Ghanaian nurses at a crossroads: Managing expectations on a medical ward
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“You are not supposed to cry, it does not help.” Death as a daily companion

When they cannot do anything again, they refer them to Korle Bu. So this place becomes like a graveyard (Matron Mary).

You come alone into this world and you go alone, that’s all. You have to take the good times and also accept the bad times. We nurses have seen so many dying that after some time, you get used to it. There is nothing you can do. You learn to deal with it (Susan).

Sophia, the young health care assistant enters the ward to start her afternoon shift. She addresses her colleague Joy: “Good afternoon, how is the ward?” Joy replies: “It’s bad. Oh, we were very busy; today I am not happy.” “What happened?” “This morning, two patients died on the ward.”

Agnes, a young trader arrived a few days ago as a referred case from a smaller hospital. She suffers from gum bleeding and she is fairly ill on admission, though a concrete diagnosis could not yet be given. At ten o’clock this morning, she becomes restless. Oxygen is applied through a small tube to ease her breathing difficulties and as she starts sweating. Nurse Grace removes the thick blanket and places a bed sheet over her. Agnes gasps for air. A young doctor takes blood for a blood transfusion ‘to fill the system’. It is difficult to find a vein. Suddenly, the patient becomes motionless. Doctor Boateng, a young female ward doctor and Nurse Grace get busy. The nurse goes for Atropine while the doctor checks the patient’s pulse at the carotid artery. She starts a heart massage. No folding screen is set up, so other patients observe the scene from their beds while a group of ten medical students is busy with a lumbar aspiration at the neighbouring bed. The doctor exclaims: “She is coming back, I will go on. As long as she is here, I have to go on, I cannot stop, help me.” Grace arrives with the medication and passes it to the cannula. The doctor calls a colleague to look after the blood transfusion. A few minutes later the doctor stops the resuscitation attempt and takes a step back, looking disappointed and sad. “She is gone.” Grace: “This morning she swallowed the
medication. It was very sudden. She leaves behind a small child. Her brother is outside, I will look for him.”

They put off the oxygen and leave the bedside; Agnes lies on the bed uncovered. The other patients remain silent in their beds; some start reading the Bible. The medical students finish the lumbar procedure, chat and leave the ward. Grace writes the report of this death in the nurses’ notes and informs the mortuary. Then she asks two younger nurses to prepare everything for the last offices to be done. They push the bed over the ward to the treatment room outside, making noise as the bed-wheels are not turning properly but leaving marks on the floor. A trolley is prepared with gloves, a syringe, three strips of gauze and cotton wool. One nurse wears a plastic apron on top of her uniform. Both put on disposable gloves and face masks. Agnes’ body is undressed, the cannula, gastric tube and urethral catheter are removed and thrown on the floor together with the diaper and her clothes. Then the eyes are closed, the ears and nose filled with cotton and the jaw is tied up with one piece of gauze. After that, the hands and feet are crossed and bound together with gauze. Two strips indicating her name, hospital number and date of death are placed on her wrist and foot. Finally Agnes is covered with her bed sheet and left in the room. The nurses have not spoken during the procedure. They finish the work by packing the patient’s belongings in a plastic bag. One hour later, the workers from the mortuary arrive to collect the body, an orderly cleans the mattress and pushes the bed back on the ward for the next patient to be admitted later.

On the ward, the routine work continues. The nursing students start to check vital signs. They arrive at Dora’s bed; she was admitted last week diagnosed with liver failure. Two days ago she became semi-conscious and confused. This morning, she was taken to the computer tomography and returned sleeping about 30 minutes ago. The students cannot find a pulse and ask nurse Joyce to come and assist them. She checks at the wrist and neck, then takes the blood pressure machine and tries to find the blood pressure. She looks at the students and says: “She is gone.” Joyce returns to the nurses’ table and convinces the doctor relaxing there to certify the death. The students are asked to push the bed to the –just emptied- treatment room and another student packs her personal belongings in a plastic bag.

