Ghanaian nurses at a crossroads: Managing expectations on a medical ward

Böhmig, C.

Citation for published version (APA):

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: http://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.

UvA-DARE is a service provided by the library of the University of Amsterdam (http://dare.uva.nl)
“Who are you and what is your mission?”
Methodology and roles

In January 2004, I visited the hospital in Accra for the first time and went straight to the nurses’ department of the administration. Entering the secretary’s room, I found myself among a group of nurses, all wearing white dresses and caps. They looked at me, invited me to sit down and asked: “Who are you and what is your mission?” It took me more than a year to show them who I was and could be, what my intentions were and which concrete plans had brought me to their hospital. “Now we got to know you, you are welcome; Tell us about your plans and ideas.” I became a person to them and was allowed to do research on their work. Early in 2005, I was introduced to the ward by the director of nursing: “This is Christine, and she will conduct a research with us, so you will see her often. It is good she came, she can help us understand what is going on. She will also work with us, it is good you meet and get to know each other.” I started my fieldwork and spent more than 10 months on the ward.

This chapter describes the methods I applied during my ethnographic research in the Ghanaian hospital and the writing of this study. After some general considerations, I will focus on the various steps I had to take in order to gain access, do my fieldwork, analyse the data and write the story presented in this book. Finally, ethical considerations and my role in the field will be discussed.

Doing ethnography requires several techniques and methods in order to gather data. Starting with Malinowski’s classic text on fieldwork techniques (1922) up to Geertz’ plea for thick description (1973) and recent textbooks, countless definitions have been provided for anthropological research. Bate distinguishes ethnography as an activity, a kind of intellectual effort and a narrative style: the process of doing, thinking and writing (Gellner & Hirsch 2001:1). Silverman mentions the range of sources of data collection, the concern with the meaning and function of social action and the use of everyday contexts in order to gain understanding (1993). For several years, the relationship between researcher and researched has received more attention and the awareness of this relationship as a valuable and important source of information and its possible influence on the study (Campbell 1998). These
features are characteristics of qualitative research where the researchers are “guided by certain ideas, perspectives or hunches regarding the subject to be investigated” (Carr 1994: 716).

Considering how ethnographic research can be carried out in a hospital, three roles seem possible: joining the staff, becoming a patient or playing the role of a visitor (Van der Geest & Finkler 2004). Morse stresses the benefits of researchers being familiar with the medical professions: “Since they are certified to practise in a healing profession, they can operate […] as practitioners as well as observers” (Morse 1989: 2). As will be shown below, my own background as a nurse and medical anthropologist was very helpful and made levels of observing participation possible. In addition, it became important and valuable to interact and mingle with the nurses and share personal stories and experiences. As Fetterman said “the ethnographer is a human instrument … relying on its senses, thoughts, and feelings, the human instrument is a most sensitive and perceptive data gathering tool” (Zaman 2008: 41).

In order to succeed in fieldwork, Evashanko conceptualises four steps that should be taken: preparation, initial contact or entrée, accomplishment and completion (1985: 135). These steps will be described in the following sections aiming at portraying the periods of data conceptualisation, gathering and analysis that took about four years.

**Preparation**

Preparing for ethnographic fieldwork in the organisation of a hospital required several steps. The first was a critical analysis of existing literature. Analysing the literature on West Africa and Ghana in particular, few written sources and descriptions could be found. There seem to exist only some historical accounts and handful recent articles on the beginning of nursing in the Gold Coast and its developments up to today’s Ghana (Patterson 1981; Vaughan 1991; Twumasi 1975; Addae 1996; Akiwumi 1995; Anderson 2004). While the country prepared to celebrate its fiftieth independence day, what seems missing is research on the actual work and perception of nursing in Ghana.

