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The Hospital as a Social Organization: A Conceptual Review of Patient–Provider Conflict and Healthcare Quality in Nigeria

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Abstract
Patient–provider conflict is an important but insufficiently theorized dimension of healthcare delivery in Nigeria. Existing studies have examined related concerns, including patient dissatisfaction, communication failures, treatment disagreement, mistrust, disrespectful care and violence against healthcare workers. These strands of evidence are often treated as separate problems, making it difficult to understand how conflict develops within the wider social and organizational environment of hospitals. This conceptual review addresses that gap by examining patient–provider conflict as a relational and social-organizational process rather than simply as an outcome of individual misconduct or patient dissatisfaction. Drawing on social conflict theory and recent empirical evidence from Nigeria, the paper conceptualizes conflict as emerging when patients' expectations, interests, preferences and perceived rights come into tension with providers' professional judgments, institutional responsibilities, communication practices and organizational constraints. The proposed framework links structural and institutional conditions to interactional processes involving communication, expectations, trust, power, participation and perceived fairness. These processes shape whether disagreement remains manageable, develops into interpersonal conflict or escalates into aggression and relationship breakdown. The review further proposes that conflict has implications for communication, satisfaction, trust, adherence, continuity, patient safety and broader dimensions of healthcare quality. The paper distinguishes its contribution from the recent structural equation model proposed by Unaam et al. (2026) by offering a sociological explanation of the mechanisms and trajectories through which organizational conditions become relational conflict. Seven conceptual propositions are advanced to guide future empirical research in Nigerian healthcare settings.

Keywords: Patient–provider conflict; patient–provider relationship; hospital organization; healthcare quality; communication; Nigeria.

1. Introduction

Hospitals are not merely places where medical procedures are performed. They are complex social organizations in which professionals, patients, relatives, administrators and other actors interact within established rules, hierarchies, expectations and institutional routines. The quality of care produced in such settings is consequently shaped not only by clinical knowledge and technological resources but also by the nature of relationships through which healthcare is delivered. From a sociological perspective, the patient–provider encounter is therefore an organizational relationship as well as a clinical one. This observation is particularly important when considering conflict. A patient may disagree with a diagnosis, reject a treatment recommendation, question a bill, complain about waiting time, demand additional information or perceive that a provider has treated them disrespectfully. A provider, on the other hand, may regard the same behaviour as unreasonable, disruptive or inconsistent with professional requirements. What appears to be a simple interpersonal disagreement can thus reflect competing expectations, unequal authority, institutional pressures and different understandings of what constitutes appropriate healthcare.

The World Health Organization (WHO) defines quality of care in terms of the extent to which health services increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge. Importantly, contemporary understandings of quality extend beyond technical effectiveness to include safety, people-centredness, timeliness, equity, integration and efficiency. People-centred care requires services to respond to individual needs, preferences and values, while timely care requires attention to delays and waiting times (World Health Organization, 2026). These dimensions place the relationship between patients and healthcare providers at the centre of healthcare quality rather than at its margins. In Nigeria, several studies demonstrate the relevance of relational and organizational conditions to patients' experiences

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of care. Akinyinka et al. (2020), for example, found among 994 recent users of health services in Lagos that waiting time, cost and providers' ability to explain clearly were important predictors of satisfaction. Patients who experienced shorter waiting times and clearer explanations were considerably more likely to report satisfaction. Similarly, Bako et al. (2022) reported substantial dissatisfaction with communication among pregnant women attending primary healthcare centres in Nasarawa State, highlighting the importance of explanations, language, courtesy and respect in patient–provider interaction.

More direct evidence comes from Odebunmi and Adeoti (2024), who examined 25 doctor–patient interactions in Southwestern Nigerian hospitals. Their analysis shows that patients' disagreement with doctors' recommendations may be managed through participatory or non-participatory interaction. The manner in which disagreement is handled reveals the operation of clinical authority and the tension between the provider's professional perspective and the patient's lived experience. Their findings are significant because they move the discussion beyond the conventional language of satisfaction and reveal disagreement itself as an important feature of clinical interaction. Recent research by Unaam et al. (2026), examined patient–provider conflict in three Nigerian tertiary hospitals using data from 400 patients and 150 healthcare providers. Their structural equation model identified unrealistic expectations and communication barriers as significant predictors of conflict, while trust partly mediated the relationship between expectations and conflict. Organizational constraints also strengthened the relationship between communication barriers and conflict. This study represents an important empirical development and makes it no longer defensible to claim that Nigerian research has completely neglected patient–provider conflict.

The contribution required is a sociological explanation of how conflict emerges within the hospital as a social organization, how power and authority shape the meaning of disagreement, how structural constraints are translated into interpersonal tensions, why some disagreements are resolved while others escalate, and how different conflict trajectories affect healthcare quality. The present paper addresses this issue by integrating insights from social conflict theory, medical sociology and recent Nigerian evidence. The paper makes three related contributions. First, it conceptualizes patient–provider conflict as a continuum extending from disagreement and tension to escalation and, in some circumstances, verbal or physical aggression. Second, it situates conflict within the organizational structure of the hospital, emphasizing that interactions are shaped by workload, waiting time, resource limitations, institutional procedures and professional authority. Third, it proposes a multilevel conceptual framework that links structural conditions, interactional mechanisms, conflict processes and healthcare-quality outcomes.

