Single-Method Research Article

The Image of Nurses and Midwives in Ghana: Patient and Family Perspectives

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Lillian Akorfa Ohene[1], Angela Kwartemaa Acheampong[2], Gladys Dzansi[1], Josephine Kyei[1], Charles Ampong Adjei[1], Samuel Adjorlolo[1], Isabella Naana Akyaa Asante[3], Philomena Woolley[3], Felix Nyante[4], and Lydia Aziato[5]

Abstract

This study aims to explore the perceptions of patients and family caregivers on the image of nurses and midwives in Ghana. The study adopted a qualitative exploratory descriptive approach. A total of 25 participants were interviewed during data collection. Content and thematic analysis were applied in the data analysis to develop themes. The findings are captured under two major themes that describe the primary influences on participant images of nurses: Thus, (1) *nurses' and midwives' attributes* with four subthemes; *staff appearance, communication strategies and behaviors, work attitudes, and professional competence* and (2) *patients' status* and subthemes were; *uneducated poor and educated rich.* We conclude that patients and families in Ghana recognize the professional attributes of the nurse and midwife, which reflect in their personality, grooming, communication, competencies, and attitudes. However, low publicity of the professional roles of nurses and midwives may have negative repercussions for their professional image. A policy to perform a regular public audit on the image of the Nurse/Midwife is important for professional advancement.

Keywords

professional image, nursing care, quality of care, patient satisfaction, Ghana

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Introduction

Nurses and midwives are widely recognized for their immense contributions to improving the delivery of quality and equitable healthcare for families and local communities (Fitzpatrick, 2020). Nevertheless, considerable efforts are required in some contexts to create public awareness about their roles and responsibilities. In line with this, the World Health Organization (WHO) marked the year 2020 as *The International Year of the Nurse and Midwife* to celebrate and recognize their contribution to global health delivery. The year 2020 also marked the 50th anniversary of the Nursing and Midwifery Council of Ghana (N&MC), and the 60th anniversary of the Ghana Registered Nurses and Midwifery Association (GRNMA). The N&MC has oversight responsibility regarding the code of conduct and standards of practice of the nursing and midwifery professions in Ghana. The GRNMA harmonizes nursing and midwifery practice, provides advocacy services and represents the interests of members. (Amann et al., 2018) argue that nursing and midwifery practice is client-driven and patient-centered, despite the existence of institutions and structures to guide standards and practice. Consequently, researchers must examine patients' and families' perceptions of nursing and midwifery practice to guide initiatives designed to shape standards of practice (McCance et al., 2015).

Background

Patients and family members are key participants in healthcare systems. They form part of the major stakeholders who contribute to shaping care services, including nursing and midwifery services in hospitals. Patients' and family

[1]University of Ghana, Legon, Ghana
[2]Wisconsin International University College-Ghana, Accra, Ghana
[3]Nursing and Midwifery Council of Ghana, Accra, Ghana
[4]Ministry of Health, Ghana, Accra, Ghana
[5]University of Allied and Health Sciences, Ho, Ghana

Corresponding Author:
Lillian Akorfa Ohene, Department of Public Health Nursing, School of Nursing and Midwifery, University of Ghana, P.O. Box LG 43, Legon, Accra +233, Ghana.
Email: lohene@ug.edu.gh

members' positive perceptions of nursing and midwifery services mostly result in high satisfaction scores. More importantly, patients' satisfaction with nursing and midwifery care is closely linked to the quality and effectiveness of healthcare care delivery (Ng & Luk, 2019). Higher satisfaction also determines the degree of public patronage for basic medical services (Amir-ud-Din & Abbas, 2020; Perriman et al., 2018). Empirical evidence from Switzerland's University Hospital suggests that pre-peri-post-natal programs planned and coordinated by midwives generate positive obstetric and neonatal outcomes which increases patient and family satisfaction (Floris et al., 2018). In a similar study conducted in Jamaica, patients expressed satisfaction with nursing care at the emergency department which reflected positively on overall satisfaction with healthcare services received at the hospital (Buchanan et al., 2015). These observations support the notion that patients' perception of nursing and midwifery care constitutes a crucial performance indicator for health care systems and institutions.