My professional nursing background had brought me to Cape Coast in Ghana in the early 1990s working in the public health sector for several months. At that time, I was intrigued and became interested in the work of nurses and the understanding of nursing as an independent profession in the Ghanaian health care system. Planning a PhD research on that topic, the question was where to locate the study. Considering the few available sources, I saw much benefit in focusing on a public hospital and not on the private or church-related clinics and health posts. Even so, the majority of the Ghanaian

---

5 Wind (2008) decided on a fourth role, ‘doing the researcher’. She pleads for reconsidering the concept of participant observation and introduced the concept of negotiated interactive observation. See also Vermeulen (2001) on his role in doing ethnographic research on a neonatal ward in Belgium and the Netherlands.
population lives in rural areas (Songsore 2004) and the accessibility of hospitals varies a lot depending on the region. Each of the ten regions has at least one public hospital and an attached nursing training college. Looking at the reputation and professional understanding of hospitals, the two academic teaching hospitals in Accra and Kumasi, (Korle Bu- and Komfo Anokye-Teaching Hospitals) stood out without any doubt. The vicinity of University of Ghana on the Legon Campus with its sociology and nursing departments and personal contacts influenced the decision to choose Korle Bu Teaching Hospital as the main research site

Entry strategies

Of the three possible roles to be taken during the fieldwork, I chose to make use of my nursing profession and join the nursing staff. The knowledge would enable me to participate in the daily routines and be more than a pure observer on the ward. In January 2004, I entered the hospital for the first time and went straight to the nursing administration. Preparatory talks with the heads of the sociology and the nursing departments at the University of Ghana had encouraged me to approach the hospital and I had a letter of recommendation from Amsterdam with me. The scene described in the beginning of the chapter illustrates the limitations of my plans. A theoretical idea and the European concept of academic curiosity and enthusiasm opened the door but gave by no means permission for the research. Nobody in the hospital knew me, so why should I be supported? Other aspects of myself turned out to be of more benefit. Talking about my previous experiences in Cape Coast, my personal affiliations with the Presbyterian Church of Ghana in Accra and the fact that I stayed with Ga-people in the outskirts of Accra gave the nurses an impression of my personal background and interest. Similarly, my social position back in the Netherlands as a married mother of two was important for them to form a picture. They could classify and link me to places and groups known to them, I became a person (Böhmig 2006). This rather informal aspect of entering the field opened the possibilities for me to establish a relationship with the nurses and influential members of the hospital organisation and to start working on the formalities of an ethnographic research.

During 2004 and early 2005, I stayed for shorter periods of four weeks in the hospital; I became acquainted with the ward and its people and they also got to know me. This brought us closer and helped me sharpen my research questions. In this process, I chose the female ward of the Medical Department as fieldwork site. There were two main reasons for this: firstly, in order to research nursing activities, their routines and interactions with patients I wanted to be on a ward where patients stayed longer than just a few days. The patients’ duration of stay in the medical department is generally longer than on the gynecological or surgical wards. Their illnesses represent the threats of daily life in Ghana, ranging from malaria and allergic reactions to hypertension, heart- kidney- and liver- failure and the newer diagnosis of leukemia and organ
cancer. Being interested in women’s lives, I preferred the female ward to the two male medical wards. The second reason was a methodological one: for several years, the Medical Department was undergoing basic renovation and the medical wards were temporarily housed in another part of the hospital, mixing the nursing staff and specialisations anew. In order to get an optimal level of anonymity next to changing all nurses’ and patients’ names and to avoid simple recognition of persons and places, this temporary state of the ward helped to achieve this goal. The director of nursing supported my plans and wrote me letters of introduction for the Medical Department. In addition, discussions with the Nurses and Midwives Council (NMC) and the Ghana Registered Nurses’ Association (GRNA) took place. The latter were interested in the general aim of my study but reluctant to support my wish to work as a nurse in the hospital. I also realised that being there as a registered nurse would make it difficult for me to remain aside of professional dilemmas and difficulties. It was decided that I should remain on the background and only assist with smaller nursing activities.