Death in the Ghanaian society is seen as part of life. A high child mortality rate (112 per 1,000 according to the WHO report 2005) and a life expectancy of 58 and 59 years (male-female) lead to a situation where death is omnipresent in daily life and regular funerals become part of the social organisation (De Witte 2001, Van der Geest 2004). On Fridays and Saturdays, small streets, compounds and churches regularly become places for extensive family gatherings, wakes and funeral ceremonies. Funeral announcements are posted along the streets, shops and on vehicles and videos and photographs of the funerals are willingly shown to visitors and friends. In contrast to this, dying is supposed to happen alone and in a secluded space (Van der Geest 2002). Public opinion is such that dying is a personal and intimate affair and no

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61 This is done to prevent an open, yawning mouth when rigor mortis sets in.
62 In Kumasi, funeral notices are mounted on giant billboards and banners along or across busy streets.
other person should interfere. This does not mean that a dying person should be lonely, but surrounded by the care and prayers of family members. Having reached old age and being firm in the Christian belief that “I will return to my maker” defines the framework for a peaceful and good death. The phenomenon of being given water to drink on the moment of dying has been researched and is mainly understood as a symbol of a final intimate act of family care or a preparation to greet the ancestors. Indeed, as an elderly member of a Ga family explained: “Death to the African is not the end of one’s life but rather, it is a transition from this physical world to the ancestral world. It is believed that if you die, you just leave this world to stay with your ancestors.”

Dying and death play an integral part of the routine in the medical department. During the research period, between 16 and 26 patients died monthly on the 30-bed ward. This chapter describes the processes around dying patients and analyses their impact on nurses. It starts with the nurse’s observation of a dying patient, carrying out the last offices and completing the written documentation. Then it turns to the reactions of patients and the notification of the deceased’s relatives and finally it sheds light on the nurses’ own emotions. It will become clear that the activities around dying and death in the medical setting both follow and compromise cultural and traditional norms in Ghana, leading to social and emotional dilemmas. As it is a universal conviction that people should die after a long and fulfilled life, serious diseases and unforeseen complications can lead to life-threatening situations that challenge this idea; people die young and before their time. Both the individual and the group around him or her have to deal with this and find an appropriate reaction. The introduction and omnipresence of biomedical care gives hope but also has to deal with limitations and the feasibility of its medical claim in the Ghanaian culture.

Nurses’ work

Dying on the ward happens in most cases suddenly and is not immediately noticed. The above examples illustrate that in cases of some younger patients like Agnes, resuscitation efforts are made and are later mourned when these are unsuccessful. However, most older patients like Dora die unnoticed. Many patients arrive at the hospital in a condition labelled as seriously ill and weak, but neither the medical staff nor the patients and their relatives ever discuss an imminent death. Only a few patients are aware of their deteriorating health as a consequence of terminated treatment. In such cases, the financial burden due to necessary medication or technological examinations becomes too much for the family and the patient remains on the ward with minimal treatment. Stopping dialysis or chemotherapy results in a death. Such a decision sometimes comes from the patient herself mentioning her wish to spend the money on the family instead or ‘just happens’. It is never a discussion

63 The cultural norms of avoiding discussing medical conditions and expressing emotions were analysed also in Chapter 14.
including medical and nursing professionals on the remaining quality of life. A sudden death refers to situations when nurses label the death of a patient as unforeseen. Nurses recall such situations as when a woman “was fine in the morning, she talked to her visitors and had her breakfast; then her mood changed, she lay down to rest and died all of a sudden, it went fast.’ Another patient was remembered as ‘she was ok, I spoke to her yesterday. She might have aspirated some food because when we looked she had vomited all over; we did not expect this.” This is different from an unnoticed death that seems to have occurred while nobody was aware of it. In the written documents it reads thus: “she was observed to have ceased breathing.” Others are found dead when nurses approach them for an activity like checking the vital signs or to wake them up in the morning. All situations have one thing in common: that patients die alone. Even with those women whose health slowly deteriorates and whose death is imminent, nurses decide not to take any action but leave them alone. This became explicit when a 43-year old women diagnosed with pneumonia and suspected tuberculosis became weak and unconscious. She was washed and tube-fed by her mother and sister who then sat at her side praying with her. Two nurses asked her relatives to leave and then checked her pulse. It was weak and hardly palpable. One nurse squeezed her finger and noticed a slight reaction. “Oh, she is not yet gone. Let’s give her more time, we will wait for a while.” Both nurses went to do other work and when they returned fifteen minutes later to check again, there was no reaction. “She is gone, let’s call the doctor to certify her death.” Only on a few occasions is death seen as a condition that should have been prevented and fought against as described in the beginning. During the research, two similar events happened when a young woman died suddenly and both nurses and doctors started resuscitation. Sucking machines were connected, heart massage started and medication was administered. The women died several minutes later.

