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TRUST IN SOURCES OF HEALTHCARE ADVICE: A MULTICENTRE STUDY OF ORTHOPAEDIC CLINIC ATTENDEES IN SOUTHWESTERN NIGERIA

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Abstract

Background: Trust in sources of healthcare advice plays a pivotal role in healthcare utilisation, treatment adherence, and clinical outcomes. In Nigeria, orthopaedic patients frequently consult a wide range of formal, informal, and digital sources of healthcare advice, which may influence care-seeking behaviour and contribute to delays in presentation. However, empirical data on patients' trust in these sources, particularly in Southwestern Nigeria, remain limited.

Methods: Multicentre cross-sectional study conducted across seven orthopaedic outpatient clinics in Southwestern Nigeria between September and October 2025. Adult patients attending orthopaedic clinics were recruited consecutively using a structured, self-administered questionnaire assessing sociodemographic characteristics, clinical diagnoses, sources of healthcare advice, and levels of trust in these sources. Trust was measured on a four-point Likert scale. Data from 478 respondents were analysed using descriptive statistics, ANOVA, and post-hoc tests, with statistical significance set at $p < 0.05$.

Results: The mean age of respondents was 42.2 ± 16.5 years, with near-equal gender representation. Fractures (37.7%) and degenerative joint and spine disorders (29.1%) were the most common diagnoses. Healthcare professionals were the most trusted sources of healthcare advice, with doctors having the highest mean trust score (3.8 ± 0.6), while traditional healers had the lowest (1.7 ± 0.8). Trust in AI-based and internet sources was relatively low but increased significantly with higher educational attainment. Male respondents and unmarried individuals demonstrated greater trust in digital sources compared with females and married individuals.

Conclusion: Orthopaedic patients in Southwestern Nigeria exhibit high trust in orthodox healthcare providers and low trust in traditional and digital healthcare advice sources. Educational level, gender, and marital status significantly influence trust in non-professional sources.

Key words: Trust, Healthcare-Advice, Orthopaedic-patients, Multicentre, Southwestern-Nigeria

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Introduction

Trust in sources of healthcare advice is critical for effective healthcare delivery, as it influences patients' decisions regarding treatment and adherence to medical recommendations. In many African settings, patients frequently obtain healthcare information and advice from a wide range of sources, including healthcare professionals, family members, friends, community leaders, traditional healers, pharmacists, patent medicine vendors, religious institutions, and, increasingly, digital and social media platforms.¹⁻⁴ The degree of trust placed in these sources often determines when, where, and how patients seek care, as well as their willingness to accept biomedical interventions. Study indicates that patients who trust their healthcare sources are more likely to engage in preventative measures and adhere to prescribed treatments.⁵

In Southwestern Nigeria, where there is a growing reliance on both traditional and modern healthcare practices, understanding how patients assess and prioritize various healthcare advice sources is essential. Factors such as cultural beliefs, education level, and access to quality healthcare can shape these perceptions.^{6,7} Delayed presentation to orthopaedic care in Nigeria has been widely reported and is often attributed to initial reliance on informal or alternative sources of healthcare advice, including traditional bone setters (TBS), spiritual healers, and unregulated drug vendors.^{8,9}

Trust in healthcare systems and providers is a multidimensional construct influenced by perceived competence, communication, cultural congruence, prior experiences, cost, accessibility, and social endorsement.^{10,11} In orthopaedic practice, where treatment often involves prolonged care, surgical intervention, and rehabilitation,

trust becomes particularly salient. Patients who distrust formal healthcare providers may delay presentation, decline recommended procedures, or discontinue follow-up, thereby adversely affecting outcomes.¹² Conversely, excessive trust in unregulated or non-evidence-based sources of advice can perpetuate harmful practices and worsen morbidity.

Research has consistently underscored the relationship between trusted communication and patient health behaviours, indicating that individuals who trust their healthcare providers are less inclined to pursue alternative treatments or rely excessively on unverified online information.¹³ However, there is a paucity of empirical data examining levels of trust in different sources of healthcare advice among orthopaedic patients in Nigeria, particularly in the southwestern region, which is characterised by relatively high healthcare facility density alongside persistent utilisation of alternative care. Understanding patients' trust profiles is essential for designing effective healthcare education strategies, improving patient-provider relationships, strengthening referral pathways, and informing policy interventions aimed at reducing delays and complications in orthopaedic care. This study aims to evaluate the levels of trust among orthopaedic clinic attendees in Southwestern Nigeria, examining which sources of healthcare advice they find most credible.