In order to stay for several months as an anthropological researcher, I needed ethical clearance from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research of the University of Ghana (NMIMR). Obtaining such clearance required, along with the recommendation from my Dutch supervisor in Amsterdam, the support of the sociology and nursing faculties, help in finding a way through the bureaucratic features of the Institute, many copies of my research proposal and the consent forms, trust and patience. In the fall of 2004, the clearance was granted. In the fall of 2004, the clearance was granted.\(^7\) Informing the nursing administration at the hospital site, I could start the main fieldwork period, which lasted seven months, in the summer of 2005.

Doing fieldwork

The initial positive welcome and support strengthened the plan to conduct the fieldwork as a participating observer. Helping the nurses with the smaller daily routines was thought to have two positive effects: I could help reduce the workload in the most practical sense of the word, participate in nursing activities and experience what it meant to be a nurse in this hospital. In addition, I assumed that ‘just’ sitting around and asking question would be less productive and limit the assertiveness and willingness of the nurses to cope with my daily presence. To make myself recognizable as (partial) member of the team, the nursing director decided on my clothing: a white coat over my trousers, a white shirt and white closed shoes. The white color distinguished me from nursing students who wear green dresses and black shoes and made it clear to outsiders that I was a member of the ward team. It took a little while till

\(^6\) In 2007, the renovation was still going on and the nurses complained the temporary housing might become permanent.

\(^7\) The ethical clearance was approved under the number FWA 1824 on October 25, 2004, and signed by the chairman of the NMIMR, Rev. Dr. Samuel Ayete-Nyampong.
it became natural to meet the nurses every morning in the small rest room and change my clothes. The coat had two spacious pockets for my jotting book and pens. In addition, I received a badge from the main administration labeling me as staff member of the Medical Department.

While gathering data on all three shifts, my main presence on the ward was during the morning shift. Arriving on the ward around half past seven, the first hour gave me insight in the last activities of the night nurses before handing over. During visiting hour, the morning shift would arrive and take up duty after 8 AM. Leaving after the afternoon shift started their work, I had witnessed the morning duties, washing, feeding and assisting the patients, joining doctor’s rounds, collecting needed medication from the pharmacy, cleaning wounds, and distributing medication on the ward. Being on the ward during the night was complicated and asked for patience and perseverance. There were rumours about negligent nurses and patients being left alone on the ward, and I realised that the nurses on this ward felt uncomfortable about my presence. Finally I succeeded and was allowed to join a few night teams. In all shifts, a lot was to be observed and experienced. As Frank writes, “getting yourself where the action is often means seeing that there is action wherever you are” (2004: 439). During my study, I took a part in bed-making, feeding and bathing/cleaning of patients, assisted in wound dressing and catheterising patients. I also helped with the last offices of deceased patients and walked with the nurses on the doctors’ rounds. In the less busy times and during the breaks, informal conversations took place when I could ask questions and procedures were explained to me. After a few weeks, my presence became normal and I was reprimanded when I arrived after 8 AM. Two examples illustrate my presence on the ward:

The nurses start their morning shift with a moment of devotion (prayer). Gathering around their table, they sing and pray, praising God for His mercy and protection and asking Him for support in their work. Unquestionably, I take part in that ritual, learn the songs and join the sharing of the grace. At a certain point, nurse Grace decides that it is my turn to lead the prayers and commands me to do so two days later. Feeling uneasy I still do it and receive thanks for it later on. Nurse Martha says “You are one of us, you understand us. God will help you with your work.”

Matron Mary saw me as part of her team and encouraged me to work. One morning she even pushed me: “Come here. Don’t you also want to train your skills? Please, help with the making of beds, remove your wrist watch” Thunderstruck, I obey and start making the bed, feeling six pairs of nurses’ eyes following each move I make and action I take. Apparently the result is accepted, the nurses smile at me and ask my assistance more often.

