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Physicians' Perceptions of Self and Patients in a Traditional Culture

Adegbola Adejunmobi
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PHYSICIANS' PERCEPTIONS OF SELF AND PATIENTS
IN A TRADITIONAL CULTURE

by

Adegbola Adejunmobi

A Dissertation Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

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1979

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VITA

The author, Adegbola Adejunmobi, is the son of Isaac Adekunle Adejunmobi and Dorcas Kehinde (Akanji) Adejunmobi. He was born March 31, 1934 in Kaduna, Nigeria.

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TABLE OF CONTENTS

	Page
ACKNOWLEDGMENTS	ii
VITA	iii
LIST OF TABLES	vi
LIST OF ILLUSTRATIONS	viii
 Chapter	
I. INTRODUCTION	1
The Setting of the Study	
The People of the City of Lagos	
Health Care Delivery Services in Lagos	
and Nigeria in Historical Perspective	
The Blending of Past and Present	
Traditional Yoruba Religion and	
Medical Beliefs and Practices	
Christianity and the Aladura Sect	
Islam	
Ideological Forces	
Economic Organization	
Level and Character of Technology	
Organization of the Health Profession	
Professional Organization and Dominance:	
Historical Rise of Physicians in Nigeria	
Access to and Distribution of	
Medical Services	
Overall Quality of Care	
II. THEORETICAL BACKGROUND AND REVIEW OF THE LITERATURE	32
A Model of Doctor-Patient Relationship	
The Socio-cultural Matrix	
Social Roles	
Social Roles of the Doctor and the	
Patient in Western Societies	
Social Roles of the Patient in Non-Western Societies	
The Work Setting and Doctor's Attitude	
Empirical Studies	
Ideal Types	

TABLE OF CONTENTS

Chapter	Page
III. METHODOLOGY	53
Description of Variables	
Dependent Variable	
Independent Variables	
Hypotheses	
The Data	
Data Collection	
The Respondents	
Design for Analysis of the Data	
IV. PHYSICIANS' PERCEPTIONS OF PATIENT ROLES AND CULTURAL ASPECTS OF INDIGENOUS HEALING	68
Technical Knowledge	
Seeking Medical Help	
Individuals in Cooperation with the Doctor	
Compliance with Medical Orders	
Motivation	
Dependency	
Other Topics	
Doctors' Views on Cultural Aspect of Medicine and Traditional Healers	
Medicine as Culturally Specific	
The Indigenous Healer and His Practice	
Indices of Orientations to the Doctor's, Modern Patient's, and Traditional Patient's Roles	
V. THE INFLUENCE OF PERSONAL AND PROFESSIONAL FACTORS IN DOCTORS' PERCEPTIONS OF THE DOCTOR-PATIENT ROLE RELATIONSHIP	103
Personal Characteristics of Doctors and Orientation to Doctor-Patient Relationship	
Professionalism and Doctor-Patient Relationship	
Organizational Structure and Doctor-Patient Relationship	

TABLE OF CONTENTS

Chapter	Page
VI. SUMMARY OF FINDINGS AND DISCUSSION	143
Discussion	
Some Implications of Findings and Suggestions	
Training More General Practitioners	
Village Projects	
Cooperation with the Traditional Healers	
Teaching	
What the Government Can Do	
The Media	
Conclusion	
Implications of Some of the Findings for Sociology	
Functionalism and Structuralism	
Professionalization	
Professional Socialization	
Occupation of Father and Community of	
Rearing as Variables	
Suggestions for Further Studies	
BIBLIOGRAPHY	175
APPENDICES	184

LIST OF TABLES

Table	Page
1. General Characteristics of Physician Respondents	64
2. Doctor's Perceptions of Patients' Sick Role Behaviors	71
3. Interrelationships Among the Indices of Orientation	100
4. Orientation to Doctor-Patient Relationship by Age	
5. Orientation to Doctor-Patient Relationship by Sex	108
6. Orientation to Doctor-Patient Relationship by Occupation of Father	111
7. Orientation to Doctor-Patient Relationship by Place of Rearing	114
8. Orientation to Doctor-Patient Relationship and Early Education	117
9. Orientation to Doctor-Patient Relationship by Premedical, Medical and Internship Training	112
10. Orientation to Doctor-Patient Relationship by Field of Practice	126
11. Orientation to Modern Patient Role by Field of Practice	127
12. Doctor-Patient Relationship by Professional Orientation	130
13. Professional Orientation by Bureaucratic Orientation	134
14. Orientation to Doctor-Patient Relationship by Bureaucratic Orientation	136
15. Doctor-Patient Relationship and the Work Setting	137
16. Orientation to Doctor-Patient Relationship by Patients' Educational Background	140

LIST OF TABLES

(continued)

Table	Page
17. Distribution of Doctors on Orientations to Doctor and Patient Roles	153

LIST OF ILLUSTRATIONS

Figure	Page
1. The Model of Doctor-Patient Role Relationship	33
2. Analytical Frame	105
3. Map Diagram of Orientations to Overall Doctor-Patient Relationship with Gammas	185
4. Map Diagram of Orientations to Doctor's, Modern Patient's, and Traditional Patient's Roles with Selected Gammas	186

CHAPTER I

INTRODUCTION

This study attempts to examine the relationship between medical practice and its socio-cultural context; thus the examination involves two levels of analysis: the societal and the institutional. On the macrosociological or societal level, the study will be concerned with the cultural influences that shape the beliefs and practices relative to sickness and health among a selected population of Nigeria; on the microsociological or institutional level, the study will emphasize the importance of the relationship between physicians and patients as an intrinsic feature of health care delivery.

A basic assumption of the study of this relationship is that the type of patient that the practicing, modern doctor in a developing society comes in contact with in his practice will be different from the one typically encountered in industrialized societies since the orientation of such a patient will be based principally on folk medical beliefs and practices. Thus, the study will (1) emphasize possible areas of tension which may arise as a result of different role expectations which both the patient and the doctor bring into the relationship; (2) find out the extent to which the doctor is aware of the cultural factors relating to illness and illness behavior of his patient, and how sympathetic he is in dealing with patients whose experience with scientific medical practices is limited or absent; (3) emphasize important policy implications by identifying problem areas in the physician-patient relationship and what can be done to improve the relationship.

As indicated earlier, the unit of analysis of this study is the Nigerian doctor, hence the role expectations and behaviors of both the patient and the doctor as they relate to each other are as perceived and reported by him. As with any other profession and its clients, doctors do not relate to their patients in similar ways; in spite of the common professional culture and outlook which they share, certain attitudes peculiar to the individual doctor will influence his behavior and his practice as he interacts with his patients; these attitudes, in turn, are affected by a number of factors including his background training and experience, his professional reference group, and the organization of his practice. These influences on the physician's attitudes and behavior as he relates to patients will be examined.

A number of considerations, both theoretical and practical, have inspired and justify this study. In any society, according to Sigerist (Bloom and Wilson, 1972: 315), health care is essentially a social relationship between the person who is sick and the one who is helping him to regain his health; hence the interaction between the two can influence in very important ways the diagnosis and the treatment given by the helping agent (Blum, 1960: x). Furthermore, the ideal relationship between the two, as Foster (1954: 24) sees it, is that both the patient and the practitioner have complete confidence, mutual respect, understanding, and an appreciation of the respective roles and appropriate behavior.

Although the ideal doctor-patient relationship is never really achieved anywhere in its entirety, it seems that greater emphasis toward its realization is needed in a society such as Nigeria. There are indications, as suggested by Lambo (1970), that some Nigerian doctors do not appreciate sufficiently the importance of socio-cultural factors on

health and disease. Osborne (1969: 196) believes that because of the professional socialization experienced by Nigerian doctors, some of them have become unable to understand and relate to the cultural world of the people who live in villages. At the present time, complaints being launched by the people and the newsmedia point to a growing friction between doctors and patients; some of these complaints are directed against some doctors who are believed to be totally unsympathetic to the needs of their patients.

The remaining portion of this introductory chapter will be devoted to the following discussions: first will be a general description of the population selected for the study. Then a description of the health care delivery system obtaining in the country will be presented; this will include an analysis of the older traditional services and the more recent Western-type of services.

The Setting of the Study

The People of the City of Lagos

The doctors who were selected for this study practice in Lagos, the capital of Nigeria. A description of the city is important, first, because all the patients these doctors treat come from among the people living there, hence it is necessary to know who these people are, and what religions they practice since religion is closely related to the beliefs they hold regarding health, disease, and illness. Secondly, the city is important to the study because it was the first point of contact with Western culture in the country. Almost all of the modern medical care services existing in the country today started there.

From the earliest beginnings of its history, the island of Lagos

was populated by many ethnic groups each having its distinctive culture. The largest of these groups were the Yoruba who first settled the island; they were joined later by other Yoruba and by Benin and other ethnic groups from the hinterland. By the beginning of the nineteenth century the island was ruled by a Yoruba monarchy recognized as divine. The city became the beachhead of British colonial expansion into the interior of the country when it was annexed to Britain in 1861; by 1900 the city was experiencing a gradual transformation into a modern metropolis. When modern Nigeria emerged as a single political unit in 1914, Lagos became its capital; by that time the city could boast of a busy harbor, railway terminus, Christian churches and schools, pipe-borne water, tramways, roads and bridges, and a hospital (Aderibigbe, 1975: 3; Cole, 1975: 33, 34).

Today the city is a teeming urban sprawl. The population has been increasing steadily since 1921 when the population was only about 100,000; the greatest increase occurred during the intercensal years between 1953 when the population was 267,400 and 1963 when it more than doubled at 665,246 or about 149 per cent increase over the 1953 figure (Ejiogu, 1968: 321). Today, the population is unofficially placed at close to, or sometimes over one million. Being the premier city, the administrative as well as the economic center of Nigeria, it has increasingly attracted many immigrants from the interior who seek better living standards and employment opportunities. Yet the increasing modernization in practically all the sectors of the life of the city has by no means obliterated many elements of traditional life of the people. As Dele Daniel (1975: 28) has observed, "behind the facade of what appears to be a teeming metropolis is that part of Lagos which can be correctly described as the 'real Lagos'." Here, he continues, "social relationships are conducted in an idiom peculiar to the

environment; political relationship are also much more tradition-bound than the thin veneer of 'westernization' would allow the observer at first sight to believe. Lagos is not only the seat of Federal and Lagos State governments, it is also the seat of a virile traditional political hierarchy headed by an Oba /king/, advised by a large council of chiefs whose power is as real as it is pervasive."

Health Care Delivery Services in Lagos and Nigeria

In Historical Perspective

In discussing the health care delivery system of Nigeria, a general model of health care delivery suggested by David Mechanic (1975: 48) will be employed; this model is useful, firstly, because it highlights certain important, independent variables which have been found to affect the development of such services in the industrialized nations of the world, and secondly, because it helps to tie the development of the services into the historical context of each country. The variables are: (1) ideological forces, (2) economic organization, (3) level and character of technology, (4) organization of health professions, (5) professional organization and dominance. These affect two other variables: (6) access to, and the distribution of health services; directly or indirectly, all of the above mentioned variables affect the (7) overall quality of care given. For the present study, this model has been modified slightly to include as initial variable the traditional medical/religious beliefs which also form a part of, and register an impact, on the system.

It is recognized that the model may not be wholly applicable to a modernizing country such as Nigeria; for example, the combinations of ideological and economic factors which gave rise to the liberal-democratic capitalistic system--the laissez-faire economy, the notion of distributive

justice, etc., all of which greatly influenced the development of health services in Europe and North America in the nineteenth century (Anderson, 1972: 24-25)--will find no parallel in Nigerian history. Yet certain trends in the history of this African country need to be traced in order that a proper perspective of their impact on the development of modern health services there may be had. Furthermore, it is felt that these historical trends can be better traced when organized according to the amended model so that pertinent information can be grouped together into a logical whole.

The Blending of Past and Present

As noted earlier in the discussion of Lagos and its people, modern and traditional social arrangements co-exist in considerable harmony because the people have successfully managed to integrate elements from the two systems. Given this fact, it is no surprise that other aspects of the cultural life of the people--such as the religious and medical--should still reflect strong traditionalism in spite of the large gains made by the new religious and medical practices. Field (1973: 38) has called attention to the fact that in past cultures (and, it can be added, in many pre- and post-colonial Third World countries of today) the religious and the medical needs of peoples are coterminous; thus a description of the traditional medical and practices among Lagosians calls for an investigation of their religious beliefs and observances as well.

Nigeria has been described as a multi-ethnic community in which the majority of the members of each ethnic groups are found in their respective geographical area (Ekanem, 1972: 68). However, as Hanna and Hanna (1971: 118) have observed, the cities usually consist of a multiplicity of

various ethnic groups where the "indigenes", i.e., those in whose geographical area the cities are located, often constitute the majority. In Lagos, however, just about every major ethnic group in the country is represented in the population, but the indigenous people, as well as the majority of the immigrants in the city, are Yoruba because the city was a Yoruba city before it was made the capital of the country (Abiodun, 1974: 343). Consequently, the dominant traditional religion in the city is the Yoruba type (Gbadamosi, 1975: 174). The relationship between religion and medical culture will be discussed, using as illustrations the beliefs and practices associated with the dominant group in the city. The traditional religion, however, enjoyed a dominance only up to the middle of the nineteenth century, at which time challenges to it were posed by the advent of Christianity and Islam. Being the major port, Lagos was the most easily accessible to the early European missionaries who brought Christianity into the country; Islam, however, was spread into Lagos from the northern hinterland by black Africans who had been converted earlier by Arab evangelists from the Mediterranean coastal areas north and east.

Traditional Yoruba Religion and Medical Beliefs and Practices

The traditional Yoruba society is one which is organized on a hierarchical basis under an oba or king and his subordinate chiefs; perhaps this fact, as Idowu (1976: 148) has suggested, is a factor in the way that they conceive of the supernatural world. Olodumare, the Supreme God, is conceived as the supreme king under whom are the lesser gods or orisha who are appointed to minister to him in the affairs of the world. The natural world to the Yoruba is a world filled with good and evil beings who may benefit or destroy one's life or damage it. Olodumare

and his orishas are therefore worshipped in order to bring prosperity, to protect one from misfortune and to ward off the evil force of the world. The ibeji or the god of the twins, for example, is prayed to for the purposes of endowing a barren woman with fertility; ogun, a patron god of the blacksmiths, is the god of iron which is believed to protect them from accidents involving metal objects; ifa is the oracle divinity who is consulted to forecast coming events or to pinpoint the perpetrator of misfortune.

For the Yoruba, religion forms the basis of medicine, since its healing power is believed to come from the Supreme Deity. Osanyin, the tutelary divinity of medicine, empowers the traditional healer to heal. A common feature of medical practice is the invocation of ancestors; it is believed that apart from God who makes healing possible to begin with, the spirits of the ancestors who were the past masters and teachers of medicine must also be invoked to make the medicine more efficacious; hence, the first traditional healer renowned as a genius in medicine. Elesije, is often invoked by the traditional healers.

Belief in magic, or in the ability to compel certain gods to do one's bidding, is rife among the Yoruba; practitioners are feared for their spells and enchantments which it is believed can cause one a misfortune. While certain gods can protect their adherents from misfortune, they can also abet the cause of magic. Thus, the divinity esu can be invoked for both licit and illicit magic; the tutelary god of small-pox, soponna, can inflict upon its offenders the disease of small-pox, while sango, the god of thunder, is reputed to be capable of hurling thunderbolts to kill or set an offender's house on fire (Idowu, 1976: 194). In addition to invoking the gods for magical purposes in healing, practi-

tioners of magic are also believed to be capable of using various types of magic to harm others, cause illness or even death of enemies from distance, or their services can be engaged for such purposes.

Witchcraft is another belief that deeply pervades the minds of many Yoruba. It is recognized as an instrument of darkness which can be employed to wreak havoc on its victims. It is believed that witches are capable of sending out their spirits at night to harm the mind, body, or the property of another person. Thus, the method of their operation is "an operation of spirits upon spirits," since it is the ethereal body of the victim that is supposed to be attacked and devoured by the ethereal body of the witch, while the human bodies of both the witch and its victim lie sleeping at their respective homes (Idowu, p. 176).

Many traditional medical practitioners are often votaries of these gods; in general, they and the treatments they give can be divided into two broad groups: the onishegun or herbalists, and the babalawo or diviners. The herbalists have knowledge of herbs, roots, leaves, barks, and some mineral substances which are compounded into medicine for curing certain external and internal ailments. They also make talismans and rings for individual users to wear for warding off the evil forces which may be human but often are spirits. The diviners are votaries of ifa, the oracle god. They recite a large number of sacred verses known as the Odu and from these find appropriate answers to fit the problems brought to them.

Two views of illness, as believed by the Yoruba, can be recognized: the supernatural and the physical. The supernatural view, as previous discussions have shown, attributes ill health to supernatural causes, particularly the anger of the gods and witches, as well as to the machinations of evil men or the jealousy of rivals. Some physical causes of illness are

also recognized; for example, excesses in food and drink are believed to cause stomach ache or diarrhea, while worms are often blamed for various types of illnesses. In spite of the acceptance of these physical causes, however, a deep-seated belief in the supernatural component still persists. Thus, to treat the physical manifestation of an illness with the appropriate medicine is not enough, because its root cause must also be treated by an appeal to the appropriate powers (Lucas and Hendrickse, 1970: 35).

Some forms of preventive measures are known; for example, liquid prophylaxis is made from herbal substances which are drunk or infused into the blood to prevent attacks of certain fevers or to render snake bites innocuous. Other preventive measures are magical: protective charms, rings, and amulets are worn; sacrificial rites are performed to ward off evil influences especially on important occasions such as weddings, naming ceremonies for a newborn baby, digging the foundation for a new building, or even on the purchase of a new car; in order to pacify ogun, the god of iron, some drivers carry charms in their vehicles to prevent road accidents.

Traditional healers do not have any formal training but some of them often claim that they are taught the art of medicine by divinities in dreams or in trances; others such as the legendary Ajanaku, who was said to have a vast knowledge of Yoruba pharmacopoeia, claim to have been carried away by the whirlwind into the forest where they are trained by the spirits (Idowu, p. 200). More common, however, is the apprenticeship which may last for a few years or sometimes as many as nine; some practitioners are trained from childhood by their fathers, since healing and divination are often family specialties (McClellan, 1959: 178).

Christianity and the Aladura Sect

One of the two world religions that first challenged the dominance of traditional religion is Christianity; in the area of health care, Christianity played a crucial role in the development of modern health services. The part played by the early Christian missionaries will be discussed later under the growth of modern medical professionalism and organization of the health professions. Of importance at this point is the phenomenon of the Aladura churches whose beliefs relating to health and illness, as well as the method of cure are an admixture of Christian beliefs and traditional beliefs and practices.

The growth of these churches is an example of a rather universal pattern found in many former colonies which had been introduced to Christianity by European missionaries. The domination of leadership in the churches by these missionaries and the general practice of discrimination against the indigenous leaders, coupled with the growing nationalism among these Africans, resulted in a crisis which caused some indigenous leaders to break away and to found what was known as the African church; from this grew the Aladura (Yoruba for "those who pray") sect. Today the sect enjoys a large following among all classes and religions in the city because it operates in many respects "on the wavelength of the people," as the following discussion will show.

The leader of an Aladura church is called a "prophet." The prophet plays the dual role as pastor and healer to members of his church. These roles represent a Christian reinterpretation of the roles of the traditional healers who are to divine and to heal. He is regarded, as the indigenous healers are, as an alagbara or one with tremendous spiritual power to perform miraculous healing. In many ways his interpretation,

diagnosis, and treatment of diseases are strongly reflective of traditional beliefs and practices.

The prophet recognizes the different types of diseases and the preternatural causes of most of them as understood by the Yoruba in general; severe physical and mental illnesses, as well as many tragic life events, are attributed to the evil force of witches. Perhaps one important reason for the sect's popularity with clients is its claim to countermand the power of witches through exorcism; like other traditional methods, the prophet stages orgies during which witches are denounced, those accused of witchcraft confess, and others accuse themselves in the hope that they will be "cleansed" of their wickedness. Since disease is also attributed to sinning, confession of such sins is believed to hasten healing. Just as the names of ancestors are invoked by the traditional healers to make medicine efficacious, the prophet similarly evokes Biblical names (e.g., Jehovah) which are believed to make prayers of healing more efficacious. Holy water plays an important part in the therapeutics of the Aladura prophet just as in Yoruba religion--water from the shrine of Osun, the goddess of the river, is drunk to cure ailments or to restore fertility in women (Mitchell, 1970: 70).

Islam

Mid-nineteenth century Lagos also saw the introduction of Islam which, together with Christianity, constituted the major challenge to the traditional religion. It seems that Islam spread wider and faster than Christianity in the country as a whole, as evidenced by the proportion of Moslems in the population in 1963 which was 47 per cent; Christians were 35 per cent; and the rest in traditional animist religion (Country Profiles, 1963: 5). Pobee's (1977: 3) explanation of why the religion made

a similarly rapid impact on the people of Ghana is instructive for Nigeria's situation. Islam was introduced into West Africa by Africans who had been converted earlier to that faith because it could not be identified, as was the case for Christianity, as a "white man's religion;" in many ways the religion readily adapted to African traditions and customs such as polygamy; it is not overly against the practice of magic, and it does not require its converts to become literate overnight as sometimes seemingly demanded by the early missionaries.

Just as Christianity has influenced traditional medical beliefs and practices as exemplified by the Aladura sect, so also Islamic ideas have influenced traditional ones. Certain words from the Koran are believed to be endowed by Allah with power and are employed as formulae for protection against evil forces. Like the Aladura prophet, the Islamic cleric is regarded as a man of power and enjoys considerable status in the society partly because of his reputation for being good at making charms. The religion was not welcome in its early days in Lagos and converts had to worship in secrecy; over time, however, it gained royal support from the ruling Oba partly because of the magical powers its clerics were reputed to have. Eventually, it won acceptance in the royal circles and later by the population at large (Gbadamosi, 1975: 178).

Islamic religion has influenced traditional African beliefs, but has itself been influenced as well; in West Africa, Allah tends to be depicted, in consonance with the customary beliefs, as one with supreme power and totally removed from men like Olodumare of Yoruba belief. He is also the giver of magical power; as Pobee has put it, "the conception of the supernatural world by the West African Moslem is an amalgam of African and Islamic beliefs."

Apart from the supernatural powers possessed by Moslems to protect or cure some diseases, some form of surgery is performed usually by Hausa surgeons. These Hausa migrants are Moslems from the northern part of the country. Some of the procedures carried out include removal of tonsils, lancing of boils, and setting of fractured bones.

This preliminary discussion is intended to provide an introductory background to the admixture of religious beliefs that shape the medical beliefs and practices of the selected populations among which the doctors practice. The following discussion will focus on the past and present state of modern medical services in the country; this will be guided by the variables suggested by the model of health care delivery systems discussed earlier, and the first of these is national ideology.

Ideological Forces

When the health care delivery system of a country is examined, the national ideology determines the extent to which the government is involved with the administration, regulation, and financing of the health services of the nation. The present health system in Nigeria is a legacy of the British colonial administration and, because of this history, some British ideological influences can be traced throughout the Nigerian system from its beginning to the present.

Government control of health services has a long history in Britain; as far back as 1912, when the National Health Insurance was in use, the government regulated the coverage, prescribed the rates of payment that a subscriber paid, and administered the procedures for claiming benefits (Glaser, 1970b: 22). Thus, it was almost inevitable that from the start the health services in Nigeria were controlled by the government. The imperatives of the colonial situation and the absence of an economic

infrastructure to support any other type are also acknowledged as other possible factors for government control. Yet, there is still some truth in the assertion that a colonial government establishes in the colony a system with which it is already familiar in the home country.

Another ideological carry-over from Britain is that suggested by Collis (1960: 260) in reviewing the health services of Nigeria. According to him, the establishment of doctors into the civil service, done in order to care for the few civil servants, was founded on the theory prevalent in Britain in the early twentieth century. This stipulated that it was unnecessary to supply medical care for the poor workman or the peasant. This ideology was reflected in colonial Nigeria when most of the medical doctors were and still are civil servants.

The ideology of racial superiority of the British professionals in the colonies was significant in determining the education and availability of Nigerian doctors during and after its colonial history. Even though a few Africans from affluent families were allowed to go to the United Kingdom to train as doctors, yet the ideology persisted, because it not only justified colonial rule but also allowed British doctors in the colonial service to monopolize appointments with the backing of the professional associations at home (Johnson, 1973: 291). One immediate effect of this policy was on the training of doctors. Like the French policy in other West African colonies, there were in Nigeria no facilities for full-fledged training of doctors even after the Second World War. Africans were trained in one form or the other, but not to become doctors (Sai, 1971: 120). A school opened in Lagos in 1930 (closed in 1948) was said to have provided a "rigorous" medical curriculum and had produced "really excellent physicians;" however, the graduates were classified as second-

class doctors or "subdoctors" since they could not practice outside Nigeria (Lucas, 1970: 92).

Another pertinent development associated with the political and medical elites after Nigeria's independence in 1960 can be called a "prestige" ideology; this calls for showing the country off by erecting impressive buildings without regard for their utility. For example, it calls for building prestigious teaching hospitals designed to train doctors, but many of these are "overtrained" and unsuitable for the more pressing medical needs of the masses. This ideology also leads to the building of a medical infrastructure which is primarily urban in form, thereby making care available to urban residents but neglecting the vast rural population. Another aspect of post-independence ideology holds that expenses for health care are seen as investments in human beings which will help to build a strong and healthy labor force for economic development. The current development plan stresses that "efficient and ample health facilities must be brought to the entire population" in order to achieve that goal (Obasanjo, 1976-77: 3).

Economic Organization

The scope and type of medical service as well as the general level of living are dependent on the economy of any community or the nation-at-large. Nigeria is a relatively poor country. Until the period 1971 to 1972, when petroleum became a major earner of foreign exchange, about 54 per cent of the national income came from agriculture. The per capita income for the financial year 1973-1974 was 33 pounds sterling or about \$70 (Country Profiles, 1973: 5). Of those constituting the working population, 70 per cent were engaged in agriculture (Ekundare, 1974: 360); of all those who could be classified as gainfully employed during the period

1966-1967, only about 5 per cent were employees earning wages, while 95 per cent were occupied on their own or as unpaid family workers (World Bank, 1974: 28).

It has been estimated that many developing countries spend between 1 and 2 per cent of their national income on health services annually, compared with between five and nine per cent in the industrialized nations (O.H.E., 1972: 13). From the estimated Gross Domestic Product of Nigeria in fiscal year 1971-1972 (Population Council, 1973: 5) and the capital expenditure on health for both the federal and state governments in the country (Birdsall, 1976: 30) it can be calculated that Nigeria spent less than 1 per cent of its Gross Domestic Product on health for that period. This low outlay on health services affects not only the number of hospitals and clinics that can be made available but also the number and distribution of doctors in the country. In an economy in which the government provides most of the resources needed for health services, coupled with a policy that emphasizes curative medicine with priority given to urban areas, it is no surprise that perhaps as many as 90 per cent of all doctors in the country are located in hospitals in urban areas.

As noted earlier, over 90 per cent of the labor force is self-employed in occupations that allow for only a subsistence existence; hence, the base for a successful health insurance is absent. The situation is not much improved for the few wage earners, because low wages and a large number of dependents are likely to make an insurance program unworkable.

Level and Character of Technology

The practice of medicine increasingly depends on the application of machinery and chemicals. Many developing countries are not likely to be

able to afford a large supply of these aids and consequently the type and scope of medical care available will be more limited than those available in the richer nations (Glaser, 1970a: 156; Mechanic, 1975: 46). Most of the equipment needed in the institutions in the country is often the same type as that built for the hospitals in the industrialized nations which are usually found in the temperate zones. Such equipment breaks down in the humid tropical climate, putting it out of use for short or long periods of time. The irregular water supply and the unreliable supply of electricity also inhibit the full use of equipment. Such problems are rife in most of the hospitals in the country. Electrical power supply, as a rule, fails almost every day. A senior doctor told of the absence of a standby electrical generator in a major maternity hospital in Lagos where all operations had to come to a stop whenever there was an electric power failure; the babies in incubators were often in danger of permanent injury or death (Sunday Times, Nigeria, 1976). Not only are the available machines in constant danger of breaking down but they are often in short supply. A constant cry of the doctors is that hospitals are inadequately supplied with needed machinery and drugs and that such shortages militate against efficient performance of their duties (Sunday Tide, Nigeria, 1977; Sunday Punch, Nigeria, 1976).

Shortages are common in respect to technical aides who operate the machinery that is so essential to modern medicine. Laboratory technologists, X-ray technicians, physical therapists, and other paramedical aides are in short supply all over the country (Solanke, 1977).

Another factor that affects shortages in the hospitals has to do with respect for public property. Since the equipment needed for the care of patients must be readily available for easy access of doctors and

nurses, keeping them under lock and key will be impractical; yet leaving supply cases open invites temptation of theft (Glaser, 1970a: 156). In Nigeria, as in many other developing countries, the junior hospital employees are often very poorly paid, and hence many succumb to the temptation of stealing supplies. Reports of pilferage of drugs, food, and other supplies are common; sometimes such stealing is not confined to the junior employees. Some doctors have been accused of diverting drugs from the government hospitals to their private clinics which they surreptitiously operate after their official work hours (Times International, Nigeria, 1976; Nigerian Herald, 1977).

Efforts are being made by the government to make up for the problems of equipment shortage and loss. The current development plan calls for the establishment of training schools for paramedics with the hope of greatly increasing their number by the end of the plan in 1980. In the area of drug supplies, the new government policy encourages the major foreign pharmaceutical companies to manufacture drugs in the country and today a number of them are already well established. The government, too, is planning to set up laboratories for the manufacturing of drugs and instruments.

Organization of the Health Professions

It will be recalled that modern medical services in the country were launched first in Lagos by the British colonial government as part of the West African Medical Services during the late nineteenth century for the care of its military forces. At that time, the service was centralized; but shortly after, the military character was changed to a colonial one which catered, first, to the civilian administrators and, later on, to the rest of the country. Various stages of decentralization

occurred which paralleled similar political decentralizations that started in 1914 until the present structure of nineteen states was established in 1974. Each state has control over its health services under the State Ministry of Health and Social Services.

The health services of Nigeria can be divided broadly into two types: (1) those provided by the federal and state governments and (2) those provided by the private sector. The federal government is concerned with public health in general, such as the control of epidemics. It is also responsible for the training of doctors, research, formulation of health laws, inspection, and so on. Each state government is responsible for curative services in its territory. It control the building, maintenance, and staffing of the hospitals, and it is responsible for the registration of vital statistics, child welfare, school health, maternal health, and environmental sanitation (Federal Govern of Nigeria, 1974; Daniel, 1975: 151). The private sector includes services provided by the missions, corporations, and other private entrepreneurs.

Most of the physicians working in Nigeria have hospital appointments and are paid by the federal and state governments. They, as the rest of the medical personnel similarly employed in hospitals, provide health services for about 85 per cent of those who receive Western-style medical care; while 15 per cent of the users are provided for by the private sector, including a small proportion of those who consult private practitioners.

The hospital staff can be divided into three units: medical, nursing, and administrative. Attention will be devoted to the first type. The medical staff is arranged in a clear hierarchy. The lowest position is that of a houseman; above this is the medical officer grade which has

three ascending levels: Medical Officer, Medical Officer Grade II, Medical Officer Grade I. On the acquisition of a "special qualification," a medical officer is promoted to Registrar Grade II and then to Registrar Grade I. Further promotion is to the post of a Consultant (corresponding to the specialist in the United States); the next higher step is the Senior Consultant grade. The controlling post of the Chief Medical Adviser of the Federal Government is the highest in the professional line (equivalent to that of the Surgeon General in the United States), and his work is chiefly administrative as set down by statute. Under him are his equivalents in each of the states, called Senior Principal Medical Officer (curative medicine) and Senior Principal Health Officer (preventive medicine) (Report of the Grading Team, 1966: 18).

