

UNIVERSITY OF GHANA
COLLEGE OF HUMANITIES

**“OUR SIDE OF THE STORY”: NURSES’ BEHAVIOUR TOWARDS
PATIENTS**

BY

PERPETUAL NANCY BAIDOO KODOM
(ID. NO. 10442584)

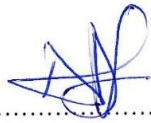
**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON, IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR
THE AWARD OF PHD IN SOCIOLOGY**

DEPARTMENT OF SOCIOLOGY

JANUARY 2023

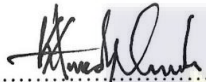
DECLARATION

I hereby declare that this thesis is the result of my research work, carried out in the Department of Sociology, University of Ghana, under the supervision of Prof. Kodjo Senah, Prof. Lydia Aziato and Prof. Akosua Darkwah. As far as I am aware, this thesis has not been submitted anywhere for a certificate or a degree. All references cited in this work have been duly acknowledged. I take sole responsibility for any misinterpretation or misrepresentation of data arising from the study.



.....
PERPETUAL NANCY BAIDOO KODOM
(CANDIDATE)

25/11/24
.....
DATE



.....
PROF. KODJO SENAH
(PRINCIPAL SUPERVISOR)

25/11/24
.....
DATE



For

.....
PROF. LYDIA AZIATO
(CO-SUPERVISOR)

25/11/24
.....
DATE



.....
PROF. AKOSUA K. DARKWAH
(CO-SUPERVISOR)

25th November, 2024
DATE



DEDICATION

I dedicate this thesis to my three mothers; the late Mrs. Mary Baidoo, my beloved biological mum, for her endless love and sacrifices; Mrs. Sophia Annobil Koufie, my aunt and foster mum, for her immense provision and Godly upbringing; and my mother-in-law, Madam Monica Baffoe without whose domestic support this four-year programme would have been a tall order.



ACKNOWLEDGEMENTS

“Your grace has taken me through, oh Lord. Your grace has done it again (Pentecost Hymn)”.

I am indebted to God whose sufficient grace and mercies have kept me alive and given me strength for this thesis. I’m incredibly grateful to my supervisors, Prof. Kodjo Senah, Prof. Akosua Darkwah and Prof. Lydia Aziato, for their commendable insights and guidance, without which this thesis would not have materialised. Thank you so much, Profs.

I appreciate the entire faculty of the Sociology Department, University of Ghana, currently headed by Dr. Dzisah for their critical comments and contributions during seminars which have shaped this work. My sincere gratitude goes to the matron, all participants and staff of the male and female wards of my research hospital for their time and for allowing me into their restricted space. A big thank you to Mr. Felix Amenorhu for his selfless support in teaching me Nvivo as well as Mr. Emmanuel Nii Adotei Baddoo for his assistance with Mendeley. To Dr. Sylvia Marfo, Dr. Diana Amoni, Dr. Joseph Ocran, Nana Ama Oppong-Duah Annin and Michael Akagbor, I’m grateful for spending time out of your busy schedules to proofread my work. Much appreciation also goes to my colleagues, Nana Ama, Michael, Baba, Doris and Afua, for being a great source of support throughout the four-year programme and to Dr. Sylvia Gyan for her inspiration.

I am indebted to my husband, Dr. Michael Kodom, who single-handedly financed this programme for three years and was constantly motivated to complete this work in a timely manner. I’m also grateful to the BANGA-Africa Project for awarding me a Thesis Completion Grant and to Dr. Collins Badu Agyemang, the PADA coordinator, for his immense psychological support.

To my family, thank you for all the encouragement and assistance, especially my siblings Prince, Betty, and Sandra, for always being there to cheer me on. Finally, to my children; Elsie, Elsa and Nana Yaw, thank you for being part of my success story.



ABSTRACT

The nursing profession is a critical component of healthcare delivery systems, playing an irreplaceable role in patient recovery through the provision of quality care. Rooted in principles of empathy, compassion, trust, and strong interpersonal relationships, nursing is expected to uphold high ethical standards. However, numerous media and empirical reports highlight behaviours among nurses in Ghana, including physical and verbal abuse, neglect, and intolerance towards patients. These behaviours contradict the fundamental tenets established by nursing pioneers like Florence Nightingale and the ethical guidelines of the Ghana Health Service. Given the necessity for quality healthcare in achieving the health-related Sustainable Development Goals by 2030, this study seeks to understand the factors contributing to the general perception of nurses' behaviours as undesirable.

While existing literature has predominantly focussed on patients' perspectives, this research pivots to explore nurses' experiences and motivations using a qualitative ethnographic approach. The study is framed within several theoretical frameworks, including Blumer's Symbolic Interactionism, Giddens' Structuration Theory, Homans' Rational Choice Theory, Foucault's Knowledge and Power, and Hochschild's Emotional Labour. The research was conducted over eleven months in a public district hospital in Accra, Ghana, involving registered nurses with at least one year of experience. A purposive sample of nurses from the medical ward was selected, and data was collected through in-depth interviews, participant observation, focus group discussions, key informant interviews, and informal dialogues, achieving saturation with thirty-two participants.

Findings reveal that nurses' behaviours towards patients are shaped by several precursors, including upbringing and socio-cultural learning. These factors influence their temperaments, communication styles, and values, affecting their professional conduct. The study identifies

that nurses motivated by altruism tend to display more desirable behaviours, while those entering the profession for economic reasons or due to familial expectations often struggle to align with nursing's caring ethos. Additionally, the research highlights how power dynamics within the healthcare system contribute to undesirable behaviours, with junior nurses often experiencing abuse of power from senior colleagues, leading to a cycle of negative interactions.

Social and structural pressures also play a significant role in shaping nurses' behaviours. Participants reported that frustrations stemming from patient anxieties, non-cooperation, and interpersonal conflicts significantly affect their behaviour. Institutional factors, such as inadequate resources and poor working conditions, further exacerbate stress and dissatisfaction among nurses, leading to diminished job commitment and increased turnover intentions. Moreover, the emotional toll of the profession, characterised by high levels of distress and psychological hazards, contributes to negative behaviours toward patients.

These findings have profound implications, suggesting nurses' behaviours influence patient care quality. The study underscores the need for institutional reforms to enhance communication skills, emotional well-being, and support for nurses. Recommendations include regular training focussed on psychological resilience, fostering collaborative environments, and addressing power dynamics among healthcare providers. Additionally, the research calls for improved resource allocation and a review of nurses' salaries and working conditions to enhance job satisfaction.

In conclusion, this study illuminates the complex interplay of individual motivations, social dynamics, and structural constraints that influence nurses' behaviours toward patients. By addressing these challenges, healthcare systems can improve patient experiences, retain nursing professionals, and ultimately contribute to achieving the health-related Sustainable Development Goals.

TABLE OF CONTENTS

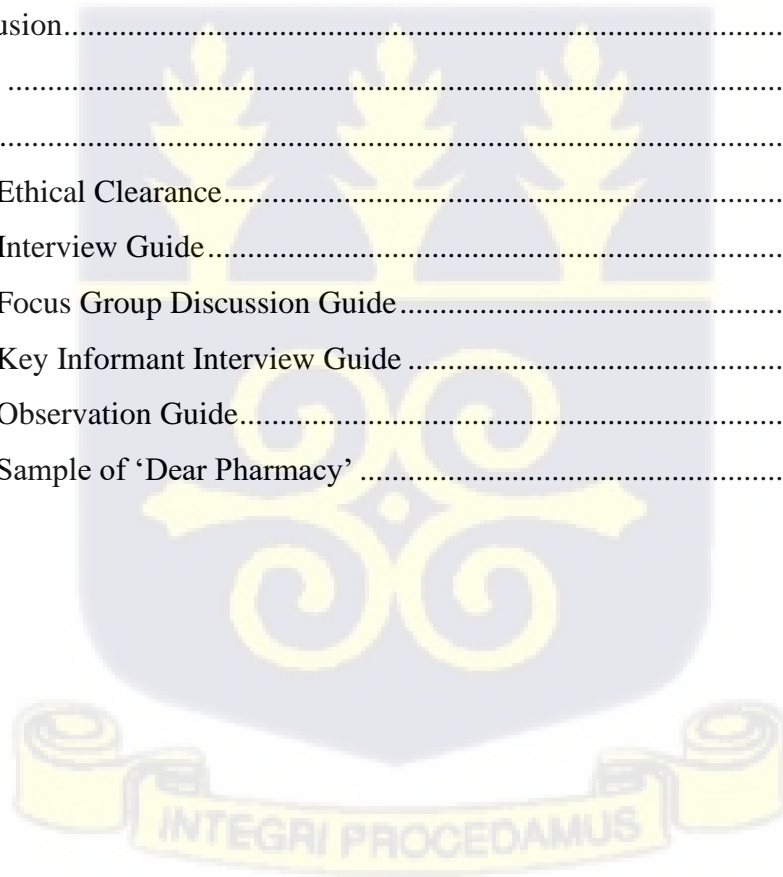
DECLARATION	i
DEDICATION	ii
ACKNOWLEDGEMENTS	iii
ABSTRACT.....	v
TABLE OF CONTENTS.....	vii
LIST OF FIGURES	xii
LIST OF TABLES	xiii
LIST OF ABBREVIATIONS.....	xiv
CHAPTER ONE	1
INTRODUCTION	1
1.1 Background of the Study.....	1
1.2 Problem Statement	4
1.3 Research Objectives	6
1.4 Significance of the Study	7
1.5 Definition of Key Concepts.....	7
1.5.1 Pressure(s)	8
1.5.2 Social Situation.....	8
1.5.3 Kin	8
1.5.4 Undesirable Behaviours.....	8
1.6 Organisation of the Study.....	8
1.7 Conclusion.....	10
CHAPTER TWO	11
LITERATURE REVIEW	11
2.1 Introduction	11
2.2 Brief History of Nursing	11
2.3 The Image of Nursing	14
2.4 Patients' Perspectives on Nurse's Negative Attitudes/Behaviours	15
2.4.1 Poor Communication.....	16
2.4.2 Judgemental	17
2.4.3 Neglect.....	19
2.4.4 Lack of Empathy	20

2.5 Factors that make Patients more Susceptible to Nurses' Negative Attitudes/Behaviours	21
2.5.1 Patients with Stigmatising Conditions.....	22
2.5.2 Women in Labour	24
2.5.3 Health Insurance Cardholders	26
2.5.4 Dependent Patients	27
2.6 Arguments for Nurses' Undesirable Behaviours	28
2.6.1 Shortage of Nurses.....	28
2.6.2 Stress.....	29
2.6.3 Post-Traumatic Stress Disorder	30
2.6.4 Job Dissatisfaction	31
2.6.5 Poor Working Conditions	32
2.6.6 Not Their Call.....	33
2.6.7 Nurse-Other Staff Relationships.....	34
2.7 Patients' Perspectives on Nurse's Positive Attitudes/Behaviour	35
2.7.1 Emphasising Quality Care Despite the Condition.....	35
2.7.2 Politeness	36
2.7.3 Financial Assistance	37
2.7.4 Participatory Care	37
2.7.5 The Exceptional Case of Male Nurses	38
2.8 Theoretical Framework	40
2.9 Conclusion.....	49
CHAPTER THREE	50
RESEARCH METHOD.....	50
3.1 Introduction	50
3.2 Research Philosophy	50
3.3. Qualitative Research	51
3.4 The Study Area.....	52
3.5 Data Collection Methods.....	53
3.5.1 Sources of Data.....	53
3.5.2 Target Population and Sampling	54
3.5.3 Entry/Initial Contact	57
3.5.4 Participant Observation and Positionality	58
3.5.5 Record Keeping	60

3.5.6 Scheduling an Interview	61
3.6 Trustworthiness/Rigour.....	63
3.6.1 Prolonged Engagement.....	63
3.6.2 Triangulation	64
3.6.3 Peer Debriefing.....	65
3.6.4 Member-Checking	65
3.6.5 Audit Trail	66
3.6.6 Reflexivity	66
3.6.7 Participant Language	67
3.6.8 Pilot Observation and Interviews	67
3.7 Ethical Considerations.....	68
3.7.1 Benefits and Risks	69
3.8 Data Analysis	71
3.9 Conclusion.....	73
CHAPTER FOUR.....	75
“A DAY IN THE LIFE OF A HOSPITAL”: THE HOSPITAL AS A SOCIAL SYSTEM ...	75
4.1 Introduction	75
4.2 The Ghana Health Service.....	76
4.2.1 The NMC and the Ethics of the Nursing Profession	76
4.2.2 Efforts to Control Poor Attitudes.....	78
4.3 A Walk through the Hospital	80
4.4 The Male and Female Medical Wards	81
4.5 The Daily Routine of Nurses.....	84
4.5.1 Handing over and Taking-up.....	84
4.5.2 Admitting and Discharging Patients.....	85
4.5.3 Checking Vitals	89
4.5.4 Documentation.....	91
4.5.5 Taking a Break.....	93
4.6 She’s the Boss - Nursing Management	95
4.7 The Role of Allied Healthcare Givers.....	97
4.8 Events	100
4.8.1 The Strike	100
4.8.2 The Commercials.....	101

4.8.3 The Workshops.....	102
4.8.4 The Durbar.....	104
4.9 Conclusion.....	106
CHAPTER FIVE	108
“SOME OF THEM ARE NOT BORN NURSES”: THE INDIVIDUAL’S FACTOR IN EXPLAINING BEHAVIOUR.....	108
5.1 Introduction	108
5.2 Socialisation	108
5.3 The Decision to be a Nurse	115
5.4 Power.....	126
5.4.1 Knowledge, Resources and Power	127
5.4.2 Ranks/Position and Power Contestations	132
5.5 Conclusion.....	140
CHAPTER SIX.....	142
THE THINGS THAT EAT ME UP IN THE HOSPITAL: SOCIAL AND STRUCTURAL PRESSURES IN THE WORLD OF NURSING	142
6.1 Introduction	142
6.2 Nurse-Patient Relationships	142
6.3 Institutional Factors.....	154
6.3.1 Insufficient Equipment/Logistics/Medication	155
6.3.2 Non-Adherence of Staff to the Job Description	159
6.3.3 Lack of Motivation	163
6.4 Systemic Factors	166
6.4.1 Poor Salaries	166
6.4.2 Study Leave and Promotion Constraints	170
6.5 Colleague-Colleague and Allied Health Professionals Relationships.....	173
6.6 Conclusion.....	180
CHAPTER SEVEN	182
“WE ARE ONE OF THE MOST DEPRESSED PROFESSIONALS YOU COULD EVER FIND”: NURSES AND PSYCHOLOGICAL HAZARDS	182
7.1 Introduction	182
7.2 Default Hazards.....	183
7.3 Escapable Hazards.....	195
7.3.1 Work-Related Injury.....	196

7.3.2 Abuse/Violence	200
7.3.3 Spirituality	206
7.4 Stress	209
7.5 Conclusion.....	216
CHAPTER EIGHT	217
SUMMARY, CONCLUSION AND RECOMMENDATIONS.....	217
8.1 Introduction	217
8.2 Summary of Findings	218
8.3 Implications of Findings.....	221
8.4 Contribution to Knowledge.....	221
8.5 Limitations of the Study	222
8.6 Recommendations for Future Research	223
8.7 Recommendations for Nurses, Management and Policy	223
8.8 Conclusion.....	224
REFERENCES	226
APPENDICES	268
Appendix 1: Ethical Clearance.....	268
Appendix 2: Interview Guide.....	269
Appendix 3: Focus Group Discussion Guide.....	272
Appendix 4: Key Informant Interview Guide	274
Appendix 5: Observation Guide.....	275
Appendix 6: Sample of ‘Dear Pharmacy’	277



LIST OF FIGURES

Figure 1: Thematic Network Analysis of the Decision to be a Nurse	72
Figure 2: Word Cloud of 100 Most Used Words Demonstrating Stress	210



LIST OF TABLES

Table 1: Social Demographic Characteristics of Participants.....56



LIST OF ABBREVIATIONS

AACN	American Association of Critical-Care Nurses
BP	Blood Pressure
BNHS	British National Health Service
CVA	Cerebrovascular accident
CHAG	Christian Health Association of Ghana
CHPS	Community-based Health Planning and Services
DHA	District Health Administration
EN	Enrolled Nurse
FGD	Focus Group Discussion
GHS	Ghana Health Service
HNM	Hospital Nurse Manager
ICN	International Council of Nurses
IC	In-Charge
IOM	Institute of Medicines
ILO	International Labour Office
IM	Intramuscular
IV	Intravenous
MoH	Ministry of Health
NG	Nasogastric
NHIS	National Health Insurance Scheme
NCDs	Non-Communicable Diseases
NMC	Nurses and Midwives Council
NOs	Nursing Officers
OPD	Outpatient Department
SPO ₂	Oxygen Saturation Level
PLWHA	People Living With HIV/AIDS
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorders
PEN	Principal Enrolled Nurse
PNO	Principal Nursing Officer
PIN	Professional Identification Number

PSI	Public Services International
RBS	Random Blood Sugar
RHA	Regional Health Administration
SEN	Senior Enrolled Nurse
SNO	Senior Nursing Officers
SSN	Senior Staff Nurses
SSNIT	Social security and National Insurance Trust
SN	Staff Nurse
SDG	Sustainable Development Goal
TBA	Traditional Birth Attendant
WASSCE	West African Senior School Certificate Examination
WHO	World Health Organisation
WMSD	Work-Related Musculoskeletal Disorders



CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Mr. Kwakye (pseudonym) rushes his eighty-two-year-old father, suffering a stroke, to a polyclinic around three o'clock in the afternoon. The doctors refer the patient to the stroke unit, which had closed an hour earlier (at 2 pm). Meanwhile, for unknown reasons, the wards are all closed, and on admission are only two elderly patients confined to wheelchairs in the mosquito-infested outpatient department (OPD). There was one doctor, four attendants at the cash office and three nurses who were not busy. The doctor tells Mr. Kwakye that his sick father would be detained so as to monitor his heart rate and blood pressure till the next morning when he would be transferred to the stroke unit. The patient is offered no support or encouragement; he only sits in the half-broken wheelchair for many hours.

The other patient slumps in his wheelchair affixed with an oxygen cylinder and some infusions lines connected to his body parts, while his son and two daughters stand by. After some time, the patient dies, and the nurses then remove all the tubes and infusions but leave the drooling dead man still in the wheelchair uncovered or screened. His children keep wailing while the doctor sits behind his computer and the nurses chit chat. After an hour, they wheel the dead man off with one of his feet dragging on the floor. Mr. Kwakye informs the doctor of his intention to transfer his father to another hospital and directs him to call the ambulance. Meanwhile, the patient's speech slurs, and he becomes semi-conscious. Yet, no staff touches him or says anything about facilitating the referral. Alas, they decide to transport him in their private car and the doctor signs the referral document as if to get rid of them. No health worker bothers to assist in lifting the patient into the vehicle. With their hands in the pockets of their scrubs, they apparently look happy to get rid of them (Branttie, 2020).

The above reportage or scenes and many similar ones flood the media now and then about the state of healthcare delivery, especially nurses' behaviour towards patients. My personal unpleasant experiences with some nurses at different hospitals motivated this study. Nurses in my experience, wore indifferent expressions, were always in a rush in their treatment procedures, and never explained the procedures to their clients. When they finally interacted, such nurses appeared to be "harsh" in their communication. It seemed they always had something to do and did not have the time to interact professionally and humanely with patients. Therefore, it is not surprising when Asamani, Agyemang, Afful and Asumeng (2018) argue that a patient might return from the hospital and would appear ignorant of what is ailing them when asked about their condition or treatment. Some friends and family narrated unpleasant encounters with some nurses to add to my anxiety.

Since it takes two to tango, the need to understand nurses' behaviour heightened after my first two research studies. The first (Kodom, Kodom & Senah, 2018) reports how some pregnant women preferred to deliver at home with the assistance of traditional birth attendants, attributing one of such reasons to nurses' and midwives' behaviours, among other reasons. The second paper (Kodom, Owusu & Kodom, 2019) which was concerned with the quality of healthcare with the National Health Insurance, also hinted at nurses' attitudes toward patients who do not have the NHIS card, which explains why they resort to facilities other than public hospitals, among other reasons. Sequel to these experiences, I was interested in investigating and understanding nurses' behaviour since the phenomenon fed into my social and academic worldviews. Most importantly, the phenomenon is becoming pronounced in access to healthcare. Thus, using my sociological imagination, as Mills (2000) advanced, I realised that my personal experience is interconnected with the larger social structure. Consequently, I need to identify and understand the forces that shape nurses' social problems and behaviour.

Every country needs good healthcare services to ensure the well-being of its citizens and the World Health Organisation (WHO) (2014) maintains that good service delivery is a pivotal element of any health system. It is crucial to achieve the health-related Sustainable Development Goal (SDG) 3, which seeks to ensure healthy lives and promote well-being at all ages by the year 2030. One way to ensure healthy lives and promote well-being is the provision of quality healthcare. However, Ghana's healthcare system and most parts of the world are sometimes bedevilled by poor quality healthcare, as illustrated in the scenarios above.

The Ghana Health Service (GHS) (2016) encapsulates quality healthcare as all the activities pertaining to healthcare delivery that the nursing, medical laboratory, pharmaceutical fields etc., constantly perform to assist without causing harm to patients. It demands that healthcare providers give attentive care to patients' needs. Hence, Mosadeghrad (2014, p. 210) sees quality healthcare as the provision of “the right healthcare services in the right way, in the right place, at the right time, by the right provider to the right individual for the right price to get the right results”. The right result satisfies patients by improving their quality of life and health status.

Though there are divergent opinions and dimensions in the operationalisation of the concept of quality healthcare, there is a consensus that it comprises services that are helpful for clients and, at the same time, meet their needs (Fenny, Enemark, Asante & Hansen, 2014). Alternatively, the World Health Organisation (2014) conceptualised quality healthcare using six dimensions, requiring that healthcare be effective, efficient, accessible, acceptable/patient-centred, equitable and safe. The GHS has adopted these six dimensions in the healthcare care quality assurance manual that Offei, Bannerman & Kyeremeh (2004) authored. One of the dimensions of quality care, interpersonal relations (patient-centred) between healthcare providers and patients, is the focus of this study. The healthcare

providers were narrowed to nurses because studies have shown that they have more regular contact with patients within the healthcare space than any other healthcare provider (Bjerså, Forsberg & Olsén, 2011; Mac Lellan, 2006; Asenso-Okyere, Osei-Akoto, Anum, and Adukunu, 1999).

Nurses play a critical role in providing trusted and credible healthcare. According to World Health Organisation (2020), nursing comprises the independent and coordinated care of all individuals of groups, ages, families, communities, sick or well and in all settings. It encompasses the prevention of illness, the care for the sick, the disabled and the dying and the promotion of good health. In short, Smith (1994, p. 50) summarises this as: “Nursing is the study of human health and healing through caring”. The Healthcare Quality Assurance Manual of the GHS (2016) outlines five expectations from nurses to patients in ensuring quality health service. These include; prompt attention, respect and dignity, friendliness, privacy, and confidentiality. According to the report, these enhance the quality of service and promote good communication, which increases compliance with treatment and contributes to client satisfaction. Concerning this, Javed and Liu, (2018) add that patients’ satisfaction is influenced by the empathy they receive from health workers and health workers’ responsiveness to the needs of patients.

This is intended to ensure quality healthcare delivery between the nurse and the patient. However, this is not always the case.

1.2 Problem Statement

Currently, in Ghana, the nursing profession has somewhat taken on a different form from the ideal norm, as emphasised earlier. The popularly widespread discourse about nurses is that they are harsh and do not treat patients with dignity and respect. There is frequent media reportage about the poor quality of healthcare in the country’s health facilities which goes

contrary to the famous and professional discourses that typify nurses as nurturing, comforting, and patient-care-motivated people (Asamani, Agyemang, Afful & Asumeng, 2018; Dapaah, 2016). There is increasing public outcry against some nurses who exhibit poor attitudes toward clients and patients in health facilities, especially as illustrated in the above scenarios. These attitudes contribute to a negative image of the profession. These portrayals often overshadow the positive contributions of many nurses who demonstrate empathy and commitment to patient care.

Some of these behaviours are captured as verbal abuse, which includes shouts, insults, and shaming of patients, physical abuse which includes beating and slapping, mostly during childbirth and against people with mental health conditions, emotional abuse which includes neglect, humiliation and discrimination (Scott et al., 2019; Kodom, Kodom & Senah, 2018; Ghana Broadcasting Corporation, 2017; Dapaah, 2016; Vogel et al., 2016; Bohren et al., 2015; Moyer, Adongo, Aborigo, Hodgson & Engmann, 2014). These behaviours not only violate the ethical standards of nursing but also have profound implications for patient health outcomes.

Some patients simply keep quiet and do whatever they are asked to do without questions to avoid these humiliations, which can compromise their autonomy and lead to negative consequences. Instances of shouting, insults, and shaming can create a hostile environment, discouraging patients from seeking necessary care. Some resort to self-medication, risking their health by not receiving professional care, while others turn to traditional or indigenous healers for help rather than go to the hospital and face one sort of undesirable behaviour from nurses (Asamani, Agyemang, Afful & Asumeng, 2018), which reflects a significant loss of trust in the formal healthcare system. Neglect and humiliation can affect patients' psychological well-being. These highlight a breakdown in patient-nurse relationships.

Empirically, a lot of attitudinal and behavioural studies have also been conducted on nurses all over the world. While some of these studies have reported positive nursing behaviours and a good commitment to contributing to quality healthcare delivery (Adugbire & Aziato, 2018; Aghoja, Okinedo & Odili, 2017; Himmelfarb, Commodore-Mensah & Hill, 2016), a lot of researchers have also found negative attitudes or wrongful behaviours (Akowuah, Agyei-Baffour & Asibey, 2018; Kyei, Otoo, Abua & Ofori, 2018; Ishimaru et al., 2017) in Ghana and other parts of the world.

The literature review in the next chapter thoroughly demonstrates these findings, highlighting the multifaceted nature of nursing behaviours. However, it is important to note that most of these studies have primarily focussed on the stories and perspectives of patients. This focus arises from the understanding that to ascertain the level of best practices in the healthcare industry, patients' perceptions of quality care must be measured, with an emphasis placed on client-centred healthcare delivery (Asamani, Agyemang, Afful & Asumeng, 2018; Camgöz-Akdağ & Zineldin, 2010). In as much as the stories from the side of patients are important, how nurses make sense of how they treat patients has received little scholarly attention. This gap in the literature indicates a need for research focusing on nurses' perspectives regarding their interactions with patients. Integrating nurse perspectives in the literature will not only enrich the discourse but also provide a more holistic view of the healthcare environment.

1.3 Research Objectives

The main objective of this study is to understand the factors that contribute to the undesirable behaviours of some nurses towards patients and their relatives. The specific objectives are:

1. To explore the everyday life of nurses in the hospital and the overall functioning of the healthcare system.

2. To identify the individual nurse's precursors that shape their behaviours towards patients and their relatives.
3. To investigate the social and structural pressures that shape nurses' behaviours towards patients and relatives.
4. To explain the psychological (occupational) hazards that pertain to the nursing profession and how that influence nurses' behaviour towards patients and their relatives.

1.4 Significance of the Study

This study is relevant for understanding nursing as a unique life-saving profession. Rather than negatively label nurses, the study helps to give researchers and readers a sociological insight into nursing behaviour in order to understand why they have been widely constructed to be negative. The findings from this study will inform the nurses who remain unaware of the impact of such behaviours on patients' healthcare-seeking behaviour since it is one of the contributing factors that deter clients from accessing healthcare services (Buor, 2004).

Nurses' interactions with patients at the hospital demonstrate that relationships remain one of the most critical challenges to achieving quality healthcare as envisioned by the GHS and the WHO. Hence, the findings will inform hospital managements, the Ghana Nursing and Midwifery Council (GNMC), and the Ghana Health Service of the nurses' experiences that inform this behaviour.

1.5 Definition of Key Concepts

Definitions of key concepts become necessary to guide the reader and avoid ambiguity. This also ensures precision and clarity in what is meant by certain terms or concepts.

1.5.1 Pressure(s)

It simply implies constraints, provocations or push factors. The chapters reveal social, structural and psychological pressures that imply social or psychological constraints.

1.5.2 Social Situation

According to Spradley (2016) ethnographic studies help to understand a particular culture under study, and the social situation becomes imperative to understanding a culture. A social situation comprises a place, actors, and activities that encapsulate a culture. Therefore, the hospital, the healthcare providers, and the activities of these individuals form the culture or their way of life, which is crucial in understanding behaviours.

1.5.3 Kin

A kin is a person's relation. In this study, I refer to a 'relative's patient' as their kin and not their patient. This is because I perceive the sick person as the hospital's patient and not the relative's patient but rather the relative's kin.

1.5.4 Undesirable Behaviours

The behaviours which are not ethically appropriate for the nursing profession and other caregivers eg. neglecting patients, insulting patients, ignoring patients, etc.

1.6 Organisation of the Study

The study is organised into eight interrelated chapters. Chapter one introduces the study's background, problem statement, objectives, motivation, and significance and has placed nurses' behaviour within the larger perspective regarding quality health service and its relevance to the WHO and attaining the SDGs.

Chapter two provides an empirical and theoretical review of the study by reviewing current literature on nurses' behaviour under different conditions and some possible explanations

attributed to these behaviours. The study adopted Blumer's (1969) Symbolic Interactionism, Foucault's (2012) Knowledge and Power, Homan's (1961) Rational Choice, Giddens' (1984) Structuration and Hochschild's (1983) Emotional Labour as a framework to make sense of nurses' behaviour.

Chapter three elaborates on the methodology used in conducting this study and explains the study's philosophies, ontology, and epistemology. The study employed an ethnographic method of data collection, emphasising the study area, selection of participants, instruments, entry and record-keeping, and data analysis. It continues with trustworthiness and ethical considerations.

Chapter four describes the everyday life of nurses in a hospital. It elaborately describes the hospital structure and recounts some of the daily routines and dynamics of nurses and their collaborative care delivery with other staff in the medical wards. The chapter continues with the codes of ethics and nursing management and finally ends with some narratives of the activities experienced during the fieldwork.

Chapters five, six and seven present the findings of the first objective on the individual precursors to understanding behaviour, the second objective on the social and structural pressures that inform nurses' behaviour, and the final objective on the psychological hazards of the nursing profession and its influence on behaviour. These are discussed coherently with empirical literature related to the findings.

The final chapter, Chapter Eight, summarises the research findings, draws conclusions, and presents some implications of the findings and recommendations for future research. It also outlines the limitations of the study.

1.7 Conclusion

The introductory chapter of the thesis outlines the background, problem statements and motivation for this study. It highlights the objectives and significance and defines some key concepts used in the study. It also gives a brief overview of the methodology and theory employed in the study, ending with how the thesis was organised. The next chapter encapsulates a review of relevant literature and extensive detail of the theory used.



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews journal articles and books relating to nursing and their interpersonal relations with patients. Since the study focuses on the nurse's story in relation to the undesirable behaviours in nursing patients, the first section of this chapter presents a brief history of nursing, an extensive review of various literature on the image of nursing and patients' negative as well as positive perceptions of nurses' behaviour. It further discusses some of the reasons reported to explain nurses' behaviour. The second section presents issues relating to the study's theoretical framework.

2.2 Brief History of Nursing

The latter part of the 19th century saw the birth of nursing as a profession with a tremendous change in the global health system. This was due to the efforts of the British Nurse, Florence Nightingale, and Mary Seacole who together developed the first scientifically based nursing school, situated at St. Thomas's hospital in London. This eventually formed the nucleus for almost all nursing programmes in the entire Western world. This establishment saw the emergence of the nursing profession through instituted objectives that shaped professional qualifications (Rafferty & Solano, 2007). Since then, nursing has stood the test of time as an inevitable profession in different parts of the world (Craven & Hirnle, 1996).

Previously, there was no formal education, but nurses received their skills and techniques through apprenticeship from older people already in the profession. Hence, after establishing the Nightingale Fund, a school was developed to formally train nurses to recognise her immaculate service during the Crimean War. Doctors and ward sisters were specially put in

place to supervise this training school (Akiwumi, 1971). She was particular on the position of building trusting relationships with patients (Rafferty & Solano, 2007) and calmly interacted with patients based on empathy, skilled communication, fashioning appealing nursing care, and creating a sense of unity by viewing the patient and the nurse as one (Radmehr, Ashktorab & Abedsaeedi, 2015).

Nursing emerged in sub-Saharan Africa due to colonialism and Christianity (Böhmig, 2010). In the late 19th century, colonial medical and nursing services began as a healthcare provision mainly for males and whites who resided in large cities. Nevertheless, the European colonial rule in almost all the African countries started to weaken after World War II, empowering Africans somewhat to begin building government, schools, and healthcare institutions. With the help of the colonists, African health officials commenced training African women and men to build a skilled, healthy, and educated people (Cooper, 2019; Falola & Jennings, 2003).

Interestingly, the people of the Gold Coast, now Ghana, had difficulty accepting the nursing profession based on cultural grounds: girls were not allowed to go to school at the time, and women were not permitted to nurse sick nonrelatives. Consequently, females did not accept the training, so they permitted boys, who were even school leavers, termed as ‘bush-boys,’ to undergo training as nurses (Owusu, 1981). With limited days off and a rigorous disciplinary system, the labour was drearily split between day and night shifts. All of this made it harder to keep the skilled nurses on staff and find enough new hires. Due to the growing mining and cocoa farming industries in the areas at the time, many young men moved to occupations that offered better pay and less demanding working circumstances. As a result, the scarcity of healthcare providers can be traced back to the very beginning. Plans to restructure the curriculum and encourage women to pursue careers in nursing were

also developed. Nevertheless, as time passed, women were included in the profession and trained in nursing and midwifery. By the 20th century, nursing had started as a hospital-based profession. British sisters were in charge of running the wards and supervising male nursing assistants. The local nurses could only be ranked as Second Division Nurses since their training was not formal, and the skills they attained depended on how much the colonial nurses engaged them. In a few cases, when they were promoted to the First Division, they were still responsible for junior activities only under strict observation of the British. Occupants of senior positions were all British nurses. Their uniform was blue, while the British wore white (Böhmig, 2010).

As a result of the limited knowledge of English, early Ghanaian nurses generally received on-the-job training basically in hygiene, first aid, human physiology, and at times, medical and surgical nursing, which were all of low standards (Kisseih, 1968). Some of the local nurses who were still interested in furthering their training were sent to Britain to follow post-basic training in nursing due to the absence of nursing training colleges in Ghana. Nursing in Ghana gradually became important; there was an increase in the number of patients to be nursed due to the spark of life-threatening diseases, high maternal and infant mortality, and the increasing acceptance of hospital services. Therefore, realising the extreme shortage of nurses, the Director of Medical Services, Dr. Balfour Kirk, advocated for more enrolment and training of nurses to support the limited staff and acquire a developed calibre of nurses comparable to the British standard of nursing (Addae, 1996) Training schools were built with an emphasis on empathy, trust, good communication, and unity between nurse and patient.

2.3 The Image of Nursing

The image of nursing is formed by how nurses see themselves and how the public also perceives nursing as a profession. Earlier researchers have established that the public image of nursing is different from the nurses' image of nursing. The nurses' self-image is grounded in their fundamental attributes of nursing. Nurses believe that their primary duty is to perform nursing care for patients and to see to their well-being (Dahlborg-Lyckhage & Pilhammar-Anderson, 2009; Fagerberg & Kihlgren, 2001). Fagermoen's (1997) study confirms that most of the participants (nurses) placed the value of care for the patient's health and well-being first, above all other things. However, according to Hoeve, Jansen and Roodbol (2014), the discrepancy in interpreting caring is that while nurses see the concept or role of caregiving as part of their profession, the public considers it a feminine quality and unprofessional. Some researchers (Liu, 2010; Dahlborg-Lyckhage & Pilhammar-Anderson, 2009) in China and Sweden even qualify care as not only feminine but also a sub-professional occupation rather than a profession.

This advances the argument for the autonomy of nursing. Florence Nightingale emphasised that nursing is independent and equal to the medical profession and not a subordinate (Nightingale, 1969). Yet, the public agrees nursing is caring and feminine but not necessarily autonomous healthcare providers (Kemmer & Silva, 2007; Takase, Maude & Manias, 2006). In the Chinese healthcare system, persons with lower status care for those with higher status, and so comparatively, they qualify nurses as caregivers with low professional status who are subordinate to doctors (Liu, 2010). This corresponds to an earlier study in which Bridges (1990) showed how the media frequently portrayed nurses as always working at the patient's bedside and performing routine activities instructed by the doctor, seemingly as the doctor's handmaidens.

The public image of nursing is diverse and inconsistent and is mainly influenced by earlier researchers' stereotypes (Gordon & Nelson, 2005; Takase, Kershaw & Burt, 2002; Parker & Hallam, 1998; Bridges, 1990). They argue that these stereotypes and misconceptions originate in inaccurate images of nurses in the media. Nurses are purported as 'angels of mercy', 'the doctor's handmaiden', 'battle-axe' and 'sexy' (Gordon & Nelson, 2005; Parker & Hallam, 1998; Bridges, 1990). These studies reveal that their professional self-image does not always match their public image.

The current public discourses in the media are not much different from the earlier ones. According to Girvin, Jackson and Hutchinson (2016), in a systematic review, even though the public saw their roles as positive and indispensable, they also perceived nurses as 'unprofessional', 'militant' or 'over-educated and failing to care'. Godsey et al. (2020) also found that nursing was perceived as disorganised, confused and lacking professionalism. In particular, studies (Gillett, 2014; Hutchinson & Jackson, 2014) from the UK portrayed a discourse of nursing as a 'troubled profession' (Girvin, 2015).

Yet, the public image of nursing as a profession is vital because it demonstrates society's perceptions and values of the services nurses provide, which also tend to influence the nurse-patient relationship (Ozaras & Abaan, 2018; Hoeve, Jansen & Roodbol, 2014). One of such strong perception is their behaviour or attitudes towards patients. The following section discusses this.

2.4 Patients' Perspectives on Nurse's Negative Attitudes/Behaviours

This section presents evidence of some patient complaints about nurses' attitudes/behaviours as reported by researchers. These illustrate instances where nurses have demonstrated negative attitudes/behaviours towards patients.

2.4.1 Poor Communication

One of the major complaints about nurses' attitudes towards patients and healthcare is poor communication. Communication is an essential part of patient healthcare which has a weighty effect on patients' perception of quality healthcare delivery (Tay, Ang & Hegney, 2012). It is a crucial component in nursing which encompasses all nursing activities and interventions such as treatment, prevention, rehabilitation, therapy, health promotion and education (Fakhr-Movahedi et al., 2011). Verderber (1998) defines communication as a transaction and the creation of messages. McCabe (2004) points out emphatically that the nurse-patient relationship strongly influences the quality of healthcare, and effective communication is a primary determinant of quality healthcare. In the same vein, poor or lack of communication skills also affects patient service provision.

Patients frequently complained that nurses did not provide adequate information about whatever questions they asked and seemed to be in a hurry, making participants upset and feeling nurses were not concerned about them as individuals (McCabe, 2004). For instance, as Asamani, Agyemang, Afful and Asumeng (2018) pointed out, in Ghanaian public hospitals, it is common to hear nurses shout and humiliate patients who seek explanation about their health condition. Consequently, some patients remain silent and simply compliant, obeying instructions without questions to avoid humiliation. Hence, patients might return home from the hospital ignorant about their health status. Similarly, Reisfield and Wilson (2003) report poor communication when healthcare providers use medical jargon and technical language to provide information to patients and relatives, which usually results in confusion and ambiguities. This also creates some distance between them and patients because they disregard the fact that patients do not always grasp what they say. Anoosheh, Zarkhah, Faghihzadeh and Vaismoradi's (2009) research also adds that a major communication obstacle, according to patients, is the aggressiveness of nurses. Participants

complained about nurses' and other staff' poor attitudes, especially in their communication, making it difficult to approach them.

Yet, patients are reluctant to openly criticise nurses because they are sometimes observed to be reserved, accepting a passive role or for fear of retribution. This has simply been accepted as a norm in the healthcare service (Attree, 2001; Pontin & Webb, 1995). Generally, nursing professionals have not made much effort to establish positive patient interactions (Bridges et al., 2013), but positive interactions show professional nursing skills in one's ability to ask questions kindly, give information in a manner that does not scare, demonstrate interest, and create feelings that portray acceptance, harmonious relationships and trust, particularly in this modern multicultural society.

The effective communication skills of health professionals are vital to quality healthcare and can consequently have positive outcomes such as decreased anxiety in pain, guilt and even disease symptoms. Additionally, they can increase patients' satisfaction, compliance, acceptance and cooperation with the medical team and enhance the physiological and functional state of the patient (Aghabarari, Mohammadi & Varvani, 2009).

2.4.2 Judgemental

Studies (Kyllieh, Tabong & Konlaan, 2018; Lim et al., 2015; Ayalew, Mengistie & Semahegn, 2014) on adolescents' reproductive health services have highlighted that societies generally perceived sexual and reproductive health issues as appropriate for adults only, leaving adolescents out of such educations and conversations. Adolescents were also envisioned to hold a sort of fear. This fear emanates from the perception that they would be reprimanded as 'bad boys or girls' should they go for services regarding sexual and reproductive health issues, even though professional health workers were educated to provide such special services to adolescents. Another reason for this deterrence was the poor attitude of some of the healthcare providers. It was reported by some adolescents that several

nurses were judgmental of the few adolescents who were bold enough to seek reproductive health services. Nurses showed attitudes such as being uncomfortable talking to young ones about sex education and unwillingness to provide condoms to adolescents as they perceived this would only empower them to experiment with sex.

Meanwhile, these attitudes even got poorer when adolescents became pregnant. They were more victimised, increasing their shyness and fear of seeking information about their pregnancy and antenatal care (Owusu-Addo, Owusu-Addo & Morhe, 2016; Atuyambe et al., 2015; Owusu-Addo, 2015; Grimes, Forster & Newton, 2014). Eventually, when the condition comes to abortion, the situation on the side of the nurses does not become any different. They were of the view that should they give adolescents access to comprehensive abortion services, it would again boost their confidence in engaging in sexual activities.

However, other community stakeholders believed that health providers were against comprehensive abortion services because it was against their religious and cultural beliefs. Nurses were incredibly judgmental about abortions. They purposed not to engage in them because abortions were signs of promiscuity and sin, and these teenagers were just eager to avoid the shame of having illegitimate children, which they (nurses) did not want to be a part of. With Ghanaians and Africans particularly being socialised to abhor abortion, no matter one's age, it has been ingrained in the minds of nurses that abortion is sinful. These attitudes sometimes scare teenagers and even grown-up women who seek or plan to have an abortion (Awoonor-Williams et al., 2018; Kyilleh, Tabong & Konlaan, 2018; Aniteye, O'Brien & Mayhew, 2016).

For suicide and suicidal ideations, findings in Ghana (Osafo, Akotia, Boakye & Dickson, 2018; Osafo, Knizek, Akotia & Hjelmeland, 2012) demonstrate that some nurses victimise suicidal patients on moralistic grounds and even accuse the patients of putting themselves

in the position they are because of their wrongdoings. Few nurses judged these patients based on professional ethics, but the majority attributed patients' behaviour to patients deeds and immorality.

2.4.3 Neglect

Relatives of patients also reported some nurses' negative attitudes, mostly centred around neglect. The family and other significant others become an essential source of social support in the event of ill-health of their loved ones. This support explains the collectivistic nature of Africans in their demonstration of compassion, mutual support, and cohesion, which are held in very high esteem as opposed to the individualistic nature of other parts of the world. Therefore, one's health and sickness become a matter of concern for not just one person but the family and, at other times, even neighbours (Constantine, 2014).

Due to this support, the stress both family and nurses experience becomes cumbersome when these two parties meet because they both have the patient's goodwill. According to Yakubu, Esmaeili and Navab (2019) Ghanaian family members conflicted with nurses regarding the open visiting policy because nurses appeared too busy and did not make much effort to interact with them or their patients. Hence, most of these relatives felt ignored, as if their presence did not matter. Nurses also perceived open visitation as difficult and a burden because they had to combine nursing care and useful interactions with the family. Yet, the family maintained that that was the best time they could also provide social support for their loved ones and even be a source of help to nurses as well.

In a current study (Owoo, Ninnoni, Ampofo & Seidu, 2022), relatives lamented how their patients are neglected when they (relatives) are not around to support caregiving. They complained that nurses ignored these patients because they were dependent, giving an excuse for heavy workloads. Other relatives also complained about the poor attitudes of

nurses and other staff, making it challenging to approach them such that relatives did not have the requisite knowledge to take care of their handicapped kin when they were discharged. Hence relatives felt they had wasted many resources to no avail and a feeling of inadequacy.

Owoo, Ninnoni, Ampofo and Seidu (2022) again reported instances where patients who had been waiting long hours at the OPD before the clinic started were completely ignored without a welcoming atmosphere when the nurses reported working. This only confirms what the participants in McCabe's (2004) study complained that nurses were more interested in completing their tasks than talking to them (patients) personally, which made participants feel neglected and less important more often.

2.4.4 Lack of Empathy

Empathy is a person's capability to identify another person's internal experience and rightly recognise the emotional components that are paramount to the given experience (Moudatsou, Stavropoulou, Philalithis & Koukouli, 2020; Dohrenwend, 2018). As Mottaghi, Poursheikhali and Shameli (2020) also allude, this ability is a necessary skill for people in careers that involve helping others. Earlier scholars Reynolds, Scott and Jessiman (1999) describe it as a requirement for good nursing care. If nurses fail to empathise with patients, they will be unable to understand or cope with their ailments effectively.

The feeling of being ignored in one's plight, be it sickness or pain, has been a significant attribute of nurses' non-empathy (Balandin, Hemsley, Sigafos & Green, 2007; McCabe, 2004). Balandin et al. (2007) consider it as a lack of interest in patients as individuals. In McCabe's (2004) study, one patient complained about nurses being non-empathetic, making her uncomfortable, sad and uncared for. Anoosheh et al. (2009) also indicated that the

relationship between nurses and patients was generally poor because of the short time nurses spent with patients when they had to express empathy towards them.

In Shoqirat's (2014) findings, patients had to endure pain because nurses did not believe they were in pain. Despite their plights, nurses were non-empathetic, even underestimating the severity of pain expressed by patients. According to these patients, nurses believed that their request for painkillers was exaggerated, therefore, some patients preferred to endure the pain rather than argue with nurses. Just like Ojo et al. (2017) also saw that one of the significant barriers to addressing some non-communicable diseases (NCDs) in communities was the negative attitudes of healthcare providers toward patients, among other factors. For instance, respondents stated that when they experienced negative attitudes from healthcare providers or did not have access to tests or medications for their ailment, it deterred them from getting further help from the healthcare centres.

Nurses need to be empathetic because it allows them to acknowledge patients' experiences and worries better and enhance trust (Mottaghi, Poursheikhali & Shameli, 2020; Reynolds, 2017). Patients who also see nurses as empathetic, emotionally supportive and compassionate are more likely to be comfortable and trust such providers enhancing genuine and open dialogue (Friedrichsen et al., 2000).

2.5 Factors that make Patients more Susceptible to Nurses' Negative

Attitudes/Behaviours

This section presents evidence of situations that make patients more prone or patients who are more prone to negative attitudes/behaviours of nurses. Some of the extensive work on a few of these conditions vis-à-vis nurses' negative attitudes/behaviours are as follows:

2.5.1 Patients with Stigmatising Conditions

The predominant complaint of patients about the improper attitudes of some nurses mainly had to do with the nature of the ailment reported to the hospital; this mostly had to do with stigmatising conditions. The literature on stigmatised conditions and nurses' attitudes suggests that nursing patients with conditions such as HIV/AIDS, mental illness, suicidal instincts and the like have more attitudinal inclinations that mostly have to do with discrimination and stigmatisation.

Nursing patients with human immunodeficiency virus infection and acquired immunodeficiency syndrome (HIV/AIDS) is one of the significant conditions that has been attached with a lot of stigmatisation and discrimination. Studies (Ishimaru et al., 2017; Wada, Smith & Ishimaru, 2016; Dapaah, 2016; Gagnon & Cator, 2015; Manganye, Maluleke & Lebese, 2013) that observed nurses' negative attitudes toward people living with HIV/AIDS (PLWHA) particularly portrayed the unwillingness of some nurses to cater for such patients for fear of contracting the virus, which is demonstrated in a bid to wear gloves and gowns in the care of PLWHA. For instance, in KwaZulu-Natal of South Africa, Famoroti, Fernandes and Chima (2013) found out that most nurses put on gloves for HIV-positive patient procedures, which were even non-invasive. Even in Thailand, most nurses did not just put on personal protection measures; they also wore double them, including gloves, whenever interacting with PLWHA (Pudpong et al., 2014). It must be realised that stigma and discrimination are discouraging factors that inhibit relentless struggles to encourage societies to get themselves tested, treated, and get other HIV preventive modalities in the fight to reduce the possibility of infections (Ishimaru et al., 2017).

While the discrimination and stigmatisation centred on HIV/AIDS has to do with contagion, that of mentally ill patients predominantly has to do with nurses' sociocultural influences

and socially restrictive attitudes toward these patients (Adjorlolo, Abdul-Nasiru, Chan & Bambi, 2018; Hansson, Jormfeldt, Svedberg & Svensson, 2013; Linden & Kavanagh, 2012). For instance, Adjorlolo, Abdul-Nasiru, Chan and Bambi (2018) on mental illness and crime indicate that nurses were more likely to focus on the criminality or the offence committed rather than the source or the contributing factors to the crime; that is, the mental illness. Thus, nurses perceived these patients as worthy of punishment rather than treatment and care. It does not, therefore, come as a surprise when those supposed to care and treat them hold negative attitudes towards them and convict them, with some patients even getting chained and lashed. These studies also added that male mental health nurses tended to hold these offenders strictly accountable for their crimes compared to their female colleagues, primarily due to sociocultural practices. For instance, because of Ghanaian patriarchy, boys are predominantly socialised to be physically strong and tough at the sight of adversities.

Meanwhile, girls are mostly perceived to be feeble and are not supposed to engage in aggressive behaviours, leaving male mental health nurses to deal with patients who demonstrate aggressive behaviours and getting mistreated when these patients have a criminal background. Other studies (McHugh, Kutney-Lee, Cimiotti, Sloane & Aiken, 2011; Jacob & Holmes, 2011) also explained that the longer nurses interacted with mentally ill patients, the more discontent and frustrated these nurses became with their jobs. It worsened for those who had practised for even longer years as they experienced more dissatisfaction and frustration, exhibiting negative attitudes towards these patients.

Researchers (Coppens et al., 2014), who investigated the concept of suicide in four European countries, including Germany, Hungary, Ireland, and Portugal, argued that community facilitators' including nurses, portrayed negative attitudes including stigmatisation toward suicidal patients because they were depressed. Yet, Fry, Abrahamse, Kay and Elliott (2019)

as well as Betz et al. (2016) affirm that stigmatisation negatively affects the management of depression, attesting that depression has been the major risk factor for suicide among older people. Meanwhile, other studies (Slemon, Jenkins & Bungay, 2017; Cutcliffe, Santos, Kozel, Taylor & Lees, 2015; Lees, Procter & Fassett, 2014; Yaseen et al., 2013) have purported that the way nurses engage with patients who experience suicidal ideation more times lacks therapeutic engagement and, at other times, lacks the fundamental principles in caregiving such as treating patients with respect and empathy.

Finally, concerning pain management, findings (Adugbire & Aziato, 2018; Aziato & Adejumo, 2014a; Larsson, Sahlsten, Segesten & Plos, 2011) have associated a lot of the impediments related to ineffective management of patients' pain with nurses. They disclosed that nurses declined to dress some patients' wounds during follow-up visits, so nursing care in such facilities was tagged as poor. Some of these behaviours deteriorated some patients' conditions leading to wound infections. They again expatiated that some nurses also used abusive words for patients' wounds and did not even pay attention to them. Also, nurses did not depend on the patient's self-report of pain but made their own decisions on the patient's pain. In understanding these sensations, Aziato and Adejumo (2014b) revealed that nurses trained in pain management disclosed that some of their colleagues did not practice the training they had received from the ward workshops.

2.5.2 Women in Labour

Childbirth is a transition to motherhood and happens to be one of the memorable proceedings in a woman's life (Namujju et al., 2018). In the event of pregnancy and childbirth, midwives and nurses play a tremendous role in the care and treatment of both mother and baby. They play this pivotal role such that the pregnant mother, her family, and the entire community cannot do without the services of midwives (Oluyemisi, Oyadiran, Ijedimma, Akinlabi &

Adewale, 2014; Adesokan, 2010). However, some negative attitudes have also been realised to affect healthcare-seeking behaviour, resulting in the low utilisation of quality health services. This leads some pregnant women to resort to alternative healthcare services, which might deter their health (Akowuah, Agyei-Baffour & Asibey, 2018; Kyei, Otoo, Abua & Ofori, 2018; Mannava, Durrant, Fisher, Chersich & Luchters, 2015).

In studies (Kodom, Kodom & Senah, 2018; Vogel, Bohren, Tunçalp, Oladapo & Gülmezoglu, 2016; Bohren et al., 2015; Moyer et al., 2014) that investigated barriers to facility-based childbirth and their facilitators, they found a lot of abuse, disrespect, mistreatment, and neglect of women which were identified as substantial obstacles for women to attend facilities for delivery. Kodom, Kodom, and Senah (2018) found out that some Ghanaian women in the Central Region preferred domiciliary delivery to facility-based delivery due to the negative attitude of some nurses. In one instance, the nurses were reported to be embarrassing women in labour who had not shaved before reporting to the hospital in the presence of their colleague nurses and other pregnant women. Alexander et al. (2014) also found that Ghanaian women interviewed about social support during delivery confirmed that they needed their partners or relatives to be around to cheer them on and encourage them to push their babies out because they knew that nurses or midwives would not do that. Others confided that they needed such companions to serve as witnesses so that the nurses/midwives would not be able to switch their babies after delivery. They also added that results were best when the support person was not a hospital staff member. In another instance, Nwameme, Phillips and Adongo (2014) reported that most pregnant women did not prefer to be referred to other health facilities should there be complications. This is because, among other factors considered, the women also envisioned a hostile attitude of nurses at the referral health facilities, deterring them from accessing a higher level of healthcare. Many respondents preferred traditional birth attendants (TBAs) not only for less

expensive sources of care but also for their nurturing, as opposed to the unfriendly and insensitive nature of some of the midwives.

2.5.3 Health Insurance Cardholders

Patients' grievances about nurses' behaviour are also realised by holders of health insurance. The National Health Insurance Scheme (NHIS), enacted in 2004, was to enhance quality healthcare delivery in Ghana. A lot of positive results have been realised from its establishment. Evidence from some selected districts in the Brong-Ahafo region showed an increase in facility-based delivery by approximately 20% over five years. This increase is due to the increasing NHIS patronage in the region (Alhassan, Nketiah-Amponsah, Spieker, Arhinful & Rinke de Wit, 2016; Blanchet, Fink & Osei-Akoto, 2012) and for which nurses' quality services in its implementation have been very instrumental.

In as much as the NHIS vis-à-vis quality healthcare provision is influential in enhancing patient-oriented healthcare delivery, some patients have also given unfavourable reports. In a large-scale community trial called the Client-Oriented Health Insurance (COHEiSION) Project, NHIS cardholders complained of getting less responsive care from health providers, including nurses, than non-cardholders. They argued that non-cardholders were given preferential treatment over cardholders, at least in their last visits as recalled (Haw, 2019; Alhassan et al., 2015).

It is also not uncommon, especially in private hospitals, to see that different queues have been made for card-holders and non-card-holders who are ready to pay out of pocket. Hence, some NHIS card-holders perceived that they would be receiving more deficient services from healthcare providers, including negative attitudes from nurses, hence their unwillingness to even access the healthcare service with the card, so they hid their cards to receive quality health services (Duku, Nketiah-Amponsah, Janssens & Pradhan, 2018;

Alhassan et al., 2016). Kodom, Owusu and Kodom (2019), in their qualitative study, also revealed that the factors that accounted for the patient's dissatisfaction with the NHIS did not only include the hours one had to spend just in a queue nor the extra money they had to pay for some kind of drugs and laboratory tests but the negative attitudes of most nurses who provided care.

2.5.4 Dependent Patients

The dislike for patients' overdependence on nurses contributes to one of the reasons for nurses' negative attitudes towards patients. Deasey, Kable, and Jeong's (2014) systematic review showed this was much more prevalent with older patients than with children. Hweidi and Al-Hassan's study (cited in Deasey, Kable & Jeong, 2014) suggest that cultural systems, religion, social structures, and values influence nurses' negative attitudes. While some cultures, such as Jordanian Muslims, are taught to value and respect older people, leading to the positive attitudes of their nurses towards older patients, other cultures may allege older people as witches, leading to negative attitudes. A nurse's exposure to and experience with elderly persons also indicates positive or negative attitudes towards older people.

The idea that older patients had to, more often than not, depend on nurses makes the latter's attitudes more negative. Due to the older patient's frailty, nurses expressed high anxiety levels in their care for the former. On the other hand, due to cognitive impairment, most older patients can neither react nor mandate a better quality of service; hence, they are often marginalised and at risk of being mistreated. This attitude may result from the incomprehension of the ageing process and the constraints that come with it (Deasey, Kable & Jeong, 2014).

Faronbi, Adebowale, Faronbi, Musa and Ayamolowo (2017) found the relationship between perception of ageing and attitudes towards the aged to be statistically significant, which

could influence nurses' attitudes toward caring for older persons. For instance, people who perceive ailment as not being a part of normal ageing development because one could age without dealing with diseases might portray a positive attitude towards enhancing the health of elderly patients.

2.6 Arguments for Nurses' Undesirable Behaviours

This section presents some of the explanations researchers have found for some of the undesirable behaviours of nurses. They are primarily provocations nurses encounter in their profession that affect positive behaviours.

2.6.1 Shortage of Nurses

The nursing profession suffers from a global shortage where the supply is significantly less than the demand in almost all countries. This deficiency poses a significant challenge in the profession's effort to provide quality healthcare, maintain good patient-nurse relationships, meet health needs, and create more robust health systems. Ghana and most African countries suffer from this human resource crisis, yet nurses interestingly continue to leave the profession as fast as the opportunity presents itself (Asamani et al., 2019; Boafo, 2016; Adzei & Sakyi, 2014). There is a significantly positive correlation between students' nursing career and their intention to travel outside after training. This finding suggests student nurses' attitudes about the nursing profession and the source of the nursing shortage (Miligi & Selim, 2014; Mwini-Nyaledzigbor et al., 2014; Al Jarrah, 2013).

Global estimates suggest that the shortage of skilled healthcare professionals will likely be fifteen million by 2030. This means that the shortage of nurses worldwide will increase even more. Should this happen, the imbalance between nurse supply and demand will quickly widen, becoming a workforce crisis that will inevitably threaten the ability to combat diseases and promote good well-being (Liu et al., 2017).

Aside from nurses emigrating, other reasons have also been given for the shortage of nurses in developing and developed countries. Researchers (Boafo, 2016; Al Jarrah, 2013; Dywili, Bonner & O'Brien, 2013) have attributed the reduction of nurse enrolment to the availability of more attractive career prospects for school leavers, the poor nursing image, which makes the profession unappealing, the unfavourable working conditions leading to dissatisfaction, and the ageing nursing workforce leading to retirement. These shortages result in an overwhelming workload for the available few. For instance, in a study in a hospital in Wa, (in the Nadowli District), Ghana, it was found that nurses had to continually refer some pregnant women and new-born cases to other hospitals because the demand on nurses was too much than they could cope with (Sumankuuro, Crockett & Wang, 2018).

2.6.2 Stress

Occupational stress is an identified matter of concern among nurses (Sarafis et al., 2016). It comes about as a result of an imbalance between the stressors in the workplace and the ability of the nurse or staff to cope, which unsatisfactorily managed results in serious health outcomes (Sahraian, Davidi, Bazrafshan & Javadpour, 2013). Globally, the pervasiveness of occupational stress among nurses ranges between 9.2% and 68.0% (Dagget, Molla & Belachew, 2016).

Many factors combine to contribute to nurses' occupational stress. They include the need to continually pay attention to patient's details (as the slightest mistake could result in a loss of life), overwhelming workloads, inadequate cooperation from patients and relatives, the need to deal with emotionally and physically draining situations, poorly rationalised shift work, insufficient nurses' autonomy (when it comes to decision making), a surge in hospital attendance (due to the National Health Insurance), etc. (Kaburi et al., 2019; Moore, 2018; Scott, 2016; Kwansah et al., 2012). Sarafis et al. (2016) also highlighted that a source of

stress could be the quality of the relationship between superiors and subordinates. Nurses lamented that sometimes there was insufficient support from superiors who only provided feedback on poor performance. This made subordinates feel that their superiors were always waiting for them to make mistakes since they were not commended for good work done. This treatment detracts from their well-being, creating occupational stress.

In effect, researchers reported that nurses perceived that they often were emotionally, psychologically, and physically worn out from stress. They highlighted that stress impacted poorly on their mental health just as on their physical health leading to stress-related diseases and their consequent debilities, aetiologies of anxiety and depressive symptoms, and increased risk of cardiovascular diseases (Kaburi et al., 2019; Moore, 2018; Sahraian, Davidi, Bazrafshan & Javadpour, 2013) as well as improper behaviours.

2.6.3 Post-Traumatic Stress Disorder

Nurses experience workplace violence at disturbing rates compared to other professions (Honarvar, Ghazanfari, RaeisiShahraki, Rostami & Lankarani, 2019), which influences their mental and physical well-being negatively (Zhao et al., 2018). At worst, some experience post-traumatic stress disorder (PTSD), that is, the experience of a traumatic event. Researchers (Lavoie et al., 2016; Mealer & Jones, 2013; Adriaenssens, Gucht & Maes, 2012) have reported that caring for patients and their relatives has much psychological toll on nurses. It is compounded by traumatic injuries, witnessing the prolonged suffering of patients of all ages and deaths of patients (especially children).