I took notes, made records to aid my memory, had informal talks, wrote down procedures and was allowed to take data from the report books and ward statistics. It soon became a habit to sit down and make notes. In the second part

---

8 Chapter 13 analyses the role of religion on the ward, the function of the morning devotion and the consequences of participation or refusal in more depth.

9 I use pseudonyms and not the real names of respondents in this study. In Appendix E, I have presented brief descriptions of the nurses and patients.
of my stay, I started more formalised interviews. Having gained the director’s permission and starting off with her, I interviewed almost all the nurses, taping their stories openly and giving them the opportunity to read it. By that I wanted to create openness and avoid mistrust. Most nurses were happy with it and never asked to read my notes. I was rather teased with my notebook and my constant writing. At one occasion, nurse Martha uttered her understanding of my research:

You want to know so much. We Ghanaians are brought up not to ask too many questions. Children who ask a lot are seen as troublesome. In the olden days we were asked to be silent. Today children are allowed to ask a bit more. You can interview us, it is a good idea. But only, we Ghanaians do not like to share secrets. If you ask something you might not get the correct answer, that is all.

It made me aware of my role, comparing me with a child asking probably obvious or inappropriate questions. To prevent major irritations, I increased my attempt to be cautious and avoid rushing. As Zaman wrote, I had to be patient: “Collecting data is like catching a butterfly; if you run after it, it flees, but when you sit quietly, the butterfly sits right on your head” (Zaman 2008: 148).

Reactions

The working staff and the patients on the ward reacted in various ways to my presence. The doctors hardly seemed to be aware of me. I was briefly introduced to the medical specialist and some doctors became interested in my work, but generally they did not take any notice. My clothing, primary interest and everyday presence with the nurses made me ‘one of them’ and not ‘one of us’. Occasionally, the matron even asked me to stay off the medical round to avoid irritations and questions. Only one doctor asked me to assist him with certain medical procedures and to inform him about one patient’s condition. When this very patient had to be readmitted to the ward months later and I informed him about a free bed for her, he smiled and said: “Oh, you did your trick and talked from nurse to nurse?”

The patients often took me for a doctor. They asked for my opinion on their medical condition and begged for efficient and fast treatment. The same reaction occurred when meeting their relatives, mainly the patients’ husbands and brothers who asked me to “please look after her” and thanked me “for coming here and helping.” Staying longer on the ward, they saw me making their beds and feeding the needy ones. One morning, an older woman asked me to come. She grabbed my hand and said: “Some people travelled and told me that you white persons do not like us blacks. But you came and even washed me. This is really being a person. I did not expect to be washed by a white person in my life.” I became friends with two younger chronically ill patients and followed their stay both as a researcher and as a friend. With them, I could
not always remain distanced but involved myself in their care, followed the doctors’ rounds and visited them after discharge at home.

The nurses’ group generally accepted me without problems. The nursing director greeted me on her regular rounds over the ward and occasionally asked me in her office to talk about my observations, findings and remaining plans. Her message to me had two aspects as she wanted to know about my research on the one side and see me work on the other side. Her opening questions would always be “How are you doing? Did you already render nursing care today or are you just observing?” The nurses in charge of the ward saw me as part of their team and assigned work to me. It was interesting to notice that they even felt the obligation to give me work to do. When the director came for her round, I was asked to stop writing and join the students with bed-making “Get up, do not sit down! Find yourself some work and be busy.” As illustrated above, it seemed normal that I would join the devotion, do smaller nursing activities, pay every now and then to the ward fund (“you are one of us, so you also pay”) and inform the matron about my presence and absence on the ward. Staying practically and emotionally distanced was difficult and I had to explain and negotiate my role as researcher on a regular base. This became especially difficult in critical nursing situations. On those occasions, the nurses were not sure whether I was one of them or if my presence formed a control or even threat to their working routine. For several weeks, two Scandinavian nursing students worked on the ward as part of their training. They had difficulties accepting their role as obedient subordinate nursing students with less autonomy and fewer responsibilities than at home and critically observed the routine on the ward. During that period, two patients died suffering from severe skin diseases. Their reaction was “Look at them! They nursed another patient to death.” While I also had my questions and doubts about the nursing care rendered, I forced myself to remain distanced and asked for the nurses’ interpretation of the situation.