Professional Organization and Dominance:
Historical Rise of Physicians in Nigeria

Wilensky (1964) is one of the sociologists identified with the notion of continuum which views the development of the professions in terms of historical stages. In an attempt to construct a "natural history" of professionalization, he made a systematic comparison of 18 occupations in the United States, isolating a set of stages which they followed to become established professions. To use his model to describe the "development" of the medical profession in Nigeria might seem at first glance inappropriate, since the profession had already become established in Britain before it was brought into the former; nevertheless, his five-stage model can be useful as a heuristic device to pinpoint some other historical events leading to the rise of the modern doctors in the country.

The first stage for occupations in the process of becoming a pro-

profession is to "start doing full time the thing that needs doing;" being a full-time occupation distinguished the professional from the amateur, and the occupation provides its practitioner with the principal source of his earned income. At this first stage in the history of the profession in Nigeria, it was a full-time occupation for Europeans who were almost its exclusive practitioners. The first European doctors to come to Nigeria were Portuguese in the fifteenth century; they came during slave expeditions in order to take care of the Portuguese slave dealers and also to help in the selection of healthy slaves. The transient nature of their visits, however, left no visible impact on the future development of physicians in the country.

Long after them, in the nineteenth century, came the missionary doctors whose first task was to care for the missionaries and later on to extend some care to converts around their clinics and hospitals. The early missionary phase produced a few Nigerian "doctors" whose training was obtained through an apprenticeship or some diploma course. The training, however, was sometimes used as a stepping stone to other more lucrative careers in trade and politics. Among the first few, fully qualified doctors in the country in 1850 were Nigerians and descendants of freed slaves from Sierra Leone; these doctors had been trained in English universities but seldom practiced medicine exclusively. Usually active in many non-medical matters and constituting an elite in the society, they held prominent positions in commerce, education, politics, and various social reforms. Some became founders of schools and business companies (Ajayi, 1965: 160; Solanke, 1977: 14).

The impact of Britain on modern medicine in Nigeria started with the doctors who were attached to trading companies in the country, as was

the case in the rest of the British empire. During the last decades of the nineteenth century, imperial power peaked; British rule was expanding and being consolidated around the world. Of necessity, an increase in administrative services and armed forces were required in the colonies. Physicians and surgeons were therefore recruited to serve the administrators and the armed forces personnel; since the military medical service was often a transient one, it was gradually phased out and a more permanent colonial cadre of medical officers was established (Johnson, 1973: 287). Thus, the medical service in Nigeria began as part of the West African Medical Services originally established to serve the military and the early colonial officers. The first government hospital was the 45-bed Colonial Hospital built in Lagos in 1873; in the same year, two other hospitals--one mental, the other for infectious diseases--were built a short distance from the island of Lagos (Daniel, 1975: 145).

The second step mentioned by Wilensky involves special training. The early recruits of the occupation press for the establishment of a training school which usually begins within a university. Since the early expanding need for doctors in Nigeria was met by the recruitment of more British and other European doctors to serve in the country, no training facilities were necessary and none were built; the few Nigerians who became fully qualified physicians at this time were trained in England. In 1930, Nigeria still being a colony, the first semblance of a medical school was opened in Lagos. However, graduates from this school were regarded in many respects as "second-class doctors." They were officially called medical assistants, were paid a much lower salary than those trained overseas, and their credentials did not entitle them to practice outside the country. The first full-fledged medical school was that

started in 1947 as part of the university college at Ibadan. Both the university and the medical school were affiliated to the University of London, but both became independent of the parent university in 1962, and, from then on, each became a separate degree-granting institution. Four other teaching hospitals have since been established in Lagos, Zaria, Nsukka, and Benin (Brown, 1970: 54; Lucas, 1970: 92). At least seven others are being proposed at the present time (1978) by the federal government; the eventual hope is to have one medical school in each of the nineteen states of the federation (Mediscope, Nigeria, 1977: 1).

Wilensky's third stage of professionalization is the establishment of a professional association; members try to convince themselves (and others) that their occupational association is actually a "profession" and so try to acquire a more prestigious image by changing the name of an existing association to a more professional one. A significant purpose of such development is to keep out those practitioners thought to be incompetent. Professional associations were becoming more common in the colonies as the imperial expansion created increasing opportunities for highly paid employment overseas. The local (i.e., in the colonies) professional associations formed by Europeans became extensions of those in their home countries in Europe which served to protect the colonial civil servants' interests at home. A by-product of the increased infusion of British professional into the colonies was the growth of the color bar which was used effectively to squeeze out the few indigenous professionals. Thus, when the (non-African) West African Medical Staff was founded in 1902, African doctors were excluded; in the same year a new regulation was drawn up which specifically restricted new membership to European medical officers (Johnson, 1972: 288). The more recent formation of the Nigerian

branch of the British Medical Association admitted qualified (M.D.'s) Nigerian doctors, and in 1951 the name was changed to the Nigerian Medical Association. The new association still retains its ties with the British Medical Association as well as with the Commonwealth Medical Association. The N.M.A. is a relatively organization as compared with similar organizations such as the American Medical Association. Unlike the A.M.A., the N.M.A. has only a marginal control over medical education, disciplining of its members, and has no control over entry into the profession. The power to control this area is vested in the Nigerian Medical Council which was established under an Act in 1963; nineteen of its 25 members are appointed by the government, and only six are elected by the N.M.A. (Currie, 1970: 364).

The fourth stage for occupations aspiring to professional status is to seek the support of the law, the protection of their job territory, and the sustaining of their code of ethics; licensing and certification are sought to protect the control of jobs by the professionals. This stage was reached in the earliest history of the profession when the colonial medical officers all belonged to the West African Medical Association. To protect their interest, they received the support of the home government in excluding Africans from their association. The then Secretary of State for the Colonies was quoted as saying that it was "pretty clear to men of ordinary sense that British officers could have no confidence in native doctors." After the organization had become indigenized, support continued to be given by the Nigerian government, which does not now recognize the traditional healers in any direct official way as it does the physicians. The Nigerian Medical Association itself has no such healers in its membership. Unlike the American

Medical Association, the N.M.A. has no control over licensing of doctors. The Medical Council does the licensing of locally trained doctors but it certifies foreign licenses as well; thus, Nigerian doctors trained overseas retain licenses granted them wherever they have trained, and the same goes for expatriate doctors. The Council keeps a list of approved medical schools from all over the world and licenses from these are honored bona fide. However, all doctors must register with the council before they can be allowed to practice anywhere in the country.

The fifth and final stage formally embodies the rules governing the occupation in a code of ethics; these codes are meant to regulate the conduct of their members in the area of competing against each other and to protect their clients by emphasizing service ideals. It also gives notice to the association that the monopoly over professional service it has granted must not be abused.

In a situation such as obtains in Nigeria, where most of the health services are provided by the government in hospitals and doctors are salaried, there is little likelihood for competition among doctors, and such competition that does exist takes a particular form. There is a growing evidence that doctors subtly "compete" with the government, as reports are common that patients are encouraged to visit the doctor in his private clinic where they are promised better care than that given in the hospital (Olamiti, Nigerian Tribune, 1977). The service ideal called for by the code appears to be regularly violated by some doctors; accusations of unsympathetic relationships with patients are common; a recurrent theme is the allegations of an overriding desire of some doctors to get rich overnight and a willingness to do anything to reach that goal (Sobowale, Times International Nigeria, 1976).

The code of ethics of the N.M.A. is an inheritance from its fore-runner, the former British Medical Association. Apparently, the growing awareness by the public of the responsibilities that doctors owe it, as well as the increasing criticisms against doctors' services all over the country, appear to have spurred the association to strive to re-legitimize itself by re-writing its codes to reflect the needs, customs, and obligations of the doctors to the people. As an editor of one of the national newspapers had remarked, the new code is "an attempt to probably repair (the doctors') public image which has been tarnished by their mindless resort to strikes at the slightest provocations . . .;" the code was also seen as a response to the need by doctors "to give the Nigerian doctor a face-lift" (Sobowale, 1976).

Access to and Distribution of Medical Services

A number of theories predominate in the literature on the concept of access, but the one that is considered appropriate here defines it as the character of the delivery system, i.e., the distribution and organization of manpower and facilities (Aday and Anderson, 1975: 2). Generally, the available data are few to allow a thorough analysis but the few that are available will be presented. Hospitals and other health institutions are few and poorly distributed in the country. In 1970, 63 per cent of the 284 general hospitals were located in three states and the federal capital of Lagos, all in the southern part of the country (Federal Office of Statistics, 1971). A disproportionate emphasis is put on facilities such as general hospitals, maternity hospitals, and teaching hospitals situated in urban areas for providing curative care. The twelve diseases implicated in about 95 per cent of all illnesses and deaths in the country

are most prevalent in the rural areas, yet these same areas are provided with token health services.

Although statistics on number of hospital beds for a given population as well as proportion of doctors to the population are said to be more appropriate for describing access to health care in the industrialized nations (OHE, 1972: 24), these indices can help give a rough idea of the situation in Nigeria. There was only one bed to about 1,700 people in 1972; the projected ratio for 1980 is 1:1,000. Similarly, the distribution of doctors in 1972 was 1:22,000 in urban areas and as high as 1:100,000 in rural areas. The shortage of health personnel is acute not only for medical doctors but also for dentists and paramedical professionals as well. There was only one dentist to 548,000 people in 1972; the ratio of nurses was 1:4,400, pharmacists 1:68,000, laboratory technologists 1:283,000, and radiographer 1:567,000 (Federal Government of Nigeria, 1974).

The paucity and the imbalanced distribution of the health facilities in the country is borne out by a recent survey which showed that 90 per cent of health services were available to 20 per cent of the population, which is primarily urban, while only 10 per cent of the services were available to 80 per cent of the remaining—principally rural—population (Daily Times, Nigeria, 1976). The government, too, admits that only 25 per cent of the population is presently covered by the available health services, and plans are afoot to extend this coverage to 40 per cent by 1980 (Obasanjo, 1976-77).

The previous discussions have examined a number of factors (religion, ideology, economic organization, level of technology, organization of health care professions, professional organization and dominance, and

access to medical care) which have shaped the health care delivery system in Nigeria. These factors, in combination, determine the quality of health services provided the people in the country; this overall quality of care will be examined in the next section.

Overall Quality of Care

Quality of medical care is a multi-dimensional concept and that is no agreement among medical sociologists regarding its precise measurement. However, from the few available studies on the subject, the following dimensions emerge (Donabedian, 1966):

Outcome.--This is defined as the rate of recovery, restoration to functional capacity, mortality or survival of patients. Some examples of outcome are the rates of surgical fatality, recovery of psychiatric patients, perinatal mortality, etc.

Process of Care.--This is defined as not just the application of technology to achieve a successful outcome but how professional and technical aspects of care are applied in what can be described as "good" medical care. The appropriateness or inappropriateness of the application of diagnostic and therapeutic procedures, including surgery and other clinical procedures, are examples of how "good" medical care can be assessed.

Structure of Care.--This involves the availability and access to a number of structures that are both physical and non-physical, such as (a) settings: hospitals, clinics, solo or group practice, maternities, sanatoria, etc; (b) facilities and equipments; (c) quality of medical staff and its organization; (d) administrative structure and operations of health care programs; (e) fiscal organization, especially the method of paying the medical staff; (f) differential care between poor and rich.

The fourth dimension of quality of medical care is distinct from the outcome, process, or the structural dimensions in that it is a composite of subtle social, psychological, and cultural factors which influence the behavior of the doctor and other health personnel toward the patient while in therapeutic interaction. Two patients with identical diagnoses may each receive care whose quality is different; for example, if one of the patients loudly proclaims his suffering while the other bears his in stoic silence, the health personnel may react differently to each, preferring to deal more gently with one than with the other, depending on which of the patients' values they share (Croog and Steeg, 1972: 288). Another way in which the quality of care is assessed is whether or not a patient seeks malpractice litigation. If negligence is established and the patient believes the doctor to be callous, unresponsive to his needs, and arrogant, the chances are very great that the patient will sue. On the other hand, a patient who is convinced that the doctor has done the best he could for him and is interested in him as a human being, such a patient is less likely to seek litigation even if negligence on the part of the doctor can be established (Mechanic, 1976: 273).

The outcome and structural dimensions of care are mostly approached in statistical terms; the type of records needed for assessment, however, are limited or wholly lacking in most of the Third World countries and Nigeria is no exception. Only a few studies (for example, see Peterson, et al., 1953-54; Price, et al., 1963) are available on quality of care; they have examined only processual dimensions. The fourth dimension which focuses on the doctor-patient relationships, has often been described by sociologists of medicine (such as Sigerist and Henderson) as the crux of medicine. Sigerist (Bloom and Wilson, p. 315) describes health care as

essentially a social relationship and that the nub of the system consists of the interplay between the sick and the helper in all of its various forms. This fact, however, is often lost in the midst of complex machinery, techniques, and organizations that characterize modern medicine. Furthermore, as Ford and his associates have observed, the studying of the doctor and the patient in actual or reported interaction is tantamount to evaluating the quality of medical care; "an important research issue in studying the physician-patient relationship, is the evaluation of professional and technical outcomes--appraising the quality of medical results" (Ford, et al., p. 16). It will be recalled that this implicit relationship, that is, the attitudes of physicians and their probable bearing on care, is the main focus of the present study.

In the following chapter, the theories that examine the nature of this relationship and the factors that influence it will be further presented.

CHAPTER II

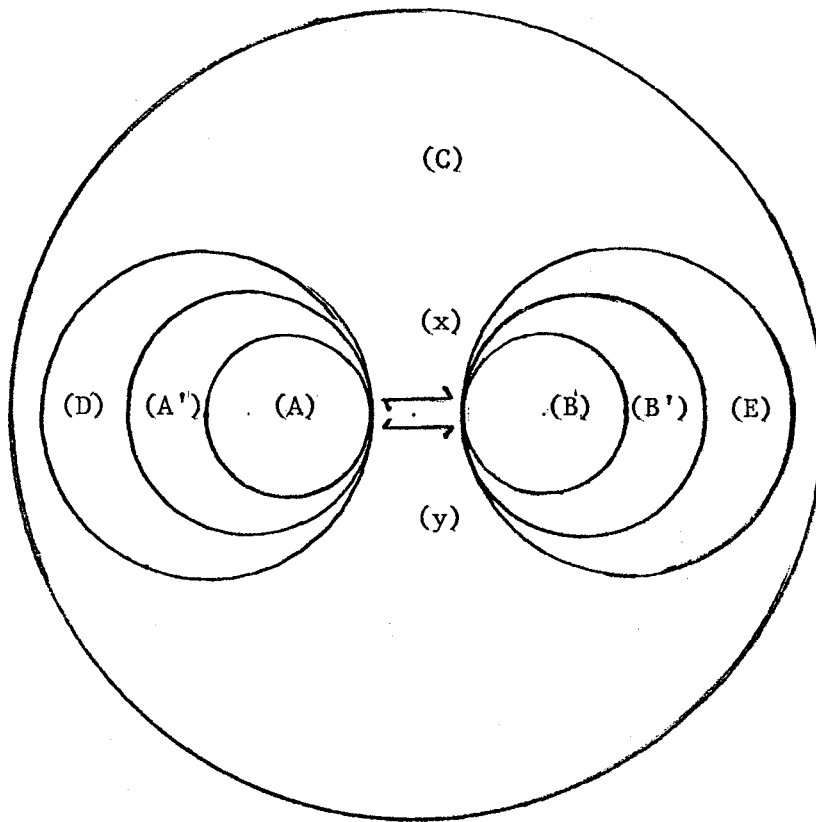
THEORETICAL BACKGROUND AND REVIEW OF THE LITERATURE

A Model of Doctor-Patient Relationship

The model which will be used for studying the doctor-patient relationship in this study is the one suggested by Bloom (1960) which considers this relationship as a subsystem of the health care delivery system. A social system (or subsystem) consists of "two or more individuals interacting according to stable social roles;" thus, in the doctor-patient relationship, doctor and patient play their respectively appropriate roles. The "field" in which this interaction takes place can be conceived as consisting of a number of elements, two of which are the personality of each of the actors in interaction (x) and the technical skill of the doctor (y) as indicated in Figure 1.

What determines the view of the patient by the doctor (a) during interaction, however, is not just the rational application of his scientific knowledge and skill to the need of the patient; rather, it is the "predisposition of individual character structure," that is, the personal attributes which he brings to the situation. In addition, his perception of the patient will also be influenced by a set of values and norms for behavior which he has internalized from the medical profession (A') as a medical student, as well as from his colleague reference groups.

Similarly, the behavior of the patient (B) is partly determined by the therapeutic situation partly by his distinguishing personal attributes. Just as the doctor's behavior during the encounter with the patient is guided by his membership in the medical profession, so also the patient's



- | | |
|--|----------------------------------|
| (A) Doctor | (D) Subcultural Reference Groups |
| (A') Profession | (E) Subcultural Reference Groups |
| (B) Patient | (x) Expressive Transaction |
| (B') Family | (y) Instrumental Transaction |
| (C) The Dominant
Sociocultural Matrix | |

Figure 1. A Model of Doctor-Patient Relationship (Bloom, 1960)



behavior is influenced by such external factors as his family and other primary social groups of which he is a member, all of which are embedded in the socio-cultural matrix (c). The doctor and the medical profession also constitute elements in this matrix as well.

The model, as presented, is only a framework to show that the doctor's relationship with the patient is not merely a dyadic relationship taking place in isolation but one closely intermeshed with the society at large. In the following sections, other concepts that are important in further understanding the doctor-patient relationship will be reviewed; these are: the socio-cultural matrix, a general description of social roles, specific role of the doctor and the patient (sick) role, the medical profession, and the organization of the health care delivery.

The Socio-cultural Matrix

Blum defines culture as the "complex heritage of language, tools, customs, and beliefs which bind a group together so that they share and pass to their offspring a way of life." Within any given culture, certain subcultural belief systems exist which influence how an individual defines health and illness; hence whatever the person chooses to believe about disease, its cause and cure are drawn from the cultural "storehouse" of his society. This choice, however, is not rational nor consciously made; rather, it is the prevailing beliefs of his family, friends, and other social components which he has absorbed. How these beliefs and values become internalized, and how they direct what the individual perceives, is partly psychological, and partly sociological.

The process of perception, King (1962: 65) asserts, is influenced by the social milieu in which an individual is reared; these milieux provide a set of factors which not only limits his perception but also the

resultant behavior. Quoting Benjamin Paul, he adds that "one of the functions performed by culture is to serve as a subtle and systematic device for perceiving the world. Since cultures vary, perceptions of the world vary correspondingly." In the field of the health professions, therefore, the concept of culture and subculture help the professionals not only to have a better understanding of their patients, but also to understand themselves. Medical care is itself a subculture in which professionals participate and an understanding of this fact can help them to function more knowingly and objectively.

Culture, according to Bloom (p. 66), prescribes to all societies how illness is diagnosed and treated, together with methods of practice which are entrusted to a particular group; from culture also certain norms have developed and have become institutionalized; these norms prescribe and proscribe appropriate behavior during the illness.

Social Roles

A social role is defined by Bloom (p. 67) as "a pattern of expected behavior;" such patterns of behavior are "regulated by cultural norms or rules of behavior, and organized into rights and obligations which have general acceptance within a group." This normative patterning has consequences for the doctor and the patient: the doctor is saved from having to explain his privileges and obligations as doctor to the patient because the patient has learned the outlines of doctor's role as a part of the repertoire of other roles he has learned as a participant in the same culture as the doctor. In the same manner, the patient has learned what his role is as patient and need not inform the doctor what it is because the doctor already knows. Important to the role concept is that the behavior of both the doctor and the patient is not acted in a vacuum but always in reciprocity to one another and the society at large. In the therapeutic

encounters also, both the doctor and the patient bring in different expectations to the relationship. As the process of diagnosis and treatment goes on, they perceive each other and interact according to the reciprocal role expectations each has toward the other (King, p. 69). Whenever distortions in perception occur, as when treatment involves an application of one culture to a subculture within a society or to another culture across societies, the relationship is greatly impaired (Fredericks and Mundy, 1973: 68). Thus far, the discussion has been on role patterns and expectations and how they influence the perceptions of the doctor and the patient; in the next section what the specific role of each of them is in their encounters will be discussed.

Social Roles of the Doctor and the Patient in Western Societies

Parsons (Bloom and Wilson, 1972) provides a basic conceptual model for functional analysis of health care in a society. According to this model, health and sickness are considered states that are vital to the functional prerequisites of a society, hence they cannot be left to chance encounters between the suffering person and the healing agent. Thus, society has devised ways of meeting the contingencies of ill health and, over time, these responses become institutionalized and form part of the social heritage of each member of a given society.

Health care evolves as a package of social role relationship between the sick person and the helping agents; the interaction between them becomes patterned and have predictable regularities. This role reciprocity, however, is a dynamic one because it consists of certain obstructing as well as facilitating factors; for example, the relationship is strained whenever differential perception of roles occurs, as noted earlier.

The doctor, according to Parsons, is the person legally entrusted with ensuring that patients regain their health; this role belongs to the general class of professional roles and highlights the physician's professional orientation and behavior. The physician's role involves: (1) "technical specificity" which, as a professional behavior, requires the application of scientific knowledge to clinical practice; (2) an "affective neutrality" orientation ensures that a distancing mechanism is set up between physician and patient so that the physician does not become the "patient's "colleague in illness;" (3) "functional specificity" in relations with the patient in guiding the physician from the penetration of the private life of the patient beyond therapeutic needs; (4) a "universalistic orientation ensures that all patients are treated alike without regard to position in life; (5) a "collectivity orientation" ensures that serving the interest of the patient is paramount and that patient vulnerability should not be exploited by the physician.

In addition to the role formulated for the physician, Parsons also developed a sick role theory which defines a generalized set of role expectations attendant on illness. The theory states that, in the face of illness, the sick person is technically incompetent to help himself and is emotionally involved because of the shock of illness; the resultant anxiety adds to his inability to do for himself what must be done to get him back to health. Therefore, his illness entitles him to certain rights, but he is required to perform certain duties as well. The rights are that he is to be exempted for his normal role responsibilities, he should not be blamed for becoming sick, and he must have the right to receive care from the other members of society. The duties of the patient are premised on the ground that society regards illness as an undesirable state and,

sometimes, even as a deviance; hence the patient must desire to regain his health, and therefore, he must seek competent help and cooperate with the therapeutic agent so that he may get well quickly.

Other writers have commented on the sick role and the physician's role theories of Parsons. King and Wilson generally reflect the basic ideas contained in the theories with some additional explanations; Wilson (1962), for example, notes that the crux of the relationship between doctor and patient is the directive and educational function of the former. Szasz and Hollander take a different view of the relationship, which, they believe, is strongly influenced by the type of disease that afflicts the patient; three models are suggested: (1) the "activity-passivity" model of interaction which calls for complete passivity on the part of the patient while the necessary activity is carried out by the doctor; (2) the "guidance-cooperation" model is one in which the patient's consent to accept advice and to follow it is necessary; (3) the "mutual participation" model is one in which the patient is able or is required to take care of himself (Freidson, 1970: 316-17).

Another approach to the analysis of the doctor-patient relationship is the structuralist theory by Freidson. He believes that, rather than being symmetrical and reciprocal, the relationship between the doctor and the patient is fraught with the kinds of conflicts which often characterize other human relationships. This is so because of the superordinate position of the doctor which requires the patient to accept what he, the doctor, recommends--and on the doctor's terms; in reality, however, patients often seek services on their own terms as well and attempt to manipulate the situation to their own advantage. What results is often a clash of perspectives and a departure from role expectations.

Furthermore, the patient's behavior in seeking help which is regarded as a response to the long-term socialization that the patient has had in his culture or subculture does not agree totally with Friedson's views. He suggests that the patient's response is conditioned more by the immediate source of reference available to him, that is, the interpersonal networks of the lay referral system. The opinions of these laymen regarding the nature of the illness or complaints and what is to be done about it are crucial to the decision taken by the patient regarding consultation with the doctor; even after the first consultation, subsequent ones are also subject to the opinions of this lay reference group. Thus, the psychological explanation of how the normative values of the larger society are internalized, as suggested by the Parsonian model, is said to be less powerful than the reinforcements to the patient's attitude provided by the lay referral system (Bloom and Wilson, p. 328).

Social Roles of the Patient in Non-Western Societies

The theoretical elements reviewed up to this point develop from the context of, and are relevant to, the modern industrial society. From the beginning, Parsons' formulation of the social system theory starts from the premise that the "case of medicine" is its main illustrative example, and that "medicine is an important subsystem of modern Western society" (Bloom and Wilson, p. 316). In the section that follows, some theoretical views relevant to the doctor-patient relationship in non-Western societies will be presented.

One of the theories that analyze this relationship in modernizing societies is that of Jansen (1973) who has done extensive medical work and study in Africa. While he believes that health is as positively valued in any developing society as in the industrialized ones, he thinks

that the role that a patient plays is interrelated with the patient's perceptions of medicine and medical aid. An indigenous patient sees as competent help that is offered by native practitioners; only through increasing acculturation can Western medical aid become less strange and gradually earn an image of being more competent than traditional methods. Unlike the situation in the West, complementarity of the role of the doctor and the patient in an intercultural setting is never fully realized; what are important and essential to the doctor-patient relationship in non-Western cultures are the prestige of the doctor, mutual confidence, and trust.

Other differences in patient's role orientations that are more commonly found in non-Western nations noted by Jansen are: (1) no individual relationship exists between healer and patient because the diviner's diagnosis is not a confidential report given to the patient alone but to the family as a group; the sick person rarely decides on consultation alone; rather, it is the family which consults the healer on his behalf; (2) the perception and evaluation given symptoms are influenced by the diagnostic healers, the value orientations, the familiarity of the symptoms to the members of the tribe, and the cultural meaning of symptoms; (3) abiding by the doctor's orders breaks down when treatment orders interfere with the patient's own life-style or fail to impress him sufficiently so that no action is taken; thus, the type of treatment and treatment setting must be taken into consideration in a therapeutic relationship.

Another writer who has investigated the doctor-patient relationship in non-Western societies with particular attention to the patient role is Glaser (1970). In his comparative study of medical services organizations in various countries he makes some observations on the roles of patient,

doctor, and other personnel in the hospital setting. The hospital, according to him, is an institutional system within each nation, but since it has achieved its present form in the historical context of the West, it fits more readily into the social system of the industrialized nations. Hence, the clinical performance and other role relationships within it have acquired certain patterned expectations which are reflective of the external social system as a whole. However, when the hospital is transplanted into a different cultural environment such as that found in the less developed societies, certain problems develop, particularly with respect to the patients.

Glaser proceeds to formulate types of patient behavior which often constitute problems for the doctor and an impediment to the therapeutic relationship. One principal problem concerns communication which is often not free-flowing between the parties; this makes rapport difficult. Some patients, for example, lack a conception of precise time; hence they find it difficult to relate events chronologically such as stating age or describing the evolution of symptoms in time sequence; they exhibit a lack of intellectual grasp of technical terms which the doctor may need to explain ideas or to teach them. Status differential also contributed to blockage of the communication system between the doctor and the patient in preindustrial societies. Whereas status differential between the doctor and patient exists in industrialized societies, yet it is not so great as to make the doctor unapproachable. In the developing nations, the masses of the poor and illiterate seldom have the opportunity to communicate with the powerful Westernized elite; when such an elite member as the doctor is, is confronted in a therapeutic situation it may be too

demanding for the patient; this contrasts with the easier access he has to consult a traditional healer.

Patients in Western and developing societies show different degrees of dependency on the doctor. In the former, a patient voluntarily chooses the doctor, actively cooperates in whatever is done to aid his recovery, and is completely dependent on the doctor's judgment because he knows the doctor possesses a medical knowledge that is superior to his own; such dependency, however, is subtle and lasts for as long as the medical need exists; thereafter the patient withdraws completely from the relationship. These role relations and expectations are possible, however, in a society where an understanding and trust of scientific medicine exists, where doctors work disinterestedly and conscientiously and the economic role of the patient is such that he is strongly motivated to work.

In developing societies, where response to illness is often the religious type, many people are accustomed to visiting traditional healers (whom they regard as semi-divine) upon whom they are totally dependent just as they are on the gods they worship. When consulting with a Western-trained physician, the patients attribute to him the same kind of omnipotence ascribed to the healer; they are passive, ask little or no questions, and are totally dependent upon him. Patients are disturbed or alienated when the doctor refuses to act according to type and sometimes when the doctor shows that he is a human being like them, he may not be trusted and his instructions are defied; this sometimes results in premature self-discharge from the hospital

Another reason for patients' distrust of the doctor and his medicine, according to Idowu (1976: 201), is the importance attached to rituals in the administration of medicine to a sick African; such medicine must be consecrated and must receive divine and ancestral blessings before a

patient accepts it with confidence. This is why the medicine prescribed by the doctor is distrusted and sometimes refused even in the face of serious illness; when it is accepted, it is often augmented by traditional remedies. In a study by Lambo (1964: 446), over 60 per cent of the patient population in a large general hospital in Western Nigeria was found to be receiving "native treatment" in one form or another; he suggests that the proportion may even be greater in a psychiatric hospital.

In the face of these pervasive beliefs, doctors trained in Western medicine are known to have advised patients that their case is not fit for treatment in a hospital or that it can be treated only in the "native way," either because these doctors themselves believe genuinely that such treatment actually works, or because they perceive a psychiatric condition which they believe the traditional healer can handle better (Idowu, 1976: 201). Noting how crucial the "factor of faith" is in medical practice among Africans, Idowu (1970: 48) suggests that Western-trained doctors must assume the multiple roles of priest, diviner, psychologist and/or psychiatrist in order to be able to deal more effectively with their patients; this combination of roles, he suggests, is historically the role set often assumed by the healer in Africa.

The Work Setting and Doctor's Attitude

The socialization process experienced by doctors during medical training has been found to provide only a limited explanation of how doctors come to acquire professional identity, interpersonal skills, and values such as affective neutrality and universalism; more recent studies suggest that the behavior and attitudes of doctors are also substantially affected by the structural situation of their work setting, as well as by their membership reference group. For example, a study by Caplowitz

shows that the medical school tends to emphasize technical knowledge and skills more than it does values on interpersonal relations; both the faculty and students tend to evaluate each other more on knowledge and skills than on values.

Another study by Mumford reveals two traditions that have emerged in medical care: academic medicine and every-day medicine in the community. These traditions have implications for the behavior of interns due to the rewards offered by the two traditions: in academic centers, the doctor is rewarded by being given priority in scientific advance, whereas for the doctor in community medicine the esteem received from the local practitioners and patients is the reward he values highly. In the area of doctor-patient relationship, therefore, the doctor in the university is more concerned with how his behavior will be judged by his superiors rather than by patients, whereas the one in the community hospital sees himself much sooner as a "true doctor," tries to learn to get along well with all types of patients and is more sensitive to their feelings (Bloom and Wilson, p. 330).

Writing about practice in the hospital, Freidson (1970) suggests that the hospital atmosphere makes the doctor more visible to his colleagues; one effect of this is that his performance becomes more open to observation and scrutiny than is ever possible in practices in individual offices. The ability to assess the quality of performance leads to some kind of control which is exercised subtle through the supervision of superiors; this is more so in teaching hospitals where superiors maintain supervisory control by systematic review of medical charts to assess the performance of juniors and student doctors.

Susser and Watson (1967) suggest that professionals who work in a

bureaucratic setting are able to act on their own. The hierarchical arrangements found among doctors in hospitals are based on age and experience; thus, any qualified doctor, from houseman at the lowest rank to the most senior consultant in British hospitals, must sometimes act on his own without waiting for consultation with his superiors.

The above picture of the relationship among doctors is somewhat different from that of hospitals in the developing nations, as a study by Glaser (1963) shows. In these hospitals, a clinical hierarchy is clear-cut and the medical superintendent has much power of control over budget, equipment and other resources. Therefore, junior and young doctors often become dependent on their superiors for career advancement since the opportunity for individual practice is limited. Once a young doctor enters the hospital hierarchy, he has more or less made a life-time commitment to practice in the hospital and he adjusts his behavior to fit what is expected of him; he learns to be careful not to jeopardize his career advancement, curbs his sense of autonomy and initiative in expressing opinions that may challenge his patron.

