Nurse-Patient Interactions in a Ghanaian Hospital Setting: Exploring Patient Rights in Clinical Communications

A Dissertation
Submitted to the College of Graduate and Postdoctoral Studies,
University of Saskatchewan, Saskatoon
In Partial Fulfillment of the Requirement for the
Degree of Doctor of Philosophy in
Interdisciplinary Studies

By
Abukari Kwame

Permission to Use

In presenting this thesis/dissertation in partial fulfillment of the requirements for a Postgraduate degree from the University of Saskatchewan, I agree that the Libraries of this University may make it freely available for inspection. I further agree that permission for copying of this thesis/dissertation in any manner, in whole or in part, for scholarly purposes may be granted by the professor or professors who supervised my thesis/dissertation work or, in their absence, by the Head of the Department or the Dean of the College in which my thesis work was done. It is understood that any copying or publication or use of this thesis/dissertation or parts thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of Saskatchewan in any scholarly use which may be made of any material in my thesis/dissertation.

Disclaimer

The poster created by the Yendi Municipal Hospital demanding patients to request receipts for all payment made was exclusively used to meet the thesis and/or exhibition requirements for the degree of **Doctor of Philosophy in Interdisciplinary Studies** at the University of Saskatchewan. Reference in this thesis/dissertation to any specific commercial products, process, or service by trade name, trademark, manufacturer, or otherwise, does not constitute or imply its endorsement, recommendation, or favoring by the University of Saskatchewan. The views and opinions of the author expressed herein do not state or reflect those of the University of Saskatchewan and shall not be used for advertising or product endorsement purposes.

Requests for permission to copy or to make other uses of materials in this thesis/dissertation in whole or part should be addressed to:

Head of the Interdisciplinary Studies Program
College of Graduate and Postdoctoral Studies
University of Saskatchewan
Room 116, 110 Science Place
Saskatoon, Saskatchewan S7N 5C9 Canada

OR

Dean
College of Graduate and Postdoctoral Studies
University of Saskatchewan
116 Thorvaldson Building, 110 Science Place
Saskatoon, Saskatchewan S7N 5C9 Canada

Declaration

I, the undersigned, declare that this dissertation is my original work. This dissertation has not been, in part or whole, submitted to this university or any other university for a degree. I further declare that all secondary sources and materials have been duly acknowledged.

AbukariKwame
…………………………

Date: March 27, 2023
Student ID: 11221377

Dedication

To Ubaida Mohammed, Mariam Katari, Yazeed Maltiti, Faaiz Dinvela, and Rayhan Nasara

Acknowledgements

This dissertation has been made successful due to the support of many people, whom I am grateful to and want to thank immensely.

I would like to express my profound appreciation to Professor Pammla Petrucka, my academic advisor, for her support, guidance, and encouragement throughout this project and my academic journey and social life in Saskatoon, Canada. Her support for my family and myself cannot be forgotten.

I am also grateful to Professor Sandra Bassendowski, my committee Chair, Professor Jim Waldram, Dr. Simonne Horwitz, and Professor Veronika Makarova who served on my student advisory committee for their diligent guidance. Together with my supervisor, the committee pushed me to explore my academic and research potential beyond what I could have imagined. Your critique, recommendations, suggestions, and critical comments helped me to produce an excellent dissertation that I am proud of. I look forward to engaging more with you all beyond this project.

My heartfelt thanks go to Dr. Hudu Fuisheni, who has been my mentor since 2010. I am grateful for your continual support and guidance and the role you played during my fieldwork in Ghana. I look forward to more interactions beyond this current project.

To the Interdisciplinary Studies program coordinator, chairs, and the CGPS, I say thank you for the support and funding provided to me for the duration of my academic studies. I am also grateful to the University of Saskatchewan (Usask) Writing Centre for reviewing my dissertation for language and grammar. I thank all my regards participants and management of the Yendi hospital for the support given me during my fieldwork in Ghana.

I appreciate Abdulai Mohammed, Idowu Mary Mogaji,and Mrs. Clara Opara, for your social support throughout this academic journey. You were part of my family during the Covid-19 lockdown. We shared ideas and perspectives as we journeyed our Ph.D. paths. Let us keep the company beyond the walls of Usask.

I express my sincere gratitude to my wife and children for the emotional support and care given to me. You endured my late-night studies, prolonged stayed at the university, and sometimes my absence during important family events. All your sacrifice has paid off.

Finally, I am indebted to Allah for my life, health, and all the favours granted me throughout my life and academic pursuit. Alhamdulillah for blessing, protecting, and guiding my life and that of my family.

Table of Contents

List of Tables

List of Figures

List of Textboxes

List of Abbreviations

AP: Action Principle
BP: Blood Pressure
CARM: Conversational Analytic Role-Play Method
CCD-Framework: Clinical Communication Dialogic Framework
CCY: Concerned Citizens of Yendi
CDS: Critical Discourse Studies
CESCR: Committee on Economic Social and Cultural Rights
CHRAJ: Commission on Human Rights and Administrative Justice
CT scan: Computerized Tomography scan
DHA: Discourse Historical Approach
DP: Dialogic Principle
FGP: Focus Group Participant
GHS: Ghana Health Service
GOG: Government of Ghana
ICN: International Council of Nurses
ICU: Intensive Care Unit
IOM: Institute of Medicine
IPA: Interpretive Phenomenological Analysis
NHIS: National Health Insurance Scheme
OPD: Outpatient Department
PC: Principle of Coherence
PCC: Patient-Centered Care
PPEs: Personal Protective Equipment
PT: Positioning Theory
SDG3: Sustainable Development Goal 3
TCPS2: Tri-Council Policy Statement 2
TTH: Tamale Teaching Hospital
UHC: Universal Health Coverage
UN: United Nations
UNICEF: United Nations Children’s Fund
WHO: World Health Organization

Abstract

Communication in nurse-patient clinical interactions impact nurse-patient relationships and healthcare outcomes. Effective communication between nurses and patients results in positive perceptions of care, patient engagement in the care process, increased patient disclosure, and reduced patients’ length of hospital stay. Moreover, good communication between nurses and patients reduces abuse, conflicts, and misunderstandings. Also, nurse-patient communication practices impact patient rights in clinical interactions. Yet, little is known in Ghana about how patient rights are implicated in nurse-patient clinical communication and interactions. The purpose of this study was to explore nurse-patient communication practices and how patient rights are reflected in that in the Yendi Hospital of Ghana. The specific objectives of the study included (1) to identify the barriers and facilitators of effective communication between nurses and patients in clinical interactions. (2) To examine patients’, caregivers’, and nurses’ experiences of patients’ rights in nurse-patient clinical interactions. (3) To determine how the Ghanaian *Patients’ Charter* provides guidance for nurses’ and patients’ communication during nurse-patient interactions, and (4) to explore how nurses’, patients’, and caregivers’ experiences about communication in clinical interactions can inform evidence-based practice and policy in healthcare institutions. An integrated exploratory qualitative research design was implemented by combining institutional ethnography, interpretive phenomenology, and critical discourse approaches. Data were gathered through in-depth individual interviews, focus groups, ethnographic participant observation, and document analysis from patients, caregivers, and nurses. Thematic and critical discourse analytic approaches were applied. Results of the study revealed critical barriers and/or gaps to effective nurse-patient communication and interaction, including high cost of care, language barriers, low health literacy, cultural beliefs, healthcare institutional culture and practices, and resource constraints. These factors affected nursing care practices leading to neglect, violation, and poor patient rights outcomes in clinical interactions. To enhance rights-based healthcare policy and practice, nurses must be trained on interpreter roles, cultural competency, and advocacy for patients. Awareness for patient rights must be intensified in Ghana, and hospitals must monitor patient rights outcomes in care delivery. In conclusion, two crucial models are provided to promote effective communication and patient-centered care.

Keywords: patient rights, nurse-patient communication, ethics of care, *Patients’ Charter*, Ghana

Chapter 1: Introduction

1.1 Problem Statement

Nurse-patient interactions in Ghanaian hospitals and other healthcare settings are complex because healthcare providers and patients have different cultural values, individual/collective perspectives on reality, and health beliefs. These differences can influence social and clinical interactions in healthcare institutions. Communication has been essential in promoting interactions among healthcare professionals, patients, and caregivers (patients' family members) in healthcare settings (Kreps, 2013). Several studies have examined the impacts of effective communication on nurse-patient interactions and patients' engagement in the care process (Dutta, 2016; Ellison, 2015; Samovar et al., 2010).

Communication is conceived of as a "dynamic process in which people attempt to share their internal state with others" through various means (Samovar et al., 2010, p. 16). Communication in interpersonal interactions is a contextual, dynamic, learned process, and self-reflective social action that has consequences (Samovar et al., 2010). For instance, among the Dagomba, it is considered a sign of disrespect to maintain direct eye contact when speaking with an elderly person. Kecskes (2010) observed that conceiving communication as an interactive process based on cooperation, rapport, and politeness has over-emphasized the role of context, socio-cultural factors, and cooperation to the detriment of an individual's prior experiences, existing knowledge, and egocentrism. As a result, Kecskes (2010) defined communication as an interplay of intention and attention among participants in a social interaction motivated by the individuals' socio-cultural backgrounds. Also, Dougherty et al. (2009) maintain that communication in the healthcare setting is an interpretive process, whereby the interlocutors socially construct meanings.

Language serves as the primary means of communication and mechanism to create meaning among humans (Samovar et al., 2010). Thus, communication becomes language in use (language use) and a dialogic process where actions and reactions are co-created during interpersonal interactions (Weigand, 2009, 2010a). Conceiving communication as a dialogic process is crucial in this study because communication in the healthcare context is essential to the extent that effective healthcare delivery is assumed to be dependent on clear communication in clinical interactions (Chen et al., 2022a; Kwezi et al., 2021; Samovar et al., 2010). In a qualitative study, Kwezi et al. (2021) explored effective communication as an element of quality of care among women surviving a maternal near-miss event and found that good communication was pivotal during care provision as it helped the women to feel grateful, supported, and cared for.

Nonetheless, implementing effective communication during care delivery has been challenging in many multilingual and multicultural contexts, including Ghana. Ghana is a multilingual and multicultural country with over 80 languages and dialects (Bergen, 2019; Kropp Dakubu, 2015), making multilingualism a norm, rather than an exception. Despite the diverse languages Ghana has, English serve as the national language and holds a prestigeous position compared to native Ghanaian languages (Bergen, 2019). Although about 11 other native Ghanaian languages are used along side English in many domains, including in healthcare institutions, patients and caregivers are likely to face severe forms of linguistic descrimination (linguicism) (Nordquist, 2017) if they are unable to speak English. Inspite of the complex languistic diversity in Ghana, studies are lacking on how language rights are observed in healthcare settings in the country.

Due to language use challenges in healthcare access, studies have examined interpreters' roles and the significance of medical interpretations during nurse-patient interaction (Acquah, 2011; Mauksch et al., 2008; Suarez et al., 2021). The importance of having professional interpreters and translators to help promote effective communication between physicians and patients has been underscored. For instance, in a study to examine the role of professional interpreters and interpretation modalities in an intensive care unit, Suarez et al. (2021) observed that medical interpreters not only transmitted healthcare information, but also served as cultural mediators and care advocates during clinical communication. Similarly, Acquah (2011) observed that patient disclosure and active engagement in the interactional process are enhanced if professional interpreters are involved compared to informal interpreters (i.e., relatives or friends). Because nurses and patients often come from different cultural backgrounds and experiences and with different views of reality and interpretations of health and illness events, healthcare interpreters ought to be culturally competent as well. Thus, cultural perceptions and communication patterns can significantly influence provider-patient interactional outcomes.

The role of culture, social context, situational variables, and significant patient characteristics (i.e., age, gender, ethnicity, social status, and education) all impact nurse-patient interactions, as these influence communication strategies. In emphasizing the role of culture in interpersonal and intercultural communication, Liddicoat (2009) observes that communication is about using culturally shaped codes to form, construct, and interpret culturally shaped meanings within culturally shaped contexts. Liddicoat's conception of communication highlights the significance of culture in communication, as it influences how we interpret communicative acts and practices. For instance, Chen et al. (2022a) argued that Chinese immigrants' interaction with healthcare providers in the United States is often constrained by Chinese cultural beliefs and norms because disclosing private family history is frowned upon among the Chinese. Also, Samovar et al. (2010) argue that patients' cultural and linguistic backgrounds shape their views of illness and well-being and affect their perceptions of healthcare outcomes. Hence, the relevance of culture in communication in social interactions is crucial in the nurse-patient dyad. As a result, Dutta (2008, 2018) called for a culture-centered approach to health communication, arguing that previous communication theories were devoid of a cultural lens and that health meanings, experiences, and constructions within marginalized settings were de-emphasized as well.

Furthermore, Riley (2008, p. 20) observed that nurses and patients bring their knowledge, attitudes, feelings, experiences, patterns of behaviors as well as their cognitive and affective abilities to the nurse-patient interaction process. Therefore, to ensure patients' full engagement in nurse-patient interactions, communicative behaviors that promote reciprocal respect are required. When nurses become empathic, better listeners and respectful of patient concerns, their interactions with patients are more likely to be therapeutic. Therapeutic nurse-patient interactions enhance patient participation in the care process and increase positive perceptions of care and recovery (Mensah, 2013; Riley, 2008; Samovar et al., 2010).

In addition, nurse-patient interactions embed with patient rights, professional codes of ethics, and other human rights instruments. The *European Declaration on the Rights of Patients* states that patient rights are fundamental human rights in healthcare, that aims at protecting patients' dignity and integrity as well as respecting patient as a person (World Health Organization [WHO], 1994). Cohen and Ezer (2013) added that the right to health and patient rights is collectively termed 'human rights in patient care'. The core human rights principles are respect for patient dignity, privacy, informed consent, and self-determination (Cohen & Ezer, 2013). The conceptualization of patient rights, as stated above, invites the creation, examination, and improvement of the patient-provider dyad. Patients' involvement in clinical interactions focuses on providing details about their health conditions by answering and asking questions, and giving their consent, where possible, before clinical examinations. Honoring patient rights also means that patients are able to make choices regarding medication and care management plans with care professionals. This is where patient rights and communication intersect. Patient rights are fundamental human rights and include non-discrimination in health promotion and service access (FXB Centre for Health & Human Rights, 2013). Miltenburg et al. (2016) added that the right to informed choice may be contextual and/or culturally influenced.

Promoting effective communication in clinical interactions and advocating the right to health and respect for patients' rights are essential to the achievement of universal health coverage (UHC). UHC is a core target of the United Nations (UN) Sustainable Development Goal 3, with the objective to ensure healthy lives and promote well-being for all by 2030 (UN General Assembly, 2015; WHO and the United Nations Children's Fund [UNICEF], 2018). Thus, to ensure universal access to healthcare, a rights-based approach to nurse-patient communication and clinical interactions is critical (Kwame & Petrucka, 2022). Enhancing patients' rights and dignity in care can promote patients' disclosure and participation in the healthcare process. It can further lead to accurate healthcare data. Demands for social justice, equity, and equality in distributing healthcare facilities, services, vaccines, and personnel are crucial for the UHC agenda (Perehudoff et al., 2019). Therefore, the right to health and patients' rights, including non-discrimination, respect for human dignity, empowerment, and participation, is indispensable. Both the right to health and patient rights were even acknowledged in *General Comment No. 14* of the UN Commission for Economic Social and Culture Rights, a body responsible for monitoring global human rights issues (UN Committee on Economic Social and Cultural Rights [UN CESCR], 2000).

Moreover, many healthcare professional bodies have developed standards of practice and professional ethical codes to promote and preserve patients' rights in healthcare settings. This uptake has been reflected internationally in the International *Code of Ethics for Midwives*, International *Code of Ethics for Nurses*, and International *Code of Medical Ethics*, among others (International Confederation of Midwives, 2014; International Council of Nurses [ICN], 2012; Zbikowski, 2014). In Ghana, the emergence of the *Mental Health Act* (2012), the *Nursing Code of Ethics*, and the *Patients' Charter* of 2002 all make provisions for patients' rights (Ghana Health Service [GHS], 2002; Doku et al., 2012).

Studies in Ghana have explored Ghanaians awareness of the *Patients' Charter* (Oppong, 2019; Tchiakpe et al., 2018; Yarney et al., 2016) but not the experiences of patient rights in nurse-patient communication practices. Besides, although these ethical codes and charters make provisions for patient rights, both patients and nurses are often unaware of these provisions (Tchiakpe et al., 2018). Further, it remains unclear to what extent these provisions are adhered to within healthcare settings during clinical encounters or how these provisions influence patients' and healthcare professionals' conduct in the nurse-patient dyad. Most importantly, patient rights in the context of nurse-patient clinical communication in the hospital setting in Ghana are unexplored. This study identifies this crucial gap and aims to examine communication in nurse-patient interactions and patient rights in a Ghanaian hospital.

1.2 Background of the Problem

Communication is crucial in nurse-patient clinical interactions and promotes good perceptions of care and outcomes among patients. Effective communication can encourage patient disclosure and active participation in the care process, thereby enhancing patient safety, understanding, and individualized care practices (Johnsson et al., 2018). When there is open communication between nurses, patients, and caregivers, patients feel respected and are more likely to be open about their health conditions. Moreover, care providers who communicate well with patients potentially enhance patient dignity, as patient concerns and needs are attended to. Poor communication between nurses and patients or between nurses and caregivers is often replete with abuse and violence, mostly conflicting patient rights, and nursing ethical principles (White et al., 2015).

Nurses and doctors occupy high social status and are accorded significant respect in the Ghanaian setting. Most patients are vulnerable due to their ill health, have low economic status, lack equal access to healthcare facilities, and may be illiterate. These differences emphasize the power differentials in the patient-provider dyad.

Furthermore, the *Constitution of the Republic of Ghana* recognizes the right to health and patient rights in Articles 15(1), 17(2), and 30 (Republic of Ghana, 1993). Also, both the *Patients' Charter* and the *Nursing Code of Ethics* in Ghana have recognized patients' rights. For instance, the *Patients' Charter* acknowledges patients' rights to information, informed consent, privacy, and confidentiality. Further, the *Charter* demands that "… in all healthcare activities, the patient's dignity and interest must be paramount"

(GHS, 2002, p. 3). On the other hand, the *Ghanaian Nursing Code of Ethics* enshrines that all nurses shall respect patients, colleagues, and others' rights and shall safeguard patients' confidence. Thus, while performing their duties, healthcare professionals are prohibited from discriminating against patients/clients on the grounds of the nature of their illness, political affiliation, occupation, disability, culture, ethnicity, language, race, gender, or religion. In addition, the *Ghana Public Health Act* of 2012 (Act 851) emphasized the importance of patient rights and respect for human dignity (as outlined in PARTS 8, 9, SIXTH SCHEDULE, and the CLINICAL TRIAL Sections of the *Act*) (Government of Ghana [GOG], 2012)

Despite these patient rights provisions, Abekah-Nkrumah et al. (2010) found that about 53% of patients in Ghana are unaware of the *Patients' Charter*. Also 67% of healthcare providers in their study also knew that patients lacked knowledge about the *Charter* and its content. Abekah-Nkrumah et al. (2010) further reported that patients said doctors were more accommodating than nurses and that nurses were impatient to listen to patient's health concerns. These findings are significant, given that the study setting was in urban Southern Ghana, with all the participants reporting high educational levels. A recent cross-sectional study by Tchiakpe et al. (2018) among 67 eye care patients and caregivers revealed that about 68% of the participants were unaware of patient rights as contained in the *Charter*. However, regarding patient responsibilities, about 52% of the respondents had knowledge of their responsibilities. Most crucially, among the eye patients who knew about the *Charter*, only two percent of them reported receiving such information from care providers. This finding highlighted the lack of patient education about the *Charter* by care providers and further suggests that many care providers also lacked knowledge about the *Charter*. In a similar cross-sectional study to examine patients' awareness of the *Charter*, Oppong (2019) reported that about 73% of the patients had good knowledge about patient rights, and expected care professionals to respect those rights. These two studies have thus presented conflicting results regarding patients' awareness of the *Charter* and their rights.

The Commission on Human Rights and Administrative Justice (CHRAJ) indicated that "there was no clear government or institutional plans towards patient's rights awareness creation and enforcement of the *Charter*" (CHRAJ, 2010, p. 111). Due to human rights violations in healthcare institutions in Ghana, the CHRAJ organized educational programs for nurses in collaboration with the GHS to train 338 trainee nurses on fundamental human rights for health professionals at Cape Coast and Ankaful in Ghana (CHRAJ, 2010, pp. 21-23). The pervasive nature of patient rights violations in hospitals made CHRAJ to extend the training sessions to the Western, Brong Ahafo, and Upper East regions of Ghana for the 2010/2011 academic year. CHRAJ further planned to undertake nationwide training of nurses and trainee nurses on the topic of patient rights.

Other studies have reported several instances of patient rights violations despite the *Patients' Charter* in Ghana (Mensah, 2013; Ohene-Amoah, 2015; Owusu-Dapaah, 2015). These violations have often led to violence between care providers and patients in most Ghanaian hospitals (Boafo, 2016; Boafo & Hancock, 2017). Not only the *Ghanaian Patients' Charter* but also nurses' ethical and professional conduct have been frequently compromised due to institutional and socio-cultural factors (Donkor & Andrews, 2011).

For instance, in a study exploring culture, nursing ethics, and practices in Ghana, Donkor and Andrews (2011) found that both cultural and institutional factors constrained nurses' ethical practices in the hospital setting. Ethical dilemmas were presented as clinical cases/scenarios. In one scenario, a patient diagnosed with leukaemia frequently asked the healthcare team questions about the diagnosis, which often went unanswered. Nearly one-third of nurses interviewed about that case agreed that the truth be kept from the patient. Donkor and Andrews (2011) interpreted this approach as being influenced by Ghanaian cultural belief that when a severe or terminal condition is diagnosed, patients should not be informed about it because of negative outcomes, although this approach contradicts the patient right to be informed about their illness. Another case presented a wealthy businessperson who verbally abused a nurse for wrongly pronouncing his name, and the hospital administrators did not say anything. Donkor and Andrews (2011) interpreted the hospital administrators' silence as reflecting a Ghanaian culture of respecting the rich and powerful in society, even when they are wrong. Furthermore, in another scenario, a patient on admission indicated that he did not want his family to visit him, which the nurse supported to fulfill the patient's autonomy and self-determination. However, 30% of nurses participating in the study were indifferent or disagreed with the nurse's action, which Donkor and Andrews (2011) found to reflect the Ghanaian context, in which family and not the individual make most healthcare decisions. These findings showed the effects of culture and social context on communication, nursing ethics, and practices among nurses.

Most patient rights violations in Ghana are linked to poor communication due to heavy workload and burnout among nurses in the care settings, as pointed out earlier (Boafo, 2016; Boafo & Hancock, 2017; Mensah, 2013; Owusu-Dapaah, 2015). The importance of effective communication in nurse-patient clinical interactions becomes fundamental in the dyad. Hospital settings are multilingual environments where English and several Ghanaian languages are used during clinical interactions. Nonetheless, Acquah (2011) observed that Ghana's healthcare system makes no provision to ensure effective communication between providers and patients. Hence, providing healthcare interpreter and/or translator services is not the responsibility of hospital managers. Therefore, Abdulai et al. (2019, p. 12) have proposed that "professional language interpretation centres [should] be created .. to support and enhance effective health communication between the healthcare providers and patients." Multiculturalism is a reality in Ghana which poses serious challenges to healthcare access and delivery in healthcare settings because healthcare providers and patients have different ethnic, cultural, and linguistic backgrounds which makes it difficult for them to interact effectively (Abdulai et al., 2019). The problem is worse when people with disabilities are involved, including deaf persons, as they find it very challenging to communicate and interact with healthcare providers in Ghanaian hospitals (Senayah et al., 2019).

This study recognizes the relevance of communication in the Ghanaian multilingual healthcare setting, generally, and its effects on patient rights in the Yendi Municipal Hospital of Ghana, specifically. Several contextual factors influence communication. Therefore, communication and patient rights constitute the focus of this project.

1.3 Research Purpose and Objective

The overarching goal of this study was to explore nurse-patient communication in the Ghanaian hospital setting to understand how nursing practices, institutional culture, and everyday language use practices affect patient rights in the healthcare institution. The specific objectives include the following:

(1) To identify the barriers and facilitators of effective communication between nurses and patients in clinical interactions.

(2) To examine patients', caregivers', and nurses' experiences of patients' rights in nurse-patient clinical communication and interaction.

(3) To determine how the Ghanaian *Patients' Charter* provides guidance for nurses' and patients' communication during nurse-patient interactions?

(4) To explore how nurses', patients', and caregivers' experiences with communication in clinical interactions can inform evidence-based practice and policy on patient rights in healthcare institutions.

1.4 Research Questions

This project's guiding research question was: what are the contributors and consequences of nurse-patient clinical communication practices on patients' rights and participation in the hospital setting? The specific research questions are as follows:

(a) What are the barriers and facilitators to effective communication during nurse-patient interactions in the healthcare setting?

(b) How do nurse-patient communication practices during clinical interactions affect patients' rights in the healthcare setting?

(c) How does the Ghanaian *Patients' Charter* guide nurses' and patients' communication and interaction during nurse-patient interactions?

(d) How can nurses' and patients' experiences about communication in nurse-patient interactions inform rights-based health policy and practice?

1.5 Reflexive Positioning

In this dissertation, I write from multiple locations, voices, and identities, as I assumed and co-constructed various identities and performed different roles during the fieldwork of this project. Also, I write as a native Dagomba and resident of Yendi, my study setting, as well as a scholar aiming to contribute to knowledge and influence healthcare practice and policy. I write to advocate for patient rights and responsibilities and to encourage patient-centred care (PCC) and communication in healthcare delivery. These multi-localities, identities, and roles are further reflected in the research methods and writing styles employed throughout this dissertation. As Creswell and Creswell (2018) maintained, in qualitative research, researchers must reflect on how their roles and personal backgrounds, cultures, and experiences might shape their interpretations. Furthermore, Creswell and Creswell (2018) advised that researcher must explicitly and reflexively identify their biases, values, past and present histories, and experiences about the research setting and participants, including their gender and social status that may potentially influence their interpretations in a study. Therefore, for the remainder of this section, I explicate my positionality.

First, I am a native Dagomba, a male Muslim, and a resident of Yendi. Dagomba culture is complex, dynamic, and fluid, where appropriate interpersonal communication is governed by complex pragmatics and socio-contextual variables. Songs, proverbs, wise sayings, metaphors, and euphemisms play central roles in interpersonal social interactions. Songs can be sung to praise and/or shame human behavior, while proverbs, wise-sayings, and euphemisms are used to communicate or conceal culturally sensitive information during social interactions. Relationships are valued with age and sex playing essential roles in communal and social engagements, as men and older people are accorded higher social positionings. For instance, Salifu (2014a, 2014b) observed that gender roles and relations among the Dagomba are defined through cultural practices and language use. Male and female statuses are directly instructed or learned from the social meanings that emerge from everyday interaction and are embedded in the meanings and use of the Dagbani language. How individuals address each other during social interaction among the Dagomba is mediated through social status, kinship ties, age, and sex of the interactants (Salifu, 2010). These socio-cultural realities informing and bounding social interaction and language use present both opportunities and challenges in the healthcare setting concerning patient rights during nurse-patient interaction.

Secondly, although I am not a nurse nor do I have any background in any health-related professions, I have had prior experience conducting research at the Yendi Hospital in 2015. The Yendi Municipal Hospital was one of my research sites for data collection in a study where I explored formal healthcare professionals’ perspectives of integrating traditional medicine and healing into the Ghanaian mainstream healthcare system. During the three-month fieldwork, I observed interactions between nurses and patients and their communicative practices, which inspired and motivated me to investigate how such complex language use dynamics might influence patient rights. The fact is that Ghana uses the English language as her official language and about nine regional Ghanaian languages, (including Dagbani) which makes most public institutional settings multilingual sites. This situation would impact communication in nurse-patient interactions and patient rights in many healthcare settings.

Furthermore, some untoward relationships between nurses and patients, or nurses and nursing managers in the hospital raised concerns among residents of Yendi. These incidents were storied by some members of the Concerned Citizens of Yendi, a youth group that criticized and petitioned the hospital management, on alleged patient negligence and/or malpractices in care. The youth engagement with the hospital led to disciplinary measures taken by the hospital management, and in some cases patients or their caregivers reacted against the care professionals. Healthcare professionals occasionally indicated being disrespected and verbally abused by patients and their caregivers. Narratives about these issues were shared with me by community members, caregivers, and nurses. The re/telling of some of these incidents occurred before I began the formal data collection process.

These storied realities bordered on issues around communication and patient rights and required a systematic investigation to examine the effect of nurse-patient clinical communication practices on patient rights and PCC. Therefore, to build and maintain trust with nurses, patients, and caregivers, I performed various roles while in the field. I ran errands and supported nurses (e.g., going for photocopies, watching over nurses' babies in the ward, and helping to transport an oxygen cylinder to other units, among others). I advocated for nurses when patients unfairly accused them of some wrongdoings. Also, I supported patients and their caregivers to access places within the hospital or to buy medicine outside the hospital. I advocated for patients, notified nurses to attend to patients when approached, served as a translator/interpreter whenever I had the opportunity to, and educated patients about a few institutional practices and care processes/routines based on my observations. Through the performance of these roles, I acquired multiple identities. Patients occasionally called me nurse, master, doctor, brother, and uncle, whereas nurses and clinicians addressed me as a researcher, academic doctor, brother, and colleague. A few nurses and unit heads suspected that I was a journalist during our initial contacts. The different positions I assumed helped me to advocate for both nurses and patients. I mediated in instances where nurses were wrongly accused, such as when patients/caregivers blame nurses for keeping them waiting or for not having care materials. I also supported patients/caregivers to understand some basic care routines, reminder nurses about the need to help patients/caregivers to understand the healtcare system, the *Patients' Charter*, and to promote patient-centered care practices.

Based on my cultural and academic backgrounds and subjective experiences, I believe that reality is multiple, that ways of knowing and being are varied, and that meanings of social practices are co-construction during interactions. As Clandinin (2006, p. 48) and Clandinin and Connelly (2000) have noted, in personal and social interactions, temporal frame, spatial location, and context of interaction affect participants' interpretive rendering of communicative actions. Thus, in this current study, participants' respective cultural, gender, age, social status, educational levels, linguistics backgrounds, and the situational and contextual moments of interaction shaped their experiences, as I will show later. I further assume that nurses and patients have different perspectives on what aspects of their communicative performance may positively or negatively affect patient rights. Following the above logic, it becomes crucial to examine what patient and caregiver attitudes, perspectives, and practices may trigger nurses' differential communicative actions and how the micro-hospital culture, care context, professional protocols, and ethical values influence clinical communication in the hospital setting.

My individual experiences, perceptions, cultural orientation, and familiarity with the research context would impact rapport building with participants thereby allowing me to approach the problem from both emic and etic perspectives (Creswell & Creswell, 2018). Additionally, sharing the same cultural and linguistic identity with participants promoted ease of access to the healthcare institutions' gatekeepers. Most participants were welcoming and open to sharing their experiences with me. My respect for cultural values on relationality was instrumental to rapport building with participants. Nonetheless, my personal biases, assumptions, experiences, and worldviews could also have potentially affected my research process, data interpretation, and representation of participants' experiences and voices. Thus, being a native Dagomba and a resident of Yendi could have influenced me to take certain things for granted or neglect to explore some aspects of the participants' experiences. Furthermore, some participants might have withheld sensitive but relevant information due to our shared socio-cultural identities so as to save face. Nonetheless, by including participants from diverse ethnic and cultural backgrounds some of these potential limiting factors were curtailed. My background in Indigenous Studies reminded me that researcher reflexivity and reflexive self-positioning were crucial, as I assumed both insider and outsider positions in this research (Kwame, 2017) to explore communication in nurse-patient interactions and patient rights. Through this reflexive positioning, I was able to avoid unconscious biases and taken-for-granted cultural assumptions.

In summary, my focus was to understand communication in clinical interactions and how patient rights were implicated and experienced in the care process as participants engaged in the telling and retelling of their lived experiences. I assumed multiple roles, some of which were ascribed to me by participants while others were reflected by my presence in certain spaces in the hospital. I observed, described, and recorded communicative behaviours and practices in clinical interactions and interpreted (or evaluated) these in the context of the Ghanain *Patients' Charter* and the *Nursing Code of Ethics*. I examined how power dynamics, social context, and healthcare institutional and professional practices affected communication during clinical interactions. I interpreted patients', caregivers', and nurses' experiences of patient rights in clinical interactions through critical, reflexive, and interpretive analytic approaches, as demonstrated throughout Chapters 3 to 6.

1.6 Interdisciplinary Focus of the Study

An interdisciplinary studies perspective was employed in this study to explore the complex problem of patient rights in nurse-patient clinical interactions. I envisioned a broad perspective of interdisciplinarity in this study based on how the term has been conceived in critical discourse studies (Unger, 2016; Wodak & Meyer, 2016). Thus, an interdisciplinary approach to research constitutes a dialogue between theories, methodologies, and analytic approaches to understand complex and multifaceted social problems (Kaiser et al., 2016; Unger, 2016). Aside from resolving complex social problems, the expectation is that interdisciplinary research must foster scientific progress, creativity, and innovativeness (Huutoniemi, 2016; Kaiser et al., 2016). Despite the relevance of interdisciplinarity in research, scholars have observed that funding, supervision, extended workload, and variations in research traditions constitute some challenges of undertaing interdisciplinary research (Huutoniemi, 2016; Kaiser et al., 2016). Another perceived challenge of interdisciplinarity in research is about achieving both depth and breadth in research outcomes. Overcoming these challenges has placed interdisciplinary researchers in a position of accountability and critical reflexivity. As a result, Huutoniemi (2016) argued that interdisciplinarity is a mode of accountability in the knowledge production process.

Also, drawing insights from Professor Susan Brown’s keynote lecture on April 13, 2022, I understood interdisciplinarity as a convergent perspective and implemented that by combining knowledge, methods, theories, and scholarly expertise to solve complex problems. As a result, interdisciplinarity was achieved in this study by combining knowledges from different academic disciplines (nursing, anthropology, linguistics) and engaging with diverse academic experts who constituted my advisory committee. I employed theories from different academic disciplines, including communication, linguistics, and sociology. Furthermore, I applied methods and analytic approaches from ethnography, phenomenology, and critical discourse studies, and used creative and innovative writing processes. Based on these disciplinary and methodological variations, as well as my different positionings, the presentation and discussion of my findings assume a non-traditional style and a departure from the usual PhD dissertation format. To honour the multiple voices, analytic engagements, and relationships with the participants in this dissertation, I used textboxes, dialogues between participants, or between participants and me, and short narratives to highlight individual phenomenological experiences and my personal ethnographic observations. I also presented critical discourse analysis to interrogate power and ideological practices underlying nurse-patient communication and interaction.

1.7 Relevance of the Study

The usefulness of this study is manyfold: to enhance nursing care practices, improve policy, provide models for nursing education, and contribute to academic knowledge in nursing and healthcare management.

Participants of this study will benefit directly by becoming more aware of patients' rights and how language use in the nurse-patient interactions affect these rights. Nurses will learn how their language use behaviours influence patient rights and their participation in the care process. By reflecting on their communicative practices and interactions with patients, nurses can promote PCC, cultural competency, and effective communication and interaction. Concerning evidence-based practice in the healthcare setting, the findings are expected to promote appropriate interpersonal communication competency among nurses. Thus, research has shown that, when care providers spend more time communicating with patients, provider-client problems associated with the lack of communication are minimized. Moreover, healthcare professionals gain more interpersonal communication skills (Ghoshal et al., 2013). Hence, the outcome of such improvement in communication will potentially enhance patient participation in the care process.

The significance of qualitative researchers engaging with policy experts is to have their study findings influence public policy (Donmoyer, 2012a). Donmoyer (2012a, 2012b) proposed that qualitative researchers must engage with policymakers to influence policy with their study findings. Similarly, Becker et al. (2004) maintain that researchers should communicate with the decision-makers and institutional leaders so that their studies can enhance vulnerable groups' and populations' wellbeing. Therefore, the results of this exploratory study are expected to influence Ghana's health policy. The outcome of this research will promote evidence-based health policy and encourage professional practices that are in line with the *Patients' Charter* and the *Nursing Code of Ethics*. Additionally, the results of this study will help care managers to assess how healthcare institutions and nurses are implementing ethical nursing provisions. Evidence provided in the study will lead to institutional-level policy change on nurse-patient interaction or administrative management.

In the larger Ghana setting, findings of this study are expected to encourage public discourses on patient rights and awareness creation, and education about the values of effective communication in patient health and recovery. I further anticipate that the study's results will propel public health policy initiatives on issues of patient rights implementation in hospitals given that there is a lack of public awareness of the *Patients' Charter* in Ghana and any implementation mechanism about the *Charter*.

For nursing education, the study's results could influence the nursing curriculum. Issues about patient rights, interpersonal communication skills in nursing, and lessons on cultural sensitivity can be incorporated into teaching and learning to equip trainee nurses with relevant knowledge. Educational materials can be developed to create awareness of patients' rights among both healthcare professionals and the public. Additionally, findings around translation and interpretation during healthcare interactions will incite interpreter training in nursing schools to equip nursing students with skills on how to overcome language barriers during care interactions with patients and caregivers.

In academia, interesting theoretical perspectives in the forms of models and caring frameworks can emerge from the localized context of this study. Since this study is interdisciplinary in focus, where knowledge and perspectives in nursing, anthropology, human rights, and linguistics are combined to explore the problem, new concepts and theories which lie at the intersections of these traditional fields of study can be discovered. Detailed knowledge regarding the problem of patient rights and nurse-patient communication may be revealed, thereby contributing to the existing literature and knowledge on nurse-patient clinical interactions.

Lastly, in line with the global agenda for universal healthcare coverage, the outcome of this study will contribute to the ongoing discourse on enhancing the right to health and making healthcare services acceptable, accessible, available, and of high quality to people, especially the most vulnerable in society. Through effective communication in nurse-patient interaction and respect for patients' rights to dignity, conflicts between nurses, other care providers, patients, and caregivers will be minimized; hence, promoting access and utility of healthcare services. Besides, effective communication and interaction between nurses and patients will encourage patient disclosure, where accurate healthcare data can be accessed to improve care quality and outcomes. Most importantly, by identifying the barriers to healthcare access and delivery and by unearthing the role language use plays in healthcare interactions, appropriate measures can be put in place to address care access impediments.

Understanding these challenges is crucial to achieving the United Nations Sustainable Development Goal 3 of ensuring healthy lives and promoting health and well-being for all by 2030, and, more specifically, universal healthcare access.

1.8 Organization of the Study

The dissertation is organized into seven chapters. Chapter 1 forms the introduction, where I present the research problem, its background, and the research questions and objectives. Also, the relevance of the study and the layout of the project are all contained here. In Chapter 2, I review the extant health, nursing, and communication studies literature as well as present the theoretical and conceptual frameworks of the study. Gaps and inconsistencies in the literature are noted thereby creating a position that this current project fills. In Chapter 3, I outline the methodology and methods used in the project. How data was gathered, analyzed, and managed is elaborated on in that chapter. Chapters 4 through 6 cover the results and a discussion of the findings, with each chapter devoted to answering at least one research question. Thus, Chapter 4 covers the institutional ethnography of the hospital setting where the barriers and or gaps to healthcare delivery and access are presented and discussed. The chapter explores everyday clinical interactions, practices, and how the participants’ socio-cultural variables influence clinical communication, interaction, and care delivery/access. Chapter 5 presents phenomenological narratives of participants’ experiences of patient rights during nurse-patient interactions in the healthcare setting. Some critical interventions on how to promote clinical communication and evidence-based healthcare policy are noted. Chapter 6 presents and discusses interventions to enhance clinical communication, nursing practices, and healthcare policy based on the participants’ experiences. Critical discourse analysis to illustrate power dynamics, discursive practices, and language use in nurse-patient interactions are presented and reflected upon throughout Chapters 4 to 6. All crucial emerging concepts and theoretical relevance are also highlighted in Chapters 4 to 6. Chapter 7 summarizes and concludes the dissertation. In that chapter, I summarize the key findings and offer recommendations for health policy and nursing care practice.

Chapter 2: Literature Review and Theoretical Framework

2.1 Introduction

In this chapter, I review the literature and present the study's theoretical framework. I will engage with the literature in section 2.2 to highlight what is known and the gaps in the literature on patient rights in nurse-patient communication and interaction before I discuss the theories and concepts that I will employ to shed light on my findings in section 2.3.

2.2 Literature Review

Communication in nurse-patient interaction and how that affects patient rights and participation in the care process is a complex social dynamic. As already pointed out, nurses and patients in the Ghanaian setting and elsewhere often come from different language and cultural backgrounds. They also have different frames of reality and unique interpretations of events about health and illness. Moreover, a recent study of communication strategies in nurse-patient interactions in sub-Saharan Africa (Kwame & Petrucka, 2020) found that communication in nurse-patient interactions is affected by several factors. These factors include patients' situational and contextual variables, non-involvement of nursing and hospital managers in nurse-patient interaction, and poor communication skills among most nurses.

Furthermore, individuals' cultural perceptions about health and illness, interpretations of communicative behaviours, and understanding of communicative practices that promote or impede patient rights differ. This section of the dissertation will fulfill two functions: Firstly, I will explore the extant literature on the topic to identify the evidence and gaps. Secondly, I demonstrate the interdisciplinary nature of the problem and why an interdisciplinary focus is required to understand and solve it.

2.2.1 Nursing Practices and PCC

Nurses form a critical workforce in the healthcare setting and their roles in promoting care and well-being among patients are crucial. They spend a significant amount of time in contact with patients. As a result, nurses' activities, healthcare practices, and communicative behaviours are important in affecting PCC. Moreover, nurses perform several essential functions in the healthcare setting, including conducting patient admission interviews and history taking, collecting patients' medical samples, explaining medical procedures and medication, and serving as medical interpreters (Han et al., 2020; Rickards &

Hamilton, 2020). PCC reflects healthcare provider practices that identify, respect, and value patient differences, preferences, and expressed care needs. PCC relieves pain and suffering through continuous and coordinated care and advocates for disease prevention and wellness, active listening, and promotion of healthy lifestyles (Institute of Medicine [IOM], 2001, 2003, 2011; Lusk & Fater, 2013, p. 89). Thus, PCC requires all care providers, including nurses, to align their care duties with the patients' needs and values.

Furthermore, Riley (2008) argues that quality of care improves in a hospital setting when the care provided is client-centred and based on caring conversations. Similarly, in a study on palliative care in Sweden, Ohlen (2004) found that attentive listening to patients' concerns and positive initial impressions promoted PCC and enhanced patients' dignity. Also, Turnock and Kelleher (2001) observed that when nurses are attentive, ask permission from patients, and involve patients and their relatives in the care process, patients' care and dignity in an intensive care unit in the United Kingdom (UK) were promoted.

Studies across different geographic locations have further shown that patients' care outcomes improve when the provided care is person-centred (Sundler et al., 2020). For example, a Canadian study on patients' care experiences offered by nurse practitioners revealed that nurse practitioners were present with patients and actively listened to their care concerns (Rickards & Hamilton, 2020). Patients were satisfied with how nurse practitioners communicated medical findings, diagnoses, management plans, medication instructions, treatment options, and adverse/side effects of medicines to them (Rickards & Hamilton, 2020). When nurse healthcare professionals implemented these PCC attributes, patients felt understood, cared for, and respected, which promoted their self-worth and dignity due to their trusting relationships with nurse practitioners (Rickards & Hamilton, 2020; Sundler et al., 2020).

In a Malawian context, Madula et al. (2018) conducted a qualitative study among 30 prenatal care patients to explore their perceptions about care during childbirth. The authors found that although some participants reported receiving adequate treatment, including warmth, sympathy, and respect, over half of the patients reported being verbally abused by the nurses and midwives (Madula et al., 2018). Care providers reportedly scolded and shouted at patients and used demeaning and derogatory words when referring to them (Madula et al., 2018). Madula and colleagues also found that nurses and midwives did not allow patients to ask questions concerning their care needs. Although these non-PCC practices were attributed to work overload, patients felt they were not involved in their care Madula et al. (2018).

Like Madula et al. (2018), Cubaka et al. (2018) investigated PCC practices related to nurse-patient communications among 15 Rwandan patients with varying literacy levels. The study reported that patients valued interacting with caring nurses, nurses who showed empathy, provided the needed information, and involved them in the care process (Cubaka et al., 2018). Patients indicated that offering proper greetings, making friendly eye contact, and listening to patients were deemed essential (Cubaka et al., 2018). Health literacy and power imbalance influence the nurse-patient interaction process, with low-literacy patients depending on the care providers for their decision-making (Cubaka et al., 2018). Cubaka et al.'s (2018) findings suggest that nurses improved their PCC practices when interacting with literate patients. Similarly, Brinkman (2014) observed that healthcare outcomes improved when patients are better informed since fewer resources and less time are required to explain care procedures to or cared for them. Even though respecting patients' rights and dignity increases patients' engagement in the care process, Brinkman (2014) argued that many health professionals promote patient autonomy without simultaneously highlighting patient responsibilities. Hence, nurses and healthcare professionals are encouraged to discuss patients' responsibilities while providing care.

Positive nurse-patient relationships are crucial in healthcare delivery. To explore the impact of nurse-patient relations on care outcomes, Nwosu et al. (2017) conducted a cross-sectional study involving 150 patients in Nigeria. Their study demonstrated that a cordial relationship between nurses and patients resulted in positive care outcomes. Nwosu et al. (2017, p. 701) observed that caring is a "morally responsible action that takes place within the nurse-patient relations," where nurses treat patients as persons and assist them in making choices and finding meanings in their illness experiences, thereby enhancing patient dignity. Research has shown that positive nurse-caregiver relationships inspire favourable healthcare outcomes.

Loghmani et al. (2014) investigated how caring communication between nurses and caregivers impacts patients' well-being and care among intensive care unit (ICU) patients in an Iranian hospital. Their data revealed that nurse-caregiver communication that promoted empathy, trust, comfort, and mutual understanding enhanced caring. Their results showed that engaging the patients' families in decision-making through consultation strengthened nurse-caregiver interactions, whereas miscommunications affected their relationships and treatment outcomes (Loghmani et al., 2014).

In the Ghanaian setting, studies have shown that uncaring nursing practices often fail to promote PCC. In a recent study, Dzomeku et al. (2020) explored midwives' knowledge and experiences of disrespect and abuse of pregnant women during intrapartum care in a tertiary health facility in Kumasi, Ghana. Results showed that the midwives were aware of abuse and disrespect in the care facility, which they described as providing inadequate care and violating PCC through verbal, physical, and psychological abuse (Dzomeku et al., 2020). Social inequalities and victim-blaming were among the precipitating factors. Dzomeku et al. (2020) observed that the most abused clients were expectant mothers, teenagers, and mental health and poor patients. A crucial perception, which was deemed normal among the midwives for abusive behaviours, was the belief that shouting, threatening, restraining, and hitting childbearing women could prevent neonatal and maternal death during the active stage of labour (Dzomeku et al., 2020). The midwives interpreted these acts as encouraging the expectant mothers to continue pushing during the active stages of labour (Dzomeku et al., 2020).

From the above review, it is paramount that PCC practices entail effective communication and understanding of patients' individual and collective needs. Providing PCC is complex and requires much attention to patients' socio-cultural variables and language use dynamics. Therefore, I engaged with nursing, communication, and medical anthropological studies in this research to explore the link between patient rights and clinical communication practices.

2.2.2 Culture, Communication, and Social Interaction

The cultural orientation of individuals impacts their communication behaviours during social interaction. Language and culture shape each other, as language reflects what is important in culture, and culture, in turn, shapes language use (Samovar et al., 2010, p. 229). Grein (2017) maintained that cultural values profoundly influence both cognition and preferences and that, in any communication, human beings bring different perceptions. Therefore, understanding the interplay of culture, communication, and social interactions between nurses, patients, and caregivers is vital, given that healthcare settings are cultural sites where intercultural communication occurs (Dutta, 2016, 2018).

The term culture is complex and often defies universal definition. Nonetheless, culture may be defined as "the learned and shared beliefs, values, and lifeways of a particular group that are generally transmitted intergenerationally and influences one’s thinking and actions” (Riley, 2008, p. 48). Both verbal and nonverbal communication strategies have universal and culture-specific meanings with a profound potential to shape social interactions. Nurses, patients, and caregivers must navigate the medical jargon and the everyday communication patterns when interacting in the healthcare setting. Hence, care providers must be culturally sensitive and communicatively competent to deal with two complex processes: managing two language use patterns (i.e., medical and everyday language use) and cultural sensitivity when communicating with patients and caregivers.

One significant area of human interaction where culture significantly impacts communication is nonverbal communication strategies. Non-verbal communication practices can confuse individuals from diverse cultural backgrounds (Purnell, 2018). The postures, gestures, signs, and symbols usually employed during interpersonal interactions have different meanings across different cultures (Purnell, 2018). The interpretation of eye contact, gazing, head nodding, touch, and silence can have different meanings among different people depending on the environment, age, sex, social status, and cultural orientation (Purnell, 2018; Samovar et al., 2010). For instance, in many parts of Africa and Asia, making direct eye contact when speaking with someone of higher status or age is interpreted as a sign of disrespect. In contrast, in North America, such an act will be considered attentive listening (Samovar et al., 2010).

Studies on patient-provider interactions have explored the role of culture in social interaction. Murira et al. (2003) investigated how nurses and pregnant women communicated in an antenatal clinic in Zimbabwe, yielding five distinct communication patterns, including impersonal, nonprivate, rigid, uninformed, and authoritarian communication types. Furthermore, Murira et al. (2003) observed that midwives exhibited impersonal communication by calling patients by the names of their medical conditions or their dress colour. In contrast, the midwives exhibited authoritarian communication by not explaining clinical decisions to the expectant mothers but required them to act as commanded (Murira et al., 2003). Another far-reaching finding of their study had sex implications, as a female patient questioned how a male provider could understand what it meant to widen the birth canal (Murira et al., 2003). Communication challenges were critical, as a patient who was informed that she had ‘cephalo-pelvic disproportion’ could not ask questions because she did not understand this medical terminology.

Furthermore, communication patterns reflected power dynamics and cultural and traditional practices in Zimbabwe society, where pregnancy is seen as a ‘women’s issue’ (Murira et al., 2003). Due to this gendered perspective, most care providers ignored men who accompanied their wives to the clinic (Murira et al., 2003). Similar gendered healthcare experiences have been reported regarding how men and women communicate in distinct cultures and contexts (Samovar et al., 2010). Thus, how gender dynamics impact communication during clinical interactions or how these are reflected in experiences of patient rights will be given attention in this study.

Healthcare settings and patients' situational and contextual factors are pivotal in determining healthcare outcomes. Ondenge et al. (2017) explored local dynamics influencing productive patient-provider interactions in five sub-Saharan African countries, including Kenya, Tanzania, Zimbabwe, Malawi, and South Africa. Four interrelated contextual factors and power dynamics that shape patient-provider interactions were found, including (a) perceived roles and identities of the ‘self’ and ‘other,’ (b) conformity or resistance to patient-persona and rules of healthcare service engagement, (c) the influence of ‘significant others’ views on healthcare service uptake, and (d) availability of healthcare service resources (Ondenge et al., 2017). These four factors were analyzed within the wider contexts of power, autonomy, and structure. Ondenge et al. (2017) argued that ‘self’ and ‘other’ provided context for how patients and care workers position themselves to enable patient-provider interactions. The study also maintained that “patient-provider interactions are complex, multidimensional, and deeply embedded in the wider contextual factors and social dynamics” (Ondenge et al., 2017, p. 4), where power, experiences, and structural constraints play crucial roles in healthcare facilities in sub-Saharan Africa. The above study's findings recognized that internal and external healthcare institution factors shape patient-provider relationships and care outcomes.

The linkages between culture, communication, and social interactions have been explored in the Ghanaian context. Andersen (2004) investigated why there was differential treatment among patients in the Upper East Region of Ghana. Personal observations conducted on the daily nurse-patient interactions and interviews among 40 participants showed that differential care and treatment emanated from socio-cultural, biomedical, and bureaucratic aspects of institutional practice. Andersen observed that social status is an essential feature of Ghanaian social interaction as individuals continuously self-position with others. It was noted that individuals' positions were based on various criteria, including age, gender, wealth, education and occupation, and the context and situation of interactions (Andersen, 2004). As a result, nurses and doctors negotiate status, even in their professional roles, with and around the people with whom they interact. In addition, Andersen (2004) found that patients were categorized as ‘good’ or ‘bad’ depending on how well they followed care providers’ rules without questioning authority or medical knowledge. Differential treatment among patients reflected social and cultural forces (Andersen, 2004). Such forces included negotiations over social status, claims to exclusive medical authority, and institutional competence. Care providers stereotypically categorized patients as insiders versus outsiders to the setting, educated versus villager, and poor versus affluent to effect differential treatment (Andersen, 2004).

The studies reviewed above have shown how culture influences communication and social interaction in the healthcare setting, thus highlighting the need for cultural sensitivity among care providers in the healthcare setting. The studies have also underscored the relevance of social determinants of health and its impact on nurse-patient interactions. Accordingly, this study will examine how cultural values influence healthcare practices, nurse-patient clinical interactions, and communication practices. Also, it will observe healthcare institutional norms and how they mediate patient rights outcomes.

2.2.3 Communication and Patient Rights

Language use is defined as a dialogic process where people do not only speak with words but act with them, as couched in the phrase, “language-use means language-action” (Weigand, 2017a, p. 2). Language use is the communicative means in which meaning differs based on individual users and the context of interaction. Hence, language use is synonymous with communication and is considered a dialogic action where participants in social interaction make utterances and act and react in dialogue. This reframing highlights the imperative that communication in nurse-patient interactions entails more than just information transmission about healthcare services and outcomes but requires an interpersonal process where individuals co-create and negotiate meanings, roles, responsibilities, and relationships through social interaction. Furthermore, this process recognizes roles, duties, and responsibilities as embedded within the human rights agenda.

Ojwang et al. (2010) explored the linguistic indicators that point to patient rights violation or promotion in the healthcare context in select Kenyan hospitals. Their study examined the extent to which patients’ rights of dignity, respect, and humaneness were observed or denied and how these were reflected in the communication patterns of the interactants. Analysis of qualitative interview data from ten patients and five nurses, each from four selected government hospitals, revealed that most nurses were impolite and used utterances and linguistic expressions that demeaned, labelled, discriminated against, and grouped patients (Ojwang et al., 2010). Ojwang and colleagues reported that many nurses labelled patients by tagging them with descriptive terms that connote moral deficiency or social inferiority, thereby diminishing patients' dignity (Ojwang et al., 2010, p. 107). Nurses' language use practices grouped patients as illiterate, ignorant, and poor. Ojwang et al. (2010) concluded that when patients' rights are denied due to nurses' poor communicative acts, patients retaliate by also violating the nurses' dignity. Ojwang et al.'s (2010) findings suggest that nurses' and patients' actions and reactions can jeopardize the envisaged mutuality and therapeutic elements in nurse-patient relationships.

Hurley et al. (2017) conducted a qualitative study of patient-provider communication styles in Mali among 69 patients and 17 care providers to assess the participants' preferred communication styles. Hurley and colleagues reported that care providers' communicative patterns that reflected high 'adamadenya' (value for personhood) promoted the right to dignity. Hurley et al. (2017, p. 544) stated, "Adamadenya is the recognition that we all are on equal ground because of our shared human qualities." Furthermore, the authors revealed that patients loved nurses who 'shared the talk' (negotiated and allowed patients to express themselves) more than those who 'owned the talk' (dominated the conversation) (Hurley et al., 2017). The patients also valued 'showing the path' (guiding patient behaviour) by honouring individuals' healthcare needs and their right to choose, thus providing personalized care and promoting the right to be treated as unique individuals (Hurley et al., 2017). Hurley et al.'s (2017) study revealed how effective communication during patient-provider interaction promoted patients' rights and care needs.

In South Africa, Makanjee et al. (2015) investigated how diagnostic imaging investigations were announced to patients by exploring the interaction and communication processes between 24 patients and 62 care providers. Their data revealed three main themes: the responsibility of disclosing medical imaging results to patients, nurses' and radiographers' roles in communicating the results, and patients' experiences and interpretations of the communication process (Makanjee et al., 2015). It was found that clinicians were responsible for disclosing the radiographic diagnostic imaging results to patients. In contrast, radiographers and nurses had the duty of preventing harm as they communicated with patients (Makanjee et al., 2015). Also, nurses were required to provide patients with detailed information in lay language, reflecting patients' rights to precise information (Makanjee et al., 2015). However, in some cases, "there was no clear diagnosis communication between the medical practitioner and patient, as the patient moved to and fro between the imaging and referring departments" (Makanjee et al., 2015, p. 201). Makanjee and colleagues (2015) reported that nurses often used 'silent treatment' by withholding information when providing care to these rural women. These authors called for sanctions on nurses whose practices contradicted standard care policies and argued for health policy reforms emphasizing patients' rights to quality care (Makanjee et al., 2015).

Within the context of Ghana, similar findings have been reported. A study on women's experiences seeking reproductive healthcare in rural Ghana showed that many participants had experienced intimidation, scolded, and ignored while being denied the right to choose and privacy (Yakong et al., 2010). Concerning the women's experiences obtaining the correct information about their reproductive health needs, the authors found that nurses failed to provide information across all reproductive healthcare issues or scolded patients requesting such information (Yakong et al., 2010). Further, observational data revealed that "nurses called the women 'ignorant, uneducated, rural, and local people who lack simple understanding'" (Yakong et al., 2010, p. 2436), violating their rights to dignity and humane treatment.

Similarly, Mensah (2013) and Amoah et al. (2019) explored nurse-patient relationships and challenges to effective therapeutic communication between nurses and patients in Kumasi, Ghana. Both studies found that a lack of knowledge of therapeutic communication and appropriate language use among some nurses was a significant challenge for nurse-patient interaction. Mensah (2013) noted that "patients considered respect for their rights as crucial for the maintenance of good nurse-patient relationship", especially by keeping information about patients' condition and other personal details confidential (p. 47). Nurses who lacked respect for patients or talked rudely to patients were either seen as 'a nasty nurse' or considered 'a distant nurse' since patients described them as not psychologically present in the nurse-patient interactions.

The studies reviewed above have shown that different communication practices during clinical interactions can enhance or constrain patient rights. This finding implies that knowledge of applied linguistics (i.e., sociolinguistics), anthropology, and patient rights charters is crucial to understanding the research problem. It is unknown what nurse-patient communication practices affect patient rights during clinical interactions in Ghana and how the Ghanaian *Patient's Charter* influences communication practices during nurse-patient clinical interactions.

2.2.4 Nursing Ethics and Patients' Rights in Nurse-Patient Interactions

Nursing ethics and standards of practice enhance efficient nursing care that meets the needs and aspirations of both patients and care providers. The ICN ethics document states that nurses have four essential responsibilities, including promoting health, preventing illness, restoring health, and alleviating suffering (ICN, 2012, 2021). Most importantly, the ICN *Code of Ethics* indicates that "inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect" (ICN, 2012, p. 1). One crucial ICN ethical principle advocates for nurses' professional responsibility to provide care for people requiring it while promoting "an environment in which the human rights, values, customs, and spiritual beliefs of the individual, family, and community are respected" (ICN, 2012, p. 2).

Several regional and national nursing and medical ethical codes, including the *Code of Ethics for European Nurses* (Sasso et al., 2008), the 2012 Standards of Practice for Registered Nurses in Nova Scotia (College of Registered Nurses of Nova Scotia, 2011), and the *Patients' Charter* and *Nursing Code of Ethics* of Ghana (GHS, 2002) strive to ensure that care providers and patients interact ethically. However, care providers' and patients' conduct, including their language use practices, do not usually align well with these ethical provisions, leading to little respect for human rights during care.