Also, there is a greater potential for traumatic stress when a nurse identifies with a victim's situation (Beavan & Stephens, 1999). Similarly, when one has a close relationship or emotional attachment with a particular patient (de Boer, Rikxoort, Bakker & Smit, 2014), or not being able to save a patient they are affectionate about, it increases PTSD symptoms

and negative attitudes (Mealer, Shelton, Berg, Rothbaum & Moss, 2007). Consequently, traumatised nurses are said to adopt some coping strategies, though ineffective. This includes avoidance, self-blame, self-distraction, denial, and behavioural disengagement. These were even severe among critical care nurses (McMeekin, Hickman, Douglas & Kelley, 2017; Lavoie et al., 2016; Adriaenssens, Gucht & Maes, 2012).

2.6.4 Job Dissatisfaction

Researchers have emphasised that the principal reason for nurses' attritions, turnover intentions and negative attitudes is the issue of low job satisfaction and reduced motivation (Bonenberger, Aikins, Akweongo & Wyss, 2014; Twigg & McCullough, 2014). A global systematic review underlined nurses' satisfaction, motivation, and retention issues. They included; financial and non-financial incentives, working conditions, nurses' empowerment at the workplace, career development, and living conditions (Halcomb, Smyth & McInnes, 2018; Vlaev, Schmidtke, Balen & Dormon, 2017). Remuneration, which includes both salary and fringe benefits, is considered the most crucial factor that has to do with the general job satisfaction and dissatisfaction of nurses (Ayalew et al., 2019; Ugwa & Charity, 2016; Sansoni et al., 2016; Schmiedeknecht et al., 2015).

For instance, Ayalew et al. (2019) reported dissatisfaction and lack of motivation among nurses in their jobs. They argued that nurses with five to ten years of experience were more likely to be dissatisfied with their jobs than nurses with less than five years of experience (those who were supposed to provide a mandatory service for at least five years after their training). Nurses with over ten years of experience were likely to have higher expectations concerning their salary, professional growth, and other benefits as soon as their compulsory service period elapsed; therefore, they were more likely to be dissatisfied if their expectations were not received. Abugri and Jarvis (2018) also emphasised that male student

nurses were of the view that their remuneration was not reasonable. This is because it is evident that Ghanaian men have much more financial responsibilities, and their underpayment reflects that Ghana's health service is not only underfunded (Zamanzadeh et al., 2013) but also is a deterrent for more males to join the profession. Efforts must be made to address issues of job satisfaction, especially remuneration, to keep nurses motivated and draw more men into the profession.

2.6.5 Poor Working Conditions

In Ghana, most nurses do not control where they will be posted to serve after their training, so many become aggrieved and dissatisfied when posted to deprived communities, referring to such postings as sacrifice (Kwansah et al., 2012). This is explained by the unusually heavy workloads that await them and the unsatisfactory working conditions, which include inadequate water supply, irregular supply of electricity, and lack of medical equipment. Other challenges include a lack of prospects for professional advancement, the lack of unclear terms of contract and promotion, and the fear of being forgotten or lost in the system. Housing, such as a private residence, is a significant worry for nurses. Kwansah et al. (2012), in their qualitative study, again illustrate that in the Upper West Region, nurses complained about the absence of housing structures for accommodation at both the health post and in and outside the community. In the Brong Ahafo Region also, even though nurses confirmed the availability of housing facilities, which had nurses' quarters, they were all congested, and many nurses were made to share single dwelling units, which were ridiculously expensive. The challenges were more unbearable for nurses who had to manage a health centre alone. They further explained that a community health nurse in the Brong Ahafo Region experienced a situation when she delivered a baby alone using a torchlight because there was a power outage. She held the torchlight between her teeth for the whole period of birthing the baby. This also demonstrates how some nurses perceive rural services as a

matter of commitment and hard work and are still devoted to working no matter the circumstances they find themselves in (Snow et al., 2011).

In another work by Kaburi et al. (2019), respondents asserted that they did not have a safe working environment but had to lift patients and other heavy equipment manually, which was detrimental to their health and the dangers of being exposed continuously to infections. Other studies (Mugambi, Palamountain, Gallarda & Drain, 2017; Udjo & Lalthapersad-Pillay, 2014) also revealed that rural health facilities again lacked laboratory services to enhance testing and prompt disease management, which puts a lot of burden on nurses. Again, Kuupiel, Tlou, Bawontuo and Mashamba-Thompson (2019) reported poor availability of pregnancy-related point-of-care (POC) diagnostic tests and the necessity to advance more of such tests in the rural primary healthcare centres in the Upper East Region because of the low test availability. This challenge is also similar in rural primary healthcare facilities in South Africa. A study by Mashamba-Thompson, Sartorius and Drain (2018) also disclosed poor POC diagnostic accessibility, availability, and usage. This study also added the high need for POC tests in primary healthcare centres to enhance nurses' decision-making for the care of patients. All these poor working conditions contributed to the poor quality of service provided, including undesirable behaviours of nurses.

2.6.6 Not Their Call

The nursing profession has been widely argued to be a vocation, a call, that is, the intense need to help sick people and an unexplainable interest in the profession (Wall, Dhurmah, Lamboni & Phiri, 2015; Eley, Eley, Bertello & Rogers-Clark, 2012). In a study by Oppong-Darko, Amponsa-Achiano and Darj (2017), they used 'passion' to characterise how nurses/midwives were motivated to choose the profession to avoid preventable ill health. They had a strong desire, especially to improve the health of pregnant women. Contrary to this aspiration, researchers (Oppong-Darko, Amponsa-Achiano & Darj, 2017; Teodosio &

Padilha, 2016) also found that some nurses have been forced into the profession due to the lack of desired professional opportunities so becoming a nurse was the only available opportunity at the moment. Meanwhile, others chose the profession, not because of the lack of their desired choice or calling but for job security, prestige, and a good salary (Asamani, Agyemang, Afful & Asumeng, 2018; Fillman, 2015; Wilkes, Cowin & Johnson, 2015).

2.6.7 Nurse-Other Staff Relationships

In one way or the other, nurses' colleagues also contribute to some of the poor behaviours of nurses. Aberese-Ako, Agyepong, Gerrits and Van Dijk's (2015) research showed conflicts between doctors and nurse-anaesthetists that normally resulted in some of the latter's improper behaviours. This usually had to do with decision-making on the client's health condition. Senior doctors typically exerted their authority on nurse anaesthetists by imposing their views on them, but junior doctors usually accommodated nurse anaesthetists by agreeing to their decisions. Senior doctors also lamented the poor attitudes of other healthcare providers towards collaboration, which led to some of them resigning themselves to accommodate staff who were sometimes hesitant to cooperate.

Some negative attitudes of doctors and nurses towards pharmacists have also been identified as causing poor relationships among healthcare providers. The discrepant attitudes among these healthcare providers resulted from differences in authority or status, training, responsibilities and cultures (Acheampong & Anto, 2015; Thomas, Sexton & Helmreich, 2003). Hughes and McCann (2003) also found that doctors were less appreciative of pharmacists in healthcare delivery. Pharmacists strongly confirmed that they constantly faced poor attitudes from doctors and nurses on the wards. Meanwhile, in another study (Makowsky et al., 2009), collaborative work and increased awareness among healthcare givers, including doctors, pharmacists, and nurses, were instrumental in enabling positive

patient outcomes. Hence, healthcare givers must establish good working relationships to provide patients with the best care.

2.7 Patients' Perspectives on Nurse's Positive Attitudes/Behaviour

Despite the complaints of poor attitudes/behaviours reported, it is also important to emphasise that nurses have had positive reports.

2.7.1 Emphasising Quality Care Despite the Condition

Although people living with stigmatised conditions especially have been associated with 'immorality' and 'dirt' and hence are not cared for well by health workers (Dapaah, 2016; Shaw, 2004), some studies have reported positive attitudes of some nurses toward such patients emphasising nurses' insistence on quality care rather than the stigma. These researchers (Boakye & Mavhandu-Mudzusi, 2019; Ishimaru et al., 2017; Ledda et al., 2017; Zarei Joulaei, Darabi & Fararouei, 2015) have established that nurses have been very caring in attending to HIV and AIDS patients. The researchers posited that nurses firmly believed that just as any other patient will be given quality care, HIV/AIDS patients should have equal rights and respect. The outcome of Boakye and Mavhandu-Mudzusi's (2019) the study indicated nurses' positive attitudes, whereby most patients portrayed higher agreements with positive attitude statements and disagreed with negative attitude statements regarding people living with HIV/AIDS (PLWHA). Dapaah (2016) also revealed that the nurses in his study showed unusual positive behaviour towards HIV/AIDS patients vis-à-vis the typical behaviour of nurses towards such patients in Ghanaian health facilities. He pointed out that these nurses went out of their way to treat, encourage and help the clients.

Also, some studies on suicide (Vandewalle et al., 2019; Cusack, Cusack, McAndrew, McKeown & Duxbury, 2018; Huber et al., 2016) have also emphasised nurses' positive attitudes and argued that nurses perceived their foremost responsibility to protect patients

by providing quality care and support them in acquiring awareness, especially when they are envisaged to re-attempt suicide. They also demonstrated positive attitudes such as observing patients strictly, restraining and secluding patients, giving psychotropic medication, and indulging in repetitive conversations to assist patients in identifying and organising their thoughts and feelings. They also believed they had a charge to reduce suicides and suicidal ideation as long as the patient was brought to the hospital; hence, they engaged patients in repeated conversations to enhance the identification and organisation of their feelings and thoughts.

2.7.2 Politeness

Dapaah (2016) portrayed how health workers were very polite to clients in the warm reception given to clients, such as hugs which were exceptional with regard to nurses' positive behaviours. He also reported how they counselled clients politely on every visit. Some studies on pain (Adugbire & Aziato, 2018; Newell & Jordan, 2015; Foust, Vuckovic & Henriquez, 2012) also reported the satisfaction of some participants when they demonstrated how nurses politely and gently dressed their wounds on every visit. Many others praised the nurses, saying that their nurture not only made the wounds painless but also made them recover speedily. In their happiness, other patients also asserted that polite communication and interactions in managing pain are very much needed since the patient is already in pain. This politeness allows patients to voice their concerns freely and creates a healthy nurse-patient relationship for quality healthcare delivery.

Similarly, Cybulski, Krajewska-Kułak, and Jamiolkowski (2015), Eltantawy (2013), and King et al. (2013) reported positive attitudes in the care of older adults. Professional nursing for older people requires not only skills but, most importantly, politeness. They specified that these favourable attitudes were seen more predominantly among student nurses who

participated in the studies. In a research on birthing experiences at the 37 Military Hospital in Ghana, participants praised the exemplary healthcare services of midwives who attended to them during their labour and delivery. The women harmonised that how the midwives politely received and comforted them was gratifying, giving them unique positive birthing experiences at the hospital (Mensah, Mogale & Richter, 2014).

2.7.3 Financial Assistance

As part of their duties in healthcare delivery, financial support is not a responsibility for nurses. Yet, there have been instances where nurses have given such assistance to patients. Researchers (Dapaah, 2016; Van der Geest & Sarkodie, 1998) illustrated situations where patients were in dire financial difficulties, unable to feed themselves or pay for treatments, and nurses came to their aid. While some of these patients were in this predicament because they were poor, relatives simply abandoned them. Some nurses financially assisted some of these impoverished patients with transportation fares home, without which such patients would have been stuck in the hospital even after discharge. Russell (2008) has attributed this moral value from nurses to patients to compassion, positing that this unusual practice by nurses goes a long way in establishing a strong relationship between nurses and patients.

2.7.4 Participatory Care

Researchers have again reported the allowance of patients to make decisions collaboratively with healthcare givers rather than imposing their decisions on patients as positive. For instance, in birthing, nurses/midwives' efforts in engaging women's participation in making decisions concerning their baby and the women's cooperation with midwives to provide adequate healthcare promote effective coordination and relationship between these two parties. This interaction makes the beginning of motherhood easier for the women, increasing their confidence and love for their new babies (Sadeghzadeh, Amiri-Farahani,

Haghani & Hasanpoor-Azghady, 2019; Namujju et al., 2018). Levine and Lowe (2015) added that midwives'/nurses' positive attitudes toward pregnancy and childbirth enlighten women and enhance their capabilities towards pregnancy, childbirth, breastfeeding, neonatal care, and the mother's self-care.

This is also similar to diabetes and hypertension. Literature on diabetes and hypertension studies indicate that diabetes is the most prevalent co-morbidity with hypertension. Patients were happy when nurses were identified as assisting them in understanding the cumbersome treatment procedures and how patients could personally take care of themselves. Nurses have participated actively in their upkeep and management for a very long time, with much emphasis on a patient-centered strategy of treatment. The positive attitude of nurses and other health professionals was seen as a motivator that enhanced engagement of self-management practices among patients. A factor that has positively led to the advancement in the quality of care and control for hypertensive patients is the changed care models and research by nurse-led clinics and teams (Aghoja, Okinedo & Odili, 2017; Himmelfarb, Commodore-Mensah & Hill, 2016).

2.7.5 The Exceptional Case of Male Nurses

Presently, the nursing profession is primarily female-dominated (Haigh, 2015). All over the world, male nurses represent the smallest percentage of all nurses in almost all health facilities. Meanwhile, even though the number of nursing training schools and registered nurses has globally increased, the proportion of men in the profession remains a handful (MacWilliams, Schmidt & Bleich, 2013). As espoused in the history of nursing in the first chapter, the first formally trained nurses in most countries, including Ghana, India, ancient Greece, and Rome, were men (O'Lynn, 2012). During the middle of the nineteenth century,

men were conceptualised as unsuitable for nursing because their thorny hands were harmful to be used for care (Cudé & Winfrey, 2007).

Currently, although men seem to be considering the nursing profession for numerous reasons, patients, on the other hand, seem to have mixed feelings when male nurses are assigned to them (Yi & Keogh, 2016). According to Budu et al. (2019), Younas and Sundus (2018), Achora (2016), Adeyemi-Adelanwa, Barton, Dawkins and Lindo (2016), participants who had healthcare provision from male nurses professed that male nurses were approachable, well-mannered, trustworthy, considerate and created an environment conducive for their patients. Interestingly, other healthcare professionals also highlighted that patients preferred male nurses more often than female nurses because of their quality and unique service provision.

However, others considered that male nurses should not give care because caring is an attribute of females. Even within the same country and among different countries, inconsistent findings have been reported on patients' opinions and satisfaction with care provided by male nurses (Younas & Sundus, 2018; Adeyemi-Adelanwa, Barton, Dawkins & Lindo, 2016; Zamanzadeh, Valizadeh, Negarandeh, Monadi & Azadi, 2013; Landry & Tillman, 2013). Herakova (2012) believed that male nurses are strategised to give quality care services such that it will nullify the perception that men are not good at caring. This has somewhat given them a 'superstar' image. According to Herakova's participants, this image was again portrayed when male nurses demonstrated their expertise in the traditional expectations of nursing care, giving emotional support and providing expert biomedical performance projecting their uniqueness. Hence, male nurses must be encouraged for their uniqueness by letting them know the benefits of employing and retaining more male nurses.

Nevertheless, there have been rivalries between male and female nurses because male nurses were more likely to be perceived as doctors. As Achora (2016) and Wall et al. (2015) purported, in rural communities, the distance from people's homes to clinics was very far, and very few doctors worked there. Hence, nurses had a lot of responsibilities, which seemed advantageous to male nurses compared to female nurses. For instance, in Uganda, Mauritius, and Togo, informally, male nurses became assistant doctors in that the community members referred to them as 'doctors' and treated and respected them. As a result of this treatment, female nurses alleged that male nurses were impersonators who desired to take over the nursing profession. Even though men naturally and culturally are not seen as caregivers, the acceptance and respect they have earned from patients because of their hard work suggest that they are not doing badly after all.

2.8 Theoretical Framework

For this study, many theories were reviewed to provide the explanatory model that best defines the subject under consideration. Some of these include the Theory of Planned Behaviour, the Ecological Systems theory, and Social Construction of Reality, inter alia. However, after examining the literature and the data obtained, it was realised that behaviour is multifaceted by several factors which need specific theories in its analysis. Hence, the researcher finally adopted Blumer's Symbolic Interactionism, Foucault's Knowledge and Power, Homan's Rational Choice, Giddens' Structuration and Hochschild's Emotional Labour as frameworks to make sense of nurses' behaviour.

The symbolic interactionism theory is a micro-level perspective that explains individual interactions in society. It analyses society from the bottom up, defining the processes of society from individual face-to-face encounters and interpreting the meanings they assign to actions using symbols and language. Contrary to dominant structural theories in Sociology,

symbolic interactionism envisages individuals as independent who can make and remake their social world (Carter & Fuller, 2015; Reynolds & Herman, 1994). This typically pertains to comprehending subjective meanings while arguing that society is made due to repeated but meaningful individual interactions (Carter & Fuller, 2015).

George Herbert Mead, one of the founders of symbolic interactionism, postulates that individuals interact with one another using symbols such as signs, gestures, facial expressions, words, etc., which they attach meanings to based on what they agree they mean. A symbol could also become significant when it controls an individual's actions. Such symbols are internalized, mean the same thing for all individuals in that group, and hence manifest similar attitudes or responses from the individuals who are producing these symbols or reacting to these symbols (Mead & Schubert, 1934). Herbert Blumer, the proponent who published and popularized Mead's work also agreed with Mead that there are no inherent meanings of objects or people but there are rather subjective meanings resulting from definitions that individuals assign to them. Simply, individual actors create and recreate experiences as a result of their interactions with others and society. These intersubjective meanings these actors attach to objects are endlessly reinterpreted through a definition of the situation.

Herbert Blumer offers three key premises which form the building blocks for symbolic interactionism. According to him;

1. Individuals act towards things based on the meanings that the things have for them.
2. The meanings of these things are derived from or come about from the social interaction that one has with others.
3. These meanings are handled and modified through an interpretative process the individual uses in dealing with the things he encounters (Blumer, 1969, p. 2).

Consequently, for Blumer, objects do not have any intrinsic meanings other than the meanings the individuals involved in the interaction give them. In the long run, the meanings individuals give to objects also determine how such individuals relate to the object. Hence, social interaction is useful for formulating, continuing, and modifying the meanings of objects. Due to this, there are no static or one-way meanings, but they are constructed and reconstructed depending on the definition of the situation and the changes in the societies. The theory has been criticized for overemphasizing individuals (Blumer, 1969). The theory has been critiqued for its over-emphasis on creating meanings from social interaction since, according to Sichach (2023), there is a physical reality outside of humanity that is entirely independent from humans.

The second theory that was adopted is Anthony Giddens' structuration theory. The foundation of the structuration theory is that there is continually an interplay that exists between structure and action. It primarily explains how social systems are produced and reproduced over time and space (Giddens, 1984). He theorises that there is a duality of structure that exists which is a consistent interaction between structure and action which is the foundation of the production and reproduction of any social organisation, implying that social systems do not simply exist just because of structure or action but due to the interaction between them. As Giddens argues, 'structure is both medium and outcome of the reproduction of practices' (1979, p. 5). Hence, structure and action are not autonomous in that 'we cannot take action without operating within structures and without producing and reproducing them' (Feldman, 2015). He calls this the 'duality' symbolising that agency and structure are but two sides of the same coin (Giddens, 1984). The structure-agency duality implies that social structures are represented in agents' choices during social practice, while agents produce and reproduce social structures.

Since structure cannot exist without action and vice versa, structure influences the behaviour of actors, also known as agents, who, in return, create and recreate that very structure. Giddens also emphasizes that structure is not necessarily physical but exists ‘as memory traces orienting the conduct of knowledgeable human agents’ (Giddens, 1984, p. 17). As a result, individuals or agents persistently influence the structure that tends to enable or constrain their actions. Should agents comply or conform to the rules of the structure, they reinforce it, but if they routinely ignore or move outside the rules, they modify the structure (Jarzabkowski, 2008). He also emphasizes that structures are embedded with rules and resources. The rules determine the boundaries of behaviour while the resources can either be allocative (materials) or authoritative (over people). Both these rules and structures constrain and enable action.

Giddens (1984) categorises three dimensions of structure: signification, which is how events should be interpreted; domination, which concerns the means that should be employed to accomplish goals; and legitimation, which is about what is supposed to happen in each situation, typically emphasizing rules. According to Giddens (1984), the established patterns of behaviour which are created and recreated across time and space become ‘institutions’, which Vaughan (2001, p. 186) observes that “Institutions persist partly because of the adherence to routines but also because people operating within them consent to do so”. Institutions mainly exist for “structuring societies”, coordinating stable activities and producing goods and services across space and time (Giddens, 2001; p. 348). Therefore, the structuration theory is constructivist since it understands people as social constructs and posits that institutions of all types are constructs sustained by how people act, with regard to their image of reality (Lye, 1997).

He also argues that individuals are inherently reflexive, subconsciously making practical everyday knowledge and, again, consciously enabling the social practice to be devised

discursively in light of new information, which he refers to as “reflexive monitoring” (Giddens, 1984). Giddens (1984) again asserts that agents are knowledgeable because they know a lot about the situations of themselves and others’ actions as well as the effects of these actions in everyday life. He called this knowledgeability, which is a prominent characteristic of structuration theory. Knowledgeability comes in three levels of awareness (Layder, 2005). The unconscious is the motivational level representing emotions and desires, even though such desires may not necessarily be put into use and may only provide outlines for potential action. Hence, Giddens focuses more on the discursive and practical levels of consciousness over which agents have control. The discursive focus is on their ability to discuss why they do what they do, while the practical is on the choices they make subconsciously. For many critics, Giddens' approach to agency is overly focussed on individual choice, neglecting the conditions and unintended consequences that may arise (Cited in Jones, 2011).

The next theory that was adopted is Michel Foucault’s Knowledge and Power. According to Foucault, knowledge and power are mutually involved and the exercise of power generates objects of knowledge that are constantly manipulated and become knowledge itself, and this becomes power again in a complex chain in which one is conditioned by the other (Foucault, 2012). He argues that knowledge comes from the power intrinsic to micro-practices. Henderson (1994) demonstrates that these micro-practices, working in the wards at the hospital at an individual level, are key to the development of knowledge.

Foucault highlights that the discourse that orders society is always the discourse of the people who are the holders of knowledge (Foucault, 2012). He argues that one side of this power relationship will always belong to that which is continually determined by the ideas coming from the ‘superiors’, that is, the class that dominates the society due to their ideas (Foucault, 2014). Baptista et al. (2017) contextualise this idea in the hospital setting and the

relationship between patients and nurses in that there is a situation whereby the nurse dominates the patient in their discourse. Illich (1975) argues that individuals who hold specialized knowledge, for instance, health professionals, have stereotyped ideas that are devoid of the patients because they perceive patients as incapable of comprehending what goes on in their bodies, thereby degrading them to the status of objects who are submissive to professional care. By reaffirming that patients are objects, there is a risk of construction that is seen in the propagation of patients as passive, creating an authority-dependent behaviour.

Foucault argues that the power of medicine is in the 'clinical gaze'; that is, the body is an object of inquiry, and the individual is a 'case'. This subjugation is essential in the advancement of medicine. Since as an object, the body is key to the formation of positive knowledge (Smart, 1985). The nature of this knowledge is attributable to the 'gaze,' which ratifies a 'reading of the patient's body.' The consequence of 'reading the body' and the importance of understanding the disease is key to Foucault's argument (Sullivan, 1986). In the advancement of medical knowledge, the human body is fundamentally seen as a pathological object through which the individual explains the diagnosis. Therefore, power gives individuals or groups the potential to change attitudes and the behaviours of others (Huston, 2021).

The rational choice theory was also adopted to explain a section of nurses' behaviour. This was pioneered by the sociologist George Homans (1961). It is a micro-sociological theory that interprets individuals' actions. Scholars have propounded theories around the idea that actions are essentially rational because people normally do cost-benefit analysis before making final decisions (Scott, 2000). It is influenced by economic theories which concern how the production, distribution and consumption of goods and services are organised using

money. Rational choice theorists apply the same principle in understanding human interactions where resources like information, time and prestige are being exchanged.

The theory emphasizes that actors are purposive and intentional about their ends and goals. The actor is also seen to have preferences even though the theory is not interested in what kinds of preferences but rather in the goal of the actor to attain their preferences (Coleman, 1990). The theorist argues that individuals are motivated by their wants and goals, which are normally driven by their desires. Since it is almost impossible for individuals to achieve all their desires, they are compelled to choose between their wants or needs and the means for attaining them. This is because, in the course of pursuing these goals, the actor is constrained because resources are scarce. Resources are always limited in supply, so the individual has the option to forgo the next most attractive action, which is termed opportunity cost.

The second constraint is the institution which normally offers both positive and negative sanctions that could either encourage or discourage social actions (Ritzer & Yagatich, 2012). Hence, they have to anticipate the outcomes of alternative courses of action and calculate the best action for them. Eventually, rational individuals make choices that are likely to offer them maximum satisfaction. The theory's foundation is that all actions are essentially rational in nature. It distinguishes from other theories because it refutes facts of actions other than being rational and calculative. It emphasises that no matter how actions may appear irrational, they are rationally motivated (Crossman, 2014). The theory was criticized for being overly rational and ignoring the fact that individuals sometimes make irrational decisions. It is also criticised for exaggerating choice and agency while overlooking relevant institutional influences (Jones, 2011).

The final theory that was adopted for this work was emotional labour. Arlie Hochschild, an American Sociologist, coined the term ‘emotional labour’ in her seminal work in 1983. She defines this term as “the management of feeling to create a publicly observable facial and bodily display.” (Hochschild, 2003, p.7). It typically involves inducing or suppressing one’s feelings to maintain an outward appearance that others see as a sense of being cared for in a pleasantly safe place (Hochschild, 1983). An underpinning feature of emotional labour is the feeling rules. These technically provide standards in the management of feelings by deciding what is owned and accepted between individuals in ‘the currency of feeling’ (Hochschild, 1983, p. 18). Therefore, employees must manage their feelings and emotional displays in exchange for wages (Hochschild, 2003).

With these rules, individuals manage their emotions using the strategy of “deep” and “surface” acting. They help the individual to present a competent and cool exterior despite the circumstance in order to ensure they are appropriate for a profession or a person. With deep acting, the individual must self-induce their real emotions or attempt to experience and express a mandatory genuinely felt emotion. Regarding surface acting, the individual suppresses genuine felt emotions or simulates unfeared emotions so as to portray a professionally appropriate response (Hochschild, 2003).

These two feeling rules, which are moral stances shaping and influencing how people behave (Smith, 2011) can be emotionally draining (Debesay et al., 2014). Surface acting has been connected to emotional dissonance, where there is an incongruity between authentic felt emotions and the expected emotional expression (Karimi et al., 2014; Cheng et al., 2013). It can again result in negative impacts such as emotional exhaustion, burnout, physical and psychological ill health as well as stress (Schmidt & Diestel, 2014). The theory has been critiqued that Hochschild commodifies emotions. Additionally, the idea that workers have

to act in order to manage feelings suggests that they become ‘crippled actors’ subject to management control (Brook, 2009).

The following shows how these theoretical underpinnings were summed in a theoretical framework. The researcher made sense of the findings with these theoretical underpinnings. As Blumer (1969) posits, the meanings nurses make out of the profession of being a nurse, the meanings they make of their social interactions with patients, colleagues, and the meanings they assign to the institutional/systemic enablers and constraints influence how they provide service and consequently behave towards patients. This is also in tandem with the fact that nurses, like all other humans, are homo economicus or rational beings who seek to attain their goals and maximise satisfaction (homo etiosus) given the limited resources, considering Homans (1961) postulation. This rationality is reflected in their decision to be nurses, and the decisions and choices they make on the ward which influence both positive and negative behaviours. Their ability to put up these behaviours is also due to their professional knowledge, which automatically enshrines in them a higher level of power in relation to patients (Foucault, 2012).

Given the institutional and structural constraints/enablers (Giddens, 1984) at the hospital which inhibit/facilitate their work respectively, nurses as knowledgeable, rational and powerful agents can recreate additional structures which further enable and constrain their care delivery thereby informing behaviour. Despite their power, the emotions (Hochschild, 1983) that outline the profession as they interrelate with patients also contribute to the performance of the behaviour. In the end, behaviour is performed from both the individual’s precursors and the external factors pertaining to the job.

In the chapters, Blumer’s symbolic interactionism was applied almost throughout all the findings chapters to explain nurses’ meaning making and interactions with patients and

colleagues. In chapter five, the decision to be a nurse was supported by both symbolic interactionism and Homans rational choice theory whereas power contestation was also explained with Foucault's knowledge/power and symbolic interactionism in making sense. In chapter six, symbolic interactionism was again applied to explain nurses' interactions with both patients/relatives and colleagues while Giddens' structuration was useful in explaining institutional and systematic factors that influence behaviours. In the last findings chapter, both symbolic interactionism and Hochschild's emotional labour were applied to make sense of psychological hazards.

2.9 Conclusion

This review of empirical literature has shown the extent of studies that have been conducted on patients' side of the story and nurses' attitudes/behaviour. Unfortunately, the nursing profession is not perceived as the picture Ozanic (1961) described in the past as the public beholding images of white uniforms, nursing caps, needles and bedpans, and for others; kindness, compassion, and empathy but rather, otherwise. It suggests that most of the codes of conduct underlining the profession have been broken as some nurses were seen to be unsympathetic, unfriendly, discriminatory, and abusive. This is where there is a call to understand the prevailing reasons underlying this behaviour.

While the arguments reviewed above is suggestive of the reasons underlying some of the 'undesirable' behaviours, this study goes a step further to unveil and understand the actual stories behind them from the nurses' side to fill the gap in the literature, using the theories expounded.

The next chapter on research methods shows how the study was conducted.

CHAPTER THREE

RESEARCH METHOD

3.1 Introduction

Divided into five sections, this chapter spells out how the research was carried out. The first discusses the philosophical stance of this study while the second section elucidates the research design of the study adopted. The next, which is crucial, highlighted the methodology involved in collecting data: data sources, sampling, field entry and positionality among others. The chapter again describes the study area briefly and then launches into how rigour was attained for the research, followed by some ethical considerations, which are very prominent in all research. The chapter ends with how the data was analysed, including the data management and interpretation.

3.2 Research Philosophy

This study uses the constructivism philosophy. Understanding nurses' behaviour was done from the subjective meanings of nurses' own experiences, specifically, the construction of their realities. With this philosophy, research is carried out to comprehend notions from the participant's perspective. Since individuals develop subjective meanings of their experiences, this approach prioritises individual differences making them stand out with regard to their personality and identity (Lincoln, Lynham & Guba, 2011).

Regarding the ontological assumption, the researcher must answer the question; what is the nature of reality (Ritchie et al., 2013)? The nature of reality is that, generally, some nurses behave 'undesirably' towards patients; that is, their behaviour sometimes does not conform to the ethics of their profession. Therefore, ontologically the research was interested in what accounts for the difference in these behaviours (the deviation from their codes of conduct).

For epistemology, the nature of knowledge is viewed as subjective (Cohen, Manion & Morrison, 2007) and hence will be acquired from individual nurses' perspectives.

3.3. Qualitative Research

This study adopted the qualitative research approach. Since the qualitative approach provides an in-depth understanding of a phenomenon under consideration (Silverman, 2001; Nelson, Treichler & Grossberg, 1992), it was the best approach to employ. This study adopted the Ethnography method.

An ethnography is a qualitative method which evolved from anthropology and is now adopted by sociologists in their research. It focuses on studying social interactions, beliefs and behaviours of small societies using observation and participation over a period and interpreting the data collected (Berry, 2011; Denzin & Lincoln, 2011; Reeves, Kuper & Hodges, 2008). Ethnography learns from people rather than studying people, so the researcher must become a student in order to discover the hidden principles of another way of life (Malinowski, 1922). Ethnography can be used for studying both complex and small societies (Brewer, 2004). Therefore, the specific type used for this study was Focused Ethnography; with this, a social situation is best understood within the local context, in a defined setting of the people in question (O'Reilly, 2012; Roberts, 2009; Silverman, 2001).

In short, focussed ethnography does not study the whole culture of a community as in typical anthropology but a part of such as an institution, which in this study, is a hospital. Currently, focussed ethnography is adopted in many health-related fields, such as nursing, where the purpose is often to improve and understand practice by studying a situation within a distinct client or professional cultures and sub-cultures (Roper & Shapira, 2000).

One of the critiques of ethnography is its propensity to influence behaviour since it largely depends on observation as one of its primary data collection tools. As a result, participants

could alter their behaviour when they are observed. Nevertheless, ethnography proponents emphasise that prolonged fieldwork counteracts such observer effects (further explanation in the subsequent section on rigour) (Atkinson & Pugsley, 2005; Brink & Edgecombe, 2003). Hence, I engaged nurses for a long time, over a period of eleven months to counter this effect. The method has again been critiqued for producing studies described as case studies without the requisite continuity. However, it is noted that ethnographic studies have attained comparable standards in many disciplines (Creswell, 2014; Atkinson & Pugsley, 2005). These criticisms guided this study in ensuring that the guiding principles of methodology are followed to ensure credibility.

3.4 The Study Area

This research was conducted in Ghana, a West African country with a common boundary with Togo, Cote d'Ivoire and Burkina Faso. Accra, the capital of Ghana, was purposively selected for this study. Although noted as the gateway city to Western Africa (Grant, 2009), the population in Accra faces health challenges consistently, which does not let the city reach its full potential (Pehr, 2010). In Pehr's (2010), report on the healthcare and infrastructure in Accra, one of the interventions for the city was to improve access to quality healthcare, which has become a challenge and which this study identifies with. Among the challenges encapsulated by the Metro Health Service of the Accra Metropolitan Assembly (AMA), such as unsatisfactory emergency care, inadequate beds, infrastructure and equipment, and a low number of experienced health professionals that inhibit the readiness of patients to access healthcare in the city quickly, the effect of the behaviour of nurses towards patients cannot be overemphasised. Hence, the report highlighted the need to improve quality care by increasing the training of healthcare workers, particularly nurses, among others. Again, according to Bofo (2016), the Greater Accra Region recorded the highest incidence of poor relationships between nurses and patients. Again, the hospital in question had been in the

news that same year for poor conducts of some nurses. Hence, Accra was selected for this study to understand nurses' situations that inform such behaviours.

The researcher believes the set and settings can shape nurses' behaviours; hence, selecting the particular hospital was crucial. Since the research deals with behaviours and attitudes, the hospital's name was anonymised, and the name XYZ District Hospital was given. Details about this are in the subsequent section on ethical considerations. Chapter four describes further details of the study area.

3.5 Data Collection Methods

In line with the study's philosophy and research design discussed, these methods of data collection were advanced:

3.5.1 Sources of Data

The study primarily used a primary source of data. With the collection of primary data, Fetterman (2019), and Reeves, Kuper and Hodges (2008) argue that ethnography's strength lies in using more than one method. The data collection process adopted techniques such as in-depth interviews, focus group discussion (FGD), observation, key informant interviews (KYI), and informal dialogues. These techniques have also been used in studying attitudes and behaviour qualitatively (Bryman, 2016; Corbin & Strauss, 2014) In-depth interviews were conducted with the participants using a semi-structured interview guide, a recorder, and a diary. The FGD was useful for interactions among colleagues, bringing different dynamics and contestations that were not obvious in the in-depth interviews.

The sources of literature used included books, journal articles, government reports and online newspapers facilitated by search engines such as Google, Google Scholar, Jstor, Pubmed and Medline, and others, to determine the position of other researchers and reporters on the topic. Search terms such as these were entered: nurses and patients, nurses' attitudes,

nurses' behaviour, nurses' attitudes towards patients, male nurses and patients, nurses and relatives of patients, challenges in nursing, shortage of nurses, nurses and stress, etc.

3.5.2 Target Population and Sampling

The population for this study were nurses in Ghana. The target population were nurses in a public hospital. This is because research has shown that undesirable behaviours are exhibited more in public hospitals than in private hospitals (Kodom, Kodom & Senah, 2018; Akowuah, Agyei-Baffour & Asibey, 2018; Haskins et al., 2014). The commonly used sampling technique for focussed ethnography is purposive sampling (Higginbottom, Pillay & Boadu, 2013). Thus, a public hospital in Accra was selected, as explained in the previous sections.

Since the behaviour of all categories of nurses cannot be studied at the hospital, the study was limited to general nurses in both male and female wards. This is because the Ghana Health Service (2018) records that more patients report and are admitted to the hospital with general medical health conditions such as malaria, typhoid, hypertension, anaemia, diabetes, etc., which do not necessarily need the service of specialised nurses. Therefore, participants were all registered general nurses with the Ghana Health Service who had worked in their current unit for at least a year. A few nurses at the OPD were also interviewed for descriptive purposes (see chapter four). The researcher believes that the working experience of nurses can play a vital role in giving a nuanced story. Hence, to avoid a one-dimensional side of the story, the researcher interviewed both senior (including nursing officers, senior nursing officers and principal nursing officers) and junior nurses (including enrolled nurses and staff nurses). Like all other qualitative studies, the sample size in an ethnography is not huge since qualitative research is not intended to represent the wider population of interest; instead, it provides an in-depth understanding of the phenomenon under investigation. In addition,

huge samples in qualitative research do not guarantee the depth of exploration, so the sample size was determined based on the principle of saturation, where no new data emerges (Polit & Beck, 2008). At the end of the data collection, which lasted eleven months from September 2020 to July 2021, the total number of participants included in the study was 32. This comprised 26 in-depth interviews, 1 FGD (in a group of 5 participants) and 1 KYI (the matron). Other focussed ethnographies that also used few participants (less than thirty) include Green, Meaux, Huett and Ainley (2009) as well as Wilkinson and Callister (2010). The focus group discussion participants were all of the same rank. Efforts to interview a GHS representative proved futile. Below is a table of the participants' social demographics.



Table 1: Social Demographic Characteristics of Participants

No.	Pseudonym	Sex	Age	Marital Status	Rank	Years Served
1	Samuela	F	33	Single	Senior Nursing Officer	11years
2	Augustina	F	30	Single	Staff Nurse	2years
3	Evelyn	F	32	Divorced	Senior Nursing Officer	10years
4	Diana	F	27	Single	Nursing Officer	4years
5	Georgina	F	29	Married	Senior Enrolled Nurse	5years
6	Eric	M	35	Married	Senior Staff Nurse	6years
7	Davida	F	31	Married	Senior Staff Nurse	7years
8	Kate	F	30	Married	Enrolled Nurse	4years
9	Stella	F	29	Married	Staff Nurse	3years
10	Francis	M	32	Married	Senior Enrolled Nurse	6years
11	Mabel	F	27	Single	Enrolled Nurse	2years
12	Monica	F	40	Married	Senior Staff Nurse	16years
13	Princess	F	27	Single	Staff Nurse	1year
14	Sandra	F	35	Married	Senior Nursing Officer	13years
15	Asamoah	M	25	Single	Staff Nurse	1year
16	Betty	F	39	Married	Senior Nursing Officer	15years
17	Awurama	F	33	Married	Staff Nurse	11years
18	Edna	F	31	Married	Staff Nurse	4years
19	Frimpomaa	F	32	Married	Senior Staff Nurse	5years
20	Joanna	F	35	Married	Nursing Officer	10years
21	Bernice	F	33	Married	Senior Staff Nurse	5years
22	Moro	M	27	Single	Staff Nurse	1years
23	Offeibea	F	36	Married	Senior Nursing Officer	11years
24	Rita	F	45	Married	Principal Nursing Officer	21years
25	Vincent	M	28	Married	Enrolled Nurse	2years
26	Edem	F	33	Separated	Senior Staff Nurse	6years
27	Martha (FGD)	F	32	Married	Senior Enrolled Nurse	8years
28	Barbara (FGD)	F	34	Single	Senior Enrolled Nurse	5years
29	Jennifer (FGD)	F	29	Married	Senior Enrolled Nurse	8years
30	Jessica (FGD)	F	30	Married	Senior Enrolled Nurse	6years
31	Franklina (FGD)	F	33	Married	Senior Enrolled Nurse	7years
32	Matron Lucy (KYI)	F	52	Married	Deputy Director of Nursing Services	29years

Source: Fieldwork 2021

From the table above, there were five males and twenty-seven females, indicating that both sexes were represented albeit unequally in the study and affirm that the nursing profession is indeed a female-dominated one (Mott & Lee, 2018). Participants' ages (except for the matron) ranged from twenty-seven years to forty-five years, and so the average age was thirty-four years. For religion, all the participants were Christians. This was unintended because both male and female wards sampled for the study did not have nurses of other

religions. Nevertheless, it is not surprising because out of the 30.7 million Ghanaians, Christians constitute 71.3%; Moslems 19.9%; Traditionalists 3.2% and other forms of religious sect 4.5%, while those who belong to no religion constitute 1.1% (Ghana Statistical Service, 2021). For marital status, twenty-three of the participants were married, eight were single, one was divorced, and one was separated. The number of children for participants ranged from one to three, and so the average number of children per participant was two. For participants' initial qualifications before the start of their service, eighteen started with a certificate in nursing, twelve started with diplomas, and only one started with a degree. At the time of the data collection, there were three enrolled nurses, seven senior enrolled nurses, seven staff nurses, six senior staff nurses, two nursing officers, five senior nursing officers, one principal nursing officer and one deputy director of nursing services. What these ranks mean is explained in chapter four. Since participants were not also of the same rank, it contributed to the discourse on power. Participants (except the matron) had served from one to twenty-one years, with the highest frequency being five years. The subsequent section reports getting access to the hospital.

3.5.3 Entry/Initial Contact

Since this is an intrusive study, I only started the participant observation after I obtained approval from the hospital administration. Then after, the matron welcomed me in her office on the scheduled day for our meeting. I reported very early that day and was directed to her office. Putting on my observation lenses, I took proper notice of our encounter. Her office was a sizeable room with a large desk and chair in a corner. There were many files neatly packed at the side of the desk. As I observed the office, she motioned that I take a seat across her. She was a woman of average height, dark-complexioned, and had a plumb body. Even though I could not see her facial expressions due to the nose mask and her reading glasses, her tone of voice however suggested that she was stern. She wore a white uniform with a

white apron, a white pair of socks and shoes. She looked impeccable from head to toe. After the exchange of pleasantries and introduction, she looked at my interview guide, nodding from time to time. She asked me a few questions and seemed satisfied with my responses.

She introduced me to the in-charge, the three nurses on duty at the male ward and admonished that they helped me get acquainted with the ward. The in-charge, Sister Betty (a pseudonym), enquired about my research and further introduced me to her colleagues. Not to be out of place, I had to observe the rules of behaviour. Cindy, who was heavily pregnant, and whom I happened to have worked with for only a week because she left for maternity leave, walked me through some codes of conduct. Just like all the nurses, I had to subsequently come to work in scrubs, crocs, stud earrings, a hair net and no wristwatches or accessories. I was advised to wear only my wedding band as engagement rings with stones could sometimes trap infections. She oriented me on the time to report for work, proper handwashing, and a technique for wearing and removing a hair net and scrubs after the day's work.

3.5.4 Participant Observation and Positionality

I started as a non-participant observer at the OPD. After a month, I had permission to be a participant observer. I started the participant observation in the male ward, then in the female ward, and then went back to the OPD. Being a participant observer gave me a direct experience of many activities in the ward. It gave me a feeling of 'being a nurse' as I was able to join staff to observe procedures, participate in workshops and durbars, have non-bureaucratic access to healthcare and use the facility just like other staff. Even though I had these privileges, I was more of an observer than a participant. This is what Adler and Adler (1994) refer to as peripheral membership, or what Spradley (2016b) calls moderate participation, or Pearsall (1970) calls an observer-as-participant. According to Spradley (2016b), this method is used when the researcher wants to be an insider and still an outsider.

To achieve this, the researcher socialises with the insiders and engages in similar actions, but, as Adler and Adler (1987) indicate, they do not engage in those activities “that stand at the core of group membership and identification” (p. 36).

While being an insider (access to the wards) was a great experience for me as I had a lot of insights into what goes on in a ward, especially with observing procedures, there were challenges too. Since I was dressed in scrubs, patients would call me for assistance or the other, and I would have to call another nurse to assist them. The doctors would ask me to explain a condition, and I would have to tell them: “I am not a nurse but a researcher”. More often, I was also lost on the ward. On the first week of being on the ward, there was an occasion when a doctor was performing a procedure, and as usual, we (including student nurses and house officers) had gathered to observe. I was told to bring an intravenous infusion set (giving set), so I quickly hurried to the nurses’ station, opened the emergency tray, and realised I did not know what a giving set was. I rushed back to the team, only for everyone to be staring at me, probably wondering why I did not come back with one. I asked for the assistance of one of the student nurses only to realise this was something I knew but did not know its name. On a similar occasion, I was told to get the spirit. I knew what a spirit looked like this time, but I did not know where it was kept. I kept opening all the cupboards and moving around in circles, only for the in-charge to come in and pick it up right behind me! I was embarrassed. This confirmed my position as an outsider, yet I was also an insider.

Since I had to observe more than participate, I needed a plan in order to become explicitly aware of the social situation and not take anything for granted. Hence, by adopting Spradley's (2016a) three phases of observation, including descriptive observation, focussed observation, and selective observation, I could encapsulate the holistic view of the social situation in a well-structured form (see Appendix 5). The first phase was the descriptive observation, where I had to take notice of every conceivable aspect of the situation. There

was no sorting out the important from the trivial. What was observed included the information on notice boards/walls, the equipment/tools available, the daily number of nurses on duty in a shift, the daily number of patients on admission, both ambulant and dependent, and the time nurses reported and departed from work.

The second phase was the focussed observation, where pre-eminence was given to the activities of individuals and groups, simply all actors on the ward/OPD. The observations made here included the daily routines on the ward and OPD, the type of nursing care (who performs what? What activities are performed together and alone?), nurses' habits (what are they fond of doing?), enthusiasm towards work, and nurses' interactions with colleagues and others.

The final phase was selective observation, where I concentrated on the elements of social action that are most salient for my research objectives, as the proponents espoused. This encapsulated the behaviour of nurses. I specifically observed their verbal and nonverbal interactions with patients and relatives, whether they gave quick responses to patients' needs and calls, were selective or stereotypical, etc.

These three phases do not necessarily mean they were done in stages but as everyday activities. For instance, daily observations and records were made of the number of nurses on duty, the procedures performed, and how nurses and patients interacted coherently.

3.5.5 Record Keeping

Keeping good records of my observations was vital in this research. I had a diary in which all daily observations, both objective and subjective, were made; hence, it was used for field notes and as a journal, even though these two records were on different sides of the book. As explained, the objective observation included the descriptive, focussed and selective observations, while the subjective observation captured my experiences, ideas, and

reflexivity since ethnography also captures the ethnographer's lived-experiences (Berry, 2011). Hence, I used both emic (participants) and etic (personal) perspectives. All the records were made in basic English. Medical processes and items I could not relate to were described in plain language and later substituted with the right terms when I discovered them. The recordings were dated and labelled appropriately, using the date and time of the shift for reference.

Not to forget anything, I made condensed notes on the ward when we were less busy and expatiated later when I got home. For instance, after joining the team to observe a procedure, check vitals, or admit/discharge a patient, I immediately recorded them in 'shorthand'. Unless, of course, Georgina was on duty. Georgina was sensitive whenever I picked my diary. She would ask: "Perp, what are you writing?" Then I would say: "Oh, it's just how many patients are here today". She wanted to know everything I was writing, and I realised the discomfort I was putting her through, so I stopped writing, especially whenever she was on duty. I had to take mental pictures of all activities with a "wide-angle lens", as Spradley (2016a; p. 58) describes it and records it at lunch or immediately after I get home. All the records, which were also my field notes, formed the data for my observation analysis.

3.5.6 Scheduling an Interview

Since being on the ward for some time offered me an insider's opportunity, I perceived scheduling an interview to be relatively easy compared to being a stranger, but I was wrong. It was a challenging moment especially being a reserved person. The initial plan was to schedule an appointment on their off days outside the hospital so I would not interfere with their jobs. The outcome of such a request was that most nurses cherished their off days so much that they were unwilling to share part of it. In fact, they jealously protected it so much! Most of them used the Covid-19 pandemic as an excuse even though I explained that I would not enter their homes and that they could choose any venue convenient to them, but they

were reluctant. The second plan was to interview them in the hospital after their shift just before leaving for the house. This also did not sound good for each of the nurses I approached. They were either too stressed after work or had to hurry home to take over babysitting or see to other commitments. For a whole month, only two nurses had agreed to the interview. Out of pity for me, the in-charge proposed that she would allow her staff to be interviewed when the ward was less busy or had much staff (more often when student nurses had come for clinical). This was my breakthrough! With a second approval from the matron, since I did not want to put any nurse in trouble, I was able to interview nurses' face-to-face, week after week, about an hour to the end of their shifts. On such days, I made sure there were enough nurses (at least three staff) on the ward before moving out one to be interviewed.

Interviews were mainly held under a tree away from the wards, wearing nose masks and keeping a distance between us, as on-site interviews are consistent with ethnographic assumptions (Spradley, 2016b; Atkinson, 2007) Upon arrival at the interview venue, I offered further explanations regarding the study and sought permission to have the interview recorded. The interview commenced with obtaining the socio-demographic data of participants. As the discussion proceeded, I used probes to explain their narratives in-depth, taking particular notice of their facial expressions and body language. They were finally allowed to ask questions after the interview, which very few did. On average, an interview lasted between forty-five minutes and a little over an hour.

One interesting thing that came as a surprise was the expressions after most of the interviews. They visibly expressed delight as to having relieved pent-up emotions. Some showed appreciation for being able to share their experiences about their "purported improper behaviours", as one put it. Another exclaimed: "Wow, no one has ever cared to know about my nursing experience all these years, and it feels good to let some of these hardships and

pain off my chest. Thank you”. Another sighed: “For once, I have felt relevant that I matter too. I am contributing to someone’s research that can impact”. While some expressed their excitement, others petitioned that they were expecting a change in some of their service conditions after this research, even though I constantly reminded them it was solely for academic purposes. The next segment reports how I maintained rigour in this study.

3.6 Trustworthiness/Rigour

Despite the capacity of the qualitative approach to bring out critical social facts, the processes of finding knowledge in qualitative research and the knowledge produced at the end have been questioned. It has, over the years, been judged as a soft science, fictional, methodologically less rigorous and subjective (Denzin & Lincoln, 2005; Goodwin & Horowitz, 2002), lacking replicability and generalisability (Mays & Pope, 1995) and as such, it is often not regarded as a scientific method of inquiry. While in quantitative studies, validity and reliability are ensured through broadly accepted standards which have principles and processes distinctively applied using statistical analysis, in qualitative studies, the trustworthiness or rigour guarantees this (De Vos et al., 2011; Polit & Beck, 2004; Aktinson & Hammersley, 1998). The main principles of ensuring rigour in qualitative studies are dependability (repeatable or obtain similar results), credibility (whether results can be believed), confirmability (results confirmed or corroborated by others) and transferability (compare results to similar context) (Talbot, 1995; Lincoln & Guba, 1985) were relevant to this study. Bennett, Glatter and Levacic (1994) recommended that you “research as if someone were always looking over your shoulder” (p.146). Hence, the next section discusses the methods that ensure trustworthiness and rigour.

3.6.1 Prolonged Engagement

One of the rudiments in ethnography is the researcher going native on the field by spending adequate time with participants to ensure that the culture under study is well understood. It

is realised that when researchers are new to the participants' culture, they will need a longer time to understand the new culture. Again, since individuals are more likely to change their behaviours when they realise they are being observed, known as the 'Hawthorne Effect' (Jones, 1992), the data gathered could be biased. Therefore, the prolonged stay of the researcher is crucial since individuals cannot pretend forever; hence it helps ensure the credibility of the data.

Again, pioneers (Spradley, 2016b; Creswell, 2009; Holloway & Todres, 2006) have reported that the initial participants recruited tend to give the researcher biased information, which might not necessarily reflect their perspectives. Due to this, the data gathered might not represent the actual emic perspectives. Hence, prolonged engagement becomes essential. By so doing, I built rapport with participants by spending enough time on the ward. I reported three or four times weekly at the hospital and stayed throughout a shift, just like the nurses. Morning shifts (6 hours) starting from 8 am to 2 pm, afternoon shifts (6 hours) starting from 2 pm to 8 pm, and night shifts (12 hours) starting from 8 pm to 8 am. Therefore, a six or twelve-hour shift a day/night gave me ample time to observe, familiarise myself with the participants and ask questions to enrich the data. The threat, however, in the researcher going native and becoming too involved for a long time is the researcher gradually beginning to think of themselves as one of the subjects under study, a phenomenon which I was conscious of (Sangasubana, 2011; Crowley-Henry, 2009).

3.6.2 Triangulation

To ensure credibility and dependability, I employed triangulation, a data collection method which uses several techniques or methods to enable the researcher to answer the research questions and ensure a comprehensive understanding (Patton, 2002). I used in-depth interviews, focus group discussions, participant observation, key informant interviews, and informal dialogues. This ensures a more comprehensive perspective than using a single data

collection method (Saks & Allsop, 2007; LeCompte & Schensul, 1999). In one instance, we were conversing one afternoon at the nurses' station when the ward was not busy. A senior staff nurse, Eric, angrily described how some doctors make nurses' jobs difficult. Earlier that afternoon, they had called on one of the resident doctors for an emergency, but the doctor did not show up till after a long wait. The nurses had to use their knowledge to save the situation, which he lamented could also have landed them in trouble had the method not worked. During my interview with him a week after this conversation, I asked about how other staff contributed to influencing nurses' improper behaviours, but he replied: "Oh, there is nothing like that". I then reminded him of the previous week's incident, which he confirmed and attested to as such instances indeed contributed to such behaviours. This implies that using more than one method, in this case, informal dialogue, participant observation, and interviews, enabled credibility, which I would not have attained had it been the interview alone.

3.6.3 Peer Debriefing

Peer debriefing was another strategy for obtaining data credibly. Four colleagues assisted in proofreading each of the chapters and gave constructive criticisms to enhance the output before submitting it to my supervisors. It ensures an external check of the research, and it is made possible by an individual whom Lincoln and Guba (1985, p. 308) refer to as a "devil's advocate" who keeps the research credible.

3.6.4 Member-Checking

This is where the researcher returns to the participants and enquires whether the report on the findings represents their experiences in understanding behaviour (Lincoln & Guba, 1985). It is useful for ensuring credibility, confirmability and dependability. According to Creswell and Poth (2016), asking a participant to react to earlier findings and interpretation can be done informally (ongoing as data is collected) or formally (after data is collected and

analysed). The member checking procedure sees to it that the emic perspective is highlighted and represented 'truthfully'. In so doing, discussions were made on feedback with some participants to ensure validity, especially in writing the correct medical terms and facts. This also ensured the study's confirmability and credibility (Hammersley, 2018; O'Reilly, 2012; Kirk, Miller & Miller, 1986).

3.6.5 Audit Trail

Regarding my (and all other students') research, the sociology department faculty members served as auditors. I went through three seminar presentations, including proposals, progress reports, and findings presentations, during which my work was vigorously scrutinised. This was relevant not only for the separation of my values and expectations from the data and analysis to the utmost extent possible (Maxwell, 2005), but also to ensure that the entire report is founded on the principles of conducting research in the social sciences for the purposes of dependability and transferability. This audit trail ensures that other researchers clarify the research process and the methodology employed in congruence with the findings arrived at (Spradley, 2016b; Creswell, 2009; Atkinson, 2007; Guba & Lincoln, 1989). My supervisors, who also have great expertise in qualitative research and were involved from the start of the study to the end, helped ensure that the study was credible.

3.6.6 Reflexivity

I constantly immersed myself in the data, reading transcripts and field notes and listening to the recordings repeatedly. This and the observation brought forth many questions and other insights I had not considered earlier, overlooked or ignored, thereby enhancing the work. This was done in not just one phase of the work but throughout the data collection, analysis and interpretation stages. This is done to comprehend and self-disclose values, assumptions, biases and beliefs concerning the topic of interest. To ensure confirmability,

the researcher becomes conscious of the biases, values, and experiences brought to a qualitative research study (Creswell & Poth, 2016).

3.6.7 Participant Language

In qualitative or ethnographic research, participant language applies to using verbatim quotations of the participant's words in reporting the findings. Using participants' specific cultural terms or words gives the reader insight into the participant's lifeworld. These contextual descriptions and the researcher's interpretation of the verbatim quotes are useful in the transferability of ethnographic studies, whereby the reader can compare findings to similar contexts. Therefore, I did my best to clarify participants' languages with unfamiliar terminologies and translate native languages used as verbatim quotations in the data to understand participants' comments easily (Patton, 2002; LeCompte & Schensul, 1999; Aktinson & Hammersley, 1998).

3.6.8 Pilot Observation and Interviews

Doing ethnography and observation for the first time requires some skill. While waiting for the hospital's approval to begin the research, I did a non-participant observation at the OPD for a month. Thrice a week, I spent an hour daily with clients on a bench, taking notes of the activities and observing nurse-client interactions at different sides of the OPD. After reviewing the relevant literature and extensively reading the rudiments of observation, I did the pilot observation. This helped me equip my skills in writing field notes and jotting down observations, thereby aiding in reporting credible findings in this study. Before the main interviews, I also conducted three pilot interviews with friends who were nurses in other public hospitals to help modify my interview guide accordingly (Spradley, 2016b; LeCompte & Schensul, 1999).

3.7 Ethical Considerations

Ethics are a matter of great concern in ethnographic studies. Researchers infiltrate not only the communities or workplaces of their participants but also their personal lives. This is why researchers must follow codes of ethical conduct in their effort to explore a subject of interest. Before the fieldwork, I requested ethical clearance from the Ethics Committee for Humanities (ETC), University of Ghana (see Appendix 1). Upon approval, I further sought permission from the Medical Superintendent of the hospital administration (not in the appendix due to anonymity). Again, I had the approval of the hospital matron, that is, the deputy director of nursing services (DDNS), before commencing the data collection.

Before the interviews, I informed participants about the research's purpose, emphasising that it was solely for academic purposes. While a few signed the written consent form, others thought it was too much of a formality and gave verbal consent. They were made aware that partaking in the research was voluntary, and their agreement to participate was subject to change if they desired at any point during the interview. Hence, they were not coerced in any way to participate in this research.

The process of seeking consent from participants was ongoing because nurses work in a shift system. I sought consent from the nurses at least a week before the day of the interview. While some declined the interview, others requested that I give them an idea of the questions to prepare themselves before the interviews. I, however, assured such participants that they were not 'technical' nursing questions, so there were no correct or incorrect answers. However, their experiences, views and ideas were vital contributions to the study. Informed consent was also sought before recording all interviews.

To ensure the anonymity of participants, each person was assigned a pseudonym, and the specific details that could reveal their identity were excluded. However, assigning a

pseudonym still did not ensure anonymity in some instances. A typical example was the matron. Most district hospitals have only one matron, so changing her name was not sufficient to ensure her anonymity. Again, a pseudonym was not adequate for the in-charges or the nurse managers of the wards because one person occupied that status. Therefore, the entire hospital had to be made anonymous, just as has been done in other hospital ethnographic studies (Dapaah, 2016; Van der Geest & Sarkodie, 1998).

Some of the participants who were hesitant to be recorded were also assured of confidentiality. They were afraid that such a recording could be used against them, but I explained that it was only to capture our conversation verbatim as I might be unable to write extensive notes on our interaction. I recorded all biodata separately in my field book before the interviews commenced so as not to capture them on the tape recorder. Even after recording the interviews on the tape, I assured them I could delete any portion if they were uncomfortable with anything they said earlier. On a password-protected computer, information shared by participants was kept confidential and stored, and this information will be destroyed after the thesis has been examined.

All references and information sources were acknowledged in the work to prevent plagiarism.

3.7.1 Benefits and Risks

The participants stood no risks in participating in this study. Since this research was conducted during the COVID-19 pandemic, I strictly adhered to the protocols to reduce the risk of infection for both the participants and myself. Like the nurses, I constantly washed my hands or used an alcohol-based hand sanitiser from time to time. Though social distancing was almost impossible because of the smaller sizes of the wards as well as the nurses' station (unlike the OPD), everyone on the ward needed to wear a nose mask,

including patients who had no difficulty in breathing. Relatives who came in without nose masks were sent out immediately.

As a researcher, I have a responsibility to protect not only my participants but also myself and my family. Since the Ghana Health Service had already issued the use of scrubs, personal protective equipment (PPE) to prevent transmitting infections, I wore a mufti from the house and changed into my scrubs, crocks and hairnet, which I carried in a separate bag to and fro just like the nurses. At the end of the shift, I changed back into my mufti. As the in-charge advised, I bathed immediately after getting home before settling in with the family. In the second wave of the pandemic in January, leading to a significant increase in deaths, I had to withdraw from the field for two months until the situation had improved.

I made participants aware that there were no benefits to the study aside from the fact that they were contributing to academic work. Some misinterpreted it as an advocacy for nurses, while others thought it was an advocacy for patients, but I corrected such impressions. Participants were compensated with GH¢20 (approximately US\$3¹) worth of recharge credit cards for the loss of their time while in-charges, and their assistants were compensated with GH¢30 (approximately US\$4) worth of recharge credit. At the end of the data collection, each unit (male and female wards and OPD) was given a pack of paper tissues in appreciation of hosting me. The choice was because nurses had to buy their tissues when they ran out of supplies. The final section espouses how the data collected was managed and analysed.