Leaving the field and writing the story

During the fieldwork I wrote daily notes on my ward activities and observations and conducted individual and focus group interviews that were recorded and transcribed. In addition I spoke to teachers and students, attended classes at the nursing colleges in Accra, collected information with nursing organisations, visited a few hospitals and health posts in the rural areas, read newspapers and gathered accidental pieces of information by visiting friends and attending cultural and Christian meetings in Accra. After seven continuous months in the field, I left Ghana to return to Europe with my data. Leaving physically is just a matter of packing suitcases and catching a flight. Becoming emotionally and psychologically detached from the field turned out to be more complicated. The nurses had shared their professional and in several

---

I want to thank here especially Osei Tutu for his excellent and precise work in transcribing the interviews for me.
aspects private life with me and we had experienced life and death together on
the ward not only as nurses and researcher but as human beings.

Saying farewell meant that my role as researcher had reached the next
level. I had to transform the data into a story. Following Frank (2004), my
research could turn into a detective story with a body to be discovered and an
explanation to be delivered. What would be my body? “The practical
qualitative research problem is how to see the action in situations where others
see only life as expected… being where the action is, is necessary but
insufficient by itself. Perceiving incongruities begins to turn action into a story”
(Frank 2004: 434f). What had been going on? In the first weeks after return to
the Netherlands I was still too attached to the nurses to be able to think of them
other than as a group I was a member of. What could be written and what
should remain unwritten in order to respect and safeguard the researched group
and avoid unintentional misunderstandings?

Months of reading and re-reading the data illuminated key aspects,
showed patterns and demonstrated possible results. The use of the qualitative
computer programme MAXQDA turned out beneficial to (re-)discover
observations and descriptions and to organise thoughts and findings. Going
back to anthropological literature was necessary to construct frameworks and
understand what was going on. Exchanging thoughts and discussing ideas with
other medical anthropologists in Amsterdam was an invaluable benefit. Slowly,
I was sufficiently detached to enter into the writing process. Two follow-up
visits in 2006 and 2007 were used to fill gaps in the data, discuss findings and
enrich the analysis of my research.

**Ethics and the role of the researcher**

No matter how far ‘participation’ may push the anthropologist in the direction of non-
otherness, the context is still ultimately dictated by ‘observation’ and externality
(Rabinow in Zaman 2008: 141).

The awareness of externality and otherness led me to questions concerning the
writing process. Should I leave parts of my report blank? Could I deliver empty
pages? These questions were and are constantly in my head. They touch ethical
considerations that need to be taken in consideration when doing qualitative
ethnographic research. There are two major aspects: Will my findings reflect
reality and be true? And am I allowed to write about everything aiming at a
balanced and objective presentation or would some observations need to be
blurred?

There are as many realities of a situation as there are participants of that
moment. Therefore an ethnography can only show a partial aspect of the
complex whole. The moment the researcher is in one place and talks to one
informant, other situations occur on the ward hidden from the researcher’s ear
and eye. “The idea that we collect data is a bit misleading. Data are not out
there waiting for collection, like too many rubbish bags on the pavement. For a
start they have to be noticed by the researcher, and treated as data for the
purpose of his or her research” (Dey in Zaman 2008: 141). Personal interest or hidden agendas can influence statements or lead to misleading assumptions. Bleek reminds qualitative researchers of the fact that informants can be lying, having valid reasons to do so or being annoyed at the (often uninvited) researcher’s presence and questions. “Not all informants are as enthusiastic about anthropological research as the fieldworkers themselves” who may “force polite informants into lying ones” (1987: 314).