After a patient is declared dead, nurses have to fulfil two duties: execute the last offices and document the passing of the woman in several files. Two nurses normally carry out the last offices in the treatment room just outside the main ward. Nurses do not like to do this work and try to avoid doing it. Younger nurses and nursing students express fear of the dead bodies, and the physical effort adds to the work labelled as tedious. The deceased uncovered woman is brought in her bed to this place, passing other patients. Asked for an explanation, nurse Edith says “The patients that we push out and prepare for the mortuary are many in number. These days when patients die, we don’t cover their faces. Some time ago, as soon as you died we would cover your face before pushing you out, but now we just push them out. The other patients got scared. We would sometimes say they are being taken for an examination or something like that. The other patients do realise somebody has died and might tell the relatives. In such cases, before the relatives are informed officially, they will have been told by other patients, ‘Oh they pushed her out’. It should be a nurse who informs the families about the death, not a fellow patient. Patients are the first people to make noise, so we try as much as possible to stay silent.”
Nurses hardly speak to each other while removing the clothes and (para-medical) devices in order to prepare the dead body for the mortuary. There are no common prayers or sayings to mark this transition; at best a remark is made about an untimely death, a patient’s last physical condition or the difficulty of doing this work with insufficient equipment and gloves. Used sheets are thrown on the floor and the deceased is finally wrapped in a cloth, preferably one of her own. Edith explains: “Otherwise, we lose too many of our own sheets; they are never returned. And there were several reasons that made us stop using the body bags. One is that it did not look nice. Another reason was that they only had one size, and many fat people did not fit in it. Finally you know our climate. The bodies in plastic seem to start rotting in the bags due to the warm weather and insufficient cooling. There were just too many negative points, so we do not use them any longer. We got used to seeing the dead bodies.” The dead women are left there till the mortuary workers come to the ward. They place the body on a stretcher and bring it to car, collecting bodies from all the wards. There are days they have to come twice.

The second duty is to do all the paperwork involved. Before closing a file and bringing it to the administration for bill assessment, the cost sheet is completed by adding cotton balls, gauze, a syringe, gloves and facemasks to the list. While reporting in the medical file is the responsibility of the doctors, nurses document proceedings in their nurses’ notes and in the 24-hour report book. The nurses’ notes often read like those in the following case of a 50-year-old woman:

6 am: slept fairly well. Is very ill and weak.
8 am: Breakfast given and little amount taken. Assisted with her personal hygiene and made neat in bed.
9.45 am: oxygen inhalation started as patient was observed to have difficulties with breathing.
10.30 am: she was observed to have ceased breathing. Dr. Mills called to certify the death. Last offices done. Body collected at 1 pm. RIP.

The report in the 24-hour book resembles these notes; there are no indications that the situation changed or became life-threatening. The only variation is whether “she was observed to have ceased breathing”, “her condition deteriorated and she ceased breathing” or “her condition changed suddenly and she stopped breathing”. It is, as mentioned before, very rare that a patient dies under acute circumstances that ask for resuscitation and medical emergency. The files do not give account of any nursing activities or reactions concerning the death. The style is factual and short. For statistical and administrative purposes, the name, age and diagnosis of the woman is listed both on the daily ward-state paper (translated into an ‘empty bed’) and on a

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64 During this procedure, jewellery like earrings and wedding rings are removed and kept aside to be given to the relatives. Traditional strings of beads wrapped around the hip or neck remain on the body.
65 For the role and function of mortuary workers, see for example S. van der Geest (2006).
66 The medical files report on the daily doctors’ rounds, the treatment plan and the patient’s condition. The dead of the patient stops this report. It mainly reads; ‘was called to the ward to see that patient who was reported to have ceased breathing at … Examinations done, death certified at … RIP. Signature.’
monthly poster hanging on the wall, joining those who had died earlier. Finally, announcing the day and time of her death in red ink completes the woman’s entry in the ward’s admission book.

