Ghanaian nurses at a crossroads : Managing expectations on a medical ward
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“By the Grace of God, we are fine.”
Religion on the ward

We are all Christians. Don’t let God ask you, ‘Where was I sick when were you?’ because He manifests in the patient. I get my blessing when I come to the hospital. Any given time of the day, our motto is ‘nursing Christ in the patient’. Whoever is sick, He is there (Matron Mary).

The morning visiting hour is over. Just after 8AM, the night nurses have finished their nursing documentation and have administered oral medication to all 30 patients on the ward. The morning shift have arrived and is getting ready to take over. Matron Mary calls all nurses to the table. Four nurses, three assistants and three students gather and form a circle. “All come for devotion. Hurry up, it is already late. Why do I always have to call you?” She calls a student: “Hey, why are you hiding behind others? You will lead us today.” They start by singing a short song, and then the student prays in Twi, asking for healing mercy and support for the work of the nurses, accident-free transportation for the night nurses back to their destinations, a cure for the patients, and strength for all. Some nurses confirm by calling out “Yes, Jesus come”, “Amen” and “Soak us all in the blood of Jesus!” Then the group says the Lord’s Prayer together, followed by the sharing of grace. The nurses form a circle holding hands. “Let’s close the circle, let the chain not break. ‘The grace of our Lord Jesus, the love of God and the sweet fellowship of the Holy Spirit shall be with us now and forever more. Amen!’ So now, let the work start, form pairs and start making the beds. We have some bed sheets, take them with you. Hurry up!”

This religious ritual takes place every morning on the ward. In case the matron is absent, the nurse in charge takes over and calls the group together. On most occasions, a young nurse or student is asked to lead the prayer. It is a crucial moment in the morning routine and sometimes it happens even in a jocular way, like sister Grace who calls, laughing, “Let’s come and pray. Don’t be so shy, or are you allergic to prayers? Or do you worship any Buddhist
tradition? Let’s pray together before we start insulting each other. Let us be together and ‘one’ today, ok?” On some mornings, older nurses start singing a hymn, clapping their hands and even dance around the table. The patients see and hear this prayer going on, but none of them joins in. The medical staff arrive during this worship, but they continue with their own work or look for files on that table; only in very rare situations would a doctor participate in the prayers. It is clearly the group of nurses forming the circle, sharing the grace and asking for blessings over their work. When asked, the nurses give their explanation. Sister Edith says: “It helps us in our work. We pray also for the doctors and patients.” Her young colleague adds, “This prayer will also encourage the patients as they see their nurses are serious Christians and do their best to care for them. It will help in the healing process.”

Hospitals are often seen and perceived as a religious and secular places, identical clones following scientific criteria worldwide. Norwood speaks of a space as an ‘insulation from the outside world’ (2006:8) in which religion has been given a marginal position both structurally and ideologically. The contrary is true in Ghana. The medical ward is, just like other wards in Ghana and elsewhere, a space where the scientific diagnosis of a situation and the complex needs of an individual including personal belief—be it that of the patient or of the health worker—meet. Following Geertz’s comprehensive definition of religion as a cultural system, Christianity delivers perspectives to individuals and groups who face the extreme situation of life-threatening diseases (1973). The following chapter shows what the role of religion is and how religion can be observed as an unconsciously, natural and self-evident part of the nurses’ and patients’ personality on the ward. Describing the views and actions of nurses and their relationship with patients, it will be shown what role belief and religion play in the daily routines of nurses and how the perception of God as the almighty power influences the acceptance of and dealing with disease and death.