Various studies, including those of Kornhauser (1963) and Wilensky (1965), to name just two, have pointed out the inherent conflicts that arise when professionals work in organizational settings. Scott (1966) identifies some of these conflicts: professional norms which have been internalized by the professionals make them resistant to bureaucratic rules which often come into conflict with their own norms; professional and organizational standards differ; professionals tend to resist bureaucratic supervision and their loyalty to the organization is often tenuous.

A study by Hall (1969) on professionalism and bureaucratization demonstrates an inverse relationship between the two, indicating the con-

flictual values are emphasized by both. Conflicts arising from such opposing values are resolved or resolvable in various ways, as Gouldner (1967) suggests; a professional person who feels that the organization in which he is employed demands his loyalty to the point that his professional goals are jeopardized may re-channel his career orientation toward the employing organization, rather than to his profession if he so chooses, in which case the organization becomes his dominant reference group.

Empirical Studies

Very few studies on medical care and health delivery have been done from the perspective of the doctor. Most of the available studies are from the perspective of the patient; similarly, studies on the doctor-patient relationship are few and mostly non-empirical in approach. Therefore, the review of empirical studies taken here will necessarily be limited.

The first group of studies relates to findings based on certain professional variables. A comparative study of interns by Mumford (1970) shows how training in the university teaching hospital and community hospital differs in shaping the attitudes of doctors. Her findings indicate that the community hospital offers a greater opportunity for the inculcation of social skills in the doctor, helping to make doctors relate more intimately to patients than their colleagues in the teaching hospitals who, because of their exposure to the values of teaching and research are generally more concerned with their standing in the opinion of their teachers than with that of the patients. The community-based intern learns earlier that he is a more authentic doctor to patients than his colleagues in the teaching hospital.

A number of studies suggest certain differences among doctors accord-

ing to their practice as a generalist or specialist. In the same study just cited, Mumford suggests that certain environmental variables of the work setting may sometimes make a surgeon less responsive to a patient's needs than the generalist. King (1962: 186) cites a number of studies which indicate that the longer training of the specialist tends to provide him with values and needs that make him more professionally oriented than a non-specialist (Hughes, 1971). Bucher and Stelling (1961) suggest that the model doctor-patient relationship that pervades the medical profession is that represented by the general practitioner or the family doctor and their patients; specialists treating patients, they continue, develop their own type of relationship, which sets them apart from generalists.

The locations of the medical school and internship have been found to influence the type of practice that a doctor adopts. A study of Puerto Rican doctors by Elinson (1962) shows that those who obtained medical training and did internship in the United States were less willing to serve in the government hospitals than those trained in Puerto Rico or elsewhere.

The second group of studies relates to influences deriving from the organization of the doctor's practice. A study by Goldman (1969: 184) shows that fee-for-service practitioners are more likely to be Republicans and more medically conservative while those in the prepaid group are more sympathetic to a wider insurance coverage plan than solo practitioners. Also, doctors on the faculty of medical schools are more supportive of Medicare than practicing physicians. Doctors in teaching hospitals and practicing physicians are found also to differ in other respects; those in the hospital, in contrast to the practitioners, tend to stress the doctor's part in the doctor-patient relationship. Their emphasis tends to be intellectual; for example, they describe the doctor as competent, respon-

sible and encountering difficulties in treatment. Practitioners, however, refer to patient more often and stress patients' problems, needs, type of illness, and the quality of treatment. They show dissatisfaction when they are unable to develop a personal relationship with the patient (Ort, et al., 1964: 33). Antonovsky (1972: 451) also finds that being salaried is likely to affect the "welcoming" behavior toward patients by doctors, that is, salaried doctors have no economic interest in encouraging revisits. Hence, they may be indifferent to such revisits or lack of revisits.

Mumford (p. 132) finds that physicians based at the university hospital and the community hospital react differently to administrative work and formal communication required by the bureaucratic machinery in the hospital. Those at the university hospital seem to complain less about "ritual," "red tape," or "just work for administrators." A study of a mental hospital reveals that personnel employed in wards where bureaucratic procedures were least required tend to be more negative in their perception of bureaucratic rigidities. However, in wards where the staff members realize they have little individual say in the bureaucratic procedures, there is less complaining about bureaucratic rigidities (p. 132).

The third and last group of studies relates to personal characteristics of doctors. The influence of age has been consistently substantiated in the literature. In a study of diffusion of medical innovation, Coleman and his group (1966) find older doctors to be more conservative toward adopting new drugs. Studying the responses of physicians to a new medical education, Counte and Kimberley (1974) find that age is negatively related to initial reception of the program. The length of time since medical training was obtained is found to affect the amount of emphasis placed on preventive care for chronically sick adults (Coe and Brehm,

1972). Older doctors are also more likely to use more traditional methods of therapy.

Some studies show that differences in the social class background of doctors result in their differential perception of, and interaction with, patients (King, p. 218). In a longitudinal study of a class of medical students, it was found that middle- and lower-class students are more likely to consider factors such as race, religion, and social class as important considerations in relating to a patient as a person; whereas those from an upper-class background do not consider such factors as important (Fredericks and Mundy, 1976: 143). In a study of the social origins of ideology of physicians, Colombotos (1969) finds that doctors from the lower-class tend to emphasize the values of success such as prestige and money more than those from an upper-class background.

Religion, as one of the early sources of socialization, has been found to influence behavior and attitudes in adult life. Empirical studies have demonstrated differences in attitudinal and behavioral mobility. In Colomboto's study cited earlier, differences are found among Jewish, Catholic and Protestant doctors in the stress they place on success values and liberalism towards government participation in medical care and other welfare issues (p. 25; also p. 18, footnote 8).

Place of rearing, that is, primary place of residence while growing up to the age of eighteen, has been found to affect a doctor's participation in rural preceptorship programs. Doctors who have been reared in a rural environment and have participated in the programs are found to be more likely to locate in rural practice than other doctors (Lewis, 1976: 70).

Although Wilson's study (1959) of the aspirations of high school boys is not concerned with high school education of doctors-to-be, yet it

is considered pertinent for the present study. His study illustrates that the influence of the school is not limited to contributing to the fulfillment of the educational aspiration of students; in a very important way, the prevailing climate of opinion in the school provides a significant influence on the decision to go to college, and on the operational aspirations as well as the political preferences he makes in later life.

Ideal Types

The review presented in this chapter has sought to present the relationship between the doctor and the patient as an open system which is influenced by external factors from the larger, dominant sociocultural environment; the factors considered include: the patterned expectations which guide the interactions between them, the beliefs and values relating to health and disease shared by each, the techniques of medical care delivery and how it is organized.

The doctor's role and the patient (sick) role models, principally Parsonian in type, have been criticized on a number of grounds: (1) the roles are appropriate to the classical dyadic doctor-patient relationship but not to the current modal type of African or non-Western practice which is the doctor group; (2) they are Western-oriented, hence cannot describe the relationship between the doctor and the patient in non-Western societies; (3) the requirements that a patient's illness should be characterized by a rapid cycle of attack and recovery is unrealistic in a situation where "the shift in causes of deaths have been from mostly acute, communicable diseases to chronic diseases," which correctly describes most of Western societies, and (4) the role of the doctor which requires "technical specificity," "universalistic orientation," "affective neutrality," "functional specificity" and a "collectivity orientation" actually

militate against a cordial relationship since they are likely to foster distrust on the part of the patient if the doctor adheres strictly to it.

Important though these criticisms may be, the utility of the theories cannot be denied as some writers, including the critics, acknowledge. Although group medical practice predominates in the current health delivery practices, at each stage of consultation, diagnosis, or treatment, the doctor and the patient must confront each other face-to-face, regardless of the fact that the patient may be able to go into the adjacent room to see another doctor if the first doctor so recommends; in other words, the dyadic relationship is still an integral part of group practice.

The requirements that the doctor should be technically competent, affectively neutral, universalistic, and functionally specific are also seen as important to the relationship (Berlant, 1975; Bloom and Wilson, 1972). It is obvious that to play his role as a scientific healer, the doctor must be competent in medical knowledge and technique; to be neutral affectively protects him from the danger of countertransference which may becloud his sense of judgment, hence the doctor can be understanding and empathize but not become sympathetic or over-involved with the patient. The universalistic orientation demands that he treats all patients alike, regardless of their social and economic standing, though it obviously does not mean that he should give identical therapies to each patient.

The importance of the Parsonian model (or that of any other sociologist on the doctor-patient relationship) is that the prescriptions given suggest a normative and ethical analysis of what the relationship of the medical profession to patients should be and that the pursuance of such rules would eventually bring about the best possible results if adhered to (Berlant, p. 17). Parsons himself does not claim that all doctors live up

to this role and its expectations, nor that the expectations will always be functional but that they are necessary. In essence, therefore, the role is an ideal-type.

Similarly, Glaser's (1970) formulations, as well as those who have written on the role of the patient in the developing nations, are ideal types. Glaser's prescriptions, which are essentially Parsonian, often contrasts the ideal role performances of the doctor and the patient in industrialized societies with their respective roles in developing nations. Since the degree of acculturation of Western medical beliefs and technology differs among these nations and indeed among urban/rural areas within each nation, some aspects of the role he describes will be differentially applicable to each nation and its component areas, depending on the degree and duration of contact with the West that the country has had.

Thus, the roles of the doctor and the patient described by the various writers just reviewed must be viewed as ideal types of such roles as found in industrialized as well as in industrializing societies. This theoretical base allows a conception of two types of patient role (Western/modern and non-Western/traditional) and one of the doctor--Western/modern. These will be further developed in the next chapter.

CHAPTER III

METHODOLOGY

The object of analysis in this study is the individual doctor practicing either in the general or teaching hospital. The relationship between doctor and patient constitutes the dependent variable; this will be described in order to have a better understanding of the concept. Also, the personal, professional, and organizational characteristics--making up the independent variables--which are likely to be associated with the attitude and behavior of doctors to patients will be described. In this chapter also the method of data collection and the mode of analysis will be described.

Description of Variables

Dependent Variable

The doctor-patient relationship is actually a multidimensional concept which can best be understood as consisting of the interactional consequences of two sets of roles: one reciprocal and one non-reciprocal. The roles to be considered are three: the role of the doctor in the relationship, the role of the "modern" patient, and the role of the "traditional" patient.

The Doctor's Role.--This refers to the set of ideal role attributes and functions of the doctor in his interaction with the patient in a therapeutic situation. These obligations/expectations are:

- a. Technical specificity: the skill and knowledge possessed by the doctor for effective patient management/treatment.

- b. Affective neutrality: the application of skills to the problems of patient without personally getting involved.
- c. Functional specificity: an orientation that guides the physician from the penetration of the private life of the patient beyond therapeutic needs.
- d. Universalism: the extent to which the doctor treats his patients equally without regard to their social and economic conditions.
- e. Collectivity orientation: the extent to which the doctor is disposed to place the interests of patients above his own.

"Western" or "modern" patient's role.--This represents a set of ideal characteristics which are typical of patients in Western societies as perceived by doctors (and patients). The characteristic attitudes and behavior of such patients, as theoretically derived, are:

General technical understanding:

- a. The patient is reasonably able to recognize and interpret physical symptoms.
- b. The patient has a fairly good knowledge of anatomical and physiological concepts, facilitating his communication with the doctor.

General definition of the sick role:

- a. The patient is responsible for seeking help and deliberately strives to get well in order that he may return to his regular social roles.
- b. The patient recognizes himself as a free agent who can choose or terminate the doctor and his treatment at any time.
- c. The patient recognizes symptoms of disease early and seeks care at an early stage.

Patient's role in interaction with the doctor:

- a. He is dependent on the doctor on a freely chosen, calculated but limited basis.
- b. The patient presents an accurate description of his illness.
- c. He is willing to yield to physical examinations.
- d. He is highly aware of time measurements and is able to keep medical appointments and give himself medications as prescribed.
- e. He follows the doctor's orders and regimen.

"Traditional" patient's role.--This is the role assumed by the patient in interaction with the traditional healer and carried over by him into the therapeutic situation while consulting with a Western-trained doctor; this role includes certain attitudes and behavior of the patient:

General technical understanding:

- a. Knowledge of disease, its cause, and remedies are based on folk concepts, not on scientific evidence.
- b. The patient's perception and evaluation of symptoms are based on supernatural interpretation.

General definition of the sick role:

- a. The patient rarely decides on consultation alone, for his illness is a family affair; his family members make decisions on his behalf.
- b. The patient often recognizes symptoms of a serious illness late, having consulted the traditional healers first; hence,
- c. Patient's recovery from serious illness is rare since valuable time has been wasted in consulting healers offering ineffective treatment.

Interaction with the traditional healer:

- a. The patient's trust in the traditional healer is often total and uncritical.
- b. The patient is often completely dependent on the healer who is seen as semi-divine; he is passive and uncritical in interaction with the healer.

Independent Variables

These are the personal and professional characteristics of each doctor. The personal characteristics which have been hypothesized to differentiate among the doctors in their orientations to patients are:

1. Age: doctors who have indicated their age as 44 or under are classified as "young," while those who are 45 and over are "old."
2. Father's occupation: is divided into four types : (a) administrative and managerial, (b) professional, including secondary school teachers, (c) skilled craftsmen, tradesmen, foremen, etc., and (d) farmers and traders. These occupational divisions have been used in a previous study on Africa by Engmann (1972) and are similar to occupational gradings in Nigeria. The first two divisions have been groups as "high" occupational status, the last two as "low."
3. Community of origin is the place where the doctor is reared; it is defined as "large" if the population is over 10,000 and "small" if under that figure.
4. Early education is the type of school attended which may be Christian mission, Islamic, or government.
5. Religion of the doctors is distinguished as Christian, Moslem, or animist.

6. Traditional cultural orientation is the doctor's knowledge of indigenous medical practices.

The professional characteristics of the doctors include:

1. The location of training refers to the premedical, medical and internship training having taken place either in Nigeria or overseas.

2. Field of practice refers to whether the doctor is a specialist or generalist.

3. Professionalism refers to a collection of personal values and behavior that are characteristic of professionals such as a sense of autonomy, participation in professional organizations, reading professional journals, the use of the professional organization as reference group, etc.

Finally, the organizational characteristic of the doctors are:

1. The present work setting is the place the doctors work full-time, either in a general hospital or in a teaching hospital.

2. The doctor's orientation to the bureaucratic atmosphere of this setting. Bureaucratic atmosphere is concerned with the need to coordinate work activities and maximize results, the organization is structured into a hierarchy of authority with rules and procedural specifications. The attitudes and behavior of doctors relating to these dimensions of bureaucracy are measured by appropriate questions to elicit information relating to the controls specified by these dimensions.

Hypotheses to be Tested

Personal characteristics

1. Age: More older doctors will be strongly oriented to the doctor, modern patient, and traditional patient roles than younger doctors.

2. Father's occupation: More physicians of high paternal occupations will be strongly oriented to the doctor and modern patient roles, while more of those with lower paternal occupations will strongly be oriented to the traditional patient role.

3. Community of origin: More physicians who grew up in large communities will be strongly oriented to doctor and modern patient roles, while more of those who grew up in small rural communities will be strongly oriented to the traditional patient role.

4. Early education: More doctors who attended Christian mission schools will be strongly oriented to the doctor and modern patient roles, while more of the attenders of non-mission schools will be strongly oriented to the traditional patient role.

5. Religion: More of the doctors from Christian background will be found among those strongly oriented to the doctor and modern patient roles, while those from non-Christian background will be found in larger number among those who are strongly oriented to the traditional patient role.

6. Traditional cultural orientation: More physicians with strong orientation to indigenous healing culture will be strongly oriented to the traditional patient role, while more of those who are weakly oriented to this culture will strongly be oriented to the doctor and modern patient roles.

Professional Characteristics

7. Location of training: More of the doctors who had their pre-medical, medical, and internship training overseas will be strongly oriented to the doctor and modern patient roles, while more of those similarly trained in Nigeria will be strongly oriented to the tradi-

tional patient roles.

8. Field of practice: More doctors who are specialists will be strongly oriented to the doctor and modern patient roles, while more generalists will be strongly oriented to the traditional patient's role

9. Professionalism: More doctors with strong professional orientation will be strongly oriented to the doctor role, while more of those with a weak professional orientation will be strongly oriented to the modern patient and traditional patient role.

Organizational Characteristics

10. Bureaucratization: More doctors with strong bureaucratic orientation will be weakly oriented to the doctor, modern patient, and the traditional patient roles, while more of those with weak bureaucratic orientation will be strongly oriented to these roles.

11. The work setting: More physicians practicing in the teaching hospital will be strongly oriented to the doctor and modern patient roles, while more of those in general hospital practice will be strongly oriented to the traditional patient role.

The Data

Data Collection

In this study, data were collected between August and October, 1977 on the orientations of doctors to their own roles and those of their patients. The selection of respondents for the study was based on the requirements that they be Nigerians and active doctors having direct contact with patients in and around Lagos.

Initially, the sample of doctors was to have been drawn from the Medical and Dental Register Published annually by the Nigerian Medical Council, selecting only those whose addresses were in Lagos; but the plan

was dropped because it was found that the register was not up-to-date in spite of the fact that the latest edition, dated January 1, 1977, was consulted. It was discovered that 32 of the 40 doctors who had listed their addresses in Lagos general hospitals could not be traced because many of them had left the hospitals and gone to other states or overseas.

This being so, a new strategy to locate the doctors was devised, based on the fact that over 90 per cent of the addresses listed in the register were in hospitals all over the country. The names of doctors currently working in Lagos hospitals were obtained from the hospital secretaries; in doing this, however, this researcher had to obtain permission from each level of the health series hierarchy: first, the Commissioner of Health for Lagos State; then, the Chief Consultants, the Consultants in various departments; and, finally, the hospital secretary who prepared the lists. Less rigidity in procedure was found at the teaching hospital, where the Provost instructed the Chief Secretary to inform the various department heads of my intention to collect survey data from the doctors in these departments.

In all, 260 names were obtained, of whom 78 were expatriates (British, Americans, Western and Eastern Europeans, Russians, Indians, Cubans, Filipinos, etc.); these were eliminated from the list. Questionnaires were to have been sent to all the remaining 182 doctors, but there were not enough questionnaires to do that since I was able to carry only 150 with me from the United States. (To make Xerox copies of the sixteen-page questionnaires would have cost the equivalent of \$6.12 per copy in Nigerian currency or \$183.60 for thirty copies.) Therefore, a random sample was drawn, first, by selecting every second name on the lists, then by selecting again every second name from the remaining names after the

first set of names had been removed from the original lists. Thus, 136 practicing physicians were finally obtained.

To get an official letter requesting cooperation of the subjects presented some problems of its own. Before leaving the United States, the writer had sent a letter to the then president of the Nigerian Medical Association; on arrival there, it was learned that he had gone overseas for a conference. However, the Chairman of the Health Council of one of the states, a physician, consented to provide the needed introductory letter; this was attached to all the questionnaires sent out. At a later stage in the data gathering process, more was learned about a newly created national agency called the Basic Health Services Scheme Implementation Agency, headed by one of the professors in the college of medicine at the teaching hospital. The director of this agency agreed to write a letter which was used as a reminder and it proved to be very helpful, since the last quarter of all the returned questionnaires came after it was sent out (see Appendix B for copies).

About the time of arrival in Nigeria, there were widespread reports that some mailmen, protesting overwork and inadequate wages, were dumping letters into streams or burying them in holes rather than going through the trouble of delivering them to their addresses. It became apparent, therefore, that letters having box numbers would be less likely to be tampered with since they would not have to be carried any distance. Therefore, distribution of the questionnaires was made by hand, sometimes giving them directly to the doctors or putting them in their mail boxes (permission having been obtained first from the mail room directors in the hospitals).

Each questionnaire was enclosed in a sealed envelope with a stamped self-addressed envelope, plus a sharpened pencil. A relative consented

to the use of his post office box number on the return envelopes. In all, 95 questionnaires were returned, representing 70 per cent return rate; all were from doctors working full-time in hospitals.

In addition to providing their questionnaire responses, some doctors were interviewed informally. These included a consultant, two senior medical officers, a colonel in the army (who had had many years of prior experience in civilian government hospitals and was also a member of the Medical Council), and two younger doctors.

It was the intention of the researcher to include doctors who were on full-time private practice in the study. However, ascertaining the number and addresses of such doctors was not possible; although the medical register listed a few private addresses, it was discovered that many of these doctors were in fact fully employed by the hospitals, perhaps having used their home addresses at the time they applied for registration. Hence, it was difficult to estimate the number of private practitioners totally independent of a government job. (One doctor told the researcher that there were perhaps 50 doctors in full-time private practice, but many of these were expatriates mostly treating other expatriates and other highly placed Nigerians.) Only one hospital owned by a Nigerian doctor was found in Lagos; others operated what amounted to no more than a clinic, and even then the doctors operating these were in fact government doctors doing extra work after their official hours.

The exact number of doctors in Lagos is difficult to determine because no up-to-date and reliable source was available. The latest record (Federal Office of Statistics, 1972) put the number at 168 in 1972. Given the fact that the doctors tended to relocate frequently or pursued further studies overseas, it is likely that 260 names on the

lists received might be close to the actual number of doctors in the city at the time of the survey.

The Respondents

Several doctors showed considerable enthusiasm about the project; some said that it was the first kind of questionnaire that really "challenged" them as to how much they knew and that it made them "think"; others, however, complained that the questionnaire was too long but filled it any way. Table 1 summarizes the descriptive characteristics of the active and practicing Nigerian physicians in Lagos who furnished the data used in this study.

The doctors were mostly males and young, 77 per cent being under 45. The family background revealed that 62 per cent had fathers in management and professional occupations; this is consonant with the general tendency to find more professional people from affluent backgrounds than from poorer people. Over four-fifths (81 per cent) of the doctors were Christians, a reflection of the general tendency to find the more educated and professional among this religious group in the country as a whole; three-fourths of the respondents attended mission schools for their primary-level educations.

Premedical and internship training were obtained mostly in Nigeria, but medical training was almost equally obtained in the country and overseas. This shows a reversal of the trend of fifteen or more years ago when medical training was done mainly overseas; the creation of five medical schools during the last two decades has facilitated the training of more doctors in the country than ever before. It is noteworthy that most of the younger doctors trained locally, while the older ones trained overseas.

TABLE 1

GENERAL CHARACTERISTICS OF PHYSICIAN RESPONDENTS

Characteristics		Percentage N = 95
Sex		
	Male	84%
	Female	16
Age		
	Under 45	77
	45 and Over	23
Occupation of Father		
	Managerial and Professional	62
	Skilled, unskilled, manual	38
Religion		
	Christian	81
	Muslim	19
Early Education		
	Mission	76
	Islamic and Government	24
Premedical Education		
	Nigeria	83
	United Kingdom	8
	United States	4
	Continental Europe and U.S.S.R.	5
Medical Education		
	Nigeria	54
	United Kingdom	32
	United States	6
	Continental Europe and U.S.S.R.	8
Intership		
	Nigeria	60
	United Kingdom	32
	United States	6
	Continental Europe	2
Main Field of Practice		
	Specialist	75
	Generalist	25
Type of Practice		
	General Hospitals	62
	Teaching Hospital	38

The main field of practice of 75 per cent of the respondents was as specialist, with over half of them in surgery and internal medicine; this large proportion of specialists is indicative of the world-wide tendency toward specialization. All the doctors were full-time employees of the government, whether in general hospitals or the university teaching hospital

Design for Analyzing the Data

The analysis of the collected data was done in two stages: the first stage was concerned with a description of patients' attitudes and behavior as perceived by the doctors; the second stage sought to determine the factors which differentiated one kind of doctor from another in his orientations to the patients; this was done by screening the data statistically by cross classification and the use of chi square and gamma.

Chi square is a test of statistical significance which helps to determine whether a systematic relationship exists between two variables --in this case, characteristics of the doctors (independent variables) and their orientations to the doctor-patient relationship (the dependent variables). Since the number of cases studied was small, cross classification was mostly by two-by-two tables in order to allow for a sufficient number of cases in each cell; also, the smallness of the sample means that the expected frequencies in the cells are likely to be smaller than conventionally allowed; hence Yates' correction was done to adjust the value of chi-square.

Although chi-square is useful in deciding whether or not variables are related, it does not estimate the strength of such association when there is one. Hence the statistic gamma was employed to indicate how strongly the dependent and independent variables in this study were

related. Gamma, an ordinal measure of association, estimates the percentage improvement in predicting the dependent variable from knowledge of the independent variable; in this present study, gamma estimated the percentage improvement in predicting the doctors' orientations from knowledge of their personal, professional, and organizational characteristics.

Important and useful as chi square and gamma are for analyzing survey data, they do not necessarily provide sufficient evidence for determining how substantively important an observation is. In a study of doctor's perception of medical care, Berkanovic *et al.* (1974: 14) observed that, in addition to the use of chi square and gamma in screening survey data, one must also examine the larger patterns of findings obtained. An isolated finding, according to them, may be statistically significant and have a sizable gamma, but if it is not part of a larger pattern of empirically consistent findings, it should not be relied upon. On the other hand, some observations may not have statistical significance with gamma values only modest at best, yet this does not mean that they should be automatically rejected; it is necessary to consider their implications, especially if they fit into a consistent pattern.

In the present study, therefore, the data to be presented in Chapter 5 take account both of technical, statistical results as well as substantive patterns of relationships. There are instances in which the findings have been interpreted even when chi square values are insignificant but the gamma substantial, as when such findings reveal a consistent pattern. Conversely, a few of the findings have been interpreted even when the gamma values were insubstantial but chi square significant, for similar reasons. Also the exploratory nature of the study and the fact

that no similar study of its type has been done appear to make it important to present the data as done so that a base for comparison can be created for future studies.

CHAPTER IV

PHYSICIANS' PERCEPTIONS OF PATIENT ROLES AND CULTURAL ASPECTS OF INDIGENOUS HEALING

The general picture of patients, which will be presented in the first part of the chapter, has been constructed from the information provided by the doctors. This information was based on the frequency of their observations of ideal typical attitudes and behaviors of patients, defined earlier as either modern (Western) or traditional; the doctor's reactions (e.g., whether certain patient's attitude or behavior is considered an obstacle or help to treatment) are not considered here, hence, no attempt is made to relate their observations to their background characteristics—that will be done in the next chapter.

The second part of this chapter will describe the doctor's own orientation to indigenous medical beliefs, values, and the traditional healers insofar as these relate to health and disease and as they influence the patients role behaviors and expectations in interaction with the doctor. As Saunders (1954: 8) has observed, "the probability of a mutually satisfactory outcome may be increased if those in the healing roles know something of their own culture and that of the patient. The responses of doctors to items dealing with cultural aspect of indigenous healing constitute their orientation to indigenous culture and is also one of the background characteristics described in the following chapters.

A description of indices of doctors' orientations will be given in the third part of this chapter; this is because the orientations are defined in terms of the reactions of the doctors to the attitudes and behaviors of the two (modern and traditional) patient types which form the major presentation in this chapter. The doctors' reactions are their responses to items tapping their attitudes and behaviors toward the behaviors and attitudes of the two patient types. Also to be included in the description are indices of their (doctors') orientations to their own role and doctor-patient role relationship.

The ideal typical attitudes and behaviors of patients, as perceived by the doctors, will be examined within the framework of Parsons' sick-role which includes the technical knowledge of the patient, symptoms recognition, search for medical help, motivation to get well, and cooperation with the doctor.

Technical Knowledge

Suchman (1965: 114-28) suggests that the first stage in the sick-role cycle begins when a person becomes aware of the symptoms of his disease. However, the perception and interpretation of what these symptoms are and what should be done are different among individuals and peoples living in different cultures. Studies of non-Western societies have shown that this cognitive aspect of symptoms' experience is distinct from that of Western views (Glaser, 1970; Jansen, 1973); the cognition of symptoms' experience for the former is largely based on folk beliefs, while the latter is based primarily on scientific interpretation.

The doctors were asked the frequency of their contacts with patients who could recognize and interpret physical symptoms based on at least some

scientific knowledge. As shown in Table 2, only a fifth (20 per cent) of them reported seeing such patients daily and weekly; about two-thirds (65 per cent) saw such patients monthly, and the rest (15 per cent) never had such patients at all. Thus, for the majority of the doctors, encounters with patients exhibiting a modern view of disease symptoms recognition were limited. When asked about patients who attributed causes and remedies for diseases to supernatural influences, about a fifth of the doctors indicated that such a view characterized "all" their patients, about a quarter (23 per cent) said it described "most" of their patients, while the rest said "some" of their patients shared this view. Perhaps this generally unscientific conception of illness held by patients explains why about a third (35 per cent) of the doctors reported that they encountered difficulties in the "frequent" occurrence of inaccurate descriptions of symptoms by patients, while the rest reported such problems occurred "occasionally."

These findings may not be surprising when it is realized that most of the patients were described by the vast majority (85 per cent) of the doctors as "illiterates or semi-literates." The findings also have parallels in other studies, such as Koos' (1954) which showed that people from the lower educational, occupational, and income levels tended to have a poor knowledge of disease symptoms as well as improper attitudes toward health care.

Seeking Medical Help

Once the initial recognition of illness symptoms is made, either by the sick person or by someone else, the sick person is obligated to seek technical competent help. In Western societies, this means that the sick person not only seeks help without further delay, but such help is to be obtained from a scientifically trained physician. To find out if

TABLE 2

DOCTORS' PERCEPTIONS OF PATIENTS' SICK ROLE BEHAVIORS

Patients' Behaviors	Per Cent of Doctors Responding				Total
	N = 95				
	Daily/ Weekly	Monthly	Never	No Response	
Patients (A)					
Could Recognize and Interpret Physical Symptoms of Disease	20%	65%	15%	--	100%
Visited Doctor After Indigenous Treatment Failed	43	50	7	--	100
Displayed Sense of Individualism	10	64	26	--	100
Showed No Active Interest to Get Well	3	72	22	3	100
Showed Maximal Dependency on Doctor	15	83	--	--	100
Showed Minimal Dependency on Doctor	51	49	--	--	100
Requested Particular Drugs or Injections	42	48	10	--	100
(B)					
	Per Cent of Doctors Responding				Total
	N = 95				
	Always and Frequently	Occasion- ally	Never	No Response	
Visited Doctor at Early Stage of Illness	14	85	--	1	100
Could Tell His Age	10	85	--	5	100
Unable to Remember Onset of Disease	38	59	3	--	100
Unable to Recall Childhood Diseases	21	73	4	2	100
Could Stick to Medical Regimen	23	74	--	3	100
Reluctant to Disrobe for Physical Examination					
Male Doctors	1	69	30	--	100
Female Doctors	19	44	37	--	100

TABLE 2

(continued)

(C)	Per Cent of Doctors Responding					Total
	All Patients	Most Patients	Some Patients	No Patients	No Response	
Attributed Causes of Diseases to Supernatural Powers	20%	23%	57%	--	--	100%
Attributed Omnipotent Magical Powers to the Doctor	--	43	54	--	3	100

patients seen by doctors had such orientations, they were asked how often they had patients who, having recognized symptoms of disease, came to the (modern) doctor as soon as possible. Only about 14 per cent (Table 2, section B) reported "always and frequently" seeing patients with such a modern orientation; the great majority (85 per cent) saw such patients "occasionally." Thus, only a few of the patients, as observed by the doctors, complied with the modern, Western ideal of going to the doctor at an early stage of illness.

Cultural factors may also prove to be a limiting influence on early search for help since in many cases the tendency of patients will be to consult with the indigenous traditional healers. The doctors were asked whether they had patients who had come to them after indigenous healing had failed. Almost half or 43 per cent of them replied that they had such patients "almost daily" and "almost weekly," while slightly more (50 per cent) reported having them "almost every month" and only 7 per cent "rarely" or "not at all" (Table 2, section A).