Materials And Methods

This study was a multicentre, hospital-based cross-sectional study conducted to assess level of trust in different sources of healthcare advice among patients attending orthopaedic clinics in southwestern Nigeria.



The study was carried out in seven orthopaedic outpatient clinics in south western Nigeria. These facilities serve as major referral centres for musculoskeletal conditions and cater to both urban and peri-urban populations.

The study was conducted over six weeks, from September 8 to October 17, 2025. The study population comprised adult patients attending orthopaedic outpatient clinics during the study period. Using the formula for calculating sample size for a cross-sectional study,¹⁴ a sample size of 384 was calculated, with an addition of a 10% attrition rate, resulting in a target sample size of approximately 422. A total of 538 patients were recruited across the study centres.

Patients aged 18 years and above, patients who attended the orthopaedic outpatient clinic for consultation or follow-up, who were able to read and write and provided informed consent were included in the study. Patients who required emergency care, patients with altered mental status or severe illness limiting their ability to respond, patients who could not read or write and patients who declined participation were excluded from the study.

Consecutive patients who met the inclusion criteria were recruited for the study using a self-administered, structured questionnaire. Each eligible participant was approached by a research assistant, either an intern or a junior registrar, and offered the option of completing the questionnaire electronically via Google Forms or on a paper-based form. Participants' demographics, sources of healthcare advice, and their level of trust in these sources were obtained, and the clinical characteristics of the participants were also noted. The research assistant extracted the final diagnosis from the patients' case files. The primary outcome was the level of trust in various sources of healthcare advice. Trust was categorised into four levels: a lot of trust, some trust,

little trust, and no trust, and was measured on a 4-point scale (1 = No trust, 4 = a lot of trust).

Data were entered into and analysed using IBMSPSS version 23 (IBM Corp., Armonk, NY, USA). Descriptive statistics were used to summarize variables. Categorical variables were presented as frequencies and percentages, while continuous variables were expressed as means and standard deviations. Comparisons of the mean trust level of sources of healthcare advice across categorical variables were performed using ANOVA. A paired t-test was used to compare the means of the trust level of sources of healthcare advice. Statistical significance was set at $p < 0.05$.

Ethical approval was obtained from the Health Research Ethics Committees of the participating institutions. Informed consent was obtained from all participants. Confidentiality was maintained by anonymising data and restricting access to study materials.

Results

A total of 538 patients were approached during the study period. Of these, 478 participants completed the questionnaire adequately, yielding a response rate of 88.9%. Figure 1 shows the distribution of the responses across the seven participating hospitals, which ranged from 8.6% at hospital F and G to 23.5% at hospital A. A chi-square goodness-of-fit test showed that responses were not evenly distributed across the seven hospitals (χ^2 , $df = 6$, $p < 0.001$), which may reflect underlying variations in patient volumes or other institutional characteristics. The mean age of respondents was 42.2 ± 16.5 years, demonstrating a diverse age range from 18 to 89. Both genders were nearly equally represented among the respondents, with males, 246

(51.5%), making up a slightly higher proportion (Table I). Around half of the group had attained tertiary education.