Historically, nurses and midwives have enjoyed a positive public image and are held in high esteem in social contexts where they are perceived to demonstrate integrity and a sense of professionalism. However, recent reports show that the public image of nursing professionals is diverse and incongruous (Hoeve et al., 2014). For example, reports from the United Kingdom suggest that midwifery practice enjoys elevated levels of prestige for continuous demonstration of care, compassion, and safety in practice (Fisher et al., 2017). Nurses in the United States of America have also received a considerable public endorsement for maintaining the highest ethical standards in practice over the decades (Donelan et al., 2008). Conversely, industrial actions by nurses and midwives in the late 1990s led to diminished public value for their services in Ireland (Attree et al., 2011). In the sub-Saharan African context, several factors, such as rural under-development, and inadequate access to continual education, contribute to the negative public image of nurses and midwives (Blank et al., 2013; Faye et al., 2013). Typically, nurses and midwives in resource-limited contexts face several challenges as a result of resource limitations, complex organizational systems, and high demands for cost-effective healthcare services (Andreatta, 2017; Goodman et al., 2018).

Scholarship on the effects of patient satisfaction on public perception of nurses and midwives in Ghana is scant. Moreover, nursing and midwifery practices in Ghana have undergone significant transformations in recent years. For example, over the past two decades, Ghana has witnessed considerable private sector involvement in nursing and midwifery practice, especially concerning providing training to improve the human resource element of healthcare delivery (Asamani et al., 2019). Similarly, corporate organizations, in partnership with government institutions, have established several new hospitals to augment the infrastructure. Additionally, healthcare financing has witnessed significant restructuring and reforms, particularly through the establishment of the National Health Insurance Scheme in 2003 (Dwumoh et al., 2014). These ongoing transformations in healthcare delivery presuppose that patients and families will expect improvements in healthcare standards in Ghana.

Unfortunately, in Ghana, disrespect and abusive care have become part of routines maternity care provided by midwives (Dzomeku et al., 2020). Health system problems and lack communication skills were among the influential factors identified in this study. Furthermore, a study conducted in one of the largest metropolitan hospitals in the southern part of Ghana reported that patients viewed nurses' communication and attitudes as poor and that nurse showed no regard for patient rights (Mensah, 2013). The problem of poor interpersonal skills among nurses and midwives was also found to be a cause of workplace violence against nurses by patients and relatives in the clinical settings of Ghana (Boafo, 2016). Also, there is limited evidence of patient and family-centered practice in the Ghanaian context (Ohene et al., 2019, 2020). It is not surprising that the above evidence suggests that the public image of Ghanaian nurses and midwives is shrouded in myths and misunderstandings (Malcalm & Boakye, 2017). The study, therefore, posed the research question, "what is the public image of Ghanaian nurses and midwives?" This study aimed to explore the perceptions of patients and family caregivers on the image of nurses and midwives in Ghana.

Method

Study Design

This study adopted an exploratory descriptive qualitative approach (Hunter et al., 2019) to explore patients' and families' perceptions of nurses and midwives in Ghana. The study intended to understand the public (patients and families) perceptions of the image of Ghanaian nurses and midwives of services users about nurses and midwives. An interpretive research paradigm, based on idealism (Ward et al., 2018) was deemed an appropriate approach to this study. Thus, considering the knowledge gaps regarding the public image of nurses and midwives in the Northern and Eastern regions of Ghana, an exploratory descriptive approach was deemed appropriate to enable the topic to be explored and described (Hunter et al., 2019).

Setting

Ghana is one of the lower-middle-income countries in West Africa. Administratively, Ghana is divided into 16 regions which fall within three broad zones: Northern, Middle, and Southern (Nsiah-Asare, 2017). Two regions were purposively selected for this study: Northern and Eastern Regions, representing the northern and southern zones respectively. These regions were chosen based on the little to no evidence on the topic from the regions. Easy accessibility by road and

air to the regions was also a factor considered. For sampling from varied populations, four hospitals; consisting of two regional hospitals and two specialist hospitals were purposively selected from the two regions. The Northern and Eastern regional hospitals have 400- and 356-bed capacities, respectively. The other two hospitals from the Northern and Eastern regions have bed capacities of 80 and 186, respectively (Nsiah-Asare, 2017). Approval from hospital gatekeepers was obtained for access and data collection. Patients and patients' families were purposively selected from three units: medical, surgical, and maternity. Records from the selected hospitals showed that these units were heavily attended by patients and their families.

