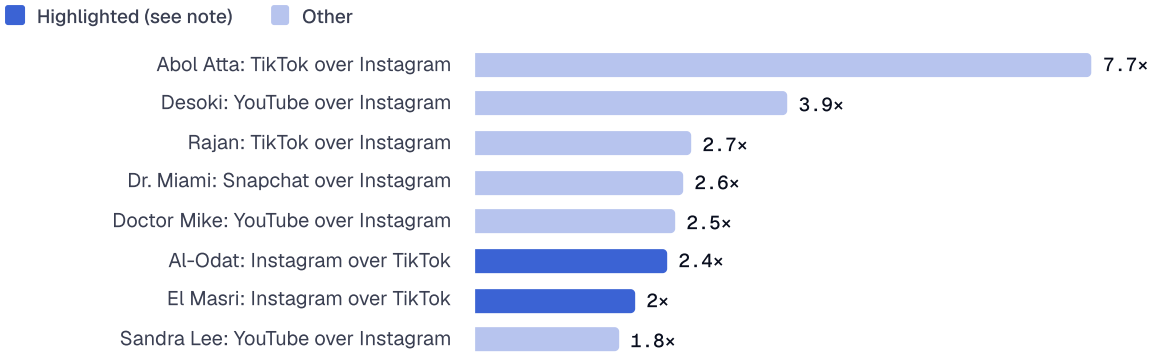
> KEY FINDING
>
> Consistency explains retention, not arrival. The mature accounts are flat on Instagram after 2020 at any cadence; growth came in one window and rode on volume inside that window.

4.8 Which platform leads, and the corrected figures

Which platform leads splits by cohort (Figure 4.18; Table 4.11). By stock, a video platform leads Instagram for the global doctor-creators, and Instagram leads for the Arab comparables (Al-Odat, El Masri and Albelooshi). By current reach the picture inverts for the 2 Arab comparables with a TikTok record (Table 4.12): Al-Odat's Instagram added at most 94K in 45 months while his 2026 TikTok uploads, 1 every 10 days, draw 100K to 659K plays; El Masri's Instagram likes fell from 3,423 (December 2023) to 136 (December 2025) while his TikTok grew from 185K to 300K. Instagram plateaus after about 2020 for every mature account, with Rajan the one counter-case. The second platform inflected years after the first, not months, and YouTube did not scale for any Arab clinician in the set except Desoki's long-form paediatrics channel. The perspective passes were answering 2 different questions, largest audience against largest live reach, and the study's instruction is to define "leads" as median views per post over the last 30 days before any strategy relies on it [168, 247, 263, 264, 266, 300, 301].

FIGURE 4.18

How far the lead platform leads, by follower stock on 16 September 2026



Source: Ratios from platform pages read on 16 September 2026 [160, 166-168, 247, 263, 266, 283, 284, 288, 300-304], with one exception: El Masri's counts come from third-party statistics pages (Social Blade for Instagram; a TikTok mirror). Each bar is the lead platform's followers as a multiple of Instagram's, or, for the Instagram-led accounts, Instagram's as a multiple of TikTok's. Stock, not reach. The ratio is over Instagram, not over each account's second-largest platform (Rajan's YouTube, Desoki's Facebook and Dr. Miami's press-reported TikTok all exceed their Instagram). The 2 Arab comparables with a ratio are highlighted.

TABLE 4.11

Which platform leads, by follower stock on 16 September 2026

ACCOUNT	LEADING PLATFORM	INSTAGRAM	RATIO	OTHER PLATFORMS
Doctor Mike	YouTube 15M	6M	2.5×	TikTok 2.9M (July 2026); X 357.8K
Sandra Lee	YouTube 9.13M	5M	1.8×	X 122.3K; TikTok unreadable
Dr. Miami	Snapchat 3.6M	1.4M	2.6×	Facebook 534,468; Threads 263.2K; X 169.1K; YouTube ~29K; TikTok 2M (press, 2022)
Karan Rajan	TikTok 5.4M	2M	2.7×	YouTube 2.24M; Facebook 1,629,625; X 5,002
Abol Atta	TikTok 4.5M	582K	7.7×	YouTube 18.2K; X 300
Desoki	YouTube 3.94M	1M	3.9×	Facebook 2,585,747; TikTok 1.8M
Al-Nemr	X 1M	Not recorded	n/a	Single platform
Al-Odat	Instagram 504K	504K	2.4× over TikTok 206.5K	Facebook 136,621; X 116.1K; Snapchat 59K; YouTube 18.9K
Albelooshi	Instagram 915,679	915,679	Instagram only	No own YouTube; TikTok unconfirmed
El Masri	Instagram 599,104	599,104	2× over TikTok ~299.8K	Facebook 63,817; YouTube 700; X 54

Source: Live platform pages and third-party statistics pages retrieved online on 16 September 2026 [160, 166-168, 247, 262, 263, 266, 283, 284, 288, 294, 299-305]. Exceptions to the 16 September date: Doctor Mike's TikTok (July 2026) and Dr. Miami's TikTok (press, 2022). Dr. Miami's YouTube and the exact Albelooshi and El Masri counts are from third-party statistics pages. Rounded values are as the platforms display them.

TABLE 4.12

The Arab comparables: audience, growth, content and positioning

MEASURE	AL-ODAT (DR.OSAMAODAT)	EL MASRI (DOCTOR.ELMASRI)	ALBELOOSHI (DRBELOOSHI)
Instagram	504K; 811 posts; at most 94K added in 45 months	599,104; 1,033 posts; engagement rate 0.06%	915,679; 1,436 posts; engagement rate 0.24%
TikTok	206.5K; 825.9K likes; active	~299,790; 619 videos; 6 a month	Unconfirmed
Growth shape	Burst 2021; plateau since December 2022	Burst June–August 2025, then ~130 a day	Untestable: no history exists
Built by	One 203K YouTube video is 23% of lifetime views; TikToks at 3.3M and 3.8M	3 clinic-shot TikToks above 8M	Press waves: 2018 first robotic knee; 2023 "1,500 surgeries"; 2025 first robotic hip
Engagement	Thousands of likes per post (bio site)	Likes per reel fell from 3,423 to 136	2,148 average likes; 5,210 on a robotics reel
Positioning	Education, first aid, myth-busting; Amman; Hashemite University lecturer	Treatment clips; Beirut and Düsseldorf	"First in the region" robotics; society president

Source: Platform-history study, readings of 16 September 2026 [168, 247, 259–264, 266, 295]. Engagement figures from third-party trackers disagree.

The second-phase study corrected 5 figures the fame study had carried from press and refined 3 further readings; this chapter uses the corrected figures throughout (Table 4.13). The pattern behind the corrections is general: every headline number checked was a cross-platform sum, a daily-views figure, an undated tracker value or a stale snippet. Third-party trackers disagreed with primary captures by up to 4 times (Desoki 435K against 1.6M).

TABLE 4.13

Press figures corrected by the dated platform histories

FIGURE OR READING AS FIRST CARRIED	CORRECTED READING
Doctor Mike, ~15M Instagram by 2025	Refuted: Instagram read 5M in October 2022 and July 2023 and reads 6M today; 15M is YouTube; the bio's "30,000,000+" is a cross-platform sum
Karan Rajan, 10M+ TikTok by 2025	Refuted: TikTok never exceeded 5.4M in any capture; "10M+" and "12M" are cross-platform totals (today's platforms sum to about 11.3M)
Doctor Mike, 100K to 1.5M within weeks of People	Half untestable, half wrong: no pre-feature capture exists; 1.5M was crossed between 27 November 2015 and 15 March 2016
Dr. Miami, ~1M Snapchat by 2016	Not found in any retrieved source; the 2015–16 press figures were daily views (200K; 700K+); the only follower figure is 97,200 on 4 September 2015; 3.6M today
Desoki, platform-native TikTok surgeon	A paediatrician; YouTube had 2.22M subscribers in July 2022 and Facebook 2.59M; TikTok (1.8M) is the later, smaller channel
Albelooshi 546K, El Masri 415K	Undated third-party counts; live pages read 915,679 and 599,104; kept off every curve
Al-Odat, Irbid-based, YouTube dormant	Amman-based; 504K Instagram today; YouTube small but not dormant (7.4K to 16.6K after his May 2020 hits; 28 uploads in the last year)
Sandra Lee's rise, television-driven	YouTube inflected February to May 2015, 32 months before TLC; the television-driven reading is refuted; what set off the 2015 inflection remains undated

Source: [160, 164, 166, 168, 171, 177, 178, 180, 181, 191, 258, 262, 263, 281, 288, 299, 301, 304, 306–309].

LIMITS OF THIS EVIDENCE

- The case set skews to English-language, US and cosmetic-adjacent fame, because that is what the press documents.
- Audience numbers in the fame study were largely self-reported or press-reported; bio and press figures often proved to be cross-platform sums, daily views or undated tracker values.
- The Saudi survey samples active social-media users and measures stated preference; the US sports-medicine survey covers one urban private practice with a 35% response rate; the urology study is cross-sectional and cannot separate cause from adoption.
- No Jordan- or Egypt-specific study of physician fame and patient choice was found.
- The Arabic platform-native cases (Abol Atta, Desoki, the Gulf Snapchat dermatologists) rest largely on profile counts, and several Arabic press pages were reachable only as search summaries; the Kilani, Hanania and Yacoub dates come from search snippets (medium confidence).
- Some platform archives were unavailable during the fame study, so its platform histories came from press; the second-phase study rebuilt them from archived snapshots.
- Archives begin capturing an account only once it is notable, so the first fame moment sits before the first snapshot in every case and cannot be tested from archive data.
- The Internet Archive was offline or rate-limiting for roughly a third of the second-phase collection, so several bursts are bracketed to 3-to-10-month windows rather than dated.
- Post-2020 Instagram is measured at 3 or 4 points for most accounts, and platform rounding limits plateau claims to about ±10K on YouTube, ±50K on TikTok and ±0.5M on Instagram; Snapchat has no public history for any account.
- Reliability of the dated histories varies by account: strong for Doctor Mike and Sandra Lee (and Karan Rajan on its separate verification); moderate for Dr. Miami, Abol Atta, Desoki, Al-Nemr, El Masri and Albelooshi; weak by construction for Al-Odat, whose Instagram account the archives do not hold.
- Some checks in the verification pass were incomplete: the Sandra Lee top-videos claim is unverified, and several YouTube and TikTok points were not retrieved again (they are omitted from this chapter's charts). Nothing was interpolated, and 48 explicit gaps were recorded.
- Several secondary details carry weak sourcing and are labelled where used: the GMC's reported decision not to act on Jessen, Doctor Mike's side-channel apology, the Dallas Morning News characterisation of Meister, and Doctora Khaloud's Instagram count.
- The research was desk-based and web-only; no fieldwork, interviews or patient data were used.

LEFT OPEN

- Are the Jordanian television health slots (the طب وصحة, medicine and health, segment of Roya's دنيا يا دنيا, Donya Ya Donya; JRTV's ألو دكتور, Allo Doctor) sold as sponsored segments, and who books the doctors?
- How are club and federation medical roles awarded in Jordan, given that the club post was not a route to fame in the December 2025 case?
- What did the brokers in the record (publicists, PR directors, agents) actually do, and what did they cost?
- What has the JMA committee approved in practice, and how fast? (Chapter 3)
- Which reference-class institutes were named by the surgeon and which by the hospital partner? (Chapter 5)
- What did the "first in the region" technology accounts own once a competitor bought the same machine? (Chapter 6)
- Which platform leads by flow, measured as median views per post over the last 30 days, rather than by follower stock?
- Did Al-Odat's 2020–21 burst have a datable trigger? Contemporaneous Jordanian press quoting his follower count would date it.
- Does Albelooshi's growth step with technology and press events? It can be tested forward with a daily reading through UAEOrtho (27–29 November 2026).
- What set off Sandra Lee's spring-2015 YouTube inflection?
- Does fame convert into patients in Jordan? No local evidence exists.
- Should Desoki, a paediatrician with a long-form YouTube channel, stay in the set of accounts compared with an orthopaedic surgeon? This is an editorial decision, not a data question.

CHAPTER 05

Brand architecture

The surgeon's name, an institution, or both: what 13 cases can and cannot settle

EVIDENCE BASE BRAND ARCHITECTURE	47 Claims generated	30 Put to verification	30 Confirmed	0 Refuted	0 Unverified	63 Sources recorded	314 Research actions

CHAPTER SUMMARY

This chapter examines how a surgeon's personal name and an institutional name have been combined in 13 core cases: 4 US orthopaedic practices, 3 Gulf healthcare groups, 4 institutional networks and 2 Jordanian examples. It codes each case on 6 separate dimensions: name origin, public hierarchy, founder dependence, rights and ownership, operating responsibility and observed outcome. A founder surname can become an institution: Rothman opened a branded office in 2021 after its founder's 2018 death, Steadman kept its founder's name through colleague changes, and Mayo's institutional name derives from its founders. Institutions can equally keep individual doctors visible, as HSS and KHCC show. The Al Habib, Saudi German and Mayo network records show that the public name, ownership of the mark and responsibility for care can be separate arrangements. Evidence on brand value comes in 3 forms that must not be conflated: contracted rates (10% of monthly net profit for Saudi German's name), a corporate stake (a 15% pre-IPO stake in Burjeel, 14.4% after listing) and a modelled valuation (US$419m). Patient studies of 341 Saudi respondents, 1,708 Jordanian adults and 171,472 English patients, read together, suggest that clinician-level and institution-level trust both deserve investigation, but none tests which name should lead. The evidence therefore keeps all 3 architecture routes open for a surgeon-founded practice and identifies 4 matters the decision should settle.

KEY FINDINGS

01 A founder surname can operate beyond its founder: AdventHealth reported a Rothman-branded Winter Park office opening on 1 July 2021, after Richard Rothman's death on 21 October 2018 [12, 13].

02 A second prominent surgeon need not enter every entity's name: on 19 February 2010 the Vail clinic announced the name The Steadman Clinic, while Philippon's name entered the research institution [310].

03 The public name, the owner of the mark and the operator can differ: Al Habib's 2020 prospectus records company-owned marks licensed to subsidiaries, and the listed MEHC held no equity in Saudi German Hospital Ajman in 2019 [311, 312].

04 Saudi German priced name use and management separately for a related-party hospital, at 10% of monthly net profit for the name/trademark and 3% of net revenue after rejections for management, with MEHC holding 23.33% of project capital [313, 314].

05 Brand-value evidence comes in 3 forms that must not be conflated: contracted rates, the 15% pre-IPO stake in Burjeel acquired by Quant Lase Lab LLC, which became 14.4% after listing while VPS retained 70%, and a modelled Brand Finance estimate of US$419m [42, 43].

06 In a Saudi survey of 341 private orthopaedic respondents, 79.2% rated surgeon knowledge, 75.7% skill and 67.2% hospital reputation very important, so clinician and institutional trust both remain relevant [315].

07 The Jordanian survey of 1,708 adults cannot represent Amman orthopaedic patients, because 81.3% held a bachelor's degree or higher and 49.7% worked or studied in health [50].

08 The English study of 171,472 hip-replacement patients linked hospital use to quality but could not separate patients' decisions from referring GPs', and hospital fixed effects reduced willingness-to-travel estimates roughly 90% [316].

09 Institutional prestige did not guarantee an overseas operating form: Johns Hopkins Singapore's clinical care moved to Tan Tock Seng Hospital on 1 November 2017, while a research institute was announced on 3 January 2018 [317, 318].

10 No retrieved study compares naming architectures, so the evidence keeps all 3 routes open and gives no measured basis for keeping or changing an existing clinic name [319].

5.1 Scope and evidence base

Brand architecture is the arrangement by which a practice's names relate to one another: which name leads, which names sit beneath it, and what each one stands behind. For a surgeon who founds a practice, the central question is how his own name relates to the name of the institution he builds. This chapter reports a desk study of that question across surgeon-founded practices and medical institutions. It asks when a personal-name brand, an institutional brand or a combined structure has worked; what happened to those names at expansion, founder withdrawal, succession, sale and the arrival of a second prominent surgeon; and what the evidence can and cannot establish for a surgeon who plans to open a clinic in Amman.

The question becomes practical at a point of change, for example when a practice established outside the capital wants to enter Amman. This chapter supplies precedents and questions for the architecture decision. It does not make that decision, which remains the practice's own.

The reference class contains 13 core cases: 4 US orthopaedic practices, 3 Gulf healthcare groups, 4 institutional networks and 2 Jordanian public-presentation examples. Johns Hopkins Singapore and U.S. Physical Therapy supply additional counterexamples outside the core matrix. Farah Medical Campus is retained only as a supporting directory observation, because its official source could not be recovered. The comparison is purposive. It is not a representative sample of successful and unsuccessful clinics, and most of its cases are durable survivors, which limits what their histories can say about failure [319].

The evidence was gathered in 6 separate perspective passes, each examining the question from a single perspective (history, patient choice, economics, architecture, Jordan, and a sceptical perspective dedicated to testing popular claims), and was then tested in an independent verification pass made up of 6 separate checks. In each check, 5 load-bearing claims were selected and tested against the original sources and counter-searches in an attempt to refute them; Chapter 2 describes the protocol. Of 47 research claims (between 7 and 9 per perspective), 30 were selected for verification. All 30 were confirmed; none was refuted and none was left unverified. The other 17 remain sourced research claims without a separate verdict, and this chapter labels them wherever they carry a figure. The logged work comprised 301 research actions across the perspective passes and the verification pass, or 314 including 13 supplementary actions, across 59 source URLs, or 63 including supplements. URLs are not independent studies, and the action count includes failed and repeated retrievals [319].

> LIMIT
>
> A 30-of-30 result means that carefully bounded claims survived checking. It does not validate every institutional self-description, establish causality, or show that a foreign case will transfer to Jordan. Confirming that a clinic opened on a given date says nothing about whether its name caused the opening.

5.2 The 6 coding dimensions and the observed architecture types

The study coded each case on 6 separate questions rather than on a single doctor-versus-institution label. The separation is itself the chapter's first finding. A clinic can bear a founder's name while being operated by successors; a differently named clinic can still depend entirely on a single doctor. Neither spelling establishes the operating model [12, 311, 320, 321].

TABLE 5.1

The 6 analytical coding dimensions

DIMENSION	WHAT IT MEANS HERE	EXAMPLE FROM THE CASES
Name origin	Founder surname, other personal namesake, place, or another institutional label	Mayo: a founder-family-derived name adopted officially in 1914[322]
Public hierarchy	Which name leads; how doctors, facilities, services and locations appear beneath it	HSS Orthopedics with Stamford Health – Westport: institution, partner and location in a single identity[323]
Founder dependence	What continues when the founder stops operating, advising or attracting referrals	Rothman: a branded office opened in 2021 after the founder's death in 2018[12, 13]
Rights and ownership	Who owns the company and mark; what is licensed, and for how long	Al Habib: company-owned marks licensed to subsidiaries at the 2020 prospectus date[311]
Operating responsibility	Who provides care, employs or contracts clinicians, and controls standards	Mayo Clinic Care Network: members remain independently owned and operated[324]
Observed outcome	An opening, continuity, transaction or withdrawal, kept separate from any causal naming effect	Johns Hopkins Singapore: the clinical operating form ended in 2017 while collaboration continued[317, 318]

Source: Dimensions as defined in the study's coding frame; examples from the cited primary and institutional sources [319].

Across the 13 cases, 4 broad patterns appear. They are descriptive groupings of what the records show, not a ranking. A founder-derived name functions as a group or institutional identity at Rothman, Steadman, Kerlan-Jobe, Andrews, Mayo and Al Habib [12, 310, 311, 322, 325, 326]. An institution leads at HSS, Moorfields, KHCC and Cleveland Clinic Abu Dhabi: the first 3 keep individual clinicians visible beneath the institutional name, while Cleveland Clinic Abu Dhabi pairs the institutional name with a geography [323, 327–330]. A group or shared name sits above separately owned or separately branded entities at Burjeel and Saudi German [312, 331]. A single personal name leads a practice website in the Amman example of Dr. Thair Afifi (د. ثائر العفيفي) [332].

FIGURE 5.1

The 4 architecture patterns observed across the 13 core cases

PERSONAL-DERIVED

Founder name as institution or group

A surname represents successors or a corporate group: Rothman, Steadman, Kerlan-Jobe, Andrews, Mayo, Al Habib.

INSTITUTION-LED

Institution leads

Named doctors appear beneath the institution at HSS, Moorfields and KHCC; Cleveland Clinic Abu Dhabi pairs the institutional name with geography.

PORTFOLIO

Shared name over separate entities

A single name spans different owners or care brands: Burjeel's portfolio; Saudi German across separately owned hospitals.

PERSONAL PRACTICE

Personal name, single practice

A first-party website leads with the doctor's name and routes inquiries to WhatsApp: Dr. Thair Afifi, Amman.

Source: Grouping of the core cases by the study's architecture column [12, 310–312, 322, 323, 325–329, 331, 332].

The typology is extended by 2 supporting observations outside the core matrix. A supplementary check of Dr. Neal Blitz's current first-party material found a personal surgeon identity, a named procedure brand (Bunionplasty) and a device company (Voom) presented together, with surgeon training offered in 3 locations. A named method or product can therefore form a further layer alongside a doctor and a practice. This rests on self-description only and was not independently verified; it establishes no sale, value, ownership of present marks or succession outcome [333, 334]. In Amman, a separate contact page uses a doctor-named centre, مركز الدكتور أسعد احمد (Dr. Asaad Ahmed Center); it is a supporting example outside the core cases, without a separate verdict [335]. Whether a procedure-level layer can support a surgeon's claim of a distinctive operation is a question for Chapter 6.

KEY FINDING

Name origin, public hierarchy, founder dependence, rights, operating responsibility and observed outcome must be coded separately; in these cases they do not move together. The Al Habib, Saudi German and Mayo network records show that the public name, the owner of the mark and the party responsible for care can be different arrangements [311, 312, 324].

5.3 The 13-case comparison

Table 5.2 sets out the 13 core cases. The dates identify documented events; they do not assert that every historical ownership arrangement still applies today. The final 2 columns carry equal weight: each case establishes a possibility, and each leaves a named set of questions open.

TABLE 5.2

The 13 core cases: architecture, documented transition, and what each can and cannot establish

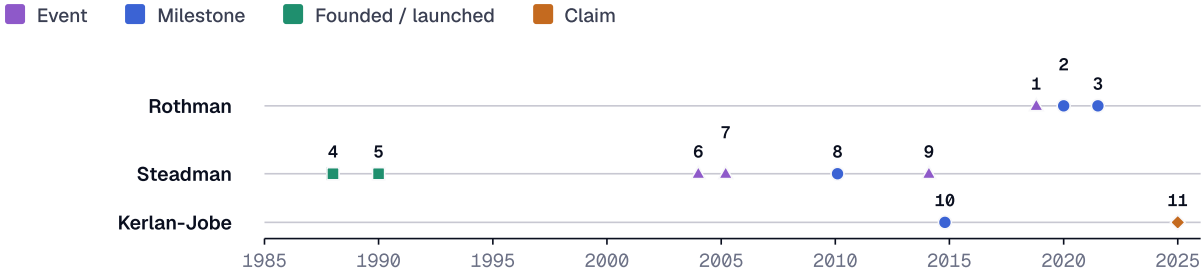
CASE	ARCHITECTURE	DOCUMENTED TRANSITION	WHAT IT ESTABLISHES	WHAT REMAINS UNKNOWN
Rothman	Founder surname as group identity	Richard Rothman died on 21 October 2018; AdventHealth reported a Rothman-branded Winter Park office opening on 1 July 2021 with other physicians[12, 13]	Post-founder operation and geographic expansion occurred	Patient retention, profit, name rights and the surname's contribution were not measured
Steadman	Founder-named clinic; separately named research institution	Hawkins left Vail in 2004; Philippon joined in March 2005; the February 2010 announcement renamed the clinic and the research institution differently; surgical retirement was announced in 2014, with advisory and research roles to continue[310, 320]	A second prominent colleague need not enter every entity's name	No measured allocation of demand or equity between the surgeons
Kerlan-Jobe	2 founder surnames within a larger affiliation	The October 2014 Cedars-Sinai announcement preserved the practice brands under Institute for Sports Sciences management; a January 2025 report describes a later contract and branding dispute[325, 336]	An affiliation can preserve a practice name	Durable control cannot be inferred; reported allegations are not court findings; the current kerlanjobe.org site names successor physicians at 2 locations, but its legal continuity with the historical network is unresolved[337]
Andrews Institute / Andrews Medicine	Founder name across distinct organisations	Gulf Breeze Institute reports a 2007 origin with Baptist Health Care (no separate verdict); Andrews Medicine describes the surgeon as clinically retired while continuing to lead its brand-development company[326, 338, 339]	Clinical retirement can coexist with active commercial founder involvement	Not evidence of complete withdrawal or of common ownership of every Andrews entity

CASE	ARCHITECTURE	DOCUMENTED TRANSITION	WHAT IT ESTABLISHES	WHAT REMAINS UNKNOWN
Dr. Sulaiman Al Habib	Founder name on a corporate group	The 2020 prospectus documents earlier sole-proprietor and holding-company stages, a public minority offering, and company-owned marks used by subsidiaries[311]	A personal-derived name can be a corporate asset	No naming premium or current trademark registrations established
Saudi German	Shared institutional name across distinct ownership arrangements	The 2019 Ajman notice states MEHC had no equity there; separate Al-Sobh name-use and management arrangements were disclosed in 2024; the trademark contract was signed in March 2025[312-314]	Name, facility ownership and management can be contractually separate	Related-party terms are not an independent pricing benchmark for another practice
Burjeel	Holding group with several care brands	The launch describes Burjeel, Medeor, LLH, Lifecare and Tajmeel (no separate verdict); audited 2022 records document minority investment and retained VPS control after listing[43, 331]	Group architecture and an investable company coexist	Equity value is not the price of the name alone; this was not complete founder exit
Mayo Clinic	Founder-family-derived institutional identity	Official name adopted in 1914; a 1919 gift (no separate verdict) established the nonprofit structure; Care Network members remain independently owned and operated[322, 324, 340]	Institutional status does not require abandoning a founder-derived name	Network membership must be distinguished from Mayo ownership or operation
HSS	Institution, partner and location in a single identity	HSS Orthopedics with Stamford Health – Westport opened in 2024 within a collaboration dating to 2016 (no separate verdict); a named physician leads the centre[323]	Partner identities and clinician visibility can coexist	Equity and trademark terms not disclosed; demand not attributed to either name
Cleveland Clinic Abu Dhabi	Institutional name plus geography	Official pages date the Mubadala agreement to 2006 and the opening to 2015; a 2021 Mubadala announcement lists 6 wholly owned assets and describes Cleveland Clinic Abu Dhabi separately as part of its network[329, 330, 341]	A documented partnership supported geographic extension	Exact ownership shares and contractual operating powers not settled
Moorfields	Institution plus overseas location	Dubai's page dates its opening to 2007 and names its clinical leader (no separate verdict); the 2020/21 accounts document a distinct Abu Dhabi joint venture; a 2025 M42/UEMS transaction adds later context[327, 342, 343]	Regional brand continuity can overlay different entities	The hospital's direct current ownership and Dubai's structure are not settled
KHCC	Institutional umbrella with visible doctors	Official pages distinguish foundation and centre roles, show board oversight, individual physician biographies and institution-mediated appointments[328, 344, 345]	An institution can contain identifiable clinicians	Nonprofit oncology is not a direct economic analogue for a private orthopaedic clinic
Dr. Thair Afifi	Personal-name Amman practice	The current first-party page leads with his name and professional profile and links appointment inquiries to WhatsApp[332]	A website advertises a local practice under the doctor's name	Actual operation, exclusive location, ownership, bookings, succession and comparative performance are unknown; an address opposite Jordan Hospital is not evidence of affiliation

Source: Case extraction and verification-pass corrections from the study ledger; dates as stated in the cited primary and institutional sources. Items marked no separate verdict are sourced research claims not selected for verification [319].

FIGURE 5.2

Documented transitions in 3 US founder-named orthopaedic practices, 1985–2026

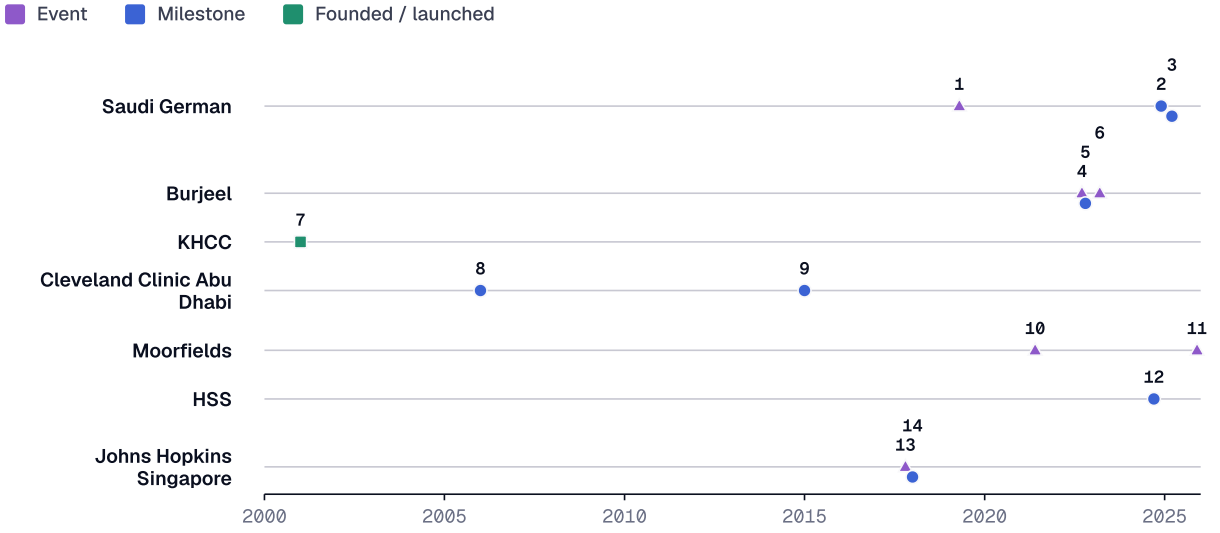


1 **Rothman:** 2018 Founder died
2 **Rothman:** 2020 AdventHealth partnership announced
3 **Rothman:** 2021 Winter Park office opened
4 **Steadman:** 1988 Research foundation
5 **Steadman:** 1990 Steadman Hawkins Clinic formed
6 **Steadman:** 2004 Hawkins relocated
7 **Steadman:** 2005 Philippon joined
8 **Steadman:** 2010 Renamed The Steadman Clinic
9 **Steadman:** 2014 Surgical retirement; roles announced
10 **Kerlan-Jobe:** 2014 Cedars-Sinai affiliation
11 **Kerlan-Jobe:** 2025 Reported lawsuit (allegations)

Source: Rothman's 1970 origin (secondary trade-press obituary), Steadman's 2023 death and the Andrews Institute's 2007 origin are sourced research claims without a separate verdict, so they are not plotted; Table 5.3 lists them. Andrews's retirement is undated in its sources, which leaves no checked Andrews event to plot. The 2025 Kerlan-Jobe entry reports allegations, not a judgment [12, 13, 310, 320, 325, 336, 338, 346].

FIGURE 5.3

Documented transitions in Gulf groups, 3 institutional networks, KHCC and Johns Hopkins Singapore, 2000–2026



1 **Saudi German:** 2019 Ajman opened; no MEHC equity
2 **Saudi German:** 2024 Trademark award disclosed
3 **Saudi German:** 2025 Trademark contract signed
4 **Burjeel:** 2022 15% sold pre-IPO
5 **Burjeel:** 2022 Listing
6 **Burjeel:** 2023 US$419m modelled brand value
7 **KHCC:** 2001 Foundation by Royal Decree
8 **Cleveland Clinic Abu Dhabi:** 2006 Mubadala agreement
9 **Cleveland Clinic Abu Dhabi:** 2015 Opened
10 **Moorfields:** 2020/21 accounts: 49% Abu Dhabi JV
11 **Moorfields:** 2025 M42 UEMS transaction
12 **HSS:** 2024 Westport centre opened
13 **Johns Hopkins Singapore:** 2017 Clinical care moved to TTSH
14 **Johns Hopkins Singapore:** 2018 Research institute announced

Source: Al Habib's 1993, 2010 and 2020 stage dates, Saudi German's trial-operations date, Moorfields Dubai's opening and the start of the HSS collaboration are sourced research claims without a separate verdict, so they are not plotted; Table 5.3 lists them. The 49% stake is a 2020/21 snapshot, not current ownership [42, 43, 311-314, 317, 318, 323, 327, 329, 330, 342-344, 347].

TABLE 5.3

Transition dates reported without a separate verdict

CASE	EVENT	DATE AS REPORTED	STATUS
Rothman	Namesake practice origin, from a secondary trade-press obituary[13]	1970	Not independently checked
Steadman	Founder's death, recorded by the clinic's official memorial[346]	2023	Not independently checked
Andrews Institute	Gulf Breeze Institute origin with Baptist Health Care[338]	2007	Not independently checked
Dr. Sulaiman Al Habib	Sole proprietorship[311]	1993	Not independently checked
Dr. Sulaiman Al Habib	Holding company[311]	2010	Not independently checked
Dr. Sulaiman Al Habib	Initial public offering: 15% of shares offered[311]	2020	Not independently checked
Saudi German (Al-Sobh hospital)	Trial operations[347]	15 September 2025	Not independently checked
Mayo Clinic	Gift establishing the nonprofit structure[340]	1919	Not independently checked
HSS	Collaboration with Stamford Health[323]	2016	Not independently checked
Moorfields	Dubai branch opened[327]	2007	Not independently checked

Source: Sourced research claims not selected for verification; each date is as stated in the cited source. Listed here rather than plotted in Figure 5.2 or Figure 5.3.[319]

Read across, Table 5.2 shows 3 regularities. First, founder-derived names in the US set operated beyond the founder's direct surgical involvement. Rothman's name was used for a distant office after the founder's death [12]. Steadman's name survived colleague changes and his surgical retirement, and the clinic still uses it after his death in 2023 (a sourced research claim without a separate verdict) [310, 320, 346]. Second, the Gulf records separate the public name from ownership and management. Al Habib's prospectus identifies the company, not the founder, as owner of the marks, with Saudi hospital entities and Dubai Hospital as licensees; the same prospectus warns that reputation and clinical-service failures can affect those marks [311]. Third, institutional networks keep clinicians visible under an institutional name. The HSS Westport centre names Samuel A. Taylor, MD, as medical director and assigns radiology to Stamford Health, which the announcement describes as independent; Moorfields Dubai names its chief medical officer (no separate verdict) [323, 327].

The 2 Jordanian examples add structural observations, not preference measurements. KHCC dates its nonprofit foundation to a 2001 Royal Decree, describes board oversight of both foundation and centre, and presents parallel Arabic and English names on its live site: مؤسسة ومركز الحسين للسرطان (King Hussein Cancer Foundation and Center) [344, 348, 349]. A royal namesake institution is not a surgeon-founder practice, and it cannot be coded as one merely because its name contains a person's name. Dr. Afifi's page gives Al-Ameen Medical Complex, opposite Jordan Hospital, as its Amman address. A counter-search found an official profile for a Thair Afifi in orthopaedics at Helios Hanseklinikum Stralsund; the link between the 2 identities was not established, which prohibits inferring exclusive Amman work or current operation from the website [332, 350].

5.4 What the difficult transitions actually show

For a surgeon who founds or expands a practice, 4 transitions are relevant to the architecture decision: the arrival of a second prominent surgeon, the founder's withdrawal, expansion and contraction, and sale. The records examined here document each of them in at least 1 case, but none measures what the name contributed.

A second prominent surgeon

Steadman is the clearest naming transition in the set. Steadman and Richard Hawkins formed Steadman Hawkins Clinic in 1990; Hawkins moved to South Carolina in 2004; Marc Philippon joined in March 2005. On 19 February 2010 the Vail clinic announced The Steadman Clinic name, citing its broader specialty scope and Hawkins's relocation, while its research institution became Steadman Philippon Research Institute [310, 320]. These are the institution's stated reasons, not a measured explanation of growth. The case supports flexible relationships between people and entities; it does not establish a universal rule about adding or removing surnames.

Founder withdrawal

Rothman's later opening supports operation beyond the founder's lifetime: the Winter Park office opened on 1 July 2021 with non-founder leadership and treating physicians, after Richard Rothman's death on 21 October 2018 [12, 13]. Steadman's and Andrews's records require more care. In January 2014 Steadman announced his retirement from active surgery while continuing as co-chairman of the research institute and intending to consult with clinic physicians; the announcement does not measure how much consultation followed. The official memorial separately records his death in 2023 (no separate verdict) but supplies no patient-retention series [320, 346]. Andrews Medicine describes James Andrews as clinically retired but continuing to lead a company that develops institutes and sells brand partnerships. Its own undated pages conflict on whether he remains the Gulf Breeze Institute's medical director, and this study does not resolve that role [326, 339, 351]. Neither case can bear the stronger claim that the business had become independent of all founder involvement.

Expansion and contraction

Johns Hopkins reports that its Singapore oncology services and clinical staff transferred to Tan Tock Seng Hospital on 1 November 2017, and Singapore's public health statistics record the centre ceasing operations that year. A subsequent hospital account describes a new NHG–Johns Hopkins Singapore Institute announced on 3 January 2018, with a research and knowledge-sharing remit [317, 318, 352]. This is a change in clinical operating form with continued collaboration. It is neither proof that the whole partnership collapsed nor evidence that its naming architecture caused the change. It does show that a prestigious institutional identity did not guarantee the survival of a particular overseas operating form.

Sale and name rights

The adjacent U.S. Physical Therapy case documents acquisitions that typically retained sellers as employed managers with minority equity. The same filing also records sellers who exited completely, so retention cannot establish that the business depended on its founder. Separately, it discloses 1 unnamed acquired tradename right limited to 6 years, and it accounts for tradenames, referral relationships, non-compete agreements and goodwill as separate quantities; most tradenames were treated as indefinite-lived, and the 6-year right is the exception [321]. A transaction therefore needs its own analysis of rights and dependence. The existence of a sale does not establish permanent name rights or seller independence, and the unnamed tradename cannot be classified as a surgeon's name.

TABLE 5.4

Transition types, the clearest case for each, and the limit of the record

TRANSITION	CASE	WHAT THE RECORD SHOWS	WHAT IT CANNOT SHOW
Second prominent surgeon	Steadman	Hawkins left in 2004 and Philippon joined in March 2005; the 2010 rename kept 1 founder name on the clinic and added Philippon's to the research institute[310, 320]	A measured growth effect or a universal naming rule
Founder death	Rothman	A branded office opened on 1 July 2021, after the founder's death on 21 October 2018[12, 13]	Profitability, patient transfer or an effect caused by the surname
Partial withdrawal	Steadman; Andrews	Surgical retirement announced in 2014 with research and consulting roles to continue; clinical retirement alongside continued brand-company leadership[320, 326]	Independence from all founder involvement; how much consultation followed; Andrews's current Institute role
Affiliation	Kerlan-Jobe	The 2014 affiliation promised continued use of 2 practice brands under Institute for Sports Sciences management; a 2025 report describes a lawsuit alleging breach of contract[325, 336]	Durable control of branding, or any finding of wrongdoing
Contraction	Johns Hopkins Singapore	Clinical care moved to Tan Tock Seng Hospital on 1 November 2017; a research institute was announced on 3 January 2018[317, 318]	Commercial loss, or any naming cause
Sale	U.S. Physical Therapy	Sellers typically retained with minority equity, some exited; 1 tradename right limited to 6 years[321]	Founder dependence, permanent name rights, or a surgeon-name classification

Source: Verified claims and verification-pass corrections in the study ledger [319].

> WHAT THIS MEANS FOR A PRACTICE
>
> Retirement breaks down into surgery, consultation, governance, ownership and name licensing; affiliation and sale likewise separate operating arrangements, ownership and name rights. Whatever architecture a surgeon chooses, the evidence points to specifying in advance what the identity should mean when the founder operates less, moves city or adds a colleague with independent recognition, and which entity holds the name. Chapter 7 examines which of these components can transfer as value.

5.5 What is and is not known about brand value

The study found 3 distinct forms of evidence bearing on the value of a medical brand: contracted rates for brand use, corporate investment, and modelled valuation. They measure different things, and they must stay separate. None of them compares an otherwise identical business under a personal name and under an institutional name, so none identifies a naming premium [42, 43, 313].

TABLE 5.5

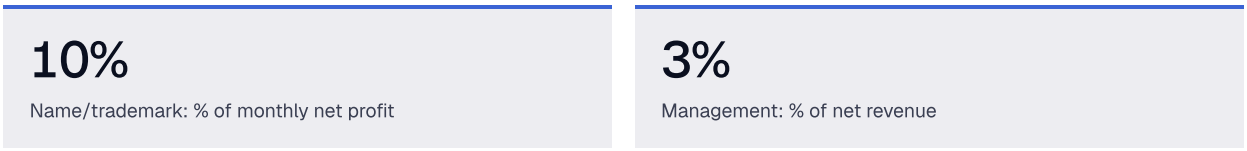
The 3 forms of brand-value evidence and what each establishes

EVIDENCE	WHAT THE SOURCE ESTABLISHES	LIMIT
Contracted brand use	Saudi German disclosed a name/trademark rate of 10% of monthly net profit, separately from management at 3% of net revenue after rejections. The award announcement was in December 2024; signing was in March 2025, with receipts conditional on net profits[313, 314]	Related parties; agreed terms, not proof of collected revenue or an arm's-length rate
Corporate investment	Burjeel's audited report records a 15% pre-IPO stake becoming 14.4% after the IPO, while VPS retained 70%[43]	A stake in an operating business, not a purchase of the name alone or evidence of founder withdrawal
Modelled brand valuation	Brand Finance published a US$419m Burjeel estimate in February 2023 using a royalty-relief approach[42]	A modelled estimate, not a realised standalone sale price; no comparison of identical businesses under alternative names

Source: Verified economics claims and verification-pass corrections [319].

FIGURE 5.4

Saudi German's separately priced name and management rates for the Al-Sobh hospital



Source: The management rate applies to net revenue after rejections. The 2 rates use different bases and are related-party terms, not market benchmarks; the Burjeel figures appear in Table 5.5 and Figure 5.5.[313, 314]

The Saudi German records are the most detailed. At Ajman, the 21 April 2019 notice, reporting an opening on 15 April, states that Ajman Healthcare Development Company owned the hospital, with Bait Al Batterjee as majority shareholder, and that the listed Middle East Healthcare Company (MEHC) held no shareholding; MEHC was entitled to 10% of pretax net profit for management supervision [312]. For the Al-Sobh hospital, the December 2024 disclosure priced the name/trademark and management contracts separately and reported MEHC's SAR70m as 23.33% of SAR300m project capital. The trademark contract was signed on 6 March 2025 for a 10-year term ending on 5 March 2035 [313, 314].

TABLE 5.6

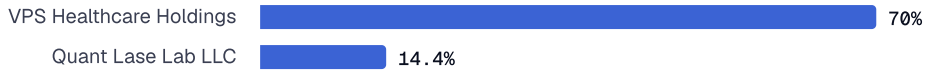
Saudi German: name, ownership and management as separate arrangements

ARRANGEMENT	DATES	OWNERSHIP	PRICED TERMS	LIMIT
Saudi German Hospital Ajman	Opened 15 April 2019; notice 21 April 2019	Ajman Healthcare Development Company; majority shareholder Bait Al Batterjee; MEHC held no shareholding	MEHC: 10% of pretax net profit for management supervision	Not a standalone trademark royalty; historical, not a 2026 ownership audit[312]
Al-Sobh hospital (Sobhi Abduljaleel Batterjee Hospital)	Disclosed 10 December 2024; trademark contract signed 6 March 2025; trial operations 15 September 2025 (no separate verdict)	Al-Sobh New Medical Company; MEHC SAR70m, 23.33% of SAR300m capital	Name/trademark: 10% of monthly net profit, 10 years; management: 3% of net revenue after rejections, 5 years	Related parties; receipts begin only when the hospital achieves net profits[313, 314, 347]

Source: Issuer and exchange disclosures [312–314, 347].

FIGURE 5.5

Burjeel Holdings shareholdings after the October 2022 listing



Source: Audited 2022 statements: on 20 September 2022 VPS sold 750,710,477 shares, then 15%, to Quant Lase Lab LLC; after the IPO that holding was 14.4%. Listing is recorded on 10 October 2022. The remaining shareholdings are not shown because the sources do not itemise them here. Brand Finance's separate modelled Burjeel brand value of US$419m (February 2023) is a different measure and is not charted [42, 43, 353].

KEY FINDING

It would be wrong to say that no published Burjeel brand valuation exists: Brand Finance published one, of US$419m, in February 2023. It would equally be wrong to relabel the Ajman management fee as a standalone trademark royalty, or to repeat the 15% pre-IPO stake in Burjeel as the post-listing share [42, 43, 312].

Brand Finance's method, as it describes it, estimates brand revenues, royalty rates and discounted forecasts, with assumptions where data are incomplete. It is primary evidence for its own modelled estimate, not for a realised transaction price or for the effect of choosing between naming architectures [42]. The useful next question for a practice is which parts of a clinic's value can persist and transfer: name rights, referral relationships, team capability, operating systems and continuing demand. Chapter 7 takes up that question. This chapter does not estimate the value of any particular clinic, and it does not claim that a different name would create a premium.

5.6 What patient evidence allows the study to say

The patient-choice evidence retrieved consists of 3 primary studies and 1 contextual counter-study, plus 2 supplementary papers that were retrieved but not independently verified. None of them compares naming architectures. They speak to which attributes patients say they value, and to how observed hospital use relates to quality, not to whether a doctor's name or an institution's name should lead [50, 315, 316].

FIGURE 5.6

Sample sizes of the 3 primary patient-choice studies

341	1,708	171,472
Saudi orthopaedic survey respondents	Jordanian adults, Jan–Feb 2022	English NHS hip patients, 2010–2013

Source: Sample sizes as confirmed in the verification pass from each study's methods. The English study covers April 2010 to March 2013 [50, 315, 316].

TABLE 5.7

Patient-choice studies: what each finds and where it stops

STUDY	DESIGN AND SAMPLE	FINDING RELEVANT HERE	BOUNDARY	STATUS
Saudi private orthopaedic survey (2026)	Clinic-recruited convenience sample; 341 private orthopaedic respondents	79.2% rated surgeon knowledge, 75.7% skill and 67.2% hospital reputation very important[315]	Self-report; no naming experiment; a strong paper title does not make the design causal	Verified
Jordanian adult survey (2023)	Cross-sectional questionnaire; 1,708 adults, 20 January–20 February 2022; 81.3% bachelor's-or-higher educated, 66.6% Amman residents, 49.7% working or studying in health	Surgeon reputation, knowledge and experience were leading stated factors[50]	Primarily about surgeon gender; no observed bookings; illiterate adults excluded and a technology bias acknowledged; cannot represent all Amman orthopaedic patients	Verified
English NHS hip-replacement study (2016)	Administrative data; 171,472 NHS hip-replacement patients, 228 providers, April 2010–March 2013	Hospital use was associated with quality measures; estimated effects were sensitive to adjustment[316]	Could not separate patient from referring-GP decisions; hospital fixed effects reduced willingness-to-travel estimates roughly 90%; no name effect identified	Verified
US retrospective survey (2007)	Telephone survey of Medicare survivors, roughly 3 years after high-risk surgery; 500 respondents to the decision-maker item	31% named the physician and 42% a shared decision[354]	Recall, nonresponse and survivor selection; not a Jordanian estimate	Contextual counter-study
US total joint arthroplasty survey (2013)	251 total joint arthroplasty (joint-replacement) patients at 2 US orthopaedic practices; importance ratings out of 5	Physician manner scored 4.68/5 and physician quality information 4.64/5; physician reputation 4.00/5 and hospital quality 4.01/5[355]	No trade-offs required; academic tertiary care overrepresented	Supplementary; not independently verified
Qassim, Saudi Arabia survey (2023)	Online snowball survey; 513 respondents, 238 reporting elective surgery	Surgeon reputation important or very important to 486/513 (94.7%); hospital reputation to 491/513 (95.7%)[356]	Nonprobability sample; reporting inconsistencies; percentages calculated from reported counts; does not show hospital outweighs surgeon	Supplementary; not independently verified

Source: Verification-pass checks of original full texts; supplementary papers were retrieved but not independently verified. The Jordanian sample composition (n=1,708: 81.3% bachelor's degree or higher, 66.6% Amman residents, 49.7% working or studying in health) is from the paper's Table 1, confirmed in the verification pass [50, 319].

FIGURE 5.7

Saudi private orthopaedic survey: surgeon and hospital factors rated very important (n=341)



Source: All 3 values were checked in the independent verification pass against the paper's Table 2. The paper's further factors, which carry no separate verdict, are in Table 5.8. Importance ratings, not observed referral shares [315].

The Saudi paper adds further measures, which carry no separate verdict and are set out in Table 5.8. Among them, 217 of 341 respondents (63.6%) reported researching online before consultation, and of the 241 who expressed a clear opinion, 42.3% associated popularity with competence. The denominators differ, and neither measure tests actual competence or booking conversion. Followers, in this evidence, are not shown to equal either competence or demand [315].

TABLE 5.8

Further Saudi survey measures reported without a separate verdict

MEASURE	SHARE	BASE	STATUS
Physician recommendations rated very important	46.9%	341 respondents	Not independently checked
Insurance compatibility rated very important	45.5%	341 respondents	Not independently checked
Family/friend referrals rated very important	39.9%	341 respondents	Not independently checked
Researched online before consultation	63.6% (217)	341 respondents	Not independently checked
Associated popularity with competence	42.3%	241 respondents who expressed a clear opinion	Not independently checked

Source: Sourced research claims from the paper, not selected for verification. Stated ratings and self-reports, not observed referral shares, competence or booking conversion [315].

FIGURE 5.8

English hip-replacement study: model-implied demand change per standard-deviation improvement in health gain



Source: Health gain measured by the Oxford Hip Score. The authors call approximately 10% an upper bound; neither estimate is an observed uplift, and neither is a marketing forecast for Amman [316].

FIGURE 5.9

Who made the decision on where to have major surgery, US retrospective survey (n=500)



Source: Self-reports roughly 3 years after high-risk surgery among Medicare survivors. Contextual counter-study identified in the verification pass; not a Jordanian estimate [354].

The defensible synthesis is that clinician-level and institution-level trust both deserve investigation. High hospital-reputation ratings keep facility trust relevant; high surgeon ratings keep clinician trust relevant. The evidence does not justify dismissing either, assigning equal promotion to both, or predicting which naming hierarchy will win locally. The English study also cautions against reading hospital use as pure patient preference, because the referring doctor's role could not be separated from the patient's. The absence of a naming comparison in the retrieved set is not a claim that none exists anywhere [50, 315, 316].

Jordanian interfaces add structural examples, not preference measurements. KHCC's doctor directory offers name, specialty and alphabetical navigation, with detailed biographies such as that of its orthopaedic-oncology consultant Ahmad Shehadeh. Appointments, however, are institution-mediated: prospective specialist

appointments go through the Jordanian Patients Affairs Office, existing patients through a patient-services office, and international patients through a separate application route [328, 345, 357, 358]. Google's own guidance treats a practitioner among several at a location differently from the only public-facing practitioner of a branded organisation, favouring a shared profile for the latter and separate organisation and practitioner profiles for the former. A directory record is therefore partly a platform representation, not a vote by patients [359].

Farah Medical Campus sits at the boundary of the evidence. A medical-tourism directory presents Farah Medical Campus and its constituent hospitals, with a founder attribution to Dr. Zaid Kilani and his team. That is a publisher's representation and a secondary historical account. These directory statements were not independently verified. Farah's official homepage could not be retrieved, and a proposed partnership article returned a 404 error. No conclusion about current ownership, profitable succession, closure or the absence of a partnership follows from those failures [360].

> KEY FINDING
>
> Surgeon attributes ranked highly among 341 Saudi respondents and 1,708 Jordanian adults, and 67.2% of the Saudi respondents also rated hospital reputation very important; the study of 171,472 English patients linked hospital use to quality. No retrieved study tests which name should lead, so the architecture question remains open on the patient evidence [50, 315, 316].

5.7 The 3 routes and the 4 matters to settle

The evidence keeps all 3 architecture routes open for a surgeon-founded practice. It supplies precedents and conditions for each, but the retrieved studies do not establish which route would attract more Amman patients or create more transferable value. What follows are conditional interpretations for review, not an approved strategy, and not an approved naming decision [50, 315, 316].

FIGURE 5.10

The 3 architecture routes the evidence keeps open

ROUTE 1

The surgeon's name leads

A surname can represent successors and an institution: Rothman, Steadman, Mayo and Al Habib.

ROUTE 2

An institution leads, the surgeon is prominent

Institutional identity can accommodate named clinicians: HSS, Moorfields and KHCC.

ROUTE 3

Distinct but linked identities

Distinct doctor, research, practice and partner identities can coexist: Steadman, Andrews, Mayo, HSS.

Source: Precedents as assigned in the study's synthesis [12, 310, 311, 322-324, 326-328].

TABLE 5.9

The 3 routes: what precedents make possible and what remains to be established

ROUTE	WHAT THE PRECEDENTS MAKE POSSIBLE	WHAT MUST BE ESTABLISHED FOR A GIVEN PRACTICE
The surgeon's name leads and becomes the practice identity	A surname can represent successors and an institution: Rothman, Steadman, Mayo and Al Habib[12, 310, 311, 322]	Whether the surgeon wants the name to represent other surgeons; who controls its use; what patients and referrers would expect when the surgeon is absent
An institution leads, with the surgeon prominently identified	Institutional identity can accommodate named clinicians: HSS, Moorfields and KHCC[323, 327, 328]	What the institution promises beyond the surgeon's own work; who else delivers it; whether the intended audience recognises and trusts it
Doctor and institution have distinct but linked identities	Distinct doctor, research, practice and partner identities can coexist[310, 323, 324, 326, 338]	Which name leads in each context; what transfers between locations; whether the distinction helps people understand who provides care. Equal prominence is not established as necessary

Source: Conditional interpretations from the study's synthesis; not an approved strategy [319].

Nor does the research give a measured basis for keeping or changing an existing clinic name. That depends on the name's own recognition, associations and rights, and on its relationship to the doctor's name, which only local measurement can establish. Whether a claimed distinctive operation can carry the identity is a question for Chapter 6 [319].

The practical inference is to define the intended institution and the doctor's role before deciding how the 2 names relate. The decision discussion should settle 4 matters. They are numbered for reference, not as a prescribed sequence.

TABLE 5.10

The 4 matters the architecture decision should settle

MATTER	QUESTION TO SETTLE	WHAT THE EVIDENCE OFFERS
1. The intended organisation	Primarily the founder's own surgical practice, or a group expected to attract patients for other clinicians as well? At what stage?	Rothman, Mayo and Al Habib show a surname representing a group; HSS and KHCC show an institution containing named clinicians[12, 311, 322, 323, 328]
2. Withdrawal and second-surgeon scenarios	What should the identity mean when the founder reduces operating time, changes city, or adds a colleague with independent recognition?	Steadman's 2010 rename and 2014 partial retirement; Andrews's continuing commercial role[310, 320, 326]
3. Transferable rights and responsibilities	Which entity would control the name and accounts, and who would stand behind care and partner claims?	Al Habib's company-owned marks; Saudi German's separately priced name and management contracts; a 6-year tradename right in a US acquisition. A practice's own rights must be established case by case[311, 313, 321]
4. The local trust path	Which name people remember first, who initiates the referral, what they ask to book, and whether they would accept another clinician	Regional studies rate both clinician and institution; none tests naming. These are fieldwork questions, not answers supplied by foreign precedents[50, 315]

Source: Decision questions as framed in the study's synthesis [319].