2. Conceptual Review Approach

This paper adopts a critical conceptual review rather than a systematic review or meta-analysis. The purpose is not to estimate the prevalence of patient–provider conflict but to integrate theoretically and empirically relevant scholarship into a coherent explanation of conflict within Nigerian hospitals. Particular attention is given to literature published between 2020 and 2026, while selected earlier sociological works are retained where they provide foundational theoretical concepts concerning social conflict, professional authority and the organization of healthcare. The review brings together four bodies of scholarship. The first concerns patient–provider communication, satisfaction and trust. The second addresses patient participation and disagreement with clinical recommendations. The third examines organizational conditions such as waiting time, resource constraints, workload and institutional procedures. The fourth consists of sociological and conflict-theoretical literature concerning power, authority, social roles and conflict. The Nigerian evidence is treated as particularly important because social relationships within hospitals cannot simply be assumed to operate in the same way across different institutional and cultural contexts. International evidence is used where it contributes theoretically or conceptually, but Nigerian studies are given priority when discussing the mechanisms through which conflict is experienced within the country's healthcare system. The review is deliberately critical. Rather than assuming that patient–provider conflict results from either difficult patients or poor providers, it considers how the organizational environment structures the interaction available to both parties. This approach is consistent with contemporary health-system thinking, which recognizes that quality depends on coordinated action across national, organizational and frontline levels (Victoria et al., 2025).

3. The Hospital as a Social Organization

3.1 Hospitals as structured social systems

A hospital can be understood as a social organization because it contains formal positions, differentiated roles, authority structures, rules, norms and patterned relationships (Nugus, 2019; Tabish, 2021). Doctors, nurses, pharmacists, laboratory scientists, administrators, technicians and support staff occupy different positions and possess different forms of expertise and authority. Patients enter the organization temporarily, but their interaction with its members is governed by institutional procedures that may strongly influence their experience of care. The organizational nature of hospitals has an important implication for understanding conflict. Individuals do not interact in isolation from institutional arrangements. A provider who spends only a few minutes with a patient may be responding partly to workload, staff shortages or scheduling pressures. A patient who becomes frustrated by delay may not be reacting solely to the provider standing before them but to a chain of organizational processes that began at registration, continued through payment or triage, and culminated in the clinical

encounter.

This distinction is sociologically important because it prevents interpersonal conflict from being reduced to personality. The behaviour of both parties may be shaped by organizational positions and constraints. The patient is expected to comply with certain institutional procedures, while the provider is expected to operate according to professional standards and organizational rules. Conflict becomes possible when the expectations associated with these roles become incompatible. Recent Nigerian research illustrates this organizational dimension. Koce et al. (2020) found that healthcare providers associated patients' bypassing of primary healthcare facilities with shortages of workers, inadequate equipment, inconsistent opening hours, unmet expectations and poor provider–patient rapport. The findings demonstrate how institutional weaknesses can affect the relationship between providers and service users and can alter patterns of healthcare utilization.

3.2 The patient–provider encounter as a social relationship

The patient–provider relationship contains an inherent asymmetry. Healthcare providers possess specialized knowledge, institutional authority and professional credentials, whereas patients typically approach the encounter from a position of greater informational uncertainty. The provider is therefore not simply another participant in the interaction. Their professional status gives them authority to interpret symptoms, establish diagnoses and recommend treatment. Such authority is necessary for safe clinical practice, but it can become relationally problematic when patients perceive professional authority as exclusionary or arbitrary. The issue is not whether providers should have expertise. Rather, it concerns how that expertise is communicated and exercised. The distinction becomes particularly visible when patients disagree with clinical recommendations. Odebunmi and Adeoti (2024) show that treatment disagreement may involve negotiation, limited participation or the suppression of patient perspectives. Their analysis suggests that clinical encounters contain competing voices: the institutional and professional voice of medicine and the experiential voice of the patient's everyday life. The social organization perspective therefore treats the patient–provider encounter as a meeting point between two institutional positions. Patients bring expectations concerning respect, information, treatment and recovery. Providers bring professional obligations, clinical knowledge and institutional responsibilities. Conflict may occur when these expectations cannot easily be reconciled.

4. Conceptualizing Patient–Provider Conflict

4.1 Disagreement, dissatisfaction and conflict

Patient disagreement, dissatisfaction and conflict are related but should not be treated as interchangeable concepts. Dissatisfaction refers primarily to a negative evaluation of a service or experience. A patient may be dissatisfied with waiting time without confronting a provider. Disagreement involves a difference in opinion, interpretation or preference. A patient may disagree with a doctor's treatment recommendation while maintaining a respectful relationship.

Conflict represents a further development, which involves incompatible interests, expectations, goals, values or interpretations that become socially consequential within an interaction. Conflict therefore requires more than difference; it involves an active or potential relationship between incompatible positions. This distinction is important because disagreement can sometimes be beneficial. A patient who asks questions or challenges a recommendation may encourage clarification and shared decision-making. Similarly, a provider who explains why a particular treatment is clinically necessary may prevent misunderstanding. Conflict becomes more problematic when disagreement is ignored, dismissed or interpreted as defiance. The present paper therefore conceptualizes patient–provider conflict as: a relational process in which incompatible expectations, interests, preferences, interpretations or perceived rights between patients and healthcare providers become interactionally expressed and generate tension, disagreement, escalation or negotiated resolution within a healthcare organization. This definition places interaction at the centre while recognizing the influence of organizational conditions.

