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Psychological Factors Influencing Doctor-Patient Relationship in Specialist Hospital Damaturu, Yobe State, Nigeria.

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ABSTRACT
The main focus of the study is to know psychological factors that influence doctor patient relationship in specialist hospital Damaturu Yobe state. The study employed quantitative instruments of the collection of data. The instrument for the collection of data will be questionnaire (open ended and closed ended questions). A total of 100 respondents drawn for the study include doctors, nursing and patients. The study recommends that management of the specialist hospital must Endeavour to adopt the collaborative practice in order to deliver comprehensive primary health care to meet the needs of patients through full and effective application of the knowledge and skills of the health care providers. Comprehensive primary assignment includes service delivery in health promotion, disease prevention (e.g., performing periodic health examinations), curative care (diagnosing and treating acute illness and injury) The management of the specialist hospital Damaturu should devise an effective method of monitoring doctor-patient relationship. The use of questionnaire, telephone lines for complaints from patient e. t. c should be exploited to elicit responses from patient and their relationship with doctors. The specialist hospital Damaturu should train and employ more doctors; more of the delay experience by patients in receiving treatment is a result of 100 patients to one doctor. The one doctor to one hundred patient ratio par days does not favor doctor- patient relationship nor effective healthcare services.

Keywords: Damaturu, Doctor, Hospital,Patients,Psychological, Relationship

I. BACKGROUND OF THE STUDY

The doctors' patient relationship is a central to the practice of medicine and is essential for the delivery of high- quality health care in the diagnosis and treatment of diseases. A patient must have confidence in the competence of their doctors and must feel that they confide in him or her. For most physicians, the establishment of good rapport with patient is important. This being said, some medical specialties, such as psychiatry and family medicine, emphasize the doctor-patient relationship more than others, such as pathology or radiology. The doctor-patient relationship forms one of the foundations of contemporary medical ethics. Most medical school and universities teach medical students from the beginning, even before they set foot in hospitals, to maintain a professional rapport with patients, uphold patient's dignity and respect their privacy (Farin& Nagl,2013).

The typical situation of consultation and treatment in western type medicine involves a one to one relationship between doctor and patient. Each of them in the social situation is expected to be familiar with his expectation as well as the expectation of the others. I n a nutshell, the doctors-patient relationship involves mutually as a kind of behavioral expectation. (Kowalski & Chang, 2007)

A patient typically presents a set of complaint (the symptoms) to the physician, who obtains further information about the patient symptoms, previous state of health, living conditions, and so forth. The physician then make a review of system (ROS) or system inquiry, which is a set of ordered questions about each major body system in order general (such as weight loss, endocrine, cardio-respiratory etc). Next comes the actual physical examination and often laboratory test, the findings a recorded, leading to a list of possible diagnoses. These will be investigated in order of probability (Colby &Shifren, 2013).

The next task is to enlist the patient's agreement to a management plan, which will include treatment as well as follow up. Importantly,

during this process the health care provider educates the patient about the causes, progression, outcome, and possible treatment of his ailments, as well as often providing advice for maintaining health. This teaching relationship is the basic of calling the physician doctors (dubious-discuss), which originally meant “teacher” in Latin. The patient-physician relationship is additionally complicated by the patient suffering (patient derives from the Latin patior, “suffer”) and limited ability to relief it on his/herown. The physician expertise from his knowledge of what his health and normal contrasted with knowledge and other people who have suffered similar symptoms (unhealthy and abnormal), and proven ability to relieve it with medicines (pharmatology) or other therapies about which the patient may initially have title knowledge (Helmes,2009)

The psychological factors that influence physician-patient relationship can be analyzed from the perspectives of ethical concern in terms of well the goals of non-malfeasance, beneficence, autonomy, and justice are achieved many other values and ethical issues can be added to these. In the different societies, periods, and cultures, different values may be assigned different priorities. For example in the last 30 years medical care in the western world has increasingly emphasized patient autonomy decision making. The relationship and process can also be analyzed in terms of social power relationship or economic transactions (Bower & Stanton 2012). Relationship is specialist hospitals is intended to give an insight into real or practical factors on the phenomena, it provides guide through which such relationship will be enhanced to promote effective social therapy in any illness condition.

STATEMENTOF THE PROBLEM: According World Health Organization (1998) Health and illness has been looked as a social concept and not a biological concept. Illness militates against performance of one’s social role and the disability and discomfort arising there from can be worrisome. Parson (1951) posits that all social action can be understood in terms of how they help society to function effectively or not. When a person is sick, he is unable to perform his social roles normally this is a form of deviance which disturbed society’s functioning.