For the fourth matter, the study specifies how second-phase fieldwork should proceed. It should ask about recent real patient and referrer decisions before hypothetical name preferences, and it should capture aggregate answers on the first remembered name, the referring party, the requested clinician, practical constraints such as insurance, travel and availability, and willingness to see a colleague. An informal follower poll should

not be treated as a causal test. No fieldwork or patient-data collection was conducted in this study. Chapter 11 sets out the next steps, Chapter 8 the Amman operating path, and Chapter 9 the translation of an eventual architecture decision into naming and identity [319].

> **WHAT THIS MEANS FOR A PRACTICE**
>
> The foreign and regional precedents remove categorical objections to each route: a founder name can become an institution, and an institution can keep its doctors visible. They do not choose between the routes. That choice turns on what the founder intends the organisation to become, who will hold the name, and how Amman patients and referrers actually arrive at a surgeon, which foreign precedents cannot answer and local fieldwork is designed to test.

5.8 Myths retired, contradictions resolved and reliability

Several common assumptions about doctor and clinic names did not survive the evidence. Table 5.11 records the principal ones; Appendix B lists every myth retired across the report. The entry on equally promoted brands is deliberately worded as unsupported rather than disproven: no retrieved evidence tests the rule that a famous doctor needs 2 equally promoted brands, and Google's conditional profile rules contradict only a universal 2-profile shortcut, since profiles and promotion are not the same thing [359].

TABLE 5.11

Myths retired or narrowed by the architecture evidence

MYTH	WHAT THE EVIDENCE SHOWS	STATUS
A founder name cannot become an institution	Founder-derived institutions and post-founder operation contradict it: Rothman, Steadman, Al Habib, Mayo[12, 311, 322, 346]	Retired
Mayo was never a person's name	Mayo's own history traces the name to the Mayo brothers' practice, adopted officially in 1914[322]	Retired
The same name means the same owner or operator	Mayo's membership terms, Saudi German's Ajman disclosure and Moorfields' dated entity record show why the inference fails[312, 324, 342]	Retired
A retired surgeon means completed succession	Steadman's 2014 announcement kept research co-chairmanship and planned consultation; Andrews continues to lead a brand-development company after clinical retirement[320, 326]	Retired
An acquisition price is the brand's value	Transaction, intangible-accounting and valuation records measure different things[42, 43, 321]	Retired
Doctor listings prove patients prefer a doctor's name	Interface and platform rules do not identify a preference effect[328, 332, 359]	Retired
Every famous doctor needs 2 equally promoted brands	No retrieved evidence tests or establishes the rule[359]	Unsupported, not disproven
Institutional branding requires hiding individual doctors	HSS, Moorfields and KHCC display named clinicians under institutional names[323, 327, 328]	Retired
A hospital affiliation replaces the practice name	The 2014 Cedars-Sinai affiliation preserved 2 practice brands[325]	Retired

MYTH	WHAT THE EVIDENCE SHOWS	STATUS
No published Burjeel brand valuation exists	Brand Finance published a US$419m estimate in February 2023[42]	Retired
Patients choose surgeons, never institutions	67.2% of Saudi respondents rated hospital reputation very important[315]	Not established
A famous institution's overseas presence is permanent	Johns Hopkins Singapore's clinical operation ended in that form in 2017[317, 352]	Retired

Source: Myths and counterpoints recorded in the perspective passes and the verification pass [319].

The study also recorded 7 tensions between sources and resolved each without choosing a winner the evidence does not support. Appendix C carries the full contradiction ledger for the report.

TABLE 5.12

Contradiction ledger for the architecture study

TENSION	EVIDENCE	RESOLUTION
Founder-derived name versus institution-first function	Mayo and Al Habib combine them[311, 322]	Code origin and present organisational role separately; retire the binary classification
Clinical retirement versus ongoing founder involvement	Steadman's 2014 announcement retained advisory and research roles; Andrews Medicine's current pages describe continuing commercial involvement[320, 326, 351]	Use partial-withdrawal wording; Andrews's current Institute directorship remains unresolved
Preserved affiliation brands versus subsequent dispute	The 2014 release and reported 2025 allegations concern different stages[325, 336]	Retain the dated announcement; do not imply uninterrupted rights or adjudicated wrongdoing
Published brand valuation versus causal architecture effect	Brand Finance models an intangible value; transaction and naming records identify no causal naming premium[42, 43, 313]	Retain the valuation with its method and date, without importing it into a smaller clinic's business
Historical Moorfields ownership versus later portfolio transaction	The 2020/21 accounts and M42's 2025 announcement concern different dates and entity levels[342, 343]	Retain the historical snapshot; present neither 49% nor 100% as today's hospital stake
Institutional trust versus individual reputation	Regional surveys and institutional interfaces support attention to both[50, 315, 328]	Keep both hypotheses for local fieldwork; no winner chosen
Prestigious expansion versus permanence	Hopkins's Singapore clinical operation ended in that form while collaboration continued[317, 318]	Treat care, research, naming and ownership as separable; assign the transition no branding cause

Source: Contradiction ledger of the study synthesis [319].

TABLE 5.13

Reliability gradient of the architecture evidence

TIER	EVIDENCE TYPES
Strongest	Dated issuer disclosures and accounts for explicitly stated transactions, rights and entity relationships; primary institutional announcements for named events; original research methods for sample and inference limits
Moderate	Institutional histories, current professional pages and published network rules, which establish self-presentation and stated arrangements but may be selective or stale
Weakest	Causal claims about naming, success-only case selection, transfer to Jordan, secondary Farah history, and reported unresolved disputes

Source: Reliability assessment in the study synthesis [319].

LIMIT

No retrieved comparison isolates the best architecture for any particular practice. The cases are selected survivors from other health systems; the patient studies measure stated attributes or observed hospital use, not names; and several key institutional facts rest on first-party self-description. Source access does not certify clinical claims, current licences or trademark status.

LIMITS OF THIS EVIDENCE

- The 13 core cases are a purposive comparison weighted towards durable survivors, not a representative sample of successful and unsuccessful clinics.
- Much of the case evidence is institutional self-description or current first-party pages, which establish stated arrangements but may be selective or stale.
- No retrieved study isolates a causal naming effect or compares personal, institutional and combined architectures; the absence of such a study in the retrieved set is not a claim that none exists.
- The patient evidence is mainly stated preference and self-report; the single observed-choice study comes from the English NHS, a different financing and referral system, and could not separate patient from referring-GP decisions.
- Of 47 research claims, 30 were independently verified (30 confirmed, 0 refuted, 0 unverified); the other 17 are sourced research claims without a separate verdict, and confirmation of a bounded claim does not establish causality or transfer to Jordan.
- No trademark registry, licence agreement, equity record, patient-retention series or causal comparison was retrieved; ownership and name rights are limited to what the primary pages state.
- Several records are dated snapshots (the 2020 Al Habib prospectus, Moorfields' 2020/21 accounts, U.S. Physical Therapy's FY2021 filing) and are not statements of current ownership or policy.
- Some official pages could not be retrieved, including Farah Medical Campus's homepage; blocked pages were logged, not converted into evidence, and Farah was excluded from the core comparison.
- Searches were bounded rather than systematic, and several perspective passes exceeded their planned number of research actions during disclosed recovery of failed sources.
- The Gulf groups and foreign institutions differ in scale, capital, services and regulation from a Jordanian surgeon's clinic; no regulatory clearance or Jordanian naming preference is inferred.
- The study was web-only desk research: no fieldwork, patient data, bookings or referrer interviews were collected.
- Source access does not certify clinical claims, current licences or trademark status.

LEFT OPEN

- Is the intended organisation primarily the founder's own surgical practice, or a group expected to attract patients for other clinicians as well, and at what stage?
- What should the identity mean when the founder reduces operating time, changes city, or adds a colleague with independent recognition?
- Which entity would control the name and accounts, who would stand behind care and partner claims, and what rights attach to an existing clinic name?
- Which name do Amman patients and referrers remember first, who initiates the referral, what do patients ask to book, and would they accept another clinician?
- When should an existing clinic name be retained or changed, and how can its recognition, associations and relationship to the doctor's name be measured?
- Which parts of a clinic's value (name rights, referral relationships, team capability, operating systems and continuing demand) can persist and transfer (Chapter 7)?
- Under an institution-led route, what would the institution promise beyond the founding surgeon's own work, who else would deliver it, and would the intended Amman audience recognise and trust it?
- Does a study that isolates the effect of a medical naming architecture exist outside the retrieved evidence set?

CHAPTER 06

Distinctiveness and differentiation

Recognisable signature, meaningful difference, and how to test a surgery claim

EVIDENCE BASE DIFFERENTIATION	38 Claims generated	30 Put to verification	30 Confirmed	0 Refuted	0 Unverified	44 Sources recorded	246 Research actions

CHAPTER SUMMARY

This chapter asks whether a surgeon's brand is better built on a recognisable signature or on a meaningful difference. The evidence shows that the question contains 5 separate questions: identification, perceived difference, clinical benefit, scarcity and durability. Consumer studies challenge the claim that buyers must consciously perceive a difference, yet they also link differentiation with economic outcomes. Patient and referrer studies show several influences but no universal sequence from recognition to evidence-based choice. Histories of 3 named procedures show that a name can persist while technique versions, utilisation and training change, so a name alone establishes neither superiority nor exclusivity. Randomised chevron osteotomy trials show how narrow a demonstrated clinical difference is. Under the Jordan Medical Association framework, substantiating a claim and expressing it publicly are separate decisions. The chapter closes by explaining how any surgeon can test a technique claim with the surgery-claim test in Appendix D.

KEY FINDINGS

01 Across 17 consumer markets, on average only 11% of current users described their brand as different and 10% as unique; this challenges the idea that buyers must consciously perceive a difference, but not the value of a better treatment [361].

02 Changes in perceived differentiation predicted subsequent accounting performance, and in a 39-brand US automobile panel differentiation was associated with higher gross contribution per car but lower acquisition and retention [362, 363].

03 In Las Vegas, 39.5% of 329 orthopaedic patients recalled researching their surgeon online before the visit, but only 8.5% named the internet as their referral source [364].

04 In the main model of 10,742 Pennsylvania CABG discharges, high online ratings had a positive modelled association with surgeon selection, while favourable report-card effects were small and insignificant [365].

05 The 2010 study associated with Bunionplasty covered 80 feet after modified Lapidus fusion, whereas the current promoter describes Bunionplasty 360 as avoiding that fusion; evidence must follow the operation's current version, not its name [15, 16].

06 UCL reconstruction utilisation rose from 4.4 to 11.9 per million enrollees between 2003 and 2014, which documents broader use rather than any causal effect of the 'Tommy John' name [25].

07 In a 47-foot chevron trial, the minimally invasive arm had higher satisfaction at 12 weeks only and hardware removal in 12 of 25 feet against 2 of 22, and 5-year follow-up of 39 feet found no significant differences [44, 366].

08 A 2024 trial that randomised 85 and analysed 71 found lower day-one pain (4.2 versus 5.3, p = .019) and greater range of motion in its percutaneous arm, while several other outcomes did not differ [367].

09 JMA Article 5(2)(ᵹ) prohibits 'first', 'only', 'most skilled' and similar terms with no exception for evidence of rarity, and Article 3 incorporates Medical Constitution provisions, so substantiating a claim and publishing it are separate decisions [8, 63].

6.1 A single argument, 5 questions

Differentiation is often framed as a contest between 2 branding camps: one holds that a surgeon needs a memorable, recognisable signature, the other that he needs a meaningful difference in what he does. The differentiation study examined the question from several distinct analytic perspectives: brand science, patient and referrer choice, named procedures, clinical comparisons, advertising regulation and branding folklore. Independent verification then checked each selected claim against its original source. The evidence shows that the contest bundles 5 distinct questions, each needing a different kind of observation (Table 6.1) [368].

TABLE 6.1

The argument between the 2 camps separated into 5 questions

QUESTION	APPROPRIATE OBSERVATION	WHAT IT DOES NOT ESTABLISH
Can people identify the doctor from a cue?	Correct cue-to-doctor attribution, including confusion with others	Trust, treatment benefit or demand
Do people perceive a difference?	Their reported associations and interpretation	A verified clinical advantage
Does the operation improve something that matters?	Comparative patient outcomes for the actual technique and indication	Recognition or permissible promotional wording
Is access or capability scarce?	Defined geography, time, service availability and qualifications	Invention, superiority or permanent exclusivity
Does value survive imitation or departure?	Referral behaviour, attribution, economics and organisational dependence over time	An answer from a name, trademark or follower count alone

Source: Analytical separation derived from the differentiation study [362, 368, 369].

This separation is analytical; it does not claim that any of the 5 measures causes growth. The Brand Asset Valuator (BAV) measure of 'differentiation' averages 2 yes/no items, whether respondents call a brand unique and whether they call it distinctive, while relevance is measured separately [362]. Cue-attribution research measures a different construct: whether people link an identity element to the correct brand [369]. Neither measures clinical superiority, so part of the disagreement between the camps concerns what is being measured.

Of the 38 research claims generated, 30 were selected for verification in 6 passes of 5 claims each, and all 30 were confirmed. This clean result reflects deliberately bounded wording, not certainty about the sources or about strategy. Independent verification also required qualifications to demographic wording, construct definitions and profitability scope, and 1 supporting clinical detail was refuted and corrected (Section 6.5). The 8 unselected claims are labelled 'not independently checked' wherever they appear. The study also graded the reliability of each type of evidence it used (Table 6.2) [368].

TABLE 6.2

Reliability of the evidence base

TIER	EVIDENCE TYPES
Strongest	Original clinical comparisons for narrowly specified outcomes; official posted JMA text and actual foreign adjudications, for what those documents say
Moderate	Original consumer experiments with limited clinical transfer; observational financial studies; surveys and administrative utilisation studies, with their sampling and identification limits
Weakest	Promoter claims about uniqueness and superiority; institutional origin stories as explanations of growth; the non-official Constitution transcription

Source: Reliability assessment of the differentiation study [368]. Case selection was purposive, not representative, and no source validates any particular practice.

KEY FINDING

The evidence supports keeping 5 things apart: recognisability, perceived difference, clinical benefit, scarcity and durable advantage. It does not establish a universal winner between a memorable signature and a real procedural difference.

6.2 What each branding camp contributes

Most of the weight in this debate rests on 4 original studies. All were retrieved in full text and none studied surgeons. Each challenges a different overstatement; none makes either camp the winner (Table 6.3).

Against the necessity of a perceived difference

Romaniuk, Sharp and Ehrenberg surveyed current users of brands in 17 consumer markets: 7 in Australia and 10 in the UK. On average, 11% of a brand's users described it as different, 10% as unique and 17% as either (Figure 6.1). This challenges the idea that every purchase requires a consciously perceived difference. It does not challenge the value of a better treatment. The same paper records conspicuous functional exceptions: 67% of Aldi users described it as different and 50% of Subway users as unique, figures that were not independently checked. Generic explicit reports also cannot show that functional or implicit differences are absent [361].

FIGURE 6.1

Current users calling their brand different or unique: averages across 17 markets



Source: Romaniuk, Sharp and Ehrenberg (2007), current users in 7 Australian and 10 UK markets [361]. The Aldi and Subway exceptions cited in the text are not charted because they were not independently checked.

Against economic irrelevance

Mizik and Jacobson combined BAV perceptions with firms' accounting and stock-return data. Changes in perceived differentiation predicted subsequent accounting performance, and contemporaneous stock returns did not fully reflect that information. The design is longitudinal and predictive, and the authors disclaim causation. The result therefore challenges the claim that differentiation is economically irrelevant. It does not show that engineering a difference creates profit [362].

Against a simple growth formula

Stahl, Heitmann, Lehmann and Neslin linked BAV perceptions, marketing measures and transaction data for 39 US automobile brands during 1999–2008. Differentiation was positively associated with gross contribution per car but negatively associated with acquisition and retention. Knowledge was positively associated with all 3 outcomes (Figure 6.2). Profit here excludes fixed advertising and R&D costs. Acquisition and retention were measured through trade-ins. The authors treat any transfer beyond US automobiles as a hypothesis [363].

FIGURE 6.2

Modelled associations of brand perceptions with customer outcomes, US automobile panel

	Customer acquisition	Customer retention	Gross contribution per car
Differentiation	Negative	Negative	Positive
Knowledge	Positive	Positive	Positive

Positive modelled association Negative modelled association

Source: Stahl, Heitmann, Lehmann and Neslin, 39 brands, 1999–2008; profit excludes fixed advertising and R&D costs [363].

Against stopping familiarity at the shortlist

Macdonald and Sharp ran an orange-cordial experiment with 462 analysed participants. They recorded actual selection, with tasting, rather than a stated shortlist. In the awareness condition, 85.5% chose the familiar brand on trial 1 (Figure 6.3). The familiar brands carried prior associations, so the test did not isolate pure familiarity. The low-involvement category also limits transfer to surgery [370]. A separate experiment reported that naming the brand directly often produced more recall than indirect elements such as logos, characters and slogans, and did not reduce ad likeability. That finding rests on a publisher abstract and was not independently checked [371].

FIGURE 6.3

Familiarity and observed choice in a low-involvement consumer experiment

462
participants analysed (472 recruited)

85.5%
chose the familiar brand on trial 1

51%
cited awareness as a reason at trial 5

Source: Macdonald and Sharp (2000), orange-cordial replication; the 51% figure is a reported reason, not a choice share [370].

TABLE 6.3

What the 4 core branding studies contribute and where each stops

STUDY	DESIGN AND SAMPLE	FINDING	BOUNDARY
Romaniuk, Sharp and Ehrenberg (2007)	Observational surveys of current users in 17 markets (7 Australian, 10 UK)	Explicit difference reports uncommon: 11% different, 10% unique, 17% either	Existing users only; no sales-effect estimate; no surgeon category
Macdonald and Sharp (2000)	Choice experiment with tasting; 462 participants analysed	85.5% chose the familiar brand on trial 1	Low-involvement category; familiar brands carried prior associations
Mizik and Jacobson (2008)	BAV perceptions linked to accounting and stock-return data	Changes in perceived differentiation predicted subsequent accounting performance	Observational; causation disclaimed; perceptual measure, not functional superiority
Stahl, Heitmann, Lehmann and Neslin (2012)	US automobile panel, 39 brands, 1999–2008	Differentiation positive for margin per car, negative for acquisition and retention; knowledge positive for all 3	Excludes fixed advertising and R&D; trade-in based; transfer is a hypothesis

Source: [361–363, 370]

LIMIT

None of the retrieved papers provides a head-to-head causal test for surgeons. Whether a recognisable signature, a useful difference, or both would increase a surgeon's fame and economically valuable demand remains unanswered.

6.3 Patients and referrers do not supply a single hierarchy

The research tested a working hypothesis: recognition earns a place on the patient's shortlist, and clinical evidence then decides the final choice. Original studies of patients and referring physicians, 6 in all, show several relevant influences; none establishes that sequence (Table 6.4)[50, 355, 364, 365, 372, 373].

TABLE 6.4

Original evidence on patient and referrer choice

STUDY	POPULATION	WHAT WAS OBSERVED	BOUNDARY
AlSamhori et al., Jordan	1,708 general adults, January–February 2022	Knowledge, experience and reputation received high importance ratings	Stated priorities, not observed orthopaedic choice; 66.6% Amman residents; 81.3% bachelor's or higher
Bozic et al., US arthroplasty	251 patients at 2 practices	Physician manner (4.68) and quality information (4.64) rated above reputation (4.00) and qualifications (3.97)	Independently rated composites; no forced trade-offs
Hoang et al., Las Vegas orthopaedics	329 patients of 6 surgeons, 2017	39.5% recalled online research before the visit; 8.5% named the internet as referral source	Self-reported; convenience sample; unvalidated questionnaire

STUDY	POPULATION	WHAT WAS OBSERVED	BOUNDARY
Forrest et al., US family practice	2,534 referral recommendations from 34,519 visits; 141 physicians, 87 practices	Personal knowledge (2.6) and prior feedback (2.5) rated above technical capacity (2.3)	Reasons accompanying recommendations, not completed care; not orthopaedic-specific
Kinchen et al., US primary care	623 of 1,054 eligible physicians responded	Medical skill of major importance for 87.5%; experience, access and communication also valued	How skill was judged not established; stated importance may not reflect behaviour
Li et al., Pennsylvania CABG surgery	10,742 discharges in the main model (from 12,521 across 184 surgeons); 2008–2017	High online ratings positively associated with selection; report-card effects small and insignificant	Could not establish who read either source or the mechanism

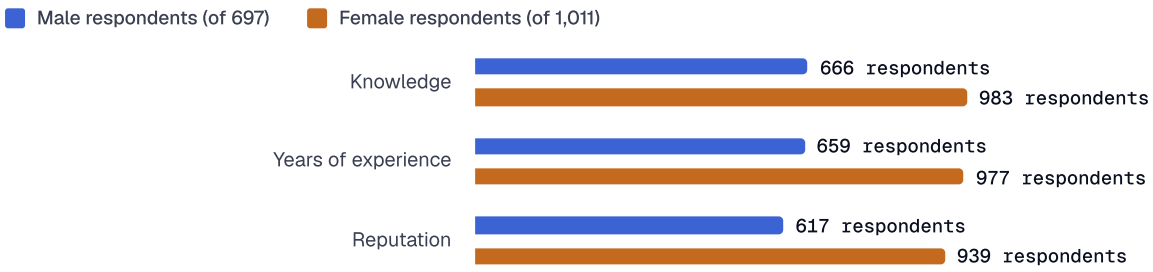
Source: [50, 355, 364, 365, 372, 373]

Patients

The Jordanian evidence retrieved is a January–February 2022 survey of 1,708 adults, who took part regardless of surgical history. Knowledge, years of experience and reputation drew the highest counts of 'important' ratings (Figure 6.4). These are stated priorities, not observed orthopaedic choices. The sample is also concentrated: 66.6% lived in Amman and 81.3% held a bachelor's degree or higher. The paper's narrative and its table give conflicting mean ages, so age is omitted here [50].

FIGURE 6.4

Jordanian adults rating each surgeon-selection factor as important, by sex (counts)

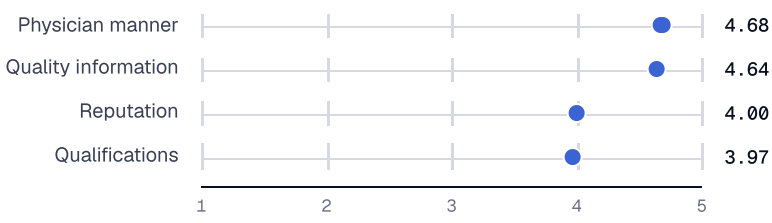


Source: AlSamhori et al., Table 2; 1,708 respondents; counts, not shares, and group sizes differ (697 men, 1,011 women); stated importance, not observed choice [50].

Among 251 patients evaluated for primary hip or knee replacement at 2 US practices, physician manner (4.68 of 5) and quality information (4.64) were rated above reputation (4.00) and qualifications (3.97) (Figure 6.5). Each domain was rated independently rather than traded against the others, and 'reputation' bundled recommendations, satisfaction ratings and complaints, so it is not a pure familiarity measure. The survey also reports that 46% agreed or strongly agreed that they had found useful information for comparing surgeons' quality or outcomes; that figure was not independently checked as a separate claim [355].

FIGURE 6.5

Mean importance ratings of provider-selection domains among arthroplasty patients (5-point scale)

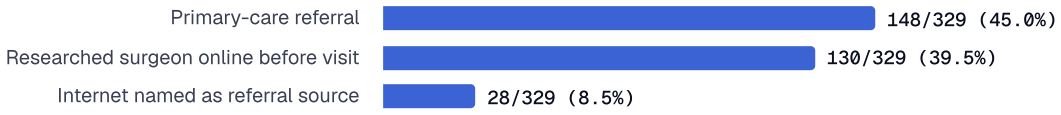


Source: Bozic et al., 251 patients at 2 US practices; independently rated composite domains [355].

In Las Vegas, 130 of 329 orthopaedic patients (39.5%) recalled researching their surgeon online before the visit. Only 28 (8.5%) named the internet as their referral source, while 148 (45.0%) named a primary-care referral (Figure 6.6). The 2 questions capture different self-reported behaviours, and the referral counts total 328 rather than 329. A low internet-referral share therefore does not mean that online information had no influence [364].

FIGURE 6.6

Online research versus stated referral source, Las Vegas orthopaedic patients



Source: Hoang et al., 329-patient convenience sample, 2017; different questions, self-reported; referral counts total 328 [364].

Referrers

A prospective US family-practice study logged 2,534 referral recommendations from 34,519 visits. As reasons for naming a particular specialist, personal knowledge (mean 2.6 on a 1–3 scale) and prior feedback (2.5) ranked above technical capacity (2.3) (Figure 6.7). Availability averaged 2.0 on the same scale, a figure that was not independently checked. Personal knowledge and feedback can include accumulated evidence of competence and collaboration, so they cannot be treated as name recognition alone [372]. A stratified national survey of primary-care physicians found that 87.5% rated medical skill as of major importance. Physicians also valued previous experience with the specialist (59.2%), appointment timeliness (55.4%) and communication (52.5%) (Figure 6.8). The authors note that the study did not establish how physicians judged skill, or whether stated importance governed actual referrals [373].

FIGURE 6.7

Mean importance of reasons for naming a specialist, US family-practice referrals (1–3 scale)



Source: Forrest et al., 2,534 referral recommendations, 1997–1999; physician-reported reasons, not completed care [372]. The availability mean (2.0) is reported in the text but not charted because it was not independently checked.

FIGURE 6.8

Primary-care physicians rating each factor of major importance when choosing a specialist



Source: Kinchen et al., Table 2, item-level denominators; stratified US survey [373].

Observed behaviour complicates stated preference. A study of Pennsylvania coronary-bypass (CABG) discharges in 2008–2017 analysed 10,742 fee-for-service discharges in its main model, drawn from a 12,521-discharge sample across 184 surgeons, and linked choices to online ratings and risk-adjusted mortality report cards. High online ratings had a positive, statistically significant modelled association with selection;

favourable report-card effects were small and insignificant. The researchers could not establish who read either source or through what mechanism. The study challenges a universal account in which evidence decides choice. It does not prove that fame overcomes quality or predict Jordanian orthopaedic behaviour [365].

> **WHAT THIS MEANS FOR A PRACTICE**
>
> Later fieldwork should measure recognition, understanding, trust, referral behaviour and final choice as separate observations. Likes are not trust. A declared importance rating is not a trade-off. Online research is not the original referral source. Survey percentages from different populations, dates and scales cannot be pooled into a surgeon-choice formula, and no pooled benchmark was calculated.

6.4 Named procedures: 3 attribution problems

A recurring question is whether named or supposedly unique procedures become durable brand assets or traps. The research examined 3 histories, and each presents a different attribution problem (Table 6.5).

TABLE 6.5

The 3 named-procedure histories

CASE	DOCUMENTED LAYER	WHAT THE CASE SUPPORTS	WHAT IT DOES NOT SUPPORT
Frank Jobe / Tommy John	Institutional anniversary account attributing the 1974 operation to surgeon Jobe and the enduring eponym to patient John	Continued institutional storytelling	Public surgeon attribution, name-caused demand or commercial exclusivity
Neal Blitz / Bunionplasty	2010 retrospective study of early protected loading after modified Lapidus fusion; the current promoter describes Bunionplasty 360 as avoiding that fusion	Evidence for the studied fusion protocol	Substantiation of every later offering sharing the promoter or brand
Ali Sadrieh / Cinderella	His own page describing a bunion operation with aesthetic and service features under a memorable name	A documented marketed package	Invention, sole-provider status or comparative benefit

Source: [15, 16, 374, 375]

Cedars-Sinai's 50-year commemoration names Frank Jobe as the surgeon who performed an ulnar collateral ligament (UCL) reconstruction on 25 September 1974, and Tommy John, a Dodgers pitcher, as the patient; it recounts John's return to Major League Baseball in 1976. The enduring eponym belongs to the patient, not the surgeon. The account does not establish who coined the name [374]. Jobe's original 1986 series of 16 throwing athletes reported that 10 returned to their previous level, 1 to a lower level and 5 retired from professional athletics, and that 2 postoperative ulnar neuropathies required further operations. These abstract-level figures were not independently checked and are not a modern success rate [376].

Neal Blitz's 2010 publication was a retrospective 2-surgeon review of 80 feet in 76 patients after modified Lapidus fusion of the first tarsometatarsal joint. Protected weight bearing began at a mean of 14.8 days, and all 80 feet united at a mean of 44.5 days (Figure 6.9) [15]. Today's promoter page describes Bunionplasty 360 Bunion Repair as avoiding that midfoot fusion [16]. The historical paper therefore cannot substantiate every later offering under the same promoter or brand; the evidence must follow the current technical version.

FIGURE 6.9

The 2010 modified Lapidus fusion cohort associated with the Bunionplasty promoter

80 feet
in 76 patients; 2 surgeons

14.8 days
mean start of protected weight bearing

44.5 days
mean time to union; all 80 feet united

Source: Blitz et al. (2010), abstract; retrospective; no randomised concurrent comparator [15].

Ali Sadrieh's page presents Cinderella as a hybrid osteotomy with internal titanium screw fixation and a side incision, packaged with short-recovery claims, concierge support and surgeon access. It acknowledges that the constituent techniques already existed. It documents a marketed package but gives no denominator, selection method, follow-up or comparator [375]. Table 6.6 and Figure 6.10 set out the attribution layers and dated events.

TABLE 6.6

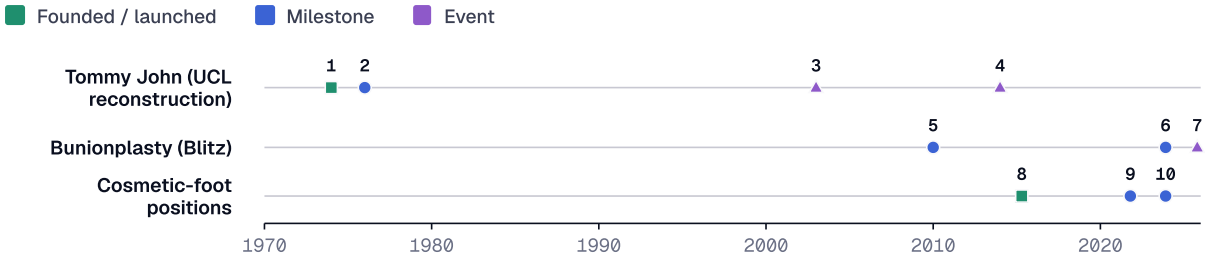
Attribution layers in the 3 named-procedure cases

LAYER	TOMMY JOHN	BUNIONPLASTY	CINDERELLA
Operator attribution	Jobe, in institutional history	Creation claimed by the present promoter	Creation claimed by the promoter
Patient eponym	Patient eponym (Tommy John)	No patient eponym claimed in the retrieved source	Fairytale-derived commercial name, not a historical patient
Clinical evidence	Original tendon-graft UCL series (abstract)	2010 Lapidus fusion cohort; current offering says it avoids fusion	Promoter description only; no original outcome study retrieved
Trademark or exclusivity	Not established	Registration 7224949 for class-010 goods; method exclusivity not established	Symbols on promoter page; legal status not established
Durability	50-year institutional commemoration; commercial value unmeasured	Current branded page; dated growth data absent	Active promoter page with media references; brand strength unmeasured

Source: [15, 16, 374-377]

FIGURE 6.10

Dated events in the named-procedure histories and the cosmetic-foot professional positions



1 **Tommy John (UCL reconstruction):** 1974 Jobe operates on John

2 **Tommy John (UCL reconstruction):** 1976 John returns to MLB

3 **Tommy John (UCL reconstruction):** 2003 4.4 per million enrollees

4 **Tommy John (UCL reconstruction):** 2014 11.9 per million enrollees

5 **Bunionplasty (Blitz):** 2010 Lapidus fusion cohort published

6 **Bunionplasty (Blitz):** 2023 Registration 7224949

7 **Bunionplasty (Blitz):** 2025 USPTO extract printed

8 **Cosmetic-foot positions:** 2015 AOFAS statement approved

9 **Cosmetic-foot positions:** 2021 AOFAS revision

10 **Cosmetic-foot positions:** 2023 ACFAS statement

Source: [15, 25, 222, 374, 377, 378]. MLB: Major League Baseball; AOFAS: American Orthopaedic Foot & Ankle Society; ACFAS: American College of Foot and Ankle Surgeons. The Cinderella offering carries no dated events in the sources and is omitted.

What happens when others learn the technique

US commercial-insurance data covering 3,133 patients aged 11–40 show rising use of UCL reconstruction. The annual rate rose from 4.4 to 11.9 per million database enrollees between 2003 and 2014 (Figure 6.11). That establishes broader use, not that the 'Tommy John' name caused any surgeon's fame or practice growth [25]. The current Bunionplasty manufacturer's page promotes training for other surgeons, so its own account cannot support describing the offering as available only from Blitz [379]. A United States Patent and Trademark Office (USPTO) extract printed on 7 October 2025 records BUNIONPLASTY registration 7224949, dated 21 November 2023, for specified class-010 orthopaedic goods owned by Silvatec Medical Company, Inc. This is dated registration evidence, not a live 2026 status check or a patent analysis, and it does not prove that a single surgeon alone may perform a technique [377].

FIGURE 6.11

UCL reconstruction utilisation in a US commercial-insurance database, 2003 and 2014



Source: Idowu et al., 3,133 patients aged 11–40; commercially insured population, not a national rate [25].

A name can therefore preserve a story or an attribution while provider scarcity changes. Training others can spread a technique and a reputation, but it can also end scarcity; neither outcome is automatic. Whether durable economic value results depends on what people attribute, who benefits and how the business works, which Chapter 7 examines.

The scope of cosmetic-foot criticism

The American Orthopaedic Foot & Ankle Society (AOFAS) and the American College of Foot and Ankle Surgeons (ACFAS) oppose appearance-only foot surgery and distinguish it from appropriately indicated reconstruction (Table 6.7). An aesthetic consequence does not make an operation appearance-only. Equally, mentioning pain does not establish that an operation is appropriately indicated, and AOFAS requires risks to be weighed against symptom severity. These are professional positions, not rulings against the 3 named doctors or Jordanian law [222, 378].

TABLE 6.7

Professional positions on cosmetic foot surgery

BODY	DATE	POSITION	WHAT IT DOES NOT ESTABLISH
AOFAS	Approved 5 May 2015; revised October 2021; AAOS endorsed 12 October 2021	Opposes surgery solely for cosmetic goals or desirable footwear; distinguishes cosmesis as a component of reconstruction from cosmesis as the primary goal; recognises pain and function benefits of appropriately indicated bunion and hammertoe operations	A ruling on any named provider; Jordanian law; automatic clearance where pain is present
ACFAS	November 2023	Opposes surgery solely to alter foot or ankle appearance or size without medical benefit	A ruling on any named provider; Jordanian law

Source: [222, 378]

6.5 What a real clinical difference looks like

The IDEAL recommendations treat surgical innovation as a complex intervention shaped by technique, patient selection, team and learning curve. They call for evaluation suited to each stage of development, with comparative trials where feasible and appropriate alternatives where not, and warn that excessive demands can hinder innovation. Novelty alone supplies no comparative outcome result [380]. Randomised comparisons of minimally invasive (MIS) and open chevron osteotomy for hallux valgus show what a demonstrated difference looks like (Table 6.8).

TABLE 6.8

Comparisons of minimally invasive and open chevron osteotomy

STUDY	DESIGN AND DENOMINATOR	FINDING	LIMIT
Kaufmann et al. (2019)	Randomised controlled trial (RCT); 47 feet (25 MIS, 22 open); single experienced surgeon	Higher MIS satisfaction at 12 weeks, not at 6 weeks or 9 months; no detected pain or functional-score difference	Both arms allowed immediate weight bearing in a postoperative shoe; K-wires versus screw; hardware removal 12/25 MIS versus 2/22 open
Kaufmann et al. (2020)	5-year follow-up; 39 of the 47 feet	No significant between-group clinical or radiographic differences	Same cohort, not replication; abstract only; nonsignificance is not equivalence
Yoon et al. (2024)	RCT at 3 institutions; 85 randomised, 14 lost, 71 analysed (36 percutaneous, 35 open)	Day-one pain 4.2 versus 5.3 (p = .019); greater total range of motion at 6 and 12 months	Later pain, FAOS, FFI, satisfaction and shoe restriction not significant; fixation configuration differed
Separate prospective study (2025)	63 feet analysed (33 MIS, 30 open); abstract only	Lower early pain, medication use and swelling; better AOFAS score and satisfaction	Random allocation not described; not independently checked as a main claim

Source: [44, 366, 367, 381]. FAOS, FFI, VAS and the AOFAS score are listed in Appendix E.

In the first trial (47 randomised feet, 1 experienced surgeon), satisfaction favoured the MIS arm at 12 weeks but not at 6 weeks or 9 months, and no pain or functional-score difference was detected (Figure 6.12). Both arms were allowed immediate weight bearing in a postoperative shoe, so early loading cannot be credited to the MIS approach alone. Fixation also differed: the MIS arm used K-wires and the open arm used a screw. As a result, neither the benefit nor the hardware problems can be assigned solely to incision size [44].

FIGURE 6.12

Endpoint-by-endpoint results in 2 randomised chevron osteotomy trials

	Kaufmann RCT (47 feet)	Yoon RCT (71 analysed)
Patient satisfaction	Higher MIS at 12 weeks only	Not significant
Early pain	No detected difference	Day one 4.2 vs 5.3, p=.019
Functional scores	No detected AOFAS-score difference	FAOS, FFI not significant
Range of motion	Not reported in the evidence reviewed	Greater at 6 and 12 months
Hardware removal	12/25 MIS vs 2/22 open	Not reported in the evidence reviewed
5-year clinical and radiographic	No significant difference (39 feet)	Not reported in the evidence reviewed

Difference detected favouring the minimally invasive or percutaneous arm
No significant difference detected
More hardware removal in the minimally invasive arm
Not applicable or not assessed (see note)

Source: [44, 366, 367]. The 5-year result is from the same Kaufmann cohort, abstract only.

The hardware record was corrected during verification. An earlier summary described both open-arm removals as symptomatic. The original paper shows 1 removal for irritation and 1 at the patient's request. In the MIS arm, 12 of 25 feet had hardware removed, all for K-wire irritation (Figure 6.13) [44]. A follow-up at 5 years of 39 of the original 47 feet reported no significant between-group clinical or radiographic differences. This follow-up is the same cohort, not an independent replication. It was retrieved only as an abstract, and it does not prove equivalence [366].

FIGURE 6.13

Hardware removal by reason in the 47-foot chevron trial, as corrected on verification

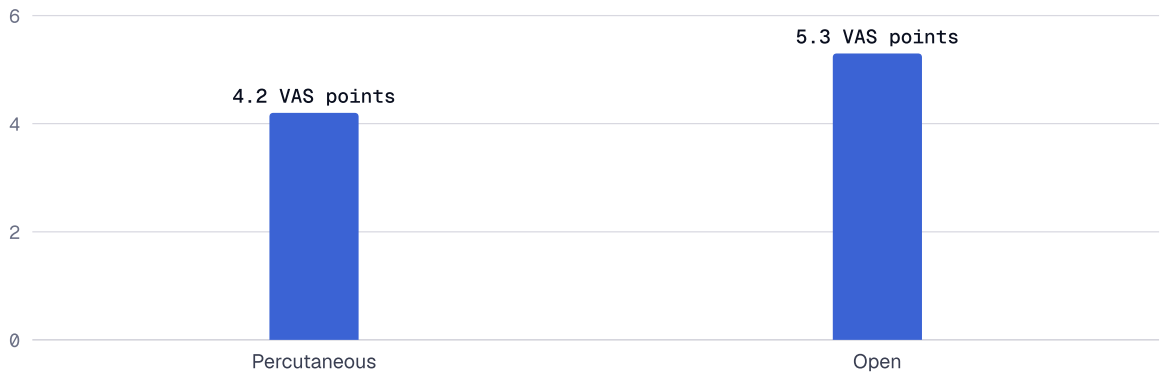


Source: Kaufmann et al., original full text; all 12 MIS removals involved symptomatic K-wire irritation [44].

A separate 2024 trial at 3 institutions randomised 85 and analysed 71 (36 percutaneous, 35 open). The percutaneous arm had lower day-one pain than the open arm: 4.2 against 5.3 on a visual analogue scale (VAS) (p = .019). It also had greater total range of motion at 6 and 12 months (Figure 6.14). Later pain, FAOS, FFI, satisfaction and shoe-restriction comparisons did not differ significantly. The authors caution that moderate effects may not justify definitive conclusions [367]. A newer prospective comparison of 63 feet also reports early advantages for the MIS arm. However, its abstract does not describe random allocation, and it was not independently checked as a main claim [381].

FIGURE 6.14

Mean day-one postoperative pain, percutaneous versus open chevron osteotomy (visual analogue scale)



Source: Yoon et al. (2024), 71 analysed (36 percutaneous, 35 open); p = .019 [367].

The 2024 trial is important counterevidence against dismissing useful differences, and equally inconsistent with declaring every minimally invasive operation universally superior. A result for one technique does not transfer automatically to another.

> KEY FINDING
>
> A real clinical difference is narrower than a broad claim of 'better'. Each claim must specify which benefit, for whom, compared with what, at what time, with which harms and with what certainty. A nonsignificant result does not prove equivalence, and a significant endpoint does not prove universal superiority.

6.6 Substantiation and permitted expression are separate decisions

The Jordan Medical Association (JMA) Instructions for Medical Advertising and Media for Doctors contain 3 relevant kinds of provision: rules for factual and scientific information, an explicit restriction on superiority language, and separate provisions on discoveries, inventions and registered specialties (Table 6.9). Article 5(2)(و) lists prohibited superiority terms and makes no exception for evidence of rarity.

> الأول، الأوحد، الأبرع، الوحيد *(translation: 'the first', 'the sole', 'the most skilled', 'the only')*
>
> JMA Instructions for Medical Advertising and Media for Doctors, Article 5(2)(و), prohibited superiority terms [8].

Article 3 incorporates Articles 5(أ) and 10 of the 1989 Medical Constitution, so the superlative clause cannot stand in for the whole framework [8]. The Constitution was recovered only as a non-official law-firm transcription with visible errors. Its broad publicity restrictions reinforce the need to assess the full framework. However, that copy is not an official consolidated edition, and it does not show how the provisions are applied in practice [63]. Chapter 3 sets out the regulatory environment in full.

TABLE 6.9

JMA provisions relevant to a differentiation claim

PROVISION	WHAT THE TEXT ADDRESSES	IMPLICATION FOR A DIFFERENTIATION CLAIM
Article 3	Incorporates Medical Constitution Articles 5(أ) and 10	The superlative clause is not the whole framework
Article 5(1)	Factual signboard details	Factual specificity exists in the text
Article 5(2)(هـ)	Scientific, educational and treated-case information requires scientific establishment or publication in refereed journals or conferences	A substantiation route for scientific content
Article 5(2)(و)	Prohibits first, only, most-skilled and similar superiority terms	Evidence of rarity does not override the wording prohibition
Article 5(2)(ز)	Bars advertising discoveries or inventions before registration with competent official authorities	Registration is not stated to establish effectiveness or exclusivity
Article 9(أ)–(ب)	Specialties must be registered with the Jordanian Medical Council; memberships, honorary certificates, titles, diplomas and courses need committee approval	Credential publicity has separate conditions (not independently checked as a separate claim)

Source: [8]; incorporated Constitution read from a non-official transcription [63].

The analysis therefore retires 2 opposite inferences. A common inference holds that legal limits force every point of difference into persona or distinctive assets. The posted text contains factual-specificity provisions and does not support that inference. The opposite view, that every proven difference may be published, does not follow either. This research does not clear any proposed wording [8].

Foreign rulings clarify evidence errors but do not replace Jordanian rules (Table 6.10). In January 2024 the UK Advertising Standards Authority (ASA) found that certifications concerning 4 doctors, only 2 of them plastic surgeons, did not substantiate the international superiority conveyed by 'World-Class Doctors', and separately upheld a complaint against unqualified safety wording (a separate issue in the same ruling, not independently checked as a separate claim) [382]. The UK Prescription Medicines Code of Practice Authority (PMCPA) found that pain-relief and shoulder-block evidence did not substantiate a promoted claim of pain-free mobility after knee surgery; a successful appeal on a separate indication issue did not erase those accepted breaches [383].

TABLE 6.10

Foreign rulings on substantiation of promoted claims

RULING	PROMOTED CLAIM	EVIDENCE OFFERED	FINDING	WHAT IT DOES NOT ESTABLISH
ASA, Care in Turkey, 24 January 2024	'World-Class Doctors'; unqualified safety	Certifications concerning 4 doctors, only 2 plastic surgeons	International superiority not substantiated; safety claim misleading and irresponsible (not independently checked as a separate claim); advertisement not to reappear as investigated	Subsequent compliance, commercial loss or the doctors' clinical competence
PMCPA, Pacira AUTH/3624/3/22	Pain-free mobility after knee surgery	Pain-relief, opioid and shoulder-block evidence	Claims exaggerated the evidence (Clauses 6.1, 14.4); breaches accepted; separate indication appeal succeeded	A universal judgement on the product or on surgeon advertising

Source: UK comparators only; not Jordanian clearance [382, 383].

The practical test is whether the exact proposition matches its evidence (Figure 6.15).

FIGURE 6.15

Substantiation errors documented in 3 cases

ASA 2024

Credentials are not superiority

Certifications for 4 doctors did not substantiate 'World-Class Doctors'.

PMCPA

Less pain is not pain-free

Pain-relief and shoulder-block evidence did not support a knee pain-free-mobility claim.

BUNIONPLASTY

Evidence belongs to one operation

A 2010 Lapidus-fusion cohort cannot substantiate a later no-fusion offering from the same promoter.

Source: [15, 16, 382, 383]

LIMIT

This research did not find an adjudicated lawful example of a surgeon expressing a real difference without superlatives. The information routes in the JMA text and the failed-substantiation cases abroad do not fill that gap.

6.7 Signatures, expertise and attention

The research paired 2 cases that illustrate different observable routes to prominence (Table 6.11, Figure 6.16). On 14 August 2018, TLC announced that Sandra Lee's procedure-centred programme Dr. Pimple Popper was renewed for a second season, with new episodes planned for January 2019 [384]. The Andrews Institute's history records its 2007 opening by Baptist Health Care with James Andrews, later sports-provider relationships and new locations [240]. A 2019 University of West Florida announcement confirms the partnership and names other team physicians, which underscores that care is delivered through an institutional system [385].

TABLE 6.11

Paired cases: a media signature and an expertise-associated institution

CASE	DOCUMENTED ROUTE	DOCUMENTED EVENTS	WHAT CANNOT BE COMPARED
Sandra Lee / Dr. Pimple Popper	Recurring procedure-centred television programme	Second-season renewal announced 14 August 2018; new episodes planned for January 2019; companion series This Is Zit	Broadcaster renewal is not clinic-prof-it evidence, an attribution experiment or proof that the depicted procedures were unique
James Andrews / Andrews Institute	Institution with sports-provider relationships and added locations	2007 opening; 2011 Pensacola Blue Wahoos provider; 2015 University of West Florida partnership; Navarre 2018; Ft. Walton Beach 2019	A self-reported history does not iso-late founder reputation from partners, capital, clinical operations or local access

Source: [240, 384, 385]

FIGURE 6.16

Documented events in the 2 paired cases



1 **Andrews Institute:** 2007 Opens with Baptist Health Care
2 **Andrews Institute:** 2011 Blue Wahoos provider
3 **Andrews Institute:** 2015 UWF medical partnership
4 **Andrews Institute:** 2018 Navarre location
5 **Andrews Institute:** 2019 Ft. Walton Beach location
6 **Sandra Lee / Dr. Pimple Popper:** 2018 Second season announced
7 **Sandra Lee / Dr. Pimple Popper:** 2019 New episodes planned

Source: Self-reported institutional and broadcaster records [240, 384]. UWF: University of West Florida.

Lee and Andrews differ in specialty, format, institution, resources, geography and outcome measures. The pair cannot show which route grew faster, lasted longer or would transfer to a Jordanian practice. It identifies mechanisms to investigate and the evidence a matched comparison would need.

Folklore tested

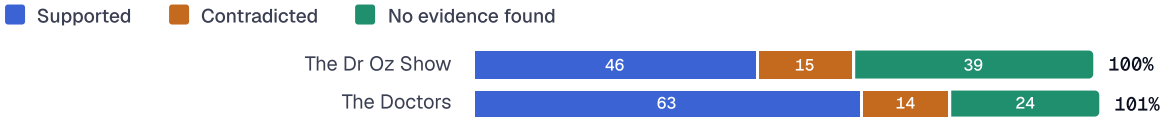
The 'familiarity with a twist' idea raised in the preparatory reading remains a hypothesis. Hekkert and colleagues' original abstract reports that typicality and novelty jointly predicted aesthetic preference for industrial products across 3 studies. It supplies neither a numerical 29-of-30 prescription nor any result about how patients choose surgeons [386]. A counter-study of product design reported a preference for moderate novelty, and it also supplies no universal ratio [387].

Attention is not the same as a favourable evaluation. Berger, Sorensen and Rasmussen found that the effects of negative publicity on books depended on prior awareness and timing. In Study 2 (252 participants) the valence effect for an unknown book faded after a delay, and in Study 3 (137 participants) the negative-review against no-review contrast for that book reached only p = .06. This is not evidence that criticism of medical safety helps a surgeon [388].

Fame also does not make advice evidence-based. A BMJ audit randomly sampled 40 episodes per programme from early 2013 and reviewed 80 recommendations per programme. For The Dr Oz Show, 46% were supported, 15% contradicted and 39% had no evidence found; for The Doctors, the figures were 63%, 14% and 24% (Figure 6.17). Recommendations included guests' statements. The audit measured evidential support, not a causal effect of fame, audience loss, clinical outcomes or revenue [389].

FIGURE 6.17

Evidential support for recommendations on 2 televised medical talk shows, early 2013



Source: Korownyk et al., BMJ; 80 recommendations per programme; figures as reported, subject to rounding [389].

LIMIT

This research documents advertising restrictions imposed in actual cases, and reasons to distrust the claim that all publicity helps. It does not quantify lost patient demand, lost enterprise value, or how far a signature contributes to disciplinary action. Those outcomes remain unmeasured.

6.8 How any surgeon can test a technique claim; myths and contradictions

The research supplies a way to test a surgeon's technique claim, not a verdict on any particular claim. The surgery-claim test is an evidence worksheet, not advertising copy. Starting from the surgeon's exact wording in the language of publication, it decides, proposition by proposition, what the evidence establishes about the operation as performed now, whether any claimed availability or ownership holds within a defined geographic boundary, whether the difference matters to patients and referrers, and whether the exact wording is permitted under the communication rules independently of whether the fact is true [8, 390].

The reason is that recognition, real benefit, availability, exclusivity and durable commercial value are separate questions, and a result on one does not settle another. Being the only locally available provider would not by itself establish invention, better outcomes or durable exclusivity, and a search in which no other provider appeared remains a search result, not proof of exclusivity. Each proposition therefore receives 1 of 5 classifications, such as 'supported within a defined scope' or 'communication restricted or unresolved', together with its sources, its limitations and the strongest counterargument. Favourable and unfavourable results are both kept, no composite score is produced, and a supported clinical fact does not automatically become the chosen brand position; the category frame and the positioning remain the practice's own decisions (Chapter 9). The test does not authorise access to patient records, publication of cases or new clinical research. The full surgery-claim test, with its recording fields and outcome classifications, is in Appendix D [390].

WHAT THIS MEANS FOR A SURGEON

To use the test, a surgeon starts from a written statement of the procedure and the evidence behind it: the exact wording, the standard operation name and current technical version, the indication, the comparator and the claimed result. Public captions and promotional summaries do not substitute for that statement. Economic durability, fee premium, succession and sale value are covered in Chapter 7. Demand in the capital and the breadth of any niche are covered in Chapter 8.

Myths retired

Table 6.12 records what the evidence shows about the broad beliefs behind this research. These are judgements on folklore, not additional claim verdicts; a qualified claim can survive verification while the broader belief does not. Appendix B collects the myths retired across the report.

TABLE 6.12

Dispositions of broad propositions about differentiation

PROPOSITION	DISPOSITION
People must explicitly perceive a difference before they buy	Too strong in the studied consumer markets; surgeon-specific necessity untested
Differentiation is economically irrelevant	Not supported by the predictive and panel evidence; causality and transfer limited
Familiarity stops at the shortlist; evidence decides the final choice	Not an established universal sequence

PROPOSITION	DISPOSITION
A branded procedure is one stable invention only its originator can provide	Histories show changing versions and promoted training; registration and clinical evidence are separate
All cosmetic-language foot operations fall under appearance-only criticism	Misstates the scope of the professional positions
Any restriction on superiority forces all differentiation into persona	Retired as unsupported by the JMA text; no converse blanket permission
A brand should keep exactly 29 of 30 familiar features	Not validated in the retrieved original
Negative attention always helps	Conflicts with conditional findings on awareness and timing
Both open-arm hardware removals in the chevron trial were symptomatic	Refuted: 1 removal was for irritation and 1 at the patient's request
A specific signature grows faster, or a narrow niche will unlock Amman	Unresolved; requires matched histories and local demand and choice evidence

Source: [8, 15, 44, 222, 361-363, 365, 370, 377-379, 386, 388]

Contradictions

The evidence contained 6 tensions. None was resolved by preferring one source over another. Each resolves once the constructs, populations, versions or outcomes are separated (Table 6.13; Appendix C).

TABLE 6.13

Contradiction ledger for the differentiation study

TENSION	RESOLUTION
Little explicitly perceived difference versus economic associations with differentiation	Different constructs, populations and outcomes; neither disproves the other
Clinical information rated highly versus weak report-card association in observed cardiac choices	Stated importance, availability, interpretation and behaviour differ; no universal pathway inferred
A historical fusion publication versus the present no-fusion brand description	Version mismatch; evidence must attach to the operation, not the name
Early benefits versus later comparisons without detected differences	Endpoints, timing, fixation and cohorts differ; neither universal superiority nor equivalence declared
Factual and scientific specificity versus publicity restrictions	Both belong to the full Jordanian framework; validation and public expression are separate decisions
A compelling fame story versus causal proof of growth	Descriptive cases reveal mechanisms but cannot rank signature-led against expertise-led growth

Source: [8, 15, 16, 44, 63, 355, 361-363, 365-367]

LIMITS OF THIS EVIDENCE

- No individual surgeon's claim was assessed; the surgery-claim test is a method, and no finding here assesses a particular operation.
- This was a web-only desk study. There was no fieldwork, no marketing copy and no publication.
- The retrieved papers provide no head-to-head causal test for surgeons of a recognisable signature against a meaningful difference. The consumer and corporate studies transfer to surgery only as hypotheses.
- All 30 selected claims were confirmed, but that reflects deliberately bounded wording, not certainty about the sources or about strategy. The 8 unselected claims were not independently verified, and 1 supporting clinical detail was refuted and corrected.
- The study recorded 44 distinct source URLs, including mirrors and abstract and full-text versions; these are not 44 independent studies. The underlying study report cited 33 numbered sources; this chapter cites 38, adding 5 further sources recorded in the verification ledger.
- Several sources were available only as abstracts, including the 5-year chevron follow-up, the 2010 Lapidus cohort, the original Tommy John series and the typicality-novelty study. Some pages returned access errors and were recovered through alternate retrieval or left limited.
- The only Jordanian choice evidence is a general-adult survey of stated preferences that centres on gender bias. Its sample was concentrated in Amman and among university graduates, and its reported mean age is internally inconsistent.
- Most patient and referrer evidence is older, US-based and specific to its setting; the observed-choice study concerns cardiac surgery, not orthopaedics.
- The incorporated 1989 Medical Constitution was read from a non-official law-firm transcription with visible errors. Administrative application of the JMA framework and the committee process were not tested.
- The USPTO evidence is a registry extract printed in October 2025, not a live 2026 status check or a patent analysis.
- Case selection was purposive, not representative, and promoter, broadcaster and institutional pages are self-interested sources for claims of superiority or growth.
- No lost patient demand, lost enterprise value or causal contribution of a signature to disciplinary action was quantified.
- No adjudicated lawful example was found of a surgeon expressing a real difference without superlatives.

