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

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Nurses in Ghana
Between tradition and change

If you know what you are doing, you do what you know. Make sure what you’re doing is the right thing. Be very proud to be a nurse (Matron Mary).

This research has described the working routine of nurses on a medical ward in the largest hospital in Ghana and unveiled perceptions and expectations both from the involved nurses and the surrounding society. It is in people’s coping with disease and in care, that core values of a culture are found. The findings show at first hand the daily routine and continuous actions of nurses on the medical ward. Looking closer, they reveal their strategies to manage the situation and perceptions justifying their work.

Like recent hospital ethnographies (Zaman 2005, Martin 2009, Mulemi 2010), this study followed the methods of participant observation and personal involvement in the world of Ghanaian nurses. While numerous researches have been carried out in hospitals, most of them focus on medical doctors, experiences of patients or the interaction of the involved groups. Literature on the work and position of nurses in general and in Ghana in particular is still limited but is needed to understand what is going on in a hospital. The hospital ward formed the stage to observe and analyze particular actions of that one profession. Applying an ethnographic approach to produce a state of the art of contemporary nursing in Ghana, it has shown what nursing means on a ward. Furthermore, the specific context of a teaching hospital in the capital of Ghana shaped the experiences on three levels: on the macro level, nurses perceive themselves as part of the biomedical family, being in contact with globalized procedures and techniques, carrying expectations and searching for similarities with hospitals in the West that serve as leading concept. On the meso level, the teaching hospital turns out to be an important place of health care and a searched for place of healing. Being situated in a country where health care facilities and their access are limited, the medical setting operates next to traditional, religious and private health institutions. On the micro level, dreams
and fears of the individual nurses in the organization become visible as they clash with, follow and question the training and work demands.

The research started with ethical and methodological considerations (chapter 2) leading to the choice of the hospital. Procedures of formal and informal consent were passed through prior to the research and I reflected on my role as participating nurse researcher during the months of data gathering on the medical ward. Working towards the formal approval and getting acquainted with the nurses made me sensitive to the research setting as part of the overarching culture. Adjustments had to be made, limitations and restrictions were experienced through the hierarchical organization and prolonged requests which positioned me as dependant on the health care providers. At the same time, my mere presence as nurse, anthropologist and European woman turned out to be an unintentional demonstration of power. Some nurses experienced it as threatening; the research situation created and maintained a perpetual situation of retrieving and exchanging signals and information. My professional background enabled me to assist and help in times of personnel shortage, but also positioned me as one ‘who knows how nursing has to be’. The nurses were proud to be part of an internationally published research but feared their stories would be taken away.

I started the research with three main questions, and can now summarize the following: As a result of extensive colonization of West Africa, nursing was introduced in Ghana alongside biomedical procedures and the rise of hospitals. British nurses started their work in the Gold Coast by the turn to the 20th century and soon trained locals to assist them in their work. As the concept and work of hospital nursing was new to the population and challenged cultural norms, they began with male apprentices. By the mid 1940s, the training program was standardized and nursing turned into a typically female profession. The presentation of nurses as disciplined, obeying and patient caregivers for the sick and dying and their appearance in the clean white uniform displayed and conveyed the image of a good woman, morally integrated Christian and possibly a perfect wife. By this, nursing became an attractive profession and gained status. Looking back on fifty years of professional nursing training, various motives can be unveiled. As shown in chapters 6 and 7, cultural norms, family expectations and current socio-economic factors play a role in the professional choice; older generations mention reasons partly different from current students. The above mentioned image is till today one reason why families support young women to enter into nursing. The current reality on the hospital work is to a great extent unknown to the future nurses and they experience a theory-practice gap when they enter the wards. A century after its introduction, nursing in Ghana is today a profession that attracts many students but faces problems to keep certified nurses working on the wards and health posts.

Secondly, the research indicated and described how nurses do manage their work under the given circumstances. The daily work is marked by routines of basic nursing care, tidying and cleaning to present a white serene ward and doing extensive administrative writing (chapter 10). Being posted to
the medical female ward rather by chance than by choice, nurses feel overwhelmed and unprepared. They need to care for severely ill patients and experience death on an almost daily basis (chapter 12). The Christian religion forms a stable frame to manage emotions, regain strength and experience togetherness (chapter 13). Their cooperation with doctors on the one side and orderlies on the other, positions the nurses as both dependent order receivers and superior instructors. Nurses perceive patients often as uneducated and accuse them of coming too late for successful treatment. Patients respect nurses as knowledgeable and their orders are followed (chapter 14). Due to their limited equipment and resources and the unpredictability of their daily work, nurses need to improvise and be creative (chapter 15).