Helping the sick in to performing their social roles once again leads to some form of social interaction or relationship. Thus the dominant from the social interaction in the health industry has traditionally been physician and the patient. The psychological factors that influencedoctor-patient relationship is intended to serve some therapeutic functions in most societies and promote some significant change in the health of the patient. In most organization like specialist hospitals, doctor-patient in some cases is much more complex, and many other people involve when somebody is ill-relatives, neighbors, rescue specialists, nurses, technical personnel, social workers and others. Most often the manual cooperation or participation of both the doctor and patient is effective. This has either led to the patient abandoning the treatment or the doctor not interested in the treatment in most case. It is against the background that the study seeks to find out some of the psychological factors that influence doctor-patient relationship in Yobe State Specialist Hospital, Damaturu

AIMS AND OBJECTIVES: The general objective of this study is to examine the psychological factors that influence doctor-patient relationship in Yobe state, specialist hospitals Damaturu. The specific are;

1. To examine the type of doctor-patient relationship in specialist hospitals Damaturu
2. To identify problems of doctors-patient relationship in specialist hospitals Damaturu.
3. To determine the psychological factors that influence doctor-patient relationship in specialist hospital Damaturu.
4. To proffer suggestion on how to enhance psychological factors that influence doctor-patient relationship in specialist hospital Damaturu

Significance of the Study: The need for the study arises from the fact that psychological factors that influence doctor-patient relationship is the dominant form of social interaction between the doctor and the patient in the health industry, an evaluation of doctor-patient relationship in specialist hospital Damaturu.The study possess some academic value and would be of interest to students, academic health, health care practitioners, health care seekers and the general public. It will serve as a contribution to existing and psychological factors that influence doctor-patient relationship in particular.

Scope and Limitation of the Study: The study essentially concentrates on psychological factors that influence doctor and patient cooperative relationship. Emphasis will be an evaluation of doctor-patient relationship. The study is limited to specialist hospital Damaturu, Yobe State.

II. LITERATURE REVIEW

A profession according to friedrison (1970) is an occupation that is based upon specialized intellectual study and training, the purpose of which is to supply skilled service or advice to others for a definite fee or salary. The health or medical profession, otherwise known as the doctors or physician concerns of himself with the prevention, diagnosis, prognoses and treatment of individuals (Metioba 2008).

In all known human societies, the practice of medicine follows certain values and ethics which physicians are supposed to abide with (friedrisons 1970). Medical ethics is the study and application of morals values, right and duties in the fields of medical treatments and research.

Richard (2007) observed that medical decisions involving morals issues are every day in diverse situations such as relationship between patient and physician, the treatment of human and animal subject in biomedical experimentation, the allocation of scarce medical resources, the complex questions that surround the beginning and the end of human life, and the conduct of clinical medicine and science research.In the view of Alubo (1994) physician obligations and values include:

Altruism- a physician is obligated to attend to the best interest of patients rather than self-interest.

Accountability- physician are usually made accountable to their patients and society on issues of public health, and their profession.

Excellence- physicians are obligated to make commitment to lifelong learning.

Duty-a physician should be available and responsive when “on call” he should accept a commitment to service within the profession.

Honor and integrity –physicians should be committed to been fair, truth full and straight forward in their interactions with patients, profession and the community.

Respect to others- a physicians should demonstrate respect for patients and their families, others physicians and team members, medical students, residents and follows.

Owing to the fact that doctor-patient relationship is two way interaction, patients has a crucial role to play because of the fact that illness and disease are discomforts which threaten normal functioning of the body system, it become necessary therefore, for the sick individual to seek medical care and in good time (Erinsho, 1982).

In addition, in seeking health care and in his interaction with the doctors, the patient should describe his symptoms to the doctors to the best of his ability. Cooperate in the provision of the information the doctors requires. Have hope or confidence that the doctor can diagnose and relieve his hurtful symptoms illness or disease.

Doctors-Patient Relationship: A consultation between doctors and a patient is thought of as an opportunity to exchange information. The conventional idea is that the patient attends a facility because he has one or more hurtful symptoms with reasonable hope that the doctor can diagnose and relieve them. It is expected that with objectives in mind, the patients will describe his symptoms to the best of his ability and that he will cooperate in the provision of information the doctor requires (cockerham 1982).

According to metioba (2008), the patients’ physician role relationship involves mutual relationship between two parties. The patient is on one side of the party and the physician on the other. The patient is expected to recognize the fact that being sick is undesirable and that he has an obligation to get well by seeking the physician help. The physician has an obligation to return the sick person to his/her normal state of functioning. The patient physician relationships are intended to some therapeutic function and promote some significant change in the health of the patient (Glasser 1980).

In his contribution to doctor and patient relationship (Alubo 1994), assert that medical profession and practice which is very vital in medicine and health care system has continued as a service which doctors and patients who voluntarily commit themselves to their professional knowledge and skills concerning health and disease.

