Article

Physician and Patients Relationship in Contemporary Times (Orthodox and Non-Orthodox): Highlighting the Consequential Outcomes

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Abstract
Understanding the dynamics and outcomes of physician and patient's relationship require a comprehensive review and synthesis of existing literature on the doctor-patient, nurse-patient, and pharmacist-patient relationships, including non-orthodox practices. This engagement analysed various interaction models and outcomes, referencing key studies and theoretical perspectives such as Talcott Parsons' functionalist view and Thomas, Szasz, and Hollender's therapeutic relationship situations. The main findings highlight that effective healthcare outcomes rely on the quality of relationships between patients and various healthcare providers. Socio-cultural compatibility, clear communication, and mutual trust significantly enhance these relationships, leading to better patient adherence, satisfaction, and overall health outcomes, particularly in diverse and socio-economically varied contexts like Nigeria. Therefore, the decision to use a health care facility when ill depends on a number of factors, including the perceived friendliness of the physician's demeanour, the efficiency and effectiveness of the services being provided, and how well-suited the therapeutic intervention is to the social status of users/health consumers government policies as important, necessary and inevitable even when such policies bring hardship on the masses.
Keywords: Medical ethics, orthodox healthcare, non-orthodox healthcare, patients, consequential outcomes

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Introduction

There exists a formal relationship between the healthcare professionals - both the Orthodox and Non- Orthodox- and their patients as a result of prescribed interaction due to the fact of illness (Even-Zohar *et al.*, 2021). In majority of cases the relationship is official (Harakas, 2023). That is between a client (patients) and health professional. Relationship is established when a client who was adjudged to be sick comes to the health centre for consultation to commune with a competent Medical Consultant who determines the prophylactic condition and recommend therapy to address the health remiss or discontinuity after a proper diagnosis. The client may be classified to be out-patient or in-patient. Out-patient pays regular visitation while in-patient is to be admitted and acquiesces with the rules and regulations of the hospital which otherwise means submission to total institutional arrangement of the hospital (Sofianos, 2023; Erinosho, 2006). The roles of nurses, pharmacists, and others follow the conclusions reached by the medical consultant. According to Desai and Kapadia (2022), one of the pillars of modern medical ethics and practices is the relationship between healthcare providers and patients. In their interactions with patients, doctors are supposed to remain objective and emotionally detached. They must also follow the code of professional conduct at all times. To improve the accuracy of diagnosis, increase patient awareness of the disease, and greatly encourage health searchers for non-fractious access to care, the degree of interaction and reciprocity between the patient and doctor is nevertheless significant to both health givers and consumers (Jegede, 2010; Maguire, 2010; Lupton, 2000; Horobin, 1975; Freidson, 1975).

The effectiveness of interactions between healthcare providers and patients is crucial. The number and quality of information concerning the patient's disease treatment from both the physician and patients will better the relationships in regards to mutual respect, knowledge, trust, shared values and knowledge about disease and life, and time available. The interactions between doctors and patients follow four patterns. Specifically, paternalism, consumerism, default, and reciprocity (Maguire, 2010). The physician-centered approach is an example of paternalism. It makes use of closed questions that only accept a “yes” or “no” response. The healthcare provider will typically adopt a disease-centered approach and be more concerned with making a diagnosis than with the patient's particular experience with illness. The consumerist paradigm asserts that the patient is fully aware of their needs and compels the doctor to take a patient-centered approach. When the patient-centered approach fails, the default pattern emerges.

The patient perceives the doctor as wanting to give up control, but the patient won't accept it, therefore there's a deadlock. The fourth pattern is when

a physician employs open-ended questions to nudge patients into discussing their issues.

The strategy is based on taking the time to hear the patient out and making an effort to comprehend their perspective. The notion that the relationship between a doctor and patient is essentially reciprocal is not always accurate (Maguire, 2010; Aluko-Arowolo *et al.*, 2021). Depending on how the patients and the doctor behave reciprocally, each of these patterns has outcomes that could be harmful or innocuous. Because the doctor is urbane, well-educated, experienced, and frequently the one on the ground, the doctor may be seen as more sophisticated than the patient. The patient's pain, which may be persistent and restricted to a lack of exposure that prevents the sufferer from playing his role, can further complicate the connection. Since sickness intrusiveness prevents people from engaging in valued activities, it may affect psychological well-being and reduce exposure to contacts that people value highly.