Research has shown that nurses and patients have been subjected to unethical practices and behaviours in healthcare settings. For instance, Abuya et al. (2015) explored disrespect and abuse during labour and delivery in a maternity ward in a Kenyan hospital using baseline and post-intervention approaches. The study revealed that, although disrespect and abuse among patients reduced between the baseline and the post-intervention data, patients' rights violations by the midwives were reported to increase during night deliveries in public hospitals. Abuya et al. (2015, p. 10) found that "the rates of verbal abuse … were several times higher than rates of physical abuse," as shown by their interviews and observational data, thus revealing how care providers' language use can affect patients' rights.

Similarly, a study explored women's perspectives and experiences of maternal health services through a human rights perspective in Tanzania (Miltenburg et al., 2016). According to Miltenburg et al., the women witnessed several sub-standard maternal healthcare services and multiple human rights violations. Nursing practices relating to patient dignity, security, privacy, autonomy, and equality were experienced differently among the participants. Miltenburg et al. (2016) reported that most participants experienced discrimination and humiliation through abusive language and practices, affecting their rights to dignity and equality. However, patients' autonomy and safety were enhanced when nurses listened to, informed, and involved patients in the care process. Although the participants experienced or witnessed various situations in which human rights principles were either respected or violated, the authors concluded that violations of multiple human rights principles could continue as the substantive meanings of these principles are not noticeably clear. This conclusion suggests that different people may interpret and experience the patients' rights principles differently.

In Ghana, Donkor and Andrews (2011) conducted a survey to ascertain how nurses in Ghana responded to ethical and cultural issues in their practice. A sample of 200 nurses across the ten regions of Ghana within different nursing specialty areas was selected. Analysis of the data on ethical dilemmas and how nurses should cope with them revealed that nurses' approaches to ethical problems in Ghana are not always in accord with the ICN Code. Donkor and Andrews (2011) noted that ethical issues during care are informed by local ethical practices based on institutional regulations, cultural norms and values, and context-specific factors. Like Miltenburg et al.'s (2016) study, Donkor and Andrews (2011) also argued that applying a universal ethical standard without paying attention to or recognizing unique local cultural norms might catalyze ethical tensions during care. Further, it is believed that cultural norms and practices based on dominant cultural views could affect nursing ethics and care practices (Donkor & Andrews, 2011).

Korsah (2011) explored factors that facilitate or impede significant nurse-patient interactions at the Holy Family Hospital in Techiman, Ghana. Analysis of the interview data obtained from 12 nurses showed that multiple factors facilitated or impeded nurse-patient interactions. One crucial factor that hindered effective nurse-patient interactions was that some nurses ignored professional ethics. Korsah reported that all the nurses who participated in the study acknowledged this factor, as they agreed that they have often failed to take proper care of their clients. Also, nurses behaved in ways that violated their clients' rights, including neglecting patients or expelling them for reporting late to the clinic (Korsah, 2011). Lapses on the part of nurses to adhere to professional standards and ethical practices led to negative nurse-client interaction. As a result, Korsah (2011) maintained that "nurses' poor attitudes to clients and their families suggest that [the] code of ethics needs to be enforced, using disciplinary measures if necessary" (p. 8).

In a recent study, Zutah et al. (2021) explored medical incidents of medical misconduct among healthcare professionals in Ghana and how the legal regime failed to enhance patient safety and rights. By analyzing legal cases, news reports, and other empirical studies in Ghana, Zutah et al. (2021) found that medical malpractices, patient negligence, breach of duty of care, and failure in healthcare institutional oversight and security responsibilities are commonplace. According to Zutah et al. (2021), these factors and the lack of a systematic legal framework to punish medical irresponsibility have resulted in recurrent medical malpractice, patient negligence, and rights violations in Ghana. In conclusion, Zutah et al. (2021) argued that the determinants of excellent or poor professional-patient relationship outcomes are contextual issues, including regulatory, institutional, political, socio-cultural, and legal factors. That is, despite the existence of the Ghanaian *Patients' Charter* (GHS 2002) and the revised *Code of Conduct and Disciplinary Procedures* for care professionals under the Ghana Health Service (GHS, 2018), patient rights are continually being abused, as well as increasing healthcare professional misconduct.

Observing nursing ethics and standards of practice while considering patients' needs and the contextual circumstances around care is crucial to enhancing the uptake and honouring of patients' rights, thereby ultimately achieving PCC. As a result, knowledge of the ethical principles in nursing and professional standards of practice, human rights, and patient rights are critical in this study and require an interdisciplinary focus.

2.2.5 Patients' Rights Awareness

Despite the emergence of patients' rights and their focus on nurse-patient interaction, most patients and nurses have little knowledge about patients' rights as codified in many patient rights charters. Mohammed et al. (2017) explored patients' rights awareness in Egypt among 514 patients at the Minia University Hospital in a cross-sectional study. Their research revealed that 76% of the patients did not know about Egypt's *Charter of Patient Rights*. Although most nurses knew about patients' right to choose, they self-reported not providing over 80% of the patients with treatment options. The lack of knowledge about patients' rights among these participants suggests that some patients might not have been able to demand PCC or fight for their rights when violated.

In Rwanda, the right to information and informed choices among patients is crucial in care. Cubaka et al. (2018) have argued that effective communication between patients and their providers is foundational to patient rights. Cubaka and colleagues reported that when patients could not meet these rights from a care provider, they expressed the desire to be attended to by different providers. The authors maintained that although patients’ demands were often ideal, these were not achievable or feasible in resource-constrained settings with high patient turnover and provider scarcity (Cubaka et al., 2018). Thus, Cubaka et al. (2018) recognized the importance of patients’ rights in nurse-patient interactions and called for provider responsibilities and awareness of these rights. However, they are pessimistic about how that can be enforced in healthcare, as resources are limited.

In Turkey, Kuzu et al. (2006) investigated patients’ understanding of their rights and found that only nine percent of patients were aware of patients’ rights regulations. They also noted that 44% of patients were reluctant to request services for fear of getting negative responses or reductions in care from healthcare personnel. Similarly, Ozdemir et al. (2009) studied patients’ rights awareness among Turkish care providers. The study revealed that, although only 34% of midwives and nurses in their study knew about legislation on patients’ rights (i.e., right to information, informed consent, freedom of choice, and knowledge about their medical records and conditions), many midwives and nurses interpreted these rights as directives. The challenge with interpreting patients’ rights as directives implied that these healthcare professionals saw patients’ rights as institutional procedures and not as core human rights principles with legal implications. Woogara (2004) reported corroborating findings when they explored healthcare professionals’ knowledge of patients’ rights in the United Kingdom. The study found that most medical and nursing staff were unaware of the relevance of the *Human Rights Act of 1998* and other provisions on patients’ rights to privacy in the UK, which compromised patients’ rights to privacy and dignity (Woogara, 2004).

Barrera et al. (2015) investigated health professionals' perceptions regarding implementing the *Law on Rights and Duties of People in Chile*. Data were obtained from 53 care professionals, including 13 nurses from high- and low-healthcare complexity centers. The study showed that health professionals perceived difficulties in implementing the law on the rights and duties of patients. Barrera et al. (2015) found that patients, professionals, and health technicians at low-complexity centers had insufficient knowledge about the law and lacked the resources to implement provisions in the Chile’s *Rights and Duties of People*. The authors remarked that overcoming the implementation gaps requires creating policy options focused on merging health professionals' education and health system performance on patients' rights and duties.

Ekwueme et al. (2019) conducted a descriptive cross-sectional study among 304 patients who accessed healthcare across three tertiary health institutions in Enugu, Enugu State, Nigeria. The study assessed patients' knowledge of their health rights and satisfaction with physicians' conduct. Their data revealed that knowledge of patient health rights among the patients was variable across the three tertiary healthcare institutions. Ekwueme et al. (2019) observed that patients who were more aware of their health rights were also satisfied with the care providers' conduct and the care outcomes. By inference, patients will likely be satisfied with the care received when they know their health rights. Also, positive relationships are built between patients and care providers when these rights are respected.

Despite the amount of patient rights violations in Ghana, many studies on patients' rights in the country are usually conducted to assess the implementation of the *Patients' Charter*. For instance, Yarney et al. (2016) conducted a qualitative study to assess the operationalization of Ghana's *Patients' Charter* in a peri-urban public hospital among 25 patients and healthcare workers. Yarney et al. (2016) observed that although the *Patients' Charter's* establishment was a step toward protecting patients' rights and responsibilities, violations of patients' rights are still prevalent in healthcare institutions. Moreover, Yarney et al. (2016) found that healthcare professionals were aware of the existence and content of the *Patients' Charter*, while many patients were ignorant about the *Charter* and its content. As a result, the authors called on health administrators to ensure that patients know their rights and responsibilities well enough to promote the *Charter's* effective implementation.

In a document analysis study, Owusu-Dapaah (2015) examined the realities of patient vulnerability in Ghana, the possibility of having a human rights model of healthcare law, and the way forward for pursuing human rights in healthcare law. Owusu-Dapaah (2015, p. 92) found that a significant segment of the Ghanaian patient population is mostly unaware of the rights protecting them throughout their clinical care experiences. He recommended that Ghana establish a human rights-based healthcare law and incorporate it into medical institutions' teaching curricula. Owusu-Dapaah (2015) observed that such a law would create a patients' rights ombudsman to monitor and resolve the abuse of patients' rights and or the compromised patient safety in Ghanaian healthcare settings. Evidence from these studies suggests that upholding patients' rights principles in healthcare interactions in Ghana is essential. Both patients and healthcare providers must be aware of patient and human rights and work collaboratively to enhance adherence to these rights in Ghanaian hospitals.

From the global to the local Ghanaian context, several factors are noted to affect communication in clinical interactions. The literature review has revealed that effective nurse-patient interactions are therapeutic and promote the active participation of patients in the care process. Moreover, many factors affect effective communication in nurse-patient interactions. These include healthcare professionals' behaviour, healthcare environments, administrative constraints, and nurses’ and patients’ cultural orientations (McQueen, 2000). Also, patient rights are crucial in the care process, and nursing standards of practice and code of ethics remain essential in enhancing cordial relationships between nurses and patients (McQueen, 2000). As a result, patient charters have been created and implemented in several countries to address patient rights in care.

In Ghana, studies have investigated interpreter roles in nurse-patient interactions (Acquah, 2011), abuse in clinical interactions (Boafo, 2016; Boafo & Hancock, 2017), awareness of patient rights (Yarney et al., 2016), and the implementation of Ghana’s *Patients’ Charter* (Abekah-Nkrumah et al., 2010). However, there has not been a single study on the Yendi Municipal Hospital or Ghana that examines how patient rights are experienced in nurse-patient clinical communication and interaction.

Little research exists on whether and how communication in nurse-patient interactions reflects patient rights in the care process. Therefore, this interdisciplinary study focuses on exploring communication in nurse-patient interactions in the Yendi Hospital to understand its effect on patients’ rights, as provided for in the Patients’ Charter and the Nursing Code of Ethics of Ghana. Verbal and non-verbal language use practices are paramount in this study because communication is the primary means of interaction between nurses and patients. An in-depth understanding of communication practices in clinical interactions can enhance health policy development to promote evidence-based practices, PCC, and education in Ghana and elsewhere. As Donmoyer (2012a; 2012b) argued, research is imperative to engage with policymakers to influence policy with research findings.

2.3. Theoretical Framework

Communication in the nurse-patient dyad is an interpersonal interactional engagement, where nurses and patients co-create meanings and interpretations about health and illnesses and patients’ care needs. In a sense, communication in the healthcare context becomes a process through which nurses, patients, and caregivers create and negotiate meanings, identities, and relationships through social interaction (Braithwaite et al., 2015).

These social actors, including nursing managers and healthcare administrators, interact relationally to exchange and interpret verbal and nonverbal behaviours and actions. Moreover, these participants in the healthcare context maintain or co-create different social selves, identities, and positions, where power, rights, and duties are distributed throughout the interactional episodes during clinical and interpersonal communications (Davies & Harré, 1990).

Furthermore, nurses, patients, and caregivers may employ different communication strategies to build good (or bad) interpersonal relationships, which can affect care outcomes and the emergent relational interaction itself. Studies have shown that patients, nurses, and caretakers' cultural orientation, linguistics, and the healthcare context affect illness experiences, social interaction, and interpersonal communication in the hospital setting (Ellison, 2015; Han et al., 2020; Rickards & Hamilton, 2020).

Three crucial theories: Face and Facework, Positioning Theory, and the Dialogic Theory of Communication, essential to our understanding of relationships in nurse-patient interpersonal communication, constitute the focus of this section. These theories conceived communication as a relational and a human interactional reality in which meanings and interpretations are co-created and negotiated. Therefore, through these theories, I examined how nurse-patient relationships are built, how interpersonal communication is initiated and maintained, and how meanings are co-created, interpreted, and negotiated in nurse-patient interpersonal communication. These theories assisted me in exploring how nurses, patients, and caregivers present and position one another in their clinical interactions. First, I present each theory and its assumption, uniqueness, and what it studies. Next, I explore how these theories broaden our understanding of patients' rights in nurse-patient interpersonal communication and interaction in the clinical setting.

2.3.1 Theory of Face and Facework

Sociologist Erving Goffman first introduced the Theory of Face and Facework in the mid-1950s to describe how people present themselves in everyday life during social interactions. Goffman noted that when people interact with others, they construct and present a particular public image or a social self, called 'face' (Goffman, 1955). Goffman noted that face is an image of the self, based on approved social attributes. It is "the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact" (Goffman, 1955, p. 213). Thus, face is said to be public and claimed during interactions; it can be saved, supported, lost, and negotiated through interaction.

Facework is the strategy people employ during social interactions to preserve face. Such approaches or ritual practices, which are governed by moral rules of the interactional order, include poise (a person's ability to control their embarrassment and its effects on others) and appropriate social skills (tack) for face-saving (Goffman, 1983).

Also, Goffman, in his work on *The Presentation of Self in Everyday Life* (Goffman, [1956] 1959), examined institutional interactions in hospitals, workplaces, mental care facilities, and public spaces to understand why and how people construct their social self or public image and what strategies they employ to maintain or restore their and others' image if lost or threatened. Using the metaphor of drama (dramaturgical metaphor), Goffman sees human interaction as a performance in a play and people as actors who deliver lines, wear costumes, and use props appropriate to each scene (Cupach & Metts, 2015). Through this performance, people in social interactions un/consciously construct an impression of themselves for others who served as audiences, observers, or co-participants.

Goffman (1959) argues that the drama of social interaction has the 'front region' and 'back region,' with all performances occurring in the 'front region.' The front region or stage, according to Goffman, consisted of the setting (public space) and the performer's 'personal front,' constitutive of their appearance (e.g., age, sex, clothing) and manner (e.g., looks, posture, gesture), which may suggest the role the performer will play. For example, in the hospital setting, the consulting room, the emergency room, the dispensary, or other designated spots can be the setting. Healthcare professionals’ uniforms, name tags, handheld devices, and other indicators constitute their personal front, suggesting their roles in the care context. Goffman maintained that the 'back region' is where the props are stored and preparation made before performers appear on stage; hence, they are invisible to the audience. As a positive public image people claim for themselves (Goffman, 1955), face occurs in the front region, where social interactions are performed. Goffman (1955) further reasoned that the combined effect of the rules of 'self-respect' and 'considerateness' yields how people will conduct themselves during social interactions to maintain their own and the other participant’s faces. The mutual acceptance of face seems to be a primary structural feature of interaction, especially in face-to-face interactions (Goffman, 1955).

Building on Goffman's face theory, Brown and Levinson (1987) developed Politeness Theory, in which face was rationalized as a person's want. They categorized face into positive and negative face wants and designated the acts that threaten face as face-threatening acts (FTAs). Brown and Levinson understood face to be a primary want of everyone satisfied by others' actions and can be socially and emotionally invested (Agyekum, 2004). A positive face becomes the claim people make to recognize and validate their social self-image. In contrast, a negative face is the maintenance and defence of a person's freedom from imposition in their social engagement with others (Agyekum, 2004). Thus, our positive face want is that our self-image is respected and appreciated, whereas our negative face want is that our individual freedom and personal autonomy prevail. Brown and Levinson's (1987) understanding of face, defined as personal want, is critiqued as being too individualistic and focusing on the individual's social psychology. Moreover, their concept of face is incompatible with non-Western cultural facework practices and deviated from Goffman's original relational interactional order account (Agyekum, 2004; Arundale, 2006, 2010).

Arundale (2006, 2010) argued for a reconceptualization of face and facework in a series of studies. He defined communication as a reciprocal conjoint process of co-creating meaning and actions through ongoing address and uptake among participants (Arundale, 2006, 2010). Arundale (2010) argued that when communication becomes a practical process where turn-taking, adjacency of utterance placement, and meaning interpretation occur, face must be refocused as a relational phenomenon. In Face Constituting Theory, Arundale (2010) defined face as a non-summative relational interactional phenomenon through which persons connect with and separate from others. With this understanding, face becomes endogenous in talk-in-interaction (Arundale, 2010). Furthermore, Arundale (2006) argued that since "social selves emerge in relationships with other social selves, face is an emergent property of relationships" (p. 201). As humans engage in interpersonal interaction and communication, "face meanings and actions arise, get maintained, and changed in relationships", meaning that face is not a public image or a personal want (Arundale, 2006, p. 202).

Given that face is the self-image a person wants to project to others and embodies how others want to be seen, it means face is a product of social interaction that can be lost or gained. Since language use or communication is a social behaviour and is culturally constrained, issues of power, social distance, and distinct cultural perceptions of politeness are critical (Redmond, 2015). Thus, a positive face embodies one’s respect for others, while a negative face is the respect one expects from others. Within the Ghanaian context, people publicly cherished facework during social interaction. Positive and negative faces are reflected in appropriate kinship terms and social deixis and considered societal behaviours (Salifu, 2010; Thompson & Agyekum, 2016). How nurses navigate their professional language and the everyday language use norms and its effects on others' faces was essential in understanding language use behaviour within patient rights contexts.

Facework is thus the construction and communication of the face. It consists of the actions and reactions one engages in to acquire face for themselves or give others a face (Samovar et al., 2010). Facework is the interactive and co-creative process of obtaining and giving face during social interaction. Both face and facework are contextually and culturally constrained, and facework can be a site for re/production of power, ideology, and confusion. How face is constructed during nurse-patient communication could directly affect patient rights in the care process; therefore, a focus of this study.

2.3.2 Positioning Theory

Positioning Theory (PT) by Davies & Harré (1990) takes conversation as a form of social interaction that involves interpersonal relations as social products. According to Harré et al. (2009), PT is concerned with the explicit and implicit patterns of reasoning observed in how people act toward others to enrich our understanding of the cognitive psychology of social action. Through this theory, Davies and Harré (1990) see interpersonal communication as unfolding through the joint activity of all participants who make their own and each other's actions meaningful and socially determined based on the positions interlocutors take. By exploring the features of the local context of unfolding conversational practices, we understand how individual competency, rights, and duties influence human saying and doing during social interaction.

Positioning Theory assumes a relationship between language and thought and language and action, where interpersonal social interaction incites the distribution and acknowledgment of power, rights, and duties (Davies & Harré, 1990; Harré, 2004; Harré et al., 2009). *Positioning* and *positions* are significant concepts in PT. *Positioning* is the discursive production of selves in a discourse, "whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced storylines" (Davies & Harré, 1990, p. 48). Positioning can be interactive or reflexive, meaning we can interactively position others or reflectively position ourselves in conversation.

Positions, as features of the local moral landscape, are "clusters of beliefs about how rights and duties are distributed in the course of an episode of personal interaction" (Harré et al., 2009, p. 9). These clusters of moral claims (positions) are dynamic, emergent, and shifting throughout social interactional episodes, thereby making the self-mutable and capable of occupying multiple positions in social interactions (Harré et al., 2009).

Human beings, in their everyday life, produce narratives of their experiences. As such, PT mirrors a narratological analysis of discursive practices as people engage in performatives. Three crucial concepts—storylines, social acts, and positions—form a positioning triangle (Davies & Harré, 1990; Harré et al., 2009) through which PT analysis revolves.

Storylines are narratives of events, experiences, and daily happenings produced in people's everyday lives. Storylines provide positions of how actors relate to each other in a sequence of acts and events and constitute how people make sense of the world and interpret things from their perspectives of what the self is (Davies & Harré, 1990; Harré et al., 2009). According to Harré et al. (2009, p. 8), *social acts* are "the illocutionary force of any human action" that gain their meaning in the local community in which they occur. Social acts are the social performative acts within events. These are the jointly produced illocutionary forces associated with language use in storylines and the meaning of relationships embedded in these acts (Harré et al., 2009). Thus, social acts are the meanings of people's actions. As the third concept of the positioning triangle, Harré and colleagues defined *positions* as the rights, duties, and power relations (moral claims) distributed among social actors in the changing patterns of storylines as people perform social acts. Slocum-Bradley (2009, cited in McVee et al., 2018) added *identity* to transform the positioning triangle into a positioning diamond to flesh out how identity construction can re/produce various positions in social actions. See McVee et al. (2018) for an overview of the development of PT.

Bamberg (1997, cited in Deppermann, 2013) and Deppermann (2013) identified three levels of positioning in social interaction to (a) capture the realities of narratology and narrative analysis in PT, (b) determine how selves and identities are constructed and located in social interactions, (c) explore life as lived vs. life as told, and (d) provide an analytical and methodological framework for PT. According to these scholars, *Level 1* positioning occurs at the story level to examine how characters in the narratives are positioned relative to one another. *Level 2* positioning occurs at the level of interaction and explores how interactants position each other in the ongoing interaction. In contrast, *Level 3* positioning becomes an ideological analysis in which the interactants achieve a sense of self-identity at the narrative level. Thus, the narrator positions himself to dominant narratives or discourses, thereby linking positioning at the micro-interactional level to broader discourses at the societal level.

Positioning Theory recognizes power dynamics, rights, obligations, and diverging cultural norms as nurses and patients interact and communicate. As applied to social interaction, PT explores and grants centrality to self, others, and situated actions in discursive social practices. This theory was relevant in this project as language use was conceived as a dialogic process where participants interacted to produce narratives in which the self, others, events, and actions are positioned. Rights, duties, and responsibilities will be re/produced, claimed, and challenged in those interactions and narratives. It was crucial to understanding how nurses, patients, and caregivers position themselves, others, events, and actions as they interact and tell their experiences. Equally significant was how language use practices impacted patient rights and the moral claims/positions taken as justifications for such practices.

2.3.3 The Theory of Dialogue

The Theory of Dialogue (Weigand, 2009, 2010a, 2010b, 2015), espoused in the *Mixed Game Model (MGM)*, was another theory I employed in this study. Weigand (2010a, p. 506) argued that language is primarily used for communicative purposes and that communication is always dialogic, and “dialogic use of language means dialogic interaction.” In the Theory of Dialogue, both competence and performance of language use are integrated into a theory of ‘competence-in-performance’ to capture human communication's complexity with the human being as the object of study and centre of focus (Weigand, 2009, 2010a, 2010b). Weigand maintains that human beings are the ones who structure the world according to their needs and purposes and have the competence to perform in the continually changing world (Weigand, 2015). As a result, any performance theory should start with the complex object – human beings – and then adapt the methodology to practice.

Dialogue means “a sequence of action and reaction” (Weigand, 2010b, p. 80). In dialogue, an interlocutor makes a claim to truth or volition, and the other fulfils the claim (either by responding, agreeing, sympathizing, objecting, executing, accepting, rejecting, postponing, or challenging the other’s claim) (Weigand, 2010a, 2010b). Through dialogue, participants engage in the interactive purpose of coming to an understanding based on the sequence of actions and reactions. Weigand (2010a) asserts that “human beings act and react in the process of negotiating meaning and understanding” (p. 506) in the dialogic theory of competence-in-performance because participants in a dialogue have different worldviews and cognitive backgrounds. In the Theory of Dialogue, language use or communication is argued to relate to other human abilities, including thinking, perception, and emotions. Hence, language use or communication is derived from the human needs and purposes of coming to an understanding and or reaching a joint decision in the ever-changing world.

The Theory of Dialogue assumes that human beings are social individuals, have interacting and integrated abilities, and are goal-driven beings whose needs, desires, and purposes influence their actions and behaviours. Human beings are cultural beings with their character influenced by cultural values and habits. Humans adapt to the ever-changing environment by drawing from broad experiences to specific ones and by specialization, thus bringing human nature, culture, and the environment into a holistic theory of language use.

To operationalize how the dialogic process of action and reaction is performed in interaction, Weigand (2009, 2010a, 2010b) proposes three principles to account for the dialogic theory of competence-in-performance. These principles include the Constitutive Principles, made up of the Action Principle (AP), the Dialogic Principle (DP), and the Principle of Coherence (PC).

The AP in dialogue constitutes any practical, communicative, or mental action instituted to achieve one's needs and purposes in interaction. Action is defined as applying appropriate means to achieve one's goal (Weigand, 2017b) in dialogue. Thus, any action in language use is said to be dialogically oriented as either an initiative act or a reaction. The DP forms the primary unit of language use and constitutes the action and reaction of the interactants. The DP is the internal mutual dependency of speech acts by the interlocutors. As Weigand (2009, p. 75) argues, "the minimal action game [consists] of the two-part sequence of initiative and reactive speech or action and reaction in general." Since communicative actions interact with other human abilities, such as thinking, perceiving, and reasoning, the Principle of Coherence (PC) integrates all these abilities to allow for cognitive, perceptive, and emotional inferences to be made from both verbal and non-verbal communicative actions. Weigand (2015, p. 205) argues that the ability to speak interacts with thinking, perception, and having emotions; therefore, "an utterance is more than the utterance form." The three constitutive principles of the Theory of Dialogue go with two other principles – the regulative and executive (Weigand, 2015). The regulative principle mediates individual self-interests and others' social concerns (the principles of politeness). This principle also connects reason and emotions (the principle of emotion) within a person, and cultural expectations concerning respect, emotions, and evaluation of behaviour, since human beings are cultural beings (culturally shaped regulative principle) (Weigand, 2015). The executive principle determines the sequence of actions, reactions, and dialogue strategies. It allows for the evaluation of behaviour to enable adaption to the complexities and uncertainties of the world. Hence, human conversations go beyond rationality and conventional forms, as human communicative behaviours operate under the principles of the probability of negotiating between self-interests and social concerns, between reasons and emotions, and between certainty and uncertainties (i.e., a complex mix of order and disorder) of the ever-changing world (Weigand, 2015).

In summary, the Theory of Dialogue takes human beings and their needs and purpose of action and behaviour in interaction as the central focus. Language use is considered a dialogic interaction of actions and reactions among people as they negotiate meaning and understanding based on individuals' experiences (including cultural and contextual ones), preferences, and emotions.

2.3.4 The Concept of Cultural Competence

Also relevant in this study was the concept of cultural competence. Knowledge of culture and cultural diversity is essential in healthcare because it affects care service delivery and uptake. Clinical encounters between patients and care professionals are shaped by social position and power issues, reflected in the differences in cultural knowledge and identity, language, and religion, among other variables (Kirmayer, 2012). Cultural competence means providing care to patients with diverse values, beliefs, and behaviours by respecting patients' social, cultural, and linguistic needs in the care delivery process (Betancourt et al., 2003). Further, Sharifi et al. (2019) defined cultural competence as a "dynamic process of acquiring the ability to provide effective, safe, and quality care to the patients through considering their different cultural aspects" (p. 1). Cultural competence in care has attributes (i.e., cultural awareness, knowledge, sensitivity, and openness), antecedents (i.e., cultural diversity, cultural encounter and interaction, cultural desire, cultural humility, organizational support), and consequences (i.e., perceptions of care quality, adherence to treatment, effective interaction, and care outcomes) (Kirmayer, 2012; Sharifi et al., 2019). Cultural competence is widely applied in nursing care and reflects other concepts, such as cultural safety, sensitivity, and humility (Kirmayer, 2012).

In healthcare contexts, cultural competence can be achieved at the institutional or health system level when educating the health professional workforce or developing interventions. In this study, cultural competence issues were critical at the institutional and care practitioners' levels as I examined clinical communications between nurses and patients. This concept helped me to understand how differences in cultural beliefs, values, rituals, attitudes, and perceptions between nurses, patients, and caregivers were reflected in communication practices during clinical interactions. The concept also assisted me in determining how and whether nurses, patients, and their caregiver sensitivity to cultural differences were reflected in or impacted care access and delivery. As Kirmayer (2012, p. 158) argued, “the self-reflexivity of practitioners and [healthcare] systems opens the door to reorganizing the delivery of services and the conduct of clinical work in ways that share power and control over healthcare.” Through the cultural competence lens, I understood how the broader Ghanaian culture, the Dagomba culture, and the micro-hospital culture co-acted to influence communication in clinical interactions and how nurses and patients reflected and navigated this cultural matrix in the hospital setting.

2.3.5. Theoretical and Conceptual Relevance

As Holmes et al. (1999, cited in Crawford et al., 2017) noted, using different theoretical perspectives and analytic frameworks in a single study can produce a rich and comprehensive analysis and help to account for broader contexts of interactions. Moreover, since interdisciplinarity can be achieved in a study by combining different theories, methodologies, and analytic frameworks or by having an interdisciplinary research team (Unger, 2016), having a dialogue among these theories and concepts was very important. The focus of this section is to demonstrate how facework, self-positioning, and dialogic communication illuminated the understanding of nurse-patient interpersonal communication and patients' rights during clinical interactions in this study.

First, all the theories conceive of communication as a relational interactional process where meanings and interpretations are co-created. They also emphasize that identity, social positions, and rights emerge through social interaction. The theories further suggest that people present their social selves and identities differently in action and conversation based on local and contextual norms, rules, and regulations. Therefore, by employing the theoretical concepts of facework, positioning, and dialogic communication on the narratives that nurses, patients, and caregivers produce during interviews and other interactional exchanges, I understood how these social actors (nurses, patients, caregivers) presented themselves in nurse-patient communication and how moral claims (rights and duties) were co-created, contested, and distributed. For instance, when nurses decided whether to use professional nursing language or everyday expressions, the intent was not purely to foster patient understanding but to create a professional identity and knowledge position to influence patient and caregiver conduct. Positioning theory has been applied in nurse-patient clinical interactions to explore how women seek health information and what rights and positioning care providers and the women assumed or were assigned (Genuis, 2013).

In particular, the relevance of dialogue theory in this study was significant since language use is influenced by human nature and cultural and environmental factors. The dialogic nature of nurse-patient interactions and how language use impacts patients' rights or participation in the care process were explored to examine how meanings, needs, and experiences were negotiated and interpreted. Besides, the theory provided a methodology and an analytical approach to language use as a dialogic action and reaction game. By engaging with the dialogic principles, I interrogated nurse-patient communicative actions, needs, and desires, which led me to propose some models to enhance clinical communication and interaction. The Theory of Dialogue further provided a window to understand that language does not exist independently but is used by human beings based on their intentions and goals in a dialogic interaction (Weigand, 2017a, 2017b). As language use interacts with other human abilities, I took notice of discursive language use practices and examined them to explicate how power and control were embedded in them.

Local context and culture are recognized as influencing factors in interpersonal communication. As a result, I reflected on how health beliefs and literacy influence communication and interactions by observing participants' behaviours in different care contexts through the lens of facework, positioning, and cultural competence. Also, I understood the impact of institutional contextual factors on therapeutic relationships, communication, and patients' rights in clinical interactions. In other words, facework, self-positioning, dialogic communication, and cultural competence became analytic and interpretive frames. I determined how nurses, patients, and caregivers built therapeutic relationships, communicated among themselves, and achieved (or did not) face as they positioned one another in dialogic interactions in the healthcare contexts.

2.3.6 Section Summary

In this section, I have presented and discussed Face and Facework, Positioning Theory, the Theory of Dialogue, and the concept of Cultural Competence.

The theory of face and facework underscores communication as a relational process through which meanings are co-created in social interaction. People perform communicative acts to save their and others' face; however, sometimes, face is threatened. Thus, how people present themselves in social interaction is influenced by culture, social background, language use practicalities, and context. Interlocutors act and react to others' actions and behaviours, which can be un/intentional. Hence, politeness is critical to protect our and others’ face. Positioning theory also takes communication as a social interactional process where people claim and assign one another rights, duties, and responsibilities. Rights and responsibilities are moral claims people take up or assign during social interactions. People can create positionings within their stories or during face-to-face interactions, where identity formation, power, and control are co-produced or performed. The Theory of Dialogue sees communication as dialogic language use and places the human being as the focal point of analysis. The theory argues that communication interacts with other human abilities such as reasoning, thinking, and feeling; as a result, they respond, agree, sympathize, accept, reject, and challenge others’ claims during communication.

All these theories conceptualize communication as an interactional process where people act and react to others to co-construct meaning. Patients, nurses, and caregivers claimed, negotiated, and challenged the positions they assigned others or were assigned and engaged in identity formation and power struggle. Through the concept of cultural competence, awareness of cultural differences and their impacts on communication and social interaction harmonizes the theories into theoretical interdisciplinarity or dialogue to better understand nurse-patient communication and patients' rights in clinical interactions.

Chapter 3: Methodology

3.1 Introduction

This interdisciplinary research project employed multiple qualitative methodological approaches and analytic techniques to explore the research problem. I brought a variety of theories, methods, academic disciplines, and experts into a dialogue to analyze, understand, and explain complex social phenomena of how patient rights are observed in nurse-patient communication and interaction. In this section, I present my choices around methodology, methods, and analytic approaches in this interdisciplinary research.

3.2 Research Design

I implemented an integrated exploratory qualitative research design in this study through institutional ethnography, interpretive phenomenology, and critical discourse studies. Communication in nurse-patient interaction is a complex phenomenon that entails understanding how people interpret others' linguistic actions during social engagements. It also involves how individuals’ sociocultural backgrounds shape their perceptions of what it means to communicate appropriately when interacting with others. Moreover, communicative practices in the hospital setting, especially those of care providers, are governed by institutional norms, professional standards, and ethical codes that place certain expectations on behaviour.

Feller (2017) argued that institutions have their values and belief systems and adhere to selected conventions and habits, which allow them to possess their own worldviews or ideology. Furthermore, Feller observed that participants in institutions get embedded in and act according to the context of the larger cultural environment that provides culture-specific values, norms, belief systems, and habits (Feller, 2017, p. 320). This assertion implies that Dagomba/Ghanaian larger culture and the hospital micro-culture regulated nurse-patient communication practices and social interaction in the Yendi Hospital. As observed among nurses, patients, and caregivers, communication practices, social relationships, and patient rights outcomes were consequential to the hospital's institutional culture and the broader Dagomba norms and values.

As a result, institutional ethnography (IE) and interpretive phenomenological analysis were applied in this study to explore participants' lived experiences regarding communication in nurse-patient interactions and its effects on patient rights and participation in the care process. I assumed that communication actions are co-constructed and interpreted in context. Thus, how individuals understand what patient rights mean, how communication and interpersonal interactions impact these rights, and how the healthcare institutional culture, values, and norms influence care delivery are subjectively experienced by care providers and consumers. Hence, an integrated methodological approach was appropriate for this study. Moreover, communication is considered a dialogic process where participants act and react to each other during interpersonal interactions (Weigand, 2009; 2010a). Creswell and Poth (2018, p. 60) argued that, in taking an interpretive perspective to research inquiry, the researcher assumes that there are multiple and varied meanings to reality, thus, allowing the researcher to "look for the complexity of views rather than narrow the meanings into a few categories or ideas." It is further believed that "these subjective meanings are negotiated socially and historically … through interaction with others" (Creswell & Poth, 2018, p. 60) and influenced by the historical and cultural norms and values that operate in individuals' lives. Given this study's interdisciplinary focus, I justified the inclusion of these qualitative research methodologies and analytic approaches in the following sections.

3.2.1 Institutional Ethnography

As the primary focus of anthropology, consideration of ethnography was imperative as it focuses on understanding how human beings adapt to their environment through a complex interaction of the self and cultural contexts (Grein, 2017; Rashid et al., 2015). Creswell and Poth (2018) observed that ethnographic inquiry involves studying the meaning of behaviour, language use, and interaction among people in a cultural setting. It consists of studying people's day-to-day lives in their shared space through extended observation and interaction with the participants. In this project, I utilized a critical perspective of institutional ethnography (Rowland et al., 2018) to understand how communication in the healthcare context was constitutive of ideologies of power, control, and manipulation.

Further, the everyday dynamics of clinical practices, patterns of interactions, communication practices, and how the context and healthcare institutional culture, structure, and rules shape interaction and experiences of patient rights were of much interest to me (Rashid et al., 2015; Rowland et al., 2018). Thus, I brought to bear Smith's institutional ethnographic approaches to data collection and analysis (Rowland et al., 2018) to understand of how everyday clinical practices, social relationships, and interactions shaped human behaviour. With this ethnographic approach, it became apparent how relations of power, ideological positioning, and institutional structures co-influence nurse-patient communication and patients' rights.

3.2.2 Discourse Historical Approach (DHA) of CDS

Given the compatibility of ethnography with Wodak, Meyer and Reisigl's (Reisigl & Wodak, 2016; Wodak & Meyer, 2009) discourse-historical approaches (DHA) of critical discourse studies (CDS), I engaged with DHA as a methodology and a data analytic approach to analyze clinical discourses as discursive social practices within which power and ideology are constituted. The DHA emphasized systematic analysis, interpretation, and critique of discourse as a site for the ideological manifestation of power and the relevance of context as having a historical function in discourse production and consumption (Wodak & Meyer, 2009, 2016). Through the DHA of CDS, I explored this complex social problem with a critical lens to promote and enhance clinical practice, nurse-patient communication, and healthcare policy by being self-reflexive.

Using CDS as a methodology, I examined the role of power and social position in healthcare communication and interaction through DHA's interdisciplinary approach to data collection, engagement with theory, and problem-solving orientation to research (Reisigl & Wodak, 2016). Moreover, the DHA privileges fieldwork and ethnographic approaches to data collection and analysis. I interrogated the contexts of discourse to point out discursive practices and ideological positioning embedded in them. As an analytic approach, I applied intertextuality and interdiscursivity to link the research data as discourse (text) to provide a holistic picture and narrative to promote the practical applications of the research findings (Reisigl & Wodak, 2016). Furthermore, the DHA enabled me to identify critical discourse topics within the data, examine the rhetorical strategies embedded in them, their linguistic realization, and what interactional or communicative goals they served. In some cases, I presented detailed linguistics analysis to reach the social practices constituted in given discourse pieces.

3.2.2 Interpretive Phenomenology Approaches (IPA)

With the IPA, I engaged with participants' lived and storied experiences, meanings, perceptions, and awareness of patients' rights in the context of nurse-patient clinical communication and interaction in the hospital setting. Paul (2017), Pietkiewicz and Smith (2014), and Smith et al. (1999) have argued that, through IPA, researchers engage in a double hermeneutic process to investigate the interpretations that participants give to their lived experiences, on the one hand, and provide a frame to capture their own interpretation of participants’ experiences as researchers, on the other. Moreover, Smith et al. (1999) maintained that in using IPA, researchers explore participants' views of the phenomenon in detail as they attend to individual participants' perceptions and accounts of the event or object and the meanings they make in their lives. Therefore, using Smith et al.’s IPA (Smith, 2011, 2017; Smith, Flowers et al., 2009; Smith, Jarman et., 1999), I provided narratives about nurses’, patients’, and caregivers’ lived experiences around patient rights and how communication during nurse-patient clinical interactions either enhanced or inhibited these rights.

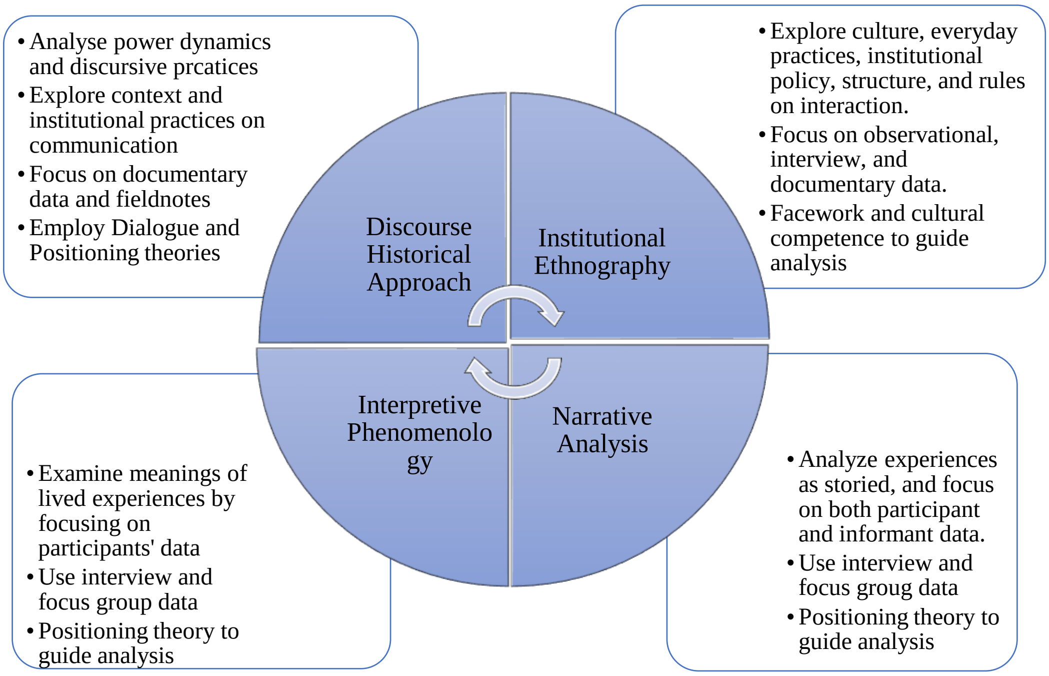
Through IPA and narrative analysis, I interrogated the informant and participant's experiences of nurse-patient communication, patients’ rights, and everyday clinical practices in the hospital setting. As Clandinin (2006) argued, through narratives, individual experiences in the world, storied both in the living and telling, can be explored by listening, observing, writing, and interpreting texts. To arrive at the participants’ lived experiences and to construct and present these meaningfully, narrative analysis was particularly suitable, as that allowed me to not only present individual experiences but also to explore how the cultural, social, and institutional narratives and practices shaped the individual experiences (Clandinin et al., 2015; Haydon et al., 2018).

Narrative scholars have also argued that, through narrative analysis, a person’s current experiences become a direct product of their past experiences and influence their future (Clandinin, et al., 2015). As a result, Connelley and Clandinin’s (Clandinin, 2006; Clandinin & Connelley, 2000; Clandinin et al., 2015) narrative analytical framework was employed to examine nurses,’ patients,’ and caregivers’ experiences of nurse-patient clinical communication and patients’ rights. The three-dimensional narrative inquiry space of temporality, spatiality, and sociality guided data analysis, allowing me to explore participants’ lived experiences (Clandinin et al., 2015; Haydon et al., 2018). Haydon and colleagues indicated that, in the hospital setting, past experiences often influence people’s expectations of their future care and give insight into their stories (Haydon et al., 2018). With the emphasis on small sample size, interdisciplinary focus, and attention to researcher-participant relationships, the three-dimensional narrative space framework (Clandinin, 2006; Clandinin & Connelley, 2000; Clandinin et al., 2015) guided my data organization to develop two models to guide nursing care practices and nurse-patient communication and interaction in the hospital context. IPA and narrative analysis are compatible, as they both attend to individual lived experiences and how these experiences are interpreted and given meaning.

Figure 1 shows an integration of the research designs, methods, theories, and analytical approaches; I utilized to examine communication in nurse-patient interactions to understand how patients' rights are observed in the care delivery process.

Figure 1:

A flow diagram of integrated research designs, methods, theories, and analytic approaches



Despite the above methodological interdisciplinarity, ethnography played a significant role in this project and provided valuable observational data to complement interview and focus group data.

3.3 Research Setting and Participants

This study was conducted in Northern Ghana at the Yendi Municipal Hospital in the Yendi Municipal Assembly. Yendi is the capital of the Dagbon traditional area of the Northern region. The Yendi Hospital is a primary healthcare referral center for Gushegu, Karaga, Zabzugu-Taletale, Saboba-Chereponi, and Nanumba North and South Districts. Also, the hospital served as a training center for the Yendi Nursing College, Gushegu Midwifery

College, and many other healthcare training institutions. The Yendi Hospital was built in 1947 as a local government hospital for the Yendi district and currently has over 30 units and departments, 270-bed capacity, and a total of 433 staff who serve a population of over 250,000 (Daily Graphic, 2020; Mission:318, n.d.). In addition to the support from the Ghana government, the hospital has received medical supplies, training, and medical operations from Global Mission Resource Centre, a Christian organization and Mission 318, a philanthropic organization from the United States of America (Daily Graphic, 2020). The nursing staff consisted of 212 enrolled nurses, 39 professional midwives, and 101 professional nurses (RN). The patient records department revealed that the hospital had a weekly average attendance of 250-300 patients in the outpatient department (OPD) during my fieldwork. From this number, an average of 150 patients are admitted as inpatients. At the time data collection, only one permanent medical doctor (a specialist gynecologist) and temporary supporting doctors served the hospital to provide healthcare services to residents of the Yendi Municipal Assembly and other districts. Details of the nursing and medical staff composition of the hospital are shown in Table 1. The numbers shown in Table 1 will have implications for care delivery, as noted in Chapters 4 - 6.

In Table 1, some gender disparities are discernible in the healthcare workforce, both in the professional nurse category and other specialized medical professions. These differences may reflect national literacy rates among men and women but deviate from the gender distribution of men and women in the nursing workforce, which is typically considered a female-dominated profession (Boafo & Gyan, 2022). There are disproportionately more female midwives and enrolled nurses than males compared to the professional nurse (RN) category. Despite the number of female nurses, only a few participated in this study compared to their male colleagues. Could this situation have been influenced by the fact that the researcher was a male? Were there some underlying power issues, or did assumptions that male nurses are better trained influence the female nurses' participation in the study? I can only speculate.

Table 1:

Summary of staff category in the Yendi Hospital

Category	**Male**	**Female**	**Total**
Biomedical scientists	4	0	4
Certified Registered Anaesthesis	2	0	2
Community health nurses	1	5	6
Community mental health officers	4	0	4
Dental technician	0	1	1
Enrolled nurses	86	126	212
Health assistants	1	2	3
Laboratory technical officer	0	1	1
Laboratory assistants	3	1	4
Medical officer – general practitioners	3	0	3
Medical officer - specialist	1	0	1
Pharmacist	1	0	1
Pharmacy technicians	4	2	6
Professional midwives	3	36	39
Professional nurses	65	36	101
Optical technical officer	1	2	3
X-Ray technical assistant	1	0	1
Total			**392**

My choice of the Yendi Hospital for this study was based on two factors. I observed nurse-patient interactions in this setting while conducting a different study in 2015. The dynamism in nurse-patient communication in that multilingual healthcare setting inspired me to explore how clinical communication practices affected patient rights in the care process. Moreover, the residents of Yendi had concerns about nurse-patient relationships and interactions and how the hospital was being managed. Furthermore, my preliminary investigations about activities in the hospital after the 2015 study revealed that no patient group advocated for patients' rights and well-being. Although the hospital has a complaint unit, patients' complaints were handled generally without proactive measures to promote patient rights. As a resident of Yendi for over 15 years and having interacted with the hospital systems on several occasions, I saw the need to examine how patient rights and nurse-patient communication and interaction manifested in clinical practices. Through my previous research engagement in the hospital (both personally and through research activities), I established a good relationship with the hospital that could be positively leveraged during this project. Most importantly, the desire to contribute to improve nurse-patient relationships and nursing care practices in Yendi Hospital was crucial and constituted a critical reason for choosing the hospital.

Participants for this study consisted of nurses, patients, and caregivers 18 years and older who accessed healthcare services in the Yendi Hospital. Given that the unit of analysis in this study was people and their experiences and the contexts of those experiences, my study sample included 43 participants (21 patients, 11 nurses, and 11 caregivers) from different patient wards. Since I was interested in the participants' experiences of patient rights, nurse-patient communication practices, and their challenges, this sample size was appropriate, especially for a study that seeks to employ IPA as one of its methodological approaches (Pietkiewicz & Smith, 2014). Moreover, Hennink et al. (2017) observed that different opinions abound regarding the sample size required to reach data saturation in qualitative research. Furthermore, qualitative research scholars have observed that data and code saturation (identifying all relevant codes) and meaning saturation (getting the full details of codes) in qualitative research can be attained with between 9 and 24 interviews depending on the study's objectives and the quality of interviews (Hennink et al., 2017, p. 600). Hence, with the rich semi-structured interview and observational data gathered from the participants, data and meaning saturation were reached after interacting with 10 participants in each category.

I engaged with both in and out-patients in the study through purposive sampling. Purposive sampling allows the recruitment of participants and key informants who had experiences of the phenomenon and were willing to share their experiences with me. These participants provided rich and in-depth data that helped me to understand how communication in nurse-patient interaction shapes patient rights. Being a resident of Yendi and through my local networks and knowledge of cultural norms and protocols, I entered the hospital community using a gatekeeper to gain access, build rapport, and recruit the participants.

3.4 Methods of Data Collection

Primary data collection tools included ethnographic participant observation of the daily nurse-patient interactions in the hospital, semi-structured individual interviews with nurses, patients, and caregivers, and one focus group with patients.

3.4.1 Ethnographic Participant Observation

Participant observation became a popular ethnographic method of data collection in anthropology through the works of Malinowski and Margaret Mead (Musante, 2015). Participant observation allows researchers to participate in the "daily activities, rituals, interactions, and events of a group of people as a means of learning both the explicit and tacit aspects of their life routines and culture" (Musante, 2015, p. 251). As a data collection tool, participant observation enables ethnographers and qualitative researchers to gather data in social settings as they observe and partake in the everyday activities of the people studied. In this project, I utilized ethnographic participant observation throughout the five-month fieldwork from December 2021 to April 2022. Nurses, patients, and caregivers' daily interactions were observed in the hospital setting to gather first-hand information about the challenges these participants faced in proving or accessing healthcare services. An observation guide (see **Appendix E**) assisted my observations. In some instances, I assumed a participant-as-observer role, especially when nurses needed me to support them, while, in other instances, I took a complete observer position (Creswell & Creswell, 2018). Observations were conducted in the patient wards, at the nurses' station, in patients' waiting areas, and during nurse-patient encounters in the healthcare setting (e.g., patient history taking, nurses' medication rounds) and clinical debriefing meetings after clinicians had finished patient case reviews. I conducted participant observations on different days and across the nurses' daily shifts (morning, afternoon, and evening). A whole week was dedicated to each patient ward within which I observed nurse-patient interactions, and I did a one-day night shift in each ward to experience what the nurses went through during that period. Approximately 450 hours of observations of nurse-patient daily interactions were conducted during the five-month fieldwork. This data-gathering method helped me build relationships with and gain the trust of the nurses, patients, and their caregivers. It also allowed me to capture both reported and actual (observed) behaviour among nurses, patients, and caregivers in the form of field notes by employing Mulhall's (2003) approach to documenting observational field data.

Furthermore, I employed Hames and Paolisso's (2015) 'continuous' and 'instantaneous' guides for recording behaviour textually during my observational sessions to capture participants' behavioural data during interactions. Hames and Paolisso (2015) asserted that continuous recording of observational data "is a moment-to-moment recording of a stream of behaviour over a brief time scale, typically not more than a half-hour" (p. 297). By employing continuous recording approaches, I captured data on clinical practices (e.g., routines in the patient wards, such as patient admission processes, nurse medication rounds). I took note of interactions (e.g., patient history taking, how nurses regulated access and entry into the patient wards by visitors and patient relatives) and communication practices (e.g., request making, social positioning, and how power and control were implemented through language use). Further, I examined communicative and interactional patterns, sequence, duration, and frequency.

On the other hand, instantaneous recordings capture dimensionless data without taking note of the duration or frequency of behaviour (Hames & Paolisso, 2015), especially during informal interactions and conversations at the nurses' station or when I observed happenings while moving between patient wards/units. With this approach, I witnessed and recorded how information was provided to patients and how patients participated (or not) in decision-making or were engaged (or not) in their care process. I recorded the ethnographic participant observation data using the note function of my mobile phone. It was common for nurses and patients to play with their phones, so I figured that taking my field notes with my phone would make the writing process less obvious than jotting things in my field notebook, as the approach was handy and less disruptive. Taking detailed field notes while observing can be challenging. Therefore, I had to rewrite the hastily written notes daily to capture each moment's impressions (Saldaña, 2015; Spradley, 2016). Detailed field notes for the entire week I dedicated to each patient ward were typed, printed, read, reflected on, and coding initiated.

In undertaking these observations, all ethical guides to participant observation in the healthcare setting were reflexively observed. I engaged in "moderate participation" as I observed clinical practices (Musante, 2015, p. 262). Thus, due to my presence in patient wards, at the nurses' station, and performing other roles for nurses, it was difficult to entirely observe events and happenings without being asked for help by the nurses, patients, or caregivers. Thus, through participant observation and the various roles I played, I became closer to and understood participants' points of view by being actively engaged in their lives

(Musante, 2015), which enhanced my data quality and interpretations. I conducted two months of participant observations before recruiting participants for in-depth individual interviews and the focus group discussion.

3.4.2 Individual In-depth Interviews

Interviews are a common means of collecting data in qualitative research on a social phenomenon that interests the researcher. Individual interviews are complex communication acts (conversational exchanges) where an interviewee and an interviewer interact orally/verbally to co-create knowledge and understanding of a social phenomenon based on the interviewee's experiences. Semi-structured individual interviews were conducted in this study. Loiselle and Profetto-McGrath (2011) observed that the semi-structured interview is a more commonly used qualitative research interview. Semi-structured interviews contain questions used as a guide but have yet to be strictly followed during these interviews to allow participants to speak in-depth about a social problem under investigation (Loiselle & Profetto-McGrath, 2011).

Participants were recruited for interviews after two months of ethnographic participant observations. **Appendices A** and **B** show the recruitment poster and information for participant recruitment. The participant recruitment poster was posted in all the patient wards/units while I was conducting participant observations. As advised by the University of Saskatchewan ethics board, the study information sheets (see **Appendix B**) and consent forms (**see Appendix C**) were provided to patients and their caregivers at the point of discharge, hoping those who were interested would call me. However, this approach proved futile because no patient called for a couple of weeks. So, I innovated the participant recruitment process by contacting patients who had recovered but were undischarged whenever they came outside the ward to rest during the evenings or early hours of the night. The nurses supported in identifying patients in their ward who had recovered and were willing to participate in an interview.

Regarding caregivers, since they were always outside, I contacted them directly to invite them to participate in the study. Some patients and caregivers instantly agreed to participate after I invited them, while others took a day or two. After the weekly observations of nurse-patient interactions in their wards, I invited nurse participants. This approach allowed me to build rapport and familiarize myself with the ward's nurses and patients. Moreover, with this approach, I avoided undue influence on the nurses because if I had invited them within the week I was observing, some might have been pressured because of my presence. So, I left five to six copies of the consent forms in each ward for the nurses after the weekly observation and after I had moved to the next ward. Then interested nurses completed the consent forms and delivered them anytime I passed by the ward.

I conducted 39 semi-structured in-depth individual interviews with nurses (n = 11), patients (n = 17), and caregivers (n = 11) who met the inclusion criteria and provided their consent to participate in the study. I made brief notes after each interview to capture my impression, date, location, and duration of the interviews. I conducted all interviews in the hospital setting, mainly during the evening between 8:00 pm and 10:30 pm. Each interview lasted an average of 21 minutes for patients, 19 minutes for caregivers, and 32 minutes for nurses. Interviews were conducted in English and Dagbani (the dominant native language of the area, of which I am a native speaker), depending on participants' preferences and English proficiency levels. I conducted all interviews with nurses and about half of the patients in English, while the rest were conducted in Dagbani. A semi-structured interview guide with open-ended questions guided my interactions with the participants, and all interviews were audio recorded with a voice recorder with the consent of the participants. That is, separate interview guides (see **Appendices F, G,** and **H**) were used to capture each participant group's experiences on the topic. Interviews in English were transcribed verbatim, and those in Dagbani were listened to, and translations were transcribed.

During these interviews, I used a person-centred approach to interviewing to obtain both participants' "informant data" and their "respondent data" (Levy & Hollan, 2015, p. 316), especially with the nurses. Only a few patients and caregivers were engaged in person-centred interviewing, as our interactions were much shorter. Levy and Hollan (2015) asserted that 'informant data' captures other people's perspectives and experiences of a phenomenon as reported by an interviewee, whereas 'respondent data' reveals the interviewee's own experiences and interpretations of the phenomenon, and both forms of data complement each other.

Through these in-depth and person-centred interviews, patients narrated their experiences, beliefs, and interpretations of specific instances of poor nurse-patient relationships and violations of patients' rights to dignity, non-discrimination, and self-determination. Participants talked about events and situations in which they felt dis/respected, neglected, mistreated, or otherwise, based on how language was used and how that influenced patients' participation in the care process. Ezzy (2010, p. 164) observed that in conducting interviews, participants and researchers engaged in emotional performativity where "the tension between the research question and the experience of the interviewee is explored." The interviewee's sense of self, the story told, and the emotional framing of the story are co-created and shaped by both the interviewer and interviewee (Ezzy, 2010). As a result, I exercised self-reflexivity and open-mindedness during my interactions with participants to reduce my academic biases, firsthand experiences, and cultural perceptions from unduly influencing the interview processes.

3.4.3 Focus Groups

A focus group was another method of data collection in this project. Hughes and DuMont (1993, as cited in Smithson, 2008, p. 357) defined focus groups as "in-depth group interviews employing relatively homogenous groups to provide information around topics specified by the researcher." For Smithson (2008), focus groups allow researchers direct access to the language and concepts that participants use to structure their experiences as they think and talk about a designated topic. Focus groups help to generate collective perspectives and meanings and language use or narratives on a topic for research purposes (Gill et al., 2008).

I conducted one focus group with four female patients in the same ward to explore their impressions, perspectives, and perceptions about patients' rights and how nurse-patient communication practices either promoted or strained that. A focus group guide with open-ended questions (see **Appendix I**) guided our interaction. The unit of analysis of the focus group data is the group, which allows group dynamics to be explored. Furthermore, it has been observed that focus groups are useful in eliciting information on collective views and the meanings embedded in those views (Gill et al., 2008). Both private and public accounts and disagreements among the participants about their experiences and challenges concerning nurse-patient communication and patient rights during clinical interaction were gathered (Flynn et al., 2018). However, Love et al. (2020) maintained that individual phenomenological narratives could be built from focus group data by following the responses of individuals across the data to construct individual narratives.

The patients who participated in the focus group had each experienced nurse-patient communication and interactions from at least two different patient wards after having gone through the OPD. For instance, some went from the emergency unit to the theatre before the present ward at the time of data collection. In contrast, others moved from the emergency, maternity, and surgical units to their present ward. These patients shared the circumstances of their interactions with nurses and narrated instances under which their own or their colleagues' interactions with nurses align or mal-align with the provisions in the *Patients' Charter*. They reflected on the barriers to healthcare access and how effective nurse-patient communications that recognize patients' rights could be enhanced.

This focus group was conducted in an empty sideward at night, and all Covid-19 protocols were observed around social distancing (Lupton, 2020). However, not all of them used facemasks. At the time of my fieldwork, Covid-19 cases in the Northern region of Ghana were minimal, in general, and at the Yendi Hospital, in particular. Not all nurses and patients wore face coverings, even in most in-patient wards. Furthermore, since the focus group size was small, it was easy to manage. It led to the generation of in-depth data on the topic because all the participants were actively engaged in the discussion (Smithson, 2008). The focus group explored these female patients' experiences, meanings, and interpretations of patients' rights and how communication during clinical interactions affected these rights and patients' participation in the care process.

I moderated and recorded the group discussion with an audio voice recorder. I assigned serial numbers, such as *FGP2, ImR* (focus group participant number 2, immediate right), and *FGP1, FR* (focus group participant number 1, far right), to the participants based on their seating position relative to me. With these serial numbers and their unique voices, I could remember who said what when transcribing the data. The focus group was conducted in Dagbani. Participants were informed about the ethical issues and challenges surrounding focus groups and reminded not to reveal any information about their conditions or any sensitive details they did not want their colleagues or me to know since I could not guarantee them full confidentiality of the information shared. Thus, the ethics of focus groups (see Morgan, 1996) were observed, as I encouraged the participants to engage reflexively in the discussion by respecting others' views and, if possible, turn-taking.