Olufemi (1978) observed that the patients need to have hope. It is a priceless commodity for them. Hope comes when patients feels something can be done for their illness and they will be actively involved in their illness treatment, armed with knowledge that has been provided by their doctor. He continued that hope is born when a physician looks into a patient and humane connection feels free to talk and a doctor listens carefully. Most of the time a patient arrive with apprehension or even fair. If a doctor succeeds in removing the fear by providing knowledge not only about what may be wrong but also about a way forward to read the patient of their condition, the patient is usually happy and will follow the doctors instructions and plans. The medical drama that occurs between doctors and patient has to do with a patient willingness to believe that a doctor can wants to help him that faith has great impact, independent of the natural courses of illness or other physiological interventions.

Types of Doctor Patients Relationship: The typical situation of consultation and treatment in

western type of medicine involve a one to one relationship between the doctor and patient. Nurses and other staffs may act as interpreters when there is language barrier, as there is often in Africa. This is merely to facilitate communication.
Hollander (1976), have argued that in this one to one relationship between doctor and the patient, the interaction that take place is usually one of three types namely: Activity passivity, guidance cooperation and mutual participation. The type of that operates in any particular situation is determined by disease condition of the patient and the treatment of the doctors considers suitable.

- ✓ **Activity Passivity Type:** In this type, doctors are active while the patient is a passive recipient of treatment. This occurs in emergencies where the patient is almost completely, helpless due to, for example, severe injury, delirium e.t.c treatment procedures are carried out on the patient without much contribution from him.
- ✓ **Guidance cooperation:** here the doctor guides and the patient cooperates, this type is implied in most of the sick role. Here the patient defers to the greater expertise of the doctor. This deference is evidenced by the symptomatic person's conscious decision to consult the doctor and his willingness to obey the instruction of the doctor.
- ✓ **Mutual participation:** here the doctor tells or teaches the patient what to do in order to help him. This applies in condition of chronic illness (for examples, diabetes mellitus), where the treatment regime is the direct responsibility of the patient with only occasional direction and teaching from the doctors.

In this situation the doctor and patient need the cooperation of each other if the treatment is to be completed. In diabetes-mellitus, the expert knowledge of the doctor needed to instruct on treatment while the doctor requires the cooperation of the patient who is expected to monitor his blood sugar levels, to watch his diet, to administer his insulin and alter the dose when the need arises. One of the limitations of Hollander's typology is that is does not exhaust the possibilities.

(Friedrison 1980), for example, suggested that cooperation guidance, mutual non-cooperation, mutual passivity as possible type.
Another, limitation according to Truckett (1986), is that the model makes erroneous assumption that both doctor and patient show the same ideas about what the patient is hoping to gain from seeing the doctor. Truckett (1986) gave an example from a study in Britain where patients dictate referral letters to their general practitioners. In such situations, is not the doctor patient who has already made up his mind about what he wants the doctor to do for him and hence requires no expert advice but cooperation from the doctors. From an African viewpoint, the types described by Hollander (1976), bear no resemble to the typical treatment situation found in the various societies, whether the symptomatic person is consulting traditional healer or receiving treatment in hospital. As the studies of Janzen (1978), Igum (1977), show the ubiquitous family is always around the symptomatic person.
The selection of therapy is largely the responsibility of kinsmen various maternal and paternal kinsmen, and occasionally their friends and associates rally for the purpose of information, lending moral support, making decision and arranging details of therapeutic consultation. The therapy managing group thus exercises a brokerage function between the suffer and the specialist whether thus be for tiernia operation by a western doctor or plant cure known to a traditional practitioner (Janzen 1978). Thus are made in the environment of kin, friends and fellow villagers who helps to monitor the progress and legitimately confirm or actually take part in decision making which determines the curse and sometimes the contents of the treatment, (Igum 1977). One may therefore, say that while the situation of consultations and treatment in industrial countries such as United Kingdom and United State tends to involve mainly the doctor and patient, most consultation and treatment in Africa (be they in western-type medical setting or traditional setting medicine), involve some form group. An extreme example of group involvement in healing is the "group therapy" reported by Igum (1977), among others. Therefore, it is true say that situation of consultation and treatment in most industrialized countries are largely "traditional" in Africa, they are largely "group" it is difficult to apply sneezes and Hollander typology to Africa situation without fundamental modifications.
Furthermore, according to Chris Nwamou (2003), observed that the type of relationship that should exist between physical and the patient are those of mutual trust, cordiality and rapport. These can be summed up a world veracity or faithfulness.

COMMUNICATION BETWEEN DOCTOR AND PATIENT

Communication between doctor and patient is attracting an increasing amount of attention within health care studies. During past two decades, descriptive and experimental research has tried to shed light on the communication process during

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medical consultations. However, the insight gained from these efforts is limited. This is probably due to the fact that among the inter-personal relationship, the doctor-patient relation is one of the most complexes. It involves interaction between individual in non-equal positions, often voluntarily, concerns issues of vital important and therefore emotionally laden, and requires close cooperation while sophisticated technologies may be used for medical diagnosis and treatment inter-personal communication is the primary tools by which the physician and the patient exchange information. Beckam H, Kaplan SH, Frankel.R. (1989).