The omnipresence of religion

Nurses, doctors and patients alike confirm that Ghana is a religious country and “if we talk about all things and don’t add the religious part, it’s like there’s nothing inside” (Cecile). Unlike experiences in Europe, where different Christian denominations challenge and dispute each other’s beliefs and dogmas, the Ghanaian reality is tolerant. The most prominent goal is to be a Christian and go to church regularly and lead a life according to the Bible’s principles. Whether the person attends a more established church (like Roman Catholic, Anglican, Methodist or Presbyterian) or one of the countless Charismatic and Pentecostal churches, is of less concern, as the individual belief is what counts. Since 1992, following the state’s liberalisation of the media terrain, television and radio stations continuously report on religious developments, telecast or broadcast Bible studies and church services. The churches play an important role in and regulate the daily lives of Christian
Ghanaians. Church welfare committees help to manage health expenditures and prayer groups support sickly church members during their time of ill-health. One example is often recalled when expressing the religiosity of the staff in the hospital: Lighthouse Chapel International, a charismatic Christian ministry, started on hospital grounds about 20 years ago. Its founder and current bishop was a medical doctor at the hospital before becoming a full-time reverend. Many nurses remember the beginnings in the hospital’s canteen. They still attend this church and recall miracle healings. It is within that reality of prayer meetings, funeral announcements, broadcast divine services and individual counselling that nurses and patients organise and understand their daily lives.

As is already visible in the women’s motivation to enter the nursing profession, Christian religion and personal belief form an important aspect of many nurses’ personalities and is suggested to be one of the motives for entering the nursing profession through the generations. Several nurses mention the calling they had. One matron reveals thus: “When I get up in the morning, my prayer is to bless my hand that I’ll bring healing to the sick. I have the calling to be a nurse. I said, ‘God, if you want me to be a nurse, let me come out with good grades so that I can go into nursing.’ And fortunately, my results were good.” (Matron Mary). Matron Regina believes that “it is God who’s keeping us here; otherwise you won’t come and be here.” Nurse Evelyn, who is about 15 years younger than the matron, shares this conviction. In her view, “as the Good Book says, we’ll give account of all these little things on the Judgment Day. And so for us nurses and doctors, we really need to sit up and do what the Lord expects from us.” Nurse Martha brings in her struggle using her belief to defeat illness and death. “I am telling you, this ward is ruled by Satan. I chose nursing because I like to care for people. I attend to them when they call me. We have to pray as we live in the end of the days.”

Being a Christian has implications for the understanding of the nursing work, it means for them ‘doing good’. The Sunday shifts are justified in the conviction that:

Jesus is in the same dress as the patient. We sacrifice our church and worship to nurse God in our patients. At any given time of the day, you nurse Christ in the sick. (Matron Mary)

Some say “be grateful to God to work and safe lives.” Sister Catherine explains that religion is and should be the main motivating factor for all nurses. “Treat all patients well, by this you serve Jesus best. And when you are a Muslim? Then you have Allah to serve well. We have to give our service to the patients; this is where you meet your creator.” They are aware that God is powerful and are grateful for their lives. As Matron Regina puts it: “I am happy that I’ve been able to work in Korle-Bu to save lives. It’s only by the grace of God. So I don’t have any ill-feeling at all and I’m grateful to God for what He has done for me.” But they also anticipate that nothing can be taken for granted.

God is real and His word that has spoken is real. He sent His word to heal us, so if
you believe in Him it will work but when you just believe in the formula it won’t. You see, God is not like a computer, when you press certain things and certain numbers come up. I’m going to seek the face of God and when I pray to him, He’ll heal me. But if you just believe because everybody does and you don’t believe in your heart, it won’t work, it won’t work. (Nurse Cecilia).

The older and more experienced nurses serve as a role model in their expressed religiosity to the students. On their first day in the Medical Department, nursing students learn and recite with the departmental director the maxim ‘Service done to mankind is service done to God’. The next step can be seen in the example in the worship to begin the day’s activities: young nurses and students are chosen to lead the morning prayers and they practise that ritual; the older nurses correct and guide them in the process of openly displaying their Christian conviction. Also in the schools, students are prepared to pray with patients in need whether they are Christians or Muslims. “You just share a few words with them. Talk about Christ to them. Even if the person is not a believer, you help the person to accept Christ.” Her friend adds: “It’s like we help the patients with their religion. Like for instance, we are told that when you’re about to prepare a patient for an operation you prepare the person physically, emotionally and then spiritually too, in terms of the person’s faith. So that if the person is a Christian and you’re also a Christian yourself, I mean the nurse, you pray with the patient and assure him that God will take care of everything and all that. It helps calm the patient down a bit so that when they go in there, they come back.” Another student says: “We are taught that if the patient is maybe a Muslem and you could help, just say, ‘Oh Allah will be with you’. It helps the patient to realise… you know he’s not kind of… let’s say foolish or mad believer, but Allah will help. The nurse taking care of him is even assuring him that Allah will take care of him. You know it helps.”

