

Power, Professional Hierarchies, and Health Service Delivery: Evidence from Yariman Bakura Specialist Hospital, Gusau

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ARTICLE INFORMATION	ABSTRACT
<p>Article history: Published on 30th Jan 2026</p> <p>Keywords: Power Professional Hierarchies Health Delivery</p>	<p>Power relations and professional hierarchies are central but often underexplored dimensions of health service delivery in developing healthcare systems. This study examines how power dynamics and professional hierarchies shape healthcare practices and patient outcomes at Yariman Bakura Specialist Hospital (YBASH), Gusau, Zamfara State, Nigeria. Using a qualitative research design, in-depth interviews and key informant interviews were conducted with doctors, nurses, pharmacists, laboratory scientists, hospital administrators, and patients. Thematic analysis revealed that hierarchical authority structures significantly influence decision-making, inter professional collaboration, and access to timely healthcare services. While professional hierarchy ensures organizational order and accountability, it also produces communication barriers, delays in service delivery, and marginalization of lower-ranked health workers and patients. The study argues that power asymmetries within hospital settings affect both the quality and equity of healthcare delivery. The findings contribute to medical sociology by highlighting how institutional power relations intersect with professional roles to shape everyday clinical practice in Nigerian public hospitals. The study recommends institutional reforms that promote collaborative practice, inclusive decision making, and participatory governance to improve health service delivery.</p>

1. Introduction

Health service delivery is widely recognized as a cornerstone of social development and human well-being. Beyond the provision of biomedical treatment, healthcare institutions function as complex social organizations where professional roles, authority structures, and power relations shape everyday practices (Cockerham, 2017). Hospitals, in particular, are arenas in which diverse professional groups interact within formal bureaucratic systems governed by institutional norms, clinical expertise, and organizational hierarchies. These social arrangements profoundly influence how healthcare services are accessed, delivered, and experienced by both providers and patients (Scott et al., 2000). Globally, sociological and organizational studies of healthcare have demonstrated that medical institutions are not neutral or purely technical spaces. Rather, they are embedded within broader systems of power, social inequality, and professional dominance (Freidson, 2001). Medical sociology has long emphasized that healthcare delivery is shaped by social relations, including professional hierarchies, institutional authority, and control over knowledge (Turner, 2008). Power within healthcare settings determines who makes decisions, whose expertise is valued, and how scarce resources are allocated. These dynamics, though often implicit, have direct implications for service quality, efficiency, equity, and patient satisfaction (Foucault, 1973; Waring & Bishop, 2010).

Professional hierarchies are a defining feature of hospital organization. Historically, the medical profession particularly physicians has occupied a dominant position due to its control over specialized knowledge, licensing, and diagnostic authority (Freidson, 1970). This dominance is institutionalized through professional training systems, legal frameworks, and hospital governance structures (Abbott, 1988). Other health professionals, such as nurses, pharmacists, laboratory scientists, and allied health workers, are positioned lower within these hierarchies despite their central roles in patient care (Allen, 2015). While hierarchical structures may promote order, accountability, and specialization, rigid hierarchies can also generate communication barriers, professional tensions, and exclusion from decision-making processes (Reeves et al., 2017). In contemporary healthcare discourse, there is increasing emphasis on collaborative, patient-centered, and interprofessional care models. These approaches recognize that effective healthcare delivery depends on cooperation among multiple professional groups and active patient participation (World Health Organization, 2010). However, entrenched power relations and professional hierarchies often undermine these ideals, particularly in public healthcare systems where bureaucratic control and resource constraints intensify institutional rigidities (D'Amour et al., 2005). Understanding how power operates within hospital settings is therefore essential for improving health service delivery and addressing systemic inefficiencies.

In low- and middle-income countries, including Nigeria, the influence of power and professional hierarchies on health service delivery is further complicated by structural challenges such as inadequate funding, workforce shortages, poor infrastructure, and uneven access to care (Akinyemi et al., 2018; WHO, 2019). Nigeria's healthcare system operates within a pluralistic framework comprising public, private, and traditional sectors, with public hospitals serving the majority of the population, especially low-income and rural communities (Federal Ministry of Health [FMoH], 2016). Despite various health sector reforms, public hospitals continue to face persistent challenges in delivering timely, equitable, and high-quality care (Obansa & Orimisan, 2013).