4.2 Conflict as a continuum

Patient–provider conflict should be understood as a continuum rather than a single event. At one end are minor differences of opinion, requests for clarification and ordinary negotiation. The next stage may involve dissatisfaction, mistrust or repeated disagreement. If these issues are poorly managed, they can develop into open confrontation, verbal abuse or withdrawal from the relationship. At the extreme end, conflict may involve threats or physical violence. This continuum is important because research that focuses only on violence captures the most visible manifestation while overlooking the earlier processes through which conflict develops. Conversely, research that focuses only on satisfaction may overlook disagreements that are socially significant but do not produce an explicit complaint. Violence should therefore be treated as one possible outcome of conflict rather than as its definition. Nigerian evidence confirms that violence against healthcare workers is a serious problem. In a multicentre study, Isara et al. (2024) documented high levels of verbal abuse and other forms of workplace violence experienced by healthcare workers. Patients and relatives were among the major sources of such incidents. Yet not every violent incident necessarily represents the same type of patient–provider conflict and violence should not be used as a substitute for analysing the broader relational process.

5. Sources and Mechanisms of Patient–Provider Conflict

5.1 Communication breakdown

Communication is arguably the most immediate mechanism through which organizational conditions become relational conflict. Patients require explanations about diagnosis, treatment options, costs, waiting times, risks and expected outcomes. When information is incomplete, delayed or communicated in language that patients do not understand, uncertainty increases. Communication is not merely the transmission of information. Tone, listening, respect, opportunity to ask questions and responsiveness also matter. A technically correct explanation can still be experienced as unsatisfactory if it is delivered dismissively. Bako et al. (2022) found that only a minority of pregnant women in their study reported complete satisfaction with communication from healthcare workers. The dimensions considered important included explanation of the patient's condition, use of appropriate language, courtesy and respect. These findings indicate that communication quality involves both informational and relational dimensions. The importance of clear explanation is also evident in the Lagos study by Akinyinka et al. (2020), in which providers' ability to explain clearly was strongly associated with satisfaction. Thus, communication can function as a protective mechanism: when patients understand what is happening and why, the likelihood that uncertainty will be interpreted as neglect or disregard may decline.

5.2 Mismatched expectations

Patients enter hospitals with expectations about treatment, recovery, attention, waiting time, staff behaviour and costs. Providers operate with a different set of expectations based on professional standards, institutional procedures and clinical realities. Conflict becomes more likely when these expectations diverge substantially. Expectations are not necessarily irrational. A patient may expect prompt treatment because they are experiencing pain, while a provider may be dealing with several other urgent cases. The patient's expectation is therefore understandable, just as the provider's prioritization may be clinically justified. The sociological issue is what happens when the two expectations collide. If there is no effective communication mechanism through which the difference can be explained and negotiated, frustration may develop into mistrust. Unaam et al. (2026) study provides direct empirical support for this pathway. Unrealistic treatment expectations were a significant predictor of patient–provider conflict and the relationship were partly explained by declining trust. The contribution of the present framework is to place expectations within a broader social-organizational process rather than treating them as isolated patient characteristics.

5.3 Professional authority and power asymmetry

Power is central to the sociology of healthcare because providers possess forms of knowledge and authority that patients generally do not possess. This asymmetry can facilitate effective treatment, but it can also create conditions under which patients perceive themselves as having little voice. The problem arises when professional authority is experienced as unilateral decision-making. A provider may consider a treatment recommendation to be a matter of clinical necessity, while the patient may perceive the same decision as an infringement of autonomy or a failure to listen. Odebunmi and Adeoti (2024) analysis is especially relevant here. Their examination of treatment disagreement demonstrates that participatory and non-participatory approaches produce different interactional outcomes. Negotiation allows the patient's concerns to enter the consultation, whereas non-participatory approaches can reproduce the dominance of the professional voice. A sociological framework should consequently avoid portraying power simply as something negative. Clinical expertise requires legitimate authority. The theoretical question is how authority is exercised because authority becomes conflict-producing when it is perceived as arbitrary, disrespectful, opaque or resistant to legitimate patient participation.

5.4 Patient participation and shared decision-making

Participation provides an important mechanism for managing the power asymmetry inherent in healthcare encounters. Shared decision-making does not require providers to surrender clinical authority. Rather, it creates a process through which professional expertise and patient preferences are brought together. Evidence from Nigeria suggests that meaningful participation remains limited in some clinical settings. Okezue et al. (2023), studying physical therapy consultations, found that most participants occupied passive roles in medical decision-making, while only a small proportion reported active involvement. The study identified adequate information and provider support as important facilitators of participation. Low participation can increase conflict when patients interpret decisions as imposed rather than negotiated. Conversely, participation can transform disagreement into discussion. The patient may still reject a recommendation, but the disagreement becomes visible and explainable rather than being interpreted as disobedience.