Certain aspects of doctor-patient communication seem to have an influence on patient's behaviors and well-being. For examples, satisfaction with care, adherence to treatment, recall and understanding of medical information, coping with the disease, quality of and even state of health, Buller Mk, Buller DB, (1987).

Interaction and communication are especially important in the case of life of threatening diseases, such as cancers. The "bad news consultations" for instance, has become an important topic for research over the last 20 years. Recently researchers of communication have increasingly been paying attention to psychological aspects of cancer. For this reason studies from psychological ontology will serve as examples in the following review. The presented literature refers mainly to British. Dutch and American data, with cross-cultural references where they are thought appropriate. To understand more fully why communication between doctors and patients (and cancer patients in particular), is a powerful phenomenon, it is important to look at the doctors patients communication the difference purposes. Chaitschiks, kreitlers, shacked s, etal (1992).

DOCTORS-PATIENT COMMUNICATION DIFFERENCE PURPOSES

Three different purposes of communication between doctors and patients can be distinguished: creating a good inter-personal relationship, exchanging information and making treatment-related decision. Richard (2007)

- ✓ **Creating a Good Inter-personal Relationship:** creating a good inter-personal relationship between doctors and patients can be seen as an important purpose of communication Roter and Hall (1981), state that 'talk is the main ingredient in medical care and it is fundamental instruments by which the doctor-patient relationship is crafted and by which therapeutic goals are archived' from this viewpoint, a good inter-personal relationship can be regarded as prerequisite for optimal medical care. Communication researchers have different opinions on how to define a good relationship. Some authors refer to this relationship mainly as social relationship where "good manners" are most important. Necessary "ingredients are: laughing or making jokes, making personal remarks, giving the patient complements, attitude, and a social orientation. Stewart MA, Roter DL (1989).

Other authors with more clinical/psychotherapeutically background claim that the importance of a good doctors-patients relationship is determined by its therapeutic qualities. Irwin etal (1989) sees clinical medicine as communication between two people aiming to establish or sustain an effective working relationships in which mutual trust exist. Many of the concepts used by this psychotherapeutically oriented researcher are based on core conditions' which are crucial to the efficiency of the therapy: empathy, respect, genuineness, unconditional acceptance, and warmth. Even though different authors define empathy in different ways, they agree that this core condition must be considered very important.

Empathy doctor-patient relations consist of eliciting fallings, paraphrasing and reflecting, using silence listening to what the patient is to saying, but also to what he is unable to say, encouragements and non-verbal behaviors. Squire RW (1990).

A closely related school of thought is represented by the so called 'patients-centered' method here the doctor-patient relationship is viewed as egalitarian, as is the case with the client-centered method. It is defined in term of doctor's responses which enable patients to express all their reason for coming, including symptoms, thoughts, feelings and expectations the keys to this approach is attention to these dimension, the good is follow patients 'leads to understand patients' experience from the point of view the ideal medical interview integrates the patients centered leads in areas where is the expert(symptoms, preferences, cancers), the doctors leads in his domain of expertise (detail of disease treatment). This is consistent with what is levenstainetal

(1989) call "reconciling the two agendas". This type of relationship is similar to what Rotor and Holl (1988), call "mutuality" which is one of the four prototypes of doctors-patients relationship distinguish by them. Exchange in which doctor's facilities patient participation and exchanges which reflects the doctor's role as an interpreter and synthesizers comprise 10%of physician talk.

Roteretal (1988), point out that "little attention has been given to this kind of statements in literature, but they may be critical markers for a relatively more egalitarian exchange". The growing number of publications concerning shared decision making can be seen as a result of growing in doctors and patients as equal partners in the relationship.

- ✓ **The exchange of information:** another many purpose of medical communication is promoting the exchange of information between the doctors and the patients. Information can be seen as resources brought to the verbal interaction by both parties, the exchange of information consist of information giving and information seeking. From a medical point of view, doctors need information to establish the right diagnoses and treatment plans. From the patient point of view two need have to be meeting when visiting the doctors. They need to know and understand. (To what is the matter? Where the pains coming from) and 'the need to feel know and understand' (to know the doctor accept him and take him seriously). In order to fulfill doctors and patient's needs, both alternate between information-giving and information-seeking. Patients have to impart information about the symptoms; doctors need to actively seek out relevant information. Once the diagnosis and treatment has been established, doctors need efficiently impart this information to their patients. Patients need to know and understand may leads to additional information-seeking what has been told Roter DL, Hall JA (1992).