LEFT OPEN

- How should a surgeon's technique claim be written down for testing: its verbatim wording, the standard operation name and current technical version, the indication, the comparator and the claimed result?
- Will a recognisable signature, an independently useful difference, or a combination of both increase a surgeon's fame and economically valuable demand?
- How do Jordanian patients and referrers actually weigh recognition, attribution, understanding, trust, access and experience when they choose an orthopaedic surgeon, and does recognition built in one Jordanian city transfer to an Amman audience?
- Does a signature-led route grow faster or last longer than an expertise-led route? Answering this requires matched histories with comparable outcomes and counterfactuals.
- What, if anything, would remain associated with the original surgeon if another qualified surgeon offered the same operation: correct attribution, documented experience, trusted referrals, teaching, team and process, or access?
- How would the JMA and the incorporated Medical Constitution be applied to a surgeon's exact wording and placement, and which registration and approval records would that require?
- Is there demand in Amman for a narrow surgical niche (Chapter 8), and what economic durability, fee premium, succession and sale value could a named signature carry (Chapter 7)?

CHAPTER 07

The medical brand as an economic asset

Pricing, referrals, transactions, licensing, capacity and crisis: what the evidence shows a medical name can and cannot carry

EVIDENCE BASE BRAND AS ASSET	39 Claims generated	31 Put to verification	30 Confirmed	0 Refuted	1 Unverified	50 Sources recorded	328 Research actions

CHAPTER SUMMARY

This chapter asks how a medical brand becomes a durable economic asset and what survives capacity limits, founder absence, crisis and reduced attention. Of 39 extracted claims, 31 were formally checked in an independent verification pass (30 confirmed, 0 refuted, 1 unverified and excluded). The evidence shows that reputation can move demand: a public hospital-ranking signal was followed by about 1% more non-emergency volume per rank position, and in a discrete-choice experiment with 422 people referred for joint replacement, surgeon reputation was the strongest of 5 tested attributes. It does not show a portable fee premium: a top-20 US hospital had the highest minimum negotiated joint-replacement price in only 1 of 5 comparable cities. Transactions and rights records (Surgery Partners' US$40.4m across 13 practice deals, Fortius, HMG's prospectus and Mediclinic) document transferable businesses and legal rights, but none prices a name separately. Arrangements that carry a famous medical name beyond its home institution bundle it with services, management or direct operation. Crisis cases (NMC, and Paterson and Spire) show that a name, an institution, a licence, investors' funds and patient trust can have different fates, and the evidence reviewed contains no decay half-life for a doctor who stops posting. The chapter sets out a measurement framework to test (section 7.6) and closes with 6 questions that only a practice's own records can answer.

KEY FINDINGS

01 No portable fee premium for a famous medical name was found: in a 2021 comparison of 61 US hospitals, a top-20 hospital had the highest minimum negotiated price in only 1 of 5 comparable cities for joint replacement and 1 of 6 for brain MRI [17].

02 Reputation has measurable preference value: in a discrete-choice experiment with 422 people referred for total joint replacement, surgeon reputation was the strongest of 5 tested attributes, and respondents were modelled as willing to wait about 10 months for an initial consultation with an excellent-reputation surgeon, although the study had no price attribute [391].

03 A public reputation signal can move demand: improvements in published hospital rankings were followed by about 1% more non-emergency Medicare volume per national rank position, although capacity limits can hide extra demand [19].

04 Patient flows reflect several distinct mechanisms: losing a primary-care physician was associated with 18.4% fewer primary-care visits and 6.2% more specialty visits among 359,470 Medicare beneficiaries, while 3 clinic acquisitions in the Twin Cities in 2007 were followed by shifts in inpatient and imaging use toward the acquiring systems, showing that ownership as well as preference can route patients [392, 393].

05 Businesses and name rights transfer, but names are not priced separately: Surgery Partners invested US$40.4m across 13 physician-practice transactions involving 17 physicians in 2015, and neither this nor the Fortius, HMG or Mediclinic records discloses a name-only allocation [18, 311, 394, 395].

06 Famous-name arrangements are not interchangeable logo licences: Mayo's network is a subscription for independent providers, Cleveland Clinic's 2019 issuer document described managing its Abu Dhabi hospital for Mubadala, and Moorfields' 2024/25 accounts describe a Dubai branch and an Abu Dhabi joint venture, with no name-only fee disclosed in any case [324, 396, 397].

07 Volume, utilisation and profit can diverge: Burjeel's outpatient visits rose 7.3% in 2024 while outpatient utilisation fell to 69% from 72%, and revenue rose 10.5% while EBITDA excluding one-offs fell 5.8% [398].

08 The closest leading indicator found was patient experience, not recall: in 132 Swiss hospitals, previous-year experience was associated with next-year standardised revenue among the 50 private hospitals ($p = .037$) but not with combined-sample profits ($p = .240$) [399].

09 Crisis outcomes separate: 34 NMC operating companies continued under creditor ownership with a US$325m facility while the FCA expected no funds to remain for the old company after creditor claims, and Paterson was erased from the medical register on 25 July 2017 while Spire's hospitals continued [400–403].

10 No defensible brand-decay half-life for a doctor who stops posting exists in the evidence reviewed; the study of 650 physicians reviewed was cross-sectional [404].

7.1 What can be an asset, and to whom

This chapter examines how a medical brand becomes a durable economic asset through pricing, referrals, expansion, licensing, sale or succession, and what survives capacity limits, founder absence, crisis and reduced attention. The useful question is not whether a name is valuable in the abstract, but which future benefit survives, who receives it and what must remain in place for it to continue. The framework in Table 7.1 is an analytical device for interpreting the evidence. It is not an appraisal of any particular surgeon or clinic.

TABLE 7.1

Benefits of a medical name, by beneficiary, with the evidence that would establish each

POSSIBLE BENEFIT	BENEFICIARY	EVIDENCE THAT WOULD ESTABLISH IT
Being remembered and considered	Doctor and prospective patient	Correct attribution in relevant care situations, followed by actual consideration
Preference despite another available provider	Practice	Observed choices, willingness to wait or travel, and reasons for the choice
Better commercial terms	Practice or institution	Comparable realised fees or margins after payer, procedure, quality and capacity differences
Demand that can move to another clinician or site	Institution or buyer	Retained appropriate patient and referrer demand when the founder is absent or the location changes
Permission to use a recognised identity and its supporting system	Network member or operating partner	Enforceable rights, defined services and quality controls, actual contract economics
A transferable economic interest	Buyer, seller and successors	Documented ownership, contracts, transition obligations and purchase-price allocation

Source: Analytical framework of the brand-as-asset desk study [405], illustrated by the HMG prospectus [311].

These benefits require separate tests. A patient may trust a name while a buyer still depends on particular surgeons remaining. The 2020 initial public offering prospectus of Dr. Sulaiman Al-Habib Medical Services Group (HMG) documents both company-owned trademark permissions and dependence on clinicians' relationships; the existence of one does not extinguish the other [311].

The evidence base for this chapter is a structured desk study in which the question was examined independently from 6 distinct analytic perspectives (pricing economics, observed referral behaviour, transactions and succession, licensing and governance, operations and measurement, and a crisis-focused sceptical perspective dedicated to testing popular claims), using sources retrieved online at the time of research; an independent verification pass then re-checked selected claims against original sources. Of 39 claims extracted, 31 were formally checked: 30 were confirmed, none was refuted and 1 remained unverified and is excluded from all findings [405]. The full verification ledger is in Appendix A. The high rate of confirmation reflects bounded wording and descriptive records, not certainty about causal brand returns. Verification nonetheless changed the synthesis: it corrected a stale hospital opening status, a denominator discrepancy in a source's abstract, the consultation endpoint in a waiting-time study and the interpretation of inconsistent prose in a Swiss study. The combined ledger contains 50 distinct evidence-source URLs, which are not 50 independent studies, and 328 logged retrieval actions, including failed attempts. Table 7.2 ranks the source types by what they can establish.

TABLE 7.2

Reliability of the evidence by source type

EVIDENCE STRENGTH	SOURCE TYPES IN THIS CHAPTER	WHAT THEY CAN AND CANNOT ESTABLISH
Strongest for what happened	Original regulator records, issuer filings, audited accounts and administrators' dated announcements	Transactions, structures, sanctions and accounting outcomes; they do not independently value a brand
Stronger empirical mechanisms	Original referral and disruption studies; hospital-ranking research	Mechanisms of demand and continuity, with their identification limits and historical populations intact
Moderate	Hypothetical surgeon choice, local stated-preference surveys and the observational Swiss experience and revenue association	Preference and association; none gives a fee premium for any particular practice
Weakest for economic attribution	Provider descriptions and corporate expansion narratives; private contract terms and founder-exit counterfactuals	Descriptions are self-interested; contract terms and counterfactuals remain unavailable

Source: Reliability note of the brand-as-asset desk study [405]. Shared sources across perspectives are not independent corroboration. No practice's own financial, capacity or transition data were inspected, and no patient-level material was collected.

KEY FINDING

A medical brand can contribute to demand and support transferable relationships: hospital-ranking research finds patient-volume responses, and documented networks and practice acquisitions carry recognised names alongside services, contracts and operating capability [19, 324, 394]. The records do not establish a universal surgeon fee premium, and they do not reveal a reliable brand-only share of acquisition prices [17, 18, 395, 406].

WHAT THIS MEANS FOR A PRACTICE

The research test for a surgeon building a name is whether preference for that surgeon can persist and transfer, with appropriate care, measurable commercial outcomes and clear rights, as other clinicians, sites or owners become involved. This is an analytical test, not a decision to use a personal name or an institute's name. That architecture decision remains each practice's own (see Chapter 5 and Chapter 11).

7.2 Does medical fame command a fee premium?

Reputation sometimes matters to choice, but the evidence reviewed does not identify a portable percentage premium for a surgeon's name. In a 2021 US price-disclosure study, Ho and colleagues compared 20 honor-roll hospitals with 41 nearby hospitals holding comparable or better CMS star ratings, collecting 6 service prices across the 61 hospitals in July and August 2021. A top-20 hospital had the highest minimum negotiated price in only 1 of 6 comparable cities for brain MRI and 1 of 5 for joint replacement (Figure 7.1); cash prices at top-20 hospitals were highest roughly half the time [17]. Independent verification found that the study's web abstract gives 1 of 5 for both services, whereas the Baker Institute report's body and its own Table 1 give 1 of 6 for MRI; the body and table are followed here. These are disclosed hospital prices, not the surgeon's collected fee. The comparison sets were small, reporting was substantially incomplete, and the design does not separate brand from quality or contracting.

FIGURE 7.1

Comparable cities where a top-20 US hospital had the highest minimum negotiated price, 2021



Source: 2021 US price-disclosure comparison by Ho, Lara, Ruiz, Cram and Short, Rice University Baker Institute [17]: 20 honor-roll hospitals and 41 nearby comparators with comparable or better CMS star ratings. Minimum negotiated prices are not average realised revenue, patient out-of-pocket cost or a surgeon's professional fee.

Any premium comparison must first state which price is being compared. The study distinguishes 5 price concepts that must be separated before premiums are compared (Table 7.3).

TABLE 7.3

Price concepts to separate before comparing premiums

PRICE CONCEPT	HOW IT APPEARS IN THE EVIDENCE REVIEWED
Hospital facility price	Ho et al. compared hospitals' disclosed minimum negotiated and cash prices; Cooper et al. compared admissions to higher- and lower-priced hospitals
Surgeon professional fee	Not captured by disclosed hospital prices; the physician-fee evidence reviewed is a market-structure association, not a named surgeon's fee
Insurer allowed payment	Baker et al. defined price as the contractual allowed amount paid by insurer and patient, not the billed charge
Quoted cash price	Cash prices at top-20 hospitals were highest roughly half the time in the Ho et al. comparison
Patient out-of-pocket amount	Minimum negotiated prices are not patient out-of-pocket cost

Source: Research implication of the brand-as-asset desk study [405], drawing on [17, 407–409].

Rival explanations that any brand-premium estimate must address come from 2 further bodies of evidence (Table 7.4). Cooper and colleagues used ambulance-company destination preferences to study emergency admissions: admission to hospitals with 2 standard deviations higher prices increased spending by 53% and reduced in-hospital mortality by about 1 percentage point overall, with the mortality benefit appearing only in less concentrated markets [407]. The design estimates the effect of receiving care at a higher-priced hospital, not of a hospital raising its own prices, and it does not test celebrity surgeons. Separately, physician-

market concentration and multispecialty organisation were associated with higher negotiated payments [408, 409]. The converse position, that all high medical prices reflect only market power, is also too strong: the ambulance-design study found better survival at higher-priced hospitals in less concentrated markets.

TABLE 7.4

Rival explanations for price differences that a brand-premium estimate must control

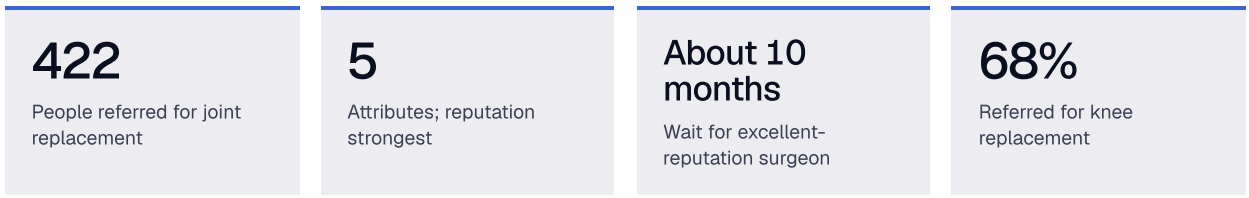
RIVAL EXPLANATION	STUDY AND SETTING	REPORTED RESULT	WHAT IT DOES NOT SHOW
Quality differences	Cooper et al.; US emergency admissions, ambulance-preference instrument	Hospitals with 2-standard-deviation higher prices: spending +53%; in-hospital mortality about 1 percentage point lower; benefit only in less concentrated markets	A brand premium, or the effect of raising one's own price
Physician-market concentration	Dunn and Shapiro; US commercial claims, cardiology and orthopaedics	A 10% increase in concentration associated with roughly 0.5–1% higher fees in cross-sectional estimates	A physician-name premium; based on the abstract and working-paper introduction only
Multispecialty bargaining	Baker, Bundorf and Kessler; 2008–2012 claims for about 40 million commercially insured people	Integration associated with higher office-visit prices, with larger effects where complementary-specialty markets were concentrated	A separately identified brand effect, or any effect on surgical fees
Payer competition (not independently checked)	Ho and Lee; California bargaining model, publisher abstract only	Simulated insurer removal produced renegotiated hospital price increases and decreases of up to about 10%	An observed insurer exit, or a fee forecast for Jordan

Source: [407–410]. The payer-competition row was not selected for independent verification and carries no weight in the conclusions.

Reputation nevertheless has measurable preference value. In a 2018 discrete-choice experiment, 422 people referred for total joint replacement made 12 hypothetical choices that varied surgeon reputation, selection process, consultation wait, surgery wait and travel time. Reputation was the strongest of the 5 attributes (Figure 7.2), and simulations indicated willingness to wait about 10 months for an initial consultation with an excellent-reputation surgeon rather than switch to one with a good reputation [391]. The endpoint is the initial consultation, not surgery. The study contains no monetary-price attribute, and only its abstract was reviewed. It supports testing preference; it does not justify applying a cash markup, and stated willingness to wait cannot be relabelled as willingness to pay.

FIGURE 7.2

Stated preference for surgeon reputation in a joint-replacement discrete-choice experiment



Source: Osteoarthritis and Cartilage, abstract indexed by the US National Library of Medicine [391]. Hypothetical choices; the wait is modelled, not observed, and is for an initial consultation, not surgery; no monetary attribute; abstract only.

WHAT THIS MEANS FOR A PRACTICE

The relevant test is to compare actual fees and contribution by procedure, payer, clinician and site, and separately to measure whether patients ask for the surgeon by name and which alternatives they considered. Neither the consumer-brand premium percentages nor the experienced-surgeon anecdote in the brand-strategy material consulted before the research supplies a surgeon's price elasticity (see Table 7.10). Fees and advertising remain subject to Jordanian rules (see Chapter 3). The Jordan Medical Association passages that restrict advertised offers, discounts and free or reduced treatment, and that refer to the fee schedule, do not make internal measurement of fees actually received impossible; nor do they establish unrestricted pricing freedom [8].

7.3 What keeps patients and referrals connected

The evidence supports several distinct mechanisms rather than a single undifferentiated form of patient captivity. Each mechanism has a different owner and a different implication for what could transfer if the founder were absent (Table 7.5).

TABLE 7.5

Mechanisms that connect patients and referrals, with evidence and limits

MECHANISM	EVIDENCE	WHAT IT DOES NOT ESTABLISH
Clinical continuity	Matched Medicare study, 359,470 beneficiaries, 2008–2017: losing a primary-care physician was associated with 18.4% fewer primary-care visits and 6.2% more specialty visits in the following year, persisting 2 years and larger after solo-practice departures	A named surgeon's retention rate, or a valuation of a name
Repeated professional relationships	2012 Massachusetts claims, 284,604 chronically ill patients: 1 standard deviation more referral concentration associated with 3.9% lower price-standardised utilisation in the baseline model; estimates varied by specification	A direct measure of brand; that every shared patient was deliberately referred
Organisational routing	3 clinic acquisitions in the Twin Cities in 2007, 12 clinic systems, 2006–2011: new ownership shifted inpatient and imaging use toward the acquiring systems, with effects varying across acquisitions; about half of allowed charges for patients mainly using integrated primary care occurred outside their system	That a new name or advertising caused the shift
Reputation as a stated criterion	2022 survey of 1,708 Jordanian adults: reputation rated important by 88.5% of male and 92.9% of female respondents	Actual switching, referrals or willingness to pay
Referral source versus choice history	808 elective hip and knee arthroplasty (joint-replacement) patients at 4 US institutions, 2024–2025: 44.9% first heard of the surgeon from a clinician; 51.9% had consulted another orthopaedic surgeon	A longitudinal retention measure
Established relationship versus initial choice (not independently checked)	Massachusetts tiered-network study, fiscal 2009–2010: no detectable association between tier ranking and existing patients switching; the worst tier had a 10% relative loss of new-patient market share among older or sicker patients and a 15% relative loss among men	Whether persistence reflects trust, habit, continuity, information or switching friction

Source: [7, 392, 393, 411–413]. The final row was not selected for independent verification.

FIGURE 7.3

Change in visits after a primary-care physician's departure

−18.4%	+6.2%	−21.5%
Primary-care visits	Specialty visits	Primary-care visits, solo practice

Source: Sabety, Jena and Barnett, matched difference-in-differences study of 359,470 Medicare beneficiaries, 2008–2017 [392]. The first 2 changes refer to the year after departure; the source gives no separate time window for the solo-practice figure. Visit-volume changes relative to controls, not percentages of patients retained.

Clinical continuity has direct observational evidence, but it is primary-care evidence from the United States, read from the study's abstract. A primary-care physician's exit differs from a founder surgeon selling, retiring from a named practice, moving cities or pausing public communication, and the percentages in Figure 7.3 should not be applied to any individual surgeon [392]. Repeated professional relationships may matter for coordination, although the Massachusetts research did not directly measure brand [411]. Organisational routing shows that a flow of patients inside a system can reflect ownership and arrangements as well as preference; integration did not produce exclusive capture [393].

The only Jordanian evidence is stated preference. Jordanian respondents rated reputation and expertise highly, but the survey was recruited through social-media forums and public facilities, its main objective was surgeon-gender preference, and its sample was weighted toward educated, Amman-based and health-related respondents. It did not track actual switching or willingness to pay [412]. Chapter 6 holds the survey's results by sex and the composition of its sample. The survey of 808 arthroplasty (joint-replacement) patients separates referral source from choice history: many respondents first heard of the surgeon from a clinician, while more than half had consulted another orthopaedic surgeon. These are self-reports about different stages of the decision, not a retention measure [7]. Chapter 9 sets out how these patients first heard of their surgeon. A further survey of 329 orthopaedic patients in Las Vegas, which was not independently checked, reported that 8.5% named an internet search or website as their referral source while 39.5% researched online before the first visit; discovery and later checking are different measures, and neither estimates the causal contribution of an online presence [364].

> WHAT THIS MEANS FOR A PRACTICE
>
> The asset hypothesis worth testing is dependable access, confidence and continuity that persist across appropriate episodes of care. More repeat surgery is not a desirable brand metric by default. The evidence does not justify obstructing patients' records or their ability to choose another clinician, and no study reviewed establishes that installing an enterprise software system creates a competitive moat.

7.4 What sold, and whether the name was priced

Transactions in the record show that medical businesses and legal rights to names change hands. None of the records reviewed reveals a separately priced surgeon name (Table 7.6, Figure 7.4 and Figure 7.5).

TABLE 7.6

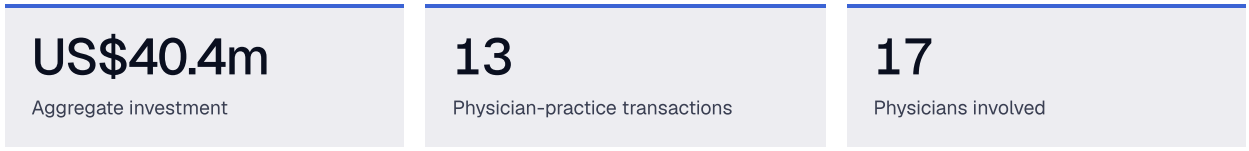
Documented transactions and rights structures, and what they leave unknown

CASE	WHAT THE ORIGINAL RECORD ESTABLISHES	WHAT REMAINS UNKNOWN
Fortius / Affidea, March 2021	Acquisition of a clinician-founded orthopaedic group (founded 2009; more than 90 specialists, 3 outpatient and diagnostic clinics, a surgical centre and a Bupa joint-replacement partnership), with the Fortius identity retained	Purchase price, founder-retention terms and a separate name allocation
Surgery Partners, 2015	US$40.4m aggregate investment across 13 physician-practice transactions involving 17 physicians	A price for any individual surgeon's name; a Jordanian orthopaedic multiple
Wider Surgery Partners acquisitions, 2015	A preliminary allocation distinguishing US$7.539m of identifiable intangible assets from US$113.812m of excess fair value over identifiable net assets, across a broader acquisition perimeter	How much of either category represented a surgeon's reputation
HMG, 2020 prospectus	Company-owned registered trademarks and 7 subsidiary consent agreements for their use, alongside explicit clinician-dependence risks	A counterfactual valuation with the founder or prominent clinicians removed
Mediclinic	The offer underlying the 2023 acquisition valued Mediclinic's equity at about £3.7bn; a 1 July 2026 notice documents subsequent separation of the Southern African and Swiss operations	A stand-alone price for the Mediclinic name

Source: [18, 311, 394, 395, 406]. Issuer announcements are self-interested; only transaction and structure facts carry weight. The figures are in different currencies, units and perimeters and are not comparable with one another.

FIGURE 7.4

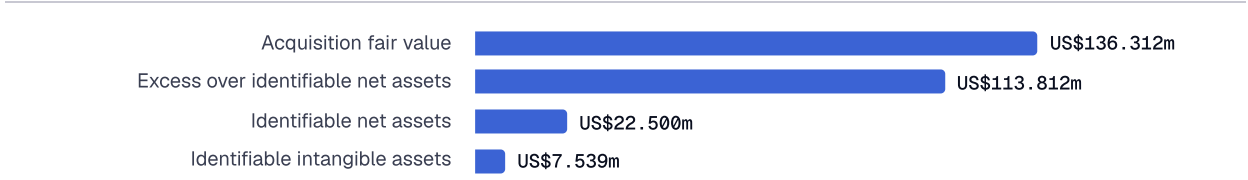
Surgery Partners' 2015 physician-practice transactions: disclosed totals, with no allocation to any surgeon's name



Source: Surgery Partners 2015 Form 10-K, note 3 [18]. The group spans several specialties; neither an individual surgeon's goodwill nor a Jordanian orthopaedic multiple follows.

FIGURE 7.5

Surgery Partners' preliminary 2015 acquisition allocation, all acquisitions combined



Source: Surgery Partners 2015 Form 10-K, note 3 [18]. Bars are separate lines of the allocation and are not additive; US$136.312m fair value equals US$22.500m identifiable net assets plus US$113.812m excess. The allocation was preliminary, covers more acquisition types than the 13 practice transactions, and does not isolate surgeon names; the excess reconciles to goodwill in note 6.

The documented conclusion is the transferability of businesses and legal rights, not a measured universal brand share of their value. Goodwill is not automatically the brand. A continuing name after a sale is evidence that the identity continued, not proof that demand or price would survive the founder's departure unchanged. The Affidea case also shows the converse: after acquiring Schoen Clinic London, the buyer announced that the hospital would become Fortius Clinic London, acquiring clinical capacity while replacing the acquired name. That announcement was not independently checked and does not show that the rebrand caused growth [414]. In the HMG prospectus, the trademark consent agreements run to registration expiry

and may be terminated by the company by written notice without compensation, while the risk section connects clinician reputation and patient relationships to patient choice [311]. Owning the corporate name did not remove the disclosed people risk. Absence of a disclosed allocation is an unknown, not proof that a name had zero value.

For future diligence, the study separates 8 elements. This is a research checklist, not a proposed sale or a valuation of any clinic.

- Ownership of names and marks
- Contractual use rights
- Physician employment and partnership terms
- Quality and care systems
- Referrer relationships
- Site and insurer access
- Earnings dependent on the founder
- Transition evidence

7.5 What an overseas name arrangement buys

The cases reviewed show a famous identity travelling with different combinations of expertise, governance, operations and rights. Subscription, management and direct operation are not the same economic arrangement, and none of the records discloses a name-only fee (Table 7.7 and Figure 7.6).

TABLE 7.7

Famous medical-name arrangements beyond the home institution, and the limits of what they show

MODEL	DOCUMENTED ARRANGEMENT	LIMITS ON THE INFERENCE
Mayo Clinic Care Network	Independent providers subscribe to specialist knowledge and clinical, educational and operational services; Mayo explicitly distinguishes this from ownership or operation	No membership price or name-only royalty was established
Mayo network identity at Augusta Health	Published brand-use rules require Mayo approval of co-branded material, keep the member logo at least as large, and prohibit implying legal partnership or market exclusivity	A single member's published rules, not the complete signed contract
Cleveland Clinic Abu Dhabi	The 2019 issuer document describes management for Mubadala; a February 2025 announcement identifies the hospital within the M42 group	Historical management evidence does not disclose current terms or a brand-only fee
Moorfields UAE	The 2024/25 accounts describe branch operations including Dubai and an Abu Dhabi joint venture; the Commercial segment also contains UK private care and the West End business	Combined commercial results cannot be labelled Dubai brand royalties

Source: [324, 396, 397, 415, 416].

FIGURE 7.6

What travels with a famous medical name in 4 arrangements

	Who owns or runs the site	What travels with the name	Name-only fee disclosed
Mayo Clinic Care Network	Independent member	Specialist, clinical, educational and operational services	No
Mayo identity at Augusta Health	Independent member	Co-branding under Mayo approval	No
Cleveland Clinic Abu Dhabi	Managed for Mubadala (2019); M42 group (2025)	Management	No
Moorfields UAE	Dubai branch; Abu Dhabi joint venture	Branch operations and a joint venture	No; results pooled in a wider segment

☐ Documented in the record reviewed ☐ Not disclosed (unknown, not zero)

Source: [324, 396, 397, 415, 416]. Absence of a disclosed fee is an unknown, not evidence that no payment exists.

Cleveland Clinic Abu Dhabi describes itself as a physician-led facility with multidisciplinary teams across more than 50 specialties. The provider presents the arrangement as more than a name applied to a local office; this self-description was not independently checked and carries no evidential weight [329]. Aspetar is treated as background only: its overview attributes its international reputation to athlete services, accreditations, research, education and sports partnerships, but quantifies no royalty, sale value or causal financial return [417]. The cases support 2 practical cautions. A licence price should not be inferred from an institution's revenue or patient counts, and ownership of the trade name, scope of permission, clinical support, quality controls, personnel and payments should be separated before any arrangement is valued.

> **WHAT THIS MEANS FOR A PRACTICE**
>
> The shorthand of licensing a name becomes a question about the exact agreement: who owns the mark, what permission is granted, which clinical support and quality controls travel with it, and what is paid. A future institution or partnership would need defined clinical and operating substance as well as a name. Which structure suits a given practice remains its own strategy decision (see Chapter 8 and Chapter 11).

7.6 Capacity, leading measures and a measurement framework

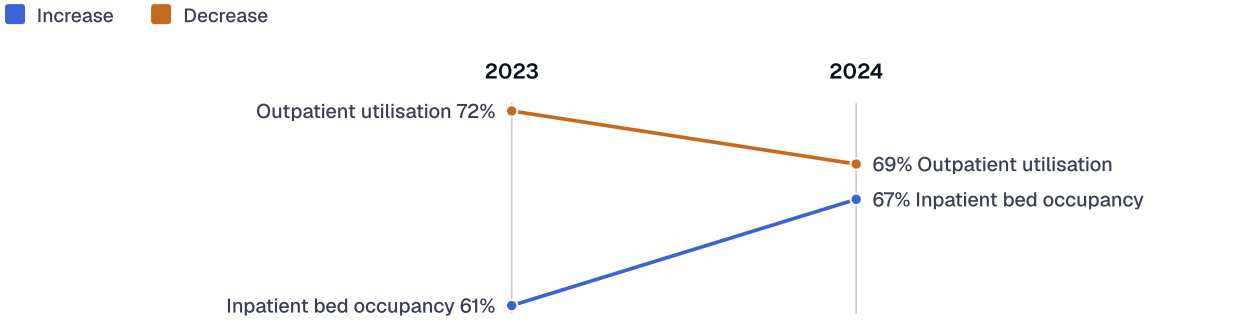
There is evidence that a public reputation signal can move demand. Pope's 2009 study connected changes in published hospital rankings with changes in non-emergency Medicare admissions, using California hospitals for 1998–2004 and nationally sampled hospitals for 1994–2002, with hospital-specialty fixed effects, quality-score controls and placebo tests; it reports about 1% more volume per national rank position [19]. It is historical US hospital evidence. It cannot distinguish whether patients or referring clinicians responded, and it does not estimate the return on a surgeon's social following. The same paper warns that capacity constraints can prevent extra demand from appearing as extra admissions [19]. Waiting, appropriate enquiries and available capacity therefore belong beside volume. It does not follow that a surgeon with a full calendar should automatically spend more, or less, on public profile; the future opportunity and the present service constraint are separate decisions.

Burjeel Holdings' 2024 disclosure gives a concrete operating example. After adding 188 doctors, to a total of 1,744, outpatient visits rose 7.3% while outpatient utilisation fell to 69% from 72% in 2023; inpatient bed occupancy, a separate measure, rose to 67% from 61% (Figure 7.7) [398]. Revenue rose 10.5% while EBITDA excluding one-offs fell 5.8% (Figure 7.8), and management cited AED52m of new-facility ramp-up losses and AED47m of increased marketing investment for international patients and expansion; these financial figures

were also checked during independent verification, though outside the 31 formally counted checks. The example demonstrates the importance of the denominator: more patients do not mechanically imply higher utilisation, and higher revenue during expansion is not proof of higher current profit. It does not isolate an effect of brand spending, and it is management's report rather than an independent causal evaluation.

FIGURE 7.7

Burjeel Holdings: outpatient utilisation fell while inpatient occupancy rose, 2023 to 2024



Source: Burjeel Holdings FY 2024 Management Discussion & Analysis, printed pp. 5–6 [398]. Company-reported indicators; no causal brand attribution.

FIGURE 7.8

Burjeel Holdings in 2024: volume and revenue growth without an immediate profit gain

+7.3%	188	+10.5%	−5.8%
Outpatient visits	Doctors added, to a total of 1,744	Revenue	EBITDA excluding one-offs

Source: Burjeel Holdings FY 2024 Management Discussion & Analysis [398]. Dated management disclosure, not the latest financial performance.

The Hospital for Special Surgery offers a capacity example with a lesson about dating. An older Spanish-language project page still described a planned 2025 opening of the Kellen Tower; the independent verification pass recovered a newer HSS announcement of its opening in March 2026, which supersedes the old page's apparent status. That update was checked outside the 31 formally counted checks [45]. Opening a facility establishes a capacity and access investment, not a brand-only financial return, and changes in the share of private rooms should not be translated into additional total beds or achieved throughput.

The closest predictive measure found was patient experience, not recall or search share. In 132 Swiss acute-care hospitals, previous-year patient experience was associated with following-year standardised revenue in the private-hospital subgroup, while the combined-sample profit relationship was not statistically significant [399]. Table 7.8 sets the finding beside the sample it rests on and the limits that apply; an internally inconsistent unadjusted-revenue passage in the article is a reason to use the adjusted results cautiously rather than to promote a headline return.

TABLE 7.8

Swiss patient-experience study: the finding, the sample and the limit

FINDING	SAMPLE	LIMIT
Previous-year patient experience (2016–2018) associated with following-year standardised revenue (2017–2019): adjusted coefficient 1789.83 (p = .037)	Private-hospital subgroup: 50 of the 132 Swiss acute-care hospitals	Observational; revenue standardised by DRG cost weights; the coefficient refers to a 1-point increase in experience, not a percentage uplift; an internally inconsistent unadjusted-revenue passage means the adjusted results are used cautiously
Profit relationship not statistically significant (p = .240)	Combined sample: 132 hospitals (82 public, 50 private)	The 5 survey items concern delivered care rather than brand; no causal or out-of-sample brand forecast was validated

Source: Giese et al., European Journal of Health Economics [399]. Experience measured 2016–2018; finances 2017–2019. Observational association only.

No validated relationship for any individual surgeon, from recall, search share, reviews or followers to future earnings, was established in the evidence reviewed. The brand-strategy frameworks consulted before the research propose pairing brand health with business outcomes. Table 7.9 treats that proposal as a research design: its predictive performance has not been validated for any practice.

TABLE 7.9

A measurement framework to test, not a validated practice dashboard

BRAND-SIDE OBSERVATION	BUSINESS OR CLINICAL-SIDE OBSERVATION	MAIN CONFOUND TO KEEP VISIBLE
Unaided recall and correct attribution for a relevant care need	New appropriate enquiries by city	Reach, sampling and seasonality
Requests specifically for the surgeon	Available slots, waits, deferred or lost enquiries and accepted alternatives	Capacity and clinical triage
Consideration and perceived expertise	Actual provider choice and reasons	Insurance, travel, price and urgency
Referrer recognition and confidence	Active referrers, concentration and appropriate referrals	Ownership, referral agreements and specialist access
Preference for the surgeon's name versus the centre	Appropriate demand retained during absence or with another clinician	Case mix, introductions and continuity arrangements
Brand trust following a service failure	Complaint resolution, access and clinical quality indicators	Severity, disclosure and changes in care delivery
Claimed pricing power	Collected fees and contribution for comparable care	Payer contracts, procedure complexity, site and clinician

Source: Research design proposed by the brand-as-asset desk study [405], informed by [19, 398, 399].

Any such measurement should use aggregate information and an appropriately governed research design. A larger follower count, a high review score or a full appointment book cannot by itself answer all 7 rows. Recurring care, referrals and clinically appropriate follow-up should be distinguished from repeat procedures.

> LIMIT
>
> Patient experience is a candidate diagnostic measure, not a proven brand-equity predictor. A local baseline would be required before any forecasting relationship could be validated for any practice, and no study reviewed selects the optimal response to a full surgical calendar.

7.7 What survives a crisis, and what decays in silence

A name, an operating institution, a licence to practise, patient trust and an equity investment can have different outcomes in a crisis. The separation is illustrated by 2 historical cases (Figure 7.9, Figure 7.10 and Figure 7.11).

NMC Health Plc entered administration in April 2020. On 25 March 2022 the joint administrators announced that 34 operating companies would leave administration and move into a new NMC group under creditor ownership, supported by a US$325m funding facility; NMC Healthcare Ltd and NMC Holding Ltd remained in administration to pursue litigation [400]. On 17 November 2023 the Financial Conduct Authority censured the old listed company, describing debt understated by as much as US$4bn and a dated expectation that no funds would remain after creditor claims [401]. Continued operations therefore cannot stand in for preserved former-shareholder value, and they do not prove that patient trust was unchanged.

FIGURE 7.9

NMC: operating continuity and the old company's financial position diverged

34	US$325m	Up to US$4bn
Companies to creditor group (2022)	Creditor funding facility (2022)	Understated debt, per the FCA (2023)

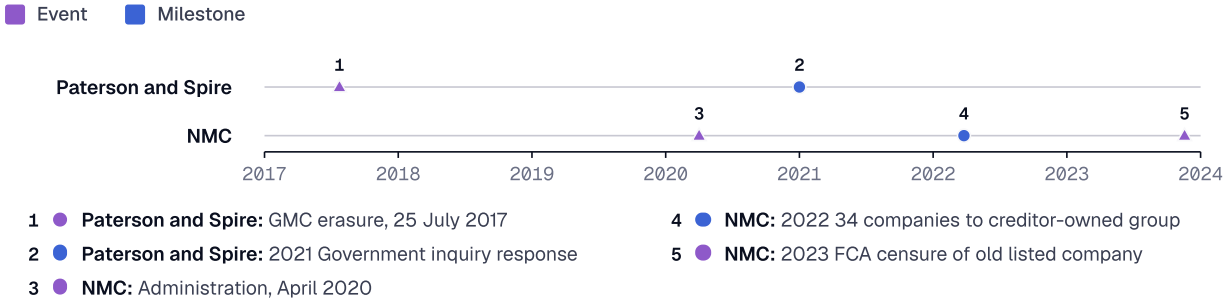
Source: [400, 401]. The FCA figure concerns the old listed parent; no final creditor or shareholder recovery is asserted.

The Paterson case shows a different separation. The General Medical Council announced the surgeon's erasure from the medical register on 25 July 2017, following a criminal conviction [402]. Spire Healthcare's later official statement documents continuing hospitals and compensation and remediation commitments [403]. This was a criminal misconduct case, not an ordinary complication, and it does not establish how a comparable Jordanian practice would respond. These records neither value the reputational damage nor show that public trust recovered. The 2 cost figures for 2024 attributed to Spire's annual report could not be reopened during independent verification, despite multiple routes being tried; they carry no weight in this report.

The 2021 government response to the independent inquiry reported that private-provider responsibility had been obscured by a "renting a room" understanding of practising privileges, and identified monitoring and accountability gaps; a later implementation update reaffirmed provider responsibility for quality and safety irrespective of the engagement model [418, 419]. The research implication is to examine the clinical governance, responsibility for complaints and continuing care that sit behind a medical name. It is not proof that a brand architecture or a governance checklist guarantees survival, and UK rules do not transfer to Jordan.

FIGURE 7.10

Dated events in the 2 crisis cases, 2017–2023



Source: [400-402, 418]. Positions within a year are approximate to the month. The 2021 government response is placed at the start of the year because its month is not given in the sources.

FIGURE 7.11

In a crisis, different assets have different outcomes

	NMC	Paterson and Spire
Operating institution	34 companies continued (2022)	Hospitals continued; remediation ongoing
Old company's finances	No funds expected after creditor claims (2023)	Not applicable
Surgeon's licence	Not applicable	Erased, 25 July 2017
Patient trust	Not measured	Recovery not established

Continued · Continued with ongoing remediation · Lost, or expected to be lost · Not applicable or not measured

Source: [400–403].

The study found no defensible numerical half-life for a physician's brand after the physician stops posting. The social-media study examined 650 physicians from 10 highly ranked US hospitals cross-sectionally, measuring public profiles, monthly activity, followers and research-network activity; it did not follow a stopping event into later recall, referrals, revenue or trust [404]. It can establish neither that silence destroys the asset nor that silence is harmless. The bounded search comprised 3 targeted searches and found no longitudinal estimate, which does not prove that none exists.

A future test would track separately 5 elements that need not move together: platform distribution, spontaneous recall, referrer activity, appropriate enquiries and established clinical relationships. This is a measurement proposal, not a proven order of decay or a posting-frequency prescription.

> LIMIT
>
> Reduced social activity, loss of a licence, financial misconduct and founder absence are different mechanisms that require different evidence. None of the cases supplies a posting frequency, a decay half-life or a valuation multiplier for any individual practice, and nothing here shows that a dormant audience has durable economic value.

7.8 Retired claims, open tensions and a practice's own questions

The study tested several positions drawn from preliminary planning material. Table 7.10 records how each was disposed of. Table 7.11 records the tensions that the evidence holds open and how the study resolved them for analytical purposes.

TABLE 7.10

Prior positions tested, and their disposition

PRIOR POSITION	DISPOSITION	WHAT THE EVIDENCE SHOWS
Professional services cannot win on scale; accumulated knowledge and enterprise software form a clinic's strategic moat	Reworked as hypotheses	No scale economies or software-caused moat were estimated; continuity and coordination have evidence; multi-site hospital growth is observable
An experienced surgeon's standing transfers directly into premium pricing	Retired as evidence for a fee premium	A teaching anecdote and a willingness-to-wait study do not estimate realised pricing power

PRIOR POSITION	DISPOSITION	WHAT THE EVIDENCE SHOWS
Price and full-price measures cannot exist because advertised offers are banned	Corrected	The JMA provisions concern advertising and refer to the fee schedule; they do not ban internal measurement, nor prove unrestricted pricing freedom
Overseas institutions simply license their name	Refined	Each contractual or ownership model must be studied separately; subscription, management and direct operation differ
Persistent institutional names (Chapter 5) and the separation of recognition, clinical benefit and uniqueness (Chapter 6)	Retained with limits	A surviving identity does not by itself price an asset; recognition, clinical evidence and economic transferability remain separate tests

Source: [8, 324, 391, 392, 396-398].

TABLE 7.11

Contradiction ledger

TENSION	RESOLUTION
Reputation can matter to choice, yet a universal fee premium is unproven; stated surgeon preferences and price-disclosure studies answer different questions	Retain preference as a plausible value channel, but require matched realised-price evidence before pricing its financial contribution
Continuity creates value, yet patient flow need not be voluntary brand loyalty; organisational routing also moves demand	Measure each mechanism separately; do not label the total brand captivity
Names can be owned, yet reputation still depends on people; HMG documents trademark permissions and clinician risk in the same prospectus	Legal rights are necessary evidence about control, not sufficient evidence of founder-independent earnings
A famous identity can travel through different structures: subscription, management and direct operation	Value the actual bundle and contractual perimeter, keeping all undisclosed royalties unknown
A reputation signal can attract demand while volume stays flat, because capacity limits what is observed	Read demand, available capacity and completed care together; no automatic budget rule follows
Institutional continuity is not universal asset preservation: NMC operations continued while old-company creditor claims were expected to exhaust funds; Paterson's sanction differs from Spire's remediation	State whose rights, funds, care access or trust survived, and at which date

Source: [17, 19, 311, 324, 391-393, 396, 397, 400-403, 411, 412, 416].

This desk study does not supply a monetary brand valuation, a permitted fee increase, a founder-exit retention rate or a posting-silence decay curve for any individual surgeon. The practice inputs that the study records as absent from the public evidence are listed below; none was inspected or estimated [405].

- Fees actually paid, by payer and procedure
- Contribution margins
- Available operating capacity
- Referrer concentration
- Continuity after absence
- Ownership and licensability of names and data
- Financial accounts

The next evidence needed is narrower than a generic brand audit. It is organised as 6 questions (Figure 7.12 and Figure 7.13), each of which requires a practice's own records (aggregate operating data and ownership documents).

FIGURE 7.12

Questions a practice's own records must answer: demand

DEMAND	TRANSFER	SOURCES
1. Who is requested? The surgeon by name, a procedure, the clinic or whoever is available, and how often the patient's first preference is unavailable.	**2. What can move?** Whether appropriate demand transfers to another clinician or site, and under which explanation or introduction.	**3. Who supplies demand?** Patient self-selection, referring clinicians, families, employers, insurers and institutional agreements, without collapsing them into a single referral number.

Source: Open questions set by the brand-as-asset desk study [405].

FIGURE 7.13

Questions a practice's own records must answer: constraint, ownership and resilience

CAPACITY	RIGHTS	RESILIENCE
4. What is scarce? Consultation availability, theatre access, support staff, clinical capacity or demand; the constraint may differ between sites or cities.	**5. What can be owned and transferred?** The names and marks, legal permissions, operating relationships and care systems; this cannot be inferred from an account's follower count.	**6. What persists through disruption?** Appropriate care, access, trust and referral relationships during planned absence or a complaint, measured without manufacturing a crisis or withholding care.

Source: Open questions set by the brand-as-asset desk study [405].

These questions are inputs to second-phase fieldwork and later strategy. They do not authorise fieldwork, access to patient records, a sale, a pricing change or a software build. Chapter 8, on market entry, is where these distinctions bear on what travels when a practice enters a new city and what must be built locally; Chapter 11 turns to implications and next steps.

LIMITS OF THIS EVIDENCE

- The study supplies no monetary brand valuation, permitted fee increase, founder-exit retention rate or posting-silence decay curve for any individual surgeon.
- Most realised-price and observed-flow evidence is historical and from the United States, largely commercial insurance or Medicare; it does not identify an Amman, Irbid or Jordanian surgeon premium.
- The only Jordanian evidence is a general-adult stated-preference survey weighted toward educated, Amman-based and health-related respondents, not revealed choices among orthopaedic patients.
- Several claims rest on original abstracts only, including the joint-replacement discrete-choice experiment, the primary-care turnover study and the physician market-power study.
- Company announcements, prospectuses and provider descriptions are self-interested; they establish transactions, structures and acknowledged risks, not brand value, clinical superiority or causal returns.
- Private contract terms, royalty rates, founder-retention clauses and founder-exit counterfactuals were unavailable; undisclosed allocations are unknowns, not zeros.
- The 2 cost figures for 2024 in a hospital group's annual report could not be reopened during independent verification and were excluded; some other original documents and later-year reports could not be retrieved, so dated cases are not presented as the latest position.
- The 50 evidence-source URLs are not 50 independent studies, and shared sources across perspectives are not independent corroboration; confirmation reflects bounded wording, not causal certainty.
- The Swiss patient-experience study contains an internally inconsistent unadjusted-revenue passage; only its adjusted results are used, and cautiously.
- The search for a brand-decay estimate was bounded to 3 targeted searches and cannot prove that no longitudinal study exists.
- Some PDF tables were read from extracted text rather than inspected in their original page layout.
- No practice's own financial, capacity or transition data were inspected, and no patient-level material was collected.

LEFT OPEN

- Who is requested: the surgeon by name, a procedure, the clinic or whoever is available, and how often is the patient's first preference unavailable?
- What can move: does appropriate demand transfer to another clinician or site, and under which explanation or introduction?
- Who supplies demand: patient self-selection, referring clinicians, families, employers, insurers or institutional agreements, measured separately rather than as a single referral number?
- What is scarce: consultation availability, theatre access, support staff, clinical capacity or demand, and does the constraint differ between sites or cities?
- What can be owned and transferred: the names and marks, legal permissions, operating relationships and care systems behind the practice?
- What persists through disruption: appropriate care, access, trust and referral relationships during planned absence or a complaint?
- Which ownership or partnership structure, if any, should carry a future institution or overseas presence remains each practice's strategy decision; the evidence documents options without selecting one.
- Unresolved evidence gaps remain: name-only transaction allocations, founder-departure price effects, private contract royalties, reliable decay rates for a silent doctor, and local brand-to-earnings estimates.

CHAPTER 08

Market entry: the capital and beyond

What carries when a surgical name enters a new city, what must be rebuilt locally, and what the available numbers can and cannot size

EVIDENCE BASE MARKET ENTRY	45 Claims generated	38 Put to verification	37 Confirmed	0 Refuted	1 Unverified	47 Sources recorded	295 Research actions

CHAPTER SUMMARY

This chapter assesses what carries when a surgical name enters another city or country, what must be rebuilt, and what evidence would make it commercially and operationally assessable for a practice from a secondary city to enter the capital and later go abroad. For a practice that already consults in the capital, the question is the incremental value of an owned clinic, not first entry. Dated institutional expansion histories (HMG, Rothman, Moorfields) show names entering alongside local staff, facilities and partners; 1 individual relocation is documented as a move only, and no case isolates a name-only return. Records for Mediclinic and Cleveland Clinic Abu Dhabi show underperformance and delay; King's Dubai shows a partner-backed structure whose accounts do not isolate a Dubai result; none shows measured brand destruction. Patient-choice studies from other settings show that some patients bypass nearby care and many research online, but supply no Jordanian patient-flow series or follower-conversion rate. Official Jordanian statistics frame the market without sizing it; the 2015 census shows lower insurance coverage but a higher private-insurance share in Amman. The chapter sets out the contribution equation, an illustrative sensitivity, 4 operating tracks for Amman and the preparation that keeps Dubai and US options open, and leaves the investment decision with the practice.

KEY FINDINGS

01 The documented institutional expansions paired a name with local capacity: HMG converted a 2007 Dubai outpatient centre of 80 clinics into a 165-bed general hospital in 2015, and Rothman's first Winter Park office opened on 1 July 2021 after a 2020 hospital partnership [12, 26].

02 No source isolates a name-only expansion return; Moorfields' 2017/18 accounts combine UK private care and UAE operations in 1 Commercial segment, so standalone Dubai profit cannot be read from them [46].

03 Established medical names did not guarantee stable activity or timing: Mediclinic's acquired Abu Dhabi business saw FY2017 pro-forma revenue fall 19% while Dubai revenue rose 5%, and Cleveland Clinic Abu Dhabi, expected to operate in 2013, reached full operation in May 2015 [420–422].

04 Patients travel past nearby care within limits: 38% of 53,307 Dutch first orthopaedic visits in 2003 bypassed the nearest hospital, while extra travel time discouraged bypassing [423].

05 Online research is common but is not acquisition: 39.5% of 329 Las Vegas attendees researched online, yet 8.5% attributed their referral to internet search, and 63.6% of 341 Saudi respondents used digital information before consultation [364, 424].

06 Amman Governorate's estimated end-2025 population of 5,004,600, against 2,210,500 in Irbid, is geographic context, not a clinic catchment or paying demand [27].

07 In the 2015 census, 41.2% of Amman residents were insured against 55.5% nationally, yet private insurance covered 22.1% of insured Jordanians in Amman against 12.3% nationally [425].

08 Payment access is a separate input: 97.5% of insurer medical-claims value in 2024 was paid in network, and the 1,015.4 thousand annual private-coverage count includes repeat counting [426].

09 Break-even volume depends on retained contribution: at assumed contributions of JOD 10, 20 or 30, each JOD 1,000 of monthly cost needs 100, 50 or 34 completed units; these are illustrative assumptions, not observed fees [427].

10 Dubai registration lasts 1 year and its 5-working-day review is only 1 stage before facility activation, and DHA asks for a surgical logbook covering at least the last 2 years [428–430].

8.1 The decision and the evidence base

The decision this chapter informs is how a practice based in a secondary city can enter the capital, Amman, and later go abroad. Entry can take several forms, from a consulting branch to an owned clinic; where a practice already consults in Amman, the relevant quantity is the incremental value of an owned clinic beyond that branch. The chapter also sets out the preparation that would keep a later move to Dubai or the US possible [431].

The most defensible inference is that a medical name can support entry, while an operating practice still needs local clinical capacity, relationships and payment access. HMG staged its Dubai outpatient and hospital operations; Rothman entered new metropolitan areas alongside hospital partners; Moorfields describes resident staff and local governance behind its overseas service [12, 26, 432, 433]. These histories do not isolate a name-only return. Official population and financing figures establish context, not any practice's accessible orthopaedic demand, fee premium or break-even volume [27, 426, 434].

The chapter rests on a web-only desk study completed on 19 September 2026. The study examined the market-entry question from 6 distinct analytic perspectives (economics and sizing, expansion history, Amman competition, regulation and operations, patient geography, and a sceptical perspective dedicated to testing popular claims), which generated 45 research claims; the economics perspective was examined within the study's coordinating pass and the other 5 as separate perspective passes. An independent verification pass then formally checked 38 of the claims against the retrieved sources: 37 were confirmed, 0 were refuted and 1 remained unverified (see Appendix A). Of the 7 claims not formally checked, 3 (the HMG Saudi sequence, the Moorfields Dubai operating account and the Madaba checklist) were confirmed in separate background checks within the study's coordinating pass; this chapter labels them background-checked, not independently verified, and they are not formal verdicts. The study drew on 47 distinct evidence-source URLs; the high confirmation rate shows that bounded claims survived checking, not that expansion is certain [431]. The chapter also draws 1 set of 2015 insurance-census figures and 2 later records (a 2025 acquisition and the 2024 national fee schedule) from the brand-strategy study reported in Chapter 9 [425, 435, 436].

> KEY FINDING
>
> Recognition may travel; access is built locally. The overseas operating cases in the evidence combined an existing name with staff, facilities and partnerships, and no source isolates what the name alone contributed to demand or profit [12, 433].

8.2 Expansion histories: sequences, setbacks and structures

Documented operating sequences

The evidence supplies dated operating sequences for 4 institutional cases and 1 individual relocation (Table 8.1). HMG's Saudi sequence (background-checked, not independently verified) began with Riyadh outpatient services in 1995, followed by its first integrated multispecialty hospital in Buraidah in 2009 and a Khobar hospital launch in 2019. Its Dubai entry was staged: an outpatient centre with 80 clinics opened in 2007 and was converted in 2015 into a general hospital with 165 beds and 6 additional clinics [26]. The 8-year interval describes this case, not a required wait, and the issuer's account reports no city-level return attributable to the brand.

Rothman's New York entry coupled a 2017 Northwell affiliation with a recently opened Tarrytown practice, the group's first in New York, and 6 hospital leadership appointments, documented in a release dated 21 September 2018 in which 2 Manhattan offices were still prospective [432]. A later record in the brand-strategy study reports that NYU Langone acquired Rothman Orthopaedics of Greater New York in January 2025 and that those practices now carry NYU Langone names (not independently checked); that study reads this as the name being lost at a partner's boundary (see Chapter 9) [435]. In Central Florida, a partnership with AdventHealth announced in 2020 preceded the first Winter Park office, opened on 1 July 2021 with 4 treating surgeons, 8 exam rooms and onsite x-ray, casting and bracing. Its therapy services, 18-physician roster and 2022 headquarters were plans, not completed outcomes [12]. Moorfields opened its Dubai branch in 2007; its 2017 operator account (background-checked, not independently verified) describes a resident specialist team, London-linked clinical governance and local licensing oversight as components of the transferred service, and names regional patients and expatriates already familiar with the name as part of the intended catchment. These are the operator's explanations, not measured causal effects [433]. The individual case is thinner: James Andrews moved his practice from Columbus, Georgia, to Birmingham in 1986, and the record documents only the relocation [437].