Some doctors offered explanations for this fairly common finding in patients' delay in coming to see them. One of them said flatly, "Nigerians do not go to the hospital until they are moribund." Many physicians pointed out that patients would first see the indigenous herbalists and faith healers, or try "their own medicines or those advised by friends." The importance of druggists in serving as the first contact point in the search for help was highlighted in the replies of some doctors; one said that "the average Nigerian visits the chemists first for any sign of disease due to lack of health education;" another said, "most come after they have tried all the chemists in town;" yet a few others mentioned self-medication by patients who would first use drugs bought from chemists

and street hawkers of medicine. This observation is given credence by the laxity in the control of prescription drugs; such drugs are easily bought in drug and provision stores without prescriptions. Expired drugs get into the hands of quacks and street vendors who dispense and sell them at give-away prices (Daily Times, Nigeria, September 19, 1977). Thus, the tendency for self-medication is encouraged by the easy availability of drugs; this also leads to much abuse and misuse which are common occurrences; certain antibiotics, especially the tetracyclines, have become cure-alls for all kinds of diseases and are as readily available in the stores as they are on the streets (Sunday Chronicle, Nigeria, May 15, 1977).

The result of all this is further delay to get to competent help, especially in diseases with insidious courses of history; one of the doctors mentioned that tuberculous patients often come in at advanced stages of their illness, while another mentioned advanced cases of cancer of the breast and acute abdominal conditions.

These results are consistent with other studies which have found that delay in seeking help from the modern doctor is a serious problem in many developing nations, particularly in diseases that are curable if only they have been correctly diagnosed and treated at an early stage. The findings also explain that what is often regarded as "competent help" is culture-bound. For many of the patients the traditional healer is such an "expert" helper. For those who have been somewhat acculturated, the chemist or druggist is such a helper who, in any case, is likely to be more accessible than the doctor. Many pharmacists are known to practice medicine of sorts since they often diagnose ills and prescribe the drugs that they sell to customer-patients (Nigerian Chronicle, November 5, 1976).

Individualism

One of the aspects of the social role of the patient as it relates to seeking of competent help is that such search is an individualistic responsibility of the sick person, to choose which doctor will treat him and to retain the right to continue or terminate the services of such a doctor. Less than a tenth of the doctors (Table 2, section A) reported finding "daily" or "weekly" patients with such an individualistic orientation, while 64 per cent found such "monthly" patients; and about a third (30 per cent) had "never" seen such patients. Thus, the predominant view of the doctors was that individualism was not a common attribute among the patients. A number of the doctors reported that patients often came to the clinic in the company of relatives, particularly the elders; some also mentioned the possibility that unfamiliarity with procedures to be followed in seeing the doctor or the fear of what to expect in the hospital might be the reason that patients frequently came to the clinic or hospital with an entourage of relatives. In most cases patients are assigned by medical clerks or nurses to see a particular doctor, eliminating the possibility of displaying freedom of choice.

The experience of Jansen (p. 63) among the Bomvana in South Africa showed that the decision to choose a doctor was usually made for the patient who first had to communicate with his family; the family would "decide" the type of disease, that is, whether it was inflicted through witchcraft or other causes, and only then would a decision be made to see either a herbalist or a diviner. Zola (1968) also found a phenomenon which he called "sanctioning" in his study of Irish, Italian, and Anglo-Saxons in an out-patient department in Massachusetts. Among the Irish, he found that the responsibility to seek aid was assumed by someone else, such as wife or

husband, rather than the patient himself. Among the Anglo-Saxons, on the other hand, most such decisions were made by the individual, having discovered that the symptoms he was experiencing in some way intererred with his work or physical functioning.

Cooperation with the Doctor

One other expected aspect of sick role behavior is that the patient should show an active interest in a quick recovery from his illness. An index of such desire is how actively the patient cooperates with the doctor in the diagnostic process as well as in activities relating to medical regimens. The doctors were asked to describe how patients fared in the ability to handle time-oriented information necessary for diagnosis, a problem said to be encountered often by doctors in non-Western societies (Glaser, 1970). About a tenth of the doctors said that they "frequently" had patients who could not state their age, while 85 per cent had such patients occasionally (Table 2, section B). It can be concluded, therefore, that many patients had little problem in knowing their age. Considering the earlier observation that most of them were illiterate, this might be an unexpected finding. However, the fact that Lagos was the first and, for a long time, the only city in the country where birth registration was available could be a partial explanation.

The doctors were also asked how often they had patients who were "unable to remember the onset of their illness;" almost two-fifths (38 per cent) reported that this was a frequent occurrence, while over half (59 per cent) said they occasionally had such patients, and 3 per cent reported that their patients never presented any difficulty in this respect (Table 2, section B). A similar diagnosis-related question was asked about patients' inability to recall childhood illnesses and diseases.

Over a fifth (21 per cent) of the doctors reported that they frequently had such patients; 73 per cent had such patients occasionally, and only 4 per cent had no patients with such difficulty.

In either of the replies to these two questions, therefore, only very small proportions of the doctors (3 and 4 per cent, respectively) had patients who could remember their childhood history of illness; the rest of the doctors frequently or occasionally encountered patient forgetfulness in their practice. Jansen's study (1973) reveals a similar situation in which previous illnesses and treatments of the Bomvana patients in South Africa could not be reviewed because of this handicap of forgetting earlier illness on the part of patients. One writer, Gelfand (1957, cited in Jansen), has suggested that African patients generally do not consider previous illnesses to be of any significance; this view, however, is shared by Jansen, who suggests that perhaps their previous illnesses are not perceived as a significant event in their history as they are for European patients. For example, an admission to the hospital tends to accentuate the importance of a certain illness, making it likely to become a sort of milestone in the life history of a patient; but many of the patients seen in the less industrialized nations have never been hospitalized. Some of the doctors interviewed for this study admitted that many of the patients they saw were in the outpatient department, and that patients generally feared being hospitalized. Furthermore, the limited number of hospital beds in the country (one bed per 1,700 population in 1972) keeps down the number of patients who have undergone the hospitalization experience.

Compliance with Medical Orders

One other index of cooperation is the extent to which patients obey doctors orders, especially in the area of medical regimens. Asked whether

or not their patients were cooperative in this respect, over a fifth (23 per cent) felt that patients were frequently cooperative; while the vast majority, over three-quarters (74 per cent), noted that they occasionally had patients who were able to use medications as ordered. On another related question, a similarly large proportion of doctors (77 per cent) observed that they frequently encountered cases in which the patients were unable to use medication as ordered, while 22 per cent experienced such a problem only occasionally (Table 2, section B).

From these responses, we conclude that doctors felt that their patients generally did not use medications as prescribed. Several doctors pointed out that patients often stopped taking drugs prescribed as soon as their symptoms were relieved. Blum (1960: 117) thought that factors such as the cultural, class, and the immediate situation could be responsible for uncooperativeness by patients. No doubt, some of these factors might have been responsible for this type of uncooperativeness on the part of the patients seen by these doctors. Studies of compliance in drug use done on Africa (Bell, 1961; Gordon, 1961), as reported by Jansen (p. 150), indicated problems in adhering to medical regimen among patients, including instances of suddenly stopping medical treatment. A study by Stott (1959) on a tuberculosis project in Kenya found that only a quarter to a third of the patients were taking their TB drugs regularly.

Motivation to Get Well

Cooperativeness with the therapeutic agent, as the sick role concept suggests, is to be combined with the motivation to get well by the patient. In this regard, only 3 per cent of the doctors reported daily and weekly seeing patients who did not show that they were interested in getting well; the majority (72 per cent) saw such patients only monthly; while 22 per

cent never had such patients (that is, their patients desired to get well). (Table 2, section A) Thus, not wanting to get well from sickness was characteristic of only a minority of the patients seen by these doctors. This finding, therefore, corroborates that of Jansen (1970), who reported that health was highly valued by the Bomvana Africans and that patients showed a strong desire to get well. Glaser (1970) noted that in some developing countries many hospitalized beggars had reasons to want to get into the hospital and for the same reasons to resist cures and discharge from the hospital. It is impossible to say what type of patient 3 per cent of the doctors reported as lacking in motivation to get well since they were not asked such a question. It can be guessed, however, on the basis of the lower status of many of the patients seen generally, that perhaps a few of these patients could be true indigents who might count themselves "lucky" to be hospitalized. It may be pointed out in this connection that being poor does not preclude one from getting medical care in the country, since care is free for anyone under eighteen, and only nominal fees (or none for those who cannot afford them) are charged adult patients.

Dependency

In the sick role, the capacity of an individual to do things for himself becomes limited, thus he becomes dependent upon others; the more severe the illness, the greater the dependency. In a Western patient role, this dependency on the doctor is expected to be limited and subtle and is terminated as soon as there is no longer a medical need for the doctor. Asked about patients who showed such minimal dependency, half (51 per cent) of the doctors reported that they had such patients almost daily or weekly, while the rest of them (49 per cent) said they had such patients about every month. For patients generally described by these doctors as "illiterate" or

"semi-literate" to display this modern type of minimum dependency on the doctor is unexpected in view of prior findings.

This response was corroborated by the doctors' answer to another question relating to patients maximal dependency: only 15 per cent of them reported that they had seen patients "daily or "weekly" who were very dependent, while 83 per cent found such patient almost every month (Table 2, section A); thus, only a few of the patients were seen as very dependent. The view has been expressed by Glaser (1970) and others that the behaviors of patients in developing societies while in consultation with modern doctors are influenced by their prior experience with the indigenous healers where the interaction between the two is the activity-passivity type of relationship described by Szasz and Hollender (1959).

The findings in this study, however, do not support that view; perhaps such views may more aptly describe a society only beginning to have contacts with modern medicine. For Lagos patients seen by doctors, it appears that the many decades of experience with the modern doctor have made him (i.e., the doctor) more approachable so that he can be talked to and asked questions. As one of the doctors said, "The patients often want to know what you are doing to their bodies." However, the lack of sophistication in modern medical knowledge may explain some type of hidden force or power which some patients still feel that the doctor has, perhaps in part because of the quick effectiveness of a certain drug (e.g., an antibiotic) in effecting a cure. Thus, when doctors were asked to estimate the number of their patients who "attributed an omnipotent magical power to the doctor and the drug he prescribes," a third (33 per cent) reported that this described most of their patients, while 54 per cent said it described only a few of their patients. One of the doctors remarked that some of

his patients "believe that the power to heal is inborn in me."

The fact that a third of the doctors reported that most of their patients thought they were omnipotent should not be surprising in a society where the healer is evaluated according to the degree of "power" he has in making charms for good or for evil, and in healing or inflicting diseases. Herbalists and other types of healers are traditionally evaluated this way. In connection with the newer religions such as Christianity and Islam, great powers are attributed to the words of the Koran and the Bible, while clerics of these religions, particularly the Muslim clerics and the Aladura prophets, are also reputed to possess such power.

Other Topics

Patients' Modesty

The perceptions that patients have of medical situations differ from culture to culture. Even though physical examinations are regarded as intrinsic to medical care, disrobing may be taken by some patients as a violation of personal privacy, leading to shame or discomfort; on the other hand, it may be seen as a benevolent action of the doctor to get at the root of a symptom and bring about some cure. The doctors were asked how often they encountered patients' reluctance to disrobe for physical examinations? Only about 1 per cent of male doctors reported experiencing any problems from female patients "frequently" while about a third (30 per cent) had "never" had such problems and the rest (69 per cent) only "occasionally." In comparison with these results, nearly a fifth (19 per cent) of female doctors had "frequently" encountered resistance to disrobing from male patients, 37 per cent had never experienced any difficulty, while 44 per cent occasionally had run into such a problem with their male patients (Table 2, section B).

Thus, about one-third each of the male and female doctors had never had any problem with patients disrobing for examinations, while about half of the group had problems occasionally. Generally, therefore, disrobing for physical examinations was not a great problem for most doctors of both sexes, contrary to observations in other developing countries (Glaser, 1970).

An important point to be noted, however, is that 19 per cent of the female doctors, compared with only 1 per cent of the male, reported having experienced this problem with patients of the opposite sex. The family structure and sex roles in many traditional societies are such that women do not give orders; and this is generally so among the patient population seen by the doctors in this study. It appears that both male and female patients accept the authority figure of the male more than the female doctor. A male doctor told of an incident where he was on call at an out-patient clinic in the company of a female specialist who was of a superior rank. He observed that many times both male and female patients would hesitate to leave the queue when it was their turn to come forward if he was still having a patient consulting with him; that is, they would rather wait to see him instead of the female doctor.

One of the ways by which female doctors coped with problems presented them by some male patients was through understanding the cultural reason for the patients reluctance to undress and trying not to fuss about it. A female doctor said, "I ask him to leave his pants on; gradually, I relax him by being friendly and eventually he undresses with no efforts from me." Another said that she usually would not bother to ask a male patient to undress and she just "examined him fully clothed." A third female doctor replied that, if the patient kept being recalcitrant, she would send him to a male doctor.

It was not only the female doctors who reported ways by which they coped with male patients who defied their instructions, particularly in the area of undressing, but some male doctors also experienced similar reluctance from female patients, although to a lesser degree. Several male doctors stated that, whenever a female patient was reluctant to cooperate in physical examination, they used to call in a female nurse or ask a member of the patient's family to be present at the examination. Only in two cases did any of the doctors report reacting sternly with the patients; one said that he would ask an uncooperative patient to "get out of the consulting room," and another said that he "would give her another appointment to see if she would be more cooperative next time."

Regarding early experiences among the Bomvana, Jansen (p. 110) found similar modesty among female patients who were embarrassed when a male doctor had to perform a physical examination. When asked to lie down on a couch, the patient would lie ventrally rather than supinely. Explanation of the reason why such examination was necessary and the presence of assisting nurses helped to gain the patient's confidence.

Injections

The treatment setting and type of treatment are vital to the therapeutic relationship. In many industrializing societies, contact with Western medicine has given rise to specific preferences for certain types of treatment that the doctor prescribes. Patients would rather have placebos than be told that their condition needs no drug therapy. Doctors were asked how often they had requests for "a particular type of treatment" (such as drugs and injections); 42 per cent reported such requests daily and weekly; about half (48 per cent) received such requests once a month. Only one-tenth (10 per cent) "never" received such requests (Table 2, section A).

Doctors generally appeared to be accommodating to their patients requests; when asked whether or not they minded being asked for certain drugs or treatments if they knew they were needed by the patient (70 per cent) said they usually approved such requests, while the rest preferred not to be asked but to leave the decision on the course of treatment to themselves. However, when a request was thought to be unsuitable, most of the doctors (86 per cent) would refuse it, while 11 per cent would give "placebos;" only 3 per cent would ask the patient "to treat himself since he knows so much." One doctor commented that "a physician's motto is to do no harm" and so he would give a treatment requested by the patient as long as it was deemed appropriate for the patient's condition. When patients made requests, some doctors commented it was usually not because of the patient's own diagnosis or knowledge of the properties of the drug but because such treatment had been given to another patient he knew or about whom he had been told. As one doctor said, "Quite a lot of patients around are not interested in knowing the indication for using any particular drug but in using a similar thing that Mr. X used to get well." Several doctors also reported that most requests received were for injections. One doctor commented that "patients are fond of injections and so think they are appropriate for every condition." A plausible explanation given for this common request for injections is that the mode of administering the drug is similar to scarification (gbere) thus many patients came to regard it as potent. A study by Onko (1960, cited in Jansen, 1973) indicated that "for many Africans, the getting of injections is the real attraction to see the European doctor" as well as African doctors trained in the European tradition.

Exposure and Knowledge

A tendency that was found and which will be explored further in the next chapter is the association between the type of patient exposure experienced by the doctor and the type of patient-role orientation he had: a doctor who was strongly oriented to the role of the modern patient also tended to have such patients as the majority of those he saw every day in his practice, while the same relationship of orientation and patient type tended to be so for the doctor who showed a strong orientation to the role of the traditional patient. It seems, therefore, that either some doctors already had a strong orientation to either of the two patient roles as a result of other factors, or they had been able to learn and accommodate the world view of the majority of the patients they interact with every day.

In the section that follows, doctors' understanding of indigenous medical beliefs and values relating to health and disease, as well as their views on indigenous healers, will be presented, based on the information they themselves provided.

Doctors' Views on Cultural Aspect of Medicine and Traditional Healers

Marriott (1955:266) pointed out the need to distinguish between "Western" and "scientific" medicine. In a narrower sense, scientific medicine involves the use of rational techniques and the search for cause and effect. When practiced by Western specialists, however, it represents a whole gamut of Western cultural elements, which include values such as personal privacy, individual responsibility, democratic nature of interpersonal dealings, etc. Although scientific medicine is embedded within this Western culture, such values are not intrinsic to the practice of scientific medicine. Thus, when scientific medicine is

exported to a non-Western culture, it must adapt itself to the interpersonal milieu of that culture since Western practices may not be compatible with the new society. A more recent writer (Leslie, 1976: 8) has also pointed out the misleading aspect of "Western medicine;" he believes that its purely scientific aspects are transcultural and hence prefers to substitute the term "cosmopolitan" medicine.

Thus, as Marriott states, for Western medicine to be accepted in the village, its roles must be defined with consideration for the village concepts and practices relating to what disease is, what causes it, and how it can be cured. Thus, Saunders (1954: 8) suggested, "When persons of widely dissimilar cultural or subcultural orientations are brought together in a therapeutic relationship, the probability of a mutually satisfactory outcome may be increased if those in the healing roles know something of their own culture and that of the patient and are aware of the extent to which behavior on both sides of the relationship is influenced by cultural factors."

Though Saunders was writing for European doctors in non-Western societies, his advice is appropriate even for a non-Western doctor who by virtue of his training in scientific medicine can also be referred to as Western. Marriott actually extended the term "Western doctors" to apply to Indian practitioners trained in Western-type institutions. An understanding of the implications of the surrounding culture for illness and health, therefore, is important for the modern (Western) doctor in non-Western societies in order that he may better understand the sick behavior of his patients. As Mechanic (1968: 164) has observed, the doctor-patient relationship can succeed to the extent that the doctor and the patient have a common frame of reference; doctors must learn to view

illness as their patients view it and describe it in the latter group's terms. To what extent, therefore, have the doctors in the present study understood the cultural influence that determine how their patients react to them, as for example in the various therapeutic situations? This is the task of the present analysis; the doctors' responses to the appropriate questions deemed to be cultural will be presented.

Medicine as Culturally Specific

Doctors were asked their views on the cultural specificity of medicine by indicating the strength of their agreement with the following statement: "I believe that medical practice is a part of the culture of any society just as are marriage, religious, and other practices." The majority of them "moderately" and "strongly" believed the statement to be so, while only a fifth (20 per cent) disagreed, with the rest (19 per cent) not giving any answer.

However, their opinions as to the cultural influence upon the perception of disease by their patients were not so clear-cut; when presented with the following statement, "I believe that Africans are justified to believe in supernatural influence in the aetiology of disease," about two-fifths (42 per cent) agreed that this was plausible from their patients view, but an almost equal proportion (37 per cent) disagreed, with the remainder (21 per cent) undecided. While it was not expected that doctors, by virtue of their scientific training, should share a belief in the supernatural (e.g., magic) as cause of disease, it was expected that they would at least be able to understand why such preternatural factor should be plausible from the view of their patients; however, less than half of them appeared to feel so.

Part of the cultural environment of the medical system relates to

indigenous practitioners; if the environmental values, beliefs, and practices related to illness must be understood in order to understand the patient's views, an understanding of the indigenous healers is equally important in further understanding the patient in interaction with the modern doctor. Jansen (p. 118) called attention to the importance of understanding the methods of indigenous diagnosis in aiding the doctor to know how the patient viewed his illness. Furthermore, he suggested that the patient often did not have an individualistic view of illness distinct from the interpretation of such illness by the healer or the community-at-large. It was important, therefore, to note that the idea of "the patient's view" was more a Western-oriented conception which was not necessarily applicable in African context. The following relevant question was asked the doctors: "To understand the patient and his illness, a doctor should have a knowledge of how the indigenous healers (such as the herbalists, diviners, and faith healers) treat their patients." There was no consensus either for or against the views since the responses were split almost in half: slightly more than two-fifths (42 per cent) believed that such an understanding was necessary, but a slightly greater proportion (48 per cent) did not believe that such an understanding was important to an understanding of the patient; the remainder or one-tenth were undecided on the issue.

In spite of the fact that over half the doctors in this study appreciated the view that medicine is to be viewed in the sociocultural matrix in which it is practiced, we must still note that the significance of an understanding of these cultural influences on the perception of illness on the part of the patients was appreciated by less than half of the doctors involved with this study. One of the doctors, in fact,

commented, "This question, to my mind, is irrelevant. To understand his italics a patient and his illness has nothing to do with how whosoever treats his patients."

Given the fact that most (83 per cent) of these doctors evaluated the majority of their patients as traditional (i.e., patients whose belief system regarding health and disease is folk in type and whose medical care experience is mainly with the indigenous healer), it would seem appropriate that an understanding of the relationship between this patient type and the indigenous healer would help the doctor in the way he approached such patients in therapeutic situations. However, less than half of the doctors felt that an understanding of patient-indigenous-healer relationship was important to an effective relationship between such traditional patients and the scientifically trained doctor.

The Indigenous Healer and His Practice

To find out what doctors thought about the efficacy of the indigenous healers' medical practices, they were confronted with several questions. One question asked whether "certain physical conditions can be treated better by the traditional healers than by scientific medicine?" About a third (32 per cent) of the doctors agreed with this statement, but almost half (46 per cent) disagreed, with 22 per cent offering no opinion. It is not surprising that more of the doctors disagreed with this statement, since an agreement might be indicative of a denial of what their whole medical training is all about. Some of the doctors I talked with referred to fullblown smallpox as one example for which the traditional method of treatment seemed more effective than hospital treatment. However, other doctors I talked with were quick to point out the incompetence of the healers and the danger that a number of their practices pose to

patients. A gynecologist cited instances in which women in obstructed labor were given external massage with herbal preparations in order to relieve a "cephalo-pelvic disproportion;" "such examples of gross incompetence," he continued, "often led to maiming and death." A number of writers (Jansen, p. 146) have agreed and disagreed as to whether indeed African indigenous healers have cures for diseases that scientific medicine cannot relieve; but the general conclusion, as stated by Gelfand (1956, in Jansen), is that the skill of the native healer cannot compete with scientific medicine in all organic (i.e., non-psychogenic) diseases.

Whether the healers are capable of treating certain psychogenic diseases better than scientific medicine is said to be a matter of dispute (Jansen, p. 147), but not quite so for the doctors in this study. They were asked whether "certain mental disorders can be treated better by traditional healers than by scientific medicine" and slightly over half (52 per cent) agreed, while less than a third (30 per cent) disagreed and 18 per cent were unsure. This substantial agreement with the ability of the indigenous healer in the area of psychogenic disease is not surprising; the doctors' views might have been influenced by the pioneering method of Lambo (1962), who started a successful use of these healers in combination with scientific psychotherapy in the country.

As indicated earlier in the introduction, the healers can be divided into four groups: the herbalists, faith healers, diviners, and magicians. When asked to rate them according to the efficacy of their practices, the majority of the doctors (68 per cent) ranked the herbalists above the rest; 18 per cent ranked the faith healers so, while only 8 per cent and 4 per cent ranked the diviners and magicians, respectively, above the rest. Thus, almost all the doctors view the herbalists and

faith healers as contributing something to healing in the country. But apart from the use of herbs, roots, barks, and a few chemicals by the herbalists (some of which the doctors agreed to be effective), about two-thirds (66 per cent) of these doctors believed that the "power" of the traditional healer was not so much derived from his technical knowledge and performance as from his personality.

The doctors were also asked the extent to which they had any dealings with the healers. Slightly less than half (46 per cent) reported having any relationship with them; of these, 28 per cent had them as relatives, 22 per cent as friends, 24 per cent as former patients, 17 per cent as actual therapists for themselves, 4 per cent as advisors in certain types of illness, and 4 per cent as all previous categories combined.

Three of the doctors admitted that they had been treated by the healers when they were children. One of them said, "As a child, I was occasionally taken to these healers for persistent headaches and febrile convulsions." Another reported that he had been treated for an "incision of an abscess in the groin" and "removal of 'wawa' from the eye region by blood-letting," claiming that it was "very effective." Others reported having been involved in a team with the healers: "I've worked with traditional healers mostly in the control of communicable diseases;" another doctor who said he had a healer as a relative and an advisor reported that he had witnessed a case where a healer's treatment proved very effective in making "sterile" women pregnant: "hystero-salpingogram showed blocked tubes in three women who, after treatment from the herbalist, became pregnant and had normal babies." Another doctor who said he had had a healer as an advisor and was once his patient declared how confi-

dent he was of the healer and said that he would "refer intractable patients, including himself," to him.

The generally favorable impression of the herbalist, as expressed by those doctors who reported having had certain direct dealings with him and those who, even though they had never had direct dealings with him, but nevertheless had some trust in his effectiveness, appear to explain the general acceptance of the herbalist as distinct from other types of healers. The doctors were asked: "Would you approve or disapprove the incorporation of the non-magical healers (such as the herbalists) into the modern medical services?" About two-thirds (65 per cent) would, while the rest either would not or gave no opinion.

Indices of Orientations to the Doctors, Modern

Patients and Traditional Patients Roles

The previous analysis was a general picture of the patients regularly seen by the doctors, constructed from the information provided by the doctors themselves. As noted earlier, this information was based on their responses to certain questions designed to elicit their observations of patients attitudes and behaviors which were theoretically suggested as classifiable into modern (Western) and traditional types. In the present section, the reactions of the doctors in the form of attitudinal and behavioral response to the different role types which they had observed in themselves and in their patients will be combined into indices of orientations to these roles. It is important to recall that the doctor-patient relationship constitutes a set of roles which include not only the doctor's expectations of the patient's social role but also how he views his own social role as well. Thus, the doctor-patient relationship as a dependent variable is a composite of the roles

of both patient and doctor. The patient's role is subdivided into two ideal types: the modern and the traditional (as discussed in more detail in the section on methodology and in the discussion in the first part of this chapter). These composite roles are referred to as indices of the doctor's orientations; how they are constructed will be briefly described in this section. But first it is appropriate to define the concept orientation.

The concept was used in reference to student doctors' orientation in a study by Ford and his associates (1967) to mean doctors' knowledge of the patient as person with a particular condition of illness and possessing certain attitudes and behaviors, to whom the doctors reacted in a particular way--either positively/favorably or negatively/unfavorably. Thus, the student doctors' "orientation to chronically ill" patients was described as "unfavorable-avoidance" because such patients were perceived as over-demanding, hostile, severely disabled, or being so ill as to be almost beyond any help; rather, they had a "favorable-approach" reaction toward patients with acute conditions and expressed preference for such patients.

In another study on preventive care for adults, Coe and Brehm (1972) referred to doctors' "orientation to preventive medicine" to mean doctors' knowledge of, and attitude (i.e., reaction) toward the patient and his condition.

In the present study, orientation is used to mean knowledge of patients as persons with values, attitudes, and behavior patterns which may be favorable or unfavorable, depending on the doctor. Thus, doctors' orientation to modern patient role means that he has knowledge of the patient as a person with values, attitudes, and behaviors, and his reaction toward that patient; since such patients are likely to possess

attitudes and behaviors that facilitate diagnosis and treatment, the doctor is likely to react in a favorable manner toward him.

His orientation to the traditional patient role also means the extent to which he views the patient as a person and his understanding of the patient's attitudes and behaviors while in interaction with him. The folk background of this type of patient in medical matters might mean that the doctor reacts in an "unfavorable-avoidance" manner. The crux of this study, however, is that this need not be so. While the doctor is not expected to endorse certain values, belief system, attitudes and behaviors of this patient type, he is expected to understand and empathize with those values, attitudes, and behaviors of the patient under his care. Thus, a doctor with a "strong" orientation to the traditional patient role, as will be explained shortly, is one who satisfies this expectation of knowledge of the patient, understands and empathizes with the values, attitudes, and behaviors of this patient.

The doctor's orientation to his own role is his professional knowledge of what his attitudes and behavior should be when in interaction with patients. His orientation to the over-all doctor-patient role relationship is a composite of his orientation to the two patient types and his own role as well; the rationale for this combination will be given in the latter part of this discussion of indices.

Index of Orientation to Modern Patients' Role

In order to find the doctors attitudes toward modern patients roles, they were asked five questions presented in two forms: hypothetical situations to which the doctors responses were used as indicators of their attitudes to a particular doctor's or patient's behavior; and actual situations in which they were involved to measure their behavior. An

example of a hypothetical question is: (1) "Suppose a patient consulting one of your colleagues showed that he had a fair knowledge of the workings of the human body and so he was able to recognize and interpret his physical symptoms (e.g., peptic ulcers). What effect do you think such traits of the patient would have on the doctor in making his diagnosis?" The responses, from which the doctor was to choose one, were that such a patient's understanding would "definitely assist," "probably assist," "probably hinder," "definitely hinder the doctor in making his diagnosis." The next question immediately following the last one is: "Whenever you encounter such a patient in your practice, do you find his attitude as assisting or hindering you in making your diagnosis (Q. 39)?" The response categories are: "I am definitely assisted, somewhat assisted, somewhat hindered, definitely hindered."

These Likert-type questions and responses were scored 4 for a most positive and 1 for the most negative responses. Other questions pertaining to the patient's definition of the sick role and his interaction with the doctor included: (2) how favorably or not the doctor was disposed toward a patient who could recognize the symptoms of his disease and went to the doctor early; (3) whether the doctor approved or disapproved of a patient who exhibited a high sense of individuality (Q. 50, Q. 51); (4) how appropriate or inappropriate the doctor thought the patient's measured and covert dependency on him was (Q. 53); (5) how helpful or hindering to the doctor's performance of his therapeutic duties was a patient who could present an accurate description of his illness (Q. 64) and use medications as prescribed (Q. 66). The scores on the responses to these questions (selected after a statistical test of internal consistency) were built into an Index of Orientation to Modern Patient Roles.

Index of Orientation to Traditional Patient's Role

The traditional patient role relates to the ideal-typical set of role expectations and behaviors emanating from traditionally sanctioned forms of interaction with the indigenous healers. These role expectations and behaviors are suggested theoretically to be what certain patients bring into the relationship with the modern, scientifically trained doctor. They include technical understanding of ill-health, sick role behavior, and interaction with the indigenous healers. The questions designed to elicit the doctors' reaction to such a patient's expectations and behaviors are: (1) attribution by the patient of the cause of, and remedies for diseases to supernatural powers (Q. 83); (2) the patient's delay in seeing the doctor until the last stages of his disease (Q. 56 and Q. 57); (3) perception of the doctor as omnipotent (Q. 41); (4) extreme dependency on the doctor (Q. 47); (5) patient's inability to remember the onset and duration of his illnesses (Q. 61); and (6) to use medications as prescribed by the doctor (Q. 62). Responses of doctors as indicating that these patient behaviors created problems for or hindered their effective practice were given the lowest score of 1, increasing to 4 for the most positive (empathic) response (i.e., not creating problems or hindrance). The results form the Index of Orientation to Traditional Patient's Role.

Index of Orientation to Doctor's Role

To measure the doctors' orientation to their role in the doctor-patient relationship, questions were asked concerning: (1) the extent to which the doctor believed that personal involvement with the patient's life was necessary to increase his understanding (Q. 28 and Q. 29); (2) the relevance or irrelevance of the patient's non-medical attributes

such as social class or wealth in determining the doctor's treatment of the patient (Q. 30 and Q. 31); (3) the degree of appropriateness or inappropriateness of maintaining an attitude of detachment from his patient's personal or emotional life while treating him. The most positive responses were scored 4 and the most negative 1. The summation of the scores formed the Index of Orientation to Doctor Role.