The other side of the coin is the researcher herself who is involved in the process of data gathering. Campbell calls for continuous reflexivity of that role and analyses how “to put personal experience into the centre of trustworthy analysis” (1998: 56). It means that the presence of the researcher influences the research side and by doing so changes the supposedly ‘original setting’. It raises the question of whether participant observation of a cultural entity is possible at all. In this case, I was aware of the partiality, grasping only fragments with my data. Next to limitations due to the language barrier and practical time constraints limiting my presence on the ward and understanding of all aspects, I experienced situations and moments when I was excluded. One example was the regular ward meetings. During these monthly meetings, all nurses meet and talk about current events and information about the hospital is distributed and professional issues clarified. At least, this is one side. I understood that these were also opportunities when problems or mistakes were discussed and consequences drawn where necessary. Attending those gathering and observing the interaction of nurses there would have enriched my data, but I was never informed nor invited to those meetings. When asked about it, the matron told me: “We discuss our work, talk about problems and praise ourselves for good work done. No, it is not interesting for you to be there, we can tell you the results.” Also the director of nursing shared that view: “Whatever is discussed and of interest for you, the matron will tell you. There is no need for you to be there.” She promised to inform me when such meeting was coming up, but I never heard from her. I accepted those closed doors and my exclusion, respecting their professional privacy.

The second question was whether I was allowed to write about all I happened to witness and participate in. Before starting the fieldwork, I had been encouraged by the nursing administration to collect my data and write about it: “You be objective, write all you see. Do not choose a side, don’t side with the nurses, it does not help your work. We are waiting for your book to come out so we learn from you. You can do a lot for us, we need your input. So write funny stories about the nurses.” Towards the end of my stay, the same nurses adjusted their advice: “Try not to hurt people and make persons and things anonymous as much as possible. Please be careful with the writing, it is a delicate matter. You saw we are trying but we are few.”

Discussing this issue with some Ghanaian friends, they explained: “Nurses know they are doing the wrong thing at times but they do not want you to write about it. We Ghanaians want to be cheated. They want you to lie and not say the full truth. So no matter what you write, there will be some who feel hurt. Everybody knows about the problems, so write about it. Write what you
saw.” I decided to discuss this matter openly with the nurses of the ward. For that matter, I got invited for one of their meetings. Explaining my study again and presenting first results and a rough outline of my study, I realised two things: many nurses had become used to my presence and saw me as somebody who helped on the ward and made notes. By leaving them, they became again aware that they had been part of a research. In my own perception I had never hidden my research aim nor my writings or academic curiosity, but most of them were still wondering what I had exactly been doing. Appearing in a publication, they said, made them proud. Secondly, they became afraid of what would be published. Nurse Catherine said “We are doing our best, do not write any demoralizing facts. The job is already difficult enough.” Matron Esther asked about possibilities of having a say in the writings before publishing. I explained my view, wanting to mention the hospital’s name and ward’s specialisation but hide nurses’ individual features. We agreed on the greatest possible anonymity of both nurses and patients. I changed all names and rearranged personal characteristics that would leave the persons less easily retraced but the message and statement unchanged.