Sample

A convenience sample of patients who were admitted to the hospital for 7 days or more and were in stable condition were recruited. Additionally, family members and close relatives directly involved in the daily care of the sick were also recruited for the study. Participants were purposively selected based on their availability and convenience. No priority was given to gender; both males and females were given equal opportunities to participate in the study. In line with Ghana's legal age limits, only patients and family members aged 18 years and above were considered for the study.

Patients who fell within the inclusion criteria but were very ill and could not communicate properly were excluded. Similarly, patients' families who had communication challenges were excluded from the study. Some of the communication challenges included language barriers and speech problems.

Information about the study was provided to the participants. Details, such as the reason for the study, data collection approach and duration, benefits, and risks associated with participation were explained to the participants. A total of 25 participants were involved in the study and this sample size was adequate to capture a reasonable range of experiences to address the aims of the study, as well as to support the findings as reported.

Data Collection

The data collection technique adopted for this research was face-to-face individual interviews. A semi-structured interview guide was used to undertake the interviews (see Supplemental File). The interview guide was developed by the researchers based on emerging concepts of patients' satisfaction with nursing and midwifery care studies (Buchanan et al., 2015; Floris et al., 2018). The interview guide was initially piloted at a regional hospital, after which ambiguous words and phrases were either removed or simplified. Two members of the research team conducted the interviews. All the interviews were done in English and digitally recorded for transcription. Interviews were conducted at the convenience of participants. Each interview lasted between 45 and 60 minutes. Data collection took place during the last quarter of 2019.

Data Analysis

A qualitative content analysis approach as described by Vaismoradi and Snelgrove (2019) and Graneheim et al. (2017) and thematic analysis by Terry et al. (2017) were adopted for data analysis. All interviews were transcribed verbatim. Individual transcripts were labeled with coded names assigned for each region. Interview transcripts were carefully read, and all identifiable names and places were removed to ensure the protection of participants' privacy and confidentiality (data cleaning). After data cleaning, all transcripts were subjected to line-by-line coding to identify codes. Four qualitative researchers of the research team coded the data. Data analysis progressed through systematic sorting of similar codes to create clusters of family codes. All identified families of codes underwent several iterations of groupings and regroupings until coherent themes were generated. The identified concepts, codes, family of codes, and themes were discussed among researchers at different research meetings until consensus was reached.

The Trustworthiness of the Study

This study began with a strong research team with varied research experiences. The initial conception of the study, through to data collection, analysis, and manuscript writing were a team effort. The data collection tool (interview guide) was pretested to avoid ambiguity. Data was generated from multiple sources; thus, patients and relatives constituted strategies aimed at ensuring trustworthiness. The researchers spent considerable time with participants in the field, to observe and understand their world. Five participants agreed to review their transcripts. This formed part of the member-checking strategy to clarify and validate data with the participants. Observations and additional data captured in the field notes during and after the interviews further gave clearer perspectives during data analysis. Constructed themes were discussed with five participants at the final stage of the analysis to ensure that identified themes resonated with participants' perspectives.

Ethical Approval

Ethical approval was gained from the Ethics Review Committee of the Ghana Health Service (GHS-ERC 011/05/19). Additionally, administrative approval was gained from the management of the selected institutions. Notices were displayed on instruction boards of the hospitals and verbally announced to publicize the research. The participants were voluntarily recruited based on informed consent. They were assured of the protection of their

privacies as well as the confidentiality of the data. This included their rights to withdraw at any point during the study without prior notification or the need to explain. All the participants gave verbal and written consent. All interviews were conducted in line with ethical principles of privacy, confidentiality, beneficence, and avoiding harm.

Findings

Demographic Characteristics

The sample for this study included 12 patients (4 males and 8 females) and 13 family members (5 males and 8 females). All participants were between the ages of 26 and 73 years. Six participants had only basic elementary education. Nine attained basic and secondary school certificates and three had first degrees. Seven participants had no formal education. Apart from four participants who were retirees, only five were in active employment within the formal sector. Sixteen participants worked in the informal sectors, such as small-scale farming, petty trading, and hair salons.