Religion as an exclusive factor

As a researcher on the ward, my role and my personal convictions became part of the ward’s routine. It soon became natural that I joined the morning prayers and helped close the circle and share grace before starting the morning shift. The nurses knew of my connections to one of the churches in Accra and shared their religious experiences with me. After several weeks on the ward, one of the matrons announced that it would now be my turn to lead the prayer. I understood that this was their way of expressing their acceptance of me, and my European reluctance to feel comfortable with their request was out of place. Apparently my prayers on that Friday morning were in tune with the nurses’ expectations; they expressed their satisfaction and said I was now ‘one of them’. A situation several weeks later explained in opposite terms which role religion played: for two weeks, three Scandinavian nursing students worked on the ward. They expected to work similarly to how they did in their home country, having been handed over responsibilities in caring for patients, administering medication independently and discussing medical issues with
doctors. Being atheists themselves, they did not join in the morning prayers, refused to lead the prayers and felt awkward about the ever-present religiosity. This difference in lifestyle and moral norms had repercussions in the work. They were labelled ‘unfriendly and disobedient’, and the nurses on the ward stopped talking to them and felt uncomfortable in their presence. The general expectations of students and trainees are friendliness and humility, and a will to be trained and to follow the older nurses as role models, also in their belief, as described earlier. The trainees’ absence during the prayer meetings was a deviation from the expected behaviour and the social role of a decent, humble woman and good nurse, independent of the objective nursing knowledge these trainees definitely had.

Religious patients

In the nurses’ interaction with patients, religion is omnipresent. It is known that some patients will have gone to traditional healers or spent time in prayer camps before coming to the hospital in search of a cure and healing. Surrendering exclusively to religious or traditional healers is generally disapproved of by the nurses and is given as one the reasons for a patient’s arriving too late at the hospital, but strengthening and holding on to one’s own belief is everybody’s goal. Just as patients have their Bibles readily available in their beds, nurses read the Scriptures during their breaks and listen (together) to broadcast services on the ward’s television. Nurses encourage patients to pray and they promise to pray for them. On her regular rounds over the wards, the department director talks to the patients, asking how they are doing: “Oh it is good that you are doing fine; we are also doing our best. We keep on praying for you” and encourages another to pray: “If you want to say something to God, you say it in the air, and He will hear for sure.” But on the ward, there were only a few concrete occasions observed when nurses would actually pray with the patients. One morning, a severely ill young woman moves hectically in her bed. She says: “Sister, please pray for me, pray for me!” Two recently graduated nurses look at each other, feeling uncomfortable. One says she only prays in her head, the other does not want to do it. Finally they hold hands and one prays asking for God’s blessings over this woman as “we are only human beings but You can do miracles.” She asks for mercy and healing power and finishes thus: “It is ok now, drink some more and then relax.” The patients generally appreciate the Christian position of the nurses. One older woman thinks that:

If you ask me about nurses, they must be called by God. If He does not call you, you cannot be a good nurse. You deal with human beings. So you have to have this calling. Most here have it.

During visiting hours, relatives and friends enter the ward, bringing in addition to food and hygiene products their anxiety about the patient’s condition and their religion with them. They regularly pray with and for their ill
family members. After having washed and powdered the patient and put down the food, they form a circle around the bed. In the case of a male visitor, he will lead the prayers and start a song, while all hold hands; when only women are around, one of them, often the oldest, prays. During these visiting moments, the ward is filled with sounds and cacophony. After all have left, the patients rest in their beds and read the Bibles that nearly all of them keep under their pillows. They appear more relaxed after a restless night, being comforted by the supportive faith of their families and trust in the healing power of their God. Nurse Cecile says: “We see relatives praying for the patients. It is good, it helps them psychologically. It helps to cope with the situation, solving problems and getting better.”