¹ At an exchange rate of US\$1 to GH¢7.5 as at the period of data collection

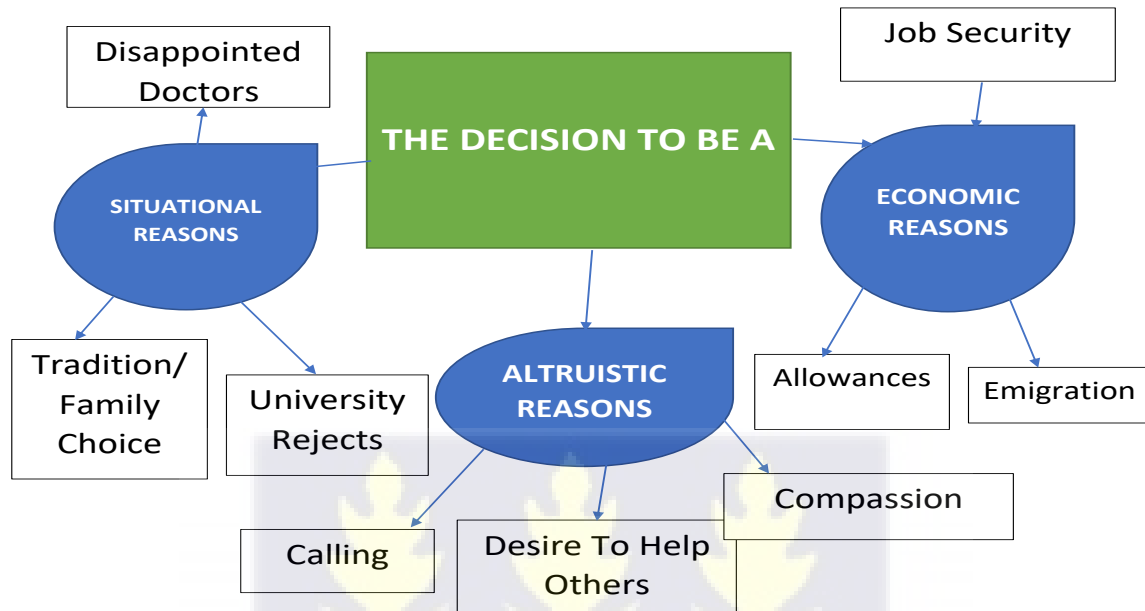
3.8 Data Analysis

The data was analysed and interpreted using thematic analysis. It involves organising and segmenting information gathered from the field into patterned categories and themes, which will be used in writing a coherent and meaningful report of the phenomenon under study (Yin, 2015). The recorded interviews were transcribed and translated into English before data analysis. Even though all my participants were literate and could express themselves in English, some arguments were best expressed in Twi (the local language). I did iteration transcription and transcribed everything that was captured on the audio verbatim; as such, the interview transcripts were “open” (Jenks, 2018, p. 123) and detailed in nature, as I treated each aspect of the conversation with the participant as necessary in tackling the study’s objectives. I listened to each audio file after transcribing it and compared it to the transcript I had generated to ensure that the textual content reflected the participants’ voices and views as captured on the voice recorder. This process ensured that all errors and omissions were checked and the transcripts cleaned for analysis. Transcripts were read several times to ensure they were well understood. I then moved on to code and interpret these transcripts.

Coding is an “interpretive art” (Saldaña, 2013, p. 4), a bridge that connects data gathering and interpretation (Charmaz, 2001) and not data analysis itself. The coding process for this study was twofold – the first stage and second stage coding. This was done iteratively. The first stage was to put the data into themes. I segmented them into global, organising, and basic themes (Attride-Stirling, 2001). The global themes were typically the three objectives. The organising themes were the major themes under each global theme, captured from the interview guide. The basic theme was the sub-themes under the organising themes derived from the findings. After each interview, I had new codes under each of these basic themes, which I continued to update. I jotted down some interesting words and phrases participants used to create the codes. This process continued while conducting interviews, transcribing

and even writing since analysis coincides in a qualitative study (Polit & Beck, 2008). This is illustrated in figure 1 below.

Figure 1: Thematic Network Analysis of the Decision to be a Nurse



Source: Fieldwork, 2020 – 2021 (Author's Construct)

I also wrote analytical memos, reflecting on the actors and discussions I had with participants and assessing the potential of the codes created in answering the research objectives during the first stage. This helped me go back and forth with participants I had already interviewed to probe further on issues that emerged as I transcribed my conversations with them. This iterative process played a vital role in structuring the findings chapters for the study.

The second stage was adding the quotations for these codes, for which I employed NVivo 12 Plus, a computer software programme used for qualitative data management. It helps generate and explain codes and themes, which is the foundation of qualitative data analysis (Sinkovics & Alfoldi, 2012). It provided me with a much simpler coding technique than manual thematic sorting would have done, giving me a detailed understanding of the analysis

process. It again presented the opportunity to actively go through all the processes involved in qualitative data analysis, organising, coding the data, and establishing patterns. I loaded all the transcripts onto the software, and with my already created themes, I created parent and child nodes and linked the quotations to them.

All the interviews, including participants, key informants and FGDs, were analysed using this same process. With the observation analysis, the data recorded in the fieldnotes (book) were typed on the computer. They were sectioned into themes with headings; descriptive observation, focussed observation and selective observation. Descriptive observation, for instance, had sections like nurses reporting time, inscriptions on the ward, number of ambulant and dependable patients, admissions and discharge, trading in the wards, etc. If I wanted to tell a story about admissions and discharge, for instance, I simply went to the theme that had all that observation and selected which observation supported the narration best. I did the same for the focussed and selective observations.

In writing the findings, the themes were analytically discussed in congruence with the quotations from the interviews and vignettes from the observation as Spradley (2016a) advises vis-à-vis the theory and related current literature.

3.9 Conclusion

The epistemological framework of ethnography comprises the meaning and the behaviour in any given situation and the linkages between them. It encompasses the awareness of behaviour change that occurs when trying to understand others, the diverse perspectives that exist in situations, the relevance of understanding behaviour and the necessity to understudy a cultural group just as it is (Mackenzie, 1994). By doing so, the chapter has laid out the philosophical assumptions underpinning the study and provided in detail the steps taken to

negotiate access to the hospital, sampling, and the methods used to obtain data from participants. It has also shed light on how data was managed and analysed.

The next chapter discusses the study area and the hospital as a social system.



CHAPTER FOUR

“A DAY IN THE LIFE OF A HOSPITAL”: THE HOSPITAL AS A SOCIAL SYSTEM

“The goal of ethnography is to grasp the native’s point of view, his relation to life, to realise *his* vision of *his* world” (Malinowski, 1922, p. 25).

4.1 Introduction

From his seminal ethnographic work among the Argonauts of the Western Pacific, the father of ethnography, Malinowski (1922), bequeathed to his disciples a ‘charter’ that should guide ethnographic studies. This charter was for ethnographers to immerse themselves in the study of society’s habitus to nuance its subjects’ behaviour and worldview. Hence, I sought to explore the everyday lives of nurses in the hospital and the overall functioning of the healthcare system. This chapter brings to light my ethnographic experience, while the remaining chapters focus on explaining nurses' behaviour.

In the study of health, health institutions are regarded as social institutions that shape the behaviour and cosmology of their participants – doctors, nurses, paramedical staff and patients in that social system. These cultural and structural elements define the identity and way of life of XYZ district hospital. This way of life includes the language, dress code, ethics or codes of conduct, values, artefacts, and knowledge, which directly reflects Tylor’s (1871, p. 24) position of culture as “that complex whole which includes knowledge, beliefs, arts, morals, laws, customs and any other capabilities or habits acquired by man as a member of the society”. The chapter describes the social system embodied in the culture and social situation, which is imperative for every ethnography encapsulating the way of life in nursing.

4.2 The Ghana Health Service

The Ghana Health Service (GHS) was established under Act 525 of 1996 as a provision of the 1992 Constitution of the Republic of Ghana as part of the country's public services. It is an autonomous executive agency in charge of implementing the national policies under the Ministry of Health. It is mandated to offer and carefully manage health services, particularly primary healthcare, at regional, district and sub-district levels concerning the acceptable national policies. Since every culture has its values, the core values of the GHS are integrity, professionalism, people-centredness, discipline, excellence, and teamwork (Ghana Health Service, 2022).

4.2.1 The NMC and the Ethics of the Nursing Profession

One of the sub-cultures of the GHS is the role played by the body of nursing in ensuring its core mandate. The Nursing and Midwifery Council (NMC) is the statutory body responsible for nursing and midwifery, whose mission is to provide the highest standard of training and practice of nursing and midwifery in the interest of the public. It has the vision to optimise the use of ICT solutions for improved nursing and midwifery regulation (Nursing and Midwifery Council, 2022). Nurse-patient/Clientele relations are a matter of great concern in nursing. Just like every culture has its norms or other professions have their ethical conduct, the nursing culture is no exception. The NMC's standards of professional conduct and efficiency published some revised codes of conduct in 2017 (Arko, 2017, p. 1-6). These codes of conduct provide information for nurses/midwives and the public on the standard of professional conduct needed (from nurses/midwives) and to be expected (by the public) in the exercise of duties. They were pasted around several places in the entire hospital. Some of these codes of conduct are but not limited to;

- You are responsible for providing safe and competent care for patients, relatives, and clients.
- Patients, their families, and clients have a role to play in the recovery process or a peaceful death, so respect and acknowledge this partnership and contributions.
- Patients, their families and clients have interests and dignities, so protect and promote them despite their economic status, gender, race, age, political affiliation, sexuality, religion, or culture.
- There should not be any abuse between the privileged relationship of patients, families, or clients and their privileged access to their property, workplace, or residence.
- Continue to provide care in the best way you can until the provision of an alternative arrangement.
- Do not disclose any confidential information the patient, family, or relative shared with you in providing care without their consent. Except for instances where such information is by law, a court jurisdiction's order or is essential for the public interest.
- Let patients, relatives, or clients understand that some of their information may be accessible to other health team staff participating in their healthcare delivery.
- Be sure to seek patients' wishes to disclose their health information to their families or others. If a patient cannot give such consent, let your supervisor be aware of making a decision.
- Know that the patient or client has every right to information about their health condition, which should be truthful, precise, and understandable.
- If a patient or client's purpose is not to receive any treatment or care, respect it. It is their right.
- You should be aware that the patient or client's consent can be given orally, in writing, or by cooperation; this should be adequately documented.

- Together with other team members, always ensure the promotion and delivery of healthcare in a safe, conducive, and therapeutic environment.
- Should you realise that you or a colleague is not fit to deliver care, whether for ill health, competence, or conduct, quickly act to protect the patient or client from any impended risks.
- Let your behaviour always indicate one who lifts the profession's image.
- Neither should you accept any gifts, hospitality, or favours that might be interpreted as exerting undue influence on you to deliver preferential treatment, nor should you accept or ask for loans from clients, patients, relatives, or friends.

The nurses had good knowledge of most of these codes during the interviews. This knowledge is crucial for the fundamentals of this research with the premise that some of these ethics have been compromised. These codes of conduct are grounded in the philosophies of the founder of the nursing profession, Florence Nightingale. As Radmehr, Ashktorab and Abedsaeedi (2015) emphasise, adhering to these ethics is about perceiving the patient and the nurse as one to build trust and create a sense of unity.

Just as there are deviants in every society, it is essential to report some of the sanctions meted out to nurses who have deviated from some of the norms above and how the NMC controls nurses' poor behaviour. The next section addresses this.

4.2.2 Efforts to Control Poor Attitudes

The Nursing and Midwifery Council (NMC) has a massive duty to address the concerns of patients and the public regarding some of its staff's undesirable behaviours. Fortunately, the council has not been reluctant but has made numerous efforts to sensitise nurses on some of these behaviours and even punish offenders. Apea-Danquah (2012), in a feature article in the Ghana News Agency, indicated that the NMC was worried about the staff's poor client-

centred care, emphasising that nurses' negative attitudes prevent several people from going to the hospital when sick. Yet, poor behaviours are a countrywide occurrence in most healthcare institutions which they are not proud. In the same article, Apem-Darko also lamented that the caring ethos of nursing that was to be exhibited through their portrayal of affection, love, empathy, and innovation was shrinking. He called for nurses to turn over a new leaf and nursing trainees to immediately imbibe these virtues in delivering professional healthcare to all.

Relatedly, Dr. (Mrs) Linda Vanotoo, Western Regional Director of Health Services, during the opening of the Ninth National Delegates Congress of Community Health Nurses in Takoradi, highlighted the negative attitudes some nurses put up and how it sometimes put fear in patients. This attitude deters patients from giving appropriate information on their visits or admission to the hospital. She explained that how a nurse talks to patients could go a long way in influencing the information patients give to nurses. Hence, she admonished nurses to show professionalism by doing away with all negative attitudes to allow patients to feel free enough to interact and receive appropriate treatments (Ghana Business News, 2009).

In a recent report from the Ghana News (2020) the Public Relations Officer of the Ghana Registered Nurses' and Midwives' Association, Mr. Joseph Krampah, in an interview appealed to nurses and midwives to retreat from defaming the profession. He explained that the profession is built on compassion, which is why they are formally trained to resist and control patients' rage, but if nurses also handle patients with a bad temper, it becomes dreadful. He illustrated that if a breadwinner suffering from a headache visits the hospital, you might not pay prompt attention to him because it is 'just a headache.' However, on his admission, this man is continuously perturbed about who will provide for his family; only

that is enough psychological stress. This is where the power of nurses' compassion comes in, in the patient's healing process.

In addition to various calls by journalists and members of the nursing profession for changes in the bad behaviour of nurses, the health authorities have gone further to institute sanctions which are administered to nurses and midwives who display poor attitudes toward patients. These sanctions include suspension for poor attitudes and the withdrawal of licences for severe offences. Sometimes, these sanctions are also announced in the newspapers to serve as a further deterrent (Graphic Online, 2019). These sanctions are necessary to serve as punishment for offenders and deterrence for other nurses.

4.3 A Walk through the Hospital

There are some assertions that hospitals sit outside communities because they are places for the treatment of psychological deviance and physical anomalies (Hahn & Gaines, 2012; Zussman, 1993). Contrary to this, most Ghanaian hospitals and clinics are located within communities and are not isolated. The Hospital is the primary healthcare centre for most inhabitants of communities and those in the environs, regardless of socio-economic background. It has an out-patient department (OPD), an administration block, a male ward, a female ward, an emergency unit, a maternity ward, a children's ward, a surgical ward, a pharmacy, a theatre, counselling rooms, a store, an infectious disease unit, a canteen, a laundry, and a car park.

The entrance of the hospital opens to the OPD, a large area that is segmented into a waiting area for patients awaiting vitals, a waiting area linked to doctors' consultation rooms, a waiting area for labs, another waiting area for dispensaries, and the last for records. Both benches and metallic chairs are provided for the waiting patients. In the space where nurses check vitals stands a giant scale in one corner. In another corner is a table usually covered

with books, hand sanitisers, a thermometer, a digital BP device, a gallipot of cotton, savlon antiseptic, paracetamol tablets and syrup (for children), and a box of malaria and HIV test kits. There are usually about two staff in this place.

The walkways narrow into the wards and the theatre. The whole hospital is surrounded by trees and grass, somewhat assuring patients of hope and well-being! There are hallways where ambulant patients stroll, relatives sit and converse, or some tired relatives spread their clothes and nap. The hospital is generally quiet except for occasional wails from the death of a kin, the screams and moans of women in labour, kitchen trolleys being dragged, or simply the hooting of a car driving in.

The Hospital staff comprises a medical superintendent, a deputy director for nursing services, administrators, doctors, specialists, nurses, accountants, clerks, orderlies, IT personnel, midwives, security personnel, lab technicians, pharmacists, etc. They all play specialised roles in healthcare delivery for clients/patients.

4.4 The Male and Female Medical Wards

In his study, Parsons (1951) labelled hospitals as institutional systems where the sick were assigned the sick role, legitimising his being taken out of his social place and reintegrated after recovery. Therefore, only persons given this role could be labelled a 'patient' and be admitted after doctors' clack. Those who went through the OPD and consultation rooms but were not admitted into the wards were not labelled 'patients' but 'clients.'

Patients are admitted into the medical wards through either the consultation rooms or mostly the emergency. Both male and female medical wards have about 14 beds each and admit patients from 13 years and above. On a typical day, there is an average of about nine patients in the female ward and ten patients in the male ward. During the research, the top twelve medical conditions that got patients on admission included diabetes, hypertension, stroke,

leg ulcers, severe malaria, bronchopneumonia, liver disease/failure, asthma, peptic ulcer, anaemia, UTI, and alcohol withdrawal. Depending on the case, patients spend two days to three months on average in the ward.

A nurse manager, popularly referred to as the in-charge (IC) and her assistant, heads the medical wards. Each ward has an average of 13 nurses (including the ICs). Each of these two wards has one nurse's toilet (clean), one patient's toilet (normally clean in the mornings and unclean by evening), one patient's bathroom (relatively cleaner than the toilet), a nurse's station, and a changing place. In the patient's bathroom is a plastic chair for dependent patients. A cylinder, an oxygen concentrator, and medical screens stand by the walls of both wards. There is also a small flat television set fixed to a wall on the wards, but mostly off so patients can rest. When it was on, the nurse in-charge tuned it to stations that showed movies or song videos as a form of entertainment for patients. The first time I witnessed patients show interest in the TV was in December 2020 during the counting of the ballots. Usually, all patients lie in beds with little or no interactions at all, but for once, the ambulant men sat up on their beds with their eyes glued to the TV set. Three argued seriously about who would win the elections. We all focussed on the TV and joined in the patients' argument occasionally. A relative of one of them cracked a joke: "Vote for one fisherman, one sea!" Turning to two of the student nurses checking vitals, he asked: "I hope you all voted for the one who will give you allowances!" We all laughed. I was excited that the patients found a reason to interact and smile for the first time.

On the notice boards, walls, and doors of the nurses' stations were pieces of paper with various messages. These included; an illustration of proper handwashing and the application of an alcohol hand rub, proper waste separation, diabetic ketoacidosis protocol management, how to manage diarrhoea, how to control seizures, a list of numbers to contact in case of

fire, contact numbers, and names of doctors and specialists, the patient's charter (rights and responsibilities of patients), and severe malaria treatment protocols. In the walls also were inbuilt wardrobes, which stored some of the extra consumables and lockers where staff kept their personal belongings. A large table covered with folders and notebooks sat at the station's centre, surrounded by a few wooden chairs. There were two beds that nurses rested on in turns during night shifts, a fridge to keep patients' medications, a microwave, and a sink, which only nurses used.

Other items in the nurse's station were trolleys which generally contained a gallipot, a kidney dish, a large bottle of savlon, plasters, cotton wools, a digital BP monitor, a glucometer, methylated spirits, a sphygmomanometer, and an emergency tray. Another trolley had plastic boxes labelled with the bed numbers in which each patient's medications were kept. In even smaller plastic containers, also labelled with bed numbers, were bowls in which pills were kept during medications. Some researchers have argued that the referral of patients with their bed numbers rather than their names objectifies patients (Leder, 1992; Smart, 1985). Yet, others argue that this is necessary for anonymity and confidentiality (Wolf, Ekman & Dellenborg, 2012; Nordgren & Fagerberg, 2007).

Some hospital ethnographers (Wolf, Ekman & Dellenborg, 2012) observed that the structure and size of the wards they researched were constraining, which is no different from those I studied. The wards were so crammed with beds that two people could not walk side by side. Patients had no privacy since there were no curtains to separate the beds. Nurses resorted to the only screen available during wound dressing, bed-bathing, diapers and catheter changing, and other procedures that required privacy. Nurses found it unhealthy to work in such a space and called it "frustrating for staff, patients and relatives" (Jessica, FGD).

4.5 The Daily Routine of Nurses

The daily activities that nurses undertake (their way of life) during caregiving are enormous, but this section describes some key ones, such as handing over/taking up, admissions and discharges, vitals checking, and documentation.

4.5.1 Handing over and Taking-up

Davida, a staff nurse, arrives at the ward and heads straight for the changing room after exchanging pleasantries with the two other nurses who reported for the night shift. She returns to the nurses' station wearing a matching set of scrubs, socks, crocs, a hairnet, and a nose mask. She washes her hands in the sink and intermittently looks up at the "six steps for proper handwashing", pasted on the wall amidst other posters right before her. Georgina, an enrolled nurse who had reported for the night shift, patiently waits for Davida to go through some folders, which are usually neatly packed at one corner of the table. Davida nods as she scans through the first folder's pages and asks for clarification from time to time. Georgina emphasises the change in treatment for the broncho pneumonia case, the awaiting lab results for bed 5, and the change of bed for the older man who had difficulty climbing the previous higher bed. Taking a folder that Davida has not opened yet, she exclaims: "Lest I forget, B8 has been moaning all night. We called the doctor, and he wrote another aspirin dosage but did not give any sleeping tablets as the patient had requested". As if she had a change of mind, she takes all the remaining folders and walks Davida through them one after the other, stressing about the changes. After Davida is satisfied with the notes, Georgina also heads for the changing room, comes back in a mufti, and bids her colleagues farewell amidst smiles.

In an interview with one of the ICs, she established that, initially, handing over and taking-up was done from bed to bed beside the patients, but due to the pandemic, folders are now kept at the nurses' station, and so is handing over and taking-up. Afterwards, they now move

from bed to bed to confirm that all the patients they are taking-up are alive. Not only do nurses hand over and take up patients, but they also hand over and take up patients' medications, ward equipment, logistics, and the admissions and discharge register. This is one of the essential rituals nurses perform before caregiving starts. Handing over means a nurse who had been on duty for a previous shift gives detailed information about each patient to another nurse who is about to start the current shift. The nurse on the current shift is the person taking-up. Handing over and taking-up happens simultaneously between two parties in a shift.

4.5.2 Admitting and Discharging Patients

It was Tuesday, the 17th of November 2020, at 8.17 in the morning. The orderly wheeled a man to the ward's entrance and left him in the care of the two older women who accompanied him. He headed for the nurses' table and told the IC about the new client. "Put a sheet on bed 5!" She, in turn, instructed the student nurse, who had been sitting comfortably on the nurse's bed, as she hurried for the wardrobe. I returned to the ward entrance and could not help but stare at the patient. He was a thin young man of average height, fair complexion, and approximately in his late twenties. He had an enormous protruded stomach that anyone would mistake for a pregnant woman if he were female! He had sores all over his lips and a few sore patches on his face. He wore a big-sized yellow tee shirt, a black pair of shorts, and a pair of flip-flops and held onto his folder with a broad grin.

The IC took his folder, looked intently into it for some time, and told him to lie on the just-laid bed. She again instructed another student nurse to check his vitals. The student hurried into the station and returned, holding a tray containing a BP monitor, a glucometer, a pulse oximeter, a thermometer, a pen, and a notebook. I looked at the young man again and the older women, who were now standing by his bed, while he looked around his new

surroundings. He was an alcohol addict and had liver failure. The IC asked him what he ate in the morning, and he replied that it was porridge with bread. She instructed one of the women to get his drugs from the dispensary while she called the other into the nurses' station and enquired about the patient's background. She took the admissions register and recorded information, including his name, age, time of arrival, level of education, occupation, and whom to contact in case of an emergency. She finally oriented her about her kin's stay in the ward as follows:

Do you see the door at this end (pointing a finger in that direction)? That is where you will locate the toilet and the bathroom. Visiting hours are from 6.30 to 7.30 in the mornings and 4.30 to 5.30 in the evenings, but we will need one relative to be around all the time to run errands to the lab, pharmacy, bank or assist in feeding (the woman nods). Early in the morning, after bathing him, there will be chat rounds, where we ask patients about any new complaints so the doctor can address them when they report later in the morning for ward rounds. The hospital feeds patients twice daily, so you must provide additional feeding. He will need a covered bowl like this (pick a bowl from under the nurses' bed; this is GH¢3 (approximately less than US\$1). The last is about paying bills. Luckily, he has health insurance, so you do not have to worry about paying for the bed, but you will pay for oxygen, some medications, and checking of his 'RBS' (random blood sugar) and a ward fund of GH¢20 (approximately US\$3²) (Fieldnotes, April 2021).

As part of the culture in the ward, patients are asked to pay the ward funds to augment the monies received from the state (financial encumbrance, discussed in Chapter 6). It is mostly used to purchase items such as tissues, batteries for the sphygmomanometer, and other consumables to run the ward. At the end of the year, the IC uses the remaining money, in addition to nurse's contributions, to throw a party for the nurses on the ward as a form of motivation. While some patients oblige when requested to pay the ward fund, others vehemently resist because they deem it inappropriate to pay that in addition to their bills. Others also felt it should be given voluntarily and not compulsion after nurses explain it.

² At an exchange rate of US\$1 to GH¢7.5 as at the period of data collection

Thereafter, Sister Sandra, the assistant IC, tried to set an intravenous (IV) line for the new patient. With 12 student nurses looking on, she pricked the man unsuccessfully at different points but to no avail. Fed up with the unfruitful effort, she called Sister Betty, the IC, for backup. The IC also tried, and after some unsuccessful attempts, she changed the colour of the cannula but was still unsuccessful. They both gave up and stood for a while as they observed the patient, who was obviously relieved from their grip and pricks. The rotation nurse cleaned the drops of blood from all the pricked parts. Sister Sandra again took over at different spots and was finally successful after the third attempt. Another student nurse put a plaster on one side and a second plaster in the form of a butterfly on the other side under the line. She regulated the given set and expressed satisfaction with the flow rate; the IC congratulated her colleague for a good job.

A resident doctor, Dr. Manu, arrived with two house officers. They exchanged pleasantries with the nurses and immediately settled down for business. Dr. Manu took the patients' folders and the nurses' notes and charts and examined them silently. He asked the IC for some clarifications from time to time and wrote in the folder. He moved from patient to patient, talked to them, examined them with his stethoscope, and made more notes again while the house officers looked on. He returned to the table and informed the IC that bed 2 had been discharged. They conversed briefly again, and he headed out. IC called for the wife of Mr. Ansah (the discharged patient), who was lying on a bench outside the ward. "Your husband is discharged!" she announced. Excited about the good news, she hurried to pack, but the IC cautioned that they could not leave until they settled all bills. They waited for the clerk to prepare their bill, and he directed her to the accountant to make the payment. On her return, she was asked to pay another GH¢20 as ward funds, which she did without argument, unlike others. The IC told them to wait for the nutritionist's counsel before they could finally go since the man was diabetic. After a long wait, Sister Sandra, who also has a certificate in

nutrition, decided to give the discharge home education. She called the man and his wife to the nurses' station and started enlightening them:

You must reduce sugar, soft drinks, salt, and carbohydrates. Eat more fruits, vegetables, and foods rich in fibre. It will be best if you get a diet regimen and a specific time to take your medications. Do not eat after 6 pm. Exercise regularly. Most importantly, cut off totally on alcohol.

The middle-aged man, who was obviously unhappy about the many restrictions on his diet and life, shook his head and smiled. The IC, understanding this gesture, reinforced that he needed to follow the instructions to the letter if he wished to stay healthy and live long. His wife assured the nurse that she would personally see to the dietary compliance. She educated them again on insulin injections and, finally, his subsequent review dates. They thanked the nurses and left the ward hurriedly. Just after his discharge, a call came in. The IC answered it, responded in the affirmative, and called out to one of the student nurses to carbonise bed 4 in preparation for another admission. The cycle begins again!

Admissions and discharges are an inevitable occurrence at the ward. It is that part of the culture that keeps the wards alive. In general, admissions require cleaning up for a new patient, registering the patient, orienting them and their relatives, and making patients feel welcomed and comfortable in their new abode. As much as the ethics are for nurses to interact with patients, much of such was not observed as reported by other researchers too (Asamani, Agyemang, Afful & Asumeng, 2018; Bridges et al., 2013). The major interactions happened during the admission and discharge days since much of the dealings during the patient's stay were between the staff and the relative, except for student nurses who were instructed to talk to patients as a way of keeping students busy. Stella, a senior staff nurse, attributes this to workload. She explains:

I just come to do my work. I hardly interact with patients unless I have to. This place is always busy, but for those we dress their wounds, as we are doing that, we interact. Nevertheless, on the day of admission, we interact a lot to ensure they are comfortable. During that, I sometimes even crack jokes for them.

Discharges also basically involve documenting, a discharge home education for the patients and relatives, billing, and most importantly, inspecting receipts to confirm that bills are indeed paid; then, a discharge is complete. In case of transfers, referrals, or death, the IC writes a report to that effect.

4.5.3 Checking Vitals

This is one of the routines in nursing I could actively partake in after seeking permission from the in-charges and matron. What is considered vital for a patient include their temperature, blood pressure (BP), oxygen saturation level (SPO₂), sugar levels (for diabetics), and weight. At the ward, checking vitals is done regularly at 2 am, 6 am, 10 am, 2 pm, 6 pm, and 10 pm for each patient daily. Student nurses are usually responsible for checking vitals, but in their absence, rotation nurses or junior enrolled nurses take over this task.

I was very excited about this on my first attempt. After watching the student nurses perform this procedure several times, it was not challenging to try it on my own. Under a senior nurse's supervision, I dipped a piece of cotton wool in savlon, an antiseptic poured in a gallipot. I cleaned the thermometer and asked the patient to lift their arm. I placed the instrument under their armpit and waited for a beep. While waiting, I took the pulse oximeter and taking the other hand's index finger, I clipped it there. Soon the thermometer beeped! I took it, cleaned it again, and recorded the figure, which should typically range from 36.1 to 37.1 degrees celsius. When a figure appeared on the pulse oximeter, I unclipped it from their finger and recorded the figure in the next column, which should typically range from 96% to 100%. Again, unfolding the cuff of the blood pressure monitor, I tied it around the patient's arm, pressed the middle button on the digital device, and automatically, the cuff inflated and tightened around the patient's arm. As it deflated, some figures appeared on the

monitor. I recorded this too. The chest's movement was observed and counted for a minute to get each patient's respiration. The figure obtained was also recorded.

I did not feel competent to check the sugar levels for the diabetics because it involved blood. Unlike the other vitals, this procedure was done every four hours on a sliding scale and hourly in case of a modified Albertis regimen³. Using a glucometer, a strip, and a lancet, the nurse cleaned the patient's thumb with a piece of cotton and spirit, uncapped the lancet, and pricked the patient's thumb. Squeezing the thumb for blood, she took the sample with the strip inserted in the glucometer. A figure popped up on the screen, and she recorded it, ensuring that the patient was within a range of 3 to 6.

At the OPD, checking vitals is the primary procedure nurses undertake. The nurse enquires from the client what their complaints are. If the client mentions fever-related symptoms, not only does the nurse check these vitals, but a malaria test is conducted as well. She further asks if the client coughs, drinks alcohol, or smokes. All these responses and vitals are recorded on printed paper which the client hands to the doctor later in the consulting room. The doctor sometimes refers some clients to the OPD for an HIV test.

The periodic checking of vitals is an integral part of nursing. Doctors depend on these vitals to know how well a patient is doing, whether they are responding to treatment, whether they have to review their medication or refer them to a higher facility etc. For diabetics especially, checking the random blood sugar was urgent and needed to be monitored closely, as the following excerpt illustrates:

Sister Rita usually orients new first-year students about the ward and checking vitals. During one of such orientations at the nurses' station, she emphasised that immediately after a figure is recorded below 3.0 for RBS, it is a clear emergency, and the students should not think of charting the vitals first but call for help. Hardly had she finished this sentence when the third-year student checking the RBS for a middle-

³ a method for controlling blood-sugar levels in diabetic patients who are being fasted

aged woman sounded the alarm of a 1.3 RBS. The IC jumped to her feet, headed for the emergency tray, fetched a 50% dextrose (a glucose or blood sugar), and, using a syringe, drew out 10mls. She passed it on to a staff nurse who immediately administered it intravenously. The IC drew out another dose which the nurse administered again. They repeated this five times to attain a total of 50mls. The patient slowly moved out from the hypoglycemia state as a figure of 4.2 was now recorded. The IC called back the relative who had been sent out because of the emergency to get her kin a bottle of soft drink to push her sugar further up. She returned after a few minutes with a bottle of coke. The patient drank it slowly, and we all returned to our previous posts, heaving sighs of relief! (Fieldnotes, April 2021).

This demonstrates the urgency in treating some conditions and highlights the stressful nature of the profession, as will be highlighted in the subsequent chapters. Another important duty is documentation.

4.5.4 Documentation

Documentation is also an integral part of nursing. I was amazed at how much documentation nurses do in addition to caring for patients. On my first night shift, for the three hours that I slept, every time I woke up, one of the two nurses was still glued to the same seat, writing! Meanwhile, she had been doing this for about an hour before I left for bed. Each time I peeped and realised she was still writing, I lamented: “You are still writing?” She would smile and shake her head each time, and, giving a weary look, I would doze off again! Documentation includes nurses’ notes, vitals charts, to-do lists, changes, admissions and discharges, transfers in and out, and referrals. All patients’ documents are stapled in a folder and put in a file encrypted with the patient’s bed number.

Charting vitals is one of the most critical forms of documentation yet, the simplest since this is the only record-keeping even first-year student nurses are allowed to do. After checking a patient’s temperature, BP, SPO₂, and sugar levels, they draw each of these readings on graph paper; this is called charting vitals. In the columns of the graph sheet are the designated times of the day each vital is supposed to be recorded, that is, 2 am, 6 am, 10 am, etc. Depending on the time of day, the nurse indicates whether morning, afternoon, or night and

charts accordingly. The charts are usually in blue ink, and they are simply lines that connect each other to indicate a rise or fall in temperature.

The nurses' notes is also a documentation of the nurses' observation and care of a patient. This includes the personal information of patients, the state in which the patient is brought (whether in a wheelchair or walks in, in distress or calm), who accompanies them, whether they can purchase the treatment on admission, what they are fed with (whether oral or through a tube), medications served, hygiene given (change of diapers, bed baths), etc. Nurses make these records for each patient until they are discharged. Morning and afternoon shift nurses record nurses' notes in blue ink, while night shift nurses continue from where the day shift nurses left off in red ink. An excerpt reads like this:

23/05/21: 4:32 pm: The client was wheeled into the ward accompanied by staff. She complained about headaches, fever, vomits, and chills for the past three days. The client had bought medications from the pharmacy, but the symptoms persisted. Vital signs checked and read as a temp – 38.2⁰ C, pulse – 80bpm, Resp. – 24cpm, BP – 120/70mmHg, SPO₂ – 98% room air. On examination, the patient looks weak and lethargic. The patient is being managed on IV artesunate 160mg 0, 12, 24hrs, IV paracetamol 1g tdsX24hrs, IV metoclopramide 10mg. The following investigations will be carried out; FBC, urine R/E, BF for mps. The patient is made comfortable in bed. Nursing care is ongoing.

8 pm: (in red ink) Took up patient care. The patient is sleeping in bed. Condition fairly stable. 10 pm: vitals signs checked and recorded (Fieldnotes, November 2020).

The next record-keeping is called 'Changes', and Sister Sandra explained it as follows:

Doctors come to review patients every day when admitted. When they come daily, they instruct, 'maybe stop this treatment, increase the dosage of this drug or extend this for another number of days, etc.' When the doctor is done with all these instructions, we write it again in the changes book, so everyone who reads will know that changes have been made with the treatment.

Another part of the documentation includes making a to-do list. This paper is pasted on the notice board in the nurses' station. It has the exact time that medications or treatments are given to patients. She continues to explain that:

Let's take patient A, for instance, the patient has to take paracetamol three times a day, and the patient took the first dose at 6 am. When you report to duty, you make a to-do list for the day, so for that same patient, you write the time he will receive the next

dose. For instance, if it is 2 pm, you note that at 2 pm, the patient will receive another dose of paracetamol. You also write if the patient is supposed to do an X-ray or something. So basically, it reminds us of duties we are likely to forget.

Documenting treatments given, vitals, changes, medications, feeding, hygiene, and others is the only proof that the work is done. As sister Betty recounts:

“Initially, the profession was considered easy and not worth a high pay because nurses did not document well. They will bath a patient, feed him, change his diaper twice, empty urine bags, and after all that, at ten o’clock, they will only write; ‘vital signs checked and recorded!’”

However, Sister Rita, the female ward IC, emphasised that "not only does documentation show the patient’s state, but it is a legal document, and nurses can lose their jobs if they are unable to produce such documents should a court order for them.” Hence, its relevance cannot be underrated.

4.5.5 Taking a Break

Unlike other healthcare givers, nurses work six hours in the morning and afternoon shifts and twelve hours in the night shift. A morning shift starts from 8 am to 2 pm and typically comprises two or three nurses and the IC. An afternoon shift starts from 2 pm to 8 pm and generally includes two or three nurses and the same IC who now closes at 4 pm because ICs run a regular working hour instead of a shift. Finally, night shifts start from 8 pm to 8 am, usually consisting of two nurses. Day shift nurses work for five days and have two days off, while night shift nurses work for four days and get three days off.

Looking at the scope of nursing work, especially during a morning shift, most nurses hardly relax, take a break, or laze about. There is always something to do. Within my first week of joining the ward, I was constantly exhausted from hours of standing and observing and could hardly keep up the pace. I always wondered how they got the energy to do this every day! I observed that very few nurses have breakfast at home before coming to work. Through informal dialogue, they mostly explained that they had to set off early from home, often by

7 am, and could not eat before setting off. Others were simply not morning eaters. Nurses take turns having breakfast on the ward when the ward is less busy. Some bring breakfast from the house or buy food on their way and go to the changing room to eat after getting permission from the IC. This is mostly done between 10:00 am and 11.30 am. They take heavy foods such as kenkey, rice, or yam more often than conventional breakfast meals such as tea or porridge. Others use the canteen during lunch breaks and, while at it, take the opportunity to chat with colleagues or check their phones.

There is relatively less to do on afternoon shifts as compared to morning shifts. Most procedures such as catheterisation, intravenous infusions, wound dressing, bed-bathing, and others are done in the mornings except for checking vitals, feeding, medications, and documentation which are repeated during each shift. Nurses on this shift have more laxity to converse or idle on phones. Nurses, mostly females, converse about everything of interest to women during such periods. Such chats centre around fashion, weight loss, make-up, hairstyles, religious activities, marriages, relationships, etc. There were also many serious conversations about their work with patients, relatives, and other healthcare givers, and this was when I used informal dialogue to enrich my data. Sometimes, I probed about it during my later scheduled interviews when I could not join in some conversations because they ended abruptly due to an emergency or something demanding their attention.

A break during night shifts is mainly for sleep. The two nurses (and sometimes there are students) sleep at most two to three hours in turns when the ward is less busy. Nurses have no sleep when the ward is full or in emergencies. On one of such busy nights at the female ward, an older woman with gastroenteritis screamed throughout the night; no one could sleep. She was in severe pain. The doctor gave her medications, but she was still in pain until about three in the morning, when it subsided, and we could all get some rest. On one

other night, when the ward was less busy, the nurses used the break to teach the five students how to document.

Although these short breaks were essential, nurses (especially on the morning shift) hardly had that luxury due to the ward rounds, workload, and staff shortage. They were always on the move.

4.6 She's the Boss - Nursing Management

As it is with most formal institutions, nursing has a hierarchy, bureaucracy, and a chain of command. Nurses are the most extensive employee group in every healthcare organisation, so their management becomes essential (Sullivan & Garland, 2013; Marquis & Huston, 2009). The Ghana Health Service appoints the Hospital Nurse Manager (HNM), also at the Deputy Director of Nursing Service (DDNS) rank, to provide administrative leadership to nurses in the regional and district hospitals. Hospital Nurse Managers, popularly referred to as hospital nurse matrons, are responsible for nursing administration by providing leadership to nurses in hospitals. They play critical roles by offering excellent patient care, promoting acceptable practices, and providing a serene environment for work (Ghana Health Service, 2018). At XYZ Hospital, the matron did not necessarily have a deputy, but the next in rank inadvertently worked as her deputy to enact her duties.

Each unit or ward also has a nurse manager. They are affectionately called In-Charge or IC at the OPD or in the wards. The IC oversees the entire ward management, including the staff and patients. The American Association of Colleges of Nursing emphasises that the hospital nurse managers' role is useful for enhancing patient care, improving services, and reforming healthcare delivery. They also contribute to hospital management decisions by advancing shared decision-making and professional autonomy and keeping staff informed of evidence-based practices (American Nurses Association, 2009).

The IC has an assistant who is the second in command and another who is the third in command. Who becomes an IC or an assistant is very dependent on one's level of education or the person with the highest rank. At XYZ Hospital, the ICs are mostly at the rank of principal nursing officer (PNO). The assistants, who are also the next in rank, are mostly senior nursing officers (SNO), followed by staff at the rank of nursing officers (NOs). Some rise through the ranks to be NOs, while some become NOs by completing the first degree. Nurses who come in with a diploma start at the rank of staff nurse (SN) and rise through the ranks to senior staff nurses (SSN) and NOs. Some come in with certificates and begin the rank as an enrolled nurse (EN) or auxiliary nurse and rise to senior enrolled nurse (SEN), principal enrolled nurse (PEN), and finally, superintendent enrolled nurses. Like most professions, nurses rise through the ranks quickly by getting higher education.

Even though each nurse has a rank, it was not visible until I enquired. This is because everyone wore scrubs as personal protective equipment (PPE) at the time, so it was difficult to distinguish one rank from the other. Again, though they mention a job description that spells out their roles, they did not strictly follow such requirements to distinguish their ranks and roles. Anyone could do any job so far as they have the technical know-how. On my first day, I was impressed to see the IC making beds; Sister Betty and Sister Rita, ICs of the male and female wards, respectively, were exceptionally hardworking; no task was beneath them.

Junior nurses referred to their colleagues as 'sisters' or IC (even if they were not the IC) to show respect. Initially, I used to call everyone aunty, but I immediately switched once I realised that was not the convention. Both ICs called me 'madam,' and I would correct them: "Please call me Perp." To show respect for senior colleagues who walk in from other units (mostly the administrators) into the wards, all nurses stand (including the IC) in reverence. If they meet a senior colleague while walking, they stand in reverence for the senior

colleague to pass before they also move. Browne (1993, p. 213) speaks to the importance of respect in the context of nursing:

A basic moral principle and human right that is accountable to the values of human dignity, worthiness, uniqueness of persons, and self-determination. As a guiding principle for actions toward others, respect is conveyed through the unconditional acceptance, recognition, and acknowledgment of the above values in all persons. As a primary nursing ethic, respect is the basis for our attitudinal, cognitive, and behavioural orientation toward all persons.

4.7 The Role of Allied Healthcare Givers

I observed that healthcare delivery for patients in the wards is a collaborative effort from nurses, doctors, specialists, clerks, relatives, and orderlies. The interdependence of these healthcare givers is crucial for service provision. Between 9 am and 9.30 am, a team of doctors, more often consisting of one resident doctor and some house officers, come in to review and perform patient procedures. Common among such procedures are setting intravenous (IV) lines, inserting nasogastric (NG) tubes, catheterisation, and palpitations. Based on the doctors' assessment, patients are discharged, transferred for surgery, or referred to a higher hospital. Nurses then start documenting the 'doctor's report' until roughly midday at the nurses' station. Even while doctors are away, a nurse could call them over the intercom for clarification, for an emergency (e.g., a sudden change in a patient's condition), or even correct a supposed error in the doctor's report. Doctors play pivotal roles in the diagnosis and fight against diseases in every healthcare system (cited in McNally & Huber, 2021; Lee, Loke & Ng, 2020).

Occasionally, nurses invite specialists such as psychiatrists, nutritionists, physiotherapists, etc., to the ward based on the doctor's review and report. They are not regular actors on the ward and are only called in when their services are needed. Sometimes, it takes a day or two for such specialists to report to the ward. Once they report, the nurse on duty directs them to the particular patient, and they then spend time examining them. Based on their report, the

resident doctor further decides about the patient's condition. The dieticians are often summoned for diabetic, hypertensive, and aged patients, whereas the psychiatrists are beckoned for patients who make intermittent noises, speak to themselves, or often laugh while not conversing with anyone.

The clerks are the accountants of the ward. When a doctor discharges a patient, a nurse phones Sammy, the clerk, a young gentleman who comes in to prepare the patient's bill, and he moves from ward to ward, preparing and dispensing these bills when needed. During my stay at the males' ward, preparing bills was also part of the nurses' job amidst all the expected requirements. When I started the female ward the following year, that role had been relegated to the clerks due to nurses' complaints of heavy workload.

Kitchen staff also play a key role in patients' stay at the ward. The hospital provides breakfast and lunch for patients, while the relatives complement this with supper or other meals. They push a trolley containing different delicacies along the hallway; its sound is always enough to announce their presence! She walks into the ward and broadcasts the meals available to the nurses. Student nurses or junior nurses would then grab a silver tray, which usually stands between the shelves, pick up each patient's covered plastic bowl, and ask them about their choices. The caterer serves the meals accordingly as the student directs and then heads to the next ward dragging the trolley noisily along.

The hospital practices a culture of relative-assisted care, making relatives active actors in the ward. As Van der Geest and Sarkodie (1998) as well as Osei (1994) have argued, relatives became integral to Ghanaian hospitals due to certain developments, such as the cash and carry system. They expatiated that relatives have to be around to buy medications (even if they have to go outside the hospital) and pay bills to keep the treatment ongoing, which is no different from my observation. They are always on an errand for their kin,

depending on the instruction of the nurse. They often liaise between the ward, the dispensary, labs, radiology, and the bank. On the ward, they also assist with oral feeding, bathroom bathing (including carrying water to the bathroom), bed-bathing, changing kin's clothes, and serving as an intermediary between the hospital and family back home. Enyonam was one of such relatives. She was the daughter of a 69-year-old diabetic man. He reported a leg ulcer and an infected amputated right leg below his knee. The infected wound was so bad that it bred worms and a foul odour. The doctors recommended further amputation above the knee for a cleaner wound. It took the older man some days to consent to this choice. Enyonam communicated this development to the remaining family, and it took them five days to arrive at a consensus after the IC kept pressuring them. Meanwhile, the young lady bedbathed her father, ran errands, fed, and often shared words of encouragement with him even though she sometimes cried outside the ward. They stayed in the ward for two months before discharge.

Every ward has one orderly responsible for cleaning, dispensing waste, fetching water into the veronica buckets for handwashing (if the taps do not flow), and other sanitation duties. The nurses have good interpersonal relations with male (in the male ward) and female (in the female ward) orderlies. In the first week at the male's ward, a tall gentleman dressed in a khaki uniform walked in at the nurses' station, and all the nurses, including the IC, excitedly welcomed him. One asked him how he had been, and another asked if he enjoyed his leave. The IC narrated how their work had been hectic without him and how the other orderlies they consulted for help, especially with lifting patients and fixing flowmeters on cylinders, were lackadaisical in assisting them. He beamed with smiles and obviously enjoyed his appellations. Clearly, the nurses were fond of him and appreciated his hard work.

The collaborative efforts of all these actors in the healthcare system are necessary for the survival of the entire structure, just as functionalists argue. Nurses, doctors, specialists, orderlies, administrators, lab technicians, pharmacists, relatives, and patients play distinct and significant roles in attaining the hospital's manifest functions and the subsistence of the entire society.

4.8 Events

There were other observations other than nursing or healthcare delivery worth recording. I witnessed a one-time event of a strike, other everyday activities (commercials), and occasional activities (workshops and a durbar), which formed part of the hospital's culture. These events are described as observed.

4.8.1 The Strike

It was a Wednesday morning, the 23rd of September, 2020. Nurses were on strike, but I still decided to show up because that was also data on how healthcare provision was undertaken without nurses, who form the majority of healthcare providers (Sullivan & Garland, 2013; Marquis & Huston, 2009). The OPD, which is always crowded in the early hours of each day, was relatively quiet and had a few patients on the benches in line at the triage area. The doctors did everything! Two busily checked patients' vitals while another female doctor called out the names of patients to get them seated at the right places depending on which consultation rooms they were going to.

I wondered if the doctors were filling in for nurses, why was the hospital relatively empty? One of the patients in front of me complained to another about the slower process. The waiting time was longer than usual, as the number of doctors in no way matched the number of nurses in every hospital. After some time, one of the doctors announced to the patients in the queues to be patient with them because nurses were on strike and the doctors had to play

double roles. As I watched, I wondered why the doctors checking vitals and those calling out names were all females. The DDNS, not in her usual white dress and mauve belt but in a mufti, hurried in and out of her office, announcing to the two women waiting for her that the nurses were on strike and that they should return when they resumed.

Meanwhile, the doctors struggled to find whatever they sought in the wards. Once in a while, one would phone the ICs who were at home to make inquiries. Later that day, they discharged most of the ambulant patients, leaving only a few dependent ones to care for. After only three days of strike, nurses were called back to post! This event only reemphasises that nurses are key and indispensable in every healthcare system (Oldland, Botti, Hutchinson & Redley, 2020; Aiken et al., 2014).

4.8.2 The Commercials

The hospital does not only serve the function of providing healthcare. Some commercial activities take place there as well. As I sat in a mufti observing the section leading to the OPD consultation rooms, a gentleman joined my bench and, in a whisper, introduced himself as an insurance marketer and started explaining some of their packages to convince me. Earlier that same morning, another gentleman in a tucked-in shirt and tie had stopped me to market the same product to me. They had even erected an umbrella in front of the hospital for this purpose.

Two other gentlemen came in with some Chinese products a few hours later. Moving from one client to the other, one approached me, and after exchanging pleasantries, he pulled a red and white rectangular box from a black leather bag strapped in front of him. Helping himself onto the bench, he removed a device from the box and started operating it. Without permission, he placed the device, which I came to know as a massager, on my belly. “This side of the device massages the belly and burns the fat”, he said, and turning on a switch, he

placed the device at my back to demonstrate another function, “and this side of the device massages the back. Do not mix the two up, but you cannot use the device on your belly if you are pregnant”, he warned. Intrigued, I took the fanciful device and asked where it was produced and how much it cost. I bought it after a long bargain! Others also sold posture corrector braces, waist trainers, and digital BP devices. Other commercial activities outside the hospital included selling food, baby products, fabrics, groceries, and a taxi rank.

Nurses were also not left out of these commercial activities. It was realised that most nurses complemented their professional jobs with one informal business or more. For those who traded in the hospital, they carried wares such as cosmetics, toiletries, adult and kids’ dresses, wigs, shoes, adult diapers, scrubs and even foodstuff from ward to ward, mostly during their time off-duty or when they closed. Nevertheless, a few were observed to be marketing their wares when their shifts had not ended. This had implications for the quality of service provided to patients (elaborated in Chapter 6).

4.8.3 The Workshops

Another interesting culture for nurses is workshops. The nursing management deems it fit to enlighten its staff in this all-changing global world. Per the regulations, one workshop is supposed to be organised monthly; however, this is not so in practice. Each ward’s responsibility is to lead one such workshop for the entire nursing staff. Memos about the upcoming seminar before the workshops are circulated in every unit. During the start time for all three workshops, the DDNS had to go around all units and wards, driving nurses out to the venue. The first time I attended, I was in the male ward. She came in to instruct all nurses, including me, to leave for the workshop, except for two nurses who were left behind to care for the patients. During her speech at the close of each workshop, she lamented how nurses must be practically begged to attend these meetings even though they knew the scheduled programme and their benefits. During one such time, she compared them to how

doctors attend their workshops, emphasising that by the stipulated time, all doctors were already seated in the conference room, unlike nurses. Due to poor attendance, the second workshop had to be rescheduled. Despite their lackadaisical approach to the workshops organised for them, some of my research participants complained about the lack of opportunities to attend workshops which inhibited them from renewing their yearly pins or getting promoted.

The workshops typically begin with registering one's name and ward and then an opening prayer. One of the nurse managers then introduces the ward and the facilitators, whose turn is to present on a topic. The Infection Prevention and Control (IPC) unit hosted the first presentation on the topic, 'Nosocomial', also known as hospital-acquired infections, with about 35 to 40 nurses present. They shared some text around the room, and we answered 15 baseline questions in 20 minutes. With very little idea of the answers, such as how to calculate a chlorine solution or the disease transmission cycle, I stole glances at the sheets of the nurses to my left and right, who were as equally lost as myself, enquiring from friends from time to time! Eventually, I circled the ones I deemed fit and ignored the instruction to write our names. After the exam, the facilitator, a senior nurse, started the presentation projected on the wall. She talked about the kinds of infections, the disease transmission cycle, strategies for avoiding infections, hand hygiene, kinds of bins for waste disposal, and finally, how to calculate chlorine solution. At the end of the presentation, another senior colleague came in with our test papers and complained of very poor performance. In fact, she was angry! The facilitator shared another round of the same set of questions to measure the endline performance after the presentation. I answered them considerably better this time because of the detailed presentation. The three-hour meeting ended with another prayer and some refreshments.

The male ward hosted the second workshop on ‘Injection Safety’. A volunteer was asked to give an opening prayer, and after a long wait, I decided to pray. Their IC highlighted the types of needles, the causes of pricks, their effects, and, most importantly, the prevention of needle pricks. Some shared experiences of their needle pricks and others asked questions, while a few made additions to the knowledge shared. It was less eventful for me than the first. The final workshop by the gynaecological ward was on ‘Oxygen Therapy’. The IC educated the audience on the sources of oxygen, the precautions in usage, the devices for use, oxygen storage, and weaning a patient off oxygen. One of the students volunteered to be a patient, and the team demonstrated the right way to fix nasal prongs and an oxygen mask. Two orderlies in the workshop demonstrated how to fix a flowmeter on a cylinder. This seemed to be a difficult task, as almost all nurses depend on orderlies in cases where oxygen needed to be administered. Three male student nurses were called to demonstrate the removal and fixing of the flowmeters but were unable to do so. Taking the spanner from them, the elderly orderly carefully demonstrated it again.

4.8.4 The Durbar

As part of the hospital culture, the hospital organises a durbar at the end of each year, where all hospital staff meet to celebrate one another for their hard work throughout the year. It was the 17th of December, 2020, at the hospital’s car park. Canopies were erected, and the whole compound was occupied by healthcare personnel, kitchen staff, orderlies, administrators, and security staff, except for a few nurses in the wards to care for patients. Most of the nurses and orderlies still had on their scrubs, while the remaining staff wore muftis. Facing the gathering was one canopy with very few people under its shade. It consisted of the hospital administrator, the medical superintendent, the DDNS, the assistant DDNS, and four senior resident doctors.

The Med. Sup., as she is simply called, gave the introductory remarks for the gathering. She introduced the personalities at the high table, after which there was some music. A doctor of foreign origin gave a long speech about an annual report, and soon afterwards, the floor was opened for questions and contributions. One nurse bitterly complained about their lack of entitlement to health insurance from the hospital. The Med. Sup. replied that their hands were tied, so all staff had to get a National Health Insurance Scheme (NHIS) card just like any other patient, as the Ghana Health Service has regulated. Another nurse also added that the NHIS cannot take care of their labs, scans, and some medications, so the hospital has to implement a health insurance policy for staff. The Med. Sup. reaffirmed her earlier position and added that all procured drugs were paid for and cannot be given out freely to the staff to the detriment of patients. The meeting, which began solemnly, was in disarray as many of the staff made noise supporting their colleague's proposition; a few others got up and threw their hands in the air in protest of the Med. Sup.'s submission. After a tough time, the gathering calmed down.

Other staff made submissions concerning security, workload, and motivation. The administrator and the Med Sup. took turns to address their concerns. Soon after, the programme launched into an awards ceremony to reward staff for their distinguished efforts. Among such staff was a doctor who assisted financially in constructing a new ward, a midwife who bought some delivery beds for the hospital, and a nurse who collaborated with an NGO to supply bedsheets. Each of these awardees received a citation and a plaque. Six retirees were also awarded for their services to the hospital. They also received a citation and a brown envelope each. The Med. Sup. explained that there were no awards for nurses or other staff for good performance because they did not yet have a criterion for such selections, and so, for now, all staff had exhibited exemplary behaviours. She promised, however, that future plans would be advanced for such awards. The gathering murmured for

some time, and she added that, as part of the end-of-year motivation, the facility would give out items instead of cash, unlike the previous years. She pointed out that they often had issues with auditors, so their new resolve was to give out a bag of rice (5kg), two tins of tomatoes, two tins of mackerel, and one bottle of oil to each staff and rotation nurse. The audience once again mumbled, obviously in protest.

A gentleman played a saxophone for a musical interlude while some members danced to the high-life tune. To conclude, the administrator invited and welcomed new staff to the front, and the crowd applauded them. The programme hilariously ended with a dancing competition among the doctors, after which all the staff trooped to the front to show off their dancing moves. Meanwhile, some shared bottles of drinks and pastries among the seated members who either danced in their chairs to the beat, laughed at others' moves or simply conversed. The three-hour programme was exciting and memorable.

4.9 Conclusion

The cultural overview of the hospital supports the premise that the hospital is not a total institution (Goffman, 1961) or an island (Cosser, 1962) as earlier Sociologists had described it. The hospital is a community on its own (a social system) with its unique culture and is still part of the larger community. An analysis of the hospital's social system reveals that nursing has its polity, education system, values, and norms, and the interdependence of these elements was useful in ensuring the functioning of the entire structure. Also, the people in the social situation were only seen as actors at the beginning of the study. After a prolonged observation, the differences in clothing, demeanours, and behaviours revealed their identities and how they each contributed their specialities to healthcare delivery. The activities, which only started as units of acts in the sight of the ethnographer, began to form patterns after some days of observation. For instance, the everyday acts of nurses attending

to patients at the ward morphed into activities such as medication, bed baths, admissions, wound dressing, checking of vitals, feeding, discharging, etc. In addressing its manifest function of providing healthcare, latent functions such as commercials, durbars, and workshops have contributed to its uniqueness (as typical of functionalism). After vividly describing the ethnographic area, its people and activities, and my experiences in the field, let us now look at how these relations, norms, and social systems influence the behaviour of nurses in the next chapter.



CHAPTER FIVE

“SOME OF THEM ARE NOT BORN NURSES”: THE INDIVIDUAL’S FACTOR IN EXPLAINING BEHAVIOUR

“Some of them are not born nurses. Those who do not have the calling come and cannot complete it. They resign or tend to displace frustrations on patients. When you’re born a nurse, you can do it no matter what” (Hospital Matron, Fieldnotes)

5.1 Introduction

This chapter aims to explore the individual precursors that contribute to nurses' improper behaviours within the healthcare setting. It posits that a nurse's behaviour is significantly shaped by their early socialization, peer interactions and perceptions of care. The discussion highlights how the meanings nurses attribute to their profession influence their career choices, whether motivated by altruism, economic necessity, or situational factors. The chapter also delves into the concept of power, illustrating how knowledge and resources impact nurses' behaviours. It argues that the power dynamics within the nursing profession can lead to both constructive and detrimental interactions with patients, depending on how that power is wielded. Employing Blumer’s (1969) symbolic interactionism and supported by Foucault’s (2012) power and Homan’s (1961) rational choice theories, the chapter reports the individual’s precursors to performing nursing behaviour.

5.2 Socialisation

The interaction one has from infancy and through to adulthood is eminent in forming behaviours. Research (Miró-Bonet et al., 2014; Costa & Coelho, 2013) shows that people are social beings who through the process of socialisation imbibe ideas, values, and dispositions that contribute to the formation of their self and identities. This is due to experiencing several socialisation processes, first from home, schools, workplaces and the media, with each agency creating and reproducing through symbols, interactional meanings

for the individual, as Blumer (1969) espouses. Through relations with significant others such as siblings, peers, teachers and colleagues (Teodosio & Padilha, 2016), the self is developed and takes on the norms and values of its environment, which in turn influence its behaviour. Socialisation acquired through both formal and informal ways gives meaning (Blumer, 1969) to how nurses explain their character, personality, and principles/perceptions of care which influences behaviour towards patients.

Character traits from the viewpoint of Eley et al. (2012) reflect sociocultural learning. The character is heightened with aspects of the individual's personality which are portrayed as consistent behaviour patterns and originate from the individual and in-person process (Burger, 2014) and are often referred to as non-cognitive skills (Jacobs et al., 2002; Bandura & Walters, 1977) because they are less conscious. Also, perceptions/principles of care acquired from interactions or learning were useful in understanding nursing behaviour towards patients.

The data revealed that undesirable behaviours of some nurses come from the nurse's character, which reflects good or poor sociocultural learning or upbringing. According to Addai-Mensah (2020), in the Ghanaian context, to have a good upbringing means to exhibit good moral values and discipline through guidance and nurturing which shape children's personalities. Included in these values are kindness, generosity, humility, respect for the elderly and compassion. Participants made meanings that nurses who are particularly rude or disrespectful towards patients lack proper home training. This is how Awurama puts it: "I see it as upbringing; it is the character. If you are arrogant, wearing a nursing uniform will not change it. If you were brought up to be humble or patient, that is who you are, regardless of your uniform, so I see it as poor upbringing."

Accordingly, some participants were of the view that this poor or good character, which is attributed to influencing proper or improper behaviours, is first evident in one's speech/communication, encapsulating one's mannerisms, choice of words, and style an individual employs when interacting with others. Interactions with unpleasant verbal utterances that suggest rudeness or arrogance, no matter the antecedents or what led to those utterances, are constructed as indicative of wrong sociocultural learning. Some also believed that a nurse might not necessarily be rude, but their way of communicating is the challenge. For instance, Bernice confessed: "As for me, I am loud. Naturally, I'm loud, so if you don't know me, you will think I'm shouting at you". Asamoah also added:

Sometimes, if you don't know a nurse well, you might misconstrue their behaviour, considering how they talk. However, if you realise that's how the person is and speaks, it doesn't bother you. They may be hardworking and do everything well on the ward, but their uncultured speech is the problem.

Indeed, such a speech is a worry to patients and the public image of nursing. Patients do not doubt the potential and hardworking trait in nurses, yet hard work is not enough to provide quality health service, but the nurse's ability to communicate cordially is also vital. Hence, proper communication skills become symbolic of proper acculturation.

A person's character is not solely reflected in their communication style; rather, nurses' values are intertwined with their sociocultural learning, which in turn influences their behaviour. Quite expected, since all the participants in this study were Christians, most of them associated and symbolised Christian values as the index for proper upbringing or enculturation, which informed how they treat patients. Participants attested that they had imbibed values such as humility, generosity, love and kindness, which usually transcend how they interact with and care for their patients. Sister Rita intimated thus: "Being a Christian will impact your values and make you a good nurse". Samuel also exemplified:

I am a member of the Church of Jesus Christ of Latter-day Saints, and we treat

customer care, family, relationships, the importance of service, and the need to care for others, even on a typical Sunday. It has transformed me, but of course, I'm a human being, and I have my negative side, so anytime I come to work, I remember those lessons, which help me behave well.

Case and Smith (2013) also found religion to determine moral values and a factor in discouraging unethical workplace behaviours. The data also revealed that performing desirable or undesirable behaviours is also influenced by aspects of a nurse's personality which seems less conscious. These include temperaments and moods, which are emotion-based and not influenced by sociocultural learning (Eley et al., 2012). Some nurses were naturally quiet, friendly, unfriendly, assertive and soldier-like on the wards, as seen in human relationships. According to participants, their temperaments, basically being introverts or extroverts, also influenced their behaviours. Awurama conceded: "Take me, for example; I don't like talking. I'm a serious introvert. When you are rude to me, I'll just ignore you because you wouldn't like what might come out of my mouth if I decide to speak." Augustina also confessed: "I am the tough type...I have a bad temper. I used to fight oo, but currently, I've become a little sober!" Princess also explained how one's moods, which Gokoglan and Bekar (2021) refer to as emotional inconsistency, contributes to behaviour: "Sometimes when a patient asks you a question, you give the feedback depending on your mood. It often happens because we are women and have biological issues!" This finding is congruent with Tatar's (2016) quantitative study found a positive correlation between an avoiding strategy and emotional inconsistency.