Themes and Subthemes

The data analysis of patient and family interviews generated two major themes that reflect participant images of nurses and midwives. The first theme, *nurses and midwives' attributes* included four sub-themes: *staff physical appearance, communication strategies, and behaviors, work attitudes, and competence*. The second theme related to the influence of patient status on the image of nursing included two subthemes: *uneducated poor and educated rich.* These themes and sub-themes are presented in Table 1 and described in detail in the following sections.

Table 1. Emerging Themes, Subthemes, and Codes.

Theme	Subthemes	Sample codes
Nurses and midwives' attributes	Staff physical appearance	Gender
		Staff age
		Younger nurses
		Older nurses
		Grooming
		Different uniforms
		Short and tight dresses
		Make-ups
	Communication strategies and behaviors	Verbal communication
		Respectful communication
		Listening
		Shouting
		Insults
		Silent treatment
	Work attitudes	Patient neglect
		Response to client calls
		Table nursing
	Professional competence	Knowing the patient
		Experience
		Technical skills
		Resourceful
Patient status	Uneducated poor	Education
		Level of understanding
		Economic status
	Educated rich	Employment
		Ethnicity
		Social background
		Age factor
		Gender

Nurses' and Midwives' Attributes

Patients and family members' descriptions of their experiences with nurses and midwives included references to various attributes that appeared to influence their images of the nurses and midwives either positively or negatively. The attributes that figured most prominently in the interviews *were staff physical appearance*, *communication*, *attitudes*, and *professional competence.*

Staff Physical Appearance

Almost all 25 participants expressed concerns about the different uniforms that nurses and midwives wore at the hospitals. According to some participants, it was difficult to differentiate staff purely by their uniforms. Others said that it was more difficult to differentiate between the professionals when they wore indoor (nurses' scrubs) attire. Participants similarly expressed concerns about the length and sizes of nurses' uniforms. Some participants reported that they were appalled by nurses who wore tight or short uniforms. They described such dresses as casual and unprofessional. Similarly, some participants had reservations about nurses who wear too much makeup. According to them, such professionals were self-centered and therefore far too conscious about preserving their makeup and appearance. This subconscious concern with personal appearance often hindered interaction with patients and therefore was perceived to reduce the quality of care. Two participants commented on the nurse's and midwives' appearance:

> I am not sure about their uniforms, the doctors [and nurses] wear blue shirts and trousers, so you cannot differentiate the nurse from the doctor. In the past, all the nurses wore green and only the nursing sisters wore white, but now, we do not know who is who. (ERP20)

> Some of them dress well, but one thing about the new nurses is they don't protect their dresses, yet they want to avoid stains. So, [they] sit at one place without attending to the patients. They don't want their dress to be dirty. Sometimes they are even protecting their make-up [more] than the patient. (NRP14)

Nurses' and midwives' ages and gender were other important personal attributes that were evident in the participants' descriptions. Older nurses and midwives were considered to be more modest and professional in the way they dressed compared to younger nurses. However, equal numbers of participants expressed a preference for older and younger nurses. Interestingly, male nurses were perceived to be more receptive, tolerant, and friendly, and therefore preferred over female nurses. The preferences for male nurses were undisputed by both male and female patients and family caregivers. For example, one family member said, *"The male nurses are good and by far, better than the ladies, the older nurses are better than the young ones." (NRPR17), Similarly, a patient stated "I know several nurses who are male nurses not female. They are so friendly more than the female." (ERP4)*

Several participants expressed concerns about the prevailing gender gap in nursing and midwifery practice, leading to women's dominance and the chronic shortage of men in the profession.

Communication Strategies and Behaviors

Nurses' and midwives' communication with patients and their families was one crucial area that participants valued greatly. The research findings revealed that information to patients' families was key to reducing anxiety and keeping them reassured. Families want to know their family member's diagnosis, medication, duration of hospital stay, and treatment cost. Often, they are eager to participate in the care of their sick relatives. However, most participants reported that they were often prevented from staying with their sick relatives in the hospital. Information provided by nurses about their sick relatives was also inadequate and scanty.