Occasionally, priests or representatives of charismatic churches come to the ward to visit patients and pray with those who request it. Most patients on this ward are too ill to attend services in the hospital chapel and depend on visits on the ward. This happens mainly on Sunday afternoons and in the evenings at the weekend when the medical doctors are absent. Clergymen are the only visitors allowed on the ward outside visiting hours. Nurse Martha is particularly keen on having them on the ward: “The patients do not go to church, they are too ill; this is the medical block. I think a priest or reverend minister should come to the wards more often. It is when you are ill that you start looking for God. Some think they got ill because they did something wrong and God is punishing them for it. They should come and pray with them.” One morning, a Catholic priest is on the ward praying with several patients. He pours olive oil from a small bottle like those sold on the market over the patients’ foreheads and gives benediction. He prays: “Jesus, come with your healing power and touch these patients. The doctors here are only human beings, but you are God Almighty and can heal. Come with Your powerful hand and give healing. We soak our lives in Your blood.” He comforts a patient who had to undergo a lower leg amputation due to diabetic gangrene: “Don’t cry, you cry for the devil. Rejoice in God, for you will be healed and alive!” Then he makes the sign of the cross with oil on the patient’s forehead and goes on to the next row of beds. The nurses do not participate in the prayers but continue feeding an unconscious girl at a nearby bed.

Faith in eternal and heavenly life without pain is prominent among severely ill patients. A medical student suggests that “religion is a form of palliative care; it helps to accept death” (Joseph). Indeed, Christian promises and dogmatic sayings are often heard when a patient dies. Patients themselves refer to God’s power when talking about their fear of dying. After the woman next to her has passed away in the night, an older woman says:

God knows best. We cannot talk too much about everything, but in all we have to give him thanks. I talked to my neighbour last night; she said her life is in God’s hands. Then I fell asleep and when I woke up, I saw you shifting the bed. We have to give thanks to God. But I am afraid when you start shifting the beds.

Mandy, a 20-year-old student, died on the ward after having suffered for several years from leukaemia. She had been a regular patient on the ward; all
the nurses and doctors knew her well. In her last days when she began suffering severely from bone pains and became restless, nurses encouraged her to pray. A matron said:

Mandy, look at me! Why are you so down? It will be well. Do you know there is somebody in Heaven who takes care of you? He always hears you. Do you know Him? Just keep calling Him. He is mighty and powerful. You have to address Him and He will come and glorify His name in you. He will come in the right moment and help you. We will also continue to pray for you.

It seems that the more severe and complex the health condition of a patient becomes, the more religiosity is displayed and called upon.

All situations and explanations of faith form a specific picture of God. He is perceived as a miracle-working God with endless power. The patients express it in the ever-same reply, “By God’s grace I am doing better, I am feeling fine today” and “I am doing much better”; “By the grace of God I am doing fine. Praise be to God”. Their faith in God’s healing seems endless as “Only God knows, it is not difficult for Him to let me go home.” One older woman rationalises her situation thus: “It is the first time I am in the hospital. God wants me to rest. And God wanted the doctors to see me. This is why He brought me here. They made an X-ray of my chest, and yesterday, they made an X-ray of my whole body. It seems God wants the doctors to see me completely, from hair to toe. Every day you have to praise God and thank Him. I am doing fine. God brought me here on a Sunday, so I have my Bible with me.” A woman who survived a severe allergic reaction (Steven Johnson Syndrome) praises God: “I learned a lot, especially to love God more. I am not better than those [who died]. I could also be lying in the fridge now, but God is saving me. And He can do it. He can tell the doctor to go to me and give me the right medication.”

The nurses on the ward share the trust in God’s healing power. They recall occasions of miraculous healing on the ward. Sister Martha is happy as one woman is discharged: “This is very amazing. She came in unconscious and in such a bad condition due to hypertension and CVA. And look at her today, 11 days later. She goes home on her own feet. She is fine, only her speech needs to improve. I remember a similar case of a patient who almost died but recovered and went home by herself. She said God decided to send her back to earth and not to die yet. Amen.” Stella, a young woman, was hospitalised for several weeks due to hypocalymia as a direct result of an unsuccessful thyroidectomy. Her condition was unstable and for days all the nurses feared she would die. A week before Christmas, she was discharged. The nurses say, “She is our little Christmas wonder. It is proof that our God is a miracle-doing God.” But they are also aware that some conditions are severe and God cannot be forced. Nursing assistant Joy assesses the situation of a patient by weighing the influence of medicine and belief: “She knows the doctor cannot heal her. The doctor can treat her, he can manage her, but the doctor cannot heal her. So she looks up to God every morning. But you know that sometimes when you give the Devil a chance, he takes over your life. So you must pray. You have to
Conclusion

The above-illustrated examples of lived Christian religious faith on the ward have several meanings and fulfil several functions. Considering the four major aspects and roles of religion, it will become clear which position the belief has for the nurses.