These three indices, Orientation to Modern Patient Role, Orientation to Traditional Patient Role, and Orientation to Doctor Role were combined into a Composite Index of Doctor-Patient Role Relationship. Each doctor, then, has been rated in terms of his orientations to (1) the two patient roles, (2) his own role, and (3) the doctor-patient role relationship by assigning index scores of from 1 to 4. The distribution of the respondents "breaks" approximately at the cumulative mean of all the scores forming each index; hence, the break points divide the respondents into two groupings. For the Index of Orientation to Modern Patient Role, for example, an orientation is described as "weak" when respondent's scores were between 2.11 and 2.78, while respondents whose scores were between 2.79 and 4.0 are described as having a "strong" orientation to that role index. Similarly, the ranges of scores for the other indices are (1) Index of Orientation to Traditional Patient Role: 1.50-2.63 ("weak"), 2.64-4.0 ("strong"); (2) Index of Orientation to Doctor Role: 1.75-2.72 ("weak"), 2.73-4.00 ("strong"); (3) Index of Orientation to Doctor-Patient Role Relationship: 2.24-2.90 ("weak"), 2.91-4.0 ("strong").

Rationale for the Overall Index of Orientation to Doctor-Patient Role Relationship

Combining the three sub-indices of orientations into an overall Index Orientation to the Doctor-Patient Relationship is justified not only on theoretical grounds but also by the nature of the location of the study

which is in a society where folk medical beliefs and practices are widespread. To relate effectively with the patient in this environment, therefore, a practicing doctor must of necessity learn not only to relate to the few enlightened (.e., in terms of familiarity with scientific medicine) patients but also the vast majority of patients whose medical culture is predominantly indigenous and traditional; this is the type of patient whom 84 per cent of the doctors themselves reported encountering in their practice every day.

Thus, ideally and theoretically, a doctor who ranks high on the overall Index of Orientation to Doctor-Patient Role Relationship will also rank high on the three subindices, reflecting his effectiveness. In reality, however, the sociological fact of human variability in attitudes and behaviors even among professionals means that some doctors will typify this ideal while others will not; the hypotheses as formulated reflect these expected variations.

Reliability of and Interrelationship Between the Indices

Reliability tests of the internal consistency of each of the indices were done; the coefficient alpha (the basic formula for determining the reliability of internal consistency) for each index is modest in value: 0.65 for the Index of Orientation to the Modern Patient Role, 0.59 for the Index of Orientation to the Traditional Patient Roles, and 0.51 for the Index of Orientation to the Doctor Role; the alpha for the overall Orientation to the Doctor-Patient Relationship is 0.55. Although these coefficients are modest, they meet the minimum standard of 0.50 suggested by Nunnally (1967: 226) for measuring instruments at early stages of research; considering the exploratory nature of the present study in an area not investigated before, with no previous indices available for com-

parison, it would seem that what are now available are sufficient for the present purpose, while further refinement of them can be done as part of a later research effort.

Table 3 shows the interrelationships between the indices. From the strengths of the associations between the sub-indices and the overall index, it is apparent that the latter index reflects a greater orientation to the modern patient's role than the other two orientations; this appears to indicate the tendency of doctors to have greater empathy toward this role than the other two, particularly the traditional patient's role.

Although each of the sub-indices are moderately consistent internally, they do not have much in common as indicated by the weak associations (gammas) between them, the association between modern and traditional patient's orientations being the weakest. It is significant to note the discrepancies between the strengths of the associations as well: one would expect the modern patient's and doctor's role orientations to associate positively (since both are supposed to be "modern" conceptually) instead of being negative. It is the orientation to the traditional role that one would expect to associate negatively with the other two, yet it is associated not only positively to them but the association between it and the doctor's role orientation is, comparatively, the strongest. Perhaps certain aspects of the doctor's role such as maintaining rapport with patients, avoidance of non-medical matters such as the patient's social position to interfere with treatments, etc., might have associated well with some of the items of the traditional patient's role. Since there is virtually no association between the traditional and the modern patient's role orientations (this was logically expected), it is likely that some interaction effects between certain items on the role orientations of the

TABLE 3
 INTERRELATIONSHIPS AMONG THE INDICES
 OF ORIENTATION

	Modern Patient's	Traditional Patient's	Doctor's	Doctor-Patient Relationship
Modern Patient's03	-.16	.94 ¹
Traditional Patient's	24	.58 ²
Doctor's		69 ³

$$1 \chi^2_{2} = 18.1, p = .0000$$

$$2 \chi^2_{2} = 7.93, p = .0049$$

$$3 \chi^2_{2} = 12.05, p = .0005$$

of the doctor (which had associated positively with those of the traditional patient's) and certain items on the modern patient's role have resulted in the negative association.

Although it was expected that some degree of dependence would be found among the three sub-variables of the doctor-patient role relationship than was found (since the three were postulated to be measures of the same concept), the degree of independence found indicates that the doctor-patient role relationship as a single concept, is multidimensional.

Summary

The sick role behaviors of the patients as perceived by the doctors were generally very traditional: about one in every five doctors reported fairly (that is, daily or weekly) often seeing patients displaying a modern patient's types of characteristics such as possession of a good technical knowledge of disease and physical symptoms, recognition of the importance of visiting the doctor at early stages of illness, and possessing a sense of individualism. About half of the doctors, on the other hand, found all or most of their patients quite traditional in their orientations--these patients believed that their illness was supernaturally inflicted; the same proportion of doctors reported that almost daily they had patients who came in with advanced illnesses, having tried indigenous treatment that failed. When the patients finally came to the doctor, a similar proportion of the doctors reported that these patients tended to see them as possessing magical power of healing.

Diagnostic problems were also reported as frequent by up to a third of the doctors, and occasionally by more than three-quarters of them; such problems were in the areas of patient's inability to tell his age, remember the onset of illnesses or childhood diseases, inability to take

medications as ordered, reluctance to disrobe for physical examination, and making requests for drugs, such as injections not needed for the patient's particular conditions.

The doctors' responses to their own knowledge of indigenous medical culture showed that many of them appeared not to recognize the importance of such knowledge as necessary for an effective dealing with their patients. Over half of the doctors, for example, could not see why their patients should think their diseases were the result of some supernatural factor, an evidence that these doctors found it difficult to share in the world view of their patients. While there was a general recognition of some contributions that the indigenous healers, particularly the herbalists, could make in health care delivery in the country, about half of these doctors did not see the connection between an understanding of the indigenous healers' method of treatment in order for them to have a deeper understanding of how to approach their own patients.

There were also discussions of indices of doctors' orientations, constructed from responses to perceived attitudes and behaviors of their patients as reported earlier in this chapter. The next stage of the data analysis, to be reported in the next chapter, is to relate these orientations (constituting the dependent variable of this study) to selected determinants.

CHAPTER V

THE INFLUENCE OF PERSONAL AND PROFESSIONAL FACTORS ON DOCTORS' PERCEPTIONS OF THE DOCTOR-PATIENT ROLE RELATIONSHIP

It is the purpose of this chapter to present an analysis of some of the doctors' attitudinal and behavioral responses to the different role types which they had observed in their own and those of their patients. These reactions collectively constitute their orientations (which were combined into indices described in the last chapter) to these roles; from their own perspective, the "modern" patient was seen as showing in general the scientific conception of disease and the modern sick role behavior, while the "traditional" patient was one whose disease orientations and sick role behaviors were indigenous in character. An underlying theme of this study is that the type of orientation of the doctor, whether empathic or non-empathic to certain patients' roles, ultimately affects the overall relationship with his patient. However, since doctors are known to differ in personal backgrounds, professional training, and other orientations and practices, they are likely to differ as well in their values, attitudes, and behaviors relating not only to the way they perform their work but also in the manner they relate to their patients.

These differential background characteristics which the doctors brought to bear on the therapeutic relationship with patients were taken as the independent variables and classified into two kinds: the personal and the professional. Each of these characteristics as a predictor

variable will be analyzed relative to its effects on the doctor's orientations to the different role types described earlier. In the next section, the personal background characteristics of the doctors will be presented to examine how they did or did not differentiate among the doctors in their various orientation (see Figure 2).

Personal Characteristics of Doctors and Orientation to
Doctor-Patient Relationship

The personal characteristics of the doctors to be analyzed are age, sex, father's occupation, place of rearing, early education, religion and cultural orientation. The first of these variables, age, will be considered.

Age

The data in Table represent a cross-tabulation percentage and gamma for the relationship between age and orientation to doctor-patient relationship. As the data show, age is associated moderately with doctor-patient relationship ($g = 0.50$); over three-quarters (77 per cent) of the older doctors, but only slightly over half (53 per cent) of the younger doctors, indicated a strong orientation to the doctor-patient relationship.

When related to the sub-variables of the doctor-patient relationship, age was found to be associated only weakly and without statistical significance to the modern and traditional patient roles.

However, it was associated moderately ($g = 0.42$) with orientation to the doctor's role; in this case, 76 per cent of the older doctors, compared with slightly over half (50 per cent of the younger ones, reported a strong orientation to this role. This last result was expected, since most of the older doctors were trained overseas and hence were more likely to agree to the modern, Western-type doctor's roles. Hypothesis one on the influence

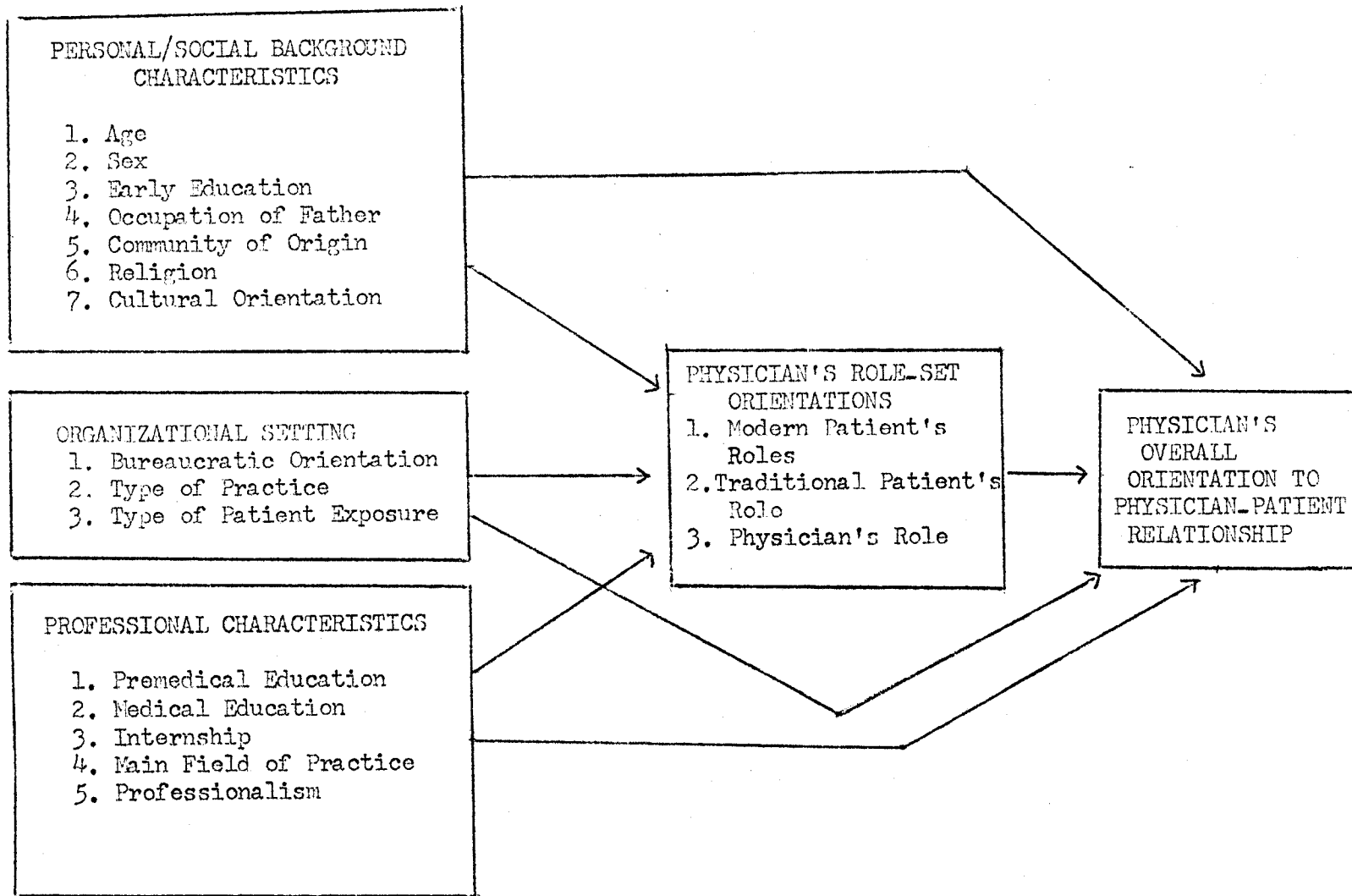


FIGURE 2.. ANALYTIC FRAME

TABLE 4
 ORIENTATION TO DOCTOR-PATIENT RELATIONSHIP
 BY AGE

	Age	
	Young N = 73	Old N = 22
Orientation to Doctor- Patient Relationship	Per Cent	Per Cent
Strong	53	77
Weak	47	23
	<u>100</u>	<u>100</u>
	$\chi^2_c = 3.05, p = .08$	
	$g = .50$	

of age was that more of the older doctors would be strongly oriented to the role of the doctor, and to those of the modern and traditional patient, than younger doctors. This was confirmed with respect to the doctor's role. No significant difference was found between the two age groupings in relation to the modern and traditional patient orientations; the hypothesis was only partially supported.

Sex

Sex was associated moderately ($g = -0.43$) with orientation to doctor-patient relationship, as data in Table 5 show. Sixty-three per cent of the male doctors and 40 per cent of the female doctors reported a strong orientation to the role. One reason for this sexual difference is that the men were more likely to be specialists than the women (89 per cent of specialists were men, 11 per cent women), and specialists were noted for their strong orientation to the doctor-patient role relationship. A slightly weaker relationship ($g = -0.38$) was found between sex and orientation to doctor's role; more men also indicated a strong orientation to this role than did women.

When the two sexes were compared on their orientation to the modern and traditional patient's role, a different pattern of relationship was found. Orientation to modern patient's role was moderately related ($g = 0.41$, $X^2_c = 1.26$, $p = NS$) to sex; in this case, three-quarters (75 per cent) of the females, compared with slightly over half (54 percent) of the male doctors were strongly oriented to the modern role. Surprisingly, however, the women doctors tended to be strongly oriented also to the traditional patient's role slightly more than men ($g = 0.18$). Although these relationships were not statistically significant, the pattern of relationships found was such that it could not be ignored, apart from the fact that substantial gamma (0.41) was obtained for one of them.

TABLE 5
 ORIENTATION TO DOCTOR-PATIENT RELATIONSHIP
 BY SEX

	Age	
	Males N = 80	Females N = 15
Orientation to Doctor- Patient Relationship	Per Cent	Per Cent
Strong	63	40
Weak	37	60
	<u>100</u>	<u>100</u>

$\chi^2_c = 1.80, p = \text{NS}$
 $g = -.43$

These results appear to indicate that, whereas more of the male doctors were more strongly oriented to the doctor's role as well as to the overall doctor-patient relationship, more of the female doctors were patient-oriented. Perhaps a reason for this sexual difference can be found in the concept of "sex-typing" in the professions; that is, certain professions such as medicine, law, engineering, etc., are sex-typed as male occupations, whereas others such as elementary school teaching, nursing, etc. are sex-typed as female occupations (Hall, 1975: 120). Although this pattern primarily describes the professions in Western societies, it has some validity in the Nigerian context where the colonial legacy might have helped to sex-type medicine as a man's occupation, since most earlier European and African doctors were male. Traditionally, too, native healing is usually (though not always) a male domain; hence, the male doctors might have been influenced by these considerations to identify more strongly with their role as doctors in all of that role's ramifications. The traditional female roles in the family requiring nurturing, socializing, and helping abilities, which are culturally learned by women since childhood, might still be an influential factor in the female doctor's being strongly oriented to both types of patients' roles.

Father's Occupation

This another variable that was hypothesized to differentiate among doctors in respect to their orientation to doctor-patient role relationships. Doctors who declared the occupations of their fathers to be professionals, administrators, managers, secondary school teachers, and ministers were ranked as having fathers in the "high" occupational level. Those whose fathers were reported to be skilled foremen (craftsmen, tradesmen, etc.), unskilled, farmers and traders were ranked as having

fathers in the "lower" occupational level. From the data in Table 6 it can be seen that the relationship between the two variables is moderate, gamma being -0.51 . Over three-quarters (79 per cent) of doctors whose fathers' occupations were of lower level reported a strong orientation to the doctor-patient relationship, compared to less than half (48 per cent) of those having fathers of a higher level occupation.

These disproportionately higher representations of doctors with low paternal occupations among those oriented strongly to the overall doctor-patient relationship and the role of the doctor was unexpected; however, after controlling for age, over-representation was found only among the younger doctors. For example, among older doctors, there were more of those having fathers with a higher occupational level among those strongly oriented to the two roles than were those with a lower level paternal occupation (83 per cent vs. 67 per cent, respectively). Thus the over-representation of doctors with low paternal occupations among those with strong orientations to the two roles was in fact an over-representation of young doctors with low paternal occupations compared with other young doctors with high paternal occupations and sharing similarly high orientations to the two roles. Controlling for the main field of practice and the type of patient exposure did not change the relationships found.

A number of explanations are suggested. First, it is likely that these doctors with fathers in lower level occupations (26 per cent of all the doctors) are not the totally poverty-stricken type that might be associated with workers in lower level occupations in a developing country. Farming or trading may be classified as low level occupations, but some farmers (especially those who grow cash crops such as cocoa) and textile traders who deal in textile merchandising can and are known to afford to

TABLE 6
 ORIENTATION TO DOCTOR-PATIENT RELATIONSHIP
 BY OCCUPATION OF FATHER

Orientation to Doctor- Patient Relationship	Father's Occupation	
	Low N = 33	High N = 56
	Per Cent	Per Cent
Strong	79	48
Weak	21	52
	<u>100</u>	<u>100</u>
	$\chi^2_c = 6.65, p = .01$ $g = -.51$	

send their children to the university or overseas. The mothers of these students may similarly be traders; these women traders are known to do even better than many men, are wealthy though illiterate, and are active in helping in the education of their children, even bearing sole responsibility for sending their children overseas (Little, 1973: 44). Highly intelligent but poor students receive scholarships from the government. The education of 80 per cent of the doctors in practice was financed by the government (Awoskia, 1977).

Furthermore, education is the main channel of upward mobility in Nigeria and the underprivileged, as elsewhere, are known to take advantage of it for status advancement (Lloyd, 1970: 21). An evidence of this is shown by the fact that, according to Lloyd (p. 57), the elite grouping in the country is constituted by many with very humble family backgrounds; also, in Ibadan (Nigeria), over a third of the university graduates in 1953 had fathers who were illiterate or semi-literate.

Although it might be argued that, despite circumstances that may not allow the full impact of low paternal occupation to influence the orientations of certain doctors, values of achievement may not be emphasized in a background of farmers and traders as much as would be found in the higher occupational backgrounds. It is likely that doctors from lower and higher occupational backgrounds share a common motivation to achieve and acquire goods.

No significant difference was found among doctors of either occupational background in their orientation to modern patient's role; more from the lower occupational background, however, reported strong orientations to the traditional patient's model (55 per cent vs. 40 per cent, respectively) though the association was rather weak but significant ($g = -0.23$, $\chi^2_c = 25.0$, $p < .001$). The probable reason for this is that doctors whose

fathers had occupations of lower status also tended to come from small, rural communities where their fathers practiced farming or other agricultural pursuits; in such an environment, they were more likely to have come in contact with traditional practices relating to healers and patients.

In summary, the hypothesis (Hypothesis 2) about the effect of father's occupation on the dependent variables, stating that more doctors whose fathers were in the higher level occupations would be oriented to modern patient's and doctor's roles, while more of those with lower level paternal occupations would be oriented to the traditional patient's roles, is only partially supported and that is in respect of the later grouping of doctors.

Place of Rearing

The community in which the doctor was reared was defined as small or large depending on whether the population was more or less than 10,000. This variable was associated moderately with orientation to doctor-patient role relationship ($\gamma = -0.46$). As the data in Table 7 show, almost three-quarters of the doctors reared in small communities reported a strong orientation to the doctor-patient relationship while only slightly over half (52 per cent) of those reared in large cities did so.

Place of rearing was also associated with orientation to doctor's role ($g = -0.37$, $\chi^2_C = 1.91$, $p < .10$). Thus, almost three-quarters (74 per cent) of doctors from small, compared with 57 per cent of those from larger communities, reported a strong orientation to the doctor's role. This unexpected result persisted even after controlling for main field of practice, age, and patient exposure; more of those reared in small communities continued to be found among those strongly oriented to the two roles. Some explanations of this discrepancy will be attempted.

TABLE 7
 ORIENTATION TO DOCTOR-PATIENT RELATIONSHIP
 BY PLACE OF REARING

	Community of Rearing	
	Small N = 31	Large N = 64
Orientation to Doctor- Patient Relationship	Per Cent	Per Cent
Strong	74	52
Weak	26	48
	<u>100</u>	<u>100</u>
$\chi^2_c = 3.53, p = .06$ $g = -.46$		

Since all the doctors are over 30 years of age, the likelihood is strong that all of them (including those reared in small communities) must have attended secondary schools in urban areas. At the time they were growing up, the very few secondary schools that were available were located in capital or provincial towns, hence most of them were boarding schools since the students came from near and far rural communities. These schools were mostly in the hands of missionaries and the government and were run on the line of English boarding schools with an entirely European curriculum (Lloyd, p. 20). It is no surprise, therefore, that doctors with this kind of background, regardless of their rural upbringing, must have internalized values that made them respond not always to type with regard to their orientations.

As expected, size of place of rearing was negatively related to a traditional patient's orientation ($g = -0.45$, $X_c^2 = 3.68$, $p = .05$). Almost two-thirds (62 per cent) of doctors reared in small communities, but only 38 per cent of those reared in large ones, reported a strong orientation to the traditional role. This negative association was anticipated; like doctors whose fathers belonged to the lower occupational level, doctors who spent their early years in small communities were also those more likely to have been exposed to the traditional aspects of medical care as it relates to patients. The respondents reared in small or large communities did not differ significantly in their orientation to modern patients' role, however.

The hypothesis (Hypothesis 3) on the influence of the community of rearing which states that "size of place of rearing is positively related to doctor's and modern patient's roles, and negatively to traditional patient's role" is only supported in terms of the traditional patient's

role. Specialization appears to have overcome earlier childhood influence among doctors who, though reared in small communities, yet were strongly oriented to the doctor's role and the overall doctor-patient relationship.

Early Education

A moderate relationship was found to exist between the type of school in which primary school education was obtained and orientation to the doctor-patient relationship, as indicated by the gamma of 0.58 ($X_c^2 = 6.06$, $df = 1$, $p = .01$). Two-thirds of doctors who attended Christian mission schools, but only a third of those who attended Islamic and other schools, reported a strong orientation to the doctor-patient relationship (Table 8).

A moderate relationship was also found between early education and orientation to the doctor's role ($g = .44$, $X_c^2 = 2.78$, $df = 1$, $p = .09$); two-thirds (68 per cent of those who attended mission schools, compared with less than half of those who attended Islamic and other schools, reported a strong orientation to the doctor's role. As expected, this pattern also obtained for the modern patient's role but weakly ($g = .13$, $X_c^2 = 4.44$, $df = 1$, $p = .02$).

Though the same pattern of result was obtained for the traditional patient's role, it was unexpected. A weak gamma (.18, $X_c^2 = 9.0$, $df = 1$, $p < .01$) was obtained for the association between early education and the traditional patient's role; here, slightly less than half (49 per cent) of attenders of mission schools, but only a little more than a third (36 per cent of attenders of Islamic and other schools, reported a strong orientation to the traditional patient's role.

It was presumed that those who attended the Islamic and other types of schools would be disproportionately represented among those with a

TABLE 8
 ORIENTATION TO DOCTOR-PATIENT RELATIONSHIP
 AND EARLY EDUCATION

	Type of School Attended	
	Islamic and Others N = 23	Mission N = 72
	Per Cent	Per Cent
Orientation to Doctor- Patient Relationship		
Strong	35	67
Weak	65	33
	<u>100</u>	<u>100</u>
	$\chi^2_c = 6.06, p - .01$	
	g = .58	

strong orientation to the traditional patient's role. A possible explanation for this discrepancy may be found in the views expressed by Idowu (1970) and Lambo (1964) that overt profession of faith as a Christian or Moslem does not always preclude participation in traditional beliefs. Since more often than not Christians attend mission schools, this may explain why those who had attended them are still aware of traditional practices, including those that relate to medical care.

Thus, the hypothesis (Hypothesis 4) stating that more of the doctors who attended mission schools would be oriented strongly to the roles of the doctor and the modern patient while more of the attenders of non-mission schools would be oriented to the role of the traditional patient is generally supported except for the second half of the hypothesis; in this case, more of the attenders of mission schools were oriented strongly to the role of the traditional patient.

Religion

Although early education in religious schools was found to influence doctor's orientations, their religion per se did not, perhaps because (at least in part) of the situation suggested by Idowu and Lambo cited earlier. Hardly any difference was found between religious groups with respect to orientations to the doctor-patient relationship, modern patient's and doctor's roles. However, a weak association ($g = .20$) between religion and orientation to traditional patient's roles was found, only among Christians (47 per cent expressed a strong orientation compared with 37 per cent of the non-Christians). This was not expected (Hypothesis 5); perhaps the reason is that orientation to traditional medical beliefs is a continuing part of the ethos of all religious groups.

Indigenous Cultural Orientation

An index of indigenous cultural orientation was constructed from scores on doctors' responses to six questions relating to the need for the doctor to understand the indigenous healing system as a prerequisite to a better understanding of his patient; some of these questions include beliefs in the views that (a) medical practice is relative to the culture of each society; (b) the native healer is better able to treat certain diseases than is a modern doctor; (c) the "power" of the healer lies more in his personality than in technical performance.

This index of cultural orientation was found to be associated weakly ($g = -.23$) and insignificantly with orientation to the doctor-patient role; similarly, it was associated weakly ($g = -.31$) with the modern patient's role. However, no association was found between it and orientations to the traditional patient's and doctor's roles. Though these results were statistically insignificant (except for the modern patient's role, which was borderline in significance), the pattern was consistent with expectation--the relevant hypothesis stated that more of the doctors who were strongly oriented to the indigenous medical culture would be oriented to the traditional patient's role, while more of those weakly oriented to this culture would be oriented strongly to the doctor's and modern patient's roles.

The first part of the hypothesis (Hypothesis 6) which anticipated that more doctors strongly oriented to indigenous culture would be oriented to traditional patient's role was unsupported. It would seem that there should be a substantial association between the two orientations since they relate to knowledge of the cultural beliefs pertaining to health, disease, and healing on the one hand and the attitudes and behaviors of patient showing those beliefs on the other. As pointed out earlier, when the doctor's

views on their patients and on cultural beliefs were discussed, mixed and ambiguous orientations were in evidence regarding their perceptions of the cultural influences on their patients as well as on their own day-to-day relationships with them. This may account for the very weak or missing association between this variable and the sub-variables of the doctor-patient relationship.

Summary

The personal characteristics which were found to be associated ($g = .40$ and above) with the overall orientation to doctor-patient relationship are: age, sex, father's occupation, place of rearing, and early education. In these cases, older doctors, males, those with fathers from the lower occupational level, those reared in smaller communities and those who attended mission schools were found disproportionately among doctors with a strong orientation to the overall doctor-patient relationship than were those who were younger, female, those with fathers from the higher occupational level, those reared in larger communities, and those who attended non-mission schools.

Only sex and cultural orientation were found to be moderately associated with orientation to modern patient's roles; here, more female doctors and those with a weaker cultural (indigenous) orientation reported a strong orientation to the modern patient role than did male doctors and those with a strong cultural (indigenous) orientation.

Father's occupation, the place of rearing, and early education were the three variables that were most associated with orientation to traditional patient's role. More respondents whose fathers had a lower level occupation, who grew up in smaller communities, and who attended mission schools were found to be strongly oriented to traditional patient's role

than were those whose fathers had higher level occupations, grew up in larger communities, and attended Islamic and other schools.

The variables which were associated the most with orientation to the doctor's role were: age (more older doctors than younger ones), sex (more male than female), place of rearing (more doctors from smaller than larger communities), and more of those who had early education in the mission than in non-mission schools.

Professionalism and Doctor-Patient Relationship

The professional variables included under this heading are three: professionalism (how doctors rated on the professionalism index), the main field of the doctors' practice, and a set of variables dealing with the early career of the doctors relative to their premedical, medical, and internship education. This last grouping of variables will be examined first as they relate to the dependent variables.

Doctor-Patient Relationship and Location of Training

As had been pointed out earlier, the doctors in this study had their medical education either locally in Nigeria or overseas. The first of the hypotheses for this study stated that where their education (that is, pre-medical, medical, and intership training) was obtained would affect the orientations that the doctors had toward the doctor-patient relationship and its three sub-variables; the data for the first relationship are presented in Table 9.

The data in Table 9 represent the cross-tabulation percentage and gammas for the relationship between orientation to doctor-patient relationship and the location of premedical, medical and intership training. Except for place of premedical education, a larger proportion of doctors with medical and intership training overseas tended to report a strong orientation to doctor-

TABLE 9

ORIENTATION TO DOCTOR-PATIENT RELATIONSHIP BY PREMEDICAL,
MEDICAL AND INTERNSHIP TRAINING

	Premedical Education		Medical Education		Internship Training	
	Nigeria N = 79	Overseas N = 16	Nigeria N = 51	Overseas N = 44	Nigeria N = 57	Overseas N = 38
	Per Cent	Per Cent	Per Cent	Per Cent	Per Cent	Per Cent
Orientation to Doctor- Patient Relationship						
Strong	61	50	53	66	54	66
Weak	39	50	47	34	46	34
	<u>100</u>	<u>100</u>	<u>100</u>	<u>100</u>	<u>100</u>	<u>100</u>
	$\chi^2_c = .23, p = NS;$		$\chi^2_2 = 1.15, p = NS;$		$\chi^2_c = .80, p = NS$	
	g = -.22		g = .26		g = .23	

patient role relationship than those locally trained: about two-thirds (66 per cent) of those who obtained their medical training overseas, compared with slightly over half (53 per cent) of those similarly trained within the country, and two-thirds (66 per cent) of those interning overseas (vs. 54 per cent of those interning locally) reported strong orientation to this role relationship. These two associations, however, were rather weak as shown by the gamma values of 0.26 and 0.23. Premedical training presented a different result when related to the doctor-patient role relationship: 61 per cent of those who had this training locally, but half (50 per cent) of those trained premedically overseas reported a strong orientation to this role; the association between the two variables, however, was weak (gamma = -.22). This different result was due to the large number of older doctors represented among those who obtained their premedical training at home, more of whom generally reported a strong orientation to this role than the younger doctors, as had been shown earlier.

In spite of the differences found among the two sets of doctors in their orientation to the doctor-patient role, the corrected chi square estimates for the three sets of associations show that the differences obtained among them are not statistically significant.

When the three sub-variables (orientations to modern and traditional patient roles and the doctor role) of the doctor-patient relationship were related to the location of training variables, a pattern of associations similar to the one just described emerged, the association being weak and not significant statistically: (1) the orientation to modern patient's role was not associated with location of premedical and medical training, but was weakly and insignificantly associated with location of internship ($g = .21$ $X_c^2 = .65$, $p = NS$) (2) the orientation to traditional patient's

role was associated weakly and insignificantly with locations of premedical training ($g = -.35$, $X^2_c = .99$, $p = NS$), medical training ($g = .12$, $X^2_c = .133$, $p = NS$), and had no association with internship training; (3) orientation to doctor's role was associated but weakly and insignificantly with locations of premedical training ($g = -.31$, $X^2_c = .77$, $p = NS$), medical training ($g = .27$, $X^2_c = 1.16$, $p = NS$) and internship training ($g = .17$, $X^2_c = .31$, $p = NS$).