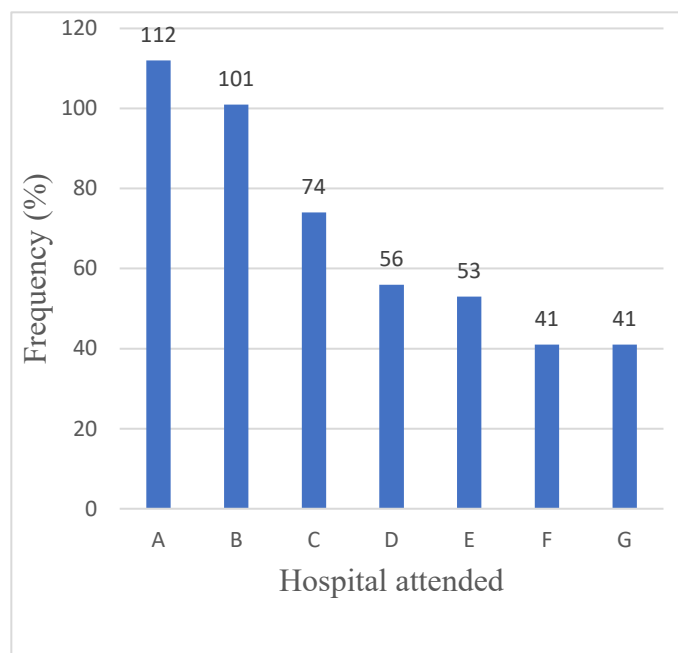


Figure 1: Frequency distribution of hospital attended

A high level of trust was reported in healthcare professionals, ranging from 87.0 % reporting a lot of trust in doctors to 42.9 % for pharmacists, compared with substantially lower levels in AI tools (10.9%), Google Search (9.8%), and other non-health-professional sources (3.3–11.3%). When ‘little trust’ and ‘no trust’ responses were combined, distrust was markedly higher in non-health-professional sources than in healthcare professionals. Combined distrust was highest in traditional doctors (83.7%) and religious leaders (59.6%), followed by family or friends (61.7%), Google (56.0%), and AI tools (57.0%). In contrast, combined distrust remained low in doctors (2.9%), nurses (10.4 %), and pharmacists (19.2%). This

finding is reflected in the total trust score, which was significantly higher among healthcare professionals compared to the others (Table II).

Table I: Sociodemographic profile of the patients

Variables	Frequency (%)
Gender	
Male	246 (51.5)
Female	232 (48.5)
Marital Status	
Single	177 (37.0)
Married	276 (57.7)
Widow	22 (4.6)
Others	3 (0.6)
Religion	
Christianity	364 (76.2)
Islam	110 (23.0)
Others	4 (0.8)
Ethnic group	
Yoruba	386 (80.8)
Igbo	53 (11.1)
Hausa	5 (1.0)
Others	34 (7.1)
Educational level	
Primary	29 (6.1)
Secondary	90 (18.8)
OND / Technical	67 (14.0)
University / HND	240 (50.2)
Postgraduate	52 (10.9)

Table II: Trust levels among sources of healthcare advice

	Doctors	Nurses	Pharmacists	AI tool	Google	Family /friends	Religious leaders	Traditional doctors
Trust	Freq (%)	Freq (%)	Freq (%)	Freq (%)	Freq (%)	Freq (%)	Freq (%)	Freq (%)
A lot of trust	416 (87.0)	243 (50.8)	205 (42.9)	52 (10.9)	47 (9.8)	44 (9.2)	54 (11.3)	16 (3.3)
Some trust	48 (10.0)	186 (38.9)	181 (37.9)	154 (32.2)	163 (34.1)	139 (29.1)	139 (29.1)	62 (13.0)
Little trust	2 (0.4)	31 (6.5)	55 (11.5)	147 (30.8)	155 (32.4)	166 (34.7)	112 (23.4)	144 (30.1)
No trust	12 (2.5)	18 (3.9)	37 (7.7)	125 (26.2)	113 (23.6)	129 (27.0)	173 (36.2)	256 (53.6)
Total	478 (100.0)	478 (100.0)	478 (100.0)	478(100.0)	478 (100.0)	478 (100.0)	478 (100.0)	478 (100.0)

Table III: Comparison of the mean trust scores in sources of healthcare advice (n = 478)

Source of advice	Mean $\pm$ SD
Doctors	3.8 $\pm$ 0.6
Nurses	3.4 $\pm$ 0.8
Pharmacists	3.2 $\pm$ 0.9
AI tools	2.2 $\pm$ 1.0
Google	2.3 $\pm$ 0.9
Family and friends	2.21 $\pm$ 0.9
Religious leaders	2.2 $\pm$ 1.0
Traditional healers	1.7 $\pm$ 0.8

Doctors had the highest mean trust score (3.8 $\pm$ 0.6), median trust score = 4 and Interquartile range (IQR) = 4–4. The mean trust for AI tools and Google was significantly lower (2.2 $\pm$ 1.0 and 2.3 $\pm$ 0.9, respectively). Trust in traditional healers was substantially lower, with a mean score of 1.7 $\pm$ 0.8, median trust score = 1 and IQR = 1–2. Using paired sample T-Test, there were statistically significant differences between the mean trust level of doctors and other sources of healthcare advice, $p < 0.001$ (Table III).