By limiting a person's own influence over both positive and bad outcomes in some crucial situations, illness intrusiveness, especially in individuals with chronic diseases, may contribute to further psychosocial decline (Solarin and Abikoye, 2013). The way a doctor and patient communicate is frequently influenced by their various social statuses, environments, and requirements. They are frequently the driving forces behind sickness behavior, both prophylactically and prognostically.

In Nigeria health system is replete with four types of healthcare models. The orthodox, traditional, alternative care and faith based. And all the four are legally recognized with each having its retinue of patronages. Sometime strict/mutual exclusiveness of clientele is almost not practicable due to the illness behavior as annotated by the prevailing culture and belief system (Aluko-Arowolo, 2006 and Jegede, 2010). Orthodox care professionals are the medical doctors, nurses, pharmacists and others who are plying their vocation within a defined hospital environment with all appurtenances akin to the Western mode of healthcare system; while the non-orthodox professionals are the core traditionalists such as herbal practitioners, diviners, traditional birth attendants (TBA) and alternative care system are non-western type of health system from oriental and Asia countries. The fourth type is Faith Based healing systems that are into syncretism and/or power of words to heal and exorcise evil/demonic spirits from the sick persons.

Healthcare professionals are described as anyone that can bring about optimum health satisfaction to people. And health to be seen as optimally satisfactory, according to (WHO, 2006) it must be in a state of complete physical, mental and social wellbeing and not merely the absence of diseases or infirmities. This is in tandem with (WHO, 1995) health promotion focus on medics and patients interaction to be the process of enabling people to increase control over, and to improve their health (Erinosho, 1998). Having a good and sound health is important in everyone’s life, so health promotion or awareness activities is important for individual to be cognizance of, and to be aware of

healthcare processes and procedures. By fostering form and encouraging patient participation, doctors and other healthcare workers are frequently urged to involve patients in the caring process. Fostering a collaborative relationship where the patient is seen as an active participant rather than a passive recipient of healthcare can increase the likelihood that the patient will experience good health (Alchurair, Simpson & Guirguis, 2012).

Literature Review

The physician-patient relationship serves as the cornerstone of effective healthcare delivery, providing a dynamic interface where communication, trust, and mutual understanding play critical roles in achieving optimal health outcomes. Recognizing the diversity of healthcare practices globally, this literature review delves into the conceptual underpinnings of the physician-patient relationship, exploring its variations across different care models. Specifically, this review encompasses three key areas of focus: the conceptual framework of the physician-patient relationship, a review of its dynamics within orthodox care facilities, and an analysis of its attributes within non-orthodox care settings.