Much of the existing literature on healthcare delivery in Nigeria has focused on macro level issues such as health financing, policy implementation, workforce distribution, and infrastructural deficits (Onwujekwe et al., 2019). While these studies provide valuable insights, they often overlook the micro-level social processes that shape everyday interactions within healthcare institutions. Power relations among healthcare professionals, administrative authority, and patient-provider interactions remain underexplored, despite their critical influence on service delivery outcomes (Adeloye et al., 2017). This gap is particularly significant given the hierarchical nature of Nigerian public institutions and the broader socio-cultural context in which authority, seniority, and professional status are deeply embedded (Ogunbekun et al., 2018). Professional hierarchies within Nigerian hospitals are influenced by colonial legacies, professional training systems and bureaucratic governance structures (Okeke, 2016). Medical doctors typically occupy positions of dominance, clinically and administratively, often serving as heads of departments and key decision-makers (Adebayo et al., 2020). Nurses and allied health professionals, though numerically significant and central to patient care, frequently have limited influence over institutional policies and clinical decisions (Oladipo et al., 2019). These hierarchical arrangements can create inter-professional tensions, restrict collaboration, and limit the effective utilization of diverse forms of expertise within hospital settings (Reeves et al., 2010).

Power dynamics in healthcare institutions also extend beyond professional relations to include administrative and managerial authority. Hospital administrators exercise bureaucratic power through control of budgets, schedules, procurement processes, and personnel management (Weber, 1978). While administrative oversight is essential for institutional functioning, excessive bureaucratic control can delay clinical decisions, constrain professional autonomy, and negatively affect patient care (Mintzberg, 2009). In emergency and resource-constrained settings, such delays can have serious consequences for health outcomes. Patients occupy the lowest position within hospital power structures. In many public hospitals in Nigeria, patients experience symbolic powerlessness due to limited health literacy, socioeconomic disadvantage, and cultural norms that discourage questioning professional authority (Waitzkin, 2000; Onyeonoro et al., 2016). The asymmetry of knowledge between healthcare providers and patients reinforces this imbalance, making patients passive recipients of care rather than active participants in decision-making (Charles et al., 1997). Such dynamics undermine patient-centered care and may contribute to dissatisfaction, mistrust, and poor adherence to treatment (Street et al., 2009).

Yariman Bakura Specialist Hospital (YBASH), located in Gusau, Zamfara State, serves as a major public referral hospital providing secondary and specialist healthcare services to residents of Gusau metropolis and surrounding rural communities. As one of the most important health institutions in the state, YBASH operates under conditions common to many Nigerian public hospitals, including high patient load, limited resources, and diverse professional staffing (Zamfara State Ministry of Health, 2022). These conditions create a context in which power relations and professional hierarchies are likely to have a pronounced impact on health service delivery. Despite the hospital's strategic importance, there is limited empirical research examining the internal social organization of YBASH, particularly regarding how power and hierarchy shape professional interactions and patient experiences. Understanding these dynamics is especially important in Zamfara State, where socioeconomic challenges, insecurity, and limited access to healthcare services heighten population vulnerability (National Bureau of Statistics [NBS], 2021). In such settings, inefficiencies arising from institutional power struggles or weak collaboration can further compromise already fragile health outcomes.

From a medical sociology perspective, examining power and professional hierarchies within YBASH provides an opportunity to understand how broader social inequalities are reproduced within healthcare institutions (Cockerham, 2017). Hospitals reflect the societies in which they operate; thus, patterns of authority, gender relations, seniority, and professional dominance within hospitals mirror wider social structures (Bourdieu, 1990). Investigating these patterns at the institutional level offers insights into how social forces shape health and illness beyond biological explanations. This study is therefore situated at the intersection of sociology, health systems research, and organizational studies. By focusing on the lived experiences of healthcare workers and patients at Yariman Bakura Specialist Hospital, the research seeks to illuminate the often-invisible social mechanisms that influence health service delivery. It moves beyond technical assessments of healthcare performance to examine how power is exercised, negotiated, and contested in everyday hospital practices (Foucault, 1980). In doing so, the study responds to calls for more context-specific, qualitative research on healthcare delivery in Nigeria (Adeloye et al., 2017). It recognizes that improving health outcomes requires not only increased funding and infrastructure but also institutional reforms that address social relations, professional boundaries, and power imbalances. By foregrounding power and professional hierarchies as central analytical lenses, this research contributes to a deeper understanding of the challenges facing public healthcare institutions and highlights pathways toward more equitable, collaborative, and effective health service delivery.