The nurses see themselves as dedicated and subscribing to the principles of nursing. They are the most visible and represent medical workers on the wards and represent not only their profession but also the concepts of biomedical health care delivery to patients and their relatives. While appearing as one group to the outside, they have internal forms of hierarchy and differentiation. Chapters 8, 11, and 16 focus on different aspects of their perception as students, registered nurses and matrons, each having their clearly demarcated position. Cultural values like respecting the older generation and appearing as balanced mature person reinforce the top-down structure of the professional hierarchy and complicate innovation and the introduction of new ideas. Their working schedule and quota, their appearance and working rationale make nurses a crucial element in health care delivery. Initially they were rewarded with a high status in society. Dissatisfaction due to sub-optimal working conditions and frustrations due to insufficient payment have led to strikes, countrywide understaffing and emigration. This challenges the status and perception of nursing both within the nurses’ group and in society.

What conclusions can be drawn from this research? Two themes have turned out to be crucial: the existence and application of power that leads to specific forms of knowledge, and the interplay between Ghanaian nurses in their cultural setting and the international profession of nursing.

Power and hierarchy in nursing

*The failure of nurses to recognise power as an issue in their interactions with colleagues and clients is closely related to their failure to confront the relationship between knowledge and power (Mulhall 1996: 633).*

Referring to the concept of power as existing element in human interactions, it is possible to detect places of its existence and the exercise of power. The display and application of power leads to a specific distribution and application of knowledge. Elements of power display and power distribution can be found in structural and flexible aspects of their work. The organization of this ward in the hospital and the set-up of the routine enable, shape, regiment or discourage relationships and interactions. It is most visible in various types of relations on the ward. In the following, five of them will be highlighted.
Forms of relations

The relation between nurses and doctors is extremely hierarchical. On the management level, the hospital structure places the nurses through their nursing director and the various deputy directors as one pillar next to the medical professions. But as the management board is headed by a medical doctor, nurses experience their position as inferior and their interests are at times neglected. The doctors are only briefly on the ward, they appear as visitors but their firmness and self-assurance in acting interrupt and dictate the nurses’ routine. They define all actions during their brief presence. Arriving mostly in groups, their status is unquestioned. Established nurses like the matrons can influence their work partly by bringing patients to their attention or pointing at shortcomings; they even try to encourage their nurses to stand firm and defend their own profession against medical orders. But also high positioned nurses have to accept delay in their work if doctors do not finish required paper work or fail to update medical prescriptions. In decisive moments, nurses are positioned in an inferior position to doctors and do not succeed in integrating and applying their nursing knowledge.

Nurses are organised in a clear top-down structure. This is apparent in their attitude towards the deputy director of nursing, whom they respect and with whose directives they comply. Possible conflicts or queries are avoided through respectful greetings, appearing busy and responsive when the ward is inspected. In the distribution of work within the group, the youngest and lowest in the hierarchy cleans and makes the beds, control vital signs, bathe bedridden patients and go for supply in the pharmacies. Higher ranked nurses do the wound dressing and documentation while nurses in charge supervise and work in the background. As the group composition fluctuates, such tasks distribution is consistent in its orientation but fluctuating in its realization. The night shift forms a special group as nurses are alone throughout the night, forced and privileged to decide by themselves how to handle in upcoming nursing situations. They escape the power of the matrons and are out of the gaze of the doctors, fulfilling an invisible routine and following their own working rationale. While some nurses feel uncomfortable during these hours, others prefer this shift that enables them to work outside the limiting hierarchy of the day.