Firstly, rituals help the nurses form a group every day. They help the nurses encourage each other and confirm their basic convictions. Religious symbols and rituals strengthen their style of living and give them authority. They are “presented as the ultimate expression of hope against the reality of death” (Van der Geest 2005: 143). For the individual nurse, belonging to the group and praying and singing aloud is a way to show and channel her emotions and experience solidarity. This togetherness enables all nurses to share the burden of the work ahead of them. While routine actions like making beds, washing and feeding patients are regularly corrupted by external shortcomings, fixed moments of religious expression and praying provide sense and shelter. This includes the aspect of socialisation nursing students undergo in their training. In following the more experienced nurses and fulfilling their tasks obediently, they grow into the position of mature, believing, caring nurses. Non-believing nurses, like the European trainees described, who represent a purely secular definition of the reality, experience misunderstanding and displacement.

Secondly, religious expression also has the function of reinforcing the image and status of a good nurse (also referring back to the colonial norms) and decent woman in the broader society (Holden 1991). Towards patients, doctors and visitors, religious expression shows that nurses’ work is grounded not only in professional theories but also in heavenly foundations. The nurses ‘do good’ and ‘serve God in the patient’; criticism of their work is therefore out of place. Nursing in an understaffed and poorly equipped environment means improvisation and balancing between the ideals and reality of nursing care. Religion is a means to deal with that stress and the uncertainties on the ward, and is also a supportive factor for nurses and patients to deal with illness.

Thirdly, religion addresses the complete person in need and not merely the physical problems. Being admitted to the hospital, patients experience fear and threats on their bodies and souls, a “quite severe time of testing” (Hallstein 1992: 249). In order to understand the hospital routine, to pull through and be discharged again, the patients are in need of certainties and referral points. All is new to the patients - the medical language, the organisation of the day and uncertainty about their individual well-being and healing. Religious belief functions in this critical and threatening situation as a referral point and framework to place one’s fears and find hope. Prayers refer to the complete being of a person, bringing together the sick body, insecure mind and searching soul. To nurses and patients alike, religion is binding, meaning that “a
fragmented world is united to form one ordered whole. Things are brought in agreement with one another.” (Van der Geest 2002: 139) The nurses are able to provide this recognisable feeling of belonging and fulfil the role of a religious leader, who “is not in control …[but] can facilitate the right conditions” to go through the liminal phase successfully (Hallstein 1992: 249). As Comelles argues in a similar way, “miracles become a functional tool, in the sense that they help resolve uncertainty” (2002: 285).

Finally, what is striking in the hospital is the absence of medical doctors in the religious rituals. They neither participate nor comment on it. It seems the nurses feel the need of sociability and care while the medical profession remains outside, representing the realm of diagnosis and therapy. Defining their part in the medical setting as decision takers without being influenced by sentiments (Comelles 2002: 267), they relish to occupy the leading role guiding the patients through the difficult time of hospital admission. At the same time, doctors do not work against the lived religiosity on the ward, but remain in their public appearance gatekeepers of the orthodox scientific realm. It is important to notice that there seems no conflict in control between the medical doctors and the belief in a powerful God. The marginalised position of religion that Norwood detects in Western hospitals is a visible and real one in the Ghanaian context. Doctors and nurses alike confirm this with the statement that ‘by God’s grace’ that they are able to do their work.

Summing up, we can see that religious expression on the ward reflects the lived religiosity of the Ghanaian cosmology. According to Clifford Geertz, religion is a system of symbols, beliefs, and patterns of behaviors by which human beings control that which is beyond their control. By using and integrating their religiosity in their work, nurses on the medical ward seem better able to face uncontrollable situations on the ward. Religion provides them with the framework to place and endure shortcomings in care and medicine and compensate by giving a sense of safety and belonging. This shows that the hospital cannot be understood simply as the deceptive familiar place and clone of Western biomedicine. In order to achieve and perceive healing, medical practices and religious symbolism have to be combined in the routine on the ward.