These data, therefore, did not support the hypothesis (Hypothesis 7) that "more of the doctors who had their premedical, medical, and internship training overseas will be strongly oriented to the doctor's and modern patient's roles than their counterparts who had such training locally; the latter group will be represented in larger proportion among those who are strongly oriented to the traditional patient's role." The tendency of doctors from developing nations to practice medicine in the manner in which it is practiced in industrialized nations where they have been trained is well documented (Glaser, 1970; discussants in Lambo, 1970, and Goodenough, 1970); the writer believed that this tendency would be carried over by Nigerian doctors trained overseas via a greater preference for patients possessing the modern role orientations over patients whose orientations were more traditional, and that more of the doctors trained locally would be likely to be more oriented to the traditional patient's role than those trained abroad. However, the findings just presented showed that, in general, neither overseas nor local medical education in all three forms (premedical, medical, internship) were associated in a significant way with the two patient role orientations.

Orientation to the Modern Patient
Role and Main Field of Practice

The main field of a doctor's practice is another professional variable which is was expected to differentiate among the doctors relative to their orientations to the doctor-patient role relationship, and it did.

As the data in Table 10 show, there is a fairly strong association between the two variables as evidenced by the gamma of 0.63; the majority (68 per cent) of specialists, but only a third (32 per cent) of the generalists, reported a strong orientation to doctor-patient role relationship.

The field of practice was also found to be associated with orientation to the modern patient role as shown by the data in Table 11. The association is positive and moderate ($g = .53$); almost nine-tenths of specialists, compared with only about two-thirds of the generalists, reported a strong modern patient's role orientation.

This moderate and positive relationship was also found when scores on orientation to doctor's role were cross-tabulated with field of practice; the gamma obtained was 0.54 ($\chi^2_c = 4.90$, $df = 1$, $p < .05$) and once again, more specialists (70 per cent) reported a strong orientation to the doctor's role than generalists (41 per cent). The relationship between field of practice and orientation to the traditional patient role, however, was rather weak ($g = -.14$; $\chi^2_c = 1.69$, $p = NS$)

The moderate associations between orientations to the modern patient and doctor role, on the one hand, and field of practice on the other, were anticipated by Hypothesis 8 which stated that more specialists than generalists would be oriented to the traditional patient role.

Thus, the findings lent an empirical support to the views expressed by Hughes (1971) that, as a result of the long years spent at training,

TABLE 10
 ORIENTATION TO DOCTOR-PATIENT RELATIONSHIP
 BY FIELD OF PRACTICE

	Field of Practice	
	Generalist N = 22	Specialist N = 71
	Per Cent	Per Cent
Orientation to Doctor-Patient Relationship		
Strong	39	68
Weak	68	32
	<u>100</u>	<u>100</u>
	$\chi^2_c = 7.48, df = 1, p/\chi^2_c < .01$	
	g = .63	

TABLE 11
 ORIENTATION TO MODERN PATIENT'S
 ROLE BY FIELD OF PRACTICE

	Field of Practice	
	Generalist N = 22	Specialist N = 71
	Per Cent	Per Cent
Orientation to Modern Patient's Roles		
Strong	68	87
Weak	32	13
	<u>100</u>	<u>100</u>
	$\chi^2_c = 3.10, df = 1, p < .10$	
	g = .53	

the specialist is highly oriented to the doctor role and has also become the role model for doctors in general. The moderate association between specialist practice and orientation to the modern patient role seems to contradict Bucher and Strauss' views (1961) that, as the "model" of doctor-patient relationship, the general practitioner is more patient-oriented than the specialist. However, Mumford (1970), in her study of interns, felt that the stereotypical views that specialists were unfeeling was not necessarily true, since there was nothing to suggest that they were less compassionate than the general practitioners. Ford et al. (1967) found in their study of doctors that the well-informed doctors who considered professional competence and valuing the patient as a person as constituting an effective practice were more likely to be specialists, particularly the surgeons. Also, the roles of the "modern" patient as presented in the questionnaire might have been seen by specialists, given their strong orientation to the role of the doctor, as facilitating patient management, and hence a better outcome.

The general practitioners were expected to be more accommodative of traditional patients role and this was found to be somewhat so, but the relationship was weak ($g = -.14$)

Doctor-Patient Relationship and Professionalism

Professionalism, defined as a collection of values or attitudes which characterize professionals, was measured by its behavioral and attitudinal components. Appropriate questions (nine in all) designed to measure these components included identification with one's professional organization as a primary reference group, belief in public service, belief in a sense of calling, a sense of autonomy, and professional involvement in attending

conferences and reading professional journals. From the individual scores on a five-point rating scale for each of the nine items, an Index of Professional Orientation was computed as was done for the previous indices already discussed. Thus, each respondent was scored as having a "weak" (scores of 1.89-3.77) or "strong" (scores of 3.78-5.00) professional role orientation depending on where his scores fell--either below or above the cumulative mean.

The influence of professionalism on the doctor's perception of the doctor-patient relationship was determined by cross-tabulating his scores on other orientations as in Table 12. A moderate association was found between the two variables as the gamma of 0.44 indicates; over two-thirds (70 per cent) of doctors who were strongly oriented to their profession were also strongly oriented to doctor-patient relationship, compared to 48 per cent for those whose professional orientation was weak.

The scores of doctors on orientations to the modern and traditional patient roles were cross-tabulated with their professional orientation scores. The following results were obtained: (1) a moderately low gamma of 0.28 ($X_c^2 = 1.33$, $p = \text{NS}$) indicating a weak association between orientations to modern patient's role and professionalism. Of the doctors who were ranked high on professionalism about two-thirds (64 per cent) also indicated a strong orientation to modern patient role; comparatively, about half (50 per cent) of doctors who were low on professionalism indicated a strong orientation to the moder patient role; (2) the association between professionalism and orientation to the traditional patient role was also weak ($g = 0.19$) and statistically insignificant; (3) professionalism was somewhat moderately associated with orientation to the doctor role ($g = 0.35$) and statistically significant (borderline, $X_c^2 = 2.23$, $p = 0.13$);

TABLE 12
DOCTOR-PATIENT RELATIONSHIP BY
PROFESSIONAL ORIENTATION

	Professional Orientation	
	Weak N = 48	Strong N = 47
Orientation to Doctor- Patient Relationship	Per Cent	Per Cent
Strong	48	70
Weak	52	30
	100	100
$\chi^2_c = 4.00, df = 1, p = .045$ $g = .44$		

in this case over two-thirds (71 per cent) of the doctors were "highly professional," but 50 per cent of those low on professionalism indicated a strong orientation to the doctor role.

These findings, except for the third one, were contrary to anticipations in Hypothesis 9. Professionalism was taken to be an important factor in the kind of commitment that the doctor might make either to his client or to his organization in which he is employed. Thus, it was expected, as the third hypothesis suggested, that professionalism would be inversely related to the modern and traditional patient roles, and directly related to doctor's role orientations. As it turned out, weak and unexpected relationships were found for orientations to the two types of patient roles-- more of the doctors who were highly professional indicated strong orientations to modern and the traditional patient roles, the results, therefore, did not support Wilensky's findings (1964) of a negative association between professionalism and client orientation, and also Coleman's finding (1967) that doctors who were highly oriented professionally were less patient-oriented. One explanation for this discrepancy may be that some doctors answered questions relating to the modern patient role out of a great deal of what Freidson and Rhea (1965) called "piety," since the questions involved norms, values, and definitions of patient's needs and obligations which have been institutionalized by the profession; to these few doctors, not to respond in the expected way might be viewed as failing the profession. It might also be, on the other hand, that these doctors actually possessed more collectivity orientation to the point that service to patients meant more loyalty to the values of professionalism; hence, some accommodation for traditional patient behavior as well. The hypothesis, however, was partially supported, since orientation to the doctor

role and professionalism are positively related; that is, doctors who ranked high on professionalism also tended to report a strong orientation to their role as doctor.

In conclusion, professionalism was found to be related to orientation to the modern patient and doctor roles. No clear-cut difference between doctors who ranked high or low on professionalism and their expressed orientation to the traditional patient role was found. The overall association between professionalism and doctor-patient relationship was moderate; doctors who were high on professionalism tended to report a strong orientation to the overall doctor-patient role relationship.

Summary

Of the five professionalism variables, the main field of practice was found to be associated most with (1) the doctors' overall orientation to the doctor-patient relationship ($g = .68$), (2) orientation to the modern patient role ($g = .53$), and (3) orientation to the doctor role ($g = .54$); in each case, the specialists, more than the generalists, were represented in larger proportions among those who reported strong orientations.

Professionalism was also associated moderately with orientations to the doctor-patient relationship and doctor role.

The locations of premedical, medical, and internship training were weakly and often insignificantly associated with the dependent variables, except that Nigerian premedical education was associated moderately with orientations to the traditional patient and doctor roles.

The influence of organizational variables on the doctor-patient relationship will be presented in the next section.

Organizational Structure and Doctor-
Patient Relationship

The relationship between bureaucratization of the work setting and the perception of the doctor-patient role relationships will be examined in this section. To do this, the bureaucratic atmosphere of the work setting as experienced by the doctor was measured by a composite of four attitude statements pertaining to hierarchy, rules, and procedures. As in the previous indices, doctors were rated according to whether they experienced a high (scores of 1.0-2.86) or low (scores of 2.87-5.00) bureaucratic atmosphere on the Bureaucratic Orientation Index. The first table examines the relationship between professionalism and bureaucratic orientation.

Professional and Bureaucratic
Orientations of Doctors

As the data in Table 13 show, the relationship was negative and low ($g = -.26$). Among doctors who reported a highly bureaucratic atmosphere, 43 per cent of them also reported being strong in their professional orientation; conversely, 56 per cent of those reporting low bureaucratic atmosphere were so oriented. This result provides moderate support for the hypothesis which predicted that the level of bureaucracy in the work setting was inversely related to professionalism; it also lent support to Engle's finding (1969) that highly bureaucratic organization tends to limit the professional autonomy of physicians. The effect of bureaucratic atmosphere on orientation to the doctor-patient relationship is analyzed next.

Doctor-Patient Relationship and
Bureaucratic Orientation

Bureaucratic atmosphere is also found to be negatively, though weakly, related to orientation to doctor-patient relationship as indicated in

TABLE 13
 PROFESSIONAL ORIENTATION BY
 BUREAUCRATIC ORIENTATION

	Bureaucratic Orientation	
	Low N = 43	High N = 47
Professional Orientation	Per Cent	Per Cent
Strong	56	43
Weak	44	57
	<u>100</u>	<u>100</u>
	$\chi^2_c = 1.09, p = NS$	
	$g = -.26$	

Table 14 where gamma equals $-.24$; almost two-thirds (65 per cent) of the doctors who recorded low bureaucratic atmosphere, but slightly over half (53 per cent) of those who reported a high orientation also reported a strong orientation to doctor-patient relationship

The relationship between bureaucratic orientation and the modern patient, traditional patient, and doctor role orientations indicated a similarly negative association, but the gamma values were very low ($-.15$, $-.03$, and $.14$, respectively) and non-significant. These findings confirm only in part Hypothesis 10 which predicted that high bureaucratic orientation would be associated with weak professionalism and weak orientations to modern patient, traditional patient, and doctor roles. Bureaucratic atmosphere of the work setting was associated negatively to the overall doctor-patient relationship as perceived by the doctors. However, no difference was found between the doctors with regard to their experience of bureaucratic atmosphere and orientations to the modern patient, traditional patient, as well as the doctor roles.

Doctor-Patient Relationship and the Work Setting

Another organizational variable that was expected to discriminate among doctors with regard to their orientation to the doctor-patient role relationship was their place of work, either in a teaching hospital or in the general hospital. The data in Table 15 indicate that there is a weak ($g = .15$) but significant association between the two variables: 64 per cent of doctors in the teaching hospital vs. 57 per cent of those in the general hospital reported a strong orientation to doctor-patient role relationship.

A somewhat strong association between the work setting and the doctor

TABLE 14
 ORIENTATION TO DOCTOR-PATIENT RELATIONSHIP
 BY BUREAUCRATIC ORIENTATION

Orientation to Doctor- Patient Relationship	Bureaucratic Orientation	
	Low N = 43	High N = 47
	Per Cent	Per Cent
Strong	65	53
Weak	35	46
	<u>100</u>	<u>100</u>
	$\chi^2_c = .972, p = NS$	
	$g = -.24$	

TABLE 15
DOCTOR-PATIENT RELATIONSHIP AND THE
WORK SETTING

	Work Setting	
	General Hospital N = 58	Teaching Hospital N = 36
	Per Cent	Per Cent
Orientation to Doctor- Patient Relationship		
Strong	57	64
Weak	43	36
	100	100
	$\chi^2_c = 4.41, df = 1, p < .05$	
	g = .15	

role orientation was found; though the association was weak ($g = .28$), it was statistically significant ($\chi^2_c = 21.16$, $p < .001$). Almost three-quarters (71 per cent) of doctors in the teaching hospital, compared to over half (59 per cent) of those in the general hospitals, reported a strong orientation to the doctor role. This result lends some support to a finding by Mumford (1970) that interns in the university teaching hospital tend to emphasize the role of the doctor by trying to be a "true doctor" earlier than their colleagues based in community hospitals; it appears that this also holds true for qualified physicians who work mainly in these two types of hospitals. A similarly weak ($g = .18$) association was found between work setting and orientation to the modern patient role. Only a very weak ($g = -.06$) but significant ($\chi^2_c = 5.76$, $p < .02$) relationship existed between work setting and orientation to the traditional patient role.

Though the associations between the various doctors' orientations and the place of their practice setting was generally weak, they were significant and they supported somewhat Hypothesis 11 which predicted that more of the doctors in the teaching hospital would be strongly oriented to the doctor and modern patient roles, while more of those in community hospital practice would be strongly oriented to the traditional patient role. Thus, doctors in teaching hospital practice tended to be more oriented to the modern patient and the doctor roles, while those in general hospital practice were slightly more understanding of the traditional patient role.

Patients' Educational Levels

One variable which may be classified under work setting is the type of patients whom the doctors come in contact with in their place of practice. The doctors were asked to indicate the educational level of the majority of

the patients they normally had in their daily practice; the results of their responses were then cross-tabulated with the various orientations to see whether there was any relationship between exposure they had to patients and their orientation to patients' roles.

In Table 16 are the results of the cross-tabulated data on patients' educational levels and the doctors' orientations to the overall doctor-patient relationship.

The gamma of 0.72 shows that there is a strong and significant ($\chi^2_c = 5.03, p = .02$) relationship between the two variables: of the doctors who reported that the majority of their patients were literate, 87 per cent strongly oriented to the overall doctor-patient role relationship, whereas among those reporting that most of their patients were illiterate, 51 per cent were strongly oriented to this role.

The type of patients to whom the doctors were exposed was also found to be associated with the other indices of orientations. For example, the variable associated very strongly ($g = 1.0$) with orientation to the modern patient role; among the doctors who reported that they had mostly literate patients, all of them (100 per cent) reported strong orientation to the modern patient role, compared with four-fifths (80 per cent) of those whose patients were mostly illiterate.

Exposure to patients was also found to be associated with orientation to the doctor role moderately ($g = .50, \chi^2_c = 1.95, p = .16$); in this case 81 per cent of the doctors who had literate patients, but 59 per cent of those whose patients were mostly illiterate, were also strongly oriented to the role of the doctor. In the case of the orientation to the traditional patient role, the variable associated only weakly ($g = -.18, \chi^2_c = .140, p = \text{NS}$) with the type of patient exposure the doctors had; however, the association is as can be expected, for over half (53 per cent) of those

TABLE 16
 ORIENTATION TO DOCTOR-PATIENT RELATIONSHIP
 BY PATIENTS' EDUCATIONAL BACKGROUND

	Patients' Educational Levels	
	Illiterate N = 76	Literate N = 15
	Per Cent	Per Cent
Orientation to Doctor- Patient Relationship		
Strong	51	87
Weak	<u>49</u>	<u>13</u>
	100	100
	$\chi^2_c = 5.103, p = .02$	
	$g = .72$	

who reported that the majority of their patients were illiterate, compared with 44 per cent of those whose patients were mostly literate, were strongly oriented to the role of the traditional patient.

Not only were relationships found between patients' educational level and the various orientations of the doctors but the former variable was also found to be associated fairly moderately ($g = -.47$, $X^2_C = 2.43$, $p = .11$) with the doctors' knowledge of indigenous medical culture. Over half (54 per cent) of the doctors who mostly had illiterate patients but less than a third (29 per cent) of those whose patients were mostly literate, reported strong orientation to the indigenous culture. These findings indicate that literacy level is strongly related to whether a patient is modern or traditional; this appears to be generally so in real life.

As in other studies on the relationship between bureaucratic and professional orientations, the relationships between them in this study was also found to be negative although weak. Bureaucratic orientation was also negatively and weakly related to the overall doctor-patient relationship. In both cases, those who felt a stronger bureaucratic atmosphere indicated a weak orientation to professionalism and to doctor-patient relationship.

While the relationships between the work setting and orientations to the doctor-patient relationship, the modern and traditional patient roles, and the doctor role were generally weak, they were statistically significant. Thus, most doctors in the teaching hospital indicated strong orientations to the modern patient and the doctor roles, as well as to the overall doctor-patient relationship. On the other hand, more of those in general hospital practice were oriented to the traditional patient role.

The results of the relationship between doctor's orientations and

his exposure to patients (classified under work setting), though unanticipated, yet were stronger than found among the other variables just reported. The results clearly indicate that the perception that the doctor had of his patients' attitudes and behaviors (perceived by him as modern or traditional), as well as his knowledge of his own roles and the indigenous medical culture, has something to do with the level of literacy of the patients with whom he regularly interacts in the course of his daily practice. Literacy level, as pointed out earlier, is, to a great extent, an index of how a patient is classified--as modern or traditional.

CHAPTER VI

SUMMARY OF FINDINGS AND DISCUSSION

This study started with the assumption that the type of patients encountered by the doctor in a developing society is generally different from the type encountered in the more developed ones. Consequently, the study sought to find out to what extent doctors would be responsive to such third world patients, the majority of whom are illiterate and function with a tradition of medical culture radically different from that of the scientifically trained doctors. Since a small proportion of the patients seen by the doctors in this study are literate and hence, familiar with scientific medical culture, two patient types were distinguished. The variations in the doctors' perception of these patient types, measured by the doctors' orientations to the roles of these patients in the doctor-patient relationship, were presented in Chapters 4 and 5 and will be summarized now.

The universe of this study consists of 182 Nigerian doctors practicing in the general and teaching hospitals in Lagos, Nigeria, during August to October, 1977. Each of the 136 doctors sampled from this universe was given a questionnaire and 95, or approximately 70 per cent of them, returned usable responses. The questionnaire, developed by the researcher from relevant information from the literature, contained attitudinal and behavioral items designed to inquire into the doctors' perceptions of the scientific and indigenous medical culture and the patients and doctors as well as the sick role behavior of patients in non-Nigerian and Nigerian

societies. The responses were combined into composite indexes of orientations to the modern and the traditional patient roles, the doctor role, and the overall doctor-patient role relationships. In addition, information was obtained on the doctors' age, sex, community of origin, type of primary education obtained, occupation of father, religion, locale of premedical, medical, and internship training and the main field and type of practice. Also included in the questionnaire were items on professional and bureaucratic orientations of the doctors.

The majority of the respondents were male (80 per cent) and young (77 per cent, under 45 years); almost equal proportions had medical training locally (54 per cent) and overseas (46 per cent). In terms of their main field of practice, three-fifths reported being in one of the specialties; about two-thirds were in full-time practice in the general hospitals with the rest in the teaching hospital.

Before the study's findings can be adequately summarized, it will be necessary to recapitulate the three sets of hypotheses tested and then note which were confirmed or disconfirmed.

The hypotheses tested for the study are:

Personal Characteristics

1. Age: More older doctors will be strongly oriented to the doctor, modern patient, and traditional patient roles than younger doctors.
2. Father's Occupation: More physicians of high paternal occupations will be strongly oriented to the doctor and modern patient roles, while more of those with lower paternal occupations will strongly be oriented to the traditional patient role.
3. Community of Origin: More physicians who grew up in large communities will be strongly oriented to doctor and modern patient roles, while

more of those who grew up in small rural communities will be strongly oriented to the traditional patient role.

4. Early Education: More doctors who attended Christian mission schools will be strongly oriented to the doctor and modern patient roles, while more of the attenders of non-mission schools will be strongly oriented to the traditional patient role.

5. Religion: More of the doctors from Christian background will be found among those strongly oriented to the doctor and modern patient roles, while those from non-Christian background will be found in larger number among those who are strongly oriented to the traditional patient role.

6. Traditional Cultural Orientation: More physicians with strong orientation to indigenous healing culture will be strongly oriented to the traditional patient role, while more of those who are weakly oriented to this culture will strongly be oriented to the doctor and modern patient roles.

Professional Characteristics

7. Location of Training: More of the doctors who had their premedical, medical, and internship training overseas will be strongly oriented to the doctor and modern patient roles, while more of those similarly trained in Nigeria will be strongly oriented to the traditional patient roles.

8. Field of Practice: More doctors who are specialists will be strongly oriented to the doctor and modern patient roles, while more generalists will be strongly oriented to the traditional patient role.

9. Professionalism: More doctors with strong professional orientation will be strongly oriented to the doctor role, while more of those with a weak professional orientation will be strongly oriented to the modern patient and traditional patient role.

Organizational Characteristics

10. Bureaucratization: More doctors with strong bureaucratic orientation will be weakly oriented to the doctor, modern patient, and the traditional patient roles, while more of those with weak bureaucratic orientation will be strongly oriented to these roles.

11. The Work Setting: More physicians practicing in the teaching hospital will be strongly oriented to the doctor and modern patient roles, while more of those in general hospital practice will be strongly oriented to the traditional patient role.

The findings will be summarized according to the strengths of association between each of the background characteristics (independent variables) and the doctors orientations (dependent variables). This means that each hypothesis will be discussed along with its corresponding independent variable, not in the order in which the hypotheses have been presented in the recapitulation.

Among the background characteristics of the respondents, a feature that stood out most significantly is the field of practice of the doctor. This variable was moderately associated with the overall orientation to the doctor-patient relationship ($X_c^2 = 7.48$, d.f. = 1, $p < .01$, $g = .68$) and to two of the subvariables of the dependent variable: orientation to modern patient role ($X_c^2 = 3.10$, d.f. = 1, $p < .10$, $g = .53$), and orientation to doctor role ($X_c^2 = 4.90$, d.f. = 1, $p < .05$, $g = .54$); in these two cases, more specialists were oriented strongly to the modern patient and doctor roles than were general practitioners. When orientation to traditional patient role was considered, more generalists than specialists were oriented strongly to the role. The findings, therefore, confirm generally the hypothesis (8), which predicted that more specialists would be oriented

strongly to the roles of the doctor and the modern patient, while more generalists would be found among those strongly oriented to the roles of the traditional patient.

Early education, the next characteristic which was associated more strongly with the overall doctor-patient relationship ($X_c^2 = 6.06$, d.f. = 1, $p = .01$, $g = .58$); the variable was also associated with orientation to doctor role ($X_c^2 = 2.78$, d.f. = 1, $p = .09$, $g = .44$) and modern patient role ($X_c^2 = 4.44$, d.f. = 1, $p = .02$, $g = .13$). In each of the associations, more doctors who had mission school education reported strong orientation to the doctor-patient relationship, doctor role, and modern patient role than those who attended other types of school. This pattern was repeated for the association between early education and orientation to traditional patient role where the association was weak but significant statistically ($X_c^2 = 9.0$, d.f. = 1, $p < .01$, $g = .18$). This last finding was unexpected because more of those with non-mission school education were expected to be strongly oriented to the role; this was explained by the views of Idowu (1970) and Lambo (1964) that an overt profession of faith as a Christian or Moslem does not mean that a person has totally divested himself of traditional beliefs and practices. These findings support partially Hypothesis 4.

Occupation of father is the next characteristic of the doctors found to be associated most strongly with the overall orientation to the doctor-patient relationship ($X_c^2 = 6.65$, d.f. = 1, $p < .01$, $g = -.51$); here the relationship is moderate. A rather weaker association was found between this variable and orientation to doctor role ($g = -.23$) and to traditional patient role ($X_c^2 = 25.0$, d.f. = 1, $p < .001$, $g = -.23$); there was no association between it and the modern patient role. Hypothesis 2 predicted that more of the doctors with fathers in the higher occupational level

would be found among those strongly oriented to the traditional patient role. As shown above, however, only part of the hypothesis was confirmed; that is, more doctors of lower paternal occupational levels were strongly oriented to the traditional patient role than were their counterparts with fathers of a higher occupational status. The tendency for doctors with fathers of lower occupational levels to be found more among those strongly oriented to the overall doctor-patient relationship and the doctor role was not found among older doctors for among this grouping, more of those with higher level paternal occupations were strongly oriented to the two roles. This was explained by the suggestion that these doctors with seemingly poor fathers might not be as poor as one would expect; education being a crucial vehicle for upward mobility, it was likely that these doctors took advantage of it to advance themselves as far as possible. Also, since government subsidy existed for those unable to afford medical training expenses, it was possible for some of these doctors to become specialists who in this study tended to be strongly oriented to the overall doctor-patient relationship and to the role of the doctor.

The next characteristic of the doctors found to be associated most strongly with orientation to the overall doctor-patient relationship is age ($X_c^2 = 3.05$, d.f. = 1, $p = .07$, $g = .50$); it is also moderately associated with orientation to doctor's role ($g = .42$). More older doctors were found to be strongly oriented to the overall doctor-patient relationship and to the doctor role. The two age groupings, however, were oriented to the two patient roles in almost equal proportions. Thus Hypothesis 1, which predicted that older doctors would be found in larger proportion among those strongly oriented to the three roles, is only partially supported.

Like the previous hypothesis, Hypothesis 3 on locale of rearing, which is the next variable most strongly associated with orientation to the overall doctor-patient relationship, is also supported in part. The variable was associated moderately with both orientations to doctor-patient relationship ($X_c^2 = 3.53$, d.f. = 1, $p = .05$; $g = -.46$) and the doctor role ($X_c^2 = 1.91$, d.f. = 1, $p < .10$; $g = -.37$), while it was not associated significantly with the modern patient role; these are contrary to the hypothesis predicting that more doctors reared in large communities would be strongly oriented to the modern patient and doctor roles. Thus, more of those doctors who grew up in smaller communities were strongly oriented to the overall doctor-patient relationship and to the role of the doctor; similarly, more of them also reported a stronger orientation to the traditional patient's role ($X_c^2 = 3.68$, d.f. = 1, $p = .05$; $g = .45$) as predicted by the hypothesis. It was suggested that these doctors, though reared in small communities, might in fact have matured in urban areas where most of the secondary schools they attended were located; having been exposed to the highly Europeanized curriculum in these boarding schools, they might have internalized values related to Western medical culture which continued to influence their orientations.

Professional orientation was found to be associated moderately with orientations to the overall doctor-patient relationship ($X_c^2 = 4.0$, d.f. = 1, $p < .05$; $g = .44$); it was associated similarly with orientations to the modern patient, traditional patient, and the doctor roles although weakly and insignificantly. Professionalism, therefore, was directly related to the overall orientation to doctor-patient relationship, while no significant difference was found among professional groups relative to their orientations to patient and doctor roles. Therefore, Hypothesis 9 is considered supported only partially.

The relationship between organization of practice and the overall orientation to doctor-patient relationship was found to be weak though significant statistically ($\chi^2_c = 4.41$, d.f. = 1, $p < .05$; $g = .15$); the variable associated similarly with the doctor role ($\chi^2_c = 21.16$, d.f. = 1, $p < .001$; $g = .28$), the modern patient role ($g = .18$), and traditional patient role ($\chi^2_c = 5.76$, d.f. = 1, $p = .02$; $g = -.16$). As these results show, more of the doctors who worked primarily in the teaching hospital were oriented to the overall doctor-patient relationship and the modern patient role as well as the role of the doctor; while more of those who worked in the general hospital were sympathetic to the traditional patient role. The findings, furthermore, confirm Hypothesis 11, which predicted that more of those strongly oriented to the roles of the modern patient and the doctor would be found among teaching hospital doctors, while more of those practicing in the general hospitals would be oriented to the role of the traditional patient.

The influence of the sex of doctors on their orientations showed that more male doctors were strongly oriented to the overall doctor-patient relationship ($\chi^2_c = 1.80$, d.f. = 1, $p = \text{NS}$, $g = .43$) and the doctor's role ($g = .38$), while more female doctors were oriented to the modern ($g = .41$) and traditional ($g = .18$) patient roles. Although these were not significant statistically, the pattern that evolves is important: that is female doctors were more sympathetic to the two types of patient roles, while males were more oriented to the doctor role, confirming, in part, the sex-typing concept discussed earlier.

Hypothesis 6 deals with indigenous cultural orientation and is confirmed only for orientation to modern patient role where the relationship was an inverse one: doctors who were high on indigenous cultural

orientation were oriented to the modern patient role than doctors who were weak on such cultural orientation; for the relationship between this variable and the overall doctor-patient relationship, and doctor and traditional patient roles, no significant difference was found between doctors who were strongly or weakly oriented to the indigenous cultural traditions.

A variable which is not part of the attributes of the doctor but that of the patient and found to be associated with the three orientations is the level of a patient's educational background: on the orientation to doctor and modern patient roles, doctors exposed to patients who were mostly literate were found in larger proportion among those strongly oriented to these roles, while more of the doctors with strong orientation to the traditional patient role were found to have a majority of illiterate patients; more of the latter group of doctors was also found to be strongly oriented to the indigenous medical culture.

Three hypotheses (the seventh, fifth, and tenth, respectively) based on location of medical education, religion, and bureaucratic orientation were unconfirmed, since the various orientations of doctors differed little and insignificantly on these three variables. In spite of this, however, a common trend was found among doctors who had their medical education (premedical, medical, and internship) either in Nigeria or overseas: there was a general tendency for doctors trained overseas to be more oriented to the modern patient roles, while those trained locally were more oriented to traditional patient and doctor roles.

In sum, these findings indicate that the background characteristics of the doctor were moderately (gammas of .40 and above) associated with the overall doctor-patient relationship; the strongest of these is field

of practice, followed by primary school education, occupation of father, age, place of rearing, professionalism, and practice in the teaching hospital ($g = .40$ but significant), in that order. The educational levels of patients to whom the doctors were exposed were also associated with the three orientations, perhaps more strongly than many of the doctor's background characteristics.

Discussion

Having presented the summary of findings, it is important to find out how the doctors are distributed on the three indices of orientations; this is presented in Table 17. From the data in the table, four broad types of doctors can be distinguished: (1) doctors who are strongly oriented to the roles of the modern and traditional patients, as well as to the role of the doctor; these number 27 or about 30 per cent of the total sample. (2) Doctors who are strongly oriented to two of the orientations but weakly to the third; the number of doctors in this category is 36 or about 40 per cent of the total. (3) Doctors who are strongly oriented to one of the role orientations but weakly to the two others; they number 26 or about 29 per cent of the total. (4) Doctors who are weakly oriented to all the three role orientations; two (2 per cent of the doctors fall into this category.

The doctor types will now be discussed in turn; by examining the strengths of associations obtained between the various doctor's characteristics with their orientations, it will be possible to obtain an idea of the background characteristics that are likely to be found among each grouping.

Type 1. The first type of doctor (27 in all) consists of those who have strong orientations to their role as doctor as well as to those of

TABLE 17
 DISTRIBUTION OF DOCTORS ON ORIENTATIONS TO
 DOCTOR AND PATIENT ROLES

		Doctor Role			
		Weak		Strong	
Traditional Patient Role		Modern Patient Role		Modern Patient Role	
		Weak	Strong	Weak	Strong
Weak	2	17	6	19	
Strong	3	12	5	27	
Totals	5	29	11	46	
g = .26			g = .36		

their patients, both modern and traditional; this grouping represents the strong archetype of professional doctors. The background characteristics of these doctors are likely to include those found to be strongly associated with each of the three orientations; these are: specialty practice, mission school education, older age grouping, low-level paternal occupation, rearing in a small community, high professionalism, teaching hospital and general hospital practices and both male and female sex.