TABLE 8.1

Documented expansion sequences and what accompanied the name

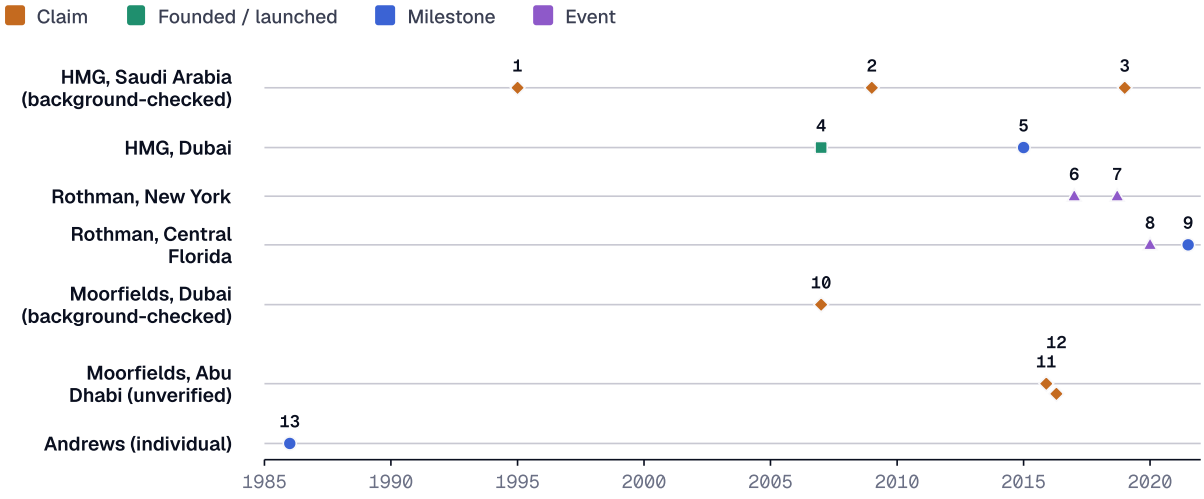
CASE	DOCUMENTED OPERATING SEQUENCE	WHAT ACCOMPANIED THE NAME	EVIDENTIAL LIMIT
HMG, Saudi Arabia and Dubai	Riyadh outpatient services 1995; Buraidah integrated hospital 2009; Khobar launch 2019. Dubai outpatient centre (80 clinics) 2007, converted to a general hospital (165 beds) in 2015	Clinics, later beds and a wider service system	Historical issuer account; the Saudi sequence is background-checked, not independently verified. 8 years is this case's interval, not a required wait. No city-level brand-only return
Rothman, New York	Northwell affiliation 2017; recently opened Tarrytown practice and 6 leadership appointments documented in a September 2018 release	Local hospital integration and clinical leadership	Manhattan office dates in the same release were prospective. No verified expansion profit. Practices acquired by NYU Langone in January 2025 (not independently checked)
Rothman, Central Florida	AdventHealth partnership announced 2020; first Winter Park office opened 1 July 2021	Local hospital partner, 8 exam rooms, imaging, casting and bracing	Additional services and recruitment in the release were plans, not completed outcomes

CASE	DOCUMENTED OPERATING SEQUENCE	WHAT ACCOMPANIED THE NAME	EVIDENTIAL LIMIT
Moorfields, Dubai	Branch opened 2007; 2017 operator account describes resident specialists and London-linked clinical governance under local oversight	Recruitment, facilities and a delivery and governance system	Background-checked, not independently verified. Operator explanations do not isolate why demand arrived or prove a name-only return
Moorfields, Abu Dhabi	Joint venture with United Eastern Medical Services documented; original records disagree on the official opening date	Local partner and clinical operating arrangements	UNVERIFIED as a composite claim: April 2016 (accounts) conflicts with a November 2015 inauguration release. No date is selected
Individual relocation (Andrews)	Moved practice from Columbus, Georgia, to Birmingham in 1986	Relocation documented; portability economics unknown	No matched Jordan or Levant case or causal financial comparison was established

Source: [12, 26, 46, 47, 432, 433, 435, 437]. The records establish stated historical milestones, not each operator's current footprint.

FIGURE 8.1

Dated milestones in documented expansion sequences, 1986 to 2021



1 **HMG, Saudi Arabia (background-checked):** 1995 Riyadh outpatient services

2 **HMG, Saudi Arabia (background-checked):** 2009 Buraidah integrated hospital

3 **HMG, Saudi Arabia (background-checked):** 2019 Khobar hospital launch

4 **HMG, Dubai:** 2007 Outpatient centre, 80 clinics

5 **HMG, Dubai:** 2015 General hospital, 165 beds

6 **Rothman, New York:** 2017 Northwell affiliation

7 **Rothman, New York:** Sept 2018 release: Tarrytown, 6 roles

8 **Rothman, Central Florida:** 2020 AdventHealth partnership announced

9 **Rothman, Central Florida:** 2021 First Winter Park office

10 **Moorfields, Dubai (background-checked):** 2007 Dubai branch opened

11 **Moorfields, Abu Dhabi (unverified):** Inauguration release, Nov 2015 (date disputed)

12 **Moorfields, Abu Dhabi (unverified):** Accounts date, April 2016 (date disputed)

13 **Andrews (individual):** 1986 Columbus, GA to Birmingham

Source: [12, 26, 46, 47, 432, 433, 437]. Month-dated events are placed at decimal years: the September 2018 release at 2018.7 (the Tarrytown opening date is not given), July 2021 at 2021.5, November 2015 at 2015.9 and April 2016 at 2016.3. Events drawn as claims were confirmed in background checks, not by formal independent verification: the HMG Saudi sequence and the Moorfields Dubai operator account. The Moorfields Abu Dhabi opening date is disputed: the accounts' April 2016 date conflicts with the November 2015 inauguration release, both are shown as claims, neither is selected, and the opening date remains UNVERIFIED.

The Moorfields Abu Dhabi joint venture with United Eastern Medical Services is documented, but its official opening date is not: the 2017/18 annual report states April 2016, while Moorfields' own inauguration release, displayed 28 November 2015, describes a completed ceremony. The composite claim, which also reports over 22,000 patients and over 700 surgical procedures, is therefore UNVERIFIED [46, 47]. The same ac-

counts combine UK private care and UAE operations, including Dubai and a share of the Abu Dhabi result, in a single Commercial segment, so neither standalone Dubai profit nor the value of the name can be read from them [46].

> LIMIT
>
> UNVERIFIED: the official opening date of Moorfields Abu Dhabi. Neither conflicting date is selected, and no recommendation in this report uses either [46, 47].

Taken together, the cases are consistent with Chapter 7's finding of no universal brand premium and no name-only expansion return. They make 3 configurations worth comparing on incremental contribution and access (continued consulting from a branch, an owned clinic and a hospital partnership) without choosing an architecture or facility for any practice [431].

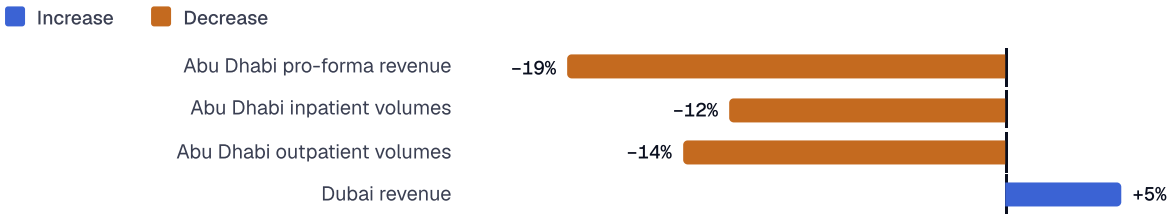
> WHAT THIS MEANS FOR A PRACTICE
>
> A decision to enter Amman compares configurations by what each adds beyond the practice's current arrangements. The dated sequences suggest staging questions, not a prescribed format; the choice remains the practice's own (see Chapter 5) [431].

Setbacks, delays and ownership structures

The evidence also documents underperformance, delay and selective exit, and ownership structures that are easily misread. Mediclinic's acquired Abu Dhabi business reported FY2017 revenue 19% below the prior year's pro-forma figure, with inpatient and outpatient volumes down 12% and 14%; the issuer discussed payer co-payment, staffing, integration, competition and disposals. The same release recorded a late Al Jowhara opening, postponed Western Region construction and selected disposals, alongside new openings, but also Dubai revenue up 5% and a positive Middle East operating profit of AED 134m, so the Abu Dhabi decline is not a regional collapse [420]. The release also records a February 2017 decision to rename the acquired Al Noor facilities, with AED 36m of accelerated amortisation of the trade-name asset (not independently checked); that is a rebranding and accounting decision, not a measure of patient awareness [420].

FIGURE 8.2

Mediclinic Middle East, FY2017: reported change by measure



Source: [420]. Abu Dhabi revenue is compared with prior-year pro-forma revenue. The same release reports a positive Middle East operating profit of AED 134m. The issuer does not estimate any effect attributable to the name.

Cleveland Clinic Abu Dhabi shows timing risk: Mubadala's December 2011 prospectus described a 364-bed project, with potential expansion to 490 beds, expected to operate in 2013; Mubadala later reported full operation in May 2015, with over 35,000 appointments and 1,500 procedures by its September 2015 release [421, 422]. In a 2011 interview, Cleveland Clinic's chief executive described moving personnel through the Mubadala relationship, with approximately 80 people already on the ground, and challenges of salary, culture and housing; this is a firsthand managerial account, not a quantified formula [438]. King's College Hospital's Dubai presence rests on an investment arrangement: Ashmore's 2016 report describes US$100m

raised for UAE healthcare private equity and work with King's and local equity partners, and the Trust's 2020/21 report places overseas work within KCH Management, which contributed a £0.93m surplus across a broader consultancy, recruitment and education business [439, 440]. The King's records establish an ownership and accounting structure, not a setback; the Trust's UK financial difficulties cannot be reassigned to Dubai [440].

TABLE 8.2

Expansion setbacks and ownership structures: what original records establish and what they do not

CASE	WHAT ORIGINAL RECORDS ESTABLISH	WHAT THEY DO NOT ESTABLISH
King's, Dubai	Ashmore's 2016 report describes investment with King's and local equity partners; the Trust's 2020/21 report places overseas work within KCH Management	A wholly owned NHS branch, the complete current shareholding or a standalone Dubai profit figure
King's, accounting scope	The Trust reports a £0.93m KCH Management surplus contribution across a broader business	Dubai hospital net profit; the Trust's UK financial difficulties cannot be reassigned to Dubai
Mediclinic, acquired Abu Dhabi business	FY2017 pro-forma revenue fell 19%; inpatient and outpatient volumes fell 12% and 14%; the issuer discusses payer co-payment, staffing, integration, competition and disposals	An estimate of damage caused by the name, or proof that the whole Middle East division failed
Mediclinic, projects	Late Al Jowhara opening, postponed Western Region construction and selected disposals	Uninterrupted expansion, or proof that a delay destroyed brand equity
Cleveland Clinic Abu Dhabi	A 2011 prospectus expected operation in 2013; the owner later reported full operation in May 2015	Financial failure or brand destruction; timing records supply neither

Source: [420-422, 439, 440]

FIGURE 8.3

Setbacks and accounting scope in 4 figures



Source: [420-422, 440]. Mediclinic Abu Dhabi revenue is compared with prior-year pro-forma revenue; the AED 134m is FY2017 Middle East operating profit. Cleveland Clinic Abu Dhabi: operation expected in 2013 in the 2011 prospectus, full operation reported in May 2015. The £0.93m is KCH Management's surplus contribution across a broader business, not Dubai hospital profit.

KEY FINDING

The Mediclinic and Cleveland Clinic records establish underperformance, delay and selective exit; the King's records establish an ownership and accounting structure. None establishes that expansion destroyed a brand, and the exact equity and licence terms behind the Cleveland Clinic and King's arrangements were not recovered [420, 431, 440].

8.3 Whether reputation and patients travel

Whether reputation, and patients, travel was examined through 4 observational studies from other health systems and 1 small counter-study. None comes from Jordan, and none measures a surgeon's name moving between cities [364, 423, 424, 431, 441, 442].

TABLE 8.3

Patient-travel and selection evidence: design, finding and limit

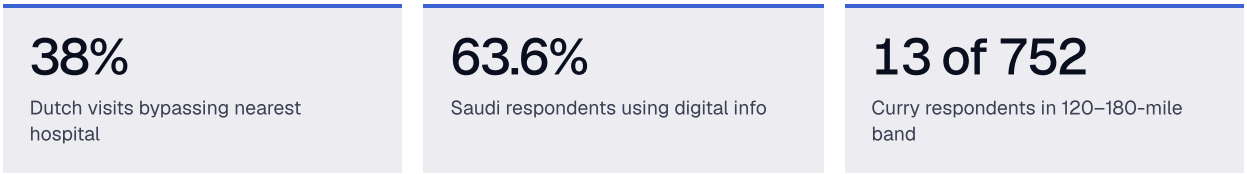
STUDY AND SETTING	SAMPLE	FINDING	LIMIT FOR A JORDANIAN PRACTICE
Netherlands, insurer records, 2003	53,307 first non-emergency adult orthopaedic outpatient visits	38% bypassed the nearest hospital; extra travel time discouraged bypassing	Trips over 60 minutes excluded; socially insured care without co-payments. Neither a universal radius nor a flow between Jordanian cities
Las Vegas, attendee survey, 2017 data	329 orthopaedic attendees	39.5% researched online; 8.5% attributed referral to internet search or site	Retrospective self-report from people who already attended; online evaluation and acquisition attribution are distinct
Saudi Arabia, private-clinic convenience survey, 2024 data	341 analysed of 416 respondents, 5 regions	217 of 341 (63.6%) used digital information before consultation	Regional evidence of digital evaluation, not tracked follower conversion or a Jordan forecast
South Florida, sports-medicine attendee survey, 2020–21	200 new adult attendees	Distinguishes social-media familiarity or use from physician search and selection	“Awareness” and “use” labels differ; the cross-platform sum is not a deduplicated patient count. No conversion figure is used
US tertiary institution survey (Curry), 2012–13	752 responses from 3 locations	Greater social-media use in the 120–180-mile travel band	The band held only 13 respondents; 12 under-18 respondents appear despite an exclusion rule. Association, not caused bookings

Source: [364, 423, 424, 441, 442]

In Dutch insurer records of 53,307 first non-emergency adult orthopaedic outpatient visits in 2003, 38% of patients bypassed the nearest hospital, while extra travel time discouraged bypassing [423]. Because trips over 60 minutes were excluded and patients were insured without co-payments, the figure is neither a universal catchment radius nor an estimate of flow between Jordanian cities. The same study found patients more likely to bypass a nearest hospital that was a university or tertiary teaching centre, although the authors could not separate patient preference, GP advice and admission restrictions (not independently checked) [423].

FIGURE 8.4

Headline figures from the patient-travel evidence



Source: [423, 424, 442]. Dutch figure: first non-emergency adult orthopaedic outpatient visits, n=53,307, 2003 insurer data. Saudi figure: 217 of 341 private-clinic respondents used digital information before consultation, 2024 data. Curry figure: respondents in the 120–180-mile travel band, 2012–13 survey. Different countries, years, designs and denominators; the figures are not comparable with one another.

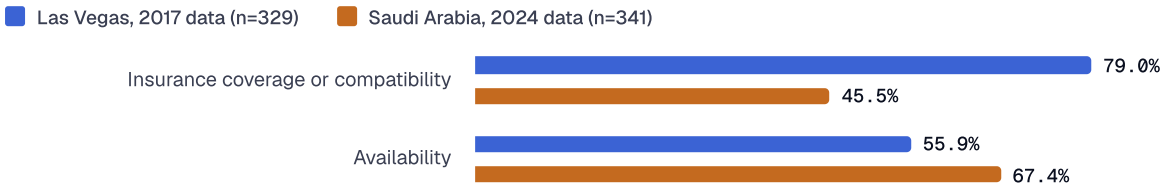
A survey of 329 orthopaedic attendees in Las Vegas, with data from 2017, separates research from acquisition: 39.5% researched online before their first visit, but 8.5% attributed their referral to an internet search or site, against 45.0% citing a primary-care referral and 14.3% an insurer referral [364]. In a Saudi private-clinic convenience sample (2024 data), 217 of 341 respondents (63.6%) used digital information before consultation; among 241 who expressed a clear view, 42.3% associated social popularity with competence and 57.7% disagreed [424]. A South Florida survey of 200 new adult sports-medicine attendees distinguishes social-media familiarity from physician search and selection, but its headline figures need care: the 96.5% is labelled awareness in the source table although the text calls it use, and the 15.5% is the authors' sum of 3

multi-select platform entries, not a deduplicated share of patients. Neither is used here as a conversion figure [431, 441]. Chapter 6 charts the Las Vegas primary-care and internet referral shares against the share who researched online before the visit.

In Las Vegas, 79.0% rated insurance coverage and 55.9% rated availability as very important; in the Saudi sample, 67.4% rated availability and 45.5% rated insurance compatibility as very important [364, 424]. These are stated ratings after selection, not estimates of causal effects on demand.

FIGURE 8.5

Share of survey respondents rating access considerations as very important



Source: [364, 424]. Las Vegas asked about insurance coverage (260/329) and availability (184/329); the Saudi survey asked about insurance compatibility and availability among 341. Stated importance after selection, not a causal effect on demand.

Against a blanket claim that digital reach and travel cannot coexist, Curry and colleagues found greater social-media use among respondents travelling 120–180 miles, but that band held only 13 of 752 respondents and the survey has an age-consistency problem. It establishes an association, not bookings caused by following a surgeon [442].

> WHAT THIS MEANS FOR A PRACTICE
>
> Awareness, consideration, source of discovery, payment access and completed appropriate care are separate measures that a later assessment would need to record separately. An existing patient willing to travel from a practice's home city and a new Amman prospect are different populations, and no Jordanian patient-flow series or portable surgeon-brand conversion rate was recovered. This does not show that fame lacks value; it shows why follower counts cannot fill the clinic-volume cell (see Chapters 4 and 7) [431].

8.4 The Amman field: comparators already offering the same categories

A purposive sample of 4 Amman alternatives tests service overlap, not fame, market share or clinical quality. Provider pages establish what each organisation publicly offers; they do not establish every privilege, available theatre session or current contract [431].

TABLE 8.4

The Amman comparator sample: published overlap, documented organisation and remaining unknowns

COMPARATOR	PUBLISHED OVERLAP AND LOCATION	DOCUMENTED ORGANISATION OR ACCESS	STILL UNKNOWN
Dr. Asaad Ahmed's Center	Foot and ankle, sports, arthroscopy and joint replacement; Al-Qasr Medical Complex, Al-Jaher Street, behind Ibn Al-Haytham Hospital	Team page identifies another orthopaedic specialist, therapy, patient-affairs, accounting and reception roles; homepage makes a general insurer-coverage statement with logos	Hospital proximity is not privileges. Named-plan and procedure eligibility, tariffs, referral volume and capacity not verified
Dr. Anas Al-Marahefah / Saudi Hospital Clinics	Hip and knee replacement, sports injuries, arthroscopy, ACL reconstruction and paediatric congenital-dislocation care; Khalda	Hospital directory association; the hospital describes admission and insurance administration and procedures that require insurer or funder approval	A directory listing is not a complete privilege schedule or guaranteed payer access
Al Khalidi Hospital	Joint replacement, ankle arthroscopy, foot reconstruction and paediatric fractures and deformities; Fourth Circle	Hospital advertises operating rooms and multidisciplinary support	Individual privileges, panel terms, theatre allocation and actual referral shares unknown
Amman Hospital	Paediatric orthopaedics, deformity correction, limb lengthening and arthroplasty; Third Circle	Hospital specialty-centre page	Page dated 23 January 2022; current service availability, staff and panel terms require checking

Source: [34, 443–447]

FIGURE 8.6

Evidence status by comparator: what provider pages establish and what they leave open



Source: [34, 443–447]. Classification of the findings in Table 8.4; for Saudi Hospital, some procedures require insurer or funder approval. No consultation tariff, episode price or realised receipt was recovered from any inspected page.

The comparison answers 1 question: broad foot and ankle, sports, paediatric and joint categories already appear in local offers. It does not test any entrant's specific surgical claim, prove an incumbent's superiority or establish that incumbents neglect social media, and no like-for-like fee gap between Amman and secondary cities was recovered. Competitors' financial goals, assumptions about entrants, response plans and exclusive referral arrangements remain unknown, and a supposed competitor social-media blind spot, scale or captivity advantages and referral shares remain hypotheses [431]. Chapter 9 covers how Amman providers articulate their positioning.

KEY FINDING

An entrant's substantial social reach does not make an Amman service category empty: several sampled local providers explicitly advertise overlapping foot and ankle, sports, paediatric and joint services [34, 444, 446, 447].

8.5 What the available numbers can and cannot size

Population, spending and private coverage

Jordan's Department of Statistics estimates end-2025 populations of 5,004,600 for Amman Governorate and 2,210,500 for Irbid Governorate [27]. These are governorate totals, not any clinic's catchment or its paying demand; the same publication notes that the Amman Qasabah district contains only parts of Amman city.

FIGURE 8.7

Estimated population by governorate, end-2025

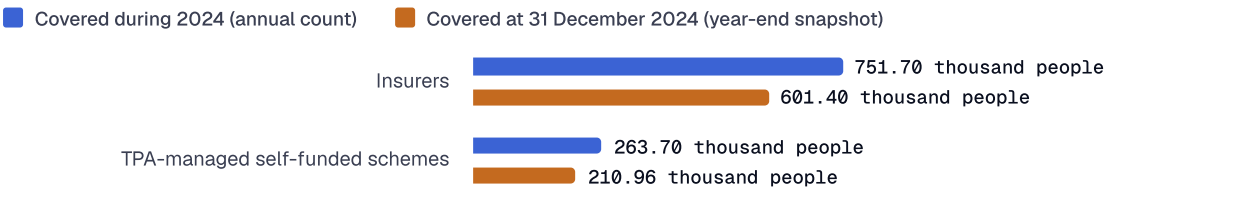


Source: [27], table 2.2. Governorate totals; neither is a clinic catchment.

The 2023 National Health Accounts report national out-of-pocket (OOP) spending of JOD 1.030 billion, printed as 37.3% of current health expenditure [434]. That is an expenditure ratio, not 37.3% of residents or orthopaedic patients; the displayed amounts recompute to 37.3548%, and the printed figure is retained. Private financing spans several channels, and the accounts disclose incomplete private-provider and private-insurer data [434]. The Central Bank of Jordan reports 1,015.4 thousand people covered during 2024 by insurers and self-funded schemes managed by third-party administrators (TPAs), warns that people switching companies are counted more than once, and separately gives about 812.3 thousand at year-end [426]. Insurer portfolios managed by TPAs overlap insurer coverage, so adding the full 699.5 thousand TPA-managed portfolio to insurer enrolment would count the same lives twice [426]. People over 60 were about 4% of insurer-covered people and 5% of those in TPA-managed schemes, and neither profile is annual joint-surgery incidence. In the insurer medical-claims table, 97.5% of paid value was in network and 2.5% outside it [426]. This is spending, not a patient count, but network access merits direct investigation.

FIGURE 8.8

Private medical coverage in Jordan, 2024: annual count versus year-end snapshot



Source: [426], p.8. The 2 counting bases (a count during 2024 and a 31 December snapshot) are shown side by side and must not be added. The annual total of 1,015.4 thousand permits repeated counting when people switch companies (estimated by the source at 20%). The year-end total is given as about 812.3 thousand; its displayed components sum to 812.36 thousand. National scope; not unique Amman prospects.

FIGURE 8.9

Insurer medical-claims value paid in and outside network, 2024



Source: [426], p.13. Shares of JOD 197.978 million in paid insurer medical claims; spending, not patients, and not a legal bar on out-of-network care. The separate TPA claims table has another denominator.

TABLE 8.5

What the official numbers can and cannot size

MEASURE	VERIFIED OBSERVATION	CORRECT USE
Population, end-2025	Amman Governorate 5,004,600; Irbid Governorate 2,210,500	Geographic context; neither is a clinic catchment
Patient-funded expenditure, 2023	National OOP JOD 1.030 billion, 37.3% of current health expenditure (as printed)	Financing context; not 37.3% of residents or orthopaedic patients
Private medical coverage, 2024: insurers and TPA-managed self-funded schemes	1,015.4 thousand covered during the year, with repeat counting; about 812.3 thousand at year-end	Preserve period and scope; do not call the annual total unique patients, add TPA-administered insurer lives again, or allocate national enrolment to Amman by population alone
Payment access, 2024	97.5% of insurer medical-claims value paid in network	Network access merits direct investigation; spending, not a prohibition or patient count
Foot and ankle, sports, paediatric and joint care	Local annual eligible episodes, accessible payment shares and attainable clinic volumes not established	No defensible numeric private-pay market size yet

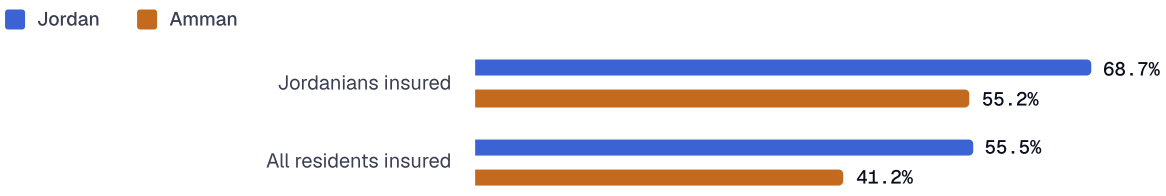
Source: [27, 426, 434]

Insurance coverage in Amman: the 2015 census

The 2015 census adds a geographic dimension that the national financing figures lack. Nationally, 68.7% of Jordanians and 55.5% of all residents were insured; among insured Jordanians, the Ministry of Health covered 41.8%, the Royal Medical Services 38.6% and private insurance 12.3%. In Amman, only 55.2% of Jordanians and 41.2% of residents were insured, but private insurance covered 22.1% of insured Jordanians, about twice the national share [425].

FIGURE 8.10

Share of the population insured, Jordan and Amman, 2015 census



Source: [425]. Shares of the Jordanian and resident populations. Census data from 2015; not a current estimate.

FIGURE 8.11

Private insurance as a share of insured Jordanians, 2015 census



Source: [425]. Shares of insured Jordanians, not of the whole population. Census data from 2015; not a current estimate.

TABLE 8.6

Insurance coverage and payer composition, 2015 census

MEASURE	JORDAN	AMMAN
Jordanians insured	68.7%	55.2%
All residents insured	55.5%	41.2%
Private insurance, share of insured Jordanians	12.3%	22.1%
Ministry of Health, share of insured Jordanians	41.8%	Not given in the source material used
Royal Medical Services, share of insured Jordanians	38.6%	Not given in the source material used

Source: [425]

> WHAT THIS MEANS FOR A PRACTICE
>
> In 2015 Amman combined lower overall insurance coverage with a private-insurance share about twice the national level. Both bear on the worksheet's rule that payment routes must count overlapping insurance and self-pay pathways without double-counting an episode; they are 2015 context, not a demand multiplier [425, 427].

Service lines before multiplication

The sizing worksheet separates 4 service lines before any multiplication and keeps persons, episodes and visits distinct. An earlier planning method of population × incidence × private-pay share × price was proposed, not validated, and has been reworked into explicit episode, access, capacity and contribution inputs, with no conversion of the national OOP share into patients [431]. An explicit top-down hypothesis can be written as: annual accessible episodes for a service line = defined catchment population × annual eligible episodes per person × accessible-payment fraction. Every multiplier after population is currently unknown. Obtainable volume then depends on patient choice and capacity, to be drawn from a practice's observed activity and tested scenarios rather than an invented market-share percentage [427].

TABLE 8.7

Service lines and the inputs each still requires

SERVICE LINE	ELIGIBLE ANNUAL EPISODES TO ESTABLISH	PAYMENT AND DELIVERY QUESTIONS	REVENUE AND COST INPUTS STILL REQUIRED
Foot and ankle	Specific diagnoses, severity, conservative versus surgical indications	Consultation, diagnostics, rehabilitation and any operation: which site, surgeon scope, payer and approval	Collected professional fee per episode; included follow-ups; consumables; hospital or implant charges only if the business actually retains or bears them
Sports	New injury, elective reconstruction and follow-up episodes separately; repeat visits excluded from the new-patient count	Team and referrer pathways, appointment speed, imaging, theatre and rehabilitation access	Visit and episode receipts, partner shares and variable costs; seasonality and clinic capacity
Paediatric orthopaedics	Age- and condition-specific new and continuing episodes; family decision and repeat surveillance distinguished	Parent payment route, age-specific facilities and privileges, diagnostic and follow-up access	Bundled or unbundled follow-ups, staffing, specialist time and retained receipts
Joint surgery	Indicated, medically suitable and willing surgical episodes; arthritis prevalence is not annual surgery demand	Surgeon, hospital and implant eligibility, preauthorisation and rehabilitation pathway	Retained surgeon or clinic collection, exclusions and denials, variable professional costs; the entire hospital invoice is not clinic revenue

Source: [427]

> LIMIT
>
> No defensible numeric private-pay market size yet exists for foot and ankle, sports, paediatric or joint care. The Jordanian hospital-cost paper retrieved is a public-hospital resource-cost study using a 2007 audit inflated to 2015; its amounts cannot substitute for 2026 private fees, rents or a surgeon's retained margin [448].

8.6 The contribution equation and its sensitivity

For each disjoint billable service unit, retained contribution equals the actual collected clinic or physician receipt minus variable cost. The core equation is: monthly operating surplus = Σ(completed units × retained contribution per unit) − fixed monthly cost − owner compensation not already counted in fixed cost. Visits and episodes must be defined consistently; if an episode price includes follow-ups, the follow-ups are not added again as revenue [427].

Where a practice already consults in the capital, the relevant quantity is incremental: owned-clinic surplus minus branch-alternative surplus minus any additional opportunity cost, such as foregone contribution in the home city and the surgeon's travel and time, without subtracting the same item twice. A positive surplus does not pay back fit-out or solve collection delays, so the worksheet keeps separate schedules for fit-out, equipment and deposits, operating cost, payer delays and denials, and cash runway, to be tested against an owner-approved maximum loss and capacity ceiling [427].

FIGURE 8.12

Illustrative only: units per month to cover each JOD 1,000 of monthly cost



Source: [427]. Whole completed units per month needed to cover each JOD 1,000 of fixed monthly cost plus owner compensation, at assumed retained contributions per unit. Calculated as ceil(1000 / assumed contribution). The contributions of JOD 10, 20 and 30 are chosen illustrative assumptions, not observed consultation fees, margins, a clinic budget or a demand forecast.

These are chosen sensitivities, not Jordanian prices. For an actual cost, the calculation is repeated as ceil((fixed cost + owner compensation) / contribution) rather than by multiplying the rounded cells, and a mixed practice sums contributions across services rather than using a single average fee [427].

For context, the brand-strategy study reports that the 2024 national fee schedule has been in force since 16 November 2024 and sets minimum–maximum bands, for example JOD 10–15 for a general practitioner and JOD 15–30 for a surgical specialist, with hospital, implant and room charges outside the doctors' schedule [436, 449]. These are listed bands, not collected receipts or retained contribution (see Chapters 3 and 9).

FIGURE 8.13

Examples of minimum–maximum bands in the 2024 national fee schedule



Source: [436]; schedule in force from 16 November 2024 [449]. Listed bands only; hospital, implant and room charges sit outside the doctors' schedule. Not collected receipts, retained contribution or a price forecast for any practice.

TABLE 8.8

Inputs the contribution model requires, and their status in this study

INPUT FOR A LATER AUTHORISED PHASE	STATUS IN THIS STUDY
Aggregate activity at any existing branch: new versus repeat episodes, service, patient origin, payer route, attendance, collected receipts, referral and search attribution	Not available from public sources; no patient-level records enter the research
The surgeon's weekly allocation across cities, sustainable clinic and theatre capacity, and clinical scope	Not available from public sources
Like-for-like service quotes and realised receipts in each city	Not recovered; listed prices alone are insufficient
Written site and procedure privileges, capacity and rehabilitation arrangements	Not verified

INPUT FOR A LATER AUTHORISED PHASE	STATUS IN THIS STUDY
Payer participation requirements, tariffs, exclusions, authorisation rules and settlement timing	Not established
Current Amman premises classification and operative rules, then fit-out, rent and staff quotations	Not verified; the clauses of Regulation 25/2025 were not read
Owner compensation, capital ceiling, tolerable cash loss and evidence threshold for proceeding	Set by the owner; not available from public sources

Source: [427, 450]

KEY FINDING

An owned clinic in the capital is not commercially assessable from audience size or population alone. How many patients a month it would need remains conditional on actual service mix, collections and cost [427].

8.7 Operating tracks in Amman and options abroad

Separate operating tracks in Amman

An owned clinic involves 4 tracks that must be verified separately: professional status, premises, hospital access and payers. Jordan's Public Health Law separates the Minister's licence to practise from the licensing and physical requirements of a medical establishment, which private hospitals and medical centres must hold before operating [451]. The Ministry of Health's Madaba checklist (background-checked, not independently verified) asks for a certified practice licence, a Jordan Medical Association no-objection, a lease or title in the applicant doctor's name, a zoning plan, committee inspection, a municipal no-objection and a medical-waste contract [452]. The official Gazette indexes a newer clinic regulation, 25/2025, whose operative clauses could not be read [450]. On the payer side, NatHealth operates a network application, and MedNet describes application, assessment, contracting and activation as distinct stages; neither page guarantees acceptance or posts an onboarding duration [453, 454]. MedNet's page is regional rather than Jordan-specific [454].

TABLE 8.9

Operating tracks for an owned Amman clinic: established and still to verify

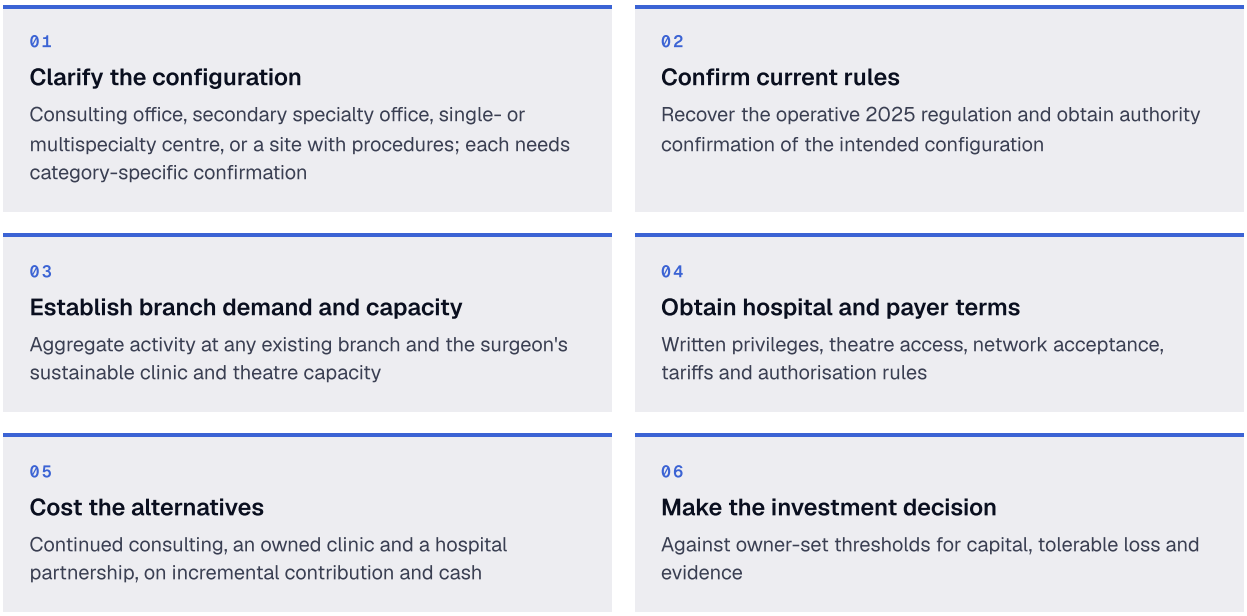
TRACK	WHAT THIS STUDY ESTABLISHES	WHAT MUST BE VERIFIED FOR THE ACTUAL PLAN
Professional status	Public-health law distinguishes a practice licence from establishment requirements	Current personal licence, registered title and specialty, and the proposed clinical scope
Premises and clinic	The Madaba checklist describes documents and inspection; the official Gazette indexes a newer clinic regulation, 25/2025	Operative clauses, Amman classification, how a practice's existing arrangements in other cities fit, premises requirements, current fees and the complete procedure
Hospital access	A hospital affiliation or accreditation is not a verified procedure-privilege schedule	The intended hospitals' own credentialing documents, authorised procedures, theatre capacity, continuity and emergency arrangements
Payers	NatHealth has a network application; MedNet (regional) describes assessment, contracting and activation as distinct stages	Actual acceptance; site, doctor, plan and procedure eligibility; tariff, authorisation, exclusions and settlement terms

Source: [450–454]. The Madaba checklist is background-checked, not independently verified.

No reliable complete Amman lead time or project budget was established: the current regulation body and the 2026 national service guide could not be retrieved, the JOD 50 fee on the Madaba page is not adopted as today's Amman fee, and hospital privileging and insurer onboarding durations remain unknown. The result is a requirements map with gaps, not an application-ready checklist (see Chapter 3) [450, 452]. For a practice considering an owned clinic, the study proposes the evidence sequence in Figure 8.14, a decision sequence rather than measured regulatory timing, which authorises no fieldwork or lease [431].

FIGURE 8.14

A proposed evidence sequence for the owned-clinic decision



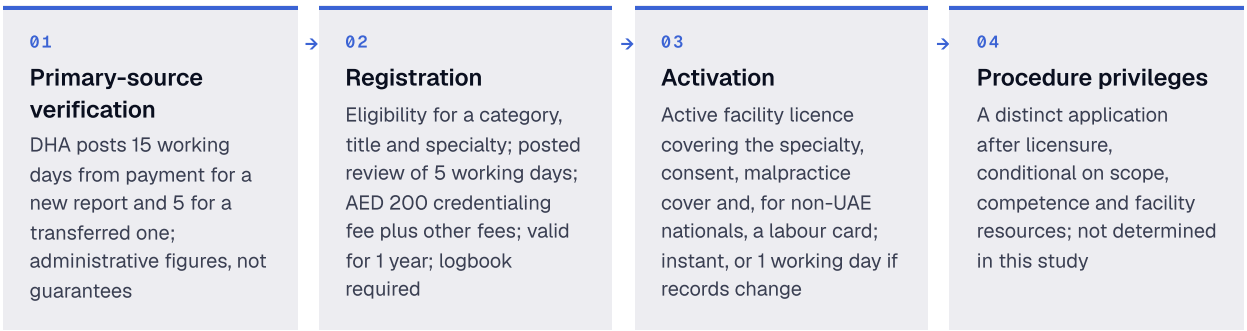
Source: [427, 431]. A proposed decision sequence, not measured regulatory timing.

Dubai

Dubai Health Authority (DHA) registration records eligibility for a category, title and specialty; it lasts 1 year and requires later activation through a facility. Its posted 5-working-day review is 1 stage after prerequisites such as primary-source verification, not the time needed to establish a practice [428]. Activation requires an active facility licence covering the specialty, among other conditions [429], and procedure privileges are a separate application after licensure [455]. DHA's FAQ asks for a signed or stamped surgical logbook covering at least the last 2 years and treats more than 2 years without clinical practice as a gap requiring further consideration [430]. The study did not determine any individual surgeon's qualification tier, specialist or consultant title, exemptions or procedure privileges; the specialty qualification tables could not be retrieved [431].

FIGURE 8.15

Dubai: the published stages between credentials and practice



Source: [428-430, 455]. Published service figures for individual stages; no end-to-end time to practice is implied.

United States

ECFMG certification and state licensure are separate. The standard certification route requires eligible school and graduation-year status, verified medical credentials, USMLE Step 1 and Step 2 CK, and qualifying clinical and communication-skills evidence; ECFMG describes certification as 1 requirement among others for licensure [456]. The claim that every foreign surgeon must repeat US residency is too broad. Florida's 2026 statute retains a conditional route for certain foreign graduates, requiring among other conditions an active unencumbered foreign licence, practice throughout the preceding 4 years, Board review of postgraduate training and a qualifying full-time Florida employment offer, followed by at least 2 consecutive years with a qualifying in-state provider [457]. The Board's route summary explicitly lists USMLE Steps I, II and III; ECFMG certification alone is insufficient [458]. None of this establishes any individual surgeon's eligibility, immigration or work permission, specialty recognition, hospital privileges or payer access [431].

TABLE 8.10

Preserving the Dubai and US options: what is established and what is not

DESTINATION	WHAT THE SOURCES ESTABLISH	NOT ESTABLISHED FOR ANY INDIVIDUAL SURGEON	PREPARATION THAT KEEPS THE OPTION OPEN
Dubai	Registration records eligibility for a category, title and specialty, lasts 1 year and requires facility activation; the 5-working-day review is 1 stage; activation needs an active facility covering the specialty; a surgical logbook covering at least the last 2 years is required	Qualification tier, specialist or consultant title, exemptions and procedure privileges	Verifiable qualification, employment and licensing records; an authenticated recent surgical logbook kept in the surgeon's secure clinical system; continuous documented practice
United States	ECFMG certification and state licensure are separate; the standard route requires Step 1 and Step 2 CK among other evidence; Florida retains a conditional foreign-training route with board review, a qualifying employment offer and 2 years of in-state employment; the Board lists USMLE Steps I, II and III	Eligibility, immigration or work permission, specialty recognition, hospital privileges and payer access	Accurate names and dates; verifiable education, training and employment; selection of an actual state and route before any time-limited application

Source: [428–430, 456–458]

> **WHAT THIS MEANS FOR A PRACTICE**
>
> Keeping both options open needs no application: accurate names and dates, verifiable education, training and employment, active documented practice, secure clinical records, documented permissions to use institutional names, and a clear line between the surgeon's qualifications and the clinic brand. The destination and route are selected before any time-limited application; no naming choice, overseas sizing or application follows from this research [431].

8.8 Claims the evidence does not permit, and contradictions

The evidence rejects several recurring overreaches, each of which would convert context into a forecast [431].

- “Amman's population is the private orthopaedic market.” Population lacks eligible episodes, payment access and attainable volume [27].
- “37.3% OOP means 37.3% private-pay patients.” It is an expenditure ratio with a different denominator [434].
- “A launch, famous name or group surplus proves branch success.” Dates and accounting scope matter [46, 432].
- “A hospital listing or insurer logo guarantees access.” Actual privileges and contracts remain separate [445, 453, 454].

- “A 5-day DHA service means a 5-day practice opening.” Prerequisites and activation are distinct [428, 429].

These overreaches are rejected by the evidence but are not counted as refuted claims, since none of the 38 formally checked claims was refuted; Appendix B lists the report's retired myths. The study's contradiction ledger records 5 tensions and how each was resolved (see also Appendix C) [431].

TABLE 8.11

Contradiction ledger for the market-entry evidence

TENSION	RESOLUTION
Recognition can travel, but access is locally constructed: overseas operating cases combine an existing name with staff, facilities and partnerships	Test portable recognition separately from accessible care and retained contribution; do not infer either from the other
Moorfields Abu Dhabi date conflict: the 2017/18 accounts say April 2016; an original inauguration release is dated November 2015 and describes a completed ceremony	Exact opening date unresolved; the composite claim remains UNVERIFIED and no timing recommendation uses it
Large annual enrolment versus unique demand: the CBJ annual count permits repeated counting, and its year-end figure uses a different temporal basis	Retain both labels and use neither as unique Amman prospects
Official local checklist versus current national rules: the Madaba page and the 2025 regulation index coexist, and the current rule body was unavailable	No current Amman fee, classification or launch timetable is declared
US standard training pathway versus state alternatives: the conventional certification and training route does not exhaust all state pathways	Identify and verify a particular implemented route; no conclusion on any individual's eligibility

Source: [12, 46, 47, 426, 433, 450, 452, 456–458]

A further tension lies between the 2 studies used in this report: the brand-strategy study cites the South Florida survey's 96.5% and 15.5% figures without the table caveats set out in section 8.3. The qualitative distinction survives; the 15.5% is cited only as the authors' sum of multi-select entries, not a deduplicated patient share [431, 441].

> LIMIT
>
> This desk study leaves open any practice's actual demand, service-line incidence, prices and collections, costs, owner thresholds, privileges and current clinic rules: inputs for later authorised work, not blanks to be filled with general frameworks [431].

These market-entry tests do not replace the fame and brand work that is this study's principal focus [431]; Chapter 10 relates them to the brand evidence, and Chapter 11 sets out next steps.

LIMITS OF THIS EVIDENCE

- Desk research only: no fieldwork, practice data, patient-level records or third-party legal, clinical or insurer advice; the operating-track findings are a requirements map, not legal clearance or an eligibility determination.
- The inputs for an owned clinic remain open: actual branch demand, service-line annual incidence, prices and collections, costs, owner thresholds, privileges and the application of current clinic rules.
- The operative clauses of Regulation 25/2025, the 2026 national service guide and Jordan Medical Association registration pages could not be substantively retrieved; no complete Amman lead time, fee or project budget was established, and hospital privileging and insurer onboarding durations remain unknown.
- The expansion cases are large institutions and hospital networks; their external validity for a single surgeon and a private Amman clinic is limited, and operator and issuer explanations are interested accounts that cannot isolate brand causation.
- The expansion records establish stated historical milestones, not each operator's current footprint.
- Patient-choice evidence comes from other settings and eras (Netherlands 2003, US 2012–13, 2017 and 2020–21, Saudi Arabia 2024); no Jordanian origin–destination dataset or portable surgeon-brand effect was retrieved, and absence in a bounded search is not proof that none exists.
- Official statistics refer to different periods (end-2025 population, 2023 spending, 2024 insurance, 2015 census) and are not synchronous 2026 estimates; printed figures are retained where they differ slightly from recomputation (the NHA's 37.3% recomputes to 37.3548%; the CBJ year-end total is approximate).
- The Amman comparator set is a purposive sample of 4 providers, not a registry census or market-share ranking; 1 service page is dated 2022, and no fees, tariffs or realised receipts were recovered.
- Some original sources and platform archives were unavailable during retrieval, including relocation studies, a national household survey and Dubai specialty-qualification tables; no figures were taken from search snippets.
- 3 of the 7 claims not formally checked (the HMG Saudi sequence, the Moorfields Dubai operating account and the Madaba checklist) were background-checked within the study's coordinating pass rather than by the independent verification pass; the economics perspective was also examined within the coordinating pass rather than as a separate perspective pass.
- Shared original sources are not independent corroboration, and the high confirmation rate reflects carefully bounded claims, not the certainty of any expansion.
- The official opening date of Moorfields Abu Dhabi remains UNVERIFIED because original records conflict; the

LEFT OPEN

- Which Amman configuration a practice should assess against its current arrangements: continued consulting from a branch, an owned clinic (consulting office, secondary specialty office, single- or multispecialty centre, or a site with procedures) or a hospital partnership.
- What a practice's existing activity shows: new versus repeat episodes, service mix, patient origin, payer route, attendance, collected receipts and referral or search attribution.
- How a surgeon's weekly time and sustainable clinic and theatre capacity would be allocated between the home city and the capital, including foregone contribution at home.
- What like-for-like services earn in realised receipts in each city, and whether any fee difference exists between Amman and secondary cities.
- Which intended hospitals would grant written procedure privileges, theatre access and rehabilitation arrangements, and on what terms and timelines.
- Which payer networks would accept the clinic, at what tariffs, with what authorisation rules, exclusions and settlement timing.
- How Regulation 25/2025 classifies the intended Amman premises, and what current fees, requirements and approval times apply.
- What owner compensation, capital ceiling, tolerable cash loss and evidence threshold an owner sets for proceeding.
- Which overseas jurisdiction and route, if any, a practice intends to pursue, and what qualification tier and title a surgeon would hold in Dubai, or what eligibility in a US state.
- How an entrant's specific services compare with those already published by Amman providers.

January 2025 NYU Langone acquisition of Rothman's New York practices is not independently checked.

CHAPTER 09

Brand strategy and articulation

Target, category frame, big idea and value stack: what famous medical brands chose, when they chose it, what proved it, and how the Amman and Gulf field articulates itself

EVIDENCE BASE BRAND STRATEGY	58 Claims generated	39 Put to verification	32 Confirmed	7 Refuted	0 Unverified	113 Sources recorded	441 Research actions

CHAPTER SUMMARY

This chapter tests the common story that famous medical institutions became famous by choosing a sharp category, a positioning statement and a big idea. The evidence does not support it. In every case the study could date, today's slogan is either a later codification of a founder-era creed or a line adopted after the institution was already known. The measured drivers of patient flow were peer reputation and rankings, and referral and word of mouth; one further study, not independently checked, found that advertising exposure shifts hospital choice. None of the studies credits message content. The frames that held were structural: a narrowed scope, a patient segment with third-party proof, or scale. In the two public breaks the study recorded, both reported in sources not independently checked, the cause was operations and finance. In Amman, and in Jordan's paid social advertising, orthopaedic providers present themselves by specialty title, usually led by the surgeon's name. No sampled provider states a big idea, and every positioning statement reconstructed from their materials fails the competitor-substitution test, an interpretive judgement the sources cannot refute. The decision splits in two: whether and where to operate, and which surgeon to choose. No Jordanian study measures either decision for elective orthopaedics. The chapter ends with twelve candidate category frames, each with a precedent, the proof it would need, its regulatory status and its main risk. None is chosen, and the choice rests with each practice.

KEY FINDINGS

01 No case in the study shows a slogan dated before fame. Mayo's current wording was in print by 2000 and codified for patients in 2001, long after visiting surgeons formed the Surgeons' Club at Rochester on 7 June 1906 [20, 21, 459].

02 Among 808 US arthroplasty (joint-replacement) patients, 44.9% first heard of their surgeon through referral and 18.7% through word of mouth, against 8.4% through online advertisements [7].

03 Rankings move elective volume, by about 1% per rank place and 5% year to year for the average hospital. The ranking itself is mostly peer reputation, which explains over 95% of the score's variation [19, 460].

04 Famous centres' advertising is emotion and prestige: of 122 patient-attracting ads from US academic centres, 61.5% appealed to emotion, and none of 21 single-intervention ads quantified its benefit [461].

05 In Jordan's paid social advertising, 13 of the 15 orthopaedic advertiser pages among the first 50 active ads are personal-name pages. 11 of them pair the name with a specialty title, one frames itself by the patient's problem, and one gives only a name and a city [462].

06 No sampled Amman provider publishes an outcome measure. The only volume counter found is one Amman centre's 1,200+ patients. Superlatives such as “أفضل دكتور جراحة ركبة وعظام” (“best knee and bone surgery doctor”) appear in the metadata layer of sampled pages; the study records the wording only, and whether the JMA text, in force since 1 February 2025, is enforced on that layer is an open question [62, 463].

07 The decision splits in two. In Kuwait, 30 of 39 women discussed surgery with family, while in Taif only 31.5% rated family or friend recommendation important in choosing a surgeon, against 84.7% for the surgeon's attention to their needs [32, 464].

08 Amman's payer base differs from the national one: in 2015 only 41.2% of Amman residents were insured, and private insurance covered 22.1% of insured Jordanians there, against 12.3% nationally [425].

09 Experience and protocol advantages are small or temporary. In an observational comparison, physicians trained in communication at Cleveland Clinic scored 92.09 against 91.09 for untrained physicians, and Rothman's per-patient bundled-payment margin fell from $2,683 to $522 between 2015 and 2018 [465, 466].

10 Jordan's 2024 fee schedule, in force from 16 November 2024, sets bands such as 15 to 30 JD for a surgical specialist, so price is bounded rather than fixed, and discounting is what is blocked [49, 436].

9.1 The big ideas, dated against fame

This chapter reports the strategy study. It asked how famous medical institutions, and the leading orthopaedic providers in Amman and the Gulf, chose and articulated a target, a category frame, a big idea and a value stack; what proof stood behind each claim; where the idea stopped in execution; and who makes up the decision unit for elective orthopaedic surgery. The study examined these questions from six distinct analytic perspectives, each in a separate pass: archival brand history, category frames, the decision unit, the regional competitive set, service execution and proof, and a sceptical perspective dedicated to testing popular claims, which was set to attack the thesis that sharp positioning caused fame. Together the six perspective passes generated 58 claims from 113 unique source URLs, searched and retrieved online at the time of research. An independent verification pass then tried to refute the 39 most load-bearing claims against the retrieved sources: 32 were confirmed, 7 refuted and none left unverified, an 18% refutation rate. Five perspective passes independently concluded that slogans post-date fame, so that claim was checked hardest. It survived for Mayo and Cleveland Clinic, with independent evidence that the fame came first, and it was corrected where it over-reached. The 19 claims not selected for verification carry the label “not independently checked” wherever they appear (Appendix A) [463].

The study applied one dating rule throughout. A slogan can be credited with causing fame only if its first dated record precedes the first dated evidence of fame. By that test, no case in the study qualifies [463].

FIGURE 9.1

Headline dating results

0 of 5	1906	77 years	17
cases with a slogan dated before fame	Surgeons' Club formed, Rochester	HSS founding (1863) to rename (1940)	years in HSS's No. 1 ranking streak

Source: The Surgeons' Club at Rochester predates W. J. Mayo's 1910 line. The HSS No. 1 orthopaedic ranking streak is 17 years long; the institution is 163 years old [21, 463, 467–469].