5.5 Trust and mistrust

Trust is both a product of interaction and a mechanism shaping subsequent interaction. When patients trust providers, ambiguous situations may be interpreted more positively. A delay, for example, may be understood as unavoidable rather than as evidence of neglect. Where trust is weak, the same event may generate suspicion. Lerch et al. (2024), in a critical review of 45 studies, identified communication, professional competence, caring, professionalism, time, continuity and shared decision-making among the important contributors to patient–physician trust. Institutional factors and payment arrangements also contributed to trust. This finding supports the present

framework's treatment of trust as a relational mechanism rather than simply an outcome. Poor communication can reduce trust; reduced trust can make subsequent communication more difficult; and repeated conflict can further erode trust and thus a circular process can therefore develop.

5.6 Waiting time and organizational constraints

Waiting time is frequently interpreted as a service-quality problem, but it can also become a source of interpersonal conflict. Patients waiting for long periods may become frustrated before they even meet a provider. When the eventual interaction is rushed, the accumulated frustration can be directed toward the provider. Akinyinka et al. (2020) found that waiting less than 20 minutes was strongly associated with client satisfaction in Lagos, Nigeria. The implication is not that every delay causes conflict. Rather, delays alter the social conditions under which interaction occurs. Organizational constraints may also affect providers because, high patient loads, shortages of equipment, inadequate staffing and bureaucratic procedures can reduce the time and attention providers are able to give individual patients. In such circumstances, patients may interpret organizational failures as individual neglect, while providers may experience patients' complaints as unfair personal criticism. This is precisely where the hospital-as-social-organization perspective adds explanatory value. The visible conflict may occur between two individuals, but the conditions producing it may exist elsewhere in the organizational structure.

5.7 Cost, access and financial expectations

Financial barriers can also produce tension because patients may expect services to be affordable, while providers may have limited control over institutional charges, insurance arrangements or payment policies. A disagreement about payment can consequently become personalized even though neither party controls the underlying financial system. The Lagos evidence indicates that low cost was strongly associated with satisfaction, demonstrating the relevance of financial conditions to patients' evaluation of healthcare (Akinyinka et al., 2020). Financial stress may become particularly conflict-producing where patients believe that payment should guarantee immediate or particular forms of treatment. The conflict mechanism here is therefore not simply patients are unwilling to pay. It is a mismatch between the meaning of payment for the patient and the institutional meaning of payment for the healthcare organization.

5.8 Respect, dignity and perceived fairness

Respect is a fundamental relational expectation because patients may tolerate delays or difficult treatment decisions more readily when they believe that they are being treated with dignity and that their concerns have been heard. Conversely, disrespect can transform an otherwise manageable disagreement into a confrontation. Perceived fairness is equally important because patients assess not only what they receive but how decisions are made. They may question why another patient was attended to first, why a particular procedure requires additional payment, or why they were not informed about a change in the treatment plan. These concerns connect patient–provider conflict to procedural justice. Even when an outcome cannot be changed, an explanation and opportunity to express concerns can make the process more acceptable.

5.9 Aggression and escalation

When conflict is not resolved, it may escalate in to something like raised voices, insults, threats or physical confrontation. The Nigerian evidence on violence against healthcare workers demonstrates that this is not merely theoretical. Isara et al. (2024) reported substantial exposure of healthcare workers to verbal abuse and other forms of violence in public healthcare facilities. However, a useful conceptual model must distinguish explanation from justification. Organizational stress, dissatisfaction and unmet expectations may help explain aggression, but they do not justify violence against healthcare workers. Likewise, professional authority may explain why patients feel excluded, but it does not mean that every clinical decision is illegitimate. A balanced framework must therefore recognize the rights and responsibilities of both sides.

6. Patient–Provider Conflict and Healthcare Quality

6.1 Communication and information exchange

Conflict can reduce the openness of communication because patients who feel dismissed may stop asking questions, while providers who anticipate confrontation may shorten interactions. Both processes reduce the quality of information exchange. This is particularly important because healthcare decisions often depend on information supplied by patients. If patients become reluctant to disclose symptoms, concerns or treatment difficulties, clinical decision-making may be affected.

6.2 Satisfaction and patient experience

Satisfaction is not identical to healthcare quality, but it is an important dimension of patient experience. Nigerian evidence shows that waiting time, cost and communication influence satisfaction. Conflict can undermine satisfaction even where the technical quality of treatment is acceptable. The relationship can also operate in reverse because, repeated dissatisfaction may increase the likelihood of confrontation. Satisfaction and conflict should therefore be conceptualized as related outcomes of the broader patient–provider relationship rather than as independent phenomena.

6.3 Trust and treatment adherence

Trust is particularly important because healthcare frequently requires patients to follow recommendations after leaving the hospital. When patients mistrust providers, they may question medications, diagnostic explanations or follow-up instructions. Lerch et al. (2024) found that trust is associated with several relational and organizational factors, including

communication, competence, caring, time, continuity and shared decision-making. Conflict can therefore undermine precisely those conditions that sustain trust.

6.4 Continuity and healthcare utilization

Conflict may influence whether patients return to the same provider or facility. Some may change providers; others may bypass lower-level facilities or seek care elsewhere. Koce et al. (2020) found that poor provider–patient rapport, alongside shortages and equipment problems, contributed to patients bypassing primary healthcare facilities. Repeated conflict can therefore have organizational consequences. It may increase patient movement across facilities, contribute to overcrowding at higher levels and further strain already limited resources. This creates the possibility of a feedback loop in which organizational pressure contributes to conflict, conflict contributes to service bypassing and bypassing contributes to additional organizational pressure.