3.4.4 Documentary Sources

Documentary materials were also collected, such as posters, correspondence letters, and notices posted in the patient wards at the nurses' stations. Most documents communicated information or guidelines to the nurses about preparing certain medicines and solutions; others were protocols for effecting specific care procedures. The two most crucial documents in this study, which were posted in every ward, were copies of the *Patients' Charter* and a poster that required patients to request receipts for payments made in the hospital. I conducted a critical discourse analysis to explore power dynamics and patient rights embedded in the poster. Also, I reflected on the Charter provisions to analyze patient rights outcomes in nurse-patient clinical interactions.

3.4.5 Other Data Sources

In addition to the above sources of primary data, I also collected data through informal chats with nurses at their stations. Creswell and Creswell (2018) advised that inquirers must include other data collection types beyond observations and interviews because such unusual forms of data create reader interest and can capture useful information that observations and interviews may miss. At the nurses' stations, several discussions and conversations came up among nurses, some of which were central to the focus of my study – institutional practices, norms, and rules that affected nurses' work and nurse-patient relationships. Many of these discussions came up naturally, while for others, I engaged the nurses in a few questions to understand activities and happenings in the ward or the hospital. These discussions constituted informal focus groups with nurses during which they freely shared information with me.

Naturally occurring conversations were captured as part of my participant observations, whereas conversations I initiated by asking them questions were more like informal focus groups. During the researcher-initiated informal discussions, I reminded the nurses to be aware of my position as a researcher. Nonetheless, based on the relationships I had built with them, nurses always shared their perspectives and frustrations with me. These informal chats and discussions also served as avenues for my data interpretation as nurses invested their opinions on some observed data around care practices, nurse-patient communication, and patient rights.

Additional data and or data interpretations were also made during my interactions with the laboratory, pharmacy, patients' records unit, and claims office staff. Although qualitative research is not to determine the truth, participants' subjective experiences, and the meaning they make in their lives (Florczak, 2017), I needed to be clear about my interpretations of some observed data. As a result, I interacted with these departments to understand the patient folder processing and movement, why patients could not undertake specific lab tests, and why so many patients had to pay for several medications and drugs at the pharmacy even when they were covered by national health insurance scheme (NHIS). Data obtained from these interactions provided clarity and meaning to the interview data.

3.5 Data Analysis

Data gathering and analysis were iterative because I performed preliminary coding of initial observational and interview data while conducting more interviews and participant observations. Recorded interviews in English were transcribed verbatim, and for those that I conducted in Dagbani, I listened to them while transcribing. I read the transcripts several times to immerse myself in the data and then performed manual coding of the data. The initial coding and analysis informed subsequent observation and interview processes. For effective manual coding of data, I read and coded the transcripts sentence-by-sentence to identify concrete codes (that capture explicit and definitive issues in clinical encounters, for example, specific barriers to accessing healthcare), conceptual codes (that explore perceptions, emotions, value judgments, and feelings, for example, trust, misconceptions, and emotional experiences around some of the barriers to care access), and other descriptive and process codes (Elliott, 2018; Hennink et al., 2017; Miles et al., 2013).

I conducted multi-level coding because of the interdisciplinary focus of my project and the need to immerse myself in the data (Elliott, 2018; Linneberg & Korsgaard, 2019). All first-level coding process was inductive, which helped me to break down the data into meaningful units. As Linneberg and Korsgaard (2019) observed, coding allows researchers to understand the phenomenon under study and the participants' perspectives on it. Also, I employed Altheide's (1987) and Berg's (2004) content analytic approaches to identify manifest and latent content codes and categories. I engaged with Braun and Clarke's (2006) and Clarke and Braun's (2013) Reflexive Thematic analytic approaches and Pietkiewicz and Smith's (2014) and Smith et al.'s (1999) approaches to IPA analysis to categorize the data into segments and portions that provided meaningful insight into participants' views in different ways.

Most of the early codes were descriptive, and *in vivo* codes (i.e., words and phrases that participants themselves uttered). These codes were used to categorize participants' experiences and perspectives (Saldaña, 2015). Examples of these descriptive or attribute codes included "pain", "no motivation", "we buy everything", "trust", look for interpreter/translator", and "cultural belief", among others. Each data set was coded together to ensure consistency in the coding and analytic processes. For instance, all patient interview data were coded together before nurses, caregivers, and the observational data. For each set of interview data, I developed codes and categories for each transcript and later collapsed these to derive a set of codes from patients', nurses', and caregivers' data. This approach enabled me to keep track of codes and categories developed from each data set. I needed to identify peculiarities and unexpected and unique experiences from each data set before the codes were merged during subsequent data analysis (Nowell et al., 2017). At the end of my first stage of data analysis, a working codebook was created alongside a reflexive journal. As As Turner (2020, p.1) rightly observed, qualitative research is complex to design, manage, and analyze; as a result, keeping a personal record of the process, critical decisions, and feelings allows the researcher to learn from the research process.

For the second-level coding and analysis, I collapsed all the codes developed in the first stage into categories, themes, and subthemes based on the study objectives (Linneberg & Korsgaard, 2019; Saldaña, 2015). To implement the integrated methodological and interdisciplinary focus envisioned in this study, I identified data pieces (from individual transcripts and segments in the observation data) from which individual narratives could be created to tell participants' unique experiences. During this theme construction and development round, I made interpretive notes in the transcripts and developed indexing techniques for locating them, as recommended by qualitative research methodologists (Creswell & Poth, 2018; Miles et al., 2013; Saldaña, 2015; Williams & Moser, 2019). For instance, an index such as (P4, p.5, lines 214-220) meant that there was relevant information in Patient four's transcript, on page 5, from lines 214-220.

During this data analysis stage, I replaced some *in vivo* codes with interpretive codes to capture the experiences of other participant groups. For instance, all instances of "buy drugs", "pay for medicine", "pay for lab test", and other related descriptive codes were put together under "cost of care," which later became a theme of "high cost of care." Also, codes, including "nurses translate/interpret", look for someone to translate", "call a relative to translate", and so on, became a theme of "shopping translators/interpreters". Alongside theme development, I categorized the themes into those that answered my specific research questions such as barriers and facilitators to care delivery and experiences of patient rights.

Further, during this data analysis stage, descriptive ethnographic data, my experiential interpretive notes, and participants' specific experiences were developed into narratives to provide phenomenological, ethnographic, and critical discourses texts on the themes I developed or generated. This process helped me document my interpretive pieces of participants' idiographic experiences and their interpretations of such experiences, thereby honouring the double hermeneutics required in IPA (Vicary et al., 2017). Thus, as IPA demands, researchers must attend to the theoretical foundations of hermeneutics and idiography by taking note of how research participants make sense of and interpret their experiences of the phenomenon as well as the researcher’s interpretation of participants’ sense-making process and his own reflections (Smith, 2017; Vicary et al., 2017).

At the third level of coding and data analysis, my focus was to raise some of the themes to a higher level of abstraction to develop models and frameworks, and interpret participants’ experiences of patient rights in relation to the Ghanaian *Patients’ Charter*. Hence, I elevated the codes and themes developed from the first two stages by engaging in abductive coding and analytic practices. I changed the names of a few categories and themes at this stage. For example, a theme that I had earlier called “nurses’ innovative practices” became “nurses coping with resource constraints” because I realized that when nurses borrowed medical equipment, asked patients to buy ward consumables, or loaned emergency medicine to patients who later buy and replace the medicines, these were coping strategies of resource constraints and not innovative nursing practices per se. Also, the theme of “attributes of a caring nurse” was split up into two themes, “being and becoming caring” and “the ethics of life, care, and caring.” These two themes provided a deeper understanding of the essence of caring and the value of human life and humanness in care.

Implementing a three-level data analysis assisted me in reporting the main findings using multiple approaches, including phenomenological idiographic narratives, critical discourse, and ethnographic thematic analyses. Ethnographic thematic analysis was focused on creating themes that reflected everyday clinical practices, institutional routines, participants' experiences of language use, and how culture, context, and participants' socio-demographic variables impact these interactions. The phenomenological narratives were targeted at presenting and interpreting individual unique experiences and linking these to the participants' familiar and shared experiences and their interpretations of those experiences.

Besides, the narratives explored the influence of context, culture, and professional practices on language use and how all these dynamics impacted patient rights and participation in the care process. Waldram (2012) observed that narratives give meaning to experiences and allow personal forms of thought and feelings to be disclosed. He further argued that narratives offer the individual an opportunity to construct order from the chaos as we storied lived experiences (Waldram, 2012). Similarly, Connelly and Clandinin’s three-dimensional narrative inquiry framework of temporality, spatiality, and sociality was observed as I analyzed the individual interview data (Clandinin, 2006; Clandinin & Connelly, 2000). I identified participants and their relationships, places, and timeframes through this framework as nurses, patients, and caregivers storied their experiences. The approach provided relational, temporal, and spatial contexts for the participants' idiographic narratives. Moreover, how these stories were co-constructed and presented between participants and I was essential to my understanding of their experiences.

In the second stage of data analysis, I also engaged with Seisigl, Wodak, and Mayer’s discourse-historical approach (DHA) of CDS (Reisigl & Wodak, 2016; Wodak & Mayer, 2009) as an analytical tool to examine embedded ideologies, power relations, and domination in nurse-patient communication interactions. Nursing practices, cultural, ethical, and legal discourses, and ideologies that both nurses and patients brought to bear, to challenge, position each other or legitimize their actions, and how these practices, beliefs, and social positionings impacted social interaction or affected patients’ rights in the care process were explored through the DHA. Notably, the contexts of discourse re/production were crucial, which I critically examined in the dialogic processes of interaction. Like the ethnographic themes or phenomenological narratives, I provided critical discourse analysis of discursive practices around language use to uncover the work of power, positioning, and ideological rhetorics that were embedded in those discourses. Included in the critical discourse analysis were “men don’t go in there”, “the discourse of needing blood vs. buying blood”, and the poster that demanded that patients request receipts for payment made in the hospital.

3.6 Rigor and Transparency in Data Analysis

For any qualitative study to provide valuable results that can influence practice and policy in healthcare research, the findings must be credible and trustworthy; and the process of arriving at such findings should be transparent and rigorous (Turner, 2020; Vicary et al., 2017). I ensured the right questions were asked on the data collection tools to achieve credible findings in this study. As a result, I first translated the interview guides into Dagbani since I knew that I would conduct some interviews in my native language. A native Dagbani speaker who is an expert Dagbani Bible translator assisted me in translating the interview guides into Dagbani while taking note of Dagbani pragmatics. After this exercise, I piloted the interview guides with nurses, patients, and caregivers (two participants in each category) in a different clinic within the study setting. The pilot interviews and the translation exercise ensured that I was asking the right questions, that the questions were unambiguous, and that participants would not face any difficulties understanding and responding to the questions.

In addition, I had a prolonged stay in the field (December 2021 – April 2022) and daily interactions with participants, which helped me to develop sustained relationships and rapport with the participants (Creswell & Poth, 2018; McGinley et al., 2021). Qualitative research scholars have recommended that to promote quality in qualitative research, researchers must have prolonged engagement in the field and invite participants to reflect on their transcripts and data (member reflections as opposed to member checking (Braun & Clarke, 2022)). They must provide rich, thick (detailed) descriptions, and engage external auditors (McGinley et al., 2021). As a result, I engaged in informal discussions to confirm and/or understand the data. I consulted other hospital community members engaged in healthcare delivery or who provided other essential services to gain further interpretation and explanation of the data. Furthermore, interview transcripts were returned to participants who agreed to review their interview data and signed the transcript release form (**Appendix D**).

All nurse participants accepted and reviewed their transcripts and provided reflections where necessary before they returned them to me. This process allowed the participants to provide feedback/interpretation of their data where feasible (Hussain et al., 2013; Rashid et al., 2015). Patients and caregivers did not agree to review their transcripts because most of them were illiterate in English; hence, that could have accounted for their unwillingness to review their interview transcripts. Moreover, many of them were not residents of Yendi, so they might have felt that they would not be accessible for follow-up. Regarding the nurses, it was easier for them because they regularly come to the hospital; as a result, it was simple for them to review their transcripts and return them to me. Although patients and caregivers did not review their transcripts, that did not negatively affect the outcome of this study. Member checking is a rigorous qualitative research criterion; nonetheless, its absence does not invalidate qualitative research findings, as other approaches to ensuring rigour were implemented (Forero et al., 2018; McGinley et al., 2021).

Data were collected through different methods (interviews, observations, informal chats) with simultaneous data collection and analysis (the iterative process in qualitative research) implemented. Data from these different sources were analyzed differently to gain a deeper understanding of the research problem. Besides, I interacted with the expert interdisciplinary committee members throughout the data collection and analysis process by sharing my data-gathering processes, data analysis practices, and personal experiences about ethical issues and interactional outcomes with them (Forero et al., 2018). These engagements helped me to resolve some challenges and rethink certain lines of analysis and interpretations.

Besides, I kept reflexive notes about my decision-making processes (audit trail) on the observational, interview, and focus group activities, as well as changes in the research process during fieldwork and throughout the analysis and report writing stages of the study, as recommended by Miller et al. (2018) and Smith (2011).

Lastly, I presented my research findings and fieldwork experiences with my advisory committee during the graduate Interdisciplinary Studies seminars (INTD 990 seminars) and shared the same with the hospital leadership. These presentations allowed me to further discuss, analyze, and reflect on the research processes and the results. To enhance transparency, I reflected on my assumptions, participants' behaviours, and happenings within the hospital environment to deepen my analytic endeavours. I also extracted all identifying participants' attributes from the data to ensure data anonymity. Furthermore, throughout this report, I referred to participants using serial codes or pseudonyms to maintain participant anonymity and confidentiality of their shared information. However, the context of data production could not be completely anonymized for all cases (Moriña, 2021). As Moriña (2021) observed, a common approach to protect participants in research reports is to respect their anonymity and provide them with a certain degree of privacy through pseudonyms.

3.7 Ethics and Ethical Approval

To ensure that all ethical principles were observed in this study, I obtained ethical approval from the University of Saskatchewan Behavioral Ethics Board responsible for reviewing and granting ethics approval for research with human subjects (Beh-ID: 2690), which was renewed before the study's completion. I further gained institutional ethics approval from the Ghana Health Service Ethics Review Committee (GHS-ERC:005/11/21), and the hospital management granted permission to collect data in the Yendi Hospital. The university's ethics approval certificate is attached as **Appendix J**. In addition, I adhered to the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada Tri-Council Policy Statement ([TCPS2], 2014) recommendations on research with human subjects.

All institutional norms and the local cultural values and practices were observed while I was in the field and throughout the written report. These formal ethics requirements and principles guided me to conduct this study respectfully and reflexively without harming myself or the participants (Cumyn et al., 2018). As Cumyn et al. (2018) argued, a significant role of researchers in qualitative research is to respect and protect research participants by ensuring that harm is minimized, communication is ongoing, and consent is continuous throughout the research process. Hence, where there were ethical dilemmas, I respected the participants' perspectives provided no harm, perceived or actual, was caused or envisioned (Reid et al., 2018). For instance, I was observing nurse-patient interactions in a patient unit; then, there was a shift change. The nurse who took over as the night shift nurse met me there for the first time. So, I introduced myself and told him what I was doing. Then he asked me whether I knew that telling him who I was and what I was doing could change his behaviour. I told him it might, but that it was ethical that I informed him what I was there for.

By engaging in reflexive ethics and respectful interactions, I completed this study's fieldwork and subsequent aspects without violating institutional, personal, and relational ethical principles (Lahman, 2018; Wa-Mbaleka, 2019). Where it was impossible to implement institutional ethical guides, creative innovations without adverse ethical consequences were implemented, especially around participant recruitment (Moriña, 2021). All foreseeable risks and challenges around satisfying anonymity and confidentiality demands were explained to participants, and these were done before individual interviews and the focus group discussion. Besides, ethical principles around ethnographic participant observations were respected. When observing care practices and nurse-patient interactions was challenging, especially in the labour and maternity wards, I exercised personal reflexivity and abandoned such participant observation (Lahman, 2018).

Participant anonymity and confidentiality were upheld during the fieldwork and the study report, as noted in section 3.6. Thus, one of the primary responsibilities of qualitative researchers is to protect participants' confidentiality, such as sensitive participants' individual and collective information from study reports (Moriña, 2021; Wa-Mbaleka, 2019). Nonetheless, Moriña (2021, p.1562) acknowledged that qualitative researchers face a dilemma regarding conveying detailed and accurate information about the social world they study while protecting participants' identities. This was particularly challenging given that references to contextual and background data could indirectly identify participants in healthcare research. Despite this challenge, I consciously avoided indirectly identifying participants, even when referring to patient wards and other background data. Finally, I observed all Covid-19 protocols around social distancing, wearing a facemask, and hand sanitizing to minimize the risk of being infected or compromising the safety of the participants (Lupton, 2020).

3.8 Inclusion/Exclusion Criteria

Participants for this study included male and female nurses, patients, and caretakers 18 years and older. Nurses were to have at least three years of practice experience in the hospital before they could be included. Since the study was to examine language use in nurse-patient interaction and patient rights, some amount of practice experience was required on the part of nurses for them to be able to discuss and reflect on how their language use behaviour, clinical practices, and interactions with patients could influence the care process. I reasoned that patients' participation could be affected by the severity of their illnesses; hence, only patients who could participate in interviews for at least 25 minutes without compromising their health conditions and who gave their free and voluntary consent were included in the study. Patients with severe health conditions were not included. Any caregivers who gave their consent were included to share their personal experiences as patient caretakers, but not on behalf of their patients. I contacted participants directly through the hospital gatekeepers and unit/ward managers. Participation in the study was voluntary.

3.9 Challenges and Limitations of the Study

A limitation of the study is its inability to generalize its findings across Ghana due to differences in ethnicity and healthcare organizational and administrative culture across the country, which might have influenced nurse-patient communication practices differently than in other hospitals. Moreover, to be able to generalize research findings, a random sample of sufficient size is required, and that was not the case in this study because the present study was an exploratory qualitative one. Besides, social distancing protocols and restrictions on human interactions could have impacted interviews and ethnographic observations due to the Covid-19 crisis. Nonetheless, participants’ experiences, perspectives, and voices were still captured using a voice recorder. Furthermore, patients with in-depth experiences might have been excluded from the study due to their healthcare conditions during data collection.

Similarly, healthcare institutional limitations imposed on researchers prevented me from observing nurse-patient interactions that could have provided crucial data for the study. Interviews with patients were also short, which led to me conducting 17 interviews. The expert interdisciplinary committee members recommended additional interviews with the patient group; however, the three additional interviews I had with patients yielded no significant new data; as a result, such interviews were not included in the analysis. Despite the above limitations, the various data collection instruments and participant groups that were engaged in this project provided in-depth and meaningful information that clarified the research problem.

Also, although participants identified attributes of effective communication, this study did not explore what ‘communication’ itself meant to the participants. Thus, research has shown that in some jurisdictions, the meaning of communication among care providers “implied a mode of instructing patients” regarding certain healthcare routines, including “when to come for the next antenatal check-up, what routine tests to undergo, when to get admitted for delivery, and how to take medication” (Ghoshal et al., 2013, p.6). Given the multilingual nature of the care setting, it would have been ideal for me to explore what communication meant to the participants, especially nurses, in the context of nurse-patient communication.

Chapter 4: "Sometimes Common Gloves We Don't Have and that Makes Our Work Stressful": Barriers and or Gaps to Healthcare Access and Delivery

4.1 Introduction

Access to affordable and quality healthcare services is crucial to achieving universal health coverage for all by 2030. Nurses face many challenges as healthcare providers to deliver practical, quality healthcare services. At the same time, patients and caregivers face barriers and gaps in their efforts to access affordable care. The narrative below provides a window into what nurses and patients go through to deliver or access healthcare services in the study setting.

Mama (a pseudonym for N10) is a registered nurse who has worked in the healthcare facility for several years in different patient units. Mama is multilingual and speaks about three languages, including the English language. Although Mama uses everyday language as opposed to nursing professional jargon when communicating with patients and caregivers, she often faces language barriers when interacting with some patients and caregivers, as she indicated in Textbox 1.

Textbox 1: A narrative about barriers to care delivery by Mama

Hmm, sometimes it's the language barrier. I don't understand Likpakpaanl (the native language of the Konkomba ethnic group), and the neighbouring communities are Konkomba. So, it's just the language barrier, how to communicate with them. Sometimes, there is a staff among us who understands the language. And it's not all the time that they are here, so at times you have to go out and find a Konkomba [to help]. Some of them understand Dagbani so they will explain to the patient what you want to tell them. The language barrier is not the only problem, we are not many, and the supplies we get are also not enough. Sometimes, common gloves we don't have, and that makes our work stressful. Even cord clamps, and you can't deliver a baby without clamping the cord. You can lose the baby. You will lay a complaint [to the leaders] and they don't provide that, expecting you

Textbox 1 continues

to continue working like that. I can't use my bare hands to collect someone's blood. So, we must write for patients/caregivers to buy some of these items. And some patients will ask, "a whole hospital and you don't have this, and I have to go and buy it. I've to buy them?" We also have the 'bed syndrome' here. Sometimes the whole ward is crowded, and they are no beds. The space is not enough, and there are risks because anything can happen. In the peak season, the ward can be full, and no beds, so we'll ask some patients to go home. Some will go and don't return. They will deliver at home. And the blame comes back to us because we asked them to go home. So, I often feel demoralized when I come to work because I have to go around to beg this small and beg for that from other wards. When patients and caregivers ask me why they have to buy these items, I feel bad because it's like we (the nurses) are the ones causing it. Some patients and caregivers do understand what the nurses go through, but others do not. For instance, there was a time a client needed three blood units/bags, so to make the work easier, I wrote three intravenous sets (given sets) for them to go and buy. The relatives asked me why I wrote three. I told them the client needed three blood units, and since they brought one blood unit, the other two units will come without the given sets, so why don't I write three for them to buy? We will use one and when the other two blood units come, we will use the other two given sets. The caregiver said they will buy the given sets one by one. Even some caregivers will tell you that they don't have money. For instance, yesterday, we had a patient, who was delivered but was reactive to an infection. We told her to invite her husband. Today, the husband came. We discussed with him, and he was to buy the injection for us to give his wife so that she will be ok before breastfeeding intensifies. The injection costs about GHS 750.00 cedis. But the man said he could not afford it. So, sometimes, another challenge we have with patients and caregivers is money issues. They pay for this, pay for that, it's a lot. Sometimes too I can come to work, and a client or caregiver will demoralize me. Some of them don't respect us, and others don't just know how to speak to people politely. They just speak anyhow. Some caregivers even insult us. They have the perception that when they come here, they spend money. Because of that some of them will not even cool down and ask why they are paying for this or that. Anyway, it's some of us nurses who spoil our name due to our behaviours. Despite these challenges, many patients and caregivers are often satisfied with the care we provide them, which makes me happy. But other clients are not grateful. It's not everybody that you will deliver … and they will thank you. But some, immediately after the baby is out, and you are looking for something for the mother to eat, the person will tell you that 'oh, I really appreciate your effort. Thank you very much. God will bless you.' Sometimes, it's the patient relatives, seeing you doing all that, when they are being discharged and they come back to get their things, they tell you, 'Thank you very much, may God bless you.'

Mama was optimistic that some of the problems could be overcome when care providers are tolerant and respect patients and caregivers. The above narrative highlighted many barriers and/or gaps that nurses, patients, and caregivers traverse in the healthcare institution. Some of the obstacles noted in the narrative included resource limitations, high cost of care, language barriers, healthcare institutional culture, and negative attitudes among care providers, patients, and caregivers. Identifying these barriers and/or gaps and examining how they impact healthcare delivery and access is a step towards achieving universal health access.

Healthcare research in other contexts has identified similar barriers to healthcare access (Han et al., 2020; Ismaila et al., 2021; Younas et al., 2022). Language use, logistics challenges, limited human resources, and poor interpersonal relationships are identified in these studies. Nonetheless, how the healthcare context reflects these impediments to care delivery and/or access in this current study setting might differ from other studies.

My aim in this chapter is to present and discuss the barriers and/or gaps to healthcare delivery and access in the referral hospital context, highlighting the uniqueness of the institutional culture and practices as nurses, patients, and caregivers navigate these challenges. It is important to note that although these hurdles to healthcare service provision and uptake are presented under different headings and sections, many of them intersect in complex ways to limit access to healthcare services. They obfuscate effective communication and interaction between nurses, patients, caregivers, and other healthcare providers.

4.2 Brief Methodological Background

Despite the detailed descriptions provided in Chapter 3 on the methodology of this study, I present a brief explanation regarding how the results presented in this chapter were arrived at. Overall, 40 interviews were conducted in this study. I conducted 11 in-depth individual interviews each with nurses and caregivers, 17 with patients, and one focus group with patients. I carried out about 500 hours of participant observation and several informal chats and discussions with nurses at the nurses' station and with five-unit heads and/or staff of the hospital. I transcribed all the interviews, wrote the field notes, read the transcripts several times, and conducted multiple rounds of data coding and analysis, as described in Chapter 3. After the multiphase coding and data analysis, I identified and grouped together all codes into categories, themes, and subthemes that provided answers to the barriers of care access in the hospital. Four broad themes and 11 subthemes, presented in Table 2, illustrate the barriers to quality healthcare delivery and access in the study setting.

Table 2:

Themes and subthemes illustrating barriers and gaps to care delivery.

Broad themes	**Subthemes**	**Illustrative codes**
Communication and language use practices	-Language use in a multilingual care setting -Professional nursing language use as identity formation -Shopping translators and interpreters -Poor communication creates misunderstanding	"the challenges relate to language barrier", you have to find someone to interpret for you", "misunderstanding causes disagreements due to our language use," "when you use the professional language they don't like that," "not communicating well with patients can affect the care delivery process"
Institutional culture, resource limitations, and care practices	-Institutional culture, context, and traditions -Equipment deficit and deficiency -Human resource constraints -Poor nurse-hospital management relationships	"long wait times", "there are no visiting hours here", "we are lacking so many things: syringes, plasters, canula, etc.", "there are a limited number of nurses", "we don't have an orthopedic nurse specialist", "the hospital management, they don't listen to us"
Health literacy and the cost of care	-Low health literacy and patient care needs -High cost of care affects care access	"patients hide information", "some patients don't know their conditions", "truly, I paid for the drugs", "the cost of medicine may make patients/caregivers delay buying it",
Healthcare beliefs and negative personal attitudes	-Health beliefs and care delivery -Negative personal attitudes	"the relatives said they have to do divination", "they have these superstitious beliefs", "some nurses speak anyhow to patients", "some caregivers are impatient"

The remainder of the Chapter will cover the participants' demographic characteristics in 4.3, the main results in section 4.4, a summary of the findings in 4.5, and a discussion of the main findings in section 4.6.

4.3 Participants' Demographic Characteristics

There were 43 participants of which 21 were patients consisting of 16 females and five males. Patient participants ages ranged from 18 – 60 years, with the average age being 26 years, and thirteen patients were below the mean age. Nine of the participants were married. The patients belonged to different ethnic groups, but the majority were Dagomba (n=13).

Two patients each were Konkomba and Ewe, while the rest were Gonja, Bimoba, Akan, and Bono. Only six patients were monolinguals in Dagbani, the rest could speak an additional native Ghanaian language (e.g., Twi, Hausa, Gonja, Krobo, Mampruli, and Sefwi) and English. Regarding the level of education, three participants never went to school, two had primary education, ten had high school level qualifications, and six had tertiary level education. The patient participants had various occupations ranging from teaching, farming, and trading (businesspersons), to being students. The average length of stay in the hospital among the patients was three days with 16 patients having a below-average length of hospital stay, whereas five patients had an above-average length of hospital stay. The longest length of stay in the hospital was 14 days, whereas the shortest was just one day, at the time of data collection.

Caregivers were 11 made up of four males and seven females. They had an average age of 32 years with an age range of 19-45 years. Eight caregivers were married, and the rest were single. Regarding their occupations, six said they were farmers, three were into trading, and the remaining two were into teaching and nursing. The caregivers had varying levels of education, with about six of them having basic level education. Two caregivers never went to school, two had tertiary-level education, and one was a high school student. Only four caregivers were monolinguals, the rest were bilinguals who spoke Dagbani, English, and one other Ghanaian language, including Fulani, Likpakpaanl, and Twi. The average length of stay in the hospital among the caregivers was 2.5 days, with five participants having an above-average length of stay in the hospital.

The nurse participants were also 11: four females and seven males, sampled across nine patient units and wards, including the OPD. The age range of the nurses was from 26 – 40 years, with an average age of 33 years, and three nurses were older than the mean age. All the nurses had tertiary-level education with either a bachelor’s degree or a diploma certificate. They were all registered nurses in midwifery, paediatric, emergency, and general nursing. Many of the nurses (n=8) were native Dagbani speakers. Except for one nurse, the rest were bilingual nurses who spoke English and at least one of the following languages: Basari, Frafra, Mampruli, Dagaare, Wali, Twi, Hausa, Fante, Likpakpaanl, and/or Dagbani. Out of the 11 nurses, only two were single. The mean years of practicing as a nurse in the hospital was six years.

These participant demographic characteristics, especially levels of education, the multilingual nature of the participants, and the patients’ and caregivers’ length of stay in the hospital, will have some impacts on nurse-patient communication and interaction. Patients' and caregivers' educational levels can influence their health literacy, health beliefs, and interaction with healthcare providers.

4.4 Barriers and or Gaps to Healthcare Delivery and Access

In this section, I will present the critical findings on barriers to healthcare delivery and access. Four broad themes were developed to capture the barriers and or gaps to healthcare delivery and access in the Yendi Hospital. The main themes are *communication and language use practices; institutional culture, care practices, and resource limitations; health literacy and the cost of care;* and *healthcare beliefs and negative personal attitudes*.

4.4.1 Communication and language use practices

Effective communication in nurse-patient interactions has a significant influence on nurse-patient therapeutic relationships and the uptake of care services. Despite the value of communication in clinical interactions, several factors make it extremely difficult to achieve that in a multilingual care setting. Three interrelated factors emerged in this study to explain how the lack of effective communication constituted a hurdle to healthcare delivery and access.

4.4.1.1 Language Use in a Multilingual Healthcare Setting. In Ghana, English is the official language of government business, the medium of instruction and interaction in public educational institutions, hospitals, law courts, and other public institutions. In addition, nine regional dominant Ghanaian languages are approved for use in public institutions, albeit without official status. This situation makes every public institution a site for multilingual practice. As a result, in the study setting, nurses, patients, and caregivers communicated using various Ghanaian languages in addition to the English language. With that, language use became a barrier if a nurse and patient or caregiver could not communicate because they did not both speak English or share a common Ghanaian language. Therefore, language use potentially became a major impediment to effective communication and interaction between care providers and healthcare service consumers.

The regional dominant language of the study setting is Dagbani; nonetheless, speakers of Likpakpaanl and Fulani, among other languages, patronize the hospital. Although many nurses are bilingual and speak English, their native language, and another Ghanaian language, not all of them could speak Dagbani or Likpakpaanl, as the following nurses observed.

> … the means of our education is English, and so, once I know that you understand that language, it makes it easier to actually communicate with you, either than that, if you come and say you are a Konkomba, I understand it just a bit, … let me put it that way, so if I am going to communicate with you, it will be very difficult. (N1)

> Mostly, Dagomba dominates here, but then our brothers and sisters from the Konkomba ethnic group patronize this facility very much. So, when they come, most of the nurses don't understand the Konkomba language. (N8)

Not only nurses but also patients and caregivers had trouble with nurse-patient communication due to language barriers. For instance, a patient (P7) indicated how he was unable to interact with some nurses because of a language barrier; "… today some nurses came and were trying to interact with me in Dagbani, but I told them I don't understand Dagbani." Another patient (P4) expressed sentiments about the language problem, "I am worried that I can't talk directly with the nurse. I will be happy if I can have someone who speaks my language, so I can speak directly with him".

Furthermore, language use setbacks were not limited to verbal communication, but also to written communication, as pointed out during a focus group discussion.

> **FGP2(Immediate right):** Sometimes, after the doctor had written in my folder, the student nurses also write things, but I often don't understand what they have written.

> **FGP4(Far left)**: What I have seen is that mostly, when the doctors write and I take it, I can't read it. Meanwhile, it's not that I don't know how to read, but their handwriting is difficult to read. So, when they write, they should explain what has been written to the patient. At least, that will help us to know what our conditions are.

> **FGP3(Immediate left):** What she said is a crucial issue. In the maternity ward, when the doctor writes, unless you take it to the nurses, you cannot understand what has been written. So, you will be sitting until you are able

> to get one nurse to explain to you that ‘this or that is what the doctor wrote,’ then you can now go and get what the doctor has requested.

Although these sentiments were related to medical doctors’ written notes in patients’ folders, the difficulty these patients expressed still speaks to the challenges of language use in clinical interactions. For instance, while undertaking participant observation in a certain patient ward, I realized that two nurses were struggling to understand some entries in a patient folder, as captured in my field notes.

> A challenge with written communication in a patient’s folder. Nurses have challenges understanding what clinicians write in the folder and even some clinicians have problems understanding what their colleagues have written. Today, a nurse didn’t understand entries in a patient folder. It was not clear if the entries were for the maintenance dose or loading dose for the patient’s condition. The nurse noted that about ten entries were made in the folder while the maintenance dose could only be six in total. The nurse had to call another nurse who worked the morning shift to understand what the entries in the folder meant. I think written communication predicaments can affect care delivery processes and outcomes. (Field notes, documented January 24, 2022).

Another written communication hiccup in a patient ward was captured as follows.

> A prescription was made in a patient’s folder by a doctor, but the nurses could not read it. They had to ask another doctor who was reviewing patient cases in the ward to help them get the name of the drug. When the doctor explained it to the nurses, one of the nurses said to the doctor, “what wrong have we done to you people? We will be much happier if doctors make their writings clear and easy to understand.” (Field notes, documented January 27, 2022)

Despite the stress nurses, patients, and caregivers experience with both written and spoken language use, some patients that interacted with nurses with a shared common language stated that they did not experience language use challenges. For example, a patient stated, “actually, I understand both Dagbani and English, so nurses that speak Dagbani to me I understand them, and those that also speak English to me, I understand that too” (P9).

Another patient, a native speaker of Likpakpaanl, had a similar experience; "I understand Dagbani and English, so anyone who comes to me and speaks English or Dagbani, I am able to interact with the person" (P8). Thus, participants that did not face language use barriers seemed to be bilingual speakers.

4.4.1.2 Professional Nursing Language Use as Identity Formation. Another communication dilemma among nurses was the problem of either using professional nursing language or normal everyday language with patients. According to the nurses, professional language use involved using nursing and medical terminology and jargon when communicating with patients, caregivers, or other nurses during care delivery. On the other hand, normal everyday language use involved communicating with participants using everyday expressions and lay descriptions of care, nursing, and medical practices. Many nurses claimed that they use everyday language in their nursing practice when interacting with patients and caregivers to avoid misunderstanding and speak the professional nursing language with their colleagues and clinicians. A nurse recounted, "we use everyday language when speaking to the client, but we the nurses use professional terms among ourselves" (N10). Also, the dialogue below illustrated a nurse's choice of language use.

> **Researcher (R):** Ok, so how will you describe the way you talk to patients or their caregivers? Do you use your professional language or the everyday normal language use?
>
> **Nurse (N5):** It's the everyday normal language that I use with them.
> **R:** Why that choice?
>
> **N5:** Eh, if you use medical jargon, they won't understand, [ok]. If you based your talk on the professional aspect, you will be using your professional terms, which they won't understand. So, it's just the normal everyday language I use.

Another nurse provided a similar response about his language use choice in the following lines.

> Well, it depends on the kind of patient you are speaking to, … if I'm a nurse and a patient, definitely, when I am being spoken to in the professional language, I'll understand. However, I won't speak to a patient

> who does not understand our terms. … I won't do that because the patient will not understand what you say, and then it will hinder the communication between us. So, it's better I use the normal everyday language and not medical jargons. (N11)

Although most nurses said they preferred using normal everyday language when communicating with patients and caregivers, a few of them believe that using the normal everyday language with patients will conceal the true nature or the severity of patient illnesses, as a nurse related.

> When patients come like that, they are anxious, so if you don't add the professional and you are using the everyday language on them. … if the condition was not critical your language might not offend the patient. But if the patient comes in a critical condition, you have to add professional language to it, because if you speak the everyday language to the person, they might not see the severity of the case. (N6)

Yet still, other nurses believed that using professional nursing language gives them the identity and authority needed to support patients and their caregivers, as the following nurse argued.

> Maybe you need the patient to understand something, so you come in a professional way to make him understand. If you just come and say anyhow, (laughs) they will not get you. You don't come with a uniform identity, you must know what you are talking about, so that your patient will believe you first, and understand that you are really a nurse, with some knowledge to say what you are saying to him or her, if not, she will not buy that idea. (N3)

The data presented above suggest that the choice of using either the everyday or professional nursing language was not only mediated by the need for effective communication but also for nurse identity formation. Using professional nursing language also created a power position to legitimize one's knowledge as a nurse. Nonetheless, using professional nursing language with patients and caregivers with limited medical knowledge and formal education obstructed nurse-patient clinical communication. Therefore, to overcome some of these communication hurdles nurses and care consumers resorted to shopping for translators and interpreters to enhance nurse-patient interactions, a topic I explore in the next subsection.

4.4.1.3 Shopping Translators and Interpreters. Different people were used during nurse-patient clinical interactions to help interpret or translate for patients, caregivers, or nurses. My data revealed that nurses, patients, caregivers, visitors, cleaners, and any other available persons (including those unrelated to the patient) were often contacted to interpret or translate during nurse-patient communication in the healthcare setting. Regarding this subtheme, a patient participant noted that when a patient does not share a common language with a nurse, the nurse

> will try to find someone who understands the patient's language. For instance, if the patient is a Konkomba by tribe, they will find someone who understands the Konkomba language to do [the] translation, if it's Dagbani or English, they get someone to translate for the patient or the nurse. (P3)

Another patient said, "the nurses will look for someone who understands Dagbani so that s/he can translate for me" (P5). When a nurse who cannot speak Dagbani comes to interact with this patient, another nurse was sought for to translate for them. When a nurse or patient could not find someone to translate the messages, the nurse and patient or caregivers will manage their interaction using gestures and signs, as I observed in a patient unit.

> I was at the OPD when a Fulani woman, her son, and a young girl came in. The girl was the patient, but the woman, her adult son, and the patient could not speak Dagbani, and there was no nurse or anyone who could speak both Fulani and Dagbani to translate/interpret for them. The nurses, the Fulani patient, and her caregivers had to manage with signs and gestures to interact. In the end, the patient and caregivers were asked to go for a lab test. (Fieldnotes, documented on March 25, 2022)

A similar experience of using sign language with a patient was reported by a nurse. According to the nurse, there was someone to translate, but he was afraid that the patient's privacy might be compromised. The nurse narrated his experience as follows.

> There was a day a patient was brought here; he was a Fulani. I couldn't speak the language, nor could the patient speak my language. And looking

> around, there was only one young man, I spoke Dagbani to him, but looking at the case, it was sensitive, and bringing in someone to interpret, I wasn't sure, if I bring in this person, the information is sensitive, and they all live in the same environment. They may talk about the patient's condition later. So, in that instance, I had a big challenge. … So, I was now using sign language with the patient, and with the sign language too, I wasn't sure if I was recording the right information from the patient, … it was one of the days I had a serious challenge communicating with a patient. (N4)

Even though the nurse had someone who could have translated for him, he was not sure the patient's privacy will be respected. The above situation implied that, even amid interpreters or translators, other factors can still impede effective nurse-patient communication, as indicated by another nurse in the extract below.

> We try to find among the nurses who understand that language. … sometimes we even go to the extent of going to other wards to find a nurse or anybody who understands the language, and we will use that person to translate for us. But it's not always effective because the meaning may change. It's not also direct interaction with the patient. (N3)

From the above data, although using interpreters and translators to mitigate the language barrier was a useful approach to enhancing nurse-patient communication, that came with its own challenges. Patient privacy and confidentiality, meaning change, and the uncertainty of what is being said still prevailed. Moreover, translation and interpretation of medical and nursing language require not just the ability to speak a language but also being knowledgeable of both medical and nursing concepts and explaining these in simple terms to patients and caregivers mattered. Much more, the patient's voice is silenced when they are unable to interact directly with the care provider.

4.4.1.4 Poor Communication Creates Misunderstanding. Another barrier to effective communication identified from the data was misunderstanding between care providers and consumers. Nurses, patients, and caregivers all agreed that disagreements and conflicts between them were attributable to misunderstanding emanating from poor communication. For instance, a patient noted that when "things are not well-explained to patients, that can cause problems between us and nurses” (P9). A caregiver further observed that poor communication could cause conflicts and misunderstandings between them and nurses or between patients and nurses, as quoted below.

> Well, at times, it depends on how nurses begin their conversation with patients or caregivers, even the tone of the nurse when speaking with caregivers and patients. Patients and caregivers come from different societies, so, for some of them, the way nurses talk to them may not be appropriate. So, when nurses talk inappropriately to patients or caregivers, it can make them angry and cause disagreements or even fights. (CG4)

According to this participant, what is considered in/appropriate in language use can be culturally specific, as a result, misunderstanding in communication can emerge due to cultural differences in language use. Several nurses acknowledged that poor communication was a significant barrier to care delivery because miscommunication usually leads to misunderstandings between nurses and patients/caregivers. For instance, nurse (N4) indicated that “misunderstanding that has to do with our choice of language and the way the patient understands it” impacted care delivery. Aside from poor communication affecting understanding, another nurse considered that poor communication impacted patient satisfaction with care outcomes, as she related:

> Yeah, sometimes (clears throat), for the community here, I know, sometimes, it’s because of poor communication, eh, patients might not be satisfied, but once you open yourself up and communicate well with them, they are fine. (N7)

The above data showed that communication and language differences were significant barriers to healthcare delivery and access in the hospital. The nurses’ ability to communicate with patients and their relatives who spoke a different language than theirs mostly affected effective nurse-patient or nurse-caregiver interactions. These communication-related barriers to care delivery limited patient disclosure and engagement in the care process and the therapeutic relationships nurses had with patients and caregivers. Other obstacles to effective care delivery had to do with the healthcare institutional culture, structures, practices, and management routines, which I present in the next section.

4.4.2 Institutional Culture, Care Practices, and Resource Availability

Aside from the communication-related barriers explored in the previous section, several other barricades to care delivery in the study setting were implicated in the institutional culture and care practices or resource availability. In this section, I present and interpret four related subthemes to explicate the role of institutional practices and resource limitations on care access and delivery in the hospital. These subthemes include *institutional culture, context, and norms, equipment deficit and deficiency, human resource constraints,* and *poor nurse-hospital management relationships*.

4.4.2.1 Institutional Culture, Context, and Norms. In the hospital setting, I conceived of the institutional culture, context, and norms as relating to the daily care and nursing activities, practices, and human relationships that regulate care delivery and access. Issues around accessing care services, waiting times, visiting hours, and the environment of the care setting all influenced care delivery. Therefore, my focus in this subsection is on visiting hours and waiting time to access care services such as retrieving patient folders, taking laboratory tests, collecting medication at the pharmacy, and consulting clinicians/nurses. Other practices that define the institutional culture will be covered in other subsections.

Before any patient could access any care services in the hospital, they must get their folders from the patient records unit, except for patients requiring immediate labour, maternity, or emergency care. Despite the critical position the patient records unit occupied in the care delivery process, the activities of the unit had severe impacts on patients and nurses. In the following, I present the procedural outline of activities of the patient's record unit to contextualize its impact on waiting time.

Textbox 2: Accessing patient folders

The patient records unit is the first point of contact before any services are accessed in the hospital. When a patient comes there, the staff will key in his/her National Health Insurance Scheme (NHIS) number into their system to determine if the person has ever been to the hospital and to locate their folder. There is software that is used to help the staff check folder location and movement. Patients who have been to the hospital for a long time ago will have their folders kept as archives. Babies who are up to three months use their mother's NHIS cards to access care services before they get their own NHIS cards. So, when it's a baby the staff must check to see if the baby had used the mother's card. This usually makes things difficult to locate babies' folders. Also, patients who are non-insured, have expired insurance, or have recently renewed their NHIS cards must pay to obtain a new folder.

Textbox 2 continues

Patient folders are not to be sold to patients, so when patients pay for a folder, the fee covers the outpatient department (OPD) services and consultations. However, there is a lack of patient education around access to the patient folder. So, when non-insured patients are charged a consultation fee, it’s because they are not aware that they are not supposed to pay for consulting a clinician, which the clinicians even know. In this unit, two software are used (i) folder management software to monitor, locate, and retrieve patient folders and (ii) claims management software, which is shared with the pharmacy for billing and processing claims. When a patient gets a folder, a claims code (CC code) is generated, written on the patient folder, and keyed into the system. The CC code shows the active status of the patient’s NHIS card. The patient then goes to the OPD, for a nurse to record their vitals (blood pressure and pulse rate, body temperature, weight, and a case history). Based on the presenting signs, symptoms, and case history, a lab test can be requested before consultation with a clinician. After seeing a clinician, the patient goes to the pharmacy, where the CC code is entered to retrieve the patient’s details. Drugs are served and noted in the system. For drugs that are not available, a NIL is entered into the system, and patients are asked to go and buy the drug. However, sometimes, there are inconsistencies in the pharmacy unit. An alternative drug may be there, but the staff will not serve it. They will write the drug for the patient to go and buy. Other times, the alternative drug is served, and the original prescription is ticked in the patient’s folder. For out-patients, drugs are served and billed, and then the folder remains at the pharmacy unit for staff of the records unit to collect and file them. On the other hand, for in-patients, the folder goes to the ward for the drugs to be administered to the patient by nurses. When the patient is discharged, the folder goes back to the pharmacy for billing, and to crosscheck all the drugs served. Staff from the records then collect the folders from the pharmacy to sort and file them. All the cost of care covered by health insurance is then billed to NHIS. Due to staff shortage, folders can get stacked at the pharmacy or in the records unit. As a result, discharged patients who return to the hospital within a week will have a hard time accessing their folders. Things will get better if there is an officer solely responsible for collecting folders at the pharmacy on daily basis. However, only three staff of the records unit are permanent members. The rest are either casual workers or national service personnel. (Personal correspondence with a staff of the patient records unit, April 1, 2022).

A significant impact of the above folder management practices is that patients often waited for long hours to retrieve their folders. As a patient remarked, “we went for the folder, and the time we waited there … if a patient needs immediate attention, s/he could have died” (P1). Another patient stated that a challenge she faced while accessing care was at the patient’s records unit, “it was only when I went to remove my folder, … but there was no staff, so we sat there. We were only two, we sat there for some time before the staff came” (P9). It was not only patients that experienced challenges created by long wait times at the patient’s record unit, but caregivers also lamented about it. For instance, a caregiver said this regarding accessing services at the patient’s records unit:

> Sometimes, you can sit there for hours without getting your patient’s folder. They will say either the system is down, or the network is bad. Patients can sometimes sit there until they become tired or fed up. So, because of that, some patients will prefer to go and buy drugs from the chemist’s shop instead of coming to the hospital to waste their time. (CG4)

The problem with waiting for several hours to access care services was not only peculiar to accessing patient folders, but across several other units of the hospital, including consultations, collecting medication at the pharmacy, or accessing services at the lab and X-ray units. The following quotes discuss patients’ and caregivers’ experiences of long wait times on various units.

> The one place where we had challenges was in the pharmacy unit. We delayed there for long. If your condition is critical and you go there and have to wait for that long, it will be disastrous. The staff there are very slow. (P15)

> In all those places, like the X-ray unit, there is a big challenge there. The staff there don’t have time for their work. Patients will be waiting there, but if not until 10:00 am, no staff will come there to serve patients. You will wait there until you are tired. (CG6)

> The only concern I have is that sometimes, doctors take a very long time before they come to conduct ward rounds. Especially on weekends, there are times before a doctor/clinician comes to the ward, it’s already mid-day (after 12:00). (CG1)

Waiting for long hours before accessing care services seemed a normal daily practice that patients and caregivers noticed, as the above quotes illustrate. A caregiver (CG4) sums up the problem of waiting for hours to access services, as follows.

> Patients and caregivers can come to this hospital and sit for hours without anyone telling them anything. Sometimes, it doesn’t even look like the patients are here to seek healing. They will wait for hours, and nobody will tell them anything. (CG4)

The above caregiver was not only concerned with the long wait times but also the fact that nobody tells them why they are waiting or what the problem is. Most participants who express the impact of long wait times on care access were caregivers because they are the people who run around to get things done for their patients. Therefore, they face many challenges to access care in the hospital.

On the other hand, nurses also indirectly experienced a fair share of long wait times on care delivery, as this affected their relationship with some patients and caregivers. The following quotes from two nurses illustrate the effects of long wait times on nurses.

> For my unit, one of the things that cause problems is the waiting time. Sometimes patients come and the doctors are not available, when we are done with them and they are waiting, they get angry at us for keeping too long. Early in the morning those who come, they keep long in the queue waiting for the doctors to come and attend to them. … apart from that, it’s the records, how to get their folders, they delay there too for some time. (N2)

> Patients can come and spend several hours without seeing a clinician or not being talked to. So, they will feel very sad, and you can see and hear it from them. They are unhappy with the situation they found themselves in, [and] sometimes, they even talk to your face. (N8)

The effects of long wait times on care delivery, access, and nurse-patient relationships can be severe. Many patients, especially those who travel from villages and distant communities to the hospital, mostly do so on market days, and they have expectations of how long they want to keep in the hospital; therefore, when they go there and must wait for hours to access care services, it affects care satisfaction.

Another institutional culture and practice that affected care delivery was the lack of visiting hours or its implementation in the hospital. Effective visiting hours do not only offer patient relatives the chance to interact with patients, but it also allows patients the time to rest. It affords nurses the opportunity to regulate patient relatives' and visitors' movement into patient wards. However, visiting hours in the hospital were either non-existent or not being enforced, even within the dictates of Covid-19 protocols. Both interview and observational data revealed that the absence of systematic visiting routines affected care delivery. A nurse stated, "the truth of the matter is that we don't have visiting hours" (N9). In some patient wards, movement in and out was so pronounced that some patients noticed it. For instance, while I was having an interview with a patient, he said to me: "I have one question. I have seen that anybody can just walk into this ward. The nurses do not ask people where they are going or whom they are visiting. Why is that so?" (P15). Unfortunately, I did not have an answer to the question.

Because of the lack of vising hours in the hospital, the leaders of some patient wards devised a discursive strategy to regulate movement into the ward. Thus, movement into the labour and maternity wards was highly regulated by the leaders and nurses in these units. For the maternity ward, a physical barrier was erected with locks on the doors. Narrative discourses gathered during participant observation and interviews revealed some practices implemented to regulate entry into the wards. One narrative was around the discourse of 'attempted baby stealing'. It was narrated that several attempted baby-stealing incidents in the ward made the nurses insist on strict visiting hours or prevent caregivers from entering the ward, especially male visitors. A nurse indicated that several attempts were made to steal babies in the ward. However, anytime an attempt was made, someone else always sees that, as noted in Textbox 3.

Textbox 3: Attempted baby-stealing

There was a day, a man came in here as if he was visiting someone. Then he picked up a baby and was leaving through the back door. Luckily, someone saw the way he was walking and suspected it, so she shouted that someone was taking a baby away. The man then threw the baby and run away. I had to ask the hospital management to provide locks for the back door. So, they came and cross it and locked the back door, and within a few weeks, it was broken again. So, we had it locked securely this time round. There was another time, we had two mothers in this side room (she pointed at the room). One of them delivered and was feeling a bit dizzy. She kept the baby by her side on the bed. The other patient was not sleeping, but the way she was lying on the bed, anyone who sees her will think she was sleeping. Then a woman came in when the nurses were busy attending to other patients in the inner part of the main ward. She quickly took the baby and was leaving. You know,

Textbox 3 continues

at night, because of the nature of the outside light, you may not see people outside, but they can see you. So, someone saw what was happening. The other patient who seems she was sleeping, also saw the thief, and called out "madam, madam, someone has taken a baby", so one of the nurses rushed out and the thief (a woman) was holding the baby at the entrance here. The nurse took the baby from her to the theater for safety first, and before they could alert security, the woman had disappeared. (Fieldnotes, documented January 26, 2022).

These incidents made the hospital management, under pressure from the nurses in the ward, fence the ward's entrance and provided locks. Therefore, to access the main ward, one must pass through three gates.

Regarding the lack of systematic visiting hours and use of a certain expression for male visitors, a nurse noted other factors that influence their interactions with caregivers.

> The gender factor is there, because 'men are not supposed to be here,' in our ward. So, sometimes, you want to explain to them why they shouldn't enter there, but they won't understand. Once the wife is here, they also want to be coming in and out of the ward. (N5)

Similarly, I observed the following interaction between a male patient relative and the nurses in a patient ward.

> A male visitor wanted to see his elder brother's wife who was brought to the ward, but the nurses refused him entry. The male visitor came to the ward with a woman, who was also the patient's relative. The nurses told the man that, 'men don't go in there.' They said if a man goes in there, he might see the nakedness of other women. Instead, they suggested that the labor patient should come to the nurses' station (NS) so that the relatives could interact with her. The woman who was with the man said they wanted to check if their patient was given the blood transfusion recommended earlier. (Field notes, documented January 17, 2022).

Although the reasons provided for not allowing men into the ward were based on cultural and religious values of the society, it impacted nurse-patient family relations and defeated the purpose of encouraging men to accompany their wives to the hospital, especially for labor and maternity-related care. The male relative stated that he came from another town and was in the hospital since the morning and just needed to see the patient before going back home. Moreover, their patient had already been delivered because the woman who was with the man went to the patient and came back with the placenta in a polythene bag.

Surprisingly, on March 4, 2022, while I was observing nurse-patient interaction in the ward, a man came in and spoke to the nurse, and requested to see his wife who was a patient in the ward. He was allowed to see his wife. So, I asked the nurse about the expression, ‘men don’t go in there.’ The nurse said usually they do allow men into the ward, but that men are not supposed to go there because sometimes the women may not cover themselves very well. So, they prefer women going in there.

Based on my observation on March 4, 2022, I reason that the expression “men don’t go in there” does not seem to apply strictly in the maternity and labour wards. Sometimes, men do go into the ward to see their patients or deliver items (e.g., medicine, food, lab tests, etc.) to the patients. Also, imams and pastors did go into the ward from time to time to pray for the patients, and there were male nurses who work in these wards and interacted with all patients. Therefore, I interpret the expression as a discourse strategy that is used as a control mechanism to regulate movement into the ward at certain times of the day. Furthermore, the expression could be interpreted as gender resistance to men’s access to the wards, given that the cultural context of the study is a male dominated society. However, this expression was not used in the female medical and surgical wards although these wards are also female in-patient wards. Moreover, despite the maternity and labour wards were headed by female nurses, other patient wards had female ward leaders, but this expression was not used there. Lastly, this expression was not only used by the female nurses in the labour and maternity wards, but all the male nurses who work in these wards used the expression regarding male caregivers and visitors not being allowed into the ward. Consequently, it is less likely that this discursive strategy was used as gender resistance, but rather as a strategy to regulate male visitations to the wards.

Another set of institutional culture and contextual factors that affected care practices were poor lighting, limited space and beds, and unstable water supply. Due to poor lighting, providing care services at night in some wards was challenging, especially in the emergency ward. Although the facility that was used as an emergency unit was a temporary structure due to the ongoing construction of a new emergency department, the lighting system in the ward affected care delivery. In many cases, nurses and I had to use our mobile phone lights to help their colleagues carry out care routines at night, including stitching and dressing motor accident patients' wounds.

Regarding limited space and beds, almost all patient wards faced this challenge. It was noted that the problem even becomes severe in the rainy season when patient turnout is huge. Moreover, except for a few beds in a ward, most beds did not have bed coverings and patients must provide their own bed linens, otherwise, they use the bed without coverings. A nurse's comment about limited space and beds in the hospital:

> We have bed syndrome here. Sometimes the whole place is crowded, and they are no beds, … the space is not also enough, … during the peak season, the ward will be full, and no beds, so we will ask some patients to go home. (N10)

Some patients were even surprised, as they did not expect to see patients lying on the floor or on mats in the hospital wards. For example, a patient remarked that "it's quite surprising, … some patients are sleeping on the floor" (P7). Another patient noted.

> What surprised me was people (patients) lying on mats instead of beds. It means that there are not enough beds, … [but] every patient deserves a bed. If not a bed like this (pointed at a bed), at least there should be a mattress on the floor for patients. (P14)

Furthermore, during an informal chat with a few nurses about things that make their work difficult, a nurse stated that,

> There are limited beds and space in the wards. There are times some patients must lie on the floor without beds during the peak seasons when we get a lot of patients. (Field notes, documented on March 9, 2022).

The above cluster of structural barriers – long wait times, no systematic visiting hours, limited space, and beds – constrained care delivery and access impacting nurse-patient interactions and relationships in the hospital. Moreover, long wait times and lack of visiting hours often led to conflicts between nurses, patients, and caregivers.

4.4.2.2 Equipment Deficit and Deficiencies. This subtheme relates to the equipment, tools, and materials that nurses use to carry out daily care practices. The lack of or insufficiency of these materials constituted a critical obstruction to healthcare access in the study setting, as it affected nurses' enthusiasm to deliver care as well as their relationships with healthcare service consumers. Throughout the data, participants made references to lack of consumables, logistics constraints, lack of resources, and shortage of supplies. In this subsection, my focus is on the daily ward consumables, insufficient equipment, and challenges nurses face when using medical tools and or equipment that had deficiencies.

First, the deficit in daily ward consumables was recognized as a significant obstacle to care delivery in the hospital. Both nurses' interview and participant observation data showed how glaring this resource deficit affected the provision of healthcare services to patients and their caregivers. Daily ward consumables included syringes (2, 5, and 10cc), plasters, gauze, cotton, cannulas, intravenous sets (giving sets), needles, gloves (i.e., surgical, medical, and gynecological), tourniquets, and aprons, among others. These consumables were supplied to each patient ward or unit on a weekly basis, at the beginning of the week. If the materials supplied to a ward were used before the end of the week, which frequently happened, then patients and their caregivers were made to buy them for their own care needs.

The following reflects what nurses related as the challenges they faced due to an insufficient supply of consumables in the wards:

> eh, provision of the consumables, that is mainly our problem, [ok]. Sometimes, we consume a lot, we use a lot of them, and the administration doesn't understand why the consumption is so high. But they have forgotten that, hmm (laughs a bit), dealing with body fluids is difficult. (N7)

> … the consumables. As in the syringes and needles, gloves, and plasters. What we will need as a people to be able to eh work with, we don't have. So, it's a big problem. (N8)

> Some of the challenges eh are most of the things that we work with, the equipment, and other things that will allow us to provide proper care. We

> don’t have them, and you know that if this thing was there, you could do better, … if those things are not there, as a nurse, you feel that the patient is not getting the full care you could have given him. (N3)

As the above participant quotes illustrate, the lack of consumables did not only affect the quality of care provided but also negatively impacted nurses’ zeal and emotions. There were times nurses, especially in the emergency unit, had to ration the use of gloves. They will work without gloves just so that they can keep the few gloves they have in case severe accident patients were brought in.

The limited supply of these materials also affected patients and caregivers. For instance, on February 6, 2022, while I was leaving the hospital around 10 pm after observing nurse-patient interactions in a ward at night, I heard a caregiver, a woman in her mid-50s, lamenting about how she was going to get giving sets for her patient who needed a blood transfusion. The patient already had three ‘bags of blood’ and needed one more, but all the giving sets that were used were thrown away. The woman was asked to buy a new set because the ward had run short of their supplies. The caregiver was also new to the town because they had come to the hospital from another town, so she was very distressed and confused. I decided to take her on a motorbike in search of giving sets at various pharmacy stores in town. We went to four different stores, two of which were already closed for the night. Fortunately, we got the only two giving sets left in one store. The woman paid for them, and I took her back to the hospital. The woman could not thank me enough as she was pleased with the support that I gave her.