Type 2. The second type of doctor represents doctors who are strongly oriented to two of the roles but weakly to one. Within this group three subtypes can be distinguished: (1) those with strong orientations to the roles of doctor and the modern patient, but weak on the traditional patient role; they number 19. (2) The group with strong orientations to the doctor and traditional patient roles but weak on the modern patient role; this group numbers 5. (3) Those with strong orientations to the modern and traditional patient roles but weak orientation to the doctor's role; there are 12 doctors in this group. Each of these three subtypes will be discussed in turn.

Subtype 1. Among the likely characteristics of the first subtype of Type 2 doctors are specialty practice and teaching hospital practice.

The significant observation is that these doctors appear to prefer patients whose knowledge of disease, symptoms, and the general sick role behavior is of the modern and scientific kind; but such patients represented less than one in five of those the doctors reported seeing frequently in their practice. Since the remaining four-fifths of their patients are the traditional type, one would expect empathy with the behavior and attitude of these patients from more of the doctors than found; obviously this is not the case, especially for specialists and those in teaching hospital practice, more of whom tended to be found among this group of doctors.

There is no agreement in the literature regarding the relationship between specialist doctors and patients. Mumford (1970) refers to the popular stereotype of specialists as less concerned with patient than general practitioners; though she admits that this is not necessarily so, she suggests that certain environmental factors may make specialists to be less responsive to patients' needs. Bucher and Stelling (1961) feel that the general practitioner, not the specialist, epitomizes the ideal doctor-patient relationship; however, Ford and his associates (1967) find specialists to value professional competence and patients as person. The present study has shown that more of the specialists tended to indicate knowledge and understanding of the behavior and attitude of modern type of patients, but not the traditional type.

These views apply also to doctors who practice in the teaching hospital, since they too appeared to be more responsive to the modern patient than the traditional one. It has been observed by Kendall (quoted in Babbie, 1970: 55) that the hierarchical structure of the teaching hospital with its attendant splintering of responsibility often leads to an impersonal attitude toward patients. It is not surprising, therefore, that a patient who perhaps cannot describe adequately what is wrong with him, how long he has been feeling that way, and who anyway has come in when his illness had reached an acute stage would be attended with less empathy than he should be receiving.

The evidence from this study lends some support to the views of Professor Adeoye Lambo (1970: 209), former dean of a medical school in Nigeria and now Deputy Director of the World Health Organization. Referring to the staff members of the medical school, he observed that they displayed a lack of appreciation for social and cultural influences on

health and disease since they considered such factors to be "unscientific" and irrelevant to medicine.

The community hospital, according to Mumford (1970), provides a better environment than the teaching hospital for developing internists interpersonal skills for dealing with all types of patients. This situation would seem to provide at least a partial explanation for the empathy with the traditional patients exhibited by more general hospital doctors.

Subtype 2. The second subtype of Type 2 doctors distinguished in this analysis are likely to be doctors whose fathers had a lower-level occupation, who were reared in a small community and attended mission school for their primary education. This type of doctor is found in larger number among those strongly oriented to the role of the doctor and the traditional patient than his colleagues whose fathers had a higher level occupation and who were reared in large communities and attended non-mission schools.

That doctors from relatively poor backgrounds are found in larger numbers among doctors oriented to these roles than those from more affluent background is due, as suggested earlier, to the fact that money seems to be no bar to medical training for poor but qualified students since the government assumes their expenses, especially in more recent times. Coincidentally, the great majority of them were specialists (85 per cent) and attended mission schools (82 per cent), both conditions could also have contributed to their orientations.

The pattern of relationship between community of rearing and the dependent variables is similar to that found between these dependent variables and father's occupation, and for similar reasons; here too, more doctors reared in small, rural communities were also found among those

strongly oriented to the roles of the doctor and the traditional patient that doctors who grew up in larger communities. Growing up in small, usually rural, communities is more likely to bring a person into closer contact with traditional medical practices, including the normative role of the patient; in addition, further exposure is enhanced by the greater likelihood that folk medicine is a more regular practice within families in small communities than in larger ones.

Western education, primary and secondary, was introduced by missionaries and was their monopoly for a long period of time in the large cities as well as in small and remote locations in the country. The first modern health institutions were also initiated by them; hence, students who attended mission schools were more easily exposed at an earlier time to some rudimentaries of Western medical practice; clinics, infirmaries, etc., were often a part of the mission school establishment, and these might have served to contribute to the stronger orientation to the roles of both the doctor and modern patient.

Since the mission school also provided missionaries with the opportunity to convert their students to Christianity, preaching against traditional beliefs, including those that had to do with traditional healing, was common. This would seem, therefore, to suggest that attenders at such schools would be less likely to compromise with the beliefs and practices which the traditional patients would bring into the relationship with the doctor; the findings of this study, however, showed that these doctors were also significantly oriented to these patients. An explanation for this could be found in the latent function served by preaching of Christian virtues such as healing the sick, caring for the poor, and feeling of compassion, which were intended to impress the student

with the merits of the new religion but which perhaps had conditioned the doctor later in life to be compassionate toward the traditional patients, in spite of the latter's "ignorance." Also, the syncretistic orientation that characterizes various religious groups in the country might also have made the doctors more aware of the indigenous medical culture relating to disease and health.

Subtype 3. The third subtype of Type 2 doctors is likely to be found among female doctors; the pattern of the orientation of these doctors shows that they were less concerned with playing the role of doctor than they were with having an understanding of all patients--both modern and traditional. This tendency toward a patient orientation on the part of the female doctors was partially explained earlier as perhaps due to the greater cultural emphasis on the nurturance role inculcated in females early in their life.

Type 3. The third type of doctors (26 in all) are those strongly oriented to one of the three roles but weakly oriented to two others. Like Type 2 doctors, three subtypes can be distinguished within this group in terms of their orientations:

Subtype 1. Those strong on the modern patient role but weak on both doctor and traditional patient role (17 in all). These doctors are likely to include doctors who are weak on orientation to indigenous medical culture.

Subtype 2. Doctors who are strong on doctor role but weak on both the modern and traditional patient roles (6 in all); this subtype is likely to include older and male doctors.

Subtype 3. Those strong on the traditional patient role but weak on on the modern patient and doctor roles; the three doctors in this grouping

are likely to be generalists and those in general hospital practice.

The general lack of empathy to the role of the traditional patient exhibited by many doctors, as discussed earlier, is also shown in the Type 3 group; while 17 (i.e., all of Subtype 1) doctors are strongly oriented to the modern patient role, only three (Subtype 3) are similarly oriented to the traditional patient role. Looked at another way, 23 doctors (combination of Subtypes 1 and 2) are weakly oriented to the traditional patient role, only nine (Subtypes 2 and 3) are weakly oriented to the role of the modern patient. Clearly, therefore, one can assume that many traditional patients are not receiving as much attention and consideration from the doctors as are given to the modern patients.

Type 4. The fourth type of doctors are those weakly oriented to the three roles; there are two of them. The characteristics of these doctors are likely to include non-mission school education.

In summarizing this section on the distribution of doctors relative to their orientations, about a third (27) indicate unmixed orientations, while the reported orientations of about two-thirds (64) are mixed. These doctors can be ranked according to their effectiveness, defined as the ability to relate properly to patients (with particular emphasis on the traditional ones) in providing quality care. Such "effective" doctors are those whose orientations, either singly or in combination with other orientations, include strong orientation to the attitude and behavior of the traditional patient. The various groupings of doctors, in the order of "most effective" to "least effective," are: (1) those strong on all the three role orientations--27; (2) those strong on both modern and traditional patient roles, but weak on doctor role--12; (3) those strong on doctor and traditional patient roles, but weak on modern patient role--5; (4) those strong on traditional patient role, but weak on modern patient

and doctor roles--3; (5) those strong on modern patient and doctor roles, but weak on traditional patient role--19; (6) those strong on modern patient role, but weak on traditional and doctor roles--17; (7) those strong on doctor role, but weak on modern and traditional patient roles--6; and lastly, (8) those who are weak on the three roles--2.

The number of doctors in the first four groupings which include a strong orientation to traditional patient role in their orientations, is 47; this represents 52 per cent of the 91 (four less than the original sample of 95 due to non-response) doctors involved in this study. In a setting where more than four-fifths (83 per cent) of the doctors described the patient being served by them as "traditional patients," it is disconcerting to note that only half of these physicians seem to exhibit a strong awareness of the importance of cultural factors in themselves and the potential impact of those factors on the traditional patients under their care.

Some Implications of Findings and Suggestions

The previous discussion has indicated that certain characteristics of the doctor do not make for the achievement of ideal health care delivery, which Sigerist defines as the outcome of a successful interplay between the doctor and the patient who receives the services. It would seem that many Nigerian doctors felt more at home with the more knowledgeable patients than with the vast majority of the traditional patients with whom they interact every day. Some implications of these findings and suggestions of what can be done to improve the doctor-patient relationship will be discussed.

Training More General Practitioners

One probable implication of the findings on specialty practice is that more doctors should be trained to be generalists rather than specialist,

since somewhat more of the first category have been found among those with empathy for traditional patients; the time and expense needed to train a specialist might be better used to increase the output of generalists. This is not to say that specialization is totally out of place in a society such as Nigeria, for specialists in the areas of tropical and preventive medicine are needed; but the more highly remote specialt^{is} which are so attractive to many doctors should be discouraged. Since it appears from the results of this study that the less highly technically trained the doctor is, the better is his relationship with the poor patients, it follows that medical auxiliaries with even less training than doctors should be used increasingly for routine medical care, while difficult cases can be referred to the doctor as the teach leader. Though not in particular reference to a better relationship between the doctor and the patient, this line of thinking has been advanced by writers such as Maurice King (1970: 1-15) in his discussion of intermediate technology as a means of bringing health care to larger proportions of urban and rural dwellers in the Third World nations.

Village Projects

There are indications that medical schools in Nigeria are taking a second look at their often uncritical duplication of Western medical education in an effort to be accepted internationally; this change is evidenced in the various village projects which are established to provide small locales outside the teaching hospital in which medical students are exposed to rural medical care. Though the emphasis is on the technical aspect of rural practice (that is, how the doctor can manage patients without access to hospital equipment and facilities), such training should include opportunities for learning at first hand the various cultural

aspects of care, particularly from the viewpoint of patients. This point has been suggested by the finding that doctors who were reared in small rural communities were more oriented to the traditional patient role than those reared in the larger community; village projects, therefore, should provide such patient experience to the latter grouping of doctors.

Another finding that lends some support to the idea of medical training in the local environment is that doctors trained within the country appeared to be more strongly oriented to the traditional patient roles, while those trained in overseas medical schools to be more oriented to the roles of the more knowledgeable patient. Though this finding is inconclusive (because of the weak and insignificant association between location of medical training and orientation to patients), the consistent pattern of findings in this area point to the likelihood that local training may produce doctors who will be more understanding of the traditional medical culture, hence to the vast majority of the patient encountered in the doctor's practice in the country.

Cooperation with the Traditional Healers

Another area which can help the doctor to learn more about indigenous medical beliefs and practices is in establishing a working relationship with the traditional healers. Less than half the doctors in this study admitted to having any kind of relationship with these healers, and less than two per cent of them had any working relationship with any of them. A rather successful cooperation between modern and traditional healers has been demonstrated by Lambo in which traditional healers were used by psychiatrists as assistants. These healers can similarly be used in the medical care area. China was reported to have laid the foundation for the widely available medical care in that nation by mobilizing traditional

health practices mixed with modern medical and health practices (Dunlop, 1975: 585). The important point here is that interaction between the doctors and healers enhances the opportunity for the doctor to learn more about the world view of the villager and consequently be better able to have a positive relationship with him.

The previous suggestions (training more generalists and medical auxiliaries, continuation and expanding village projects, and cooperation by the doctor with traditional healers) are aimed at improving the doctor's knowledge of the patients so he can better relate to them. An important finding of this study is the strong relationship between the exposure that the doctor has to patients and his knowledge of them; it was found that doctors who were exposed to traditional patients were represented in a larger number among those with strong orientation to traditional patient role and to the general indigenous medical culture. Similarly, doctors who were exposed mostly to relatively modern patients were found in larger proportion among those with strong orientation to the modern patient and doctor roles. These findings, therefore, suggest an additional reason for implementing the previous suggestions and reinforce the view that for the doctor to really know his patients and to better relate to them, particularly the traditional patients, it is important that he maintain a close contact with them.

Teaching

One of the major jobs of the physician, according to Kaplan (quoted in Hedinger, 1976: 26) is to teach. There are many areas in which the doctor can help the patient to begin to have a more objective, as opposed to supernatural, conception of disease. In a study on environmental sanitation in Nigeria, Okediji and Aboyade (cited in Okediji, 1972: 315)

found a direct relationship between education and income level, on the one hand. The poorest and most illiterate were the least informed; this category experienced little difficulty in understanding the linkage between health and personal hygiene but found it difficult to see the connection between health and the state of environmental sanitation. This is no surprise in a population where most people have no knowledge of the germ theory and where diseases are seen as due to the machinations of evil doers and other supernatural forces. It is in areas of this type that the doctor can be helpful in informing the patients to cultivate the right perceptions of illness and health. He can also teach the patient the values of early diagnosis and care, the importance of using drugs as prescribed, and the keeping of appointments.

What the Government Can Do

Medical care delivery in many developing nations is characterized by an overwhelming shortage of doctors. The doctor-patient ratio in Nigeria, for example, is between 1:30,000 and 1:100,000, and this heavy patient load is compounded by an acute shortage of facilities and equipment. When doctors work under such dire conditions, it will be difficult, except for the most compassionate and those really called into medicine, for doctors to have enough patience in dealing with traditional patients who often find it difficult to ask pertinent questions within the short space of time that the doctor has available to see them. The government should be committed to providing health care to all the people by allocating more funds for the training of more doctors and providing more facilities and equipment. Considering that money is spent on grandiose projects such as civic halls, sports stadia, etc., more careful planning can curb such wastefulness and the money saved

an be used for more worthwhile projects such as health services. The current year's budget gives some attention to providing more funds for health and social services, but the allocation is still less than 2 per cent of the gross national product--this is very low, especially when it is remembered that about 5 to 9 per cent of similar income is allocated to health care in industrialized nations.

Perhaps more crucial than anything that the government can do toward enlightening the people is the expansion of educational facilities for all. Currently, the literacy rate is under 30 per cent; therefore, both the primary education for the young and adult education for the old should be expanded.

The Media

The press, TV, and radio can also help in disseminating health information which will provide the people with alternative views on health and disease different from the prevailing ones that are often of a folk and preternatural nature. In a two-month period (June and July, 1977), about twenty articles on health issues were found in the various Nigerian newspapers published in the English language. The articles covered various topics: preventive care, food and nutrition, immunization, community health, sewage disposal system, food poisoning, rheumatism, psychosomatic illness, and female problems. This appears encouraging, but the readership of these papers is only a part of the literate population, which in turn is less than a third of the population as a whole; thus, there is a need for similar articles in the newspapers which are printed in the local languages and are read by less sophisticated readers. Video materials should be made available for those who cannot read, both in the urban and the rural areas.

Conclusion

A basic assumption of this study, and one which has support from other writers (Donabodian, 1966; Ford et al ., 1967; Croog and Steeg, 1972), is that the quality of care given by the doctor is determined not only by the process of care or the outcome of such care (that is, the use of equipment in surgery or the application of drugs which help the patient to regain his health) but also by the kind of social relationship generated by the interaction between the sick person and the healing agent. This means that where a doctor is committed to serve a patient, he is more likely to provide the necessary technical care suited to the patient's condition.

Therefore, quality care, as an important aspect of the doctor's role performance, is related to his background characteristics as well as to his professional training (Coe and Grehm, 1972). In this study, a number of background characteristics of the doctor were found to be associated with his empathy and orientations: these include his type of practice, age, community of rearing, professionalism, and practice setting. In terms of sensitivity to patients' needs, doctors were found to be generally more attuned to the modern than the traditional patient role, even though the latter represented over three-quarters of the patients seen by them. While 75 (82 per cent) of the 91 doctors (Table 16) included strong orientation to modern patient role among their other orientations, the comparative figure for those whose orientations included a strong one to traditional patient role is 47 or 52 per cent of the total.

In formulating the three roles constituting the dependent variable,

the concept of ideal type was resorted to, as indicated earlier, in order to differentiate between the two patient types which are the modern and the traditional. In doing this, however, it is still questionable whether these patient types can indeed be found in the real world or whether they are just convenient artifacts forced to suit a conceptual model for the sake of analysis. This reconsideration seems warranted since some of the roles assigned to these patients, particularly the modern (Western) patient, may not be exclusive to any one particular type; for example, the sense of individualism which calls for the sick person to seek medical aid on his own and assigned as one of the modern patient's role aspects, is not always an individual decision or responsibility even in Western societies (Zola, 1968). Similarly, the mystical-religious element in the traditional patient's view of the doctor can also be found in the doctor-patient relationship in the West as well (Wilson, 1963), and, as Blum asserts (1960), animistic-magical thinking about disease is not limited to folk societies but is widespread in Western societies as well.

All these views, therefore, appear to confound the dichotomy of the modern (Western) and traditional patient types. However, the ideal type concept allows certain modal patterns of patient behavior to be selected to represent what may be found in Western societies; that is not to say that there are no people with differing perceptions and reactions to illness (since such differences among the social classes are well documented), but that there are certain behavioral characteristics that in fact differentiate patients who are conversant with the demands of doctor-patient interactions within the context of scientific medical culture from patients who are used to folk or nonscientific medical culture.

The literature is replete with examples of class as well as intercultural differences in patient behavior (see, for example, Saunders, 1954; Foster, 1965; Jansen, 1973). Though similar differences can be found within different classes in Western societies, as Bloom and Wilson (1972) point out, the differences are multiplied over and over in intercultural situations when scientific medicine is introduced to non-Western cultures. There is evidence, such as that provided by Jansen, that those in non-Western societies who have assimilated Western ideas and values through formal education show patterns of illness behavior which are distinct from those shown by their counterparts who are illiterate but similar to those seen in Western societies. The results of the present study confirm this; it also shows that the distinction made between the modern and the traditional patients is not only valid but actually exists in real life.

A number of suggestions were made, based on the findings of the study; included are the need for increasing the number of general practitioners and medical auxiliaries, continuation and expansion of the existing village projects whereby doctors are enabled to practice for periods of time in rural environments, cooperation between doctors and indigenous healers, teaching as an important role of the doctor, and the roles that the government and the media can play in providing technical and informational aids for better health care delivery. These suggestions in the main are an attempt to get the doctor into closer contact with the patients since such contacts have been shown to enhance his understanding of them.

Implications of Some of the Findings for Sociology

Many of the investigations done on health care delivery within various organizational contexts are from the perspective of the patient while those done from the perspective of the doctor are, comparatively, very few and often theoretical in nature (Coe and Brehm, 1972: 25). Most of these investigations are concerned with organizations in Western societies; similar investigations on non-Western contexts are very few and largely anthropological. The present study, therefore, is not only a contribution to the investigations of health care delivery done from the perspective of the doctor, but it is also an empirical inquiry based on a non-Western society.

Functionalism and Structuralism

Underlying the functionalist sick role analysis are assumptions of mutuality and reciprocity of expectations which facilitate a symmetrical relationship between the doctor and the patient; the structuralist view, on the other hand, emphasizes a conflictual relationship because of the ambivalence characterizing the expectations of participants. The present study points out empirically that where a doctor's role expectations differ from those the patient is able to enact, a conflictual situation arises; thus, doctors are strongly oriented to the role of the more enlightened patients; when presented with hypothetical, tradition-oriented patients, they indicate lower preference (as indicated by their low orientation scores) for such patients. However, the opposite is the case when doctors are confronted with a hypothetically more enlightened patient; in this instance, the doctors are more positively disposed to such patients' attitude and behavior.

Professionalization

Studies such as those of Wilensky (1964) and Coleman et al. (1967) point to an inverse relationship between professionalism and client orientation, that is, professionals who are highly oriented to their profession are less oriented to clients. The present study, however, indicates that it is possible for some doctors to be oriented strongly to their patients (especially in the case of patients who need extra empathy such as the traditional ones) while at the same time to be strongly inclined to the medical profession.

One reason for this kind of association is given by Freidson and Rhea (1965) who suggest that some doctors answer questions relating to professionalism out of "piety" for the profession; thus, one may suspect that some of the doctors in the present study who indicated strong orientation to patients might in fact be weakly oriented in practice were it not for their pious responses. This might or might not be the case since it is difficult to evaluate a doctor's motives for responding in a certain way to professionalism items in a questionnaire. It is possible, however, for doctors, like other professionals, to harbor mixed orientations; this was found to be the case by Babbie (1970)—certain academic doctors who were strongly oriented to research were also strongly oriented to patient care. These varied results, therefore, appear to call for a re-examination of the relationship between professionalism and client orientation, for the relationship between the two may not always be an inverse one.

Professional Socialization

Medical education provides an avenue for imparting special knowledge and attitude to the physician; however, some aspects of medical

orientation may have been learned and become firmly entrenched even before the start of medical education. The effects of such early influences, e.g., in the region in which the doctor was reared, were found on the attitudes of doctors to Medicare in a study by Babbie (1970: 181). In the present study, it is significant to find two categories of doctors who were consistently found more among doctors who were strongly oriented not only to the traditional patients but also to a general knowledge of indigenous medical culture: the doctors whose fathers were farmers and who were raised in rural communities. These background characteristics must have continued to exert their influence, from childhood and through the years of professional training. This may not mean that the doctors in question are less scientifically oriented than their colleagues, but it appears to mean that they are better able to accommodate to traditional beliefs than are their colleagues from more affluent backgrounds and large cities.

Occupation of Father and Community of Rearing as Variables

The present study has indicated that these variables must be used with caution when studying African societies. A low-grade occupation, such as farming or trading, may not necessarily indicate poverty, nor that children of farmers or traders are necessarily condemned to total ignorance of Western ideas and values since many such children are exposed to such ideas (like other children from more affluent backgrounds) in highly Europeanized schools and often reside in urban areas where most of these boarding schools are located and where such ideas are widespread. This is similarly true of a person born and raised in a rural community who has very likely attended schools in urban areas as well. Thus,

more information about the father's income, father's ambition for the child, length of residence in both rural and urban areas at various times in the life of the respondent, his reference groups (e.g., a close or distant relative, members of the same town, etc.) and other similar information must be asked before categorizing respondents in survey studies.

Suggestions for Further Studies

The quality of care given by the doctors in this study is partly determined by the strength of his orientation to the patient types: strong orientation implies a positive attitude, and weak orientation suggests that the doctor is negatively disposed to the patient. This is due, as pointed out in the theoretical section, to the fact that the quality of care is often related to the extent to which both the doctor and the patient share similar value systems--the more dissimilar such value systems are, the more likely will the doctor or the nursing personnel categorize the patient as a nuisance, a hypochondriac, or a similar epithet. Whereas when both the doctor and the patient share similar value systems, the greater is the likelihood that the doctor will feel comfortable with such patients. In each case, the quality of care given by the doctor will be affected for bad or for good (Croog and Steeg, 1972: 288).

Such an evaluation can only be partial since it does not explain how such doctor's perspective of the patient affects the clinical care given that patient. It is a truism that, as with any other profession, some doctors perform medical tasks better than others; but an evaluation of such performance by studying the type and number of tests ordered for particular disease symptoms and the way the symptoms are managed, includ-

ing direct observation of the doctor at work, will give more reliable results. Hence, future research, designed to measure the influence of patient perception by doctors on their actual clinical performances, will throw more light on the extent to which the traditional patients are actually being short-changed.

The study of the relationship between the doctor and the patient from the perspective of the doctor is a valid one. Though few studies now exist there are enough that have taken this line of approach. However, a deeper understanding of the relationship will be likely if future studies investigate also the patient's own views of the doctor, modern medical practice, and his experience with the traditional healers. Such studies will provide insight into the patient's satisfaction with either of the two healing agents and what his expectations from both are.

One other area in which future studies can supplement the present one is the inclusion of certain other variables which were not explored: these are functions of the doctor and communication between the doctor and the patient. Assuming a teaching role by the doctor can help to enlighten the patient about attitude and behavior appropriate to modern medical practice. However, the present study had no hypothesis based on teaching so that something could be learned about which types of doctors already practice this and which would be more disposed to practicing it than others. Another variable that was not explored was communication; the importance of communication in the relationship between the doctor and the patient cannot be overemphasized. Several studies have already been done on it. Any future study, particularly if it is to study the patient's views of the relationship, should take this variable into account.

The sample of doctors studied in the present research was urban and limited to only one city (although the city, Lagos, is the second largest city in population and contains at least a quarter of all the doctors in the country). Thus, the problem of extrapolating the present findings to the rest of the country exists. Future studies should include as many doctors as possible who practice mainly in the rural and other less urbanized areas. This will enable more definitive views of doctors toward traditional patients and indigenous medical culture to be obtained; it will also help in finding out whether the influence of early childhood socialization on orientations to traditional patient and indigenous culture is more or less important than is proximity to these patients and rural environment.

The problem of doing survey work in a developing country when there is no strong financial support for the researcher was borne out by the problem of access to clerical facilities, especially in preparing the questionnaires. The number of questionnaires sent out to the doctors was limited by the number that could be carried from the United States; hence, even with a return rate of 70 per cent, the sample is small. This small size affects the analysis of the data since it does not allow for controlling certain variables; very often the cell frequencies obtained were below 5, thus making them unstable for making tests of significance and allowing only zero-order gammas in assessing the strength of the relationships. A larger sample, perhaps selected from the country as a whole, is surely needed for future studies.

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APPENDIX A

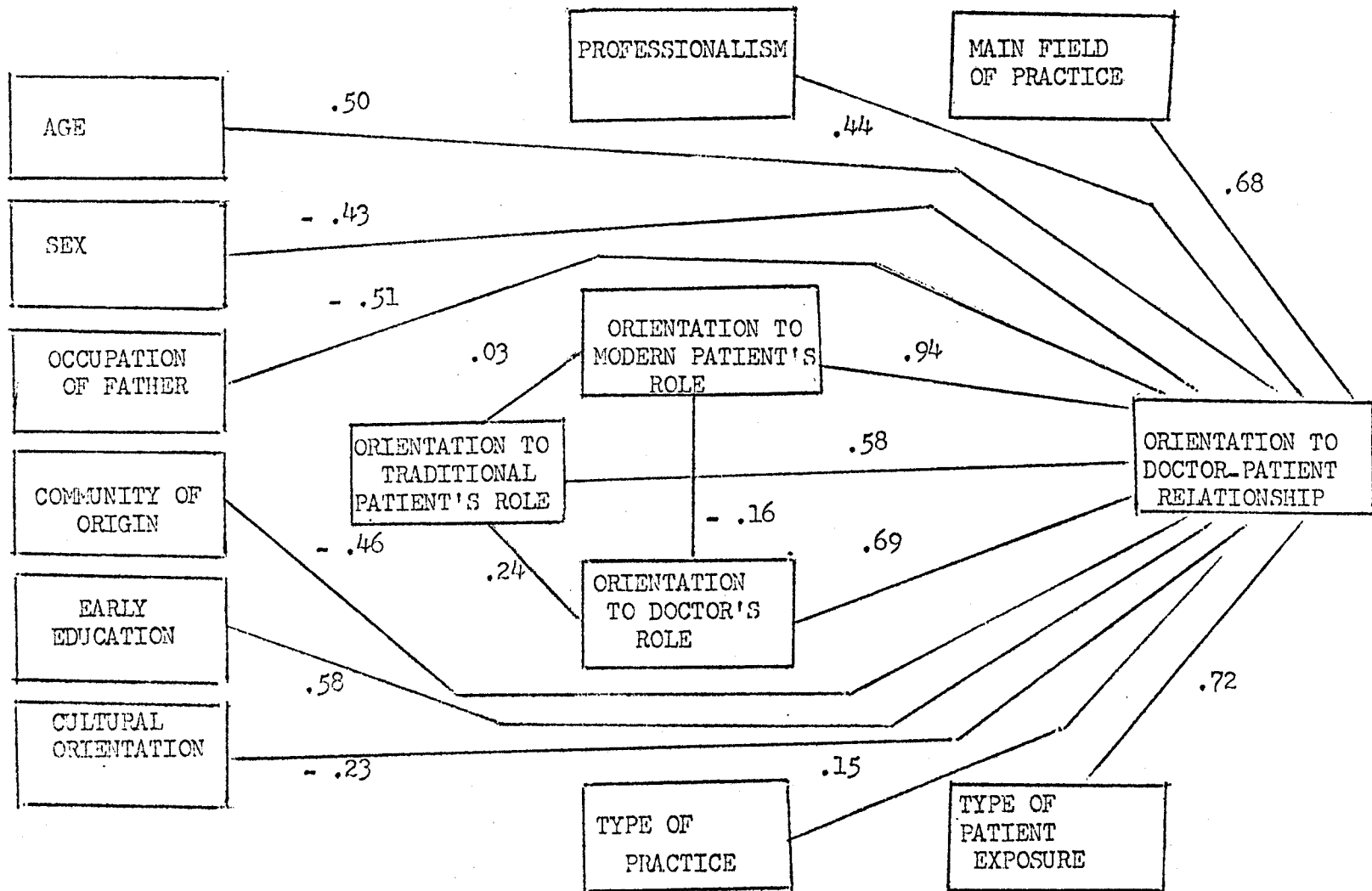


FIGURE 3. MAP DIAGRAM OF ORIENTATIONS TO OVERALL DOCTOR-PATIENT RELATIONSHIP WITH GAMMAS

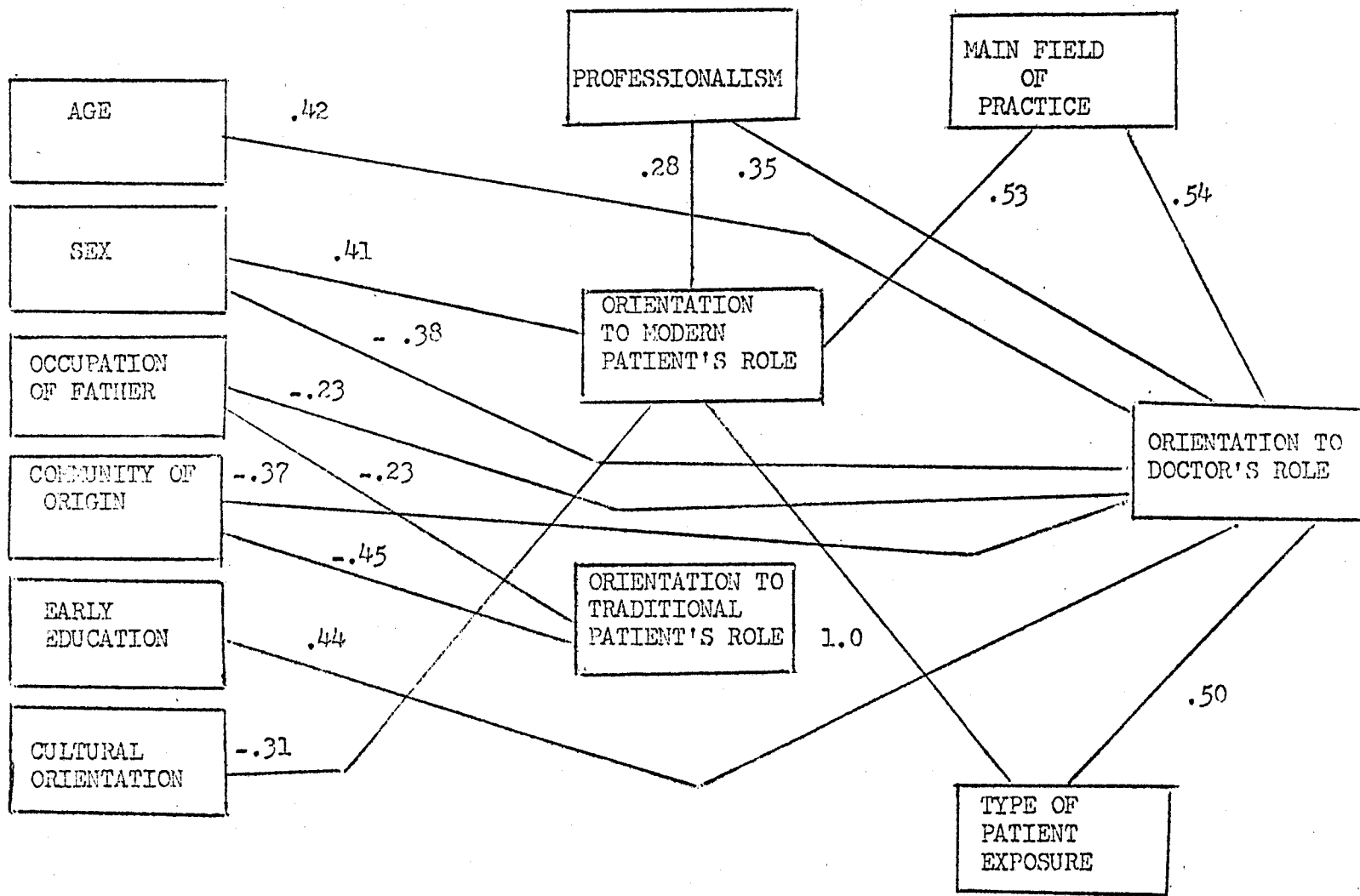


FIGURE 4. MAP DIAGRAM OF ORIENTATIONS TO DOCTOR'S, MODERN PATIENT'S, AND TRADITIONAL PATIENT'S ROLES WITH SELECTED GAMMAS

APPENDIX B

Dr. Victor L. Lawoyin,
(Chairman),
Oyo State Health Council,
Ibadan

August, 1977.