Almost all participants reported that they were unsure whether nurses and midwives were attentive to patients' complaints. In most cases, patients felt nursing staff ignored their grievances and concerns regarding their healthcare experiences. Complaints were often met with stern looks, silent treatments, or dismissive responses. According to family members, any effort to demand accountability from nurses and midwives often led to insults and abusive language as some put it:

> Some nurses are very snobbish. They do not have manners. They talk to us with disrespect. I have encountered a nurse recently at this Hospital here [a senior nursing officer] and I requested a change of my bed due to the discomfort from my assigned bed. She asked me if I had brought a bed from my home to the hospital. (ERP6)

> There are two categories. Some have the potential to the work and have the heart to help the patients. The others become annoyed at the least thing, and they would be shouting at the patient. (NRP12)

Despite these negative perceptions about nurses' and midwives' professionalism, several participants acknowledged that some professionals communicate in respectful ways. Participants also suggested that only "God-fearing staff "demonstrated respectfulness in their communication. Hence, good communication was associated with religiosity and spiritual connections. For example, a patient thought that nurses who were "raised well" in a highly religious home were calm, humble, and respectful. . .. . .and stated: *"they are very down to earth, humble, and respectful. They have the fear of God in them"* (ERP20)

Work Attitudes

Findings from the study suggest that the distinction between good communication and personal attitudes is often blurred. Participants felt that deliberate snobbery by nurses was a sign of a bad attitude or apathetic culture. Others attributed such behavior to poor communication skills. Most participants thought nurses and midwives who neglected patient calls had "bad attitudes" and suggested that night nurses were particularly fond of ignoring patient calls. There were also frequent reports that nurses were often slow to respond to client calls, requests, and demands. These delays were perceived as either deliberate, intentional, or signs of professional negligence. Often no reasons or explanations were given by nursing staff for these delays. Excessive use of mobile phones by nurses was another negative behavior that participants reported. Nurses were noted for their long hours of phone calls to the detriment of patients' health and wellbeing.

> What they pretend to do best is table nursing [report writing]; they write all the reports and then continue to sit at the nursing station and make long calls on their mobile phones. The nurses chat [conversations not related to patient care]. When I was in the hospital, and I called the nurses to attend to me they neglected me. (NRPR1)

> They [midwives] will not attend to my wife immediately and then they will be there pressing on their mobile phones or making long hours of calls. Some midwives too will be sitting and having conversations. I do not know if it is a rule for the staff or hospital rules, that we the family members should stay out of the wards. Meanwhile, without families, patients are neglected. Some people will die because of negligence. (NRPR5)

Professional Competence

Nurses' and midwives' professional competence was another issue that figured prominently in participant descriptions of their healthcare experiences. Participants provided examples that showed that when nurses were highly skilled or competent, they were capable of understanding and responding to patient needs and could even remember previous patients. One patient happily recalled how a midwife had recognized her after previously assisting with her safe delivery at the same labor ward. Participants also explained that the way some nurses and midwives demonstrate professionalism and

genuine care and concern for patients often set them apart. Most participants agreed that the majority of nurses were skillful and professional. However, participants also expressed worrying concerns about nurses' sense of urgency, given that healthcare for patients was often delayed. It was reported that experienced staff was easy to identify. Such nurses were recognized for being *skillful, resourceful, and responsive to patients' needs*. For example, one patient drew attention to the nurse's responsiveness in this statement *"experienced nurses and midwives showed empathy and love and are easily approachable"* (ERP2).

Patient Status

The image participants had of nurses and midwives was influenced by the differential treatments they observed in the care provided. Reports of differential treatments were perceived to be based on the level of education and economic status of patients.

Uneducated Poor

Participants in this study experienced disparities and inconsistencies in the quality of care received. Social status and educational attainment were significant in how nurses related with patients. Consequently, participants reported that nurses discriminated against them on grounds of occupation, poverty, and social standing. For example, traders received better care, compared to farmers. It was also revealed that nurses and midwives from northern Ghana were perceived to be more hostile to patients from their region. The participants shared sentiments that the educational levels of community members in the northern area were low, hence the few educated individuals who qualified as health professionals looked down on them. Conversely, nurses from other regions were deemed to be more caring and sympathetic. To support these assertions one family member said:

> Each time my wife was in pain, and I called [staff was called], the nurses will not immediately attend to me, they will wait till the time that they are free. It makes me worried; it makes me think that because I am just a farmer that is why they treat us this way. (NRPR15)

Educated Rich

Some descriptions of healthcare reflected the superior quality of care and preferential treatments provided to patients and their families who were perceived by nurses and midwives as educated and rich. One patient who is a banker was very satisfied with the quality of care she received, disparities in the type, and of the hospital received, and acknowledged that she was "one of the lucky ones." She observed that less educated patients were treated differently and admonished healthcare professionals to practice with fairness. She narrated how she witnessed several instances of unfair treatment toward less educated patients:

> I know that some rich people give the nurses tips or bribes so they can be treated better, or their relatives will be treated special. I do not give out anything extra. I came in as an ordinary patient, but I pay bills. So, if we are here, we do not need to distinguish who is rich or poor. Everybody needs healthcare. So, fairness is key. (ERP12)

Participants reported that families often enticed nurses with monetary incentives to offer preferential treatment to their sick relatives. However, not all families are sufficiently resourced to negotiate these informal arrangements. Consequently, their sick relatives were often neglected or given sub-standard treatment, compared to patients from affluent families. One patient's family member intimated that affordable healthcare is beyond the means of Ghanaians who work in the informal sector.

> Yes, I gave one nurse some money [the aim is to entice the nurse for extra care] so that in case my sick brother calls for help, she can help him. You know what, I am not available all the time. So, if my money can do equally what I must do, why not? There is nothing wrong with that. (ERPR3)

Discussion

Key findings from this study illuminate cultural and context-specific issues related to patients and families, healthcare facility type, and enduring perceptions that patients and families hold about nurses and midwives in Ghana. Of concern is that patients' educational and economic status appear to be directly related to the provision of differential care by nurses and midwives, thereby affecting the image of nurses among both patients and family members in the study setting. Although underlying patient narratives were the belief that healthcare should be equitable, participants perceived that nurses and midwives needed to be enticed with money or other types of bribes to secure adequate and quality care. Playing into this dynamic were observations that nurses and midwives were often more concerned with other things such as phone calls, talking with each other, and their appearance, and as such needed to be persuaded in some way to be responsive to care needs.

Romero-García et al. (2019) and Hu et al. (2020), observed that patients' socio-demographic characteristics and facility factors, including income and insurance influenced their level of satisfaction with hospital experiences. The literacy level in Ghana is estimated at 79.04% of the population which is 30,768,198 million (Crous & Attlee, 2014). This suggests that more than 20% of the population are illiterate or have no formal education. It is also estimated that about 66.7% of the population is economically inactive and therefore dependent on the remaining 33.3% (Crous &

Attlee, 2014). If indeed sociodemographic characteristics influence the care provided by nurses and midwives as shown in this study, then these statistics help to explain why there may be wide variations in patient and family experiences related to nursing and healthcare delivery in Ghana. Thus, professionals' provision of differential treatments to patients and families can result in negative perceptions about care received and also negatively affect the image of nursing and midwifery.

The findings of this study, related to communication, attitudes, and competence which described the patients' perceptions of nurses and midwives, are consistent with that of similar studies which examined patients' satisfaction with nursing and midwifery care (Kol et al., 2018; Kwame & Petrucka, 2020). In line with the findings of Kwame and Petrucka (2020), participants in this study differentiated between therapeutic communication and negative communication. Nevertheless, they frequently observed nurses and midwives communicating poorly with patients. In their scoping review, Kwame and Petrucka (2020) also identified similar reports of poor midwife-patient communication at antennal units. In a different study, poor nurse-patient communication reports were observed among primary healthcare providers (Amoah et al., 2019; Osei Appiah et al., 2022). Only a few studies have reported caring and therapeutic communications in ICU, post/operative, HIV/AIDs (Ddumba-Nyanzi et al., 2016) and pediatric settings (Osei Appiah et al., 2022). We, therefore, agree with Kwame and Petrucka (2020) that empirical gaps exist within nurse/midwife-patient communication in the sub-Saharan African context.

This study also revealed that nursing competence or technical skills constitute attributes that patients and families valued highly. Similar to a study conducted by (Kol et al., 2018) in the Mediterranean region of Turkey, these attributes received the highest satisfaction score. Regarding the negative attitudes observed in this study (Coban et al., 2015) also reported similar observations whereby clients reported negative attitudes about nurses. It is worth noting that in the Ghanaian clinical contexts, distinctions between professional nurses/midwives and supporting staff can be unclear. As reported by participants in this study, informal dress codes can result in misidentification and misdirection of blame toward nurses or midwives.