6.5 Patient safety

Patient safety is another important concern because safe care depends partly on effective communication, disclosure and cooperation. When patients are reluctant to speak or providers are unable to communicate effectively, opportunities to identify errors or misunderstandings may be reduced. The World Health Organization emphasizes that quality healthcare should be safe, effective and people-centred, and that improvement requires action across health-system and facility levels. Patient–provider conflict should therefore be regarded as a quality and organizational issue rather than merely a behavioural problem.

6.6 Effects on healthcare workers

Conflict also affects providers because repeated confrontation, verbal abuse and threats can produce emotional strain and may contribute to defensive communication. Providers who feel constantly challenged may become less willing to engage in extended discussions with patients.

This does not mean that patients should be discouraged from questioning care. Rather, healthcare organizations need mechanisms through which disagreement can be expressed safely. A complaint system that provides patients with a legitimate voice may reduce the likelihood that dissatisfaction will be expressed through confrontation.

7. Social Conflict Theory and Medical Authority

This paper is primarily anchored in Social Conflict Theory, particularly the contributions of Dahrendorf (1958, 1959) and Coser (1998), is complemented by the sociological perspective of medical authority and professional dominance. Social Conflict Theory is appropriate because patient–provider relationships occur within a hospital organization characterized by unequal authority, different interests, competing expectations and unequal control over information and decision-making. Rather than viewing conflict as an abnormal breakdown of healthcare relationships, the theory regards conflict as a normal consequence of differences in power, interests, expectations and access to resources. Social Conflict Theory rests on several interconnected assumptions. First, social organizations contain unequal distributions of power and authority. Dahrendorf (1958) argues that authority is attached to social positions and that individuals occupying different positions have different capacities to influence decisions and behaviour. Second, social actors possess divergent interests, which may generate disagreement when their expectations or goals are incompatible. Third, conflict is regarded as normal and potentially unavoidable in organized social relationships rather than necessarily being dysfunctional. Fourth, conflict may produce either constructive or destructive consequences, depending on how it is managed. Coser (1998) emphasizes that conflict can expose grievances, clarify expectations, strengthen relationships and stimulate institutional adjustment when effectively regulated.

Conversely, poorly managed conflict can intensify hostility and undermine social relationships. Finally, conflict is shaped by the social structures within which interaction occurs; therefore, individual behaviour cannot be fully understood without considering organizational rules, authority structures, resource constraints and institutional practices. These assumptions are particularly relevant to hospitals because healthcare providers possess specialized knowledge, professional authority and institutional legitimacy, whereas patients often depend on providers for information, diagnosis, treatment decisions and access to services. This creates an inherent asymmetry that may influence communication, participation, trust and perceptions of fairness. The theory is complemented by the concept of medical authority and professional dominance. Freidson (1988) demonstrates how medical professionals have historically exercised considerable control over specialized knowledge and clinical decision-making. In patient–provider encounters, professional authority is necessary for safe clinical practice; however, it can become problematic when professional expertise is translated into unilateral decision-making or limited recognition of patients' perspectives. Adebayo (2021), in a qualitative study of physician–patient interactions in Nigeria, found that communication problems, limited empathy, inadequate information disclosure and cultures of power influence patient–provider relationships. Similarly, Odebunmi and Adeoti (2024), through analysis of doctor–patient interactions in Nigerian hospitals, demonstrated that disagreements over medical recommendations are managed through both participatory and non-participatory approaches. Their findings illustrate how professional authority and patients' attempts to express their concerns can generate interactional tensions. These studies demonstrate that conflict is not simply an interpersonal problem but is also connected to the distribution and exercise of authority within healthcare encounters.

Several studies demonstrate the usefulness of Social Conflict Theory in understanding healthcare conflict. Zhou et al. (2016) explicitly applied social conflict perspectives associated with Dahrendorf and Coser to medical disputes. They argued that differences between doctors and patients can generate conflicts because the two groups may possess different interests, expectations, knowledge and power. They further suggested that appropriately managed conflict can contribute to improved communication, dispute resolution and healthcare services. In Nigeria, Yunusa (2024) applied Social Conflict Theory to doctors–nurses conflict in public hospitals and identified professional hierarchy, power differences, lack of trust and competition for recognition as important sources of conflict. Yunusa et al. (2025) similarly found that professional hierarchy, poor communication and unclear roles contributed to conflict and affected patient well-being. Although these studies focus on interprofessional rather than patient–provider conflict, they demonstrate the applicability of the theory to healthcare organizations and provide contextual evidence concerning how authority, organizational structures and communication shape conflict.

Building on these perspectives, this paper conceptualizes patient–provider conflict as a process that develops through the interaction of organizational conditions, unequal authority, competing expectations, communication, trust, participation and perceived fairness. Organizational constraints such as workload, waiting time, bureaucratic procedures, staffing shortages and limited resources may intensify tensions between providers and patients. These structural conditions influence everyday interactions and may determine whether disagreement is negotiated constructively or escalates into dissatisfaction, complaints, verbal abuse or other forms of conflict. The framework therefore proposes the following pathway: organizational conditions, authority and competing expectations, interactional processes, trust, participation and perceived fairness, patient–provider conflict, conflict regulation or escalation, healthcare-quality outcomes. This theoretical position allows the paper to move beyond explanations that attribute conflict solely to individual attitudes or patient behaviour. It instead locates patient–provider conflict within the broader social organization of healthcare and highlights the importance of organizational mediation in determining whether conflict becomes destructive or contributes to institutional learning and improvement.