TABLE 9.1

Big ideas of famous cases: wording, earliest dated record and position relative to fame

CASE	WORDING (VERBATIM)	EARLIEST DATED RECORD	BEFORE OR AFTER FAME	PROOF OFFERED	STATUS IF USED IN JORDAN UNDER THE JMA TEXT (CHAPTER 3)
Mayo Clinic	1910: “The best interest of the patient is the only interest to be considered, and in order that the sick may have the benefit of advancing knowledge, union of forces is necessary.” Today: “The needs of the patient come first.”	Rush Medical College commencement, 15 June 1910; current wording in print by March 2000; set down for patients in the Model of Care, “crafted in 2001”	After: visiting surgeons formed the Surgeons' Club at Rochester on 7 June 1906	Institutional culture; the Model of Care page says its elements “are the reason patients come to Mayo”	A value statement with no superlative; a permissible form
Cleveland Clinic	“Patients First”; the institution also cites a 1920s founder creed, “a patient is the most important person in the institution” (Lower)	Mantra unveiled by Cosgrove, chief executive 2004 to 2017; redefined as an operating frame from 2006; Office of Patient Experience and first chief experience officer in 2007. The Lower line was not found in a 1920s primary document; the 1948 memorial issue has only “The sole criterion in his decisions was the welfare of the patient.”	After: by Cosgrove's account the clinic was already known for “excellent results” and ranked above the hospital a family chose instead	Satisfaction scores “solidly improved”, with no figures	Permissible form
HSS	1863: “Hospital for the Relief of the Ruptured and Crippled”. 1940: “Hospital for Special Surgery”. Today: “the preeminent musculoskeletal hospital in the world” and “The world's leading academic medical center focused on musculoskeletal health”	1940 rename dated; current lines undated	Current lines undated and almost certainly post-fame	U.S. News No. 1 for 17 consecutive years; more than 45,864 orthopaedic procedures in 2025; “among the lowest” readmission and infection rates, with no rates given	“Preeminent”, “world's leading”, “No. 1” and “lowest” are banned superlatives

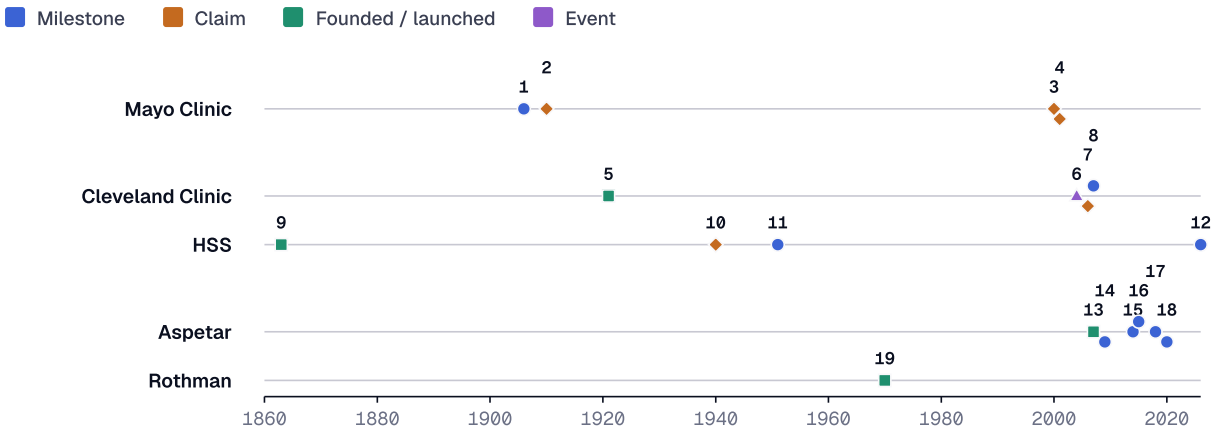
CASE	WORDING (VERBATIM)	EARLIEST DATED RECORD	BEFORE OR AFTER FAME	PROOF OFFERED	STATUS IF USED IN JORDAN UNDER THE JMA TEXT (CHAPTER 3)
Aspetar (Qatar)	"a world-leading specialised orthopaedic and sports medicine hospital and the first of its kind in the Middle East"; Arabic: "سبيتار، مستشفى متخصص رائد عالميا في مجال جراحة العظام والطب الرياضي، وهو الأول من نوعه في منطقة الشرق الأوسط" ("Aspetar, a world-leading specialised hospital in orthopaedic surgery and sports medicine, and the first of its kind in the Middle East region")	Frame at the 2007 opening (self-reported); current wording undated	Frame at founding; proof after: FIFA 2009, IOC 2014, IHF 2015, Accreditation Canada Diamond 2018, AFC 2020	Dated third-party accreditations; state backing through Aspire Zone	The wording is banned ("رائد عالميا", "world-leading"; "الأول من نوعه", "the first of its kind"); the frame itself is not
Rothman Orthopaedics	Mission: "To provide our communities with high quality, compassionate, and affordable musculoskeletal care that is grounded in evidence-based medicine, the results of which will exceed expectations." Tagline: "One United Network Specializing in You"	Founded 1970; tagline undated	Undated	"190+ Physicians", "34 Locations", "60,000 Annual Surgical Volume"; "the largest full-service orthopedic practice in the world"	"Largest … in the world" is banned; whether plain counts are permitted is an open question
Shouldice (not independently checked)	Single-procedure hospital (inguinal hernia)	Not established	Not established	Peer-reviewed recurrence of 1.6% across 1,120 consecutive repairs at a median of 16 months; the "0.8% vs 10%" figure is legend and was not retrieved from a primary source	Outcome data is not a superlative; its publication form is an open question

Source: Mayo's heritage film page says Dr. Will's 1910 words form the basis of the primary value. JMA column: Jordan Medical Association advertising instructions as reported [20, 21, 33, 62, 459, 467–481].

Mayo shows the pattern most clearly. W. J. Mayo's 1910 sentence differs from today's wording, which was in print by March 2000 and codified for patients and learners in two documents crafted in 2001 [20, 459, 467]. The fame came first: surgeons visiting Rochester formed the Surgeons' Club on 7 June 1906 [21]. The continuity story, that the founders instilled the value from the start, is Mayo's own account [459, 482]. Cleveland Clinic, founded in 1921 [483], adopted "Patients First" when, by its chief executive's own account, it was already known for results, and it redefined the slogan after a family chose a lower-ranked hospital because it had heard the clinic had "no empathy" [475].

FIGURE 9.2

Founding, fame markers and first dated appearance of each big idea



1 **Mayo Clinic:** 1906 Surgeons' Club formed
2 **Mayo Clinic:** 1910 Rush commencement line
3 **Mayo Clinic:** 2000 Current wording in print
4 **Mayo Clinic:** 2001 Model of Care crafted
5 **Cleveland Clinic:** 1921 Founded
6 **Cleveland Clinic:** 2004 Cosgrove becomes chief executive
7 **Cleveland Clinic:** 2006 Patients First made operational
8 **Cleveland Clinic:** 2007 Experience office; first CXO
9 **HSS:** 1863 Founded (Ruptured and Crippled)
10 **HSS:** 1940 Renamed Special Surgery
11 **HSS:** 1951 Cornell affiliation ratified
12 **HSS:** 2026 17th consecutive No. 1
13 **Aspetar:** 2007 Opens with athlete frame
14 **Aspetar:** 2009 FIFA accreditation
15 **Aspetar:** 2014 IOC recognition
16 **Aspetar:** 2015 IHF
17 **Aspetar:** 2018 Accreditation Canada Diamond
18 **Aspetar:** 2020 AFC
19 **Rothman:** 1970 Founded

Source: Current taglines for HSS, Aspetar and Rothman could not be dated because web-archive snapshots were unavailable. Aspetar's 2007 frame is self-reported. Two later events that were not independently checked, Aspetar's 2022 World Cup athlete services and the 2025 NYU Langone acquisition of Rothman's New York practices, are left off the chart; they appear in Table 9.6 and Table 9.16. [20, 21, 33, 48, 435, 459, 467–469, 472, 473, 478, 480, 483]

KEY FINDING

No slogan in the study can be credited with causing fame. The founders' creeds were real and early, but they were spoken by surgeons who were already famous and codified into slogans and operating systems decades later. The sharp-sounding lines now on the HSS, Aspetar and Rothman pages show how famous institutions talk today, not how they became famous, and nearly all carry their proof in a superlative of a kind the JMA text bans in Jordan [459, 467, 475].

Two readings survive checking. The verification pass refuted the synthesis that nothing verbal existed before fame: both flagship cases trace today's slogans to founder-era creeds (1910 and the 1920s) [467, 475]. And because web-archive snapshots were unavailable, the current HSS, Aspetar and Rothman lines could not be dated earlier than their live pages [33, 468, 480]. Chapter 4 places these cases in the wider account of how doctors become famous.

Evidence strength

TABLE 9.2

Evidence strength by source type

TIER	SOURCE TYPES	EXAMPLES IN THIS CHAPTER
Strongest	Peer-reviewed quantitative studies read in full text during independent verification; primary institutional pages checked against raw HTML; dated primary records	Laverdiere 2025, Pope 2009 (manuscript), Larson 2005, Boissy 2016, Krueger 2021, the Jordanian census analysis, Hariri 2025; the Aspetar, Rothman and HSS pages, the Amman sites and the Gulf titles; Mayo's 1910 citation, the SEC 8-K filing, the JMA text as reported
Moderate	Saudi Likert surveys (stated importance; convenience or online samples, often young or health-sector-heavy); a qualitative study; institutional self-retelling, labelled as such	Saudi surgeon-choice surveys; the Kuwaiti study (thin, 2013, women on a public waiting list); Mayo, Cleveland Clinic and Aspetar accounts of themselves
Weakest	Vendor or consultant narratives; university self-summaries; self-published programme books; trade-press interviews; advertising listings that show page names only	Gallup on Cleveland Clinic; the KC and Kim summary; the Cleveland Clinic percentile claim; medical-tourism trade press; the Meta Ad Library pulls

Source: Grading from the strategy study's reliability note. Known biases: a strong US skew in the choice studies, no Jordanian study of elective orthopaedic decisions, undated current taglines, and Gulf samples that lean on institutions' own pages [463].

9.2 What moved patients

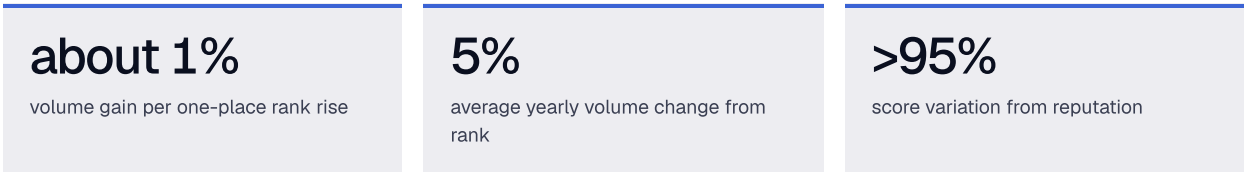
In the measured studies, peer reputation, rankings, referral and word of mouth moved patients; one further study, not independently checked, found that advertising exposure shifts hospital choice. None credits message content [7, 460, 484, 485].

Rankings and peer reputation

In the United States, hospitals that improve their U.S. News rank attract significantly more patients: for the average hospital in Pope's sample, rank changes caused a 5% year-to-year change in non-emergency Medicare volume. The author's manuscript reports that a one-place improvement is associated with about 1% more non-emergency volume and revenue, and that a one-place gain within a state brings 6% to 7%. Between 1993 and 2004 the rankings moved more than 15,000 Medicare patients and more than $750M [19, 460]. The ranking itself is mostly peer reputation. Reputation explains over 95% of the variation in the U.S. News score, while risk-adjusted mortality explains less than 1% [19]. Sehgal found reputation minimally associated with objective quality, with a mean ρ^2 of 0.03 (not independently checked) [484]. Pope never tested slogans, so nothing here compares rankings with messaging.

FIGURE 9.3

Rankings, reputation and elective volume in the United States



Source: Pope: US Medicare non-emergency admissions, 1993 to 2004. Sehgal's reputation–quality ρ^2 of 0.03, not independently checked, is reported in the text and in Table 9.5. [19, 460]

TABLE 9.3

U.S. News 2009 top-50 ranking reproduced by reputation score alone

RANKING BAND	SHARE REPRODUCED BY REPUTATION SCORE ALONE	STATUS
No. 1 hospital in each specialty	100%	Not independently checked
Top 5	97%	Not independently checked
Top 10	91%	Not independently checked
Top 20	89%	Not independently checked

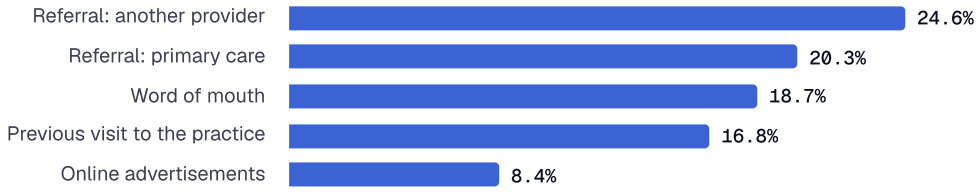
Source: Sehgal: cross-sectional study of the top 50 hospitals in 12 specialties; limited to ranked hospitals. Shown as a table because the figures were not independently checked [484].

Referral and word of mouth

Among 808 US arthroplasty (joint-replacement) patients at four high-volume centres, asked how they first heard of their surgeon, 44.9% cited referral, 18.7% word of mouth and 8.4% online advertisements [7]. The question measures the awareness route, not the final choice, and the sample had a mean age of 66 and was mostly commercially insured. Among 200 US sports-medicine patients, 96.5% used social media but only 15.5% used it to find or select a physician, and 50.5% used Google. Online reviews were cited by 42% (not independently checked) [441]. A systematic review of 86 studies also finds reputation, word of mouth and physician referral dominant, with distance mattering too [486]. A 2022 survey of 329 patients points the same way [364]. A single-centre survey with a 15.3% response rate found physician referral at 50.2% [487].

FIGURE 9.4

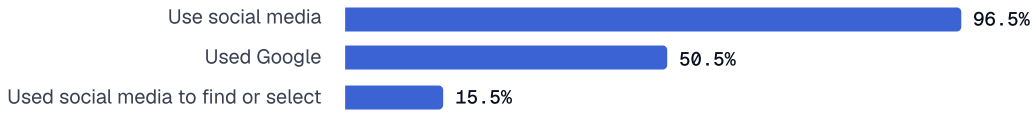
How 808 US arthroplasty (joint-replacement) patients first heard of their surgeon



Source: Four US centres, January 2024 to January 2025; the two referral rows sum to 44.9%. Measures the awareness route, not the final decision [7].

FIGURE 9.5

Social media use against its use in choosing a sports-medicine physician (n=200)



Source: Single US academic centre, February 2020 to May 2021; multi-select answers. The online-reviews figure (42%), a factor cited in selection rather than a channel used, was not independently checked and is reported in the text and in Table 9.5 instead [441].

Advertising exposure and advertising content

One study, known only through a university summary and not independently checked, found that television advertising exposure shifts hospital choice, especially among wealthier patients who lived far from the hospital [485]. The study measured exposure or spend, not the frame or the message. What famous centres actually advertise is mostly emotion and prestige: 16 of the 17 US academic centres on the 2002 honour roll

advertised to attract patients, and none of their 21 single-intervention ads quantified its benefit claims [461]. In 409 unique cancer-centre ads from 2012, 85% used emotional appeals and only 2% quantified benefits (not independently checked; Table 9.4) [488].

FIGURE 9.6

Content of 122 patient-attracting ads from famous US academic centres



Source: Categories overlap, since one ad could use several strategies. None of the 21 single-intervention ads quantified its benefit, and 1 mentioned harms [461].

TABLE 9.4

Content of 409 US cancer-centre ads, 2012

AD CONTENT	SHARE OF THE 409 ADS	STATUS
Emotional appeals	85%	Not independently checked
Hope for survival	61%	Not independently checked
Cancer as a fight or battle	41%	Not independently checked
Fear	30%	Not independently checked
Described benefits	27%	Not independently checked
Carried disclaimers	15%	Not independently checked
Described risks	2%	Not independently checked
Quantified benefits	2%	Not independently checked

Source: 102 cancer centres; magazines and television; internet ads excluded. Shown as a table because the figures were not independently checked [488].

TABLE 9.5

The measured drivers of patient flow in the evidence base

STUDY	SETTING AND SAMPLE	WHAT WAS MEASURED	MAIN RESULT	EVIDENTIAL STATUS
Pope 2009	US Medicare, non-emergency, 1993 to 2004	Effect of U.S. News rank changes on volume	5% year-to-year change from rank changes; about 1% per rank place	Confirmed; US only
Sehgal 2010	2009 U.S. News top 50, 12 specialties	Reputation against ranking and objective quality	Reputation reproduces the ranking; $\rho^2 = 0.03$ with objective quality	Not independently checked
Laverdiere 2025	808 US arthroplasty (joint-replacement) patients, 4 centres	How patients first heard of their surgeon	Referral 44.9%, word of mouth 18.7%, online ads 8.4%	Confirmed; awareness route, not final choice
Greif 2022	200 US sports-medicine patients	Channels and factors in selecting a physician	Social media 15.5%, Google 50.5%; online reviews cited by 42%	Confirmed except online reviews (42%), not independently checked; single centre
Yahanda 2016	Systematic review of 86 studies	Factors patients use to choose a surgeon	Reputation, word of mouth, physician referral; distance	Confirmed

STUDY	SETTING AND SAMPLE	WHAT WAS MEASURED	MAIN RESULT	EVIDENTIAL STATUS
Larson 2005	16 advertising honour-roll centres, 122 ads	Advertising content	Emotion 61.5%, prestige 60.7%; 0 of 21 quantified benefits	Confirmed
Vater 2014	102 US cancer centres, 409 ads	Advertising content	Emotional appeals 85%; benefits quantified in 2%	Not independently checked
KC and Kim	Massachusetts, more than 220,000 visits over 24 months	Advertising exposure and hospital choice	Television advertising shifts choice	Not independently checked; university summary

Source: [7, 19, 441, 460, 461, 484-486, 488]

KEY FINDING

Peer reputation, rankings and referral move patients; one study, not independently checked, finds that advertising exposure shifts choice. No study in the set credits the frame or the message itself. The strongest data come from the US system, so their transfer to Jordan is untested [7, 460, 461, 485].

9.3 Category frames and what changed

The frames that held were structural rather than verbal: a narrowed scope, a patient segment with third-party proof, or scale.

TABLE 9.6

Category frames in the evidence base: the choice, the change and the cost

CASE	FRAME AND CHANGE	DATE	WHAT THE EVIDENCE SHOWS	STATUS
HSS	Narrowed scope: the hernia department was dropped and the name changed from “Hospital for the Relief of the Ruptured and Crippled” to “Hospital for Special Surgery”	1940; Cornell affiliation agreed 1949 and ratified 1951	The hospital had been orthopaedic since 1863, so the rename dropped hernia work rather than adding orthopaedics. The new name does not say “orthopaedic”.	Confirmed; the affiliation date was corrected in the verification pass
Cleveland Clinic	Reorganisation into organ- and disease-based institutes	2007, 86 years after the 1921 founding	An internal restructure; no source shows how patients classify the brand	Not independently checked; sources disagree on 18 or 22 institutes and on 2007 or 2008
Aspetar	Specialty plus patient type: athletes, then clubs and federations, then the public	From the 2007 opening	Held from opening and proved by dated accreditations; rests on a state owner and a sport-federation mandate	Confirmed; that the frame dates from 2007 is not shown by any archived page
Mayo Clinic cardiac surgery	A “focused factory” inside a broad brand	Reported 2014	Fitted 67% of patients and cut resource use, length of stay and cost; no measure of demand	Not independently checked; self-reported by the implementers

CASE	FRAME AND CHANGE	DATE	WHAT THE EVIDENCE SHOWS	STATUS
LCA-Vision	LASIK-only chain	Third quarter of 2009	Revenue of $27.6M against $37.4M a year earlier; closure of 10 centres announced	Not independently checked; shows exposure, not that niches fail
Rothman Orthopaedics of Greater New York	Founder-named practices acquired by NYU Langone	January 2025	The practices now carry NYU Langone names	Not independently checked; primary release retrieved
Cosmetic-foot frame	A brand named for cosmetic foot work	HSS page updated 21 December 2018; AOFAS position statement	Sits against the public position of the specialty's reference institutions	Confirmed

Source: [33, 48, 378, 435, 468, 476, 477, 479, 483, 489–492]

FIGURE 9.7

Three structural frames that held, and one internal restructure with no patient-facing evidence

HSS

Narrowed scope

HSS dropped hernia work and took a broader name in 1940; operations carried the frame.

ASPETAR

Segment with third-party proof

Athlete frame from 2007 (self-reported), proved by FIFA 2009, IOC 2014, IHF 2015, Accreditation Canada 2018 and AFC 2020.

ROTHMAN

Scale

190+ physicians, 34 locations, 60,000 annual surgical volume.

CLEVELAND CLINIC

Internal restructure

The institutes were an internal restructure; no source shows whether they changed how patients classify the brand (not independently checked).

Source: The dates of Cleveland Clinic's institutes and of NYU Langone's acquisition of Rothman's New York practices were not independently checked; they are given in Table 9.6. [33, 435, 468, 480, 483, 489]

Three points stand out. First, HSS changed its frame when its scope changed, and the new name was broader rather than more descriptive [468, 476]. Second, Aspetar's segment frame has held since opening (self-reported; no archived page shows the frame in 2007). Its public still enters under the athlete frame (“وللعامة”, “and the public”) [477], and the frame rests on a state owner and a sport-federation mandate that a private surgeon cannot copy [479]. Third, narrowing inside a broad brand improves operations, but no source ties it to demand; the one measured case is self-reported by its implementers and was not independently checked [490]. LCA-Vision, a case not independently checked, shows how exposed a narrow discretionary frame is to a demand shock, not that niches fail: it was a corporate chain in a cash-pay market during a recession (Table 9.7) [491].

TABLE 9.7

LCA-Vision, a LASIK-only chain, before and during the 2009 demand shock

MEASURE	Q3 2008	Q3 2009	STATUS
Quarterly revenue	$37.4M	$27.6M	Not independently checked
Procedure volume	21,484	15,335	Not independently checked

Source: Form 8-K exhibit 99.1, 27 October 2009; 10 centres were to close. Shows exposure to a demand shock, not that niches fail [491].

The cosmetic-foot frame

> *"Cosmetic surgery on a pain-free, well-functioning foot is never appropriate."*
>
> Chief of the Foot and Ankle Service, HSS, on a page titled "Cosmetic Foot Surgery: Not Recommended", updated 21 December 2018 [492].

> *"does not support foot and ankle surgery where the goal is solely cosmetic or for the purpose of fitting into aesthetically desirable footwear"*
>
> American Orthopaedic Foot & Ankle Society, position statement on cosmetic foot and ankle surgery [378].

As Chapter 6 sets out, these positions address solely cosmetic surgery on a pain-free, functional foot. They do not cover every foot operation described in cosmetic language. The risk the strategy study adds concerns the frame. A brand named for cosmetic foot work would carry that argument into its dealings with referring doctors and peer surgeons [378, 492].

Entry situations: when people balk at surgery

Category entry points are untested in healthcare within this evidence base; the only explanations found were written by consumer-goods vendors [463]. What was measured are the situations in which people balk at surgery. The most common reason given by 629 Saudi patients reluctant to have a recommended knee replacement was fear of anaesthesia complications (50.4%), and 36.9% cited "unavailability of experienced surgeons" [493]. This was a low-rigour online convenience sample. Among 704 Al-Ahsa adults with chronic knee pain, 74.1% had poor knowledge of the procedure [494]. Among 39 Kuwaiti women on a knee-replacement waiting list, 12 raised difficulty praying normally and 9 raised consultation abroad [32].

FIGURE 9.8

Reasons for refusing a recommended knee replacement, 629 reluctant Saudi patients



Source: Online convenience sample recruited partly through orthopaedic forums and social media; low rigour [493].

> WHAT THIS MEANS FOR A PRACTICE
>
> The study records a risk at the level of the frame, not a verdict. Whether a brand named for cosmetic foot work should carry that risk with referrers and peer surgeons is part of the category-frame decision, which remains each practice's own (Section 9.8) [378, 492].

9.4 Who decides, and who pays

There are two decisions, and the studies measure different ones. Merging them was the most common error the verification pass caught: three of the seven refutations were one-sided pictures of who decides. Whether, and where, to operate is a deliberation between clinician and family, shaped by people who have had the operation. Which surgeon to choose depends more on the surgeon's manner, reviews, access and referral, and social-media fame weighs more in the Saudi samples than in the US ones [6, 32, 464, 495].

TABLE 9.8

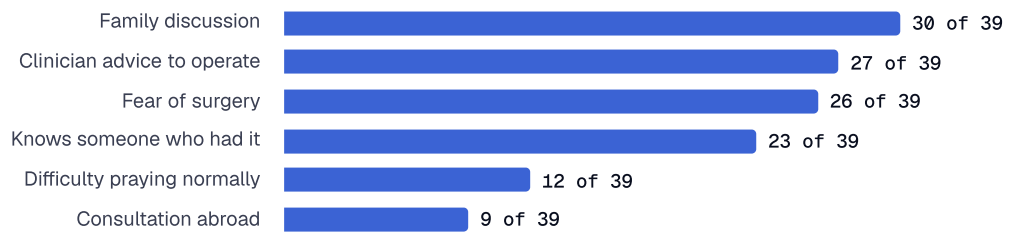
The two decisions and what the evidence shows about each

DECISION	WHAT THE EVIDENCE SHOWS	SOURCE AND STRENGTH
Whether, and where, to operate	Clinician advice was the most-raised sub-theme (39 mentions from 27 of 39 participants). Family discussion was raised by 30 of 39, knowing someone who had the operation by 23, and fear by 26. Consultations took place in Bahrain, Syria, Dubai, Saudi Arabia and Jordan, mostly when patients accompanied their families on holiday. Participants trusted their surgeons fully but were dissatisfied with the information they received.	Al-Taiar 2013: Kuwait, 5 focus groups, 39 women at a public hospital. Qualitative and thin, but the only study in the set that traces how the knee-replacement decision is reached within the family.
Whether, and where, to operate	Saudi knee-replacement patients preferred a paternalistic approach "along with a full disclosure of the risks". Independent verification found the surgeon is not the sole node; the family is the other.	Alabdullah 2023: 51 patients and 67 doctors, one hospital.
Whether, and where, to operate	In Jordanian oncology, shared decisions involve physicians, family and "key figures, especially the patient spouse or eldest male relative". Jordanian physicians also show persistent paternalism.	Shamieh 2026; Obeidat 2016: oncology, not orthopaedics.
Whether, and where, to operate	81.4% of 221 Jordanian physicians would share information when family assistance is crucial (the source's second 81.4% is arithmetically 82.4%). Only 48% would consistently seek consent first.	Karasneh 2025: measures information-sharing, not decision authority.
Which surgeon	US: referral 44.9%, word of mouth 18.7%, previous visit 16.8%, online ads 8.4%; trust rated highest.	Laverdiere 2025: awareness route, not the final choice.
Which surgeon	Taif, 609 real clinic attendees: the authors conclude that the surgeon's attitudes (attention to needs 84.7%, time 83.9%, communication 82.6%) contributed most, ahead of reputation; hygiene (91.3%) and easy appointments (89.7%) were rated important by more respondents. Family or friend recommendation scored 31.5%.	Alosaimi 2022: stated importance.
Which surgeon	Saudi nationwide, 3,133 patients: manner 4.58, quality of information 4.32, reputation 4.24. Qualifications scored lowest, at 4.10, and social-media popularity was the lowest single item, at 3.70.	Al-Faifi 2023: the abstract's order contradicts its own table.
Which surgeon	Saudi general population, 1,242 respondents: 31.7% rely on a doctor's social-media fame when booking non-cosmetic care; 39.6% prefer socially famous doctors; Instagram (41.3%) is the main platform for finding doctors.	Hariri 2025: young sample (mean age 27.9); 55.6% work or study in health.
Which surgeon	Jordan, 1,708 adults: reputation, knowledge and experience were the most important factors. About 92% of those with a gender preference preferred a male surgeon for orthopaedics.	AlSamhori 2023, surfaced during independent verification.
Which surgeon	Qassim, 513 respondents: recommendations from friends and family "play a less significant role".	Alsalamah 2023: recruited through messaging and social platforms.

Source: [6, 7, 32, 356, 412, 464, 495-499]

FIGURE 9.9

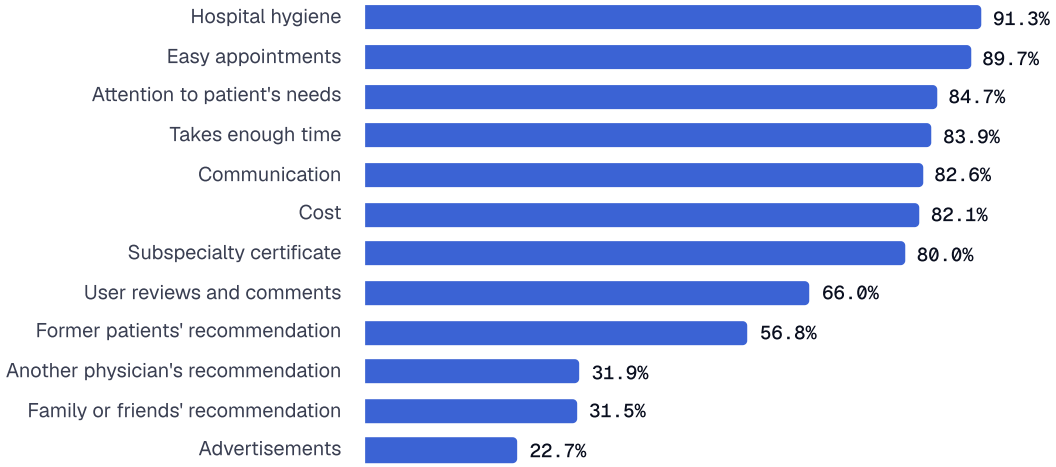
Kuwait: participants raising each theme, of 39 women on a knee-replacement waiting list



Source: By number of mentions, clinician advice leads (39) ahead of family discussion (37). 5 focus groups, Al-Razi Hospital, 2013 [32].

FIGURE 9.10

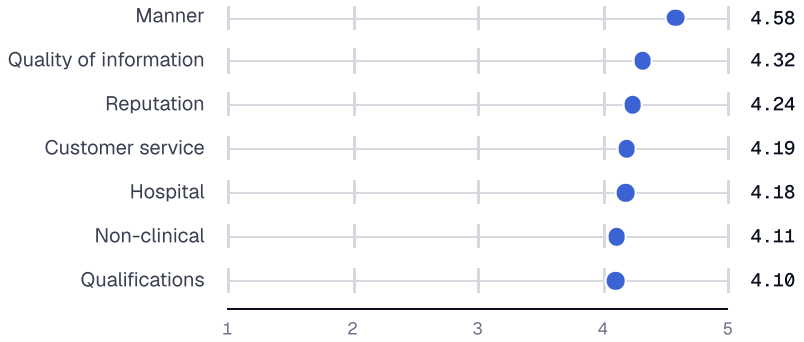
Taif: share of 609 clinic attendees rating each factor important in choosing a surgeon



Source: Elective-surgery clinic attendees; stated importance, August to November 2022; all elective surgery, not orthopaedics alone. The authors conclude that the surgeon's attitudes contributed most to selection, ahead of reputation [464].

FIGURE 9.11

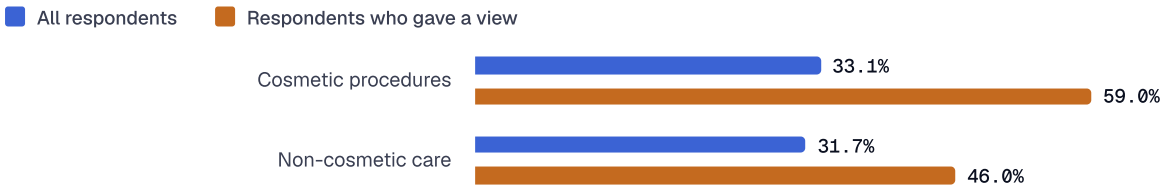
Saudi nationwide: mean importance of surgeon-choice domains, Likert scale assumed 1–5 (n=3,133)



Source: Domain means from the paper's Table 2. The paper reports Likert means without stating the scale's end points; the axis assumes 1 to 5, consistent with the reported means. The abstract's ranking of “manner, then qualifications” contradicts this table. The lowest single item was social-media popularity, at 3.70 [495].

FIGURE 9.12

Saudi general population: reliance on a doctor's social-media fame when booking (n=1,242)



Source: Second series recalculated during independent verification among respondents who gave a view on each item: 411 of 696 for cosmetic (43.9% had answered “I do not care about cosmetics”) and 393 of 862 for non-cosmetic. The gap is about 13 points, not 1.4 [6].

TABLE 9.9

Jordanian evidence adjacent to the surgical decision; none measures who decides on elective orthopaedics

MEASURE	POPULATION	N	VALUE	SOURCE
Would share information when family assistance is crucial	Physicians in Jordan	221	81.4%	Karasneh 2025
Would consistently seek patient consent before disclosure	Physicians in Jordan	221	48%	Karasneh 2025
Prefer a male surgeon for orthopaedic surgery	Jordanian adults with a gender preference	1,708 surveyed	About 92%	AlSamhori 2023
Knew robotic surgery was available in Jordan	Surgical outpatients in Amman	700	14.9%	Alkousheh 2026

Source: Each row measures a different thing in a different population [412, 497, 499].

TABLE 9.10

Social media's weight by population and measure; the figures are not directly comparable

MEASURE	POPULATION	N	VALUE	SOURCE
First heard of the surgeon through online advertisements	US arthroplasty (joint-replacement) patients	808	8.4%	Laverdiere 2025
Used social media to find or select a physician	US sports-medicine patients	200	15.5%	Greif 2022
Rely on a doctor's social-media fame when booking non-cosmetic care	Saudi general population	1,242	31.7%	Hariri 2025
Prefer doctors who are famous on social media	Saudi general population	1,242	39.6%	Hariri 2025

Source: The measures differ: first-heard route (US arthroplasty patients), use in selection (US sports medicine) and stated reliance or preference (Saudi) [6, 7, 441].

> LIMIT
>
> No Jordanian study measures either decision for elective orthopaedics. On this evidence, family weight falls mainly on whether and where to operate, and on logistics and travel; the choice of surgeon depends more on the surgeon's manner and communication, reviews, access and referral. Both remain hypotheses for Jordan until second-phase fieldwork measures them [463].

Who pays

In the 2015 census analysis, 68.7% of Jordanians and 55.5% of all residents were insured. Among insured Jordanians with a single insurer, the Ministry of Health covered 41.8%, the Royal Medical Services 38.6% and private insurance 12.3%; only 1.3% of insured Jordanians had more than one insurer. Amman differs. Only 55.2% of Jordanians and 41.2% of residents there were insured, and private insurance covered 22.1% of insured Jordanians, about twice the national share [425]. A secondary summary misdates the census to 2016 [500]. The data are stale: about 72% of Jordanians were reported covered in 2023 [501]. Chapter 8 presents these census figures and uses them in market sizing.

Cross-border institutional payers bring volume and credit risk together. Jordan's private hospitals signed a fixed-price agreement with the Libyan government on 7 November 2011, and by June 2012 Jordan was demanding over $200M from Libya [502-504].

FIGURE 9.13

An institutional payer as volume source and credit risk: Jordan's private hospitals and Libya

01
7 November 2011
Fixed-price agreement with the Libyan government, based on the Ministry of Health-approved price list

→ 02
Early 2012
Industry body reports Libya has paid 25% of what it owes

→ 03
June 2012
Jordan demands over $200M from Libya

→ 04
Later
Libya pledges to pay a $350M debt to Jordanian private hospitals

Source: One trade-press interview with the industry body, plus two press reports; no orthopaedic breakdown. The industry body's wording ("only down 25 percent") is ambiguous; the article's arithmetic supports the "paid 25%" reading [502-504].

Two gatekeepers sit outside the patient and family: rankings, shown in Section 9.2, and "official hospital" status with sports teams, which has been partly bought since the mid-1990s [195]. HSS today presents itself as "the Official Hospital of over 30 professional teams, schools and organizations" [505].

FIGURE 9.14

Bought team titles: the sponsorship route to "official hospital" status

Mid-1990s
first known medical sponsorship deals

$1.5M
solicited by the Yankees after 1999

23
NFL teams with official providers, 2013

30+
official-hospital roles HSS claims

Source: The first known deals were signed by the Carolina Panthers and Jacksonville Jaguars; the New York Yankees solicited $1.5M for health-care marketing rights after winning the 1999 World Series. The count of 23 is a 2013 hand count that the league declined to confirm. The 30+ figure is HSS's own description of itself as the official hospital of over 30 professional teams, schools and organisations [195, 505].

9.5 The Amman and Gulf competitive set, in their own words

The study used the positioning formula ("To [target], [brand] is the [category] that [point of difference], because [reasons to believe]") as an extraction form, with two tests: competitor substitution and relevance to the target. In the Amman sample, the frame is the specialty title, usually led by the surgeon's name, and no provider states a big idea. Every positioning statement reconstructed from these materials fails the substitution test: put any other Amman surgeon's name into the frame and every clause stays true. The test is an interpretive judgement that the sources cannot refute [34, 35, 506, 507].

TABLE 9.11

How Amman providers and Jordanian advertisers describe themselves, verbatim

PROVIDER	WHERE THE LINE APPEARS	VERBATIM WORDING	TRANSLATION
Dr. Asaad Ahmed's centre	og:description (excerpt)	مركز الدكتور أسعد احمد لجراحة المفاصل والطب الرياضي متخصصون في زراعة المفاصل الصناعية وجراحة المنظار والإصابات الرياضية	Dr. Asaad Ahmed Center for Joint Surgery and Sports Medicine: specialists in joint replacement, arthroscopy and sports injuries
Dr. Ghassan Al-Khayyat	Page title (typo kept)	الدكتور غسان الخياط - دكتور استشاري جراحة العظام و تبديل المفاصل والطب الرياضي عمان الاردن	Dr. Ghassan Al-Khayyat, consultant in orthopaedic surgery, joint replacement and sports medicine, Amman, Jordan
Arab Medical Center	Page heading	ORTHOPEDICS & JOINT REPLACEMENT CENTER	English original

PROVIDER	WHERE THE LINE APPEARS	VERBATIM WORDING	TRANSLATION
Dr. Anas Al-Marahefah	Directory title	أخصائي جراحة العظام والمفاصل	specialist in orthopaedic and joint surgery
Institutional advertiser	Ad Library page name	المركز الاستشاري المتخصص لجراحة العظام والمفاصل	The Specialised Consultative Centre for Orthopaedic and Joint Surgery
Problem-led advertiser (the only one)	Ad Library page name (excerpt)	علاج الم الدسكات والركبة والمفاصل	treating disc, knee and joint pain
Heaviest advertiser (16 of 50 ads)	Ad Library page name	الدكتور علاء حوا - أخصائي جراحة العظام والمفاصل	Dr. Alaa Hawa, specialist in orthopaedic and joint surgery

Source: Provider pages checked against raw HTML during independent verification, except the Tebcan directory title, which was confirmed from a text rendering of the page rather than its raw HTML. Dr. Asaad Ahmed's English page also calls the centre “Dr. Asaad AlSheikh's Center”, a naming inconsistency on its own site [34, 35, 462, 506, 507].

Paid social uses the same wording. Two Meta Ad Library queries of active ads reaching Jordan, both run on 24 September 2026, point the same way; the first query's results were not independently checked. In the second, 13 of the 15 orthopaedic pages among the first 50 ads are personal-name pages. The heaviest advertiser placed 16 of the 50 ads; in the first query, the same page's link titles pointed to a personal Instagram account (not independently checked). The library returns page names, not ad text; the pull covers all of Jordan, includes some advertisers outside it and captures one day's active set [462].

TABLE 9.12

Two Meta Ad Library queries, Jordan, active ads, 24 September 2026

QUERY	SEARCH TERM	ESTIMATED ACTIVE ADS	SAMPLE EXAMINED	FINDING
First (not independently checked)	“جراحة العظام والمفاصل” (orthopaedic and joint surgery)	106	First 25 ads (11 advertiser pages)	8 of 11 pages named “[Dr. name] – [title] of orthopaedic and joint surgery”; one problem-led page; the heaviest advertiser's link titles point to a personal Instagram account (not independently checked)
Second	“جراحة العظام” (orthopaedic surgery)	130	First 50 ads; 15 orthopaedic pages	13 personal-name pages, of which 11 pair the name with a specialty title; 2 institutional pages; the heaviest advertiser placed 16 of the 50 ads

Source: Page names only, no ad body text; one attempt to retrieve an ad snapshot failed [462].

FIGURE 9.15

Advertiser pages among the first 50 active orthopaedic ads reaching Jordan



13 Orthopaedic personal-name pages (59.1%)

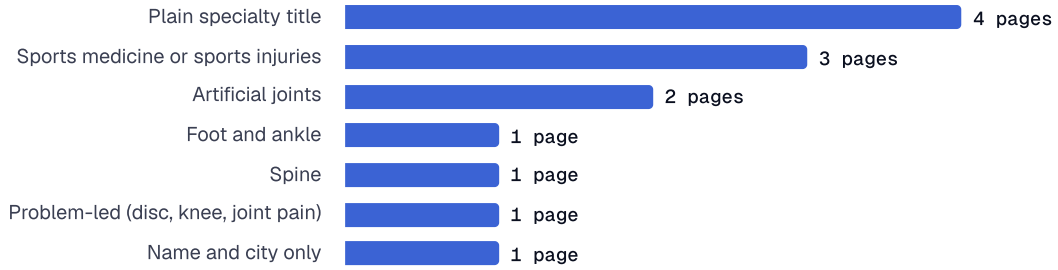
2 Orthopaedic institutional pages (9.1%)

7 Other medical or non-provider pages (31.8%)

Source: Second query (“جراحة العظام”), 24 September 2026. Some advertisers are outside Jordan (EUR, EGP and INR currencies; one centre in the West Bank) [462].

FIGURE 9.16

Sub-frames used by the 13 orthopaedic personal-name advertiser pages



Source: Coded from page names; the first five rows (11 pages) pair a name with a specialty title. Keyword match on creative text; not a census of Jordanian orthopaedic advertisers [462].

FIGURE 9.17

Jordan's paid-social field for orthopaedics in three numbers

130	13 of 15	16 of 50
active ads, "جراحة العظام"	orthopaedic pages named for a person	ads from the heaviest advertiser

Source: Second query ("جراحة العظام"); estimated active ads on 24 September 2026. The first query's 106 active ads, not independently checked, appear only in Table 9.12. [462]

KEY FINDING

The competitor-substitution test fails by construction. The sampled Amman pages use the specialty title, usually led by the surgeon's name. Of the 15 orthopaedic advertiser pages, 11 pair a personal name with a specialty title (sometimes with a sub-specialty), 2 are institutional pages built on the specialty title, 1 is problem-led and 1 gives only a name and a city [462, 506].

Superlatives in the metadata layer

The JMA advertising instructions took effect on 1 February 2025 [62]. Superlatives appear on sampled pages modified after that date, mostly in the metadata layer rather than in visible Arabic body copy. The providers concerned are anonymised here (Table 9.13); the study records wording only, and whether the JMA text is enforced on these layers is an open question. On one Amman surgeon's site (Provider A; schema dateModified 27 August 2025), "أفضل دكتور جراحة ركبة وعظام" ("best knee and bone surgery doctor") appears only in the schema description and the logo title attribute [463]; first-pass page summaries reported it as visible copy, and the verification pass corrected this against raw HTML. An Amman centre's English heading (Provider B), modified on 2 March 2025, reads "Providing the Best Medical Care for Our Patients" [463]. Chapter 3 treats the regulatory text in full.

> "أفعال التفضيل مثل (الأول، الأوحد، الأبرع، الوحيد) أو ما يشابهها" *("superlatives such as first, sole, most skilled, only, or the like")*
>
> Jordan Medical Association advertising instructions, the superlatives clause, as reported on 24 December 2024 [62].

TABLE 9.13

Superlatives and firsts in the anonymised Amman and Gulf sample, by where they sit

PROVIDER (ANONYMISED)	LAYER	WORDING (VERBATIM)	TRANSLATION OR NOTE	DATE CONTEXT
Provider A (Amman surgeon)	Schema description; logo title attribute	أفضل دكتور جراحة ركبة وعظام	“best knee and bone surgery doctor”; absent from visible text	Page dateModified 27 August 2025
Provider A	Video titles	أول عملية زراعة مفصل ركبة باستخدام الروبوت المساعد في الاردن	“first robot-assisted knee replacement in Jordan”; a “first” claim, not verified	Same site
Provider A	Proof bullet	مستشار لمؤسسات رائدة في تطوير الأجهزة والمعدات الطبية	“adviser to leading institutions developing medical devices”; device-related wording (Chapter 3)	Same site
Provider B (Amman centre)	English heading	Providing the Best Medical Care for Our Patients	A superlative	Modified 2 March 2025
Provider C (Amman medical centre)	English body copy	recognized as a pioneer in treating bone disorders in Jordan	“Pioneer” read as a “first” claim	Page dated 28 January 2019, before the rules
Provider D (Ad Library advertiser page)	Page name	A doctor's name in English, then in Arabic (not reproduced)	English placed before Arabic	Active ad, 24 September 2026
Provider E (Abu Dhabi hospital)	Page title	Best Orthopedic Surgeon in Abu Dhabi	A search string	Live page
Provider F (Dubai hospital)	Page title; body copy	Best Orthopedic Surgeons in Dubai; the United Arab Emirates' first EOS imaging machine	“Best” and “first”	Live page
Provider G (Dubai surgeon)	Page title	Best Orthopedic Doctor in Dubai, UAE	The phrase appears 12 times in the page source	Live page

Source: Providers are anonymised. The table records wording only; it makes no finding of breach, and whether the JMA text is enforced on these layers is an open question (Chapter 3) [462, 463].

FIGURE 9.18

Superlatives, counts and main proof across the sampled providers

	Superlative or "first"	Volume counts	Main proof offered
Provider A (Amman)	"best" (metadata); "first" (video titles)	None reported	Fellowships; foreign training; years of experience
Provider B (Amman)	"Best Medical Care" heading	1,200+ patients (unaudited counter)	Years in practice; staff count; insurer list; media appearances
Al-Marahefah (Amman)	None reported	None reported	12+ years at Royal Medical Services; 4.9/5 from 33 ratings
Provider E (Abu Dhabi)	"Best" in page title	1,500+ procedures; 28,000+ out-patient visits	Named device
Provider F (Dubai)	"Best" in title; UAE's first EOS machine	None reported	"one stop shop"; 0% instalments
Provider G (Dubai)	"Best" in title	None reported	Over a decade in London; awards (not independently checked)
Aspetar (Doha)	"world-leading"; "first of its kind"	None reported	Dated accreditations, 2009 to 2020

Volume counts published; whether the lawful form permits them is open (Chapter 3) Not applicable or not assessed (see note)

Source: Providers A to G as in Table 9.13; Aspetar is the benchmark case named throughout the chapter. No sampled Amman provider publishes an outcome measure. The awards claimed on Provider G's page were not independently checked [33, 463, 507].

Gulf headlines are search strings, not positioning

The Gulf page titles are search-keyword strings shared across competitors. Beneath them, an Abu Dhabi hospital (Provider E) publishes counts, names a device and carries the tagline "Robotic joint replacement, minimally invasive arthroscopy, and performance-driven rehabilitation— by a trusted orthopedic team." [463]. A Dubai hospital (Provider F) offers a "first", an organising frame ("one stop shop") and a monetary lever ("0% INTEREST INSTALLMENT PLANS") [463]. A Dubai surgeon (Provider G) offers one culturally specific psychological line, "from prayer to play" [463], which matches the Kuwaiti theme of difficulty praying normally [32]. In Jordan, "best", "first", named devices and instalment advertising outside the clinic are all forms the JMA text restricts; the study records the wording and makes no finding of breach. Only Aspetar passes the substitution test, and it passes on structure, not wording; this too is an interpretive judgement that the sources cannot refute [33, 478]. At hospital level, one Amman hospital's quoted mission, "the best in class in every service we offer", is generic (not independently checked; secondary source) [463]. Cleveland Clinic Abu Dhabi lists no orthopaedic institute among its eight (not independently checked) [508].

Amman proof is credentials, not outcomes: fellowships and foreign training ("M.B,B.S. FRCSI, FAAOS, DSM"; Irish training from 1993 to 2000; "20 عامًا من الخبرة", 20 years of experience) [35]; more than 12 years at Royal Medical Services, society memberships and 4.9/5 from 33 ratings [507]; and an insurer list and media appearances [463]. A claim that no Amman provider publishes volumes was refuted. Provider B's page carries counters in its static HTML: 1,200+ patients, 15 years and 250+ staff, plus "75+ branch clinics", which looks like a template leftover. Among Amman providers, only this centre names the companion as someone it serves [463].

9.6 Value stacks and the proof behind them

The value stack separates functional, psychological and monetary value and asks what proof stands behind each.

TABLE 9.14

Value stacks: claims, the proof offered and what the evidence says about it

ROW	WHAT FAMOUS BRANDS CLAIMED	THE PROOF ACTUALLY OFFERED	WHAT THE EVIDENCE SAYS ABOUT THAT PROOF
Functional	Outcomes, specialisation, reliability	HSS: ranking streak, volume, relative outcome claims with no rates. Aspetar: accreditations. Geisinger: protocol compliance rising from 59% to 100% (not independently checked). Rothman: episode cost and length of stay. Amman: credentials, plus one unaudited patient counter (Provider B, an Amman centre: 1,200+ patients); no outcome measures.	Geisinger improved 8 of 9 outcomes in trend, but only discharge likelihood was significant (not independently checked). HSS publishes no link between volume and outcomes. None of 21 single-intervention ads from famous academic centres quantified its benefit. In Amman, plain procedure counts and named accreditations would be an unoccupied proof position, if the JMA permits them.
Psychological	Empathy, reassurance, being understood	Cleveland Clinic's empathy programme. Amman: “quality of life”, “return to normal activities” (not independently checked). Dubai: “from prayer to play”.	The peer-reviewed effect of the training is small (Section 9.7). The “24th to 99th percentile” story comes from a book by the programme's own leaders. The measured regional demand is information: Kuwaiti participants trusted their surgeons fully but received insufficient information, and in Taif the authors conclude that the surgeon's attitudes contributed most to selection, ahead of reputation.
Monetary	Value for money, predictability	Geisinger: a fixed per-case rate covering the whole episode where insurers agree (not independently checked). Rothman: bundled-payment savings. Provider F, a Dubai hospital: 0% instalments. Amman: an insurer list.	Rothman's per-patient margin fell from $2,683 to $522 as Medicare reset its targets, though its patients were also sicker. Jordan's 2024 fee schedule sets minimum–maximum bands, and hospital, implant and room charges sit outside it.

Source: [32, 33, 436, 461, 463–466, 469, 506, 509–512]

Three results reshape an earlier working reading: that the functional row is table stakes, the psychological row is the lever, and the monetary row must be reframed as transparency. In the functional row, Amman proof is credentials plus one unaudited patient counter and no outcome measures, so plain procedure counts and named accreditations would be unoccupied rather than table stakes [34]. In the psychological row, what the regional evidence measures is a demand for information and communication, and the measured effects of empathy programmes are small [32, 465]. In the monetary row, the reframing holds, but Jordan's fees are bands, not fixed points [436].

The 2024 fee schedule took effect on 16 November 2024. It is 60% above the 2008 schedule, phased in three 20% steps, after one month, one year and two years. The Health Minister issued it under the Public Health Law, and it sets minimum–maximum bands, such as 15 to 30 JD for a surgical specialist [436, 449, 513]. A claim that the schedule's immediate changes were +100% for general-practitioner visits, +50% for specialists and +20% for procedures, and that insurers had agreed to apply it, was refuted. Those were the insurers' own terms, and the JMA president called them unauthorised, holding that only the tariff published in the Official Gazette is valid [49]. Price is therefore bounded, not fixed; what the schedule blocks is discounting and going below the minimum. Chapter 8 sets out the schedule's fee bands.

> **WHAT THIS MEANS FOR A PRACTICE**
>
> For a practice in Jordan, the monetary row can hold clarity about the total episode, a written list of what is included, and insurance acceptance. Warranties, guarantees and advertised fixed-price packages are recorded as cases only, and whether a fixed episode price counts as a prohibited “offer” is an open regulatory question (Chapter 3) [463].

9.7 Execution: where the idea became operations, and where it stopped

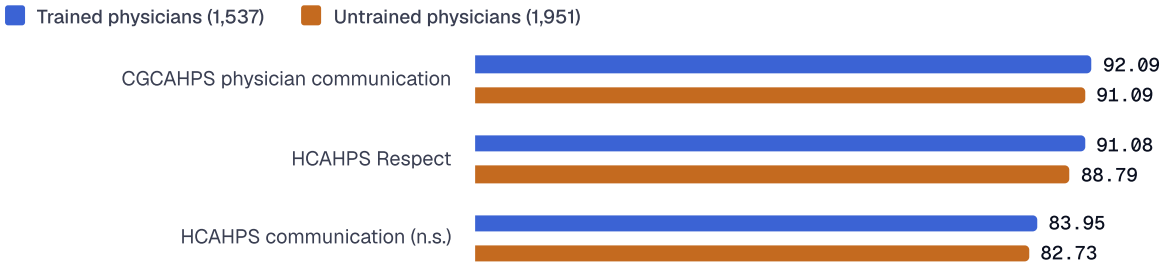
Cleveland Clinic turned a slogan into an operating system, against resistance. From 2006 it made rooms, food, visiting hours and records access patient-facing. An Office of Patient Experience and the first chief experience officer followed in 2007 [473, 475]. The chief executive's book gives three reasons. The change was the right thing to do; research showed that patients do better with empathetic care; and there was a business case, because technology "can level the playing field" on outcomes. Empathy training later reached all 43,000 caregivers [510].

> *"Surprisingly, the greatest resistance came from physicians." One physician asked: "What is this, patients first and doctors last?"*
>
> The Cleveland Clinic Way, excerpt hosted by Cleveland Clinic [475].

The measured effect of the training is small. A peer-reviewed observational study compared 1,537 trained with 1,951 untrained physicians over a course run from 1 August 2013 to 30 April 2014. Adjusted CGCAHPS physician-communication scores were 92.09 against 91.09 ($p < 0.03$), and HCAHPS communication did not differ significantly (Figure 9.19) [465]. The "24th to 99th percentile" story comes from a book by the programme's own leaders [511]. The two use different measures and designs, and the self-authored figure carries no weight here.

FIGURE 9.19

Cleveland Clinic communication training: adjusted patient-experience scores, trained against untrained physicians



Source: Observational, not randomised; $p < 0.03$, $p = 0.02$ and $p = 0.22$ respectively [465].

Where Cleveland Clinic's promise stopped was safety operations. In June 2014 federal inspectors cited 23 health and safety issues, including operating-room fires that burned patients and surgeons whose credentials had not been checked for the procedures they performed. It was at least the third such warning in four years, and the response was operational: credentialing and inventory tracking (not independently checked) [514]. Where Mayo's promise stopped was payer mix: a late-2016 internal speech by the chief executive asked staff to prioritise commercially insured patients over Medicare and Medicaid patients when needs were equal, and when reported in March 2017 it drew a Minnesota civil-rights inquiry and a walk-back (not independently checked) [515, 516].

> *"Patient medical need will always be the primary factor"*
>
> Mayo Clinic's chief executive, walking back the payer-mix remarks, March 2017 (not independently checked) [516].

Protocol advantages are real but temporary. Across 9,195 Medicare primary joint replacements at Rothman from 2015 to 2018, discharge to rehabilitation fell from 23% to 14% and length of stay from 2.1 to 1.7 days, while readmissions stayed flat at 6%. As Medicare reset the target price, the per-patient margin fell from

$2,683 to $522 (Table 9.15) [466]. The authors note that their 2018 patients were sicker, and they present the erosion as a flaw in the target-price method, which penalises caring for more complex patients.

TABLE 9.15

Rothman under Medicare bundled payments, 2015 against 2018

MEASURE	2015	2018
Medicare target price per patient	$22,280	$18,971
90-day episode cost per patient	$19,954	$18,449
Margin per patient	$2,683	$522
Discharge to rehabilitation	23%	14%
Length of stay	2.1 days	1.7 days
Readmissions	6%	6%

Source: 9,195 Medicare primary joint replacements; all changes P<.001 except readmissions (P=.945). The authors note that their 2018 patients were sicker. Values as reported by the authors; the 2015 margin is not the simple difference between the target price and the episode cost shown [466].

Aspetar pairs its facility with a run of accreditations. It was the exclusive provider of athlete services to all 32 teams at the 2022 World Cup (self-reported; not independently checked) [33]. The service-design reading of Mayo holds that patients “turn detective, looking for evidence of competence, caring, and integrity” [517]. Only its introduction could be retrieved, so the clue examples were not verified.