Notwithstanding that one's character and personality are essential to demonstrating behaviours, this is not unique to nurses since people in other professions have these traits. This is why there is resocialisation in nursing training schools to integrate students into the profession properly and its ethics. Awurama pointed out:

When we go for nurses' training, that's not where they train our character. Your character is already formed. They train you on expertise, skill, and ethics. Yet, it

doesn't mean that your character automatically changes when you say these are your ethics. You will have to conform consciously.

This means the foundation is crucial, right from the individual's formative stages before further socialisation from the nursing school. Participants expressed a good knowledge of the profession's ethics or codes of conduct (as seen in the previous chapter) but had different perceptions or principles of care, which is instrumental in understanding behaviour. Some are bent on keeping a good name no matter the circumstance and hold principles like hard work, diligence and tolerance. Awurama again shared her principle of care relative to her training from school:

During nursing school, they educated us on all the ethics we should practice as professional nurses. We were never taught to speak harshly to our patients. We learnt in ethics that when a person is sick, we should assume that the person is not normal, so don't expect the person or relatives to act nicely. If the patient speaks to you abnormally, you should be the person to know how to handle them since you are not only normal but also trained.

Bernice enlightened on her principle and what it meant for her caregiving:

'Nnipa ho ye toro' (individuals are susceptible to making trouble), so we should have patience. I always say that no matter the patient's anger, you might only meet them once in your lifetime. If you can tolerate them, and they get well and leave, you may never meet them again, and you would have also maintained your good name! Otherwise, someone will tarnish your image in just one encounter. Patience!

As Midilli, Kirmizioglu and Kalkim (2017) opine, nurses have different expectations and priorities about care, confirming Evelyn's contrary perception of who a patient is and how that reflects in her principle for caregiving. Evelyn highlighted:

...anyone who is sick is already frustrated. The person is not as normal as we think. Anyone ill is not their usual self, so the name 'patient' was given to a sick client. This means that when you are sick, despite what you are going through, you need to have patience because you are not normal. You are anxious, and anyone anxious behaves 'abnormally'. Any questions you pose, the person will not give you a friendly response, and they might be seen as rude. It is because of the individual's situation, that is, their altered state and so the name 'patient' was given to them to remind people that you need to be patient when you are sick.

According to Evelyn, the symbolic meaning of who a patient is reflects the role a patient should play. While this nurse perceives 'patience' as a virtue for only the sick and not the

nurse, then the responsibility for good interaction between the nurse and patient solely rests on the patient. Yet, knowing very well from the quote that the sick are not normal due to their ill health, who has a bigger duty to be patient? This is reflected in some of her interactions with patients, especially clients who perceived their condition to be an emergency and believed they should receive outright services. On one such occasion, a patient with a large plaster on his forehead and a bandage on his left leg asked me to change his plaster because it kept coming off. He complained that he had earlier called Evelyn some forty minutes ago but she told him to be ‘patient’ since she was busy at the moment. I prompted the other nurse, who secured the plaster for him. Evelyn was offended that the patient was persistent even when she had admonished him that she would be with him soon. This scenario made sense after I realised her perception of ‘who a patient is’ during the interview.

Informal dialogues about the perception some nurses held about public health services were also informative. Three nurses were conversing about the systemic failures and bemoaning the constraints in the work one late afternoon. One of them retorted: “*σε ενυε me Papa adwuma*’ so I can’t come and kill myself (this is not my father’s job/business, so why should I stress over it)!” Such perceptions about public service contribute to lackadaisical attitudes, including laziness and lateness (discussed in the next chapter), which other studies in Ghana and beyond affirm (Abdul-Nasiru et al., 2014; Kolthoff et al., 2010; Andersen, 2009). Some public service workers’ behaviour affects proper behaviour and employee commitment due to the meanings they attribute to government work. These perceptions could be learnt and replicated by others consciously or unconsciously, which then becomes a norm by which others are socialised.

Augustina confessed how others’ perceptions of caregiving both positively and negatively influenced her:

When I started work, the nurses I met were very nice and good people. They were ready to teach you everything. The PNO was friendly and was like a mother to me so I particularly found myself transferring such positive energy to the clients. Later, a senior colleague advised me that when you are too nice to patients, they will just 'use' you. They will always say, 'please, can you do me a favour? Can you get that for me? Forgetting that you are supposed to take care of them and not run errands.' I learnt both lessons!

This shows a misconstruction of the nursing profession as an act of service to say 'slavery'.

If the senior colleague who advised Augustina perceives caring for a patient's need as a burden, then she does not understand the rudiments of nursing care. It also illustrates how interactions lead to modification in behaviour on the part of Augustina when she says, 'I learnt both lessons' as Blumer (1969) postulates that the meanings made out of the interpretative process are modified based on encounters. Princess summarised:

We copy people blindly, so unconsciously, you don't know you're learning that behaviour in question. Sometimes, when someone is rude, as long as you stay with that person, you unconsciously learn it as well as the positive ones. It is unconscious because no one in their sane state will try to copy bad behaviour from someone. It happened to me and it was unconscious!

As behaviourists have explained, our responses to environmental stimuli shape our actions and gradually, an individual learns from observing, retaining, and imitating the acts of others (Skinner, 1988; Bandura, 1976). Kruk et al. (2018) explain this process using an instance of interacting with bullies that, in places where abusive care is seen to be normal, it becomes repetitive, accepted, and anticipated. Subsequently, the learnt undesirable behaviours from interactions become part of the person, which subconsciously transcends to the patient. In short, as nurses become socialised with this culture, they tend to share and transmit it. Hence, despite one's good character, personality or knowledge of ethical conduct, it is still imperative for nurses to hold the correct perceptions and principles about caregiving.

This section explains Blumer's (1969) premise that individuals act towards things or others based on the interpretive meanings they assign to them. It has shown how nurses' characters, personalities, and perceptions of care are facets of their interactions, and the meanings

assigned to them explain their behaviour. The symbolic meanings of what the nursing profession is to individuals also influence the decision to be a nurse, another critical factor in understanding nurses' behaviours.

5.3 The Decision to be a Nurse

Sir William Osler, a renowned physician at Johns Hopkins School of Medicine in the late 19th and early 20th century, remarked that he taught medical students because he had always felt that was the most valuable and important job he had been called for (Osler, 1920). Like Osler, most people perceive that the profession one chooses should be a 'calling' or altruistic, especially nursing, since it enables nurses to sacrifice themselves, tolerate difficult times and motivate them in the care of patients (van der Wath & van Wyk, 2020; Milton, 2012). Florence Nightingale popularised nursing as a vocation because she argued that vocational duties demand nurses care for all kinds of people by putting patients first before the nurses' needs which typifies the profession as a calling (White, 2002). People with a 'calling' symbolised individuals born to be nurses because they are likely to demonstrate proper nursing care. Hence, choosing a nursing career for altruistic reasons is the first and most preferred consideration for people who intend to commit to treating the sick.

From the data, the aspiration to help people, care for others, and compassion, mainly dominated the discourse on what inspired individuals to choose to nurse, as others also found (Al Jarrah, 2013; Eley et al., 2012). Even though such participants expressed altruism by feeling compassionate about sick people and having a passion for nursing, the generic word was having 'a calling'. According to one of the ICs and matron, this is the prerequisite to proper behaviours as already emphasised. Sister Rita remarked: "People are in a rush to be nurses, but it is a calling, and it comes with a passion for doing it. Nurses who don't have the calling are the ones likely to misbehave. If you do what you like best, you do it with a

lot of passion. You don't see it as work." The matron also explained the repercussions of the 'uncalled': "Some of them are not born nurses. Those who do not have the calling come and cannot complete it. They resign or tend to displace frustrations on patients. When you're born a nurse, you can do it no matter what".

The decision to be a nurse was more of a rational choice than an unplanned one. According to Homans (1961), individuals are motivated by their wants and goals and are driven by personal desires. They anticipate the outcomes of alternative courses of action and calculate the best step for them. Ultimately, rational individuals choose the course of action that will give them the greatest satisfaction. This is also in congruence with Blumer's meaning-making in that how the nursing profession is interpreted (say, as a means for job security) also outlined a rational choice for the profession. Of the 31 nurses, 8 attributed their choice for the profession to altruistic (desire to help others, compassion, a calling) reasons, and 23 attributed their choice to situational and economic reasons. This is of great concern for a care profession since it has to do with people's lives, unlike other occupations. I present four nurses and I juxtapose their choice for the nursing profession and their behaviours.

Georgina was among the first group of three nurses I met in the male ward and the first person I interviewed at the hospital. She was assertive, hardworking, intelligent, and particularly interested in teaching and quizzing the student nurses. While at it, she explains nursing theories to them and assists with their case studies, whether they requested such help or not. Even as a certificate holder (senior enrolled nurse), her colleagues and the IC referred questions to her because she was abreast with current nursing literature. During the interview, she called herself 'a nurse educator' due to her particular interest in reading and teaching. She had contemplated choosing between a career in teaching and nursing career but chose the latter due to her passion for the sick. She was the only nurse who constantly

explained procedures to patients while treating them, a requirement that almost all the other nurses ignored.

Just like Georgina, Kate also distinguished herself particularly with the duty most of the nurses abhorred; wound dressing. Kate was an enrolled nurse and had been on the ward for four years. She was hardworking and passionate about the job. She gave particular attention to wound dressing, and everyone tagged her with that duty and as a workaholic. On her days off, her colleagues were reluctant about that role and assigned rotation nurses (national service personnel) to it. During her interview, she explained that she had always dreamt of being a nurse because she loved to help people who were sick. Coming to work to put smiles on their faces was exciting, and she always looked forward to that. Unlike most of her colleagues, who abhorred dressing infected wounds due to the stench that accompanied some of them, she did not have an issue because she believed every patient deserved quality care regardless of their condition. Again, since she did not want such patients to feel discriminated against, she always hurriedly showed up for it and smiled and chatted with these patients while at it.

Offeibea was a senior nursing officer (SNO) who had practiced for 11 years. She was quiet and always kept to herself. Since she held a senior rank, she did not actively partake in duties but performed mainly supervisory tasks. Despite her parent's opposition, Offeibea had always dreamt of studying business at the university and applied to the University of Ghana Business School. Her parents wanted her to be a nurse because of job security. They constantly explained to her that she would receive allowances while in school, get immediate placement after school and not have to think of hunting for jobs. They bought the nursing forms and secured placement in a nursing training college. However, Offeibea was passionate and persistent about her business programme. After a long wait without hearing from the university, she gave in to her parent's choice. She was only in her second week in

nursing school when her admission came from the university. She was hurt because fees for her nursing education had already been paid and there was no way she could personally finance her university education, so she continued studying nursing. According to her, nursing school was not a pleasant experience for her and she did not like to be in school.

Nevertheless, after she started working and got acquainted with the job, she started developing an interest, but this was not long-lived because she could not endure the institutional constraints and the ill health (musculoskeletal pains) she suffered on the job. She complained bitterly about the poor work conditions daily and appeared lackadaisical during work. Currently, her only dream is to secure huge amounts of money so that she can leave nursing and start her own business. She expressed much passion for this business and a burning desire to leave her current job.

Samuela was a 34-year-old nursing officer with 10 years of job experience. She was inspired to choose nursing by her family because they found she had compassion for people who were sick in the household, even though she had always wished to enrol in a business programme just like Offeibea. As much as she did not see herself as compassionate as her family asserted, she decided to enrol when a few friends also confirmed that nursing was a good choice for her. Eventually, after school, she began loving the job but that did not abort her love for the business programme either. She enrolled in an evening school to read project management because she felt that was her first love. She argued that project management could be related to every profession and saw the patient's routine care as a research or a project she was embarking on. She intimated: "Previously, I thought you should be working on a big building to be termed as a project but the everyday work of attending to the client and doing your nursing care plan on clients are all projects." She again furthered with health administration, where she learned about finance and administration. On the ward, she had a

particular interest in documenting, writing bills (before that duty was delegated to a billing officer), and the managerial aspects of the job. She preferred to do all the paperwork while her colleagues did the caregiving. She commanded much respect due to this expertise and had a good relationship with patients and relatives. According to her, patients love her because of her nursing style to the extent that some patients have even become like family.

These stories typically exemplify categories of nurses; those who chose the profession and love the job, those who ended up in the profession for whatever reason but have reconciled with the profession and are doing well, and those who ended up in the profession and still do not want it. Unlike Georgina and Kate, who were ‘born nurses’, it was obvious that nurses who did not have this calling struggled to keep up just like the case of Offeibea, who was compelled to join the profession for economic reasons and now desperately wanted to quit, confirming the matron’s position. Such nurses lacked the zeal to withstand the demands and constraints of the work and tended to perform undesirable behaviours. Jirwe and Rudman (2012) emphasised that students who were compelled into the profession or ended up in it “by default” and not because they were willing often were more stressed about the job than those who chose it based on their autonomy. Samuela is a typical case of nurses who join for non-altruistic reasons yet, come to terms with it and begins to enjoy the profession, impacting her behaviour positively.

Having a secured career was very important for those who chose the profession for economic reasons, as stability and security in one’s life are essential. Just as this resonates with other findings, the profession is envisioned as popular, lucrative and job-ready in every part of the world (Wilkes, Cowin & Johnson, 2015; Al Jarrah, 2013; Eley, Eley & Rogers-Clark, 2010). From the Ghanaian perspective, according to Asamani, Agyemang, Afful and Asumeng (2018), due to the high unemployment rates in the country, students are forced to choose

their future careers wisely. Consequently, many join the nursing field not with a similar mindset as Florence Nightingale but to secure job placements.

Even though those who chose for economic reasons were not too explicit about it, the student allowances, the assumed good salaries and job security mainly inspired this rational choice.

The government of Ghana pays monthly stipends to student nurses to support their education, popularly termed allowance or ‘allawa’. This allowance has become a form of enticement for many young people and parents to enrol themselves or their wards, respectively, considering the economic hardships. More interestingly, since the payment of the allowances to fresh students is usually delayed, huge sums of money are paid as ‘back pay’ to such students after the delayed months (or sometimes even a year). The bulk of funds received becomes capital for a small business, investments, fees, and acquiring properties.

Davida revealed: “There are some colleagues, judging from their poor attitudes, they don’t have nursing at heart, but due to the allowances, they claim to be nurses.” Eric also pointed out the ‘supposed good salaries’: “Some want money because they think the government pays nurses a lot of money. Unfortunately, when they come, they end up shocked and frustrated about the salaries we take!”

The economic reasons are not only for the present but also for future financial security. That is, receiving a lump sum of money and monthly benefits after retirement as public sector workers are entitled. This Social Security and National Insurance Trust (SSNIT) for pensioners also informs the choice for the profession. Hence, the job is not only beneficial for the present but also for future pension. Job security abroad is another crucial economic reason for choosing the profession. With the limited number of jobs in the country, it is only prudent for people to rationally consider nursing, looking at its benefit in ensuring a secured career both within and outside the country, just as others have reported on the emigration of nurses (Galbany-Estragués et al., 2019; Bofo, 2016).

The situational factors to joining the profession typically stemmed from family's choice/tradition, university rejects and 'disappointed doctors'. Some researchers (Wilkes, Cowin & Johnson, 2015; Neilson & Jones, 2012) affirm that family tradition always comes up as one of the primary considerations for choosing renowned professions. As has been the trend for some families that their children hold similar careers as the parents, grandparents or other relations with prominent jobs, this was the case for some nurses who were either advised or compelled to join the profession to uphold the family's image. Some others (Wall, Dhurmah, Lamboni & Phiri, 2015; Price, 2009; Beck, 2000) similarly attest that early socialisation experiences, including interactions with nurses and the healthcare setting, also have a strong influence on an individual's perception of nursing and the decision to be a nurse. This was precisely the case for Sister Rita, and this is her explanation for how she naturally fell in line with the profession: "Nursing has always been a part of me. My mum was a nurse; she worked at Nyaho Clinic for 20 years, so I had been in the nurse's quarters all my life. There were days I even accompanied her to work. That's how I just fell in line with the tradition!"

University rejects who had desired to be graduates of other programme in business, law, social sciences, engineering etc. but were denied due to their inability to attain the cut-off points of the respective courses, rationally considered nursing as another career opportunity. For instance, Augustina (Staff Nurse) said: "I didn't do well in Mathematics but I told my dad I didn't want to rewrite it because I would fail again so I'll do the nursing he had been insisting on because I already love the nursing uniforms".

This can be attributed to the availability of many nursing institutions. Unlike the universities, individuals who made poor grades and did not meet their cut-off points could still enroll in nursing training schools to be auxiliary nurses (certificate programme). This probably

explains why the majority (18) of the participants were certificate holders as compared to those with diplomas (12) and degrees (1). Sister Betty explained:

When they don't pass their West African Senior School Certificate Examination (WASSCE), they prefer to do certificate nursing to be enrolled nurses instead of the person to rewrite. Since it's for only auxiliary nursing, you can still be admitted even if you do not pass well.

The availability of these certificate nursing training schools worried many participants. Participants believed that the certificate course in nursing, which is the enrolled nurses/auxiliary nurses/HAC (health assistant clinical), is unnecessary since it does not train students to be full-fledged nurses. This is because the grounds for their training is that the Ministry of Health created auxiliary nursing to be non-professional nurses who will mainly work under the supervision of health professionals. It was made for senior high school graduates with relatively lower grades than the professional nursing programme required. They also do not require any previous knowledge in any health-related field to be admitted. Hence, they are trained to assist professionals (Ministry of Health, 2011). Yet, from observation and as participants also confirmed, there was no difference in the jobs staff nurses and enrolled nurses performed in the wards. This is because nurses at both male and female wards did not strictly follow the job descriptions for each of the ranks, so participants did not see the need for making one an assistant if they were virtually going to do the same task.

Even the ICs especially, wanted this system scrapped because according to them, by regulation, every shift is supposed to have at least one staff nurse and one enrolled nurse. Yet, there are instances where ICs cannot implement this regulation because more enrolled nurses are posted to the hospitals, thus, outnumbering the staff nurses. However, enrolled nurses are not required to manage a ward alone due to their limited training (two years compared to three or four years for a diploma or degree, respectively). Since most of such

nurses only took advantage of the availability of the certificate programme (even though some chose them out of ignorance because they could have enrolled into the diploma programme), most were not ‘called’ nurses, so they tended to behave more poorly than the ‘called’. This corroborates the views of researchers (Oppong-Darko, Amponsa-Achiano & Darj, 2017; Teodosio & Padilha, 2016) who found that some nurses have been forced into the profession due to the lack of desired professional opportunities and so, becoming a nurse was the only available opportunity at the moment.

To meet the global standard of patient safety, good nursing leadership, and quality care, the WHO has charged countries to have their nurses educated to at least a degree or higher (World Health Organisation, 2009). This agrees with the Institute of Medicine’s (IOM) recommendation in 2010 for at least 80% of registered nurses to acquire and practice with a bachelor’s degree by the year 2020 (AMN Healthcare, 2016), as seen in many developed countries such as the USA and the UK. Thus, becoming a nurse is only through getting a bachelor’s degree at the university and not as an alternative plan when people cannot enrol in their choice programmes, as is the order in Ghana.

The final category is what I term ‘Disappointed Doctors’. They are those who initially wanted to be medical doctors but could not pass their final examination from the senior high schools with the required grades to read medicine. Even though they were hurt, they consoled themselves by attending nursing training schools because it was all part of caring for the sick. Diana recounts and even rationalised this decision as an even better option:

I’ve always dreamed of reading medicine, so I usually say I’m a disappointed medical student! (laughs) Yet, I saw nursing as another opportunity where I could help people. With nursing, you are even privileged to spend more time with the sick and help them better. The doctors only come around to prescribe, but nurses are with patients till they are discharged.

In another study about the choice for the nursing profession, participants confessed to similar facts that they settled for nursing schools because they did not qualify for medical school, which was their first choice. Nevertheless, since their goal was to give care, they opted for nursing as a second choice (Teodosio & Padilha, 2016). Also, four out of the five male nurses initially wanted to be medical doctors but did not pass into medical school and decided to choose to nurse. Nevertheless, three of these four still had plans to pursue medicine after some years of nursing, or they made this rational choice as a stepping stone to becoming doctors in the future. Moro also had a similar plan: “I love the health side, so I settled for nursing, but from here, I’m going to be a doctor.”

On the contrary, none of the females who had initially wanted to be doctors still had that plan at the time of the study. They mostly attributed this to parenting and a lack of funds, although the males also faced similar constraints. The fact that the males still envisioned being doctors is also reflected in their behaviours. They were gentle, reserved, hardworking and friendly with patients. Unlike some female nurses who took intermittent breaks now and then, the male nurses were constantly on their feet during work and only sat when they had to document or eat. They were also instrumental in manual duties such as lifting patients, pushing them in wheelchairs and fixing flow meters on cylinders. Even on days, the wards were very busy, they did not appear stressed or worn-out but still managed to smile while attending to patients, unlike some of their female colleagues who looked weary and whose behaviour was likely to be poor when stressed. Since they are also more often perceived as doctors (Achora, 2016; Wall, Dhurmah, Lamboni & Phiri, 2015), it boosted their confidence too. Even though the nursing profession has been female-dominated since time immemorial and according to Mott and Lee (2018), male nurses have always been the odd ones out, these male nurses did not envisage their oddness as a weakness but an excellent resource for the ward and hospital. Moro emphasised:

I see that health facilities welcome and cherish male nurses better than females. Every facility would like a male nurse even though we are scarce. Most patients think we are doctors, so they respect us better than our female colleagues. Even those who know we are nurses still give us better respect because they are not used to seeing male nurses.

Whereas the male nurses felt privileged over their female colleagues and admitted their gender as a valuable resource to the institution, they argued that it challenged them to behave even better. This was also a rational choice in anticipation of having good recommendations for their future goal of being doctors.

This also aligns with the prejudiced gendered conception that nursing is a female job and doctors, a male one. LaRocco (2008), highlighting the stages through which men are socialised into nursing, discovered that in the first stage, which usually happens in senior high schools, teachers and counsellors only recommend nursing as a career to female, not male students. Male students are advised to consider other medical careers, such as physicians, physical therapists or physician assistants, before considering nursing when these male-centred jobs fail. Others (MacWilliams, Schmidt & Bleich, 2013; Pryjmachuk et al., 2009) have also claimed that male nurses are more likely to drop out of nursing school than their female colleagues because of the strain they experience in a female-dominated profession. They mostly felt lonely and alienated (Christensen & Knight, 2014) and sometimes were even stereotyped as unmanly and gay (Dyck, Oliffe, Phinney & Garrett, 2009). Ellis and Meeker (2006) espoused that the few who decided to remain considered the investments already made into the academic programme.

The situational decision to be a nurse also included a few instances where participants revealed they were enrolled in the nursing training colleges because they knew prominent people in a nursing college so after the university rejected them, they just had to use that opportunity. A few also attributed this choice to their admiration for the cute nursing

uniforms.

Though it cannot be concluded emphatically that all nurses who choose the profession for situational and economic reasons are the culprits of poor behaviours, from observation, nurses like Georgina and Kate who chose to be nurses were exceptional in their duties, unlike Offeibea who was forced into the profession, has given up, and is thus lackadaisical. Similarly, male nurses using nursing as the path to a career as doctors were also not observed engaging in poor behaviours. As has been reported, when people do not have an interest in their jobs, there is a high tendency for poor-quality work (Ha, 2015; Koushali, Hajiamini & Ebadi, 2012). Therefore, developing an interest in the job even if one did not have a ‘calling’ is imperative, just like Samuela, who devised means of accepting and coming to terms with the profession. Asamani et al. (2018), as well as Danziger and Valency (2006), also emphasised that when there is a congruence between the career one aspires and the demands that come with it, such individuals are more likely to be more involved, evaluate their career positively and achieve satisfaction with the job than those who lack such congruence. As Jirwe and Rudman (2012) also reported, those who did not choose the profession for altruistic reasons were more stressed than those who did. Since this is the reality, patient-nurse relationships are likely to suffer. Therefore, as a rational choice was made to be a nurse, a rational and conscious development of interest, inner drives, and the right competencies is necessary to provide exemplary care and a satisfying work experience with patients/relatives.

5.4 Power

Whether they are aware or not, nurses occupy a place of power relative to their patients (Corless, Buckley & Mee, 2016). In his seminal work on nursing, Foucault (1977), analysing the relationship between patients and nurses had stated that, the oscillatory effect of power

emerges in the nurse-patient relationship due to his position that, “for patients, nurses are holders of knowledge for the act of care and, for this reason, they are submitted to power and knowledge both by need or dependency and by the authority of the professional discourse and the truth that power imprints on it” (p. 27). Power, thus, becomes a prism through which the behaviour of nurses can be analysed. In some studies, such as the works of Baptista et al. (2017) and that of Sepasi, Borhani and Abbaszadeh (2017), nurses’ agency in terms of the feeling of power emanated from their ability to advocate and speak on behalf of patients, participate in inter-professional rounds, have good relations with doctors, and be involved in the plans for patients care. In this study, however, power manifested in the forms of knowledge, resources, and ranks/positions embedded within the network of relations between nurses and their patients. It typifies Blumer’s stances of symbolic interactionism in that interactions with patients are premised on these forms and the meanings nurses assign to them.

5.4.1 Knowledge, Resources and Power

In his post-structuralist discussion on power, Foucault (2003) argued that there is a dialectical relationship between power and knowledge in that power produces knowledge and knowledge, in turn, produces power. This Foucauldian analogy was evident during interviews conducted for this research as the findings indicate that, the more knowledgeable a nurse was, the more powerful they were considered on the unit. It was realised that acquiring the prerequisite knowledge and skills in nursing just like everyone else was not extraordinary. Exceptional nurses had some unique or additional knowledge in addition to the rudiments of the nursing profession, which gave them a sense of power. According to Sepasi, Abbaszadeh, Borhani and Rafiei (2016), having up-to-date knowledge, skills and experience is the bedrock of power in nursing. This is typical in the case of Georgina,

described earlier. Though she was an enrolled nurse, her up-to-date knowledge of nursing literature placed her on a higher pedestal among her peers.

In addition to their nursing licences, a few nurses also had certificates in specialised fields such as pharmacy, nutrition, geriatrics, and project management. Even though these nurses did not work as specialists but as general nurses, this additional knowledge made them stand out in their healthcare delivery. Some were also known for their exceptional skills, such as setting IV lines with only one or two attempts, giving painless intramuscular (IM) injections, and single-handedly managing a ward. According to participants, these additional certificates and skills more often influenced behaviours towards patients positively than negatively. Samuela, the nursing officer with an additional degree in project management, asserted:

They say it's a business course, but to me, it can be related to every profession. The care of the patient is a project you are embarking on. I also did health administration and management, so they teach you a bit about finance, administration, and business so you become a utility nurse. I can work in every department they put me in, which gives me extra confidence in the job.

This suggests an expression of power evidenced in her confidence which is useful in patient care. Fackler, Chambers and Bourbonniere (2015) also attributed confidence to power. The case of Augustina suggested that knowledge did not have to be scientific to lead to a sense of power. She confided in possessing a spiritual knowledge of events before they unfolded. Augustina is a thirty-year-old junior staff nurse with two years of work experience. She is single, a Christian and the first child among three children. Even though she had always aspired to be a journalist, her grandfather insisted that nursing would suit her better. She only obliged because she already admired the cute nursing uniforms. However, work as a nurse has not been all rosy because of her ability to see some events, especially death, even before they occurred.

She experienced this first before her father died when she was younger. The events unfolded before her eyes even though she was wide awake. Not comprehending what was happening, she confided in her mother, who rebuked her for speaking ill of her father. A few days later, the events occurred just as she had seen, though her mother felt it was a coincidence. She perceived that this ability started manifesting after being baptised at about twenty-one years of age. She also confessed to having pre-seeing the death of her uncle and other family members. She has not been able to open up to colleagues about this for fear of being branded a witch, just like her mum did not believe initially. Enquiring how this spiritual knowledge impacts her work, she revealed:

Some of us nurses see things beyond the physical. I can perceive if a patient will die, so I'm scared of getting close to them because they might "die on me". I don't want to be the one who was nursing them when they died. Once, there was this child who was admitted and very restless. She struggled with every nurse who came to her. She undressed and even removed the cannulas. I realised she would die soon, and I didn't want to get close, but when they all couldn't help because they didn't understand what was happening, I went to her and calmly said, I know what is happening, be calm...be calm, let me reset this intravenous (IV) fluid for you, and then you can go in peace. She calmed down, and I did it. I left for the house, and when I returned the next morning, she had died that night. Since I know they will die, I usually don't want to be around during that shift. It's not easy knowing something and yet being helpless about it. I have seen several such circumstances, but I don't want to talk much. They are not pleasant sights to be recalled. Let's end it here.

As much as this knowledge confers on her a subjective power, that is, a sense of individual power (Smith, Wigboldus & Dijksterhuis, 2008) and could be instrumental in her care delivery since she could control situations better, as she asserts. She rather avoids such instances or patients due to the distress that accompanies them. This scenario also shows that the power that comes from this knowledge could be channeled to profit patients, in the case of Samuela, or destructive to impede quality healthcare, in the case of Augustina.

Knowledge is not the only determinant of power. Another facet of gaining power and what it meant for nurses' interactions with colleagues and patients was resources. Hawks (1992)

envisages empowerment as the capacity to use resources to attain goals. These resources give a person the possibility to ‘influence’ others as well as achieve goals (Sepasi et al., 2016). Owning a car was a ‘big deal’ among the nurses in XYZ district hospital. While others considered it a necessity due to feasible transportation to work, some participants deemed it a luxury, and the persons who owned it were perceived as powerful. Participants confessed that nurses who personally drive to work are accorded a different kind of respect by other staff than those without cars. They attributed this to the fact that nurses’ salaries in Ghana are meagre, so it was quite unusual for a nurse to acquire such expensive assets. Therefore, one’s ability to attain this, breaking out from the status quo, is remarkable and worthy of respect. One nurse in Sepasi et al.’s (2016, p. 12) study conceded: “The truth is that power is absolutely meaningless without money, I cannot define power without financial resources; power does not really make any sense without financial resources.”

As Bourdieu (1986) calls it, this economic capital serves as a fuel to prestige and confers a sense of power to such nurses. Kate (not a car owner) intimated: “In this hospital, if you don’t have a car, they don’t respect you. It is a common thing. They see you as poor. It even comes with the type of cars you use!” Participants were optimistic that this reality in the hospital put a strain on nurses who desired to own one but were incapable and those who owned one yet struggled to maintain it. Sister Betty (a car owner) also revealed:

Here, everybody wants to buy a car. I’ve heard that there’s even a club for car owners. It puts unnecessary pressure on the other staff who don’t own one. I’ve heard instances where people have fought their husbands because other husbands bought a car for their wives. After forcing oneself to own one, now the person uses it for two to three weeks, only to realise they’re on foot again. They had forgotten about fuel costs, insurance, maintenance, and all the expenses of owning a car. Yet, you’ll continue paying for the loan you took to get the vehicle! It can even affect caregiving because such nurses are under mental stress.

Enquiries to investigate this ‘car club’ proved futile as participants who owned cars refuted being part of the group even though they were aware such a group existed. Nonetheless, it

was clear that the strain that comes with it could affect interpersonal behaviours. Sister Rita recalls:

Some people choose to misbehave in the hospital by virtue of what they possess, but it's not the best. They're rich, so they misbehave. One of them bitterly insulted me because I parked my then old car in the car park. In her view, since she drove a new car, she needed a better spot to park than I did, so I should rather park under the trees. This lady is only an enrolled nurse at another ward, and I was not only a principal nursing officer but also an IC!

She admitted that she was so mad about the situation that it almost affected her interpersonal relations and caregiving that day. This is no different from another resource in the form of 'connections', which Bourdieu (1986) refers to as social capital. Some nurses were highly connected to influential people in Ghana, including ministers, parliament members, and some Ghana Health Service officials, among others. While some participants confirmed that such connections did not necessarily affect how they behaved towards patients directly, they admitted such links made some nurses pompous, causing them to behave lackadaisically on the job, affecting productivity and interpersonal relations with colleagues and, consequently, patients. Offeibea remarked:

...sometimes, they say protocol. This person came from this... he's the director's cousin, a minister's niece, or whatever! Who asked the person to work here (raising her voice)? When the person misbehaves, nobody talks about it because nobody wants to have their name in the bad books of those people!

There were also nurses whose influence came from being close acquaintances with officials in management and administrative positions within the XYZ hospital. These nurses mainly attained this status because of the long duration of work in the hospital. Davida observed: "Some know the big people in these offices, so she will ignore whatever you say even if you are her senior". Sister Betty also added: "I've worked here for a very long time, and because I'm hardworking, I've earned my name and become very influential in this hospital!"

While there is nothing wrong when people are influential or have connections with prominent people who can be of support in times of need, the worry is if such privileges are

consciously abused to act improperly. As confirmed, individuals may intentionally make conscious decisions to act wrongly (Anckarsäter, Radovic, Svennerlind, Höglund & Radovic, 2009), and they may have such confidence because of the influential people they know, which supports Foucault's theory of how knowledge and resources empower nurses. The next section emphasises how nurses' power affects proper patient care.

5.4.2 Ranks/Position and Power Contestations

Foucault (1979) posited that knowledge ascribes authority and truth value to power, serving as its conducting element. The knowledge and experience nurses acquire confers on them ranks/positions which puts one above the other. This rank/position and its accompanying power were visible in how nurses perceived themselves. Junior nurses (including enrolled nurses and staff nurses) expressed delight in having passed all their requisite credentials or secured their current ranks in nursing and being in control. This is how Princess, a junior nurse, describes it: "It feels great! Yeah, great! It's a dream come true. It's like travelling and waiting to board the car, and finally, it arrives...and the best part is arriving at your destination! That's what the feeling is like!" Not only did junior nurses express joy in feeling powerful, but senior nurses (including nursing officers, senior nursing officers and principal nursing officers), who had also attained higher ranks, such as senior staff nurses or nursing officers, expressed similar sentiments. Sister Betty remarked: "Before assuming this position, if some changes needed to be done, my IC could ignore my suggestion because I'm not in charge, but now that I am the IC, I have the final say here!" Fackler, Chambers and Bourbonniere (2015) call this the 'powerful self' when they espoused that nurses having their voices heard positively impacts their patients and themselves. These expressed sentiments demonstrate that power first comes from actualising one's dreams or goals and when one is placed in control of people, which supports Parsons' (2010) position of power

as the capability to achieve goals. What is eminent in this section is how power explains some nurses' undesirable behaviours towards patients.

Researchers affirm that the discrepancies over power generate conflicts that impact the work environment negatively (Arias, Moreno, Callata & Manrique, 2020). The ranks in the nursing profession show that nursing has a pyramid structure in which power levels are stratified (Sepasi, Borhani & Abbaszadeh, 2017), as presented in chapter 4. The colour of one's belt differentiates these ranks, the colour of one's uniform, or the colour of one's collar. In descending order of administrative structure, the matron wears a white dress and a purple belt; principal nursing officers wear a white dress and a green belt; senior nursing officers wear a white dress and a blue belt. Nursing officers wear a white dress and a white belt. Staff nurses (seniors and juniors) wear a green dress with a white collar and a full white band on the sleeve, while enrolled nurses (seniors and juniors) wear green with a green collar and a full white band on the sleeve. Students in a degree programme wear a white skirt and top, diploma students wear a green dress with a white collar, and certificate students wear a green dress with a green collar. The number of white strips on the sleeve of a student's uniform indicates whether she is in the first, second, or third year (which makes it easy to identify and assign roles on the ward during their clinical work). On the other hand, male enrolled, staff and student nurses wear white shirts and brown khaki trousers until they get to the rank of nursing officers, where they wear white shirts and white trousers.

Nurses who start their profession with a diploma (staff nurses) and certificate (enrolled nurses) feel they have a lot of practical experience since they do more practical than theory as compared to nurses who begin with a degree (nursing officers) who do more theory and research than practical. Since nurses with degree certificates enter the profession at a higher status, the old and experienced non-degree-holding nurses must take instructions from the

new and somewhat inexperienced highly educated nurses bringing about some contestations.

This is how Evelyn explained the issues relating to ranks:

The ranks bring many conflicts which sometimes affect patients. If someone starts as a staff nurse, they will work for about 5 years before becoming a senior staff nurse. It will take another 4 to 5 years before she becomes a nursing officer (NO). The staff nurse will work in the ward for about 9 to 10 years before becoming an NO. Meanwhile, someone finished a degree course in nursing, and with no work experience, she is already a NO. Both are supposed to wear white dresses; this alone is a big problem among nurses. The fact that one just came straight from a university to become an NO is enough reason for that nurse to be hated. Some of the NOs who have just come from the university feel they know better than the diploma holder, who is even more experienced so when a graduate NO tells a staff nurse with experience to do this, she is like, 'who are you to tell me what to do? Because you came from the university, you think you know more than I do? Do you know how long I've been here?' My sister, it is a big issue! I've been on the ward for 10 years. I see this happening day in and day out, and when we struggle over this, contesting over power, it is patients who suffer because then, you don't show positive attitudes or give off your best.

Sister Rita also added:

I am a principal nursing officer (PNO) and have worked for twenty years. Someone is also a PNO and has worked for twelve years because she attended school early or university. We are both at the same rank, but when one has to be an IC, they will choose me before they choose her, and she will not accept it. There are grievances among the rank holders. Some will not want to accept someone's rank because she was in the hospital before the other came. That "you cannot tell me what to do" attitude ultimately affects patients because we ignore them, thinking this person has to do this duty and not me.

Further, aside from the rank conflicts, a display of power suggested domination and coercion between seniors and juniors. As Sieloff (2004) found, powerless and oppressive behaviours continually happen because of individual interactions within workplace environments. Foucault (2014) attributes this power relationship to being determined by superiors' ideas, which are usually undisputed. Duffy (1995) also reinforces that these oppressed individuals are afraid of challenging the oppressor for retaliation, and so, they direct negative feelings such as anger towards their own group or others who are less likely to retaliate, in this case,

to patients. Due to this senior versus junior nurses' brouhaha, some senior nurses wrongfully exercise their power on junior colleagues, affecting junior ones and, consequently, proper nursing care. Junior nurses expressed that senior colleagues often discriminated against them, had zero tolerance for mistakes, and lorded their positions over them. Augustina, a junior nurse, recalls how a senior nurse lorded her position over her:

She did not allow anyone to sit even if they were not busy. You'd stand even though there was a chair available, and so we were always tired, and you know, stress affects output. There are people like that who lord their positions [over others]. Others are naturally unfriendly and don't talk to anyone when they come to work. If we don't communicate, how do we nurse patients?

I observed student nurses on the female ward go through a similar experience that Augustina described. They were sometimes made to stand for long hours even when nothing was going on and according to the IC, she wanted to keep them active. This buttresses Fackler, Chambers and Bourbonniere's (2015) observation that some of the more experienced nurses who are to serve as mentors to less experienced nurses lord it over them as a sign of their powerful selves. Wilson (2016), describing the situation in the United Kingdom and other countries in a systematic review recorded that about 20-25% of nursing staff experience bullying behaviour from senior ones and this confidence comes from the positions seniors occupy. That is, one experienced and the other inexperienced, which impacts patient care negatively. In fact, Moore, Leahy, Sublett and Lanig (2013) discussing nurse-nurse interpersonal relations expounds that such behaviours have become persistent and, in some settings, the norm. Yet no one sees anything wrong with that. Diana, a nursing officer, also illustrated how colleagues' behaviour affects patients:

Assuming you make a mistake and your superior talks to you harshly, how she approaches the situation can offend and affect you. For example, when I was a junior some years back, my IC asked why I had not served a patient's medication. I told her I thought my colleague had done it because I saw her serving medications. She reprimanded me badly for not checking, and I ended up displacing my anger on the patient while I served it. Yet, it was not the patient's fault. I later apologised to the patient.

As much as this IC was right about reprimanding Diana since this negligence in caregiving could cost a patient's life and should not be tolerated, the emphasis is on the manner in which this was done. Power applied on the part of a senior nurse can lead to a junior nurse's anger which is then displaced on a patient. The ability of a junior nurse, who is even at fault, to behave poorly to a patient illustrates that power and domination is not the preserve of only senior nurses. The poor power dynamics between junior and senior nurses could be a source of strain for junior nurses and patients. This has been affirmed by other scholars, such as Sarafis et al. (2016) who lamented that sometimes there was insufficient support from superiors who only provided feedback on poor performance. This made juniors feel that their seniors were always waiting for them to make mistakes since they did not get recognised for good work.

Augustina also described how seniors sometimes abused juniors: "She once asked my colleague in the presence of patients, 'what use are you as a nurse? Who asked you to be a nurse?'" My colleague cried the whole day. Since then, we realised she didn't have confidence in the work again and became very timid and couldn't get treatments right, almost affecting patients." Mabel, an enrolled nurse, also corroborated this view:

There are some seniors (chuckles)...you suffer when you work with them. They have attitude problems, and it is so bad that it can affect your delivery. Your IC can scold you so harshly that you can't even work. You can't do the job well because you get frightened whenever you see the IC. There is no use putting fear in people!

This finding substantiates other findings that show powerlessness also has the propensity to influence nurse outcomes. They argued that the sentiment of powerlessness among nurses and the lack of control over their work affects patient care quality and leads to job dissatisfaction and turnover (Aiken et al., 2013; Perron, 2013). According to Sepasi et al. (2016), nurse managers display this domineering power that leads to fear and is ultimately

doomed to failure. Nevertheless, participants also commended some senior nurses who are down-to-earth, and motivating, still do odd jobs and can properly put juniors under control.

On the flip side, junior nurses were also not devoid of undesirable behaviours. Though participants commended most of them for being well-behaved, they admitted that a few were lazy, disrespectful and pompous. Some of these traits sometimes get on the nerves of seniors during supervisory roles, leading them (seniors) to behave as discussed above. This is what Joanna, an assistant in-charge noticed:

When you don't control the students and juniors, they won't work. You'll see them in their numbers, but they won't do anything meaningful to help you. When they are wrong, you need to reprimand them because they can be very stubborn and can make trouble for you, so you have to control them.

Which of these two groups is the culprit for poor behaviours towards patients/relatives? Between senior and junior nurses most participants admitted that senior nurses were more likely to misbehave towards patients than junior ones. They explained that junior nurses were mostly timid, reserved, inexperienced, careful to stay out of trouble to avoid any sanctions, and lacked the confidence to be rude to patients. Meanwhile, senior nurses, especially those who had been on the ward for long, were more assertive and frank but analytically, this is because seniors are highly skilled and knowledgeable of their profession as compared to juniors confirming Foucault's (1977) position. An example was Bernice, a senior staff nurse who, although not an IC, commanded a lot of authority. She is the nurse who described herself as being loud and perceived to be shouting if one did not know her as mentioned earlier. She hardly smiled, and her command to relatives to leave the ward when visiting was over was always loud and imposing. Most relatives got offended by that. She was the only nurse in the female ward I witnessed, challenging doctors on several occasions if she did not agree with their treatments. Even though relatives and student nurses tried hard to avoid her, her colleagues admired her assertiveness and fearlessness. Some participants

opined that seniors wielded more power and so were more likely to have the confidence to be rude. This is what Davida, a senior staff nurse, expressed about higher ranks and their relative behaviour:

I wonder whether it's a spirit or something that suddenly possesses them when they rise. Maybe I'm saying this because I'm not yet there, but I see that mainly as a habit of the nursing officers, the senior nursing officers, and the principal nursing officer positions. All those who wear white, that spirit (undesirable behaviours) is in those categories than the rest of us! Their behaviour is not so nice to patients and even us!

Similarly, other studies (Rosen et al., 2015; Leape et al., 2012; Prytherch et al., 2012) have attested that senior colleagues or providers who have worked in a facility for long engaged in the disrespectful treatment of clients because of the exposure to the unrelenting challenges in the health system and had become less compassionate. This validates Benner's (1984) analysis of the distinction between a novice, an advanced beginner and a competent nurse. Benner postulates that younger nurses are focussed on the patient and more occupied with their learning process and ability to gain their competencies and skills than senior colleagues who are more advanced in caregiving. Unsurprisingly, most of the participants in this study argued that junior nurses were less likely to engage in wrongful behaviours.

The few who felt junior nurses were more likely to behave poorly towards patients also explained that junior nurses have more contact with patients since senior ones mostly perform supervisory roles. Monica, a senior nurse, observed:

Usually, it's the junior nurses who are rude to patients. As your rank increases, your responsibilities to the patients are not very direct. You mostly do administrative work and only supervise the junior nurses. You are there to teach, criticise and correct them. The junior nurses are more responsible for everything the patient needs.

Aside from junior nurses who have more contact with patients and are hence more prone to undesirable behaviours, as some participants confided, Luttik et al. (2017) and Blöndal et al. (2014) also attest that younger nurses and nurses with lower educational levels also tend to consider relatives burdensome and stressful since such nurses were inexperienced as

compared to their senior colleagues. Nevertheless, this argument seemed to be a blame game between senior and junior nurses, but from observation, senior nurses were mostly the culprits and because they wielded more knowledge and more power as Foucault (1977) rightly argues. They mostly wore straight faces when interacting with patients and relatives and always appeared busy documenting.

Interestingly, male nurses did not care about the symbolic power their knowledge or position offered them nor were they concerned about the rank contestations. Francis observed: “The ladies are always more concerned about their belts, too concerned! Guys are not like that. You meet a male senior colleague and he’s in khaki instead of white trousers. He doesn’t care but the females always fight over power.” This ‘carefree behaviour’ could be because the male nurses were mostly perceived as doctors, and so they did not have to contest for power, they already owned a ‘powerful self’. In addition, since their goal is to be doctors, they somewhat did not ‘have the belongingness’ in the profession so why spend time fighting over nursing ranks?

In sum, as Huston (2021) posits that power is instrumental in interactions and the demonstration of behaviours as well as a potential for changing the behaviour and attitudes of others. While most studies (Baptista et al., 2017; Sepasi et al., 2016; Polifroni, 2010; Foucault, 1977) on nurses’ power have emphasised how knowledge empowers nurses in relation to patient care, this theme adds to the domination and coercion as an expression of power and who is more likely to abuse their power on patients between senior and junior colleagues. It sides with White (2009) that as much as knowledge is an essential antecedent to self-power, in the display of improper behaviours, it is not a sufficient condition but other precursors, such as the level of experience, the positions, and resources owned become essential. This shows how power is a factor to explaining nurses’ behaviour.

5.5 Conclusion

This chapter sought to understand individual nurses' precursors to some improper behaviours. It was found that the individual's behaviour is first formed from socialisation at home, which shapes their character. Nurses' good or poor characters mainly were revealed in their speech and values, while personality, the less conscious aspect of the individual, manifested in nurses' temperaments and moods. Most importantly, the perceptions of care nurses held as a result of secondary socialization from schools and peers also defined how a nurse perceived a patient. The perceptions of state-owned institutions were also instrumental in understanding behaviour. Such perceptions and the meanings they made for nurses, as Blumer postulates, influenced nurses' behaviours towards patients and relatives.

Again, the symbolic meanings nurses make of the profession also inform their choice for the career, be it altruistic, economic or situational. It was realized that most nurses made a rational choice for the career purposely for financial and job security (economic) and not necessarily because they had a calling or passion for the profession (altruistic). Others became nurses because they were compelled to by their families, could not make it into the university, or were 'disappointed doctors' (situational). Hence, some nurses' undesirable behaviour is due to the fact that they did not want to be nurses in the first place. While others had adjusted to the job by consciously developing an interest in the profession, nurses who had still not come to terms with it were more likely to be lackadaisical about the job.

Finally, the meanings and interpretations nurses made for the power they wielded were useful in understanding nurses' behaviour. Just as Foucault has championed, power first manifested in the knowledge nurses held, which was crucial in contributing to proper or improper behaviours. It was again realised that not only knowledge conferred a sense of power on nurses, but also the resources owned (social or economic capital), as well as the

positions held, helped understand the contestations between nurses and how that consequently influenced poor behaviours towards patients.

The need to maintain professionalism by getting more committed to their service to patients, according to Roulin, Jonniaux, Guisado and Séchaud (2020), would go a long way to transform the current situation with patients. Hence, the right perceptions of care, consciously developing interest in the profession, and exercising power correctly are crucial to appropriate nursing care. Nevertheless, the individual's precursors are not the only contributors to performing behaviours; other factors are also imperative in understanding nurses' behaviours towards patients/relatives. Hence, the next chapter discusses the social and structural factors influencing nurses' behaviour.



CHAPTER SIX

THE THINGS THAT EAT ME UP IN THE HOSPITAL: SOCIAL AND STRUCTURAL PRESSURES IN THE WORLD OF NURSING

“I come to work because I must come; the passion and commitment with which I started nursing no longer exist. They have reduced considerably because of some occupational challenges” (Davida, fieldnotes)

6.1 Introduction

This chapter delves into the social and structural pressures influencing nurses' behaviours and their impact on patient care. It highlights how interactions with patients, relatives, and colleagues can create significant challenges for nurses, often leading to undesirable behaviours that compromise therapeutic engagement. The chapter also addresses the institutional and systemic factors that affect job commitment among nurses. Issues such as inadequate salaries, lack of motivation, and insufficient resources are discussed. The chapter employs Anthony Giddens' (1984) structuration and Herbert Blumer's (1969) symbolic interaction to analyse the social and structural precursors to understanding the undesirable behaviour of some nurses.

6.2 Nurse-Patient Relationships

Nurses interact with patients and relatives from admission to discharge, playing an integral role in healthcare delivery to patients (Babiarczyk et al., 2020; Midilli et al., 2017). The data reveals that a nurse's behaviour reciprocates a patient's or relative's actions or inactions. That is, nurses constantly interpret patients' behaviours, and the symbolic meanings of these behaviours have been found to serve as triggers for how some nurses behave (Blumer 1969). This was mainly demonstrated in patients/relatives' ability to cooperate with healthcare providers in the therapeutic process.

In healthcare provision, participants mainly identified that the degree of cooperation from patients/relatives made their work more manageable and facilitated corresponding and conforming behaviour from nurses. Even though nurses acknowledged they always had to put on their best behaviours in caregiving, it was effortless when patients exhibited certain good traits of mannerisms, respect, cooperation, adherence to financial obligations and when relatives assisted in caregiving. Hall and Glew (2017) also identified that the readiness for patients to open up because nurses are in a more suitable position to cultivate a solid therapeutic relationship and establish trust leads to quality care from nurses and patient satisfaction.

Nurses expressed delight not only in well-mannered patients but also in those who appreciated nurses' efforts. They conveyed an inner joy and a sense of fulfilment when patients/relatives used words like "thank you", "God bless you", "had it not been for you...", "you saved me", etc. These words and gestures, according to participants, indicated that they were doing something valuable despite negative public perceptions about them, compelling them to behave even better, especially to such patients. Some patients and relatives who were pleased with a nurse's care might express their gratitude through words and by offering gifts or monetary rewards. It was common to see discharged patients giving money to nurses at the nurse's table. The usual phrase is: "I can't thank you all nurses enough for your care. Please accept this small token to buy some water." The nurse in-charge will then protest, "Oh auntie, we are only doing our work, please keep it; we are grateful". However, when the patient insists, the IC accepts the offer on behalf of her colleagues. Sometimes, based on the IC's discretion, the money is added to the ward fund (discussed in Chapter 4) or used to buy soft drinks for the nurses on duty. Participants also recounted occasions where some patients tipped them individually: Augustina admitted: "Some will take your contact number to appreciate you and later realise that they have sent you 'momo' (mobile money) because

they know you will not accept their gifts. Some even go to your in-charge to commend you to them.” Edna added:

I had one patient who bought me a pair of shoes. There was another who kept calling me because she wanted to bring me gifts. We get rewards. It makes us happy that we’re being appreciated and doing something good. You feel delighted.

Nevertheless, almost all the participants cautioned that receiving these gifts before the patient’s discharge was not proper and ethical. They explained that that was the most straightforward way a patient could ‘buy’ a nurse - meaning, you feel indebted to such patients and run at their beck and call. Some participants even disclosed that “they feel insulted” whenever patients attempt to give them gifts; they would rather accept the gift when they were discharged. This emphasises the concept of gift-giving and reciprocity, where the giver tends to create and maintain a relationship by using gifts with the intention of receiving some favour in return, as espoused by Marcel Mauss (Heins, Unrau & Avram, 2018; Mauss, 2002).

Nevertheless, it is essential to acknowledge that these appreciations, both verbal and non-verbal, from some patients/relatives indicate that nurses’ behaviour is not always undesirable. Dapaah (2016), found that many health workers, especially nurses, show respect and are patient with clients. In studies on diabetes and hypertension, some researchers found that nurses behaved desirably with patients who cooperated with the patient-centred strategy of treatment (Aghoja, Okinedo & Odili, 2017; Himmelfarb, Commodore-Mensah & Hill, 2016). Others, on oral care (Andargie & Kassahun, 2019), geriatric care (Cybulski, Krajewska-Kułak & Jamiolkowski, 2015), and pain management (Adugbire & Aziato, 2018) also found positive nurses’ behaviour such as patience, empathy, and friendliness, especially with patients who cooperated. Hence, the precursor for the positive behaviour of nurses lies in the mutual respect between these two parties. When nurses acknowledge that they are on duty (or have a job) because patients respect the office

of nurses and cooperate, both parties do well in reducing the nurse-patient brouhaha, thereby ensuring quality healthcare delivery.

Similar to how some nurses attribute their positive behaviours to patients' actions and inactions, in the same vein, some nurses attribute their poor behaviours to patients' actions and inactions. Therefore, based on Blumer's (1969) symbolic interactionism, the meanings nurses make of patients' social actions resulting from their interactions are crucial in influencing nurses' behaviour. Participants attributed some of these precursors to patients'/relatives' anxiety, visitation time-outs, patients who believe they know their rights, iatrophobia (doctor's fright), absconding, relatives abandoning their patients and complementary healthcare. According to participants, these forms of non-cooperation often result in verbal exchanges between patients/relatives and nurses.

Patients and relatives, in most cases, expressed anxieties due to their altered states of health or that of their kin, respectively. It was a norm to see restless relatives pacing up and down the corridors just outside the wards, arguing about first-come-first-served or asking health providers the same questions repeatedly. During medical treatments or processes such as catheterisation, intramuscular injections (IM), or the setting of intravenous (IV) lines, some patients would sing, cry or talk to themselves or nurses in an effort to calm themselves. According to participants, these anxious moments for both patients and their relatives was the time most of these clients pushed some nurses to put up some improper behaviours. Evelyn, a senior nursing officer, narrated instances of anxiety in the case of relatives:

Relatives are not physically sick, but they are psychologically sick because of their kin who is ill and so ninety percent of the relatives are agitated and tend to be trouble-makers (making a frown). When a nurse tries to calm them, they sometimes talk back provocatively! They sometimes make the work unbearable because immediately they bring in their sick kin; from their perspective, the nurse is supposed to stop whatever she is doing and give them all her attention. When this does not happen, they start

complaining about nurses' insensitivity, reporting the news to their communities and the media but the majority of such information is lies. Relatives really cause trouble!

Finding patients'/relatives' anxieties and agitations troubling and not because of their altered states of health or minds (in the case of relatives) symbolises the nurses' perception of care and socialisation, which enforces the earlier discussion in the previous chapter. It is unsurprising that Evelyn has this view about relatives because she already perceives that it is the client's duty to be patient and not necessarily the nurse's. This perception then results in such retaliations to the said patient or relative in question.

'Iatrophobia' on the patients' part was another occurrence that ignited poor behaviours of nurses. In an informal discussion at the nurses' station, three nurses lamented that some patients would complain about their aches, symptoms or plight, which they document accordingly. Yet, during doctors' ward rounds, such patients interestingly refuse to disclose or admit such complaints to the doctors. Even in some cases, patients deny what they described to the nurses, thus making the nurses look like they are making up these symptoms. Therefore, when the same patients make similar complaints in the absence of doctors, the nurses also ignore them. According to researchers, iatrophobia usually happens from the fear of learning about a dreaded diagnosis, the fear of a physician's reaction to one's condition (Hollander & Greene, 2019; Persoskie, Ferrer & Klein, 2014) or the fear of the supposed treatments that might be needed for that diagnosis especially surgery (Masjedi et al., 2017). Yet, nurses being aware of such conditions and ignoring such patients provide evidence to the fact that nursing is a calling (in the previous chapter) and needs compassion and empathy to promote good nurse-patient relationships. This is also not without institutional lapses, such as the unavailability of standby clinical psychologists who could be summoned to attend to such patients promptly since psychological support and other encouragement ensure a waning in the fear of doctors (Hollander & Greene, 2019). It usually

took a day or two for specialists to report to the wards when cases were referred to them and this delay impedes the quality of service and often health outcomes.

Some relatives' refusal or inability to honour their financial obligations towards their sick relations, thereby abandoning their kin on the ward, resulted in some nurses' refusal to give such patients any attention. One Tuesday afternoon, the nurses bemoaned the abandonment of a 99-year-old man who had been admitted in the ward for a week without any relative visiting. The doctors could not make any diagnosis except 'old age'. He was put on drips and catheterised. However, relatives refused financial obligations and other necessary medications because they assumed he was in his terminal stage. According to the only relative who brought him to the hospital and whom the IC contacted a day after, "their mother was also very old and died two days after admission, so they did not know why he was taking too long to die!" Blatantly saying this without shame, the IC became furious and asked them to come for him, but the relatives refused to show up.

Though the nurses were appalled at the relative's behaviour, they fed the patient at their own expense and gave him the medications he needed by writing a 'dear pharmacy' letter (See Appendix 6 for a sample) to the pharmacy and the administration to support a financially dependent patient. He died after a week, and it was only then that three relatives came to claim his body and a death certificate. Consequently, the nurses also refused to give the relatives any attention, thereby incurring the wrath of these relatives, who branded such nurses as rude. Van der Geest (2000) explains the behaviour of these relatives in the Ghanaian context. He discloses that families indeed spend more time and money on funerals than on caring for the elderly (premortem). This means they care more for the dead than the living, confirming the Akan⁴ proverb that '*Abusua do funu*' (the family loves the dead). He

⁴ The largest ethnic group in Ghana (Addai-Mensah, 2020)

goes on to explain that a funeral is public and so produces much more commitment and expenditure than pre-mortem care, which is a private matter. Even though neglecting the elderly is wrong, it is less shameful because the public does not observe it.

This also explains the behaviour of patients who abscond. At the time of the fieldwork, the National Health Insurance Scheme did not cover a lot of patient's treatments. It catered for the admission (bed), meals and some medications, resulting in some impoverished patients normally absconding, relatives abandoning some and others laying helplessly on their beds with their tests and scan requests undone. Hence, it is unsurprising that participants preferred patients of better economic status. Bernice explained:

It's not for any other reason that I prefer a 'rich' patient, for their ability to pay and make our work easy, less stressful, and less emotional. For the poor, you always must sympathise and, at times, use your money for their medicines and food because you can't watch them die or starve if you are sensitive. Whatever we do, the guilty conscience haunts us. If you know what you did resulted in the patient's death, can you even sleep well? It will haunt you. So even if you don't have, you are compelled to find ways and means to save the patient. In short, we wish to receive patients who can afford their bills just to escape the poor person's plight.

This quote brings to light Blumer's (1969) argument of symbols and meanings. To Bernice, a poor patient (who cannot afford bills) symbolised a financial burden on nurses and one with a possibility to abscond or be abandoned, while a rich patient (one who can afford bills) symbolised an ease in healthcare delivery to such patients. These meanings hence created informed positive or negative attitudes to such patients respectively.

Another reason nurses attribute some of their behaviours to patients is when patients/relatives complement the orthodox medicine given with religious or herbal concoctions in the ward. Taher et al., (2020) theorised that individuals are more susceptible to becoming superstitious when they encounter death, illness, or adverse events, some patients not only believed their conditions were spiritual but also complemented the allopathic medicine with religious practices even when health professionals diagnosed the

condition as pathogenic. As Van der Geest and Sarkodie (1998, p. 1375) put it: “The ward was not merely a place for practising medicine, it was also a ‘place of worship’”. Religion as a complementary health-seeking behaviour was evident in patients praying, chanting and reading religious documents; a few wore cowries, rosaries, threads on the waist and other accoutrements. I recall encountering one of such scenarios illustrated thus:

A patient wore a chain of cowries across his shoulders, making an ‘X’ at his chest and back. Whenever it was time to check his vitals, I made conscious efforts not to come into contact with the chains of cowries across his chest. Trying to play ignorant, one afternoon, I enquired about why the patient wore that from the two nurses who were busy documenting at the nurses’ station. One alleged it was for religious purposes. The other also exemplified how a man wore a chain of cowries around the waist and refused to nurse him because she was afraid of unforeseen implications (Fieldnotes, January 2021).

As Blumer highlights, the symbolic meaning attached to the chains of cowries propelled a modification in behaviour in this nurse's case. The wearing of these spiritual accoutrements was not even considered threatening to patients as compared to ingesting religious items orally. According to participants, there were countless times when they had chanced on relatives giving ‘anointing oil’ or concoctions to their kin to drink, including patients who were even on NG tubes. Jessica, a focus group participant, narrated a similar encounter:

When I was in the VIP ward (also a medical ward), where patients are in cubicles, unlike this open ward, one had to go inside patients’ cubicles before one could see what was happening there. A client’s relatives visited, and I decided to check up on the patient after a while. They had smeared oil all over the patient and filled the bed with stones and other unknown stuff! I was shocked! They said our medication does not seem to work so they wanted to try the spiritual. I told them they had to try it at home instead. I was so frightened even to clean up that mess from the patient, but I dealt with them.

Several factors contribute to the popularity of complementary therapies (in this case, religious ones), but the primary reasons the participants identified and which Hall, Brosnan, Cant, Collins and Leach (2018) also observed is holistic healthcare beliefs. Since there are beliefs that sickness is not a result of only physiological or explained by the germ theory,

patients/relatives try to complement healing from the religious side as well, just in case it has spiritual underpinnings. In these instances, nurses' grudge against such patients/relatives is not their complementary care (since nurses are also culprits) but practising it while the patient is still in their care. This is because nurses would be held responsible should the worst happen. This results in many rebuttals between these two parties, demonstrating improper behaviours while nurses try to defend this course.