2. Literature Review

Power as a Central Concept in Healthcare Organizations

Power has long been a central concern in sociological analyses of healthcare organizations. Early organizational theorists viewed hospitals as rational systems governed by rules and authority, but later sociological scholarship revealed them to be contested spaces where power is negotiated among professional groups (Scott et al., 2000). Power in healthcare institutions determines access to resources, control over knowledge, and authority in decision-making processes. Rather than being solely concentrated at

the top of organizational hierarchies, power is dispersed across professional practices, institutional routines, and informal interactions. This understanding is crucial for analyzing how health services are delivered, particularly in complex hospital environments. From a Weberian perspective, power in healthcare organizations is institutionalized through bureaucratic authority, hierarchical supervision, and formalized roles (Weber, 1978). Hospitals rely on clearly defined chains of command to coordinate specialized labor and manage risk. However, Weber also acknowledged that bureaucracy can produce rigidity, inefficiency, and depersonalization, especially when rules overshadow professional judgment. In healthcare settings, bureaucratic power may delay service delivery and constrain clinical autonomy, thereby affecting patient outcomes.

Professional Dominance and the Medical Profession

The concept of professional dominance remains central to understanding power relations in healthcare. Freidson (1970) argues that the medical profession achieved dominance by monopolizing specialized knowledge, controlling entry into practice, and securing autonomy from external regulation. This dominance enables physicians to define the terms of healthcare delivery, including diagnosis, treatment protocols, and standards of care. Hospitals, as institutional settings, reinforce this dominance by positioning physicians at the top of clinical hierarchies. Subsequent studies suggest that although managerial reforms and evidence-based medicine have challenged some aspects of medical autonomy, physicians continue to wield significant power within hospital systems (Freidson, 2001; Scott et al., 2000). Medical dominance shapes interprofessional relations and often marginalizes the contributions of other health workers, even when collaborative care models are formally endorsed.

Professional Hierarchies and Division of Labor in Hospitals

Hospitals are characterized by a highly stratified division of labor, with professional hierarchies structuring roles, responsibilities, and authority. Abbott's (1988) theory of professional jurisdiction explains how different health professions compete for control over tasks and areas of expertise. In this competition, medicine has historically secured the most prestigious and authoritative jurisdictions, while nursing and allied professions operate within more constrained boundaries. Empirical studies show that nurses and allied health professionals often possess extensive experiential knowledge of patient care but lack institutional power to influence decisions (Allen, 2015). These hierarchical arrangements can lead to frustration, reduced morale, and underutilization of professional skills. The literature consistently demonstrates that rigid hierarchies impede teamwork and reduce the effectiveness of healthcare delivery.

Inter professional Relations and Collaboration

Inter professional collaboration has emerged as a key strategy for improving health service delivery, particularly in complex care environments. The World Health Organization (2010) emphasizes that collaborative practice enhances patient safety, efficiency, and workforce satisfaction. However, research indicates that collaboration is difficult to achieve in contexts where power differentials and professional hierarchies remain entrenched (D'Amour et al., 2005). Studies across various healthcare systems reveal that hierarchical dominance by physicians often limits open communication and shared decision-making (Reeves et al., 2017). Nurses and allied health professionals may be reluctant to voice concerns or challenge decisions, even when patient safety is at risk. These findings underscore the need to address power relations as a prerequisite for effective inter professional collaboration.

Power, Communication, and Clinical Decision-Making

Communication within healthcare teams is deeply shaped by power relations. Research on patient safety and organizational behavior shows that hierarchical cultures discourage speaking up and critical dialogue (Waring & Bishop, 2010). Junior staff frequently defer to senior professionals, leading to missed opportunities for error prevention and quality improvement. Decision-making authority concentrated at the top of professional hierarchies can also marginalize alternative perspectives. Nurses and laboratory scientists often report that their observations are overlooked despite their proximity to patients and diagnostic processes. Such exclusion not only undermines professional dignity but also affects the timeliness and quality of care.