For patients, the lack of these materials added to their cost of care. Nurses asked many patients to buy these consumables when the wards run out of their supplies, as these nurses indicated:

> [there are] instances that patients come and the things that you suppose to use are not there. And you have no option but to write them for the patient to go and buy. The patient going there is a problem, already the patient has issues with the hospital. They say, ‘when you come to the hospital, it’s always this thing go and buy, that thing go and buy.’ So, at the end of the day, even if you are trying to get their attention, it’s always a challenge. So, the lack of logistics is a challenge that patients outside are aware of, that

> when I come to the hospital sometimes, there are things I have to go and buy. So, that one is a challenge. (N4)

> We have to write for them (patients/caregivers) to go and buy some items, [and] in the process of speaking to them, they ask you, ‘a whole hospital, and you don’t have this, and I have to go and buy it. All these, I have to buy them.’ (N10)

Therefore, the lack of sufficient healthcare materials constituted a significant impediment to care delivery. It added extra costs to patients care, demoralized nurses, and caused conflicts between nurses and patients.

Aside from the lack of daily ward consumables, there was also a deficit supply of several medical tools and equipment that nurses commonly use in nursing care. Some of the tools and equipment that were in limited supply included the hand-held blood pressure (BP) apparatus, stretchers, oxygen concentrators and cylinders, BP monitors, surgical blades, and cord clamps. More advanced equipment the hospital lacked included computerized tomography (CT) scans and kidney and liver function machines. Nurses struggled on daily basis to meet their patients’ care needs due to the scarcity of these medical tools and equipment, as observed:

> … most of the problems or eh, the bad moments, I will say, we have, is when we get a case that we knew, if we had this thing, if we have these devices, or these resources available, we could have helped the patient [ok], and it’s basically not there, … maybe you needed oxygen to give the patient, and it’s not available [ok], or maybe a particular kind of medical intervention that would have better helped relieve the patient, … so those kinds of things demoralize us. (N1)

Another nurse revealed that the lack of a CT scanner in the hospital affected their ability to manage a patient who was brought to the hospital with a head injury. The nurse related,

> One day we had a case, eh, an assault case. A son used a cutlass to butcher his father, and they brought the father to the hospital. The man (patient) was unresponsive, we suspected a head injury. But we couldn’t do a CT

> scan here. So, we refer them to Tamale for a CT scan and further treatment.
> (N6)

Lack of equipment in the study setting did not only affect care delivery but also threatened the survival of patients. For instance, a nurse narrated that some time ago, they needed a suction pump to revive an emergency patient, but it was not available. The nurses had to run to other patient wards to get this equipment, and before they got a manual suction pump from another ward, the patient had died, with the cause of death being suffocation. Therefore, it was a common practice for nurses to move from one ward to another to borrow a tool or equipment to deliver care services. This situation emphasized the dearth of materials and equipment in the hospital for care delivery. For instance, I was on a ward on January 13, 2022, when two nurses from a different ward came to the ward I was on. These nurses were looking for a stretcher and had already gone to the theatre and female wards. The staff of the ward they came to told them to go to the OPD because there was only one stretcher in the ward which was being used. Even for the nurses on that ward, anytime a patient was occupying the stretcher and they needed to move another patient to a different ward or to the X-ray unit, the nurses must move the patient on the stretcher to a different bed. Similar things happened with the use of the oxygen concentrator and BP monitors.

Furthermore, equipment deficiency was another factor that affected healthcare delivery in the study setting. One single most important piece of equipment that was used frequently but which regularly had deficiencies was the hand-held digital BP apparatus. Every patient ward had one which was run on batteries. Although there was a regular supply of batteries for these machines, an incident caught my attention, while I was observing nurse-patient interactions in one unit, which I noted in my field notes as follows.

Textbox 4: Battery for patients' lives

In this 21st century, it was a great surprise that a simple battery could prevent a whole unit in a hospital from functioning. Whose responsibility was it to supply the battery and why were the nurses reluctant to go for the battery or buy one? I went to this unit to observe clinical interactions for the morning shift. When the nurses for the morning shift took over from the night shift nurse, the BP machine was not working. The night nurse had used his personal machine so when his shift was over, he took his machine away. Apparently, the BP machine was not working because the batteries were dead. One of the nurses on the morning shift made several calls to their ward in charge and other units but did not get the batteries. It was noted that these batteries were kept by one officer who was not in the hospital since it was a weekend. Also, one of the persons the nurse had called earlier claimed that the ward had requested batteries the previous week and was given two pairs (4 batteries) with the belief that the unit was using two BP machines. However, there was only one machine there, which uses four batteries. The nurses said since they could not get batteries for the machine, they were going to work without using the BP machine, despite that, every patient who came to the unit must have their vitals checked and recorded. The nurses didn't feel the need to buy the batteries, because they felt that their work was not appreciated much. They also worried about the bureaucracies around accessing the barriers from the officer in charge or even asking for reimbursement for the batteries. I intervened and we were able to arrange for a pack of 6 batteries for the machine. It appears that many of the nurses in the unit were not happy working there not because they didn't love their job or the care they provide for patients, but because the system had failed them: it has failed to motivate them, provide them the simple tools and equipment they need to do their work, or honor them the respect they deserve. There was a growing apathy and resentment towards the system. The nurses deserve better, and patients and caregivers deserve the best care services and relationships with the nurses. (Field notes, documented January 8, 2022)

Besides, for many of the BP apparatus, some nurses did not trust their readings because the machines frequently break down. For instance, on March 1, 2022, I was at the female medical ward when an elderly woman came in, she wanted to have her blood pressure checked but the nurses told her that the BP apparatus was not working. The nurse told the woman to check the OPD or emergency unit, but the woman told them the OPD BP apparatus could not be trusted. She seemed to be a previous care professional who had worked in the hospital for some time because later I met her again when I went to the maternity ward, where she was checking her blood pressure with the maternity ward BP machine. The nurses in the female medical ward had challenges with this essential tool because they often borrowed the female surgical ward BP machine. I was told that the female medical ward had requested a new BP machine several months ago since theirs was broken. However, they were yet to receive a new one. As a result, they kept borrowing this equipment from the female surgical ward.

Other instances of equipment deficiency were noted regarding the hospital laboratory (henceforth, lab) test results. Many patients and their caregivers were often asked to go outside the hospital to undergo medical tests in private labs, as a nurse related.

> Another thing is the lab test results, most times, when we requests a lab test, we want to see what goes on in the patient's body before we start treatment, and sometimes, some of the tests are not done here. Patients and their relatives may have to go outside the hospital to get those lab tests done, and some patients have problems with that. (N11)

Due to inconsistencies in some lab results, many nurses and clinicians doubted medical test results from the hospital lab. A case in point was what I observed in one ward on March 8, 2022, as captured in Textbox 5.

Textbox 5: Patients face challenges with the hospital lab tests

A sick child was brought to the ward. The child was anemic, so the nurses needed to know his blood level. Two lab tests were conducted in the hospital lab, but the nurses doubted the accuracy of the results and asked the caregiver to do the same test outside the hospital in a private lab. The nurses indicated that even after the baby was given one blood infusion, the difference between the previous and recent results was not encouraging. Two nurses also complained about malaria test results they had for another child. The nurses said when the result came in, the number of parasites indicated was unbelievable. The nurses thought the lab staff either didn't take their time or the equipment in the lab was faulty. Also, they stated that there were certain medical tests that could not be performed in the hospital's lab. It was stated that the hospital did not have kidney and liver functioning machines to conduct these tests. A full blood count could not be conducted in the hospital, because either the hospital did not have the machine for that, or it was not functioning. So, patients were often directed to go outside the hospital to perform these and many other medical tests in private labs. When I heard these concerns, I was wondering whether the equipment in the lab were old to produce accurate results or the suspected errors were due to faulty

Textbox 5 continues

recording on the part of the lab staff. If the lab equipment were old, did the staff or unit leader notify the hospital management? I engaged myself in this self-dialogue for a while. The question I asked myself was, whose responsibility was it to ensure that these machines were available or functioning in the hospital? How did the absence of these machines affect effective nurse-patient interactions, care outcomes, and patient-centered care? How did the cost of running these tests outside the hospital impact patient/caregiver relationships with nurses? With these bothering questions in mind, I scheduled a meeting with the laboratory unit leader for his perspectives on the issues raised. (Fieldnotes, documented on March 8, 2022).

A follow-up with a member of the hospital lab revealed that many tests were not conducted in the lab because of the cost involved in running those tests. I also learned that top-up payments for some tests had not been discussed with the hospital management, community leaders, and patient representatives. The staff explained that many lab tests could be done in the hospital, but because it was not clear yet how the top-up cost would be settled, patients had to go outside the hospital for those lab tests. Furthermore, it was revealed that there were technical challenges around the count of parasites for certain infectious illnesses depending on what approach was used (i.e., microscopic or antigen approaches). As a result, discrepant test results were often produced, including some malaria tests. The information received from my interaction with the laboratory staff showed that indeed issues around equipment availability and functionality, as well as the staff expertise, affected care delivery and quality in the study setting.

4.4.2.3 Human Resource Constraints. For healthcare delivery to be efficient with quality care outcomes, there should be sufficient human resources with the requisite skills and training. Unfortunately, the shortage of human resources, including nurses, clinicians, doctors, and other specialist professionals (social health workers, orthopedics, physiotherapists, etc.) was a serious stumbling block to care delivery and access in the Yendi Hospital. Although many nurses were registered professional nurses and midwives with high-quality training, their numbers compared to patient volume were still low, thereby affecting healthcare service delivery. The following view expressed by a nurse underscored how critical nurse shortage limited nurse-patient interactions and healthcare service delivery and access.

> Here, and in other places, I do not know about all hospitals, but I am sure that in most hospitals, it’s patient relatives who go for medications because there is a limited number of nurses. There can be three nurses during the night shift taking care of close to 60 patients, especially in the medical and pediatric wards. You see, you can’t be the very nurses who are attending to the patient’s problems, you have to give them, e-know, medication, feed them, all that, and only two, three nurses. It’s not possible. (N1)

Other nurses noted similar challenges around human resource constraints in the hospital. For example, a nurse (N4) said, “the number of nurses compared to patients, the poor care provider-patient ratio is a big challenge” for care delivery. Another nurse stated that “the nurses, we are not many, so it makes our work stressful” (N10). A nurse (N5) believed that some patients have psychological problems due to relationship pressure at home which nurses can help them overcome through therapeutic conversations. However, staffing problems will not allow nurses to engage meaningfully with patients.

The problem of human resource constraint was not limited to only the nursing workforce but extended to clinicians, doctors, and physicians. These nurses pointed out a major challenge they faced with an insufficient number of clinicians in the hospital.

> Ideally, the emergency environment should have been that we should have had eh a clinician, if not an emergency specialist, … a medical officer, or a physician assistant stationed with us so that once we are doing our nursing interventions, he takes care of the medical aspect. But our clinicians, we have them in limited numbers. (N1)

> We don’t have doctors. I don’t know if something can be done about it. Because the clients are suffering a lot. They will come, and there is no doctor. Only one doctor is here, and the other one and his sister are just temporary, … our hospital is too big for this. The clinicians do their best, but they need doctors to confirm their work. Sometimes, some cases are just for the doctors. There should have been doctors there to see patients. Some cases that come there are beyond the clinicians. (N5)

The challenge is that clinicians who served at the OPD were the same people who conducted patient ward rounds for reviews; therefore, the above nurses’ narratives revealed how shortage of clinicians also affected care delivery. Some clinicians noted this challenge. For instance, on January 11, 2022, I was at the nurses' station in one patient ward when a clinician came in for a ward round to review patient cases. After the review, we had a little chat, and he made the following remark.

> There is supposed to be a clinician here, but currently, there is none. These are some of the challenges we have. I am supposed to come for an afternoon shift, but I came here (to the hospital) in the morning to do ward rounds because there was no available clinician. Then I waited for my afternoon shift. It's tiring! (Fieldnotes, documented on January 11, 2022)

The excerpt above supported what many nurses said about staff shortage. Because there was no clinician stationed in the emergency unit, when an emergency case required a clinician, the nurses had to call for one at the OPD. However, the nurses could call a clinician who may have other patients to attend to at the OPD or on other patient wards. This situation did not make it easy for these care professionals to attend to emergency patients promptly. Sometimes, it took hours before a clinician to showed up. On such occasions, I often asked myself, what happens to patients whose emergency cases require immediate attention?

Besides nurses, clinicians, and doctors, the hospital also lacked specialist care professionals to provide certain care services. A nurse participant revealed that "in this hospital, we don't have an orthopedic unit, not even an orthopedic nurse specialist in the hospital" (N1). Moreover, there were no social workers to provide social care and support to patients and nurses who needed such services. Besides, at the time of my fieldwork, the hospital just received three new sanitation and hygiene specialists who had previously been nonexistent in the hospital.

The human resource constraints noted above had implications for care delivery. First, insufficient nurses meant that caregivers were to perform most other duties nurses would normally do, such as taking patient specimens to the lab for tests, moving patients to other wards/units, and taking care of inpatients' personal hygiene needs (e.g., bathing and cleaning them). Secondly, limited numbers of clinicians and doctors affected nurses' work and their relationships with patients and caregivers, as nurses were often at a crossroads. Thus, poor staffing at the patient records unit and few clinicians at the OPD often resulted in patients insulting and blaming nurses for long waits at the OPD. Thirdly, in some instances, nurses had to perform the role of clinicians, which mostly resulted in ethical dilemmas and conflicts, some of which I will highlight later. Furthermore, many nurses developed apathy for their job and resented working in the hospital due to what they called management neglect of their affairs and personal growth, some of which are reflected on in the next subsection.

4.4.2.4 Poor Nurse-Hospital Management Relationships. Effective healthcare leadership has a positive impact on healthcare staff, service provision, and interpersonal relationships and interactions. In a healthcare institution, where the staff feels appreciated, valued, and managed well by their leaders, the staff is happy to perform their duties beyond expectations. However, the nursing workforce in this study felt not listened to, motivated, and supported. Several nurse participants indicated that there were poor management practices and relationships between the nursing staff and the hospital management, which affected the nurses' sense of duty to the facility and care consumers. I present a narrative by Kate (a pseudonym for N5) to illustrate some of the issues several other nurses pointed out as being problematic and which affected care delivery and nursing practices in Textbox 6.

Textbox 6: Nurse-hospital management relationships by Kate

I have worked in this hospital for a very long time. When we started, you could be the only nurse on duty in a ward taking care of all the patients. Now, it's better. We can be three or four nurses on duty. Even though things are improving, we still have many challenges in our ward and throughout the hospital. There is a shortage of personnel and insufficient equipment. There are also administrative factors that affect our work. We don't have doctors. Yes, doctors are not here, and not that they are not willing to come. But they hear about this place, 'if you go there, this or that is what happens.' Will they come here? And theirs is not like nurses, where they can just push you anywhere. The nurses too, sometimes they will post five of them here and only one will come. The rest will not come. Just because of that notion, 'when you go there, if you want to go to school, you can't go. If you want to do this, you can't do it.' You can't do further studies. Those things discourage nurses from working here, so nobody wants to come. Because this is what they hear about this place. We used to get doctors who do their housemanship here, but they have not been coming. Also, the administration, our leaders don't listen to us. If we have issues, you don't know who to send the issue to. When you go there, they shout at you. They don't listen. They are not good listeners (0.7). I don't know why. The town has concerned citizens. So, whatever the concerned citizens come to tell them, they just take that one. But, as for nurses, they don't care. Yes, they should make themselves available, so, that if somebody has a problem, the person can confront [consult] them.

Textbox 6 continues

The problem too is that as nurses we don’t often meet to discuss things because here there is no freedom of speech. Sometimes, you will say something, and they will say, you said this. Under normal circumstances, we should have been having that kind of leadership, if you have a complaint, you go and meet that person, and then it is carried on. But this hospital, it’s not there. So, when you even have a problem, you don’t know whom to talk to. And when you go to the administration, they make you look stupid. And for the work to go on well, they should be good listeners. Whatever I come to pour to you, just listen, but they are not like that. So, sometimes, we keep our problems to ourselves. Meanwhile, if there was someone to listen to you, it could help you. Another issue is about going to school for further studies. You’ll see that seniors [nurses] will be there, and juniors are going to school. You can fill out your study leave form; it will go, and they won’t endorse it. So, that one too is not helping us. It doesn’t encourage us. You will see that you will not be happy working. When you are due to go for further studies, they will tell you that if they allow everybody to go who will work?’ but when you are at a workplace, there should be room for personal growth, [because] I don’t have to be stacked at one place. Like, you cannot go near the administration, or anybody at the administration and tell them, ‘Oh, I want to do this.’ So, for me, this is what I want you to capture. Instead of them to listen [to us], they don’t. So, they don’t care about what we say. They don’t care. And that’s not how to rule people. Whatever they are saying, all the nonsense, they may be something you can use to correct yourself. But don’t just preoccupy your mind that whatever they (nurses) are saying is nonsense, or I won’t mind them. The work cannot go on well, with such attitudes. That little understanding can cause somebody’s life. If I am frustrated working, will I care more about the patient? Especially the school aspect, when we came here, we were not many. We sacrificed. We never did further studies. We were just there. For if you leave, the work will not go on well. So, there should be a time when the administration should even call some of us and ask, ‘won’t you go to school? It seems, they [the management] seem not to care about anything. They are just doing what they want. If you want, go to hell. That’s the situation here. I am sure you have heard other nurses complaining about the same issues.

The above narrative by a nurse identified several management-related issues that affected the relationships between nurses and hospital leaders. Many other nurse participants expressed similar frustrations and challenges about management practices in the hospital. Some of the specific management-related issues that nurses frequently talked about at the nurses’ stations included lack of motivation, difficulties around getting paid study leave, lack of support for nurses who had professional and personal challenges, as well as not being heard when they have problems. Other concerns were mistrust of nurses and a culture of fear and silence in the hospital that prevented nurses from speaking up, or even when nurses speak up nothing has changed. Regarding motivation, several nurses lamented the lack of motivation in the hospital, as noted below:

> Motivating staff is just something that is not there at all. The staff is not motivated, and when they have issues, members are left to handle that by themselves. All those things are conditions that are very, very unfavorable to us, as a unit. (N8)

> … one of them is motivation. As a nurse, … we need to be motivated. Not necessarily being given money. So, yes, motivation is one of those factors. Another factor is communication between the nurses and the management. Most times the communication gap is very wide because is like we are not close. … the communication system should be enhanced to make sure that all nurses can get closer to the management. (N11)

Another nurse said that motivating nurses is something he has not seen in the hospital, “I am not seeing such things here. There is no just motivation here. Also, things don’t get improved. (In) other places, they are no longer using folders, but we still do” (N4).

Regarding paid study leave, many nurses were not happy about the handling by the hospital management. The following nurses spoke about study leave saying:

> It’s a challenge. I have worked elsewhere before coming here. There, if you wanted to go for further studies, they will not disturb you. They will support you. In some facilities, they will facilitate that for you. So, nurses there will feel that their work is being appreciated. Because no matter how high the person goes, he will definitely come back to offer his/her services to the facility. (N4)

> Our seniors, we normally hear that they (referring to the hospital management) don’t help them to get paid study leave. … if I am a nurse and have been working for over six years, I have been trying my possible best to get study leave, but the hospital doesn’t do anything or doesn’t care about me, you see that it will affect me. Because I would have also wanted to go and further my education, but since the hospital doesn’t care about

> me, or my welfare, then I will also be doing anything I want in the ward.
> Yes, and sometimes, the treatment the hospital gives to many of the nurses is not fair. (N11)

The above nurses' perspectives showed that lack of motivation and the difficulty with getting paid study leave affected many nurses' enthusiasm to deliver compassionate care. These nurses felt that their welfare was not a concern to their managers. The situation was worse as many nurses looked at their colleagues and classmates who work in other hospitals. The nurses saw that their colleagues in other hospitals upgraded their skills and qualifications, yet they did not have such opportunities. On January 7, 2022, while I was at the nurses' station on a patient ward, the nurses talked at length about management-related challenges they face in the hospital. Many nurses were dissatisfied with the way the hospital management treated them, especially concerning the lack of motivation in the hospital. One nurse even said if any hard-working nurse comes to the hospital, the work culture will turn him/her into a lazy nurse.

Similar topics often came up at the nurses' station across different patient wards. The nurses remarked that there was no law and order, no motivation for them, and minimal or no support for them to get paid study leave. Some nurses stated that when new nurses, clinicians, and physician assistants are posted to the hospital they refuse to come because of the management-related challenges in the hospital. A nurse recollected that when they completed college, many nurses were posted to the Yendi Hospital but only two of them came. Another nurse remarked that even when nurses come to the hospital they want to leave after working there for two years. The nurses who were engaged in this discourse believed that the problems in the hospital were systemic ones. They said the management hierarchy of the hospital lacked separation of powers, checks, and balances between the top management officers. A nurse said,

> the matron, medical superintendent, and administrators have teamed up. So, anytime there was an issue involving a nurse, instead of the nurse manager looking into the matter, it will become the whole management's issue. This has resulted in a culture of fear and silence: speak up and get punished or be silent and have your peace. (Field noted, documented on March 1, 2022)

Similarly, on March 2, 2022, a nurse made the following remark concerning their welfare in the hospital:

> Nobody fights for nurses in this hospital. When you get a problem, you are on your own. When there is a problem with a nurse and you take it to the matron, she will also take it to the medical sup. Whatever decision the medical sup takes is what the matron will act on. (Field notes, documented on March 2, 2022)

Thus, motivation, study leave, and nurses' welfare were major discourse topics at the nurses' stations in the hospital. In addition to the above, the nurses felt that there was a culture of fear or silence in the hospital, as mentioned earlier. With the culture of fear and silence, people were afraid to speak up, or even if they did, nothing changed. The following excerpt from nurses illustrated the culture of fear and silence:

> It is just the hierarchy, people are afraid of them to an extent that even those of us the junior ranked personnel you cannot express your, your frustrations and feeling, or opinions to them. They will tend to block your salary for months. So, all these things are issues that have not been helping at all. (N8)

> Nurses who have personal or professional needs and problems can't easily go there or reach out to them. Sometimes, they even make nurses fear going closer to them. (N11)

> Eh well, in that direction, maybe let me say … the culture of silence that I want to say is when you speak up, if you are not even punished, but nothing is going to change. (N9)

Closely related to the culture of fear and silence was institutional bureaucracy. Institutional bureaucracy was about the challenge nurses faced with getting things done, especially related to getting resources on time to provide care for patients. A nurse captured the effects of institutional bureaucracy on care delivery in the following words:

> The bureaucratic nature of the hospital, you may have to write to this office, that officer, and so on. There are instances you need oxygen, and a

> simple call should have gotten us that, but sometimes you talk to this or that person before. So, such processes make our work difficult. (N4)

Earlier, I narrated how nurses in a ward nearly work without a BP machine simply because of the bureaucracy around getting batteries from the management. These bureaucratic practices around the use of material resources seemed to have been fueled by mistrust between nurses and the hospital management. For instance, I was informed that nurses were banned from bringing backpacks to the hospital during their shifts. The reason for the ban was that the hospital management suspected that some nurses steal supplies in their wards. Furthermore, connected to the mistrust was the notion of whistleblowing, a practice where a few nurses were believed to be feeding the hospital management information about other nurses. Therefore, the fear of being reported to the hospital management silenced many nurses on issues that affected care delivery, nurses' welfare, and safety, including enforcing or instituting visiting hours on their wards.

For instance, on February 2, 2022, a discussion on visiting hours came up at the nurse's station in one patient ward. The nurses complained about how caregivers frequent themselves in the ward. I asked them why they were not enforcing visiting hours or regulating the visitations. A nurse said if they wanted to implement the visiting hours, caregivers insult them, and the hospital management does not do anything to change the situation.

> We have just left things to be like that. Whatever it is, we don't care much about it. We don't want to have issues with the caregivers, after all, if there is a problem, the management will not even support you. (Field notes, documented February 2, 2022)

The final management-related practice which had an impact on nurses' work was what many nurses called the annual rotation or reshuffle of nurses to different patient wards/units. As an annual management practice, some nurses were transferred from one patient ward to another ward. The nurses had different opinions about this management-related practices. For some nurses, the practice had both positive and negative effects, while others thought that it was not the best practice. Two nurses said the following about the practice.

> It does affect us negatively and positively, [ok]. Because most of us are general nurses, so you are fit to work at any unit you find yourself in. So, if they are taking you from one unit to the other, probably you won't do the same things you were doing at the other unit, but you will learn. You will learn. However, if you were already in an old ward that you worked for a year or two, you have adapted to their culture, the way they do things. So, it affects us positively and negatively. (N6)

> Yes, those annual changes should be like two years. It shouldn't just be yearly. A year is too short. For those changes, if you come to a patient ward, at least you should stay there for two years before they change you. So, yes, this is a challenge. (N5)

Other nurses felt that the problem was not the rotation per se, but the lack of uniformity in its enforcement because some nurses claimed that a few of their colleagues refused to accept the reshuffling, and nothing happened to them. It was assumed that ward leaders and the matron were not fair in how they determined who was moved to another ward.

Aside from nurses, few caregivers spoke about how poor management practices affected care access. A caregiver remarked that waiting for long hours, not getting one's folder on time, and not having clinicians to consult were system-related problems attributed to poor management. She said, "it's a management-related problem … which makes the work of nurses difficult" (CG4). Also, on January 10, 2022, while I was at the emergency unit, a visitor came to see a patient. After the visit, he was complaining to another visitor about what he went through in that ward the previous week when he brought his son to the ward. He said he had to request a discharge and took his patient to another clinic because of "poor services". He added, "the administration of the hospital is weak, that is why the hospital lacks so many things".

The above cluster of factors impacted on care delivery and/or access in the hospital and ignited negative perceptions among patients and caregivers about the hospital and nurses. Many residents of Yendi had discouraging reservations about activities in the hospital. These negative views about the hospital led to poor relationships between the hospital management, nurses, and the Concerned Citizen of Yendi (CCY), a youth-based social pressure group in Yendi. This group petitioned the hospital management severally on issues, including poor institutional resource management, unsatisfactory care practices, patient negligence, and alleged medical malpractices. It can be argued that most of the above management practices that affected nurses' welfare could have been byproducts of interventions the hospital leaders instituted to look favorable in the society and in response to CCY.

4.4.3 Health Literacy and the Cost of Care

Health literacy in this study was conceived as the ability of healthcare consumers to receive, process, and understand healthcare information that could help them make decisions about their care needs and routines. Although being literate through formal education can have a positive relationship with health literacy, it is not always so. Thus, in this study, low health literacy appeared to be an impediment to healthcare access among many patients and caregivers.

Despite Ghana having established an NHIS to reduce the cost of care for insured patients, patients and caregivers still had to purchase significant care services elements with cash. Patients paid for medical tests, medication and drugs, and medical materials used in patient wards. This situation affected patients' ability to access care and further strained their relationships with nurses. I explored how low health literacy and high cost of care affected care delivery and access herein.

4.4.3.1 Low Health Literacy and Patient Care Needs. Nurses believed that many patients and caregivers who accessed care services in the Yendi Hospital had low health literacy. Based on participant observation and nurses' conversation, health literacy among patients and caregivers reflected their ability to understand care routines and practices, and their role in the care delivery process. Thus, low health literacy among patients and caregivers impacted care routines, patient disclosure, nurse-patient communication and interaction, and patient self-care management. This situation resulted in negative perceptions of care outcomes and a lack of appreciation of what care providers do. Low health literacy among patients and caregivers, which was captured as the lack of knowledge about care process and what patients and caregivers must do to enhance positive care outcomes, was evident in the study data.

One effect of low health literacy on care delivery was that patients and caregivers interfered with or obstructed care processes, as emphasized in the following:

> The triaging center, as I said earlier, I told you that when patients come, we triage them, and when we do that, we may know which patients need

> immediate attention, but patients who were here earlier than the one needing immediate attention will not understand. They will say they came first and now you want to send somebody else before them. It becomes a problem. Because you are a nurse, you see what the patient is going through during triaging, but they don't see it, they are always fighting us over it, sometimes you explain to them, and they don't understand. (N3)

Another nurse (N6) explained how low health literacy among patients and caregivers impeded care delivery, especially during emergency care.

> Here, sometimes, caregivers do interrupt our work. there was a case we had that we were preparing to send to the theatre. I explained to the caregivers that they shouldn't give anything by mouth to the patient. Then a new patient came in, we were all concentrating on that, then I saw a man holding a cup and spoon. What was inside? Tea: that the patient said he was thirsty, he was feeling hungry and so the caregiver wanted to give him tea small. So, they don't see porridge or tea to be food. When you are going to explain to them that they shouldn't give anything, you don't use food only, you must include water. Don't give water, because they will give porridge, tea, and water, and when you ask, has the patient eaten? They will say no. Then when you go down, what of porridge, they will say, oh he took porridge small. (N6)

These nurses' experiences illustrate how caregivers' low health literacy impacted care delivery. In the case of nurse (N6), the nurse believed that the outcome of the surgical operation would have been unpleasant if the patient had consumed the tea.

In addition, low health literacy can affect medical data as patient disclosure could be compromised. Patients can withhold critical care information about their illness because either they are unaware of its value, or they are afraid nurses and other healthcare professionals will blame them. When patients fail to provide full disclosure about their health conditions, documented health data can become misleading, and treatment options may not target the right condition, thereby resulting in poor care outcomes, as a nurse suggested.

> Some patients are not well-educated that if you go to a hospital and they give you this or that medicine, it is done purposely for your own health.

> Sometimes when they come [and] you ask them questions, they will give you answers, and later you will find out that they had given you contradictory answers. So, that one is always a challenge when you are going to take care of that patient. (N4)

Again, low health literacy affected care practices around patient self-care management. Regarding this challenge, some patients and their caregivers demanded discharge even when the patient was still critically ill or required a blood transfusion. For instance, some caregivers whose patients required blood transfusion requested that the patients be discharged claiming that when they go home, they will arrange the remaining quantity of blood needed by the patient, as noted here.

> When the doctor said they should check her blood and they did, we were supposed to get people to come and donate blood for her, but we didn't get anyone then. It was yesterday that two people came and donated. But we were thinking if they give her one pound of blood, we could go home and get the other one. (CG11)

A similar case came up in the maternity ward when I was observing nurse-patient daily interactions on January 28, 2022. A caregiver came to request from the ward in charge that he wanted his wife discharged so that they could manage her at home. The patient was having low blood count. She was given three units/bags of blood and still needed one or two more. The caregivers were asked to get more blood for the patient. The ward leader informed the caregivers that their patient could not be discharged because patients with low blood count and high blood pressure needed to be kept in the ward for close monitoring to get them stabilized.

The ward leader's response was logical on medical grounds; however, she failed to ask why the caregivers wanted their patient to be discharged. Was it because they could no longer bear the cost of providing more blood for their patient? Did the patient ask them to make the request? What was the patient's opinion about the request? I thought the midwife would have asked these questions. However, the midwife told the caregivers that she had no capacity to discharge patients and that it was the doctor's responsibility. She believed that when the patient was discharged and taken home, the husband would do nothing to manage the patient's low blood count problem.

The above two scenarios illustrated a lack of understanding regarding blood transfusion and reflected low health literacy among those caregivers. How were they going to get the blood outside the hospital, and even if they did, how will they get it into the patient's body? Perhaps, a private nurse could be called upon to help, but that would defeat the whole purpose of leaving the hospital in the first place.

I observed another incident that I interpreted as a reflection of low health literacy. On February 1, 2022, I went to one patient ward to observe nurse-patient interactions. When I got into the ward, a doctor was in to review patient cases. I sat at the nurse's station. I realized that the doctor was not happy with the patient he was interacting with. Later I learned that the patient came to the ward the previous day and was attended by the same doctor. The patient was asked to go for her folder, but she left and never came back, despite her critical conditions (i.e., high blood pressure and over-term pregnancy). Even though the patient may have had her reasons, I interpret what happened the previous day as suggesting low health literacy. The incident implies that some patients do not appreciate or comprehend the severity of their health conditions, possibly due to a lack of knowledge.

Narratives about other events further demonstrated low health literacy among patients and caregivers. One narrative was the case of "*no injection means no treatment*." The nurses reported that some patients and caregivers think that when they go to the hospital for any treatment, they must get an injection. If they are not injected, they feel that they have not been treated. For instance, on January 20, 2022, while I was interacting with nurses in the labour ward, it was revealed that many patients get dissatisfied when they come to the hospital and are not given an injection or drips as part of their treatment. The same topic came up in another ward. A nurse narrated that a patient once told her that if he was not injected, he would never recover. So, the nurses injected the patient with distilled water. These narratives suggested that some patients have perceptions and expectations about their care needs in the hospital, and when those expectations are not met, they think they have not been treated properly.

Furthermore, whereas these incidents suggest low health literacy, they also highlight patients' and caregivers' care expectations, as well as the need for health education. Patients and caregivers need to know that different illnesses require different treatments, and that not every illness requires an injection or infusion. By informing patients and caregivers about basic healthcare processes and practices, including medication plans, treatment options, and reasons why certain care routines are performed, healthcare consumers can understand their conditions better and what roles they must play to enhance self-care and recovery.

Despite the assertion of low health literacy among most patients and caregivers, few patients demonstrated being knowledgeable about the care process and their role as patients. For instance, recognizing the relevance of full disclosure, a patient (P10) took all the drugs and medicine he bought from drug stores when he was sick and went to the hospital. The patient said,

> When I was coming here, all the drugs I told you that I bought from the drug stores, I brought all of them here. Even when I was going to see the doctor, I took all the drugs there. (P10)

Another patient (P7) indicated that he was familiar with the care processes required for his health and so he always interacted with nurses.

> I see myself being familiar with the processes here, and I speak well with the nurses. I ask them a lot of questions, if you ask one of them, they can even testify to that. (P7)

Note that patients (P7) and (P10), unliked many other patients, had formal education, as they were post-secondary students at the time of data collection. Therefore, their level of education could have influenced their claims of high health literacy.

Health-literate patients sometimes face challenges in the hospital, despite the negative impact low health literacy had on nurse-patient interactions. Patients and caregivers who are health literate and wanted to express their views in the care delivery process are perceived to be “too known”. These patients and caregivers usually quarrel with nurses, get neglected, or refused certain care services. For instance, on February 1, 2022, I was observing clinical interactions in a patient ward. A caregiver whose patient was in the ward shared his experiences with me when I asked him about his relationship with the nurses. He told me his relationship with the nurses was not good because they ‘killed his baby’ some time ago. I was shocked and asked him to explain what he meant by that statement. Then he related the following.

> My wife was in labor, so I rushed her here to the labour ward. She was calling the nurses for support, but they neglected her. When she was about

> to deliver, she told the nurses the baby was coming but they didn't mind her. So, we lost the baby. The nurses said my wife was telling them how to do their work, so they were annoyed with her, and when she was calling them and screaming that the baby was coming, they didn't bother to attend to her.

This narrative suggested that the patient might have asserted her rights as an enlightened patient which angered the nurses. She became a patient in the "too known" category and was neglected, even when she was in a critical state. Although some patients and caregivers can provoke or treat nurses badly, healthcare service users may genuinely be health literate and want to assert their rights or participate in the care process.

The above analysis and interpretations show how health literacy impacts care delivery and access in this context. Other factors (e.g., cost of care) can intersect with health literacy in certain circumstances. I explored how the cost of care affects care access in the next subsection.

4.4.3.2 Cost of Care. Cost of care was determined to be a critical hurdle to healthcare access in the study setting. It was encapsulated in the many things patients and caregivers buy or pay for in the hospital while accessing care. And before I delve much into how the cost of care affected healthcare access in the hospital, I present the experiences of Mba (pseudonym for CG6). Mba was a 40-year-old male caregiver who brought his sick mother to the hospital. They had stayed in the hospital for three days prior to my interaction with him. Mba was multilingual and could speak at least two languages effectively. He was a farmer and butcher and had only a basic level of education. Mba shared the following personal experiences about the cost of care in the hospital.

Textbox 7: Experiencing cost of care.

I brought my sick mother here and we have been here for 3 days now. My mother's interaction with the nurses is good because she is an elderly person, you know our culture. But since we came here, all the things we need for my mother's health and care, we have to buy it, some from outside the hospital. Almost everything, I have to buy. Even if they say they are going to give you this or that, in the end, I have to go out and buy it, or they will say if you have money, we have the items and will sell to you here. We have a valid NHIS card, but we still buy everything here. Even the small pipe they use when giving a patient water, they will say bring money, someone is selling it here. The nurses will tell me the hospital has run short of the item, but if I bring money, they can sell what they have to me. Regarding my communication with the nurses, I don't have problems with that. They speak Dagbani to us all the time. Sometimes you can go to the pharmacy for medicine, and they will tell you they don't have the drug. They will tell me if I have money, I can get it to buy in the hospital. If I have money, they will sell some of the drugs to me in this hospital, and those they don't have here to sell, then they will ask me to go outside and buy them. If I don't know anything and want to ask questions for clarification, it will turn into a fight. It will turn into a fight. They will tell me they know what they are doing, and why am I asking them. Actually, what has surprised me about this hospital is the number of things patients have to buy. Patients are buying a lot of things. We buy too many things. Sometimes the item will be here, but they will tell you to pay for it. You must pay before you get it. If it was outside, you know that the hospital doesn't have it, but many items are in the hospital, but they will tell you that this or that is not covered by NHIS. They will tell you to bring money before they serve you that. … that's it. [And] already, you don't know what is covered or not under NHIS. … for some patients, if the nurses ask them to do this or that but the patient doesn't have money to buy them, the nurses will leave him and attend to others. Unless the patient's caregivers/relatives come and buy those things, nobody will look at him/her. They will come and deliver written notes to me and tell me to go and buy the drugs or items written [on the note]. Sometimes, you can even be told to go and buy medicine at the pharmacy and when you go, the staff there will be toasting you up and down. Some of them will even tell you that they have closed for the day, yet the person who will take over from them is not yet in. I have experienced [it] at the pharmacy. Yes, the person will tell you that he has closed; meanwhile, someone must come, the staff will hand over their shift before leaving, but he will just say, he has closed. So, this is also a challenge. They will tell you they have closed, that they are going to do some calculations. So, the buying is too much in this hospital.

The experiences of Mba resonated with comments of many other caregivers and patients. Many nurses also confirmed that patients and caregivers did buy or pay for several things in the hospital, including materials commonly used in the wards. This obstacle to healthcare access was crucial because many patients had NHIS coverage. The rhetoric is that patients and caregivers who had NHIS coverage were the ones who reported receiving poorer care. Like Mba, another caregiver (CG1) said following about the cost of care in the hospital.

> I think paying for medicine and other items causes problems [between patients and nurses]. We pay for medicine than we are given. Only drips that we mostly get without paying. … they will say this or that is not covered by NHIS, so we must pay for them. Sometimes we pay for things in the ward, other times we pay at the kiosk in the lab, and other times we buy medicine outside the hospital. (CG1)

Buying or paying for things in the hospital became a major cause of tensions between nurses and patients/caregivers. For other participants, it was a source of worry.

> There are challenges, that is why I said they should just tell us our bill so that we can see what to do. It’s better because for now, we don’t know how much we are owing. We know they will discharge us, but we don’t know yet, how much we will be paying for everything that we have accessed. We have bought different medicines and paid for them, but we have not been told the amount we will pay for others before they discharge us. So, for now, we are in darkness. (CG11)

For this caregiver, not knowing how much they owe was a source of worry because they were unaware of the amount they would be required to pay before the patient was discharged.

Other patients were surprised that they had to pay for medicine at the pharmacy because they were valid NHIS holders. Moreover, the pharmacy staff did not inform them why they were paying for the medicine. One participant narrated:

> Hmm, the only thing that surprised me was the pharmacy there, they gave me drugs, some drips, and injections and asked me to pay GHS 60. 00. I didn’t know what the GHS 60.00 was about, because I [had] a valid health card (NHIS). I didn’t want to ask. I wanted to know the reason why I was paying that GHS 60.00, but maybe you may ask the people and if they are quick-tempered, they may get angry. I feel bad because I am the type of

> person when I do something, I prefer to know the reason I am doing it. So, paying the money without knowing the reason why I was paying it. And since yesterday, I have been wondering. (P8)

The patient wanted to inquire about the payment, but she feared being scolded or labelled a “too known” person, if the staff was quick-tempered. Here the patient positioned herself as being powerless and to save his positive face (not to be embarrassed), she did not pursue the matter further. Even though not every care service and medication are covered by NHIS, insured patients must be made to understand why they pay for certain services and medicines to reduce their anxieties and worries.

In contrast, patients without health insurance coverage were not surprised when asked to pay for drugs, medicine, or lab tests. For instance, without a valid NHIS card, the following patient had to pay for several things.

> We bought some drugs. We were told to go to the lab to pay at the GCB kiosk and come back. We paid for the lab test (GHS 20.00), and another GHS 20.00 at the clinician’s place before we were directed to the pharmacy. At the pharmacy, we paid GHS 116.00 before I came to this ward. (P17)

Hence, patients and caregivers who had no health insurance were in for “cash and carry”, knowing they must pay for every service before it is rendered to them, except in emergency cases, as a nurse said.

> I think our response to emergencies is better than in the wards, in the sense that if a patient is non-insured, you wait for the person to finance the cost before they get treatment. But in an emergency, you carry on the necessary procedures, and they will pay later. (N6)

The above nurse’s contribution explained why patients and caregivers were surprised or complained about paying and buying a lot of things even with valid NHIS cards. Thus, if non-insured persons must pay before care services are rendered to them, insured patients will be surprised when put in the same situation. During the focus group, additional information about the subject was revealed.

> **FGP4(LF):** For me, I have a valid NHIS card. But the only medicine we get is paracetamol. If there is any other thing, it’s water infusion, and they will even ask you to go and pay for it. You will pay before you go for the medicines.
>
> **R**: Do they tell you why you are paying?
>
> **FGP4(LF):** No, they won’t tell you. You will just pay. Also, they will tell you to go to the lab for a test, then you will do the test and pay for it.
>
> **FGP3(L Im):** It was yesterday that my NHIS card expired. And when you go for medicine at the pharmacy, it’s paracetamol they give you.
>
> **R**: So, before your NHIS card was renewed, for every service you accessed here, you paid for it?
>
> **FGP3(L Im):** Yes.
>
> **FGP2(R Im):** For me, this morning after the operation when we went there, they handed a bill of GHS 291. 00 to me. It was my husband who went and paid the cost.

The above discussion highlighted the plight of patients around the cost of care and whether having valid NHIS coverage was helpful. Some of the participants complained that they paid a lot for services, drugs, and medicine, yet they received less than what they paid. It was even a challenge for nurses to ask patients or their caregivers to buy healthcare materials. This situation made nurses, patients, and caregivers as victims of circumstances because the hospital’s lack of these medical materials was outside their control. A nurse reported how they felt whenever they asked patients to buy things that the hospital should have provided.

> With regards to the challenges, when patients come to the ward, without the ward or hospital having basic things that we should have had, like the cannula, giving sets, and other things, that we needed to have, we write it for patients to go and buy. And it looks like we are depriving them from enjoying those things. Sometimes they don’t understand. … they think we are the ones squandering those things and telling them to buy it. (N11)

Therefore, the high cost of care, as reflected in what patients and caregivers buy or pay for, was a significant impediment to care access. The situation could have been influenced by a few factors, both internal and external to the hospital setting. Within the hospital, material resource limitations and the desire to increase internally generated funds (IGF) for hospital-related management activities could have accounted for the situation. Among patients and caregivers, poverty, or lack of knowledge about what is covered by NHIS could have also influenced their healthcare-related expenditure. An external factor that could have contributed to resource limitation, especially the daily ward consumables, was delays in reimbursing the hospital with the claims by NHIS. Whatever the trigger factors are, the reality is that cost of care was a critical barricade to healthcare delivery and access in the Yendi Hospital.

Another significant issue relating to the high cost of care that could have strained nurse-patient relationships and impacted care outcomes was a poster requesting care consumers to demand receipts for payments made. Through a critical discourse lens, I analyzed and interpreted the poster to be a rhetorical tool with embedded power in Textbox 8.

Textbox 8: A discourse analysis of a poster

PLEASE DEMAND RECEIPT FOR ALL PAYMENTS MADE

SAMPLE RECEIPT

MINISTRY OF HEALTH / GHANA HEALTH SERVICE

BY MANAGEMENT

Textbox 8 continues

“Please demand receipt for all payments made”: The poster has three crucial visual components. There is a directive sentence written in capital letters and in red color. Two photos with different denominations of the Ghana cedis and two hands exchanging money come below the bolded sentence. Then a sample receipt comes next after the photos. By physical description, the directive sentence requests that once money is exchanged for any healthcare service or item, a receipt must be collected. Not any other receipt, but the one bearing the Ministry of Health/Ghana Health Service title. The receipt must indicate the payer, amount, and services paid for. It must be dated and signed. The poster shows that it was issued by the hospital management. Thus, the agents specified or implied in the poster are the institutional management, care providers and consumers, the financial representatives of the institution, money, and the receipt.

From a critical discourse perspective, the poster seemed to be a discursive tool with embedded power. First, who is the subject of the directive sentence, emphasized in the text (written in upper case and colored)? Presumably, it’s the patient or their relatives. Who enforces that directive: the patients, nurses, or hospital management? The document constitutes a potential source of conflict between nurses and patients/caregivers. Demanding a receipt for things bought or services received, especially in the labor and maternity wards can be a face-threatening act (FTA) to nurses and can affect nurse-patient relationships. When nurses retail daily ward consumables to patients and caregivers when the hospital run short of supply of these materials, how would they issue receipts for the materials sold to healthcare consumers, since the money will not be going to the hospital. Could the care received be affected? Certainly, yes, because any patient or caregiver who demands any receipts will be positioned as being “too known/demanding”. Further, the poster implies that patients will pay for things and services in the hospital, yet no information is provided about what services or items patients must paid for. This leaves the issue of payment very open to anything within the hospital. Moreover, despite that there is an embedded power in the poster, the question is who has that power. And how will that embedded power implicate patient rights in nurse-patient communication around the cost of care already discussed?

Per the above analysis, conflicts and ethical dilemmas were to be expected when patients/caregivers demanded receipts for buying things or paying for care services in certain care contexts. Furthermore, instead of putting patients and caregivers in vulnerable situations, the hospital management could have demanded that receipts be provided for all payments made to shift the responsibility of providing receipts onto the selling agent.

4.4.4 Personal Attitudes and Health Beliefs

Other obstacles to healthcare delivery and access in the Yendi Hospital included negative personal attitudes and health beliefs influenced by cultural values and practices. In this subsection, I present and interpret participants' personal attitudes and health beliefs and their impact on care in the study setting.

4.4.4.1 Health Beliefs and Care Access. In this study health beliefs were understood to mean individual and societal perspectives, worldviews, and understandings about the cause of certain illnesses and their remedies. These beliefs are often based on people's experiences, knowledge, and observations about illnesses, their causes, and modes of treatment. The beliefs may align with or contract biomedicine and medical practices. A few health beliefs were noted in this study, their implications for healthcare delivery and access, as well as care outcomes. Many of these beliefs were noted during clinical observations of nurse-patient daily interactions and in nurse participants' interview data.

One crucial health belief was the incompatibility of injection with some illnesses. Some nurses reported that a patient with a boil or stroke will refuse an injection. For instance, among the Dagomba, it is believed that these illnesses become worse and could even kill a patient when s/he is injected. As a result, patients with boils or stroke will either not go for hospital treatment at all, or even if they do, they will refuse any form of injection. A nurse (N3) reported the following about boils and injections:

> They are some beliefs that make it difficult to talk to some patients. For example, it's common here, that when a patient has a boil, it is very difficult for you to convince such a patient to come to the hospital. They believe that when they come to the hospital and you give them an injection, they will die. So, belief systems affect our relationships with patients. When they come and you try to explain to them, they see that you are challenging their beliefs, they assume that you think their beliefs do not exist. (N3)

Also, on January 14, 2022, while I was observing nurse-patient interactions in the emergency ward, a patient was rushed in. According to the relatives, the patient collapsed at home. He was supported to stand on his feet, but he could not move his leg or speak, so the relatives brought him to the hospital. Upon clinical examination, the patient was diagnosed with a mild stroke. The patient was stabilized but his speech was a bit impaired. The next day when I went back to the ward, the relatives asked me to speak to the clinician on their behalf. They did not want the patient to be injected and that they had also spoken to other family members, and it was agreed that the patient should be discharged so he could be taken home for "local" (traditional) treatment. The caregivers feared that if the patient was injected, his situation would get worse (e.g., he may never recover or could even die). I told the nurses what the patient's relatives had requested from me. Then the nurses called the clinician and informed him of what the caregivers said. The clinician asked them to write a letter requesting discharge against medical advice, which they did, and the patient was discharged.

After this incident, I had some thoughts. Although the patient was being discharged against medical advice, I wondered if that reflected his wishes or his relatives. Was the situation a medical dilemma? I wondered whether the patient would have wished to be discharged if he could speak or if the patient had the same beliefs about stroke and injection as his caregivers. Moreover, the nurses had a different opinion. They believed that it was not right for the relatives to take the patient home for traditional treatment. One nurse indicated that usually patients who are discharged against medical advice often do not get any better and may have to return to the hospital. The nurse said a similar issue occurred in another ward with a patient who had comorbidity (stroke and other conditions). The relatives took him home and when his health was not improving, they brought the patient back, but unfortunately, the patient died.

Other health perspectives and their effects on care delivery were reported by nurses. For example, a nurse revealed that there are times a patient is transferred to the Tamale Teaching Hospital for further management of their health condition. However, instead of the caregivers being prompt with the transfer, they wanted to perform spiritual consultations to determine whether the patient will be successfully treated when they honour the transfer, as narrated in this dialogue.

> **Researcher (R):** Are there some societal or cultural factors that also affect your work or relationship with patients?
>
> **Nurse (N4):** Yes, at times, patients come with cases and you want to refer them for further management, like [Tamale Teaching Hospital] TTH, you will meet the relatives and explain to them how far you have gone with arrangements, instead of them listening to you as a professional, they will

> say before they go, they have to also do some consultations to see if the road is safe for them.
>
> **R:** Consultation as in informing other family members or doing divination?
>
> **N4**: Yeah, going to do divination to ascertain whether it is safe for the patient to be taken there. And sometimes, the patient will come with a fracture and because we don't have an orthopedic surgeon, you will want to send the patient to Tamale to see a specialist, and they will tell you that they want to go for a local treatment. They will say they know someone who has ever been there and was treated well. They believe in the local treatment than going to Tamale for the orthopedic specialist to see the patient.

From the above dialogue, it was revealed that caregivers and patient relatives engage in spiritual activities to determine if certain biomedical practices would yield positive health outcomes for their patients. Such beliefs and practices sometimes influence patients and caregivers to combine both traditional medicine and biomedicine even when receiving treatment in the hospital. For instance, regarding using traditional medicine, a nurse remarked that patients' health beliefs at times affected nurses' work, although such practices are becoming less frequent. The nurse said:

> Now it's better. At first, it was frequent. … Things have changed. They used to bring in local concoctions. A patient can be in this ward and the relatives will still prepare the local concoction and bring it here to give to the patient. Now, it's better, we don't see it much. (N5)

Many patients and caregivers believed that certain illnesses are better treated using traditional or biomedicine or a combination of both medical systems. Therefore, when a patient uses traditional medicine while receiving treatment in the hospital, it is because of such beliefs. Nonetheless, most nurses, clinicians, and doctors detest such practices. Patients are usually insulted, scolded, or even neglected when they use traditional medicine while at the same time, they are receiving treatment in the hospital. Note that Ghana operates an integrative healthcare system, and the Yendi Hospital has an herbal medicine unit. Moreover, the study participants noted that because patients and caregivers believe that some illnesses are better treated with traditional medicine, they can request patient discharge against medical advice. Other patients and caregivers will not even go to the hospital with certain illnesses, including stroke, boils, born fractures, and spiritual-related illnesses.

Regarding infant and child health, a few health beliefs were found to impact child and maternal care practices, according to nurse participants. A nurse (N11) reported that "some mothers have 'superstitious' beliefs that when they give their children eggs or meat, the child will become a thief" when they grow up. Also, during my clinical observations of nurse-patient interaction and communication in a ward, a conversation came up about health beliefs, and the narrative below was noted.

> It's a cultural belief among this ethnic group (name withheld) that when a new baby is born, the mother does not touch the baby or even breastfeed it until after a week. 'They don't even allow skin-to-skin contact, so you cannot place the baby on the mother's chest immediately after delivery'. So, the baby will be kept at the Neonatal Intensive Care Unit (NICU) until a week has passed and they have performed their traditional rituals. 'There was a day we had a patient, the husband requested that when the baby is born, we shouldn't give it to the mother, that it was their cultural practice, so after the baby was born, we called the husband and the baby was handed to his mother, who took the baby to NICU. (Field notes, documented January 28, 2022)

Nurses may have different perceptions about these beliefs and practices, nonetheless, they respected patients' beliefs and supported them and their caregivers in the process. The above scenario demonstrated that some nurses are culturally competent and are aware of how cultural beliefs and differences influence healthcare practices. Inferring from the data, cultural sensitivity and competence will be critical to honouring patients' health beliefs during care delivery, especially in this multicultural setting. However, how these cultural practice impact child and infant health, especially regarding infant nutrition is outside the scope of this study.

Aside from patients and caregivers, nurses also believed that spiritual activities did interfere with their caring roles. The following dialogue illustrates how spirituality and health beliefs influence healthcare access/delivery and nurse-patient interactions.

> **Researcher (R):** So, for the period that you have worked in this hospital, what has surprised you about nurse-patient interaction and communication practices?
>
> **N9:** Nurse-patient interaction and spirituality, [ok],
>
> **R:** Please, explain that to me.
>
> **N9:** Let me say that, without scientific proof but physical proof of someone being inflicted with a disease and the supposed or accused person accepting such accusation, performing rituals and later the patient is discharged and seemed to be looking better in that regard.
>
> **R:** You have witnessed that yourself?
>
> **N9:** Yeah, yeah, it happened here in this hospital.
>
> **R:** That is surprising then. How did you feel about that situation?
>
> **N9**: Oh, well, it was something we never believed, … let me give you a few lines about the story. … so, the issue was that, like, we had this patient we were treating for some time ago, that was in the female ward. Then, the relatives were talking about spirituality, that someone afflicted the patient with the illness. We never believed it until the accused person came to the ward. Ah, we gave them some privacy. She went in with the patient, whatever they did, the patient got healed, it was surprising.
>
> **R:** So, the person was accused, and s/he accepted it and treated the patient.
>
> **N9:** Yes, they had to bring the person to the ward and the patient became well.

A similar report about health beliefs, spirituality, and care delivery was noted when I was observing nurse-patient interactions in a patient ward. At the nurses’ station, different discourses came up on different healthcare topics. A narrative was presented about what happened some months back, as captured below.

> There was a female patient who had stayed in this ward for over a month. I was worried about the patient, so I began observing her. I noticed that anytime her family/relatives came to visit her, she could not speak, even if she wanted to talk. You could see that she was struggling. So, when I observed that for some time, I informed the hospital leadership about it, and they told me that I should never allow those people into the ward where the patient was. So, anytime they came, I will collect the food they brought myself and send it to the woman. When we did that for a few days, the woman suddenly recovered. Meanwhile, we conducted test after test and couldn’t find what was wrong with the woman. But she was well a few days after we stopped the relatives from visiting her. And later when she gave birth, she came here to thank me for saving her. She said, after she delivered, some of her family members didn’t come to the naming ceremony, claiming that she had accused them of witchcraft. I asked her, ‘didn’t the child get a name when those family members refused to come?’ She said the baby was named. Again, I asked her, “did their refusal to come for the naming ceremony stop the ceremony?’ She said, No. I told her the most important things were her safety and her baby. (Fieldnotes, documented January 26, 2022)

This narrative showed how health beliefs, including notions of spiritual illnesses, to some extent, regulated nursing care practices and nurse-patient relationships during care delivery. These narratives recognize that nurses are aware of the spiritual dimension of health although sometimes they dismiss that dimension.

Another prime aspect of healthcare delivery that had several health beliefs around it and which presented challenges for nurses and clinicians was the issue of blood donation. The nurses’ narratives and participant observation data revealed that some patients and caregivers have fears when they are told that they should look for blood. It was even reported that members of certain ethnic groups will never donate blood to their patients, as described in the following nurse’s story.

> As for people from these ethnic groups (names withheld), they don’t want to hear the expression ‘go and donate blood for your patient.’ They will say I want to buy. Who will donate blood for you to buy? The hospital has

> arranged with some people who usually come to donate blood for the hospital. How can you then go and tell the lab staff that you want to buy blood? (Field notes, documented January 28, 2022).

The above remark was made when a caregiver from an ethnic group, whose members are believed to dislike donating blood, was asked to get blood for his labouring patient. The caregiver told the nurses that he did not get blood from the lab, so the nurses asked him and his friend to donate blood for their patient, but the caregivers said they did not have a matching blood group. The midwife advised them to donate whatever blood type they could get so that the lab staff would replace it with the type their patient needed because another patient may need the blood group they donated someday. After listening to the back-and-forth discussion between the nurses and the caregivers, I had a dialogue within the self: Why do people from these cultural groups find it hard to donate blood to their patients? Is it that they lack health education or that they have cultural norms that prohibit them from donating blood? While I was still engaged in this self-dialogue, one of the nurses said that a day ago, a caregiver from that ethnic group said he would not donate blood because he was a farmer and believed he did not have enough blood. According to the nurse, the caregiver said the farming season was beginning and that if he donated blood, it would affect his health, energy level, and ability to farm for the season.

Aside from health beliefs and the fear of donating blood, I think that low health literacy, lack of health education, and inability to perform daily social roles may be some mitigating factors making it difficult for members of those ethnic groups to detest donating blood. Instead, they prefer to buy blood. Thus, caregivers' and patient relatives' resistance to donating blood led to a discursive discourse around accessing blood from the hospital blood bank. In Textbox 9, I undertake a critical discourse analysis of the discourse of accessing blood in the hospital.

Textbox 9: A discourse of needing blood vs. buying blood.

Accessing the blood bank or getting blood from the hospital lab has a rhetorical discourse around it. When a patient needs blood and goes to the lab to request it, whether s/he will get it depends on how the request is made. If the patient or the caregivers say they are going to buy blood (the discourse of buying blood), the lab staff will not give them the blood, even if they have the blood type the patient needs. However, if the request is made in a way that the patient is looking for blood to support his/her health (the discourse of needing blood), then they will get it. The patient or their caregivers will be helped to get it even if they cannot donate or get someone to donate the blood group needed by the patient, a different blood group type could be donated to replace the one given out. The condition is that "once a patient or their caregivers say they are going to buy blood, they will not get it, because the lab does not sell blood. People come to donate blood to the hospital, so a discourse of buying blood will not produce any positive results; a discourse of needing blood will prove fruitful. "You don't buy blood, you beg for it", a nurse will tell a patient. A significant reason why 'a discourse of buying blood' will fail was based on some events around accessing blood in the hospital. It was alleged that people accessed blood from the hospital blood bank for spiritual and ritual purposes, as a result, people who used to donate blood to the hospital refused to do so. This situation made it difficult for the hospital's blood bank to provide blood for patients. Stakeholder consultation was held with the hospital management, laboratory staff, and other hospital and community members which led to a consensus that selling blood for non-medical use or for use outside the hospital was prohibited. This event perhaps regulated the discourse of accessing blood from the hospital. (Field notes, documented January 28, 2022)

Therefore, the nurses coached patients and their caregivers who needed blood on what to say when they went to the lab. Otherwise, using the wrong expression could deny or delay their success in getting blood from the blood bank. The discourse of buying blood vs. needing blood was a rhetorical practice for two reasons. First, patients and their caregivers did pay to get blood from the blood bank if the patient's caregivers cannot donate blood (either the required blood type or any other). The second reason is that caregivers who requested blood needed it for their patients' survival. Nonetheless, to think that the hospital sells blood would be morally questionable, given that blood in the blood bank is often donated freely to the hospital by individuals of goodwill. As a result, the discourse of needing blood positions the hospital as a moral entity subjectable to social ethics.