That hierarchy is very visible in the distribution of the limited space. Nurses do not have a conference room; a simple table serves as documenting and reflecting place. All written work is carried out there and the table is sometimes made available to doctors when they demand it. The nurses’ room outside the ward is very small and serves as cloak and resting room only. The matron’s office is used for stock keeping and discussing confidential matters with nurses and patients. The matrons retreat here for organizational purposes and to have their rest period separated from the other nurses. The key to this room is closely guarded and nurses are given access to this room for special reasons only. The higher in the hierarchy they are, the more space is available
to nurses. Given the changing working schedule, nurses meet in different combinations in each shift. This leads to continuous redistribution of work and responsibilities within the group. Being in charge on one day and subordinated to a nurse in a superior position the next day, demands flexibility and creates shifting categories. The group manoeuvres to find and remain in balance displaying and exercising power and sharing nursing knowledge.

Different ranks demand different appearances. This is visible in the dress code. Different colours, belts and shoes announce without words the power of their bearer and her position in the hospital (chapter 11). Older nurses checking the neatness of the clothes of younger nurses is one overt aspect of establishing and confirming their power and non-negotiable authority. The whiteness of their dresses strengthens their appearance as a group, the colour places them near the more powerful medical profession and is an expression against transitory situation of the ward and the dirt in the streets.

Nursing students and young nurses learn the tricks of the trade of how to negotiate and handle responsibilities through observation, imitation and staying in their role as subordinated and obedient helpers. Nursing students as a group are perceived as being at the receiving end of the disciplinary measures (chapter 8). Being emotionally challenged by the reality of the ward, some question their professional choice, but they have little means to discuss their perspective with nurses and teachers or initiate change. This group consists of two ‘parties’, the diploma students from the nursing training college (NTC) and the degree students from university. While the first wear green dresses and are by this easily recognizable, they are trained for practical work. The latter students wear white imitating the registered nurses but lack practical skills due to their rather theoretical study. Between those groups exists little communication and both try to position themselves so as to be respected by the nurses. Some students feel unequal to the challenge. They have limited means to display their power as necessary helpers and participate in the transfer of knowledge by introducing new nursing concepts. But they understand that they are indispensable workers on the ward. Their status as students allows them to come late to work or leave early, explaining this with lectures or indisposition. As the nurses depend on them, they on their side have little means to reprimand them. Some teach and encourage the students, trying to keep them motivated and invite them to ask questions; others expect respect and obedience. Everybody knows that the students represent the new generation that will either take over one day or quit the work in the hospital ‘for greener pastures’ abroad, leaving the older nurses behind.

In relation to patients, nurses act authoritatively. Multiple moments of supervision are executed during a shift. Nurses exercise power in giving orders to patients and dividing their days by means of bed making, serving food and carrying out nursing procedures. Nurses label patients as educated and uneducated and rich or poor and these labels have implications for their attitude towards counselling and bringing patients needs to the attention of doctors (Chapter 14).
The old architecture of the ward has one room, only divided by semi-walls, leaving limited privacy for the patients. Screens are few and used for some procedures only. In general, patients are watched and watch each other. Nurses control the space of patients, which is restricted to their bed, assist them when going to the toilet or bathroom and they prevent or allow visits. This is a power to label and socially control patients. Most patients are silent and seem unable to discuss treatments or consider alternative options because they are in an unfamiliar ward, confronted with an often unclear diagnosis, personal fears and the covert accusation from doctors and nurses of arriving late in the hospital. The absence of a cost covering insurance system contributes to the insecurity of the patients in their social and family position and to the frustration of the nurses of being unable to carry out nursing procedures adequately. Most patients recognise the power and hierarchy of nurses. Nurses know that patients and their relatives have influence on the nurses’ perception in society through public appraisal and criticism. They are aware of the growing importance of patients’ rights and discuss possible consequences of their actions.

The use and application of language help to understand the hierarchy within the nurses’ group and with other groups. Language transports meaning and by this influences the direction and understanding of interaction (Holden & Littlewood 1991). While English is the official language of Ghana and the working language in the hospital, patients mainly speak local languages. Language functions both as inclusive and exclusive phenomenon. Medical staff and nurses here form one group and exchange information orally and in written English, using in addition biomedical terminology. Most patients accept their exclusion from communication through their limited knowledge of English and of medical jargons. They respect doctors and nurses as authoritative actors and expect them to decide on diagnosis and therapy and direct their behaviour during their stay in the hospital. Exclusion and inclusion as exemplified in language happens both as unplanned barrier in the constant exchange of knowledge and functions as a mean of power display.