TABLE 9.16

Execution: the operating change behind each idea, and where the promise stopped

CASE	OPERATING CHANGE	WHERE THE PROMISE STOPPED	STATUS
Cleveland Clinic	Patient-facing rooms, food, visiting hours and records access (from 2006); Office of Patient Experience and first chief experience officer (2007); empathy training for 43,000 caregivers	June 2014: 23 federal health and safety citations, including operating-room fires and unchecked credentials	Operating changes confirmed; 2014 citations not independently checked
Mayo Clinic	Model of Care and Model of Education (2001)	Late 2016 payer-mix speech; March 2017 civil-rights inquiry and walk-back	2001 documents confirmed; 2016–2017 episode not independently checked
Rothman	Protocol-driven joint pathway under Medicare bundled payments	Margin fell from $2,683 to $522 as target prices reset	Confirmed
Geisinger	Protocol, a fixed per-case rate and, from 2014, orthopaedic offerings with a 45-point checklist	No break recorded; proof limited to process data (only discharge likelihood significant)	Not independently checked
Aspetar	Facility plus dated accreditations; 2022 World Cup athlete services	No break recorded in the study	Accreditations confirmed; World Cup role self-reported, not independently checked

Source: [33, 459, 466, 473, 475, 509, 510, 512, 514–516]

KEY FINDING

The idea travelled when it became offices, roles, protocols and training. In the two public breaks recorded, both from sources not independently checked, it broke where operations or finance contradicted it. No case shows a slogan repairing an operating gap. Chapter 7 takes up what this implies for the brand as an economic asset [475, 514, 516].

9.8 Twelve candidate category frames, none chosen

The study lays out candidate category frames for testing. Frames 1 to 3 describe the local field; frames 4 to 12 each exist somewhere, with a named proof requirement. None is chosen [463].

TABLE 9.17

Twelve candidate category frames, laid out for testing

#	FRAME	PRECEDENT FOUND	PROOF IT WOULD NEED	REGULATORY STATUS	MAIN RISK
1	Specialty title (“consultant orthopaedic and joint surgeon”)	Every sampled Amman page; 13 of 15 orthopaedic advertiser pages (11 personal-name, 2 institutional)	Credentials	Permissible	Fails substitution by construction; it is the parity baseline
2	Body region (knee, spine, foot and ankle)	One foot-and-ankle page and one spine page in Jordan's ads	Region-specific outcomes; a JMC-registered specialty	Only registered specialties may be advertised	A cosmetic foot sub-frame collides with HSS and AOFAS positions, a legitimacy risk with referrers
3	Problem-led (pain, disc, knee)	One Jordanian advertiser	Scientifically established education content	Education must be substantiated	Generic unless tied to specific entry situations
4	Population: athletes and sport	Aspetar; HSS team roles; Provider B (an Amman centre)	Earned federation or club roles; third-party accreditation	Naming a club may collide with the sponsor ban	“Official” status is often bought, and a state-backed model cannot be copied
5	Life-return outcome (mobility, “from prayer to play”)	Provider G (a Dubai surgeon); the Kuwaiti “difficulty praying” theme	Consented same-patient material; patient-reported outcomes	Before and after images only with written consent, never intra-operative	Generic unless culturally specific and proven
6	Explanation and information (“the surgeon who explains”)	Kuwaiti finding of trust but too little information; Taif attitude drivers; Provider B's “Enhancing Patient Awareness” (not independently checked)	An independent patient-reported communication measure	Permissible	Measured empathy effects are small; this has to be operated, not claimed
7	Reliability and risk reduction (protocol, what is included)	Geisinger (not independently checked); Rothman	Process data; clarity about the total episode	A fixed price may be an “offer”	Payer-facing, and the advantage erodes; answers the fear barrier (50.4%)
8	Technology or implant	Provider A (robot); Provider E (named device); Provider G (custom implants)	Device-neutral description	Naming devices and claiming “first” are banned	14.9% of Amman surgical outpatients knew robotic surgery was available in Jordan
9	Single named procedure	Shouldice (not independently checked); LCA-Vision shock (not independently checked)	Published outcome data	Unregistered discoveries are banned	Exposed to demand shocks if discretionary

#	FRAME	PRECEDENT FOUND	PROOF IT WOULD NEED	REGULATORY STATUS	MAIN RISK
10	Family and cross-border (“Jordan for the Gulf family”)	Kuwaiti families consulting in Jordan on holiday; an Amman hospital's Gulf target (not independently checked)	Institutional credentials; access logistics	Permissible	Payer concentration and credit risk (Libya)
11	Founder values (“the patient's interest first”)	Mayo Clinic; Cleveland Clinic	A dated founder document plus operating proof	Permissible	Generic unless operated; both precedents codified it after fame
12	Scale or network	Rothman	Counts of surgeons, sites and volume	“Largest” is banned; plain counts are an open question	Not available at a single-surgeon practice's scale; the name can be lost at a partner's boundary (NYU Langone case not independently checked)

Source: Regulatory status as read from the JMA text (Chapter 3). Providers A, B, E and G as in Table 9.13. [32, 33, 195, 378, 435, 462–464, 466, 480, 481, 491–493, 497, 502, 512]

Whether any frame fits a given practice depends on facts a desk study cannot supply: its registered specialties, actual patient mix and referral routes, claimed procedures, and who comes to consultations. An earlier working hypothesis, that a big idea must be broad enough to last from a home city to Amman to Dubai, is parked. No case shows a big idea travelling; what travelled was structure: HSS's scope, Aspetar's segment and Rothman's scale [463].

What second-phase fieldwork has to measure

- Intake route for every new orthopaedic patient at each of a practice's sites, in fixed categories (physician or physiotherapist referral, family or friend, previous patient, Instagram or social media, insurer network, sponsoring body), recording consultations and surgery separately, for comparison with the US baseline and the Saudi social-fame figures.
- Who attends the consultation, who asks the cost and recovery questions, and who confirms the booking, to test the family's role in whether to operate against its role in choosing the surgeon.
- Cosmetic-foot enquiries against joint and sports enquiries: route, payer and conversion, kept in aggregate only, with no patient data.
- The number of distinct referring physicians and their share of referrals, as a brand-asset measure alongside follower count.
- Regulatory follow-up (Chapter 3): plain procedure counts; named accreditations; a fixed episode price or complication cover; naming a sports club; a metadata-layer audit; English-first page names.

The myths the study retired and its contradiction ledger appear in Appendices B and C. Chapter 11 turns the fieldwork list into next steps.

> **WHAT THIS MEANS FOR A PRACTICE**
>
> The study lays out the field; it does not choose. The category frame, like the brand architecture (Chapter 5) and the Amman path (Chapter 8), is each practice's own decision, to be informed by the proof each frame would need and by the intake data from second-phase fieldwork [463].

LIMITS OF THIS EVIDENCE

- This is desk research only: a web-based first pass with no fieldwork or patient data.
- Of the 58 claims, 19 were not selected for independent verification. Where they are used they are labelled “not independently checked”.
- Agreement across perspectives is sometimes one source rather than several. Three perspectives rest on Laverdiere 2025, four on the Kuwaiti Al-Taiar 2013 study and five on Aspetar's About page.
- The choice studies are strongly skewed towards the US, and no Jordanian study of elective orthopaedic decisions was found.
- Web-archive snapshots were unavailable, so no current tagline could be dated earlier than its live page.
- The Ad Library pulls show page names only, not ad text. They cover all of Jordan, include some advertisers outside it, and capture one day's active set through a keyword match; they are not a census. The first query's results were not independently checked.
- The Saudi surveys measure stated importance on Likert scales in convenience or online samples, often young or health-sector-heavy. The Kuwaiti study is qualitative, thin, from 2013 and limited to women on a public waiting list.
- Institutional self-retelling (Mayo, Cleveland Clinic, Aspetar) is used and labelled as such. The weakest sources are vendor or consultant narratives, university self-summaries, self-published programme books and trade-press interviews.
- First-pass page summaries misreported three items (a metadata superlative shown as visible copy, a “London heritage” reference, and empty counters). The verification pass corrected all three against raw HTML.
- The Gulf samples lean on institutions' own pages, and several publisher and institutional pages could not be retrieved.
- Coverage gaps: the big ideas of Dr. Sulaiman Al Habib, Moorfields, Steadman, Andrews and Kerlan-Jobe; Cleveland Clinic Abu Dhabi's orthopaedic page; the own pages of Dr. Thair Afifi, Amman Hospital and Saudi Hospital Clinics; ad body text; Berry and Seltman 2007; the detail of the service-clue article.
- The Jordanian insurance data come from the 2015 census and are stale; about 72% of Jordanians were reported covered in 2023.

LEFT OPEN

- Which category frame, if any, a practice should adopt. The study lays out twelve candidates and chooses none.
- Whether plain procedure counts and named accreditations are permissible under the JMA text. If they are, they would be an unoccupied proof position in Amman.
- Whether an advertised fixed episode price or complication cover counts as a prohibited “offer”.
- Whether naming a sports club in marketing collides with the JMA ban on sponsors.
- How a practice's new orthopaedic patients arrive, and how the social-media share compares with the US baseline (referral 44.9%, word of mouth 18.7%, ads 8.4%) and the Saudi figures.
- Who attends consultations, who asks the cost and recovery questions, and who confirms bookings: the family's role in whether to operate against its role in choosing the surgeon, in Jordan.
- How cosmetic-foot enquiries compare with joint and sports enquiries on route, payer and conversion.
- How many distinct physicians refer to a surgeon, and what share of patients they account for, as a brand-asset measure alongside follower count.
- A practice's registered specialties, actual patient mix, referral routes and claimed procedures, without which no frame's fit can be judged.
- Whether competitors' metadata-layer superlatives and English-first page names are enforced, and what a compliant audit of titles, schema alt text and video titles would require.

PART III

Synthesis

10 Discussion

11 Implications and next steps

12 Limitations

13 Conclusion



CHAPTER 10

Discussion

What the evidence says when the studies are read together

10.1 Through-lines across the evidence

Read together, Chapters 3 to 9 converge on a small number of patterns. None was assumed at the outset; each is stated below with its evidence, the chapters it draws on and its own limit.

TABLE 10.1

Through-lines across Chapters 3 to 9

THROUGH-LINE	EVIDENCE	CHAPTERS	LIMIT
Attention is granted by third parties before it is built	In 12 of the 15 best-documented cases a producer, editor, publicist, sports agent or institution granted the first audience; the 2 named counter-cases both sat on institutional titles [1, 143, 150]. Peer reputation explains over 95% of the variation in a ranking that moves elective volume [19].	4, 9	The case set skews to English-language, US and cosmetic-adjacent fame.
Patients state that credentials outrank popularity; observed social-media effects are small	Qualifications 91.7% and review positivity 91.6% against 45.9% for likes (n=1,242) [6]; board certification scored 9.12 and team affiliation 4.75 (n=382) [152]; about 7 more prostatectomies a year with a social-media presence [153].	4, 5, 7	Stated preference; no Jordanian study of elective orthopaedic decisions was found.
Referral and word of mouth dominate first contact; online research is common but is not acquisition	44.9% referral, 18.7% word of mouth, 8.4% online advertisements (n=808) [7]; 39.5% researched online but 8.5% named the internet as their referral source (n=329) [364]; 63.6% of 341 Saudi respondents used digital information before consultation [315].	6, 8, 9	US-based baselines; arrival routes for Jordanian practices are unmeasured.
Businesses and rights transfer; no sale reviewed priced a name separately	US$40.4m across 13 practice transactions with no name-only allocation [18]; where a name was priced, it was a related-party contracted rate (10% of monthly net profit for the name, separately from 3% of net revenue after rejections for management) [313] or a modelled estimate (US$419m for Burjeel) [42], not a market price for the name.	5, 7, 8	Private contract terms were unavailable; undisclosed allocations are unknowns, not zeros.
Current slogans followed the fame; founder-era creeds were codified later	No case studied shows a current slogan dated before fame; Mayo's current wording was in print by 2000 and codified for patients in 2001, long after visiting surgeons formed the Surgeons' Club at Rochester on 7 June 1906 [20, 21, 459]. Founder-era creeds existed, Mayo's in 1910 and Cleveland Clinic's founder line by its own account, and were codified into slogans and operating systems later [467, 475].	9	Web-archive snapshots were unavailable, so no current tagline could be dated earlier than its live page.
Proof devices are regulated; substantiation and publication are separate decisions	Credentials, education, broadcast, books and institutional roles are lawful in every regime read; testimonials range from a criminal offence in Australia to lawful with written consent in Dubai [54, 55]; Article 5(2)(و) bars “first” and “only” without exception [8].	3, 6	JMA committee output is unpublished; application to specific wording is untested.
Audiences burst, ramp and plateau; later media buy small lifts	1 burst, a multi-year ramp and a plateau on every video-platform account with usable resolution [23, 24]; +16% in 62 days and +5% in 33 days around television [162, 163].	4	Archives miss the first fame moment; platform rounding limits plateau claims.
A bounded search that finds nothing is a search result, not proof of absence	No brand-decay half-life was found [404]; no study comparing naming architectures was retrieved [14].	5, 6, 7	Each negative can be overturned by a single later source.

Source: [1, 6-8, 14, 18-21, 23, 24, 42, 54, 55, 143, 150, 152, 153, 162, 163, 313, 315, 364, 404, 459, 467, 475]

How patients say they choose, and how they first hear

The patient evidence is consistent in direction and limited in reach. Where patients are asked what matters, credentials and reviews rank far above popularity signals. Where first contact is measured, referral and word of mouth lead, and online advertising is a small share, although many patients research a surgeon online before the visit. One further study, not independently checked, found that advertising exposure shifts hospital choice (Chapter 9). None of these studies is Jordanian. The figures are charted where the evidence was first examined: first contact among 808 US arthroplasty (joint-replacement) patients in Chapter 9, the Saudi importance ratings and the television lifts in Chapter 4, and online research against stated referral source in Chapter 6.

KEY FINDING

Across chapters, the record shows attention granted by third parties; where first contact is measured, referral and word of mouth lead, and the rankings that move volume rest mostly on peer reputation. Self-published content appears in the record mainly as the vehicle for a platform-native burst, followed by a ramp and a plateau.

10.2 A synthesis map

The map below records, for each substantive chapter, whether it contributes strong, partial or no evidence to each strategic question. It is an editorial reading of the chapter findings, not a measured score. “Strong” means the chapter answers part of the question directly with verified evidence; “partial” means it supplies evidence that bears on the question without answering it; “none” means the chapter contributes nothing material to it.

FIGURE 10.1

Where each chapter contributes evidence to the 7 strategic questions

	Q1 Whose brand	Q2 Known for what	Q3 Fame	Q4 Asset	Q5 What travels	Q6 Distinct or different	Q7 Find and book
Ch 3 Regulation	None	Partial	Partial	None	Partial	Partial	Partial
Ch 4 Fame	Partial	Partial	Strong	Partial	None	Partial	Partial
Ch 5 Architecture	Strong	None	None	Partial	Partial	None	Partial
Ch 6 Differentiation	None	Partial	Partial	Partial	None	Strong	Partial
Ch 7 Asset	Partial	None	None	Strong	Partial	None	Partial
Ch 8 Market entry	Partial	None	None	Partial	Strong	Partial	Partial
Ch 9 Strategy	Partial	Strong	Partial	Partial	Partial	Partial	Partial

Strong: answers part of the question directly · Partial: evidence bears on the question · None: no material evidence

Source: Editorial coding of the chapter findings, key findings and open questions for Chapters 3 to 9; not a statistical measure.

Read by column, the map shows 1 chapter with strong evidence for each of Q1 (Chapter 5), Q2 (Chapter 9), Q3 (Chapter 4), Q4 (Chapter 7), Q5 (Chapter 8) and Q6 (Chapter 6). Q7, how patients find and book, has partial evidence in all 7 chapters and strong evidence in none, because the study dedicated to it has not yet run.

Read by row, Chapter 9 touches every question, which reflects its role as the stream that tested strategy claims against the record, and Chapter 3 bears on most questions as a constraint rather than as an answer. For the 3 open decisions (Q1, Q2 and Q5) the strong evidence sits in 1 chapter each; the remaining inputs are a practice's own records, a JMA clarification and fieldwork.

> LIMIT
>
> The map records where evidence exists, not how favourable it is to any option. A “strong” cell can hold evidence that keeps options open, as in Chapter 5, where the strongest finding is that all 3 architecture routes remain available.

10.3 The 3 decisions

3 decisions recur for a surgeon building a name: the brand architecture, the category frame and, for a practice outside the capital, the path into Amman. The sources leave each open. The table sets out, for each, what the evidence establishes, what it cannot establish, and what only the practice itself can supply.

TABLE 10.2

The 3 open decisions: what the evidence establishes and what it needs

DECISION	WHAT THE EVIDENCE ESTABLISHES	WHAT IT CANNOT ESTABLISH	WHAT ONLY THE PRACTICE CAN SUPPLY
Brand architecture (Q1; Chapter 5)	A founder surname can operate beyond its founder (a Rothman office opened 1 July 2021, after the founder's death on 21 October 2018) [12, 13]; institutions can keep individual doctors visible; the public name, the owner of the mark and the operator can differ [311]; Saudi German priced name use for a related-party hospital at 10% of monthly net profit, separately from management at 3% of net revenue after rejections (related-party terms, not market benchmarks) [313].	Which name should lead; any causal naming effect; the recognition, associations and rights of an existing clinic name; which name Amman patients and referrers remember first [14].	Whether the organisation is the surgeon’s own surgical practice or a group expected to attract patients for other clinicians, and at what stage; which entity controls the name and accounts; what the identity should mean if the surgeon reduces operating time, changes city or adds a colleague.
Category frame (Q2; Chapters 9 and 6)	Frames that held were structural (narrowed scope, a patient segment with third-party proof, or scale); among the first 50 active ads on 24 September 2026, 13 of the 15 orthopaedic advertiser pages in Jordan's paid social were personal-name pages [462]; no sampled Amman provider states a big idea or publishes an outcome measure; superlatives are prohibited [8].	Which frame grows faster or lasts longer; how Jordanian patients and referrers weigh recognition against difference; how views convert to cases.	The surgeon’s verbatim surgery claim (Arabic and any English version), the standard operation name and current version; registered specialties; actual patient mix; referral routes.
Amman path (Q5; Chapters 8 and 7, Appendix D)	Documented expansions paired a name with local capacity [26]; established names did not guarantee timing [421, 422]; Amman's payer base differs from the national one [425]; break-even depends on retained contribution [22].	Demand for an Amman presence; service-line incidence; fees and collections; hospital privileges and payer onboarding times; the operative clauses of Regulation 25/2025; any name-only expansion return.	Aggregate activity at any existing Amman sessions (new versus repeat episodes, service mix, patient origin, payer route, receipts, attribution); fees by payer and procedure; weekly time allocation between cities; owner compensation, capital ceiling, tolerable cash loss and evidence threshold; the configuration to assess.

Source: [8, 12-14, 22, 26, 311, 313, 421, 422, 425, 462]

Evidence bearing on the architecture decision

Patient evidence suggests that clinician-level and institution-level trust both deserve investigation, but none of it tests which name should lead. In a Saudi survey of private orthopaedic respondents, the surgeon's knowledge and skill and the hospital's reputation were all rated very important by clear majorities [315]

(charted in Chapter 5). The Jordanian survey of 1,708 adults cannot represent Amman orthopaedic patients, because 81.3% held a bachelor's degree or higher and 49.7% worked or studied in health [50].

Evidence bearing on the Amman decision

Official statistics frame the Amman market without sizing it. Amman Governorate's estimated population is more than twice Irbid's, but governorate totals are not catchments or obtainable patients [27]. In the 2015 census, Amman residents were less often insured than the national average, yet those insured in Amman were more often privately insured [425] (both charted in Chapter 8). The census is stale; about 72% of Jordanians were reported covered in 2023 (Chapter 9).

> **WHAT THIS MEANS FOR A PRACTICE**
>
> Each decision can be advanced now without being taken now. The architecture decision advances when the surgeon states the intent for the organisation and the control of its name; the frame decision when the verbatim surgery claim and the patient mix are written down; the Amman decision when aggregate activity records and the owner's thresholds are available.

10.4 Candidate category frames

Chapter 9 tested the common account that famous medical institutions became famous by choosing a sharp category, a positioning statement and a big idea, and found that the record does not support it. In the case record, the frames that held were structural: a narrowed scope, a patient segment with third-party proof, or scale. In the 2 public breaks the study recorded, both reported in sources not independently checked, the cause was operations and finance.

In Amman and in Jordan's paid social advertising, orthopaedic providers present themselves by specialty title, usually led by the surgeon's name. No sampled provider states a big idea, and every positioning statement reconstructed from their materials fails the competitor-substitution test, an interpretive judgement the sources cannot refute. Superlatives such as "أفضل دكتور جراحة ركبة وعظام" ("best knee and bone surgery doctor") survive in metadata on pages modified after the rules took effect on 1 February 2025 [34, 35, 62].

FIGURE 10.2

How 13 personal-name orthopaedic advertiser pages in Jordan's paid social present themselves



Source: [462]. The 13 personal-name pages were among 15 orthopaedic advertiser pages in Jordan's paid social. First 50 active ads on 24 September 2026; page names only, one day's active set, not a census.

Against this field, Chapter 9 lays out candidate category frames, each with its precedent, the proof it would need, its regulatory status and its main risk. The list is not repeated here. Read as a group, the frames fall into a few kinds, and the evidence says more about what each kind would require than about which would work. Table 10.3 sets out the proof and regulatory status by kind. None is chosen; the choice rests with each practice.

- Proof. In the case record, the frames that held were structural: a narrowed scope, a patient segment with third-party proof, or scale (Chapter 9). In Amman no sampled provider publishes an outcome measure, and the only volume counter found is 1,200+ patients [34]; plain procedure counts and named accreditations would therefore be an unoccupied proof position, if the JMA permits them.

- Regulation. Every kind of frame must be expressed without superlatives, and “first” and “only” are barred without exception [8]. The kinds meet the text at different points: scope frames at the rule that only registered specialties may be advertised, segment frames at the ban on sponsors, outcome frames at the consent rule for before-and-after images, reliability frames at the exclusion of guarantees and the ban on offers, and signature frames at the bans on naming devices, claiming “first” and advertising unregistered discoveries.
- Unresolved points. Whether plain counts, a fixed episode price and a named sports club are permissible is not settled by the text; the written query to the JMA on the decision agenda (Chapter 11) is the route to an answer.
- Fit. No frame’s fit to a given surgeon can be judged until that surgeon’s registered specialties, patient mix, referral routes and verbatim surgery claim are known.

TABLE 10.3

What each kind of candidate frame would need

KIND OF FRAME	FRAMES IN CHAPTER 9	PROOF IT WOULD NEED	REGULATORY STATUS UNDER THE JMA TEXT
Scope: specialty title, body region or patient problem	1–3	Credentials; region-specific outcomes; scientifically established education content	Permissible; only registered specialties may be advertised, and education must be substantiated
Patient segment: athletes and sport, Gulf families	4, 10	Earned federation or club roles and third-party accreditation; institutional credentials and access logistics	Naming a club may collide with the ban on sponsors; the family frame is permissible
Outcome, explanation and reliability	5–7	Consented same-patient material and patient-reported outcomes; an independent patient-reported communication measure; process data and clarity about the total episode	Before-and-after images only with written consent, never intra-operative; the explanation frame is permissible; guarantees excluded; a fixed price may be a prohibited “offer”
Signature: technology, implant or a single named procedure	8, 9	A device-neutral description; published outcome data and the surgery-claim test	Naming devices, claiming “first” and advertising unregistered discoveries are banned
Founder values	11	A dated founder document plus operating proof	Permissible
Scale or network	12	Counts of surgeons, sites and volume	“Largest” is banned; whether plain counts are permitted is an open question

Source: Grouped from the candidate frames in Chapter 9, which gives each frame’s precedent and main risk; regulatory status as read from the JMA text (Chapter 3) [8].

TABLE 10.4

Open questions that bear on any category frame

OPEN QUESTION	WHY IT BEARS ON A FRAME	CHAPTER
Are plain procedure counts and named accreditations permissible under the JMA text?	If they are, they would be an unoccupied proof position in Amman: no sampled provider publishes an outcome measure, and the only volume counter found is 1,200+ patients [34]	9, 3
Does an advertised fixed episode price or complication cover count as a prohibited “offer”?	Price is bounded rather than fixed: the 2024 schedule sets bands such as 15 to 30 JD for a surgical specialist, and discounting is what is blocked [49, 436]	9
Does naming a sports club in marketing collide with the JMA ban on sponsors?	Bears on any sports-led frame [8]	9, 3
Are competitors' metadata-layer superlatives enforced?	Determines what a compliant presentation must avoid across titles, schema, alt text and video titles	9, 3

Source: [8, 34, 49, 436]

> LIMIT
>
> The competitive reading rests on public materials and one day’s active ad set. Coverage gaps include the own pages of several Amman providers and ad body text; the frames’ fit to any one practice is untested until its own inputs are available.

10.5 What the evidence does not support

The programme treated retiring false claims as a finding in its own right. Refuted claims appear in this report only as myths retired, and claims the evidence does not support are recorded with the evidence that displaces them. 2 retirements are especially consequential: the claim that no Jordanian orthopaedic surgeon had a documented fame arc, and the claim that Jordan's advertising rules are not visibly enforced. Both regulation-stream refutations moved the answer toward more enforcement and more compliance (Chapter 2); the complaint counts and the audit of 26 Jordanian physician advertisers are in Chapter 3. Appendix B consolidates every retired claim with its evidence; here they are grouped by subject.

TABLE 10.5

Myths retired, grouped by subject

SUBJECT	CLAIMS RETIRED	WHAT THE EVIDENCE SHOWS	CHAPTERS
What the rules forbid	Jordan requires a licence for every social post; before-and-after is illegal in Jordan; testimonials are banned everywhere	No per-post approval clause exists, and the only fee in the issued text is 10 dinars for a website licence; before-and-after is lawful for the same patient with written consent, while intra-procedure imagery is prohibited; testimonials range from a criminal offence in Australia to lawful with written consent in Dubai [8, 54, 55]	3
Whether the rules are enforced	Jordan's medical-advertising rules are not visibly enforced; Albelooshi's Dubai page displays no permit number	Both refuted by verification: 2 radio reports of 12 May 2026, and a page footer that displays a permit number; the JMA committee's counts cover all complaint types, and no advertising count or named advertising decision is published [9-11, 29-31]	2, 3
What fame delivers	No Jordanian orthopaedic surgeon has a documented fame arc; consistent posting compounds growth; followers become patients; a named procedure makes the surgeon famous	The Jordanian claim was refuted by verification: Osama Al-Odat was profiled at 307,000 Instagram followers in July 2021; accounts show 1 burst, a multi-year ramp and a plateau; the only social-to-volume effect found is about 7 more prostatectomies a year among 195 California urologists; in 12 of the 15 best-documented cases a third party granted the first audience [1, 2, 5, 23, 24, 153, 160]	2, 4

SUBJECT	CLAIMS RETIRED	WHAT THE EVIDENCE SHOWS	CHAPTERS
What a name or procedure is worth	A famous surgeon's name commands a universal, portable fee premium; an acquisition price is the brand's value; a doctor who stops posting has a known brand-decay half-life; a branded procedure is one stable invention that only its originator can provide	A top-20 hospital had the highest minimum price in only 1 of 5 comparable cities; the transactions reviewed disclose no name-only allocation; no half-life was found, and the study of 650 physicians reviewed was cross-sectional; a procedure name can persist while technique versions, utilisation and training change [15-18, 25, 394, 404]	5, 6, 7
Markets, fees and history	Amman's population is the private orthopaedic market; Jordan's fees are fixed and insurers agreed to the new schedule; nothing verbal came before fame	5,004,600 residents is context, not catchment or paying demand; the other 2 were refuted by verification: the 2024 schedule sets bands, such as 15 to 30 JD for a surgical specialist, and founder-era creeds existed and were codified later [27, 49, 436, 467, 475]	2, 8, 9
How evidence is read	Agreement between research perspectives corroborates a claim; bio and press follower numbers are data	1 study underpinned 3 perspectives, another 4 and 1 institutional page 5; such follower figures often proved to be cross-platform sums, daily views or undated tracker values [7, 32, 33]	2, 4, 9; Appendix D

Source: Appendix B consolidates every retired claim with its evidence [1, 2, 5, 7-11, 15-18, 23-25, 27, 29-33, 49, 54, 55, 153, 160, 394, 404, 436, 467, 475].

KEY FINDING

The retired myths run in both directions. Some overstated what the rules forbid (every post needs a licence; before-and-after is illegal); others overstated what fame delivers (followers become patients; a famous name commands a portable premium). The evidence narrows both the fears and the hopes.

CHAPTER 11

Implications and next steps

The decisions, the measures and the remaining programme

11.1 Decision agenda

The decision agenda separates 3 decisions that a surgeon building a name must take from the inputs each requires. The sources leave all 3 open. What they do establish is that each decision rests on information desk research cannot observe and that the practice either holds or can obtain. The agenda below lists those inputs, the regulatory clarification that only the JMA can give, and the decisions themselves.

FIGURE 11.1

The 3 decisions that remain with the practice

CHAPTER 5

Brand architecture

Personal name, institutional name or both. The evidence keeps all 3 routes open and gives no measured basis for retaining or discarding an existing clinic name.

CHAPTER 9

Category frame

What the surgeon is to be known for. Chapter 9 sets out candidate frames; none is chosen.

CHAPTER 8

Amman path

For a practice outside the capital, the incremental value of each step into Amman, up to an owned clinic. The investment decision remains with the practice.

Source: Chapters 5, 8 and 9.

TABLE 11.1

Decision agenda: inputs, clarifications and decisions

ITEM	TYPE	HELD BY	CHAPTER
Written query to the JMA: the unit of the Article 8 advertisement licence, the committee's form and turnaround, and whether plain procedure counts and named accreditations are permissible; whether an advertised fixed episode price counts as a prohibited offer; and whether naming a sports club collides with the ban on sponsors	Regulatory clarification	The JMA, on query from the practice	3, 9
The verbatim surgery claim in Arabic and any English version; the standard operation name and current version; indications, comparator and claimed result	Input to the surgery-claim test	The surgeon	6; Appendix D
Review of the practice's own posts, pages and listings against the JMA text: superlative and elative wording, before-and-after images and their consent status, intra-operative imagery, and anything that could read as an offer	Compliance check	Practice	3
Owner-held account analytics (reach, demographics, growth history)	Data for the measurement plan	Practice	4
Aggregate activity at any Amman sessions, fees by payer and procedure, costs and capacity	Data for the Amman worksheet	Practice	7, 8; Appendix D
Owner compensation, capital ceiling, tolerable cash loss and evidence threshold	Decision parameters	Practice	8; Appendix D
Intent for the organisation; control of the name and accounts; rights attached to any existing clinic name	Decision parameters	Practice	5

ITEM	TYPE	HELD BY	CHAPTER
Access for patient and referrer interviews and clinic observation	Fieldwork access	Practice	9, 12
Brand architecture	Decision	Practice	5
Category frame	Decision	Practice	9
Amman configuration and path	Decision	Practice	8

Source: Open questions recorded in Chapters 3, 5, 6, 7, 8 and 9 and in Appendix D.

The Amman path illustrates why a practice's own inputs are decisive. The worksheet's break-even arithmetic is simple, but its inputs are not public: at assumed contributions of JOD 10, 20 or 30 per completed unit, each JOD 1,000 of monthly fixed cost plus owner compensation requires 100, 50 or 34 units a month [22] (charted in Chapter 8). These are illustrative assumptions, not observed fees or forecasts.

> WHAT THIS MEANS FOR A PRACTICE
>
> A written query to the JMA and the practice's own inputs are the next steps toward making all 3 decisions assessable, alongside fieldwork. None of the inputs or clarifications on the agenda requires publishing anything or committing capital.

11.2 A measurement plan to start now

Several gaps in the evidence can begin to close immediately from records a practice already holds or can export. The measures below use aggregate figures only. None requires patient-identifying data to leave the clinic; clinical evidence, where needed, would be requested in aggregate, de-identified form through an authorised process (Appendix D).

TABLE 11.2

Measures to start now

MEASURE	WHY IT MATTERS	HOW TO CAPTURE IT	SOURCE CHAPTER
Platform leadership by flow	Follower stock can rank a surgeon's platforms differently from current attention; leadership should be judged by flow	Median views per post over the last 30 days on each platform, from owner analytics	4
Dated growth history	Public archives begin capturing an account only once it is notable, and bursts can go undated	Export growth charts from Instagram Insights and TikTok's creator centre; date the crossings of follower milestones	4
Reach and audience demographics	Plays include replays and are not reach; demographics are invisible publicly	Monthly export of reach, accounts engaged, location and age	4
Engagement rate, measured directly	Third-party trackers and direct readings of the same account can disagree several-fold	Compute per post from owner-side data rather than third-party trackers	4
New-patient arrival route	The only first-contact baseline is from the US (referral 44.9%, word of mouth 18.7%, online ads 8.4%) [7]	Record each new patient's route (referral, family, previous patient, social media, insurer network) separately at each site	7, 9

MEASURE	WHY IT MATTERS	HOW TO CAPTURE IT	SOURCE CHAPTER
Distinct referring physicians	A brand-asset measure alongside follower count	Count distinct referrers per quarter and the share of patients each accounts for	9
Who is requested	Separates demand for the surgeon from demand for a procedure or the clinic	Record whether the patient asked for the surgeon by name, a procedure, the clinic or whoever was available, and how often the first preference was unavailable	7
Decision unit at consultation	No Jordanian study measures who decides on elective orthopaedic surgery	Record who attends, who asks the cost and recovery questions and who confirms the booking	9
Enquiry mix and conversion by service line	Attention by topic does not show which service lines convert; conversion is unmeasured	Tag enquiries by service line (for example joint, sports, foot, paediatric) and track route, payer and conversion	9
Activity and receipts at any second site	The Amman contribution equation cannot be run without it	Aggregate new versus repeat episodes, service mix, patient origin, payer route, attendance and collected receipts	8; Appendix D
Capacity	Capacity limits can hide extra demand [19]	Log consultation availability, theatre access and waiting time by city	7
Patient experience	The closest leading indicator found: previous-year experience was associated with next-year standardised revenue among 50 private Swiss hospitals (p = .037), but not with combined-sample profits (p = .240); adjusted results only [399]	Routine, aggregated patient-experience survey after each episode	7
Online ratings	One 1-star review cut new-patient volume 2.3–2.6% for at least 16 weeks in a US study [154]	Monitor ratings on booking listings and maps, recording date and score	4

Source: [7, 19, 154, 399]; open questions in Chapters 4, 7, 8 and 9.

LIMIT

These measures describe a practice's own patients and audience. They will show what is happening, not why; causal questions, such as whether a signature-led route grows faster than an expertise-led one, require matched histories with comparable outcomes (Chapter 6).

11.3 The remaining research programme

The first pass completed the streams with the largest consequences for the 3 decisions. 6 desk studies remain: branding tactics; awareness and mental availability; word of mouth and partnerships; personal brand construction; brand story and message; and patient search and booking. Fieldwork follows. Each inherits specific open questions from this report, and each would draw on inputs that only a practice can supply; the table lists both.

TABLE 11.3

Remaining studies, the questions each inherits and the practice inputs each needs

STUDY (QUESTIONS SERVED)	WHAT IT WILL EXAMINE	QUESTIONS CARRIED FROM THIS REPORT	PRACTICE INPUTS NEEDED
Branding tactics (Q1, Q2, Q6)	Distinctive assets, naming, taglines, design codes and consistency; which cues famous doctors and clinics own	Whether an existing clinic name should be retained or changed when its recognition and associations are unmeasured (Chapter 5)	Intent for the organisation; which entity controls the name and accounts; rights attached to the clinic name
Awareness and mental availability (Q3)	The megaphones that reach households in Amman and Jordan; how doctors got on air and into print; entry points for orthopaedic care	Whether the طب وصحة (medicine and health) segment of Roya's دنيا يا دنيا (Donya Ya Donya) and JRTV's ألو دكتور (Allo Doctor) are sold as sponsored segments, and who books the doctors; what brokers did and cost (Chapter 4)	Owner-held account analytics: reach, audience location and age, and the dated growth history
Word of mouth and partnerships (Q3, Q4)	Team-doctor, federation, hospital and society roles; offline influentials; retold stories	How club and federation medical roles are awarded in Jordan (Chapter 4); whether naming a sports club collides with the ban on sponsors (Chapter 9)	Each new patient's arrival route, and distinct referring physicians per quarter, from clinic records
Personal brand construction (Q1, Q3)	How doctor personal brands are assembled: layers, primary platform, volume, proof under the rules, alliances	Which platform leads by flow (Chapter 4); how a surgeon's brand coexists with a clinic brand (Chapter 5)	Median views per post over the last 30 days on each platform, from owner analytics; which entity controls the name and accounts
Brand story and message (Q2)	How famous clinics cast patient and doctor, the first seconds of a page or broadcast, Arabic-language messaging	How a real difference is expressed without superlatives (Chapter 6); the candidate frames (Chapter 9)	The verbatim surgery claim in Arabic and any English version; registered specialties; actual patient mix
Patient search and booking (Q7)	What patients search, which surfaces decide the booking, and the booking paths of Amman practices	Whether an advertised fixed episode price counts as a prohibited offer (Chapter 9)	Enquiry mix and conversion by service line; fees by payer and procedure
Fieldwork (Q1–Q7)	Patient and referrer interviews, clinic observation, recognition and recall tests, and a recorded session with the surgeon	Arrival routes, decision unit and family role (Chapter 9); the verbatim surgery claim and the surgery-claim test (Chapter 6; Appendix D); completion of the Amman worksheet (Chapter 8)	Access for patient and referrer interviews and clinic observation; the recorded session; aggregate activity and receipts at any second site; owner compensation, capital ceiling, tolerable cash loss and evidence threshold

Source: Open questions in Chapters 2, 4, 5, 6, 8 and 9; research programme plan (remaining streams); practice inputs as listed in the decision agenda and the measures to start now in this chapter.

FIGURE 11.2

How the remaining evidence will be assembled (indicative order)

01

First-pass desk research

Chapters 3 to 9: 7 streams and a platform-history follow-up, 16–24 September 2026. Complete.

02

Practice inputs and JMA query

Verbatim surgery claim, owner analytics, activity records and thresholds; a written query on the Article 8 licence unit.

03

Remaining desk studies

Branding tactics; awareness and mental availability; word of mouth and partnerships; personal brand construction; brand story and message; then patient search and booking.

04

Second-phase fieldwork

Patient and referrer interviews, clinic observation, recognition and recall tests, and a recorded session with the surgeon.

05

Instruments completed

Surgery-claim test administered; Amman sizing worksheet populated with a practice's aggregate data.

06

Practice decisions

Brand architecture, category frame and Amman path, taken by the practice on the assembled evidence.

Source: Chapter 2 (programme); Appendix D (instruments). Steps 2 and 3 are not strictly sequential.

WHAT THIS MEANS FOR A PRACTICE

The remaining studies are designed to close questions this report has made specific. A recorded session in which a surgeon states the surgery claim in their own words is a shared dependency: open questions in Chapters 6, 8 and 9 and the surgery-claim test in Appendix D wait on it.

CHAPTER 12

Limitations

What this research can and cannot establish

12.1 Limits of desk research

The first pass was desk research on public sources only. It included no patient, referrer or public interviews, no recognition or recall tests, and no inspection of any practice's fees, capacity, referral sources or account analytics. It therefore observes what doctors, institutions and regulators have published and what archives have kept. It does not observe how patients in Jordan choose, what an audience does after watching, or what a clinic earns.

Desk research also inherits the biases of what is published. Case selection was purposive and skews to documented successes and to English-language, American and cosmetic-adjacent fame, because that is what the press records. Institutional histories and origin stories are self-retellings that compress timelines and omit brokers, and the slogans studied were codified after fame. Archives begin capturing an account only once it is notable, so the first moment of fame sits before the first snapshot in every case.

Some sources were unavailable. The Internet Archive was offline or restricting access for roughly a third of the platform-history research and blocked during the strategy stream; several publishers refused access; one Jordanian hospital's official site could not be recovered; and some platform archives were unavailable or supported only advertiser lookup. Pages that could not be retrieved were logged, not converted into evidence.

TABLE 12.1

What desk research could not observe, and the instrument that can

NOT OBSERVED	WHY DESK RESEARCH CANNOT REACH IT	INSTRUMENT THAT CAN	CHAPTER
How new patients arrive, who attends and who confirms bookings	Held in clinic records and patients' accounts, not in public sources	Patient and referrer interviews; aggregate intake records	9
Recognition and recall of a doctor's name and a clinic name	Requires testing with the intended audience	Recognition and recall tests with the intended audience	5, 6
A surgeon's own statement of the surgery	Captions exist, but reel audio was not transcribed and no surgeon was contacted	Recorded session; surgery-claim test	6; Appendix D
Account reach, demographics and growth history	Visible only to the account owner	Owner analytics	4
Fees, margins, capacity and referral sources	Not public	A practice's records; Amman sizing worksheet	7, 8
The JMA committee's practice	Committee output is unpublished and hearings are secret by law	Written query to the JMA	3

Source: Limitations and open questions in Chapters 2 to 9 and Appendix D.

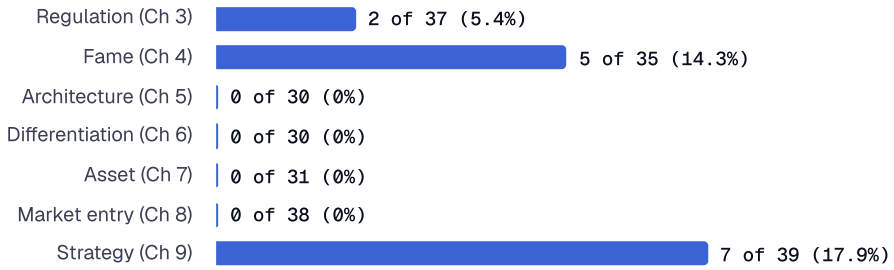
> LIMIT
>
> Foreign cases are precedents, not predictions. Transport of a finding from an American institute or a Gulf hospital group to a surgeon in Jordan is not established by any source in this report.

12.2 Limits of the evidence base

Verification was selective by design. The verification pass checked about 5 load-bearing claims per perspective, so 128 of the 368 research claims were not formally verified; they are labelled wherever used. Confirmation reflects deliberately bounded wording, not certainty: the streams with no refutations still had dates, fees, ownership shares and denominators corrected. Programme totals are approximate, because research actions were counted as all actions taken during the research and verification passes in some streams and as logged web actions in others, the platform-history count excludes one verification check that was repeated as a standalone check (Chapter 2), and sources were counted per report with overlap.

FIGURE 12.1

Claims refuted by verification, by stream



Source: Chapter 2 and the verification summaries of Chapters 3 to 9. The programme total of 16 refutations is taken across all streams and the platform-history follow-up (Chapter 2).

FIGURE 12.2

The size of the unverified and unobserved remainder

128 of 368	4	48
Claims not formally verified	Claims left unverified after checking	Gaps in platform histories

Source: Chapter 2 (128 of 368 research claims not selected for formal verification; 4 left unverified after checking); Chapter 4 (48 explicit gaps recorded in the platform histories; nothing interpolated).

TABLE 12.2

Consolidated limits of the evidence base

LIMIT	WHERE IT APPLIES	CONSEQUENCE FOR THE CONCLUSIONS
Purposive, success-weighted case selection	Chapters 4, 5, 8, 9	Patterns describe survivors and documented cases, not a population; failures are under-represented.
Stated-preference patient evidence, often from samples skewed toward the educated, the young or health-sector workers	Chapters 4, 5, 6, 7, 9	Importance ratings cannot be read as Jordanian choices; the Jordanian survey of 1,708 adults had 81.3% graduates and 49.7% in health [50].
No Jordanian study of elective orthopaedic decisions	All chapters on patient choice	The weights Jordanian patients and families give to reputation, referral and cost are unknown.
Self-interested sources: institutional self-description, promoters, prospectuses	Chapters 5, 7, 8, 9	They establish stated arrangements and transactions, not brand value, clinical superiority or causal returns.
Abstract-only or non-official reproductions	Chapters 3, 6, 7	Findings are not upgraded to full-text or official evidence; the Medical Constitution was read from lawyers' transcriptions.

LIMIT	WHERE IT APPLIES	CONSEQUENCE FOR THE CONCLUSIONS
Unpublished regulatory practice	Chapter 3	Licence counts, turnaround, refusals and advertising-specific sanctions in Jordan are unknown; a DHA circular of 23 August 2025 was not read [57].
Dated and non-synchronous statistics	Chapters 8, 9	Figures refer to end-2025 population, 2023 spending, 2024 insurance and the 2015 census; none is a 2026 market estimate.
Platform data limits	Chapter 4	Post-2020 Instagram is measured at 3 or 4 points for most accounts; rounding limits plateau claims.
Practice data not collected	Chapters 7, 8	Reach, demographics, fees, capacity and referral sources of individual practices are absent from every finding.

Source: Limitations sections of Chapters 2 to 9 [50, 57].

> LIMIT
>
> Agreement between perspectives was treated as a risk signal, not as corroboration. Where several perspectives rested on one source, as in the strategy stream where 1 study underpinned 3 perspectives, another 4 and 1 institutional page 5, the shared source was disclosed rather than counted as corroboration [7, 32, 33].

12.3 What would change the conclusions

The conclusions of this report are conditional on the evidence available in September 2026. The following developments would change them, and several are within a practice's reach.

- A Jordanian study, or a practice's own intake records, showing that social media is a leading first-contact route for orthopaedic patients would weaken the transport of the US baseline in which referral (44.9%) and word of mouth (18.7%) lead [7].
- A JMA answer that the Article 8 advertisement licence is issued per advertisement, rather than per site, would change the cost and cadence of compliant publishing; an answer that procedure counts and named accreditations are permissible would open a proof position no sampled Amman provider occupies [8].
- A surgeon's verbatim claim with supporting records would allow the surgery-claim test to run and could move the differentiation question from open to classified [28].
- Aggregate data from an existing Amman site on episodes, payer route and receipts would make the Amman contribution equation assessable and could move the Amman path from open to evaluable [22].
- A study isolating a causal naming effect in medicine, or comparing personal, institutional and combined architectures, would narrow the architecture routes that Chapter 5 keeps open [14].
- A longitudinal study of brand decay for doctors who stop posting would replace the current absence of any defensible half-life [404].
- The DHA circular of 23 August 2025, once read, could modify the Dubai reading, which rests on ST-21 version 1.1 of 2022 [55, 57].

CHAPTER 13

Conclusion

What the evidence adds up to, and what comes next

The first pass set out to make 7 strategic questions answerable, and for 6 of them it has assembled dated, verified evidence; the seventh, how patients find and book, awaits its own study. The central pattern is consistent across chapters. A doctor's first large audience was usually granted by someone else, a producer, editor, agent or institution, in 12 of the 15 best-documented cases [1, 2]; audiences then grew in a burst, a long ramp and a plateau (on video-platform accounts with usable resolution) [23, 24]; and in every case the study could date, today's slogan was either a later codification of a founder-era creed or a line adopted after the institution was already known [20, 21, 459]. The synthesis that nothing verbal came before fame, only structure, was refuted by verification: founder-era creeds existed and were codified later (Appendix B).

Patient evidence points the same way, within clear limits. Patients say they weigh credentials and reviews above popularity [6], and in a study of 808 US arthroplasty (joint-replacement) patients [7], referral and word of mouth accounted for 44.9% and 18.7% of first contact against 8.4% for online advertisements. The observed effect of a social-media presence on surgical volume is small [153]. None of this evidence is Jordanian, and none measures elective orthopaedic decisions in Irbid or Amman; it describes where the evidence lies, not what Jordanian patients will do.

Regulation shapes expression more than it prevents fame. The JMA instructions license doctor marketing, set a 10-dinar website licence and prohibit a defined list that includes superlatives, offers and intra-procedure imagery [8]. Across the regimes read, credentials, institutional roles, education and broadcast were lawful everywhere, while the sanctioned doctors in 5 jurisdictions shared a pattern in which a camera or a promotion changed clinical behaviour or exposed a patient's identity [58–60]. Whether a claim is substantiated and whether it may be published are separate decisions.

On value and expansion, businesses and name rights transfer, but no transaction reviewed prices a name separately [18], no portable fee premium was found [17], and the documented institutional expansions paired a name with local staff, facilities and partners [12, 26]. For a practice outside the capital that wants to enter Amman, the question is the incremental value of an owned clinic, and it becomes assessable only with the practice's own records and thresholds, and with privileges, payer terms and clinic-rule requirements that the first pass could not establish; the investment decision remains with the practice.

This report does not resolve the 3 decisions that face a surgeon building a name: brand architecture, category frame and the path to Amman. It narrows each to specific inputs, most of them held by the surgeon or the practice: a verbatim surgery claim, account analytics, clinic activity and receipts, and thresholds for capital and risk. With those inputs, the remaining desk studies and the second-phase fieldwork, the decisions become assessable on evidence rather than on assumption.

BACK MATTER

References

Every source cited in this report, numbered in order of first citation.

Bracketed numbers in the text refer to this list. All sources were public and were retrieved online in September 2026; each supported claim was traced to a fetched page, not to memory. Where a page could not be retrieved at the time of checking, the text says so.

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PART IV

Appendices

A	Verification ledger
B	Claims the evidence retired
C	Contradiction ledger
D	Research instruments
E	Glossary
F	Open questions by chapter
G	Source register

APPENDIX A

Verification ledger

Every checked claim, by study and verdict

Each study put its most load-bearing claims through an independent verification pass that tried to refute them against the retrieved sources. Verdicts are CONFIRMED (the source says it), REFUTED (the source contradicts it, and the claim was removed or corrected) and UNVERIFIED (no retrievable source settled it; the text carries the label). Refuted claims appear in this report only as retired claims (Appendix B).

TABLE A.1

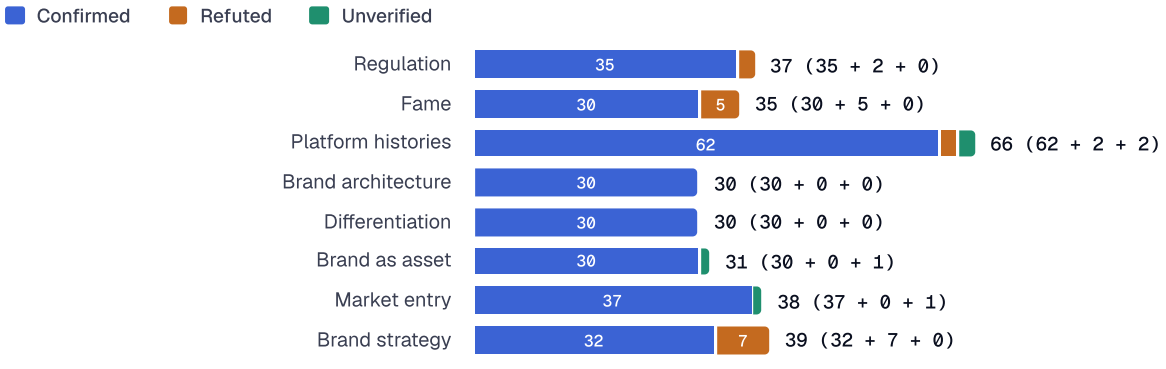
Verification outcomes by study

STUDY	PERSPECTIVES	CLAIMS	CHECKED	CONFIRMED	REFUTED	UNVERIFIED	RESEARCH ACTIONS	SOURCES
Regulation	7	69	37	35	2	0	954	166
Fame	7	72	35	30	5	0	562	237
Platform histories	8	275 dated points	66	62	2	2	1,336	with Fame
Brand architecture	6	47	30	30	0	0	314	63
Differentiation	6	38	30	30	0	0	246	44
Brand as asset	6	39	31	30	0	1	328	50
Market entry	6	45	38	37	0	1	295	47
Brand strategy	6	58	39	32	7	0	441	113
Programme	52	368 claims + 275 points	306	286	16	4	4,476	720

Source: Rubikn research ledgers, 16–24 September 2026. Research actions are searches, page retrievals and source reads. Source counts are per study and overlap. The platform-history study checked dated archive points rather than research claims.

FIGURE A.1

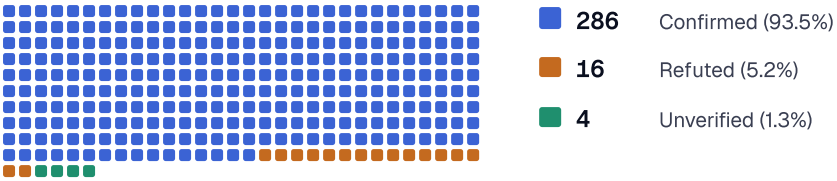
Verdicts on checked claims, by study



Source: Rubikn research ledgers, September 2026.

FIGURE A.2

All 306 checked claims by verdict



Source: Rubikn research ledgers, September 2026.

A.1 Editorial verification of this report

The report itself was checked the same way. Each chapter was drafted from the full text of its source studies and then independently checked: every number, quote, chart value and reference was compared with those studies. The checks raised 282 issues across the chapters and the synthesis, and each was corrected. A completeness review of the whole report then led to a structural edit that removed duplicated charts and anonymised third parties. A second round of independent checks on that edit raised 56 further issues, and those were corrected before typesetting. Charts show only values stated in the source studies. Where a chart shows a share or total, it is computed from stated counts, and the note says so. No value was interpolated or estimated.

APPENDIX B

Claims the evidence retired

Popular or plausible claims that did not survive checking

These 187 claims circulate in advice about medical branding, in press coverage or in earlier planning documents. A claim tested in more than one chapter is listed once, with each chapter named. Each was tested and either refuted or narrowed. They are listed so that none of them re-enters the strategy by default.

TABLE B.1

Retired and narrowed claims, by chapter

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
2	Jordan's medical-advertising rules are not visibly enforced, and searches for enforcement return nothing.	Refuted in the regulation stream's verification pass: two Husna FM reports of 12 May 2026 quote a former JMA committee head citing referrals for misleading advertising and an advertising violation by a named-case doctor, and the JMA spokesman conceding the syndicate lacks sufficient legal powers. Enforcement is weak and undocumented, not absent [29, 30].
2	Albelooshi's Dubai page displays no permit number.	Refuted: the page footer carries a licence-style number valid from 16 September 2024 to 16 September 2025, now expired [31].
2, 4	No Jordanian orthopaedic surgeon has a documented fame arc.	Refuted: Jordan News profiled Osama Al-Odat, orthopaedic and trauma surgeon, at 307,000 Instagram followers on 24 July 2021 [5].
2	Doctor Mike launched his YouTube channel in 2017, two years after his fame.	Refuted: the channel launched in 2016, about one year after the 2015 press trigger [36].
2	James Andrews met Roger Clemens in 1986.	Refuted: the surgery was in August 1985; the 20-strikeout game followed in April 1986 [3].
2	Oz's syndicated show ran 1,681 episodes, produced by Harpo.	Refuted as stated: Wikipedia's per-season episode list sums to 2,209; Harpo produced seasons 1 to 8 only, with Oz's own company producing seasons 9 to 13; the Oprah appearance count also varies by source (62 in Newsweek's timeline, 55 on Wikipedia's show page) [1, 37, 242].
2, 4	Sandra Lee's rise was Instagram-first, with no press trigger.	Refuted: her own accounts contradict it. Her brand's history puts YouTube first [38], and in a 2019 interview she describes a BuzzFeed pickup in April 2015 that took her following from 2,000 to 20,000 within the day [39]. The platform-history follow-up later confirmed a platform-native rise led by YouTube, which inflected between February and May 2015, before any television [180, 275]; what set off that inflection remains undated.
2, 4	Osama Al-Odat's YouTube channel is dormant.	Refuted: archived captures show 7.4K subscribers in 2020 and 16.6K in December 2022, growth after his May 2020 videos, and 28 uploads were added in the last year [40, 41].
2, 9	The surgeon's authority is the decision node for surgery in the Gulf.	Refuted: the family is the other node, and clinician advice is the leading trigger in the Kuwaiti knee-replacement study [32].
2, 9	Gulf patients choose a surgeon by reputation.	Refuted: in Taif the surgeon's attitudes lead, and reputation items score low [464].