Limitations

The study setting was limited to a few selected hospitals and smaller sample size was used. Hence, the generalizability of the research findings is limited in terms of context and scope. Nevertheless, this qualitative study does not aim to generalize findings. Rather, it provides detailed descriptions of patients' and families' perceptions of nurses and midwives in Ghana. Consequently, broader questions regarding the public image of nurses and midwives in Ghana require further exploration. Also, there is the assumption that patients with language barriers constitute part of a vulnerable group who may be ill-treated by professionals. Therefore, the exclusion of potential participants due to communication challenges was acknowledged as one of the limitations of this study.

Conclusion

Patients and families in Ghana recognize the professional attributes of the nurse and midwife, which reflect in their personality, grooming, communication, competencies, and attitudes. Whilst patients endorsed professional uniforms, inconsistencies in dress code often led to the misidentification of healthcare professionals. It was perceived that Ghanaian nurses and midwives were competent regarding their practical knowledge and skills. However, attitudes and communication skills were perceived to be poor. There is a need to improve the communication skills of nurses and midwives in Ghana, with an emphasis on therapeutic communications. Also, to improve the overall quality of care for everyone, the healthcare delivery system must pay attention to reinforcing the importance of equitable healthcare. Family members' wish to be involved in care must be granted and encouraged as all these contribute to improving the image patients and families have of nurses and midwives.

Implications for Nursing and Midwifery Practice

The study has implications for nursing and midwifery identity and interpersonal relationships with patients and other service users. The study findings concur with assertions that uniforms and other insignia constitute integral aspects of the nursing and midwifery professions, given that uniforms engender homogeneity, collective identification, and a common sense of purpose (Nagle, 2021). However, nursing and midwifery uniforms have lost significance in some contexts. Moreover, the expansion and emergence of a new cadre of professionals witnessed in the health sector pose a challenge to how nursing and midwifery professionals are perceived and recognized. These revelations, therefore, suggest that beyond uniforms and established systems of identification, nurses and midwives must explore other opportunities to publicize their unified purpose and standards which define their code of practice. The standards must also embody principles of good communication skills to empower professionals in ways that encourage patients and families to participate actively in healthcare delivery.

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Author Contributions

Conception of the study: FN, PW, and LA. Study design: LA, LAO, AKA, GD, JK, CAA, SA, and INA. Data collection: LAO, CAA. Data analysis: LA, LAO, AKA, GD, JK, CAA, SA, and INA. Study supervision: LA, FN, and PW. Manuscript writing: LAO, AKA, GD, JK, CAA, SA, INA, FN, PW, and LA. Critical revisions for important intellectual content: LA, FN, and PW.

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ORCID iD

Lillian Akorfa Ohene https://orcid.org/0000-0002-5837-9311

Supplemental Material

Supplemental material for this article is available online.

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Author Biographies

Lillian Akorfa Ohene, PhD, MPhil, BSc., PN, RN, is a Senior Lecturer at the Department of Public Health Nursing, School of Nursing and Midwifery, University of Ghana, Legon.

Angela Kwartemaa Acheampong, PhD, MPhil, BSc., RN, is a Senior Lecturer at the School of Nursing and Midwifery, Wisconsin International University College-Ghana.

Gladys Dzansi, PhD, MPhil, BSc., RN is a Senior Lecturer at the Department of Adult Health Nursing, School of Nursing and Midwifery, University of Ghana, Legon.

Josephine Kyei, PhD, MPhil, BSc., RN, is a Senior Lecturer at the Department of Public Health Nursing, School of Nursing and Midwifery, University of Ghana, Legon.

Charles Ampong Adjei, PhD, MPhil, BSc., RN is a Senior Lecturer at the Department of Public Health Nursing, School of Nursing and Midwifery, University of Ghana, Legon.

Samuel Adjorlolo, PhD, MPhil, BSc., RMN is a Senior Lecturer at the Department of Mental Health Nursing, School of Nursing and Midwifery, University of Ghana, Legon.

Isabella Naana Akyaa Asante, BSN, RN, is a Board Chair, Nursing and Midwifery Council of Ghana.

Philomena Woolley, MPhil, BSc. RN is the Acting Registrar, Nursing and Midwifery Council of Ghana.

Felix Nyante, MA, BA, RN, is the Head of Health Training Institutions, Ministry of Health, Ghana.

Lydia Aziato, PhD, MPhil, BA, RN, ONC, is a Professor at University of Allied and Health Sciences.