Throughout this study, the concept of power was disclosed as a phenomenon that exists in all interpersonal relations and influences persons in their actions and reactions. According to Foucault (1977: 194), “power produces: it produces reality; it produces domains of objects and rituals of truth.” Power oscillates and the actors try to gather power and apply it according to their wishes and goals. This means that, “power is everywhere not because it embraces everything, but because it comes from everywhere” (Foucault 1978: 93). Working with nurses on the medical ward, aspects of power were revealed in the research setting by looking closely at the daily routines exemplified in the relations within the nurses’ group and in their interactions with other groups. All those recapitulated aspects form the mosaic that outlines the work of nurses on the ward. They provide structures and are powerful in forming the frame for their actions. This power is not centralised but circulating, stimulating exchange of information and teamwork, enabling actions and also limiting possibilities and spheres of influence. As unravelled in
various forms of interaction, actors with power have the ability to produce and apply knowledge that influences nursing actions (Ceci 2004, Riley & Manias 2002). There is no neutral space, as such power exists and needs to be recognised. Nursing students enter a stage where relations and interdependence are already formulated; nurses work with other professions and have to obtain and defend their status while nurses in charge need to shape and reshape their position in the organization of the ward and hospital.

Nurses and their cultural environment

Looking back in time and taking cultural norms and values into consideration is crucial to understanding nursing in modern Ghana. As part II illustrates, culture and social structures prepare, set and largely define the setting in which nurses work. Traditions, gender roles and the interplay of generations in the organization of daily life position women and leave them with limited options.

Religion and the expression of religious feelings are important elements in the life of most nurses as it is for most members of the society. The hospital, mirrors society while religion ‘colours’ the interaction between nurses and patients. In Ghana healing sessions are offered by Pentecostal congregations; advice and guidance is sought not only at birth, wedding and funerals but also on a daily basis (chapter 3). Similarly, praying, referring to God as almighty power and encouraging patients in regular Bible reading are important features of nursing. Religion enables nurses to process their working reality and manage their lack of power. This is reflected in morning devotions where nurses share their faith and show it to the patients. It both consoles the nurses faced with the unpredictability of the day and sets the frame within which they act and patients can expect to be approached. The power of their faith radiates in their attempt to come to terms with serious disease and death. Belief in an Almighty God and eternal life helps nurses and patients alike to deal with medical impotence and untimely death.

A second theme that shapes the nurses’ situation is respect. Accepting hierarchy and obeying senior colleagues are closely interwoven with cultural patterns and norms touching on the role of women and on the relation between generations. The society is based on the idea of respect and intergenerational exchange of knowledge (Müller 2005). Respect towards older persons is an important element in interpersonal relations and taught from childhood; opposition to the advice or decision of senior family members is reprimanded (Van der Geest 1989). An adult person and accepted member of the society is known by her balance, visible in her appearance and handling of emotions. Saving face and avoiding a social faux pas are important to reach and remain an honoured position (Geurts 2002). To the nurses, this means accepting given limitations and withstanding the pressures that challenge them in their work on the ward and constitute a threat their status in society. It is unquestionable that younger nurses respect their senior colleagues. Even though society is changing and elements of the ongoing globalization have introduced new forms of
communication, today’s nurses are raised and socialised with the norms of respect and obedience towards older generations.

The future of Ghanaian nursing as a profession

Tomorrow’s nurse is expected to be multipurpose in function. Qualities considered to be most important to the nurse include being observant, punctual, responsible, truthful, patient, accurate, educated and respectful (Akiwumi 1994: 57).

Akiwumi, one of the first Ghanaian nurse researchers and head of the Nursing Department in the University of Ghana for several decades, formulated this postulate in the early 1990s, looking back on forty years of nursing education in the country. Fifteen years later, Ghanaian nurses find themselves in this ‘tomorrow’, facing multiple demands and managing various situations in their health posts. Some young women are not free in their professional/occupational choice but are directed through family desires and socio-economic pressure. As ‘objects’ in the family decision, they try to cope and regain some control over their life in the process of becoming and being a nurse. They face an unexpected reality on the wards and have limited choices to react and improve their situation.