Power, Inequality, and Health Service Outcomes

Power relations within healthcare institutions are closely linked to health inequalities. Sociological research demonstrates that hospitals can reproduce broader social inequalities through differential treatment, access barriers, and institutional bias (Bourdieu, 1990). Marginalized patients are more likely to experience neglect, disrespect, or delayed care, reinforcing patterns of inequality. Hierarchical fragmentation and poor collaboration also contribute to inefficiencies in health service delivery. Studies show that institutions with rigid power structures tend to have lower staff morale, higher error rates, and poorer patient outcomes (D'Amour et al., 2005). These findings highlight the importance of addressing power relations as part of health system reform.

Professional Hierarchies and Power in Nigerian Healthcare

The Nigerian healthcare system reflects many of the hierarchical patterns identified in the global literature. Studies consistently show that doctors dominate clinical and administrative decision-making, while nurses and allied health professionals have limited influence (Oladipo et al., 2019). Inter professional tensions, poor communication, and bureaucratic delays are widely reported challenges (Adeloye et al., 2017). Cultural norms emphasizing seniority, respect for authority, and professional status further reinforce hierarchical relations in Nigerian hospitals. These socio cultural factors interact with institutional structures to shape how power is exercised and contested in everyday practice.

Foucauldian Perspectives on Medical Power and Knowledge

Michel Foucault's work offers a complementary lens for understanding power in healthcare institutions. Foucault (1973, 1980) conceptualizes power as relational, productive, and embedded in knowledge systems rather than merely repressive or hierarchical. In hospitals, medical power is exercised through clinical knowledge, diagnostic categories, surveillance technologies, and institutional discourses that define what constitutes illness and appropriate treatment. This form of power shapes professional identities and regulates patient behavior, often without overt coercion. Foucauldian analyses highlight how hospitals discipline both healthcare workers and patients through routines such as ward rounds, case notes, and performance evaluations. These practices normalize certain behaviors while marginalizing others, reinforcing professional hierarchies and institutional authority. Importantly, this perspective reveals how power operates at the micro level of everyday clinical interactions, making it particularly useful for qualitative studies of health service delivery.

3. Methodology

Research Design: A qualitative research design was adopted to capture participants' lived experiences and perceptions of power and hierarchy within the hospital setting. This approach allows for in-depth exploration of social processes and institutional practices.

Study Area: The study was conducted at Yariman Bakura Specialist Hospital, Gusau, the largest public specialist hospital in Zamfara State. The hospital provides secondary and tertiary healthcare services and serves patients from Gusau metropolis and surrounding rural communities.

Study Population and Sampling: The study population included healthcare professionals and patients at YBASH. Purposive sampling was used to select participants with direct experience of hospital operations and service delivery.

Participants included: Medical doctors, nurses and midwives, pharmacists, laboratory scientists, hospital administrators and patients receiving care at the hospital. A total of 30 participants were interviewed.

Data Collection Methods: Data were collected through In-depth interviews (IDI) with healthcare workers and patients. Key informant interviews (KII) was conducted with hospital administrators. Interviews were conducted in English and Hausa, depending on participants preferences, and were audio recorded with informed consent.

Data Analysis: Data were transcribed verbatim and analyzed using thematic analysis. Coding was done inductively, allowing themes to emerge from the data. Key themes were identified around authority, decision making, communication, and patient experiences.

4. Findings

The findings of this study are presented using thematic analysis below.

4.1 Hierarchical Authority and Decision Making

Participants reported their views and understanding on hierarchy, authority and decision making in the hospital. One of the participant of this study reported that:

Doctors, particularly senior consultants, hold dominant decision-making power. Nurses and allied health professionals often felt excluded from clinical decisions, even when they possessed relevant experiential knowledge.

Another respondent informed that:

As far as this hospital concern, doctors are almost everything with regard to decision making and issues of authority. They dominate every section and they are the one heading and holding the chief executive position. Whatever they say or they do is the final. Their decision is supreme and is difficult for anyone challenge it.

When ask about his knowledge and understanding of the issue of hierarchy, authority and decision making in the hospital a patient respondent averred that:

Medical doctors control this hospital, and not only here every hospital you go. Because I was been to so many hospitals. The thing is very open and very clear to all. The rest of the staff is only assisting doctors. Whatever you want you will hear that it is only doctor that can approved or disapproved it.