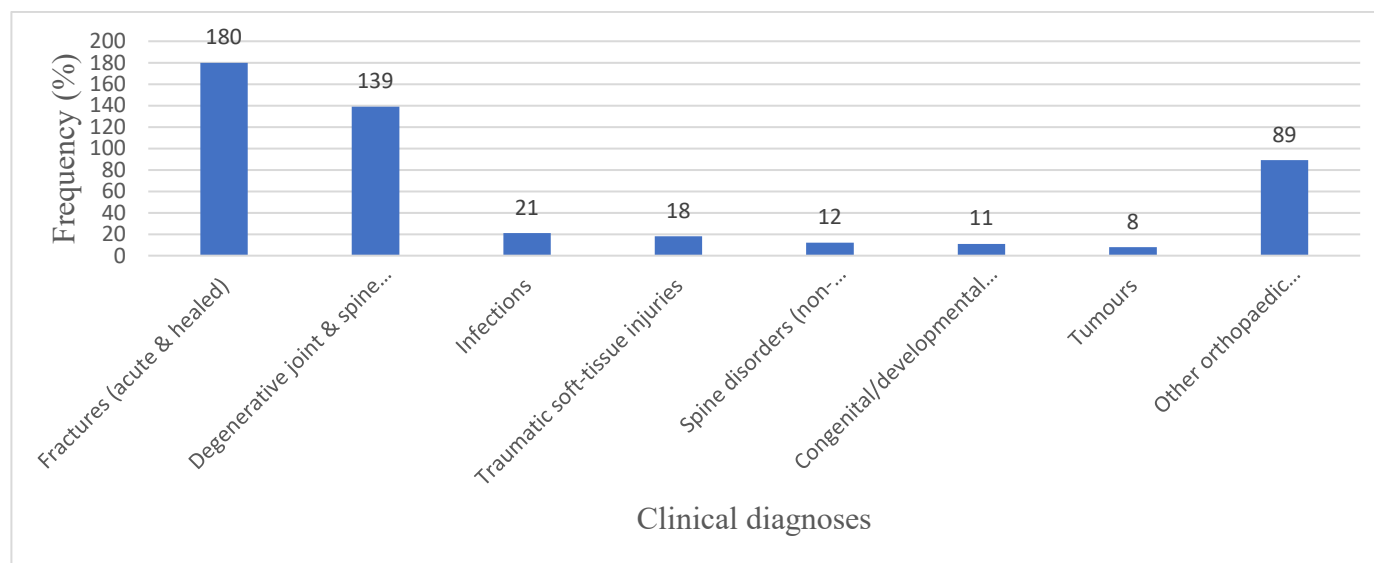


Figure 2: Frequency distribution of clinical diagnosis

Fractures (acute & healed) were the most common final diagnosis of the respondents' condition (37.7%), followed by degenerative joint and spine disorders (29.1%). Other conditions, such as traumatic soft-tissue injuries (3.8%) and tumours (1.7%), showed lower frequencies, indicating a particular concentration on musculoskeletal issues in the patient population. (Figure 2).

Table IV: Mean trust scores for sources of healthcare advice by level of education

Source of healthcare advice	Level of education					<i>p</i> value
	Primary	Secondary	OND / Technical	University / HND	Postgraduate	
Doctor	3.90	3.80	3.85	3.80	3.81	0.901
Nurse	3.52	3.44	3.45	3.30	3.38	0.303
Pharmacist	3.28	2.96	3.10	3.20	3.35	0.099
AI-based sources	1.69 ^a	2.13 ^{ab}	2.04 ^{ab}	2.34 ^b	2.44 ^b	0.001
Google / Internet	1.93 ^a	2.14 ^{ab}	2.24 ^{ab}	2.39 ^b	2.46 ^b	0.028
Family / friends	2.28	2.22	2.30	2.13	2.37	0.419
Religious leader	2.72 ^b	2.20 ^a	2.18 ^a	2.08 ^a	2.06 ^a	0.032
Traditional bone setter	2.00	1.69	1.64	1.62	1.63	0.230

^{ab} Mean values sharing the same superscript within a row are not significantly different on post hoc testing (Tukey HSD or Tamhane's *T*2, $\alpha = 0.05$).