By then or the next day, the assessment of the bill is done and the relatives are informed of the amount to be paid when they come to take the belongings away. They take the file to the accountant and return with the file and receipt. The death certificate is written days later, long after the body has been taken to the mortuary and the bereaved family has paid the outstanding bill to the hospital. The doctor has to fill in two copies of the death certificate form. One remains on the ward in the book and the other is given to the relatives once they bring the receipt of the paid bill. They write their name, address, date and relationship to the deceased on the back of the part that remains on the ward. Thus, the bill receipt and death certificate are exchanged. With the death certificate, relatives can now go to the mortuary to collect the body for the funeral. If the doctor decides that a post-mortem (PM) should be done, collecting the body takes longer, sometimes up to a few weeks. In such a case, the deceased’s relative takes the file and the postmortem request to the mortuary, identifies the body and returns with the file. Nurses play an informal but crucial role in this process. Next to the obvious control of exchange, they are the main contacts for the relatives who have come to request the death certificate. Busy days prevent the medical doctors from filling in this form quickly; sometimes it takes days. It is up to the nurses to negotiate the conflicting schedules of the doctors (and their wish not to be reminded of their duties) and the desire of families to handle the papers, organise the funeral and come to terms with the death.

The following situation is characteristic of this dilemma: A man came to the ward early October to collect the death certificate for his deceased wife. “She died three weeks ago and we are planning the funeral in November. I want to see her. I am chasing up the paper. Yesterday, a young nurse told me I should come today. But I do not see my folder. Without the folder, I do not get the body and burial certificate. You have to understand that it is not easy. My boss will not allow me to leave my work everyday to come here and look for the things. Why is it still not done?” The nurses remain friendly and start looking for the file while asking the man to be patient. “It is not our fault if the certificate is still not written. We tell the doctors to sit down and fill out the forms, but this is all we can do. We are not in the position to force them. And you do not need to visit the dead body. They keep it well there, nothing will happen to the body till the funeral. They use formalin there to preserve them; you cannot enter the place anyhow. Once you have the certificate they will show you the body. She will be ok.” Finally the file is found and the widower is relieved. He decides to wait outside till the doctors come for their round and ask them to write the certificate. Nurse Catherine expressed her joy: “Thank God we found it. Losing such a file is really a problem. They can sue you for losing it. Without a file, there is no death certificate and no easy and fast funeral. In cases where the cause of death is not completely clear, the doctors request a PM [post mortem]. This is especially meant to avoid accusations
later. You know, sometimes the relatives are outside when the patient dies, and later they come and enquire after the cause. They will come with all kind of ideas like food poisoning and so forth. In such a case, it is good if you have a clear PM. It not only protects us nurses, but also the relatives.” This example repeated itself often, and the nurses have to manage the various expectations.

Patients and relatives

As has been explained, dying happens openly on the ward and other patients are witnesses. They are afraid and doubt their own fate while hospitalised. After one young woman died during the night, a patient tells me in the morning:

>This night I could not sleep. This girl died; she made so much noise. She was breathing strangely and then she died. They pushed her along past my bed. I saw her, her eyes were still open, like she was looking at me. Oh, I could not look at her and then it was impossible to sleep. It happened around half past three in the morning. I was afraid. Her relatives were outside. I heard them crying and shouting.

This remark expresses both her insecurity about her own health and the general fear of the night. It is widely believed that death comes at night. Therefore, many patients try to convince the nurses to leave some light burning and they remain awake, resting again during daytime. Another woman expresses her disbelief: “Why is she dying? I am much thinner than she is, so why her?” Another adds: “I am not better than those women, I could also lie in the fridge. So I pray, I pray God will save me and bring me home again.” Younger patients are particularly vulnerable to what they witness. A father of a young sickle cell patient is concerned because “during her admission, she saw too much. The people were dying and she saw it all, she suffered a lot.” Normally they do not speak about what they have seen but remain calm and prayerful, reading their Bibles or trying to rest. The nurses do not inform other patients of the death of a woman; they simply wheel out the deceased’s bed and clear her locker.

Relatives are hardly ever present when their loved one dies. Nurses justify this with the disturbance of their work and possible ‘misbehaviour’ of the family members, as nurse Grace states:

>Dying patients do get our care. We look after them; it is just that we are understaffed. But relatives at the bedside will disturb us and we can’t do our work.

An older nurse shares her experience:

>Some people cannot control themselves and will start crying. And this will disturb the other patients too much. And then the other patients will ask themselves ‘Will I also die here?’ So we normally do not ask them in. But when you ask the relatives to leave, they know what is happening and start getting used to the idea outside the ward.
Nurse Maggie adds:

Yes, when they are about to die, we ask the family to go out. Some people cannot control themselves. They will cry and shout and disturb the whole ward. In Europe, you cry silently, but here, some people make noise or even fall on the floor or collapse. Also Christians or even nuns can collapse. I do not understand it, at least they should be calm, but they also cry and shout.