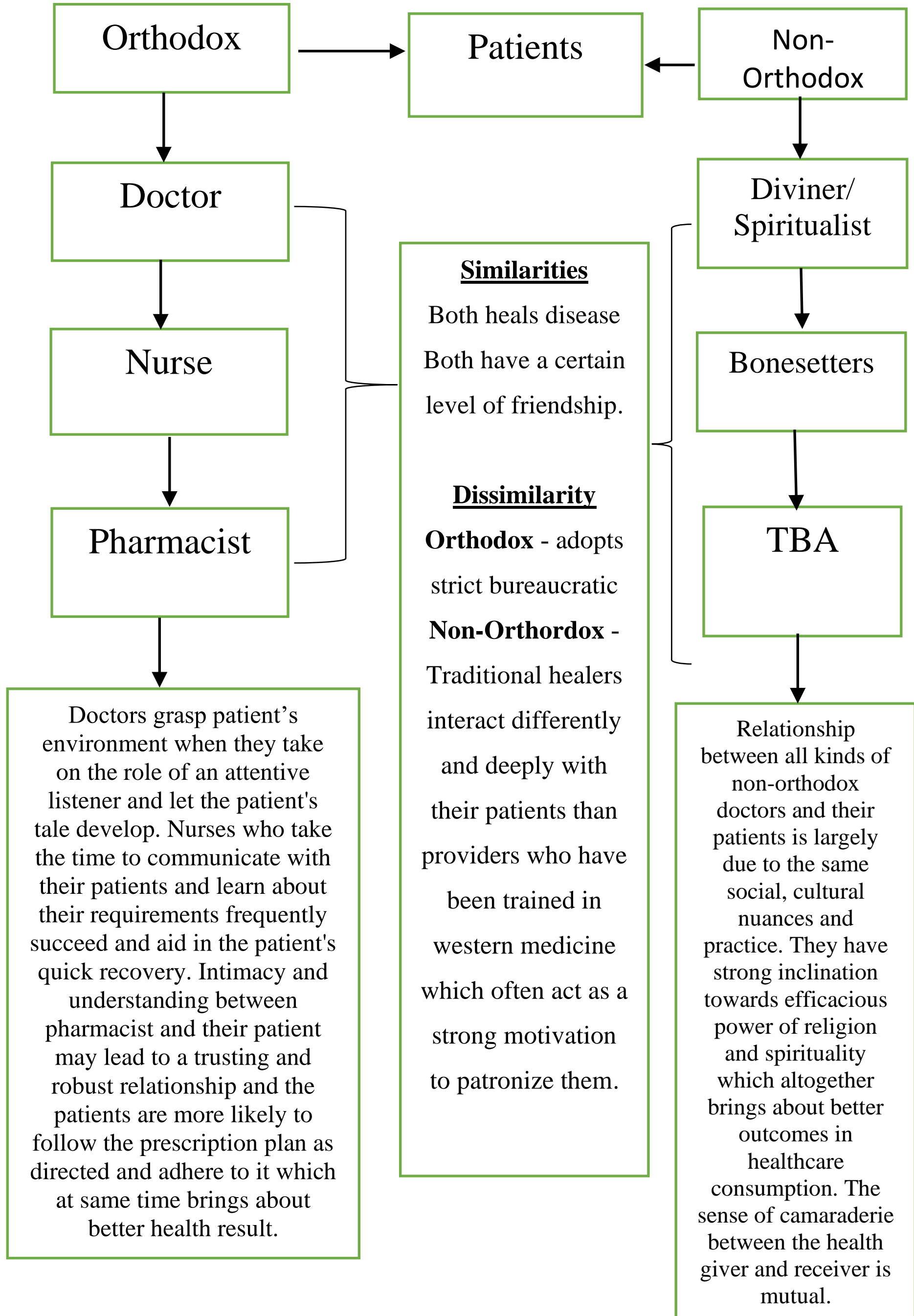
The conceptual framework provides the foundation for understanding the theoretical dimensions and variables that shape the interactions between physicians and patients. By examining core principles such as communication styles, trust-building mechanisms, and shared decision-making processes, this section establishes the basis for subsequent evaluations.

Following this, the review focuses on the orthodox care facilities, where standardised practices and evidence-based medicine govern interactions. The physician-patient relationship in these settings is characterized by formalized protocols, structured consultations, and regulated ethical considerations, which will be analysed in detail.

Lastly, attention is shifted to non-orthodox care facilities, where alternative medical practices, including traditional and complementary therapies, influence the relational dynamics. Here, cultural beliefs, holistic approaches, and personalized care are examined to highlight their implications on patient engagement and satisfaction. This systematic approach aims to provide a comprehensive understanding of the evolving nature of physician-patient relationships, offering insights into its significance across diverse healthcare landscapes.

Conceptual Framework

Conceptual Frame Work on Orthodox and Non-Orthodox Patient's Relationship



Review of Physician and Patients Relationship from Orthodox Care Facilities

Doctor – Patient Relationship

According to studies, doctors are the most influential personnel in the healthcare industry. Talcott Parson (1951), who examined the relationship from a functionalist perspective, claimed that patients and doctors were playing out socially prescribed roles in their interactions. A sick person's responsibility is to actively seek expert medical advice and give their complete cooperation to the medical team. Doctors are supposed to put their knowledge and abilities to work for their patients' benefit, to interact with patients in an emotionless and dispassionate manner, and to always operate in accordance with a code of professional conduct. The duty to be affectively neutral falls on the doctor as well as other doctors. Reducing possible tension, conflict, and mistrust in doctor-patient interactions is better for the patient. Also, it is expected that both parties voluntarily subscribe to a common set of values. In the knowledge that the doctor will always act in a way that protects the patient's health and wellbeing, the patient acknowledges the doctor's authority.