Although patients almost information as possible physician seem under estimate patients desire for information several studies report where cancer is concerning. The need for information is especially great. Blanchard CG (1988), for example, found 92% of the interview is cancer patient desires all information about their disease good or bad. Much of cancer patient's dissatisfaction with the exchange of information stems from a lack of concordance between the perception of patient and doctors. When information of informing cancer patient about their disease, doctor may defines medical information objectively. (Type of disease, its stage, types of treatments). While, patient defines it in terms of its personal relevance (will fully recover? How much pain will have?).

As a result, the physician may feel he has given precise and relevant information, whereas the patient may feel he has learned nothing new. A recent study showed that 47% of the cancer patient reported that no information had been given about handling of their disease, although the majority desires such information. Physicians should therefore first encourage their patients to discuss their main cancer without interruption. Also, doctor should be striving to elicit patients' perceptions of the illness and the feelings and expectation associated with disease in order to achieve effective exchange of information. Follow filed LJ, Baum M, Maguire (1986).

- ✓ **Medical Decision-Making:-** another purpose of medical communication is to enable doctors and patients to make decisions about treatment. Traditionally the ideal doctors-patients relationship was paternalistic; the doctor directs care and makes decisions about treatment during the last two decades, this approach has been replace by ideal of "shared decision making".

It appears logical that in order to make such decisions. Patients need information, the relationships between medical decision-making and patients. For informational needs has received much attention. For example, one study indicated that patient suffering from various chronic diseases expressed a strong desire for medical decision-making information. However, the same patient also replaced responsibility for medical decision-making by their doctors. As noted earlier, the desire for information about diagnosis, prognosis and treatment is especially great among patients who suffer from a life-threatening disease. Again several studies point in the direct of relative independence between the need for

information and shared decision making. Blanchard CG, Labreque MS, Ruck deschel JK, etal (1986). Found that the majority (92%) of hospitalized adult cancer patient preferred all possible information to be given (either good or bad), but only 69% preferred to participate in treatment-related decisions of these wanting all information, almost one fourth preferred a more authoritarian relationship with their oncologist. Result from a similar study showed a trend toward information-seeking with increase preferred for participation in treatment decisions. Many of the interviewed cancer patient actively sought information however, 63% felt the doctor should take primary responsibility in the decision-making process, only 10% felt that they themselves should have major involvement.

Another recent study indicated that a woman who newly diagnosis with breast cancer prefer to entrust control over treatment decision to their physician. Follow field LJ (1990). Explain the difficulty in giving cancer patient responsibility will then also assume responsibility for the outcome of treatment, if the diseases re-occurred. Patient may have feel that they have made "the wrong choice" they suggest that what many cancer patients probably want, rather than the ultimate decision on treatment, is more adequate information as to why the physician recommends one treatment over another.

Medical decision-making seems especially difficult where clinical trials are concerned. In a study by Smirnoff (1989), it was found that 82% of breast cancer patients made final decisions about the treatment. Doctor where very clears about their own treatment preferences. Overall, patients followed these recommendations. However, only 45% of the trial-eligible cancer patients chose to enter offered trials. It appears that physician not recommendation for clinical trials as effectively as non-trials treatments. Especially information about specific benefits of the treatments and rated side-effects to be both more probably and secured. They also felt that, their physician appeared leisure about the treatment recommendation. Nevertheless, results indicated that breast patients still rely heavily on their doctor to make therapeutic decisions.

However, before patients decide whether or not to share decision-making power, they must first be offered the choice of participation by their doctors and share responsibility for medical decision-making seems to be related to a clearly defined set of attitudes and belief that determines future behavior. More specifically, a distinction can be made between so called 'therapists' and 'experiments' with majority of physicians (71%) are falling in the first category. These therapist's are reluctant to enter their eligible patients and wish to preserve the role of physician as responsible for primary decision-making-experimenters on the other hand, prefer to share decision making power with their patients. They view doctor's loss of personal decision-making in clinical trials as a prerequisite for pure scientific research Smirnoff (1991).

THE INFLUENCE OF COMMUNICATIVE BEHAVIORS ON PATIENT'S OUTCOME

Beside identifying and analysis of communicative behaviors, communication researchers have become interested in consequences of "talk" several physician behaviors seem have an influence on patients behaviors and well-being used in health care studies to assess the extent of this influence "outcomes" as it is used in health care studies can be defined as an observable consequences of prior activity occurring after an encounter, or some portion of the encounter is completed. Many different patients outcomes have been identify for use over the last two decades,for example, satisfaction compliance (adherence to treatment), knowledge, understanding, coping, and quality (anxiety depression) Castajon J, and Lopez-Roigs, (1993).

PATIENTS SATISFACTION

Patient satisfaction as outcome measure is by far the most recognized and widely used. This has to do with the fact that is has "logical and intuitive appeal". Yet patients are frequently dissatisfied with the information they receive. Also the proportion of dissatisfy patients has remained remarkable constant over the last 25 years the media %+ dissatisfied for hospital is 38 for general practice and community sample it is 26, and for psychiatric patients is 39%. This is partly due to the fact that the physicians often under estimated patients desire for information. In 65% of the

encounter doctors under estimate desire patients information, in 6% they over estimated and 29% they estimated correctly. In a recent study by Castajon (1993), result showed that 52% of the interviewed cancer patients reported desire for additional information, especially about prognosis and treatment handling of disease.