4.4.4.2 Negative Personal Attitudes and Professional Practices. Negative personal attitudes and professional practices by nurses, patients, caregivers, and clinicians constrained nurse-patient therapeutic relationships and communications, impeding effective care delivery and access in the Yendi Hospital. Negative personal attitudes were behaviours that did not promote good relationships during healthcare practices and clinical interactions. In contrast, negative professional practices were clinical practices by nurses and clinicians that deviated from ethical and standard care delivery practices. These individual attitudes and professional practices stifled communication and affected people's emotions. Below, in Table 3, I summarize the significant personal attitudes and professional practices that these participants considered improper in the care setting. These summaries are based on both the interview and observational data.

Table 3:

Summary of negative personal behaviours and professional practices

Categories	Examples of negative attitudes
Patients	• refusing to follow or take prescribed medicine. • absconding without being formally discharged • doubting nurses' knowledge and skills • disrespecting and insulting nurses • having negative preconceived mindsets about nurses • running away from the hospital after being admitted for surgery. • leaving the ward to go home and bathe and missing clinical reviews. • reporting healthcare conditions late to the healthcare facility • refusing to be admitted for treatment
Caregivers	• not observing visiting hours • fighting or quarreling with nurses • refusing to stay outside the ward when nurses and doctors do clinical rounds. • disrespecting and insulting nurses • not appreciating nurses' support • looking into patients' folders and discussing other patients' illnesses • accuse nurses of stealing patients' drugs/medicine
Nurses	• shouting at patients and caregivers • getting angry at the least provocation by patients/caregivers • demeaning and insulting patients/caregivers • discriminating against patients/caregivers • failing to properly coordinate care with other nurses. • discussing patients' conditions with student nurses without the patient consent

	• not engaging patients/caregivers in the care process/decision-making • lateness and absenteeism at work
Clinicians	• dismissing nurses’ suggestions and recommendations • disrespecting nurses • consulting patients in public spaces and in the presence of other people • lateness and absenteeism at work • closing early from work or leaving the hospital without notifying nurses who work directly with them. • not explaining patients’ medical test results or health conditions to patients

Source: Fieldwork, 2021-2022

As shown in Table 2, patients exhibited several attitudes during clinical interactions that nurses considered detrimental to effective healthcare delivery. For example, a caregiver (CG7) observed that “the nurses are the ones providing the patient with care, so if they give a patient medicine and s/he refuses to take it, then the nurses won’t see that as good”. Some patients doubted nurses’ knowledge and skills, as a nurse explained:

> Sometimes patients think we don’t know our left from right when we are trying to do our professional work. So, we may feel disrespected, but we keep it to ourselves. Sometimes you get home and remember it, and it hurts you. (N3)

Doubting nurses’ skills and knowledge resulted in conflicts when nurses could not control themselves. Another patient attitude that nurses disliked was when patients reported their health conditions late at the hospital. A patient participant in a focus group discussion espoused, “Even the day I came here, the nurses were blaming me and accused me for not coming to the hospital early …” (FGP4). However, as a patient noted, many of these negative patient attitudes were attributed to pain and the patient’s illness state.

> No matter how the patient reacts to a nurse, we are here for their help. They shouldn’t take things personally. Some people are there if they are, for instance, me, when I am seriously sick; even those who are close to me, you will get angry at me. The things you expect me to do, I won’t do it exactly. So, my only advice for nurses is to be patient with us. (P8)

It was not only patients whose conduct affected clinical interactions. Certain caregiver behaviours also constrained care processes and nurse-patient relationships. Caregivers’ poor attitudes that nurses considered hostile included refusal to leave the ward when clinicians come for case reviews or during nurses’ medication rounds. Also, when caregivers disrespected nurses and/or accused them of stealing patients’ drugs/medicine, nurses reported this as bad behaviour. Other negative caregiver attitudes were reading or looking into patients’ folders and discussing patients’ illnesses.

Regarding these caregiver behaviours, a patient (P15) stated that “when nurses come to give medication to patients and ask caregivers to leave, some of them don’t want to go out,” which often causes conflicts. A nurse also believed that untoward caregiver behaviours influenced some patients to misbehave during nurse-patient clinical interactions. The nurse said:

> When a caregiver insults you or misbehaves in front of the patient, there is no way the patient will cope with you; she won’t obey you. She will even disrespect you. (N10)

Another nurse explained how caregivers’ negative perceptions of nurses affected nurse-patient relationships and interactions in the hospital.

> Some people at home often feel that we (the nurses) are not doing our best. So, when they come to the hospital, they have a preconceived mindset, and are already angry with the hospital staff. So, sometimes if you meet such a person, it doesn’t make your work easy. Any little thing, he starts shouting, you know. (N1)

The above patient and caregiver attitudes negatively impacted nurse-patient communication and interaction and affected nursing care practices and patients’ perceptions of their care outcomes.

Nurses’ behaviours also affected their communication with patients and caregivers. Both interview and observational data showed that nurses’ conduct, including shouting at, disrespecting, fighting, insulting, and demeaning patients and caregivers affected nurse-patient therapeutic relationships. The most talked about negative attitudes/actions of nurses that impacted negatively on nurse-patient interaction and communication were shouting at or getting angry at patients/caregivers. Others were discriminating and/or neglecting patients’ needs or requests. Regarding some of these nurse attitudes, a patient said, “There are some nurses, when they shout at you, even living here with them for just one day will make you want to leave the hospital” (P2). Another patient remarked, “I don’t like it when someone shouts at me, and some of the nurses, something small, the way they’ll react, the next time you enter the ward, you will be having some fears” (P8).

Caregivers believed that patient negligence and nurses’ disregard for caregivers affected nurse-patient-caregiver interactions and care access.

> The thing that causes problems here is patient negligence. When we call them, and they delay, sometimes you can go back to remind them, and they get angry. So, if the caregiver is not also patient and gets annoyed, then there can be a quarrel. So, if a caregiver calls a nurse and the nurse is busy, s/he should tell us that they are doing this or that. However, if they don’t and shout at us or even try to send us away as if we don’t matter, that’s when we also become angry. (CG1)

Many nurses acknowledged the poor attitudes and conduct of their colleagues. One nurse observed that “some nurses try to engage patients when angry, so they exchange words, and I think that hasn’t been good” (N2).

These negative attitudes among patients, caregivers, and nurses impacted their relationships and the care provided. Being aware of these attitudes and exercising patience and understanding among all the parties will minimize these poor personal behaviours.

Finally, clinicians’ attitudes and work ethics affected their professional relationships with nurses and the care rendered to patients. Although the study was focused on nurse-patient interaction and communication practices, the work of clinicians emerged as crucial and determinative of successful care outcomes. Clinicians’ conduct did not only affect nurses’ care practices and routines, but it also determined patients’ care. Some clinicians’ behaviours pushed nurses, patients, and caregivers into compromised and conflictual relationships. Lateness to work, absenteeism, and leaving early from work were observed among a few clinicians. There were times nurses had to search for clinicians to attend to patients. Such situations motivated me to interact personally with a few clinicians regarding my observation of their clinical practices and attitudes toward nurses.

4.5. Summary of Findings

Four complex and interlocking barriers and/or gaps to effective health delivery and clinical interactions are presented in this chapter. These obstacles to effective care delivery included communication and language use challenges, shopping translators and interpreters, and using nursing professional language. Language barriers between nurses, patients, and caregivers affected communication during nurse-patient clinical interaction, and this situation influenced patients' and caregivers' perceptions of nursing care in the hospital.

Healthcare institutional culture and care practices also determine therapeutic care delivery. Within that broad theme, material and human resource limitations and poor relationships between nurses and hospital management were found to obscure nurse-patient communication, interaction, and healthcare service provision. Furthermore, low health literacy and high cost of care constrained healthcare access and nurse-patient relationships, including trust. Negative personal attitudes of nurses, patients, caregivers, clinicians, and health beliefs also influenced clinical nursing practices and nurse-patient communication outcomes.

In the following section, I discuss these barriers to healthcare access in the context of universal healthcare coverage, effective communication, and nurse-patient-caregiver therapeutic relationships. I further reflect on these in Chapter 5 when I explore patient rights in clinical interactions and how these impediments to healthcare delivery and access enhanced or inhibited these rights.

4.6 Discussion of the Findings

The purpose of this chapter was to consider the first research question: What are the barriers and facilitators to effective communication during nurse-patient interactions in the healthcare setting? Several obstacles to primary care delivery and access were noted in the results. In this section, I discuss the findings considering the extant literature to demonstrate how these barriers affect realizing the health-sustainable development goal.

One of the significant impediments to healthcare service provision and uptake identified in this study was directly related to communication. Multiple interrelated factors affected healthcare interactions and nurse-patient relationships. These included language barriers, professional nursing language, the use of translators/interpreters, and poor communication. Linguistic diversity among patients, caregivers, and nurses has been identified as a challenge to effective communication and interaction due to language barriers

(Adebayo et al., 2020; Agyemang-Duah et al., 2019, 2021). Studies across different geographical locations have acknowledged the role of communication in healthcare delivery and how communication barriers often interfere with the process, leading to poor healthcare outcomes (Al-Kalaldeh et al., 2020; Dhungana & Dhungana, 2020; Sethi & Rani, 2016). For instance, Sethi and Rani (2016), in a cross-sectional descriptive study in Pune, Maharashtra, revealed that language, cultural, and environmental barriers affected nurse-patient communication. According to Sethi and Rani (2016), language differences between nurses and patients and nurses' lack of communication skills impacted effective communication.

This current study found that many nurses, patients, and caregivers in the Yendi hospital are bilingual speakers. Nonetheless, language barriers emerged as a force that limited communication and interactions. Similarly, Younas et al. (2022) reported native language differences between nurses and patients and patient illness states emerged as barriers to effective communication and PCC in two acute hospitals in Islamabad, Pakistan. Younas et al. (2022) observed that because nurses could not speak patients' language, patients and their caregivers felt reluctant to interact and communicate their needs. This study found similar results, as language barriers, especially the lack of shared language between nurses, patients, and caregivers, muddled effective communication in the Yendi Hospital.

The appropriateness of language use due to cultural differences was a challenge to effective communication in the Yendi hospital. A nurse categorically stated that there are medical and nursing concepts he could not explain in his first language, let alone in another language, which underscored the difficulty that language differences pose in clinical communication. Nyaaba et al. (2020) previously reported the language barrier as a significant obstacle to hypertension control in Northern Ghana. Nyaaba and colleagues observed that "communication difficulties in translating hypertension to people in the local languages (Dagbani or Gurune) were attributed to the lack of a local word or group of words to explain the medical condition to patients (Nyaaba et al., 2020, p. 18). The problem of language discordance observed in the above studies reflected communication as a theory of competence-in-performance (Weigand, 2010a; 2015; 2017b), where linguistics competence must balance with pragmatic performance.

Communication challenges around language use and the effects of cultural differences in nurse-patient interactions are reported in the literature (Han et al., 2020; Lum et al., 2016). Unexpected communication competency arising from differences in first-second language discourse markers incongruency, language proficiency, tone, and other cultural differences in language use presented communication challenges to both nurses and patients in Canada (Han et al., 2020). It is observed that participants actively engaged in creating joint attention and exchanging information among themselves during social interaction; as a result, when participants in clinical communication do not use the same first language, a language barrier arises due to a mismatch in vocabulary (Han et al., 2020, p.107). The findings of all these previous studies are consistent with the results of this current study, as language use challenges were apparent between nurses and patients who had no common first language. Even where nurses and patients could speak a shared second language, issues around cultural appropriateness and politeness in language use still affected interactions.

Furthermore, Amoah et al. (2019), in a study on barriers to therapeutic communication among nurses and patients in Ghana, found that language use barriers were significant to nurse-patient communication. They noted that many nurses resorted to speaking Twi, which many patients could not understand. Amoah et al.'s (2019) study setting was Kumasi, the traditional capital of the Ashanti Kingdom, where Twi is the dominant local language. Therefore, the nurses had assumed that many patients understood Twi. From the perspectives of positioning theory and cultural competence, the nurses had positioned the cultural context as a determining factor to guide language use. Although English is the national language in Ghana, nine other regional Ghanaian languages (Owu-Ewie, 2006; Owu-Ewie & Eshun, 2015), including Twi, are used. The nurses' assumptions about their language choice could have conflicted with many participants' preferred linguistic choices.

Amoah et al.'s (2019) findings about the language barrier corroborated my results. Despite Dagbani being the local dominant language in this study's setting, many nurses, patients, and caregivers had challenges using or understanding it. This realization underscored the complexity that multilingualism brings to the healthcare context, in general, and in nurse-patient communication and interaction, in particular.

The communication barriers in this present study also impacted nurse-nurse and nurse-clinician professional interactions, especially regarding written communication. Nurses had difficulty understanding their colleagues' or clinicians' written entries in patient folders, which could have significantly affected patient health outcomes. Engen et al. (2020) reported similar results regarding nurses' experiences documenting the mental health of older patients in long-term care. Engen et al. (2020) showed that nurses found it difficult to ensure mental health patients' confidentiality while making the information understandable. Finding the correct vocabulary and the fear of negatively depicting mental health patients shaped nurses' documentation of patients' mental healthcare (Engen et al., 2020).

The challenges around understanding written communication among nurses in Engen et al.'s (2020) study corroborated my results, as nurses and patients found it challenging to understand entries in patients' folders. For instance, in this study, maternity patients expressed how challenging it was to understand clinicians' and/or nurses' notes in their folders. Ensuring written communication in patient folders is simple, legible, and clear can empower patients to understand their healthcare condition and contribute to their self-care practices.

From the perspective of Face Theory, the problem of language barriers in clinical interactions is itself a face threat to patients and caregivers. Being unable to interact with nurses freely can position patients and their caregivers in a difficult situation since some patients may want to avoid a third party intervening in their clinical interactions involving sensitive healthcare issues. It is equally a face threat to nurses who cannot help their patients because of language challenges.

In this current study, overcoming some language use barriers necessitated using interpreters and translators. However, patient privacy and confidentiality of their health information became compromised, as some interpreters/translators were unrelated to patients. Nurses noted that meaning change could arise when interpreters/translators are used. Moreover, using interpreters/translators in nurse-patient communication was not a direct interaction. Furthermore, the interpreters and translators who supported nurse-patient communication were not trained to interpret. Hence, medical and nursing ethics, including patient privacy, could be compromised (Van den Berg, 2016). The relevance of medical interpreters and translators in clinical communications has been noted in the literature (Drugan, 2017; Suarez et al., 2021).

Using professional in-person interpreters and family members to enhance clinical communication can be challenging (Suarez et al., 2021). Suarez et al. (2021) reported that in-person interpreters must be culturally competent. Also, using remote interpreters led to miscommunication due to differences in cultural contexts, and family members could not be trusted to report the right messages (Suarez et al., 2021). The challenges Suarez et al. (2021) reported regarding the use of interpreters and translators were similar to this current study's findings about engaging interpreters/translators in nurse-patient communication. Similarly, Drugan (2017) argued that there is insufficient attention to professional interpreter roles; as a result, the ethical aspects of professional communication can be compromised. Moreover, the risk of miscommunication, trust in what has been reported, inaccuracy in messages due to misinterpretation or mistranslation, translation/interpreter errors, and other intercultural factors do affect translation/interpretation outcomes (Adebayo et al., 2020; Drugan, 2017; Van den Berg, 2016). Therefore, professional interpreters and translators require consistent training and education (Drugan, 2017) to enhance their skills.

This present study found that nurses faced the challenge of whether and when to use professional nursing language and/or jargon versus simple everyday language when interacting with patients and caregivers. Many nurses reported using everyday language when communicating with patients and caregivers to avoid misunderstanding and miscommunication. However, despite being aware of how medical jargon and nursing concepts can impact effective communication, other nurses still use professional language when interacting with patients. These language use practices were motivated by the desire to maintain power and for identity formation to legitimize certain nursing practices. Previous studies have noted that nurses occupy a power position and often determine what knowledge from patients and caregivers is relevant to the care process (Foucault, 2003; Glasdam et al., 2020). In this current study, using professional nursing and medical language conferred power on nurses to apply the ‘medical gauze’ and to say and do what appeared normal to them. As Foucault argues, the clinic is a site for power struggles and constitutes a body of knowledge (Foucault, 2003; Glasdam et al., 2020). Healthcare providers must speak in plain language devoid of medical jargon (Ratna, 2019) to increase patients’ understanding and update of medical information and guidance. When nurses use simple language, patients’ and caregivers’ health literacy can be enhanced.

Other healthcare institutional level and management-related obstacles, including material and human resources scarcity and poor relationships between nurses and hospital management, affected nursing practices and nurse-patient communication. Studies have reported similar barriers to primary care and nurse-patient therapeutic relationships in Iran (Norouzinia et al., 2016), rural Bangladesh (Hamiduzzaman et al., 2021), Hong Kong (Lam et al., 2020), the United Kingdom (Roche & Jones, 2021), Ghana (Ismaila et al., 2021; Nyaaba et al., 2020; Tia et al., 2020), and other African countries (Oleribe et al., 2019). In most of these studies, an insufficient workforce, poor leadership, and limited medical equipment surfaced as essential factors that impeded healthcare service delivery and update. These obstacles affected communication outcomes (Nyaaba et al., 2020), positive nurse-patient relationships, and healthcare providers' psychology, especially in healthcare facilities enriched with nurse-nurse manager conflicts (Oleribe et al., 2019). Ellison (2015) maintained that nurses desire a work environment with strong administrative support, including adequate staffing, effective communication, professional accountability, and trust. These problems in healthcare institutions influence nurses' ability to manage patients effectively, often affecting interprofessional healthcare relationships (Tia et al., 2020). Effective nursing leadership to enhance positive psychology and mental health among nurses was often lacking in the Yendi Hospital leading to mistrust and poor relationship between nurses and the hospital management.

Institutional culture and healthcare practices, such as long wait times, lack of systematic visiting hours, and no motivation and support for nurses' professional development, constrained care delivery, consistent with Boafo's (2016) findings. In this present study, some patients refused hospital admission, while many admitted patients left the wards to go home to shower, causing them to miss medical reviews and treatments. Data from this study revealed that long wait times to consult doctors, access patient folders, or collect medication at the pharmacy resulted in some patients avoiding hospital care altogether, a finding that resonates with the results of previous research (Hamiduzzaman et al., 2021).

This current study found low health literacy among patients and caregivers negatively affected nurse-patient communication and care outcomes. Poor patient health literacy affected their engagement in the care process and perceptions about nurses and hospital care. It also determined patients' and caregivers' ability to observe simple medical instructions, procedures, and disclosure. Low health literacy reflected notions of superstitious health beliefs and particular patient or caregiver behaviours, which influenced nurse-patient interactions. The consequences of low health literacy on patients' self-care management are well-documented in the healthcare literature (Berhe et al., 2022; Kreps et al., 2020). Research has shown that low or poor health literacy affects healthcare service consumers' ability to obtain and process health information, understand healthcare system complexity, and engage in effective clinical communication (Kreps et al., 2020).

Low health literacy exposes patients and their caregivers to the risk of missed appointments and medication side effects. Moreover, due to low health literacy, patients may not correctly apply medical procedures during self-care management practices or understand medical diagnostic and prognostic information (Kreps, 2018; Kreps et al., 2020). Patients can lose their agency and become passive participants in the care delivery process if they lack health literacy. Research has shown that language barriers and cultural factors affect health literacy (Chen et al., 2022b), especially in multilingual and multicultural healthcare settings like the Yendi Hospital.

High health literacy among patients has a positive influence on care outcomes. Nonetheless, it also negatively affects nurse-patient interactions, as found in this study. Some nurses claimed that highly health-literate patients make nurses’ work difficult and show less appreciation. In the literature, such patients are often called 'too known' for demonstrating their health literacy or demanding better care services (Amoah et al., 2019). This finding is crucial given the relevance healthcare researchers and educators place on high health literacy as a promoter of positive healthcare outcomes and interactions (Allen-Meares et al., 2020; Crossley et al., 2021). An important fact to note is that many patients now consult online sources and social media for health information. Therefore, healthcare providers should understand that they are no longer the only de-facto sources of health information or medical knowledge. Patients who bring alternative discourses to clinical interactions must be listened to and educated if the information they provide is inaccurate. Showing respect and understanding while responding to inaccurate information patients bring to clinical discourses will be essential to healthcare information uptake. Patients and caregivers should also know that not every information they access online or through social media is correct.

Another barrier to care access was the high cost of care. Costs of care emerged as a significant hindrance to positive patient-provider relations. This study found that nurse-patient interpersonal engagements were impeded when patients were made to buy medical supplies and/or pay for medicines and lab tests, even when they had health insurance coverage. Patients and caregivers were often annoyed with healthcare providers, mistrusted them, and sometimes engaged in verbal exchanges with them. Nurse-patient disagreements regarding costs of care were common, especially when healthcare providers failed to inform them why they were paying for certain services. Patients reported paying a lot for things yet receiving fewer medical services. This situation caused conflicts between care providers and patients/caregivers. Economic and social barriers have been reported in the literature to hinder healthcare access, patient self-management practices, and patient-provider relationships (Agyemang-Duah et al., 2019; Boucher et al., 2022). Financial constraints due to poverty affect healthcare access in Northern Ghana because patients must cover the cost of healthcare services and medications not covered by the NHIS (Nyaaba et al., 2020). In Iran, low insurance coverage, low incomes, and high transportation costs limit access to healthcare services, particularly among adults with disabilities (Soltani et al., 2019). These obstacles, which affect access to healthcare, impact efforts to achieve universal healthcare coverage (Soltani et al., 2019).

Furthermore, the cost of hospital-based care is increasing health inequities among poor and vulnerable populations, with out-of-pocket expenses for hospital visits, blood supplies, cost of medications, and hospital accommodation consuming higher proportions of household incomes (Price et al., 2016). A study in Malawi on barriers to healthcare access among persons with disability identified the costs of care as a significant obstacle (Munthali et al., 2019). Also, in the United States (US), depression among adults aged 65 and older is increasing due to delays in seeing a doctor due to medical costs (Cheruvu & Chiyaka, 2019). Similarly, Females, Hispanics, Blacks, and people with three or more chronic health conditions reported symptoms of depression, with medical costs being a barrier to seeking health care in the US (Allen et al., 2013; Cheruvu & Chiyaka, 2019). The rising cost of care affects healthcare access, outcomes, and satisfaction, and strains household and individual incomes, thereby causing mental and psychological stress (Cheruvu & Chiyaka, 2019). Experiences of how medical costs affected healthcare access were reported by patients in the current study, irrespective of their health insurance status. Such experiences propel negative attitudes toward the NHIS, which is consistent with the findings of Agyemang-Duah et al. (2019) regarding clients' perceptions of NHIS. Moreover, the high patient turnout in the Yendi Hospital on Yendi market days appeared to have been motivated by the need for easy access to transportation services to reduce the burden of transportation costs on the overall medical costs.

Another complex mix of factors that obstructed effective healthcare delivery and access in the Yendi Hospital was health beliefs and personal attitudes among nurses, patients, and caregivers. Individual behaviours that affected patient-provider relationships, communication, and healthcare outcomes were nurses' untoward attitudes (i.e., insulting, demeaning, shouting, scolding, and dismissing) towards patients and caregivers. Patients' and caregivers' also disrespected and mistrusted nurses. Many patients and caregivers failed to adhere to medical instructions, refused to observe visiting hours, and had preconceptions about nurses and the hospital. Many patients returned home after being admitted, thereby missing medical reviews. These negative personal attitudes and behaviours among nurses, patients, and caregivers affected clinical interactions and healthcare outcomes (Al-Kalaldeh et al., 2020; Nyaaba et al., 2020).

A study examining the barriers to effective patient-provider communication in an emergency care setting in Palestine (Al-Kalaldeh et al., 2020) reported that nurses' reluctance to hear patients' concerns was perceived as a critical impediment to effective nurse-patient communication. Negative personal attitudes often lead to conflicts, abuse, poor safety outcomes, and reactive violence against patients and providers (Boafo, 2016; Dzomeku et al., 2020; Laschinger, 2014). Laschinger (2014, p. 288) observed that negative interpersonal interactions among nurses, patients, and other health professionals, interfere with effective communication about patient care needs and care routines and may hinder the delivery of high-quality patient care. PCC practices, risk of patient safety, perceptions of care quality, and trust in healthcare systems and providers always emerge from provider-patient interpersonal mis/conduct (Boafo, 2016; Laschinger, 2014). Healthcare providers' negative attitudes, abusive behaviours, and patient neglect significantly impact maternal health in Ghana, contributing to most pregnant women choosing not to attend healthcare facility-based delivery and other care services (Dzomeku et al., 2020; Maya et al., 2018).

Despite these negative attitudes and behaviours, especially from healthcare providers, many patients and caregivers in this study trusted nurses and their care. Nurses were trusted as knowledge bearers and capable of helping patients to meet their healthcare needs. Previous research shows that when there is trust between nurses and patients, appreciation of caring practices, satisfaction with care outcomes, and respect for nurses increase (Ozaras & Abaan, 2018). Therefore, healthcare providers and consumers must avoid negative personal attitudes and build mutual trust to promote PCC and encourage patient participation in the care process.

Health beliefs, cultural practices, and ethnic orientations impacted this caring practice and nurse-patient communication in the study. Beliefs about specific illnesses and care practices made a few patients and caregivers request patient discharge against medical advice or reject other healthcare services. Participants reported that cultural values and beliefs around blood donation, stroke, and spiritual issues influenced nurse-patient relationships. Nyaaba et al. (2020), Abdulai et al. (2019), and Amoah et al. (2019) have also reported that health beliefs and cultural practices determined effective patient-provider communications and healthcare service uptake in Ghana. Health beliefs determine health behaviours, perceptions of care, and communication during clinical interactions.

In this present study, it was found that some patients often combined traditional remedies with biomedicine. However, nurses dislike patients who utilize traditional medicine while receiving hospital-based care. To reduce problems of this nature and provide care that meets patients’ cultural values and perspectives, healthcare professionals must embrace cultural competence and sensitivity to medical pluralism (Abdulai et al., 2019; Douglas et al., 2018). Mental health, maternal health, infant health, and other primary care practices in this study and the literature are replete with health beliefs and traditional practices which require an understanding of diversity in health philosophy (Savic et al., 2016; Zuckerman et al., 2015). Although nurses and other healthcare professionals often discuss patients' and caregivers' beliefs as superstitious, a false dichotomy is implied, suggesting that biomedicine and its practitioners are scientific while traditional beliefs and medical practices are not. Such assumptions seem misleading given that people's health beliefs and traditional medical practices are grounded in real-life experiences and observational knowledge, which are equally valid ways of knowing.

Except for poor lighting, limited beds, and difficulty accessing water, noise and poor ward hygiene did not emerge as significant barriers to healthcare access or nurse-patient therapeutic relationships in the Yendi Hospital. Unconducive and noisy environments have previously been found to interrupt effective communication and healthcare delivery in Ghana (Amoah et al., 2019). Poor environmental conditions, including limited beds, poor ward hygiene, and difficulty with access to water, can affect patients’ health and overall perceptions of care (Lambert et al., 2018). These challenges are even severe in maternity, labour, emergency, and intensive care contexts where the rate of infection and contamination are high (Buxton et al., 2019). In this current study, access to water and limited beds impacted patients’ willingness to be admitted, to maintain stability in their ward, and their general perception of the healthcare institution.

Lastly, social factors, including age, gender, ethnicity, social status, and level of education, had varying degrees of impact on nurse-patient communication and healthcare access in this study. Elderly persons, people with higher education, and patients with higher social status experienced difficulty accessing healthcare differently than patients and caregivers without these sociodemographic features. Despite age's role in nurse-patient interactions and the position that elderly patients and caregivers occupy in Ghana, research has shown that elderly patients sometimes get abused in Ghanaian hospitals and care homes (Malmedal & Anyan, 2020). Social determinants of health influence healthcare access globally, with poor, marginalized, vulnerable people, and rural inhabitants suffering significant challenges when accessing healthcare services (Agyemang-Duah et al., 2021; Hamiduzzaman et al., 2021). The present study found that men and women had different demands and needs for health information. Also, elderly patients had power and voice over their care needs and commanded respect from nurses.

Nurses reported facing fewer challenges communicating with educated and health-literate patients and caregivers, while people with higher social standing demanded preferential treatment. These results partly reflect what had been reported in the literature (Agyemang-Duah et al., 2021; Kalaldeh et al., 2020). For instance, Al-Kalaldeh et al. (2020, p. 6) noted that cultural and religious differences affected communication less than differences in age and gender. Although culture and religion had less impact on communication in Al-Kalaldeh et al.'s (2020) study, these demographic characteristics and ethnic variations impacted nurse-patient communication and interactions greatly in this current study, as also reported in Abdulai et al. (2019), Agyemang-Duah et al. (2021), Akibu et al. (2018), and Asogwa et al. (2022). The literature identified cultural beliefs and norms, illiteracy, poverty, and levels of education as critical factors that drive maternal mortality rates and low uptake of maternal healthcare services in Ethiopia (Akibu et al., 2018) and Nigeria (Asogwa et al., 2022).

The findings of this study on communication barriers are critical in the sense that despite the multilingual nature of the Ghanaian healthcare setting, studies have not explored the impact of multilingualism on healthcare communication, nor has there been significant research on the use of translators and interpreters in medical communication and interaction in Ghana. To the extent that dialect variation impacts health communication and patient-provider interactions (Abdulai et al., 2019), language barriers and multilingualism in health communication must be explored in Ghana and elsewhere. This current study provides a way forward for future research.

Communication and language barriers, use of untrained translators/interpreters, institutional structural and resource limitations, negative personal attitudes and behaviours, health beliefs, and high cost of care are complex, interrelated factors affecting healthcare access. These impediments to healthcare services provision or utilization can profoundly affect efforts to achieve the health sustainable development goal (SDG3) by 2030. Unless conscious efforts and planning are made to address these social determinants, resource limitations, and the cost of healthcare, providing affordable and high-quality care for all by

2030 will only be a dream (Kwame & Petrucka, 2022). Providing quality and accessible primary care that addresses the needs of people and their communities, enhances PCC, and honours human and patient rights must be a priority (WHO & UNICEF, 2018). For most of these obstacles to healthcare, ways to improve them and elevate effective and therapeutic nurse-patient communication, interaction, and relationship will be discussed in Chapters 5 and 6.

Chapter 5: “Could that be a Case of Patient Right Violation?” Experiences of Patient Rights in Nurse-Patient Communications and Interactions

5.1 Introduction

Respect for patients’ rights in clinical practice has become a cornerstone in global health discourse and advocacy for patient-centered care practices in clinical interactions. To elevate and enhance people’s health, PCC demands that healthcare systems and their practices are focused more on people rather than on services (Sundler et al., 2020). Central to PCC practices are respect for patients and their caregivers, effective communication, engagement of patients and their families in the care process, and tailoring healthcare services to patients’ needs, contextual circumstances, and cultural values (Karlsen et al., 2020; Kwame & Petrucka, 2020; Sundler et al., 2020). Similarly, achieving universal health coverage of Sustainable Development Goal 3 (SDG3) is premised on valuing patients’ and human rights in healthcare delivery and access (ICN, 2021; Kwame & Petrucka, 2022). Moreover, the World Health Organization’s (WHO, 2021) global patient safety action plan emphasizes patients’ safety and rights as essential to enhancing universal health access and positive healthcare outcomes among patients.

The above brief literature review in the above paragraph has demonstrated that promoting patient safety, participation in the care processes, and effective communication are all relevant to advancing patient rights in nurse-patient clinical interactions and are essential for meeting the universal healthcare coverage milestone. In this chapter, I present and discuss patients’, caregivers’, and nurses’ experiences of patient rights in clinical interactions as well as explore the (dis)enablers of effective nurse-patient communication and interaction as contingent on the realization of patient rights.

The chapter is organized to first provide a brief methodological presentation about how the findings were derived. In section 5.3, I present findings on patient rights in nurse-patient interactions in the Yendi Hospital while in section 5.4, I examine the (dis)enablers of effective nurse-patient communication in the study setting. The findings in this section focus on what care practices and nurse-patient communication and interactional routines either promote or inhibit effective communication during clinical interactions. It also covers what needs to be done to minimize or reduce the barriers to communication and interaction between healthcare providers and consumers. I summarize the findings in section 5.5 and present a discussion of the findings in section 5.6.

5.2 Brief Methodological Orientation

Following the broad methodological discussion in Chapter 3, the themes presented in this chapter were generated after the general data analysis was completed. First, all instances of nurse-patient communication practices and interactions that impacted specific patient rights were noted across the data sets. Secondly, to provide an interpretive phenomenological analysis of the data, I wrote brief interpretive notes about the categories to provide meaningful insight to the data. I identified individual narratives and linked them to specific patient rights provisions in the *Patient's Charter*. For instance, regarding patient rights to privacy and confidentiality, nurse-patient communication and interactional practices around shopping for translators/interpreters, clinical consultations, and activities in the patient wards were noted. Regarding patient rights to information, I examined specific clinical practices, such as patients not being informed about their health condition or laboratory test results, patients not being informed about their rights and responsibilities, or why certain payments were made across the data sets. Participant experiences around the right to safe and prompt care, the right to dignity and respect, the right to participate in their care, and the right to self-determination were all noted.

The essence of this analysis was to determine how the Ghanaian *Patients' Charter* influences nurse-patient interaction and clinical practices. Thus, I paid attention to the different patient rights provisions outlined in the *Patients' Charter* document. After I explored the experiences of patient rights throughout the data, I reorganized few themes to illustrate how they influence nurse-patient communication or the realization of patient rights among nurses, patients, and caregivers.

I have structured this chapter into two broad sections: Sections I and II. Section I (*Patient rights in nurse-patient communication and interaction*) has two themes, while Section II, *(Dis)enablers of effective communication and patient rights in clinical interactions,* has four themes, as shown in Table 4 below.

Table 4:

Development of themes/subthemes on experiences of patient rights

Sections	***Themes***	***Sample quotes***
Section 5.3: Patient rights in nurse-patient interactions	**1**. "They don't know their rights": awareness of patients among nurses, patients, and caregivers **2**. Experiences of patient rights in clinical interactions	"I don't know about the *Patients' Charter*" (P1), "I am aware of the *Charter*, but I can't remember the content" (N3), "the unfortunate thing is that patients don't know their rights" (N5),
Sections 5.4 & 5.5: (Dis)enablers of effective nurse-patient communication in clinical interactions	**3**. Being and becoming a caring nurse	"nurses should have patience and understand patients' pain and struggles" (CG4), "caring nurses accept their mistakes and correct them or don't repeat them" (N8),
	4. Honoring the ethics of life, care, and caring	"know that a patient is a person" (N4), "… a human being is a human being, and everyone has their position in life" (CG3)
	5. Attending to and resolving barriers to care delivery -awareness of gender and social dynamics in care -valuing communication -building trust and showing appreciation -nurses coping with resource constraints	"you have to understand the culture of the people to be able to deliver better services to them" (N9), "I wish to express my gratitude to the nurses, they are doing their best" (P2), and "patients are asked to buy some of the consumables" (fieldnotes)
	6. Politeness, use of address terms, and making requests	"if they are grown up, we can say, oh, m-ma … the way you address her will make her feel comfortable" (N7)

The themes presented in this chapter are not in isolation because the participants' experiences that I present throughout the chapter can illustrate more than one patient rights implication. Furthermore, my interpretations of these experiences must not be understood as passing judgment. My intent is to show how certain clinical practices and social interactions between nurses, patients, and caregivers present human and patient rights implications or dilemmas, thereby affecting PCC as well as jeopardizing the safety of patients, caregivers, and nurses. Moreover, these patient rights experiences will have consequences on healthcare quality, outcomes, and perceptions.

5.3 Patient Rights in Nurse-Patient Interactions

This section will cover two major themes: awareness of patient rights and the participants' experiences of patient rights in clinical interactions. The first theme captures the participants' knowledge about the *Patient's Charter*, and both interview and participant observation data revealed that many participants were unaware of or had little knowledge about the *Charter*. On the other hand, the second theme illustrates the experiences of nurses, patients, and caregivers about patient rights to dignity and respect, privacy, information, self-determination or autonomy, and participation during clinical interactions. In the next section, I examine the participants' awareness of patient rights in the Yendi Hospital.

5.3.1 "They don't know their rights": Awareness of Patient Rights

The Ghanaian *Patients' Charter* stipulates all the rights and responsibilities of patients in Ghana and copies of this document were posted in all patient wards and units throughout the hospital. Having knowledge about the Ghanaian *Patients' Charter* is a prerequisite to the participants' awareness and knowledge of patient rights. As a result, participants were asked if they knew about the *Patients' Charter*. For those who answered in the affirmative, I asked them to tell me what they knew about the *Charter*. From the data analysis, it appeared that all caregivers and almost all patients had no knowledge of the *Charter*. Furthermore, among the 11 nurses who participated in the study, two were not aware of the *Charter*, and three nurses who knew about the *Charter* could not remember anything about the *Charter's* content, although copies of the *Patients' Charter* were posted in all patient wards across the hospital. In addition, I asked patients and caregivers if they had received any information from nurses about the *Patients' Charter*. I also asked nurses if they provided any form of education about the *Charter* to patients/caregivers. All patients and caregivers indicated that they were not informed about the *Charter*, and all the nurses confirmed that they did not provide any education to patients and caregivers about the *Charter*. The responses to the two questions are shown in Table 5.

Table 5:

Participants’ knowledge and awareness of the Patients’ Charter

Participants Category	**Aware of *Charter***	**Not aware of *Charter***	**Aware but can’t remember the *Charter’s* content**	
Patients	3	18	0	
Caregivers	0	11	0	
Nurses	6	2	3	
	Education on the *Patients’ Charter*			
	Educated about the *Charter*?		**Provided education on the *Charter*?**	
	Yes	No	Yes	No
Patients	0	21	-	-
Caregivers	0	11	-	-
Nurses	-	-	0	11

As Table 5 shows, many patients and caregivers were unaware of the Ghanaian *Patients’ Charter* compared to nurses. And although several nurses knew about it, they did not educate patients and caregivers. This knowledge difference suggests that patients and caregivers were in a disadvantaged position as far as honoring their rights is concerned. For instance, regarding knowledge of the *Charter*, patient participants (e.g., P1 and P6) and caregivers (e.g., CG3) mostly indicated, “I don’t know about the *Patients’ Charter*”, to my question “do you know about the Ghanaian *Patients’ Charter*?” One nurses even remarked; “the unfortunate thing is that patients don’t know their rights” (N5).

On the other hand, many nurse participants provided the following responses when asked about the *Charter*: “Yes” (N1), “Yeah, I know about it” (N11), “Yeah, I heard about it” (N9), or “I am aware of the *Charter*, but I can’t remember the content” (N3), and “Yes, I heard about the *Charter,* but I don’t know much about it” (N8). The nurses who knew about the *Charter* identified the following patient rights and responsibilities: “the patient has the right to refuse treatment” (N1), “the patient has the right to privacy and confidentiality” (N2), “the right to know their conditions” (N6), and “patients have the responsibility to take their medication” (N5).

Despite the nurses’ awareness and knowledge of the *Charter,* they did not educate or inform patients about these rights, as captured in the following responses. “We don’t tell patients their rights, we fear that if you tell them this or that is your right, it’ll affect the care process” (N3); “I don’t usually tell my patients their rights/responsibilities” (N4); “we don’t often tell them their rights" (N5); and "to be frank, patient education is a problem" (N6). Although, the nurses attributed the lack of education on patient rights and responsibilities to limited staff and high patient turnout, I am of the view that the response of nurse (N3) fully captured the main reason why patients and caregivers are not informed about their rights. That is, many nurses fear that patients or caregivers will overact to make the care delivery process difficult for nurses. Moreover, other nurses thought that "the *Charter* does not emphasize patient responsibilities and does not give any rights to care providers" (N9). It appears that nurses, who have the knowledge to direct clinical care practices, are afraid that they may be positioned peripherally should patients and caregivers become enlightened about their rights. The nurses' responses further suggest that emphasizing patient rights might undermine the privileged positions of power, trust, and medical knowledge that nurses have enjoyed in the study context. These issues will become apparent through the theme of building trust and showing appreciation in section 5.4.3.3 of this chapter.

5.3.2 Experiences of Patient Rights in Clinical Interactions

In this section, I draw from provisions in the Ghanaian *Patients' Charter* to assess the experiences of the study participants regarding patient rights. Certain events, interactional episodes, and communicative practices will be interpreted alongside the *Patients' Charter* and the nurses' code of ethics. The essence of this section is to demonstrate how the lack of attention to these rights in clinical practice can constrain nurse-patient communication and interaction, outcomes, and perceptions of care quality. The different patient rights scenarios presented here are by no means exhaustive or isolated. These cases and experiences intersect with other human rights in care.

5.3.2.1 The Right to Safe and Prompt Care. Providing safe and prompt care to patients is significant in enhancing patient safety and assurance of their psychological stability as many patients and their families arrive at hospitals and healthcare centers anxious, confused, and in a state of fear. Despite the value that safe and prompt care may have on patients' recovery and perception of care outcomes, not many patients received prompt care in this study setting. I construct a narrative about a focus group patient participant (FGP4) and use data excerpts from other participants to illustrate their experiences with safe and prompt care in the hospital.

Below in Textbox 10, I present Emmanuella (pseudonym for FGP4), a 22-year-old female focus group participant, who had stayed in the hospital for four days at the time of data collection. Emmanuella's story relates to issues around safe and prompt care and highlighted how she felt about her condition and her stay in the hospital.

Textbox 10: The right to prompt care

I came to the hospital on Tuesday. I came to do weighing, so I went to the nurses. I had already taken a scan. I was told to go for my folder which I did. Then I was asked to see a doctor. I told them I wasn't sick. The nurses told me to see the doctor because they knew what was wrong with me, they said after I have seen the doctor, whatever it is, I will know. I came here and was waiting for the doctor. After that, I was asked to go to the maternity ward. When I went there, they took my folder, checked through and said I was going to be admitted. When they told me that, I called my husband and told him what the nurses said, and he said ok, and that he was on his way. When he came, they told him I had this condition. I was admitted on Tuesday through Wednesday, and Thursday and nobody said anything to me. They only gave me paracetamol. It was yesterday they brought me here (a change of ward) and said I am going to go for surgery. And since then, we have not been told anything again. I was told to arrange for blood, which we did, and since then, we have heard nothing from the doctor. For me, the way I see it is that, when a patient comes here and has a critical condition, they should pay more attention to that patient. Because in my case, the condition they said I have, I don't know what it is and whether it can affect my life or not. Unlike other patients, I was told what my condition is. I was told they are going to do D&C, but the D&C, since I have been here up till today, it's been several days now, and I don't know whether tomorrow being a Saturday, I will get treatment. I'm worried because I am not being treated nor discharged. If the condition I have can affect my life, then it would, because I didn't know about it since I was home, now that they said this or that is it, they should treat me immediately, but that is not happening. Even the day I came here, the nurses were blaming me. And accused me of not coming to the hospital early, so now that they know about it, and told me what it is, which I have accepted and trusted their words, I should get immediate treatment. I am really worried about the way patients are treated in this hospital. This afternoon, I was feeling stomach pains. They did their scan and told me the problem, yet I have been here for days, and no procedure has been done. The doctor comes to ask me questions and I describe everything. I tell them how I feel, but still, no treatment has been carried out. They even ask me to go for an X-ray, and I did. The photo is just lying there. … Nobody has come to look at the photo yet or to tell me what it shows.

As this narrative shows, Emmanuella was anxious and worried about her life and health. Although Emmanuella was informed about her health condition, the treatment process was not explained to her, including the findings of the X-ray while she waited for days. This incident intersects with the right to safe and prompt care, patient engagement, and information. This experience of not providing prompt care and/or information to patients was not peculiar to Emmanuella.

Several other patients and caregivers expressed concerns about having to wait for hours to access different care services, as already noted in chapter 4. A few other events and incidents that reflected patients' right to safe and prompt care are noted below.

> When you call them [the nurses], they answer your calls, when you ask them to respond to your patient's needs, some will, but others will not do that. Because for some of them you can call them and they will say "go I will come", and that's all, he/she will never show up. Some of them will tell you to wait until their colleagues come and attend to your patient. For instance, yesterday, our patient was supposed to take one of his medicines at noon, but it was delayed up till after 3:00 pm, we call them and the nurse said when the afternoon shift takes over, they will attend to our patient. (CG1)

This caregiver's experience of having to wait for three hours before his patient was given his medication further illustrates the plight of some patients. The above incident cannot be attributed to the shortage of nurses but rather to a poor attitude to work that affects patient healthcare outcomes.

Furthermore, while I was conducting participant observation in one patient ward on March 29, 2022, I noticed two patients with critical conditions. An experienced nurse suggested that the patients be transferred to Tamale Teaching Hospital (TTH) for further management, but no clinician was available or perhaps willing to do that. The patients' conditions required further tests to be conducted which, could not be carried out in the Yendi Hospital. It was on this ground the nurses suggested that the patients be sent to TTH. The nurse even predicted that the patients would die if they stayed in the ward for a few more hours, which was what happened: one patient died while arrangements were being made to transfer him to TTH, while the other one died shortly after arrival at Tamale. It was sad to hear about these events and I wondered whether these patients would have survived had they been transferred on time. Nurses were often devastated when, for lack of timely care, patients lost their lives. These events, including waiting for several hours to access healthcare services, reflect how patients' right to safe and prompt care were experienced by both patients and nurses.

5.3.2.2 Patients' Right to Dignity. The right to dignity is an entitlement that every human being may desire. In the healthcare setting, this right becomes critical because many patients are in vulnerable conditions and situations, and so any undignified treatment they receive can negatively impact their well-being. The right to dignity is emphasized in the Ghanaian *Patients' Charter* that "in all healthcare activities, the patient's dignity and interest must be paramount". In this section, I explore a few cases and incidents that illustrate how the right to dignity was reflected in nurse-patient interactions.

The first case in Textbox 11a illustrates a patient I call N-yaba (pseudonym for P16), a male patient in his 60s who was admitted to the Yendi Hospital. M-yaba was a wealthy farmer with no formal education. When his condition started, he went to a different hospital where he stayed for three days without any improvement. So, N-yaba requested a discharge and then came to the Yendi Hospital. He came to the hospital with three caregivers, but one returned home leaving only his son and wife. He was assigned a bed on a sideward, where he was the only patient. It was N-yaba's first time in the Yendi Hospital, and he had the following to say about his experiences with nurses and clinicians.

Textbox 11a: Respect for patient dignity

When my condition started it was hard for me to breathe. I went to a different hospital, [where] I stayed for three days. I couldn't sleep on the third day. So, I pleaded with them to transfer me to this hospital. I was discharged on Friday, but I couldn't sleep when I went home. So, I came to this hospital yesterday, and I thank Allah for the care and support I receive so far. The nurses here are doing their best. Both the nurses and the clinicians are doing their best. From time to time, they check on me. Nobody has abandoned or neglected me. So, pray for Allah's blessing on them. Any time they want to do something; they will excuse me or inform me before. That makes me happy. They have shown me respect, humaneness, and care. None of them has treated me badly. When I came here, first we went for my folder, then to the OPD, and to other places. Everywhere I go, they take my vitals, and everybody is doing their work well. I am not dissatisfied with anybody here, or with the care. I thank them all the time. I appreciate their work. The nurses clean this tray, the bed, and the louver blades. I don't experience bad smells that could affect me. The place is neat, even at home, we don't experience this sort of cleanliness (we both laugh). You asked about the patient's Charter. I don't know anything about the Charter, but what the nurses do for me is good. They inform me before doing things, they ask for my permission, and sometimes they explain things to me. They told me about my condition

Textbox 11a continues

and even took an X-ray photo of my chest. They also took my blood sample for tests and prescribed medications for me. When the doctor came, I told him that anytime I want to pray and bend down, I experience shortness of breath. That was when he requested that I go for an X-ray, and we have done that. The photo is on the table. If I am asked to advise nurses on how to communicate with patients, well, they know better than us, so, I would rather remind them and not advise them, to have patience with caregivers and patients.

From the above narrative, it appears that N-yaba was treated with dignity by the nurses and clinicians. He was excited and had a sense of humor throughout my interactions with him. Based on his experiences, N-yaba was always appreciative of the nurses. Moreover, as an older person, he enjoyed respect from the nurses, was positioned in a privileged space, and trusted the nurses and clinicians as medical knowledge bearers. However, not every patient had the same experiences N-yaba had. In Textbox 11b, I relate the experiences of another male patient, whom I call Ndoo.

Textbox 11b: Routine centered care

On January 12, 2022, I was observing nurse-patient clinical interactions in a patient ward when a motor accident patient (I named Ndoo) was brought into the ward around 5:30 pm in an ambulance. The nurses needed to know about Ndoo's relatives and the cause of the accident. The ambulance staff reported that Ndoo was ambulatory (active) and that he wasn't having deep cuts. Although the wounds were already dressed, Ndoo was still bleeding from his head, toes (both his right and left toes), and left elbow. To attend to the patient, the nurses needed a bed that could be easily cleaned off blood stains since Ndoo was still bleeding. They sent for a clinician while taking Ndoo's vitals. Also, the nurses had to clean Ndoo's wounds and dressed them again. While adjusting the bed, the attending nurses were focused on getting the bed to a position that would be comfortable for them to work on the patient rather than for the patient's comfort. They didn't ask Ndoo to know if he was comfortable in that position. I reminded them to find out if the patient was ok. Ndoo was given several stitches when the nurses were dressing the cuts on his head, cheek, inside his mouth, above his eyebrows, and his three toes, without a pain relief injection. At a point, Ndoo could no longer bear the pain. He told the nurses to stop with the stitching. I think it was good that the nurses stitch the deep cuts, especially those on the toes to enhance the healing process. But Ndoo said, No.

Textbox 11b continues

He asked the nurses: Don’t you fear God? I will become like you someday (implying that he aspired to become a nurse). So, will I be doing this to others? Today, it’s me, tomorrow, it will be someone else, please be patient with me. I left the ward around quarter to 7 pm, while the nurses were still managing Ndoo’s wounds. The nurses were tired because they had many patients during their shift. So, they were much interested in completing their nursing routines and tasks. (Field notes, documented January 12, 2022)

The above narrative highlighted another case of a patient’s right to dignity in care. Compared with the experiences of Mba, patient rights to dignity seemed to have been compromised during Ndoo’s treatment. Also, PCC and safe medical practices were far-fetched. Before I left the ward, I asked the nurses, who attended to Ndoo, why they did not give him a pain relief injection and they said it was not covered by NHIS. But did the nurses ask Ndoo if he needed a pain relief injection before his cuts were stitched even if it was not covered by NHIS, the answer was No.

Similarly, a patient (P15) reported observing nurse-patient interaction which he interpreted as less dignifying, as noted in the following dialogue.

> **Researcher (R):** Has anything surprised you about nurse-patient interaction since you came to this ward or hospital?
>
> **Patient (P15):** It was yesterday I witnessed something between a nurse and one elderly patient. The patient was feeling hot and decided to sprinkle water on himself, and the way the nurse spoke to the patient, I wasn’t happy. The way the nurse spoke to the man was not proper.
>
> **R:** Was the nurse speaking in a harsh manner or high tone showing that s/he was angry?
>
> **P15:** No, the nurse asked the man, what he did, if it were in his room/house, would he have done that? The nurse told him to let his caregivers come and mop the floor. That incident didn’t make me happy.

The elderly patient’s dignity as a person was questioned by the nurse, and the patient’s sense of morality was called to doubt. Moreover, the nurse’s utterance constituted a face threat to the patient and could have positioned him in an awkward space in the ward, given that other patients were observing what happened.

5.3.2.3 Patient's Right to Information. Both the Ghanaian *Patients' Charter* and the *Nurses Code of Ethics* recommend that patients and their caregivers must be provided adequate information about their healthcare conditions and information to help them make informed medical decisions. For instance, about eight articles of the *Patients' Charter* refer to the right to information, thereby underscoring its relevance in healthcare and nurses' clinical practices. In this subsection, I present a few events and scenarios to showcase the study participants' experiences of the right to information.

First, I introduce the case of a female patient, whom I call Ema (pseudonym for P13), to elucidate how a nurse-patient relationship derailed because of disregard for the patient's right to information. Ema came to the hospital as an emergency patient and was later moved to a different ward after she was stabilized. When she was admitted into that ward, she was given a bed that according to the nurses was reserved for asthmatic patients. However, Ema was not informed about this or made aware that she would be changed to a different bed if an asthmatic patient was admitted. Later, a new patient was brought in, and Ema was forced to vacate her bed for the new patient which, Ema was not happy about. The narrative in Textbox 12 captures Ema's feelings.

Textbox 12: The patient's right to information

When I came to this hospital, first I was in the emergency ward before they moved me here. When I came to this ward, I was using one bed, then a new patient came in, and they told me to change to a different bed. They said the bed was for asthmatic patients. So, they took me to the sideward and gave me a bed there. But I can't sleep there. I didn't want to leave my previous bed. Yes, I told them that, but my master who brought the other patient forced me to leave the bed. The bed they changed for me is not good. I struggled on the bed throughout last night. If they don't get me a different bed, I might have to sleep on the floor. There was another bed, but they said someone just died on that bed, and it wasn't cleaned properly yet. But if I don't get a different bed, I will sleep on the floor (said with a disturbing tone and with anger). The female nurses are gossips. Any little thing a patient does, she gets angry and starts shouting, telling everyone what the patient did; "she did this, and she did that." (Participant was angry about what happened to her). Me, I have refused to talk to any nurse or answer their questions, since the incident, I don't talk to any of them. I don't have their time. The nurses I was free with and those I conversed with have finished their shift and left, the afternoon shift nurses. As for the nurses who are here now, I don't talk to

Textbox 12 continues

them, I listen to what they say, but I don’t talk to any of them. The current nurses don’t care. Even when you feel weak and can’t go to the washroom to vomit and you vomit in a bag, the nurse will be saying “is that how they do things, see what you have done, look at that, go and put it in the dustbin.” So, I don’t talk to them. At the time they changed my bed, I said I was not going to leave the bed, so the nurse was very angry with me. It was my schoolteacher who told me to leave it. I was not going to get up. I see those things on TV, the nurses pretend to be caring or that they like you but when your parents leave, they begin to treat you differently. It was a female nurse, she spoke in a high tone, [and] everyone here could hear what she was saying. If I had the chance to speak with the matron, I will tell them that some of the nurses are rude. And for the nurses, I will tell them to stop being rude, when they want to change patients a bed, they should ask the patient first if s/he wants to change a bed. They should respect patients and treat them well.

This case demonstrates how effective communication and respect for the right to information can enhance nurse-patient relationships and patients’ perceptions of care. Before being assigned the bed, was the patient informed prior that the bed was reserved for asthmatic patients and that she will be changed to a different bed whenever an asthmatic patient is admitted into the ward? This missed opportunity for information later acted as a barrier to a therapeutic nurse-patient relationship. The patient was denied the right to information and subsequently forced to leave the bed for another patient, an act that compromised her right to dignity and respect.

Several patients complained that nurses and clinicians did not inform them about their health conditions even at the point of discharge. This situation implies that many patients attended the hospital, got treated, and were discharged without knowing what brought them to the hospital. For example, a patient stated, “yesterday, I wanted to know my blood pressure, but the nurses didn’t want to disclose it. One nurse mentioned it and the other nurse said they are not supposed to mention it to patients” (P14). Another patient said, “apart from what I told them about how I was feeling, whatever they have found from their own investigation (diagnosis), they have not told me” (P10). Moreover, although patients were not informed of their conditions or diagnoses, some nurses discussed patients’ health with student nurses, as noted below.

> No, I have not been informed, but I heard one nurse who came here with some student nurses telling them about my condition and explaining to

> them what it is. The nurse just told me that the medicine they are giving me will make me well, but he didn't tell me the condition. (P15)

In the above case, the patient was used as a case study to teach the student nurses, although he was not informed what his condition was. Furthermore, I wonder if the patient's consent was sought before his condition was disclosed to the student nurses. Nonetheless, a few patients stated that they were told about their condition or that clinical procedures were explained to them. For instance, one patient indicated, "Yes, the nurse told me my condition and what I can do to help myself" (P8).

Not only patients but caregivers and nurses also observed that patients were not often provided information either about their health conditions or certain care procedures. A nurse stated that "in this hospital, it's a normal phenomenon for patients not to know their condition, … even a patient might be taking a drug without knowing its effects" (N9). Other nurses confirmed that patients are often not informed of their condition except when it is a retroviral infection (RVI), that is the only time the patient is counseled before they are told what the infection is. Similarly, a caregiver said that "most nurses don't tell patients their health condition" (CG6).

From the above data, it is apparent that some troubling nurse-patient relationships are caused by not sharing relevant information with patients and caregivers. I think that when patients are better informed, self-care management and patient disclosure can improve leading to positive care outcomes. The right to information and informed consent are closely connected, yet these rights were mostly compromised when patients and caregivers were uninformed about their care conditions, care routines, or why patients/caregivers must (or not) do certain things.

5.3.3.4 Right to Privacy and Confidentiality. Nurse participants in this study indicated that keeping patients' health information and treatment options confidential and ensuring patient privacy in clinical practice are not just patient rights but they are also central to nursing and medical ethics. It was noted that respecting patients' right to privacy and confidentiality can prevent stigma if a patient has health conditions that others can stigmatize. Nonetheless, patients' privacy and the confidentiality of their care conditions at the Yendi Hospital were in jeopardy because of the nature of patient wards and healthcare professionals' behaviour. I offer a few cases that exemplify how patients' privacy and confidentiality were experienced or handled in care provider-patient interactions.

First, regarding clinical consultations, it was a norm in the study setting for nurses to collect patients' folders for the clinicians' office, and to call out patients' names one after the other. Each patient then goes in for the clinician to consult them in the presence of the nurse. Although these nurses often helped to translate or interpret for patients and the clinician when there was a language barrier, the practice did constrain patient privacy and confidentiality. Secondly, in most patient wards, patient admission into the ward often occurred at the nurses' station. While taking a patient's case history, other patients, nurses, and student nurses could be seated there. Although every ward had an office for the ward-in-charge and other spaces, these places were not defined to be used during patient admission, even if using such spaces could have promoted patient privacy and confidentiality. A nurse even lamented that it was not easy to implement some patient rights because of the nature of the environment. The nurse said, "here, it's not that easy to implement patient rights, because sometimes you are talking to the patient and other patients are listening to the conversation" (N2).

Another clinical practice that compromised patients' privacy and confidentiality was when clinicians consulted patients in public spaces instead of in their offices. Several participant observation data revealed this phenomenon. For example, on February 24, 2022, I was observing clinical interaction at the nurses' station in one patient unit around 9 pm. Not only did the clinician on duty came to work very late, but he also consulted patients at the nurses' station. While consulting one female patient in the presence of the nurses, the clinician told the patient that she was not sick, that she did not want to "service" her husband, so she pretended to be sick. The clinician remarked, "you eat and drink soup, yet you said you are sick". He then asked the patient what brought her to the hospital, but the patient refused to talk. Although the clinician could have been playing with words by saying what he said, I assume that the patient needed some privacy, which was why she refused to speak. The nurses told the clinician to complete his consultations in his office. This scenario illustrated a case of disregard for patient privacy during clinical consultations.

With the above experiences around patients' right to privacy and confidentiality, it seems that completing clinical practices and routines was positioned higher in the care process than observing patients' privacy. Furthermore, due to recurrent language barriers, and the nature of the care context (i.e., limited space, the use of translators and interpreters), patient privacy became a secondary matter. Thus, patient privacy was relegated to the background, with nurses and clinicians focusing their energies on the care and health needs of patients. What then could be the impact of this situation on patient disclosure? What happens to the right to privacy in healthcare access? This situation was a dilemma in clinical practice that must be examined in context because many patients' needs, and care outcomes were positioned above their rights to privacy. The situation further implies that implementing some patient rights can be a negotiated engagement where nurses and patients must balance patients' needs versus their rights.