According to the nature of the medical problem, the patient's requirements, and the setting of the meeting, the doctor-patient relationship also alters contextually. Activity/Positivity, Co-operation/Guidance, and Mutual Participation are three examples of these therapeutic relationship situations (Thomas, Szasz, Knoff & Hollender, 1958).

- Activity/Positivity: Situations where the doctor takes the lead, such as during operations and medical emergencies.

- Cooperation/Guidance: This scenario occurs when the patient is obedient, cooperative, and plays a passive role in receiving medical counsel.

- Mutual Participation: When the patient and doctor are on an equal footing, as in the case of a chronic illness where a significant amount of self-care is necessary for the condition to be successfully controlled.

In comparison to Parsons Formulation, this idea was more complex. Because of broader social and cultural influences, there are systematically different therapeutic relationships between doctors and patients. For instance, interactions between doctors and patients are more likely to be marked by mutual participation when both parties share the same social backgrounds,

socioeconomic status, geographic area, and cultural heritage. The likelihood of an active-passive interaction is also higher when patients and clinicians have different sociocultural backgrounds. Yet, if such patient involvement is to be promoted, then it is crucial that there is a larger sharing of knowledge and information between experts and patients. Passive patient could be substituted with active patient.

Studies reveal that doctors (urbane and middle-classed professionals) with middle class patients tend to get more information, either willingly or in response to direct questions, in comparison to their working class counterparts (Aluko-Arowolo *et al.*, 2021; Solarin and Abikoye, 2013; Maguire, 2010 and Lupton, 2000). Working class patients' reluctance to ask questions might not be due to a lack of curiosity, but rather to a reflection of the status divide, which might act as a communication barrier. However, there is some data to support the idea that doctors are less receptive to questioning from female patients and are more likely to provide their male patients with a more thorough and technical explanation of their medical condition (Jegede, 2010). Language limitations, religious tenets, cultural and social barriers, and variations in nonverbal behaviour are all frequent reasons of miscommunication in medical meetings, particularly with patients from minority ethnic backgrounds.

In a similar submission, Bloor and Horobin (1975) discussed how conflict can arise when patients are put in a double-blind situation with opposing expectations. People are required to know more about health-related topics so they may recognise the symptoms that call for specialised medical care. Bloor and Horobin stated that the ideal patient is one who can determine which health issue (or issues) call for a trip to the doctor. On the other side, patients are expected to be submissive, accept the diagnosis, and readily adhere to the recommended treatment according to the role and expectations that doctors have of them. Different emergencies require various levels of urgency according to doctors and patients. There is a lot of evidence that doctors keep a close eye on the consultation process and that their major goal is to get the patient to provide the details needed to make an accurate medical diagnosis. The relationship, in whatever form, has the following intentional and unintended consequences:

- ***Nurse – Patient Relationship***

  The relationship between Nurse and Patient could be described as being similar to mechanistic compliance of a customer to a cashier (Aluko-Arowolo *et al.*, 2021). That is, dotting to give instruction to the patient as someone incapable of helping herself/himself. More nurse engagement in this situation is essentially a reaction to a biological model of care that, via its reliance on technology, dehumanizes patients, treats them like objects, and abrogates their human dignity. In this case, patients and in particular pregnant women in Nigeria and other developing countries have portrayed the health providers particularly nurses in the formal

sectors as unpleasant, inconsiderate, unkind, and unsympathetic in general (Aluko, 2008; Safe Motherhood Fact Sheet (SMHFS), 2000).

Being the first point of contact, nurses are thought to establish an atmosphere that allows them to get insight into the social and personal lives of their patients. As a result, nurses are in a better position to identify health needs and implement suitable treatment regimens. This does not frequently occur (Aluko, 2008). The patient should be seen by nurses as an objective, logical individual with whom they should forge a friendly relationship in order to promote his or her welfare. In addition to creating and sustaining a therapeutic environment, the nurse's responsibility includes becoming involved in the nurse-patient relationship to the point where they act as the patient's supporter.