8. Proposed Conceptual Framework

The framework developed in this paper conceptualizes patient–provider conflict as a multilevel social-organizational process. The first level consists of structural and institutional conditions, including staffing, workload, resource availability, waiting time, cost, access barriers and bureaucratic procedures. These conditions influence the amount of time, attention and flexibility available during clinical encounters. The second level consists of interactional conditions, particularly communication quality, treatment expectations, health literacy, respect and patient participation. These conditions shape how patients and providers interpret one another. The third level consists of relational mechanisms. Trust, perceived fairness, power asymmetry, clinical authority and negotiation determine how interactional differences are processed. These mechanisms feed into the conflict process, which may move from disagreement to tension and then either toward constructive resolution or destructive escalation. Constructive conflict management includes explanation, dialogue, shared decision-making, de-escalation and accessible complaint resolution. Destructive or unmanaged conflict may involve mistrust, verbal abuse, withdrawal, non-adherence, relationship breakdown and, at the extreme, violence. The final stage concerns healthcare-quality outcomes, including communication, satisfaction, trust, adherence, continuity, patient safety, timeliness, people-centredness and service utilization. The conceptual pathway can therefore be summarized as: Structural/institutional conditions → interactional conditions → relational mechanisms → conflict process → constructive resolution or destructive escalation → healthcare-quality outcomes. The framework also includes a feedback mechanism. Conflict does not simply end after the encounter. Repeated negative experiences can reshape patients' expectations, future trust and patterns of healthcare utilization. Similarly, repeated aggression may change providers' communication practices and willingness to engage with patients. Thus, the relationship is dynamic rather than linear.

9. Conceptual Propositions

The framework generates seven propositions that can guide future empirical research.

Proposition 1

Greater mismatch between patients' expectations and the realities of healthcare delivery increases the likelihood of patient–provider conflict. Where expectations concerning waiting time, treatment, cost or recovery differ substantially from what the organization can provide, dissatisfaction is more likely to become relational tension.

Proposition 2

Communication barriers increase the likelihood of patient–provider conflict directly and indirectly through declining trust. Poor explanations, inappropriate language, limited listening and insufficient opportunities for questions can produce uncertainty, while uncertainty may weaken trust and make subsequent disagreement more difficult to resolve.

Proposition 3

Power asymmetry becomes more strongly associated with conflict when professional authority is perceived as arbitrary, dismissive or exclusionary. Clinical expertise does not automatically generate conflict.