5.3.2.6 Patients' Right to Self-determination (self-autonomy) and to Choose. Patient-centered care principles recognize that patients must be encouraged to contribute to the management of and/or determine the course of their care. As I read copies of the *Patient's Charter*, it states that patients have the right to choose from alternative procedures that best suit their care needs and circumstances. It further stipulates that there should be "respect for the patient as an individual with a right of choice in the decision of his/ her health care plans". Furthermore, the *Charter* emphasizes patients' right to choose in Article 14, which mandates that patients be granted the right to a second medical opinion if they so desire. The right to choose and self-determination recognize that patients come from different cultural, social, and financial backgrounds, and, as a result, their circumstances may affect healthcare access and outcomes. The right to self-determination (individual autonomy) is in tandem with the right to dignity because being able to make a choice that is respected by care providers is dignifying, in itself; however, that could be difficult to realize in certain clinical contexts (e.g., emergency situations). Several nurse-patient clinical interactions and communication practices implicated the right to self-determination in the study setting. A few such cases are exemplified and interpreted in this subsection.

One significant area in which the right to self-determination was fully implemented was when patients requested that certain nursing care practices should (or not) be performed on their patients due to cultural and religious beliefs. Examples included when caregivers asked that their patient who suffered a mild stroke should not be injected, that a newborn baby should not be breastfed for some days, or request a discharge because they believed that a particular illness requires local traditional remedies. The following data illustrate the right to self-determination during care by a female patient.

> Ok, at times, I have my rights, … in case they are to give me something and I don't agree to it, I can decide on that. Let's say, for instance, this morning, I was having pains with my IV line, I told them that I don't want that line, [so] they have to pass a new line for me. (P3)

In the above data, the patient self-determined how she wanted to be treated. This example and all instances of patient discharge against medical advice aligned with patients' right to self-determination.

Additionally, a few nurses recognized patients' right to self-determination when they stated that patients have “the right to refuse treatment and to seek a second opinion” (N1), or “different treatment options” (N2). Despite these claims of self-determination, many events and experiences of patients and nurses presented two important ethical and medical dilemmas. The first dilemma was about balancing individual self-autonomy against collective rights, especially in cases where the caregivers are the ones exercising the right to self-determination (e.g., accepting patient discharge against medical advice). The second dilemma concerns balancing patient rights and risk of care. When nurses and other care providers respect patients' and caregivers' cultural values and their right to self-determine the course of their care, how does that affect the risk of care? For instance, on February 25, 2022, the issue of patient discharge against medical advice came up when I was interacting with a clinician on some observed data. The clinician stated that a patient who was discharged against medical advice two days ago had returned to the hospital. The clinician was not happy with the patient because he refused their advice and left. With this scenario, one wonders whose decision it was to have the patient discharged: The patient or his caregivers? And what risk did that pose to the patient's health?

5.3.2.7 Patient's Right to Participation. Patient engagement in their own care is another important PCC dimension in healthcare discourse and promotes patient rights. By engaging patients in their own care, patients learn about self-care, care disclosure improves, and patients and their families are empowered with relevant knowledge about clinical routines. Despite the value that patients' and caregivers' engagement in the care process has on healthcare delivery, not all nurses encouraged this significant practice. Many patients and caregivers reported not being allowed to ask questions, not being talked to, or not having care routines explained to them. For example, a caregiver (CG6) remarked:

> No, they don't give us the chance to ask questions. They (nurses) just come and do what they want to do. If you don't understand anything and want to ask questions for clarification, it will turn into a fight. They will tell you they know what they are doing, [so] why are you asking them? (CG6)

A patient also stated, “No, I don’t get the chance to ask questions. They will come and do their things” (P11). Although patient and caregiver engagement in the care process goes beyond just having the chance to ask questions, to these participants, having the ability to ask questions and receive positive responses were crucial elements, perhaps because of the power differences that exist between nurses and care consumers. Nonetheless, with this understanding of engagement, many patients and caregivers submitted that they were engaged. For instance, patient (P6) claimed that she took part in her care process because any time the nurses did something that she did not understand or gave her a note to execute something she knew nothing about, she always asked the nurses, and they would explain and provide her reasons. Sometimes, patient engagement was limited to nurses telling patients what to do regarding their prescribed medication.

Again, most nurses reported that they often engage patients and caregivers in the care process, especially when planning patient care or medication routines. To illustrate, a nurse explained that during labour, labour patients find it difficult to observe some care routines, so in such instances, the patient relatives are engaged to help the patient go through the procedures. The nurse said, “We engage the relatives, patients do trust them more than us, so sometimes we explain and interact with the patient relatives, and work with them to explain things to the patient” (N10). The nurse further explained that a patient was reactive to a viral infection, and after delivery, she was asked to invite her husband for them to discuss the modalities around injecting the baby to prevent cross-infection. The patient’s husband came, and they interacted with him to reach a conclusion. Similarly, another nurse (N11) stated that when they explain things to a patient and the patient still has problems or is naïve about the care processes, they will get the patient’s relatives who may understand the process to interact with the patient. He said the following: “Because family members understand each other better, we will get a family member to intervene and explain to the patient, the need to accept whatever we are telling him/her” (N11). From the above examples, it became apparent that caregiver engagement only happens when nurses find it difficult to get patients to complete certain care routines or processes.

Participant observation data revealed a mismatch between what nurses say they do versus what they actually do. I found that there was little patient engagement in the care process beyond the question-and-answer form of engagement. Additionally, less social talk was observed between nurses and patients; hence, there was no social care. By social care, I mean having a concern for and paying attention to a patient’s social needs, circumstances, and background in the care process. For nurses to promote social care, they must develop an awareness of the social circumstances that enhance positive care outcomes for patients. The lack of social care became visible during nurses' medication rounds, where nurses were interested in completing care routines (e.g., serving the patient's medication) sometimes without any conversation between them and the patients.

For instance, on March 30, 2022, I noted the following while observing nurses' morning medication round in a female ward.

> The nurses are conducting the morning medication rounds but it looks like many of them are more concerned with completing care routines – dressing wounds, giving medication, and taking vital signs – than talking with the patients. There is little or no communication with patients. A nurse can be with a patient for about five to ten minutes or more without even engaging the patient in any conversation. There is no inquiry about how the patient felt, is coping with their condition, whether they slept well the previous night, or about their social relations (Fieldnotes, documented March 30, 2022)

Therefore, actual patient engagement was an uncommon practice, which may be accounted for herein. First, there was low health literacy among patients and caregivers, so their understanding of engagement might have been limited. Second, many patients and caregivers trusted that nurses are the knowledge bearers, have their patients at heart; hence, they will do things in the interest of their patients. Lastly, knowledge and awareness of patient rights were limited which means that patients and caregivers lacked knowledge about their entitlements. Therefore, to not upset nurses and perhaps jeopardize their care, patients and caregivers would not force their participation in the care process if nurses did not invite them. Along this line of reasoning, a patient responded to my query whether they were engaged in the care process, "No, I don't know. It may be that I don't ask, or they don't invite my opinion. Usually, they just come with the medicine and say, 'this one, you have to take it at this time'". (P15)

5.3.2.8 Right to Non-discrimination. When nurses treat every patient respectfully based on their care needs and circumstances, it is consequential to healthcare access and perceptions of care outcomes. The right to non-discrimination is highly regarded in medical and nursing ethics. Discrimination in clinical interactions and nursing care practices is often seen in ‘differential patient treatment’: treating patients differently based on their social, cultural, and bio-demographic characteristics. Although positive discrimination (affirmative action) under certain care circumstances (e.g., during an emergency and critical care situations) may be tolerated, patients and other healthcare consumers generally frown on discrimination in the healthcare delivery process.

In this study, all data sources revealed minimal discrimination and differential treatment. Regarding differential patient treatment, these were the observations of two patients.

> Since I came to this ward, I have not seen any differences in how nurses treat patients. The nurses give both rich and poor patients the same attention. So, there are no differences in treating patients with these features. (P2)

> Here, I have not seen some, but in other places, I have experienced that because where I did my clinical practice, they are big, big men with special treatment; they are always being kept in private wards. (P3)

Even though these patients felt that all patients were treated the same, other participants noted that some discrimination was evident. For instance, a caregiver stated she was discriminated against at the pharmacy when she went there for medication. She believed patients’ age, gender, level of education, or higher social factors could influence how nurses treat them. She related:

> These differences (i.e., age, gender, ethnicity, socioeconomic status) can lead to different treatment of patients by nurses. Because you may come here first, and they will leave you and attend to someone else they know; meanwhile, you are also a patient. But just because you are not related to them or because they don’t know you, the nurses will leave you and attend to people they know. (CG8)

Other participants had similar perspectives about differential treatment as both a nurse and a patient pointed out.

> Sometimes too, some people come and there, they feel that they should have been treated some way, some special way bi, [ok], if they are not

> getting it, maybe he is a big person in town, and he comes in, and then you treat him the same as other patients. Most people don't take it lightly. (N1)

> I only hear outsiders talk about nurse-patient ratios and relationships; I heard that the nurses here are good, but that they are biased when treating some people. They treat those (patients) that they know first before others. And they are not supposed to do that. (P9)

As the above data shows, people use their social status and social relationships to gain an advantage to access healthcare services in the hospital. However, other participants felt that patients' pain state, health condition, or respect for older people induced differential patient treatment, as noted below.

> The condition may influence. For instance, there is this elderly patient; anytime his condition is bad, the nurses must come to attend to him. However, for those of us whose conditions are a bit stabilized, unless it's time for our medication, [that is when] the nurses will come to us. (P15)

> Yes, there is a difference, but that depends on the nature of the illness. Some patients have critical conditions, so the nurses attend to them more than others with mild conditions. (P17)

The above participants' viewpoints suggested that patients' health conditions, including their pain state, can demand much attention from nurses to stabilize them, just as in emergency and critical care situations.

In addition, other participants explained that age was a significant factor in driving differential treatment, as declared by these nurses.

> … eh the required respect for the patient, because most of them come here, they are aged, are elderly, could even eh, be grandfathers to most of the nurses, and you know this our local setting, they believe in me being an older person, I should be treated as such. So, when they come, and you want to treat them like your age mate, or colleague, it doesn't go well with them. Moreover, sometimes, the culture within the society we find ourselves in, for instance, if a chief comes, their treatment or the way of

> handling them will be of a different dimension than any ordinary individual. (N8)

> Yes, most times, as a nurse, you are supposed to speak to or treat all patients the same way. You shouldn’t say that because this one is educated and that one is not; you will speak to them differently. However, as they say in our local language, you should give much respect to older people, so the older [elderly] patient might receive more attention than someone else, though they should be treated and spoken to the same because they are all patients. No matter their level of education or social status, they should all be attended to in the same way. (N11)

According to these participants, the age of patients and caregivers can influence how they are treated. Thus, in this study’s cultural setting, age is positioned high on the social scale. It determines how communication unfolds and influences access to healthcare services. Age and social status; therefore, privileged some patients and caregivers concerning healthcare access and better care services. Age and social status are hegemonized during access to social services, including healthcare services. The Dagbon society expects elderly people not to join queues or wait long hours to access services. It is, therefore, a social practice for elderly persons to be singled out from queues in banks, food vendors’ shops, and other service access points to be served. This situation explains why many participants believed that treating elderly people differently does not constitute discrimination but rather a moral obligation. The critical question is how does this status quo intersect with the predominantly individualized patient rights? I will revisit this in the discussion section.

Other factors that limited the observation of patient rights were institutional bureaucracy and lack of law enforcement. A nurse (N1) believed that healthcare institutions and their laws do not work well regarding patient rights protection. He argued that some patients might know their rights and when those rights are being curtailed; however, institutional bureaucracy affects these rights. Despite the institutional lack of attention to patient rights, patient education about their rights, as provided in the *Patients’ Charter,* was also lacking. I interpret the lack of intent by nurses to educate or inform patients about their rights as a form of discursive practice that nurses use to maintain their position of power and to control what patients can (and cannot) do or how they should behave in the care setting.

Perhaps when patients are less aware of their rights, they may not demand that from healthcare providers.

Having examined the experiences of patient rights in this section, I will turn to other nurse-patient communication and interactional practices that either fostered or impeded effective therapeutic relationships and patients' entitlements in the care delivery process.

5.4 (Dis)Enablers of Effective Nurse-Patient Communication and Relationships

Several clinical practices, nurse-patient communication strategies, and relational approaches were found that either promoted better nurse-patient interactions or obscured communication and patient rights outcomes. In this section, I explore four complex but interrelated themes and subthemes that explicate the above topic.

5.4.1 Becoming a Caring Nurse

In clinical practice, nurses often exhibit attributes that may define whether they appear caring to their patients. According to participants of this study, nurses who demonstrated professionalism, effective communication, and/or treated patients with respect and care were seen as caring. Eight characteristics that define a caring nurse were identified. These defining features, derived from the participants' interview data, are presented in Table 6.

Table 6:

Attributes of caring nurses derived from the interview data.

Caring nurses:
-listen to patients and caregivers
-don't shout at patients and caregivers
-speak nicely to people
-respect patients, caregivers, and other care providers
-have patience with people
-protect clients' information
-present a friendly face when interacting with people
-understand patients' situation
-support fellow nurses
-accept their mistakes, correct them, or don't repeat them

A nurse is viewed as caring by possessing these attributes or attempting to develop these traits. As a caregiver said, "A caring nurse is a person (a nurse) who is patient, understands patients' pain and struggle" (CG4). Similarly, a patient observed that caring nurses do the following:

> When it is time, they are supposed to visit their patients, and many nurses are always on time. They give listening ears to their patients. When a patient complains, they find out, and then if there is anything they can do to resolve the problem, they do it. They know how to care for their patients. (P14)

Active listening and supporting patients to overcome their care challenges were some caring practices patients and caregivers expected from nurses.

As noted here, many nurses shared their perspectives regarding who a caring nurse is.

> A caring nurse is a person [who], irrespective of what you are doing, should always ensure that you put your patients first. It's because of them that I am here. So, they come first, and any other thing comes after that. When caring nurses are called to work, they don't ask what it is; they just come. Caring nurses are punctual and responsive to patients' and caregivers' needs. (N9)

> Well, [being] a caring nurse is not just how you appear and not just mouth-saying that I am a caring nurse. It takes a lot to be a caring nurse. You must possess some qualities. One of them is the way and manner you talk to patients. Not communicating well with patients negates the principle of being a caring nurse. So, good conversation is very important. (N11)

According to these nurse participants, putting the patient first in the care process and communicating well with them is crucial to being viewed as caring. Other nurses hammered on respect as crucial for being a caring nurse; as a nurse explained, "caring nurse is tolerant and respectful. No matter who the patient is, you must respect him/her" (N10). All these caring nurses' attributes are also enablers of effective nurse-patient communication and interaction. These responses suggest that positive nurse-patient relationships can be built by respecting, tolerating, and putting the patient first in the care process, allowing for meaningful interactions between healthcare providers and patients/caregivers.

On the other hand, participants identified practices and attitudes that resulted in a nurse appearing uncaring. For example, shouting at, demeaning, and disrespecting patients and caregivers were consistently stated as uncaring behaviours. Not engaging patients and caregivers, failing to understand patients' situations, and outright patient neglect were among the uncaring attributes that curtailed good nurse-patient interactions. As patients and caregivers indicated, these uncaring behaviours among nurses also impacted nurse-patient relationships and care outcomes. For instance, a patient believed that an uncaring nurse is "one who neglects patients when they ask for help. Such a nurse doesn't feel pity for patients" (P5). Another patient stated that uncaring nurses "don't care about their patients. Whatever the patient is going through, they are not always there for the patient" (P9). Thus, a nurse who neglects patients, lacks empathy for the patients' experiences, and/or is not supportive of patients cannot be called a caring nurse. Many nurses agreed with what patients and caregivers said about who a caring nurse is.

5.4.2 Honour the Ethics of Life, Care, and Caring

This theme explores what it means to be human and need care and support from healthcare providers. Participants of this study identified values that promote caring, including respect for human life. For the participants, the ethic of life consisted of being humane in healthcare delivery.

For instance, when patients and caregivers wait for their turn without forcing their way through or using their social status to gain favours, they honour ethical values of care. Furthermore, some nurses spoke about the ethics of life and care in the following manner:

> I understand that it's not easy to be a patient. The health condition can change their behaviour. As a nurse, you need to put yourself in their shoes. Try to say, if you were the one in their shoes, how would you feel or behave? Then you will know how to treat them. If you put yourself in the patient's shoes, you will feel the same way they feel. (N2)

> First of all, realize that the client/patient you are dealing with is just as human as nurses, just that we can't all be nurses. Nurses must understand that we are care providers; we give care and help patients recover; for those who will not recover, we help them to die peacefully. (N8)

These nurses acknowledged that being human must be the focus when delivering care. Nurses must put themselves in patients' shoes; then, they will realize that being a patient is not easy. With that logic, nurses can provide humane care that respects the patient's dignity.

Caregivers and patients also shared their views about the ethics of life and caring. A patient who came to the hospital as an emergency patient was so worried about her social responsibilities and how her children would fare if she were to die. A nurse noticed and interacted with her to reassure the patient that her condition would improve. The patient reflected on life and later offered a piece of advice to nurses regarding humanness and caring along the following lines,

> I have just one message for nurses; they should always think first before acting. They should know that they can also become a patient one day. They should know that we are all humans. The nurses have relatives like us, the patients, so they should treat patients as they will treat their relatives. (P5)

Similarly, a caregiver worried about another patient in the same patient ward as her relative. The caregiver narrated the following, which touched on the ethics of life.

> A patient is in there, and we have been worried about her. Since we moved to this ward, she has had a small boy with her as her caregiver. Since she came to this hospital, nobody has come here to visit her. It’s the boy who provides her with water and food, even washing her things. The nurses saw that the boy was very young to be a caregiver. We were worried about her but didn’t know what to do. However, today, when the nurses realized she had no other caregiver besides the boy, they went for water, cleaned her up, and provided her with food. So, because of that, I am grateful to the nurses for their work. **Because a human being is a human being**, for any person to be sick in the hospital and has no caregiver, nobody here to support her, is worrying. (CG3)

For these participants, respect for life and humanity is the highest care one can receive in the hospital. The following core values in Table 7 were summarized from all the participants’ interview data as promoters of the ethics of life and care.

Table 7:

Values that honour the ethics of life, care, and caring

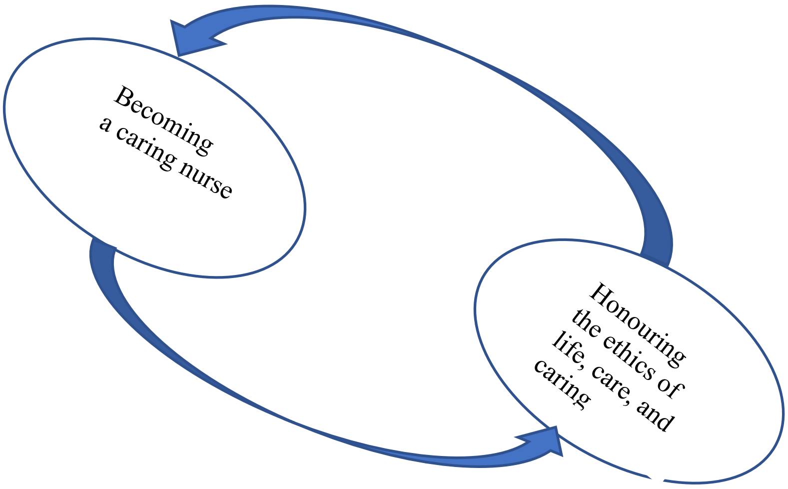
For ethical nursing care that honours human life, nurses must
-value human life
-see patients as human beings
-realize that every human being desire respect
-put themselves in the patient’s shoes
-treat everybody as they want to be treated
-know that people have different characters, backgrounds, and beliefs

This theme is closely related to the previous theme. However, the fundamental difference is that the ethics of life, care, and caring are centred more on humanness, personal and moral obligations, and care practices that honour human life. Firstly, patients as human beings come to the hospital with different care conditions, are from various cultural backgrounds, and may have unique needs and challenges. Hence, not discriminating based on patients’ social standing or being fair in dealing with patients and caregivers were noted as part of ethical caring practices. Secondly, the participants noted that respect is key in every human relationship, so, the ethic of life demands that everyone be respected and treated with dignity. Therefore, to honour the ethics of life, care, and caring means that nurses, patients, and caregivers must observe or acknowledge certain moral obligations around life and being human.

From the themes of *being and becoming caring* and *honouring the ethics of life, care, and caring*, I developed a model, The Caring Space, as illustrated in Figure 2 below.

Figure 2:

The Caring Space



The Caring Space, as a model, connects the values of becoming caring with those of the ethics of life, care, and caring. To be or become caring, a nurse must honour the ethics of life, care, and caring. Caring nursing practices will flow naturally when nurses and other healthcare providers honour the ethics of life and care. A nurse might not be caring but making an effort to become caring is an essential skill every healthcare provider must strive to develop. Respect for human rights and dignity is at the core of honouring the ethics of life and caring. To honour life, one must value people no matter their socio-cultural status. When be in the caring mode, they and patients must be tolerant, respectful, and treat others as themselves. Therefore, the model requires nurses and other care providers to reflect on their life and align their behaviour and healthcare practices with the core values of being and caring, as noted in Table 5. Their care and medical practice must honour the ethics of life and caring, as identified in Table 6. Thus, for nursing care, care practices, and nurse-patient interactions to be dignified, *becoming caring* must interlope with *honouring the ethics of life and caring* to form the Caring Space within which nurses operate.

5.4.3 Resolving Barriers to Care Delivery

In this section, I present some strategies to minimize the barriers to care delivery. There are five essential findings that can help minimize the impact of the barriers and gaps to healthcare access, presented in Chapter 4. These factors include awareness of gender and social dynamics in care delivery and valuing communication. The rests are building trust and showing appreciation, nurses coping mechanisms to resource constraints, and politeness and use of address terms. It is important to note that these strategies have embedded power and positioning dimensions as critical issues that impact nurse-patient communication and interaction. Thus, together with gender, trust, appreciation, and other social variables, these factors intersect to either enhance nurse-patient communication and interactional practices or obscure them. Hence, in all the subthemes, I explore how they either enhanced or implicated effective communication and interaction between nurses and patients/caregivers.

5.4.3.1 Awareness of Gender and Social Dynamics in Care Delivery. Several gendered factors and social dynamics were found to impact care delivery in the study setting. These complex issues are examined in this subsection. Gender, as presented here, relates to socially assigned roles to men and women within the cultural setting of the study. As a result, references to gender are limited to men and women as other gender categories were of no relevance to the participants or social interaction in the study context. That is, gender and sex became conflated.

Interview and observational data revealed that certain health behaviours and practices were more aligned with one gender compared to the other. For instance, regarding patient admission to the hospital, it was found that female patients disliked being admitted compared to men. The following observation about gender and patient admission was made by a nurse:

> The ladies, they often refuse admission, … they don’t want to be admitted. So, I often convince them and let them know why it’s necessary that they accept the admission. There are environmental challenges, so some of them complain about the facility. Because there are things they don’t get here. So, we let them know that admission is very important than the things they may be lacking in the facility. They need to outweigh their health over those things. Sometimes too they have issues like they are alone in the house, they have kids, and who will be there to take care of the kids? (N3).

From the above quote, I posit that the refusal of female patients to be admitted was socially motivated as many of them thought about their social responsibilities vis-a-vis the care environment. It appears that female patients who had challenges accepting hospital admission did so because they position their social responsibilities above their own healthcare needs.

Another gendered health dimension was that some female patients prefer to be attended to by male nurses, as observed by another nurse.

> For the women, when they come to the facility, they have preferences about whom to talk to and what to tell them. You can be sitting here, both male and female nurses, and sometimes, you will see a woman coming and you would expect that she will talk to the female nurse, but most of the time they come to a male nurse to tell him their problems. (N3*)*

Given the influence of Islam in the Northern region as well as issues around privacy, one would have thought that female patients would prefer to interact with female nurses. Nonetheless, a few nurses revealed that the opposite occurred. The nurses attributed this trend to the privacy of the information shared, as they assume that female patients felt male nurses would keep their information confidential. That opinion was supported by a female patient (P13) who stated that most female nurses gossiped about patients.

Regarding communication in general, other participants had similar perceptions. It was believed that interacting with men and women differed, especially with reference to communication and demand for information. For instance, a female focus group participant stated that “the male nurses are better than the female nurses when it comes to communicating with patients” (FGP2). The following nurses observed that female patients/caregivers demanded more information compared to male patients.

> Men sometimes, in our setting here, tend to be very easy and understanding as compared to eh the lady’s gender. So, talking or dealing with them, you don’t have to talk so much for men to understand, but for women, you must explain yourself a lot before they get whatever you are trying to tell them. (N8)

> When it comes to women, … eh, they need more of talk. The men too are such that they come to hospitals with, eh with acute complaints. … They come when they are not able to do anything about it. (N9)

As noted in the above quotes, women require more talk from nurses, perhaps to understand the care needs of their patients or themselves when in the hospital, whereas men report their health conditions late to the hospital. The nurses stated that most men come to the hospital when their health has deteriorated and possibly only once it has affected their ability to work. Women commonly come to the hospital, either as patients or caregivers; therefore, it seems normal that they engage more with nurses to know about healthcare activities and the conditions about themselves or their sick relatives.

Another social dynamic that I noted earlier was age and social interaction. Within the study setting, age plays a significant role in how communication unfolds. Some participants observed that there were a lot of differences in how nurses communicated with elderly patients compared with others. For example, a patient said, “there is more effective communication between nurses and elderly patients than compared to the youth. Elderly patients are respected more and treated with care and dignity” (P17). In addition, other participants reported that level of education and ethnicity all impacted care access. The effects of ethnicity on communication and social interaction may be apparent because of differences in language use, cultural values, and beliefs between nurses, patients, and caregivers, as discussed in Chapter 4. These variables associated with ethnicity did impact clinical interactions and communication practices.

Participants further observed that levels of education influenced social and clinical interactions in the hospital. For instance, a patient claimed that “nurses respect and treat their colleagues or educated patients better than other patients” (P17). This observation was supported by a nurse who argued that,

> When an educated person comes, we assume that he is enlightened a little bit about how hospital protocols and other things are done. But for a layperson, he comes in as a completely new person to the facility, so the way you will talk to him, means you provide an overall orientation for that person. So, how you talk to them is actually very different from the way we talk to people who are educated. (N8)

According to the above nurse, people who are educated may be easier to talk to as they may have some level of knowledge about hospital processes compared to others who are not literate. Even though people’s level of education can influence communication outcomes, it is not true that every educated person may be easier to talk to in the healthcare context. As another nurse noted previously (in section 4.3.2.2), people’s level of medical knowledge, and frequency of visits to the hospital, among other factors, may impact their communication with nurses and not just their level of education. Generally, therefore, gender/sex, age, language differences, religious beliefs, social status, and literacy levels acted as (dis)enablers of effective nurse-patient communication and interaction. Concerning these variables, a nurse sums up everything when he said that “in all, the underlying influence is the culture, culture plays a major role” (N9). According to this nurse, the cultural orientation of nurses, patients, and caregivers is what determines how they communicate and interact with others in the hospital setting.

From a Positioning theory perspective, it seems that social norms in care delivery have some traction and agency. Thus, respect for cultural values and beliefs was often positioned higher by patients/caregivers even above what medical experts say. This was evident in instances where patients signed letters for a discharge against medical advice. Moreover, as noted in Chapter 4, section 4.4.4, patients’ cultural norms and health beliefs influenced their reception of certain nursing care practices such as blood infusion or donation, and baby-to-mother skin contact for newly delivered babies, among others. Furthermore, a person’s age had agency in this study’s cultural context. That is, the study participants reported that elderly patients had social standing which allowed them to demand special attention due to their age. Therefore, socially, age positioned elderly patients in a position of control (power domain) during clinical interactions (also see the role of age in the subsection on politeness and request making).

5.4.3.2 Valuing Communication. The value of effective communication in clinical interactions cannot be overemphasized. In Chapter 4, I illustrated the challenges poor communication brought to healthcare interactions. Issues around miscommunication, misunderstanding, and language use barriers all converge to demonstrate the unique position communication occupies in healthcare interactions. For instance, a nurse emphasized that “not communicating well with patients negates the principle of being a caring nurse” (N11). According to this nurse, engaging in meaningful conversation with patients has healing within it, as he believes that “ the way and manner a nurse speaks with patients, without even giving them any treatment can tell the patient that the nurse is caring” and that “for some patients, it’s not just the medicine they receive, but sometimes they need psychological support [in the form] of someone speaking to them in a good manner.” This nurse trusted that having good communication with patients is therapeutic and could define a caring nurse. He argued that “a bad nurse can emanate from poor communication to patients or to other nurses.”

Other nurses maintained that a nurse is supposed to communicate and interact well with patients and caregivers, therefore, any nurse who is unable to perform this important role properly cannot be a better nurse. For instance, a nurse commented that being a “caring nurse manifests in the way you communicate with your patients” (N1). Nonetheless, he believed that “healthcare providers sometimes underrate what communication can do. It can positively impact the kind of care you are going to give the patient.” Therefore, valuing communication in clinical interactions can ameliorate many challenges to healthcare access and delivery. For instance, the following was said about communication and its potential to foster positive human relationships.

> Communication is very important and knowing how to communicate with a patient is crucial. We are all human beings and need good communication, if you know how to communicate, I don’t think you will quarrel with patients. They may disagree with you, but not quarrel. So, you should know how to communicate well, and your choice of words. (N5)

The need for effective communication is paramount, and from the Theory of Dialogue point of view, communication must start with knowing the human being you interact with and valuing their needs. Therefore, effective communication does not only enhance meaningful interactions but also helps to curtail conflicts between care providers and consumers. On that note, a focus group participant advised patients, caregivers, and, more particularly, nurses in the following lines about the need to be mindful of their utterances.

> Our tongue is a weapon, yet people don’t train their tongues very well. If people are careful, they won’t speak badly or hurtful words to others. Nurses must be trained to understand “please be patient, let me do this,” or “please, don’t do this”. Even if you do something that will hurt another person, but you use “please” the person might not even feel the pain much, because, you have already pleaded with him/her before performing the act. (FGP4)

From the above quote, care providers and consumers are reminded about the relevance of good language use and the choice of words people make when talking to others. Again, the Theory of Dialogue informs us that speaking interacts with other human abilities, including thinking, perceptions, and emotions which allows human beings to make emotional, perceptive, and cognitive inferences when verbal and non-verbal acts are made during social interactions. Thus, in clinical communication, the tongue is likened to a weapon, which, when not controlled, can cause emotional and psychological harm to people and damage relationships.

5.4.3.3 Building Trust and Showing Appreciation. Participants of this study agreed that nursing care must be based on trust and having a genuine interest in the health of the people for whom care is provided. Data about this theme revealed that patients and caregivers had mixed feelings when it came to trusting their nurses.

On the one hand, I found that many patients and caregivers appreciated the support that nurses gave them during their stay in the hospital. Many patients who appreciated and expressed their gratitude to nurses were the ones who trusted that nurses had the knowledge and skills to provide the needed care, as shown in the following quotes.

> I wish to express my gratitude to the nurses, they are doing their best, and many of them don't sleep. They are always here to help patients and their relatives. Especially, the labour ward nurses are doing their best. (P2)

> Because it's their work, I generally don't ask them questions. Because I know it's their work so whatever they are doing, I believe that they are doing their work [and] I have seen that they are doing well. I would advise them to continue doing their best. (P10)

These patients trusted the work the nurses did for them. Some nurse participants confirmed that most patients trusted them and acknowledged the services they rendered. As a nurse noted, "for some patients immediately after the baby is delivered and you are looking for food for the mother to take, she tells you, I really appreciate your efforts. God will bless you" (N10). Other nurses said the following about patients showing appreciation.

> We often experience exciting moments when we treat patients, [and] they get well and become happy. Such patients often bring things for us. For example, a child was malnourished, so we started a treatment routine. We prepared feds for the baby and with time he became well and was looking great compared to when they came to the hospital. The mother, on one market day, brought the ward eggs to appreciate what we did for her and the baby. (N11)

> Most patients when they come with serious conditions, and perhaps, they are already thinking that with this condition I am not going to make it, and you are able to relieve them of the pain, or that situation, usually, most of them will feel happy. One man told us that when he is better and gets home, he will kill us a goat (laughs), because he was excited, and we also feel happy that way. Sometimes, that alone gives us a lot of satisfaction. (N1)

The data presented thus far indicated that many patients and caregivers did not question nurses' practices because they believe that nurses have the knowledge; hence, whatever they say patients and caregivers must follow. This situation presents what I refer to as the "knowledge as power" position, that nurses and other healthcare providers occupy.

On the other hand, despite many patients trusting nurses and believing that the nurse will do the right thing, other patients trusted their caregivers rather than the nurses. Many nurses observed that caregivers and patients who had negative preconceived mindsets mistrusted them, while other patients and caregivers showed less appreciation for the care they receive. The quote below illustrates an instance of mistrust for nurses.

> In emergency situations, when patients come, sometimes, we have to use our emergency drugs and medicine so that later they will buy them for us to replace the ones we have used. But sometimes, the patient relatives will buy the drugs and when you want to replace the ones you have used on their patient, they will go like, 'the nurse is stealing our drugs/medicines.' What surprises me is the caregiver who was there, and you explain to him/her, and they agree that you should use it, but when the other family members accuse you, that person will not say anything. So, you feel like the people didn't even appreciate your efforts, because you can't keep the patient waiting for the caregivers to bring their health insurance card, process everything, and pick up the medication before you begin treatment. (N6)

As the above quote shows, caregivers often mistrust nurses and accuse them of stealing their patients' medicine. The above situation shows both mistrust and a lack of understanding by some caregivers. Also, when patients and caregivers doubt nurses' knowledge and medical expertise to advise them, it creates a notion of mistrust. As a nurse stated, “some patients may think that you are not professional enough to solve their problems, so they do things contrary to what you tell them” (N4). This nurse narrated that some time ago he interacted with hypertensive and diabetic patients on a diabetics-clinic-day. He was educating them about the importance of coming for their medication before using the last one. He encouraged the patient to monitor their diet and regulate their consumption of sugar as well. As he was talking to the patients, one of the diabetic patients said to him, “as for sugar, I can’t stop using it. I have used sugar for 74 years now, and I am still alive” (N4). The nurse realized that the patient was also using alcohol, so he advised him on that, and the patient said “he has been taking alcohol all his life and he was not dead yet. The patient then mentioned names of prominent people in the community who died although they were not taking alcohol and asked me what killed them” (N4).

From Positioning theory, Face, and Politeness perspectives, the refusal of the patients to take the nurse’s counsel not only insinuated mistrust but also invoked face work. The nurse’s advice was interpreted as a face threat to the patient’s negative face, as it positioned the patient as being weak and helpless. So, to avert the situation, the patient repositioned himself as having agency over his life and health, then through legitimation discourses – ‘I have used sugar for 74 years, but I’m not dead yet’, and ‘people have died without drinking alcohol’ – he repositioned himself as capable of managing his life.

From the above analysis, it becomes obvious that having trust and showing appreciation in the care process can potentially stimulate effective nurse-patient relationships and interactions. On the other hand, mistrust, fueled by negative preconceptions and a lack of gratitude among nurses, patients, and caregivers, can stagnate care delivery, especially in resource-scarce settings.

5.4.3.4. Nurses Coping with Resource Limitations. In Chapter 4, section 4.3.3, I highlighted the consequences of resource limitation on care access. I noted that the lack of daily ward consumables, insufficient nurses and clinicians/physicians, and deficient medical equipment in the hospital affected not only the work of nurses but also constrained nurse-patient relationships. In this subsection, I present and analyze how nurses cope with some of these resource constraints and the implications of their coping strategies on care outcomes, patient rights, and clinical interactions and relationships.

Moving forward, I identified the following coping strategies from the data that nurses employed to manage resource scarcity in the care setting. The approaches included (a) retailing (buying and selling) care and medical materials to patients (b) asking patients and their caregivers to buy medical supplies, and (c) lending emergency medicine and drugs to patients. Other coping strategies were (d) consulting and prescribing medication for patients in the absence of clinicians, (e) shopping for translators and interpreters to enhance communication, and lastly, (f) borrowing medical equipment and consumables from other patient wards.

My observation data revealed that, due to limited material resources, some nurses would buy supplies from pharmacy stores and keep them in the ward to sell to patients who may need these items. Other nurses will simply ask the patients to go and buy the items they need from pharmacy shops, as a nurse clarified during an informal discussion at the nurse's station, "patients are usually made to buy a lot of things, when we run short of supplies in the ward, they must buy these things for their own care" (Field notes, documented March 9, 2022). On a few occasions, nurses spoke to other patients and used their medicine, drugs, and materials to treat other patients who needed it urgently so that later the recipient patient's caregivers would buy the medicine and return it to the patient from whom they borrowed it. Similarly, nurses could use emergency medicine in the ward on patients then the patient or their relatives would later buy the drug or medicine to be replaced, as a caregiver reported.

> Yes, even there are times, they need to give the patient some medicine, but you don't have it, they will give the patient the medicine they have, then you will go and buy it for them to replace the one they have used. Sometimes, they can use another patient's medication on your patient, then you will buy it for them to give back to that patient. Only someone who has your welfare or your patient's recovery at heart will do that for you. (CG3).

Even though these coping strategies helped nurses to provide the needed care to patients and caregivers, a few of these strategies had ethical implications. First, when nurses sell medical supplies to patients, it will reduce the stress on caregivers who might have to walk to pharmacy stores to buy these items. However, such items might be sold to patients at higher prices than at the pharmacy stores. Moreover, patients and their caregivers might fear that not buying these items from the nurses who attend to them can influence the care they receive. Lastly, patients and caregivers may think that these supplies are from the hospital and are meant to be used for their care. As a result, nurses could be accused of selling ward consumables that are already covered by health insurance, thereby leading to conflicts.

Another coping strategy by nurses to deal with the shortage of clinicians was that a few nurses prescribed medication and consulted patients, which often resulted in ethical challenges. To illustrate, my observation data revealed the narrative below.

> On one night, a child was rushed in to one of the children's wards in this hospital. The child was severely anemic. There was no clinician and all attempts to get one failed, so the attending nurse, based on his experience, prescribed, and administered blood infusion for the baby. The child was stabilized and responded positively to the procedure without any adverse effects. However, the nurse was arrested the next day on the complaints of a clinician assigned to the ward. The clinician argued that the nurse was not supposed to prescribe or even administer blood to a patient without a clinician's note. As a result, the hospital management sided with the clinician, and the nurse was arrested. (Field notes, documents on February 4, 2022)

Although the nurse had saved the life of the child, and no harm was caused during the care procedure, the nurse was punished for what the hospital leaders interpreted as a violation of the *Nursing Code of Ethics*. However, the situation seemed a medical dilemma in which the ethics of saving life superseded professional boundaries. In the above scenario, the nurse acted in the interest of patients' health. Despite that he was not supposed to prescribe medication, his action saved the life of the child. Thus, the clinician and the hospital management reactions were too punitive because in Ghana, it is a common practice for experienced senior nurses, due to their long years of practice, to consult and prescribe medication for patients at rural/remote and resource-scarce healthcare facilities. Moreover, most of the clinicians who practiced in the Yendi Hospital were senior nurses who upgraded their skills. In the context of patient rights, the behaviour of the clinician and hospital management would have violated the child's right to prompt care if the nurse had failed to act and the child died.

Similarly, a nurse on duty noticed that a caregiver and his patient whose condition was stabilized were about to abscond because they were not insured and had stayed in the hospital for several days. To avoid the hospital losing money, the nurse took the patient to the accounts office for them to settle their bills and issued the necessary receipts. The patient got their receipts and left, and the nurse completed his shift. A few days later, the nurse was summoned for discharging a patient. He explained what happened to the hospital management and even invited the accounts officer who confirmed what the nurse said. Nonetheless, the nurse was disciplined.

These cases illustrate what some nurses go through in their practice to provide care in the face of resource scarcity. However, some nurses may have ulterior motives for certain practices and attitudes. Nevertheless, nurse managers must examine ethical dilemmas critically before issuing disciplinary measures. Many nurses may become apathetic toward performing roles that seemed outside their practice protocols, no matter how life-saving the intervention might be. Besides, these incidents could widen further the power differences between nurses and clinicians, as participant observation showed that some clinicians' attitudes positioned nurses lower in the medical knowledge domain. Without any systematic care collaboration between nurses and clinicians in the Yendi Hospital, many nurses were left with the feeling that they could not provide basic emergency and life-saving clinical care in the absence of clinicians and physicians.

5.4.3.5. Politeness, Use of Address Terms, and Making Requests. Politeness in the cultural context of this study is signaled through various approaches, including the use of address terms and appropriate request making. Furthermore, greeting people when you meet for the first time and during social interactions is a cherished cultural norm in Dagbon. Although the hospital serves different people from different cultural backgrounds, the dominant Dagbon culture did influence many social interactions, including how politeness and requests were performed and interpreted.

Regarding the use of address terms, the way nurses addressed patients and caregivers differed from how patients and caregivers addressed nurses. The difference in the use of address terms somewhat reflected a power difference between nurses and patients/caregivers. Data from my participant observations revealed that nurses often call patients by their first or full names, and patients must respond to the call before they go to the nurse, otherwise, they are sent back to their seat. For instance, while observing nurse-patient clinical interactions at the OPD, a female patient was called who came to the nurses' station without first responding. A nurse asked a colleague, "did she respond?" The colleague said, No. The nurse told the patient to go back to the waiting area "because they called your name and you refused to answer." So, the patient was sent back to their waiting area and her folder was kept under the rest of the patients' folders.

Refusing to attend to the patient and even sending her back to the waiting area constituted a face-threatening act to the patient's positive face. Although a call-and-response is an adjacency pair, in conversational terms, violating such a speech act should not result in such a punitive outcome. Since the patient did go to the nurse, by implication, the sequence of call-and-response acts was completed. Furthermore, the Dialogue Principle of the Theory of Dialogue sees communication as a two-part sequence of action and reaction or initiative speech and reactive speech. Hence, the action of calling the patient was completed by the patient going to the nurse at the nurses' station.

Regarding elderly patients, certain social titles, and address terms, including honorifics, such as Alhaj, Hajia, m-ma (my mother), m-baaba (my father), m-paɣa (my grandmother), and n-yaba (my grandfather) are attached to their names or used as a stand-alone title. On a few occasions, neutral social titles that did not reflect social rank or age difference were also used, including n-tuzo paga (my sister), n-ŋahaba (my uncle), m-pɨriba (my aunt). A nurse narrated the following regarding use of address terms and their impact on patients' psychology:

> … when caring for patients, you need to respect them. Usually, personally, if they are grown up, we can say, oh, m-ma. We refer to them as, m-ma, m-ma so, so, and so, or mama, that is fine. But if you are of the same height, age or you are a bit older than her, it's a different approach. The way you address her will make her feel comfortable. But there are other ways that you can approach her and she will feel low (not respected). (N7)

Thus, appropriately addressing a patient may affect their relationships with nurses, as the above quote suggested. Furthermore, there were instances when nurses addressed patients and caregivers by their ethnic identity, such as Fulani or Fulan'paga (a Fulani lady/woman), and mo'doo (a Moosi man), among others. Although some people may not bother when called by their ethnic titles, other people may feel offended or belittled depending on the context and whether they interpreted such terms as derogatory or demeaning.

Lastly, nurse midwives occasionally referred to maternity and labour patients using medical terms rather than patient names. For instance, on January 18, 2022, I was observing clinical interactions in a ward when a new patient came in. The nurses were not sure whether to take the patient or send her to another ward. So, after examining her, the attending nurse said that the patient was a 2-centimetre (2cm) and that they only take labour patients who were 4cm and above, as a result, the patient was sent to the maternity ward. Later, a labour patient was screaming due to pain, and another nurse remarked that anytime she hears such screaming, she thinks of joining the caesarean section (CS) people when she is ready for a baby. In these cases, the patients became medical procedure (CS), and measurements (2cm/4cm – a measure of how wide the cervix had dilated) during labour rather than persons with names. Thus, patients can acquire new names including the hernia man, 2cm, 4cm, or CS people, among other labels.

Caregivers were also called by their first names or with reference to their patients. For instance, nurses could call out, “Alhassan Amina niriba baa?” (Where are the relatives of Alhassan Amina?), the caregiver/s will respond and go to the nurses’ station to perform whatever role the nurses require of them. However, on a few occasions, nurses did address patients and caregivers they assumed were educated with address terms, such as mister, sir, or madam.

On the other hand, nurses were often addressed as madam, sir, nurse, master, or doctor. Most of these terms were used when patients or caregivers needed nurses to do something for them. Again, a careful examination of the use of address terms and politeness markers, as shown above, unearthed certain underlying power dimensions between nurses and patients/caregivers, which were often mediated by age, social status, and one’s level of education.

On requests and how it was performed, I found that patients’ and caregivers’ requests took different structures. These included a simple declarative sentence form, with or without a politeness marker, or an interrogative sentence. For example, on March 8, 2022, while I was observing nurse-patient interactions in a children’s ward, a caregiver came to a nurse and said, “My child’s water has finished.” The nurse followed the caregiver to the patient’s bed to check and disconnect the infusion set. When the nurse returned, I asked him whether that was a normal way patients/caregivers make requests, and he responded positively. He further indicated that other expressions patients/caregivers mostly used included “Please, come and check this out,” “Master, the water has finished,” or “Please, my patient needs XYZ.” Previously, on March 4, 2022, I noted the following forms of requests while observing nurse-patient/caregiver clinical interactions in another patient ward.

(a) Nurse, my patient’s water has finished.

(b) Sister, my patient said I should do XYZ.

(c) Madam, can you come and do XYZ?

Many patient and caregiver requests took the form of a statement either with a politeness marker or an address term, as noted through participant observation. With the statement form of requests, as in (a) and (b), the patient or caregiver commits themselves less to the imposition that requests have on the requestee. That is, by simply making a statement, the requester positions themselves as a messenger who delivers a message, rather than directly asking the requestee to perform some role. This request form is like using interrogative sentences, as in (c), to make a request. These indirect forms of requesting reduce the imposition on the requestee as well as honours the power and social status differences that may exist between the requester and the requestee. Also, there could be a situation where a patient or caregiver makes a direct request (using a command sentence) without a politeness marker, in which case the power difference is offset. This situation could occur when there is no social distance between the care provider and patients (e.g., they know each other very well) or the patient/caregiver occupies a higher social position (e.g., a wealthy person, a chief, or a local community gatekeeper).

In conclusion, being polite and using the appropriate address terms or making a polite request influenced nurse-patient relationships and interactions. Therefore, nurses, caregivers, and patients must know the value of being polite, as a focus group participant believes that being nice and polite when making a request or talking to nurses and patients can foster a peaceful and respectful atmosphere:

> It should be, “please, let me do this,” or “please, this is that”. That is how life should be. But if a patient says, “please, my sister I want to do this,” and the nurse speaks badly to her, if she also gets annoyed, then things will not go well. (FGP3)

Being polite also requires sensitivity to cultural differences and values since that knowledge might be significant in implementing polite requests or using address terms.

5.5. Summary of Findings

In this chapter, I identified and presented participants’ experiences of patient rights and (dis)enablers of effective nurse-patient communication. While reflecting on the Ghanaian *Patients’ Charter*, I interrogated and interpreted different cases that bothered patient rights in nurse-patient clinical interactions in the Yendi Hospital. First, this study found that patients and caregivers lack awareness about the *Patients' Charter*. Secondly, while nurses are aware of or know about the *Charter*, there is little education on patient rights. The lack of awareness of and education on the *Charter* led to several clinical practices and interactions compromising patients' rights deliberately (or not). Thus, patients' rights to information, privacy and confidentiality, dignity, participation, self-determination, and safe and prompt care were often affected. To enhance observance of these rights and effective communication, I identified several factors that could promote meaningful interactions and relationships among nurses, patients, caregivers, and other care providers. The main findings were being and becoming caring, honoring the ethics of life, care, and caring, and resolving barriers to clinical interactions. The study found that being caring and honoring the ethics of life and care will create a Caring Space for nurses and healthcare providers to deliver effective care. The study revealed that when obstacles to care delivery are minimized and nurses become sensitive to gender and social dynamics in care, nurse-patient relationships can be enhanced. The results show that when nurses, patients, and caregivers build trust and show appreciation, are polite and use appropriate address terms when requesting things or interacting, PCC and positive care outcomes will be actualized in the Caring Space.

5.6. Discussion of Findings

The focus of this chapter was to explore and provide answers to two of the research questions. (i) How do nurse-patient communication practices in clinical interactions influence patients' rights? (ii) How does the Ghanaian *Patients' Charter* guide nurses' and patients' interaction in the Yendi hospital? Factors that affect effective nurse-patient communication, healthcare delivery, and patient rights are discussed. Particularly, I discuss the findings of Chapter 5, bearing in mind some Dagbon and/or Ghanaian ethical values that may influence patient rights or how individual and collective rights can shape interpersonal interactions in healthcare institutions in Ghana.

Several interesting findings were noted regarding experiences of patient rights in clinical interactions and how the Ghanaian *Patients' Charter* and nursing ethics guide (or not) the realization of patient rights in Ghana.

A crucial finding of this study was the lack of knowledge about patient rights among patients and caregivers, a finding consistent with the results of many other studies (Owusu-Dapaah, 2015; Yarney et al., 2016). This current study found that the patient and caregiver participants had no knowledge about the *Patients' Charter* and its content, except for a few of them. This finding is significant given that the *Charter* was developed in 2002 and has existed for two decades at the time of this study. Without knowledge of the *Charter* and its content, patients and caregivers cannot demand respect for their rights. On the other hand, many nurses knew about the *Charter,* although some could not remember the detailed provisions about patient rights and responsibilities.

Furthermore, many nurses did not educate patients and caregivers about their rights. Some nurses even believed that educating patients about these rights would negatively affect care delivery because patients may demand too much from healthcare providers. Perceptions of this nature do not encourage patient empowerment nor the implementation of the *Charter* provisions, which are made to enhance PCC. Research in Ghana has shown that even when patients know about their rights, the Ghanaian medical culture and lack of enforcement of patient rights still prevent healthcare professionals from implementing patient rights in many healthcare institutions (Obu, 2020; Owusu-Dapaah, 2015, 2021; Zutah et al., 2021; Yarney et al., 2016).

The lack of knowledge about patient rights among patients, caregivers, and care professionals has been reported in other countries, including Nigeria (Ekwueme et al., 2019), Egypt (Mohammed et al., 2017), Chile (Barrera et al., 2015), and across several other countries (Mpouzika et al., 2021). Violations of patient rights, some of which come in the form of physical and verbal abuse, neglect, and disrespect, often result in conflicts and reactive violence against healthcare providers by patients and their relatives (Boafo, 2016; Boafo & Hancock, 2017; Miltenburg et al., 2016). For patients to enjoy their rights as consumers of healthcare services in Ghana and other countries, patient rights education and awareness creation must intensify and enforcement regulations instituted (Barrera et al., 2015; Mohammed et al., 2017; Yarney et al., 2016).

Also, the results of this study revealed that the Ghanaian *Patients' Charter* had little influence on nurse-patient communication and clinical interaction, and two reasons accounted for this situation. First, patients and caregivers who could have demanded respect for their rights had little or no knowledge about the *Charter*. Without in-depth knowledge of the *Charter*, patients and caregivers played little role in propelling nurses to observe its stipulations in nursing care practices. The second reason is that nurses who knew about the *Charter* did not implement its provisions. Limited nursing staff, high patient turnout, and scarce material resources were identified as factors affecting nurses' ability to observe the *Patients' Charter* regulations. Moreover, although nurses claimed that their code of ethics guided their communicative practices and interaction with patients, such claims were not evident in practice. The *Nurses Code of Ethics* and the *Patients' Charter* have complementary guidelines, which, when observed, will directly promote respect for patient rights (ICN, 2012; 2021; Jerofke-Owen, 2022).

Article 3 of the *Code of Ethics for Nurses* in Ghana prescribed, "All Service personnel shall respect the Rights of patients/clients colleagues and other persons and shall safeguard patients'/client' confidence" (GHS, 2002, p. 1). Since the provisions of these guiding documents did not influence much of the nurse-patient interactional and communicative processes, many care practices and interpersonal interactions in the clinical space focused less on patient rights. Patient and caregiver experiences of the right to dignity and respect were variable. Some patients and caregivers were treated with dignity and respect, especially when their requests for specific care needs, including discharge against medical advice and respect for their cultural beliefs were honoured (see **Textbox 11a** on dignified caring). However, other patients and caregivers have experienced being insulted, demeaned, denied a voice in the care delivery process, or poorly treated (see **Textboxes 11b and 12**). Respect for patient dignity is said to promote positive patient-provider relationships, trust in care providers, and improvement in patient disclosure because patients feel valued (Miltenburg et al., 2016; Ostaszkiewicz et al., 2020). The core attributes of dignity in care include respect for patient needs and values, showing empathy and trust, honouring patients' privacy and autonomy, and engaging them through effective communication (Ostaszkiewicz et al., 2020).

Another critical finding is that patients and caregivers were often not provided with the needed information to help them understand their healthcare conditions and the care needed. These experiences among the care consumers limited their right to information and education. It was found that patients often come to the hospital, receive treatment, and get discharged without them knowing what health problems brought them to the hospital in the first place. Although some patients reported being informed about their care conditions and educated on medication, most patients and caregivers suffered from an information deficit. The consequences of not respecting patient rights to information and education are low health literacy among patients, poor patient disclosure, and lack of patient participation in their own care, further impacting patients' right to participation and engagement in the care process (Jerofke-Owen et al., 2022). Jerofke-Owen et al. (2022) observed that there is often confusion in clinical interaction around patient engagement. As found in this study, many patients' understanding of engagement was limited to asking and answering questions, even if their opinions and suggestions made little impact on care management. Thus, patients and caregivers might have been involved in the care process periodically but not engaged or allowed any meaningful participation (Jerofke-Owen et al., 2022). The overall effect of disregard for the patient's right to information and engagement or participation is poor perceptions of care outcomes and self-care management practices.

When patients and their caregivers are provided with the needed information and allowed full participation in the care process, they can make meaningful contributions to self-improvement in their overall health. By determining the cause of their care through informed decision-making based on sound judgment, patients' right to autonomy and self-determination are also enhanced (Barclay, 2016; Høy et al., 2016). Despite the values that promoting patient participation and self-determination bring to the quality of patient healthcare outcomes, nurse-patient interactions, and relationships, many nursing care practices and communication strategies do not focus on promoting these rights. Patients were less engaged in their care, and those who made efforts to be involved in the care process were either ignored or told that the nurses knew what they were doing. As Barclay (2016, p. 138) argued, many behaviours, institutional practices, built environments, and interpersonal interactions in the healthcare setting can threaten people's ability to uphold their values and standards, especially in contexts of vulnerability and pain as experienced in hospitals. Not respecting patients' right to self-determination and participation in decision-making violates patient-centred care principles and nursing ethical values (ICN, 2021; Jerofke-Owen et al., 2022). Jerofke-Owen et al. (2022) maintained that the nursing code of ethics outlines and mandates patients' rights for engagement, involvement, or participation in nursing practice. Patients' right to self-determination, informed decision-making, respect, and honouring their healthcare preferences are crucial to PCC practices (Miltenburg et al., 2016). Nonetheless, nurses and other healthcare providers minimally observed many of these rights, as found in this current study.

Nurse-patient communication and clinical interactions also affected patient rights to safety, prompt care, privacy and confidentiality. Due to limited space, language barriers, and negative attitudes from some clinicians (e.g., consulting patients in public spaces), observing patient rights to privacy and confidentiality were affected. Furthermore, due to limited nurses and clinicians, deficit and defective medical equipment, and lack of appreciation for patient rights, patients experienced long delays, compromising their rights to safe and prompt care.

When patient privacy and confidentiality are compromised, the consequences are mistrust of care providers, poor patient disclosure, and perceptions of care (Ceylan & Cetinkaya, 2020; Ozaras & Abaan, 2018). Ceylan and Cetinkaya (2020) asserted that privacy has different dimensions, including psychosocial, cognitive, and physical, which are crucial in hospital care settings. Also, confidentiality and safety of patient healthcare information are closely connected to privacy which healthcare providers must safeguard.

This study identified specific approaches to enable or facilitate better clinical interactions among nurses, patients, caregivers, and other healthcare professionals to promote effective nurse-patient communication and relationship that uphold ethical nursing practice and patient rights. Two interrelated concepts which define the core of nursing and caring were developed from the data. Thus, (a) becoming caring and (b) honouring the ethics of life, care, and caring. Participants of this study identified crucial attributes of a caring nurse, which included having patience, listening to patients/caregivers, speaking nicely, respecting patients/caregivers, supporting others, and being professional. Therefore, these attributes must be present or reflected in a nurse's life and practice for them to become caring nurses. Also, the participants noted another set of features that targeted the human being and life itself. These attributes reflect ethical caring and place the human being at the center of care. Nurses and healthcare providers were reminded to value human life, see patients as human beings, and understand that everyone desires respect. Further, care providers were always admonished to put themselves in the patient's shoes, treat everybody as they want to be treated, and realize that people have different characters, backgrounds, and beliefs.

By observing these ethical values and striving to become or be caring, nurses' practices and relationships will align with the nurses' code of ethics and the *Patients' Charter* provisions (GHS, 2002; ICN, 2021; Vaismoradi et al., 2021). These findings corroborate previous research on ethical nursing and ethical caring practices (Haddad & Geiger, 2022). During care delivery, nurses and other healthcare professionals face several ethical dilemmas and challenges where difficult choices must be made. In such instances, honouring the ethics of life, care, and caring (i.e., where the human being and life) take precedence over medical routines should be paramount (Ostman et al., 2019). Balancing patient rights and ethical nursing care, healthcare requirements, and guidelines may be challenging, as nurses' personal values, virtues, and professional norms may conflict with patient needs, beliefs, and desires (Haddad & Geiger, 2022; Ostman et al., 2019). For instance, Haddad and Geiger (2022) observed that balancing patient rights with their care needs can be problematic as autonomy may clash with care guidelines and nurses' recommendations.

From the concepts of *becoming caring* and *honouring the ethics of life, care, and caring*, a model was developed, which I called the *Caring Space*. This model argues for ethical caring by valuing human beings and their lives while providing care. Observing the two core principles of this model gives life to nursing care, as electric current lights up electric bulbs. The model acknowledges both external (nursing and medical guidelines) and internal (personal virtues and moral values) dimensions of ethics (Ostman et al., 2019). This model emphasizes Simone Roach's (2002) theory of caring as a human mode of being. On the part of patients and caregivers, this model promotes freedom and responsibility because, when they also put themselves in the care provider's shoes, see them as human too, and respect and speak nicely to them, everyone in the caring process will be valued leading to strong positive therapeutic relationships. Nonetheless, as Read (2019) advised, healthcare providers are responsible for nurturing such therapeutic relationships through effective communication and collaboration.

At the core of the *Caring Space*, nurses must ensure emotionality (enhancing emotional balance), relationality (promoting positive relationships), and professionalism (maintaining professional and ethical conduct) in the caring process. Given the impact of communication on social interactions, care delivery, and patient health outcomes, incorporating Frank-Bader et al.'s (2016) "Social 10" principles can be significant while implementing this current model. Thus, making time for social care and/or social talk in the caring process could make patients feel valued and not seen as people with medical conditions (medical bodies) that need medical attention and fixing. According to Frank-Bader et al. (2016), spending just ten minutes (Social 10) talking and listening to, interacting with, and getting to know patients better resulted in better bedside communication and enhanced therapeutic nurse-patient relationships. When human beings and life are valued, and the care provided is ethical, patient and caregiver abuse and neglect, as well as violence against healthcare professionals, can be minimized (Akibu et al., 2018; Ntoimo et al., 2019; Udenigwe et al., 2022), especially in healthcare contexts involving vulnerable patients.