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
2, 9	Saudi patients rank a surgeon's qualifications second.	Refuted: qualifications were the lowest-rated domain (4.10); the study's abstract contradicts its own table [495].
2, 9	Nothing verbal came before fame; only structure did.	Refuted as a synthesis over-reach: founder-era creeds existed, such as W. J. Mayo's 1910 line, and were codified into slogans and operating systems later [467].
2, 9	HSS renamed itself in the year it affiliated with Cornell.	Refuted: the rename was in 1940; the affiliation was agreed in 1949 and ratified in 1951 [48].
2, 9	Jordan's medical fees are fixed, and insurers agreed to the new schedule.	Refuted: the schedule sets minimum and maximum bands; insurers issued their own terms, which the JMA president called unauthorised [49].
2	No Amman orthopaedic provider publishes volumes.	Refuted: one provider's page carries counters in its static HTML (1,200+ patients); what no sampled provider publishes is an outcome measure [34].
2, 6	Both open-arm hardware removals in the chevron trial were symptomatic.	Refuted as a supporting detail: one was an irritation case and one a patient-request case [44].
2	A clean verification sweep means the answer is certain.	Each of the four streams with no refuted main claim states that the result means no bounded claim collapsed under checking, not certainty; causality and transfer to Jordan remain unestablished.
2	Agreement between several research perspectives corroborates a claim.	Agreement is treated as a risk signal because perspectives can share one source or one base-rate mistake; convergent claims were verified first and hardest, and shared sources were disclosed as single sources.
2, 4	Bio and press follower numbers are data.	Every headline number checked in the platform-history follow-up was a cross-platform sum, a daily-views figure, an undated tracker value or a stale snippet; third-party trackers disagreed with primary captures by up to 4 times.
2	A reference-library note can stand as a finding about a practice.	The frame restricts the library to questions and extraction forms; an earlier draft of the research plan that drew conclusions from library notes was rewritten and those conclusions struck.
2	A search that finds nothing proves absence.	A perspective's search-based report that the Jordanian text existed only in press reproduction was superseded by five perspectives that fetched the file; bounded searches are labelled as such in the reports.
3	Jordan requires a licence for every social post.	Art. 7 licenses a website for 10 dinars and Art. 8 defines an advertisement-licence application without a unit; no per-post clause exists. The reading comes from the dropped September 2024 draft and a May 2026 paraphrase by a former head of the JMA professional-conduct committee. The ambiguity cuts both ways: a committee can assert wider scope [8, 29, 51].
3	The fee is 50 dinars per website plus 5 dinars per social page.	Those were the September 2024 draft figures; the issued text sets 10 dinars for the website and nothing per page [8, 51].
3	The 10-dinar licence covers the social-media account.	Art. 7 covers the facility's or doctor's website; social pages are not mentioned in it [8].
3	Health-education content needs prior JMA approval.	Art. 5(2)(هـ) is a substantiation test (scientifically established or refereed), not an approval gate; the approval reading is the private-sector objectors' statement of 24 December 2024 [8, 70].

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
3	Doctors are banned from television and awareness programmes.	Art. 5(2)(د) bars exploiting appearances for direct promotion; appearances themselves need no approval [8].
3	Before-and-after is illegal in Jordan.	Art. 9(ج) permits it for the same patient with written consent, on social media and television; only intra-procedure imagery is banned. Before-and-after is banned in Saudi Arabia, Qatar and Kuwait [8, 98].
3	Free consultation is banned outright.	Art. 5(2)(ج) allows offers with committee approval, Art. 9(هـ) bans them without exception, and Constitution Art. 42 bans advertising set free-treatment times; the text is internally inconsistent [8, 63].
3	Free consultation is fine, because booking platforms advertise it.	A booking platform's listing is the platform's wording; the doctor's liability under Art. 9(ز) runs to his own site and page, so third-party listings are a gap in the text, not proof the rule is dead [8, 518].
3	The rules were suspended or amended after the January 2025 review.	A six-month monitored run-in was announced; no amendment has been published and the PDF's server date is unchanged [8, 71].
3	No Jordanian doctor has ever been sanctioned for advertising.	Unprovable and contradicted by the JMA's own report of pursuing "undisciplined promotion" and by a described fine; what is true is that no named, dated, advertising-specific decision is public, and the law keeps hearings secret [10, 11, 76].
3	Jordan's advertising rules are not visibly enforced; searches return nothing (a claim generated in one perspective pass, refuted by verification).	Two Husna FM reports of 12 May 2026 cite referrals of some misleading-ad violators and an advertising violation by a named-case doctor, and the JMA spokesman concedes insufficient legal powers; enforcement is weak and undocumented, not absent [29, 30].
3	Regulation makes doctor marketing impossible in Jordan.	The text licenses websites, social media, broadcast, credentials, consented before-and-after, evidence-based education and committee-licensed free days [8].
3	The rules are on paper only.	The JMA runs a live, if secret, disciplinary process and the Ministry closes premises beside it: 169 centres closed in 2023 and 47 court cases with 21 convictions to mid-2024 [10, 82].
3	Dubai issued new rules in September 2026.	The 17 August 2026 circular links the 2022 v1.1 PDF; the banned-word list in the press is §6.11 of that text [55, 56, 133].
3	Dubai bans before-and-after and discounts and needs a permit number on every ad.	Before-and-after is permitted with conditions, fee statements and instalments are on the acceptable list, and the licence number sits on the account, not the ad; the per-creative approval and inducement-pricing ban come from consultancy guides [55, 136, 137].
3	The DHA issues the advertising permit.	The licence number a Dubai facility account must show is issued federally by MOHAP; the DHA regulates content [55, 92].
3	The DHA bans first-in-the-region claims.	"First" is not on the §6.11 list, although "pioneer", "unprecedented" and "the only" are; a DHA-licensed facility site carries "first surgeon in the Middle East" claims without visible sanction [31, 55].
3	Albelooshi's page displays no permit number (a claim generated in one perspective pass, refuted by verification).	The page footer carries "LU53683 Valid From: 16/09/2024 Valid To: 16/09/2025", a licence-style number with an unlabelled issuer, now expired [31].

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
3	Gulf doctors cannot show prices.	Saudi rules require total fees in an ad and license discounts; Dubai lists fee and instalment statements as acceptable; the price bans are Kuwait (unlicensed price publicity) and Jordan [8, 55, 98, 102].
3	Saudi Arabia bans doctors from social media.	The law sets a default ban on self-advertising with regulation-defined exceptions and a permit regime; a relocation notice was expressly upheld as a legitimate right; what is banned is patient images, testimonials, superlatives and unapproved offers [97, 98, 100].
3	Saudi Arabia warned doctors off social media in 2017.	The July 2017 warning was specific: filming surgeries, offering discounts in exchange for publishing operation footage, and posting surgical clips [91].
3	Kuwait's 2025 decision bans clinic influencers.	Decision 9/2025 governs pharmacies and pharmaceutical retail; the instrument for doctors and clinics is Resolution 87/2023 [102, 106].
3	Kuwait suspended a surgeon for operating-room posts.	The posts were a post-operative ward video and case posts made with the patient's written consent; the ministry objected to identity disclosure and non-scientific purpose [59].
3	Egypt struck off "Hossam Al-Awadi".	The struck-off doctor is Diya al-Din Shalabi al-Awadi, an anaesthetist; Hossam Mowafi is the television professor [147, 148].
3	Khaled Al-Nemr and Tariq Al-Habib hold weekly MBC slots.	Al-Nemr's slot could not be verified; Al-Habib's rests on an unsourced Wikipedia line [145, 146].
3	The GMC prohibits testimonials.	The word does not appear in the GMC texts; the GMC defers to CAP, which permits testimonials with evidence and permission [109, 111, 141].
3	Testimonials are banned everywhere.	Australia bans them outright; Dubai permits them with written consent; the JMA text does not mention them; the UK and US permit them with conditions [8, 54, 55, 123, 141].
3	Australia lifted the testimonial ban.	The repeal was withdrawn in 2022 and s133(1)(c) still carries a $60,000 penalty; the 2025 Amendment Act does not touch it [54, 138, 139].
3	Before-and-after photos are banned in the UK and, since September 2025, in Australia.	CAP allows them with signed and dated proof; Ahpra's 2025 guidelines allow them under conditions, including a prominent results-vary warning [117, 119].
3	"Results may vary" makes a US testimonial safe.	16 CFR 255.2 states that such disclaimers are insufficient; the generally expected result must be disclosed [123].
3	US doctors cannot show results.	AMA 9.6.1 allows advertising absent deception and the FTC requires typicality disclosure rather than prohibition; Florida's rule has no before-and-after clause [123, 127, 131].
3	Tagging the clinic makes an influencer post compliant.	The ASA ruled tagging insufficient in LIFT Aesthetics (2023); a clear ad label is required [113].
3	Grawe was revoked for TikTok.	The revocation rested on standard-of-care violations while performing for the camera, patient harm and two ignored warnings; social media was the vehicle [58].
4	Post consistently, use hooks, go viral, and fame follows.	No case in the record shows cadence producing the first fame moment; the dated triggers were an editorial pick, a network commission, a deletion-forced pivot with a PR hire, a publicist's bookings, an agent's referral and a lockdown window. Consistency explains retention afterwards, not arrival [36, 149, 171, 172].

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
4	Post consistently and growth compounds.	The mature accounts are flat on Instagram after 2020 at any cadence; growth came in one window and rode on volume in that window [164, 284, 288].
4	Followers become patients.	No study found measures it; the systematic review offers only an association with Google placement; the only social-to-volume effect found is about 7 cases a year; the circulating "47% increase in consultations" traces to a single surgeon's personal-experience article [153, 223].
4	A named procedure makes the surgeon famous.	Tommy John surgery carries the patient's name; Jobe published 12 years after the operation; the public name migrated to the highest-volume operator [182, 183, 217].
4	Television is dead; platforms replaced it.	Every platform-native doctor in the set converted to a network or a publisher, mostly within 3 years (Rajan's book came 4 years after his burst): TLC, WE tv, a book, a media company [143, 149, 151, 181].
4	Television makes the step.	In the 2 cases with monthly resolution across a television launch, it added 5% and 16% for 1 to 2 months on a curve already rising, then nothing [162, 163].
4	A book or a controversy moves the curve.	Neither did, on any platform read: Rajan's January 2024 book and Doctor Mike's November 2020 controversy left no inflection [164, 165].
4	Team doctors are chosen for being the best surgeon.	In the United States the title is largely a hospital sponsorship purchase [195, 196].
4	Regulation blocks doctor fame in the Gulf and Egypt.	The enforcement record targets promotion, imagery and out-of-specialty claims; the same regulators award compliant television doctors (Mowafi's syndicate award is attested by Arabic Wikipedia only) [91, 147, 269].
4	Educational content wins on the algorithm.	Of top plastic-surgery posts in 2020, 4.76% were educational and 4.17% were by board-certified surgeons [192].
4	Saudi Snapchat doctors are a proven path.	The search returned listicles; the one sourced Saudi case is a professor with a weekly MBC slot; "Doctora Khaloud" is lifestyle content [146, 253].
4	Oprah discovered Dr. Oz.	He had a Discovery series with Oprah as a guest in 2003, a booking brokered by Gayle King; sources disagree whether the regular slot began in 2004 or 2006 [1, 169].
4	The Arab comparables grew on "first in the region" claims.	Untestable for Albelooshi, for whom no history exists, and wrong for El Masri, whose growth came from clinic-shot treatment clips with no press or television in the record [262, 264, 266].
4	Doctor Mike has about 15M Instagram followers; Rajan has 10M+ on TikTok.	Doctor Mike's 15M is YouTube (Instagram 6M); Rajan's TikTok never exceeded 5.4M, and "10M+" is a cross-platform total [160, 166, 288].
4	People took Doctor Mike from 100K to 1.5M Instagram followers within weeks.	No pre-feature capture exists; the first capture, 10 days after the feature, reads 1,051,110, and 1.5M was crossed between 27 November 2015 and 15 March 2016 [177, 178].
4	Dr. Miami had about 1M Snapchat followers by 2016.	No retrieved source states it; the 2015–16 press figures were daily views, and the only follower figure is 97,200 on 4 September 2015 [171].
4	Desoki is a platform-native TikTok surgeon.	He is a paediatrician whose YouTube (2.22M in July 2022) and Facebook long predate his smaller TikTok [299, 307].

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
4	Doctor Mike's YouTube channel came 2 years after his fame (2017).	Refuted by verification: the channel was created in August 2016, about a year after the BuzzFeed piece [36, 170].
4	Andrews met Clemens in 1986, 13 years into practice.	Refuted by verification: the surgery was on 30 August 1985, 12 years into practice; the 20-strikeout game was 29 April 1986 [3].
4	The Dr. Oz Show ran 1,681 episodes produced by Harpo.	Refuted by verification: Wikipedia's per-season list sums to 2,209 episodes, and Harpo produced seasons 1–8 only; Oprah appearance counts vary between 55, 60+ and 62 [1, 242].
4	Saudi patients rate traditional factors 20 to 50 points above social presence.	Corrected by verification: 80.1% rate the practice's social presence important, so the gap to traditional factors is roughly 6 to 15 points; the direction holds [6].
4	Dropped as unsourced: Dr. Miami's two-year waitlist as fact; a vendor's "35% chose a doctor via social media"; a "half a million knees a year" microfracture figure; Huberman and Attia income figures from industry blogs.	None was found on its cited page as a fact; none is used in this report. Dr. Miami's backlog appears only as a self-reported, journalist-observed remark [225].
5	A founder name cannot become an institution.	The absolute claim fails against founder-derived institutions and post-founder operation: Rothman opened a branded office in 2021 after its founder's 2018 death; Steadman's name survived his surgical retirement and remains in use after his death (the latter without a separate verdict); and Al Habib and Mayo are founder-derived institutions [12, 311, 320, 322, 346].
5	Mayo was never a person's name.	Mayo's own history traces the name to the Mayo brothers' practice and dates its official adoption to 1914 [322].
5	The same name means the same owner or operator.	Mayo Care Network members remain independently owned and operated; MEHC held no equity in Saudi German Hospital Ajman; Moorfields' 2020/21 accounts record a 49% Abu Dhabi joint-venture stake held through MEH Ventures LLP [312, 324, 342].
5	A retired surgeon means completed succession.	Steadman's 2014 announcement retained research co-chairmanship and planned consultation; Andrews continues to lead a brand-development company after clinical retirement [320, 326].
5	An acquisition price is the brand's value.	Transaction, intangible-accounting and valuation records measure different things; U.S. Physical Therapy accounts for tradenames, referral relationships, non-competes and goodwill separately [42, 43, 321].
5	Doctor listings prove patients prefer a doctor's name.	Interface and platform rules, including Google's conditional practitioner-profile guidance, do not identify a preference effect [328, 332, 359].
5	Every famous doctor needs 2 equally promoted brands.	No retrieved evidence tests or establishes the rule. It remains an unsupported prescription, not a disproven numerical hypothesis [359].
5	A hospital affiliation necessarily replaces the practice name or means a full acquisition.	The October 2014 Cedars-Sinai announcement preserved the Kerlan-Jobe and Santa Monica practice brands under a separate management arrangement [325].
5	Institutional branding requires hiding individual doctors.	HSS, Moorfields Dubai and KHCC display named clinicians under institutional names; these are counterexamples, not effectiveness comparisons [323, 327, 328].
5	No published brand valuation exists for Burjeel.	Brand Finance published a modelled US$419m Burjeel brand value in February 2023 using a royalty-relief approach [42].

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
5	The Ajman management fee is a trademark royalty, and the 15% stake in Burjeel is the post-listing share.	The Ajman 10% of pretax net profit remunerated management supervision; the 15% pre-IPO stake in Burjeel became 14.4% after listing [43, 312].
5	A separately charged royalty measures independent brand value.	Saudi German's rates are related-party terms with rights scope and bundled institutional support; they are not an arm's-length market rate [313].
5	A successful IPO proves that the chosen name created the value.	Burjeel's transaction concerns corporate equity; the naming contribution is unidentified [43].
5	An institutional name automatically creates a saleable, founder-independent asset.	U.S. Physical Therapy's filing shows acquisitions alongside typically retained sellers and a bounded 6-year name-use right; this is an adjacent case, not a Jordanian valuation model [321].
5	Patients choose surgeons, never institutions.	67.2% of 341 Saudi respondents rated hospital reputation very important, alongside high ratings for surgeon knowledge and skill [315].
5	Hospital demand proves institutional branding works.	The English study measured hospital quality, geography and actual use with unresolved decision-maker and confounding problems; it did not manipulate names [316].
5	Jordanian family-name ratings decide personal-brand architecture.	The Jordanian survey's family-name and origins item concerns a surgeon's background, not a named-surgeon clinic versus an institutional brand [50].
5	Followers equal competence or booking demand.	The Saudi survey separates online research (217 of 341, 63.6%) from beliefs about popularity (42.3% of 241) and tests neither actual competence nor conversion; these figures carry no separate verdict [315].
5	A hospital used as an address landmark establishes an affiliation.	Dr. Afifi's address opposite Jordan Hospital is not evidence of affiliation, an admitting relationship or common ownership [332].
5	A royal namesake institution is a surgeon-founder personal practice.	KHCC cannot be coded as a surgeon-founder practice merely because its name contains a person's name [344].
5	A famous international institution's overseas presence is necessarily permanent or commercially successful.	Johns Hopkins Singapore's clinical centre ceased operating in 2017 and care moved to Tan Tock Seng Hospital; collaboration continued in another form, and no causal blame is assigned to architecture [317, 318, 352].
5	Expansion, longevity or clinical promises measure the causal value of a name.	The cases are selected organisational histories, profiles and accounts, without a naming intervention or a counterfactual [319].
5	Farah's survival, expansion narrative or institutional label establishes profitable succession.	Farah's official source could not be retrieved; the directory account is secondary and not independently verified, and no conclusion about ownership, succession, sale or branding-caused success is admissible [360].
5	A US or Singapore case prescribes the right Jordanian brand.	These sources test possibilities and boundaries; they do not estimate the local effect of any naming choice [319].
6	People must explicitly perceive a difference before they buy.	Too strong in the studied consumer markets: on average 11% of current users called their brand different and 10% unique across 17 markets. Whether surgeon choice requires a perceived difference remains untested [361].
6	Differentiation is economically irrelevant.	Not supported. Changes in perceived differentiation predicted subsequent accounting performance, and differentiation was associated with higher gross contribution per car in a 39-brand panel. Causality and transfer remain limited [362, 363].

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
6	Familiarity only wins a place on the shortlist; evidence decides the final choice.	Not an established universal sequence. Familiarity influenced observed selection in a choice experiment (85.5% chose the familiar brand on trial 1), and in observed cardiac-surgery choices report-card effects were small and insignificant [365, 370].
6	A branded procedure is one stable invention that only its originator can provide.	The histories show changing technical versions (a 2010 fusion cohort against a current no-fusion offering), manufacturer-promoted training of other surgeons, and rising utilisation. Trademark registration and clinical evidence are separate questions [15, 16, 25, 375, 377, 379].
6	Every foot operation described in cosmetic language falls under the professional criticism of appearance-only surgery.	Misstates the scope. AOFAS and ACFAS distinguish appearance-only intervention from appropriately indicated reconstruction; equally, symptoms alone do not establish appropriateness [222, 378].
6	Any legal restriction on superiority forces all differentiation into persona or distinctive assets.	Retired as an unsupported inference. The JMA text contains factual and scientific-information provisions alongside the superlative restriction [8].
6	Every proven difference is publishable.	Does not follow. The superlative restriction and the incorporated Medical Constitution remain relevant whatever the clinical truth, and their administrative application is unresolved [8, 63].
6	A brand should retain exactly 29 of 30 familiar category features.	Not validated. The retrieved original reports joint typicality and novelty effects on aesthetic preference for industrial products, with no numerical prescription and no surgeon-choice result [386].
6	Any attention is beneficial and negative publicity always helps.	The universal form conflicts with conditional findings. Negative-publicity effects on books depended on prior awareness and timing, and 1 key contrast reached only p = .06 [388].
6	Fame makes medical recommendations evidence-based.	A content audit found 46% of sampled Dr Oz Show recommendations supported, 15% contradicted and 39% without evidence found; the audit did not measure fame's causal effect [389].
6	A low internet-referral share shows that public online visibility has little value.	Overreach. 39.5% of patients researched their surgeon online before the visit even though only 8.5% named the internet as their referral source; the 2 questions measure different behaviours [364].
7	A famous surgeon's name commands a universal, portable fee premium.	A top-20 US hospital had the highest minimum negotiated joint-replacement price in only 1 of 5 comparable cities; the reputation study measured willingness to wait, not to pay, and had no monetary attribute. No practice-specific premium was estimated [17, 391].
7	An experienced surgeon's standing transfers directly into premium pricing.	Retired as evidence for a fee premium. A teaching anecdote and a willingness-to-wait study do not estimate realised pricing power; local Jordanian evidence is stated importance only [391, 412].
7	Price or full-price measures cannot exist because the Jordan Medical Association bans advertised offers.	Corrected. The JMA provisions restrict advertised offers, discounts and free or reduced treatment and refer to the fee schedule; they do not ban internal measurement of fees received, nor do they establish unrestricted pricing freedom [8].
7	Professional medical services cannot scale, and enterprise software lock-in is a clinic's strategic moat.	Reworked as hypotheses. Multi-site hospital growth is observable, continuity and coordination have evidence, and no study established a software-caused moat [392, 398, 411].

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
7	Stable referrals prove a durable brand moat.	Not established. Observed studies expose competing mechanisms (repeated coordination, ownership ties and ongoing patient relationships), and none isolates a pure brand effect [393, 411].
7	Patients who value reputation will follow the doctor indefinitely or pay a premium.	Not established. The Jordanian evidence is stated importance (88.5% of men and 92.9% of women rated reputation important); departure evidence shows continuity disruption and cannot price an asset [392, 412].
7	A small internet-origin share measures the full contribution of online reputation.	Unsupported metric substitution. In a survey that was not independently checked, 8.5% named an internet source as their referral origin while 39.5% researched online before the first visit; neither estimates causal contribution [364].
7	Organisational integration guarantees exclusive patient capture.	Contradicted in the Twin Cities setting: about half of allowed charges for patients mainly using integrated primary care occurred outside their system [393].
7	A hospital or practice acquisition headline is a price for the doctor's name.	No transaction reviewed allocated a price to a surgeon's name; the Surgery Partners allocation separates identifiable intangibles from residual goodwill without isolating names, and goodwill is not automatically brand [18, 394].
7	A company that owns its trademarks is immune to clinician departures.	HMG's prospectus documents company-owned trademarks and 7 consent agreements alongside explicit dependence on clinicians' reputation and patient relationships [311].
7	Famous overseas medical institutions simply license their name.	Refined. Mayo operates a subscription network, Cleveland Clinic's 2019 issuer document described managing its Abu Dhabi hospital, and Moorfields' 2024/25 accounts describe a branch and a joint venture; these are not interchangeable logo licences [324, 396, 397].
7	More patients means fuller capacity.	Burjeel's outpatient visits rose 7.3% in 2024 while outpatient utilisation fell to 69% from 72%, after 188 doctors were added; the capacity denominator can expand faster than visits [398].
7	Revenue growth during expansion proves profitable, brand-caused growth.	Burjeel's revenue rose 10.5% while EBITDA excluding one-offs fell 5.8% in 2024, amid ramp-up losses and increased marketing; no brand return was isolated [398].
7	The absence of a volume increase at full capacity shows that demand did not grow.	Pope explicitly identifies full capacity as a reason admission counts may fail to reveal increased demand [19].
7	A famous medical name surviving a crisis proves durable shareholder value.	NMC's 34 operating companies continued under creditor ownership while the FCA expected no funds to remain for the old company after creditor claims [400, 401].
7	Institutional survival after a single surgeon's misconduct means the crisis was absorbed without lasting cost.	Spire's official statement documents continuing compensation and remediation commitments after Paterson's misconduct; the specific 2024 cost amounts could not be verified and are excluded [403].
7	A doctor who stops posting has a known brand-decay half-life.	Not established. The study of 650 physicians reviewed is cross-sectional and cannot show that silence destroys or preserves a brand [404].
7	Every medical crisis is equivalent.	NMC concerned financial disclosure and restructuring; Paterson concerned criminal misconduct and professional erasure; neither estimates the effect of a routine complication [401, 402].
8	A familiar medical name proves that a new city will be financially successful.	None of the documented expansion sources isolates a name-only financial return; service delivery, local access and organisational investment accompanied entry [12, 26, 46, 433].

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
8	A famous medical brand guarantees that an expansion will open on time and attract sufficient patients.	Cleveland Clinic Abu Dhabi was expected to operate in 2013 and reached full operation in May 2015; Mediclinic's acquired Abu Dhabi business saw FY2017 pro-forma revenue fall 19% [420–422].
8	A disposal, delayed project or accounting write-down proves the medical brand was destroyed.	The same Mediclinic release reports Dubai revenue up 5% and a positive Middle East operating profit of AED 134m; project timing, payer access and accounting treatment are distinct from awareness and trust [420].
8	Any overseas hospital bearing a famous name is an owned branch of the home institution.	King's Dubai was built with Ashmore and local equity partners, and the Trust places overseas work within KCH Management [439, 440].
8	A profitable licensor or management company proves the local hospital is profitable.	King's £0.93m surplus is KCH Management's contribution across a broader business, not the Dubai hospital's result [440].
8	Announced, founding and opening dates can be used interchangeably.	Rothman's Manhattan offices and further Florida services were prospective in their releases, and Moorfields Abu Dhabi carries 2 conflicting opening dates [12, 46, 47, 432].
8	A documented individual relocation proves that a similar move will pay off.	The Andrews record documents a 1986 move only; it supplies no denominator, counterfactual or financial comparison [437].
8	Patients who follow a relocated established doctor prove demand in the new city.	Existing-patient continuity and new-resident acquisition are different populations; the original relocation studies could not be retrieved, and no follow rate is claimed [431].
8	Patients always choose the nearest provider.	38% of 53,307 Dutch first orthopaedic visits bypassed the nearest hospital, although extra travel time discouraged bypassing [423].
8	Social media is irrelevant because referrals dominate.	39.5% of Las Vegas attendees researched online and 63.6% of Saudi respondents used digital information before consultation, alongside referral routes [364, 424].
8	Follower count establishes paying demand in the next city.	None of the studies reviewed supplies a follower-to-patient conversion or an account's geographic audience, payer access or need [364, 424, 441].
8	Amman's population is the private orthopaedic market.	The 5,004,600 figure is a governorate total without eligible episodes, payment access or attainable volume [27].
8	37.3% OOP means 37.3% private-pay patients.	It is the printed share of current health expenditure, an expenditure ratio with a different denominator [434].
8	Annual covered-person counts are unique people.	The Central Bank's 1,015.4 thousand annual count explicitly permits repeated counting; about 812.3 thousand were covered at year-end [426].
8	An old public-hospital cost study can establish a 2026 private fee premium.	The study used a 2007 audit at 1 public hospital inflated to 2015; it is not a private tariff or a fee comparison between cities [448].
8	Jordan's doctor fees are fixed.	The 2024 schedule, in force since 16 November 2024, sets minimum–maximum bands, for example JOD 15–30 for a surgical specialist, with hospital, implant and room charges outside it [436, 449].
8	A hospital listing or insurer logo guarantees access.	Privileges and payer contracts are separate: the hospital conditions some procedures on insurer approval, and network participation is a staged application [445, 453, 454].
8	Fame, followers or society memberships establish licensing or an overseas title.	Licensing, a DHA specialist or consultant title and US board eligibility are separate determinations [428, 451, 456].

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
8	A 5-day DHA service means a 5-day practice opening.	The 5-working-day review is 1 stage after prerequisites; activation requires an active facility covering the specialty [428, 429].
8	Every foreign surgeon must repeat US residency.	Florida's statute retains a conditional foreign-training route with board review, a qualifying employment offer and 2 years of in-state employment [457, 458].
8	An Amman service category is empty because an entrant has substantial social reach.	Several sampled Amman providers explicitly advertise overlapping foot and ankle, sports, paediatric and joint services [34, 444, 446, 447].
9	The Mayo brothers said “The needs of the patient come first.”	The 1910 line is different: “The best interest of the patient is the only interest to be considered…”. The current wording is a later rewording, in print by 2000 and codified for patients in 2001 [20, 459, 467].
9	“Patients First” made Cleveland Clinic famous.	It was adopted after the clinic was known for results and ranked above rivals. It was redefined because the clinic had a reputation for “no empathy” [475].
9	Cleveland Clinic's empathy programme took it from the 24th to the 99th percentile.	That figure comes from the programme leaders' own book. The peer-reviewed observational estimate is a gain of about 1 point in physician communication, with no significant change in HCAHPS communication [465, 511].
9	The Saudi knee-replacement paternalism study is the one Gulf study of elective orthopaedic decisions (refuted).	A Kuwaiti focus-group study of the knee-replacement decision itself records family involvement in all steps of the care pathway, and a Saudi study of 629 patients reluctant to have knee replacement also exists [32, 493, 496].
9	In the Gulf, clinicians mainly delay the surgery decision with conflicting advice (refuted).	In the Kuwaiti study, professional medical advice to have the operation was the most-raised decision sub-theme (39 mentions from 27 participants), ahead of family discussion (37 from 30); clinicians are the leading trigger, not only a source of delay [32].
9	The Taif respondents were largely making a hypothetical choice (refuted).	The methods describe a random sample of patients attending elective-surgery clinics in Taif hospitals [464].
9	No Amman provider publishes volumes (refuted).	One Amman centre's page carries counters in its static HTML (1,200+ patients). What no sampled Amman provider publishes is outcomes [463].
9	Cleveland Clinic's stated reason for “Patients First” was that outcomes had converged.	Outcome parity was one of three stated reasons. The book puts the moral reason first, followed by research on empathetic care [475].
9	A medical brand's name must state its category.	The HSS name adopted in 1940 does not say “orthopaedic”, yet HSS has held the U.S. News No. 1 ranking in orthopaedics for 17 consecutive years [468, 469].
9	Fame alone decides where a patient goes.	In Cosgrove's own account, a family skipped the better-known, higher-ranked Cleveland Clinic for another hospital because they had heard it had “no empathy” [475].
9	Instagram fame fills the operating list.	Only 15.5% of US sports-medicine patients used social media to choose a physician, and online advertisements were the first route to the surgeon for 8.4% of arthroplasty (joint-replacement) patients. The Saudi figures are higher (31.7% to 39.6%) but come from young, health-sector-heavy samples, and neither transfers to Jordan untested [6, 7, 441].

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
9	In Arab culture the family picks the surgeon (narrowed).	The family weighs most on whether and where to operate, and less on which surgeon: 31.5% in Taif, and in Qassim recommendations from friends and family “play a less significant role” [356, 464].
9	Mayo Clinic is a physician-referral-only brand.	Mayo's referral page could not be retrieved, and press reporting indicates that Mayo accepts self-referred patients and segments by payer in operations (not independently checked) [515].
9	Specialisation is proven to build a brand.	Shouldice and Mayo's focused factory show gains in operations and outcomes, and neither source measures demand, fame or brand equity; both cases were not independently checked [481, 490].
9	Category entry points are an established tool in healthcare.	The study found only consumer-goods vendor explanations and no healthcare study; the concept is practitioner opinion in this evidence base [463].
9	Warranties sell surgery.	The ProvenCare evidence is about process reliability and payer economics. Of 9 outcomes, only discharge likelihood improved significantly, and no retrieved source measured whether patients chose the provider because of a warranty (not independently checked) [509, 512].
9	Bundles and protocols are a lasting cost advantage.	Rothman's per-patient margin fell from $2,683 to $522 as Medicare reset target prices against its own improved baseline [466].
9	Advertising and brand do not matter in healthcare (the opposite myth).	One study finds that television advertising measurably shifts hospital choice. What remains unproven is the role of the frame or message, not the role of exposure (not independently checked) [485].
9	“Best orthopaedic surgeon in [city]” is a positioning line.	It is search-intent capture, and the same string appears across competitors in Abu Dhabi and Dubai [463].
9	Team physicians are chosen for their excellence.	Since the mid-1990s many “official” designations have been paid sponsorship deals with signage and endorsement components [195].
9	A strong big idea builds recognition, loyalty and equity for a medical brand.	No retrieved study links a medical big idea to demand. The claim is retired as medical evidence and kept only as an extraction template [463].
9	Legends circulating about famous cases: Cosgrove's 40,000 “Patients First” buttons; Shouldice's “0.8% vs 10%” recurrence; a German fellowship attributed to an Amman surgeon; slogans should be under six words.	None was verified from a primary source; all came from search snippets or listicles, and none is used [463].
D	A universal passing score, such as a "29 of 30" rule, can decide whether a claim or brand cue works.	The instrument prohibits invented universal scores and any "29 of 30" passing rule; thresholds are set from the actual decision and the available baseline [28]. The original abstract of the study on typicality and novelty supplies no numerical 29/30 prescription (see Chapter 6) [386].
D	Being the only locally available provider establishes invention, better outcomes or durable exclusivity.	The instrument states that local availability would not itself establish any of these; each proposition is split out and tested separately [28]. Status: instrument rule (logical), not an empirical refutation.

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
D	Finding no other provider in a search proves that nobody else performs the operation.	"No other provider found in this bounded search" remains a search result; the search must define its boundary, include known-provider positive controls and save its date and coverage [28]. Status: instrument rule (logical), not an empirical refutation.
D	A registered procedure name proves that a surgical method is exclusive or clinically superior.	The instrument separates trademark, patent, device rights, licensing and technical know-how, and states that a registered name does not by itself prove exclusivity or superiority [28]. Chapter 6 reviews one example, a dated United States registration extract for a procedure name, which is not a live status check [377]. Status: instrument rule (logical), not an empirical refutation.
D	Every surgical innovation must already have a large randomised trial before any claim can be assessed.	The instrument applies stage-appropriate evaluation logic and expressly rejects that rule [28]; the IDEAL recommendations fit the evaluation to the development stage of the technique [380]. Status: instrument rule (logical), not an empirical refutation.
D	A non-significant difference shows equivalence, and a significant one shows universal superiority.	The uncertainty field states that nonsignificance is not equivalence and significance is not universal superiority [28]. Status: instrument rule (logical), not an empirical refutation.
D	Views, likes, recall, follower counts or social following measure trust, durable value or Amman volume.	The instrument forbids inferring trust from views, likes or recall; a procedure name or follower count does not answer questions of durability or capital-city demand; and social following cannot fill the missing volume inputs [22, 28]. Status: instrument rule (logical), not an empirical refutation.
D	Recognition earned in one city can be assumed to transfer to Amman.	The instrument requires the geographic-transfer observation to be repeated with the intended Amman audience rather than assumed; whether recognition transfers is untested [28]. Status: instrument rule (logical), not an empirical refutation.
D	A clinical fact that is proven may be advertised in any wording.	Proof of a fact does not automatically make every promotional formulation permissible; the exact wording and placement are mapped to the JMA instructions and the Medical Constitution [8, 28, 63]. Status: instrument rule (logical), not an empirical refutation.
D	Symptoms establish that an operation is appropriate, or an aesthetic result establishes that it is appearance-only.	Symptoms alone do not prove appropriateness, and an aesthetic consequence alone does not establish appearance-only purpose; professional positions distinguish appearance-only intervention from indicated reconstruction [28, 222, 378]. Status: instrument rule (logical), not an empirical refutation.
D	Population, out-of-pocket share and insurance counts together give an Amman market size.	No defensible absolute service-line market estimate follows from those rows alone; neither the national health accounts nor the Central Bank figures supply a demand multiplier [22, 426, 434]. Status: instrument rule (logical), not an empirical refutation.
D	The prevalence of arthritis indicates annual joint-surgery demand.	The joint-surgery line counts indicated, medically suitable and willing surgical episodes; prevalence of arthritis is not annual surgery demand [22]. Status: instrument rule (logical), not an empirical refutation.

CH.	CLAIM	WHAT THE EVIDENCE SHOWS
D	A 97.5% in-network share means out-of-network care is prohibited.	The worksheet states that the figure does not establish a legal ban on out-of-network care, or a practice's contract, patient coverage or tariff [22, 426]. Status: instrument rule (logical), not an empirical refutation.
D	A 2016 hospital cost paper can serve as a private-clinic budget.	No figures from it are imported: its archived 2007 audit inflated to 2015 is not a current private-clinic tariff or cost quotation [22, 448]. Status: instrument rule (logical), not an empirical refutation.
D	A positive monthly operating surplus means the clinic pays for itself.	A positive operating surplus does not pay back fit-out or solve cash-collection delays, and accounting depreciation does not fund upfront cash [22]. Status: instrument rule (logical), not an empirical refutation.

APPENDIX C

Contradiction ledger

Where sources disagreed, and how each disagreement was resolved

Disagreement between sources is recorded, not smoothed over. Where two credible sources conflict, the ledger names both positions and the reading this report adopts.

TABLE C.1

Contradictions and their resolution, by chapter

CH.	TENSION	RESOLUTION
2	Agreement between perspectives looks like corroboration, yet shared sources or shared mistakes can produce it.	Convergence is treated as a risk signal; convergent claims in the fame, regulation, platform-history and strategy streams survived at the source level, with counter-cases recorded, overreach corrected, two bursts reclassified and, in the regulation stream, no divergence found on re-reading.
2	Four streams returned no refuted main claim, which could be read as certainty.	Each report states that the clean result means no carefully bounded claim collapsed under checking; causality, current status and transfer to Jordan remain open, and verification still corrected details.
2	The press record says a gatekeeper granted the first audience, while archived snapshots show platform-native bursts.	The two records describe different phases: archives begin capturing accounts once they are notable, so the first fame moment sits before the first snapshot; both findings stand.
2	One regulation perspective reported the Jordanian text as available only in press reproduction, while five perspectives fetched the file.	Fetched evidence governs; the search-based negative is superseded, and the verbatim press reproduction changes nothing.
2	The fame stream's case-historian perspective found no Jordanian orthopaedic surgeon with a documented fame arc; its verification pass found a dated press profile of one.	Refuted on the evidence found in verification; the research plan's case list was amended to add Osama Al-Odat.
2	The research plan expected the differentiation stream to settle the library's two camps on distinctiveness and differentiation.	Reworked expectation: the stream settles which constructs and evidence must be separated and does not manufacture a surgeon-specific winner where matched evidence is missing.
2	Original records disagree on the opening date of Moorfields' Abu Dhabi centre: April 2016 in the accounts and a November 2015 inauguration release.	The composite claim is left UNVERIFIED and no timing recommendation uses it [46, 47].
2	Intermediate page summaries misreported three items in the strategy stream, which the raw HTML showed differently.	Raw HTML governs; verification corrected all three misreported items in the strategy stream.
2	Library notes state positions, such as that a big idea must be broad enough to last from a provincial city to the capital and abroad, that the evidence does not support.	Library positions are tested as hypotheses and their dispositions recorded; none is adopted as a finding.
2	The fame stream held that surgeons built institutions only through a hospital partner or philanthropy; the architecture stream documented further group and corporate structures.	Scope narrowed: neither purposive sample can establish a universal sequence, and neither is turned into one.

CH.	TENSION	RESOLUTION
3	Offers: Art. 5(2)(ج) ends "provided the committee approves", while Art. 9(هـ) repeats the ban without the proviso and adds instalment plans.	Recorded as an internal inconsistency; a strict committee reads Art. 9; the source study plans on no offers unless a written approval exists [8].
3	One perspective pass reported the text as available only as a press reproduction; five others retrieved the PDF.	The PDF exists at the JMA legislation path and matched across independent downloads; the search-based negative is superseded, and Alwakeel's reproduction is verbatim [8, 62].
3	Per-post licensing: the text sets a website licence and an application of undefined unit, while a former head of the JMA professional-conduct committee (May 2026) paraphrased "no pages or ads without prior licence".	The text governs; her reading is what the committee may enforce; the source study budgets one licence per property and expects the committee to assert more [8, 29].
3	Media appearances: objectors read them as banned; the text makes them lawful unless used for direct promotion.	The text governs; the operational test is no clinic name, phone, price or booking call inside the segment [8, 70].
3	Enforcement: one perspective pass found nothing; Husna FM reported referrals and a violation; the JMA said its powers are insufficient.	That claim was refuted in the verification pass: Jordanian advertising enforcement is weak and undocumented, not absent [29, 30].
3	Dubai "new rules": the press called the September 2026 wave new; the primary is the 2022 v1.1 re-circulated, alongside an unread 23 August 2025 regulations circular and a supporting guideline on the circular page.	v1.1 is the operative standard; the 2025 layer is an open item for Dubai planning [56, 57, 133].
3	Albelooshi's permit number: one perspective pass reported none displayed; the verification pass found a footer number "LU53683 Valid 16/09/2024–16/09/2025", issuer unlabelled.	Refuted on that fact; the legal mapping stands, and the expired number is itself evidence of how loosely the display rule is kept [31].
3	Kuwait: an earlier study in this programme framed the 2024 suspension as over operating-room posts.	The posts were a post-operative ward video and case posts made with the patient's written consent; the lesson is that consent does not cure identity disclosure in Kuwait [59].
3	Egypt: the research brief named the struck-off doctor as "Hossam Al-Awadi".	The struck-off doctor is Diya al-Din Shalabi al-Awadi, an anaesthetist; Hossam Mowafi is the television professor, whose syndicate award rests on an unfooted Wikipedia line [147, 148].
3	Ad Library counts: raw keyword totals (24,000+ all-time for «عيادة») versus the audited samples.	Raw totals are polluted by spam; only the 26-advertiser sample and the 7-ad free-consultation count carry weight [85, 86].
3	Saudi television slots: Al-Habib's weekly MBC slot and Al-Nemr's were cited as fact.	Downgraded to "attested by Wikipedia only" for Al-Habib; nothing was found for Al-Nemr [145, 146].
3	The JMA conduct committee: an August 2026 press piece called it frozen; the JMA annual report records more than 30 meetings.	The press piece names no sources and is reported as unattributed opinion beside the JMA's own account [10, 84].
3	The "first disciplinary referral" was reported as an enforcement of the new instructions.	The 16 November 2024 referral concerned the fee schedule and predates the instructions [74].
3	The Cadia HIPAA settlement is dated 30 September 2025 in two law-firm sources and April 2025 in one secondary summary.	The 30 September 2025 date is used; the regulator's quote carried in the secondary summary is a paraphrase of fuller wording [126, 519].
4	Does Jordan's JMA permit health-education content without approval? One press reading says educational content is permitted when scientifically verified or peer-reviewed; another says any scientific or health-education content and any media participation needs JMA approval.	Parked in the fame study for the regulation study, which read the text itself and resolved it the same day: the text imposes a substantiation standard on education content (scientifically established or refereed, Art. 5(2)(هـ)), not an approval gate, and media appearances need no approval, only no direct promotion (Art. 5(2)(د)). See Chapter 3 [62, 70].

CH.	TENSION	RESOLUTION
4	Broadcast versus platform: 6 research perspectives found fame granted by gatekeepers and broadcasts, against 2 counter-cases (Rajan on TikTok in lockdown; Al-Nemr on X over years, with no burst).	Both hold with conditions: platform-only fame has so far required an institutional title and either a timing window or years of accumulation, and every platform case that became a household name added a network or publisher within 3 years (Rajan's book followed 4 years after his burst).
4	Sandra Lee's trigger: format-driven and Instagram-first with no press trigger, against her own first-person accounts.	The dates stand and the trigger is contested; she is not cited as the clean platform-native case. The archived curve later dated the YouTube inflection to February to May 2015, 32 months before TLC.
4	When Oz's Oprah run began (2004 or 2006) and how many appearances (55, 60+ or 62).	Immaterial to the mechanism; cited as several dozen appearances from 2004–06.
4	Steadman's ski-team appointment: 1974 or 1976.	Immaterial; noted.
4	Snapchat in the Gulf: the dominant reach channel, against a minor doctor-search channel (11.6%).	Not a contradiction once the metric is named: reach and discovery are different jobs; the Saudi survey is the only measured discovery evidence and it is stated preference.
4	Does fame convert? Salzhauer's self-reported backlog against a measured ~25% effect and surveys that rank likes last.	The self-pay cosmetic case is the anomaly; for a referral-and-insurance practice the measured record shows small effects driven by reviews and credentials.
4	Follower counts as evidence for the Arabic platform cases (Abol Atta, Desoki, Khaloud, the Gulf dermatologists).	Recorded as presence, not fame; no load-bearing claim rests on them.
4	Does television create a burst? Dr. Miami's premiere coincides with his fastest Instagram window (1,330 a day against 450 before); Sandra Lee's special and series produced none.	Normalised to the base, both are small temporary lifts (+16% in 62 days on 500K; +5% in 33 days on 3.2M), never a step; the television-patron path remains a first-audience mechanism, not a growth engine.
4	Which platform leads: stock (Instagram, for the Arab comparables) against flow (TikTok).	The perspective passes answered different questions; the strategy question is flow, measured as median views per post over 30 days, which an account's own Insights answer directly.
4	Al-Odat's YouTube: dormant, according to one perspective pass, against the verification pass.	Refuted on the evidence of the verification pass (7.4K to 16.6K after the May 2020 hits; 28 uploads in the last year); "never scaled" stands.
4	Doctor Mike's December 2020 YouTube slowdown: real or rounding?	The no-dent conclusion is safe; the brief-slowdown sub-claim sits inside rounding and is dropped.
4	Abol Atta's and El Masri's bursts.	Points added in the verification pass show sustained multi-week runs already under way before the stated windows; they are recorded as runs, and no single video is credited with them.
5	Founder-derived name versus institution-first function: Mayo and Al Habib combine them [311, 322].	Code name origin and present organisational role separately; retire the binary classification.
5	Clinical retirement versus ongoing founder involvement: Steadman's 2014 announcement retained advisory and research roles, and Andrews Medicine's current pages describe continuing commercial involvement [320, 326, 351].	Use partial-withdrawal wording. Andrews's precise current Institute directorship remains unresolved because its own pages differ.
5	Preserved affiliation brands versus subsequent dispute: the 2014 Kerlan-Jobe release and reported 2025 allegations concern different stages [325, 336].	Retain the dated announcement; do not imply uninterrupted rights or adjudicated wrongdoing.

CH.	TENSION	RESOLUTION
5	A published brand valuation versus a causal architecture effect: Brand Finance models an intangible value, while the transaction and naming records do not identify a causal naming premium [42, 43, 313].	Retain the valuation with its method and date, without importing it into a smaller clinic's business.
5	Historical Moorfields ownership versus a later portfolio transaction: the 2020/21 NHS accounts and M42's 2025 UEMS announcement concern different dates and entity levels [342, 343].	Retain the historical snapshot; current direct hospital ownership remains unreconciled, so neither 49% nor 100% is presented as today's hospital stake.
5	Institutional trust versus individual reputation: regional surveys and institutional interfaces support attention to both while leaving the trade-offs unmeasured [50, 315, 328].	Keep both hypotheses for local fieldwork; no winner is chosen.
5	Prestigious expansion versus permanence: Johns Hopkins Singapore's clinical operation ended in that form while collaboration continued [317, 318].	Treat care, research, naming and ownership as separable; do not assign the transition a branding cause.
6	Explicitly perceived difference is uncommon among current users of the brands studied in 17 markets, yet perceived differentiation is associated with economic outcomes [361–363].	The studies use different constructs, populations and outcomes. Descriptive purchase patterns do not disprove useful benefits, and predictive associations do not prove that an intervention will grow a clinic.
6	Patients rate clinical quality information highly, yet report cards showed only a weak association with observed cardiac-surgeon choice [355, 365].	Stated importance, information availability, interpretation and actual behaviour differ. No universal patient pathway is inferred.
6	A historical fusion publication sits beside a present-day brand description of a no-fusion operation [15, 16, 379].	This is a version mismatch. Evidence must attach to the operation actually offered, not merely to the name.
6	Early benefits of minimally invasive chevron osteotomy were detected in 1 trial, while later comparisons found no significant differences [44, 366, 367].	Endpoints, timing, fixation and cohorts differ. Both findings are preserved without declaring universal superiority or equivalence.
6	The JMA text provides for factual and scientific specificity, yet it also imposes publicity restrictions [8, 63].	Both belong to the full Jordanian framework. Internal validation and public expression are separate decisions; the actual copy and its administrative application remain open.
6	Compelling fame stories sit beside the absence of causal proof of growth [240, 384].	Descriptive cases can reveal mechanisms to investigate, but without comparable outcomes and counterfactuals they cannot rank signature-led against expertise-led growth.
7	Reputation can matter to choice, yet a universal fee premium is unproven; stated surgeon preferences and price-disclosure studies answer different questions [17, 391, 412].	Retain preference as a plausible value channel, but require matched realised-price evidence before pricing its financial contribution.
7	Continuity creates value, yet patient flow need not be voluntary brand loyalty: departure and referral studies show relationships matter, while acquisition research shows organisational routing also moves demand [392, 393, 411].	Measure each mechanism separately; do not label the total brand captivity.
7	Names can be owned, yet reputation still depends on people: HMG documents trademark permissions and clinician risk in the same prospectus [311].	Legal rights are necessary evidence about control, not sufficient evidence of founder-independent earnings.
7	A famous identity can travel through different structures; subscription, management and direct operation are not the same economic arrangement [324, 396, 397, 416].	Value the actual bundle and contractual perimeter, keeping all undisclosed royalties unknown.

CH.	TENSION	RESOLUTION
7	A reputation signal can attract demand while volume stays flat: ranking research detects volume responses but identifies capacity as a measurement limit [19].	Read demand, available capacity and completed care together; no automatic budget rule follows.
7	Institutional continuity is not universal asset preservation: NMC operations continued under restructuring while the regulator expected old-company creditor claims to exhaust funds, and Paterson's professional sanction differs from Spire's ongoing remediation [400-403].	State whose rights, funds, care access or trust survived, and at which date.
8	Recognition can travel, but access is locally constructed: overseas operating cases combine an existing name with staff, facilities and partnerships [12, 433].	Test portable recognition separately from accessible care and retained contribution; do not infer either from the other.
8	Moorfields Abu Dhabi date conflict: the 2017/18 accounts say April 2016, while an original inauguration release is dated November 2015 and describes a completed ceremony [46, 47].	The exact opening date is unresolved; the composite claim remains UNVERIFIED and no timing recommendation uses it.
8	Large annual enrolment versus unique demand: the Central Bank's annual count explicitly permits repeated counting, and its year-end figure uses a different temporal basis [426].	Retain both labels and use neither as unique Amman prospects.
8	Official local checklist versus current national rules: the Madaba page and the 2025 regulation index coexist, and the current rule body was unavailable [450, 452].	No current Amman fee, classification or launch timetable is declared.
8	US standard training pathway versus state alternatives: the conventional certification and training route does not exhaust all state pathways [456-458].	Identify and verify a particular implemented route; no conclusion on any individual's eligibility is drawn.
8	The brand-strategy study cites the South Florida survey as 96.5% social-media use but only 15.5% using social media to find or select a physician; the market-entry study's verification pass found the 96.5% labelled awareness in the source table and the 15.5% a sum of 3 multi-select platform entries [431, 441].	Keep the qualitative distinction between social-media use and physician selection; cite the 15.5% only as the authors' sum of multi-select entries, not a deduplicated patient share.
9	Family against clinician as the decider. The Kuwaiti study shows clinician advice as the most-raised theme and the family as central; Taif and Qassim put family recommendation low for choosing a surgeon; Jordanian oncology and physician data show family involvement alongside persistent paternalism.	These are two decisions. The family weighs on whether and where to operate; the surgeon's manner, reviews and access weigh on which surgeon. Jordanian elective orthopaedics is untested, so the question goes to second-phase fieldwork [32, 356, 464, 497-499].
9	How much social media matters. US samples are low (8.4% ads; 15.5% social media), while Saudi samples are higher (31.7% rely on social fame; 39.6% prefer famous doctors).	The populations differ in age, health-sector share and health system, and the measures differ (awareness route against stated reliance). Practice-level intake data would decide; parked for second-phase fieldwork [6, 7, 441].
9	Brand matters against message does not. One study, not independently checked, finds that advertising exposure shifts hospital choice, and rankings move volume, yet famous centres' ads are generic emotion and prestige.	Consistent. Exposure and peer reputation move patients; no study in the set credits the frame or the message itself [460, 461, 485, 488].

CH.	TENSION	RESOLUTION
9	Founder creed against post-fame slogan.	Both are true. The creeds were early but came from founders who were already famous, and they were codified decades later. Neither case shows the creed causing the fame [467, 475].
9	Cleveland Clinic's empathy effect: a jump from the 24th to the 99th percentile against a 1-point gap.	Different measures and designs: organisation-wide over years, against trained and untrained doctors inside an improving system. Parked; the self-authored figure carries no weight [465, 511].
9	Cleveland Clinic dates. The Office of Patient Experience is dated 2006, 2007 or 2009 across sources; the institutes 2007 or 2008, and 18 or 22 of them (the institutes claim was not independently checked).	Unresolved. No finding depends on the exact year [473, 489, 511].
9	Is price a lever in Jordan? The official schedule sets bands, hospital, implant and room charges sit outside it, and discounts are banned.	Price competition is out, but clarity of total cost is available. Whether an advertised fixed episode price is an “offer” is an open regulatory question (Chapter 3) [49, 436].
9	Trust is not a barrier in the Kuwaiti study, while 36.9% of reluctant Saudi patients cite the unavailability of experienced surgeons.	The samples differ: patients on a waiting list against people who refused surgery. The surgeon's credibility matters most for people not yet committed, which is consistent with testing frames 6 and 7 on reluctant patients [32, 493].
9	An earlier working hypothesis held that a big idea must be broad enough to last from a home city to Amman to Dubai.	Parked. No case shows a big idea travelling; what travelled was structure (HSS's scope, Aspetar's segment, Rothman's scale), and Rothman's name was lost at a partner's boundary (not independently checked) [435, 463].
9	An earlier working reading held that the functional value row is table stakes, the psychological row is the lever, and the monetary row must be reframed as transparency; and that for a surgeon the family is often the decider while referrers and insurers are gatekeepers.	Reworked. Functional proof in Amman is credentials plus one unaudited patient counter and no outcome measures, so lawful counts would be unoccupied; the regional psychological demand is information, and measured empathy effects are small; fees are bands. The decision unit splits into two decisions, and private insurance is 12.3% of insured Jordanians nationally against 22.1% in Amman [34, 425, 463].
9	An earlier working reading held that cosmetic-foot content might make a surgeon top of mind for the wrong category entry points.	Left to the frame choice. The strategy study adds a referrer and peer legitimacy risk for a frame named for cosmetic foot work, consistent with Chapter 6, which limits the professional positions to solely cosmetic surgery on a pain-free, functional foot [378, 492].
D	An account of the claim relayed by others and the surgeon's own confirmed statement may differ.	The instrument records them separately, and the surgeon's own statement is the input for the claim record [28].
D	The published national out-of-pocket share of 37.3% versus a recomputed value of 37.3548%, conventionally 37.4% to one decimal.	37.3% is retained only as the published figure; the source supplies no demand multiplier either way [22, 434].
D	1,015.4 thousand annual covered people with repeat counting versus about 812.3 thousand at end-2024; the year-end total also differs slightly from the sum of its rounded components.	The figures use different counting bases and the year-end total is approximate; neither is a count of unique Amman prospects [22, 426].
D	Training other surgeons can spread a technique and a reputation, yet it can also end provider scarcity.	The instrument states that neither outcome is automatic and lists each surviving advantage as a hypothesis until measured [28].