Mean trust scores for sources of healthcare advice categorized by level of education are shown in Table IV. Trust in orthodox healthcare providers, including doctors, nurses, and pharmacists, did not differ significantly across educational categories ($p > 0.05$). Similarly, reliance on family or friends and traditional bone setters did not differ statistically across educational levels ($p > 0.05$). In contrast, level of education was significantly associated with trust in digital healthcare information sources. Trust in AI-based healthcare advice increased progressively with higher educational attainment, with respondents holding university and postgraduate qualifications reporting significantly higher mean scores compared with those with primary education ($p = 0.001$). A similar educational gradient was observed for trust in Google or internet-based sources of healthcare information, which was lowest among respondents with primary education and highest among those with postgraduate education ($p = 0.028$). Educational level was also significantly associated with reliance on religious leaders for healthcare advice ($p = 0.032$). Respondents with primary education reported the highest trust in religious leaders, while trust declined steadily with increasing educational attainment.

Marital status was not significantly associated with trust in doctors, nurses, pharmacists, family members, or traditional bone setters (all $p > 0.05$) (Table V). However, significant differences were observed for digital and faith-based sources. Unmarried respondents reported significantly higher trust in AI-based healthcare advice

compared with married respondents ($p < 0.001$), with widowed respondents showing intermediate scores. Trust in Google/internet-based sources also differed by marital status, with higher scores among single respondents than married respondents ($p = 0.037$). In addition, trust in religious leaders varied significantly across marital categories, being lowest among single respondents and highest among widowed respondents ($p = 0.034$).

Table V. Mean trust scores for sources of healthcare advice by marital status

Source of healthcare advice	Marital status			<i>p</i> value
	Unmarried	Married	Widowed	
Doctor	3.80	3.83	3.82	0.861
Nurse	3.30	3.41	3.41	0.345
Pharmacist	3.15	3.15	3.45	0.303
AI-based sources	2.45 ^b	2.09 ^a	2.32 ^{ab}	<0.001
Google / Internet	2.44 ^b	2.21 ^a	2.41 ^{ab}	0.037
Family / friends	2.22	2.19	2.41	0.564
Religious leader	2.00 ^a	2.25 ^{ab}	2.32 ^b	0.034
Traditional bone setter	1.60	1.68	1.73	0.551

^{ab} Mean values sharing the same superscript within a row are not significantly different on post hoc testing (Tukey HSD or Tamhane's T_2 , $\alpha = 0.05$).

Table VI. Mean trust scores of healthcare advice by gender

Source of healthcare advice	Gender		
	Male (n = 246)	Female (n = 232)	p value
Doctor	3.83	3.80	0.589
Nurse	3.41	3.33	0.262
Pharmacist	3.25	3.06	0.028
AI-based sources	2.33	2.13	0.029
Google / Internet	2.39	2.20	0.026
Family / friends	2.21	2.20	0.879
Religious leader	2.20	2.11	0.338
Traditional bone setter	1.82	1.50	<0.001

^{ab} Mean values sharing the same superscript within a row are not significantly different on post hoc testing (Tukey HSD or Tamhane's T2, $\alpha = 0.05$).

Sex-based differences were also evident. Male respondents reported significantly higher trust in pharmacists, AI-based sources, internet sources, and traditional bone setters compared with female respondents, while trust in doctors, nurses, family members, and religious leaders did not differ significantly by sex (Table VI).

Discussion

The findings of our study on trust in sources of healthcare advice among patients attending orthopaedic clinics in Southwestern Nigeria illuminate critical insights into patient behaviour and healthcare dynamics in the region.