In general, the matron or one nurse who has had a special training will try to counsel the relatives, preparing them to anticipate the passing away of an admitted family member.

The nurses’ perception of the relatives is biased. Traditionally, people are to die at home, cared for by female family members till the end. Death in a hospital is a recent development. Nurses see the driving force behind this in the changed perception of death, and also in several practical reasons. Death in the house can shed a dubious light on the family; suspicion about the cause of death might arise and old conflicts may be revived. Nobody wants death to enter his house. Vivian elaborates:

They will wait in the house till the last moment and then rush the patient to the hospital. The same applies to the private clinics: too many deaths give them a bad name; they refer their hopeless cases to us as a last resort. This is why so many people die here in Korle Bu. These are the reasons: people do not have enough money to come on time, are too sick and then they cannot buy all medications or do all the needed tests. Some have chronic diseases. You can see them tired after taking medications for 20 years. They decide to stop and just die. In other cases, it is the family that decides to stop buying the medications. Over here, it is the family that decides on your health. And then they wait till you are dead and they will spend a lot of money on the funeral.

Lydia adds: “People do not want their family member to die at home. In such a case, they have to report to the police and it becomes a coroner’s case. So they bring the women here when it gets critical and leave them.” Another reason is a financial one. In today’s Ghana, funerals often take place weeks to months after the person has died. In the meantime, the body is stored in a mortuary, referred to as ‘the fridge’. These are linked to hospitals. The cost of the mortuary is lower when the person died in the hospital after being ‘brought in through the OPD’ instead of ‘brought in dead’. Nurses are therefore not happy about the new role they are given to participate in the dying process. In their opinion, relatives withdraw from their duty to provide financial and emotional support when health deteriorates. They may do this by delaying the supply of necessary medication and reducing their visiting frequency. While relatives are kept out of the ward when a patient dies, nurses also feel left alone.

Breaking the news to family members is the duty of the nurse in charge or the matron. This is done preferably outside the ward in the matron’s office or

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67 A sudden and unclear death is labelled as coroner case. It is reported to the police who will then send for a post-mortem examination to exclude an unnatural cause like murder or poisoning.
at the table. They ask the visitor to sit down. “We let them cry.” In most cases they know already the poor outcome of their relative’s health. The following situation is typical:

Mary, died in the early morning. At only 48 years of age, she had suffered from various medical conditions, including diabetes, a peristaltic ileus and severe hypertension. She had been unconscious the last day and was on oxygen support. Her daughter arrives with two friends at 7:30 am to visit her. She notices the empty place and walks slowly to the table. Nurse Joyce is sitting there writing.

“What happened to my mother?” she asks anxiously.

“You sit down first.”

“I want to know what happened to her, tell me.” She starts crying, looking at the nurse in hope and despair.

“I am sorry, we lost her. Sorry.”

The young woman starts crying aloud; she stands up and starts walking to the place where her mother’s bed stood. Then she stiffens and throws herself on the ground. Some patients look on, they know what has happened, but nobody speaks to her. Her friends also cry and help her to stand up. Joyce walks over to her and guides her back to the chair. She tries to make some phone calls informing the family of the death. Joyce talks to her: “Listen, this is a time of challenge. Today, your mother has joined the Lord in heaven. So let your life be a memorial for her, so she can be proud of you. The Lord will guide you through the days to come. Let the champion in you arise and stand up. Let your young life be a joy to our Lord. These challenging times are to show your strength and belief. You know that your Redeemer liveth, God is in control. Yes, you will weep and cry, but you will also live. Do not look down, stand up and rise, the Lord is with you. Now go home and inform your people. Come back later for the bill.”

The nurses appear calm and sober in such exhortations. They refer to the correct procedure, the sudden death that could not be prevented, and the shared belief in God who takes care both of the beloved deceased and the bereaved family left behind. Such commiseration with relatives and patients is rare.

Nurses’ emotions

How do nurses deal with their own emotions? Are they touched or indifferent, frustrated by their unsuccessful efforts or sad about another life lost? Being faced with death in such regularity poses the question as to how they manage their feelings and to what extent they can intercalate this in their perception of nursing. Two ways are followed here: nurses have their professional attitude leading to ideas and explanations of the patients’ conditions that lead to death, and they have their personal convictions trying to find a way to show or conceal their emotions.