Other identified enablers and/or facilitators of effective nurse-patient communication and interaction included awareness of gender and social dynamics in patient-provider clinical interactions, valuing communication, building trust, and showing appreciation. Gender and social dynamics significantly influence nurse-patient interaction and clinical communication, as already pointed out in Chapter 4, section 4.6. It was found that male and female patients and caregivers had varying demands for information and interaction with nurses. Although some nurses reported that many female patients preferred being served by male nurses, I doubt if such a preference is strong among maternity and labour patients, given the influence of Islam and Dagbon culture on gender relations, including clinical interactions (see Salifu, 2014a, for gender and sexism in Dagbani language). Despite my reservation, this finding is consistent with that of Budu et al. (2019), who reported that many female patients preferred male nurses because male nurses are polite and courteous and provide relaxing treatment.

On the other hand, this finding contradicted the results of Binder et al. (2012), who explored the use of interpreter services in obstetrics care among Somali and Ghanaian immigrant and White British women in Greater London, UK. Binder et al. (2012) found that male interpreters’ interaction with women was challenging, as the women expressed a gender preference for having a female interpreter. Further, the women preferred seeking healthcare from female providers (same-sex care providers), with whom they communicated more easily (Binder et al., 2012).

Another enabler of effective care delivery and communication would be care collaboration among nurses and between nurses and clinicians. This study found no effective care collaborations around patient transfer to other patient wards in the Yendi Hospital. Also, there was less collaboration between nurses and clinicians, which resulted in clinicians sometimes dismissing nurses’ suggestions. Reeves et al. (2017) systematically reviewed randomized control trials on practice-based interventions to improve interprofessional collaborations. The diverse interventions explored included interdisciplinary rounds, interprofessional meetings, interprofessional activities with an external facilitator, and an interprofessional checklist of medical practices. These were evaluated regarding their impact on the continuity of care, use of healthcare resources, collaborative working, team communication, patient health outcomes, patient-assessed quality of care, clinical process efficiency, and adherence to recommended practices. Reeves et al.’s (2017) study showed that these interventions had varied effects on the assessed variables. Overall, medical collaborations are deemed relevant for improving healthcare quality and access.

Results of this current study also revealed that highly educated, elderly, and patients with higher social status had some amount of control in nurse-patient encounters than patients without these demographic features; as a result, being aware of these dynamics and their influence on communication and interaction in the healthcare setting is essential (Afulani et al., 2019; Atinga et al., 2016). Moreover, the value of communication in healthcare delivery and nurse-patient-caregiver interactions must be considered, especially in the face of heightened language barriers. Furthermore, the findings of this study revealed that building trust and showing appreciation among patients, caregivers, and healthcare professionals can enhance effective communication and patient-provider relationships. Despite the challenges of resource limitations, insufficient staff, and high cost of care imposed on primary care access, when there is mutual trust and appreciation of the roles that patients, caregivers, and nurses play in the care delivery process, relationships are promoted, and conflicts are reduced which can lead to positive care outcomes. Caregivers perform significant roles in the care delivery process (Kusi et al., 2020), yet their healthcare providers often treat them as a nuisance and dismiss their perspectives and opinions.

Providing affordable healthcare services, essential medicines, and alternative healthcare to patients in tune with their financial capabilities is regarded as a progressive realization of human rights in care and an enabler of universal healthcare coverage (Ntoimo et al., 2019; Perehudoff et al., 2019). Looking at the healthcare costs and related challenges patients and caregivers face when accessing healthcare services, including essential medicines, in the Yendi Hospital, strengthing the NHIS in Ghana to provide coverage for patients is a step in the right direction. The primary purpose of the scheme was to make healthcare accessible by removing cost-related barriers (e.g., the cash-and-carry system). However, recent happenings in most Ghanaian hospitals suggest that the unpopular cash-and-carry system has gradually returned to many Ghanaian public hospitals and healthcare facilities (Kotoh et al., 2018). Patients who desire effective care and services must access these in private healthcare centers where they will pay for any healthcare service rendered. Further studies are thus needed to evaluate the current state of the NHIS regarding how it is still mitigating the cost of care and care access in public healthcare institutions.

Recognizing the forces of social and gender dynamics on healthcare interactions and forming trusting relationships also means that healthcare providers and managers must appreciate the role of power, ideological perspectives, and discursive practices in therapeutic interactions. The results of this study indicated that several discursive practices, power misuse, and controlling language use strategies were not only between care providers and patients/caregivers but also between nurses and clinicians, and nurses and the hospital management or nurse managers. These social practices affected care delivery, communication, and relationships in the hospital, consistent with previous studies' findings (Al-Kalaldeh et al., 2020; Sepasi et al., 2016).

More significantly, evidence of power display could be noticed around politeness practices, request-making, and using address terms (including social titles/honorifics and medical terms). In Dagbon, the study's cultural setting, "seniority in age commands a lot of prestige, respect, and positive self-image"; as a result, during social interactions where verbal exchanges occur, "respect and deference must be shown to those older than oneself and to people of higher status" (Salifu, 2010, pp. 276-277). Similarly, gender dynamics and kinship address terms embed such discursive power relations in speech and social interactions among the Dagomba (for details on gender relations in Dagbon, see Salifu, 2014a, 2014b). As Salifu (2014b, p. 45) observed, among the Dagomba, when a person is summoned/called, "the speaker requires or orders the addressee to not only make a verbal response but also to produce himself or herself before the speaker." A person summoned must respond to the call and go to the speaker. These discursive practices have power underlying their use and make visible how nursing, medical, and caring values and norms as discursive practices legitimize the social order and practices of routine care in the hospital setting and other social spaces (Moreau & Rudge, 2019; Salifu, 2010; Sepasi et al., 2016). Such sociolinguistic practices are reported about the Bugis people of Asia (Gusnawaty et al., 2022).

From a discourse-historical approach perspective, some of these discursive practices became ideologies (i.e., became opinions, attitudes, evaluations) held by a group of people, in this study context, nurses, clinicians, hospital management, or healthcare consumers (Wodak, 2015). As Wodak observed, through ideologies, unequal power relations are established and maintained through discourse, where hegemonic identity narratives and control of access to specific discourses or public spheres become tools to effect power asymmetry (Wodak, 2015). Moreover, Wodak (2015, p. 4) argued that language is not powerful but a means to gain and maintain power among people and that any asymmetric relationship among social actors who assume different social positions or belong to different social groups is a manifestation of power. Thus, when nurses insisted that men must not go into the labour and maternity wards, that patients/caregivers must respond to calls before they come to them, or when the laboratory staff made access to the blood bank difficult for patients/caregivers who said they wanted to buy blood rather than needing blood, all these had underlying power and controlling ideology. The hospital environment itself, patients' vulnerability status (i.e., experiences of pain, loss of privacy, loss of social responsibility), and the institutionalized healthcare structures, routines, norms, and medical/technical procedures all created unequal relationships of power (Baptista et al., 2018).

The above findings signify that much needs to be done to promote human and patient rights in care and address the barriers to healthcare delivery. As noted from the previous and this current chapters, many patient rights violations had their roots in resource constraints and poor interpersonal relationships and are further implicated in sociocultural norms and practices around language use in social interactions, as I elaborate on in the next chapter.

Chapter 6: “…But the System Has Failed Them”: Enhancing Healthcare Institutional Practices and Policies on Care Delivery

6.1 Introduction

Developing strong healthcare institutions and interventions to mitigate healthcare challenges is crucial to achieving health for all by 2030. As I presented in the previous two chapters, several institutional practices complicated both healthcare delivery and experiences of patient rights. My focus in this chapter is to reflect on the findings in chapters 4 and 5 and present new proposals based on observation data. Since one of my objectives in this study was to use participants’ experiences about communication in clinical interactions to inform evidence-based practice and policy on patient rights in healthcare institutions, I developed the Clinical Communication Dialogue Framework (CCD-Framework) model consisting of Dialogue Rings to enhance dialogic communication across different levels of clinical interactions.

The chapter is organized as follows: In section 6.2, I present a brief methodology I employed in the study to arrive at the findings presented in this chapter. Next, I present my findings in section 6.3, a summary of the findings in section 6.4, and then discuss the results in section 6.5.

6.2 Brief Methodology

Since my focus in this chapter is to present interventions and reflect on some of the findings in Chapters 4 and 5, the findings of this chapter were more solution oriented. After I developed the themes from all the data sets through inductive coding and data analysis, I reflected deeply on the themes and categories created. I explored my previous studies since the commencement of my doctoral program (Kwame & Petrucka, 2020; 2021; 2022) and the literature to identify concepts and gaps that could allow for a model to be created based on my data. This approach enabled me to examine the themes, categories, and codes once more to identify which of them could be moved further to build interventions that could be applied to promote nursing care and patient-centred healthcare practices beyond the study setting.

I looked across the barriers to healthcare access and delivery, challenges of nurse-patient communication and interaction, and healthcare practices that affected patient rights and brought these issues into dialogue with my theories. Through this process, I noted that there was a need to trace the pathways to patient rights violations, the need for an intervention to guide clinical communication at different levels of interactions, and the need to reflect on a modality to reduce the negative effects of using translators and interpreters in clinical communication.

Having identified these critical areas, I perused the interview transcripts and fieldnotes, and the constructed codebook to further develop some of the themes and categories while noting supporting quotes from these different data sources. After this round of data analysis, the following findings in Table 8 were organized for this chapter.

Table 8:

Themes generated as findings for this chapter.

Theme	***Supporting data***
a. Sources and pathways to patient rights violation/promotion	Reflection on data about institutional practices (e.g., nursing care, management routines) that affect nurse-patient relationships and patient rights
1. *Enhance capacity for and awareness of the Patient's Charter*	
2. *Monitor care practices to align with core provisions in the Charter.*	
b. Clinical communication dialogic framework	Interviews and participant observations data on causes of disagreements are used.
c. Provide training and education	Reflection on some themes in chapter 4 plus participant observation data
1. *Promote patient education*	-the hospital radio system as a medium -medical rounds and bedside interactions -the nurse's station
2. *Training on effective nurse-patient communication practices (e.g., during medication rounds, at the patient bedside, etc.)*	-Data on shopping translators/interpreters and the need for interpreter-role-play training in schools and in care institutions -expectations and challenges arising from healthcare interpretations/translation
3. *Training in interpreter/translator roles*	-awareness of how class, gender, culture, language, and power manifest in medical interpreter roles
4. *Cultural competency and culture-sensitive care*	- the concept of "cultural-sensitive care" and data on cultural beliefs and care delivery

e. Promoting efficient resource utilization	- "we borrow supplies from the other wards, especially from paed 2", "… the Yendi Hospital management refused to do the same only waiting for the government to provide them with the software or money to buy it (the software)"

Now, I present and interpret these findings in the next section and discuss the results with reference to the literature in section 6.5.

6.3 Enhancing Healthcare Institutional Practices on Care Delivery

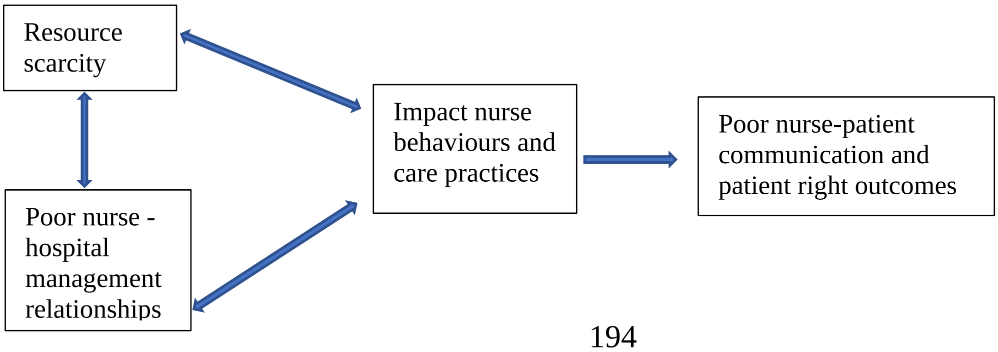
In this section, I present and reflect on the findings presented in Table 7 above with the aim of elevating healthcare institutional practices and health policy. A few interventions are developed while recommendations and critical proposals are offered to promote evidence-based healthcare practices that are anchored on human and patient rights and PCC principles. My overarching goal is to ensure that nursing care practices, care provider and client relationships, and healthcare outcomes are human dignifying and person-centered rather than routine-based.

6.3.1 Sources and Pathways to Patient Rights Violation and/or Promotion

Reflecting on the barriers and or gaps to healthcare delivery and access presented in Chapter 4 and the (dis)enablers to nurse-patient communication and interactions, I found two critical sources and/or pathways through which patient rights in clinical interactions are affected. These routes are (a) resource scarcity pathway and (b) nurse-hospital management relationship pathway. These sources interact in complex ways to undermine nurses' practices and how they felt about their work, thereby implicating both patient rights and healthcare outcomes as already noted in Chapters 4 and 5. The interactions between these routes and how they lead to poor patient rights outcomes are diagrammed below.

Figure 3:

Sources and pathways to poor patient rights outcomes



Due to resource limitations (i.e., both material and human resources) nurses' care practices and behaviours were impacted which often led to poor nurse-patient relationships and care outcomes as presented in Chapter 4, section 4.3.3 and Chapter 5, section 5.3.2. This route to poor patient rights outcomes manifested in the forms of long wait times and added healthcare cost to patients/caregivers, as nurses often asked patients to buy these materials for their own care needs. On the other hand, the pathway of poor nurse-hospital management relationships generally affected the nurses' psychological and emotional states, as discussed in section 4.3.3. Poor relationships between nurses and the Yendi Hospital leaders (see **section 4.4.2.4** and **Textbox 6**) affected nurses' care practices and their relationships with patients and caregivers leading to complicated patient rights outcomes in care. These pathways, exemplified by the case of "battery for patients' life" (see **Textbox 4**), mistrust between nurses and the hospital management, and lack of motivation, among other factors, made some nurses develop apathy for the hospital and/or put-up uncaring behaviours, which ultimately impacted patient right outcomes. However, as explained earlier, although some resource limitations and poor nurse-management relationships had their origins outside the hospital setting, nurses and patients/caregivers still attributed them to poor leadership in the hospital. Most importantly, the two pathways interact because resource allocation was the responsibility of the hospital leadership. Furthermore, nurses developed coping strategies to manage some of these constraints; hence, the bidirectional arrows in Figure 3. Therefore, understanding these pathways and their effects on nurses, care practices, patient rights, and care outcomes is crucial to promoting effective care delivery and rights-based healthcare outcomes.

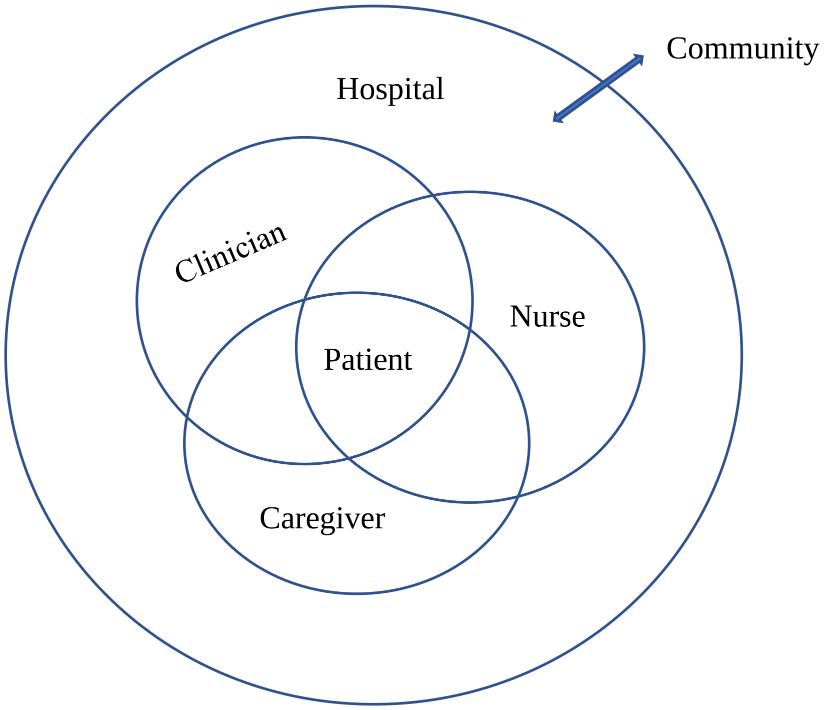
The mere awareness of these routes to poor patient rights in care would not be enough to guarantee rights-based care practices, as a result two significant actions must be implemented by the Yendi Hospital management and nursing training schools. These are (1) enhancing capacity for and awareness of the *Patients' Charter* and (2) monitoring care practices to align them with the core provisions in the *Charter* and the *Nursing Code of Ethics*. For instance, my participant observation data and interactions with nursing students from different nursing colleges who came to the Yendi Hospital for their clinical practice revealed that the *Patients' Charter* was already being incorporated into nursing education, but the students were not tasked to monitor how provisions in the *Charter* were being observed in clinical practice. There was no single objective in the students' clinical practice guides that targeted patients' rights. Thus, no objective in their clinical guides required them to observe incidents, events, or activities relating to patient rights in nurse-patient clinical interactions.

6.3.2 The Clinical Communication Dialogic Framework (CCD-Framework)

Given the enormous challenges poor communication brings to clinical interactions, I reasoned that a model that targets clinical communications at different levels in the healthcare setting is desired. Thus, the clinical communication dialogic framework (CCD-Framework) is a holistic approach to clinical communication and interaction that acknowledges the role *professional, emotional, relational, and ethical factors* play in clinical interactions and which either enhance or impede effective healthcare communications. Furthermore, the CCD-Framework consists of different dialogue rings to target communication and interaction at different levels and relationships in the clinical space. This framework was developed by taking note of the factors that consistently caused misunderstanding among the various participants engaged in healthcare service provision and consumption – patients, caregivers, nurses, clinicians, and all hospital management units. At the core of the CCD-Framework is the notion of PCC, depicted by the centrality of the patient in the model. The CCD-Framework is presented in Figure 4 below.

Figure 4:

A Model of Clinical Communication Dialogic Framework



The CCD-Framework has dialogue rings (**spaces**) occupied by different participants in the care setting. These participants interact and relate with one another (**relationships**) during the healthcare process. Healthcare **practices** are performed in providing care for healthcare service consumers across and within different spaces. The dialogic rings have spaces within which these practices occur, and relationships are established. Below is a brief description of the composition of each ring as well as what practices and relationships may occur.

a. The clinician ring is composed of medical professionals such as doctors, physicians, clinicians, physiotherapists, and all other specialized professional groups, including the traditional medicine unit and its practitioners. Medical practices and services are provided by these members.
b. The nurse ring consists of all categories of nurses, including registered nurses, midwives, auxiliary nurses, nursing assistants, nurse practitioners, and all nurse specialists. Nursing care practices and services are what these members provide.

c. The caregiver ring is made of patients' families, relatives, and friends, among others. They provide support and care for the patient's well-being. The caring support provided by caregivers may be distinctive from nursing or medical care in terms of the professional expertise involved.
d. The patient ring includes all persons who seek healthcare services for their own health and well-being. Care and medical services are consumed directly by these members. Self-care and healing/recovery practices occur within this ring.
e. The hospital ring constitutes the physical hospital space and the staff of other units in the hospital who are not part of the nursing and clinician rings. This includes pharmacists, laboratory staff and technicians, staff of the patient records unit, financial officers, NHIS staff, and the hospital management/leadership, among others. Paramedic, laboratory, pharmacy, records management and administrative practices and services occur here, and members of the other rings interact with the hospital ring throughout the care delivery process.
f. There is also a hospital-community interaction/relationship. Healthcare institutions exist within communities and societies whose members access healthcare services from those institutions. In this study, one form of such relationships or interactions was the activities of the Concerned Citizens of Yendi (a youth group) which constantly engaged the hospital and its management over certain alleged healthcare malpractices, including patient negligence. Members of the CCY dialogued with the hospital community and leadership on how to provide safe, effective, and quality care to the community. Other spiritual leaders (i.e., Imams, Pastors) also often came to the hospital to pray for patients and the hospital staff and community. All these individuals and groups had interest in what goes on in the hospital.

Membership in these rings may be fluid for some participants as healthcare institutions and care providers continue to evolve. Healthcare collaborations and medical team formations may challenge a rigid zonation of healthcare providers in these institutions.

Participants engage themselves in various *relationships* and dialogic communication practices during clinical interactions, leading to inter- and intra-relationality. Therefore, embedded within the CCD-Framework are relationships such as nurse-patient, nurse-clinician, nurse-management, nurse-caregiver, clinician-patient, clinician-caregivers, patient-patient, patient-caregiver, et cetera, which various healthcare studies have explored. The zones of intersection among these rings are inter-relational spaces where conflicts and/or synergies also occur.

For instance, although rarely studied, patient-caregiver relationships can be complex and replete with conflicts as the following two cases demonstrate. The first case involved a female caregiver who brought her niece to the hospital. They had stayed in the hospital for six days at the time of my interview, and the patient had no valid NHIS coverage. The following dialogue revealed a conflict between the patient and the caregiver when the doctor came to review the patient's case.

> **Caregiver (CG11):** Yes, they say one story invites more stories. The day before yesterday, when they connected her (the patient) with a catheter, it was not flowing well, and she was feeling pain. The doctor came in and was speaking to her, but she didn't mind the doctor. She was in pain, so she didn't respond when the doctor was speaking to her. The doctor became angry and asked why he was speaking to her, but she didn't respond. **When I came in, I almost cried because of my patient's behaviour.** The doctor said even if she didn't understand, she should have just given a sign that she was not following. He said he was not happy because the patient didn't signal to him that she was in pain. When we came here (referring to the hospital), the doctor helped us a lot. When we came, she was feeling much pain, so the doctor told the nurses to attend to her quickly. They took her to the theatre.
>
> **Researcher (R):** Ok, these are some of the things I am looking into. Care providers are aware that patients do feel pain from time to time, and the doctor should know that.
>
> **CG**: Ahan! Yes
>
> **R:** So, these are some of the issues we want to explore to understand what goes on when patients interact with care providers.
>
> **CG**: **I was annoyed with my patient because the doctor helped us a lot when we came here**. It was then she told me that she was in pain. You know, we owe the doctors our lives, so we must respect them. And

> sometimes, patients' illness state can cause misunderstandings between them and care providers. So, the problem was that she didn't inform me about the pain, which almost affected our relationship with the doctor.

From the above dialogue, it can be seen that the caregiver was angry with the patient because she felt that the patient should have interacted with the doctor. According to the caregiver, they were indebted to the doctor for the support he gave them, as a result, she interpreted the patient's behaviour as improper, although she had not asked the patient why she acted that way towards the doctor until the issue with the pain was mentioned.

The second case occurred on February 22, 2022. It was about a mental health patient and her caregiver who had a quarrel that attracted the attention of other people. The patient had used the washroom and left her clothes there on the floor and came outside the ward bare naked. So, the caregiver brought her clothes to her, which made the patient angry, and she hit the caregiver. The patient's conduct annoyed the caregiver, who warned and threatened that she would leave the patient if she misbehaved again. The patient was not bothered. She said the caregiver could go away, and that she didn't care whether the caregiver was there or not.

Even though the patient's behaviour could have been influenced by her mental health, the caregiver could not contain her frustration which resulted in them getting physical with each other (i.e., the patient hit the caregiver). These cases show that caregivers who mostly go through physical, emotional, psychological, and financial stress to support their sick relatives do have disagreements with their patients. Regarding relationship challenges involving the other healthcare participants, see section 4.3.3.4 on nurse-hospital management relationships, section 4.3.5.2 for causes of relationship challenges for patients, caregivers, nurses, and clinicians, and section 5.4.3.4 for some nurse-clinician practice and relationship conflicts.

The CCD-Framework will be applicable in various contexts, including multicultural and multilingual healthcare settings where resource constraints, poor management, and language use challenges are most intractable, thereby negatively impacting healthcare practices and communication. Even in contexts where these challenges are less pronounced, the CCD-Framework can still be applicable through its focus on PCC, and advocacy for and awareness of the impact of *professional, emotional, relational, and ethical* factors and practices in healthcare service provision.

6.3.3 Training and Education for Nurses and Patients

Another significant intervention to reduce the barriers and or gaps to healthcare delivery and access is enhanced nurse professional training and education through the following approaches (a) patient health education; (b) training on effective nurse-patient communication practices; (c) enhancing cultural competence among nurses and other care providers; (d) training and education on translator/interpreter roles in care; and, lastly, (e) efficient healthcare resource utilization.

6.3.3.1 Patient Health Education. Educating patients about healthcare routines, practices, and their health conditions is imperative as an empowerment approach. By understanding the care delivery process and their care conditions, patients can appreciate their own roles and self-care practices needed to upscale their health.

Similar to education on patient rights, the results of this study revealed varied views on whether or not nurses provided health education to patients to help them understand care processes and their needs. Educating patients on some key patient vital signs, health conditions, medical procedures, care routines (medication rounds, patient case reviews, etc.), medication and side effects, laboratory tests, medical results, etc. can be rewarding, as these can help boost patient health literacy. A few patients and caregivers stated that they were not educated or informed about their care conditions and other care processes as already noted in Chapters 4 and 5. However, other patients, caregivers, and nurses confirmed that some patient education was performed by nurses, mostly on medication dosage and a few care routines as the following patients described:

> There is a female student patient here. When the nurses gave her the medication, she said she didn’t like one of the drugs because she reacts to it. The nurses explained to her that the drug was the main medicine for her illness. They asked if she ate before taking the drug and she said no. So, the nurse reminded and encouraged her to always eat before taking the drug. (P2)

> Ok when it’s time for patients’ medication, the nurses will come and plead with you to take your medicine and educate you on how to take some of the medicines and their doses. (P12)

> After the surgery, they said I shouldn't lie down too much. They said I should move around from time to time because it will help me to heal better. (P14)

The above quotes illustrated that some patients were educated on medication and self-care practices to enable them to understand their health conditions better and what needed to be done to promote their own care. Aside from the above, some nurses reported that they educated patients about their health problems or routines, as stated herein:

> Yes, through education about the condition you try to tell the patients some of the things they may not be able to do, or things they can do to help themselves. Sometimes, we … tell them, "If you do this or that it will help us." So based on their conditions, we tell them what they should or should not do to help them get well. (N3)

> Yes, eh in discussing treatment issues with the patient, you need to understand the patient's nature and the condition they are suffering from, after that you find out whether they know how to manage it at least. You can then add your little professional knowledge and understanding of the ailment to help them accept and follow the plan you are giving to them. (N8)

As these nurses indicated, some patients are educated about their health conditions and how to manage the illness by first understanding their nature and what knowledge they have about those conditions. However, my participant observation showed that patient education was not consistent. It was minimal and often occurred during nurses' ward medication rounds or at the point of discharge when the patients or their caregivers are provided information about how to use the medicine at home. Patient health education, like education on patient rights, was affected due to language barriers, poor nurse staffing, and low health literacy rates among patients. For instance, a patient who said she was a porridge seller often came to the hospital due to dehydration. The patient said anytime she went to the hospital, they will give her several drips (water infusion). She also stated that she does not often drink much water. Despite this consistent health challenge, she was not educated on the potential impact of her job on her health. Also, on January 18, 2022, I noted the following in my field notes regarding caregiver education.

> The midwives and maternity nurses have problems with patient caregivers. Patient relatives are always told to limit their visits to the labour or maternity ward when the patients are taken in, but the caregivers don’t want to listen to that. Shouldn’t there be education for caregivers or patient-family? From time to time, the nurses can go out there and talk to the relatives about the importance of not frequenting the labour ward because that can cause infections. The caregiver frequent movement into the ward does not allow labour patients to get enough rest, interrupts labour processes, etc. Just telling them not to come inside the ward is not enough, some education must be provided. (Field note, documented January 18, 2022)

As the above notes illustrate, many caregivers and patients were often told not to do certain things without nurses providing them with reasons or information why they should not do those things. Without nurses telling caregivers or patients why they should (or not) act in certain ways, the process becomes controlling rather than informed, which caregivers disliked. Patient education in the Yendi Hospital and its environs will be significant in promoting effective care delivery. The hospital’s internal radio and other public radio stations can be used to drive critical patient education on specific healthcare topics, processes, and procedures, as well as issues that affect patient-provider relationships. Providing this kind of education and information to the public will reduce conflicts as well as enlighten the public, thereby reducing misconceptions about the hospital and its healthcare staff.

6.3.3.2 Training on Effective Nurse-Patient Communication Practices. Effective nurse-patient communication in healthcare institutions is crucial to impactful and meaningful care delivery, as a result, nurses and other healthcare providers must be provided the requisite training on how to effectively communicate with patients and their caregivers. The desire for training to improve nurse-patient communication came up in both the interview data and participant observations of nurses’ care practices. As already noted in several subsections of this dissertation, including 4.4.1 and 5.4.3.2, numerous nurse-patient interpersonal and interactional conflicts were often caused by a communication breakdown. Issues around poor patient engagement, nurses not communicating with patients during medication rounds, and at patients’ bedside, meant that many nurses undervalued the impact of communication in nursing care. To the extent that poor nurse-nurse interactions, especially when transferring patients between wards within the hospital, could lead to confrontations due to a breakdown in communication was mind-boggling. For instance, on January 10, 2022, I was in the emergency ward observing nurse-patient interactions and care practices, when an incident occurred. I attributed the problem to poor communication and insufficient care coordination. I captured the incident in my field notes as follows.

> There seems to be a lack of care coordination and effective communication between patient units. I witnessed a near-fight between two nurses regarding moving a patient to another ward. Because of insufficient equipment in the emergency unit (EU), an elderly female patient could not be supported further with emergency care. When I came to the ward, the patient was on a BP monitor, and later the nurses realized that her condition was stabilized, so they transferred her to the female medical ward. However, the female ward lacks oxygen concentrator and BP monitor, so the female ward staff claimed that they were not given adequate information to prepare for the patient. The fact is that there was only one oxygen tank and a concentrator/monitor in the EU, any patient whose condition was out of danger must be trans-out to another ward, in this case, the female medical ward. However, it appeared there was a miscommunication between the two wards. Despite the lapse in communication, I think the nurses could have discussed and resolved the problem privately in the in-charge office, instead of arguing and shouting at each other in front of patients and everyone in the ward. (Fiend notes, documented January 10, 2022)

The above data revealed that poor communication was not only inimical to effective nurse-patient interaction, but also to nurse-nurse relationships and care coordination. Moreover, as a nurse said, “we sometimes underrate what communication can do” (N1). Therefore, providing ongoing training on communication to nurses will be significant in reducing some of the interpersonal interaction challenges. Thus, due to poor nurse-patient communication and less patient engagement in the care process, nurses may miss the opportunity to educate patients. Even poor communication between nurses and their managers was noted to affect care delivery, as discussed in sections 4.4.1 (subsection 4.4.1.4) and 4.4.2 (subsection 4.4.2.4).

In line with the need to enhance communication between and among nurses, patients, caregivers, clinicians, and even nurse managers, relationships in the CCD-Framework must be taken seriously, and training on interpersonal interaction will be key to enhancing relationality in the hospital.

6.3.3.3 Training on Interpreter/Translator Roles. In addition to providing education and training on effective communication strategies to nurses and other healthcare professionals, equally important was the desire for training and education on interpreter/translator roles to elevate medical translations and interpretation during nurse-patient interactions. By using an interpreter-role play approach, healthcare providers, including nurses, can be trained in schools and in care institutions on how to use interpreters, handle expectations and challenges arising from healthcare interpretation/translation, and reflect awareness of how class, gender, culture, language, and power are manifest in medical interpreter roles. Given the multilingual and culturally diverse nature of the people who access healthcare services in the Yendi Hospital, nurses and other care providers need training and education on interpreter/translator roles and how such roles or responsibilities are impacted by culture, healthcare contextual variables, and medical practices. As already pointed out in section 4.4.1, subsection 4.4.1.3), medical translations could result in meaning change and, more significantly, may further distance direct client-provider interactions. The following participant's quote emphasizes how crucial interpreter/translator education and training have to healthcare quality and outcomes. A nurse explained how challenging it can be to translate medical terms when even interacting with patients and caregivers who share the same native language.

> Our hypertensive patients, most of them, we try to let them understand what is happening, because you know, in English, it's not the same as our local language. And there are things that we cannot explain very well … If we say hypertension, in Dagbani, "bɛ yen yelmi ni ʒiduli" (translated as, in Dagbani, "they will say the blood has risen"). Patients may understand it to mean the quantity of blood is too much (we both laugh). So, we try to make them understand that it's actually about the pressure, not the [quantity]. So, we try to get them to understand the possible dangers associated with not being able to control the pressure. We help them to understand that if the pressure is not well-controlled, it can lead to stroke, it can lead to kidney

> damage, eh, and sight problems. Sometimes, if you make them understand it, they will now know that with this condition, these are the eminent dangers. So, they become more serious about managing the condition. (N1)

The nurse added that it was challenging to translate for other patients who do not share the same native language as him, “because there are things I cannot even translate into my own language from English, and that affects our communication” (N1). This nurse recognized the challenges that come with providing translation or interpretation services to patients and caregivers.

Therefore, to reduce such problems, healthcare providers need to be trained and educated in translator/interpreter roles and the complexities embedded in such engagements. Translator/interpreter role-playing can be used to offer such training both in nursing colleges and on the job. Nurse managers and healthcare facility administrators have crucial roles to play in providing the needed environment and resources to support such on-the-job training opportunities. The need for in-service training for healthcare providers, especially nurses, was acknowledged by nurse participants in this study, not only in the areas of effective interpersonal communication strategies and interpreter/translator roles but also in cultural competency, which I take up in the next subsection.

6.3.3.4 Cultural Competency and Culture-Sensitive Care. From the results presented in chapter 4, section 4.4.4.1, and chapter 5, section 5.4.3.1, it became apparent that culture has significant influence on healthcare service uptake and practices. This study found that issues around gender and care, health beliefs and cultural norms, use of address terms and politeness in social interaction, as well as the language of medicine are all culturally potent. The impact of these cultural variables on health demands that healthcare providers are culturally competent and sensitive to cultural differences in clinical interactions.

I captured the following notes during participant observation in one patient ward which may relate to cultural sensitivity in healthcare service consumption.

> Today, an important issue came up concerning what I refer to as patient-caregiver “solidarity”. This solidarity describes a practice in which patient relatives, neigbours, and other visitors come to the labour and maternity wards to visit new mothers and their babies. I observed that the midwives often had problems with some of these visitors. So, I asked the nurses why they always have problems with these healthcare participants, especially

> when they refused them access to the patient wards. Then, it was narrated that when a labour client is delivered her baby, both family members and friends want to come to the hospital to greet the patient and share in her joy. However, there have been instances when a newly delivered mother will ask the nurses not to allow some friends or family members to visit her. When I heard this narrative, I had a momentary self-dialogue with a few questions: why is that so? Could some relatives have malicious intent for visiting? With the show of solidarity among the different ethnic groups who patronize this health facility, how will the nurses manage the duty of care (protecting maternity patients) while observing this cultural value? (Field notes, documented January 20, 2022)

Again, on February 5, 2022, I noted the following around the need for in-service training on cultural competence and patient rights in my notes while I observed nurse-patient interactions in another ward.

> Lack of regular in-service training: I asked a few nurses (while chatting with them at the nurses’ station in a patient ward) if they have had in-service training since they started working in the hospital and they said no, except for one senior nurse, who said prior to Covid-19, there was in-service training but since Covid-19, they have not had one. I remarked that nursing is a dynamic field, so nurses need regular in-service training to upscale their skills and practices to align with global trends. The ICN code of ethics for nurses has just been revised in 2021, how many nurses here know about the changes made in the revised version which now emphasized person-centered care, practices that enhance universal care access, cultural competence in care, and respect for human and patients’ rights? Shouldn’t there be a workshop on patients’ rights, cultural competence, or on the revised ICN 2021 ethical codes, and how care practices impact that? The nurses agreed with me that there should be in-service training but doubted if they will get one anytime soon. (Field notes, documented February 5, 2022)

Participant observation revealed that many nurses demonstrated sensitivity to cultural differences when patients asked for discharge against medical advice, or when patients with stroke or boils refused to be injected because of their cultural health beliefs. However, other nurses, especially the less experienced ones, needed further training on cultural competency to be able to deliver culture-sensitive care: care that respects patients and their caregivers' cultural values and norms. This study revealed that culturally sensitive care does not only arise due to health beliefs but also in language use and communication practices, where issues of politeness and appropriate language use are culturally constrained.

6.3.3.5 Promoting Efficient Resource Mobilization and Utilization. Efficient resource mobilization and utilization was determined as one approach to reducing barriers to care. When resources are made available for healthcare providers, access to care becomes easy thereby advancing patient rights to health. Both interview and observation data revealed that some practices promoted efficient material resource use in the hospital, although more support for efficient resource mobilization and use is needed. For instance, patient wards were mostly supplied with their daily ward consumables on a weekly basis, and once the nurses run out of their supply allotment, patients bear the burden of buying these items. To reduce the challenges that came with the shortage of daily consumables, nurses sometimes had to borrow supplies from other wards and pay them back later. A nurse stated the following during my informal interactions with them at the nurses' station.

> Regarding supplies for this ward, we usually don't run out of supplies, but if that happens, we borrow from the other wards, especially from paed 2. However, the staff of paed 2 borrow more supplies from us than we do from them. (Field notes, documented March 8, 2022)

My observation data also showed that batteries for use on the BP monitors were supplied by the nurse managers but once the officer was not available, access to these became problematic. Just as the patient wards kept emergency supplies, allowing the ward leaders to keep some emergency batteries and account for them could have been a simple approach to enhance access to these batteries when needed in the absence of the nurse manager. Another efficient resource use challenge came up during my interaction with the nurses in one patient ward, during which the following statement was made.

> The lack of oxygen is a major problem in this hospital. It was recently that they (the hospital management) installed the oxygen plant in the labour ward. Even with that, we have a limited supply and distribution of oxygen. Patients who need this are suffering. (Field notes, documented March 9, 2022)

For other material resources, including personal protective equipment (PPEs) for infectious or complicated illnesses, effective distribution of these materials can enhance nurses' safety and ability to support patients with infectious illnesses, as a nurse remarked:

> Ok, yeah, some patients have macerations, when that happens, you a nurse, you can't just go to the patient, you need to protect yourself. So, when this protection is not there, it affects nurse-patient relationships. But when there is protection, for example when we went to Liberia for the Ebola virus, the protection was there, the PPEs. So, when there is protective equipment, you can visit isolated patients and interact with them, but if that is not there, you have the fear to go to them. And the problem is the distribution of these items. So, this can affect nurse-patient communication, [especially during this Covid-19 era], yeah. So, this can also affect nurse-patient relationships. (N3)

Linked to the above data was a narrative about how a nurse got punished for inquiring about the PPEs that were supplied to the hospital to help protect healthcare providers from the coronavirus (Covid-19), but which were not yet distributed. The nurses expressed their anxiety and fears working without such PPEs at the peak of the pandemic. Another nurse stated that "there are certain things we don't have, you will lay the complaints and they don't provide that, expecting you to continue working" (N10). The above data suggests that untimely coordination and supply of resources could lead to inefficiencies and poor utility of such supplies, which can result in poor healthcare quality; not to mention staff challenges, if nurses become ill.

Furthermore, accessing patients' folders in the hospital was not easy, as already noted in Chapter 4. Many nurses believed that the hospital management could overcome the problem, as captured during a chat with nurses in a patient ward.

> Other critical issues that came up during this interaction were record-keeping and accessing patient folders. An officer came in to record some information from the patient's admission logbook. However, several pages were torn off so he could not trace and connect the information for some patients. The staff lamented about the poor state of the book and talked about why it was important to migrate to digital recordkeeping. They said several hospitals, including a few clinics in Yendi and Tamale, have bought software that allowed them to have a digital platform for keeping patient data. But the Yendi Hospital management refused to do the same, only waiting for the government to provide them with the software or money to buy it. (Filed notes, documented February 14, 2022)

The nurses remarked that the hospital could purchase such software from its internally generated funds so that, whenever they receive government funding, they can replace the money spent on the digital recordkeeping systems.

Regarding human resources, such as nurses and doctors, many nurse participants spoke about the need to mobilize more nurses and doctors. It was noted that oftentimes when nurses are posted to the facility, only a few of them report or even stay longer in the hospital, while the rest do not come. The nurses indicated that nursing managers must follow up on those nurses posted to the facility to retain them. Other nurses wished that the hospital management would request more doctors and/or encourage those who come to the hospital for their housemanship to stay permanently afterward. These participants' perspectives suggested that more resources needed to be mobilized and used effectively to promote quality care in the hospital.

6.4 Discussion of the Results

This chapter explores the final research question: How can nurses' and patients' experiences regarding communication in nurse-patient interactions inform rights-based health policy and practice? Promoting rights-based health policy and practice requires some interventions, whether they are health institution-specific or nationwide. This chapter identifies a few interventions, and new proposals are made to influence health policy and practice that will result in positive nursing practices and care outcomes. The major themes discussed in this chapter include sources of patient rights violations, enhancing clinical practices through education and training on patient health literacy, effective nurse-patient communication strategies, and cultural competency in care delivery. A clinical communication dialogic framework (CCD-Framework) model was developed to further guide healthcare service delivery and management for positive healthcare interaction and communication.

Providing solutions to problems, first and foremost, depends on identifying the root cause of those problems. Therefore, overcoming the challenges of compromised patient rights in clinical interactions and enhancing rights-based healthcare practice and policy requires that their sources are identified and dealt with. This study's findings showed that human and material resource constraints, including the lack of awareness about patient rights among patients and some healthcare professionals, are the major causes of the disregard for these rights in clinical interactions. Three proposals are imperative to realizating rights-based healthcare practice and policy in Yendi Hospital and within the Ghanaian context. These are (a) building capacity for and creating awareness of patient rights in national healthcare policy and institutional care practices, (b) monitoring care practices in healthcare institutions to ensure that they align with nursing ethics and provisions in the *Patients' Charters,* and (c) respecting human and patient rights during clinical practices and healthcare interactions.

These findings and proposals are consistent with the results of previous studies in Ghana (Owusu-Dapaah, 2015; 2021; Yarney et al., 2016; Zutah et al., 2021) and elsewhere (Ekwueme et al., 2019; Mpouzika et al., 2021). In Ghana, Owusu-Dapaah (2015, 2021) called for a national healthcare law that will mandate the institution of an ombudsman to enforce human and patient rights in healthcare institutions. Zutah et al. (2021) observed how difficult it is to punish medical negligence and other healthcare professional malpractices. They suggested a review of the prevailing legal and political contexts of Ghana regarding how patient and human rights can be maintained in healthcare institutions (Zutah et al., 2021). Given the effects of low health literacy, lack of knowledge about patient rights, and resource limitations, among other obstacles, building capacity and creating awareness about patient rights will be critical to promoting rights-based healthcare practices. Except for Oppong (2019), who reported that patients were aware of their rights, many studies, including this current one, found that patients and caregivers lack knowledge about their rights. Therefore, providing education on patient rights is imperative to increase awareness. Initiating such education during the pre-service phase for nursing students in Ghana is an opportunity to embed patient rights at the forefront of healthcare interactions in the future.

Hospital administrators, nurse managers, and other healthcare officials in management capacity must monitor healthcare delivery practices to make sure that healthcare providers adhere to the ethical standards and patient and human rights charters. As Williams and Hunt (2017) argued, to achieve SDG3, accountability and monitoring of human rights healthcare delivery must be paramount. Healthcare quality control departments and officers must be tasked to gather and evaluate data on human and patient rights practices within their institutions. Patient complaints about human and patient rights violations should be taken seriously. In line with this mandate, respect for human and patient rights should be a collective goal in healthcare facilities and institutions, and in consonance with the model of *Caring Space* discussed in Chapter 5. Although there was ongoing monitoring of nurses both during the day and night shifts, such monitoring activities were superficial. I observed that the night nurse manager did make rounds checking the wards to see if nurses were on duty. He also often asked them if there were problems. However, without spending time in the ward, not checking the patient section, or even randomly asking patients how things were going, the night nurse manager could have missed knowing about actual happenings in the patient wards. In a critical review study, Kwame and Petrucka (2022) highlighted nurse managers' critical roles in stimulating a rights-based approach to healthcare delivery. We argued that optimizing patient rights in care will only be possible with enabling environments and support for nurses (Kwame & Petrucka, 2022). The present study's findings show that the lack of trust between nurses and their managers, healthcare management abuse of power, the culture of silence and fear, and logistic constraints are significant risks to rights-based healthcare practices.

Patient education on care practices, routines, and rights is vital to effective communication. This current study found that because of the limited nursing staff, high patient turnout, and resource constraints, nurses are hard-pressed to meet their patients' medical and care demands. This state of affairs in many healthcare institutions forces most providers to prioritize communication less (Aboba, 2021; Amoah et al., 2019). Therefore, providing training and education on effective communication and PCC practices is a positive means to motivate a rights-based approach to care delivery. To accomplish that goal, applying the person-centred care and communication continuum (PC4 Model) developed by Kwame and Petrucka (2021) during the early phase of this project must guide nurses' clinical interactions.

Furthermore, the CCD-Framework developed in this study recognizes various dialogue rings (consisting of relationships, practices, and spaces) within the confines of healthcare institutions as relevant to healthcare interactions. Training care providers, including nurses and their managers, on improving interpersonal interaction through communication cannot be overemphasized. From the PC4 model (Kwame & Petrucka, 2021), person-centred care places the human being at the center of care, recognizing how critical the different dimensions (physical, emotional, spiritual, social, and psychological) of the human being affect their health. As a result, Frank-Bader et al.'s (2016) "Social 10" can be one crucial communication strategy to elevate social care in nurse-patient clinical interactions. Also, educating patients and caregivers can enhance their health literacy, thereby influencing their health beliefs and practices. Research has shown that low health literacy leads to inadequate knowledge about patients' health and the healthcare system, poor access and uptake of health services, and increased hospitalization (Budhathoki et al., 2017). Improved health literacy will propel patient participation in their care, ease access to health information, and increase patient autonomy (ICN, 2015).

The need for education and training for nurses and other care providers in interpreter/translator roles is related to enhancing effective communication. This study found that many untrained translators/interpreters were involved during nurse-patient communication. Although this practice enabled nurses and clinicians to overcome some communication barriers, it only solved some problems. Issues around patient privacy and other challenges with the translation/interpretation itself persisted. Therefore, education and training in interpreter/translator roles must be provided to nurses and other healthcare professionals. Interpreter/translator role-playing can be an approach in this regard. Previous researchers have proposed having professional interpreters in hospitals (Abdi et al., 2020). Much as this approach is laudable, using one or two professional interpreters can be exhausting in contexts where linguistic diversity is severe.

Besides having one or two professional interpreters/translators for specialized cases, nurses and other care providers must have a working knowledge of interpreter/translator roles. In doing so, they must recognize the effects of culture, gender, age, power dynamics, clinical contexts, and other social variables on medical translations/interpretations (Binder et al., 2012; Krupic et al., 2016). For instance, in a study on using interpreters to help immigrants access healthcare in Sweden, Krupic et al. (2016) found that interpreters' lateness to work, lack of professionalism, and unmet expectations by patients affected interpreter services. The authors advised that “interpreters should be linguistically, culturally and socially competent” to provide effective clinical interpreter services that will result in quality healthcare outcomes and interactions (Krupic et al., 2016, p. 1727).

Research has further shown that by using audio-visuals and a Conversational Analytic Role-Paly Method (CARM), dialogue interpreting practices can be undertaken both in-class for nursing students and on-the-job training for practicing nurses to equip them with skills and knowledge on how to interpret authentic medical conversations (Niemants & Stokoe, 2017). In a pre/postintervention study on interpreter roles and overcoming interpretation challenges in a palliative care setting, Goldhirsch et al. (2021) used dialogues, role-playing, and feedback from interpreters to improve interpreter confidence and skills. According to Goldhirsch et al. (2021), the intervention, consisting of facilitated and structured dialogues, didactics, brainstorming challenges and solutions, and role-playing, produced significant improvements in interpreter confidence.

Healthcare providers must be provided training and education on cultural competence and culturally sensitive care. Due to the multicultural nature of the study setting, healthcare professionals must engage with Narayan and Mallinson’s (2022) concept of “cultural-sensitive care” while interacting with patients or providing care. Awareness of cultural sensitivity in care and understanding what it means to be a culturally competent healthcare provider have far-reaching consequences for care outcomes and perceptions of quality of care. To the extent that cultural competence is indispensable in the medical interpreter/translator roles (cultural interpreters) is beneficial for nurses (Abdi et al., 2020; Binder et al., 2012). For instance, in this present study, many nurses who were Dagomba often demanded that when they call patients, the patient must respond before s/he comes to the nurses. This speech act of summon-response is a politeness speech act among the Dagomba (Salifu, 2014). However, demanding such performative acts from non-native Dagomba often resulted in a cultural clash, requiring cultural sensitivity for such nurses.

Moreover, cultural competency entails cultural safety and awareness in care delivery and the recognition of unequal power relationships in clinical interactions (Horrill et al., 2021; Sharifi et al., 2019). Cultural factors affect healthcare practices, language use, interpersonal relationships, and how patients perceive and receive healthcare services, especially in maternity and infant care (Acheampong et al., 2022). Nursing scholars must call for training for nurses on providing culturally sensitive care to patients. To elevate nurses’ cultural competence and support them in providing culturally sensitive care, nurses must develop cultural self-awareness, be sensitive to cultural differences, and see patients/caregivers as unique cultural beings. Patients' cultural values and norms will not be stereotyped with these skill sets, and nurses will understand the unique cultural approaches required.

Narayan and Mallinson (2022, p. 158) observed that when nurses and other healthcare providers become culturally competent, it helps them "to avoid assumptions and misunderstandings based on their own cultural perspective, learn implicit cultural nonverbal communication and etiquette norms […] and ask effective questions." Given the relevance of sensitivity to cultural differences and uniqueness in nurse-patient interpersonal interactions and healthcare service utilization, embracing and promoting cultural competence in care is an essential rights-based strategy for healthcare delivery. Purnell's (2005) model of cultural competence has identified relevant skills and competencies that healthcare professionals must possess and/or be aware of when providing care and interacting with healthcare service consumers. When healthcare providers recognize, respect, and integrate patients'/caregivers' cultural beliefs, values, and norms into healthcare practices, interventions, plans, clinical interactions, and communication strategies, respectful and dignified relationships are forged (Purnell, 2005).

Patient advocacy forms another strategy through which rights-based healthcare can be promoted. Whichever way advocacy is conceived of in healthcare settings (patient advocacy, policy advocacy, or advocacy as information provision), nurses perform several advocacy roles during healthcare interactions and when providing care to patients and their caregivers (Abbasinia et al., 2020; Dadzie et al., 2017; Kalaitzidis & Jewell, 2020), which demands that they become sensitive to cultural differences. When nurses perform patient advocacy roles and adherence to patient rights, public trust in nurses can gain momentum (Galuska, 2016; Kalaitzidis & Jewell, 2020). The findings of this study revealed that nurses did advocate for patients, for instance, by asking clinicians to transfer patients whose conditions could not be managed effectively to different healthcare facilities or teaching caregivers what to say when requesting blood at the hospital laboratory.

Besides, when patients were afraid to ask clinicians questions during clinical consultations or had problems with a particular medication, nurses took the patient back to the clinician to get the correct information or medication change. Nonetheless, a power struggle often occurred between nurses and clinicians, with clinicians mostly disregarding nurses' advocacy for patients. This finding confirmed previous research on nurses' advocacy roles in Ghana (Dadzie et al., 2017). Despite the power asymmetry between nurses and other healthcare professionals, especially doctors and physicians, nurses can be surrogates for patients and caregivers when their rights are disregarded (Dadzie et al., 2017).

Promoting efficient resource mobilization and utilization in healthcare institutions will directly shape patient rights in care, as high healthcare costs are a stumbling block to nurse-patient communication and interaction. Healthcare financing in Africa faces significant challenges, including development partners' and donor institutions' regulations (Boidin, 2019; Ifeagwu et al., 2021). Many governments in Africa cannot meet the budgetary requirements of their health ministries and healthcare institutions, and facilities are underfunded, leading to poorer quality of care (WHO Regional Office for Africa, 2013). The WHO Regional Office for Africa (2013, p. 5) believes that distributing healthcare expenditure financial burden equitably, promoting efficient resource use, and enhancing close collaboration between the ministries of finance and health is vital.

In Ghana, although an NHIS exists, funding challenges persist. Hospitals are not regularly reimbursed for the costs they incur in providing healthcare to insured patients. Consequently, many public hospitals and healthcare facilities face severe problems in meeting the increasing health demands of the population. At the Yendi Hospital, this reality led to many patients and caregivers being asked to access laboratory services outside the hospital, where they had to pay for such services. Also, the lack of essential medicines was a norm, and patients and their relatives had to buy some prescribed drugs and medicines in pharmacy stores outside the hospital.

Previous studies (e.g., Adua et al., 2017; Kotoh et al., 2018) on healthcare financing in Ghana reported similar findings. For instance, Adua et al. (2017) observed that the primary challenges of the Ghanaian healthcare system are a shortage of healthcare personnel and facilities and limited financial investment in healthcare. Kotoh et al.'s (2018) mixed-method study explored barriers and facilitators to membership retention on the NHIS and found that corrupt practices among healthcare providers, poverty, traditional risk-sharing practices, shortage of essential drugs in healthcare facilities, and challenges around service delivery and politics prevented households and individuals from enrolling and renewing their membership of the NHIS. Because people only enroll or renew their membership when they fall sick, the NHIS must reevaluate the membership requirements to ensure that people pay their premiums and have valid insurance coverage several months before they access healthcare through NHIS coverage. The NHIS mainly operated with revenue deficits making it very difficult for the scheme to reimburse hospitals their claims for providing healthcare to insured members (The National Health Insurance Authority, 2013). For instance, at the close of December 2013, the Authority earned total revenue of GH¢904.30 and expenditure of GH¢1,001.10 with a net operating deficit of GH¢96.80 million cedis (The National Health Insurance Authority, 2013, p. 11). This problem persists because government funding for the scheme is insufficient while individuals also cut corners with their premium contributions, as Kotoh et al. (2018) observed.

Participants of this present study believed that some healthcare providers and facility managers are deliberate in their efforts for the NHIS to collapse so that the healthcare system will return to cash-and-carry for healthcare services. Similar findings were noted in Kotoh et al.’s (2018) study. Care providers often forced patients to pay for services, claiming that filling out the health insurance forms was complicated, while others directly sold medical supplies to patients/caregivers (Kotoh et al., 2018). This present study observed instances when prescriptions in the patient folder were marked, yet the drugs and medicines were not provided, which means that NHIS would be charged for undelivered patient services. All these practices within healthcare facilities affect the revenue base of NHIS and its ability to provide coverage for medical costs.

With the above challenges around healthcare financing in Ghana, hospitals and healthcare administrators must ensure efficient and accountable resource mobilization and management. Internally generated funds (IGFs) by hospitals must be prioritized in how such monies are spent to provide material resources, including essential medicine and medical equipment for quality healthcare provision.

The CCD-Framework is consistent with previous nursing theories and models, such as Heidegger’s (1962) philosophy of Dasein, Peplau’s (1991, 1992, 1997) theory of Interpersonal Relations, and the Africanist Ubuntu philosophy and ethics of life, which makes it an innovative tool for nursing practice. Heidegger’s (1962) philosophy of Dasein acknowledged the relevance of relationships (Being-with) and social context or space in nursing care. In applying Heidegger’s (1962) philosophies in nursing practices, Gullick et al. (2020) explore how using Dasein in nurse-patient relationships impacts care outcomes. Gullick et al.’s (2020) study found that nurses who employed their experiences and operated in a “self-mode” by seeking connection [knowing], and openness [unknowing] with patients promoted positive nurse-patient relations and care outcomes compared to nurses who operated with a “they-mode”, such as being task-orientated, busy, or handled patients roughly. Their results underscored the significance of connecting with patients' shared humanity which constitutes a core value of nursing.

In Peplau's (1991, 1992, 1997) theory, good relationships and ethical practices are emphasized in three phases – orientation, working, and termination – of nurse-patient clinical interactions. Nurses are encouraged to respect patients' humanness, beliefs and virtues and communicate therapeutically, with the patient being the focus of any communicative encounter. According to this theory, healthcare systems comprise a network of relationships, power, authority, and responsibility at various levels (Deane & Fain, 2016; Peplau, 1997). At each level of interaction, the nurse presents him/herself to the patient or caregiver. The kind of face and position taken by the nurse or how care practices are carried out will have consequences on the ensuing relationships that are co-created in the caring process. As Deane and Fain (2016) argued, the three phases of Peplau's theory consider the nurse and patient's feelings, emotions, and behaviours crucial for effective nurse-patient interactions. Given the central position that the patient occupies in the CCD-Framework and having learned from the Theory of Dialogue that communication interacts with other human abilities (feelings, emotions, and cognition) (Weigand, 2009, 2010a, 2010b), we cannot do otherwise than to emphasize positive relationships as critical to nurse-patient communication.

Since relationships and care practices occur in different spatial locations within healthcare institutions and facilities, ethics becomes a core pillar in the CCD-Framework, connecting it with the African philosophy of Ubuntu. The philosophy of Ubuntu holds high the ethic of respect for life, community, relationality, and solidarity. It posits that "to be a human being … requires one to promote the dignity of others" (Mkhize, 2018, p. 39). As Mkhize (2018) observed, Ubuntu's ethical principles are justice, caring, and being truthful and righteous in solidarity with others and the environment. From an Ubuntu perspective, "caring is the essence of nursing," which must uphold the sanctity of human life (Havenga et al., 2018, p. 182). Some core values of Ubuntu consist of valuing human well-being, respecting relationships, and promoting people-centred leadership. The Ubuntu worldview further embraces the ethics of life and what it means to be human (Berghs, 2017), valuing individuality and community because individuals are an extension of their community from which they derive their identity and values (Havenga et al., 2018).

In this study, patients, nurses, and caregivers stated that human life and humanness should be valued in nursing care and that healthcare providers must put themselves in the patient's situation when delivering care. According to the participants, promoting social justice, feeling the pain of others, and respecting life became core expectations when delivering care. Thus, when human beings and their lives are put at the center of nursing and medical care, human and patient rights will become the guiding principles of nurse-patient communication and interaction. Healthcare providers can balance individual and collective rights, knowing that the individual and the community (e.g., family, society) must coexist.

oncerning the case in Textbox 12, I reason that the patient who left her bed for a fellow patient did the right thing on moral grounds. However, in principle, the patient's right to respectful treatment was undermined. This patient was a student, and her teacher, who brought the other patient (also a student), forced her to leave her bed, which was claimed to be reserved for asthmatic patients, for the new patient. The alternative bed provided for the patient to give out her bed was uncomfortable. Do some patients have more rights than others in the care process? A unitary approach to human rights will say no to this question. However, a collectivist ethic, based on an African ethic of care and the Ubuntu philosophy, will say yes, based on the principle of we-ism. Although the patient's right to information and respectful treatment was compromised, it was good that she left the bed reserved for the asthmatic patients who needed it the most. The patient acted in the spirit of Ubuntu.

In conclusion, to realize a rights-based healthcare practice and policy, The PC4 model, the *Caring Space*, the CCD-Framework, and other models, including the FREDA (fairness, respect, equality, dignity, and autonomy) principles by Curtice and Exworthy (2010) must be adhered to in healthcare practice and policy formulation. The following vital strategies are crucial to promoting human and patient rights in healthcare practice and policy: (a) put human rights principles and standards at the heart of policy and planning; (b) empower staff and patients with knowledge, skills, and organizational leadership and commitment to achieve human rights-based approach; (c) enable meaningful involvement and participation of all key stakeholders; (d) ensure clear accountability throughout the organization; and (e) recognize non-discrimination and attention to vulnerable groups in the design and implementation of health policy and practice (Curtice & Exworthy, 2010, p. 151; Department of Health, 2008). Human and patient rights must be promoted in healthcare organizational culture for healthcare providers to implement them in practice. The process will depend on systematic and efficient leadership.

Chapter 7: Summaries, Conclusions, and Recommendations

7.1 Introduction

This chapter summarizes the study's critical findings in section 7.2, the principal conclusions reached in section 7.3, and a recommendation for policy, healthcare practice, and future research in section 7.4.