Patient and nurse relationships can fall into one of four categories: Clinical involvement comes in initially and may be ranked lowest; this kind of interaction is most common when a patient is being treated for a minor ailment. Patients are often treated as outpatients. The second is referred to as Therapeutic; it is the most common type and also applies to short-term cases where the patient has clear, modest needs that may be rapidly satisfied. Each party's job expectations are distinct and unmistakable (Solarin *et al.*, 2013; Alchurair, Simpson & Guirguis, 2012). The third sort of relationship is referred to as a "Connected Relationship"; it arises when a nurse and a patient have had repeated interactions, leading to the nurse's perception of the patient as both a person and a patient. The fourth scenario, sometimes involving intense interaction, is known as "Over-involved" since the nurse is more involved in the connection and therefore more likely to transgress the "rules." where the elbow is extended with the hands. The nurse may begin to take on the position of patient advocate in interactions with medical personnel if it is determined that doing so is in the patient's best interests, the patient grows to trust the nurse, and the connection between the two parties matures. These relationships can lead to specific results that can speed up recovery after surgery or convalescence.

➢ *Non-Orthodox – Patient Relationship*

Non- Orthodox professionals are those that are not involved in bio-medical process or strict scientific process and procedural way of bringing health to patient but they could provide effective health satisfaction to their patients all still the same. They are referred to as traditional health practitioners and include: bone setters, traditional surgeons, herbalists, diviners (syncretic healers), and more. It is evident

that practically anyone who has the capacity to heal using conventional techniques falls within the criteria of a traditional health practitioner. Another way to treat ailments without using medical intervention is through faith-based healing. The believers choose faith above medicine.

Pathways to health care in Nigeria are often not mutually exclusive, in that patronage is straddled between the orthodox and no-orthodox alike. The non-orthodox practices in Nigeria society are mostly patronized by non-literate and to some extent the literate ones also patronize the mode. Both literate and illiterate people behave similarly in dire health situations as mental, infertility, and so on and typically turn to traditional healers and other non-Western health professionals for assistance. But non-literate people frequently choose to receive medical care in the facilities of traditional healers rather than in western medical facilities, largely because they find the latter's formalities, such as waiting in lines for cards, registration, physical examinations, etc., burdensome, strange, and seemingly alienating (Labhardt, Aboa, Manga, Bensing & Langewitz, 2010; Erinosho, 2006). Studies have discovered a number of explanations for the popularity of traditional practitioners, and the most frequently cited reasons include patient perception of quality of care, or quality of interaction with traditional healers, as the main determinant for consulting a traditional medicine; consistency with native cultural values and beliefs; a better healer-patient relationship; and proximity and lower cost compared to western healthcare practitioners (Deepak, Vidushi & Uday, 2020; Jegede, 2010; Erinosho, 2006; Chiwuzie and Okolocha, 2001).

Analysis

Table 1: Findings on Doctor-Patient Relationship

Finding	Authors	Discussion
The doctor-patient relationship is influenced by socially prescribed roles, emphasising affective neutrality and professionalism.	Talcott Parsons (1951)	Parsons' functionalist perspective posits that doctors and patients assume specific roles where doctors act in the patients' best interest and patients comply with treatment. This model emphasises trust and professional ethics.
Contextual variations in doctor-patient relationships: Activity/Positivity, Cooperation/Guidance, and Mutual Participation.	Thomas, Szasz, Knoff & Hollender (1958)	The type of interaction depends on the situation, with more collaborative relationships emerging in chronic care scenarios and directive roles seen in emergencies. These

Finding	Authors	Discussion
		variations enhance adaptability in healthcare delivery.
Mutual participation is more common when doctors and patients share similar social and cultural backgrounds.	Aluko-Arowolo *et al*. (2021); Solarin & Abikoye (2013); Maguire (2010); Lupton (2000)	Shared backgrounds promote better communication and trust. Conversely, status and cultural divides can hinder interaction, particularly with working-class patients, affecting the quality of information exchange.
Working-class patients provide less information during consultations compared to middle-class patients.	Aluko-Arowolo *et al*. (2021); Solarin & Abikoye (2013)	This gap arises from the hierarchical dynamics and perceived social distance between doctors and working-class patients. Empowering patients with health literacy can bridge this divide.
Doctors are less receptive to female patients' queries and provide male patients with more detailed explanations.	Jegede (2010)	Gender biases in communication can impact patient satisfaction and care quality. Addressing these disparities is essential for equitable healthcare practices.
Language barriers, cultural differences, and nonverbal miscommunication are prevalent in consultations with minority patients.	Aluko-Arowolo *et al.* (2021); Maguire (2010)	Miscommunication reduces patient satisfaction and compliance, underscoring the need for cultural competency training for healthcare providers.
Conflicts arise when patients are placed in double-blind situations, such as being expected to recognise health issues but also act submissively.	Bloor & Horobin (1975)	This dual expectation leads to tension, especially when patients are uncertain about the urgency of their health concerns. Educating patients about health literacy can mitigate these conflicts.
Doctors focus on eliciting information for diagnosis, sometimes prioritising medical facts over patients' experiences.	Bloor & Horobin (1975); Aluko-Arowolo *et al.* (2021)	While efficient for diagnosis, this approach may overlook the patient's emotional and contextual experiences, leading to dissatisfaction and reduced