Studies have investigated the impact of instrumental and effective behaviors on patient's satisfaction. Roteretal and Hall (1987), Found that doctor's instrumental behaviors, especially doctors' information-giving, were significantly related to patients' satisfaction.

THEORITICAL FRAME WORK

The study is based on the theory of functionalism. Functionalist theory is prominent in the work of August Comte (1798-1857), Herbert Spencer (1820-1903), Emile Durkheim (1958-1917), and refined by Talcott persons (1902-1979).

The concept of 'function' in functionalist analysis refers to contribution of the part to the whole. More specially, the function of any part of the society is the contribution it makes to meet the functional prerequisites of the social system parts of society are functional in so far as they maintain the system and contribute to its survival. Functionalist also employs the concept of dysfunctions to refer to the effect of any social institution which detract from the maintenance of the society.

However, in practice they have been primarily concerned with the search for functions, and relatively little used have been made of the concept of dysfunctions, functionalist analysis has focus on the question of how social systems are maintained. This focus has tended to result in a positive evaluation of the parts of society. With their concern for investigating how functional prerequisite are met, functionalist have concentrated on the functions rather than dysfunctions, this emphasis has resulted in many institutions being seen as beneficial and useful to society.

Person (1951) observed that social life is characterized by mutual advantage and peaceful cooperation rather than mutual hostility and destruction. Considered a functionalist, parson regarded society as tending toward a self-regulating, self-maintaining entity with certain basic needs, including the preservation of the social order, the delivery of goods and services and the care of the children. According to functional theory, society is an organism and aech part serves a purpose or maintains a function, members of cooperation to fulfill society needs because they share common goals and values.

The relevance of the functionalist theory to the study finds expression in the fact that Talcott parsons was the first social scientist to theorize the doctor-patient relationship and his functionalist role-based approach defined analysis of the doctors-patients relationship. For the next two decades, parson (1951), (1958), (1978), began with the assumption that illness, exempted people from work and other responsibilities and this was potentially detrimental to the social order if uncontrolled. Maintaining the social order required the development of legitimized 'sick role' to control this deviance, and make illness a transitional state back to normal role performance. In western society, parson saw four norms governing the functional sick role.

i. The individuals is not responsible for their illness
ii. Exemption of the sick from normal obligations
iii. Illness is undesirable and
iv. The illness should seek professional help.

For person, the physicians' role is to represent and communicate these norms to the patients to control their deviance. Physicians exemplify for persons the shift to "affect neutral" relationships in modern society with physician and patients being protected by emotional distance. Medical education and social role expectations import normative socialization to physicians to act in the interests of the patients rather than their own material interest, and to be guided by an egalitarian universalism rather than a personalized particularism. Because physicians have mastered a body of technical knowledge, it is functional for the social order to allow physicians professional autonomy and authority, controlled by their socialization and role expectation.

Looking at doctors-patients relationship from the stand point of social life characterized by roles, norms, mutual cooperation, the functionalist theory became the most appropriate the functionalist theory became the most appropriate theoretical backing for the study.

Imperatively, (functionalist theory) provides for this study base, a guide and a focus by which inter-personal relationship as the level (doctor-patient relationship), could be analyzed. Although in this type of relationship the patient clearly depends on the doctor for enquiry, counseling and assistance, it is functional that the patient needs being therefore the doctor to play his role. By this out right symbiotic affair functionalist explanation appears to be ideal analytical tool. It also emphasize that one cannot function without

another and the bond now is the temporary interpersonal relationship which is characterized by both verbal and non-verbal components of communication. The long and short of it therefore, is that applicable theories and model in the study of this relationship is best provided by the schools of the functionalist perspectives.

III. METHODOLOGY

Background of the Study Area: Damaturu, town is a capital of Yobe State in north eastern Nigeria. Damaturu became the capital of newly state in1991. The town lies in a plains region that is covered by the savanna and support crops of millet, sorghum (guinea corn, groundnut). The town is market centre on the road between Potiskum and Maiduguri. According to census Population (2006) of Damaturu local government 88,014.

Population of the Study: The populations of the study will consist of male and female doctors from various unit in specialist hospital in Damaturu local government.

Sample Size Sampling Metod: The sample size of the study will be one hundred (100) out of the entire population of doctors and patients in specialist hospital Damaturu local government. Stratified and purposive sampling methods will be used to collect the data for the study.