Another respondent reported that:

Sometimes we see things earlier than the doctors, but our opinions are not always considered because of the rank. Most of the doctors are senior in rank compare with other staff. Most of the position of authority and decision making are most suitable for them. They are the one with proper requirement to hold such position of power base on their experience and

knowledge. You most of the decision here are for the general administration of the hospital and it required someone with vast knowledge and experience of the system

4.2 Communication Barriers and Inter professional Tensions

Participants reported their views and understanding on communication barrier and inter professional tensions. A respondent reported that:

Rigid professional hierarchies limited open communication among healthcare workers. Junior staff reported fear of questioning senior colleagues, which sometimes resulted in delays in patient care.

Another respondent reveals that:

You cannot easily challenge a senior doctor, even if you know something is wrong. It is worrying that this thing is happening. You understand clearly something is wrong but that barrier of seniority will not allow you to say anything. Even you say it, hardly to take with any seriousness. Because they believe that you are at lower and in terms of everything including the knowledge and understanding.

It is also found out that:

Some of the senior doctors fell highly authoritative. They give directives that sometimes it is not even clear. But out of fear of seniority you don't have the zeal to question for clarification. This generates a serious tension not only to our working relationship but also to the safety of our client. Because whatever we do here we are doing it for larger benefit of our client that is the patient. Sometime these issues affect the safety of the patient.

4.3 Power and Administrative Control

Participants reported their views and understanding on the power and administrative control of the hospital. With this regard a participant of this study says that:

Hospital administrators exercised bureaucratic power through policies, schedules, and resource allocation. Delays in approval processes often affected service delivery, particularly in emergency situations.

Another respondent informed that:

You know administration and governance is not an easy task everywhere you go. So that is also how it is here in this hospital. The one here is more critical because it affect the life and the survival chance of the individual. Sometime there is some bureaucratic procedures that you most follow and doing so people thing like you are putting their life or the life of their love ones at risk. All the process that you see is going on here before that process approved to take place all the life safety and concern of the most important person here (patient) must be put into serious consideration.

4.4 Patient Experiences of Powerlessness

Participants reported their views and understanding on the patients experiences of powerlessness. An interview with participant of this study reveals that:

There is a feeling of intimidation and exclusion from decision making processes. Many felt unable to ask questions or complain about services due to fear of victimization or neglect. You see something that you want ask or you want request but being out of fear for victimization or abandonment you have to just leave it and left with no option than to keep quite.

Another respondent insisted that:

I don't know why you are not involved in the decision that affects your life. You suppose to be the most powerful person with regard to whatever is going to happen to you. The issue is that for you to even ask or talk is a problem. To my own understanding this is wrong.

It is also emphasized by another respondent that:

You just accept whatever they tell you because they are the professionals. You are not in any way carry along the decision that affects your life. What they think they are professional for that matter therefore, they can do and on do.

4.5 Discussion

The findings demonstrate that professional hierarchies at YBASH are both enabling and constraining. While hierarchy provides organizational order, it also reinforces power asymmetries that hinder collaboration and patient-centered care. Consistent with Foucauldian perspectives, power operates through every day practices, professional norms, and institutional routines rather than solely through formal authority. The marginalization of nurses and allied health professionals limits the potential benefits of team-based care. Furthermore, patients' symbolic powerlessness reflects broader social inequalities reproduced within hospital settings. These dynamics contribute to inefficiencies and inequities in health service delivery.

5. Conclusion and Recommendations

5.1 Conclusion

This study highlights the significant role of power and professional hierarchies in shaping health service delivery at Yariman Bakura Specialist Hospital. Hierarchical structures influence decision-making, communication, and patient experiences, often with negative consequences for service quality and equity. Addressing these issues requires institutional reforms that promote inter professional collaboration, empower frontline health workers, and enhance patient participation in care.

5.2 Recommendations

The study recommended to promote inter professional team based care models within the hospital. It is also recommend establishing inclusive decision making platforms that incorporate nurses and allied health professionals. It is further suggested providing training on communication, power awareness, and collaborative practice. The study finally proposes to strengthen patient rights education and feedback mechanisms and streamline administrative procedures to reduce bureaucratic delays.

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