Dear Colleagues,

I like to introduce you to Mr. Gbola Adejumobi and to ask you for a favour.

Mr. Adejumobi is collecting materials for his doctoral desertation and he has some questionnaires for you. At a glance the questionnaire papers appear bulky and cumbersome but, believe me, they are not all that difficult to complete. It took me about 22 minutes to complete mine and I am a slow reader.

I am soliciting your cooperation in completing these questionnaires. You will be helping a fellow Nigerian to achieve his educational goal when you do.

Thank you for giving me a few minutes of your precious time.

Sincerely,

(Dr. Victor L. Lawoyin), MD
Chairman,
Oyo State Health Council.

c/o 5 Force Road, Flat 8
Lagos, Lagos State
August 22, 1977

Professor E.A. Elebute, Provost
College of Medicine
University of Lagos
Lagos, Nigeria

Dear Sir,

I am a graduate student in the department of sociology at Loyola University of Chicago, Illinois, U.S.A. I am in the process of writing a dissertation which will attempt to investigate the doctor-patient relationships and how they can be improved. The data needed for the study are to be collected through questionnaires which are to be filled by Nigerian doctors, plus some interviewing.

Lagos and its metropolitan areas constitute the major focus of this study. Among physicians in this area, those at the College of Medicine represent the largest group, albeit an academic one, and this is why they are of very great importance to this study. I am, therefore, seeking your kind permission to distribute questionnaires to them and interview a few of them as necessary. Such permission, I am sure, will facilitate the contacts which are so crucial to the success of the data-gathering process.

I do not have any letter from my school to introduce me. However, I am attaching a copy of a letter from the Dean of the Graduate School of the school which notified me of the approval of my dissertation outline. As a further proof of my identity, I am bringing along my student identification card No. 512-50-6716 for the current academic year.

Thank you very much for your time and cooperation.

Sincerely yours,

Adegbola Adejunnobi

BASIC HEALTH SERVICES SCHEME IMPLEMENTATION AGENCY
c/o INSTITUTE OF CHILD HEALTH OF THE UNIVERSITY OF LAGOS

**HEALTH CENTRE BUILDING
BANDLE AVENUE SURULERE**

DIRECTOR:
PROFESSOR OLIKOYE RANSOME-KUTI, MB, FRCP, FMCPAED.

AG. SECRETARY:
OLAYINKA AJALA, DIP. BM. ACIS.

CABLE: CHILINST. LAGOS.
TELEGRAM: CHILINST. YABA.
TELEPHONE: 41604
POSTAL ADDRESS:
P. M. B. 1001 SURULERE.
LAGOS, NIGERIA.

Ref :

26th September, 1977.

Dear Colleagues,

Mr. A. Adejumo recently sent to you, a questionnaire for a survey of doctors' opinions relating to their patients and work in general. Having become acquainted with the study which is now at its data-collection stage, I believe that it is an effort that should be supported with our responses.

Much of the information that has come to us on doctor-patient relationship is a result of similar studies conducted in many western countries in the past. Such studies have shown beyond doubt the importance of social and cultural factors as they influence an effective delivery of health services. However, since these studies are based on cultures that are relatively foreign to ours, some of the findings therefrom cannot be extrapolated to our conditions and needs. This is why it is important for us to conduct similar investigations that will take our social and cultural environments as a starting point. Very few of such studies are now available, and that is why I believe that we should give our serious support to the one being currently conducted by Mr. Adejumo.

Needless to say, I know how very heavy our schedules are and how difficult it is for us to have extra minutes for ourselves, not to talk about filling questionnaires. However, I trust that you will do all you can to return the questionnaire already mailed to you duly completed. I have been told that a strict anonymity will be maintained; there is, therefore, no need for your name to appear on the questionnaire itself.

I thank you for your time and your co-operation.

Yours faithfully,


O. RANSOME-KUTI
Director

c/o 5 Force Road, Flat
Onikan, Lagos
Lagos State
November 3, 1977

Dear Sir/Madam,

I would like to express my gratitude to the doctors who had completed and returned the questionnaires sent to them a few weeks ago. Their participation in the survey of physicians' activities and their relationship to their patients will no doubt contribute immensely to the scientific understanding of these phenomena and help toward a betterment of the health care delivery to the citizens at large.

For various reasons some doctors have not been able to return their questionnaires. Perhaps I should point out once again that all the doctors who had been included in the survey were scientifically selected and, by now, it is impossible to re-select another group to replace those who still have not returned theirs. Therefore, another opportunity is being given to those who may still wish to be included among the participants in the study; this they can do by completing and returning their questionnaires at their earliest convenience.

I thank you all for your past and present cooperation.

Very sincerely yours,

A. Adejunmobi

APPENDIX C

SURVEY OF DOCTORS' OPINIONS

Either pen or pencil may be used to complete the questionnaire. Please disregard the numbers which appear in the text of the questions. They are for the use of IBM tabulating machine operators.

In the first section, I would like to learn something about your interests, activities, and opinions regarding your practice and the medical profession in general.

Part I. PROFESSIONAL INTERESTS, ACTIVITIES AND OPINIONS

Beside each of the statements presented below, please indicate whether you Strongly Agree (SA), Moderately Agree (MA), Undecided (U), Moderately Disagree (MD), or Strongly Disagree (SD) by putting a check mark in the appropriate box. (Check only one box for each statement.)

	<u>SA</u> 1	<u>MA</u> 2	<u>U</u> 3	<u>MD</u> 4	<u>SD</u> 5
1. I receive professional stimulation from my colleagues in my practice	07 ()	()	()	()	()
2. I have a direct communication with my patients and an access to all vital information concerning them	08 ()	()	()	()	()
3. I believe in practising high quality medicine with minimum compromise in standards	09 ()	()	()	()	()
4. Whenever it is necessary, I am able to alter a treatment procedure (e.g., giving or stopping a medication) which lies within my area of medical specialization	10 ()	()	()	()	()
5. I systematically read the professional journals (e.g., <u>British Journal of Medical Education, Lancet, etc.</u>)	11 ()	()	()	()	()
6. The national professional medical organization doesn't do much for the average member	12 ()	()	()	()	()
7. I think my profession, more than any other, is essential to the society	13 ()	()	()	()	()
8. I regularly attend professional meetings at the national level	14 ()	()	()	()	()
9. Whenever I am the attending physician I am able to discharge a patient <u>on my own</u> if I feel that his treatment is completed	15 ()	()	()	()	()

Page 2

- | | <u>SA</u>
1 | <u>MA</u>
2 | <u>U</u>
3 | <u>MD</u>
4 | <u>SD</u>
5 |
|--|----------------|----------------|---------------|----------------|----------------|
| 10. Although I would like to, I really don't read the journals too often | 16 | () | () | () | () |
| 11. I believe that professional medical organization(s) should be supported by membership | 17 | () | () | () | () |
| 12. Other professions (e.g., clergy, law) are actually more vital to society than mine | 18 | () | () | () | () |
| Note: Please <u>skip</u> items 13-16 if your practice is <u>solo</u> . | | | | | |
| 13. Whenever there is a professional superior around, I normally refer every clinical procedure to him for an answer | 19 | () | () | () | () |
| 14. I am expected to follow standard procedures in all situations | 20 | () | () | () | () |
| 15. Doctors feel that they are constantly being watched to see that they obey all rules | 21 | () | () | () | () |
| 16. If a doctor wants to progress he must learn to defer to professional superiors | 22 | () | () | () | () |

In this section, I hope to learn something about your opinions on traditional beliefs relating to illness and the traditional healers such as the herbalists, diviners, and faith healers.

Part II. OPINIONS ON TRADITIONAL BELIEFS AND TRADITIONAL HEALERS

Beside each of the first five statements presented below please indicate whether you Strongly Agree (SA), Moderately Agree (MA), Undecided (U), Moderately Disagree (MD), or Strongly Disagree (SD) by checking the appropriate box. (Check only one box for each statement.)

- | | <u>SA</u>
1 | <u>MA</u>
2 | <u>U</u>
3 | <u>MD</u>
4 | <u>SD</u>
5 |
|---|----------------|----------------|---------------|----------------|----------------|
| 17. I believe that to understand the patient and his illness a doctor should have a knowledge of how the indigenous healers (such as the herbalists, diviners and faith healers) treat their patients | 23 | () | () | () | () |

Page 3

- | | <u>SA</u>
1 | <u>NA</u>
2 | <u>U</u>
3 | <u>MD</u>
4 | <u>SD</u>
5 |
|---|----------------|----------------|---------------|----------------|----------------|
| 18. I believe that medical practice is a part of the culture of any society just as are the marriage, religious and other practices | 24 | () | () | () | () |
| 19. I believe that there are justified reasons for Africans to believe in supernatural influence in the aetiology of diseases | 25 | () | () | () | () |
| 20. I believe that certain physical disorders can be treated better by traditional healers than by scientific medicine | 26 | () | () | () | () |
| 21. The "power" of the traditional healer lies more in his personality than in his technical performance | 27 | () | () | () | () |
| 22. I believe that certain mental disorders can be treated better by traditional healers than by scientific medicine | 28 | () | () | () | () |
| 23. How would you rank the traditional healers in terms of the efficacy of their healing practices? (Place <u>1</u> opposite the highest, <u>2</u> opposite the <u>next</u> to the highest, etc.) | | | | | |
| 29 | () | () | () | () | () |
| | () | () | () | () | () |
| | () | () | () | () | () |
| | () | () | () | () | () |
| 24. If by accepting the traditional healers ranked highest by you as members of the health team a doctor can help these healers improve their practice, would you accept them? (Check <u>one</u> of the following.) | | | | | |
| 30 | () | () | () | () | () |
| | () | () | () | () | () |
| | () | () | () | () | () |
| | () | () | () | () | () |
| | () | () | () | () | () |
| 25. Would you approve or disapprove the incorporation of the non-magical healers (such as the herbalists) into the modern medical services? (Check <u>one</u> of the following.) | | | | | |
| 31 | () | () | () | () | () |
| | () | () | () | () | () |
| | () | () | () | () | () |
| | () | () | () | () | () |
| | () | () | () | () | () |
| 26. Do you now have or have you ever had any kind of relationship with any of the traditional healers? | | | | | |
| 32 | () | () | () | () | () |
| | () | () | () | () | () |

27. If yes, what kind? (Check more than one if necessary.)

- 33 () 1. As friend(s)
- () 2. As relatives
- () 3. As adviser(s) in certain types of illness
- () 4. As patient(s)

Comment
.

In this section, I hope to learn about what you and your colleagues do in certain situations, as well as about your patients. In responding to some of these questions, please keep in mind similar cases that you have treated in the past.

Part III. OPINIONS ON PRACTICE AND PATIENTS

28. It is generally recognized that some medical duties require that the physician have a considerable understanding of the personal problems of his patients' lives. Generally speaking, should your colleagues consider this orientation as appropriate to the type of patient contacts that you know they normally have? (Check one of the following.)

Personal involvement to increase understanding is

- 34 () 1. definitely appropriate
- () 2. probably appropriate
- () 3. probably inappropriate
- () 4. definitely inappropriate

29. How do you generally relate to your patients? (Check one of the following.)

- 35 () 1. Always establish rapport with them
- () 2. Frequently establish rapport with them
- () 3. Occasionally establish rapport with them
- () 4. Never establish rapport with them

Comments
.

30. The nature of the physicians' work is such that it brings them into contact with all kinds of patients having various social and economic backgrounds. How should doctors treat these patients? (Check one of the following.)

Such non-medical factors (e.g., wealth, education) should be

- 36 () 1. considered wholly irrelevant
- () 2. considered somewhat irrelevant
- () 3. considered somewhat relevant
- () 4. considered wholly relevant

31. How do you treat patients having different social and economic backgrounds? (Check one.)

- 37 () 1. I always treat them as equal
- () 2. I usually treat them as equal
- () 3. I occasionally treat them as equal
- () 4. I never treat them as equal

Any comments?

32. Suppose a patient tells the doctor what he thinks to be wrong with him and what type of treatment he needs. If he should ask for a specific treatment (such as a particular drug or an injection), how should the doctor treat such a patient if the self-diagnosis is accurate and the drug or injection appropriate even though not what the doctor would ordinarily prescribe for the condition? (Check one.)

- 38 () 1. Definitely accede to the patient
- () 2. Probably accede to the patient
- () 3. Probably refuse the patient
- () 4. Definitely refuse the patient

33. What do you do when a patient asks you for a particular type of treatment and you know that it is indeed needed? (Check one.)

- 39 () 1. I give the treatment but let the patient know that it is done only on sound medical basis
- () 2. I tell the patient that it is better to leave such decisions to the doctor
- () 3. I tell him that he should have treated himself since he knows so much
- () 4. I am angered and let him know I am

34. What do you do when you know that the treatment asked is in fact not needed? (Check one.)

- 40 () 1. I give him a placebo
- () 2. I tell him that it is better to leave such decisions to the doctor
- () 3. I tell him that he should have treated himself since he knows so much
- () 4. I am annoyed and I tell him so

35. How common or uncommon are such requests made to you? (Check one.)

- 41 () 1. Almost every day
- () 2. Almost every week
- () 3. Almost every month
- () 4. Not at all

Comments

36. It is often asserted that some medical duties call for a definitely detached attitude on the part of the doctor. Generally speaking, should a doctor consider this orientation as appropriate or inappropriate to the type of patient contacts that you know he normally has? (Check one.)

Page 6

Personal attachment is

- 42 () 1. definitely appropriate
- () 2. probably appropriate
- () 3. probably inappropriate
- () 4. definitely inappropriate

37. How do you generally deal with your personal feelings when treating patients? (Check one.)

- 43 () 1. Always keep my personal feelings from interfering with treatment
- () 2. Occasionally keep my personal feelings from interfering with treatment
- () 3. Never able to keep my personal feelings from interfering with treatment

Comments

38. Suppose a patient consulting one of your colleagues showed that he had a fair knowledge of the workings of the human body and so he was able to recognize and interpret his physical symptoms (e.g., peptic ulcers). What effect do you think such traits of the patient would have on the doctor in making his diagnosis? (Check one.)

- 44 () 1. Would definitely assist the doctor
- () 2. Would probably assist the doctor
- () 3. Would probably hinder the doctor
- () 4. Would definitely hinder the doctor

39. Whenever you encounter such a patient, do you find his attitude as assisting or hindering you in making a diagnosis? (Check one.)

- 45 () 1. I am definitely assisted
- () 2. I am somewhat assisted
- () 3. I am somewhat hindered
- () 4. I am definitely hindered

40. How often would you say that you encountered such patients in the course of your past practice? (Check one.)

- 46 () 1. Almost every day
- () 2. Almost every week
- () 3. Almost every month
- () 4. Not at all

Comments, if any

41. Some patients who are used to consulting traditional healers (such as the herbalists, faith healers, and diviners) may attribute an omnipotent magical power to them; coming to the modern doctor, these patients tend to ascribe a similar power to him as well as the drug(s) prescribed. How would you suggest that your colleagues should react to and treat such patients? (Check one.)

- 47 () 1. Explain the limits of the help the patients can expect from them as doctors
- () 2. Try to understand why the patients perceive them in that way
- () 3. Regard the patients as uninformed and superstitious
- () 4. Remind the patients that a modern physician could not be equated with the traditional healers

Page 7

42. Whenever you find that some patients perceive you as having an omnipotent healing power, what is your reaction toward them? (Check one.)

- 48 () 1. I explain to them the limits of the help they can expect from me
- () 2. I try to understand why they perceive me in that way
- () 3. I regard such view as uninformed and superstitious
- () 4. I remind them that, as a modern physician, I can not be equated with the traditional healers.

43. How many of your patients perceive you in this way? (Check one.)

- 49 () 1. All
- () 2. Most
- () 3. Few
- () 4. None

Do you have any comments?

44. Some people are able to recognize symptoms of a disease early and go to the doctor as soon as possible. How favorable or unfavorable do you think your colleagues should be toward such a person if they had him as a patient? (Check one.)

- 50 () 1. Highly favorable
- () 2. Favorable
- () 3. Unfavorabel
- () 4. Very unfavorable

45. How do you personally feel toward such patients when you have them? (Check one.)

- 51 () 1. Compliment them for their sense of responsibility
- () 2. Am favorably disposed to them.
- () 3. Feel they are screwat over-concerned with their health
- () 4. Such patients could be hypochondriacs

46. How often do you encounter patients of this type in your practice? (Check one.)

- 52 () 1. Always
- () 2. Frequently
- () 3. Occasionally
- () 4. Never

Any comments?

47. Some people who consult traditional healers (such as the herbalists, diviners, and faith healers) often develop a total and uncritical faith in such healers. When they consult a modern doctor they put a similar faith in him so that they become totally dependent, that is, are passive, unquestioning, and leaving all decisions to the doctor. How do you think your colleagues should feel toward such patients who are so dependent? (Check one.)

- 53 () 1. Such patients could become pests
- () 2. Treat them strictly on medical terms and ignore the dependency
- () 3. Treat them strictly on medical terms and discourage the dependency
- () 4. Treat them strictly on medical terms and try to fulfill their dependency need

48. When you encounter such very dependent patients, how do you react toward them? (Check one.)

- 54 () 1. I feel they could become pests
- () 2. I treat them strictly on medical terms and ignore their dependency
- () 3. I treat them strictly on medical terms and discourage their dependency
- () 4. I treat them strictly on medical terms and try to fulfill their dependency need

49. Would you say that you encounter such patients always or not at all in your practice? (Check one.)

- 55 () 1. Always
- () 2. Frequently
- () 3. Occasionally
- () 4. Never

Comments, if any

50. Patients sometimes recognize that they are a free agent, that is, that they have the right to choose or terminate the physician and his treatment as they choose. Would you say that your colleagues should approve or disapprove such attitude on the part of the patients? (Check one.)

- 56 () 1. Strongly approve
- () 2. Somewhat approve
- () 3. Somewhat disapprove
- () 4. Strongly disapprove

51. From your own experience, do you generally approve or disapprove such an attitude when displayed by any of the patients you had in the past? (Check one.)

- 57 () 1. Strongly approve
- () 2. Somewhat approve
- () 3. Somewhat disapprove
- () 4. Strongly disapprove

52. Do you often or rarely have such patients? (Check one.)

- 58 () 1. Almost every day
- () 2. Almost every week
- () 3. Almost every month
- () 4. Not at all

Comments

53. As patients continue to see the doctor some of them develop trust and confidence in him and often become dependent on him; such dependency may be very subtle, that is, the patient is not totally passive since he is able to ask questions relating to his treatment. Generally speaking, should this type of dependency be deemed appropriate or inappropriate by your colleagues? (Check one.)

- 59 () 1. Definitely appropriate
- () 2. Probably appropriate
- () 3. Probably inappropriate
- () 4. Definitely inappropriate

54. From your past experience, did you encourage or discourage such type of dependency when displayed by any of your patients? (Check one.)

- 60 () 1. I always encouraged it
- () 2. I sometimes encouraged it
- () 3. I sometimes discouraged it
- () 4. I always discouraged it

Comments

55. How frequently do you encounter patients who, though somewhat dependent, yet are able to take some active part in asking and answering questions during consultation with you? (Check one.)

- 61 () 1. Almost every day
- () 2. Almost every week
- () 3. Almost every month
- () 4. Not at all

Comments

56. Some people with symptoms of serious disease sometimes consult the indigenous healers (such as the herbalists, diviners, and faith healers) because they don't have an easy access to a modern doctor but at other times because they just prefer to see these healers anyway; they ultimately come to the modern doctor after indigenous healing has failed but by this time the illness has progressed to an advanced stage. How in your opinion, should your colleagues treat such a patient whenever he consults them? (Check one.)

- 62 () 1. Definitely rebuke him for his irresponsibility
- () 2. Mildly rebuke his for his irresponsibility
- () 3. Mildly rebuke him, but noting that the delay can be understood
- () 4. Do not rebuke him, noting that the delay can be understood

57. When you had a patient with an advanced disease consulting you for the first time, what did you do? (Check one.)

- 63 () 1. I referred him to another doctor
- () 2. I hated to get involved but I was obligated to treat him anyway
- () 3. I did all I could to help him, and I tried to understand why the delay occurred.
- () 4. I did all I could to help him, understanding why the delay occurred

58. How commonly or not at all do you generally have patients of this type? (Check one.)

- 64 () 1. Almost every day
- () 2. Almost every week
- () 3. Almost every month
- () 4. Not at all

Any comments?

Patients differ in the way they conceive of time in terms of the clock or the calendar; birth records and birthdays are not always kept. The experiences of some of these patients may indicate that the traditional healers whom they normally consult hardly, if at all, ask questions that are related to time. Such patients may find it difficult to be cooperative when in consultation with a modern physician who is likely to ask them time-related questions or perform time-related tasks. Generally, to what extent do you think that the following patient traits or attitudes should interfere or be helpful to the way in which your colleagues relate to, or treat such a patient? (Check one box for each item.)

Physicians find this

	Definitely Helpful 1	Somewhat Helpful 2	Somewhat Hindering 3	Definitely Hindering 4
59. Patient is unable to state his exact age	65 ()	()	()	()
60. Patient is able to use internal medication on time as ordered by the doctor	66 ()	()	()	()
61. Patient is unable to remember the onset and duration of his symptoms	67 ()	()	()	()
62. Patient cannot recount his childhood illnesses or diseases	68 ()	()	()	()
63. Patient is unable to apply external medication in the time interval prescribed by the doctor	69 ()	()	()	()
64. Patient is able to present an accurate description of his illness	70 ()	()	()	()

To what extent were these traits helpful or constituted an interference with your treatment of patients when they consulted you in the past? (Check one box for each statement.)

	Definitely Helpful 1	Somewhat Helpful 2	Somewhat Hindering 3	Definitely Hindering 4
65. Patient is unable to state his exact age	71 ()	()	()	()

		Definitely Helpful 1	Somewhat Helpful 2	Somewhat Hindering 3	Definitely Hindering 4
66.	Patient is able to use internal medication on time as ordered by the doctor	72 ()	()	()	()
67.	Patient is unable to remember the onset and duration of his symptoms	73 ()	()	()	()
68.	Patient cannot recount his childhood illnesses or diseases	74 ()	()	()	()
69.	Patient is unable to apply external medication in the time interval prescribed by the doctor	75 ()	()	()	()
70.	Patient is able to present an accurate description of his illness	76 ()	()	()	()

How often have you had patients who displayed each of these traits? (Check one box for each statement?)

		Always 1	Frequently 2	Occasionally 3	Never 4
71.	Patient is unable to state his exact age	77 ()	()	()	()
72.	Patient is able to use internal medication on time as ordered by the doctor	78 ()	()	()	()
73.	Patient is unable to remember the onset and duration of his symptoms	79 ()	()	()	()
74.	Patient cannot recount his childhood illnesses and diseases	80 ()	()	()	()
75.	Patient is unable to apply external medication in the time interval prescribed by the doctor	87 ()	()	()	()
76.	Patient is able to present an accurate description of his illness	88 ()	()	()	()

Comments

Page 12

The experience of some doctors has shown that some women are reluctant to disrobe for physical examination or treatment if the doctor is male; similar reluctance has been found among the male patients by female doctors.

77. (FOR FEMALE DOCTORS) How often do you encounter such a problem with male patients? (Check one.)

- 09 () 1. Always
 () 2. Frequently
 () 3. Occasionally
 () 4. Never

78. (FOR MALE DOCTORS) How often do you encounter such problem with your female patients? (Check one.)

- 10 () 1. Always
 () 2. Frequently
 () 3. Occasionally
 () 4. Never

Generally, what do you do whenever you encounter such patients?

Comments

79. Some patients are highly motivated to recover from their illness (e.g., eager to be discharged from the hospital and go back to work) while others are less so. How favorable or unfavorable should doctors feel toward such patients? (Check one.)

- 11 () 1. Highly favorable
 () 2. Favorable
 () 3. Unfavorable
 () 4. Very unfavorable

80. Whenever you have a patient showing no desire to get well, what do you do or how do you react? (Check one.)

- 12 () 1. I feel a doctor could do nothing if a patient lacked the desire to get well
 () 2. I feel that motivation to get well is unimportant as long as I treat the patient
 () 3. I sometimes encourage him in any way I can to be interested in getting well
 () 4. I always encourage him to be interested in getting well

81. How often have you had patients who, for one reason or another, showed a lack of desire to recover from their illness? (Check one.)

- 13 () 1. Almost every day
 () 2. Almost every week
 () 3. Almost every month
 () 4. Not at all

82. In general, how literate or illiterate are your patients? (Check one.)

- 14 () 1. Highly literate
- () 2. Literate
- () 3. Semi-literate
- () 4. Illiterate

83. Some people attribute the cause of, and remedies for, diseases to supernatural powers; lacking a knowledge of the workings of the human body these people are unable to interpret physical symptoms even in a rudimentary scientific manner. If a patient of this type consulted any of your colleagues, should such traits of the patient constitute a problem or should it constitute no problem for the doctor in his treatment procedures? (Check one.)

- 15 () 1. Definitely a problem
- () 2. Probably a problem
- () 3. Probably no problem
- () 4. Definitely no problem

84. Whenever you have patients whose orientation to illness and cure was of this type, how do you react to or treat them? (Check one.)

- 16 () 1. I tell them that they are being superstitious
- () 2. I am surprised that patients can hold such views
- () 3. I feel that they are only reflecting their culture's view
- () 4. I try to teach them about physical cause of illness

85. Would you say that this view of illness is characteristic of most or none of the patients that you normally see? (Check one.)

- 17 () 1. Most
- () 2. Some
- () 3. None

Comments

86. Some patients cooperate very well with the doctors while others do not. Generally, how much cooperation should doctors expect from patients? (Check one.)

- 18 () 1. Total (full)
- () 2. Much
- () 3. Some
- () 4. Hardly any
- () 5. None at all

87. How cooperative in general are your patients? (Check one.)

- 19 () 1. Completely cooperative
- () 2. Usually cooperative
- () 3. Usually uncooperative
- () 4. Completely uncooperative

Comments

88. It is recognized that physicians have strong needs for affection and gratitude to be expressed by their patients toward them. How important to you are these expressions of respect and appreciation from patients? (Check one.)

- 20 () 1. Extremely important
- () 2. Fairly important
- () 3. Fairly unimportant
- () 4. Not at all important

89. How often do your patients usually or rarely show their respect for and appreciation to you? (Check one.)

- 21 () 1. Always
- () 2. Frequently
- () 3. Occasionally
- () 4. Never

90. How high would you say that you enjoy the prestige accorded you by your patients?

- 22 () 1. Very high
- () 2. High
- () 3. Low
- () 4. Very low

91. How would you describe the social class of the patients that you had during your internship? (Check one.)

- 23 () 1. Lower
- () 2. Middle
- () 3. Upper

Comments

Finally, I would like to ask you a few questions about your background. If you feel that any question is too personal, then please feel free to skip it. However, all questionnaires will be completely anonymous and since this section is very important to the study, I hope that you will answer each question.

Part IV. PERSONAL BACKGROUND

92. Sex

- 24 () 1. Male () 2. Female

93. Age

- 25-26 () 1. under 35
- () 2. 35-44
- () 3. 45-54
- () 4. 55-64
- () 4. 65 or over

Page 15

94. What was the type of community in which you lived most of the time prior to entering the university? (Please check one.)
- 27 () 1. Small farming community
 () 2. Small town (less than 10,000 population)
 () 3. Medium-sized town (10,000-25,000 population)
 () 4. City (over 25,000 population)
95. 28 What is (was) your father's occupation? (Please be specific).....
96. What is your religious preference?
- 29 () 1. Christianity
 () 2. Islam
 () 3. Other (specify).....
 () 4. None
97. How important is your religion to you now?
- 30 () 1. Extremely important
 () 2. Fairly important
 () 3. Fairly unimportant
 () 4. Not at all important
98. What school did you attend for most of your primary education? (Check one.)
- 31 () 1. Government
 () 2. Mission
 () 3. Islamic
 () 4. Other (specify).....
99. In what year did you receive your medical degree? (Check one.)
- 32-33 () 1. Before 1955
 () 2. 1955-59
 () 3. 1960-64
 () 4. 1965-69
 () 5. 1970-74
 () 6. 1975 and later
100. Where did you have your premedical education? (Check one.)
- 34 () 1. Nigeria
 () 2. Britain
 () 3. U.S.A.
 () 4. Elsewhere (specify).....
101. Where did you attend medical school? (Check one.)
- 35 () 1. Nigeria
 () 2. Britain
 () 3. U.S.A.
 () 4. Elsewhere (specify).....

Page 16

102. Where did you intern? (Check one.)

- 36 () 1. Nigeria
 () 2. Britain
 () 3. U.S.A.
 () 4. Elsewhere (specify).....

103. Where did you do your residency? (Check one.)

- 37 () 1. Nigeria
 () 2. Britain
 () 3. U.S.A.
 () 4. Elsewhere (specify).....

104. What is your main field of practice? (Check one.)

- 38 () 1. General practice
 () 2. Internal medicine
 () 3. Surgery
 () 4. Pediatrics
 () 5. Obstetrics-Gynecology
 () 6. Public Health
 () 7. Other (specify).....

105. What type of practice do you now have? (Check one.)

- 39 () 1. Private practice
 () 2. Academic medicine
 () 3. Full-time salaried position (in government hospitals and other institutions)
 () 4. Full-time salaried position (in private, mission, or corporation hospitals and other institutions)
 () 5. Public health and preventive medicine
 () 6. Other (specify).....

106. If private practice, what kind? (Check one.)

- 40 () 1. Solo
 () 2. Partnership
 () 3. Group

Thank you for your time and consideration in completing this questionnaire. If there are any further comments you would care to make in regard to this study or any of the issues covered in the questionnaire, the remaining space has been provided for that purpose and I welcome your remarks.

APPROVAL SHEET

The dissertation submitted by Adegbola Adejunmobi has been read and approved by the following committee:

Dr. Ross P. Scherer, Chairman
Associate Professor, Sociology, Loyola

Dr. Paul Mundy
Professor, Sociology, Loyola

Dr. Kirsten A. Grønberg
Assistant Professor, Sociology, Loyola

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

December 15, 1978

Date

Ross P. Scherer, Ph.D.

Director's Signature