Instrument of Data Collection: The instrument of data collection for this study is by using questionnaire guide. The questionnaire will contain uniform question i.e. open and close-ended questions. The first part socio-demographic variables, while the second part includes the substantive issues of the research. This will also be used to gather qualitative data from the selected sample in order to make the research more reliable and valid.

Method of Data Collection: The method of data collection in the study will be primary and secondary data sources. Primary sources of the data were further divided into qualitative and quantitative methods of data collection. The quantitative method of data collection is questionnaire guide, while the qualitative method of data collection is interview guide. Thus, the primary data will be collected through the administration of questionnaire and the conduct of in-depth interviews (IDI).The secondary sources of data will include data sourced from journal articles, text books, seminar papers, conference proceedings, internet sources, and government documents. The selected materials will be utilized based on their relevance to the scope and focus of the study.

Method of Data Analysis: The quantitative data were analyzed using the statistical package for social sciences (SPSS). The questionnaires would be coded and process using SPSS software. Descriptive statistics such as frequency distribution tables, simple percentages, were used to analyze the quantitative data. Qualitative data would be analyzing base on the objective.

IV. DATA PRESENTATION AND ANALYSIS

SECTION A SOCIO-DEMOGRAPHIC DATA

Table 4.1: Gender Distribution of the Respondents

Gender	Frequency	Percentage
Male	78	82%
Female	22	18%
Total	100	100%

Source: field survey, 2026

The above table shows that, 78% of the respondents were male while 22% 0f respondents were female. Therefore most of the respondents were male.

Table 4.2 AGE of the Respondent

AGE	FREQUENCY	PERCENTAGE
18-29	21	21%
30-40	54	54%
41 And Above	25	25%
TOTAL	100	100%

Source Field survey, 2026

The tables above shows that, 21% of the respondents were between the ages of 18-29, 54% of the respondent were between the age of 30-40 and 25% and above were between the ages 41 and

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above. Therefore majority of the respondent were between the ages of 30-40.

Table 4.3: Marital status

MARITAL STATUS	FREQUENCY	PERCENTAGE
Single	51	51%
Married	38	38%
Divorce	11	11%
Total	100	100%

Source field survey, 2026

The above table shows that 51% of the respondents were single, while 38% of the respondents were married and 11% of the respondents divorce. Therefore most of the respondents were single.

Table 4.4: Educational Qualification of the Respondent

Qualification	Frequency	Percentage
S.S.C.E	10	10%
ND/N.C.E/	52	52%
BSC/HND	31	31%
Masters/P.H.D	07	7%
TOTAL	100	100%

Source: field survey, 2026

The above table shows that 10% of the respondents were S.S.C.E holders, 52% of the respondents were ND/NCE/HND holders, 31% of the respondent were Bsc /HND while 07% masters and PhD holders. Therefore majority were ND/N.C.E/holders.

Table 4.5 Types of doctor patient relationship

types of doctor patient relationship	Frequency	Percentage
Active	20	20%
Cooperate	55	55%
Mutual	25	25%
Total	100	100

Source: field survey, 2026

The above table shows that 20% of the respondents were active, 55% of the respondents were cooperating and 25% 0f the respondents were mutual. Therefore most of the respondents were cooperate.

Table 4.6 feel satisfied with the doctors' language communication

Language	Frequency	Percentage
Yes	85	85%
No	15	`15%
Total	100	100

Source: field survey, 2021

The above table shows that 85% of the respondents satisfied with the language communication while 15% of the respondents did not satisfied the language communicated by the doctor. Therefore most of the respondents satisfied with the language communicate by doctor.

Table 4.7 abuse or neglecting

Abuse or neglect	Frequency	Percentage
Yes	68	68%
No	42	42%
Total	100	100

Source: field survey, 2026

The above table shows that 68% of the respondents were on the view that doctors usually abuse and neglect the patient while 42% of the respondents were on the view that doctors did not abuse or neglect the patients during consultation. Therefore most of the respondents the view that doctors usually abuse and neglect the patient

Table 4.8 ways to improve doctor patient relationship

Ways to improve	Frequency	Percentage
Sympathy	15	15%
Focus on positive	25	25%
Decision making	40	40%
Cultural differences	20	20%
Total	100	100

Source: field survey, 2026

The above table shows that 15% of the respondents were on the view that sympathy by the doctor will improve relationship, 25% of the respondents were on the view that focusing on positive will improve doctor patients relationship, 40% of the respondents were on the view that decision making will improve doctor patients relationship and while 20% 0f the respondents were on the view that cultural difference will improve doctor patient relationship. Therefore most of the respondents were on the opinion that decision making is the proper ways to improve doctor patient's relationship

Table 4.9 satisfied with the treatment

Satisfied with the treatment	Frequency	Percentage
Yes	55	55%
No	45	45%
Total	100	100

Source: field survey, 2026

The above table shows that 55% of the respondents satisfied with treatment by the doctor while 45% of the respondents did not satisfied with the doctors' treatment. Therefore majority of the respondents satisfied with the treatment.