Issues of visitation time were not so much of a problem since the hospital practices a culture of relative assisted care (as mentioned in Chapter 4). More often than not, it was observed that nurses needed complementary assistance from relatives of patients due to the limited staff, so the visitation time was not strictly adhered to. However, relatives had to vacate the ward when it was time for the doctor's review or ward round to allow for privacy. On some of these occasions, some relatives refused to comply because they felt entitled to know or witness whatever was going on with the care of their kin, resulting in some nurses shouting at them and exchanging words. This is because nurses believe they are the caregivers with the expert knowledge and the right to the professional care of the patient but not the relative who only assists with non-medical care. Meanwhile, some relatives' refusal to give privacy on some of these occasions suggests a distrust in healthcare givers. For instance, Alexander et al. (2014) reported that during childbirth, some women wanted a relative around to serve as a witness so that the nurses/midwives may not switch their babies after delivery. Hence, in Luttik et al. (2017), as well as, Gusdal et al's. (2017) studies, while most of the nurses deemed relatives as instrumental assistants for patients in healthcare delivery, nurses were most unlikely to include relatives in the care of their kin due to their unwillingness sometimes to cooperate as seen in this finding as well.

At other times when many relatives visited at a time, they were often outraged when nurses instructed them to go out and come in smaller batches of two. Davida observed:

For some particular groups, especially if their kin is admitted, I do not know if it is announced for the whole community! They will not even enter the ward in twos or threes. They all come in together, and if you tell them to come in smaller numbers, it turns into an argument. Once they have arrived, they have arrived and must be permitted to see their sick!

According to Yakubu, Esmaeili, and Navab (2019), one-way Ghanaian family members conflicted with nurses was through the open visiting policy. Nurses perceived open visitation as difficult because they had to combine nursing care and quality interactions with the family. On the other hand, the family also believed that that was the best time for them to provide social support for their loved ones and even help nurses. When this kind of supportive interaction is managed well, it could enhance calming effects on both sides, but when coordinated poorly could result in poor mannerisms, poor communication, and frustration in family members (Ramos, Fumis & Schettino, 2014).

According to participants, issues with patients become more complicated when such patients are literate and especially when they know their rights as patients. Some researchers who did a patient-focussed study attributed patient's non-cooperation to their social status, age, previous hospital experiences, and cultural backgrounds but especially to their level of education (Midilli, Kirmizioglu & Kalkim, 2017; Dzomeku, Ba-Etilayoo, Perekuu & Mantey, 2013; Coban & Kasikci, 2010). Even though this study did not interview patients, it was observed that patients who had insights (their level of education is unknown) on nurses' duties, ethics, patients' charter, and other information demanded total quality care, which sometimes infuriated nurses when such demands were not politely made, simply put, 'I know my rights patients'. Contrary to this, Abdel Maqsood, Oweis and Hasna (2012) also noticed that patients' level of education did not necessarily affect patients' satisfaction with

nursing care. Again, it was interesting to discover that the gender of a patient, more often than not, influences perceptions of care, and this is inferred from the patient's cooperation, ability to endure pain, and attitude towards healthcare. Barbara, one of the FGD participants, observed:

When you are nursing women, they are very supportive and tend to assist you in helping them, unlike the men. I've been in the male ward for 7 years while I've been in the female ward for only 6 months, and it's not easy nursing a man. If you tell a female patient you will give them medication at this time, they will even remind you of the exact time. The men allow themselves to be very sick before they report to the hospital, while women report the slightest pain, such as headaches. Men will stay home until the condition is terrible, so when they finally report, they are in bad condition and are anxious and furious, making it difficult to nurse them.

Georgina also highlighted:

I prefer nursing females anytime, any day. For funny reasons, relatives don't care for their sick male kin. Since some fathers do not cater for their children, their relatives always abandon them when they are sick, so we have more male patients absconding than females. Some are alcoholics, and some also have a bad attitude towards healthcare. For instance, some will have high blood pressure yet won't take their medication because they believe their manhood will 'die'! Such men always come back with a stroke! Even taking injections is an issue. The men are challenging to handle. When they are on the verge of dying, they become submissive, but it might be too late.

It was observed that nurses ignored most of these patients who refused their medicines and other treatments and documented their actions as evidence. A similar observation about the attitude of some male patients was made one Thursday morning.

The man in bed 2, who keeps moaning and singing hymns from time to time, is wearing an oxygen mask today, and standing beside his bed is a huge cylinder. The night shift nurse complains to his relative that he keeps taking off the cannula and oxygen mask; meanwhile, his veins are weak, and it's very difficult to find a vein, so they need a relative to sit by his side to monitor him to make their work easier. The relative, an average-aged woman, defends him that he was doing that because he is in pain, and the nurse also explains that the drip would subside the pain if he did not pull out the cannula. The relative volunteers to stay and stops her kin several times whenever he attempts to pull out the cannula. A few hours later, the IC comes in with a gauze bandage, binds it around both cannulas on each arm, covers them completely, and ties each arm to the bed rails. This plan is successful but he continues to moan and subsequently sleeps off, enabling the relative to leave. Waking up and spotting me close to his bedside, he murmurs through the oxygen mask. Realising he wants to speak, I ask permission to pull down his oxygen mask and in a frail voice,

he apologises for his actions, explaining it isn't intentional, but he was in pain, but he feels much better after the drip. I cheer him up and convey his apology to the IC (Fieldnotes, December 2020).

Male nurses also agreed that nursing females was easier than males and could recall several instances where male patients had pushed them to their limits because of their (male patients) negative attitude towards healthcare and sometimes the unwillingness of some of them to cooperate contrary to female patients. Yet, they still preferred nursing males because it was much more convenient for them than for female patients. This mainly concerns some aspects of caregiving such as bed-bathing, dressing, changing diapers of female patients or giving enema. Male nurses were of the view that in as much as female patients perceived male nurses as caring, some were uncomfortable, especially the young ladies when it came to the performance of these particular duties, which required an invasion of their privacy. This reflects researchers' reports on patient's opinions and satisfaction with care provided by male nurses (Younas & Sundus, 2018; Adeyemi-Adelanwa et al., 2016).

To sum up, this section suggests that the non-cooperation of patients and relatives interrupts nursing care negatively and induces undesirable behaviours of some nurses. Similar to Dapaah's (2016) study, patients and relatives who were labelled 'non-cooperative' incurred the wrath of nurses. They were either spoken to harshly or denied treatment which is congruent to this study's findings. Analytically, the underlying issue with the non-cooperation of patients has to do with the symbolic meaning each of these two parties (patients/relatives versus nurses) attaches to actions or inactions, which results in poor communication or interaction between them. On the side of the patients/relatives, they feel nurses owe them quality healthcare because even though NHIS subsidises the cost of services, they are still making financial commitments. Again, as expected of client relations, the service provider has to be extra nice in order to win more clients and so similarly, they expect nurses to be tolerant of patients' behaviour since 'the customer is

always right' (Alola et al., 2019). Meanwhile, as realised from the previous chapter, the perceptions of care some nurses hold, such as the attitude towards state-owned organisations (public hospitals) intersecting with nurses' characters or personalities determines whether such interactions will be done soberly or harshly. Also, since some nurses believe they are the holders of the knowledge to treat patients of their ailment, it means it is patients/relatives who must be submissive and comply. The fact that the majority of the participants did not choose nursing even though some have aligned with the profession now, others still did not have the profession at heart and hence were unable to tactfully handle some of these pressures from patients resulting in the improper behaviours of such nurses. Finally, the section revealed the interplay of power between nurses and patients and how nurses' specialised knowledge enshrined their powerful selves in their interactions with patients, who, in this case, are the recipients of the outcomes of nurses' power, whether positive or negative.

6.3 Institutional Factors

Giddens (1984) regards the established forms of human behaviour, which are produced and reproduced across time and space as 'institutions.' According to Vaughan (2001, p. 186), "Institutions persist partly because of the adherence to routines but also because people operating within them consent to do so". Subsequently, institutions play the role of "structuring society, coordinating stable activities, and the production of goods across time and space" (Giddens, 2001, p. 348). Just as Giddens postulates that institutions which the process of structuration has created tend to be both enabling and constraining, participants highlighted such constraints in the XYZ district hospital which were also observed and how it becomes a precursor to improper behaviours towards patients. These mainly pertained to insufficient equipment or logistics, non-adherence to the job description and the issue of motivation.

6.3.1 Insufficient Equipment/Logistics/Medication

Every month, the hospital supplies wards and units with logistics, supplies, consumables, medications, etc., which Giddens (1984) terms allocative resources. However, the items often run out before the next consignment arrives from the central stores, so students are sent from one ward to another, asking for gloves, spirits, cotton, plaster, syringes, and other items. The shortage of gloves was particularly the concern of most nurses because they could easily contract nosocomial infections and spread them to other patients and even their families just by contact with body fluids such as patients' sweats, urine, saliva, and faeces from changing diapers. Thus, nurses were always reluctant to work when gloves were finished. The effect of this was witnessed on one of such typical days.

It was time for medications. A student nurse carried the drug in a container and served all the patients. She got to bed 8 and realised he was not in bed. She searched the corridors, thinking he was outside relaxing or strolling as patients sometimes advised, but there was no sign of him. The IC fetched his folder and phoned his relative, only for an elderly woman to reply that they were taking their kin away. She lamented that she asked one nurse to help her put the patient in bed about thirty minutes earlier, but the nurse replied that she could not touch him since she was not wearing a glove because the gloves were all finished! This made the elderly woman angry and hence, her reason for carrying her kin away. I guess she assumed the nurse was insinuating the fear of COVID-19. After the phone call, the IC called all of us, recounted the conversation, and asked which nurse did that. There were two staff nurses, twelve student nurses, and me. No one owned up to the accusation! (Fieldnotes, November 2020).

This improper behaviour was attributed to the constraint from the institution's scarce resources needed to run the ward. When such logistics were almost consumed, the ICs usually hid the few remaining gloves in their drawers for procedures more demanding of them, such as setting up intravenous infusions, and only gave them out after inquiring why a nurse needed them. Once, I asked Sister Rita, the female ward IC, why she was so hard on the students when giving out gloves. She replied that student nurses on clinicals are so keen on wearing gloves that they wear them even for procedures that do not require gloves. However, during their time as students, their ICs made them use polythene bags as gloves,

so nurses learned not to waste them when they finally got the opportunity but, in her view, present-day student nurses are very wasteful. The lack of gloves and other logistics obviously had a ripple effect on nurses' interpersonal relations with patients. Bernice lamented:

We do not have the items we need to work with. If you need a glove, you need to borrow from another ward; you need that, you must go around borrowing. You just walk around in search of basic things, yet there is still work to be done before handing over. If not, you look incompetent, so you do well to finish up quickly before colleagues on the next shift take up. That is why we sometimes look frustrated or angry when patients interact with us.

The situation was no different from equipment. A ward would need a cylinder to supply oxygen for a patient, but often, either there was no oxygen in the cylinder, or there was oxygen, but the flow meters were in short supply or broken down or had been borrowed.

Edna intimated:

Yesterday we needed oxygen. We had to go around the entire hospital, but oxygen was in short supply, so we had to put the patient in bed 3 on a concentrator. Yet, how much oxygen will that give the patient? The whole hospital had no oxygen! Again, there were no wheelchairs. The few wheelchairs available had been pushed to the consulting rooms, and the doctors had not attended to the patients using them! These things infuriate me because you need to work and help patients.

This situation pertains not only to XYZ hospital but also to a few public hospitals. In Osman, Ninnoni, and Annim's (2021) research in a Ghanaian public hospital, 81.2% of nurses and midwives attributed their biggest constraint to the inadequate supply of consumables, thereby inhibiting quality healthcare. This is in tandem with Sakyi, Atinga and Adzei (2012) who emphasized that one of the enormous challenges in most Ghanaian public hospitals remains the low improvement in the equipment and logistics. In 2017, nurses at the Wa Hospital refused to admit any patients due to the lack of consumables such as gloves, savlon lotion, bandages, etc., because they stood at risk of infections if they continued to work without these logistics (The Finder, 2017). Nevertheless, at XYZ hospital, in some cases

where possible, nurses demonstrated practical knowledgeability, as Giddens calls it, and their agentic power by improvising some items in the care of patients. For instance, a tube may be tied around a patient's arm in place of a tourniquet. When the only screen in the ward was in use, nurses used patients' clothes as a screen by standing and holding the ends of the cloth until a procedure was performed. At other times, nurses not only improvise but also buy some of the items they need, including gloves, usually with limited ward funds. Sister Rita recalls:

We need a suction machine, and I have requested one since January (seven months ago), but I have not received it. If you have a patient and need to use a suction machine, you have to borrow from another ward, but what if it is in use? What do you do? As humans, you will get frustrated and that is stressful enough. Currently, if I do not buy batteries for the sphygmomanometer, it means it will not work. When I was going on leave, I had to buy two sets of batteries. Work needs to be done but it's frustrating!

The ICs and the matron attributed this inadequacy to the shortfall of the state subventions called the 'Financial Encumbrance'. According to them, by regulation, the government is supposed to send sums of money to all public hospitals to aid in running the facilities. However, these subventions, even in their reduced quantum, are hardly received, supporting Adinkrah's (2016) report that Ghana's healthcare system is immeasurably underfunded. This invariably affects the availability of supplies, equipment, and logistics needed to run the hospitals.

Concerning the shortage of medications, the matron again attributed this to the regulation by the GHS for hospitals to depend solely on medicines from the central medical stores. All medical procurements are made at the central medical stores, and hospitals are prohibited from purchasing drugs elsewhere. Even though hospitals could purchase medications elsewhere in exceptional cases of shortage, getting approval to do so goes through a long bureaucratic process, which is frustrating. This restriction led to many anxieties, especially

when hospitals did not have the required medications to treat patients. The matron expressed her concerns thus:

When items are finished at our storeroom, we need to request procurement. The government has made it such that one cannot use the hospital's money to purchase anything in the market when they are short; we will get into trouble. We must wait for the supplies from the central medical stores. You should see the orders we have placed but still not received. At times, there will not be drugs as common as paracetamol, and patients and relatives become furious, yet it is not our fault. You need to work here to feel our pain. We are trying.

Though this regulation by GHS is the norm, or as Giddens puts it, the rule, it produces many constraints, such as shortages. This resulted in much grumbling as the nurses always complained about logistics on the ward. At worst, it led to unprofessionalism, such as ignoring a patient, as was illustrated in the vignette above. This sides with Manso, Annan and Anane's (2013) assessment of logistic management in Ghana, who concluded that the lack or insufficient logistics for effective and efficient healthcare delivery is indeed a factor for the poor service delivery in our health facilities. This structural issue is not only pertinent in Ghana but produces similar experiences. Patients who accessed healthcare from Seshego Hospital (South African Government News Agency, 2012) as well as in ten public sector hospitals in the Gauteng Province (Modisakeng, Matlala, Godman & Meyer, 2020) both in South Africa reported a shortage of basic consumables and poor service delivery. The lack of essential commodities, including equipment and drugs, in some Bangladesh hospitals was also reported to affect the quality of healthcare delivery (Islam & Biswas, 2014).

Nevertheless, the unwanted behaviors some nurses put up with the excuse of this institutional constraint also have an individual factor, that is, poor communication skills, mostly resulting from poor socialisation, as discussed in the previous chapter. In the vignette above, for instance, the nurse in question could have used her discursive knowledgeability, as Giddens (1984) calls it, to communicate to the patient/relative to calm them despite the logistical constraint. Again, the unwillingness of the nurse to improvise or even her inability

to report the situation to the IC, who could have suggested a solution, knowing very well that the lack of gloves was a usual constraint on the wards, yet patients are always taken care of. This demonstration of non-empathy for the sick and the inability to put the patient first, which are the core tenets of the profession, again suggests a non-commitment to the job.

6.3.2 Non-Adherence of Staff to the Job Description

Most participants again attributed the non-adherence of allied health professionals to their jobs to some of their (nurses) poor behaviours. Health delivery is an integrative care for the sick (World Health Organisation, 2018) not just from nurses but a collaboration from all hospital personnel, including nurses, doctors, specialists, lab technicians, pharmacists, orderlies, administrators, kitchen staff, security personnel, and relatives as described in chapter four. These personnel have unique roles to ensure patients' recovery and quality service. Yet, according to the participants, some of them, especially doctors, laboratory technicians, and kitchen staff, contribute to the pressures that influence the undesirable behaviour of some nurses. Every profession has a job description, which serves as a guide for job performance. It was realised that most professionals do not strictly go by what has been stipulated as their jobs but leave them for nurses to perform. According to Giddens (1984), recurrent social practices, whether deliberately or not, start to produce structures via routines that are often taken for granted or unquestioned.

The findings reveal that first, the setting of IV lines is supposedly the work of doctors, but nurses must incorporate this into their jobs because doctors are few and have more challenging conditions to treat. Participants who had earlier worked in regional or teaching hospitals such as Korle Bu and the Cape Coast teaching hospitals argued that in their former workplaces, setting lines was strictly doctors' duty but realized that doctors in the district hospitals did not particularly adhere to this norm. Consequently, these participants did not know how to set lines and were compelled to learn when they commenced work in a district hospital. According to participants, taking patients' blood samples is not the nurses' job but

the laboratory technicians. However, laboratory technicians are fewer than nurses and are more often overburdened. Therefore, moving to and fro the laboratory and the wards to draw blood samples and testing them takes ages if nurses decide to wait on them. Meanwhile, the results are needed to diagnose and treat inpatients quickly. Consequently, nurses are compelled to add on to this job. Monica shared her experience:

We do everyone's work; we do doctors' work, we do pharmacists' work, and we do laboratory technicians' work too. We are not supposed to set lines; that is for doctors. We are not supposed to take blood samples; that is the lab people's work. However, after the relative has made the payment, they send the receipt to the lab, and the lab technician hands a test tube to the relative to bring to us. Sometimes, I get furious, and if I'm busy, I ask the relatives to inform them to come here and take the sample, but since they always delay and the results are needed on time to make a diagnosis, I end up taking the sample. We do everybody's work.

This non-adherence to the job description pertains not only to health professionals but also to the kitchen staff. Joanna also complained about how they sometimes must incorporate their duties:

We argue with them every day. When a nurse reports for night duty, she makes a diet list; we have patients who will have light diets and surgical cases who take soups only, while the rest take regular diets. Hence, the book goes to the kitchen before they cook, so they are the ones that are supposed to come around, mention the names, take the bowls, and serve, but they will not do it. They will just stand by the food trolley in the corridor and tell us to bring the patients' bowls so they can serve them. We end up abandoning our duties to pick up patients' bowls. The administration must address this because they could at least come in twos, one for picking up the patients' bowls while the other for putting the food in. It ends in arguments.

According to Ganz et al. (2016) and Powers (2013), nurses ideally have to practice within their optimum scope of practice with the most effective use of their nursing resources (International Council of Nurses, 2014). This is because in practice, while some nurses function below their scope of practice (underutilization), most practice above their scope and hence the resultant behaviours accompanying it. In many sub-Saharan African (SSA) countries, nurses are compelled to add on the jobs of other staff and are the primary

healthcare contacts, especially in rural areas. In Botswana, for example, research found that municipalities pressured nurses to work beyond their scope of practice by adding on the work of other staff due to inadequate numbers of these other healthcare givers (James, Debra & Thabo, 2016). Yet, as Giddens (1984) stipulated, the social actions of people in a group create the structure, but the structure of these groups also empowers or limits the actions of the individuals. Similarly, the actions of health professionals not adhering to their job descriptions and how normal it had become have produced a structure in the hospital, which, in turn, constrains all of them, including nurses. This also influenced poor relations between nurses and patients/clients. A typical instance of such behaviour occurred because the records unit was not adhering to their job.

One Tuesday morning, I followed two student nurses sent to transfer a surgical case to the male ward from the theatre. On our return, we observed an intense argument between the IC and an angry-looking tall man with his hands in his pockets standing at the entrance of the nurses' station. Sister Sandra, the assistant IC, intervened and addressed the man: "The only one to sort you out is the IC whom you just insulted, so if I were you, I would apologise to her." The man retorted: "I won't apologise for anything. She deserves whatever I told her, and if she's the only one to do it, she should just come out and do it... she's very stupid!". Meanwhile, Sister Betty the IC, kept moving around the ward quietly as if searching for something, totally ignoring the angry man. I felt uncomfortable that the IC of the ward was being insulted in our presence, so I left the scene intending to get the whole story from Sister Sandra later in the day. On my return, I met the man now outside the ward, pacing up and down the aisle, murmuring angrily to himself. I wanted to know the whole story, but I knew the timing was inappropriate as both ICs wore straight faces throughout the morning shift. A week later, I discussed the issue with Sister Sandra during her interview. This was her feedback when I enquired about that incident:

Yes, I remember. The man absconded refusing to pay his bills. A few months later, he still had the confidence to report another ailment to this hospital. When the records unit could not find his folder, he was told to come to the ward if it was still there after his last admission. He had the nerve to come here to enquire! Anyway, we also had to know when he was discharged to retrieve the folder, and so when Betty asked, he became angry and shouted: “I am coming for my folder, and you are asking me stupid questions. Are you stupid?” I heard the scuffle in the ward, and I asked Betty, and she said the man called her stupid when she tried sorting him out. I asked the man to apologise to Betty because she was the only person who could help him, but the man was adamant. I went out and when I returned, he had left.

I enquired again how she knew he had absconded, and she continued:

I went to his bed to serve medications, and I learned he was outside, not knowing he had absconded. When that happens, we write ‘absconded’ on the folder. That particular patient is someone we know. He is a regular patient, so we recognised that he had absconded when he came. What is irritating is when patients behave like ‘I know my right’. Even if you have concerns, you can politely say so without attacking us!

The questions worth asking are why should the record unit ask a patient to retrieve his folder from the ward? Why wasn’t the folder returned to the records so it could be easily traceable on the patient’s subsequent visits? This is a typical instance of non-adherence to one’s job and how that, in turn, has created routines that end up being constraining as Giddens advances. After a patient is discharged from the ward, their folders remain in the ward for easy accessibility when they return in a week’s time for their review. The patients pick up their folders from the wards to the doctors in the consultation rooms. However, if the patient does not show up for their review, nurses have to return them to the records on the eighth day, which more often than not, they forget to do. Therefore, as at the time of the fieldwork, when patients showed up months later for healthcare, they were burdened to move back and forth between the wards and the records unit, and at worst, they must be able to recall their last visits to trace folders (records are currently computerized). The non-commitment of some healthcare professionals to adhere to their roles yet effectively collaborate affects quality healthcare delivery. Nonetheless, while this patient rightly knew his role as a patient

was not to recover folders, ignoring his earlier responsibility, that is, his duty to fulfill financial obligations and not to abscond considering that the National Health Insurance Schemes even provides subsidies defeats the patient's side of fulfilling the contract after receiving healthcare. His subsequent action to insult nurses in their interaction is also completely condemnable. Therefore, the flawed interaction between this patient and the nurses is a product of how healthcare professionals have created a structure and the constraints thereof. Again, the poor communication skills on the part of both the nurses and the patient also inhibit good interpersonal relations.

6.3.3 Lack of Motivation

The final concern participants raised about the institution is the issue of motivation. To provide quality nursing care, there must be both intrinsic and extrinsic motivation for care (Halperin & Mashiach-Eizenberg, 2014). Motivation, in this case, extrinsic is a crucial determinant of one's influence to work (Ridgeway, 1982), which is the case for this study's participants. Participants would have preferred some quarterly incentives, meals, end-of-year awards, or even regular verbal appreciation, but this was not the case. According to the ICs, other staff, including doctors, pharmacists, lab technicians, and accounts staff, receive daily meals from the kitchen, which is not the case for nurses. The doctors also have access to accommodations around the hospital, reducing the daily road traffic stress. The nurses have been exempted from these privileges because there are too many; when all the other staff are summed, nurses still outnumber them just as the World Health Organisation (2016) reports that nurses represent the largest number of conventional health professionals in most institutions worldwide.

Hence, nurses always must wait for the end-of-year incentives where they, as well as all other staff, receive a bag of rice (5kg), two tins of tomatoes, two tins of mackerel, and one

bottle of oil (that is worth approximately GH¢100/ US\$13⁵). During the durbar, when the medical superintendent announced the end-of-year package, most grumbled while others expressed disgust. According to participants, a few of them refused to collect their packages. Since most nurses do not feel motivated, the ICs try to make up by organising ward parties at the end of the year with the remaining ward fund (plus contributions from the nurses), where they eat and dance. Other forms of motivation from the ICs included financial support when staff are in need (still from the ward funds), giving a day or two off when they have urgent issues at home, making the roster flexible and verbally appreciating them. One of the ICs remarked:

They do not motivate nurses. They motivate lab technicians, accounts staff, doctors, pharmacy staff, and almost all departments except nurses. They say we are many. Pharmacy staff are about ten while lab staff are even less than that. There are also about twenty-five resident doctors. However, nurses are about four hundred, and since they cannot decide which nurses to give an incentive and whom to leave out, all nurses have been exempted.

Evelyn also intimated:

In institutions with very deprived structures, the staff are compelled to put in more effort. With time, it's only fair that they are motivated so that they still feel they are being appreciated irrespective of what they go through. However, if they go all out in such situations and there are no motivation schemes, that is when they become fed up and put up all sorts of behaviours and vent their frustrations on patients.

A key concern about motivation was the absence of an awards ceremony to acknowledge hardworking nurses. Participants grumbled that there was nothing like the 'best nurse award' as it is celebrated in other facilities. The medical superintendent again, explained during the durbar that they do not give such awards because the hospital does not yet have a criterion for selection. During the interview, the matron also further explained that it is challenging to provide such an award because the person must be 'perfect and blameless' in all

⁵ At an exchange rate of US\$1 to GH¢7.5 as at the period of data collection

dimensions to avoid any backlash or complaints of unfairness from other nurses. Therefore, it was simply averted to prevent problems from giving such an award.

Nurse managers in Adatara et al.'s (2018) study in the Volta Region of Ghana also lamented that in as much as their role was more demanding and challenging, there was no form of monetary motivation as responsibility allowances that could induce them to perform more willingly. They even earned the same salary as their colleagues in the same ranks who did not have managerial roles. This buttresses Hsu et al's. (2015) position that, when individuals are motivated and satisfied in their job it induces a positive correlation with organisational commitment as well as Odeku and Odeku's (2015) argument that employees need to merit more than only salaries or wages.

While this institutional norm is indeed constraining and unfair to nurses since they are the only professionals left out of the incentives or compensations given, this as well emphasizes the decisions that influence the choice of the profession. The nurses who chose to be nurses, such as Georgina and Kate, as highlighted in the previous chapter, were already intrinsically motivated and did not actually have to wait for extrinsic motivation to be able to perform better. Unlike Offeibea who ended up being a nurse for non-altruistic reasons and bitterly complained about the lack of compensations and how that affects her commitment to the job. Therefore, though the structures that individuals create (rules and resources), according to Giddens tend to constrain or enable them, in this case, the former, nurses as knowledgeable agents have to consciously intrinsically motivate themselves in one way or another in order to maintain the standards of the profession and promote good interpersonal relations with patients despite the institution's constraints.

6.4 Systemic Factors

In almost all healthcare systems in the world, the effectiveness of the healthcare system is positively related to the quality of the nursing care (Osman, Ninnoni & Anim, 2021). The system (or sub-system) in this study was operationalised to include the external health regulatory and policymaking bodies, including the Ghana Health Service (GHS) and the Nursing and Midwifery Council (NMC). However, most concerns were attributed more to the GHS than the NMC. As has already been pointed out about the duality of structure and how structures (rules and resources), according to Giddens, are both constraining and enabling, participants mostly associated some of these improper behaviours with the constraints in the system. Yet, nurses are not completely overpowered by the system, but they show their agency (Giddens, 1984) in their ability to employ other means, which is rather enabling, yet consequently creating further structures that have an influence on the poor quality of patient care. Participants identified two main systemic pressures including the poor salary structure and promotion/study leave issues.

6.4.1 Poor Salaries

The discussion on poor salaries gives an overview of the financial plights of most nurses. Participants expressed deep emotions when they spoke about salary. This is how the focus group discussants deliberated on the topic:

Jennifer: I'm at the same rank as Martha (both senior enrolled nurses), but my salary is GH¢1,500 (approximately US\$200) while hers is GH¢1,600 (US\$214) (pointing to Martha).

Jessica: And she (also referring to Martha) has even worked for about ten years and should be earning more than GH¢1,600. These peanuts as salaries are torturing! If we talk about mental people, nurses are the first. Let's not even talk about salaries. It is unfortunate, very, very sad.

Martha: Our salary is not good. If Nana (referring to the President of Ghana) were standing here, I would be bold to tell him! How can I work for ten good years and my

salary is not up to GH¢1,800 (US\$240) yet? Aunty Maggie, a nurse who has been working for over twenty years, earns around GH¢2,000 (US\$267).

Barbara: How can you even save from this salary to get married? Your family would even think you are useless.

Martha: You will see us in our nice uniforms, but it is God's grace that keeps us.

Jennifer: That is why we recently went on strike, and yet they made us come back to work, promising us a raise. Still, nothing has changed.

Martha: It is painful. I like the job, and I yearn to continue to do this work, but the money aspect is troubling. Even transportation alone to and from work takes half of the salary. How much can you save? Sometimes feeding becomes a problem...

Jennifer: Don't forget children's school fees, hospital bills, parent welfare, etc. We have a lot of responsibilities, so by the middle of the month, you realise the money is all gone!

The conversation about salaries in both in-depth interviews and the focus group discussion ignited a lot of emotions among nurses as they complained about their meager salaries, especially nurses who had worked for a long time and were expecting bigger salaries, as demonstrated above. This corroborates Ayalew et al's. (2019) finding that nurses who have more than ten years of experience were likely to have bigger expectations concerning their salaries than nurses with less experience. When participants were asked at the end of the interviews what they would like to change about the nursing profession if they had the opportunity, the majority mentioned salaries. They explained that the amount of work they do in no way matches the pay they receive. Since this systemic issue is a constraint to nurses' standard of living, after a process Giddens (1984) refers to as reflexive monitoring, they use their agentic ability and the knowledge acquired to their advantage by providing extra services to make up for the meagre salaries.

Therefore, according to the participants, more than half of the nurses at the XYZ district hospital do additional jobs. Such nurses take either morning, afternoon, or night 'contracts' for an extended period for such a purpose. A 'contract' is an in-group term suggesting the

preference for only one type of shift mostly so they can do an additional job in another health facility. This practice of working in another health facility, locum, has been the practice for many medics since time immemorial. According to Solomon and Dodor (2014), locum is a French word that refers to someone who works for another temporarily. They illustrate that a locum may be a nurse who works in a regular nurse's stead when that nurse is absent, or when a hospital is short of staff or usually to earn extra income. While nurses manoeuvre their way in the system in a bid to make extra money, it unintentionally leads to the recreation of structures (Giddens, 1984) with locum becoming the new norm. This was evident in an informal dialogue at the nurses' station, where Sandra, the assistant IC of the male ward, exclaimed: "Locum was the 'ish' some time back," meaning it was the trend at that time. Asking her to throw more light on that, she explained that nurses who worked in a private hospital part-time in addition to the official public hospital were the ones considered hardworking and serious in life since they were the ones who made more money. She recounts; "Sometime back, all the single nurses in my ward were locum nurses. I was the only single nurse left out because my uncle would not let me. He insisted I focussed on one job so I could rest well. Due to this, I was labelled as the laziest on the ward". While she acknowledges that the rate of locums in the ward has reduced especially when female nurses marry, it was still common.

Eric was one of the nurses who had taken a night contract due to another private hospital he had to oversee during the day. Getting an interview with Eric was difficult due to his busy schedule, but when we finally did, he explained why he does two jobs: "I'm a family man and can't live on this salary alone. I work in a company clinic too, and they run a company time from 8 am to 4.30 pm and after that, I come for the night here, so I have to 'squeeze' myself." Francis, another locum nurse also admitted: "We don't live in Accra on one job". The money is not enough, but I'm married with children so I do other stuff. I do locum in

homecare, run a mobile money agency my wife oversees, and I'm also a rider, so I do deliveries occasionally again." Four out of the five male nurses (80%) and 9 out of the 27 female nurses (33%) were locums. So even though more females were locums because they are in the majority as compared to males, the percentage of male locums on the medical ward is higher than female ones. This sides with Abugri and Jarvis' (2018) assertion that male student nurses believed nurses' remuneration was unreasonable since Ghanaian men have much more financial responsibilities than women. However, this assertion is not the case in this study because most of the female non-locum nurses also complemented their salaries with other side businesses.

The female participants had side jobs (as indicated in Chapter 4), like online businesses and petty trading, to supplement their incomes. Some owned online fashion shops and others had cement shops, bakeries, mobile money outlets, and salons, where they worked during their free time. Others did mobile trading, where they carried their wares, such as perfumes, make-ups, scrubs, wigs, jewellery, cosmetics, and adult and children's clothes from ward to ward when their shifts ended, all to supplement their income. Consequently, this new structure that had been created tends to be both enabling and constraining as Giddens posits. Enabling in the sense that such workers get access to diverse work environments or fields which an employee of one permanent work may not encounter and most importantly, earn additional income (Morgan, 1996). A recent study by Mula, Middleton, Muula, Solomon, and Varga (2021) also shows how the staffing level of a hospital in Malawi is cushioned by locum nurses who come from other hospitals, or retirement and others who were waiting to be employed, such that there were more locum nurses than the ones allocated on the ward. Yet, it is also constraining and interfered with work, in that, although most female nurses who moved from ward to ward with their wares were officially off-duty, it interrupted caregiving since other staff were still working. Again, adding on an extra job with hours just

like the regular one means extra hard work and extra stress for the locum nurses, affecting care delivery. Frimpomaa revealed its effect on interpersonal relations:

90% of nurses add on other jobs, especially locum. Those engaged in locum work at other facilities like private hospitals. They normally do a night shift there, come here, and do the day shift, so they're normally tired. And because they're exhausted, with the least trivial thing, they flare up!

As Asamani, Agyemang, Afful, and Asumeng (2018) report, while these locum nurses work back-to-back shifts alternating between their regular jobs and the locums, though it will pay off in their pockets, the ripple effect is seen in their indifference and impatience to patients/relatives due to exhaustion. Since these additional jobs could impede the quality of service provided, it was necessary to investigate what the authorities made of locum. According to the matron, there is nothing wrong with it if it does not interfere with one's reporting time and performance, but for health reasons, she does not support locum or a contract shift but a blended one. The matron expressed:

As I sit here, I can do locum. If I close from here, I can go on the night shift somewhere, and it is allowed. It is your wish to work extra to support your family. Nobody will restrict you, but I'm telling you that you should do the right thing. Who will talk about your locum if you come to work early, at 7 am or 6 am? My problem is it should not affect the time you report here. So, it's up to you. The only thing is that you're killing yourself!

To buttress the matron's position, even though male nurses appeared calm and collected as compared to female locums who sometimes appeared visibly tired, both male and female participants attested that alternating between two jobs was indeed stressful and detrimental to their health and the quality of service provided. These show how the new structure they have recreated comes back to affect the same individuals and quality care.

6.4.2 Study Leave and Promotion Constraints

The second concern other than salary/side jobs topics pertained to study leave and promotion issues. As part of the GHS policy, nurses have the privilege of furthering their education

after working for some years. The government gives these eligible nurses paid study leave, meaning, one still receives their monthly salary during this time. Ideally, enrolled nurses must work for about five years before they are eligible for a study leave to pursue a diploma/degree programme, and staff nurses have to work for three years before they can obtain one. Despite this clear policy nurses do not obtain study leave when they are due and apply for them. They still must wait in a queue of applicants and are processed on a first-come-first-served basis. According to the matron, this could take five to nine years before one finally obtains clearance for study leave. All participants complained about how this systemic failure is constraining their promotion, salary raise and progress. Therefore, nurses as knowledgeable agents, have devised other means of reaching these goals faster. Since it is easier to rise through the ranks with higher education than with years of work experience, most nurses find it reasonable to further their education after a few years of practising, thereby recreating another structure as Giddens advances in subtle ways.

The female IC also explained that most nurses hurry to further their education before they begin childbirth to reduce the future stress of performing multiple roles as a student, wife and mother should they finally get the study leave. Therefore, many nurses have personally financed their higher education by working on weekends or by taking on only night shift 'contracts' while schooling in the day. This diversion is not without sanctions. According to participants, the GHS refuses to recognise any additional certificate obtained without a sanctioned study leave. Nevertheless, most nurses ignore this consequence by rationalizing their actions. Some participants have even obtained a master's degree but are yet to be recognised, so the plan is to wait until their promotion is due so they can present such certificates. Rita expressed her opinion on this thus:

It is frustrating. I see no reason why GHS should tell us not to school, or else they will not promote us with the certificate we have attained. It takes forever for one to get

study leave, so if we are willing to self-finance our education by pursuing evening courses, they should permit it and promote us accordingly. They are part of our frustration! They frustrate us a lot, and this affects the commitment of many nurses to the work.

Davida added:

I have a degree, and if I were at my previous facility, the Christian Health Association of Ghana (CHAG), I would have been far from promoted. My colleagues who are with CHAG did not take study leaves, but they have been promoted accordingly, and their salaries have been raised. Their facility even sees it as motivation because the person personally funded their education. As motivation, why not add our further attained certificates to our credentials since it does not hurt anyone?

Davida fails to realise in her quote that, while GHS is a public institution, Christian hospitals are owned by private churches, so CHAG might not be able to afford paid study leaves for all its nurses. When a nurse under CHAG pursues higher education on their own, it becomes motivating for the institution to promote and raise their pay accordingly because they do not incur any cost compared to if they had to pay nurses during their leave. GHS, however, would not find this motivating because the number of promotions and salary raises will be overwhelming for the government.

In as much as pursuing higher education is imperative, analytically, this is a means to an end. While nurses are in a hurry to attain higher certificates, get promoted (increases prestige), and receive higher pay, what they ignore is the fact that they stress more, and this inadvertently threatens their health and the quality of nursing care. When one is patient enough to attain a study leave, for that period of study, they will not have to work except during clinicals (practicals). Sadly, after the pursuit, most nurses have to wait until they are due for promotion before the attained certificate is recognised. At the end of the interview, when nurses were asked about what they regretted in their career, most of such nurses mentioned they regretted not waiting for their study leaves since the certificates attained were not recognised.

Much dissatisfaction has been expressed by nurses who do not experience professional growth and other benefits during the long periods they have worked (Ayalew et al., 2019). Unsurprisingly, participants identified this drawback as a threat to their job commitment, generating a feeling of resignation and despair, especially among nurses who entered the profession for economic reasons. This consequently affected the quality of care provided to patients.

6.5 Colleague-Colleague and Allied Health Professionals Relationships

Collaborative and interprofessional team support in nursing care delivery is crucial to quality care and patient satisfaction (Morley & Cashell, 2017). Participants did not entirely attribute undesirable behaviours to institutional or systemic pressures but to their colleagues and other health professionals. The relationships among nursing colleagues on the wards were mostly cordial. Most of the nurses were hardworking and occupied themselves with the daily duties as well as maintained mutual respect for one another. Some nurses would stand in for their colleagues when the other was sick or had a pressing situation. While these healthy interactions transcended patients/relatives positively, the reverse was also true. As typical of most human interactions, colleagues would step on others' toes in the process of their work. This can escalate into mistrust among colleagues, deviant behaviours, and decreased levels of commitment (Hsu, Chiang, Chang, Huang & Chen, 2015), which then affects proper care for patients. The basis for misunderstandings on the wards mostly pertained to laziness and lateness, and this can be understood from Gidden's (1984) use of Blumer's meaning, making that social life is created and recreated with regard to the meanings people make of their actions. This is evident in the vignette below:

Stella and Kate angrily exchange words one morning shift. Kate, an enrolled nurse, who normally works night or morning shifts, appeals to the IC to schedule her for afternoon shifts for the coming month since she has to attend to something. Stella, a staff nurse, intrudes in their negotiation jokingly: "If you don't want to come for mornings, who should be doing the wound dressings?" Infuriated by this question,

Kate also retorts: “Has wound dressing been labelled on my forehead, or has it been willed to me?” The two continue for a while, but the IC stops them when the exchange of words seems unending (Fieldnotes, January 2021).

Since individuals act based on the meanings they assign to objects or situations, in this case, wound dressing being inconvenient, it was typical of Stella and other nurses to reserve wound dressing for Kate (introduced in the previous chapter) because it is Kate who loved that duty. This attitude was typical of some nurses especially when they had to dress infected wounds. Georgina described the attitude of such colleagues:

Some will never finish the duties in their shift, especially wound dressing. Some will always leave that for others to do, claiming they are busy, but no matter how busy the ward is, you have to manage to do everything; it is part of the job. If you leave dressing for the afternoon, due to the sun, it becomes more offensive, and the ward smells. We all know this yet we have to fight about it!

This is an impediment to quality healthcare and such patients who normally witnessed some of these scuffles felt discriminated against. Not only were most lackadaisical about wound dressing, participants also mentioned that some nurses were just lazy on the job. They complained that some colleagues liked doing nothing. They would sit at the table conversing or just fidget with their phones, which was mostly common during afternoon shifts, while others would sometimes move in and out of the ward for unknown reasons. Some also preferred table nursing, that is, the paperwork, while others did hands-on work. This was not mainly a problem if the nurses on duty agreed on such an arrangement (that one sat to document whereas the other served treatments), but doing nothing and writing nothing was an issue because the work became burdened on just one or two people.

It was also surprising to observe that lateness was a problem on the ward and also a norm. The one to take up could be more than thirty minutes or an hour late, and the other still had to wait for her before she could hand it over. For instance, at the end of the afternoon shift, which is 8 pm, a nurse could still wait till 9 pm before her colleague takes up. When they

finally reported, they would have to go through the handing-over notes, which also took about thirty minutes to complete before those handing over could eventually leave. Some colleagues would phone the ones waiting to hand over if a particular challenge was holding them up, such as traffic, a sick child, or others, but others were just accustomed to reporting late. This brings up misunderstandings and risks, especially for those who have to wait at the bus stop at night. There was one report of theft and attempted rape during this study. Lateness inadvertently affects nurses' relations and their behaviour towards patients. Joana explained:

Some of them do not report early. You will just be waiting. Assuming you were here for the night shift, which is 12 hours, and instead of leaving at 8 a.m., sometimes by 9 a.m., no one is still coming to take over. Then, while waiting, a new admission is brought in. You would not feel enthusiastic enough to work because you are officially off-duty and already stressed out.

The pervasiveness of lateness was a detriment to patient care. Nurses who were officially off-duty but still waiting for colleagues sometimes fumed and appeared reluctant to continue work as can be inferred from the above quote. On some occasions, some murmured about the long wait while taking care of patients. Should a patient or relative provoke such a nurse, they could displace the pent-up emotions on them. The IC never reprimanded anyone for being late because she had given up on that topic except for the student nurses whom she always questioned or applauded when they were late or early, respectively. She prioritised disciplining the students to be time-conscious than her colleagues who had become reluctant. Yet, what she failed to realise was that the students could also learn the lateness behaviour from observing the regular staff. When I interviewed the male ward IC about how they handled the issues of lateness on the ward and why she never reprimanded the latecomers, she replied:

I used to complain about it several times, but the individual pretends to have changed for a few days and returns to their habits. When you report, no one does anything about it; they have accepted it. The matron will say, 'oh, I'll talk to them' yet there has been

no change! Our matron is very nice; she is very lovely, so with the things she has to be even strict about, she's still nice about them. Currently, what I do is 'you do me, I do you', that is if you come early but others keep relieving you late, you also should come late next time! I used to go to work as early as 6:40 am. Then the person who will come to take over in the afternoon will arrive at 4 pm! Two hours late! What would you do in this situation? I also stopped coming early!

This modification in behaviour, resulting in lateness, according to Blumer (1969), results from the interpretive meanings assigned to social actions. Even though the matron also admitted lateness was an issue and was firm about punishing such culprits accordingly, the fact that the menace seriously persisted showed that it had not received such strict attention as she claimed, and that gave nurses the power to remake the rules concerning lateness. Hence, the structural rule (Giddens, 1984) regarding the reporting time has been replaced with the new norm and its consequent sanction, which is 'you do me, I do you' through the nurses' agency.

Nevertheless, both participants and matron disclosed that 'on paper' punishments for offences such as lateness (and other improper behaviours) usually come in query letters, which warn the culprit at the first instance. Subsequent offences are meted with the denial of 'off days' and changing one's ward. More serious offences, such as abusing clients or colleagues or stealing drugs and other items, come with stricter punishments, such as placing an embargo on one's salaries and, at worst, withdrawing certificates. Yet, in reality, these were not strictly enforced since none of the participants admitted they had ever received any query letter for being late and so since punishment is not enforced, it contributed to preconceived notions that reporting early or late did not make any difference.

This lateness and lackadaisical behaviours are also typical illustrations of the perception and the meaning individuals hold towards state-owned institutions as mentioned earlier in the previous chapter. The mentality that that job is not theirs or a private hospital influences

their commitment to the work, which can also affect patient care. Hence, Hsu et al. (2015) advise that nursing management must encourage nurses to commit better to the job as well as promote cordiality among colleagues which can foster reliability, dependability, and concern, ensuring a family-like atmosphere and engendering desirable behaviours.

Aside from some of their nursing colleagues who contributed to some of their undesirable behaviours, almost all participants singled out doctors among the other allied health professionals as having a huge influence on their behaviours, supporting Lahana et al.'s (2019) similar viewpoint about doctors, that they normally contribute to most of the nurses' stresses. This did not concern the institutional constraints of doctors' non-adherence to their job description discussed earlier but doctors' attitudes towards nurses. Nurses observed doctors were bossy, negligent, and incorrigible.

Most nurses' conversations about doctors emphasised how doctors made their work difficult. For instance, during a handing over one early morning, one of the two nurses on the night shift complained to us about that night's incident. She was unable to secure an IV line for a new patient. Both nurses tried several times but to no avail. They called a doctor on the intercom for reinforcement and it took several minutes for the doctor to show up at the ward. He also attempted to find a vein pricking the patient several times but to no avail (One IC explained that this usually happens when the veins collapse due to dehydration, shock, multiple organ failure or excessive bleeding). He took a break and attempted again whereas the two nurses remained at the nurses' station to continue documentation. After a while, the nurse telling the story went to the ward only to find the doctor's tray on the chest table, and plaster on the patient's arm while the doctor was nowhere to be found. She lamented that he could have at least told them he was leaving instead of just abandoning the patient with her IV still unsecured. She phoned him several times, but no feedback. Both

wondered how they were supposed to serve treatments to the patient. Unable to do anything about the situation, they allowed the patient to rest until the doctors reported for review in the morning.

This is a typical case of poor communication skills between two health professionals. Arias, Moreno, Callata and Manrique (2020) identified conflicts of a communicational-staff nature, which has the propensity to deteriorate relations due to poor communication among professionals in health institutions. This normally stems from the assumption that one is more powerful than the other. According to Giddens (2001), when individuals have more knowledge about their social situation and social structure, they tend to assume more capacity when exercising their agency which could also lead to domination.

I had always assumed doctors were the bosses in every clinical setting, but this was not always the case. I witnessed Sister Betty, the male ward IC, challenge doctors in many instances, just like Bernice did in the female ward. She was a tough lady and called herself, a 'nurse advocate'. According to her, doctors are not their bosses and defended nurses anytime a doctor tried to be bossy over nurses. She enlightened:

Doctors have their hierarchy and so do nurses. The DDNS or matron is the boss for nurses and not doctors. There used to be a gap. Doctors felt they were doctors, and so were the bosses (she moves her shoulders up to demonstrate), but it is not like that anymore. Now we have defined our roles. Initially, even an elderly nurse or the IC would be seated, and a doctor, a young doctor, would come in, and the nurse would stand for the doctor to sit. It created the impression that the doctor was more important than the nurse. Now, I tell the young doctors who come in that they have their hierarchy of authority and we also have ours! They now understand it. They are getting it.

As posited by the American Nurses Association (2009), nurses play the role of patients' advocates and have to observe a professional and therapeutic relationship. This study points out that nurse managers are not only patient advocates but also nurse advocates who represent and intervene for nurses in the doctor-nurse relationships as well as the interactions

between nurses and the institution. Similar to research by Aberese-Ako, Agyepong, Gerrits and Van Dijk (2015), they realised that most of the doctor-nurse conflicts were centred on decision-making on client care. Senior doctors exercised authority over nurse anaesthetists by resorting to ‘force’, but junior doctors accommodated the nurses by agreeing with their decisions. In Senah’s (2002) paper, he explains that doctors’ education gives them rare knowledge and skill. Yet, this education is still deficient, making them “un-Ghanaians by its inability to inculcate in them traditional etiquette in speech and manners” (p. 58). He goes ahead to attribute this shortfall to colonialism and Western education. Meanwhile, Abraham and Shanley (1992) advanced that doctors indulged in this “behaviour to ensure that their authority and expertise remain unchallenged as authority figures” (p. 82) since that symbolised power as Blumer highlights. In the end, it is the patient who suffers as a result of this doctor-nurse strain as illustrated in the vignette.

In an informal discussion with his colleagues, Eric shares how a few doctors were particularly negligent and continually made mistakes regarding the dosage of medications to patients. Being experienced on the ward and knowing how some medications are administered, he (and others) would correct wrong dosages and call the doctors to inform them of their mistakes. Some doctors would accept the error and appreciate the correction, but others would refuse to be corrected. Stella reiterated this point:

Most of the doctors do not like nurses suggesting to them. Therefore, they would refuse to accept the nurse’s opinion, which sometimes would be correct. When that happens, you do not feel like correcting them in future instances. At times, some medications they write might be incorrect, but you must do what is right for the patient. It is for the patient’s good.

According to one of the ICs, a nurse must suggest or correct a doctor if she realises that is the proper medication or an error. This is because if she goes ahead to serve the wrong medication because the doctor made a mistake, she will be held liable. After all, she should be knowledgeable enough to know what she is administering to a patient. When a nurse

points out an error in medication to a doctor, and the doctor refuses the suggestion, the nurse has to go ahead and administer the medicine, when the medication or dose is unlikely to cause any harm and document it appropriately to serve as evidence. Researchers have observed that nurses have always been the scapegoats for medication errors (Urban, 2018; Menzel, 2015) and this is simply due to how doctors have been perceived to be bosses over nurses because of their specialised knowledge. This affirms Silva's (2017) position that in health institutions, the demanding nature of the work ignites an internal conflict among employees in everyday experiences that affects proper patient care.

6.6 Conclusion

This chapter has reported findings on the social pressures from patients and colleagues as well as the structural factors that in one way or the other contribute to the performance of undesirable behaviours which affects the therapeutic engagement and management of patients/relatives' conditions. In all, the pressures from patients, relatives, colleagues and other staff have to do with the quality of communication as the symbolic interactionism theory analyses. Since nurses encounter all manner of patients with 'altered state of minds' due to their ill health, as well as anxious relatives, not to mention colleagues and other staff who are certainly under pressure just like nurses, the burden normally rests on nurses (they spend more time with patients than the other caregivers) to be accommodative to reduce the incidence of unexpected, undesirable behaviours within these relationships. Bové, Lisby and Norlyk (2020), Dzomeku, Ba-Etilayoo, Perekuu and Mantey (2013) as well as Swasey (2013) acknowledged that good communication, sensitive cooperation, support, and respect is fundamental in ensuring healthy caring relationships.

The issue with the institutional and systemic factors tends to do with commitment to the job. Even though the structure produces constraints such as poor salaries, poor motivation,

insufficient logistics, etc., which affect work, the structuration theory espouses that nurses also have the capability to create and recreate further structures that could be more enabling. Therefore, the behaviour of some nurses is not only influenced by these structures but reinforced by individual factors such as perceptions of state-owned jobs, socialization and the decision to be a nurse, which also play critical roles in ensuring appropriate nursing behaviours and quality healthcare. Hence, the individual factors discussed in the previous chapter were useful in analysing the social and structural precursors to understanding the undesirable behaviour of some nurses. The next chapter, reports findings on psychological hazards and how they also explain the performance of nurses' behaviours.



CHAPTER SEVEN

“WE ARE ONE OF THE MOST DEPRESSED PROFESSIONALS YOU COULD EVER FIND”: NURSES AND PSYCHOLOGICAL HAZARDS

We always get attached to patients, but we don't show it. There have been instances when a patient has died, and we close the door and cry. When someone opens it, they will see us conversing as if nothing has happened (Georgina, fieldnotes)

7.1 Introduction

Some job contexts are characterised by highly salient emotion-based cues (Farh, Seo & Tesluk, 2012) and mentally draining needs (Scanlan & Still, 2019) that activate employees' psychological demands. While the previous chapters explained nurses' behaviour from the individual, social and structural factors, this chapter presents findings of how their behaviour emanates from occupational hazards, that is, the sources of potential harm to nurses in their daily work environment (Rogers & Travers, 1991), characterised by emotions which tend to influence their behaviour. Whereas occupational hazards come in various forms, including biological and infectious hazards, chemical hazards, environmental and mechanical hazards, and physical hazards (Amare et al., 2021; Rogers & Travers, 1991), pre-eminence was given to the psychological hazards because participants' stories confer so. They emanate as situations encountered from the job expectations, which tend to affect the nurses psychologically and emotionally (Rogers & Travers, 1991) and has the tendency to induce negative attitudes and undesirable behaviours, including dealing with death, injury, stress, spiritism, and the complexities of shift work. Arlie Hochschild's (1983) emotional labour theory and Blumer's (1969) symbolic interactionism were used to understand these hazards. They were mainly captured in three significant themes: default hazards, escapable hazards, and stress.

7.2 Default Hazards

The job expectations of the healthcare profession, which require healthcare professionals to transform individuals with altered states of mind and physiologies back to normalcy, generate some risks for professionals. Psychological hazards have been identified to include aspects of occupational hazards such as injections, dressing wounds, risk from medication administration, etc. (Amare, Tesfaye, Girmay & Gebreagziabher, 2021; Misiak et al., 2020; Khudhair et al., 2017) which affects nurses and caregivers during healthcare delivery. The researcher further distinguishes psychological hazards into hazards that one is likely to encounter and others that one is unlikely to encounter and their effect on nurse-patient relationships.

The researcher terms 'default hazards' as the risk that emanates from the unavoidable part of the profession or the job expectations. Meaning that there are aspects of the job which, by default, expose the nurse to emotionally demanding situations. The findings reveal that the distress that comes with these hazards ignited emotions such as anxiety, frustration, affection and fatigue, which is in congruence with the emotional labour theory that the profession is characterised by high emotion-based cues. These default hazards mainly come from the fact that nurses have to always encounter deaths of patients, the ubiquity of sick people or constantly seeing sick people and unpleasant sites. The hazards come from the cognitive appraisal that such events or incidents are displeasing and distressing, and such evaluation elicits both negative and positive attitudes/behaviours.

Death and dying are inseparable and integral phases of life which have always been with humans. This stage encompasses feelings of anxiety and fear, which makes the experience depressing and distressing (Seredocha, 2017). During the eleven months of fieldwork, I witnessed the death of six patients: three males and three females. Two of the men died from

diabetes, and the other from cerebrovascular accident (CVA), commonly referred to as 'stroke', while all three women died from stroke. One of these three women was Maimuna who was admitted for stroke, chronic kidney disease (stage 3b), right leg ulcer and severe hypertension. She had been on admission two weeks prior to my entry at the female ward and I noticed her properly when a doctor requested that I assist in holding the tray as she changed Maimuna's nasogastric (NG) tube. Maimuna went through a ritual of excruciating pain each day during the procedure since the tube was passed through her nose into her stomach for feeding. The woman always groaned intensely and was relieved from the doctor's 'torture' only when the procedure was over. She occasionally opened her eyes but did not talk at all. She only groaned and made sounds to express pain. Perhaps, what was more concerning about this woman was her fifteen-year-old daughter, who had to suspend school to take care of her sick mother. She was always at the ward assisting the nurses with bed-bath, feeding, changing and running errands for her mother. According to the IC, her dad, who only visited at dawn, warned other relatives to keep off his wife and instructed his daughter not to let any of their relations see her mother if they dared visit. Hence, only the young girl was burdened with the care of her mother. She ate, bathed, and slept (on the floor on days the beds were full) in the ward every day. At the end of my third month of being in the female ward, Maimuna died during one night shift.

It was sad because we all were always optimistic that she would make it. I found myself reminiscing about the fruitless efforts of her daughter as well as all the care I had assisted the nurses delivering to her, especially on that night shift when we struggled to change her diaper. For the first time, I saw nurses teary at the nurses' station and pretended there was nothing wrong when someone knocked. This is because nurses had to do what Hochschild (2003) calls 'surface acting' to suppress their pain in order to look professional.

This is a typical psychological hazard for most health personnel, especially nurses. The dying process comes with a feeling of helplessness when other participants also confessed anxiety from not knowing what to do after making all efforts to save such patients proved futile. This is how Awurama, a senior nurse, illustrated the ordeal.

A patient can be steadily recovering when the condition suddenly changes for the worse! You feel your hands are tied because there's nothing the doctor or nurse can do anymore, yet, the patient is passing out. There have been times even a week after the death, I keep brooding over the events. Mentally, I see the dead patient when I come to work! I'll then be thinking about whether I faulted in any way that could have led to the patient passing so just imagine if it was really my fault! The trauma would be unbearable!

Anderson, Kent and Owens (2015) similarly expressed distressing instances where nurses suffer ongoing guilt and regret after continually reliving the experience of things they should have done differently in a patient's death and dying, typical of Awurama's sentiments. Eric also admitted: "What's rather frustrating is the patients who never recover. You spend so much time, energy and even sometimes your money on them, and they still die. It's very frustrating". Francis expatiated:

Even though, we nurse people to peaceful deaths, in instances where you see a client you were hopeful would recover die in your care, sometimes you want to give up the job! After all, what is the essence of life? When nursing, I aim to get the patient to their previous state, so I'm psychologically [dis]stressed if it ends otherwise.

According to participants, the emotions of patients' death could make a nurse behave improperly when further provoked. Bernice, a senior nurse, also illustrates:

A patient died unexpectedly and the way it all happened affected me mentally. Then a relative of another patient also came in to ask me a question. She went and came back again, and I gave her the same feedback concerning the same question. Then she came the third time, bothering me with the same issue...I shouted... 'ahh madam *nya aboterε aah*,' (be patient madam)!! She made me mad, and I know I reacted that way because of the death earlier. Not only can it affect your output, you can also act unprofessionally.

As seen in these accounts, the loss of a patient can affect the behaviour of nurses. As much as most nurses had experienced a lot of deaths in their line of work, some still had not adapted to it but expressed distress whenever it happened again. This is particularly due to

how they interpreted the relationships they established with such patients and what it meant for them, as Blumer postulates, which induces such emotions. These relationships were not necessarily spelt out between the nurse and the patient because according to Hochschild (2003), workers manage their feelings and emotions in exchange for wages. Such relationships are based on the familiarity of the patient, the similarity of the condition to that of the nurse's experience, the manners, as well as the traumatic nature of the death, which caused a lot of psychological distress and emotions. Other studies have also found that similar features of patients' health condition, the suddenness of the death, and the age of the patient at death also influence nurses' grief (Kostka, Borodzicz & Krzemińska, 2021; Khalaf et al., 2018; Adwan, 2014; Chan et al., 2013).

The first characteristic was typical with patients who had been on the ward for a long time. Patients who had been admitted for a long time (say a month and beyond) were somewhat considered 'members of the house' like the case of Maimuna. This is the same with serial patients, those admitted and discharged from time to time. Eric recounts:

There was this asthmatic client whom I cared for whenever he was rushed in. He didn't have money, so when the doctors gave him a prescription, I 'catered' for it. On my off days, I would call to check on him. When he wasn't admitted but got an attack on my off day, he would call me, and then I would also call the ward to find out who was on duty and how to 'sort him out.' One day, he was admitted and was given oxygen and other treatment, but nothing worked. We tried everything to no avail! That guy's death really pained me. Subsequently, I remember him when I get asthma admissions and unconsciously get close to such patients.

Another characteristic was well mannered or courteous patients. Participants emphasised that such patients are particularly humble, full of smiles, and take instructions to make their care relatively easier. Just as impolite patients are abhorred, well-behaved patients are naturally loved. This accentuates that the reciprocity of liking can influence attitudes and behaviour. For instance, Hall, Horgan, Stein, and Roter (2002) found that physicians liked their healthier patients more than their sick patients and healthier patients liked their

physicians more. Similarly, nurses reciprocated by being friendly and effective to patients/relatives who demonstrated the same attributes and by being indifferent to those who were ill-mannered. Therefore, the death of such loved ones was also depressing. Kate affirmed:

Oh, my patient that I lost! That patient was a 72-year-old man. He was hilarious and wanted to chat all the time. He enjoyed vitals checking time so he could chat and ask questions. He would sometimes walk to you saying, “aunty nurse, I want to chat with you”. He became my friend and won’t allow anyone to check his vitals if I were around. That day he died, I really cried as if I had lost my father. More often, the way they relate makes the difference. Some people make us feel like we are their family and I also saw him as a father.

This quote suggests that the patient initiated chatting with the nurses by walking to them or taking advantage of the time for checking vitals, confirming that nurses spent little time with patients which they normally attributed to the workload (as mentioned in chapter four). However, if the patient made deliberate attempts to converse, nurses made time for it. This is to the detriment of patients who are shy, timid, too sick and could not initiate these conversations, yet they all have the right to such positive behaviour of the nurse just as the patient who made such attempts. Nevertheless, nurses grieved when these friendly patients died.