It is the nurses’ general conviction that patients lack sufficient awareness of their health conditions and come too late to the medical centres. Veiling one’s health problem, resorting to religious or traditional healers and being afraid of excessive costs at the hospital prevent timely hospital admission in many cases. The matron is firm in her condemnation of this attitude:
All say: ‘go to Korle Bu and die.’ That is the Ghanaian attitude. So people come here when they have exhausted all their resources. They go round, round and when there’s nothing for them to do, they come and if we can’t do anything, the patient dies. And because of that I call Korle Bu ‘last stop’, or the medical block ‘mortuary annex’.

Many nurses share this view and blame a traditional mentality when patients do not come in time. In their perception, managing seriously-ill patients is within their capability, but complications and lack of medical resources can lead to an untimely death. A nursing student captures it this way: “They won’t come in their early stage, they come in their chronic stage. They wait till the thing has developed complications. They’ve gone to seek treatment from some herbal centres, prayer camps, other things. So most of the time, when they come, they come in their terminal stages. Nothing or little is done and they pop off. But those who come in their early stages, they are managed and they go home again.” Relatives also play a role here. They are seen as the main religious, emotional and financial support to sick family members. It is supposed that when such support fails, the patient gives up. The death of a young girl suffering from symptoms of paraplegia is explained by the lack of maternal support. The matron explains:

Her mother was very sad, she had given up. I saw her on Friday and she had no more power. I tried to talk to the mother to prepare her, but she was so fragile and tense, so I decided to leave her. There was nothing more we could do and the girl died two days later.

The reaction of the nurses to these situations is mainly to give nursing care. One of the nursing directors explains:

What can we do with all these problems? Why should they start dialysis or chemotherapy in a chronic or complicated case? Let Thy kingdom come! We don’t want to give false hope. All we can do is TLC- tender loving care. You see, again and again, death is laying its icy hands on our wards.

All nurses and nursing students express that ‘empathy’ is the attitude nurses have to show towards patients and relatives. The students repeat what they learned during their training, that “if you have this patient on a ward dying, the parents come weeping, crying and all that, you should not join them in crying. That’s not professional, though we should be with them help them and help. We should empathise with them, we shouldn’t get emotionally involved.” Nurses explain that “those relatives are already stressed out because they also have other problems, so we should rather be there for them than joining them in their expressions of grief.” Indeed even the health care assistants say that “if you’re very emotional, you can’t do this work; you should go and do something else.”

On the personal level, coming to terms with death is not easy for the nurses, especially when a patient with whom they had established a relationship dies. This is particularly true in the cases of several young patients who died of leukaemia after years of repeated admissions and therapies. The death of one of them was one of the few occasions when nurses felt sad and cried. One
expressed how all felt: “today is a sad day on the ward, there is no life in me.”
Susan summarises the situation:

You are not supposed to cry; it does not help. You come alone into this world and you 
go alone, that’s all. You have to take the good times and also accept the bad times. 
We nurses have seen so much dying, after some time, you get used to it, and there is 
nothing you can do. You learn to deal with it.

Martha adds her religious conviction combining it with her professional 
attitude:

I am telling you, this ward is ruled by Satan. There are diseases you do not understand. It is 
wonderful. Things do happen here, am I telling lies? You sometimes work hard and think the 
patient is exaggerating and before you realise it, the patient is dead. There is nothing we can 
do but pray to the Lord to glorify His name.

The emotional burden of being faced with death in such regularity puts 
stress on the nurses. Students and nurses alike mention that they had not 
expected to see so many patients die and be overwhelmed by it. As most nurses 
did not opt to work on this ward but were posted there by the main 
administration, their apparent emotional distance can also be understood as a 
mechanism to protect themselves and keep the level of frustration low.

Conclusion

Nurses on this ward are confronted with suffering and dying patients on a daily 
basis. They experience the dilemma that their hospital is known as one of the 
best places for medical treatment and cures, while at the same time it is 
associated with hopeless situations and death. Their profession teaches them to 
care for patients and support their healing processes, but many patients arrive 
(too) late or are brought in to die in the hospital instead of at home. Following 
this, conclusions can be drawn on three levels, concerning a dilemma between 
culture and medical practise, challenging practical issues and the concern for 
the hospital’s reputation and showing an increasing medicalisation of death and 
dying in Ghana’s metropolitan centres. Nurses have the task to bring together 
the contrasting views of the omnipresence of death and the unspokeness of the 
act of dying.