Table 4.10 do you think the doctor listen to our explanation effectively

Explanation	Frequency	Percentage
Yes	30	30%
No	70	70%
Total	100	100

Source: field survey, 2026

The above table shows that 30% of the respondents belief that the doctor listen to their explanation effectively while 70% of the respondents belief that the doctor did not listen to their explanation effectively. Therefore majority of the respondents where on the view of not listen to their explanation.\

SUMMARY: The central focus of the study has been an evaluation of doctor-patient relationship in health institution in special hospital Damaturu. The doctors' patient relationship forms one of the foundations of contemporary medical ethics. Thus the dominant form of social interaction in the health industry has traditional been the physician and the patient. The doctor-patient relationship is intended to serve some therapeutic functions in most societies and promote some significant change in the health of the patient.

Doctors-patient relationship is that of opportunity to exchange information, it has to do with a patient willingness to believe that a doctor can and wants to help him which faith has great impact independent of the illness or other psychological interactions. The conventional idea is that a patient attends a facility and describes his symptoms to the best of his ability and the Cooperate in the provision of information the doctor require. The doctor in his part using his skills and laboratory techniques' diagnose and prescribes medication and give institution to help the patient regain for skill.

Types of doctor-patient relationship includes activity passivity in which the doctors is active while the patients is passive guidance cooperation in which the doctor guides and the patient cooperate and the mutual participation type where both pities cooperate with each other.

Some of the important factors that influence doctor-patient relationship include, the knowledge of the professional, expectation of the client, exposure of the two to the system , the cultural and religious background, biological (sex) factor as well as several economic factors effecting as man relationship in any situation this factors can effect (positively or negatively), the provision of health care services which have implication for the well-being of the patient, job satisfaction of the doctor and the achievement of set goals by the organization (healthcare facility). Problems associated with doctor-patient relationship can be view from the perspective of the doctor and the patient respectively. From the perspective of the doctor, lack of cooperation from the patient, illiteracy, adherence to culture, traditional and religion, believes inability of patient to pay for service and flagrant disobedience to follow prescription and instructions are problem associated with doctors-patient relationship. Too much billing for service lack of dedication to duty by the doctors, impatience and impolite attitude of doctors for patient, delayed or prolonged diagnosis and too much bureaucratic procedure are problems associated with doctor-patient relationship from the perspective of the patient.

V. CONCLUSION:

The study has enabled me to have a fundamental understanding on the meaning, type and nature of doctor-patient relationship as well as its problem in specialist hospital Damaturu. The important of doctor-patient relationship cannot be over emphasized. This because the medical profession is important in the provision of healthcare as a service which doctor give to patient who voluntarily commit themselves to their professional knowledge and skills concerning health and diseases.

The quality of the patient physician relationship is important to both parties. The better relationship in terms in mutual respect, knowledge, trust share values and perspective about disease and life and time available, the better will be the amount and the quality of information about the patient disease transferred in both direction of enhancing accuracy of diagnosis and increasing the patient knowledge about the disease. When such a relationship is poor the physician ability to make a full assessment is compromised and the patient is more likely to destruct the diagnosis and proposed treatment.

Doctor-patient relationship is involves mutual relationship in which each participant in the social situation is expectation of the others. The problem of doctor's patient relation in specialist hospital Damaturu leaves much to be desired considering the important of doctor-patient relationship and the benefit if this relation based on mutuality is positive. Concerted effort should be made to enhance positively doctor-patient relationship in specialist hospital Damaturu.

VI. RECOMMENDATION:

Base on the issue and problems discussed in this study, the following recommendation are made:

- Patient should be encouraged to cooperate with doctors. The patient should describe his/her ability. The situation where patient hide information of their sickness from their doctor does not anger well for doctor-patient relationship or the provision of effective healthcare
- Doctor should be trained and retrained the rough workshop and seminars to learn how to create a conductive atmosphere for patients to be able to have confidence in them.
- Patient should always learn to keep appointment with their doctors, follow doctor's instructions and prescriptions.
- The problem of prolonged or delayed diagnosis and treatment prevalent in the hospital should be addressed. The internal process and procedure of the hospital should be over looked.
- The management of the specialist hospital Damaturu should devise an effective method of monitoring doctor-patient relationship. The use of questionnaire, telephone lines for complaints from patient e. t. c should be exploited to elicit responses from patient and their relationship with doctors.
- The specialist hospital Damaturu should train and employ more doctors; more of the delay experience by patients in receiving treatment is a result of 100 patients to one doctor. The one doctor to one hundred patient ratio par days does not favor doctor-patient relationship nor effective healthcare services.
- The management of the specialist should improve its facilities and always make sure investigative material\apparatus are not only available but is procedures should also be fast
- Both patients and doctors should be discouraged from answering relationship

on religion, family ties, and personality influence of the person.

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