The traumatic nature of a patient’s death also engendered emotions of grief and distress. For instance, one nurse narrated an instance where a three-year-old girl died after a large pot of boiling soup was poured on her while she was playing in the kitchen. She was admitted for third-degree burns, but there was not much anyone could do, so she died only two days after admission, which made nurses very sad and angry about the negligence of the parent(s). In another instance, a participant recounted a car accident resulting in the death of a family of five: a father, a mother, their two daughters and a son as they were returning home from an event. In both instances, they admit a lot of staff shed tears at the heart-breaking sight of the traumatic deaths. Anderson, Kent and Owens (2015) also delineate the effect of such

traumatic experiences on their participants as resulting in sleeplessness, re-experiencing the traumatic ordeal in dreams, resorting to some totally avoiding similar clinical situations, taking extended leaves, and even quitting the nursing profession. This affirms that the emotional nature of the profession can have a graving effect on nurses, thereby affecting the quality of healthcare.

Researchers who have explored the distressing incidence of patients death among nurses, especially first-time encounters of nurses with deaths, expressed similar emotions of shock, grief, fear, denial, sadness, guilt, helplessness, and a loss of confidence just as reported (Kostka, Borodzicz & Krzemińska, 2021; Khalaf et al., 2018; Croxon, Deravin & Anderson, 2018; Heise, Wing & Hullinger, 2018; Ranse, Ranse & Pelkowitz, 2018). While these studies describe the experiences of early career nurses with patients' death at first encounter, this study adds that the situation is not only depressing for novice nurses but also for experienced nurses who repeatedly must go through these ordeals. However, individual personality traits (discussed in Chapter 5) and other attributes such as resilience, emotional intelligence, and cultural expectations of the expression of grief regarding gender become a factor in the display of emotions at the death of patients. Though cultural norms expect men to be stoic and 'emotionless' as compared to women (Jarvis et al., 2017; Kuo, 2011), male nurses also built such relationships and expressed grief when particular patients died. Nevertheless, how men expressed their grief was different from the females. Whereas the men mostly talked about it, the women not only talked about it, they also appeared moody and sorrowful. This corroborates the point made by Cunico, Sartori, Marognolli and Meneghini (2012) that women possess a much greater emotional empathy, which could be due to how they are socialised to be more expressive with their emotions than men, who are more emotionally controlled. These depressing situations, which are hazardous to emotional and mental well-being, trigger negative attitudes and undesirable behaviours such that

nurses may feel agitated at the slightest provocation and behave poorly towards patients and their relatives, as illustrated above.

As a coping strategy for nurses, only a few acknowledged that they needed the services of a psychologist who could intermittently counsel them through this phase. This is because some felt such emotions are part of their job while others did not want to be labelled as being depressed. Religion also played an instrumental role in adjusting to these hazards. Participants assessed and constantly rethought how they have been favoured to be alive despite all the deaths they see daily, hence, increasing their faith in God rather than staying depressed about the loss of lives. This affirms that individual factors such as socialisation (discussed in Chapter 5), which transmit religious values, are crucial not only in the performance of behaviour but also in the management of emotions. Other studies such as Khalaf et al. (2018), Sampaio et al. (2015), as well as MacDermott and Keenan (2014) posit that these experiences made nurses feel closer to God and strengthened their spiritual beliefs. They also agreed that spiritual coping strategies are most efficient in recovering from these heartbreaks and hence, the most frequently adopted since religion has always contributed to explaining the phenomenon of death and the eternity of life.

In as much as participants believe that the pain, heartbreaks, and agony that come with the profession are very depressing for some nurses, the irony of the situation is that, sometimes, participants felt they had to hide their grief in order to appear professional. This affirms Hochschild's (2003) theory that there are feeling rules in emotional labour jobs which expect individuals to present a collected and cool front despite the emotionally distressing circumstances. Georgina, a senior enrolled nurse revealed:

IC has been very worried about the man on bed 8 whose leg needs to be amputated, but she speaks to the relatives without emotions, so they feel we do inhumane things, but trust me, it's very depressing. One thing I keep saying is nurses need psychologists. We need counselling! We are one of the most depressed professionals you could ever find...I tell you!

According to Kirk et al. (2021) hiding grief makes one look 'professional' because nurses must present a capable, calm and competent front. Hochschild (2003) refers to this as surface acting, as illustrated in Georgina's quote about the IC; where patients see you as emotionless and unsympathetic of their plights because the healthcare giver tries to hide their grief in order to appear professional which can be emotionally draining (Debesay et al., 2014).

Some nurses did not have any emotions concerning the death of patients, especially patients who do not have any of the aforementioned characteristics. Participants confessed many nurses have developed sensory adaptations, making them civil and inattentive to these frequent occurrences such that death no longer disturbed them. Davida, a senior staff nurse with 6 years of experience affirmed:

I don't know if it's because we've practised for a long time. Some of us are emotionless when we see the dead and I feel we need periodic vacations to be refreshed. I even feel indifferent if my relation dies, especially the elderly. It's not like we don't have emotions, but we feel less of them than others. We are hardened, so even death is no longer news!

Monica, another senior staff nurse with 16 years of experience also illustrated:

Sometimes, when a patient dies during the night shift, some orderlies may not come for the body until morning, so we just go to sleep! We cover the corpse with a bedsheet and screen them [off] so other patients do not get scared. For us, there is no fear. I just perceive them to be asleep. We even must perform the last officing by dressing them, putting cotton in the nose, ears, and anus to soak the puss so we are used to dead bodies.

Watts and Morgan (1994) termed this feeling as malignant alienation in their study on psychiatric patients. They defined it as the gradual waning of the therapeutic relationship between nurses and patients and a weakening in the sympathy and support from staff. The waning of compassion tends to lead to the description of some behaviours of nurses as unconcerned or unsympathetic. In sum, while some withhold or express feelings at the death of patients, and are expected to manage it to appear professional, others do not feel any of such emotions at all and are regarded as unsympathetic, confirming the idea that this default

hazard makes the profession emotionally demanding. In such a case, nurses have to go through ‘deep acting’ (Hochschild, 2003) to induce emotions so as to look empathetic.

The second default hazard emanated from the ubiquity of sick people. The sad reality that I always woke up to see sick people was depressing as this was something that had never been part of my lifeworld. However, was this experience similar for nurses? For most nurses, it was normal as the majority of the participants expressed that newer and less experienced nurses were more likely to be ‘carried away’ by a patient’s plight than the more experienced ones just as other studies have found (Heise, Wing & Hullinger, 2018; Ranse, Ranse & Pelkowitz, 2018). Yet, from the findings, it was not only about nurses’ years of experience but also, factors like the severity of the condition, the age, and even the resemblance of the patients to other acquaintances that induced emotions similar to the experiences of death discussed above. This finding on the ubiquity of sick people, another default hazard, though ignites emotions such as distress, sympathy and affinity for patients of certain characteristics, propels positive behaviour towards such patients more than negative. It also advances the literature on empathy; an essential ability to feel the emotions and thoughts of others. It allows nurses to better understand patients’ experiences and concerns, communicate effectively, and trust mutually (Mottaghi, Poursheikhali & Shameli, 2020; Reynolds, 2017; Marcella & Kelley, 2015; Cunico et al., 2012).

Although participants alleged that they had to treat all patients equally, sometimes, they found themselves being more affectionate towards some patients than others and hence exhibiting a more sober behaviour towards them. Again, this is due to the symbolic interactions or the meanings they assign to such interactions, as Blumer posits. Georgina, interpreting youthfulness with good health, admits to the severity of patients’ conditions: “It’s depressing...it’s depressing... it is depressing! Sometimes, when you see a 30-year-old

with diabetes, a chronic one! It's sad. We are humans ooo. People think we have no empathy, but we don't show it because we can't attend to the next patient if we do." This confirms Kirk et al.'s (2021) position and Hochschild's (2003) feeling rule that it is functional for nurses to disconnect emotionally so they are quickly able to move on to the next patient to ensure the running of the ward.

The age of patients, according to participants, induces a lot of emotions and distress. The medical ward admits patients thirteen years and above. Participants narrated stories of how they found themselves being more affective, particularly to the younger and elderly patients. They see these categories of patients as the most vulnerable who do not only deserve more attention but empathy as well, which influences positive attitudes towards them. Diana conceded: "I get attached to the elderly because of my great-grandmother. I feel they are very helpless to the core". Sister Betty also recalls: "A 13-year-old boy had diabetes mellitus and was often admitted. His family didn't have much, so I sometimes bought insulin for him. Even when I was absent, he would call, and I would buy it for him. I get emotional whenever I see him".

Most participants also emphasised that the nurse's past influenced their behaviour towards patients. For instance, some described scenarios where they/their relations/friends suffered similar conditions, making them recall the experiences of such acquaintances and how they channel that affection to patients of similar characteristics. Similar sentiments go for patients who resemble acquaintances of nurses. Francis recalled:

He was a known alcoholic, and he was like a father figure to me because he was age mate with my father... that's all I saw in him, my father. I got so much attached to him. I wanted him to survive to quit it, but the alcohol had destroyed his kidney and liver. When I see such patients after that, I get emotional. I've done it more than once and know I have to hold this back, or I might probably cross the line.

Just as Mottaghi et al. (2020) highlighted, nurses are always exposed to events that more often demand empathy. On the flip side, they argued, empathy tends to lead to extreme and absurd responsibility towards patients; in this case, patients they are affective towards. This affinity could even affect nurses' ability to manage the crisis of these categories of patients and affect performance. Again, while nurses spend more time with these same categories of patients; other patients may feel ignored. That is why Talcott Parsons, admonished affective neutrality in the healthcare giver-client relationship (Parsons & Shils, 2017; Parsons, 1951).

Nevertheless, some participants pointed out that though they might have emotions for patients of these characteristics, they do not show it or else the patients or relatives could take advantage of that. Georgina revealed:

We get attached to them all the time, but we just don't show it because immediately, a relative realises that you are 'attached' to their relation (the patient), and they ask for too many favours. They want to take your phone number; they want you to favour them in the bills; they even want you to come home, so we don't show it.

Participants also found it disquieting with certain 'unpleasant sights', the final default hazard, that tended to trigger negative attitudes. I had my first cultural shock on the first day I joined the hospital. In the male ward, I joined the two student nurses to observe the wound dressing a rotation nurse performed. The patient was an elderly diabetic man with an amputated right leg from the knee to the foot. The remaining stump, wrapped in bandages, was severely infected. This leg always rested on a black plastic bag-covered pillow. The rotation nurse, Makafui, brought in a tray containing items for the dressing and pulled a green screen across him for some privacy. As the nurse carefully took off the bandages, he started moaning and wailing "oopla mi eh"... "oopla mi eh" (you are hurting me...you are hurting me). The wound started getting offensive as she continued to unwrap, but I tried not to show an odious look. When the wound was completely unwrapped, I was astonished and dumbfounded to see worms coming out of a person's body for the first time! The stench that accompanied it was so pungent but I tried my best to stay composed, passing on the items

needed for the dressing as she requested. The man let out a loud cry at each wipe. Makafui was obviously uncomfortable as she struggled to wipe off the moving creatures on the wound. Surprisingly, even after two days of this experience, I could still perceive the stench from that wound!

Most participants acknowledged worms in wound dressing were their most detestable sighting due to the discomfort as this story illustrates. Still, others also lamented about vomitus, blood, puss in the nose and ears, sores and soiled diapers. Augustina, a junior nurse, complained:

You are instructed to dress a wound which stinks, but what can you do? You chose to be a nurse so you must endure it! I remember the day I was asked to change a woman's diaper; my dear, how does even a baby's loaded diaper look like, let alone an adult? What I saw was very inconvenient but I had to look at the colour, smell it and chart it. Sometimes, you must pour it into a measuring cup to measure, too! That day, it wasn't easy for me! [Both laugh]

Another also expressed: "I saw one woman who had sores from her waist to her legs. It was terrible! A colleague saw her and collapsed. If it's your first time, you can collapse, vomit or cry." Joana, the assistant IC also lamented:

Sometimes when I get to work and have not eaten, I cannot eat during the entire shift because of the encounter with suffering patients, dead bodies, blood, vomit, and sores! One time, I cried while consoling a patient. Psychologically, it gets to a time when you become so emotional about many things. When you get to work, you're already down for the day.

These are also typical cases of occupational burnout where individuals are overwhelmed with emotional, mental and physical exhaustion due to long-term involvement in situations regarding emotional burden (Wilczek-Rużyczka & Zaczyk, 2015). As seen from the previous chapter as well as Adugbire and Aziato's (2018) study, some nurses exhibit improper behaviours by refusing to dress infected wounds or attend to patients with unpleasant sores due to the discomfort and burnout associated with this. Just as it was pointed out that nurses develop sensory adaptations to seeing the dead, it is similar to constantly seeing sick people. Most participants expressed civil inattentiveness to the sight

of the sick and sometimes unpleasant sights but the literature reports little about such adaptations. Nurses who also chose the profession, like Kate (as discussed in Chapter 5), tended to express better emotions, such as empathy and favourable behaviour towards these default hazards, such as dressing infected wounds, than nurses who did not have the profession at heart.

The discussions above, including the death of patients, the ubiquity of sick people and awful sights are described as default because an individual is likely to experience this (even if once) in their lifetime as a nurse. All participants had experienced emotions such as pain, sadness, anxiety, distress, etc., in one way or the other resulting from the death of a particular patient, or emotions from a patient's condition or an unpleasant sight from infected wounds, vomitous, faeces, etc. that ignite some emotions due to these work-related hazards. These are mostly experienced at the beginning of one's career as the literature has affirmed (demonstrated in the discussion above).

7.3 Escapable Hazards

As already indicated, most psychological hazards have been reported to include injections, musculoskeletal disorders, injury etc. (Amare, Tesfaye, Girmay & Gebreagziabher, 2021; Misiak et al., 2020). Though these are potential threats to nurses, not every nurse encountered them according to participants. Therefore, while sickness, awful sights and deaths are inevitable experiences on the ward (default hazard), what the researcher terms escapable hazard is another potential threat on the ward even though some nurses do not experience them due to carefulness. The researcher defines 'escapable hazards' as the work-related hazards that one might never experience. This is because though a substantial number of participants had experienced some of these injuries, a few had not due to proper care (especially in the case of injury). However, those who encountered these hazards reported psychological distress and anxieties that, in one way or another, triggered undesirable

behaviours. These had to do with injury, abuse and issues of spirituality, which ignited emotions of anxiety, fear and grief and which tended to influence poor behaviours towards patients.

7.3.1 Work-Related Injury

Among the work-related injuries nurses unfortunately encounter including falls, cuts from sharps, and musculoskeletal disorders from lifting patients/loads, needle pricks were the most prevalent in XYZ hospital. It was not surprising then when the matron was very keen about that workshop on injection safety (discussed in Chapter 4). She zealously drove nurses out of the wards to the conference room due to the numerous reports she persistently received about pricks. Perry, Jagger and Parker (2003) reported an estimate of 600,000 to 800,000 needlestick injuries each year in all healthcare settings through injections (21%), suturing (17%), and drawing blood (16%).

The victims of needle pricks did not only have to stay home (sick leave for about two weeks and beyond), they were also mandated to take antibiotics and other medications to avert any damage from the pricks as well as undergo numerous tests. During such times, they go through mental breakdowns that sometimes affect their job delivery and attitudes towards patients subsequently. This is how Evelyn, a senior nursing officer, narrates her experience:

I was discarding a used needle when it pricked me. What even hurt me most was my inability to identify whose needle it was, so I had to take retro medications. Taking the drugs was not easy, and I was pregnant, too. It really disturbed me... it wasn't easy. For about a week, my blood pressure was always high. Thankfully, all the tests I did every two weeks came out negative, but I was still in fear until the sixth month, which confirmed I was genuinely negative.

Diana also recounts the story of a colleague:

A colleague had a needle prick, and the patient was a retro. She said she told the patient to be still and just after injecting him, he moved, and it pricked her. She became so angry and abhorred the patient. You should have seen what she did to the patient! She really insulted and dealt with him, and I don't blame her because she could have had HIV. Subsequently, when you tell her to give an injection, she refuses to do it. I run

the ward with her on the same shifts a lot of time and anything to do with injectables, she isn't ready to do.

Princess described the anxieties and effects of a needle prick:

You are so traumatised, and it makes you more furious and how to even attend to other patients becomes a problem for you. It discourages you from work. Then the question... "so does it mean I've got this kind of infection? What if I've contracted HIV? What if I've gotten Hepatitis B? ...and all that. Your mind will be playing a whole lot of scenarios for you. It can subsequently influence your attitude, especially how you treat other patients.

Though the study's focus is not on HIV/AIDS patients, some of these patients were admitted to the medical ward to be treated for other comorbidities such as diabetes, asthma, hypertension, malaria etc. and so the fear heightened the more when such needles pricks had to do with these patients and exposure to other blood-borne pathogens which pose a threat to nurses' health. Consequently, it tends to negatively affect the infected nurse's attitudes and behaviours towards the patients who cause such accidents consequently ignoring them in future instances, as seen above. This illustrates a rebellion from the expected norm, that is, suppressing or managing feelings versus the reality, that is ignoring the patient, which indicates the stress in emotional labour (Hochschild, 1983). Georgina, one of the nurses introduced in chapter five as the one who loved reading and teaching colleagues, was pricked when discarding a needle and was observed to be passing through periods of anxiety and distress whenever she had to use a needle. Thus, one's tendency to get a prick had nothing to do with whether one chose the profession for altruistic reasons or not, or the nurse's gender but simply about carefulness.

There were other injuries some participants suffered from because of falls (in two cases where they had to rush to get a doctor during an emergency because the intercom was spoilt) or when there were spills unknowingly. One participant had suffered a hip dislocation from one of such falls resulting in a pain she believes she has to live with forever. A few participants were also troubled after unfortunate instances of patients unintentionally

vomiting on them. Though vomitus is not injurious, it is another inconveniencing and anxious experience because of their propensity for infections. Studies that have also focussed on work-related injuries show that caregivers' primary adverse medical events were contact with contagious body fluids, transfusion reactions, falls, assaults on the ward, and equipment-related injuries. This observation is evident in Ghana (Alhassan & Poku, 2018; Acheampong, Tetteh & Anto, 2016) and other clinical settings abroad (Assiri et al., 2018; Mercer et al., 2016; Yin et al., 2014). These studies also add that needlestick pricks and contact with infectious bodily fluids were common among auxiliary nurses, while professional nurses mostly suffered assaults on the wards, falls and equipment-related injuries. This distinction was, however, not observed in this study.

Participants also complained of the consequences they had to suffer from lifting loads daily and how some were compelled to lift heavy patients on occasions when there were no orderlies and relatives to assist. The current recommended weight limit for manual lifting for healthcare workers, calculated from the National Institute for Occupational Safety and Health (NIOSH) Lifting Equation, sets the recommended maximum lift per nurse at 16kg (Relias Media, 2022). Participants, including in-charges, were not aware of this expected weight but they were encouraged by supervisors to roll objects or turn patients (for instance, in changing diapers) even though this was not always feasible. Hence, nurses who had suffered injuries from lifting patients and loads such as equipment had a negative attitude towards it and were less likely to assist a patient in the future. Lifting loads, according to the matron, is now the sole duty of the orderlies as many female nurses especially had been affected. Sandra, an assistant IC, recalls her predicament:

A very heavy patient tried getting out of bed and fell. I was the only one around and couldn't ask the remaining patients, to assist me lift the patient. Meanwhile, I was just five months post-partum. I fetched another nurse from the next ward, who, unfortunately, was also a few months post-partum. As we struggled to carry her onto the bed, I felt a sharp pain in my back, and till now, I have severe back pains. Presently,

I don't attempt to lift a patient not because I won't do it; I can't even do it!

This relays a deficiency in the wards as to why a patient has to fall out of bed in the first place. There were electric beds with adjustable rails for non-ambulant patients, but they were insufficient, so when such patients were put in the beds without rails, their legs and arms were tied to the bed with a piece of cloth to prevent falling. Yet for a patient to still fall out is a shame and an impediment to quality health service and for nurses to also risk lifting a patient is unfortunate and a detriment to their health. This systemic failure affects their readiness to provide similar assistance to patients in the future.

Again, the physical demands of the nursing profession, which require nurses to bend, twist, turn, bath, dress, seat and transfer patients to their beds and the toilets, also contribute to the prevalence of work-related musculoskeletal disorders⁶ (WMSD) among nurses (Kgakge, Hlongwa & Ginindza, 2021; Ellapen & Narsigan, 2014; Anap et al., 2013). This is because nurses' duties demand that they adjust their body position from the normal anatomical posture to ensure the successful completion of the task. In some procedures, they must maintain these deviant postural alignments for prolonged periods, increasing the risk of WMSD (Rathore, Attique & Asmaa, 2017; Choi & Brings, 2016; Ellapen & Narsigan, 2014). These disorders are a major public health problem among healthcare workers and are becoming one of the most typical causes of morbidity among these workers, particularly nurses (Punnett & Wegman, 2004). According to participants, nurses who suffered these falls, waist pains, needle pricks and other work-related injuries more often put up negative attitudes such as refusing or ignoring such duties when they had to repeat specific care delivery that had the propensity for these injuries as illustrated because they found the

⁶ Musculoskeletal disorders (MSD) are defined as “conditions that include a gamut of inflammatory and degenerative conditions that affect the tendons, muscles, joints, ligaments, peripheral nerves, and supporting blood vessels with consequent pain, ache, or discomfort” (Punnett & Wegman, 2004, p. 13).

suppression of such emotions as Hochschild (1983) posits almost impossible. It consequently also affected nurses' commitment to the job, especially amid structural constraints and a lack of compensations other than a two-week off-duty, as participants reported.

7.3.2 Abuse/Violence

Second, abuse or violence from patients/relatives, another escapable hazard also contributes to psychological hazards. It has been identified that patients and their relatives are the significant perpetrators of workplace violence against nurses (Babiarczyk et al., 2020; Boafo, 2018; AbuAlRub & Al-Asmar, 2014). The World Health Organisation (WHO), together with the International Council of Nurses (ICN), the International Labour Office (ILO), and Public Services International (PSI) in 2002, identified two primary forms of violence; physical and psychological violence. They defined them as:

Physical violence is the use of physical force against another person or group, which results in physical, sexual or psychological harm. For instance, beating, kicking, slapping, stabbing, shooting, pushing, biting, and/or pinching, among others. Psychological violence is the intentional use of power, including the threat to use physical force against another person or group that can result in harm to physical, mental, spiritual, moral or social development. Psychological violence includes verbal abuse, bullying/mobbing, harassment, and threats (ILO, ICN, WHO & PSI, 2002, p. 11).

Participants in this study reported hostile behaviours from patients leading to physical, emotional, and sexual forms of abuse/violence. Physical abuse mainly manifested in physical attacks. For instance, one focus group discussant, Franklina, a senior enrolled nurse, recalled: "Sometimes they attack us. I have even taken slaps before (laughs)". Francis, a senior staff nurse, also narrated:

Some relatives visited a patient, but they were many, so I asked them to come in twos. One of the guys just came out from the group and pushed me. I fell. I fell flat on my back. When I got up, I asked him why he did that, and he waved me off rudely shouting, *fior...fior!* (get away...get away)!

Not only were nurses abused physically, there were also reports of how they felt emotionally abused by patients and relatives. According to the alliance's definition above, emotional abuse is a form of psychological violence. From the findings, this abuse first comes from verbal abuse. Participants admitted that some relatives were particularly rude and verbally abusive because they were either frustrated, anxious, or it was just their personalities. For instance, Bernice intimated:

A patient's husband was talking to us, and a man who came with him kept interfering in the conversation. At some point, my in-charge said, "Ah, brother... this is her husband, allow him to talk." He retorted, "Go away with your foolishness! You don't respect... eh?" We also told him our peace of mind! Sorry to say this, but sometimes, you need to put sense in them when it gets to such a point!

Another is the preconceived notion that nurses have poor behaviours. Participants argued that many patients report to the hospital with preconceived ideas of how disrespectful nurses are, so at the slightest provocation from a nurse, they vent their fits of anger on them because the clients were already prepared for the nurses' poor behaviour before they arrived. Nurses also explained that these patients' behaviours typically stem from the fact that some have experienced poor behaviours from nurses in this or other facilities, or that they have heard of others' experiences from friends and families who attended other hospitals. Hence, this notion becomes the standard for interacting with all nurses which exemplifies meaning-making and modification in behaviour in Blumer's (1969) symbolic interactionism.

Josephine elaborated:

Sometimes patients and relatives come in with preconceived ideas about us. They have heard that nurses are not good, so they are ready for you even when you ask the most straightforward question, which only demands a yes or no. If you have not met someone but are prepared for them already, they will also readily meet you. When you come along with trouble, I will also meet you with trouble—simple!

As some studies have reported, if a profession is deemed essential, that evaluation is due to how prestigious the society accords that profession. Therefore, the positive attitude of

patients to the nursing profession is not only due to the quality of nurse-patient relationships but also to a positive nursing image. In the same vein, the negative attitude toward the profession results from the negative nursing image (Midilli, Kirmiziloglu & Kalkim, 2017; Akgün & Kardas, 2014). Therefore, it was not surprising for nurses to say that patients disrespect them because of their preconceived notions about the nursing profession.

Looking down on nurses is another form of emotional abuse nurses complain about, resulting in improper behaviours between themselves and patients/relatives. Some clients consider nursing as inferior or think nurses do not know their jobs. They rank doctors higher than nurses, just as Zhang et al. (2017) found that the nursing profession in China has a relatively lower social ranking than doctors because nursing is deemed less prestigious than a doctor's job. Hence, even if patients/relatives object to a particular treatment (whether they understand it or not), they are more likely to vent their frustrations on nurses rather than on doctors; nurses then become victims of abuse. Stella, a staff nurse purported: "Sometimes we get some patients or relatives who tell you that you are not competent enough to care for their kin. That is when I come in, blast them, and make them understand that that is not how you talk to people!"

Another much-expressed way of emotional abuse comes from 'patient's payback'. It is not uncommon for nurses in Ghana to financially support incapacitated patients in their financial obligations. Bernice was angry one mid-morning, as she narrated her ordeal to her colleagues. She phoned a patient's relative and informed him that his sick relative needed medication worth GH¢100 (approximately US\$13). The man pleaded that he did not have any money and asked the nurse to buy it so that he refunds the money when next he visited. Due to the urgency of the situation, she purchased the medicine and informed her colleague who came for the next shift. The patient was discharged the next day, but none of her

colleagues on that shift knew this arrangement, and the informed colleague was not on duty on that day. The man did not pay and did not say a word about this debt upon discharge. She was very hurt. Subsequently, a patient who asked for a similar favour was denied financial assistance. While this is not a duty for nurses, Van der Geest and Sarkodie (1998), as well as Dapaah's (2016) hospital ethnographies, also showed instances where nurses rendered financial support to patients.

In the interviews as well, some participants recounted how they sacrificed for patients in many ways, only for some patients to 'betray' them. Such sacrifices include paying for medications for patients who never return to pay back just as illustrated, providing patients with food out of pocket, or paying for patients' treatments. Nurses see such occurrences as a stab in their back, so some of the nurses have sworn never to assist patients in similar situations in the future. Thus, in the future, when nurses refuse to give such assistance, some patients describe them as mean and inhumane, though financial obligations are outside the remit of a nurse, leading to some retaliations. This modification in such nurses' behaviour can be understood from Blumer's (1969) third premise that the encounters individuals make through interactions can propel a change in meanings and, hence, a change in behaviours.

Betty observed thus:

Sometimes, it is painful to sacrifice for patients. It hurts when the patient you fed from your own pocket does not acknowledge your effort. Some insult us, so you retaliate and tell them your peace of mind. It cools your soul. Now, we have stopped assisting patients financially. They are taking advantage of us.

The narration on sexual harassment was captured under two sub-themes: verbal expressions and unsolicited touches. These were particularly male patients who attempted to express sexual interest while on the ward. Though this was normal between two adults, the setting was ethically inappropriate. Sister Rita explained that it was more courteous for a male patient to express such interest when the female nurse was off-duty. What was rather

offensive were the patients who attempted to touch female nurses' bodies sexually. Samuela confessed:

I was setting his line when he touched my buttocks. At first, I pretended nothing had happened, just to give him the benefit of the doubt. Then, when it happened again, I gave him a stern warning. Since then, I did not nurse him again because I heard of a situation where a nurse was raped.

Georgina also elaborated:

Sometimes male patients want to kiss or hold you, so if you are on night duty with such a patient, you always have to be alert. A patient said he wanted to kiss me. His wife was outside the ward, so I asked her to come in and do her wifely duty [both laugh]. Some will look at you lustfully; some will be hallucinating and will even go to the extent of touching your hair.

These stories have implications for the safety of female nurses especially. Thus, some affected nurses ignore such patients or pay little attention to them due to some of these occurrences. Others no longer preferred nursing male patients. Hence, presenting a cool and collected self (Hochschild, 1983) after such nurses had experienced any of such abuses was emotionally demanding. Male nurses interviewed had not experienced any form of sexual advances from female patients. This suggests that while the abuse of the female nurses by patients was physical, verbal, and sexual, the abuse of male nurses by patients was not sexual but physical and verbal denoting a power play and the sexual vulnerability of women as compared to men.

The physical, sexual harassment and emotional/psychological abuse of nurses are consistent with those of other researchers on workplace violence. In Babiarczyk et al.'s (2020) report on workplace violence against nurses in five countries, including Poland, the Czech Republic, the Slovak Republic, Turkey, and Spain, more than half of the participants (nurses) in each of these countries had experienced psychological violence, while a few had experienced physical attacks in the last 12 months before the study. Nevertheless, one-third of the participants had experienced both types of violence/abuse. Verbal abuse was the most

common, followed by threats, physical violence, sexual harassment, and organised disturbances, and these were prevalent in emergency and paediatric departments. Globally, China has the highest prevalence of violence and abuse of nurses (Zhang et al., 2017). These findings are also in harmony with other studies focussed on violence towards nurses (Schablon, Wendeler, Kozak, Nienhaus & Steinke, 2018; Fisekovic, Trajkovic, Bjegovic-Mikanovic & Terzic-Supic, 2015). While workplace violence against nurses is universal, the nurses in these countries (China, Germany, Serbia by the researchers above) still have good reputations. This can be attributed to the strict supervision enabled by advanced technology such as CCTV (closed circuit television) cameras in the wards (Wang, Huang & Wang, 2022; Desai, 2010) which monitors work and promotes quality healthcare delivery unlike the case of most public hospitals in Ghana which does not have these resources. Yet, human supervision was also poor, which is evident in the previous chapter, where punishment, in the case of lateness, is not strictly enforced.

Just like the participants in this study, most victims of workplace violence studies do not report such incidents primarily because they claimed it did not make any difference and so was considered a 'useless' effort. Others, especially nurse managers who were verbally abused, felt ashamed to report such incidents because it would tarnish their image even though Zhang et al. (2017) on the contrary, established that when a nurse's social status is high, there is the likelihood of receiving tremendous respect and a lower chance of being prone to violence. The rest did not report because they had no information about whom to report to (Babiarczyk et al., 2020; Arnetz et al., 2015). Findings of studies by Schablon et al. (2018), Viotti et al. (2015) as well as Jiao et al. (2015) again support this study's findings on the effect of the abuses on nurses' behaviour. It results in the total rejection of nursing some patients for fear of further abuse, job dissatisfaction, decreased morale, absenteeism, low-quality care, and even quitting the job altogether.

7.3.3 Spirituality

The final escapable hazard but another cognitive duress concerns matters of the spiritual world. Branford and Thompson (1994, p. 972) termed it supernatural because they are “not attributable to, or explicable by, the laws of nature; magical, mystical”. These are also escapable hazards because not everyone encountered them, but those who did report anxieties and fears. The two most common ones are the ‘spirits/ghost escapades’ and the other is ‘mischievous eventualities. These frights go a long way to contributing to psychological hazards and influencing poor behaviours and attitudes.

The ‘spirits/ghost escapades’ were especially narrated by participants who had been night superintendents. This is a duty of senior nurses, where one moves from one ward to the other in the entire hospital, collecting data and writing notes about admissions, deaths, and discharges for report making. Since in-charges do not work at night, the night superintendents play the role of in-charges during night shifts. The matron chooses the night superintendents from one ward to the other. The most common sign that one has encountered such spirits is herpes, a kind of rash that occurs at the sides of one’s mouth. Monica recalled:

A week after the night supervision, I saw some rashes on my face. A pastor asked me if I walk at night. I inquired about the reason for that question, and he replied, ‘I met a ghost,’ but I didn’t notice it! He further explained that it didn’t harm me because I don’t have any evil intentions and besides, I’m strong-spirited. I told him that I’m a nurse and I do night supervision. He added that I had goosebumps on my arms when I met the spirit, but I didn’t observe it, hence, the herpes on my mouth affirms this.

There were spirits whom the nurses physically recognised, too. Frimpomaa recounts an experience of a colleague:

My colleague narrated that a patient had died, so he had to fetch the resident doctor to certify the death. When he returned from the doctor’s office, he saw the supposed dead patient leaving the ward towards the hospital’s exit. Yet, when he rushed to the ward, the body was still lying there!

Martha, a participant in the FGD, also shared an incident from her previous hospital thus:

A colleague on night shift dozed off, forgetting to check a diabetic patient’s random

blood sugar (RBS) but such conditions can lead to death when the patient is not monitored. This was one of such cases and unfortunately, the patient died. This lady felt so sure she was the cause of the patient's death. She started telling us about seeing the ghost of the patient. Sometimes, she would start screaming that the ghost was around; this happened often. Whenever she got to the ward, she would begin pointing to the ghost and screaming! The 'supposed ghost' indeed haunted her for a long time. In one instance, during a night shift, she said the ghost and all the patients who had died on the ward were coming in her direction and screaming all night! Her family took her to a prayer camp. I heard she quit nursing.

In the eighteenth century, the sceptic Charles Ollier suspected that ghosts were merely symptoms of illness. He established:

It may be laid down as a general maxim that anyone who thinks he has seen a ghost may take the vision as a symptom of deranged bodily health. Let him, therefore, seek medical advice, and ten to one, the spectre will no longer haunt him. To see a ghost is, *ipso facto*, to be a subject for the physician (quoted in McCorristine, 2010, p. 75).

However, in de Swardt and Fouché's (2017) In this study, most of the participants believed in the presence of spirits and their potency to harm or be good, as this study also found. According to participants in this study, not only did such spirits exist, but they also confirmed that their presence could be felt by goosebumps on one's skin. The consequences of such outcomes emanated fear for nurses who had experienced them and those who were told these narratives. It is even compounded with eerie stories.

Besides the ghost escapades, participants narrated other creepy stories, which the researcher refers to as 'mischievous eventualities' that occasionally happened, instigating fear and other distress. The following are a few narratives beginning with Davida's account of her experience:

In my third year of nursing at Sunyani, there was a traditional priest who died, and the mortuary attendants had to carry him out of the ward. When one died, they had to be wheeled to the exit gate then the mortuary attendants would pick them out of the bed. In this case, the priest's bed could not be moved. They could neither lift the body from the bed nor move the bed with the body, so they had to wait till the head of the mortuary team arrived because he was more experienced in spirituality. On his arrival, he performed some rituals before they could finally move the body.

Evelyn, an FGD participant also shared as follows:

My colleague narrated that she was sitting at the table documenting some stuff at night.

At that place, the nurses' station was at the ward's centre with beds on the left and right. She just lifted her head, and a patient was standing right in front of her with no head on his neck but instead, his head was held in-between his legs. She said, "I screamed and run so fast into the nurses' room as never before". For this reason, she fears night shifts and when she is compelled to do one, she never sits at the nurses' station after 10 pm. She will give one excuse or the other just to stay in the nurses' room.

Barbara, another FGD participant, shares a personal experience:

In my previous place, we didn't have a nurses' room, so we slept in the same room with the patients. One night, I peeped to see if the patients were okay so I could go back to sleep. I could see a man squatting on the bed (also squats to demonstrate) and moving his hands and head while rolling his eyes as if making some incantations as seen in the movies. I was extremely shocked, and my heart skipped a beat! He was facing the wall. I didn't want him to notice me, so I glanced at him. I don't know the spiritual implications of what he was doing, but I think he knew someone was observing, so he turned sharply in my direction. I pretended to be sleeping; I opened my eyes slowly and looked at him through the corner of my eyes. He was still looking in my direction, but this time, his eyes looked so bright, like a torchlight. Then I started whispering, "Jesus, Jesus, Jesus, save me"! [All laugh]. I never went for the night shift again until he was discharged. I forcefully opted for morning shifts.

Contrary to the disbelief in the existence of ghosts and these mischievous eventualities because they are logically incomprehensible, the African traditional cosmology affirms the reality of such spirituality. Such literature (Appiah, 1993; Mbiti, 1990; Minkus, 1980) show spirits have always existed and have been an active part of the world, with their influence penetrating almost every sphere of life, including their ability to harm which is the more reason why they are feared which can be understood from the symbolic meanings (Blumer, 1969) we assign to situations as a result of social constructions. Hence, the reality of this kind of experience has to do with one's belief.

The belief in spirits/ghosts and the reality of dark forces is rooted in socialisation. In Ghana, folklore is a fundamental and essential aspect of our daily lives (Asante & Edu, 2018). Traditional myths and folktales ingrained in individuals right from childhood as a form of storytelling become part of an individual's lifeworld, making one susceptible to belief in this phenomenon. For instance, children are told stories such as 'Madam Moke', a ghost with one shoe who hunts for the missing pair, and other similar stories, which substantiate the

beliefs and reality of such entities. According to Fischer (1963), folklore enhances psychological processes as well as social realities. The media also portrays movies (Garritano, 2017) from various cultures using characters who are assumed to be ghosts or spirits and their tendency to harm people. Religion and indoctrination about evil spirits and ghosts (Ketchum, 2015) also become a paramount precursor here. With all the participants being Christians, this outcome is not surprising since spirits and ghosts are also facets of charismatic Christian doctrine.

According to the participants who purported to have had these encounters, there is an experience of distress during such occasions and there is a fright of the reoccurrence of a similar incidence in the future; hence, the likelihood of a post-traumatic stress disorder (PTSD). That is, a psychiatric disorder that could occur from direct or indirect exposure to traumatic events (Yehuda et al., 2015). In the nursing literature, while PTSD has mainly been attributed to death, injury, and violence (Zhao et al., 2018; Lavoie et al., 2016; Mealer & Jones, 2013; Adriaenssens, Gucht & Maes, 2012), this study adds that PTSD can also come about when nurses experience frightening spiritual encounters as emotional labour. By implication, nurses with such traumatic disorders were more likely to put up wrongful behaviours and attitudes to affect patients and relatives. To cope, nurses with PTSD resort to avoiding patients (Lavoie et al., 2016), whereas others end up in blame games and denial (McMeekin et al., 2017). In this case, participants who had had such experiences refused to nurse such patients.

7.4 Stress

Occupational stress is a significant psychological hazard identified as a great concern among nurses (Sarafis et al., 2016). It comes from an imbalance between the stressors at the workplace and the ability of the nurse or staff to cope (Sahraian, Davidi, Bazrafshan & Javadpour, 2013).

least is up to 96. For stroke patients, too, you must change the diaper and bed bath them. It is difficult and very stressful. Especially when there are a lot of dependent patients, and there are no relatives to assist.

Edna also intimated:

Stress brings up some of these behaviours because the working hours are not enough for what we must do. Yesterday, for instance, I was just in a hurry to go because I was so tired...I was just so tired! The doctors came for review, and we had to stay with one person for a long time, and there were twelve patients. By the time we finished, three hours were gone! (chuckles) Yet, I still had much to do before the afternoon shift nurses came. You don't want to create an impression that you are incompetent or lazy, so you must finish up so that you don't overstress them by adding your unfinished work to theirs.

Stella also highlighted being selective when stressed: "When I'm stressed, I personally pay attention to the seriously ill ones, and so if you are not seriously ill, even though I give you attention, it's not as compared to those who are seriously ill." The conversation on nurses' workload awoke emotions of despair, misery, and suffering. Other studies have also associated burnout and fatigue with work overload and stress from the nurses' work (Eldevik et al., 2013; Øyane et al., 2013) and some have emphasised that fatigue is a common feeling among nurses (Raftopoulos, Charalambous & Talias, 2012).

At the start of the data collection, getting any interviews was challenging since nurses were always busy. Despite the vast amount of work, they were more often also burdened to add on some of the jobs of the other professionals, as discussed in the previous chapter, compounding the stress. According to participants, they are even more stressed from working overtime which, in most cases, they have no choice but to do. Evelyn confessed:

There is no payment for overtime, so it's sacrificial work. As human as we are, we get exhausted, and once you are overstressed, your body mechanism will make you inefficient, so for a single task you might be doing, you sit down repeatedly; hence, productivity is low, and when that happens, you now tend to displace your stress and frustrations on patients.

Some scholars have explained that some nurses are not compassionate due to stress. The overstress results in what has been termed compassion fatigue (Mottaghi et al., 2020; Armstrong, Rispel & Penn-Kekana, 2015; Hunsaker et al., 2015). As established, when

compassion fatigue particularly sets in, nurses are more irritable, more prone to mistakes, and insensitive to the needs of others since they are stressed. This may be the reason behind negative attitudes and behaviours because, according to them, the aggregate of compassion expended by the nurse exceeds their ability to cope with the stressors. As such, most found it difficult to present well-collected and smiling faces as desired, due to these emotions (Hochschild, 1983) resulting from stress.

Most participants also attributed the enormous workload to the poor staffing or shortage of nurses. According to their hypothesis, when there are more hands, the workload decreases, so nurses are less likely to be stressed and less likely to put up negative attitudes. The female ward IC argued:

It's the nurse-patient ratio. The workload supersedes the staff's strength; sometimes, they put up those behaviours when they get stressed. You might have a few that are rude by nature, but from my experience, it's the workload. The frustration causes them to misbehave.

Franklina from the FGD also stated:

Every nurse's wish is to 'get more hands'. One motivation is that the work is more manageable when we get more hands, so it's all about staffing. If the staff is sizeable, you know that when you work and you get tired, you can rest for a while, but if there's pressure on you, you might even shout at someone unintentionally and later ask yourself, "What did I just do?"

The shortage of nurses, which has become a global problem, has persisted for a long time (World Health Organisation, 2016; Heinen et al., 2013). A needs-based estimate in 2013 shows a report of more than 9 million nurses/midwives shortage globally (World Health Organisation, 2016), and almost half of the WHO member states reported fewer than three nurses/midwives per 1,000 population (World Health Organisation, 2017). In Ghana, there is a shortage of nurses in the urban centres, and it is even worse in the rural areas (Ghana Health Service, 2018). Even though the nurse-patient ratio as of 2019 was 839 clients:1nurse. Daily Guide Network (2019) shows a tremendous improvement compared to previous years, and considering WHO's recommendation of 1000:1, this in no way has

solved the problem of heavy workloads as observed in the findings. Nurses must work stressful hours of heavy workloads coupled with inadequate resources, overcrowding of patients and workplace violence (Kaburi et al., 2019; Xu et al., 2019; Abraham et al., 2018; Adatara et al., 2018; Crilly et al., 2017) which is in congruence with this study. In sum, considering nurses' workloads, as Asamani et al. (2018) pointed out, the wide disparities in the nurse-patient ratio, coupled with the workload is prone to affect nurses' attitudes toward patients due to burnout just as others (Misiak et al., 2020; Glerean et al., 2017; Rezaei-Adaryani et al., 2012) also demonstrate. This is also evidence that structural lapses indeed affect nurses' work as seen in the previous chapter.

Finally, the shift system was attributed to be one of the main precursors of stress. The International Council of Nurses (ICN) in 2007 maintained that if nurses are to provide 24-hour care, then the shift system is required (Abdalkader & Hayajneh, 2008). As laid out in chapter four, the morning shift begins from 8 am to 2 pm, another group of nurses take over during the afternoon shift from 2 pm to 8 pm, while the final group continues from 8 pm to 8 am, which ensures a complete 24-hour healthcare delivery for patients. As much as this all-around healthcare system is advantageous to patients, it does not necessarily favour some nurses, especially those assigned to the night shift. Participants explained that night shifts are detrimental to their health, safety, and even their intimate relationships with their partners. They found it particularly stressful and inconvenient and did not allow nurses to put out their best healthcare delivery and behaviours. For instance, Augustina complained thus: "It got to a time I had to take sleeping tablets to sleep at home. I can't sleep". Jessica, an FGD participant also complained about the afternoon shift:

I have a colleague who reaches home at about 11 pm after every afternoon shift. The following day you expect the person to get to work at 8 am for a morning shift. When they come, they're visibly tired and that affects the delivery. With nursing, our headache is the shifts...the roster... the timing!! Every day nurses cry about the roster. The stress is just too much.

Martha, another participant of the FGD, also narrated:

Last week there was a student at the female ward whose bag was snatched at the roadside. Apparently, the nurse for the night shift didn't report early, and the nurse on duty who could have relieved the student didn't release her till about 9:30 pm instead of 8 pm when the nurse for the night shift arrived. According to the student, as she stood awaiting a taxi, she was attacked by two men with a knife, and all her belongings were taken, including her bag and phone. She had to walk for a distance to the nearest police station but since the robbers had escaped already, the police officers on duty dashed her money for transport fare. Sometimes we are at risk just by being nurses because the shifts and timing don't help us.

While the shift system is relevant for around-the-clock nursing care, its potential negative impact on nurses' health, the quality of healthcare delivered and performance cannot be overemphasised (Abdalkader & Hayajneh, 2008). Earlier studies (Bohle et al., 2008; Reinberg et al., 1989) revealed that about 20% of shift workers experience shift work maladaptation syndrome at some point in their careers, leading to the inability to work due to sleep deprivation, exhaustion, and unsynchronised cycles. Those on night shift especially experience fatigue more quickly and report poor sleep quality compared to day shift workers. Generally, nurses assessed working conditions as worse in all aspects of their work especially because of the shift work due to its accompanying mental and physical burden (Misiak et al., 2020). In Taiwan, it is reported that 70% of nurses have sleep problems due to the poor quality of sleep (Lin, Liao, Chen & Fan, 2014) which consequently, in the long term, affects the quality of patient care, high turnover rates, and nursing errors (Ball et al., 2015; Keller, Berryman & Lukes, 2009; Surani, Murphy & Shah, 2007).

These findings add to the shift work maladaptation syndrome and its contributing effect on sleep problems and poor behaviours consequently. While the literature emphasises the health effects of the shift system, the findings also reveal an essential aspect of safety. If a nurse closes from an afternoon shift at 8 pm and has to walk to a bus stop in the night via public transport, they stand at a risk of unforeseen attacks from criminals, as inferred from

the last quote. Hence, if their life is at risk because of their job, quality healthcare delivery could be compromised.

Again, shift work, especially the night shift, also affected intimate relationships. Augustina intimated: “I heard nurses don’t have blissful marriages or courtships while some never get married because people always snatch our spouses from us. You have to go for night duty, and by the time you return, another woman has taken your place!” This supports studies that show that nurses encounter many spousal problems and contribute to the disturbance of the family and social functioning just by working on shifts, especially night shifts (Cybulski, Krajewska-Kułak & Jamiolkowski, 2015; Tai et al., 2014). These studies explain that both female nurses and doctors find balancing family and work exhausting due to working under non-typical schedules. This could affect quality healthcare delivery as well as interpersonal relations with patients.

Shift work is not unique to Ghana, but the structural and individual issues that the nurses encounter make the shift work challenging as this section has revealed. Individual behaviours such as reporting late to work (discussed in the previous chapter), such that a person on the afternoon shift does not leave exactly at 8 pm and so has to encounter systemic constraints such as poor transportation which means they could get home at 11 pm and the risk of criminal attacks as seen in Martha’s quote make nurses’ shift work in Ghana stressful and hazardous which as well has a ripple effect on quality healthcare delivery.

In sum, work-related stress is a contributing factor to emotional, psychological and physical burnout, and not only does it cause stress-related diseases and their consequent incapacities, aetiologies of anxiety, depressive symptoms, and increased risk of cardiovascular diseases (Kaburi et al., 2019; Moore, 2018; Sahraian, Davidi, Bazrafshan & Javadpour, 2013), they are also a precursor to negative attitudes and undesirable behaviours.

7.5 Conclusion

Based on the narratives and observations, this chapter explains that the job situations encountered by the nurses, which mainly pertain to death, sicknesses, unpleasant sites, injury, spirituality, work overload, and the complexities of shift work, are potential threats to nurses' psychological and emotional well-being and a trigger to burnout and distress, as well as related debilities such as undesirable behaviours, if not managed well. The exposure to these working conditions explains some aspects of their behaviour, both positive and negative.

This chapter adds to the discourse on psychological hazards in that, researchers (Amare et al., 2021; Misiak et al., 2020; Khudhair et al., 2017) have associated [dis]stress, anxieties and depression, as a result of shift work, injuries, deaths and violence to psychological hazards but this work extends the discussion to include superstitions, the ubiquity of sick people, and the contribution of what is default and escapable, and how psychological hazards explain the undesirable behaviours of some nurses in their interpersonal relations with patients.

In as much as the emotional labour theory (Hochschild, 1983) shows how essential it is for nurses to manage their feelings in order to appear professional, from the findings, it is almost impractical to suppress emotions when one sees a ghost, suffers an injury (especially a needle prick), or is sexually abused. Again, when nurses show tears and vulnerability, they are considered unprofessional. Again, when they do not, they are considered unempathetic and wicked. In both cases, nurses are compelled to manage their feelings in exchange for wages.

CHAPTER EIGHT

SUMMARY, CONCLUSION AND RECOMMENDATIONS

8.1 Introduction

The nursing profession is an indispensable arm of every healthcare delivery system, and nurses play an irreplaceable role in the recovery process of the sick through the provision of quality healthcare. The profession's foundation is built on empathy, compassion, trust and good interpersonal relations between nurses and patients. However, there have been numerous media and empirical reports worldwide and in Ghana, particularly, of poor behaviours of some nurses to patients demonstrated in physical abuse, verbal abuse, intolerance and neglect. These are contrary to the tenets on which the founder, Florence Nightingale, established the profession and the ethics of the Ghana Health Service. Meanwhile, the provision of quality healthcare is necessary for patients and attaining the health-related Sustainable Development Goals, which seeks to ensure healthy lives and promote well-being at all ages by the year 2030.

Therefore, this study sought to understand why nurses' behaviour towards patients/relatives has been generally constructed as 'undesirable' and commonly tagged as unfavourable. Since many of such related studies focussed on the patient's side of the story, this study concentrated on the nurses' side of the story in understanding their behaviours using Blumer's Symbolic Interactionism Theory, Giddens' Structuration Theory, Homans Rational Choice Theory, Foucault's Knowledge and Power, and Hochschild's Emotional Labour. It employed the qualitative approach, precisely, an ethnography, to understand nurses' precursors of undesirable behaviours in a public district hospital in Accra. The target population included both registered senior and junior nurses who had at least a year's experience. Nurses in the medical ward were purposively sampled for the study. At the end

of the eleven months of ethnography, which employed a triangulation of in-depth interviews, participant observation, focus group discussion, key informant interviews and informal dialogues in its data collection, thirty-two participants were attained after applying the principle of saturation. This concluding chapter purposely summarises the study's findings, draws conclusions, and gives recommendations based on the findings.

8.2 Summary of Findings

The study's findings were organised into four chapters. Chapter four gives an elaborate account of the study area, the hospital as a social system, the culture, and some ethnographical experiences. It tells a story about the everyday life of a hospital, including daily routines, the nursing hierarchy, the collaborative roles of other healthcare providers, and the Ghana Health Service.

The first objective sought to identify the individual nurse's precursors that shape their behaviours towards patients and their relatives. The data revealed that one's upbringing or social interaction at both home and school defined nurses' character and personalities in that it informed their temperaments, communication skills, values (primarily religious), principles/perceptions of care, and perceptions of state-owned institutions. Nurses are mostly informed by socio-cultural learning and the interpretations they make when interacting with their families, patients/relatives and colleagues. The meanings nurses make from such interactions influence nurses' behaviour.

Also, the decision to be a nurse, which is a rational choice, applying Homans theory, informed desirable or undesirable behaviours. Nurses who joined the profession based on altruistic motives, such as perceiving the job as a call out of passion or compassion for the sick, felt they had to withstand the obstructions. For nurses who joined because of situational factors such as their family's choice/tradition, or due to being university rejects or being

‘disappointed doctors’; and for those who joined due to economic reasons such as to secure a job, or good salaries/allowances, some were able to develop interest and align with the profession. Others still struggled to fit in and even desired to leave the profession. It was observed that nurses who did not have a career at heart were more prone to undesirable behaviours when ‘pushed’, thereby affecting the quality of work.

Applying Foucault’s knowledge and power, the knowledge nurses hold puts them in a place of power in their relations with patients/relatives and colleagues. Junior colleagues, especially, narrated instances where senior colleagues lorded their position or abused their power on juniors and patients, and how juniors also consequently displaced them on patients. Contestations about nurses’ ranks also generated a lot of conflicts affecting interpersonal relations and the quality of healthcare provision. The ownership of resources such as assets, wealth, connections and specialised knowledge also distinguished some nurses and enabled power, which had implications for both positive and negative behaviours.

The second objective also sought to investigate the social and structural pressures that shape nurses’ behaviours towards patients and relatives. This was a result of the meanings nurses made about the actions and inactions of staff in the ward as Blumer posits. Participants attributed social pressures to some patient’s/relative’s unwillingness to cooperate with nurses due to their anxieties, visitation time-out struggles, patients absconding, patients who believe they know their rights, iatrophobia (doctor’s fright), relatives abandoning their patients, and complementary religious practices which tended to provoke nurses and its resultants improper behaviours. They again explained that some of their behaviours were a result of retaliations from colleagues and other allied health professionals’ behaviours. These included grudges about laziness and lackadaisical attitudes of some nurses, and non-

cooperation on the side of doctors, lab technicians etc. These social pressures resulted from poor communication which affected interpersonal relations and quality healthcare delivery.

There were structural pressures pertaining to institutional and systemic factors which participants found constraining or enabling. There was a lack of job commitment due to institutional factors such as insufficient supplies/equipment/medication, poor supervision, poor motivation, and non-adherence to job descriptions which participants found constraining. This is not in the absence of other systemic failures such as poor salaries, promotion, and study leave issues, which do not put the interest of the nurse at heart. Though participants were knowledgeable agents as Giddens terms it, and were able to find their way around these constraints, these added to the stress of the work, affecting the quality of service provided.

The final objective sought to explain the psychological hazards (emotions) that pertain to the job and how that influences nurses' behaviour towards patients and relatives. It was observed that the nursing profession is characterised by emotions which Hochschild refers to as emotional labour. This emanates from the occupational hazards that confront work at the ward. Priority was given to psychological hazards and how they explain undesirable behaviours. They were the distress, anxiety, and grief that accompanied some 'default' hazards, such as witnessing deaths, the ubiquity of sick people, and some awful sites. There were other hazards, termed 'escapable hazards', such as work-related injury, abuse/violence from patients and spiritualities which some nurses confronted and had implications for post-traumatic stress disorder, although these were 'escapable' when care was taken. Finally, stress, resulting from work overloads and the shift system, also contributed to ill health, distress and aetiologies of anxiety, which had implications for quality healthcare delivery.

8.3 Implications of Findings

In considering a health facility for care, the attitude of nurses is highly considered. While participants have explained the reasons behind some of these wrongful behaviours, which in this study were primarily demonstrated in poor communication skills (mainly in the tonation used and body gestures), giving silent treatments (how nurses appeared busy when a relative approached them on their table or ignoring them), some rebuttals, and being on phones during work, it demonstrates that these wrongful behaviours are indeed existent and tends to discourage patients from using public facilities. Just as Asenso-Okyere, Osei-Akoto, Anum, and Adukunu (1999) have pioneered in earlier studies, this will resort to health-seeking from others such as traditional healthcare givers since herbalists and fetish priests make ample time for their clients as compared to nurses. Well-resourced clients will also resort to private hospitals to be treated with respect, thereby defaming and losing trust in nursing care at public hospitals as Kodom et al. (2018) also reported.

Moreover, at the end of the interviews, even though most of the participants alleged that they do not regret choosing nursing as a career if they had to recommend the nursing profession to upcoming students, they would advise them to select nursing outside the country. Some participants even declared their intention to leave the public hospital for private ones or other businesses should they get the opportunity. The implication of job dissatisfaction, leading to weak job commitment, would only result in a higher turnover of qualified nurses that the government has spent years training.

8.4 Contribution to Knowledge

1. The study has filled a significant gap in the literature by presenting nurses' perspectives, thereby providing a more nuanced understanding of their experiences. This study offers valuable insights into the underlying factors that contribute to these behaviours.

2. The public narrative, as seen in the literature, is useful in shaping the perception/image of nurses.
3. The study adds to the literature on psychological hazards by introducing two concepts; default hazards and escapable hazards.
4. Studies on nurses' interpersonal relations with patients have fundamentally focussed on attitudes. This sociological research adds a more comprehensive and observable way of understanding the phenomenon to the literature on nurses' behaviour.
5. Spirituality in the hospital, encompassing nurses' encounters with ghosts and other mischiefs, was a significant contribution as this was not too evident in the literature.

8.5 Limitations of the Study

Although this study is in-depth and detailed, a few limitations hinder it. Religiously, all participants were Christians. This was not deliberate as there were no participants of other religions within the medical wards. Just as explained in the third chapter, this is not surprising since Christians outnumber (71.3%) Moslems (19.9%), Traditionalists (3.2%) and other forms of religious sects (4.5%) present in the country (Ghana Statistical Service, 2021). This would have strengthened the section on socialization and illustrated how different religious backgrounds affect behaviour, enhancing our understanding of it.

Again, for age distribution, except for the hospital matron who was in her 50s and two other nurses in their early 40s, the remaining twenty-nine participants were all in their 20s and 30s, with those in their 30s forming the majority. Upon enquiry from the in-charge (nurse manager) of the male ward about why the nursing staff is relatively young, she explained that due to the nature of the job that requires them to stand for long hours, bend, and lift patients, elderly nurses are considered unsuitable for the role and as such are more often assigned administrative positions in the office or given supervisory roles to monitor the

work. However, the interplay of younger and older nurses would have been useful for a nuanced analysis of generational gaps and the meaning it makes for explaining and understanding behaviour (if any).

Also, from the total number of thirty-two nurses interviewed, although both sexes were represented in the study, there were only five male nurses due to the cultural perception that nursing is a female profession and consequently, female-dominated (Mott & Lee, 2018).

Nonetheless, this study was conducted rigorously and contributes to the Sociology, literature.

8.6 Recommendations for Future Research

1. Due to the limitation of diverse religions, I suggest that future research should include participants of different religions. This would help to provide a more comprehensive understanding of the topic across different belief systems.
2. Future research should include a more diverse age participant pool to enhance an understanding of the situation among different age groups.
3. For further studies on nurses' behaviour, researchers can investigate the phenomenon from other healthcare providers, including doctors, pharmacists, etc.
4. While this study concentrated on general registered nurses, future research could concentrate on the behaviour of nurses with specialisations such as surgical, orthopaedic, etc., if there would be a difference in the behaviours portrayed.

8.7 Recommendations for Nurses, Management and Policy

1. Nurses should be intrinsically motivated to provide quality care for patients, as this deep-rooted passion enhances their commitment and empathy. Such motivation not only improves patient outcomes but also fosters a more compassionate and supportive healthcare environment.

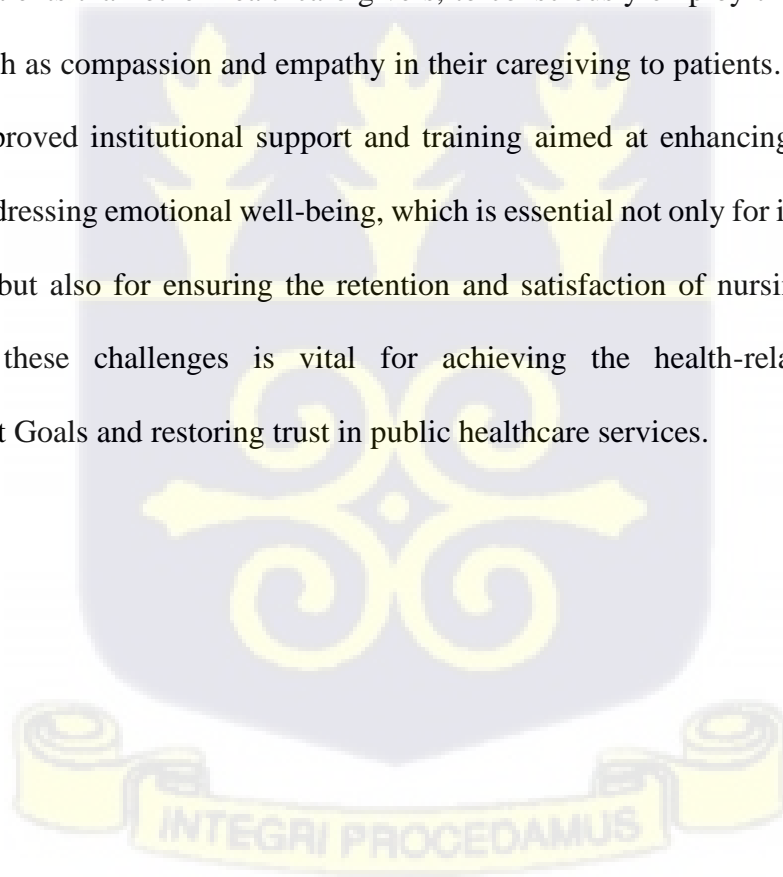
2. Nursing management should offer regular in-service training that provides psychotherapeutic drills, information on stress management, emotional intelligence, and psychological capital, which will propel nurses to exhibit positive behaviours even in challenging times and emotionally demanding situations.
3. Hospital management or medical superintendents should facilitate discussions around power relations within healthcare settings, encouraging a culture of respect and collaboration between nurses and other healthcare givers.
4. Nursing management should enlighten relatives on how to effectively collaborate with healthcare providers in the treatment process of their kin.
5. Nursing management should enforce the codes of conduct more strictly and supervise them properly. Wrongful behaviours that contradict the profession's ethics should be punished and completely discouraged (e.g., lateness). In the same vein, awards should be given to hardworking nurses to encourage others to give their best.
6. Ghana Health Service should provide sufficient equipment and logistics to facilitate healthcare delivery conveniently.
7. The government should also periodically review nurse salaries to reduce locums and their related stress so nurses can give their best. Nurses due for promotion and study leave should be rewarded accordingly by the authorities in charge and on time to motivate them.