My presence on the ward: Perception and reciprocity

Looking back, I understand that my presence in the hospital threw up questions: being a woman and researching a female dominated profession positioned me in an interesting spot within the hospital organisation. As described above, the nurses saw me as one of them and accompanied my nursing activities and data gathering. The mainly male doctors defined me as ‘one of them’ and hardly took notice of me. This showed next to professional segmentation and also the existence of separated lifestyles. On top of that, younger nurses perceived me as representative of the West who could inform them about Europe and working possibilities there. The interest in migration increased, I was asked about visa-regulations, skill requirements and salary expectations. At the same time, their image of ‘the West’ was in many cases hazy and unrealistic. With the older nurses and the nursing administration, the distribution of power played a role. In some situation I was the researcher and presented like that to outsiders. At other times my role was that of the visiting nurse having to work along and give account of my participation. All participants in my research were aware that their cooperation and information was welcome and influenced the course and outcome of my research. The question of equality in research was unspoken but continuously present. The nurses had the power to conceal or hide information from me to produce enriching or misleading data. But they could not refuse my presence or prevent me leaving the ward and return to Europe to write about them. I was aware of the limitation of the research in time and space and the remaining distance. A nursing teacher said to me: “They will let you in for a while, but it is clear you will never fully get into the group and understand completely what is going on.” My role shifted almost daily between my identities as researcher, nurse
and person. My presence changed the reality, increased existing tensions and challenged nurses to reflect on the established routine.

Be a person

*It is not only the anthropologist who knows about the fundamental contradiction inherent in fieldwork; the informants know about them as well* (Bleek 1979: 201).

Following an anthropological question and doing fieldwork in a hospital outside one’s own culture leads to methodological and ethical challenges. This is true both for the researcher and the researched group. The process of data gathering, analysis and writing is accompanied by open questions and closed doors. It is impossible and also undesirable to bridge the gap between the anthropologist and the group. In my case, that led to three things:

During fieldwork I lost my innocence as researcher. Witnessing critical nursing situations, asking for the nurses’ perceptions and trying to understand underlying convictions dragged me into the nurses’ world and appealed to my subjective feelings. Reflecting my own actions and subjective feelings opened the floor to discussions with nurses and patients. Following Campbell’s idea, I realised and understood the interconnectedness of my study and me and integrated my own experience and presence into the understanding of my data.

Secondly, this very involvement also showed me my limitations. Being a Western trained nurse who had worked in Europe, I was aware of the basic and general procedures of nursing on the ward. This made me partly ‘native’ and withheld me from certain questions. I was not ‘blank and ignorant’ and the nurses knew that I knew how they were supposed to work. On the one hand, they felt extra critically observed and apologised for irregularities, even though it was never my intention to point on those. Also, they used my knowledge to have me join the team. Like Frank said: “I did not have any new insights after all; I had only put into prose what everybody already knew. My preferred term for what social science can offer, *an articulate imagination.*” (2004: 437). I represented both the outsider and the member of the group. I was part of the imaginary worldwide professional nurses’ network and familiar to the hospital routine at large and at the same a foreigner in the Ghanaian culture and emic realisation of the work.

Finally, I learned that I both chose and was given a role. The role I had chosen was that of a researcher, coming with my own background and curiosity. My identity of researcher was formalised through letters, the ethical clearance and my badge and uniform. I was interested and full of questions, hoping to understand what was going on. To bridge the gap and reduce the feeling of reserve, I added to my role that of the assisting nurse, aiming at making me more accessible. I soon discovered that I was also given a role. To the hospital staff I was a foreigner and by that both a threat and an opportunity. A threat as I took part in their daily work and was going to write about the successes and failures I had witnessed. And it was known that I would leave again and write about the observed. At the same time, I was perceived as a
representative of ‘the West’ and by that defined as somebody with solutions, incorporating endless career possibilities abroad and financial solutions to daily problems. Several groups expected answers from me to questions I had never thought of and was unable to answer. In addition to that and, my personal life and social engagement in Ghana was of interest to the nurses. I could not remain the distanced researcher but they took part in my adventures and explained to me their culture. To achieve my research goals I had to constantly negotiate my roles, sharpening them through interaction and finding a balance between work and free time, being a researcher and a person, being one of them and distancing myself. This is similar to Geurts experiences when she worked with the Anlo-Ewe on the notion of the senses. “What we write up, after extensive fieldwork, are historically situated texts concerning a set of people in a place during a time when we were present to witness and document the goings on - an admittedly strange blend of subjectivity and empiricism” (2002: 25).
PART II

NURSING IN GHANA
HISTORY AND TRAINING