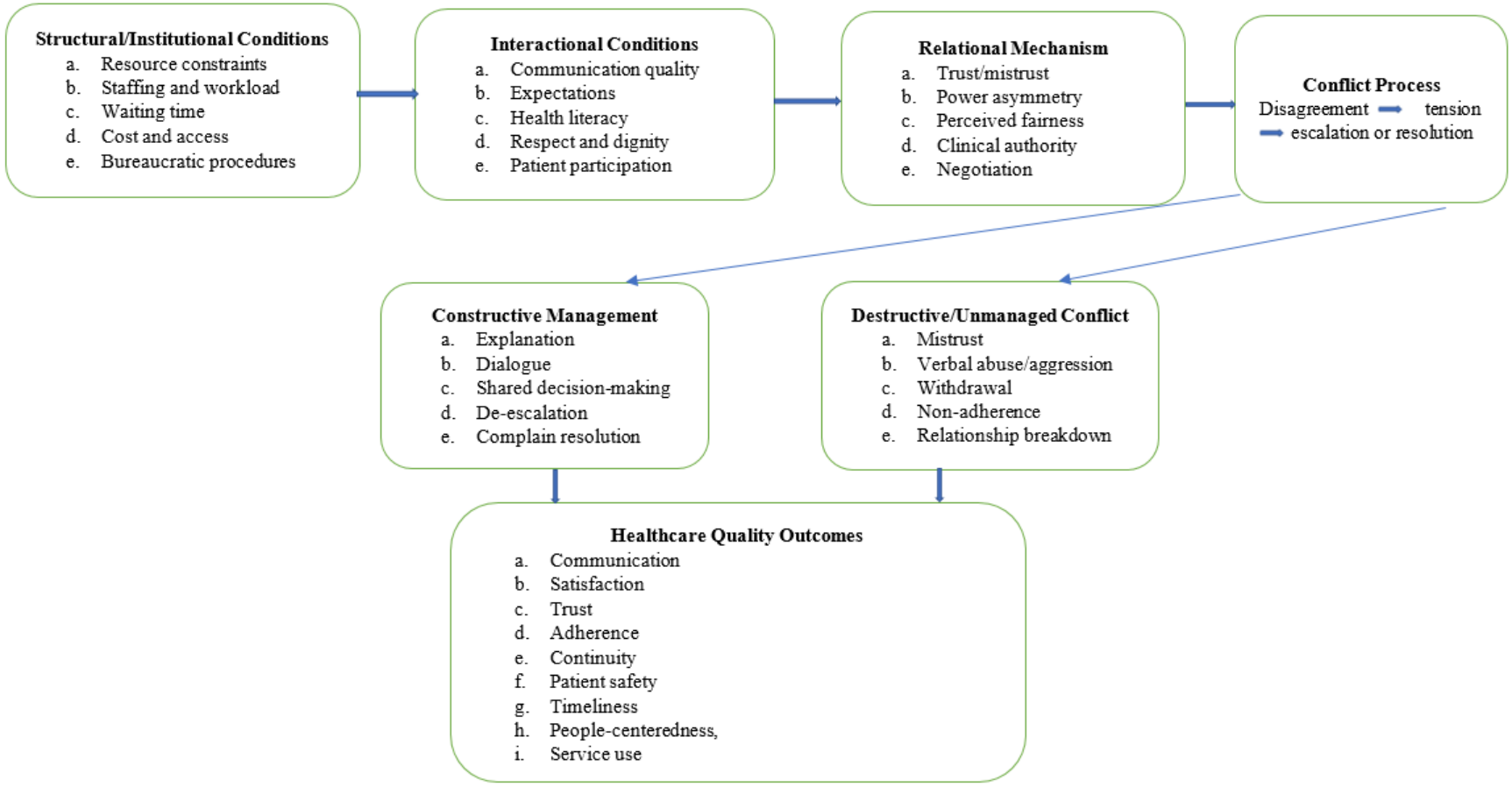


Figure 1. Conceptual framework of patient–provider conflict as a multilevel social-organizational process

(The figure illustrates that conflict is neither exclusively an individual-level phenomenon nor a direct mechanical consequence of organizational failure. Instead, organizational conditions influence interaction, interaction shapes relational mechanisms and these mechanisms influence the trajectory of conflict.)

Conflict is more likely where patients perceive that expertise is being used to silence rather than inform them.

Proposition 4
Meaningful patient participation weakens the relationship between treatment disagreement and conflict escalation. When patients are allowed to express concerns and providers explain the reasoning behind recommendations, disagreement is more likely to remain within the boundaries of constructive negotiation.

Proposition 5
Organizational constraints amplify the conflict-producing effects of communication failures. A communication problem occurring in an adequately staffed environment may be resolved through additional explanation. The same problem in an overcrowded facility with severe workload pressures may escalate more rapidly.

Proposition 6
Constructive conflict-management mechanisms transform potentially destructive disagreement into opportunities for clarification, participation and relationship repair. Explanation, dialogue, mediation, de-escalation and complaint resolution can interrupt the progression from disagreement to confrontation.

Proposition 7
Repeated unmanaged patient–provider conflict negatively affects healthcare quality by weakening trust, communication, adherence, continuity and patient safety. Conflict should consequently be regarded as both a relational outcome and a potential mechanism through which organizational problems become quality problems.

10. Theoretical Contribution: Distinguishing This Paper from Unaam et al. (2026)

The publication of Unaam et al. (2026) is particularly important for positioning the present paper. Their study directly examined patient–provider conflict in Nigeria and empirically tested relationships among unrealistic expectations, communication barriers, trust and organizational constraints. Using structural equation modelling across three tertiary hospitals, they reported significant effects of expectations and communication barriers on conflict, partial mediation through trust and moderation by organizational constraints. The present paper does not attempt to reproduce that model. Its theoretical contribution lies at a different level. First, Unaam et al. (2026) provide an empirical explanatory model, whereas this paper proposes a sociological conceptual model. Their study asks which variables predict conflict and how their statistical relationships operate. The present paper asks how those variables become socially meaningful within the organizational structure of hospitals. Second, the present framework gives greater analytical attention to power and authority. Communication does not occur between socially equal actors. Providers possess professional authority and specialized knowledge, while patients occupy a position of greater informational dependence. The manner in which authority is exercised can determine whether disagreement becomes negotiation or confrontation.

Third, the framework expands the concept of conflict beyond predictor variables to include conflict trajectories. Conflict may begin with disagreement, develop into tension and then move toward constructive resolution or destructive escalation. This allows researchers to investigate not only why conflict occurs but what happens after it begins. Fourth, the framework introduces patient participation as a mechanism of conflict transformation. The relevant question is not simply whether patients disagree but whether healthcare organizations provide institutional space for disagreement to be expressed and negotiated. Fifth, the paper explicitly connects conflict to healthcare-quality outcomes. Conflict is conceptualized as potentially affecting satisfaction, trust, adherence, continuity, safety and timeliness. This places patient–provider conflict within the broader sociology of healthcare quality. Finally, the present framework emphasizes organizational mediation. Structural constraints do not directly determine interpersonal outcomes. Their effects depend on interactional processes and relational mechanisms. This distinction makes it possible to explain why similar resource conditions may produce different conflict trajectories across hospitals, departments or provider–patient encounters. In this sense, the contribution is complementary rather than competitive. Unaam et al. (2026) provide important empirical evidence for several relationships contained within the present framework. The present paper provides a broader sociological architecture within which those relationships can be interpreted, extended and tested.