Finding	Authors	Discussion
		adherence to treatment.

The findings collectively highlight the complexity and multidimensional nature of doctor-patient relationships, which are shaped by social, cultural, and contextual factors. Parsons' framework emphasises professionalism and neutrality, serving as a foundational model for understanding healthcare interactions. However, the more nuanced classifications by Thomas *et al.* (1958) reveal the dynamic nature of these relationships, where the interaction style shifts based on the medical scenario.

Social and cultural congruence enhances mutual participation and trust, as shown in studies by Aluko-Arowolo *et al.* (2021) and Maguire (2010). Yet, status divides and communication barriers, including language, gender biases, and cultural misalignments, impede effective care. Addressing these challenges requires fostering health literacy among patients and cultural competency among physicians.

Lastly, the tension between patients' autonomy in recognising health issues and their expected submission in consultations underscores the importance of collaborative decision-making. This approach can bridge the gap between professional expertise and patients' lived experiences, ultimately enhancing the therapeutic alliance and health outcomes.

Table 2: Findings on Nurse-Patient Relationship

Finding	Authors	Discussion
Nurse-patient interaction often mirrors mechanistic compliance, dehumanising patients and compromising dignity.	Aluko-Arowolo *et al.* (2021); Aluko (2008); SMHFS (2000)	Nurses in formal healthcare systems are frequently viewed as unkind and unsympathetic. This mechanistic approach reduces the therapeutic potential of the relationship and may alienate patients, particularly in developing nations.
Nurses are in a unique position to identify health needs and implement appropriate care regimens due to their proximity to patients.	Aluko (2008)	Despite their potential, many nurses fail to establish meaningful relationships that leverage their insights into patients' social and personal lives, often due to systemic and cultural barriers.
Nurses are encouraged to foster friendly and supportive relationships with patients to promote patient welfare.	Aluko-Arowolo *et al.* (2021)	A patient-centered approach that emphasises empathy and advocacy enhances trust and patient satisfaction, contributing to better health outcomes.
Four types of nurse-patient	Solarin *et al.*	These categories reflect varying

Finding	Authors	Discussion
relationships: Clinical, Therapeutic, Connected, and Over-involved.	(2013); Alchurair, Simpson & Guirguis (2012)	degrees of interaction, ranging from superficial clinical care to deeply personal connections. Over-involvement carries risks of boundary transgressions but also opportunities for advocacy
Nurses acting as patient advocates can build trust and improve patient outcomes.	Solarin *et al.* (2013); Aluko (2008)	Advocacy demonstrates the nurse's commitment to the patient's well-being, fostering trust and potentially accelerating recovery.

The nurse-patient relationship is central to patient care and has significant implications for recovery and patient satisfaction. Unfortunately, findings indicate that nurses in formal healthcare settings, particularly in developing nations like Nigeria, often adopt a mechanistic approach, viewing patients as passive recipients of care rather than active participants. This perception dehumanises patients and undermines the therapeutic potential of the relationship.

The typology of nurse-patient interactions ranging from clinical to over-involved—illustrates the spectrum of engagement. While clinical involvement represents the most superficial level, connected relationships and advocacy roles reflect deeper trust and understanding. However, over-involvement, though potentially beneficial, risks boundary violations.