8.8 Conclusion

This study provides an exploration of the factors influencing nurses' behaviours towards patients and their relatives within the healthcare system. By employing theoretical frameworks such as Blumer's (1969) Symbolic Interactionism, Foucault's (2012) Knowledge and Power, Homan's (1961) Rational Choice, Giddens' (1984) Structuration

and Hochschild's (1983) Emotional Labour, the research illuminates the complex interplay between individual motivations, social dynamics, and structural constraints. With regards to the self, nurses' upbringing, perceptions of care and perceptions of state-owned institutions, as well as the non-altruistic reasons for the decision to be a nurse, were crucial in explaining behaviours. Undesirable behaviours were evident when these 'self' factors were concurrently influenced by pressures from patients, colleagues, the institution or the system and even became more obvious when the nurse experienced emotional distress from the work-related hazards.

To attain the quality of healthcare desired, the onus lies on nurses, since they spend more time with patients than other healthcare givers, to consciously employ their mothering act of caring such as compassion and empathy in their caregiving to patients. There is also the need for improved institutional support and training aimed at enhancing communication skills and addressing emotional well-being, which is essential not only for improving patient experiences but also for ensuring the retention and satisfaction of nursing professionals. Addressing these challenges is vital for achieving the health-related Sustainable Development Goals and restoring trust in public healthcare services.



REFERENCES

- Abarca Arias, Y. M., Espinoza Moreno, T. M., Llerenan Callata, S. G., & Berrios Manrique, N. Y. (2020). Labor Conflicts Types and their Management in Nursing Practice. *Enfermeria Global*, *19*(1), 470–478.
<https://doi.org/10.6018/eglobal.19.1.364491>.
- Abdalkader, R. H., & Hayajneh, F. A. (2008). Effect of Night Shift on Nurses Working in Intensive Care Units at Jordan University Hospital. *European Journal of Scientific Research*, *23*(1), 70–86.
- Abdel Maqsood, A. S., Oweis, A. I., & Hasna, F. S. (2012). Differences between Patients' Expectations and Satisfaction with Nursing Care in a Private Hospital in Jordan. *International Journal of Nursing Practice*, *18*(2), 140–146.
- Abdul-Nasiru, I., Mensah, R., Amponsah-Tawiah, K., Simpeh, K. N., & Kumasey, A. S. (2014). Organisational Commitment in the Public Service of Ghana: An Empirical Study. *Developing Country Studies*, *4*(1), 49–55.
- Aberese-Ako, M., Agyepong, I. A., Gerrits, T., & Van Dijk, H. (2015). “I Used to Fight with Them but Now I Have Stopped!”: Conflict and Doctor-Nurse-Anaesthetists' Motivation in Maternal and Neonatal Care Provision in a Specialist Referral Hospital. *PloS One*, *10*(8), 1–20.
- Abraham, C., & Shanley, E. (1992). *Social Psychology for Nurses: Understanding Interaction in Health Care*. London: Edward Arnold.
- Abraham, L. J., Thom, O., Greenslade, J. H., Wallis, M., Johnston, A. N. B., Carlström, E., Mills, D., & Crilly, J. (2018). Morale, Stress and Coping Strategies of Staff Working in the Emergency Department: A Comparison of Two Different-Sized Departments. *Emergency Medicine Australasia*, *30*(3), 375–381.
- AbuAlRub, R. F., & Al-Asmar, A. H. (2014). Psychological Violence in the Workplace among Jordanian Hospital Nurses. *Journal of Transcultural Nursing*, *25*(1), 6–14.
- Abugri, A., & Jarvis, M.-A. (2018). Northern Ghana Final-Year Nurses' Attitudes towards Nursing and Remaining Post Qualification. *Curationis*, *41*(1), 1–7.
- Acheampong, F., & Anto, B. P. (2015). Perceived Barriers to Pharmacist Engagement in Adverse Drug Event Prevention Activities in Ghana Using Semi-Structured Interview. *BMC Health Services Research*, *15*(1), 1–8.
- Acheampong, F., Tetteh, A. R., & Anto, B. P. (2016). Medication Administration Errors in an Adult Emergency Department of a Tertiary Health Care Facility in Ghana. *Journal*

- of Patient Safety*, 12(4), 223–228.
- Achora, S. (2016). Conflicting Image: Experience of Male Nurses in a Uganda's Hospital. *International Journal of Africa Nursing Sciences*, 5, 24–28.
<https://doi.org/10.1016/j.ijans.2016.10.001>
- Adatara, P., Asamani, J. A., Nyande, F., Sciences, A., & Anthony, K. (2018). Make it Clear to Engage your Readers. *Nursing Management*, 25(5).
<https://doi.org/10.7748/nm.2018.e1773>
- Addae, S. (1996). *History of Western Medicine in Ghana 1880-1960*. London: Durham Academic Press.
- Addai-Mensah, P. (2020). *The Role of Akan Values on Moral Upbringing of Children in Contemporary Society*. *Journal of Mother-Tongue Biblical Hermeneutics and Theology*, 2(4), 96-101. <https://doi.org/10.38159/motbit.2020101>
- Adesokan, F. O. (2010). Maternal Mortality and Morbidity Reproductive Health for all Ages. *Nigeria: Faxwell LTD*, 74–75.
- Adeyemi-Adelanwa, O., Barton-Gooden, A., Dawkins, P., & Lindo, J. L. M. (2016). Attitudes of Patients towards being Cared for by Male Nurses in a Jamaican Hospital. *Applied Nursing Research*, 29(1), 140–143.
- Adinkrah, J. M. (2016). *Healthcare System in Ghana – Problems & Ways Forward*. <https://eyeonglobalhealth.com/2016/11/10/healthcare-system-in-ghana-problems-ways-forward/> [Accessed: 4/10/2021]
- Adjorlolo, S., Abdul-Nasiru, I., Chan, H. C., & Bambi, L. E. (2018). Mental Health Professionals' Attitudes Toward Offenders with Mental Illness (Insanity Acquittes) in Ghana. *International Journal of Offender Therapy and Comparative Criminology*, 62(3), 629–654. <https://doi.org/10.1177/0306624X16666802>
- Adler, P. A., & Adler, P. (1987). *Membership Roles in Field Research* (Vol. 6). Thousand Oaks, CA, US: Sage Publications.
- Adler, P. A., & Adler, P. (1994). Observational Techniques. In N. K. D. & Y. S. Lincoln (Ed.), *Handbook of Qualitative Research* (pp. 377–392). Thousand Oaks, CA, US: Sage Publications, Inc.
- Adriaenssens, J., De Gucht, V., & Maes, S. (2012). The Impact of Traumatic Events on Emergency Room Nurses: Findings from a Questionnaire Survey. *International Journal of Nursing Studies*, 49(11), 1411–1422.
- Adugbire, A. B., & Aziato, L. (2018). Surgical Patients' Perspectives on Nurses' Education on Post-Operative Care and Follow-Up in Northern Ghana. *BMC Nursing*,

- 17(1), 1–9. <https://doi.org/10.1186/s12912-018-0299-6>
- Adwan, J. Z. (2014). Pediatric Nurses' Grief Experience, Burnout and Job Satisfaction. *Journal of Pediatric Nursing*, 29(4), 329–336.
- Adzei, F. A., & Sakyi, E. K. (2014). Drivers of Return Migration of Ghanaian Health Professionals: Perspectives from Doctors and Nurses in Urban Ghana. *International Journal of Migration, Health and Social Care*, 10(2), 102–120.
- Aghabarari, M., Mohammadi, I. S. A., & Varvani, F. A. (2009). Barriers to Application of Communication Skills by Nurses in Nurse-Patient Interaction: Nurses and Patients' Perspective. 22, 19–30.
- Aghoja, O. C., Okinedo, P. O., & Odili, V. U. (2017). Knowledge, Attitude and Practice of Hypertensive Patients towards Hypertension in a Secondary Health Care Facility in Delta State. *Pharmaceutical and Biosciences Journal*, 24–33.
- Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R., Diomidous, M., Kinnunen, J., Kózka, M., & Lesaffre, E. (2014). Nurse Staffing and Education and Hospital Mortality in Nine European Countries: A Retrospective Observational Study. *The Lancet*, 383(9931), 1824–1830.
- Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., Sermeus, W., & Consortium, R. (2013). Nurses' Reports of Working Conditions and Hospital Quality of Care in 12 Countries in Europe. *International Journal of Nursing Studies*, 50(2), 143–153.
- Akgün, S. Z., & Kardas, Ö. F. (2014). The Levels of Satisfaction of Patients in Terms of Nursing. *Izm Univ Med J*, 2, 1–10.
- Akiwumi, A. (1971). *Higher Education for Nurses*. Accra: Ghana Universities Press.
- Akowuah, J. A., Agyei-Baffour, P., & Asibey, B. O. (2018). A Qualitative Study on the Pathways to Evidence-Based Antenatal Care in Periurban Ghana. *Obstetrics and Gynecology International*, 2018.
- Aktinson, P., & Hammersley, M. (1998). *Ethnography and Participant Observation. Strategies of Qualitative Inquiry*. Thousand Oaks, CA, US: Sage.
- Al Jarrah, I. A. T. (2013). Associate Nursing Students' Perceptions Toward Nursing Profession in Jordaz. *European Scientific Journal*, 9(6), 1857–7881.
- Alexander, A., Mustafa, A., Emil, S. A. V, Amekah, E., Engmann, C., Adanu, R., & Moyer, C. A. (2014). Social Support during Delivery in Rural Central Ghana: A Mixed Methods Study of Women's Preferences for and against Inclusion of a Lay Companion in the Delivery Room. *Journal of Biosocial Science*, 46(5), 669–685.

- Alhassan, R. K., Duku, S. O., Janssens, W., Nketiah-Amponsah, E., Spieker, N., van Ostenberg, P., Arhinful, D. K., Pradhan, M., & Rinke de Wit, T. F. (2015). Comparison of Perceived and Technical Healthcare Quality in Primary Health Facilities: Implications for a Sustainable National Health Insurance Scheme in Ghana. *PloS One*, *10*(10), e0140109.
- Alhassan, R. K., Nketiah-Amponsah, E., Spieker, N., Arhinful, D. K., & Rinke de Wit, T. F. (2016). Assessing the Impact of Community Engagement Interventions on Health Worker Motivation and Experiences with Clients in Primary Health Facilities in Ghana: A Randomized Cluster Trial. *PloS One*, *11*(7), e0158541.
- Alhassan, R. K., & Poku, K. A. (2018). Experiences of Frontline Nursing Staff on Workplace Safety and Occupational Health Hazards in Two Psychiatric Hospitals in Ghana. *BMC Public Health*, *18*(1), 1–12.
- Alola, U. V., Olugbade, O. A., Avci, T., & Öztüren, A. (2019). Customer Incivility and Employees' Outcomes in the Hotel: Testing the Mediating Role of Emotional Exhaustion. *Tourism Management Perspectives*, *29*, 9–17.
- Amare, T. G., Tesfaye, T. T., Girmay, B., & Gebreagziabher, T. T. (2021). Exposure to Occupational Health Hazards Among Nursing and Midwifery Students During Clinical Practice. *Risk Management and Healthcare Policy*, *14*, 2211.
- American Nurses Association. (2009). *Nursing Administration: Scope and Standards of Practice*. Nursesbooks.org.
- AMN Healthcare. (2016). *Driving Factors Behind the BSN by 2020 Initiative*. Driving Factors Behind the BSN by 2020 Initiative RN.com
- Anap, D. B., Iyer, C., & Rao, K. (2013). Work Related Musculoskeletal Disorders among Hospital Nurses in Rural Maharashtra, India: A Multi Centre Survey. *Int J Res Med Sci*, *1*(2), 101–107.
- Anckarsäter, H., Radovic, S., Svennerlind, C., Höglund, P., & Radovic, F. (2009). Mental Disorder is a Cause of Crime: The Cornerstone of Forensic Psychiatry. *International Journal of Law and Psychiatry*, *32*(6), 342–347.
- Andargie, S. T., & Kassahun, C. W. (2019). Knowledge and Attitude of Nurses' Towards Patient's Oral Care at University of Gondar Comprehensive Specialized Hospital, Northwest Ethiopia. *International Journal of Africa Nursing Sciences*, *11*, 1–7. <https://doi.org/10.1016/j.ijans.2019.100165>
- Andersen, L. B. (2009). What Determines the Behaviour and Performance of Health Professionals? Public Service Motivation, Professional Norms and/or Economic

- Incentives. *International Review of Administrative Sciences*, 75(1), 79–97.
- Anderson, N. E., Kent, B., & Owens, R. G. (2015). Experiencing Patient Death in Clinical Practice: Nurses' Recollections of their Earliest Memorable Patient Death. *International Journal of Nursing Studies*, 52(3), 695–704.
<https://doi.org/10.1016/j.ijnurstu.2014.12.005>
- Aniteye, P., O'Brien, B., & Mayhew, S. H. (2016). Stigmatized by Association: Challenges for Abortion Service Providers in Ghana. *BMC Health Services Research*, 16(1), 1–10.
- Anoosheh, M., Zarkhah, S., Faghihzadeh, S., & Vaismoradi, M. (2009). Nurse–Patient Communication Barriers in Iranian Nursing. *International Nursing Review*, 56(2), 243–249.
- Apea-Danquah, S. (2012). *Nurses and Midwives Council Expresses Concern about Poor Client Care*. Nurses and Midwives Council expresses concern about poor client care %7C Ghana News Agency (gna.org.gh)
- Appiah, K. A. (1993). *In my Father's House: Africa in the Philosophy of Culture*. London: Oxford University Press.
- Arko, J. (2017). *Nurses and Midwifery Council of Ghana. Code of Professional Conduct – Nursing And Midwifery Council Of Ghana*. <https://nursinginghana.com/code-professionalconduct-nursing-midwifery-council-ghana/>
- Armstrong, S. J., Rispel, L. C., & Penn-Kekana, L. (2015). The Activities of Hospital Nursing Unit Managers and Quality of Patient Care in South African Hospitals: A Paradox? *Global Health Action*, 8(1), 1–9.
- Arnetz, J. E., Hamblin, L., Ager, J., Luborsky, M., Upfal, M. J., Russell, J., & Essenmacher, L. (2015). Underreporting of Workplace Violence: Comparison of Self-Report and Actual Documentation of Hospital Incidents. *Workplace Health & Safety*, 63(5), 200–210.
- Asamani, J. A., Amertil, N. P., Ismaila, H., Francis, A. A., Chebere, M. M., & Nabyonga-Orem, J. (2019). Nurses and Midwives Demographic Shift in Ghana—the Policy Implications of a Looming Crisis. *Human Resources for Health*, 17(1), 1–5.
- Asamani, L., Agyemang, B. C., Afful, J., & Asumeng, M. (2018). Work Attitude of Ghanaian Nurses for Quality Health Care Service Delivery: Application of Individual and Organizational Centered (IOC) Interventions. *International Journal of Research Studies in Management*, 7(1). <https://doi.org/10.5861/ijrsm.2018.3003>
- Asante, E., & Edu, J. (2018). From Anansesem to Anansegoro: “Literalizing” Akan

- Folktales. *International Journal of Advanced Research and Development*, 3(1), 348–353.
- Asenso-Okyere, W. K., Osei-Akoto, I., Anum, A., & Adukonu, A. (1999). The Behaviour of Health Workers in an Era of Cost Sharing: Ghana's Drug Cash and Carry System. *Tropical Medicine and International Health*, 4(8), 586–593.
<https://doi.org/10.1046/j.1365-3156.1999.00438.x>
- Assiri, G. A., Shebl, N. A., Mahmoud, M. A., Aloudah, N., Grant, E., Aljadhey, H., & Sheikh, A. (2018). What is the Epidemiology of Medication Errors, Error-Related Adverse Events and Risk Factors for Errors in Adults Managed in Community Care Contexts? A Systematic Review of the International Literature. *BMJ Open*, 8(5), 1–31.
- Atkinson, P. (2007). *Ethnography: Principles in Practice* (3rd ed.). London: Routledge.
- Atkinson, P., & Pugsley, L. (2005). Making Sense of Ethnography and Medical Education. *Medical Education*, 39(2), 228–234.
- Attree, M. (2001). Patients' and Relatives' Experiences and Perspectives of 'Good' and 'Not so Good' Quality Care. *Journal of Advanced Nursing*, 33(4), 456–466.
- Attride-Stirling, J. (2001). Thematic Networks: An Analytic Tool for Qualitative Research. *Qualitative Research*, 1(3), 385–405.
- Atuyambe, L. M., Kibira, S. P. S., Bukonya, J., Muhumuza, C., Apolot, R. R., & Mulogo, E. (2015). Understanding Sexual and Reproductive Health Needs of Adolescents: Evidence from a Formative Evaluation in Wakiso District, Uganda. *Reproductive Health*, 12(1), 1–10.
- Awoonor-Williams, J. K., Baffoe, P., Ayivor, P. K., Fofie, C., Desai, S., & Chavkin, W. (2018). Prevalence of Conscientious Objection to Legal Abortion among Clinicians in Northern Ghana. *International Journal of Gynecology and Obstetrics*, 140(1), 31–36.
<https://doi.org/10.1002/ijgo.12328>
- Ayalew, F., Kibwana, S., Shawula, S., Misganaw, E., Abose, Z., Van Roosmalen, J., Stekelenburg, J., Kim, Y. M., Teshome, M., & Mariam, D. W. (2019). Understanding Job Satisfaction and Motivation among Nurses in Public Health Facilities of Ethiopia: A Cross-Sectional Study. *BMC Nursing*, 18(1), 1–13. <https://doi.org/10.1186/s12912-019-0373-8>
- Ayalew, M., Mengistie, B., & Semahegn, A. (2014). Adolescent-Parent Communication on Sexual and Reproductive Health Issues among High School Students in Dire Dawa, Eastern Ethiopia: A Cross Sectional Study. *Reproductive Health*, 11(1), 1–8.

- Aziato, L., & Adejumo, O. (2014a). Determinants of Nurses' Knowledge Gap on Pain Management in Ghana. *Nurse Education in Practice, 14*(2), 195–199.
- Aziato, L., & Adejumo, O. (2014b). The Ghanaian Surgical Nurse and Postoperative Pain Management: A Clinical Ethnographic Insight. *Pain Management Nursing, 15*(1), 265–272. <https://doi.org/10.1016/j.pmn.2012.10.002>
- Babiarczyk, B., Turbiarz, A., Tomagová, M., Zeleníková, R., Önlér, E., & Cantus, D. S. (2020). Reporting of Workplace Violence towards Nurses in 5 European Countries – A Cross-Sectional Study. *International Journal of Occupational Medicine and Environmental Health, 33*(3), 325–338. <https://doi.org/10.13075/IJOMEH.1896.01475>
- Balandin, S., Hemsley, B., Sigafos, J., & Green, V. (2007). Communicating with Nurses: The Experiences of 10 Adults with Cerebral Palsy and Complex Communication Needs. *Applied Nursing Research, 20*(2), 56–62.
- Ball, J., Maben, J. E., Murrells, T. J., Day, T. L., & Griffiths, P. (2015). *12-hour Shifts: Prevalence, Views and Impact*. London: National Nursing Research Unit, King's College.
- Bandura, A. (1976). Self-Reinforcement: Theoretical and Methodological Considerations. *Behaviorism, 4*(2), 135–155.
- Bandura, A., & Walters, R. H. (1977). *Social Learning Theory* (Vol. 1). Englewood Cliffs, N.J.: Prentice Hall.
- Baptista, M. K. S., Santos, R. M. dos, Duarte, S. J. H., Comassetto, I., & Trezza, M. C. S. F. (2017). The Patient and the Relation between Power-Knowledge and Care by Nursing Professionals. *Escola Anna Nery, 21*(4), 1–9. <https://doi.org/10.1590/2177-9465-ean-2017-0064>
- Beavan, V., & Stephens, C. (1999). The Characteristics of Traumatic Events Experienced by Nurses on the Accident and Emergency Ward. *Nursing Praxis in New Zealand Inc, 14*(1), 12–21.
- Beck, C. T. (2000). The Experience of Choosing Nursing as a Career. In *Journal of Nursing Education* (Vol. 39, Issue 7, pp. 320–322). SLACK Incorporated Thorofare, NJ.
- Benner, P. (1984). From Novice to Expert. *Menlo Park, 84*(1480), 10–1097.
- Bennett, N., Glatter, R., & Levacic, R. (1994). *Improving Educational Management: Through Research and Consultancy*. Thousand Oaks, CA, US: Sage Publications Ltd.
- Berry, K. (2011). The Ethnographic Choice: Why Ethnographers Do Ethnography.

- Cultural Studies? Critical Methodologies*, 11(2), 165–177.
- Betz, M. E., Arias, S. A., Segal, D. L., Miller, I., Camargo Jr, C. A., & Boudreaux, E. D. (2016). Screening for Suicidal Thoughts and Behaviors in Older Adults in the Emergency Department. *Journal of the American Geriatrics Society*, 64(10), 72–77.
- Bjerså, K., Forsberg, A., & Olsén, M. F. (2011). Perceptions of Complementary Therapies among Swedish Registered Professions in Surgical Care. *Complementary Therapies in Clinical Practice*, 17(1), 44–49.
- Blanchet, N. J., Fink, G., & Osei-Akoto, I. (2012). The Effect of Ghana's National Health Insurance Scheme on Health Care Utilisation. *Ghana Medical Journal*, 46(2), 76–84.
- Blöndal, K., Zoëga, S., Hafsteinsdóttir, J. E., Olafsdóttir, O. A., Thorvardardóttir, A. B., Hafsteinsdóttir, S. A., & Sveinsdóttir, H. (2014). Attitudes of Registered and Licensed Practical Nurses about the Importance of Families in Surgical Hospital Units: Findings from the Landspítali University Hospital Family Nursing Implementation Project. *Journal of Family Nursing*, 20(3), 355–375.
- Blumer, H. (1969). *Symbolic Interactionism* (Vol. 9). Englewood Cliffs, NJ: Prentice-Hall.
- Boafo, I. M. (2016). Ghanaian Nurses' Emigration Intentions: The Role of Workplace Violence. *International Journal of Africa Nursing Sciences*, 5, 29–35.
<https://doi.org/10.1016/j.ijans.2016.11.001>
- Boafo, I. M. (2018). The Effects of Workplace Respect and Violence on Nurses' Job Satisfaction in Ghana: A Cross-Sectional Survey. *Human Resources for Health*, 16(1), 1–10.
- Boakye, D. S., & Mavhandu-Mudzusi, A. H. (2019). Nurses Knowledge, Attitudes and Practices towards Patients with HIV and AIDS in Kumasi, Ghana. *International Journal of Africa Nursing Sciences*, 11, 100147.
<https://doi.org/10.1016/j.ijans.2019.05.001>
- Bohle, P., Di Milia, L., Fletcher, A., & Rajaratnam, S. (2008). Introduction: Aging and the Multifaceted Influences on Adaptation to Working Time. *Chronobiology International*, 25(2–3), 155–164.
- Böhmig, C. (2010). *Ghanaian Nurses at a Crossroads*. The Netherlands: Ipskamp Drukkers, Enschede.
- Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Coneglian, F. S., Diniz, A. L. A., & Tunçalp, Ö. (2015). The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLoS Medicine*, 12(6).

- Bonenberger, M., Aikins, M., Akweongo, P., & Wyss, K. (2014). The Effects of Health Worker Motivation and Job Satisfaction on Turnover Intention in Ghana: A Cross-Sectional Study. *Human Resources for Health, 12*(1), 1–12.
- Bourdieu, P. (1986). *The Forms of Capital*. (J. Richardson (Ed.)). Westport, CT, Greenwood: Pp. 241-258.
- Bové, H. M., Lisby, M., & Norlyk, A. (2020). Do the Carers Care? A Phenomenological Study of Providing Care for Patients Suffering from Alcohol Use Disorders. *Nursing Inquiry, 27*(1), 1–9. <https://doi.org/10.1111/nin.12322>
- Branford, W., & Thompson, D. (1994). *The South African Pocket Oxford Dictionary of Current English*. London: Oxford University Press.
- Branttie, S. (2020). Korle Bu's Poor Quality of Service; Management Initiates Investigations. Graphic Online. <https://www.graphic.com.gh/news/general-news/korle-bu-s-poor-quality-of-service-management-initiates-investigations.html> [Accessed: 21/05/2021]
- Brewer, J. (2004). Ethnography. In C. Cassell & G. Symon (Eds.), *Essential Guide to Qualitative Methods in Organizational Research* (pp. 312–322). Thousand Oaks, CA: Sage Publications Ltd.
- Bridges, J. M. (1990). Literature Review on the Images of the Nurse and Nursing in the Media. *Journal of Advanced Nursing, 15*(7), 850–854.
- Bridges, J., Nicholson, C., Maben, J., Pope, C., Flatley, M., Wilkinson, C., Meyer, J., & Tziggili, M. (2013). Capacity for Care: Meta-Ethnography of Acute Care Nurses' Experiences of the Nurse-Patient Relationship. *Journal of Advanced Nursing, 69*(4), 760–772.
- Brink, P. J., & Edgecombe, N. (2003). What is Becoming of Ethnography? *Qualitative Health Research, 13*(7), 1028–1030.
- Brook, P. (2009). In Critical Defence of 'Emotional Labour' Refuting Bolton's Critique of Hochschild's Concept. *Work, Employment and Society, 23*(3), 531–548.
- Browne, A. (1993). A Conceptual Clarification of Respect. *Journal of Advanced Nursing, 18*(2), 211–217.
- Bryman, A. (2016). *Social Research Methods*. Oxford University Press, Oxford.
- Budu, H. I., Abalo, E. M., Bam, V. B., Agyemang, D. O., Noi, S., Budu, F. A., & Peparah, P. (2019). "I Prefer a Male Nurse to a Female Nurse": Patients' Preference for, and Satisfaction with Nursing Care Provided by Male Nurses at the Komfo Anokye Teaching Hospital. *BMC Nursing, 18*(1), 1–9. <https://doi.org/10.1186/s12912-019->

0369-4

- Buor, D. (2004). Determinants of Utilisation of Health Services by Women in Rural and Urban Areas in Ghana. *GeoJournal*, 61(1), 89–102.
- Burger, J. M. (2014). *Personality*. USA: Cengage Learning.
- Camgöz-Akdağ, H., & Zineldin, M. (2010). Quality of Health Care and Patient Satisfaction: An Exploratory Investigation of the 5Qs Model at Turkey. *Clinical Governance: An International Journal*, 15(2), 92–101.
- Carter, M. J., & Fuller, C. (2015). Symbolic Interactionism. *Sociopedia. ISA*, 1(1), 1–17.
- Case, S. S., & Smith, J. G. (2013). The Genesis of Integrity: Values and Virtues Illuminated in Judaism, Christianity, and Islam for Workplace Behavior. In *Integrity in Organizations* (pp. 307–344). New York: Springer.
- Chan, H. Y. L., Lee, L. H., & Chan, C. W. H. (2013). The Perceptions and Experiences of Nurses and Bereaved Families towards Bereavement Care in an Oncology Unit. *Supportive Care in Cancer*, 21(6), 1551–1556.
- Charmaz, K. (2001). Grounded Theory. In R. M. Emerson (Ed.), *Contemporary Field Research: Perspectives and Formulations* (2nd ed., pp. 335–352). Prospect Heights, IL: Waveland Press.
- Cheng, C., Bartram, T., Karimi, L., & Leggat, S. G. (2013). The Role of Team Climate in the Management of Emotional Labour: Implications for Nurse Retention. *Journal of Advanced Nursing*, 69(12), 2812–2825.
- Choi, S. D., & Brings, K. (2016). Work-Related Musculoskeletal Risks Associated with Nurses and Nursing Assistants Handling Overweight and Obese Patients: A Literature Review. *Work*, 53(2), 439–448.
- Christensen, M., & Knight, J. (2014). “Nursing is No Place for Men”—A Thematic Analysis of Male Nursing Students Experiences of Undergraduate Nursing Education. *Journal of Nursing Education and Practice*, 4(12), 95.
- Cohen, L., Manion, L., & Morrison, K. (2007). *Research Methods in Education*. London: Routledge.
- Coleman, J. S. (1990). *Foundations of Social Theory*. Cambridge: Belknap.
- Constantine, M. (2014). The Role of the Family in African Society in Economic Development. <https://theuniversityofzambia.academia.edu/MaxeoConstantine> [Accessed: 14/04/2020].
- Cooper, F. (2019). *Africa Since 1940: The Past of the Present* (Vol. 13). Cambridge: University Press.

- Coppens, E., Van Audenhove, C., Iddi, S., Arensman, E., Gottlebe, K., Koburger, N., Coffey, C., Gusmão, R., Quintão, S., & Costa, S. (2014). Effectiveness of Community Facilitator Training in Improving Knowledge, Attitudes, and Confidence in Relation to Depression and Suicidal Behavior: Results of the OSPI-Europe Intervention in Four European Countries. *Journal of Affective Disorders*, *165*, 142–150.
- Corbin, J., & Strauss, A. (2014). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Thousand Oaks, CA: Sage.
- Corless, L., Buckley, A., & Mee, S. (2016). Power Inequality between Patients and Nurses. *Nursing Times*, *112*(12–13), 20–21.
- Coser, R. L. (1962). *Life in the Ward*. East Lansing: Michigan State University Press.
<https://books.google.com.gh/books?id=MtA5nwEACAAJ>
- Costa, L. H. R., & Coelho, E. de A. C. (2013). Ideologies of Gender and Sexuality: The Interface between Family Upbringing and Nursing Education. *Texto & Contexto-Enfermagem*, *22*, 485–492.
- Craven, R., & Hirnle, C. (1996). *Nursing and Professionalism Defined Fundamentals of Nursing 2nd ed* (2nd ed.). Philadelphia, Pennsylvania: JB Lippincott Company.
- Creswell, J. W., & Poth, C. N. (2016). *Qualitative Inquiry and Research Design: Choosing among Five Approaches* (4th ed.). Thousand Oaks, CA: Sage Publications.
- Crilly, J., Greenslade, J., Lincoln, C., Timms, J., & Fisher, A. (2017). Measuring the Impact of the Working Environment on Emergency Department Nurses: A Cross-Sectional Pilot Study. *International Emergency Nursing*, *31*, 9–14.
- Crossman, A. (2014). *An Overview, Rational Choice Theory*.
<http://sociology.about.com/od/Sociological-Theory/a/Rational-Choice-Theory.htm>
- Crowley-Henry, M. (2009). Ethnography: Visions and Versions. In J. Hogan, P. Dolan & P. Donnelly (Eds.), *Approaches to Qualitative Research: Theory and its Practical Application. A Guide for Dissertation students* (pp. 27–63). Ireland: Oak Tree Press.
- Croxon, L., Deravin, L., & Anderson, J. (2018). Dealing with End of Life—New Graduated Nurse Experiences. *Journal of Clinical Nursing*, *27*(1–2), 337–344.
- Cudé, G., & Winfrey, K. (2007). The Hidden Barrier: Gender Bias: Fact or fiction? *Nursing for Women's Health*, *11*(3), 254–265.
- Cunico, L., Sartori, R., Marognolli, O., & Meneghini, A. M. (2012). Developing Empathy in Nursing Students: A Cohort Longitudinal Study. *Journal of Clinical Nursing*, *21*(13–14), 2016–2025.
- Cusack, P., Cusack, F. P., McAndrew, S., McKeown, M., & Duxbury, J. (2018). An

- Integrative Review Exploring the Physical and Psychological Harm Inherent in Using Restraint in Mental Health Inpatient Settings. *International Journal of Mental Health Nursing*, 27(3), 1162–1176.
- Cutcliffe, J. R., Santos, J. C., Kozel, B., Taylor, P., & Lees, D. (2015). Raiders of the Lost Art: A Review of Published Evaluations of Inpatient Mental Health Care Experiences Emanating from the United Kingdom, Portugal, Canada, Switzerland, Germany and Australia. *International Journal of Mental Health Nursing*, 24(5), 375–385.
- Cybulski, M., Krajewska-Kulak, E., & Jamiolkowski, J. (2015). Perception of the Elderly by Junior High School Students and University Students in Poland. *Progress in Health Sciences*, 5(2), 93–98.
- Dagget, T., Molla, A., & Belachew, T. (2016). Job Related Stress among Nurses Working in Jimma Zone Public Hospitals, South West Ethiopia: A Cross Sectional Study. *BMC Nursing*, 15(1), 1–10.
- Dahlborg-Lyckhage, E., & Pilhammar-Anderson, E. (2009). Predominant Discourses in Swedish Nursing. *Policy, Politics, & Nursing Practice*, 10(2), 163–171.
- Daily Guide Network. (2019). *Ghana's Nurse Patient Ratio Improves*.
<https://dailyguidenetwork.com/ghanas-nurse-patient-ratio-improves/>
- Danziger, N., & Valency, R. (2006). Career Anchors: Distribution and Impact on Job Satisfaction, the Israeli Case. *Career Development International*, 11(4), 293–303.
- Dapaah, J. M. (2016). Attitudes and Behaviours of Health Workers and the Use of HIV/AIDS Health Care Services. *Nursing Research and Practice*, 2016, 1–9.
<https://doi.org/10.1155/2016/5172497>
- de Boer, J., van Rikxoort, S., Bakker, A. B., & Smit, B. J. (2014). Critical Incidents among Intensive Care Unit Nurses and their Need for Support: Explorative Interviews. *Nursing in Critical Care*, 19(4), 166–174.
- de Swardt, C., & Fouché, N. (2017). “What Happens Behind the Curtains?” An Exploration of ICU Nurses’ Experiences of Post Mortem Care on Patients who have Died in Intensive Care. *Intensive and Critical Care Nursing*, 43, 108–115.
<https://doi.org/10.1016/j.iccn.2017.05.005>
- De Vos, A. S., Delpont, C. S. L., Fouche, C., & Strydom, H. (2011). *Research at Grass Roots: A Primer for the Social Science and Human Professions*. Van Schaik Publishers.
- Deasey, D., Kable, A., & Jeong, S. (2014). Influence of Nurses’ Knowledge of Ageing and Attitudes towards Older People on Therapeutic Interactions in Emergency Care: A

- Literature Review. *Australasian Journal on Ageing*, 33(4), 229–236.
<https://doi.org/10.1111/ajag.12169>
- Debesay, J., Harsløf, I., Rechel, B., & Vike, H. (2014). Dispensing Emotions: Norwegian Community Nurses' Handling of Diversity in a Changing Organizational Context. *Social Science & Medicine*, 119, 74–80.
- Denzin, N. K., & Lincoln, Y. S. (2005). *The Sage Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publication.
- Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications.
- Desai, S. (2010). Violence and surveillance: Some unintended consequences of CCTV monitoring within mental health hospital wards. *Surveillance & Society*, 8(1), 84–92.
- Dohrenwend, A. M. (2018). Defining Empathy to Better Teach, Measure, and Understand its Impact. *Academic Medicine*, 93(12), 1754–1756.
- Duffy, E. (1995). Horizontal Violence: A Conundrum for Nursing. *Collegian*, 2(2), 5–17.
- Duku, S. K. O., Nketiah-Amponsah, E., Janssens, W., & Pradhan, M. (2018). Perceptions of Healthcare Quality in Ghana: Does Health Insurance Status Matter? *PloS One*, 13(1), e0190911.
- Dyck, J. M., Oliffe, J., Phinney, A., & Garrett, B. (2009). Nursing Instructors' and Male Nursing Students' Perceptions of Undergraduate, Classroom Nursing Education. *Nurse Education Today*, 29(6), 649–653.
- Dywili, S., Bonner, A. N. N., & O'BRIEN, L. (2013). Why Do Nurses Migrate?—A Review of Recent Literature. *Journal of Nursing Management*, 21(3), 511–520.
- Dzomeku, V. M., Ba-Etilayoo, A., Perekuu, T., & Mantey, R. E. (2013). In Patient Satisfaction with Nursing Care: A Case Study at Kwame Nkrumah University of Science and Technology Hospital. *International Journal of Research in Medical and Health Sciences*, 2(1), 19–24.
- Eldevik, M. F., Flo, E., Moen, B. E., Pallesen, S., & Bjorvatn, B. (2013). Insomnia, Excessive Sleepiness, Excessive Fatigue, Anxiety, Depression and Shift Work Disorder in Nurses having Less than 11 Hours in-between Shifts. *PloS One*, 8(8), 1–9.
- Eley, D., Eley, R., Bertello, M., & Rogers-Clark, C. (2012). Why Did I Become a Nurse? Personality Traits and Reasons for Entering Nursing. *Journal of Advanced Nursing*, 68(7), 1546–1555. <https://doi.org/10.1111/j.1365-2648.2012.05955.x>
- Eley, R., Eley, D., & Rogers-Clark, C. (2010). Reasons for Entering and Leaving Nursing:

- An Australian Regional Study. *Australian Journal of Advanced Nursing, The*, 28(1), 6–13.
- Ellapen, T. J., & Narsigan, S. (2014). Work Related Musculoskeletal Disorders among Nurses: Systematic Review. *J Ergonomics*, 4, 1–6.
- Ellis, D. M., & Meeker, B. J. (2006). Exploring Men's Perceived Educational Experiences in a Baccalaureate Program. *Journal of Nursing Education*, 45(12), 523.
- Eltantawy, S. (2013). Relation between Nursing Students' Knowledge of Aging and Attitude towards Elderly People and their Will and Intent to Work with the Elderly. *Relation*, 4(27), 125.
- Fackler, C. A., Chambers, A. N., & Bourbonniere, M. (2015). Hospital Nurses' Lived Experience of Power. *Journal of Nursing Scholarship*, 47(3), 267–274.
<https://doi.org/10.1111/jnu.12127>
- Fagerberg, I., & Kihlgren, M. (2001). Experiencing a Nurse Identity: The Meaning of Identity to Swedish Registered Nurses 2 Years after Graduation. *Journal of Advanced Nursing*, 34(1), 137–145.
- Fagermoen, M. S. (1997). Professional Identity: Values Embedded in Meaningful Nursing Practice. *Journal of Advanced Nursing*, 25(3), 434–441.
- Fakhr-Movahedi, A., Salsali, M., Negarandeh, R., & Rahnavard, Z. (2011). Exploring Contextual Factors of the Nurse-Patient Relationship: A Qualitative Study. *Koomesh*, 23–34.
- Falola, T., & Jennings, C. (2003). *Sources and Methods in African History: Spoken, Written, Unearthed* (Vol. 15). University Rochester Press.
- Famoroti, T. O., Fernandes, L., & Chima, S. C. (2013). Stigmatization of People Living with HIV/AIDS by Healthcare Workers at a Tertiary Hospital in KwaZulu-Natal, South Africa: A Cross-Sectional Descriptive Study. *BMC Medical Ethics*, 14(1), 1–10.
- Farh, C. I. C., Seo, M.-G., & Tesluk, P. E. (2012). Emotional Intelligence, Teamwork Effectiveness, and Job Performance: The Moderating Role of Job Context. *Journal of Applied Psychology*, 97(4), 890–900.
- Faronbi, J. O., Adebowale, O., Faronbi, G. O., Musa, O. O., & Ayamolowo, S. J. (2017). Perception Knowledge and Attitude of Nursing Students towards the Care of Older Patients. *International Journal of Africa Nursing Sciences*, 7, 37–42.
<https://doi.org/10.1016/j.ijans.2017.06.004>
- Feldman, M. (2015). Theory of Routine Dynamics and Connections to Strategy as

- Practice. In *Cambridge Handbook of Strategy as Practice* (pp. 317–330). Cambridge, UK: Cambridge University Press.
- Fenny, A. P., Enemark, U., Asante, F. A., & Hansen, K. S. (2014). Patient Satisfaction with Primary Health Care—A Comparison between the Insured and Non-Insured under the National Health Insurance Policy in Ghana. *Global Journal of Health Science*, 6(4), 9.
- Fetterman, D. M. (2019). *Ethnography: Step-by-Step* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Fillman, V. M. (2015). Career Interest, Self-Efficacy, and Perception in Undecided and Nursing Undergraduate Students: A Quantitative Study. *Nurse Education Today*, 35(1), 251–255.
- Fischer, J. L. (1963). The Sociopsychological Analysis of Folktales. *Current Anthropology*, 4(3), 235–295.
- Fisekovic, M. B., Trajkovic, G. Z., Bjegovic-Mikanovic, V. M., & Terzic-Supic, Z. J. (2015). Does Workplace Violence Exist in Primary Health Care? Evidence from Serbia. *The European Journal of Public Health*, 25(4), 693–698.
- Foucault, M. (1977). *Discipline and Punish: The Birth of the Prison*. Tr. A. Sheridan. London: Allen Lane Penguin.
- Foucault, M. (1979). *A Arqueologia do Saber*, 7^a. México: Edición Siglo XXI.
- Foucault, M. (2003). Estratégias, Poder-Saber: Ditos e Escritos IV. *Rio de Janeiro: Forense Universitária*, 203–222.
- Foucault, M. (2012). *A Arqueologia do Saber* (8^a ed.). Rio de Janeiro: Forense Universitária.
- Foucault, M. (2014). *A Ordem do Discurso*. (24^a ed.). São Paulo: Edições Loyola.
- Foust, J. B., Vuckovic, N., & Henriquez, E. (2012). Hospital to Home Health Care Transition: Patient, Caregiver, and Clinician Perspectives. *Western Journal of Nursing Research*, 34(2), 194–212.
- Friedrichsen, M. J., Strang, P. M., & Carlsson, M. E. (2000). Breaking Bad News in the Transition from Curative to Palliative Cancer Care—Patient’s View of the Doctor Giving the Information. *Supportive Care in Cancer*, 8(6), 472–478.
- Fry, M., Abrahamse, K., Kay, S., & Elliott, R. M. (2019). Suicide in Older People, Attitudes and Knowledge of Emergency Nurses: A Multi-Centre Study. *International Emergency Nursing*, 43(December 2018), 113–118.
<https://doi.org/10.1016/j.ienj.2019.01.003>

- Gagnon, M., & Cator, S. (2015). Mapping HIV Nursing Core Competencies in Entry-Level Education: A Pilot Project. *Journal of Nursing Education*, 54(7), 409–415.
- Galbany-Estragués, P., Millán-Martínez, P., del Mar Pastor-Bravo, M., & Nelson, S. (2019). Emigration and Job Security: An Analysis of Workforce Trends for Spanish-Trained Nurses (2010–2015). *Journal of Nursing Management*, 27(6), 1224–1232.
- Ganz, F. D., Toren, O., & Fadlon, Y. (2016). Factors Associated with Full Implementation of Scope of Practice. *Journal of Nursing Scholarship*, 48(3), 285–293.
- Garritano, C. (2017). The Materiality of Genre: Analog and Digital Ghosts in Video Movies from Ghana. *Cambridge Journal of Postcolonial Literary Inquiry*, 4(2), 191–206.
- Ghana Broadcasting Corporation. (2017). *SEND Ghana Survey Reveals “Poor Attitude” of Nurses Towards Patients*. <https://www.gbcghana.com/1.11405521>
- Ghana Business News. (2009). *Ghanaian Nurses Told to Change Negative Attitudes*. <https://www.ghanabusinessnews.com/2009/08/09/ghanaian-nurses-told-to-change-negative-attitudes/>
- Ghana Health Service. (2016). *Healthcare Quality Assurance Manual for Sub-Districts, with Support From Danida*.
- Ghana Health Service. (2022). *History*. <https://www.moh.gov.gh/ghana-health-service>
- Ghana News. (2020). *Nurses, Midwives Admonished to Change Negative Attitude towards Patients*. <https://www.ghanaweb.com/GhanaHomePage/NewsArchive/Nurses-Midwives-admonished-to-change-negative-attitude-towards-patients-982594>
- Ghana Statistical Service. (2021). *Ghana 2021 Population and Housing Census: General Report Volume 3N*.
- Giddens, A. (1979). *Central Problems in Social Theory: Action, Structure, and Contradiction in Social Analysis* (Vol. 241). Berkeley: University of California Press.
- Giddens, A. (1984). *The Constitution of Society: Outline of the Theory of Structuration*. Cambridge, UK: Polity Press.
- Giddens, A. (2001). *Sociology*. Polity, Cambridge.
- Gillett, K. (2014). Nostalgic Constructions of Nurse Education in British National Newspapers. *Journal of Advanced Nursing*, 70(11), 2495–2505.
- Girvin, J. (2015). The Public Understanding of Nursing—Time for a Step Change? In *Journal of Clinical Nursing* (Vol. 24, Issues 23–24, pp. 3341–3342). Wiley Online Library.
- Girvin, J., Jackson, D., & Hutchinson, M. (2016). Contemporary Public Perceptions of

- Nursing: A Systematic Review and Narrative Synthesis of the International Research Evidence. *Journal of Nursing Management*, 24(8), 994–1006.
- Glerean, N., Hupli, M., Talman, K., & Haavisto, E. (2017). Young Peoples' Perceptions of the Nursing Profession: An Integrative Review. *Nurse Education Today*, 57, 95–102.
- Godsey, J. A., Houghton, D. M., & Hayes, T. (2020). Registered Nurse Perceptions of Factors Contributing to the Inconsistent Brand Image of the Nursing Profession. *Nursing Outlook*, 68(6), 808–821.
- Goffman, E. (1961). Asylums Harmondsworth. In *England: Penguin Books*. 196a.
- Gokoglan, E., & Ozen Bekar, E. (2021). The Relationship between Nurse Managers' Personality Traits and their Conflict Management Strategy Preferences. *Journal of Nursing Management*, 29(5), 1239–1245. <https://doi.org/10.1111/jonm.13262>
- Goodwin, J., & Horowitz, R. (2002). Introduction: The Methodological Strengths and Dilemmas of Qualitative Sociology. *Qualitative Sociology*, 25(1), 33–47.
- Gordon, S., & Nelson, S. (2005). An End to Angels. *AJN The American Journal of Nursing*, 105(5), 62–69.
- Grant, R. (2009). *Globalizing City: The Urban and Economic Transformation of Accra, Ghana*. Syracuse University Press.
- Graphic Online. (2019). *Nurse, Midwife Suspended for Unprofessional Conduct*. <https://www.graphic.com.gh/news/general-news/ghana-news-nurse-midwife-suspended-for-unprofessional-conduct.html>
- Green, A., Meaux, J., Huett, A., & Ainley, K. (2009). Constantly Responsible, Constantly Worried, Constantly Blessed: Parenting after Pediatric Heart Transplant. *Progress in Transplantation*, 19(2), 122–127.
- Grimes, H. A., Forster, D. A., & Newton, M. S. (2014). Sources of Information used by Women during Pregnancy to meet their Information Needs. *Midwifery*, 30(1), 26–33.
- Guba, E. G., & Lincoln, Y. S. (1989). *Fourth Generation Evaluation*. Newbury Park, CA: Sage Publications.
- Gusdal, A. K., Josefsson, K., Thors Adolfsson, E., & Martin, L. (2017). Nurses' Attitudes toward Family Importance in Heart Failure Care. *European Journal of Cardiovascular Nursing*, 16(3), 256–266. <https://doi.org/10.1177/1474515116687178>
- Hahn, R. A., & Gaines, A. D. (2012). *Physicians of Western Medicine: Anthropological Approaches to Theory and Practice* (Vol. 6). Springer Science & Business Media.
- Haigh, M. (2015). *Men in Nursing: A Quantitative Study from the Perspective of West Australian Nursing Students*. The University of Western Australia.

- Halcomb, E., Smyth, E., & McInnes, S. (2018). Job Satisfaction and Career Intentions of Registered Nurses in Primary Health Care: an Integrative Review. *BMC Family Practice, 19*(1), 1–14.
- Hall, H., Brosnan, C., Cant, R., Collins, M., & Leach, M. (2018). Nurses' Attitudes and Behaviour towards Patients' Use of Complementary Therapies: A Mixed Methods Study. *Journal of Advanced Nursing, 74*(7), 1649–1658.
<https://doi.org/10.1111/jan.13554>
- Hall, H., & Glew, P. J. (2017). Introduction to Nursing, Midwifery and Person-Centred Care. In *Fundamentals of Nursing and Midwifery: A Person-Centred Approach to Care* (3rd ed., pp. 4–19). Philadelphia, Pennsylvania: Lippincott Williams and Wilkins.
- Hall, J. A., Horgan, T. G., Stein, T. S., & Roter, D. L. (2002). Liking in the Physician–Patient Relationship. *Patient Education and Counseling, 48*(1), 69–77.
- Halperin, O., & Mashiach-Eizenberg, M. (2014). Becoming a Nurse - A Study of Career Choice and Professional Adaptation among Israeli Jewish and Arab Nursing Students: A Quantitative Research Study. *Nurse Education Today, 34*(10), 1330–1334.
<https://doi.org/10.1016/j.nedt.2013.10.001>
- Hammersley, M. (2018). *What's Wrong with Ethnography?: Methodological Explorations*. London: Routledge.
- Hansson, L., Jormfeldt, H., Svedberg, P., & Svensson, B. (2013). Mental Health Professionals' Attitudes towards People with Mental Illness: Do they Differ from Attitudes held by People with Mental Illness? *International Journal of Social Psychiatry, 59*(1), 48–54.
- Haskins, J. L. M., Phakathi, S., Grant, M., & Horwood, C. M. (2014). Attitudes of Nurses Towards Patient Care at a Rural District Hospital in the Kwazulunatal Province of South Africa. *Africa Journal of Nursing and Midwifery, 16*(1), 32–44.
<https://doi.org/10.25159/2520-5293/1485>
- Haw, N. J. L. (2019). Utilization of the Ghana National Health Insurance Scheme and its Association with Patient Perceptions on Healthcare Quality. *International Journal for Quality in Health Care, 31*(6), 485–491. <https://doi.org/10.1093/intqhc/mzy185>
- Hawks, J. H. (1992). Empowerment in Nursing Education: Concept Analysis and Application to Philosophy, Learning and Instruction. *Journal of Advanced Nursing, 17*(5), 609–618.
- Heinen, M. M., van Achterberg, T., Schwendimann, R., Zander, B., Matthews, A., Kózka,

- M., Ensio, A., Sjetne, I. S., Casbas, T. M., & Ball, J. (2013). Nurses' Intention to Leave their Profession: A Cross Sectional Observational Study in 10 European Countries. *International Journal of Nursing Studies*, 50(2), 174–184.
- Heins, V. M., Unrau, C., & Avram, K. (2018). Gift-Giving and Reciprocity in Global Society: Introducing Marcel Mauss in International Studies. *Journal of International Political Theory*, 14(2), 126–144.
- Heise, B. A., Wing, D. K., & Hullinger, A. H. R. (2018). My Patient Died: A National Study of Nursing Students' Perceptions after Experiencing a Patient Death. *Nursing Education Perspectives*, 39(6), 355–359.
- Henderson, A. (1994). Power and Knowledge in Nursing Practice: The Contribution of Foucault. *Journal of Advanced Nursing*, 20(5), 935–939.
<https://doi.org/10.1046/j.1365-2648.1994.20050935.x>
- Herakova, L. L. (2012). Nursing Masculinity: Male Nurses' Experiences through a Co-Cultural Lens. *Howard Journal of Communications*, 23(4), 332–350.
- Higginbottom, G.M.A., Pillay, J.J. and Boadu, N.Y. (2013) Guidance on Performing Focused Ethnographies with an Emphasis on Healthcare Research. *The Qualitative Report*, 18, 1-16. <https://doi.org/10.7939/R35M6287P>
- Himmelfarb, C. R. D., Commodore-Mensah, Y., & Hill, M. N. (2016). Expanding the Role of Nurses to Improve Hypertension Care and Control Globally. *Annals of Global Health*, 82(2), 243–253. <https://doi.org/10.1016/j.aogh.2016.02.003>
- Hochschild, A. R. (1983). *The Managed Heart. Commercialisation of Human Feeling*. Berkeley: University of California Press.
- Hochschild, A. R. (2003). *The Commercialization of Intimate Life: Notes from Home and Work*. Berkeley: University of California Press.
- Hoeve, Y. ten, Jansen, G., & Roodbol, P. (2014). The Nursing Profession: Public Image, Self-Concept and Professional Identity. A Discussion Paper. *Journal of Advanced Nursing*, 70(2), 295–309.
- Hollander, M. A. G., & Greene, M. G. (2019). A Conceptual Framework for Understanding Iatrophobia. *Patient Education and Counseling*, 102(11), 2091–2096.
- Holloway, I., & Todres, I. (2006). Ethnography. In K. Gerrish & A. Lacey (Eds.), *The Research Process in Nursing* (5th ed., pp. 208–222). Oxford: Blackwell Publishing.
- Homans, G. C. (1961). *Social Behavior: Its Elementary Forms, Brace & World*. London: Routledge and Kegan Paul.
- Honarvar, B., Ghazanfari, N., Shahraki, H. R., Rostami, S., & Lankarani, K. B. (2019).

- Violence against Nurses: A Neglected and Health-threatening Epidemic in the University Affiliated Public Hospitals in Shiraz, Iran. *The International Journal of Occupational and Environmental Medicine*, 10(3), 111–123.
- Hsu, C. P., Chiang, C. Y., Chang, C. W., Huang, H. C., & Chen, C. C. (2015). Enhancing the Commitment of Nurses to the Organisation by Means of Trust and Monetary Reward. *Journal of Nursing Management*, 23(5), 567–576.
<https://doi.org/10.1111/jonm.12180>
- Huber, C. G., Schneeberger, A. R., Kowalinski, E., Fröhlich, D., von Felten, S., Walter, M., Zinkler, M., Beine, K., Heinz, A., & Borgwardt, S. (2016). Suicide Risk and Absconding in Psychiatric Hospitals with and without Open Door Policies: A 15 year, Observational Study. *The Lancet Psychiatry*, 3(9), 842–849.
- Hughes, C. M., & McCann, S. (2003). Perceived Interprofessional Barriers between Community Pharmacists and General Practitioners: A Qualitative Assessment. *British Journal of General Practice*, 53(493), 600–606.
- Hunsaker, S., Chen, H., Maughan, D., & Heaston, S. (2015). Factors that Influence the Development of Compassion Fatigue, Burnout, and Compassion Satisfaction in Emergency Department Nurses. *Journal of Nursing Scholarship*, 47(2), 186–194.
- Huston, C. (2021). *Professional Issues in Nursing: Challenges and Opportunities* (3rd ed.). Philadelphia, Pennsylvania: Lippincott Williams & Wilkins.
- Hutchinson, M., & Jackson, D. (2014). Troubling Fragments and Small Stories: An Analysis of Public Commentary on Nursing through a Web Blog. *Collegian*, 21(2), 81–88.
- Illich, I. (1975). A Expropriação da Saúde. In *Nêmesis da Medicina*. (3^a ed.). Rio de Janeiro: Nova Fronteira.
- International Council of Nurses. (2014). *Nurses: A Force for Change. A Vital Resource for Health*. Geneva, Switzerland: International Council of Nurses.
- International Labour Office, International Council of Nurses, World Health Organization, Public Services International, P. S. I. (2002). *Framework Guidelines for Addressing Workplace Violence in the Sector*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector.
- Ipek Coban, G., & Kasikci, M. (2010). Reliability and Validity of the Scale of Patient Perception of Hospital Experience with Nursing Care in a Turkish Population. *Journal of Clinical Nursing*, 19(13-14), 1929–1934.
- Ishimaru, T., Wada, K., Hoang, H. T. X., Bui, A. T. M., Nguyen, H. D., Le, H., & Smith,

- D. R. (2017). Nurses' Willingness to Care for Patients Infected with HIV or Hepatitis B/C in Vietnam. *Environmental Health and Preventive Medicine*, 22(1), 1–7.
- Islam, A., & Biswas, T. (2014). Health System in Bangladesh: Challenges and Opportunities. *American Journal of Health Research*, 2(6), 366–374.
- Jacob, J. D., & Holmes, D. (2011). Working under Threat: Fear and Nurse–Patient Interactions in a Forensic Psychiatric Setting. *Journal of Forensic Nursing*, 7(2), 68–77.
- Jacobs, J. E., Lanza, S., Osgood, D. W., Eccles, J. S., & Wigfield, A. (2002). Changes in Children's Self-Competence and Values: Gender and Domain Differences across Grades One through Twelve. *Child Development*, 73(2), 509–527.
- James, G. L., Debra, R. W., & Thabo, T. F. (2016). A Benchmark Qualitative Study of Health Service Delivery in Botswana in 1989: Nurse Assessments of the Primary Healthcare System before the Nationwide Spread of HIV/AIDS. *Journal of AIDS and HIV Research*, 8(2), 6–11.
- Jarvis, K., Richter, S., Vallianatos, H., & Thornton, L. (2017). Reintegration of Women Post Obstetric Fistula Repair: Experience of Family Caregivers. *Global Qualitative Nursing Research*, 4, 1–9.
- Jarzabkowski, P. (2008). Shaping Strategy as a Structuration Process. *Academy of Management Journal*, 51(4), 621–650.
- Javed, S. A., & Liu, S. (2018). Evaluation of Outpatient Satisfaction and Service Quality of Pakistani Healthcare Projects: Application of a Novel Synthetic Grey Incidence Analysis Model. *Grey Systems*, 8(4), 462–480. <https://doi.org/10.1108/GS-04-2018-0018>
- Jenks, C. J. (2018). Recording and Transcribing Social Interaction. In *The Sage Handbook of Qualitative Data Collection* (pp. 118–130). Thousand Oaks, CA: Sage Publications Ltd.
- Jiao, M., Ning, N., Li, Y., Gao, L., Cui, Y., Sun, H., Kang, Z., Liang, L., Wu, Q., & Hao, Y. (2015). Workplace Violence against Nurses in Chinese Hospitals: A Cross-Sectional Survey. *BMJ Open*, 5(3), 1–9.
- Jirwe, M., & Rudman, A. (2012). Why Choose a Career in Nursing? *Journal of Advanced Nursing*, 68(7), 1615–1623.
- Jones, M. (2011). Structuration Theory. *The Oxford Handbook of Management Information Systems*, 113–137.
- Jones, S. R. G. (1992). Was There a Hawthorne Effect? *American Journal of Sociology*,

- 98(3), 451–468.
- Kaburi, B. B., Bio, F. Y., Kubio, C., Ameme, D. K., Kenu, E., Sackey, S. O., & Afari, E. A. (2019). Psychological Working Conditions and Predictors of Occupational Stress among Nurses, Salaga Government Hospital, Ghana, 2016. *Pan African Medical Journal*, 33, 1–15. <https://doi.org/10.11604/pamj.2019.33.320.16147>
- Karimi, L., Leggat, S. G., Donohue, L., Farrell, G., & Couper, G. E. (2014). Emotional Rescue: The Role of Emotional Intelligence and Emotional Labour on Well-Being and Job-Stress among Community Nurses. *Journal of Advanced Nursing*, 70(1), 176–186.
- Keller, S. M., Berryman, P., & Lukes, E. (2009). Effects of Extended Work Shifts and Shift Work on Patient Safety, Productivity, and Employee Health. *Aaohn Journal*, 57(12), 497–504.
- Kemmer, L. F., & Silva, M. J. P. da. (2007). Nurses' Visibility According to the Perceptions of the Communication Professionals. *Revista Latino-Americana de Enfermagem*, 15, 191–198.
- Ketchum, M. J. (2015). *Specters of Jesus: Ghosts, Gospels, and Resurrection in Early Christianity*. Madison, N.J.: Drew University.
- Kgakge, K., Hlongwa, M., & Ginindza, T. (2021). The Distribution of Work-Related Musculoskeletal Disorders among Nurses in Sub-Saharan Africa: A Scoping Review Protocol. *Systematic Reviews*, 10(1), 1–6.
- Khalaf, I. A., Al-Dweik, G., Abu-Snieneh, H., Al-Daken, L., Musallam, R. M., BaniYounis, M., AL-Rimawi, R., Khatib, A. H., “Habeeb Allah,” A., Atoum, M. H., & Masadeh, A. (2018). Nurses' Experiences of Grief Following Patient Death: A Qualitative Approach. *Journal of Holistic Nursing*, 36(3), 228–240. <https://doi.org/10.1177/0898010117720341>
- Khudhair, L. A., Ali, R. M., & Mohamed, Z. J. (2017). Impact of Work Place Psychological Hazards upon Nurse Midwives Quality of Care at Delivery Rooms in Maternity Hospitals in Thi-Qar Governorate. *Nursing*, 50(60), 4.
- King, B. J., Roberts, T. J., & Bowers, B. J. (2013). Nursing Student Attitudes Toward and Preferences for Working with Older Adults. *Gerontology & Geriatrics Education*, 34(3), 272–291.
- Kirk, J., Miller, M. L., & Miller, M. L. (1986). *Reliability and Validity in Qualitative Research*. London: Sage.
- Kirk, K., Cohen, L., Edgley, A., & Timmons, S. (2021). “I Don't Have Any Emotions”:

- An Ethnography of Emotional Labour and Feeling Rules in the Emergency Department. *Journal of Advanced Nursing*, 77(4), 1956–1967.
- Kisseih, D. A. N. (1968). Developments in Nursing in Ghana. *International Journal of Nursing Studies*, 5(3), 205–219.
- Kodom, M., Owusu, A. Y., & Kodom, P. N. B. (2019). Quality Healthcare Service Assessment under Ghana's National Health Insurance Scheme. *Journal of Asian and African Studies*, 54(4), 569–587. <https://doi.org/10.1177/0021909619827331>
- Kodom, P., Kodom, M., & Senah, K. (2018). “Why We Deliver Elsewhere”: Women's Preferred Places of Delivery and their Effects. *Sociology and Anthropology*, 6(3), 321–329.
- Kolthoff, E., Erakovich, R., & Lasthuizen, K. (2010). Comparative Analysis of Ethical Leadership and Ethical Culture in Local Government: The USA, The Netherlands, Montenegro and Serbia. *International Journal of Public Sector Management*, 7(5.10.), 596-613.
- Kostka, A. M., Borodzicz, A., & Krzemińska, S. A. (2021). Feelings and Emotions of Nurses Related to Dying and Death of Patients - A Pilot Study. *Psychology Research and Behavior Management*, 14, 705–717. <https://doi.org/10.2147/PRBM.S311996>
- Koushali, A. N., Hajiamini, Z., & Ebadi, A. (2012). Comparison of Nursing Students' and Clinical Nurses' Attitude toward the Nursing Profession. *Iranian Journal of Nursing and Midwifery Research*, 17(5), 375.
- Kruk, M. E., Kujawski, S., Mbaruku, G., Ramsey, K., Moyo, W., & Freedman, L. P. (2018). Disrespectful and Abusive Treatment during Facility Delivery in Tanzania: A Facility and Community Survey. *Health Policy and Planning*, 33(1), e26–e33.
- Kuo, B. C. H. (2011). Culture's Consequences on Coping: Theories, Evidences, and Dimensionalities. *Journal of Cross-Cultural Psychology*, 42(6), 1084–1100.
- Kuupiel, D., Tlou, B., Bawontuo, V., & Mashamba-Thompson, T. P. (2019). Accessibility of Pregnancy-Related Point-Of-Care Diagnostic Tests for Maternal Healthcare in Rural Primary Healthcare Facilities in Northern Ghana: A Cross-Sectional Survey. *Heliyon*, 5(2), 1–16. <https://doi.org/10.1016/j.heliyon.2019.e01236>
- Kwansah, J., Dzodzomenyo, M., Mutumba, M., Asabir, K., Koomson, E., Gyakobo, M., Agyei-Baffour, P., Kruk, M. E., & Snow, R. C. (2012). Policy talk: Incentives for Rural Service among Nurses in Ghana. *Health Policy and Planning*, 27(8), 669–676. <https://doi.org/10.1093/heapol/czs016>
- Kyei, S., Otoo, F. L., Abu, E. K., & Ofori, A. A. (2018). Knowledge, Attitude and

- Practices of Ghanaian Midwives regarding the Use of Ophthalmic Medications among Pregnant Women. *International Journal of Africa Nursing Sciences*, 8(February), 59–65. <https://doi.org/10.1016/j.ijans.2018.03.002>
- Kyilleh, J. M., Tabong, P. T.-N., & Konlaan, B. B. (2018). Adolescents' Reproductive Health Knowledge, Choices and Factors Affecting Reproductive Health Choices: A Qualitative Study in the West Gonja District in Northern Region, Ghana. *BMC International Health and Human Rights*, 18(1), 1–12.
- Lahana, E., Tsaras, K., Kalaitzidou, A., Galanis, P., Kaitelidou, D., & Sarafis, P. (2019). Conflicts Management in Public Sector Nursing. *International Journal of Healthcare Management*, 12(1), 33–39.
- Landry, T., & Tillman, K. (2013). Patients' Perceptions of being Cared for by Male Nurses. Proceedings of the 38th Annual Conference of American Assembly for Men in Nursing at Seton Hall University College of Nursing (USA). New Jersey: American Assembly for Men in Nursing, 34.
- LaRocco, S. A. (2008). A Grounded Theory Study of Socializing Men into Nursing. *The Journal of Men's Studies*, 15(2), 120–129.
- Larsson, I. E., Sahlsten, M. J. M., Segesten, K., & Plos, K. A. E. (2011). Patients' Perceptions of Nurses' Behaviour That Influence Patient Participation in Nursing Care: A Critical Incident Study. *Nursing Research and Practice*, 2011, 1–8. <https://doi.org/10.1155/2011/534060>
- Lavoie, S., Talbot, L. R., Mathieu, L., Dallaire, C., Dubois, M., & Courcy, F. (2016). An Exploration of Factors Associated with Post-Traumatic Stress in ER Nurses. *Journal of Nursing Management*, 24(2), 174–183.
- Layder, D. (2005). *Understanding Social Theory*. London: Sage Publications.
- Leape, L. L., Shore, M. F., Dienstag, J. L., Mayer, R. J., Edgman-Levitan, S., Meyer, G. S., & Healy, G. B. (2012). Perspective: A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians. *Academic Medicine*, 87(7), 845–852.
- LeCompte, M. D., & Schensul, J. J. (1999). *Designing and Conducting Ethnographic Research* (Vol. 1). London: Altamira Press: A Division of Sage Publications Inc.
- Ledda, C., Ciccì, F., Puglisi, B., Ramaci, T., Nunnari, G., & Rapisarda, V. (2017). Attitude of Health Care Workers (HCWs) toward Patients Affected by HIV/AIDS and Drug Users: A Cross-Sectional Study. *International Journal of Environmental Research and Public Health*, 14(3), 284.
- Leder, D. (1992). A Tale of Two Bodies: The Cartesian Corpse and the Lived Body. In

- The Body in Medical Thought and Practice* (pp. 17–35). New York: Springer.
- Lee, J. Q., Loke, W., & Ng, Q. X. (2020). The Role of Family Physicians in a Pandemic: A Blueprint. *Healthcare*, 8(3), 198.
- Lees, D., Procter, N., & Fassett, D. (2014). Therapeutic Engagement between Consumers in Suicidal Crisis and Mental Health Nurses. *International Journal of Mental Health Nursing*, 23(4), 306–315.
- Levine, M. S., & Lowe, N. K. (2015). Measuring Nurse Attitudes about Childbirth: Revision and Pilot Testing of the Nurse Attitudes and Beliefs Questionnaire. *Journal of Nursing Measurement*, 23(2), 287–301.
- Lim, M. S. C., Zhang, X.-D., Kennedy, E., Li, Y., Yang, Y., Li, L., Li, Y.-X., Temmerman, M., & Luchters, S. (2015). Sexual and Reproductive Health Knowledge, Contraception Uptake, and Factors Associated with Unmet Need for Modern Contraception among Adolescent Female Sex Workers in China. *PloS One*, 10(1), 1–17.
- Lin, S. H., Liao, W. C., Chen, M. Y., & Fan, J. Y. (2014). The Impact of Shift Work on Nurses' Job Stress, Sleep Quality and Self-Perceived Health Status. *Journal of Nursing Management*, 22(5), 604–612. <https://doi.org/10.1111/jonm.12020>
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalist Inquiry*. Beverly Hills, CA: Sage.
- Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic Controversies, Contradictions, and Emerging Confluences, Revisited. *The Sage Handbook of Qualitative Research*, 4(2), 97–128.
- Linden, M., & Kavanagh, R. (2012). Attitudes of Qualified vs. Student Mental Health Nurses towards an Individual Diagnosed with Schizophrenia. *Journal of Advanced Nursing*, 68(6), 1359–1368.
- Liu, J. X., Goryakin, Y., Maeda, A., Bruckner, T., & Scheffler, R. (2017). Global Health Workforce Labor Market Projections for 2030. *Human Resources for Health*, 15(1), 1–12.
- Liu, Y. (2010). Nurses' Work Role in the Context of Gender and Chinese Culture: An Online Forum Study. *Journal of Nursing Research*, 18(2), 117–125.
- Luttik, M. L. A., Goossens, E., Ågren, S., Jaarsma, T., Mårtensson, J., Thompson, D. R., Moons, P., & Strömberg, A. (2017). Attitudes of Nurses towards Family Involvement in the Care for Patients with Cardiovascular Diseases. *European Journal of Cardiovascular Nursing*, 16(4), 299–308. <https://doi.org/10.1177/14745151166663143>
- Lye, J. (1997). *Structuration Theory and Organizations*. Canada: Brock University.