11. Critical Synthesis and Future Research Focus

The literature reviewed suggests that patient–provider conflict in Nigeria should no longer be treated as a peripheral issue. Recent studies have provided evidence concerning communication, disagreement, participation, trust, satisfaction and conflict itself. Nevertheless, several gaps remain. First, much of the Nigerian literature examines individual components of the relationship rather than conflict as a process. Satisfaction studies tell us what patients evaluate positively or negatively; communication studies identify weaknesses in information exchange; violence studies document extreme outcomes. Fewer studies trace how these processes interact over time. Second, more research is needed across different levels of healthcare. Evidence from tertiary hospitals should not automatically be generalized to primary healthcare centres, private hospitals or secondary facilities. Organizational conditions differ substantially across these settings. Third, future studies should examine conflict from both sides of the relationship. Patients

and providers may interpret the same encounter differently. A patient may understand repeated questioning as advocacy, while a provider may interpret it as non-compliance. Comparative patient–provider studies could reveal where these interpretations converge and diverge.

Fourth, longitudinal research is needed because, cross-sectional studies can identify associations but cannot adequately explain conflict trajectories. Following patients and providers over repeated encounters would make it possible to examine how trust changes after conflict and whether conflict affects future service utilization. Fifth, researchers should investigate the role of relatives and accompanying persons. In Nigerian healthcare settings, family members frequently participate in healthcare decisions and interactions. Conflict involving patients, providers and relatives may have dynamics that differ from dyadic patient–provider conflict. Sixth, future studies should examine institutional mechanisms for managing disagreement. Complaint systems, patient advocates, mediation structures, communication training and shared decision-making initiatives should be evaluated not merely in terms of satisfaction but in terms of their capacity to prevent escalation. Finally, measurement remains a challenge. Patient–provider conflict should not be measured solely through violence or complaints. Future instruments should distinguish disagreement, dissatisfaction, mistrust, perceived disrespect, communication breakdown, confrontation and violence.

12. Implications for Hospital Management and Health Policy

The framework has implications for healthcare managers and policymakers. If conflict is understood only as individual misconduct, organizational interventions will remain limited. A broader perspective suggests that hospitals need systems capable of preventing and managing relational tensions. Communication training should form part of professional development, but training alone is unlikely to solve the problem where providers are chronically overloaded. Organizational reforms should therefore accompany communication interventions. Staffing, appointment systems, waiting-time management and information processes can influence the social conditions under which clinical encounters occur. Hospitals should also strengthen mechanisms through which patients can express concerns without confrontation. Accessible complaint procedures, patient liaison mechanisms and opportunities for explanation may prevent minor disagreements from escalating. At the same time, patient-centred reforms should recognize professional responsibilities. Shared decision-making does not mean that every clinical preference can be accommodated. Patients should have meaningful opportunities to participate, while providers retain responsibility for evidence-based clinical judgement and patient safety. The WHO's quality framework supports this integrated perspective by emphasizing that quality requires action from governments, health systems, healthcare workers and patients. For Nigeria, the implication is particularly important because, improvements in healthcare quality should not be evaluated solely through infrastructure, equipment or clinical outcomes. The quality of the social relationship through which care is delivered should also receive systematic attention.

13. Limitations of the Conceptual Review

This paper has several limitations. It is a conceptual review rather than a systematic review, and it does not provide a quantitative synthesis of the available evidence. The Nigerian literature on direct patient–provider conflict remains relatively limited compared with literature on satisfaction, communication, violence and healthcare quality. Consequently, some elements of the framework are theoretically derived and require empirical testing. The framework also emphasizes hospitals and may not fully capture conflict in community-based or informal healthcare settings. In addition, patient–provider relationships vary by profession, clinical specialty and institutional setting. Conflict between a patient and a doctor may differ from conflict involving nurses, pharmacists, laboratory professionals or other providers. These limitations should not be interpreted as weaknesses of the conceptual approach. Rather, they identify areas where the propositions developed in this paper require empirical examination.

14. Conclusion

Patient–provider conflict should not be understood simply as a consequence of difficult patients, poor communication, or individual professional misconduct. Rather, it is a social-organizational phenomenon shaped by unequal expertise and authority, competing expectations, organizational constraints, and the conditions under which healthcare interactions occur. Waiting times, workload, resource shortages, costs, bureaucratic procedures and institutional routines influence how patients and providers experience and interpret one another. Within these conditions, communication, participation, respect, trust, perceived fairness and power determine whether disagreement remains manageable or escalates into destructive conflict. The conceptual framework developed in this paper integrates these dimensions by proposing that structural and institutional conditions shape interactional processes, which are mediated by authority, power, trust, participation and perceived fairness. These mechanisms influence conflict trajectories and, ultimately, healthcare outcomes including satisfaction, adherence, continuity, safety, trust and service utilization. The framework complements the recent empirical model of Unaam et al. (2026). While their study statistically demonstrates relationships among expectations, communication, trust, organizational constraints and patient–provider conflict, this paper situates these relationships within a broader sociological understanding of hospital organization, professional authority and patient participation. Overall, improving healthcare quality in

Nigeria requires attention not only to clinical competence and material resources but also to the social organization of patient–provider interaction. Hospitals that promote respectful communication, meaningful participation, appropriate authority and constructive conflict management can transform disagreement into opportunities for clarification, trust-building and improved quality of care.

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