Nurses' unique role as the first point of contact enables them to gain invaluable insights into patients' social and personal contexts. Despite this potential, systemic barriers and professional norms often hinder their ability to form meaningful, supportive relationships. Encouraging nurses to adopt a patient-centered approach, emphasising empathy and advocacy, can address these issues. Building trust through consistent, compassionate care not only enhances patient satisfaction but also contributes to quicker recovery and better health outcomes, underscoring the critical importance of fostering effective nurse-patient relationships.

Table 3: Findings on Pharmacist-Patient Relationship

Finding	Authors	Discussion
The pharmacist's role has evolved from dispensing medication to providing	Mohuddin (2019); Alchurair,	This shift necessitates closer relationships with patients, enabling pharmacists to take on expanded

Finding	Authors	Discussion
comprehensive pharmaceutical care.	Simpson & Guirguis (2012)	responsibilities, such as addressing health disparities and promoting wellness through collaborative care.
Trust between pharmacists and patients improves medication adherence and outcomes.	Mohuddin (2019); Garjani *et al.* (2009)	Patients are more likely to adhere to prescribed treatments when they trust their pharmacist, resulting in better health outcomes. Trust fosters transparency, enabling pharmacists to make informed interventions.
Trusting relationships foster patient loyalty and satisfaction.	Mohuddin (2019)	Patients who trust their pharmacist are more likely to return to the same pharmacy, creating a sense of community and boosting customer retention. Positive experiences often lead to word-of-mouth referrals.
Pharmacist-patient interactions can directly influence patient expectations and satisfaction levels.	Alchurair, Simpson & Guirguis (2012)	Patients value pharmacists who prioritise their well-being over financial gain, reinforcing trust and satisfaction. These interactions can shape how patients perceive pharmaceutical care and the healthcare system.
Pharmacy practice is becoming intervention-oriented, with pharmacists collaborating with healthcare providers.	Mohuddin (2019); Garjani *et al.* (2009) Amplicare (2019).	Collaborative practices allow pharmacists to contribute to clinical decisions, optimising therapeutic outcomes and reducing adverse effects through targeted interventions and ongoing patient engagement.

The evolving role of pharmacists emphasises patient-centered care and active involvement in improving health outcomes. This transition from traditional medication dispensing to comprehensive pharmaceutical care necessitates building strong pharmacist-patient relationships. Such relationships are critical for enhancing medication adherence, improving clinical outcomes, and fostering patient trust and satisfaction.

Trust is a cornerstone of these interactions. When pharmacists provide honest and transparent advice, patients are more likely to share vital information, such as medication history or concerns, which aids in tailoring effective treatments. A strong pharmacist-patient bond not only benefits the patient's health but also fosters loyalty and encourages word-of-mouth referrals, particularly for independent pharmacies that rely on community reputation.

The integration of pharmacists into collaborative healthcare practices further underscores their expanding role. By working closely with other healthcare providers, pharmacists can optimize treatment plans, minimize

adverse effects, and ensure patient safety. The ongoing assessment of patient satisfaction and outcomes ensures that pharmaceutical practices remain effective and responsive to patient needs.

The pharmacist-patient relationship is foundational to modern pharmacy practice. It transforms the pharmacist's role into that of a trusted healthcare partner, enhancing both the quality of care and the patient experience.

Table 4: Findings on Non-Orthodox-Patient Relationship

Finding	Authors	Discussion
Non-orthodox professionals include bone setters, herbalists, diviners, and faith-based healers who provide alternative healthcare.	Labhardt *et al*. (2010); Erinosho (2006)	These practitioners offer health satisfaction using culturally relevant methods. They are often preferred for their personalised approach and alignment with traditional beliefs.
Faith-based healing is a prominent pathway where believers prioritise faith over medical interventions.	Jegede (2010); Deepak *et al*. (2020)	This mode of healing reflects a spiritual approach to health, rooted in cultural and religious values, often chosen during mental health crises, infertility, or other conditions perceived as beyond biomedical solutions.
Non-literate individuals often prefer traditional healers due to familiarity and accessibility.	Labhardt *et al.* (2010); Erinosho (2006)	Traditional healers are perceived as less formal and more accommodating compared to the structured processes of orthodox medical facilities, making them appealing to non-literate populations.
Both literate and non-literate populations consult traditional healers during dire health situations.	Deepak *et al.* (2020); Erinosho (2006)	The appeal of traditional practitioners cut across education levels, particularly for conditions like infertility and mental health issues where western medicine may be perceived as inadequate.
Traditional healers are favoured for their proximity, lower cost, and alignment with cultural values and beliefs.	Deepak *et al.* (2020); Jegede (2010); Chiwuzie & Okolocha (2001)	Factors such as affordability, cultural compatibility, and a better healer-patient relationship make traditional healthcare an attractive option, especially in rural or underserved areas.