The ward is the domain of nursing knowledge that is transmitted either through training or experience; older nurses dictate to younger colleagues what to do and when. The nursing routine consists of planned treatments and reactions to unforeseen situations; an appropriate action following official nursing standards is at times difficult to carry out. The main maxim is: ‘do what you learned that proved right’; innovations like a care plan are difficult to carry out. Students and newly graduated nurses have to adjust their plans and actions by looking at and following orders from older nurses. Professional unions like the GRNA and NMC, acting from the outside of hospitals, have influence on the nurses’ situation; they function as mouthpieces, connect nurses all over the country and set procedures to guarantee or raise the position of nursing. They operate as official spokespersons and negotiate the status of Ghanaian nursing nationally and internationally. Nurses want to be recognised as having an independent profession; the university degree is one example to link up to international standards.

Akiwumi’s quotation at the beginning of this section puts the emphasis on the nurse in her Ghanaian context. The expected attitudes have a slightly different connotation than the definition of nursing given by the ICN as quoted in the introduction, where the nurse is called to work as an independent partner in the health system. So, where does the Ghanaian nurse stand in the twenty-first century? Through the worldwide shortage of nurses and a declining image, the discipline of nursing in Ghana is also at a crucial point in its development and needs to choose a direction. Under the given training system and working circumstances, the trained nurse has limited tools to bridge the gap between cultural expectations and professional demands. Medical systems are complex and are more than just scientific institutions. As demonstrated in other
ethnographies on hospitals, the health service is situated and operates within the society. Biomedical rational explanations and evidence-based approaches clash with cultural and traditional beliefs that combine social, religious and physical elements to understand and oppose disease.

The Ghanaian situation is not corresponding well with the image of the globalised technological biomedical hospital. Biomedicine with its high technology, exchange of information and flow of knowledge, objects and images represents globalization. It is intensified by the urban hybrid culture (Kapuscinski 2008: 32) of Ghana’s capital. Nurses and doctors alike know this and imagine themselves as part of it, but experience their reality differently. Horton describes the ongoing exodus of doctors, nurses and technicians, the lack of financial incentives and the inappropriate medical infrastructure as major challenges to keep and motivate doctors and nurses in the health sector (2001). For those who have difficulties with the actual work in the Ghanaian health service, the only options to escape are: working in a private clinic, leaving the profession or migration. Others want to change the position of nurses and nursing in the country and empower nurses to present and defend nursing as an independent profession that is needed to improve the delivery of health service in Ghana. Some nurses decide to enter university for a degree and equip themselves with more knowledge before retuning to the health service on a higher level and interfere constructively in the current definition and distribution of responsibilities and power. Schuster emphasises the importance of nurses for a sustainable development process in her research in Zambia:

Despite differences in philosophies of development, and despite the wide range of theoretical orientations in the literature on the roles of women in... the development of health care facilities, there is a virtual consensus that the work of professional nursing is vital no matter what the orientations of the health care system (1980: 78-79).

Berger and Luckmann (1966) argued some decades ago that social reality is constructed by the actions, concepts, representations and reciprocal roles of the involved individuals: “Compared to the reality of everyday life, other realities appear as finite provinces of meaning, enclaves within the paramount reality marked by circumscribed meanings and modes of experiences” (1966:25). In Ghana, the experience of the reality is marked by challenges and demands, and this shapes the reaction of the nurses (Emerson 1970). The distribution and display of power, the dissemination of knowledge, reactions to planned and unforeseen situations, the delegation and acceptance of responsibilities and the individual management of goals and dreams form and define the relationships within the nurses’ group and in their interactions with patients, doctors and visitors on the ward. Nurses working on the ward define and constantly redefine their situations; they are the representative of the biomedical setting and members of their Ghanaian cultures. All come together in their described behaviour, their use of language, their definition and treatment of patients’ bodies and personalities. A constant creation of a biomedical environment and
professional nursing gaze is not always possible. It is corrupted and threatens to collapse due to shortcomings from various sides. This leads to several realities existing next to each other. Foucault emphasises the positive nature of power:

> What makes power hold good, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression (1984: 61).

Recognising power as a productive tool can help the nurses to organise their work and stabilise their position in the hospital. The display and negotiation of power and knowledge by all actors on the hospital ward weave a net that makes the management of the situation possible and leads nurses through their daily work.