Trust in healthcare providers is crucial for positive health outcomes. This study showed higher levels of trust in orthodox healthcare professionals compared with digital sources of healthcare advice, such as AI chatboxes and Internet search engines, as well as non-orthodox sources,

including traditional bone setters and family members. This is in alignment with previous reports from other studies.^{15,16}

The very high trust in physicians, with just 2.9% of respondents expressing distrust, is encouraging but must be interpreted within context. First, this study population may be considered as self-selected, respondents had already chosen to seek care in a hospital setting and may therefore be predisposed toward orthodox healthcare. Second, the questionnaire was administered by the treating physicians or their assistants, which may have influenced responses. Nonetheless, the study corroborates previous studies and may be particularly important in emphasizing the need to maintain this trust for sustenance of patient adherence and satisfaction.^{15,16} The comparatively lower trust observed for non-orthodox sources of healthcare advice, such as digital, religious and traditional practitioners, should be interpreted with similar caution, if similar study is done in the community, the response could be different from the hospital based study. This consideration is particularly relevant in our setting with its comparatively high rates of discharge against medical advice among orthopaedic patients.^{17,18}

The clinical diagnosis of the respondents were consistent with the epidemiology of orthopaedic conditions in Nigeria, where trauma and degenerative musculoskeletal disorders disproportionately affect individuals in their productive years.¹⁹ The predominance of fractures and degenerative joint and spine disorders as final diagnoses aligns with previous Nigerian and sub-Saharan African studies that identify trauma from road traffic crashes and age-related degeneration as leading causes of orthopaedic clinic attendance.²⁰

Further analysis revealed that trust levels in AI and internet sources varied significantly across educational levels, supporting earlier research that indicates higher education often correlates with improved healthcare literacy and skepticism about non-professional healthcare advice.²¹ Individuals with higher education levels are typically more discerning consumers of healthcare information, often relying on scientifically backed sources. This underscores the necessity for healthcare systems to develop tailored healthcare communication strategies that are audience-specific, especially considering the varied backgrounds of patients.²²

The study also found an interesting relationship between marital status and trust in healthcare sources. Single individuals exhibited greater trust in healthcare professionals compared to married individuals, which can be related to differing social support systems. Research indicates that social support can influence healthcare behaviour and information seeking.²³ Married individuals may have other sources of healthcare information and support, potentially leading to different dynamics in how they value healthcare advice.

Sex differences were evident primarily in relation to non-professional sources of healthcare advice. Male respondents reported significantly higher trust in AI-based sources, internet-derived information, and traditional bone setters, while trust in doctors, nurses, family members, and religious leaders did not differ by sex. This pattern suggests greater male inclination towards non-institutional healthcare information sources compared to females. This finding aligns with the report by Picchiello *et al.*²⁴ among American patients, which demonstrated that men considered the

internet to be a more reliable source of healthcare information compared to women.

Patients who have trust in informal healthcare advice could have a delay in accessing orthopaedic care, and this could lead to potential complications or worsened healthcare outcomes.^{8,25} Though cultural beliefs, long-standing community trust, perceived affordability, and ease of access have been identified as major drivers of this behavior.^{26,27} Understanding and addressing these trends requires collaborative efforts from healthcare policymakers, providers, and community leaders to design targeted education that addresses misconceptions surrounding formal healthcare systems while promoting the benefits of evidence-based practice.²⁸

Conclusion

Our study provides valuable insights into trust in sources of healthcare advice among orthopaedic patients, which may have important implications in Southwestern Nigeria. Enhancing trust in formal healthcare providers while addressing skepticism towards alternative sources, particularly digital platforms, presents a significant opportunity for improving patient outcomes. Future research could delve deeper into the qualitative aspects of these trust relationships and explore strategies to enhance patient-provider communication further, ultimately leading to more effective healthcare delivery and improved patient satisfaction.

Limitations

Reliance on self-reported data may have introduced recall bias, particularly regarding timelines and prior sources of healthcare advice. In addition, as a hospital-based study, a

bias toward orthodox sources of healthcare advice cannot be excluded. The cross-sectional design also limits causal inference between sources of healthcare advice and clinical outcomes, although causal relationships were not a primary focus of this study. Nonetheless, the multicentre design enhances the generalizability of the findings across Southwestern Nigeria.

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