CH.	TENSION	RESOLUTION
D	A proposition can be clinically supported while its proposed wording is restricted.	Communication status is classified independently of clinical truth, and a supported clinical fact is not automatically converted into the chosen brand position [28].
D	Stated importance of a concern versus actual patient and referrer choice.	The fieldwork tests actual trade-offs with access, communication and experience, because stated importance alone does not reveal choice [28].
D	A positive monthly operating surplus versus the upfront cost of fit-out and delays in payer collection.	Capital, operating cost, collection delays and cumulative cash runway are kept in separate schedules and tested against owner thresholds [22].

APPENDIX D

Research instruments

The surgery-claim test and the Amman sizing worksheet prepared for second-phase fieldwork

APPENDIX SUMMARY

This appendix presents the 2 instruments prepared on 19 September 2026 for second-phase fieldwork, in a form any surgeon or practice can use. The surgery-claim test, in 7 sections, sets out how a procedure that a surgeon presents as a signature operation is recorded in 6 fields and matched to evidence across 8 fields. It then tests availability, ownership, relevance, durability and permissible wording, and returns a record for each proposition in one of 5 classifications. The Amman sizing worksheet, for a practice that wants to enter Amman, separates what official figures establish now from the service-line, volume and cost inputs that the practice must supply. The official figures are an end-2025 Amman Governorate population estimate of 5,004,600, a 2023 national out-of-pocket share of current health expenditure of 37.3% and a 2024 in-network share of insurer medical-claims value of 97.5%. The worksheet also sets out the equations, the rule for the monthly volume needed to cover fixed cost plus owner compensation and the capital and cash schedules. Neither instrument is completed here, and neither selects a position or approves an Amman path.

KEY FINDINGS

01 The surgery-claim test returns a proposition-by-proposition record in 5 classifications, not a composite score, and treats communication status independently of clinical truth [28].

02 Before interpretation, the test fixes the claim in 6 fields; it then matches each proposition to evidence across 8 fields, from original publication to uncertainty [28].

03 A bounded search in which no other provider is found remains a search result, and a registered name does not by itself prove an exclusive or superior method [28].

04 Amman Governorate had an estimated end-2025 population of 5,004,600, against 2,210,500 in Irbid Governorate, but governorate totals are not catchments or obtainable patients [22, 27].

05 National out-of-pocket spending was 37.3% of current health expenditure in 2023, and in-network payments were 97.5% of insurer medical-claims value in the 2024 table; neither supplies a demand multiplier [22, 426, 434].

06 Of the 7 sizing layers, 4 rest on observed official inputs and 3 are not established or not supplied, so no defensible absolute service-line market estimate follows [22].

07 For an actual cost, the monthly volume needed is ⌈(F + W) / contribution⌉, recalculated before rounding and using the sum of contributions for a mixed practice; the worksheet's illustrative contribution levels are not fees or forecasts [22].

08 The worksheet needs 7 categories of evidence, most of it held by the practice, from aggregate existing activity to the owner's capital ceiling and evidence threshold, before it can produce any estimate [22].

D.1 Purpose, status and scope of the instruments

This appendix sets out the 2 research instruments prepared on 19 September 2026 for second-phase fieldwork. The first, the surgery-claim test, specifies how a procedure that a surgeon presents as a signature operation can be recorded, matched to evidence and classified [28]. The second, the Amman sizing worksheet,

specifies the inputs and arithmetic for the incremental case for an owned Amman clinic, for a practice that wants to enter Amman [22]. Both are instruments rather than findings. Neither is completed here with any surgeon's own words, records or accounts, and neither selects a position or approves an expansion path.

The surgery-claim test is the companion instrument to Chapter 6. Its stated purpose is to distinguish recognition, real benefit, availability, exclusivity and durable commercial value before any position is chosen. It has not been administered, and it is not wording for publication: the procedure, the exact words and the supporting records are supplied by the surgeon when it is used [28]. The sizing worksheet is the companion to Chapter 8. It is a decision worksheet, not a demand forecast, tariff, opening budget or approved expansion plan; its arithmetic has been independently checked, and the practice inputs are left blank [22].

The worksheet starts from the practice's existing position. For a practice that already serves Amman patients, for example through a consulting branch, the question is not whether it has an Amman presence, but whether an owned clinic adds enough to justify itself against that existing alternative [22].

Both instruments were prepared within the desk-research programme described in Chapter 2 and share its constraints: web-only sources in the first phase, no fieldwork and no patient data. They are reproduced here in instrument form so that a surgeon or practice can see, before using them, which questions will be asked, which inputs it must supply, and which kinds of answer each instrument can and cannot return.

FIGURE D.1

The 2 second-phase instruments at a glance

COMPANION TO CHAPTER 6

Surgery-claim test

Separates recognition, real benefit, availability, exclusivity and durable commercial value before a position is chosen. Status: prepared; practice inputs and fieldwork pending.

COMPANION TO CHAPTER 8

Amman sizing worksheet

Organises the incremental case for an owned Amman clinic. Status: arithmetic independently checked; practice inputs pending.

Source: Rubikn research instruments, prepared 19 September 2026 [22, 28].

TABLE D.1

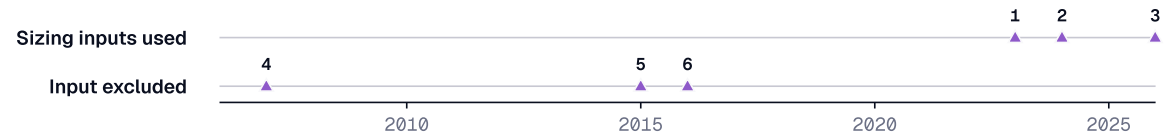
Comparison of the 2 instruments

ATTRIBUTE	SURGERY-CLAIM TEST	AMMAN SIZING WORKSHEET
Companion chapter	Chapter 6	Chapter 8
Status	Prepared; practice inputs and fieldwork pending; not administered	Arithmetic independently checked; practice inputs pending
Question	Which precise propositions in the claim are supported, for whom, compared with what, and whether they may be communicated	Whether an owned Amman clinic yields an incremental surplus over the practice's existing alternative
Output	Proposition-by-proposition decision record in 5 classifications	Monthly operating surplus, incremental surplus, and separate capital and cash schedules
What it does not do	Combine observations into one brand score, or convert a supported clinical fact automatically into the brand position	Forecast demand, set a tariff, fix an opening budget or approve expansion
Data boundary	No access to patient records, publication of cases or new clinical research	No patient-level records; aggregate activity only

Source: Compiled from the 2 instruments [22, 28].

FIGURE D.2

Dates of the evidence used by the instruments



1 **Sizing inputs used:** Out-of-pocket share 37.3% (2023)
2 **Sizing inputs used:** Central Bank 2024 insurance table
3 **Sizing inputs used:** End-2025 population estimate
4 **Input excluded:** 2007 Archived hospital audit
5 **Input excluded:** Audit inflated to 2015
6 **Input excluded:** 2016 Cost paper published

Source: Population [27]; out-of-pocket share [434]; insurance table [426]; excluded cost paper [448]; as used in [22].

> WHAT THIS MEANS FOR A PRACTICE
>
> Both instruments convert open questions into specified inputs. The decisions they inform, namely the position to adopt and the Amman path, remain the practice's own. What the instruments fix in advance is the evidence those decisions will rest on and the errors of inference each is designed to prevent.

D.2 The surgery-claim test: recording the claim and matching the evidence

The surgery-claim test has 7 numbered sections (Figure D.3). Sections 1 and 2 are set out below, sections 3 to 6 in section D.3 and section 7 in section D.4 [28].

FIGURE D.3

The 7 sections of the surgery-claim test

01
1. Preserve the claim before interpreting it
Verbatim wording, date, context and audience; split compound claims into propositions.

02
2. Match the evidence to the current operation
Record whether each source tests this version, indication, comparator and follow-up.

03
3. Test availability and ownership separately
Bounded search with positive controls; jurisdiction, owner, scope and current status of any ownership right verified separately.

04
4. Test whether the difference matters — later fieldwork
Recognition and attribution, understanding, relevance and choice, trust and geographic transfer, kept separate.

05
5. Ask what survives imitation
List each remaining advantage as a hypothesis until measured.

06
6. Check the exact communication against its jurisdiction
Map exact wording and placement to the Jordan Medical Association instructions and the Medical Constitution.

07
7. Return a proposition-by-proposition decision record
Classify each proposition, with sources, limits, counterargument and next information needed.

Source: Surgery-claim test, sections 1 to 7 [28].

Section 1. Preserve the claim before interpreting it

The first section fixes the claim in its original form before any interpretation. The researcher records the surgeon's exact Arabic wording, any English version, the date, the context and the intended audience. Ambiguity is preserved rather than resolved by translation: "special" is not rendered as "unique", and "different technique" is not rendered as "better outcome". What was relayed by others and what the surgeon personally confirms are recorded separately [28].

TABLE D.2

Claim record: fields and required inputs

FIELD	REQUIRED INPUT
Exact statement	Verbatim words and source; no reconstructed quote
Clinical identity	Standard operation name, current technical version, equipment/fixation and what actually changes
Intended patient	Condition, symptoms, severity, selection and exclusions
Claimed dimension	Name/identity, local availability, invention, exclusivity, process, outcome, experience or access
Comparison	Compared with which technique/provider, in which geography, during which period?
Claimed result	Endpoint, magnitude, time horizon and conditions; distinguish protected loading from unrestricted activity

Source: Surgery-claim test, section 1 [28].

Of the 6 fields, 2 illustrate the discipline. The clinical-identity field requires the standard operation name and the current technical version, so that evidence attaches to the operation actually performed rather than to a name. The claimed-result field requires the endpoint, magnitude, time horizon and conditions, and it separates protected loading from unrestricted activity, so that a result achieved under one set of conditions is not read as a result under another [28].

A compound claim is split into individual propositions, each tested on its own. The instrument gives the governing example: being the only locally available provider would not itself establish invention, better outcomes or durable exclusivity [28].

Section 2. Match the evidence to the current operation

For each proposition the researcher records the source and whether it actually tests this version of the operation, this indication, this comparator and this follow-up. The standard applied is stage-appropriate evaluation of surgical innovation, in which the design of the evaluation fits the development stage of the technique [380]; the instrument expressly rejects a rule that every innovation must already have a large randomised trial [28]. Chapter 6 sets out that evaluation logic in full.

TABLE D.3

Evidence match: fields to record or check for each proposition

EVIDENCE FIELD	WHAT TO RECORD OR CHECK
Original publication	Authors, date, complete citation, actual retrieval level; promotional summary kept separate
Design	Comparative or uncontrolled; prospective or retrospective; randomised if feasible; preregistration where available
Denominator	Consecutive eligible cases, included cases, exclusions, losses and actual endpoint denominator

EVIDENCE FIELD	WHAT TO RECORD OR CHECK
Outcomes	Patient-relevant benefits, harms, complications, revisions, recovery and follow-up; absolute results where supported
Comparison quality	Selection, baseline severity, operator/team experience, learning curve and risk adjustment
Technique match	Current technique, device, rehabilitation protocol and date; every material difference from the cited study
Independence	Other operators/sites, independent replication, conflicts and sponsor roles
Uncertainty	Precision, missing data and clinical importance; nonsignificance is not equivalence, significance is not universal superiority

Source: Surgery-claim test, section 2 [28]; evaluation standard [380].

LIMIT

Clinical evidence is to be requested in aggregate, appropriately de-identified form through an authorised later process. The instrument does not authorise access to patient records, publication of cases or new clinical research [28].

D.3 The surgery-claim test: availability, relevance, imitation and communication

Section 3. Test availability and ownership separately

The availability test begins by defining its boundary: the home city, Jordan, a wider region or the world. The researcher then searches Arabic and English standard names, synonyms, devices, hospitals, professional directories and publications, and includes known-provider positive controls so that a poor search is not mistaken for exclusivity. The search date and coverage are saved with the result [28].

> *"No other provider found in this bounded search" remains a search result, not proof that nobody else performs it.*
>
> Surgery-claim test, section 3 [28].

The instrument also separates current service availability from advertising visibility, training, hospital privileges and actual case experience. Where ownership is claimed, it distinguishes trademark, patent, device rights, licensing and technical know-how, and requires the jurisdiction, owner, scope and current status to be verified from the relevant record. A registered name does not by itself prove that a surgical method is exclusive or clinically superior [28]. Chapter 6 reviews one example, a dated United States registration extract for a procedure name, which is not a live status check [377].

TABLE D.4

Availability and ownership: what must be distinguished

DIMENSION	WHAT MUST BE DISTINGUISHED OR VERIFIED	WHAT DOES NOT SUBSTITUTE FOR IT
Search boundary	The home city, Jordan, a wider region or the world, defined before searching	An undefined or shifting boundary
Search quality	Known-provider positive controls; search date and coverage saved	A search without positive controls
Availability	Current service availability versus advertising visibility, training, hospital privileges and actual case experience	Advertising visibility, training, hospital privileges or case experience; and "no other provider found" is not proof of absence
Ownership	Trademark, patent, device rights, licensing and technical know-how; jurisdiction, owner, scope and current status	A registered name

Source: Surgery-claim test, section 3 [28]; dated trademark-registration example reviewed in Chapter 6, not a live status check [377].

Section 4. Test whether the difference matters — later fieldwork

The fourth section is reserved for later fieldwork. Its observations are kept separate rather than combined into one brand score. Recruitment, consent, stimuli and analysis are to be designed before fieldwork begins. Decision thresholds are to be set from the actual decision and the available baseline; the instrument prohibits invented universal scores and any "29 of 30" passing rule. No fieldwork was conducted in the first phase [28].

TABLE D.5

Fieldwork observations, kept separate

OBSERVATION	QUESTION	GUARD AGAINST MISREADING
Recognition and attribution	After exposure to the proposed cue, who is remembered: the surgeon, the clinic, the generic procedure or another provider?	Not combined with other observations into one brand score
Understanding	What benefit and limitations does the person believe the statement conveys?	Record unintended superiority or certainty inferences
Relevance and choice	Which concerns matter to eligible patients and referrers?	Test actual trade-offs with access, communication and experience; stated importance alone does not reveal choice
Trust	What evidence changes confidence, and what sounds implausible?	Do not infer trust from views, likes or recall
Geographic transfer	Does the result hold with the intended Amman audience?	Do not assume recognition in the home city travels; other countries require their own evidence and rules

Source: Surgery-claim test, section 4 [28].

Section 5. Ask what survives imitation

The fifth section asks what would remain associated with the surgeon if another qualified surgeon could perform the same operation. Each candidate advantage is listed as a hypothesis until measured. Training others can spread a technique and a reputation; it can also end provider scarcity. The instrument states that neither outcome is automatic [28]. Economic durability, fee premium, succession and sale value are addressed in Chapter 7, and capital-city demand and niche breadth in Chapter 8. A procedure name or follower count answers neither set of questions.

- Correct attribution of the operation to the surgeon
- Documented experience
- Trusted referrals
- Teaching
- Team and process
- Access
- Other independently evidenced advantages

Section 6. Check the exact communication against its jurisdiction

For Jordan, the exact wording and its placement are mapped to the full Jordan Medical Association (JMA) instructions [8] and the Medical Constitution they incorporate (consulted through a non-official transcription) [63], including the provisions on scientific substantiation, superlatives, discoveries and inventions, and registered specialties. The surgeon's actual registration and the relevant publication and advertising process are to be confirmed. Proof of a fact does not automatically make every promotional formulation permissible. Foreign rulings, such as those reviewed in Chapter 6 [382, 383], are comparative examples, not Jordanian clearance [28]. Chapter 3 describes the Jordanian framework.

Clinical indication is kept separate from cosmetic wording. Professional positions distinguish appearance-only intervention from appropriately indicated reconstruction [222, 378]. The instrument adds 2 symmetrical cautions: symptoms alone do not prove appropriateness, and an aesthetic consequence alone does not establish appearance-only purpose [28].

TABLE D.6

Where each proposition type is tested, and what cannot substitute

PROPOSITION TYPE	INSTRUMENT SECTION	WHAT DOES NOT SUBSTITUTE FOR THE TEST
Clinical outcome	Section 2: evidence matched to the current operation	Nonsignificance as equivalence, or significance as universal superiority
Local availability	Section 3: bounded search with positive controls	"No other provider found" in a bounded search
Ownership or exclusivity	Section 3: trademark, patent, device rights, licensing, know-how	A registered name
Recognition and trust	Section 4: later fieldwork	Views, likes or recall
Durable advantage	Section 5: what survives imitation	A procedure name or follower count
Permissible wording	Section 6: JMA instructions and Medical Constitution	Proof that the underlying fact is true

Source: Compiled from sections 2 to 6 of the surgery-claim test [28]; Jordanian framework [8, 63].

D.4 The surgery-claim test: the proposition-level decision record

Section 7. Return a proposition-by-proposition decision record

The instrument returns a decision record, one row per proposition, rather than a single verdict on the claim. Each row is assigned one of 5 classifications. The classifications can coexist across the rows of one claim: one proposition may be supported within a defined scope while another is classified differently, and the communication status of each is assessed separately [28].

TABLE D.7

Decision-record classifications

CLASSIFICATION	MEANING
Supported within a defined scope	Evidence supports this precise proposition, population, comparator and time horizon
Promising; more evidence needed	A plausible signal exists, with explicit missing tests
Unsupported or contradicted	The evidence does not support the proposition, or credible counterevidence conflicts
Clinical scope unresolved	Procedure, indication or current version is insufficiently specified
Communication restricted or unresolved	Wording/context faces a specific rule or an unresolved application question, independently of clinical truth

Source: Surgery-claim test, section 7 [28].

Every row carries 4 attachments. Both favourable and unfavourable results are retained, and the record concludes with what is established and what remains open [28].

- The sources on which the classification rests
- The limitations of those sources
- The strongest counterargument
- The next information needed

The record is read row by row. A proposition classified as supported within a defined scope carries its population, comparator and time horizon with it, and the classification does not extend beyond them. A proposition classified as promising names its missing tests. A proposition classified as clinical scope unresolved cannot be assessed until the procedure, indication or current version is specified, which is the purpose of the claim record in section 1. The fifth classification is assessed independently of clinical truth: a proposition can be supported clinically and still be restricted in communication, and the instrument does not automatically convert a supported clinical fact into the chosen brand position [28].

> WHAT THIS MEANS FOR A SURGEON
>
> The test will not return a yes-or-no answer on whether an operation is the surgeon's own. It will return a set of precise statements, each with its evidence, its limits and its status for publication. The choice of position among the statements that survive remains the surgeon's decision (see Chapter 9).

D.5 The Amman sizing worksheet: what can be sized now

The worksheet opens by separating what official sources already establish from what they do not. Of its 7 layers, 4 have observed inputs: geographic population, the payment environment, private medical coverage and network relevance. The remaining 3 do not: annual accessible service episodes, obtainable monthly volume and incremental economics [22]. The observed inputs come from the Jordan Department of Statistics (DOS) [27], the 2023 National Health Accounts (NHA) [434] and the Central Bank of Jordan (CBJ) [426]. The worksheet is explicit that no defensible absolute service-line market estimate follows from the observed layers alone.

TABLE D.8

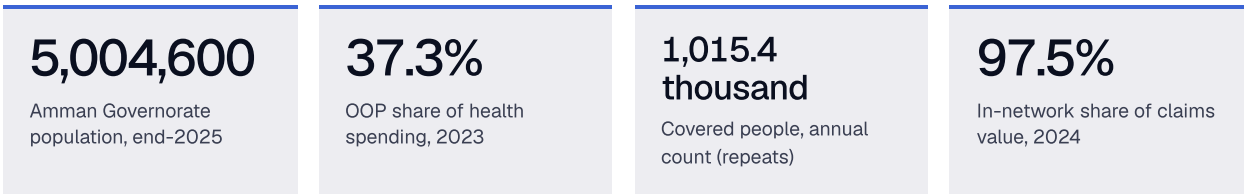
What can be sized now, and what each input does not establish

LAYER	OBSERVED INPUT	WHAT IT DOES NOT ESTABLISH
Geographic population	End-2025 Amman Governorate 5,004,600; Irbid Governorate 2,210,500	City limits, travel-time catchment, annual need, private accessibility or obtainable patients
Payment environment	2023 national out-of-pocket (OOP) spending 37.3% of current health expenditure	A private-pay patient proportion or willingness to pay for an orthopaedic service
Private medical coverage: insurers and self-funded schemes managed by a third-party administrator (TPA)	1,015.4 thousand annual covered people with repeat counting, versus about 812.3 thousand at end-2024	Unique Amman prospects, all Jordan insurance or access to a particular surgeon or clinic
Network relevance	In-network payments 97.5% of insurer medical-claims value in the 2024 table	A legal ban on out-of-network care, or a practice's contract, patient coverage or tariff
Annual accessible service episodes	Not established for any of the 4 service lines	No defensible absolute service-line market estimate follows from the rows above alone
Obtainable monthly volume	Existing appointments, patient origins, attendance, service mix and capacity, to be supplied by the practice	Social following cannot fill these blanks
Incremental economics	Actual collected receipts, variable costs, rent, fit-out, payroll and hospital terms, to be supplied by the practice	No current fee premium between Amman and other cities or project payback is established

Source: Amman sizing worksheet [22]; population [27]; OOP share [434]; coverage and network [426].

FIGURE D.4

The 4 official figures the worksheet can use now



Source: Full definitions: end-2025 Amman Governorate population estimate [27]; 2023 national out-of-pocket spending as a share of current health expenditure [434]; annual covered people with repeat counting, insurers and TPA-managed self-funded schemes, and in-network payments as a share of insurer medical-claims value in the 2024 table [426]; as used in the Amman sizing worksheet [22].

Chapter 8 charts the Amman and Irbid governorate populations and the 2 private-coverage counting bases, and sets out the worksheet's illustrative break-even sensitivity; this appendix keeps the worksheet's input templates, equations and schedules.

The worksheet does not treat governorate population as a measure of opportunity: a governorate total says nothing about city limits, travel-time catchment, annual need, private accessibility or the patients a practice could obtain [22].

The worksheet records 2 precision notes. The national health accounts' displayed amounts recompute to 37.3548%, conventionally 37.4% to one decimal; 37.3% is retained only because it is the published figure [22, 434]. The Central Bank's year-end total is approximate and differs slightly from the sum of its rounded components [22, 426]. Neither source supplies a demand multiplier [22].

FIGURE D.5

Sizing readiness by layer

	Observed input in hand	Yields a service-line estimate alone
Geographic population	Yes: DOS end-2025	No
Payment environment	Yes: NHA 2023	No
Private medical coverage	Yes: CBJ	No
Network relevance	Yes: CBJ 2024 table	No
Annual accessible episodes	Not established	No
Obtainable monthly volume	Practice input needed	No
Incremental economics	Practice input needed	No

Observed input available Not available, or does not follow

Source: Amman sizing worksheet, "What can be sized now" [22]; [27, 426, 434].

KEY FINDING

Of the 7 sizing layers, 4 rest on observed official inputs and 3 are not established or not supplied. No defensible absolute service-line market estimate follows from the observed layers alone [22].

D.6 The Amman sizing worksheet: service lines and equations

The worksheet requires the service lines to be separated before any multiplication. It uses a defined period and geographic catchment. A person may have several episodes, and an episode may contain several visits; those units are kept separate, and overlaps are removed before lines are added [22].

TABLE D.9

Service-line inputs to establish

SERVICE LINE	ELIGIBLE ANNUAL EPISODES TO ESTABLISH	PAYMENT AND DELIVERY QUESTIONS	REVENUE AND COST INPUTS STILL REQUIRED
Foot and ankle	Specific diagnoses, severity, conservative versus surgical indications; any proposed signature procedure specified through the surgery-claim test	Consultation, diagnostics, rehabilitation and any operation: which site, surgeon scope, payer and approval?	Collected professional fee per episode; included follow-ups; consumables; hospital/implant charges only if this business actually retains or bears them
Sports	New injury, elective reconstruction and follow-up episodes separately; exclude repeat visits from new-patient count	Team/referrer pathways, appointment speed, imaging, theatre and rehabilitation access	Visit/episode receipts, partner shares and variable costs; seasonality and clinic capacity
Paediatric orthopaedics	Age/condition-specific new and continuing episodes; family decision and repeat surveillance distinguished	Parent payment route, age-specific facilities and privileges, diagnostic and follow-up access	Bundled/unbundled follow-ups, staffing, specialist time and retained receipts
Joint surgery	Indicated, medically suitable and willing surgical episodes; prevalence of arthritis is not annual surgery demand	Surgeon/hospital/implant eligibility, preauthorisation and rehabilitation pathway	Retained surgeon/clinic collection, exclusions and denials, variable professional costs; the entire hospital invoice is not clinic revenue

Source: Amman sizing worksheet, "Separate the service lines before multiplying" [22].

Equation D.1 Top-down hypothesis of accessible episodes

annual accessible episodes$_s$ = defined catchment population × annual eligible episodes per person$_s$ × accessible-payment fraction$_s$

Every multiplier after population is currently unknown. The payment term must account for overlapping insurance and self-pay pathways without counting the same episode twice. Actual obtainable volume then depends on patient choice and capacity, and is to be estimated from observed evidence of existing activity and tested scenarios rather than from an invented market-share percentage. The worksheet states that this equation organises missing information and produces no estimate yet [22].

Equations D.2 and D.3 Monthly break-even

For each disjoint billable service unit s: c_s = actual collected clinic/physician receipt$_s$ – variable cost$_s$

monthly operating surplus = Σ(completed units$_s$ × c_s) – F – W

TABLE D.10

Terms of the break-even equations and their current status

TERM	DEFINITION IN THE WORKSHEET	CURRENT STATUS
s	A disjoint billable service unit; visits and episodes defined consistently	Service lines named in the worksheet; billable units to be defined
c_s	Actual collected clinic/physician receipt minus variable cost, per unit	To be supplied by the practice
Completed units$_s$	Units actually completed in the month	Unknown; to be estimated from observed evidence of existing activity and tested scenarios
F	Fixed monthly cost	To be supplied by the practice
W	Desired owner compensation, only if not already included in F	To be supplied by the practice

Source: Amman sizing worksheet, "Monthly break-even" and "What can be sized now" [22].

If an episode price includes follow-ups, the follow-ups are not added again as new revenue [22].

Equation D.4 Incremental case against the existing alternative

incremental surplus = owned-clinic surplus – existing-alternative surplus – additional opportunity cost not already counted

Opportunity cost may include foregone contribution at the home site and the surgeon's travel and time. The same salary, time or lost volume is not to be subtracted twice. A positive operating surplus still does not pay back fit-out or solve cash-collection delays; those are handled in the capital and cash schedules described in section D.7 [22].

FIGURE D.6

Order of work in the Amman sizing worksheet

01

1. Define period and catchment

Governorate population is a starting layer, not a catchment.

02

2. Separate service lines

Keep persons, episodes and visits apart; remove overlaps before adding.

03

3. Establish contribution

c_s from collected receipts less variable cost, per disjoint unit.

04

4. Compute monthly surplus

Sum of completed units times c_s, less F and W.

05

5. Compare with the existing alternative

Incremental surplus net of opportunity cost not already counted.

06

6. Schedule capital and cash

Test slower ramp and lower collection against owner thresholds.

Source: Amman sizing worksheet [22].

D.7 The Amman sizing worksheet: required volume, capital and evidence needed

For a practice's own costs, the worksheet's break-even logic gives the whole units needed each month [22].

Equation D.5 Required volume for an actual cost

$$\text{required whole units/month} = \lceil (F + W) / \text{contribution} \rceil$$

LIMIT

The 3 illustrative contribution levels are not observed Jordan prices. For an actual cost, the worksheet requires $\lceil (F + W) / \text{contribution} \rceil$ to be recalculated before rounding; already-rounded illustrative values are not to be multiplied. For a mixed practice, the sum of contributions is used instead of a single average fee [22].

Capital and cash are kept in separate schedules. Accounting depreciation is not to be used as though it funds upfront cash. A slower ramp and a lower collection scenario are to be tested against an owner-approved maximum loss and capacity ceiling. Those thresholds have not been supplied [22].

TABLE D.11

Capital and cash schedules

SCHEDULE	RULE APPLIED IN THE WORKSHEET
Fit-out, equipment and deposits	Upfront cash; accounting depreciation does not fund it
Recurring operating cost	Kept separate from fit-out; fixed monthly cost enters the surplus as F, with owner compensation W added only if not already in F
Payer collection delays and denials	Kept in a separate schedule
Cumulative cash runway	A slower ramp and a lower collection scenario tested against an owner-approved maximum loss and capacity ceiling (not yet supplied)

Source: Amman sizing worksheet, "Capital and cash" and "Monthly break-even" [22].

No figures from the 2016 public-hospital cost paper are imported into the budget. Its archived 2007 audit, inflated to 2015, is not a current private-clinic tariff or cost quotation [22, 448].

Evidence needed in a later authorised pass

The worksheet lists 7 categories of evidence needed in a later authorised pass. The first is aggregate only: no patient-level records enter the research record [22].

TABLE D.12

Evidence needed in a later authorised pass, and the worksheet element each informs

NO.	EVIDENCE NEEDED	WORKSHEET ELEMENT IT INFORMS
1	Aggregate existing activity serving Amman patients: new versus repeat episodes, service, patient-origin geography, payer route, attendance, collected receipts and referral/search attribution	Obtainable volume; existing-alternative surplus
2	The surgeon's weekly allocation across cities, sustainable clinic/theatre capacity and clinical scope	Capacity ceiling; opportunity cost
3	Like-for-like service quotes and realised receipts in each city; listed prices alone are insufficient	c_s
4	Written site/procedure privileges, capacity and rehabilitation arrangements	Service-line delivery questions
5	Payer participation requirements, actual tariffs, exclusions, authorisation rules and settlement timing	Accessible-payment fraction; collection-delay schedule
6	Current Amman premises classification and operative rules, then actual fit-out/rent/staff quotations	F; capital schedule
7	Owner compensation, capital ceiling, tolerable cash loss and evidence threshold for proceeding	W; maximum loss; decision threshold

Source: Amman sizing worksheet, "Evidence needed in a later authorised pass" [22]. The third column maps each item to the worksheet's own terms.

Current Jordanian clinic-rule clauses and end-to-end approval and privileging times were not verified in the market-entry research reported in Chapter 8 [22]. A public private-clinic checklist from another governorate does not clear the proposed configuration [452]. The worksheet states that no lease, application, fieldwork or pricing action follows from it [22].

WHAT THIS MEANS FOR A PRACTICE

The worksheet cannot be completed from the public sources reviewed. Most of its 7 evidence categories come from the practice's own activity, capacity, receipts, privileges and payer arrangements; the current premises rules must be confirmed and quotations obtained; and its thresholds for maximum loss, capacity, capital and evidence are the owner's to set. Until they are supplied, the worksheet organises the Amman decision but produces no estimate [22].

APPENDIX E

Glossary

Terms as they are used in this report

Adversarial verification	A check, made independently of the perspective pass that produced a claim, in which the cited source is re-read with the aim of disproving the claim and the outcome is recorded as CONFIRMED, REFUTED or UNVERIFIED.
Article 8 advertisement licence	The licence for an advertisement provided for in Article 8 of the JMA instructions. The text leaves undefined whether it is issued per site or per advertisement (Chapter 3).
Big idea	The single organising message a brand expresses across its communications. In Chapter 9, big ideas are dated against the moment an institution became famous.
Burst, ramp and plateau	The growth shape found in the dated platform histories: 1 platform-native surge in followers, a multi-year period of slower growth, and then little or no growth (Chapter 4).
Category frame	The category in which a brand asks to be considered and remembered, such as a specialty, a body part, a patient type or an outcome. It is a choice, not a given (Chapter 9).
CONFIRMED	A verification verdict that the cited source supports the claim as worded. Confirmation of a bounded claim does not establish causality or transfer to Jordan.
Contribution per unit	The receipts retained from 1 completed unit of service after variable costs. In the Amman sizing worksheet, it sets the volume needed to cover fixed cost and owner compensation (Chapter 8; Appendix D).
Correlated error	Error shared across apparently separate lines of evidence because they rest on the same source, method or assumption, so that agreement overstates corroboration (Chapter 2).
Decision unit	The people who take part in a surgical decision, such as the patient, the family, the referring doctor, the insurer or a club. Chapter 9 separates the decision whether and where to operate from the choice of surgeon.
DHA	Dubai Health Authority, the health regulator for Dubai. Its advertising standard ST-21, version 1.1 of 2022, remained the operative text when read (Chapter 3).
Distinctive asset	A cue, such as a face, colour, phrase, format or symbol, that identifies a brand without its name. It is the subject of the branding-tactics study still to run.
Evidence badge	The standard strip printed under each chapter title that reports, for the research behind that chapter, the claims generated, checked, confirmed, refuted and unverified.
Flow and stock	Stock is an account's accumulated follower count; flow is current attention, defined in this report as median views per post over the last 30 days. Platform leadership is judged by flow.
JMA	Jordan Medical Association. Its medical-advertising instructions, in force since 1 February 2025, govern how doctors in Jordan may advertise (Chapter 3).
Mental availability	The likelihood that a brand comes to mind when a buyer faces a relevant need. Its application to surgeons is the subject of the awareness study still to run.
Myth retired	A claim that verification refuted, or that the evidence does not support. Such claims appear in this report only as retired myths (Appendix B).

OOP	Out-of-pocket payment: health spending paid directly by patients or households rather than through insurance or public funding. A national OOP share does not equal the share of private-pay patients (Chapter 8).
Perspective	One methodologically distinct research viewpoint within a stream, examined in its own independent perspective pass. Each perspective's most load-bearing claims were passed to independent verification.
Perspective-guided desk-research protocol	The multi-perspective desk-research protocol, adapted in-house, under which the programme ran: in each stream 6 to 8 methodologically distinct perspectives, one of them a sceptical perspective dedicated to testing popular claims, examined the question using sources retrieved online at the time of research, and an independent verification pass re-checked load-bearing claims.
Purposive sample	Cases chosen deliberately for relevance and documentation rather than at random. Findings from such samples describe the cases, not a population.
REFUTED	A verification verdict that the source, or a better source, contradicts the claim as worded. Refuted claims appear only as myths retired.
Research action	One logged research step, such as a web search, a page retrieval or a source read, taken in a perspective pass or in the verification pass. Programme totals of research actions are approximate, because streams counted them differently (Chapter 2).
Sceptical perspective	A perspective dedicated to testing popular claims, included in every research stream to separate retold origin stories and popular claims from the dated record.
Second-phase fieldwork	The planned stage after desk research: patient and referrer interviews, clinic observation, recognition and recall tests, and a recorded session in which a surgeon states, in his or her own words, the work and the claim.
Stated preference	What survey respondents say they value, as distinct from choices observed in behaviour. Most patient-choice evidence in this report is stated preference.
Substantiation	The evidence that supports a claim. Under the JMA framework, whether a claim is substantiated and whether it may be published are separate decisions (Chapter 6).
Substitution test	The competitor-substitution test: a competitor's name is placed in a brand's positioning statement; if the statement remains true, it does not differentiate (Chapter 9).
Surgery-claim test	The instrument in Appendix D that fixes a surgeon's claim in 6 fields, matches each proposition to evidence across 8 fields and returns 1 of 5 classifications per proposition, not a composite score.
TPA	Third-party administrator: an organisation that processes claims and manages provider networks on behalf of insurers or self-funded schemes. It bears on the payer-network questions in Chapter 8.
UNVERIFIED	A verification verdict that a claim could be neither confirmed nor refuted from available sources; such claims carry the label wherever used. Claims never selected for verification are labelled “not independently checked”.
Value stack	The functional, psychological and monetary value a brand claims, each paired with the proof behind it (Chapter 9).
Verification pass	The independent stage of the programme that re-checked the most load-bearing claims from each perspective pass against their cited sources, under the programme's verification protocol, and recorded each outcome as CONFIRMED, REFUTED or UNVERIFIED.

APPENDIX F

Open questions by chapter

What the desk research leaves for fieldwork

Chapter 2 · Methodology

1. Which brand architecture, category frame and path into a new market fit a given practice; the research deliberately leaves these decisions open.
2. How new patients actually arrive (referral, family, previous patient, social media, insurer network), who attends consultations and confirms bookings, and how many distinct physicians refer to a surgeon: second-phase fieldwork measures.
3. An account owner's own analytics, which would date audience bursts and measure current reach directly, including platform leadership defined as flow (median views per post over 30 days).
4. The unit of the Article 8 advertisement-licence application and the JMA committee's turnaround, which only a written query to the JMA can settle.
5. A practice's fees by payer and procedure, contribution margins, available capacity and continuity during absence, required by the asset and market-entry frameworks.
6. The six planned streams not yet run: branding tactics, awareness and mental availability, word of mouth and partnerships, personal brand construction, brand story and message, and patient search and booking.

Chapter 3 · The regulatory environment

1. Is the Article 8 advertisement licence issued per site or per advertisement, and does "duly licensed" in Article 5(2) mean the practice licence or an advertising licence?
2. What are the advertising committee's form, turnaround and refusal record, and how many licences has it issued?
3. Are committee-approved offers lawful under Article 5(2)(ج), or barred by Article 9(هـ)?
4. Has any advertising-specific disciplinary referral been made since 1 February 2025?
5. What does the DHA circular of 23 August 2025 add to the ST-21 standard?
6. Is the discount and superlative wording observed in the audit still in circulation three months later?
7. How will a Jordanian board credential be described in the US, where "board certified" is reserved for ABMS or AOA boards in Texas, California and Florida?
8. Does third-party booking-platform wording, such as a listed free consultation, engage the incorporated fee-schedule and free-treatment rules, given that the text addresses only the doctor's own site and page?

Chapter 4 · How doctors become famous

1. Are the Jordanian television health slots (the طب وصحة, medicine and health, segment of Roya's دنيا يا دنيا, Donya Ya Donya; JRTV's ألو دكتور, Allo Doctor) sold as sponsored segments, and who books the doctors?
2. How are club and federation medical roles awarded in Jordan, given that the club post was not a route to fame in the December 2025 case?
3. What did the brokers in the record (publicists, PR directors, agents) actually do, and what did they cost?
4. What has the JMA committee approved in practice, and how fast? (Chapter 3)
5. Which reference-class institutes were named by the surgeon and which by the hospital partner? (Chapter 5)
6. What did the "first in the region" technology accounts own once a competitor bought the same machine? (Chapter 6)
7. Which platform leads by flow, measured as median views per post over the last 30 days, rather than by follower stock?
8. Did Al-Odat's 2020–21 burst have a datable trigger? Contemporaneous Jordanian press quoting his follower count would date it.
9. Does Albelooshi's growth step with technology and press events? It can be tested forward with a daily reading through UAEOrtho (27–29 November 2026).
10. What set off Sandra Lee's spring-2015 YouTube inflection?
11. Does fame convert into patients in Jordan? No local evidence exists.

12. Should Desoki, a paediatrician with a long-form YouTube channel, stay in the set of accounts compared with an orthopaedic surgeon? This is an editorial decision, not a data question.

Chapter 5 · Brand architecture

1. Is the intended organisation primarily the founder's own surgical practice, or a group expected to attract patients for other clinicians as well, and at what stage?
2. What should the identity mean when the founder reduces operating time, changes city, or adds a colleague with independent recognition?
3. Which entity would control the name and accounts, who would stand behind care and partner claims, and what rights attach to an existing clinic name?
4. Which name do Amman patients and referrers remember first, who initiates the referral, what do patients ask to book, and would they accept another clinician?
5. When should an existing clinic name be retained or changed, and how can its recognition, associations and relationship to the doctor's name be measured?
6. Which parts of a clinic's value (name rights, referral relationships, team capability, operating systems and continuing demand) can persist and transfer (Chapter 7)?
7. Under an institution-led route, what would the institution promise beyond the founding surgeon's own work, who else would deliver it, and would the intended Amman audience recognise and trust it?
8. Does a study that isolates the effect of a medical naming architecture exist outside the retrieved evidence set?

Chapter 6 · Distinctiveness and differentiation

1. How should a surgeon's technique claim be written down for testing: its verbatim wording, the standard operation name and current technical version, the indication, the comparator and the claimed result?
2. Will a recognisable signature, an independently useful difference, or a combination of both increase a surgeon's fame and economically valuable demand?
3. How do Jordanian patients and referrers actually weigh recognition, attribution, understanding, trust, access and experience when they choose an orthopaedic surgeon, and does recognition built in one Jordanian city transfer to an Amman audience?
4. Does a signature-led route grow faster or last longer than an expertise-led route? Answering this requires matched histories with comparable outcomes and counterfactuals.
5. What, if anything, would remain associated with the original surgeon if another qualified surgeon offered the same operation: correct attribution, documented experience, trusted referrals, teaching, team and process, or access?
6. How would the JMA and the incorporated Medical Constitution be applied to a surgeon's exact wording and placement, and which registration and approval records would that require?
7. Is there demand in Amman for a narrow surgical niche (Chapter 8), and what economic durability, fee premium, succession and sale value could a named signature carry (Chapter 7)?

Chapter 7 · The medical brand as an economic asset

1. Who is requested: the surgeon by name, a procedure, the clinic or whoever is available, and how often is the patient's first preference unavailable?
2. What can move: does appropriate demand transfer to another clinician or site, and under which explanation or introduction?
3. Who supplies demand: patient self-selection, referring clinicians, families, employers, insurers or institutional agreements, measured separately rather than as a single referral number?
4. What is scarce: consultation availability, theatre access, support staff, clinical capacity or demand, and does the constraint differ between sites or cities?
5. What can be owned and transferred: the names and marks, legal permissions, operating relationships and care systems behind the practice?
6. What persists through disruption: appropriate care, access, trust and referral relationships during planned absence or a complaint?
7. Which ownership or partnership structure, if any, should carry a future institution or overseas presence remains each practice's strategy decision; the evidence documents options without selecting one.

8. Unresolved evidence gaps remain: name-only transaction allocations, founder-departure price effects, private contract royalties, reliable decay rates for a silent doctor, and local brand-to-earnings estimates.

Chapter 8 · Market entry: the capital and beyond

1. Which Amman configuration a practice should assess against its current arrangements: continued consulting from a branch, an owned clinic (consulting office, secondary specialty office, single- or multispecialty centre, or a site with procedures) or a hospital partnership.
2. What a practice's existing activity shows: new versus repeat episodes, service mix, patient origin, payer route, attendance, collected receipts and referral or search attribution.
3. How a surgeon's weekly time and sustainable clinic and theatre capacity would be allocated between the home city and the capital, including foregone contribution at home.
4. What like-for-like services earn in realised receipts in each city, and whether any fee difference exists between Amman and secondary cities.
5. Which intended hospitals would grant written procedure privileges, theatre access and rehabilitation arrangements, and on what terms and timelines.
6. Which payer networks would accept the clinic, at what tariffs, with what authorisation rules, exclusions and settlement timing.
7. How Regulation 25/2025 classifies the intended Amman premises, and what current fees, requirements and approval times apply.
8. What owner compensation, capital ceiling, tolerable cash loss and evidence threshold an owner sets for proceeding.
9. Which overseas jurisdiction and route, if any, a practice intends to pursue, and what qualification tier and title a surgeon would hold in Dubai, or what eligibility in a US state.
10. How an entrant's specific services compare with those already published by Amman providers.

Chapter 9 · Brand strategy and articulation

1. Which category frame, if any, a practice should adopt. The study lays out twelve candidates and chooses none.
2. Whether plain procedure counts and named accreditations are permissible under the JMA text. If they are, they would be an unoccupied proof position in Amman.
3. Whether an advertised fixed episode price or complication cover counts as a prohibited “offer”.
4. Whether naming a sports club in marketing collides with the JMA ban on sponsors.
5. How a practice's new orthopaedic patients arrive, and how the social-media share compares with the US baseline (referral 44.9%, word of mouth 18.7%, ads 8.4%) and the Saudi figures.
6. Who attends consultations, who asks the cost and recovery questions, and who confirms bookings: the family's role in whether to operate against its role in choosing the surgeon, in Jordan.
7. How cosmetic-foot enquiries compare with joint and sports enquiries on route, payer and conversion.
8. How many distinct physicians refer to a surgeon, and what share of patients they account for, as a brand-asset measure alongside follower count.
9. A practice's registered specialties, actual patient mix, referral routes and claimed procedures, without which no frame's fit can be judged.
10. Whether competitors' metadata-layer superlatives and English-first page names are enforced, and what a compliant audit of titles, schema alt text and video titles would require.

Appendix D · Research instruments

1. What are the surgeon's exact words for the claim, in Arabic and any English version, and which propositions does the surgeon personally confirm?
2. What is the standard name and current technical version of the operation, and for which patients, indications and exclusions?
3. Against which technique or provider, in which geography and period, is the claimed difference made, and with which endpoint and magnitude?
4. Does any other provider offer the operation within the defined boundary, and is any ownership right (trademark, patent, device rights, licensing or know-how) actually held?
5. Does recognition of the surgeon, rather than of the generic procedure, hold with the intended Amman audience?

6. What, if anything, would remain associated with the surgeon if another qualified surgeon performed the same operation?
7. Which exact wordings are permissible under the JMA instructions and the Medical Constitution once the surgeon's registration and advertising process are confirmed?
8. What does aggregate activity at any existing site serving Amman patients show about new versus repeat episodes, patient origin, payer route and collected receipts?
9. What are the realised receipts, variable costs, fixed costs, payer terms and privileges that determine c_s, F and the accessible-payment fraction for each service line?
10. What owner compensation, capital ceiling, tolerable cash loss and evidence threshold will a practice set for proceeding with an owned Amman clinic?

APPENDIX G

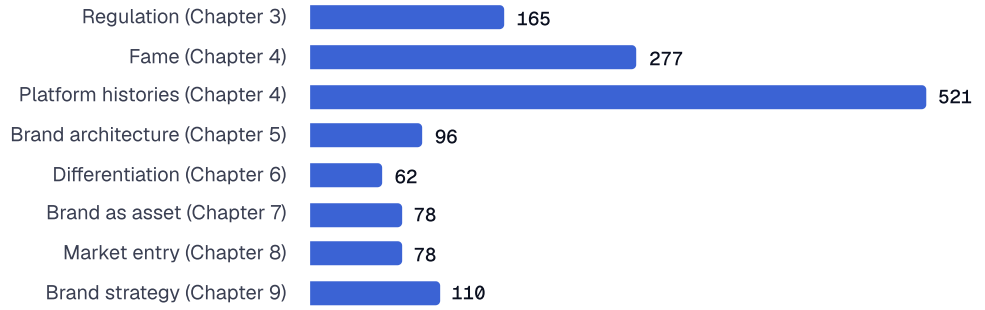
Source register

Every web source retrieved and recorded during the research, grouped by study.

This register lists 1,330 unique web addresses recorded in the research ledgers behind this report, including archived snapshots used to date platform histories. It is broader than the References list, which holds only the sources cited in the text. Entries link to the page as retrieved; some pages may since have moved.

FIGURE G.1

Unique web sources retrieved, by study



Source: Rubikn research ledgers, September 2026. A source used by two studies is counted in each.

Regulation (Chapter 3) 165 SOURCES

'Staff too fearful to speak out': Cosmetic surgery sector is a work in progress abc.net.au

Cosmetic surgeon Daniel Lanzer resigns as medical practitioner abc.net.au

TikTok star Dr Daniel Aronov banned by regulator from performing cosmetic surgery abc.net.au

TikTok star Dr Daniel Aronov banned by regulator from performing cosmetic surgery (2021-11-29) abc.net.au

DHA Standards for Medical Advertising on Social Media (agency blog, cites CIR-2026-00000144) abspartners.ae

Top Ads: high-performing auction ads (region JO) ads.tiktok.com

Ads Transparency Center (region JO) adstransparency.google.com

Advertising compliance and enforcement strategy ahpra.gov.au

Advertising higher risk non-surgical cosmetic procedures ahpra.gov.au

Booming billion-dollar cosmetic industry on notice with new cosmetic procedures guidelines (3 June 2025) ahpra.gov.au

Guidelines for advertising a regulated health service ahpra.gov.au

Medical Board accepts undertaking not to practise from Dr Lanzer (2021-10-30) ahpra.gov.au

National Law amendments ahpra.gov.au

Putting patients first: New guidelines for cosmetic procedures (2 Sept 2025) ahpra.gov.au

Testimonials: Understand the requirements ahpra.gov.au

(19-05-2025) النمر يحذر من تغريدات بمعلومات طبية غير موثوقة ajel.sa

مطالبات بنقابة الأطباء الأردنية بالحذو حذو أطباء سوريا وتفعيل لجنة ضبط المهنة لمواجهة التجاوزات (12-08-2026) الرقمية akhbarna.net

(12-08-2024) ضحايا حروق الليزر... فتيات غير مؤهلات يعملن بمراكز أردنية بلا رخصة alaraby.co.uk

(7 Jul 2026) الأطباء تقاضي مروجي ملصقات شعار الطبيب المزورة على المركبات albaladnews.net

(24-12-2024) "أطباء القطاع الخاص" تستهجن التعليمات الجديدة لنقابة الأطباء - بيان alghad.com

(09-05-2023) "الأطباء" تتجه لفرض نظام يضبط الإعلانات الطبية على وسائل التواصل alghad.com

(25-01-2025) "الأطباء": "الإعلان الطبي" قيد المراجعة الفورية خلال 6 أشهر alghad.com

(16-11-2024) أول إجراء من نقابة الأطباء.. إحالة طبيب لمجلس التأديب alghad.com

(13-09-2024) قريبا.. نقابة الأطباء تبحث تعليمات جديدة للإعلانات والإعلام الطبي alghad.com

(10-07-2024) جدل في المنصات الكويتية بعد إيقاف طبيب نشر مقطع فيديو لمريض aljazeera.net

(01-2026) "الغذاء والدواء": مستحضرات تجميل غير مرخصة يروج لها عبر وسائل التواصل الاجتماعي almamlakatv.com

(19-04-2025) عيسى الخشاشنة نقيبا للأطباء للدورة الخامسة والثلاثين almamlakatv.com

(09-07-2024) الكويت.. إليك سبب إيقاف الدكتور حمد جبر العنزي almashhad.com

(06-07-2026) إلى الأردنيين.. احذروا وضع هذه الملصقات على مركباتكم.. الأطباء تقاضي alsaa.net

(04-01-2026) يونس: ضبط الإعلانات المضللة للمستحضرات التجميلية ضرورة alsaa.net

(18 June 2026) الصحة تباشر إجراءات نظامية بحق ممارسين صحيين بسبب منشورات ترويجية alshaamal.com

نقابة الأطباء تصدر تعليمات الإعلانات والإعلام الطبي alwakeelnews.com

(24-12-2024) نقابة الأطباء تصدر تعليمات الإعلانات والإعلام الطبي alwakeelnews.com

Article – Ministerial Decision on Medical Advertising: What You Need to Know alyaqoutlg.com

حسام موافي — ويكيبيديا العربية ar.wikipedia.org

طارق الحبيب — ويكيبيديا العربية ar.wikipedia.org

Kuwait shuts down 5 medical facilities, refers 23 to authority for violations arabtimesonline.com

"الصحة السعودية" تُحدد ضوابط إعلانات الأطباء وتحذر من تضليل المرضى argaam.com

ASA Ruling on LIFT Aesthetics (A22-1158433) asa.org.uk

ASA Ruling on Pall Mall Medical (Manchester) Ltd (A24-1252542) asa.org.uk

ASA Ruling on Transform Hospital Group Ltd (A21-1135822) asa.org.uk

Before and after photos – Advice online asa.org.uk

Cosmetic interventions: Social responsibility – Advice online asa.org.uk

Cosmetic surgery – Advice online asa.org.uk

Enforcement Notice issued to non-UK based cosmetic surgery providers to tackle irresponsible ads asa.org.uk

Enforcement Report: Cosmetic surgery abroad asa.org.uk

Testimonials and endorsements – Advice online (CAP Code 3.47–3.52, 12.18) asa.org.uk

طبيب تجميل شهير يواجه تهمة هتك عرض أحداث في الأردن (11-05-2026) assawsana.com

Health Practitioner Regulation National Law (NSW) – Sect 133 Advertising classic.austlii.edu.au

AMA Code of Medical Ethics Opinion 9.6.1 Advertising and Publicity code-medical-ethics.ama-assn.org

State Medical Board of Ohio — Approved July 12, 2023 Board Minutes dam.assets.ohio.gov

dha.gov.ae page indexed 2026-08-13 'Standards for Medical Advertisement Content on Social…' — now returns Error 404 (evidence a 2026 document was published then removed/moved) dha.gov.ae

Standards for Medical Advertisement Content on Social Media, Version 1.1 (DHA/HRS/HPSD/ST-21) dha.gov.ae

DHCR Advertisement Policy and Procedure PP/AD/001/03 dhcc.ae

Circulars | Department of Health Abu Dhabi doh.gov.ae

DoH Circular No. 26/2023 – Training Programme on Abu Dhabi Healthcare Guidelines for Health Media & Advertising System doh.gov.ae

بعد قرار الهيئة التأديبية بنقابة الأطباء.. الصحة تلغي ترخيص ضياء العوضي وتغلق عيادته ems.org.eg

Ad snapshot: Elite Laser&Derma Clinic Karak — 'جلسة تنظيف عميق للبشرة' facebook.com

Ad snapshot: عيادة الدكتور الارقم مكاوي — 'جلسة شد الجلد المترهل للجسم' facebook.com

Meta Ad Library API (ads_archive) — used via ads_library_search facebook.com

Meta Ad Library search API (search_terms 'كشفية مجانية', countries JO, active) – run 2026-09-16 facebook.com

Meta Ad Library search: country JO, 'استشارة مجانية عيادة', active ads (queried 2026-09-16) facebook.com

Meta Ad Library — Jordan, active ads, keyword خصم عيادة facebook.com

Meta Ad Library — Jordan, active ads, keyword عظام facebook.com

Meta Ad Library — Jordan, active ads, keyword عيادة facebook.com

Meta Ad Library — UAE, active ads, keyword clinic Dubai facebook.com

Meta Ad Library — UAE, active ads, keyword عيادة دبي facebook.com

رسميا: نتائج الفائزين بعضوية مجلس النقابة للدورة 35 (JMA Facebook, login-walled — council list not readable) facebook.com

نقابة الاطباء تصدر تعليمات الإعلانات والإعلام الطبي للأطباء (JMA Facebook post, 24 Dec 2024) facebook.com

106 شكاوى ضد أطباء خلال عام.. وجراحة التجميل تتصدر القائمة (12-07-2026) factjo.com

طبيب يحذر من هوس التجميل والسقوط في فخ الإعلانات المضللة ويكشف كواليس التحقيقات (22-06-2026) factjo.com

نقابة الأطباء تقرر إيقاف طبيب جراح عن العمل وإغلاق عيادته (11-06-2026) factjo.com

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Cosmetic interventions – professional standards (PDF, GMC/CI/1224) gmc-uk.org

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Using social media as a medical professional (PDF, GMC/SMMP/1224) gmc-uk.org

Attention influencers and businesses: Abu Dhabi licensing requirements for social media ads (effective July 1) gulfnews.com

Dubai issues social media rules for doctors, health facilities and influencers: bans misleading claims (2026-09-01) gulfnews.com

Saudi Arabia suspends doctor, launches legal action over illegal exosome injection promotions on social media gulfnews.com

الدستور الطبي الأردني haddadlawyer.com

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