An untimely death is defined as a ‘bad death’ that can lead to suspicion 
and conflicts in the family. Certain forms of diseases and social behaviour are 
clustered as causing problems and can lead to a death that manoeuvres both the 
deceased and her relatives into a complicated social situation. Nurses are 
aware of this but find themselves exposed to possible reproaches and 
accusations. They try to avoid being involved in such a ‘bad death’ and its 
circumstances, or turn it into a ‘good death’. Two features contribute to this

68 Death as the consequence of undefined or untreated diseases and the consequences of 
accidents is in many cultures labelled as ‘bad’ or ‘bothersome death’. See for example Lerer 
behaviour: in verbal communication and statements, nurses strengthen the apparent well-being of the patients, while on the ward they are content with the ‘suddenness’ of death. This also corresponds with the attitude to keep illness, and dying secret and secluded. While nurses might make judgments on the patient’s behaviour and (unsatisfactory) compliance with the hospital treatment during admission, this stops with the death of the patient. It is only with aged patients that it is said that “they were old; it is good they died, there was nothing we could do for them in this world.” Otherwise, the death of each person is labelled as ‘sudden and unexpected’. In addition, the standardised ways in which nurses’ notes and reports are written do not reveal the concrete circumstances of the death, nor do they give any individual assessment of the last moments before death. Reading the files, the patients were weak, received bodily care and feeding. It is up to the medical doctors to define the cause of death or request a post-mortem examination.

The Christian belief both of patients and medical staff plays a crucial role in helping them to place death in their lives\(^{69}\). Praying in front of the patients, reading the Bible (both patients and nurses) and affirming one’s trust in God’s ultimate plan are regular expressions of individual belief. Death is labelled as a transition to eternal life in the absence of pain and suffering\(^{70}\). A common expression is: “If it is her time, she should go meet her Maker and rest in perfect peace. If it is not her time, God should glorify His name and make her return home so that our work is not in vain.” Nurses mention their religiosity as one motive of choosing the nursing profession, and say it supplies them with mental support to cope with the situations on the ward and organise their own emotions. Giving ‘tender loving care’ is inspired by the Christian view, and nurses say, “It hurts but we have to be strong to support families. It does not help when you break down. You need to support the relatives and let them cry. With some patients, you know there will come a day they come and do not leave again.” By holding on to their religion, nurses are able to manage their emotions and do their work on the ward. Mourning is the task of the family in preparation of and during the funeral rites, and nurses do not normally attend funerals of their patients. Individual moments of grieving and sadness do occur among the nurses but are preferably kept secret. Christian hope and cultural norms dictate self-restraint and form the base of their facade\(^{71}\).

Most researches on Ghana emphasise the importance of dying in one’s own house, preferably in one’s own room and after being served some water to drink. The phenomenon of dying in the hospital occurs more and more often and challenges this ideal. It can be understood as an indication of the increasing role Western medical care is given by today’s society. The patient and her