Finding	Authors	Discussion
The quality of interaction with traditional healers is a primary determinant of their popularity.	Deepak *et al.* (2020); Jegede (2010); Erinosho (2006)	Traditional healers offer a personalised and empathetic approach, fostering trust and satisfaction in their patients, which contrasts with the perceived impersonality of western healthcare systems.

The non-orthodox healthcare system, encompassing traditional healers and faith-based practices, holds significant relevance in Nigeria. These practitioners play a pivotal role in providing health solutions that resonate with the cultural and spiritual values of their communities. Their popularity stems from a variety of factors, including accessibility, affordability, cultural alignment, and personalized care.

The relationship between non-orthodox practitioners and patients is often characterized by empathy, familiarity, and trust, contrasting with the structured and often impersonal nature of orthodox medical systems. Non-orthodox practitioners cater to both literate and non-literate populations, with the latter group particularly favoring them due to their informal approach and avoidance of bureaucratic hurdles. This preference highlights the importance of cultural competence in healthcare delivery.

Faith-based healing is another critical aspect of the non-orthodox system. It appeals to patients who believe that their health issues are spiritual rather than physical. This approach is especially prevalent in cases where western medicine is perceived as ineffective or inaccessible, such as mental health challenges or infertility.

Despite the criticisms of non-orthodox practices, they continue to serve as a vital component of healthcare in Nigeria. Integrating elements of traditional medicine with orthodox healthcare systems could enhance overall patient care by addressing the diverse needs and beliefs of the population.

Synthesis of Findings on Healthcare Relationships of Physician and Patients Relationship in Contemporary Times

The dynamics of healthcare relationships between physicians and patients highlight the pivotal role of communication, empathy, and cultural understanding in achieving positive health outcomes. When doctors adopt a patient-centered approach, acting as attentive listeners and considering the broader cultural and societal contexts of their patients' experiences, they foster a therapeutic bond that encourages patient adherence and satisfaction. Conversely, the imposition of bureaucratic or strictly formalized interactions, where the doctor prioritizes biomedical facts over the patient's narrative, often results in a breakdown of rapport and diminished personal and shared medical satisfaction. This disconnect can lead patients to seek alternative care

providers, particularly in multifaceted healthcare systems like those in Sub-Saharan Africa, where cultural practices often overlap with biomedical systems.

In contrast, traditional healthcare providers, including healers, diviners, spiritualists, and traditional birth attendants (TBAs), excel in building relationships grounded in shared cultural and social norms. These providers often eliminate the bureaucratic barriers prevalent in orthodox care, creating a sense of camaraderie and trust that encourages patients to prioritise their care. The incorporation of spiritual and religious practices further strengthens the healer-patient bond, often making these providers the first point of contact in communities where health and spirituality are deeply intertwined.

Similarly, nurses and pharmacists in orthodox settings who prioritise open communication and empathy often achieve better patient outcomes. By engaging with patients, understanding their unique needs, and allowing time for expression, they not only enhance satisfaction but also foster adherence to medical and therapeutic regimens.

In contemporary times, a synthesis of these findings underscores the need for a hybrid approach in healthcare systems. Combining the scientific rigour of orthodox care with the relational and culturally sensitive practices of non-orthodox care can bridge gaps, improve patient satisfaction, and enhance overall health outcomes.

Concluding Remarks

In Nigeria the doctor-patient relationship plays a significant role in determining how people behave when they are unwell and seek medical attention. A tense relationship could prevent regular attendance and undermine rigorous commitment to the recommended treatment plan. This means that the decision to use a health care facility while ill may depend on a number of factors, including the perceived friendliness of the physician's demeanor, the efficiency and effectiveness of the services being provided, and how well-suited the therapeutic intervention is to the social status of users/health consumers. Nonetheless, it is undeniable that because of their amiable demeanor, alternative health systems, including conventional treatments and Faith-Based Healing, draw sizable crowds.

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