- <http://www.brocku.ca/commstudies/courses/2F50/>
- Mac Lellan, K. (2006). *Management of Pain: A Practical Approach for Health Care Professionals*. Oxford: Nelson Thornes Ltd.
- MacDermott, C., & Keenan, P. M. (2014). Grief Experiences of Nurses in Ireland who have Cared for Children with an Intellectual Disability who have Died. *International Journal of Palliative Nursing*, 20(12), 584–590.
- Mackenzie, A. E. (1994). Evaluating Ethnography: Considerations for Analysis. *Journal of Advanced Nursing*, 19(4), 774–781.
- MacWilliams, B. R., Schmidt, B., & Bleich, M. R. (2013). Men in Nursing. *AJN The American Journal of Nursing*, 113(1), 38–44.
- Makowsky, M. J., Schindel, T. J., Rosenthal, M., Campbell, K., Tsuyuki, R. T., & Madill, H. M. (2009). Collaboration between Pharmacists, Physicians and Nurse Practitioners: A Qualitative Investigation of Working Relationships in the Inpatient Medical Setting. *Journal of Interprofessional Care*, 23(2), 169–184.
- Malinowski, B. (1922). *Argonauts of the Western Pacific*. London: Routledge and Kegan Paul.
- Manganye, B. S., Maluleke, T. X., & Lebeso, R. T. (2013). Professional Nurses' Views Regarding Stigma and Discrimination in the Care of HIV and AIDS Patients in Rural Hospitals of the Limpopo Province, South Africa. *African Journal of AIDS Research*, 12(1), 33–40.
- Mannava, P., Durrant, K., Fisher, J., Chersich, M., & Luchters, S. (2015). Attitudes and Behaviours of Maternal Health Care Providers in Interactions with Clients: A Systematic Review. *Globalization and Health*, 11(1), 1–17.
- Manso, J. F., Annan, J., & Anane, S. S. (2013). Assessment of Logistics Management in Ghana Health Service. *International Journal of Business and Social Research (IJBSR)*, 3(8), 75–87.
- Marcella, J., & Kelley, M. Lou. (2015). “Death is Part of the Job” in Long-Term Care Homes: Supporting Direct Care Staff with their Grief and Bereavement. *Sage Open*, 5(1), 1–15.
- Marquis, B. L., & Huston, C. J. (2009). *Leadership Roles and Management Functions in Nursing: Theory and Application*. Philadelphia, Pennsylvania: Lippincott Williams & Wilkins.
- Mashamba-Thompson, T. P., Sartorius, B., & Drain, P. K. (2018). Operational Assessment of Point-Of-Care Diagnostics in Rural Primary Healthcare Clinics of KwaZulu-Natal,

- South Africa: A Cross-Sectional Survey. *BMC Health Services Research*, 18(1), 1–8.
- Masjedi, M., Ghorbani, M., Managheb, I., Fattahi, Z., Dehghanpisheh, L., Salari, M., & Karami, A. (2017). Evaluation of Anxiety and Fear about Anesthesia in Adults undergoing Surgery under General Anesthesia. *Acta Anaesthesiol Belg*, 68(1), 25–29.
- Mauss, M. (2002). *The Gift: The Form and Reason for Exchange in Archaic Societies*. London: Routledge.
- Maxwell, J. A. (2005). *Qualitative Research Design: An Interactive Approach*. Newbury Park: CA: Sage.
- Mays, N., & Pope, C. (1995). Qualitative Research: Rigour and Qualitative Research. *Bmj*, 311(6997), 109–112.
- Mbiti, J. S. (1990). *African Religions & Philosophy*. London, UK: Heinemann.
- McCabe, C. (2004). Nurse–Patient Communication: An Exploration of Patients’ Experiences. *Journal of Clinical Nursing*, 13(1), 41–49.
- McCorristine, S. (2010). *Spectres of the Self: Thinking about Ghosts and Ghost-seeing in England, 1750-1920*. Cambridge: University Press.
- McHugh, M. D., Kutney-Lee, A., Cimiotti, J. P., Sloane, D. M., & Aiken, L. H. (2011). Nurses’ Widespread Job Dissatisfaction, Burnout, and Frustration with Health Benefits Signal Problems for Patient Care. *Health Affairs*, 30(2), 202–210. <https://doi.org/10.1377/hlthaff.2010.0100>
- McMeekin, D. E., Hickman Jr, R. L., Douglas, S. L., & Kelley, C. G. (2017). Stress and Coping of Critical Care Nurses after Unsuccessful Cardiopulmonary Resuscitation. *American Journal of Critical Care*, 26(2), 128–135.
- McNally, S., & Huber, J. (2021). Developing a ‘Doctors’ Assistant’ Role to Ease Pressure on Doctors and Improve Patient Flow in Acute NHS Hospitals. *BMJ Leader*, 5(1), 62–64.
- Mead, G. H., & Schubert, C. (1934). *Mind, Self and Society* (Vol. 111). Chicago: University of Chicago Press.
- Mealer, M., & Jones, J. (2013). Posttraumatic Stress Disorder in the Nursing Population: A Concept Analysis. *Nursing Forum*, 48(4), 279–288.
- Mealer, M. L., Shelton, A., Berg, B., Rothbaum, B., & Moss, M. (2007). Increased Prevalence of Post-Traumatic Stress Disorder Symptoms in Critical Care Nurses. *American Journal of Respiratory and Critical Care Medicine*, 175(7), 693–697.
- Mensah, R. S., Mogale, R. S., & Richter, M. S. (2014). Birthing Experiences of Ghanaian Women in 37th Military Hospital, Accra, Ghana. *International Journal of Africa*

- Nursing Sciences*, 1, 29–34. <https://doi.org/10.1016/j.ijans.2014.06.001>
- Menzel, N. N. (2015). Nurses as Scapegoats in Ebola Virus Disease Response. *International Journal of Nursing Studies*, 52(3), 663–665.
- Mercer, S., Furler, J., Moffat, K., Fischbacher-Smith, D., & Sanci, L. (2016). *Multimorbidity: Technical Series on Safer Primary Care*. Geneva: World Health Organization.
- Midilli, T. S., Kirmiziloglu, T., & Kalkim, A. (2017). Affecting Factors and Relationship between Patients' Attitudes towards the Nursing Profession and Perceptions of Nursing Care in a University Hospital. *Journal of the Pakistan Medical Association*, 67(7), 1059–1064.
- Miligi, E., & Selim, A. (2014). Saudi Nursing Students' Attitudes towards the Nursing Profession. *European Journal of Business and Management*, 6(29), 197–208.
- Mills, C. W. (2000). *The Sociological Imagination*. New York: Oxford University Press.
- Milton, C. L. (2012). Altruism. *Nursing Science Quarterly*, 25(3), 222–224.
- Ministry of Health. (2011). *Human Resources for Health Country Profile. Ghana Edition*.
- Minkus, H. K. (1980). The Concept of Spirit in Akwapim Akan Philosophy. *Africa*, 50(2), 182–192.
- Miró-Bonet, M., Bover-Bover, A., Moreno-Mulet, C., Miró-Bonet, R., & Zaforteza-Lallemand, C. (2014). Genealogy as a Critical Toolbox: Deconstructing the Professional Identity of Nurses. *Journal of Advanced Nursing*, 70(4), 768–776. <https://doi.org/10.1111/jan.12236>
- Misiak, B., Sierżantowicz, R., Krajewska-Kułak, E., Lewko, K., Chilińska, J., & Lewko, J. (2020). Psychosocial Work-Related Hazards and their Relationship to the Quality of Life of Nurses—A Cross-Sectional Study. *International Journal of Environmental Research and Public Health*, 17(3), 755.
- Modisakeng, C., Matlala, M., Godman, B., & Meyer, J. C. (2020). Medicine Shortages and Challenges with the Procurement Process among Public Sector Hospitals in South Africa; Findings and Implications. *BMC Health Services Research*, 20(1), 1–10.
- Moore, L. W., Leahy, C., Sublett, C., & Lanig, H. (2013). Understanding Nurse-to-Nurse Relationships and Their Impact on Work Environments. *Medsurg Nursing*, 22(3), 172.
- Moore, P. V. (2018). *The Threat of Physical and Psychosocial Violence and Harassment in Digitalized Work*. International Labour Office Geneva.
- Morgan, M. (1996). *Marketing for Leisure and Tourism*. Prentice-Hall International.

- Morley, L., & Cashell, A. (2017). Collaboration in Health Care. *Journal of Medical Imaging and Radiation Sciences*, 48(2), 207–216.
<https://doi.org/10.1016/j.jmir.2017.02.071>
- Mosadeghrad, A. M. (2014). Factors Affecting Medical Service Quality. *Iranian Journal of Public Health*, 43(2), 210.
- Mott, J., & Lee, O. D. (2018). Navigating Unfamiliar Waters: Men in Nursing Academia. *Journal of Professional Nursing*, 34(1), 42.
<https://doi.org/10.1016/j.profnurs.2017.07.005>
- Mottaghi, S., Poursheikhali, H., & Shameli, L. (2020). Empathy, Compassion Fatigue, Guilt and Secondary Traumatic Stress in Nurses. *Nursing Ethics*, 27(2), 494–504.
<https://doi.org/10.1177/0969733019851548>
- Moudatsou, M., Stavropoulou, A., Philalithis, A., & Koukouli, S. (2020). The Role of Empathy in Health and Social Care Professionals. *Healthcare*, 8(1), 26.
- Moyer, C. A., Adongo, P. B., Aborigo, R. A., Hodgson, A., & Engmann, C. M. (2014). ‘They Treat you like you are not a Human Being’: Maltreatment during Labour and Delivery in Rural Northern Ghana. *Midwifery*, 30(2), 262–268.
- Mugambi, M. L., Palamountain, K. M., Gallarda, J., & Drain, P. K. (2017). Exploring the Case for a Global Alliance for Medical Diagnostics Initiative. *Diagnostics*, 7(1), 8.
- Mula, C. T., Middleton, L., Muula, A., Solomon, V., & Varga, C. (2021). Nurses’ Role in Antibiotic Stewardship at Medical Wards of a Referral Hospital in Malawi: Understanding Reality and Identifying Barriers. *International Journal of Africa Nursing Sciences*, 15, 100311.
- Mwini-Nyaledzigbor, P. P., Atindanbila, S., Agbakpe, G. F., & Abasimi, E. (2014). *Psychological Factors Influencing the Perception and Choice of Nursing as a Profession: A Study at Korle-Bu Nurses’ Training College*. 3(1), 25–32.
- Namujju, J., Muhindo, R., Mselle, L. T., Waiswa, P., Nankumbi, J., & Muwanguzi, P. (2018). Childbirth Experiences and their Derived Meaning: A Qualitative Study among Postnatal Mothers in Mbale Regional Referral Hospital, Uganda 11 Medical and Health Sciences 1117 Public Health and Health Services 11 Medical and Health Sciences 1110 Nursing. *Reproductive Health*, 15(1), 1–11.
<https://doi.org/10.1186/s12978-018-0628-y>
- Neilson, G. R., & Jones, M. C. (2012). What Predicts the Selection of Nursing as a Career Choice in 5th and 6th year School Students? *Nurse Education Today*, 32(5), 588–593.
- Nelson, C., Treichler, P. A., & Grossberg, L. (1992). *Cultural Studies: An Introduction*.

- Cultural Studies*, 1(5), 1–19.
- Newell, S., & Jordan, Z. (2015). The Patient Experience of Patient-Centered Communication with Nurses in the Hospital Setting: A Qualitative Systematic Review Protocol. *JBIC Evidence Synthesis*, 13(1), 76–87.
- Nightingale, F., & Nursing, N. O. (1969). *What It Is and What It Is Not*. New York, New York: Dover Press.
- Nordgren, L., Asp, M., & Fagerberg, I. (2007). An Exploration of the Phenomenon of Formal Care from the Perspective of Middle-Aged Heart Failure Patients. *European Journal of Cardiovascular Nursing*, 6(2), 121–129.
- Nursing and Midwifery Council. (2022). *Who We Are*.
<https://www.nmc.gov.gh/web/howeare-mobile>
- Nwameme, A. U., Phillips, J. F., & Adongo, P. B. (2014). Compliance with Emergency Obstetric Care Referrals among Pregnant Women in an Urban Informal Settlement of Accra, Ghana. *Maternal and Child Health Journal*, 18(6), 1403–1412.
<https://doi.org/10.1007/s10995-013-1380-0>
- O’Lynn, C. E. (2012). *A man’s Guide to a Nursing Career*. Springer Publishing Company.
- Odeku, O. F., & Odeku, K. O. (2015). Importance of the Welfare Facilities in the Workplace: Issues in Perspectives. *Socioeconomica*, 4(7), 23–34.
<https://doi.org/10.12803/sjseco.4712315>
- Offei, A. K., Bannerman, C., & Kyeremeh, K. (2004). *Health Care Quality Assurance Manual*. Ghana Health Service, Accra.
- Ojo, T. T., Hawley, N. L., Desai, M. M., Akiteng, A. R., Guwatudde, D., & Schwartz, J. I. (2017). Exploring Knowledge and Attitudes toward Non-Communicable Diseases among Village Health Teams in Eastern Uganda: A Cross-Sectional Study. *BMC Public Health*, 17(1), 1–11. <https://doi.org/10.1186/s12889-017-4954-8>
- Oldland, E., Botti, M., Hutchinson, A. M., & Redley, B. (2020). A Framework of Nurses’ Responsibilities for Quality Healthcare—Exploration of Content Validity. *Collegian*, 27(2), 150–163.
- Oluyemisi, A. F., Oyadiran, G. O., Ijedimma, M. O., Akinlabi, B. O., & Adewale, A. J. (2014). Perception of Pregnant Women towards Midwives: Attitude and Practice during Child Delivery in Health Institutions in Ogbomoso, South-West, Nigeria. *Epidemiology, Biostatistics and Public Health*, 11(2).
- Oppong-Darko, P., Amponsa-Achiano, K., & Darj, E. (2017). “I Am Ready and Willing to Provide the Service... Though My Religion Frowns on Abortion”—Ghanaian

- Midwives' Mixed Attitudes to Abortion Services: A Qualitative Study. *International Journal of Environmental Research and Public Health*, 14(12), 1–11.
- Osafo, J., Akotia, C. S., Boakye, K. E., & Dickson, E. (2018). Between Moral Infraction and Existential Crisis: Exploring Physicians and Nurses' Attitudes to Suicide and the Suicidal Patient in Ghana. *International Journal of Nursing Studies*, 85, 118–125.
- Osafo, J., Knizek, B. L., Akotia, C. S., & Hjelmeland, H. (2012). Attitudes of Psychologists and Nurses toward Suicide and Suicide Prevention in Ghana: A Qualitative Study. *International Journal of Nursing Studies*, 49(6), 691–700.
- Osei, Y. (1994). Family Support for Psychiatric Patients in Kumasi/Ghana. *Curare*, 17(1), 35–38.
- Osler, W. (1920). *Aequanimitas: With other Addresses to Medical Students, Nurses and Practitioners of Medicine*. HK Lewis.
- Osman, W., Ninnoni, J. P. K., & Anim, M. T. (2021). Use of the Nursing Process for Patient Care in a Ghanaian Teaching Hospital: A Cross Sectional Study. *International Journal of Africa Nursing Sciences*, 14, 100281.
- Owoo, B., Ninnoni, J. P., Ampofo, E. A., & Seidu, A.-A. (2022). Challenges Encountered by Family Caregivers of Prostate Cancer Patients in Cape Coast, Ghana: A Descriptive Phenomenological Study. *BMC Palliative Care*, 21(1), 1–11.
- Owusu-Addo, E. (2015). Midwives' Perceptions and Experiences of Health Promotion Practice in Ghana. *Global Health Promotion*, 22(3), 4–14.
- Owusu-Addo, S. B., Owusu-Addo, E., & Morhe, E. S. K. (2016). Health Information-Seeking Behaviours among Pregnant Teenagers in Ejisu-Juaben Municipality, Ghana. *Midwifery*, 41(1), 110–117.
- Owusu, M. (1981). *History of Nursing Services in Ghana*. Accra.
- Øyane, N. M. F., Pallesen, S., Moen, B. E., Åkerstedt, T., & Bjorvatn, B. (2013). Associations between Night Work and Anxiety, Depression, Insomnia, Sleepiness and Fatigue in a Sample of Norwegian Nurses. *PLoS One*, 8(8), 1–7.
- Ozanic, I. (1961). Nursing in Ethiopia. In *Addis Ababa: Ethiopian Nursing Association*.
- Ozaras, G., & Abaan, S. (2018). Investigation of the Trust Status of the Nurse–Patient Relationship. *Nursing Ethics*, 25(5), 628–639.
- Parker, J., & Hallam, J. (1998). From Angels to Handmaidens: Changing Constructions of Nursing's Public Image in Post-War Britain. *Nursing Inquiry*, 5(1), 32–42.
- Parsons, T. (1951). *The Social System*. Glencoe: Free Press. Publisher.
- Parsons, T. (2010). *Essays in Sociological Theory*. Simon and Schuster.

- Parsons, T., & Shils, E. A. (2017). Systems of Value-Orientation. In *Toward a General Theory of Action* (pp. 159–189). Routledge.
- Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods*. London, Sage Publications.
- Pearsall, M. (1970). Participant Observation as Role and Method in Behavioral Research. *Qualitative Methodology: Firsthand Involvement with the Social World*, 340–352.
- Pehr, J. L. (2010). Health Care and Infrastructure in Accra, Ghana. *Advanced Issues in Urban Planning, April*, 1–21.
- Perron, A. (2013). Nursing as ‘Disobedient’ Practice: Care of the Nurse’s Self, Parrhesia, and the Dismantling of a Baseless Paradox. *Nursing Philosophy*, 14(3), 154–167.
- Perry, J., Jagger, J., & Parker, G. (2003). Nurses and Needlesticks, Then and Now. *Nursing2022*, 33(4), 22.
- Persoskie, A., Ferrer, R. A., & Klein, W. M. P. (2014). Association of Cancer worry and Perceived Risk with Doctor Avoidance: An Analysis of Information Avoidance in a Nationally Representative US Sample. *Journal of Behavioral Medicine*, 37(5), 977–987.
- Polifroni, E. C. (2010). Power, Right, and Truth: Foucault’s Triangle as a Model for Clinical Power. *Nursing Science Quarterly*, 23(1), 8–12.
- Polit, D. F., & Beck, C. T. (2004). *Nursing Research: Principles and Methods*. Philadelphia, Pennsylvania: Lippincott Williams & Wilkins.
- Polit, D. F., & Beck, C. T. (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. Philadelphia, Pennsylvania: Lippincott Williams & Wilkins.
- Pontin, D. J. T., & Webb, C. (1995). Assessing Patient Satisfaction. Part 1. The Research Process. *Journal of Clinical Nursing*, 4(6), 383–389.
- Powers, J. (2013). Are you Practicing to your Full Potential? *Nursing Made Incredibly Easy*, 11(3), 4.
- Price, S. L. (2009). Becoming A Nurse: A Meta-Study of Early Professional Socialization and Career Choice in Nursing. *Journal of Advanced Nursing*, 65(1), 11–19. <https://doi.org/10.1111/j.1365-2648.2008.04839.x>
- Pryjmachuk, S., Easton, K., & Littlewood, A. (2009). Nurse Education: Factors Associated with Attrition. *Journal of Advanced Nursing*, 65(1), 149–160.
- Prytherch, H., Kakoko, D. C. V, Leshabari, M. T., Sauerborn, R., & Marx, M. (2012). Maternal and Newborn Healthcare Providers in Rural Tanzania: In-Depth Interviews Exploring Influences on Motivation, Performance and Job Satisfaction. *Rural and*

- Remote Health*, 12(3), 1–15.
- Pudpong, N., Srithanaviboonchai, P.K., Chariyalertsak, S., Chariyalertsak, C., Smutrapapoot P., Sirinirund, P., ... Nyblade, L. (2014). 'Reducing HIV-Related Stigma and Discrimination in Healthcare Settings: An Initiative from Thailand'. In *Poster presentation at 20th international AIDS conference*.
- Punnett, L., & Wegman, D. H. (2004). Work-Related Musculoskeletal Disorders: The Epidemiologic Evidence and the Debate. *Journal of Electromyography and Kinesiology*, 14(1), 13–23.
- Radmehr, M., Ashktorab, T., & Abedsaeedi, Z. (2015). Nursing Care Aesthetic in Iran: A Phenomenological Study. *Nursing and Midwifery Studies*, 4(2), 1–8.
- Rafferty, A. M. & Solano, D. (2007). The Rise and Demise of the Colonial Nursing Service: British Nurses in the Colonies, 1896–1966. *Nursing History Reviews*, 15(1), 147–154. <https://doi.org/DOI: 10.1891/1062-8061.15.147>
- Raftopoulos, V., Charalambous, A., & Talias, M. (2012). The Factors Associated with the Burnout Syndrome and Fatigue in Cypriot Nurses: A Census Report. *BMC Public Health*, 12(1), 1–13.
- Ramos, F. J. da S., Fumis, R. R. L., Azevedo, L. C. P. de, & Schettino, G. (2014). Intensive Care Unit Visitation Policies in Brazil: A Multicenter Survey. *Revista Brasileira de Terapia Intensiva*, 26(1), 339–346.
- Ranse, K., Ranse, J., & Pelkowitz, M. (2018). Third-Year Nursing Students' Lived Experience of Caring for the Dying: A Hermeneutic Phenomenological Approach. *Contemporary Nurse*, 54(2), 160–170.
- Rathore, F. A., Attique, R., & Asmaa, Y. (2017). Prevalence and Perceptions of Musculoskeletal Disorders among Hospital Nurses in Pakistan: A Cross-Sectional Survey. *Cureus*, 9(1).
- Reeves, S., Kuper, A., & Hodges, B. D. (2008). Qualitative Research Methodologies: Ethnography. *BMJ*, 337(7668), 512–514.
- Reinberg, A., Motohashi, Y., Bourdeleau, P., Touitou, Y., Nougquier, J., Levi, F., & Nicolai, A. (1989). Internal Desynchronization of Circadian Rhythms and Tolerance of Shift Work. *Chronobiologia*.
- Reisfield, G. M., & Wilson, G. R. (2003). Ambiguity in End-of-Life Communications. *J Terminal Oncol*, 2, 61–66.
- Relias Media. (2022). *NIOSH Sets 35-lb Limit as the Max for Safe Lifts*. <https://www.reliasmedia.com/articles/108096-niosh-sets-35-lb-limit-as-the-max-for->

safe-lifts

- Reynolds, L. T., & Herman, N. J. (1994). *Symbolic Interaction: An Introduction to Social Psychology*. Lanham, MD: Altamira.
- Reynolds, W. J. (2017). *The Measurement and Development of Empathy in Nursing*. Routledge.
- Reynolds, W. J., Scott, B., & Jessiman, W. C. (1999). Empathy has not been Measured in Clients' Terms or Effectively Taught: A Review of the Literature. *Journal of Advanced Nursing*, 30(5), 1177–1185.
- Rezaei-Adaryani, M., Salsali, M., & Mohammadi, E. (2012). Nursing Image: An Evolutionary Concept Analysis. *Contemporary Nurse*, 43(1), 81–89.
- Rezai Sepasi, R., Borhani, F., & Abbaszadeh, A. (2017). Nurses' Perception of the Strategies to Gaining Professional Power: A Qualitative Study. *Electronic Physician*, 9(7), 4853–4861. <https://doi.org/10.19082/4853>
- Ridgeway, C. L. (1982). Status in Groups: The Importance of Motivation. *American Sociological Review*, 76–88.
- Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. Thousand Oaks, CA: Sage Publications.
- Ritzer, G., & Yagatich, W. (2012). Contemporary Sociological Theory. *The Wiley-Blackwell Companion to Sociology*. Oxford: Wiley-Blackwell, 98–118.
- Rogers, B., & Travers, P. (1991). Overview of Work-Related Hazards in Nursing: Health and Safety Issues. *Heart & Lung: The Journal of Critical Care*, 20(5 Pt 1), 486–497.
- Roper, J. M., & Shapira, J. (2000). *Ethnography in Nursing Research* (Vol. 1). Thousand Oaks, CA: Sage Publications.
- Rosen, H. E., Lynam, P. F., Carr, C., Reis, V., Ricca, J., Bazant, E. S., & Bartlett, L. A. (2015). Direct Observation of Respectful Maternity Care in Five Countries: A Cross-Sectional Study of Health Facilities in East and Southern Africa. *BMC Pregnancy and Childbirth*, 15(1), 1–11.
- Roulin, M., Jonniaux, S., Guisado, H., & Séchaud, L. (2020). Perceptions of Inpatients and Nurses towards the Importance of Nurses' Caring Behaviours in Rehabilitation: A Comparative Study. *International Journal of Nursing Practice*, 26(4), e12835.
- Russell, S. (2008). Demand-Side Factors affecting Health Seeking Behaviour in Ghana. *The Georgetown Undergraduate Journal of Health Sciences*, 5(1).
- Sadeghzadeh, N., Amiri-Farahani, L., Haghani, S., & Hasanpoor-Azghady, S. B. (2019).

- Iranian Midwives' Attitudes and Beliefs toward Physiological Childbirth: A Cross-Sectional Study. *BMC Pregnancy and Childbirth*, 19(1), 1–8.
<https://doi.org/10.1186/s12884-019-2509-y>
- Sahraian, A., Davidi, F., Bazrafshan, A., & Javadpour, A. (2013). *Occupational Stress among Hospital Nurses: Comparison of Internal, Surgical, and Psychiatric Wards*. 1(4), 182–190.
- Saks, M., & Allsop, J. (2007). Introduction: The Context for Researching Health. *Researching Health: Qualitative, Quantitative and Mixed Methods*. London: Sage Publications.
- Sakyi, E. K., Atinga, R. A., & Adzei, F. A. (2012). Managerial Problems of Hospitals under Ghana's National Health Insurance Scheme. *Clinical Governance: An International Journal*, 17(3), 178–190.
- Saldaña, J. (2013). *The Coding Manual for Qualitative Researchers* (2nd ed.). London: Sage Publications Ltd.
- Sampaio, A. V., Comassetto, I., Mancussi e Faro, A. C., Dos Santos, R. M., & Monteiro, F. S. (2015). The Experience of Nursing Students Facing Death and Dying. *Investigacion y Educacion En Enfermeria*, 33(2), 305–314.
<https://doi.org/10.17533/udea.iee.v33n2a13>
- Sangasubana, N. (2011). How to Conduct Ethnographic Research. *Qualitative Report*, 16(2), 567–573.
- Sansoni, J., De Caro, W., Marucci, A. R., Sorrentino, M., Mayner, L., & Lancia, L. (2016). Nurses' Job Satisfaction: An Italian Study. *Ann Ig*, 28(1), 58–69.
- Sarafis, P., Rousaki, E., Tsounis, A., Malliarou, M., Lahana, L., Bamidis, P., Niakas, D., & Papastavrou, E. (2016). The Impact of Occupational Stress on Nurses' Caring Behaviors and their Health Related Quality of Life. *BMC Nursing*, 15(1), 1–9.
- Scanlan, J. N., & Still, M. (2019). Relationships between Burnout, Turnover Intention, Job Satisfaction, Job Demands and Job Resources for Mental Health Personnel in an Australian Mental Health Service. *BMC Health Services Research*, 19(1), 1–11.
- Schablon, A., Wendeler, D., Kozak, A., Nienhaus, A., & Steinke, S. (2018). Prevalence and Consequences of Aggression and Violence towards Nursing and Care Staff in Germany—A Survey. *International Journal of Environmental Research and Public Health*, 15(6), 1274.
- Schmidt, K.-H., & Diestel, S. (2014). Are Emotional Labour Strategies by Nurses Associated with Psychological Costs? A Cross-Sectional Survey. *International*

- Journal of Nursing Studies*, 51(11), 1450–1461.
- Schmiedeknecht, K., Perera, M., Schell, E., Jere, J., Geoffroy, E., & Rankin, S. (2015). Predictors of Workforce Retention among Malawian Nurse Graduates of a Scholarship Program: A Mixed-Methods Study. *Global Health: Science and Practice*, 3(1), 85–96.
- Scott, A. J. (2016). Shift Work. In *Physical and Biological Hazards at the Workplace* (pp. 139–176).
- Scott, J. (2000). *Rational Choice Theory*. In G. Browning, A. Halcli, & F. Webster (Eds.), *Understanding Contemporary Society: Theories of the Present* (pp. 126-138). London: Sage Publications. <http://dx.doi.org/10.4135/9781446218310.n9>
- Scott, P. A., Harvey, C., Felzmann, H., Suhonen, R., Habermann, M., Halvorsen, K., Christiansen, K., Toffoli, L., & Papastavrou, E. (2019). Resource Allocation and Rationing in Nursing Care: A Discussion Paper. *Nursing Ethics*, 26(5), 1528–1539.
- Sehlen, S., Vordermark, D., Schäfer, C., Herschbach, P., Bayerl, A., Pigorsch, S., Rittweger, J., Dormin, C., Bölling, T., & Wypior, H. J. (2009). Job Stress and Job Satisfaction of Physicians, Radiographers, Nurses and Physicists working in Radiotherapy: A Multicenter Analysis by the DEGRO Quality of Life Work Group. *Radiation Oncology*, 4(1), 1–9.
- Senah, K. A. (2002). 'Doctor-Talk' and 'Patient-Talk' Power and Ethnocentrism in Ghana. In Geest Svd, Reis, R (eds.), *Ethnocentrism, Reflections on Medical Anthropology*. Amsterdam Aksant Academic Publishers (pp. 43–66).
- Sepasi, R. R., Abbaszadeh, A., Borhani, F., & Rafiei, H. (2016). Nurses' Perceptions of the Concept of Power in Nursing: A Qualitative Research. *Journal of Clinical and Diagnostic Research: JCDR*, 10(12), 10–15.
- Seredocha, K. (2017). Man in the Face of Death - An Anthropological Approach. In E. Żywucka- Kozłowska E (Ed.), *Death in Many Guises*. Olsztyn: Kortowski Przegląd Prawniczy Monografie (pp. 299–305).
- Shaw, I. (2004). Doctors, "Dirty Work" Patients, and "Revolving Doors." *Qualitative Health Research*, 14(8), 1032–1045.
- Shoqirat, N. (2014). "Sleepless Nights and Sore Operation Site": Patients' Experiences of Nursing Pain Management after Surgery in Jordan. *Pain Management Nursing*, 15(3), 609–618.
- Sichach, M. (2023). Truisms: a Critique of Symbolic Interactionism. Available at SSRN 4475305.

- Sieloff, C. L. (2004). Leadership Behaviours that Foster Nursing Group Power. *Journal of Nursing Management*, 12(4), 246–251.
- Silva, M. C. (2017). Labor Suffering in the Team of a Rural Family Health Center in Southern Chile. *Revista Chilena de Salud Pública*, 21(1), 10–18.
- Silverman, D. (2001). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction* (2nd ed.). London: Sage Publications.
- Sinkovics, R. R., & Alfoldi, E. A. (2012). Progressive Focusing and Trustworthiness in Qualitative Research. *Management International Review*, 52(6), 817–845.
- Skinner, B. F. (1988). *The Selection of Behavior: The Operant Behaviorism of BF Skinner: Comments and Consequences*. CUP Archive.
- Slemon, A., Jenkins, E., & Bungay, V. (2017). Safety in Psychiatric Inpatient Care: The Impact of Risk Management Culture on Mental Health Nursing Practice. *Nursing Inquiry*, 24(4), e12199.
- Smart, B. (1985). *Michel Foucault*. Tavistock Publications, London.
- Smith, M. C. (1994). Arriving at a Philosophy of Nursing: Discovering? Constructing? Evolving. *Developing a Philosophy of Nursing*, 43–60.
- Smith, P. (2011). *The Emotional Labour of Nursing Revisited: Can Nurses Still Care?* (2nd ed.). London: Palgrave Macmillan.
- Smith, P. K., Wigboldus, D. H. J., & Dijksterhuis, A. P. (2008). Abstract Thinking Increases One's Sense of Power. *Journal of Experimental Social Psychology*, 44(2), 378–385.
- Snow, R. C., Asabir, K., Mutumba, M., Koomson, E., Gyan, K., Dzodzomenyo, M., Kruk, M., & Kwansah, J. (2011). Key Factors Leading to Reduced Recruitment and Retention of Health Professionals in Remote Areas of Ghana: A Qualitative Study and Proposed Policy Solutions. *Human Resources for Health*, 9(1), 1–11.
- Solomon, A., & Dodor, A. (2014). Improving the Service Quality of Healthcare in Ghana: The Role of Locum Nursing. *Australian Journal of Business and Management Research*, 3(12), 1.
- South African Government News Agency. (2012). *Shortage of Consumables at Seshego Hospital Shocking*. <https://www.sanews.gov.za/africa/shortage-consumables-seshego-hospital-shocking> [Accessed: 12/03/2020]
- Spradley, J. P. (2016a). *Participant Observation*. Illinois: Waveland Press.
- Spradley, J. P. (2016b). *The Ethnographic Interview*. Illinois: Waveland Press.
- Sullivan, E. J., & Garland, G. (2013). *Practical Leadership and Management in*

- Healthcare: For Nurses and Allied Health Professionals*. N.J., US: Pearson.
<https://books.google.com.gh/books?id=IT1HIQEACAAJ>
- Sullivan, M. (1986). In What Sense is Contemporary Medicine Dualistic? *Culture, Medicine and Psychiatry*, 10(4), 331–350.
- Sumankuuro, J., Crockett, J., & Wang, S. (2018). Perceived Barriers to Maternal and Newborn Health Services Delivery: A Qualitative Study of Health Workers and Community Members in Low and Middle-Income Settings. *BMJ Open*, 8(11), e021223.
- Surani, S., Murphy, J., & Shah, A. (2007). Sleepy Nurses: Are We Willing to Accept the Challenge Today? *Nursing Administration Quarterly*, 31(2), 146–151.
- Swasey, M. L. (2013). *Physician and Patient Communication: A Grounded Theory Analysis of Physician and Patient Web-Logs*. Southern Utah University. Department of Communication. 2013.
- Taher, M., Pashaeypoor, S., Cheraghi, M. A., Karimy, M., & Hoseini, A. S. S. (2020). Superstition in Health Beliefs: Concept Exploration and Development. *Journal of Family Medicine and Primary Care*, 9(3), 1325.
- Tai, S. Y., Lin, P. C., Chen, Y. M., Hung, H. C., Pan, C. H., Pan, S. M., Lee, C. Y., Huang, C. T., & Wu, M. T. (2014). Effects of Marital Status and Shift Work on Family Function among Registered Nurses. *Industrial Health*, 52(4), 296–303.
<https://doi.org/10.2486/indhealth.2014-0009>
- Takase, M., Kershaw, E., & Burt, L. (2002). Does Public Image of Nurses Matter? *Journal of Professional Nursing*, 18(4), 196–205.
- Takase, M., Maude, P., & Manias, E. (2006). Impact of the Perceived Public Image of Nursing on Nurses' Work Behaviour. *Journal of Advanced Nursing*, 53(3), 333–343.
- Talbot, L. A. (1995). *Principles and Practice of Nursing Research*. New York: Mosby Incorporated.
- Tatar, A. (2016). The Development of Short-Form Five Factor Personality Inventory. *Anatolian Journal of Psychiatry*, 17, 14–23.
- Tay, L. H., Ang, E., & Hegney, D. (2012). Nurses' Perceptions of the Barriers in Effective Communication with Inpatient Cancer Adults in Singapore. *Journal of Clinical Nursing*, 21(17-18), 2647–2658.
- Teodosio, S. S. C., & Padilha, M. I. (2016). “To be a Nurse”: A Professional Choice and the Construction of Identity Processes in the 1970s. *Revista Brasileira de Enfermagem*, 69(3), 428–434. <https://doi.org/10.1590/0034-7167.2016690303i>

- The Finder. (2017). Wa Hospital Stops Fresh Admissions for Lack of Consumables. <https://thefinderonline.com/news/item/7278-wa-hospital-stops-fresh-admissions-for-lack-of-consumables> [Accessed: 14/06/2021]
- Thomas, E. J., Sexton, J. B., & Helmreich, R. L. (2003). Discrepant Attitudes about Teamwork among Critical Care Nurses and Physicians. *Critical Care Medicine*, 31(3), 956–959.
- Twigg, D., & McCullough, K. (2014). Nurse Retention: A Review of Strategies to Create and Enhance Positive Practice Environments in Clinical Settings. *International Journal of Nursing Studies*, 51(1), 85–92.
- Tylor, E. B. (1871). *Primitive Culture: Researches into the Development of Mythology, Philosophy, Religion, Art and Custom* (Vol. 2). UK: John Murray.
- Udjo, E. O., & Lalthapersad-Pillay, P. (2014). Estimating Maternal Mortality and Causes in South Africa: National and Provincial Levels. *Midwifery*, 30(5), 512–518.
- Ugwa, E. A., & Charity, U. (2016). A Narrative Review of Factors Affecting job Satisfaction among Nsansonu Nurses in Africa. *Hospital Practices and Research*, 1(3), 79–82.
- Urban, A. M. (2018). Textually Mediated Discourses in Canadian News Stories: Situating Nurses' Salaries as the Problem. *Nursing Inquiry*, 25(3), 1–9. <https://doi.org/10.1111/nin.12233>
- Van der Geest, S. (2000). Funerals for the Living: Conversations with Elderly People in Kwahu, Ghana. *African Studies Review*, 43(3), 103–129.
- Van der Geest, S., & Sarkodie, S. (1998). The Fake Patient: A Research Experiment in a Ghanaian Hospital. *Social Science and Medicine*, 47(9), 1373–1381. [https://doi.org/10.1016/S0277-9536\(98\)00179-8](https://doi.org/10.1016/S0277-9536(98)00179-8)
- van der Wath, A., & van Wyk, N. (2020). A Hermeneutic Literature Review to Conceptualise Altruism as a Value in Nursing. *Scandinavian Journal of Caring Sciences*, 34(3), 575–584.
- Vandewalle, J., Beeckman, D., Van Hecke, A., Debyser, B., Deproost, E., & Verhaeghe, S. (2019). 'Promoting and Preserving Safety and a Life-Oriented Perspective': A Qualitative Study of Nurses' Interactions with Patients Experiencing Suicidal ideation. *International Journal of Mental Health Nursing*, 28(5), 1119–1131. <https://doi.org/10.1111/inm.12623>
- Vaughan, B. (2001). Handle with Care: On the Use of Structuration Theory Within Criminology. *British Journal of Criminology*, 41(1), 185–200.

- Verderber, R. (1998). *The Art of Communication*. London: Wadsworth Publ Co.
- Viotti, S., Gilardi, S., Guglielmetti, C., & Converso, D. (2015). Verbal Aggression from Care Recipients As a Risk Factor among Nursing Staff: A Study on Burnout in the JD-R Model Perspective. *BioMed Research International*, 1–17.
- Vlaev, I., Schmidtke, K. A., Balen, J., & Dormon, F. (2017). Healthworkers' Motivation in Low-and Middle-Income Countries: A Systematic Review of the Literature. *Medical Research Archives*, 5(8), 1–32.
- Vogel, J. P., Bohren, M. A., Tunçalp, Ö, Oladapo, O. T., & Gülmezoglu, A. (2016). Promoting Respect and Preventing Mistreatment during Childbirth. *Bjog*, 123(5), 671–674.
- Wada, K., Smith, D. R., & Ishimaru, T. (2016). Reluctance to Care for Patients with HIV or Hepatitis B/C in Japan. *BMC Pregnancy and Childbirth*, 16(1), 1–6.
- Wall, B. M., Dhurmah, K., Lamboni, B., & Phiri, B. E. (2015). “I Am a Nurse”: Oral Histories of African Nurses. *The American Journal of Nursing*, 115(8), 22–32; quiz 33.
- Wang, H., Huang, J., Wang, G., Lu, H., & Wang, W. (2022). Surveillance Camera-based Cardio-respiratory Monitoring for Critical Patients in ICU. *2022 IEEE-EMBS International Conference on Biomedical and Health Informatics (BHI)*, 1–4.
- Watts, D., & Morgan, G. (1994). Malignant Alienation: Dangers for Patients Who Are Hard to Like. *The British Journal of Psychiatry*, 164(1), 11–15.
- White, K. (2002). Nursing as Vocation. *Nursing Ethics*, 9(3), 279–290.
- White, K. A. (2009). Self-Confidence: A Concept Analysis. *Nursing Forum*, 44(2), 103–114.
- Wilczek-Rużyczka, E., & Zaczyk, I. (2015). Professional Burnout among Polish Nurses—Meta-Analysis. *Hygeia Public Health*, 50, 9–13.
- Wilkes, L., Cowin, L., & Johnson, M. (2015). The Reasons Students Choose to Undertake a Nursing Degree. *Collegian*, 22(3), 259–265.
<https://doi.org/10.1016/j.colegn.2014.01.003>
- Wilkinson, S. E., & Callister, L. C. (2010). Giving Birth: The Voices of Ghanaian Women. *Health Care for Women International*, 31(3), 201–220.
- Wilson, J. L. (2016). An Exploration of Bullying Behaviours in Nursing: A Review of the Literature. *British Journal of Nursing*, 25(6), 303–306.
<https://doi.org/10.12968/bjon.2016.25.6.303>
- Wolf, A., Ekman, I., & Dellenborg, L. (2012). Everyday Practices at the Medical Ward: A

- 16-Month Ethnographic Field Study. *BMC Health Services Research*, 12(1).
<https://doi.org/10.1186/1472-6963-12-184>
- World Health Organisation. (2009). *Global Standards for the Initial Education of Professional Nurses and Midwives*. Geneva: World Health Organisation.
- World Health Organisation. (2014). *Ten Facts on Patients Safety*. Geneva: World Health Organisation.
- World Health Organisation. (2016). *Global Strategy on Human Resources for Health: Workforce 2030*. Geneva: World Health Organisation.
http://www.who.int/hrh/resources/16059_Global_strategyWorkforce2030.pdf?ua=1&ua=1
- World Health Organisation. (2017). *WHO Global Report on Nursing*, Geneva. Switzerland. Geneva: World Health Organisation.
- World Health Organisation. (2018). *Continuity and Coordination of Care: A Practice Brief to Support Implementation of the WHO Framework on Integrated People-Centred Health Services*. Geneva: World Health Organisation.
- World Health Organisation. (2020). *State of the World's Nursing 2020: Executive Summary*. Geneva: World Health Organisation.
- Xu, H. (Grace), Johnston, A. N. B., Greenslade, J. H., Wallis, M., Elder, E., Abraham, L., Thom, O., Carlström, E., & Crilly, J. (2019). Stressors and Coping Strategies of Emergency Department Nurses and Doctors: A Cross-Sectional Study. *Australasian Emergency Care*, 22(3), 180–186. <https://doi.org/10.1016/j.auec.2018.10.005>
- Yakubu, Y. H., Esmaeili, M., & Navab, E. (2019). Family Members' Beliefs and Attitudes towards Visiting Policy in the Intensive Care Units of Ghana. *Nursing Open*, 6(2), 526–534. <https://doi.org/10.1002/nop2.234>
- Yaseen, Z. S., Briggs, J., Kopeykina, I., Orchard, K. M., Silberlicht, J., Bhingradia, H., & Galyunker, I. I. (2013). Distinctive Emotional Responses of Clinicians to Suicide-Attempting Patients-A Comparative Study. *BMC Psychiatry*, 13(1), 1–9.
- Yehuda, R., Hoge, C. W., McFarlane, A. C., Vermetten, E., Lanius, R. A., Nievergelt, C. M., Hobfoll, S. E., Koenen, K. C., Neylan, T. C., & Hyman, S. E. (2015). Post-Traumatic Stress Disorder. *Nature Reviews Disease Primers*, 1(1), 1–22.
- Yi, M., & Keogh, B. (2016). What Motivates Men to Choose Nursing as a Profession? A Systematic Review of Qualitative Studies. *Contemporary Nurse*, 52(1), 95–105.
- Yin, H. S., Dreyer, B. P., Moreira, H. A., van Schaick, L., Rodriguez, L., Boettger, S., & Mendelsohn, A. L. (2014). Liquid Medication Dosing Errors in Children: Role of

- Provider Counseling Strategies. *Academic Pediatrics*, 14(3), 262–270.
- Yin, R. K. (2015). *Qualitative Research from Start to Finish*. New York: Guilford publications.
- Younas, A., & Sundus, A. (2018a). Experiences of and Satisfaction with Care Provided by Male Nurses: A Convergent Mixed-Method Study of Patients in Medical Surgical Units. *Journal of Advanced Nursing*, 74(11), 2640–2653.
- Younas, A., & Sundus, A. (2018b). Patients' Experiences and Satisfaction about Care Provided by Male Nurses in Medical Surgical Units in Islamabad, Pakistan: A Pilot Study. *Nursing Forum*, 53(1), 12–19.
- Zamanzadeh, V., Azadim, A., Valizadeh, L., Keogh, B., Monadi, M., & Negarandeh, R. (2013). Choosing and Remaining in Nursing: Iranian Male Nurses' Perspectives. *Contemporary Nurse*, 45(2), 220–227.
- Zamanzadeh, V., Valizadeh, L., Negarandeh, R., Monadi, M., & Azadi, A. (2013). Factors Influencing Men Entering the Nursing Profession, and Understanding the Challenges Faced by Them: Iranian and Developed Countries' Perspectives. *Nursing and Midwifery Studies*, 2(4), 49–56.
- Zarei, N., Joulaei, H., Darabi, E., & Fararouei, M. (2015). Stigmatized Attitude of Healthcare Providers: A Barrier for Delivering Health Services to HIV Positive Patients. *International Journal of Community Based Nursing and Midwifery*, 3(4), 292.
- Zhang, L., Wang, A., Xie, X., Zhou, Y., Li, J., Yang, L., & Zhang, J. (2017). Workplace Violence against Nurses: A Cross-Sectional Study. *International Journal of Nursing Studies*, 72(April), 8–14. <https://doi.org/10.1016/j.ijnurstu.2017.04.002>
- Zhao, S., Shi, Y. U., Sun, Z., Xie, F., Wang, J., Zhang, S., Gou, T., Han, X., Sun, T., & Fan, L. (2018). Impact of Workplace Violence against Nurses' Thriving at Work, Job Satisfaction and Turnover Intention: A Cross-Sectional Study. *Journal of Clinical Nursing*, 27(13–14), 2620–2632.
- Zussman, R. (1993). Life in the Hospital: A Review. *The Milbank Quarterly*, 7(1), 167–185.

APPENDICES

Appendix 1: Ethical Clearance



UNIVERSITY OF GHANA ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No...ECH 019/20-21...

August 24th, 2020

Perpetual Nancy Baidoo Kodom
Department of Sociology
University of Ghana
Legon

ETHICAL CLEARANCE (ECH 019/20-21)

The protocol title below has been reviewed and approved by the ECH Committee.

TITLE OF PROTOCOL: OUR SIDE OF THE STORY: NURSES BEHAVIOUR TOWARDS PATIENTS

PRINCIPAL INVESTIGATOR: PERPETUAL NANCY BAIDOO KODOM

Please note that the final review report must be submitted to the Committee at the completion of the study. Your research records may be audited at any time during or after the implementation. Any modification of this research project must be submitted to ECH for review and approval prior to implementation.

Please report all serious adverse events related to this study to ECH within seven (7) days verbally and in writing within fourteen (14) days.

This certificate is valid till August 20th, 2021. You are to submit annual reports for continuing review.

Please accept my congratulations.

Yours Sincerely,

Professor C. Charles Mate-Kole
ECH Chair

Cc: Professor Kodjo Sena, Department of Sociology, UG
Professor Lydia Aziato, Department of Nursing, UG

Tel: +233-303933866

Email: ech@ug.edu.gh

Appendix 2: Interview Guide

Demographics

Sex

Ages

Religion

Marital statuses

Number of children

Positions/Ranks

Number of years in practice

Duration of practice in this hospital

1. How did you become a nurse?
2. What are your primary roles at the ward?
3. What are some of the nursing codes of conduct?
4. From your experience, please tell me any situations that enhance your relationship with patients?
 - b. Please tell me situations that negatively affect your relationship with patients?
To be followed up with these specific questions if not captured in the previous.
5. How does the behaviour of patients and relatives enhance your service for patients?
 - b. How does the behaviour of patients and relatives negatively affect your service for patients?
6. Please tell me about any interpersonal relations with staff that enhance performance? (nurses, doctors, specialists, religious leaders etc.)
 - b. Please tell me about any interpersonal relations with staff that affect performance?
7. How do institutional enablers in this facility influence your performance?
 - b. How do institutional challenges in this facility affect your performance?
8. Please describe any structural enablers of Ghana Health Service that improve your performance?

- b. Please describe any structural challenges in Ghana Health Service that affects your performance? (same for Nursing & Midwifery Council)
9. In what instances have other aspects of your life other than this job enhanced your performance at work? (eg. marriage, children, family demands, other dependants).
- b. In what instances have other aspects of your life other than this work negatively affected your performance at work?
10. What are the distresses of being a nurse?
- b. What are the excitements of being a nurse?
11. How do you feel seeing sick people every day?
- b. How do you feel when patients die?
- c. spirituality
12. Please describe the stress related to your job (e.g. concerning overtime, work shifts, transportation etc.).
13. In addition to nursing, what other job do you do?
14. Please tell me if you have ever had any work-related injuries (e.g. with needles, from patient's violence, etc.)
- Probe – influence on future relations with patients.
15. How have you ever been attached to a patient?
- b. If you have the opportunity, which categories of patients would you prefer nursing? (concerning their gender, age, health condition, socio-economic backgrounds, ethnicities, etc.)
16. In what way(s) have you been rewarded by patients?
- b. In what way(s) have you been abused by patients?
17. Have you developed habits from the hospital due to routinisation? (eg. eating patterns, sleeping patterns, etc.).
18. How do your beliefs of what is right or wrong (normative beliefs) influence relations with patients/relatives?
19. Please tell me how your position (as a Snr./Jnr. nurse) influences your relationship with patients.
20. How does your background/personality influence your relations with patients? (e.g. religious beliefs, cultural beliefs, ethnicity, gender, temperaments, upbringing).
21. How do the resources you own (in addition to the nursing) influence relations with patients? (e.g. connections, wealthy family, other certificates, skills, etc.)
22. In what way(s) are 'lawful' nurses rewarded or awarded in this facility?

23. In what way(s) are 'deviant' nurses sanctioned in this facility?
24. Over the years, how have you learnt to treat patients based on your past experiences?
(e.g. from being a patient at a point - pre-nursing)
 - b. Over the years, how have you learnt to treat patients based on others' past experiences? (stories heard, etc.)
25. Generally, how satisfied are you with your job?
26. What regrets do you have?
27. What would you change if there was anything you could change about your profession?
28. If you had to decide whether to become a nurse again, would you still choose this career?
 - b. If a friend or family member asked your advice about taking a nursing job would you encourage them?

This is the end of the interview; do you also have any questions (s) for me?

THANK YOU VERY MUCH FOR YOUR TIME



Appendix 3: Focus Group Discussion Guide

Demographics

Sex

Age

Religion

Marital status

Number of children

Position/Rank

Number of years in practice

Duration of practice in this hospital

1. How did you become a nurse?
2. From your experience, please tell me any situations that enhance relationships with patients?
 - b. Please tell me situations that negatively affect your relationship with patients?
To be followed up with these specific questions if not captured in the previous.
3. How does the behaviour of patients and relatives enhance your service for patients?
 - b. How does the behaviour of patients and relatives negatively affect your service for patients?
4. Please tell me about any interpersonal relations with staff that enhance performance? (nurses, doctors, specialists, religious leaders etc.)
 - b. Please tell me about any interpersonal relations with staff that affect performance?
5. How do institutional enablers in this facility influence your performance?
 - b. How do institutional challenges in this facility affect your performance?
6. Please describe any structural enablers of Ghana Health Service that improve your performance?
 - b. Please describe any structural challenges in Ghana Health Service that affects your performance? (same for Nursing & Midwifery Council)
7. In what instances have other aspects of your life other than this job enhanced your performance at work? (eg. marriage, children, family demands, other dependants).
 - b. In what instances have other aspects of your life other than this work negatively affected your performance at work?
8. What are the distresses of being a nurse?
 - b. What are the excitements of being a nurse?

9. How do you feel seeing sick people every day?
 - b. How do you feel when patients die?
 - c. spirituality
10. Please describe the stress related to your job (e.g. concerning overtime, work shifts, transportation etc.).
11. How do your beliefs of what is right or wrong influence relations with patients/relatives?
12. Please tell me how your position (as a Snr./Jnr. nurse) influences your relationship with patients.
13. How does your background/personality influence your relations with patients? (e.g. religious beliefs, cultural beliefs, ethnicity, gender, temperaments, upbringing).
14. How do the resources you own (in addition to the nursing) influence relations with patients? (e.g. connections, wealthy family, other certificates, skills, etc.)
15. Generally, how satisfied are you with your job?

This is the end of the interview; do you also have any questions (s) for me?

THANK YOU VERY MUCH FOR YOUR TIME



Appendix 4: Key Informant Interview Guide

Based on the findings from participants, the researcher sought to understand some of the concerns raised from the matron's point of view.

1. Can you please tell me the roles you play for nurses?
2. What is your view about nurses' behaviour?
3. How is the nurses' shift system in the hospital supposed to be arranged?
4. How do you ensure nurses' safety?
5. Can you please tell me how you handle nurses in an accident (injury, needle pricks etc.)?
6. Why do nurses have to pay for their hospital bills?
7. How does the hospital decide who gets a study leave?
8. Can you please tell me why registered nurses who self-finance their education are not recognised/promoted for it?
9. Can you please tell me how you ensure nurses' rights and protection?
10. How does the hospital motivate nurses, please?
11. How do you handle nurses who go contrary to the regulations?

This is the end of the interview. Do you please have any questions for me?

Thank you very much for your time



Appendix 5: Observation Guide

Guidelines for Participant Observation

To attain objectivity and avoid observer bias, the researcher used Angrosino and Rosenberg's (2011) three phases of observation as a guide.

Descriptive Observation

The first phase is the observation of every conceivable aspect of the situation. There is no sorting out the important from the trivial. What to observe:

- number of nurses on duty per shift
- number of patients on admission; ambulant and dependent
- time nurses report to work/departure
- information on notice board/wall
- equipment available

Focussed Observation

At this point, the researcher discerns the relevant from the irrelevant. Focussed observations usually concentrate on well-defined types of group and individual activities. What to observe:

Daily routines on the medical ward and OPD

- type of nursing care (task-oriented, team nursing).
- nurses' habits
- enthusiasm towards work.
- nurses' interactions with colleagues and other staff members (verbal and non-verbal).

Selective Observation

This is the third and final step which is also the most systematic. At this point, ethnographers could concentrate on the elements of social action that are most salient for their research objectives. What to observe:

- Nurses' verbal and non-verbal interactions with patients
 - do they select/stereotype?
 - quick response to patient's need and call?
 - explanation of procedures?
 - moods, demeanours, body postures, facial expressions
- Nurse's verbal and non-verbal interactions with relatives.



Appendix 6: Sample of ‘Dear Pharmacy’

Name of Patient: Adwoa Mansah (pseudonym)

Dear Pharmacy,

I will be glad if you can serve the patient named above who has financial challenges with 500mls of 50% Dextrose as an emergency.

Counting on your usual cooperation.

.....

Thank you.

Dr. Abena Afriyie (pseudonym)

Mobile number: +233 111111111