\(^{69}\) Most patients and all nurses were Christians of various denominations, ranging from established churches to Pentecostal congregations. Only few patients were Muslims, therefore my analysis focuses on the Christian group.  
\(^{70}\) See Spronk (2004) on a Biblical understanding of death; its core message was also told or even recited to me during interviews and conversations with Christian Ghanaians.  
\(^{71}\) Van der Geest (2002) describes the construction and display of cultural norms with regard to death. Geurts (2002) explains the concept of ‘balance’ as a major characteristic of adults in Ghanaian culture.
family decide on a hospital admission despite its costs hoping for therapy and a cure. Most patients expect to leave the hospital cured and a deteriorating health condition anticipating death is not openly discussed. At the teaching hospital, roughly two groups of severely ill patients can be met: chronically ill patients suffering from a severe form of hypertension, diabetes, liver and kidney disease or cancer, or acutely ill persons admitted or referred after an uncontrollable disease outbreak. As life-threatening diagnoses are often hidden to avoid emotional breakdown, discussing the possibility of an early return home is not encouraged. In addition, family members seem to have an interest in a hospital death. When their health conditions deteriorate, patients express the wish to return home (to die), while family members might prefer them to stay in the hospital and out of the house. The brother of a seriously ill patient formulates the problem: “Look at her, she is not walking any longer. I don’t know what to do. She remains in bed and the hospital costs pile up. But at home we cannot help her, as we do not know when she is dying. We do take people home to die, but only if there is somebody to take care of them. There is nobody in our house, so she has to stay here.” The dilemma often remains unresolved as the patient is too weak to force her way home, and in the end time decides. As described above, organisational and financial reasons also play a role here, namely the complicated police investigations if a person dies unexpectedly at home and the reduced mortuary fees for in-patients. Relatives want to avoid accusations of having caused the death of a family member or having been negligent. By admitting her to hospital, it is shown that all has been done to try to save her, and neither trouble nor expenses were spared. Mentioning the hospital as the place of death on the funeral announcement can be understood as a supporting aspect of this idea. Tijmstra (1987, 1989) also found such behaviour among relatives of transplant patients in the Netherlands, calling it ‘anticipated decision regret’. This term explains the behaviour of relatives who try and support medical treatment in order to avoid an anticipated feeling of regret (“we haven’t tried everything”) later. The Dutch context of course differs from that of the Ghanaian by, for example, working within the framework of a health insurance system and allowing for a more open discussion of possible options and the risks of a given therapy with patients and their families. Therefore, the idea of an ‘anticipated decision regret’ is only related to the decision of the families to admit a patient and leave her in hospital to die.

The reasons given above do offer an explanation as to why so many patients die on the ward. The question remains as to how nurses deal with this and, maybe more prominently, why patients are left alone in this situation. It is against most cultural codes and convictions to die alone and this is avoided whenever possible. On the ward, however, the patient is left by herself to die,

72 The original Dutch term Tijmstra introduced is ‘anticiperende beslissingsspijt’.
73 The high costs of therapy and medication are in the Ghanaian situation rather a cause for late admission and delayed treatment. Families find themselves in the dilemma of choosing between desired medical intervention and practical financial problems. See also Chapter 14 on the relations between patients and their families.
and relatives are asked to leave. Nurses do not take additional action to emotionally support or soften the dying-process. The concept of palliative care and pain-reducing medication is absent on this ward. The line between being left alone and being abandoned is hard to draw in this situation. It was also suggested during this research that such behaviour creates a legitimate way for the dying to send all relatives out of the room (to get the water) and die peacefully and alone. In doing this, the dying person can keep her dignity and show neither fear nor emotional agitation. An older woman in Accra confirms that “people here want to die alone. When you are with them, they cannot go. You have to give them some space to leave this earthly place. This is why they ask for water or other things, just to send you away.” In that light, the apparent negligence of nurses concerning dying patients can be understood as a way of establishing an atmosphere of dignity and seclusion for the person to die. A Ghanaian Christian minister suggests that “In hospitals or at home, when people are going to die, we believe that the soul/spirit moves out of the body. It is a moment of struggle, and sometimes it is a bit difficult for the soul/spirit to move out of the body when there are people around. So in hospitals, the relatives of the dying person are driven out or kindly asked to go out. The period or the moment of death is a critical moment which many people in Africa are not able to withstand.” The nurses seem overwhelmed but display a professional attitude, appearing knowledgeable and in control. The individualised and emotional care for the dying person that is so crucial to Western nursing theories is not (yet) practised in the Ghanaian culture. The predominant goal seems to be having a quiet and well-ordered ward with patients resting in their convalescence. Each death forms a threat to that goal and challenges the nurses.

Finally, it is clear that there is an increasing medicalisation and professionalisation of dying and death in Ghana. Similar to developments in America, Ghanaian narratives of the dying become increasingly medicalised stories (Rubinstein 1995; Long 2004). Sick and dying persons are admitted to the wards. The patients surrender and try to comply with the medical system, their relatives hope for successful treatment through Western biomedicine that will be within their financial means. The building, the machines and the pharmacy as well as the medical doctors and nurses represent this last hope, but sometimes turn out to be part of a fictional feasibility. The dying patient and the nurses meet on the ward and remain distant. The clash of religious, financial and family obligations with the medical, laboratory-based, individualised system leads to intricate, interwoven dilemmas. All this makes dying on the ward an awkward and undesired situation displaying the problems of the current state of the Ghanaian health system.