7.2 Summary

In this dissertation, four research questions were explored to examine how patient rights are reflected in nurse-patient clinical communication and interactions in the hospital setting. Particularly, I was interested in identifying the barriers and facilitators of effective nurse-patient communication and interaction; exploring the patients', nurses', and caregivers' experiences of patient rights in clinical interactions; examining how the Ghanaian *Patients' Charter* guides nurse-patient communication practices; and lastly, determining how to promote rights-based health policy and practice by using nurses', patients', and caregivers' experiences. After analyzing the interview, focus group, and participant observation data, the study's results were reported and discussed in Chapters 4, 5, and 6. In this section, I summarize the key findings of the study.

Regarding the barriers and facilitators of effective nurse-patient communication, the study found that several interrelated and complex factors impinge on effective clinical interactions. These included:

Communication and language use barriers. These consisted of (i) challenges of multilingualism; (ii) professional nursing language use as identity formation; (iii) difficulties around finding and using interpreters/translators; and (iv) misunderstanding arising out of poor communication. That is, people who access healthcare services from the Yendi Hospital were from diverse linguistic and cultural backgrounds. Nurses, patients, and caregivers had challenges understanding one another when they did not share a common language. This situation made it very difficult for effective communication between care providers and patients/caregivers. Another recurring issue was nurses using professional medical and nursing language with patients or everyday language when conveying healthcare-related information/instructions. Although care providers reported using everyday language to facilitate understanding when communicating with patients/caregivers, some nurses preferred medical and nursing jargon to appear professional, serious, and knowledgeable. Therefore, using professional nursing language to promote the nurse identity affected effective communication, as not all patients and caregivers could comprehend the medical and nursing language.

Where differences in language impeded communication, nurses and patients/caregivers resorted to using translators/interpreters whom they shopped within the hospital setting. Nurses, patients, caregivers, visitors, cleaners, and anybody handy were used to help translate/interpret for nurses, patients, and clinicians. Even using these untrained translators/interpreters had challenges for effective communication. Differences in cultural values around communication, misinterpretation, and privacy issues, among other factors, constrained the use of these interpreters. Lastly, misunderstandings due to poor communication affected meaningful interactions between care providers and patients/caregivers. These communication and language use challenges were not limited only to verbal communication but also to written communication. Nurses and patients had difficulties reading or understanding review comments and other information in patient folders.

Institutional culture, practices, and resource availability affected communication and interaction in the healthcare setting. This impediment to effective clinical interactions had branches. These included unfavourable institutional culture, context, and norms (operationalized as long wait times, no systematic visiting hours, limited space and beds, and poor lighting) and material resource constraints (seen as deficit and deficient medical tools and equipment). Another barrier to effective clinical interactions was the shortage of human resources, such as nurses, clinicians, doctors, and other specialized care providers. These challenges impacted healthcare access and provider-patient interaction and communication. Poor relationships between nurses and the hospital management affected nurses' enthusiasm and willingness to serve, negatively impacting their interaction and communication with patients and caregivers.

Issues such as mistrust, the culture of silence, lack of care provider motivations, lack of support for nurses' personal/professional growth, and management misuse of power in/directly affected nurse-patient therapeutic relationships and communication. These institutional factors induced apathy among some nurses, dictated nursing care practices (some of which came with ethical dilemmas) and hugely inhibited nurse-patient interactions. Thus, in certain instances, nurses and patients/caregivers became victims of circumstances as they had no control over the events that affected them.

Health literacy and the cost of care also emerged as critical variables influencing effective communication and interaction in the clinical setting. Low health literacy among patients and caregivers conditioned them to act and behave in ways that shaped their interactions, relationship, and communication with care providers. Due to low health literacy, patients and their caregivers often miss their medical reviews, ignore nurses' advice, and misunderstand certain medical and nursing practices (e.g., injections, blood donation, infusion). High cost of care, which came in the form of buying and/or paying for medical tests, drugs, medicines, and materials, even when patients had health insurance coverage, significantly impacted nurse-patient relationships and communication. Patients and caregivers mistrusted some care providers, had reduced interest in hospital care, and often quarrelled with healthcare professionals.

Also, personal attitudes and health beliefs among nurses, patients, and caregivers imposed some challenges on effective communication and interaction. Patients' and caregivers' health beliefs about certain illnesses (e.g., stroke, boils), care practices (e.g., injection, maternal and infant care, receiving blood infusion), and spirituality had constrained provider-patient communication. These beliefs often led to patient discharge against medical advice and/or patients refusing to observe or consume certain healthcare services. Besides, negative personal attitudes by care providers, patients, and caregivers affected clinical communications, nurse-patient relationships, and healthcare outcomes. Insulting, neglecting, demeaning, disrespecting, yelling at, shouting at, dismissing, abusing, and disregarding others (nurses, patients, caregivers, clinicians) in the care process stifled effective communication. Even in the abundance of quality healthcare facilities and services, negative personal attitudes, especially from care providers, can prevent patients from accessing healthcare services.

Care providers disregard for patient rights in clinical interactions constrained effective communication between nurses and patients or their caregivers. Disregarding patient rights often led to maltreatment, poor interpersonal relationships, and sometimes hostile verbal exchanges between patients and healthcare professionals.

Overcoming these barriers to effective nurse-patient communication and interactions seemed critical to improving healthcare access, reducing conflicts in clinical interactions, and improving patient-provider relationships. Based on this study's findings, I argue that when healthcare access increases, patient-provider conflicts are reduced, and relationships are improved, there will be positive perceptions of healthcare quality and outcomes. Thus, I outline the enablers or facilitators of effective nurse-patient clinical communication and interaction in this study. These facilitators included:

- Patient engagement in their own care. When patients are engaged and allowed active participation in the care process, the potential exists for communication to become smooth, trust to be established, and positive relationships to be built. The result of having trusting relationships is meaningful interactions and positive care outcomes.
- Patient education. Educating patients on their roles, self-care practices, care processes, routines, and rights/responsibilities will increase health literacy and engaged communication. An enlightened patient is an engaged patient (ICN, 2015). When more education and information are provided to the patients and their relatives/caregivers, interactions become less conflictual, participation in their care improves, and the length of hospital stay reduces.
- Understanding patients, their care needs and cultural orientations have the potential to enhance communication between healthcare providers and consumers. Since communication is both contextually and culturally framed, understanding the patient’s culture and care needs can position care providers to meet patients’ care demands. Patients’ health beliefs can be appreciated, and reflections on their effects on care delivery, access, and outcomes can be shared with patients.
- Nurses must value communication and pay attention to patients’ communicative abilities. Patients are vulnerable because of their presence in the hospital seeking healthcare services. Therefore, nurses and other healthcare providers must recognize the therapeutic values of effective communication and work to implement that.
- Avoiding negative personal attitudes and behaviours will reduce their adverse effects on clinical interactions and communication. Healthcare providers and consumers must embrace politeness and show appreciation because being polite towards each other during clinical interactions is a face-saving mechanism. Everyone’s self-worth is essential and must be protected and respected. Thus, observing and implementing the components of the

Caring Space (as described in Chapter 5, sections 5.4.1 and 5.4.2) in clinical practice will enhance effective communication and interaction.

7.3 Conclusions Reached

The critical conclusions reached in this dissertation are itemized below.

1. There are multitudes of complex factors in the Yendi Hospital that co-act to prevent effective nurse-patient communication, care delivery and access, and trusting relationships between healthcare providers and service consumers. Conscious efforts must be made to reduce or overcome these challenges to healthcare access. Without effective communication between providers and patients, especially in this multilingual context, there is a high risk of misdiagnosing, poor patient disclosure and substandard care quality (Deumert, 2010). When patients cannot communicate with care providers, the patient's voice is silenced, resulting in poor patient disclosure and dissatisfaction with care.
2. Findings of this study revealed that many patients and caregivers are unaware of the Ghanaian *Patients' Charter* and its provisions; as a result, they are unable to assert their rights when violated or compromised. Education and awareness of patient rights should be enhanced to promote rights-based healthcare practices and interactions.
3. Many nurses know about the *Patients' Charter* but do not educate patients and caregivers about these rights and responsibilities. Some nurses fear that when patients are educated about their rights, it will make care delivery difficult because patients will overact in the name of respect for patient rights.
4. Patient rights violations or compromises emanate from two interrelated sources: the resource constraints route and the negative interpersonal relationship route. Awareness of these sources and working to address them can help improve patient rights in clinical interactions.
5. Health education is a critical component of health promotion. Providing health education to patients and caregivers can improve health literacy and positive healthcare outcomes.

6. Clinical practices and communication dynamics have embedded power within them. Nurses and other healthcare professionals must know about the power asymmetry between them and care service consumers. Some clinical discourses are ideologized and used as discursive tools for manipulating, controlling, and exercising power.
7. Sociocultural factors, including gender, age, social status, level of education, and age, significantly influence healthcare communication practices and social interaction. Cultural competence in clinical interactions can support healthcare providers in managing the impact of these variables on nurse-patient clinical communication and interaction better.
8. Neglect of nurses' personal and professional growth negatively impacts healthcare delivery. Therefore, having positive and trusting relationships between care providers, particularly nurses, and healthcare institutional managers/administrators, motivating the healthcare staff, and providing enabling environments for nurses can have lasting results on care delivery. When nurses know they have the support of their superiors, whom they can easily approach, and who have listening ears, they will be motivated to serve.
9. To achieve the health sustainable development goal (SDG3) in Ghana, efforts must not be targeted only at healthcare financing and expansion of healthcare facilities and services but also at patient-provider relationships and issues around patient rights. Although very important, the availability of healthcare facilities, services, and professionals does not necessarily guarantee universal healthcare access if patients are constantly abused, neglected, and/or demeaned. Therefore, the social determinants of health, including the right to health and patient rights, must be critically examined while expanding services/facilities and addressing the challenges within the other relevant components of the healthcare system. That is, what happens within healthcare institutions can severely impact healthcare access.

7.4 Recommendations

The following recommendations, proposals, and suggestions are posited to improve healthcare policy, practice, and further research.

- Interprofessional dialogue and collaboration are vital for effective care delivery and continuity of care. Nurses and clinicians should collaborate and develop healthcare teams to share ideas and practice skills to promote quality care. Nurses, clinicians, and staff of the disease control unit must collaborate to drive critical clinical research that can help improve care quality and access.
- Patient knowledge of their healthcare condition can facilitate self-care management practices. However, many patients attended the hospitals, consulted clinicians, got admitted, treated, and discharged without knowing what health condition brought them to the hospital. Nurses should help patients to know about their healthcare problems, at least during discharge, to promote post-discharge self-care planning.
- Positive hospital-community relationships and dialogic interactions can increase and restore community trust in the hospital and its healthcare practices. Such hospital-community collaborations will engage organizations such as the CCY, among others, to resolve conflicts amicably. A similar relationship was seen to be critical by Oyovwe and Woolhead (2021) towards improving maternal healthcare service provision in Eku, Delta State, Nigeria.
- Nurse advocacy for patient rights can stimulate the implementation of the Ghanaian *Patients' Charter*. However, not all nurses were conversant with the content of the *Charter,* while others believed that promoting patient rights would undermine smooth care delivery practices. To elevate nurses' capacity to promote patient rights through nurse advocacy, education and training must be provided to nurses. Over the years, the Commission on Human Rights and Administrative Justice (CHRAJ, 2010) organized training for nursing students and nurses in practice on patient and human rights. Further training opportunities should be provided for nurses across the country. Nursing training schools must also include deliverable objectives as part of nursing students' clinical practice sessions to task them to observe or look out for patient rights outcomes in clinical interactions as part of the sensitization process.

- Healthcare institutions in Ghana are expected to adopt the *Charter* to ensure that healthcare service providers, patients/clients, and caregivers understand their rights and responsibilities (GHS, 2002). However, hospitals have no mechanism for monitoring patient rights or implementing provisions of the *Charter* in clinical practice. Therefore, healthcare institutions should begin to monitor the occurrence of patient rights abuses and put in place mechanisms to deal with such events.
- Nurses are compromised when ward supplies are used up, and patients/caregivers are asked to buy these items. In response, patients and caregivers treat nurses unethically. Without any corresponding rights and protection for nurses, situations such as this affect nurse's ability to render compassionate care. The Ghanaian *Patients' Charter* is silent about nurses' rights. Moreover, research is lacking regarding how the nurses' code of ethics protects nurses in healthcare institutions. These gaps predispose nurses to violent attacks by patients/caregivers. I recommend that the *Charter* be expanded to include the rights of care providers to make the document inclusive of all parties. Such expansion will require the document's name to be changed to "The Ghanaian Charter of Rights and Responsibilities of Patients and Healthcare Providers" to reflect this change.
- Furthermore, patient education through public mass media is desired in Ghana to enhance awareness about the Ghanaian *Patients' Charter*, patient rights, and human rights in general. This education may help improve patient-provider relationships and patient rights implementation in clinical interactions.
- The *Patients' Charter* makes a generic reference to healthcare providers and hospitals, suggesting that its application may be limited to biomedical practitioners and healthcare institutions. What is the position of the *Charter* regarding traditional medicine and healing and traditional medical practitioners? No context is provided for including these rights when accessing traditional medical care. Given that Ghana is charting a clear path for integrated healthcare systems, more research is needed on how the *Charter* can be applied in traditional medicine and healing contexts. This call

is also relevant in achieving universal healthcare coverage and patient-centred care inclusive of traditional medical practices. As many Ghanaians patronize traditional medical services, the *Charter* must be elaborate enough to capture this parallel medical system.

- Although the Ghanaian *Patients' Charter* prohibits discrimination based on culture, ethnicity, and language, among other demographic variables, it does not provide a guideline regarding how patients' and caregivers' language rights can be respected. Thus, patients must have the right to receive healthcare in the language of their choice. This study found that nurses and patients face significant language barriers, which could be similar in many other hospitals across the country. Therefore, Ghana needs a health language policy to consider nurses' linguistic capacity when posting them to serve in different communities. To send nurses to communities where they are not linguistically capable of interacting with patients and their families violates patients' language rights, reflecting a form of linguicism (Nordquist, 2017).
- Interpreter/translator training and role-playing should be incorporated into the nursing curriculum to provide some basic skills for nurses and other healthcare professionals on how social and cultural factors affect medical interpretations. Knowledge of this nature can position nurses and other care providers to examine how these variables, including power dynamics, influence the translation/interpretation process, patient disclosure, patient privacy, and other taken-for-granted communication practices. Hospitals should make provisions for professional interpretation/translation and guidelines for using medical interpreters/translators. Research shows that "using a relative or a friend as the interpreter is often problematic and may have a negative impact on the quality of the communication outcome" (Krupic et al., 2016, p. 1726); therefore, providing nurses with some skills and education on interpretation/translation can help minimize such problems (Deumert, 2010).
- Healthcare professionals must be trained and educated on issues around cultural competency in care delivery. In line with this proposal, researchers have called for intercultural training for the staff of the GHS to promote "intercultural communication between healthcare providers and patients"

(Abdulai et al., 2019, p. 12). These scholars have also argued that nurses' linguistic ability and cultural sensitivity" should be considered when posting them to healthcare facilities and areas with diverse languages (Abdulai et al., 2019, p. 12).

- The cost of care still prevents many people from accessing healthcare services from the hospital, including those with health insurance coverage, as observed by other studies (Agyemang-Duah et al., 2019). Therefore, further research is needed to explore how hospital culture and practices affect the NHIS services in hospitals and how healthcare service consumers perceive health insurance and healthcare cost. Despite budget deficits within the scheme and delays in reimbursement of medicine dispensed by hospitals, among others (Ashigbie et al., 2016), certain practices in the hospital pharmacy unit around clinicians' prescriptions and what drugs and medicines patients received suggested that there were some inconsistencies. Moreover, insured patients had to buy too many things or pay for several services, drugs, and medicines. Lastly, public education must be intensified since many patients do not know what drugs, medicines, and healthcare services are covered or not under the NHIS. When patients know what they are entitled to, some of the observed discrepancies can be minimized, thereby reducing unnecessary costs on NHIS.
- Research is needed in Ghana and elsewhere on the impact of multilingualism on healthcare interactions. Although many regional dominant local Ghanaian languages are used alongside the English language during clinical interactions, many nurses and patients/caregivers cannot communicate with each other due to the lack of a shared language. A study in South Africa on institutional responses to linguistic diversity in different public hospitals found that multilingualism affected doctor-patient relationships, medical diagnoses, and interpreter services (Deumert, 2010). Deumert (2010, p. 59) maintained "that language issues impede the equitable and effective delivery of public health care, and that something needs to be done urgently." Based on this assertion, there is an imperative for a call for further research on how multilingualism influences healthcare interactions and care outcomes.

- The Clinical Communication Dialogic Framework, which embraces the Caring Space and Kwame and Petrucka's (2021) PC4 Model, should be implemented in clinical practice to guide healthcare interactions and relationships in different practice locations.

References

Abbasinia , M., Ahmadi, F., & Kazemnejad, A. (2020). Patient advocacy in nursing: A concept analysis. *Nursing Ethics*, 27(1), 141-151. https://doi.org/10.1177/0969733019832950

Abdi, K. A., Hassan, A. A., & Sarfo, V. O. (2020). *Cultural interpreter in healthcare – Literature review.* Laurea University of Applied Sciences.

Abdulai, M., Alhassan, A.-R. K. & Sanus, K. M. (2019). Exploring dialectal variations on quality health communication and healthcare delivery in the Sissala District of Ghana. *Language and Intercultural Communication,* 19(3), 242-255. http://dx.doi.org10.1080/14708477.2019.1569671

Abekah-Nkrumah, G., Manu, A., & Atinga, R. A. (2010). Assessing the implementation of Ghana's Patient Charter. *Health Education,* 110(3), 169-185.

Aboba, M. (2021). *Seeking new understanding of primarycare policy constraints: A qualitative assessment of health workers and community perspectives on the role of communication in the implementation of Ghana's National Community Health Policy* [MA Thesis] (Vols. 2020-current.103). James Madison University. https://commons.lib.jmu.edu/masters202029/103

Abuya, T., Ndwiga, C., Ritter, J., Kanya, L., Bellows, B., Binkin, N., & Warren, E. C. (2015). The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. *BMC Pregnancy and Childbirth,* 15(224). doi:10.1186/s12884-015-0645-6

Acheampong, A. K., Ganga-Limando, M., & Aziato, L. (2022). Qualitative exploration of perceived barriers of exclusive breastfeeding among pregnant teenagers in the Greater Accra Region of Ghana. *BMC Public Health,* 22(1885). https://doi.org/10.1186/s12889-022-14277-4

Acquah, A. S. (2011). *Physician-patient communication in Ghana: Multilingualism, interpreters, and self-disclosure* [Doctoral dissertation]. Ohio University.

Adebayo, C. T., Walker, K., Hawkins, M., Olukotun, O., Shaw, L., Parcell, E. S., Dressel, A., Luft, & Mkandawire-Valhmu, L. (2020). Race and Blackness: A thematic review of communication challenges confronting the Black community within the U.S. health care system. *Journal of Transcultural Nursing*, 397-405. https://doi.org/10.1177/1043659619889111

Adua, E., Frimpong, K., Li, X., & Wang, W. (2017). Emerging issues in public health: A perspective on Ghana's healthcare expenditure, policies and outcomes. *EPMA Journal,* 8, 197-206. https://doi.org/10.1007/s13167-017-0109-3

Afulani, P. A., Phillips, B., Aborigo, R. A., & Moyer, C. A. (2019). Person-centred maternity care in low-income and middle-income countries: Analysis of data from Kenya, Ghana, and India. *Lancet Global Health,* 7(1), e96-e109. https://doi.org/10.1016/S2214-109X(18)30403-0

Agyekum, K. (2004). The socio-cultural concept of face in Akan communication. *Pragmatics and Cognition,* 12 (1):71-92.

Agyemang-Duah, W., Adeia, D., Appiah, J. O., Peprah, P., Fordjour, A. A., Peprah, V., & Peprah, C. (2021). Communication barriers to formal healthcare utilisation and associated factors among poor older people in Ghana. *Journal of Communication in Healthcare,* 14(3), 216-224. https://doi.org/10.1080/17538068.2020.1859331

Agyemang-Duah, W., Mensah, C. M., Peprah, P., Arthur, F., & Abalo, E. M. (2019). Facilitators of and barriers to the use of healthcare services from a user and provider perspective in Ejisu-Juaben municipality, Ghana. *Journal of Public Health,* 27, 133-142. https://doi.org/10.1007/s10389-018-0946-0

Akibu, M., Tsegaye, W., Megersa, T., & Nurgi, S. (2018). Prevalence and determinants of complete postnatal care service utilization in Northern Shoa, Ethiopia. *Hindawi: Journal of Pregnancy,* 1-7. https://doi.org/10.1155/2018/8625437

Al-Kalaldeh, M., Amro, N., Qtait, M., & Alwawi, A. (2020). Barriers to effective nurse-patient communication in the emergency department. *Emergency Nurse*. doi:10.7748/en.2020.e1969

Allen, J. D., Mars, D. R., Tom, L., Apollon, G., Hilaire, D., Iralien, G., Cloutier, L. B., Sheets, M. M., & Zamor, R. (2013). Health beliefs, attitudes and service utilization among Haitians. *Journal of Health Care for the Poor and Underserved, 24*(1), 106-119.

Allen-Meares, P., Lowry, B., Estrella, M. L., & Mansuri, S. (2020). Health literacy barriers in the health care system: Barriers and opportunities for the profession. *Health and Social Work,* 45(1), 62-64. doi:10.1093/hsw/hlz034

Altheide, D. L. (1987). Ethnographic content analysis. *Qualitative Sociology, 10*(1), 65-77.

Amoah, K. M. V., Anokye, R., Boakye, S. D., Acheampong, E., Budu-Ainooson, A., Okyere, E., Kumi-Boateng, G., Yeboah, C., & Afriyie, O. J. (2019). A qualitative assessment of perceived barriers to effective therapeutic communication among nurses and patients. *BMC Nursing,* 18(4). https://doi.org/10.1186/s12912-019-0328-0

Andersen, M. H. (2004). "Villagers": Differential treatment in Ghanaian hospital. *Social Science & Medicine, 59,* 2003-2012.

Arundale, R. B. (2006). Face as relational and interactional: A communication framework for research on face, facework, and politeness. *Journal of Politeness Research*, 2,193216. doi:10.1515/PR.2006.011

Arundale, R. B. (2010). Constituting face in conversation: Face, facework, and interactional achievement. *Journal of Pragmatics,* 42(8), 2078-2105. https://doi.org/10.1016/j.pragma.2009.12.021

Ashigbie, P. G., Azameti, D., & Wirtz, V. J. (2016). Challenges of medicines management in the public and private sector under Ghana's National Health Insurance Scheme – A qualitative study. *Journal of Pharmaceutical Policy and Practice,* 9(6). https://doi.org/10.1186/s40545-016-0055-9

Asogwa, U. S., Jemisenia, O. J., & Asogwa, N. U. (2022). Women's perceptions of the causes of maternal mortality: Qualitative evidence from Nsukka, Nigeria. *Sage Open*, 1-12. doi:10.1177/21582440221079817

Atinga, R. A., Abekah-Nkrumah, G., & Domfeh, K. A. (2011). Managing healthcare quality in Ghana: A necessity of patient satisfaction. *International Journal of Health Care Quality Assurance,* 24(7), 548-563.

Atinga, R. A., Bawole, J. N., & Nang-Beifubah, A. (2016). 'Some patients are more equal than others': Patient-centred care differential in two-tier inpatient ward hospitals in Ghana. *Patient Education and Counseling,* 99(3), 370-377. https://doi.org/10.1016/j.pec.2015.09.008

Badu, H. I., Abalo, E. M., Bam, V. B., Agyemang, D. O., Noi, S., Budu, F. A., & Peprah, 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(47). https://doi.org/10.1186/s12912-019-0369-4

Baillie, L. (2009). Patient dignity in acute hospital setting: A case study. *International Journal of Nursing Studies,* 46, 23-37. doi:10.1016/j.ijnurstu.2008.08.003

Baptista, M. K. S., dos Santos, R. M., Costa, L. M. C., de Macêdo, A. C., & Costa, R. L. M. (2018). The power in the nurse-patient relationship: Integrative review. *Revista Bioética,* 26(4), 556-566. doi:10.1590/1983-80422018264274

Barclay, L. (2016). In sickness and in dignity: A philosophical account of the meaning of dignity in health care. *International Journal of Nursing Studies,* 61, 136-141. http://dx.doi.org/10.1016/j.ijnurstu.2016.06.010

Barrera, C. R., Negron, C. P., Barrıa, R. M., & Mendez, C. A. (2015). Rights and duties policy implementation in Chile: Health-care professionals' perceptions. *Health Expectations,* 19, 1062-1070.

Bartlett, R. (2012). Modifying the diary interview method to research the lives of people with Dementia. *Q ualitative Health Research,* 22(12), 1717-1726. doi:10.1177/1049732312462240

Becker, S. H., Gans, J. H., Newman, S. K., & Vaughan, D. (2004). On the value of ethnography: Sociology and public policy. *ANNALS, AAPSS, 595*, 264-276.

Berg, B. L. (2004). *Qualitative research methods for the social sciences* (5th ed.). Pearson.

Bergen, R. (2019). *Language imperialism in post-colonial Ghana: Linguistic recovery and change.* SASAH 4th Year Capstone, Publications 6. https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1005&context=sasahyr4pub

Berghs, M. (2017). Practices and discourses of ubuntu: Implications for an African model of disability? *African Journal of Disability,* 6, a292.

Berhe, K. K., Mselle, L. T., & Gebru, H. B. (2022). Barriers to self-care management among Type 2 diabetes patients in Tigray, Ethiopia: A qualitative study. https://doi.org/10.21203/rs.3.rs-1745404/v1

Berwick, R. C., & Chomsky, N. (2016). *Why only us: Language and evolution.* MIT Press.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, 118(4), 293-302.

Binder, P., Borne, Y., Johnsdotter, S., & Essen, B. (2012). Shared language is essential: Communication in a multiethnic obstetric care setting. *Journal of Health Communication*, 1-16. doi:10.1080/10810730.2012.665421

Boafo, M. I. (2016). "... they think we are conversing, so we don't care about them ...": Examining the causes of workplace violence against nurses in Ghana. *BMC Nursing,* 15(68). doi:10.1186/s12912-016-0189-8

Boafo, M. I., & Gyan, S. E. (2022). Gender and higher education in nursing: Experiences of male nursing trainees in Ghana. In A. CohenMiller, T. Hinton-Smith, F. H. Mazanderani, & N. Samuel (Eds.), *Leading change in gender and diversity in higher education from margins to mainstream (pp. 106-124).* Routledge. file://cabinet.usask.ca/work$/abk384/My%20Documents/10.4324_9781003286943-10_chapterpdf.pdf

Boafo, M. I., & Hancock, P. (2017). Workplace violence against nurses: A cross-sectional descriptive study of Ghanaian nurses. *Sage Open*, 1-9. doi:10.1177/2158244017701187

Boidin, B. (2019). Sustainable development goals: An opportunity for health in Africa? *Global Health Promotion*, 26(1), 91-94. doi:10.1177/1757975916677513

Boucher, L. M., Shoemaker, E. S., Liddy, C. E., Leonard, L. MacPherson, P. A., Presseau, J., Martin, A., Pineau, D., Lalonde, C., Diliso, N., Lafleche, T., Fitzgerald, M., & Kendall, C. E. (2022). “They’re all struggling as well”: Social and economic barriers and facilitators to self-managing chronic illness among marginalized people who use drugs. *International Journal of Qualitative Studies on Health and Well-Being*, 17, 2082111. doi:10.1080/17482631.2022.2082111

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3(2), 77-101. doi:10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2022). Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher. *International Journal of Transgender Health*. https://doi.org/10.1080/26895269.2022.2129597

Brinkman, A. (2014). Balancing rights with responsibilities. *Kai Tiaki Nursing New Zealand,* 20(9), 38-39.

Brown, P., & Levinson, S. C. (1987). *Politeness: Some universals in language usage*. Cambridge University Press.

Budhathoki, S. S., Pokharel, P. K., Good, S., Limbu, S., Bhattachan, M., & Osborne, R. H. (2017). The potential of health literacy to address the health related UN sustainable development goal 3 (SDG3) in Nepal: A rapid review. *BMC Health Services Research,* 17(237). doi:10.1186/s12913-017-2183-6

Buxton, H., Flynn, E., Oluyinka, O, Cumming, O., Mills, J. E., Shiras, T., Sara, S., & Dreibelbis, R. (2019). Barriers and opportunities experienced by staff when implementing infection prevention and control guidelines during labour and delivery in healthcare facilities in Nigeria. *Journal of Hospital Infection*, 103(4), 428-434. https://doi.org/10.1016/j.jhin.2019.07.018

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada. (2014). *Tri-Council policy statement (TCPS2): Ethical conduct for research involving humans,.*

Ceylan, S. S., & Cetinkaya, B. (2020). Attitudes towards gossip and patient privacy among paediatric nurses. *Nursing Ethics,* 27(1), 289-300. https://doi.org/10.1177/0969733019845124

Chen, X., Li, M., & Kreps, G. L. (2022a). Addressing the health communication challenges facing Chinese American immigrants. In D. K. D. Kim, & G. L. Kreps (Eds.), *Global health communication for immigrants and refugee* (pp. 35-47). Routledge.

Chen, X., Li, M., & Kreps, G. L. (2022b). Acculturation and health literacy among Chinese speakers in the USA with limited English proficiency. *Journal of Racial and Ethnic Health Disparities,* 9, 489-497. https://doi.org/10.1007/s40615-021-00979-9

Cheruvu, V. K., & Chiyaka, E. T. (2019). Prevalence of depressive symptoms among older adults who reported medical cost as a barrier to seeking health care: Findings from a nationally representative sample. *BMC Geriatrics,* 19(192). https://doi.org/10.1186/s12877-019-1203-2

Clandinin, D. J. (2006). Narrative inquiry: A methodology for studying lived experience. *Research Studies in Music Education, 27*, 44-54.

Clandinin, D. J. & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research.* Calif: Jossey-Bass.

Clandinin, J., Caine, V., Estefan, A., Huber, J., Murphy, M. S., & Steeves, P. (2015). Places of practice: Learning to think narratively. *Narrative Works: Issues, Investigations, & Interventions*, 5(1), 22-39.

Clarke, V. & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist,* 26(2), 120-123.

Cohen, J. & Ezer, T. (2013). Human rights in patient care: A theoretical and practical framework. *Health and Human Rights,* 15(2), 7-19.

College of Registered Nurses of Nova Scotia. (2011). *The 2012 Standards of Practice for Registered Nurses.* Nova Scotia: College of Registered Nurses of Nova Scotia.

Commission on Human Rights & Administrative Justice (CHRAJ) Ghana. (2010). *Seventh annual report 2010.* CHRAJ.

Creswell, J. W. & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). Sage.

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Sage Publications.

Crossley, S. A., Baylan, R., Liu, J., Schillinger, D., Karter, A. J., & McNamara, D. (2021). Developing and testing automatic models of patient communicative health literacy using linguistic features. *Health Communication,* 36(8), 1018-1028. doi:10.1080/10410236.2020.1731781

Cubaka, K. V., Schriver, M., Cotton, P., Maindal, T. H., Nyirazinyoye, L., & Kallestrup, P. (2018). 'He should feel your pain': Patient insights on patient-provider communication in Rwanda. *African Journal of Primary Health Care and Family Medicine,* 10(1). doi:10.4102/phcfm.v10i1.1514

Cumyn, A., Ouellet, K., Côté, A.-M., Francoeur, C., & St-Onge, C. (2018). Role of researchers in the ethical conduct of research: A discourse analysis from different stakeholder perspectives,. *Ethics & Behavior*. https://doi.org/10.1080/10508422.2018.1539671

Curtice, M. J., & Exworthy, T. (2010). FREDA: A human rights-based approach to healthcare. *The Psychiatrist,* 34, 150-156. doi:10.1192/pb.bp.108.024083

Dadzie, G., Aziato, L., & de-Graft Aikins, A. (2017). “We are the best to stand in for patients”: A qualitative study on nurses’ advocacy characteristics in Ghana. *BMC Nursing,* 16(61). https://doi.org/10.1186/s12912-017-0259-6

Daily Graphic. (2020, January 29). *USA medical team conducts free surgery at Yendi Hospital*. Graphic Online: https://www.graphic.com.gh/news/health/usa-medical-team-conducts-free-surgery-at-yendi-hospital.html

Davies, B. & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the ‘Theory of Social Behauiour,* 20(1), 43-63.

Deane, W. H., & Fain, J. A. (2016). Incorporating Peplau’s Theory of Interpersonal Relations to promote holistic communication between older adults and nursing students. *Journal of Holistic Nursing,* 34(1), 35-41. doi:10.1177/0898010115577975

Department of Health. (2008). *Human rights in healthcare: A framework for local action. (2nd ed.).* Department of Health. https://hscbusiness.hscni.net/pdf/Human_rights_in_healthcare_2nd_edition_DOH.pdf

Deumert, A. (2010). ‘It would be nice if they could give us more language’: Serving South Africa’s multilingual patient base. *Social Science & Medicine,* 71, 53-61. doi:10.1016/j.socscimed.2010.03.036

Dhungana, G., & Dhungana, S.M. (2020). Determinants on nurse patients communication barrier as perceived by patients: A case of Chitwan Medical College Teaching Hospital, Chitwan. *International Journal of Nursing Education,* 12(4), 49-54.

Doku, V. C. K., Wusu-Takyi, A., & Awakame, J. (2012). Implementing the mental health act in Ghana: Any challenges ahead? *Ghana Medical Journal,* 46(4), 241-150.

Donkor, N. T., & Andrews, L. D. (2011). Ethics, culture, and nursing practice in Ghana. *International Nursing Review,* 58, 109-114.

Donmoyer, R. (2012a). Can qualitative researchers answer policymakers' what --- works question? *Qualitative Inquiry,* 18(662).

Donmoyer, R. (2012b). Two (very) different worlds: The cultures of policymaking and qualitative research. *Qualitative Inquiry,* 18(798).

Dougherty, D. S., Kramer, M. W., Klatzke, S. R., & Rogers, T. K. K. (2009). Language convergence and meaning divergence: A meaning centered communication theory. *Communication Monographs,* 76(1), 20-46. doi:10.1080/03637750802378799

Douglas, M. M., Pacquiao, D., & Purnell, L. (Eds.). (2018). *Global applications of culturally competent health care: Guidelines for practice.* Springer International Publishing AG. doi:10.1007/978-3-319-69332-3

Drugan, J. (2017). Ethics and social responsibility in practice: Interpreters and translators engaging with and beyond the professions. *The Translator,* 23(2 [Special issue]), 126-142. https://doi.org/10.1080/13556509.2017.1281204

Dutta, M. J. (2008). *Communicating health: A culture-centered approach.* Polity Press.

Dutta, M. J. (2016). Cultural context, structural determinants, and global health inequities: The role of communication. *Frontiers in Communication,* 1(Article 5), 1-9. https://doi.org/10.3389/fcomm.2016.00005

Dutta, M. J. (2018). Culture-centered approach in addressing health disparities: Communication infrastructures for subaltern voices. *Communication Methods and Measures,* 12(4), 239-259. doi:10.1080/19312458.2018.1453057

Dzomeku, V. M., Mensah, A. B. B., Nakua, E. K., Agbadi, P., Lori, J. R., & Donkor, P. (2020). “I wouldn’t have hit you, but you would have killed your baby:” Exploring midwives' perspectives on disrespect and abusive care in Ghana. *BMC Pregnancy and Childbirth,* 20(15). https://doi.org/10.1186/s12884-019-2691-y

Ekwueme, O. C., Ekwueme, A. C., & Ochonma, O. G. (2019). Patients' knowledge of health rights and satisfaction with outpatient services at the tertiary hospital in Enugu State, Nigeria. *Nigerian Journal of Medicine,* 28(1), 31-40.

Elliott, V. (2018). Thinking about the coding process in qualitative data analysis. *The Qualitative Report,* 23(11), 2850-2861.

Ellison, D. (2015). Communication skills. *Nursing Clinics of North America,* 50, 45/57. http://dx.doi.org/10.1016/j.cnur.2014.10.004

Engen, E. J. H., Devik, S. A., & Olsen, R. M. (2020). Nurses’ experiences of documenting the mental health of older patients in long-term care. *Global Qualitative Nursing Research,* 7, 1-10. https://doi.org/10.1177/2333393620960076

Ezzy, D. (2010). Qualitative interviewing as an embodied emotional performance. *Qualitative Inquiry,* 16(3), 163-170. doi:10.1177/1077800409351970

Feller, S. (2017). Dialogue in institutions. In E. Weigand (Ed.)*, The Routledge handbook of language and dialogue* (1st ed.) (pp. 318-329). Routledge: Taylor & Francis.

Florczak, K. L. (2017). Adding to the truth of the matter: The case for qualitative research. *Nursing Science Quarterly,* 30(4), 296-299. https://doi.org/10.1177/0894318417724466

Flynn, R., Albrecht, L., & Scott, S. (2018). Two approaches to focus group data collection for qualitative health research: Maximizing resources and data quality. *International Journal of Qualitative Methods,* 17(1), 1-9. doi:10.1177/1609406917750781

Forchuk, C., Westwell, J., Martin, M. L., Bamber-Azzapardi, W., Kosterewa-Tolman, D., & Hux, M. (2000). The developing nurse-client relationship: Nurses' perspectives. *Journal of the American Psychiatric Nurses Association*, 6, 3-10.

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., McCarthy, S., & Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC Health Services Research,* 18(120). https://doi.org/10.1186/s12913-018-2915-2

Foucault, M. (2003). *The birth of the clinic: An archaeology of medical perception.* London: Routledge.

Frank-Bader, M., Keller, R., Rumohr, G., & Sritharan, S. (2016). Strengthen nurse-patient communication with the “Social 10”. *Nursing Management,* 47(9), 49-53. doi:10.1097/01.NUMA.0000491125.30236.86

FXB Centre for Health & Human Rights and Open Society Foundation. (2013). *Health and human rights resource guide* (5th ed.). Harvard school of public health, Harvard University.

Galuska, L. (2016). Advocating for patients: Honoring professional trust. *AORN Journal,* 104(5), 410-416. http://dx.doi.org/10.1016/j.aorn.2016.09.001

Genuis, S. K. (2012). Social positioning theory as a lens for exploring health information seeking and decision making. *Qualitative Health Research,* 23(4), 555–567. doi:10.1177/1049732312470029

Ghana Health Service. (2002). *The Patient's Charter.* Ghana Health Service. https://www.ghanahealthservice.org/ghs-subcategory.php?cid=2&scid=46

Ghana Health Service. (2018). *Ghana Health Service Code of Conduct and Disciplinary Procedures.* Accra: GHS. https://www.ghanahealthservice.org/downloads/GHS_Code_of_Conduct_and_Disciplinary_Procedures_2018.pdf

Ghoshal, R., Madhiwalla, N., Jesani, A., Samant, P., Badhwar, V., & Surve, S. (2013). The absent discourse of communication: Understanding ethics of provider-patient relationship in six hospitals in urban India. *Journal of Medical Ethics and History of Medicine,* 6(2).

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal,* 204, 291-295. doi:10.1038/bdj.2008.192

Glasdam, S., Jacobsen, C. B., & Boelsbjerg, H. B. (2020). Nurses’ refusals of patient involvement in their own palliative care. *Nursing Ethics,* 27(8), 1618-1630. doi:10.1177/0969733020929062

Goffman, E. (1955). On face-work: An analysis of ritual elements in social interaction. *Psychiatry: Journal for the Study of Interpersonal Processes*, 18, 213-231.

Goffman, E. (1959). *The presentation of self in everyday life.* Allen Lane Penguin Press.

Goffman, E. (1983). The interaction order. *American Sociological Review,* 48(1), 1-17. https://www.jstor.org/stable/2095141

Goldhirsch, J., Halpenny, B., Scott, N., Ma, Y., Rodriguez, M. S., & Abrahm, J. L. (2021). What's lost in translation: A dialogue-based intervention that improves interpreter confidence in Palliative care conversations. *Journal of Pain and Symptom Management,* 62(3), 609-614. https://doi.org/10.1016/j.jpainsymman.2021.02.027

Government of Ghana (GOG). (2012). *Public health act, 2012 (Act 851).* GOG.

Grein, M. (2017). How culture affects language and dialogue. In E. Weigand (Ed.), *The Routledge handbook of language and dialogue* (1st ed.) (pp. 347-366). Routledge, Taylor & Francis.

Gullick, J., Wu, J., Reid, C., Tembo, A. C., Shishehgar, S., & Conlon, L. (2020). Heideggerian structures of being-with in the nurse–patient relationship: Modelling phenomenological analysis through qualitative meta-synthesis. *Medicine, Health Care and Philosophy,* 23, 645-664. https://doi.org/10.1007/s11019-020-09975-y

Gusnawaty, G., Lukman, L., Nurwati, A., Adhad, A., Nurhawara, N., & Edy, A. (2022). Strategy of kinship terms as a politeness model in maintaining social interaction: Local values towards global harmony. *Heliyon,* 8, e10650. https://doi.org/10.1016/j.heliyon.2022.e10650

Haddad, L. M., & Geiger, R. A. (2022). Nursing ethical considerations. *StatPearls Publishing, Treasure Island*.

Hames, R., & Paolisso, M. (2015). Behavioral observation. In H. R. Bernard, & C. C. Gravlee (Eds.), *Handbook of methods in cultural anthropology* (2nd ed.) (pp. 293-312). Rowman & Littlefield.

Hamiduzzaman, M., De Bellis, A., Abigail, W., Kalaitzidis, E., & Harrington, A. (2021). The world is not mine – Barriers to healthcare access for Bangladeshi rural elderly women. *Journal of Cross-Cultural Gerontology,* 36, 69-89. https://doi.org/10.1007/s10823-020-09420-w

Han, Y., Segalowitz, N., Khalil, L., Kehayia, E., Turner, C., & Gatbonton, E. (2020). Do nurses use discourse markers differently when using their second language as opposed to their first while interviewing patients? *The Canadian Modern Language Review/La Revue canadienne des langues vivantes,* 76(2), 91-113. doi:10.3138/cmlr-2018-0268

Harré, R. (2004). Positioning theory. 1-12. https://www.massey.ac.nz/~alock/virtual/positioning.doc

Harré, R., Moghaddam, F. M., Cairnie, T. P., Rothbart, D., & Sabat, S. R. (2009). Recent advances in positioning theory. *Theory & Psychology,* 19(1), 5-31. doi:10.1177/0959354308101417

Havenga, Y., Temane, A., Ramukumba, T., & Nolte, A. (2018). Ethics in nursing - A South African perspective. In N. Nortje, W. A. Hoffmann, & J.-C. De Jongh (Eds.), *African perspectives on ethics for healthcare professionals. Advancing global bioethics 13* (pp. 175-188). Springer.

Haydon, G., Browne, G., & van der Riet, P. (2018). Narrative inquiry as a research methodology exploring person centred care in nursing. *Collegian,* 25, 125-129. doi:10.1016/j.colegn.2017.03.001

Heidegger, M. (1962). *Being and time (trans: Macquarrie, J., and Robinson, E.).* New York: Harper & Rowe.

Hennink, M. M., Kaiser, B. N., & Marconi1, V. C. (2017). Code saturation versus meaning saturation: How many interviews are enough? *Qualitative Health Research,* 27(4), 591-608. doi:10.1177/1049732316665344

Horrill, T. C., Martin, D. E., Lavoie, J. G., & Schultz, A. S. H. (2021). Nurses as agents of disruption: Operationalizing a framework to redress inequities in healthcare access among Indigenous Peoples. *Nursing Inquiry,* 28(3), e12394. https://doi.org/10.1111/nin.12394

Høy, B., Lillestø, B., Slettebø, A., Sæteren, B., Heggestad, A. K. T., Caspari, S., Aasgaard, T., Lohne, V., Rehnsfeldt, A., Raholm, M.-B., Lindwall, L., & Naden, D. (2016). Maintaining dignity in vulnerability: A qualitative study of the residents' perspective on dignity in nursing homes. *International Journal of Nursing Studies,* 60, 91-98. http://dx.doi.org/10.1016/j.ijnurstu.2016.03.011

Hurley, A. E., Harvey, A. S., Keita, M., Kennedy, E. C., Roter, D., Dao, S., Doumbia, S., & Winch, J. P. (2017). Patient-provider communication styles in HIV treatment programs in Bamako, Mali: A mixed-methods study to define dimensions and measure patient preferences. *SSM - Population Health,* 3, 539-548. http://dx.doi.org/10.1016/j.ssmph.2017.05.012

Hussain, M. A., Elyas, T., & Nasseef, O. A. (2013). Research paradigms: A slippery slope for fresh researchers. *Life Science Journal,* 10(4), 2374-2381.

Huutoniemi, K. (2016). Interdisciplinarity as academic accountability: Prospects for quality control across disciplinary boundaries. *Social Epistemology: A Journal of Knowledge, Culture and Policy, 30*(2), 163-185. https://doi.org/10.1080/02691728.2015.1015061

Ifeagwu, S. C., Yang, J. C., Parkes-Ratanshi, R., & Brayne, C. (2021). Health financing for universal health coverage in Sub-Saharan Africa: A systematic review. *Global Health Research and Policy,* 6(8). https://doi.org/10.1186/s41256-021-00190-7

Institute of Medicine [IOM]. (2001). *Crossing the quality chasm: A new health system for the 21st century.* The National Academies Press. Committee on Quality of Health Care in America Crossing the Quality Chasm.

Institute of Medicine (2003). *Health professions education: A bridge to quality*. National Academic Press

Institute of Medicine (2011). *The future of Nursing: Leading change, advancing health.* National Academy of Sciences. https://nap.nationalacademies.org/read/12956/chapter/5#27

International Confederation of Midwives (2014). *International code of ethics for midwives*. Reviewed and adopted at Prague Council meeting, 2014. https://internationalmidwives.org/our-work/policy-and-practice/international-code-of-ethics-for-midwives.html

International Council of Nurses [ICN]. (2012). *ICN code of ethics for nurses.* ICN. www.icn.ch/images/stories/documents/about/icncode_english.pdf.

International Council of Nurses [ICN]. (2015). *Informed patient: ICN position statement.* Geneva: ICN.

International Council of Nurses. (2021). *The ICN code of ethics for nurses (Revised).* Geneva: ICN. https://www.icn.ch/system/files/2021-10/ICN_Code-of-Ethics_EN_Web_0.pdf

Ismaila, Y., Bayes, S., & Geraghty, S. (2021). Understanding the barriers to Ghanaian midwives' ability to provide quality care: Using classic Grounded theory methodology in a new context. *International Journal of Africa Nursing Sciences,* 15, 100374. https://doi.org/10.1016/j.ijans.2021.100374

Jerofke-Owen, T. A., Tobiano, G., & Eldh, A. C. (2022). Patient engagement, involvement, or participation—Entrapping concepts in nurse-patient interactions: A critical discussion. *Nursing Inquiry,* e12513. https://doi.org/10.1111/nin.12513

Johnsson, A., Wagman, P., Boman, A., & Pennbrant, S.,. (2018). What are they talking about? Content of the communication exchanges between nurses, patients and relatives in a department of medicine for older people: An ethnographic study. *Journal of Clinical Nursing,* 27, e1651-e1659. doi:10.1111/jocn.14315

Kaiser,M. I., Kronfeldner, M., & Meunier, R. (2016). Problems and prospects of interdisciplinarity: The case of philosophy of science. *Interdisciplinary Science Reviews,* 41(1), 61-70.

Kalaitzidis, E., & Jewell, P. (2020). The concept of advocacy in nursing: A critical analysis. *The Health Care Manager,* 39(2), 77-84. doi:10.1097/HCM.0000000000000292

Karlsen, M. M. W., Happ, M. B., Finset, A., Heggdal, K., & Heyn, L. G. (2020). Patient involvement in micro-decisions in intensive care. *Patient Education and Counseling,* 103, 2252-2259. https://doi.org/10.1016/j.pec.2020.04.020

Kecskes, I. (2010). The paradox of communication: Socio-cognitive approach to pragmatics. *Pragmatics and Society,* 1(1), 50-73. doi:10.1075/ps.1.1.04kec

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry,* 49(2), 149/164. doi:10.1177/1363461512444673

Korsah, A. K. (2011). Nurses’ stories about their interactions with patients at the Holy Family Hospital, Techiman, Ghana. *Open Journal of Nursing,* 1, 1-9. doi:10.4236/ojn.2011.11001

Kotoh, A. M., Aryeetey, G. C., & Van der Geest, S. (2018). Factors that influence enrolment and retention in Ghana’ National Health Insurance Scheme. *International Journal of Health Policy Management,* 7(5), 443-454. doi:10.15171/ijhpm.2017.117

Kreps, G. L. (2013). *Communication and health: Systems and applications (Chap. 14).* Routledge.

Kreps, G. L. (2018). Promoting patient comprehension of relevant health information. *Israel Journal of Health Policy Research,* 7(56). https://doi.org/10.1186/s13584-018-0250-z

Kreps, G. L., Neuhauser, L., Sparks, L., & Labelle, S. (2020). Promoting convergence between health literacy and health communication. *Studies in Health Technology and Informatics*, 269, 526-543.

Kropp Dakubu, M. E. (2015). *The languages of Ghana.* Routledge.

Krupic, F., Hellstrom, M., Biscevic, M., Sadic, S., & Fatahi, N. (2016). Difficulties in using interpreters in clinical encounters as experienced by immigrants living in Sweden. *Journal of Clinical Nursing,* 25, 1721-1728. doi:10.1111/jocn.13226

Kusi, G., Mensah, A. B. B., Mensah, K. B., Dzomeku, V. M., Apiribu, F., & Duodu, P. A. (2020). Caregiving motivations and experiences among family caregivers of patients living with advanced breast cancer in Ghana. *Plos One,* 15(3), e0229683. https://doi.org/10.1371/journal.pone.0229683

Kuzu, N., Ergin, A., & Zencir, M. (2006). Patients' awareness of their rights in a developing country. *Public Health*, 120, 290-296. doi:10.1016/j.puhe.2005.10.014

Kwame, A. (2017). Reflexivity and the insider/outsider discourse in indigenous research: My personal experiences. *AlterNative: An International Journal of Indigenous Peoples*, 1-8. doi:10.1177/1177180117729851

Kwame, A., & Petrucka, P. M. (2020). Communication in nurse-patient interaction in healthcare settings in sub-Saharan Africa: A scoping review. *International Journal of Africa Nursing Sciences,* 12, 1-22. https://doi.org/10.1016/j.ijans.2020.100198

Kwame, A., & Petrucka, P. M. (2021). A literature-based study of patient-centered care and communication in nurse-patient interactions: Barriers, facilitators, and the way forward. *BMC Nursing,* 20(158). https://doi.org/10.1186/s12912-021-00684-2

Kwame, A. & Petrucka, P. M. (2022). Universal healthcare coverage, patients' rights, and nurse-patient communication: A critical review of the evidence. *BMC Nursing,* 21(54). https://doi.org/10.1186/s12912-022-00833-1

Kwezi, H. A., Mselle, L.T., Leshabari, S., Hanson, C., & Pembe, A. B. (2021). How communication can help women who experience a maternal near-miss: A qualitative study from Tanzania. *BMJ Open,* 11, e045514. doi:10.1136/bmjopen-2020-045514

Lahman, M. K. (2018). *Ethics in social science research: Becoming culturally responsive.* Sage.

Lam, W., Wong, F. Y., Chan, A. E. (2020). Factors affecting the levels of satisfaction with nurse-patient communication among oncology patients. *Cancer Nursing,* 43(4), E186-E196. doi:10.1097/NCC.0000000000000672

Lambert, J., Etsane, E., Bergh, A.-M., Pattinson, R., & van de Broek, N. (2018). I thought they were going to handle me like a queen but they didn't': A qualitative study exploring the quality of care provided to women at the time of birth. *Midwifery,* 62, 256-263. https://doi.org/10.1016/j.midw.2018.04.007

Laschinger, H. K. (2014). Impact of workplace mistreatment on patient safety risk and nurse-assessed patient outcomes. *The Journal of Nursing Administration,* 44(5), 284-290. doi:10.1097/NNA.0000000000000068

Levy, R. I. & Hollan, D. W. (2015). Person-centered interviewing and observation. In H. R. Bernard & C. C. Gravlee (Eds.), *Handbook of methods in cultural anthropology* (2nd ed.) (pp. 313-342). Rowman & Littlefield.

Liddicoat, A. J. (2009). Communication as culturally contexted practice: A view from intercultural communication. *Australian Journal of Linguistics,* 29(1), 115-133.

Linneberg, M. S., & Korsgaard, S. (2019). Coding qualitative data: A synthesis guiding the novice. *Qualitative Research Journal,* 19(3), 259-270. https://doi.org/10.1108/QRJ-12-2018-0012

Loghmani, L., Borhani, F., & Abbaszadeh, A. (2014). Factors affecting the nurse-patients' family communication in intensive care unit of Kerman: A qualitative study. *Journal of Caring Science,* 3(1), 67-82. doi:10.5681/jcs.2014.008

Loiselle, G. C., & Profetto-McGrath, J. (2011). *Canadian essentials of nursing research* (3rd ed.). Lippincott Williams & Wilkins.

Love, B., Vetere, A., & Davis, P. (2020). Should interpretative phenomenological analysis (IPA) be used with focus groups? Navigating the bumpy road of “iterative loops,” idiographic journeys, and “phenomenological bridges”. *International Journal of Qualitative Methods,* 19, 1-17. doi:10.1177/1609406920921600

Lum, L., Dowedoff, P., & Englander, K. (2016). Internationally educated nurses’ reflections on nursing communication in Canada. *International Nursing Review,* 63, 344-351.

Lupton, D. (. (2020). Doing fieldwork in a pandemic (crowd-sourced document). https://docs.google.com/document/d/1clGjGABB2h2qbduTgfqribHmog9B6P0NvMg VuiHZCl8/edit?ts=5e88ae0a#

Lusk, J. M., & Fater, K. (2013). A concept analysis of patient-centered care. *Nursing Forum,* 48(2), 89-98.

Madula, P., Kalembo, W. F., Yu, H., & Kaminga, C. A. (2018). Healthcare provider-patient communication: A qualitative study of women’s perceptions during childbirth. *Reproductive Health,* 15(135). https://doi.org/10.1186/s12978-018-0580-x

Makanjee, C. R., Bergh, A.-M., & Hoffmann, W. A. (2015). Multiprovider and patient perspectives on conveying diagnostic imaging investigation results in a South African public health care system. *Journal of Medical Imaging and Radiation Sciences,* 46, 197-204. http://dx.doi.org/10.1016/j.jmir.2015.02.003

Malmedal, W., & Anyan, C. (2020). Elder abuse in Ghana – A qualitative exploratory study. *The Journal of Adult Protection,* 22(5), 299-313. https://doi.org/10.1108/JAP-04-2020-0011

Mauksch, L. B., Dugdale, D. C., Dodson, S., & Epstein, R. (2008). Relationship, communication, and efficiency in the medical encounter: Creating a clinical model from a literature review. *Archives of Internal Medicine,* 168(13), 1387-1395.

Maya, E. T., Adu-Bonsaffoh, K., Dako-Gyeke, P., Badzi, C., Vogel, J. P., Bohren, M. A., & Adanu, R. (2018). Women's perspectives of mistreatment during childbirth at health facilities in Ghana: Findings from a qualitative study. *Reproductive Health Matters,* 26(53), 70-87. https://doi.org/10.1080/09688080.2018.1502020

McGinley, S., Wei, W., Zhang, L., & Zheng, Y. (2021). The state of qualitative research in hospitality: A 5-year review 2014 to 2019. *Cornell Hospitality Quarterly,* 62(1), 8-20. doi:10.1177/1938965520940294

McQueen, A. (2000). Nurse-patient relationships and partnership in hospital care. *Journal of Clinical Nursing*, 9, 723-731.

M cVee, M. B., Silvestri, K. N., Barrett, N., & Haq, K. S. (2018). Potioning theory. In D. E. Alvermann, N. J. Unrau, M. Sailors, & R. B. Ruddell (Eds.), *Theoretical models and processes of literacy* (7th ed.). Routledge

Mensah, O. N. (2013). *Understanding the nurse-patient interaction at Komfo Anokye Teaching Hospital: The patients' perspectives and experiences.* [Master's thesis]. University of Ghana, Legon.

Miles, M. B, Huberman, A. M. & Saldaña, J. (2013). *Qualitative data analysis: A methods sourcebook* (2nd ed. ed.). Thousand Oaks, CA: Sage.

Miller, R. M., Chan, C. D., & Farmer, L. B. (2018). Interpretive phenomenological analysis: A contemporary qualitative approach. *Counselor Education & Supervision*, 57, 240-254. doi:10.1002/ceas.12114

Miltenburg, S. A., Lambermon, F., Hamelink, C., & Meguid, T. (2016). Maternity care and human rights: What do women think? *BMC International Health and Human Rights,* 16(17). doi:10.1186/s12914-016-0091-1

Mission:318. (n.d.). *Our friends in Yendi*. Retrieved from Yendi: https://mission318.com/yendi/

Mkhize, N. (2018). Ubuntu-Batho approach to ethics: An invitation to dialogue. In N. Nortje, W. A. Hoffman, & J.-C. De Jongh (Eds.), *African perspectives on ethics for healthcare professionals. Advancing global bioethics 13* (pp. 25-48). Springer. https://doi.org/10.1007/978-3-319-93230-9_3

Mohammed, E. S., Seedhom, A. E., & Ghazawy, E. R. (2017). Awareness and practice of patient rights from a patient perspective: An insight from Upper Egypt. *International Journal for Quality in Health Care*, 30(2), 145-151. doi:10.1093/intqhc/mzx182

Moreau, J. T., & Rudge, T. (2019). How “care values” as discursive practices effect the ethics of a care-setting. *Journal of Organizational Ethnography,* 8(3), 298-311. https://doi.org/10.1108/JOE-04-2018-0024

Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology, 22,* 129-152.

Moriña, A. (2021). When people matter: The ethics of qualitative research in the health and social sciences. *Health & Social Care in the Community,* 29, 1559-1565. doi:10.1111/hsc.13221

Mpouzika, M., Karanikola, M., Panayiotou, E., Raftopoulos, V., Middleton, N., & Papathanassoglou, E. (2021). Nurses' attitudes and knowledge regarding patient rights:

A systematic review. *Revista da Escola de Enfermagem da USP,* 55. https://doi.org/10.1590/S1980-220X2019037603678

Mulhall, A. (2003). In the field: Notes on observation in qualitative research. *Journal of Advanced Nursing,* 41(3), 306-313.

Munthali, A. C., Swartz, L., Mannan, H., MacLachlan, M., Chilimampunga, C., & Makupe, C. (2019). “This one will delay us”: Barriers to accessing health care services among persons with disabilities in Malawi. *Disability and Rehabilitation,* 41(6), 683-690. https://doi.org/10.1080/09638288.2017.1404148

Murira, N., Lützen, K., Lindmark, G., & Christensson, K. (2003). Communication patterns between healthcare providers and their clients at an antenatal clinic in Zimbabwe. *Health Care for Women International,* 24(2), 83-92. https://doi.org/10.1080/07399330390170060

Musante, K. (2015). Participant observation. In H. R. Bernard & C. C. Gravlee (Eds.), *Handbook of methods in cultural anthropology* (2nd ed.) (pp. 251-292). Rowman & Littlefield.

Narayan, M. C., & Mallinson, R. K. (2022). Transcultural nurse views on culture sensitive/patient-centered assessment and care planning: A descriptive study. *Journal of Transcultural Nursing,* 33(2), 150-160. https://doi.org/10.1177/10436596211046986

Niemants, N., & Stokoe, E. (2017). Using the conversation analytic role-play method in healthcare interpreter education. In L. Cirillo, & N. Niemants (Eds.), *Teaching dialogue interpreting* (pp. 293-322). John Benjamins. https://doi.org/10.1075/btl.138

Nordquist, R. (April 13, 2017). *Linguicism: Glossary of grammatical and rhetorical terms.* ThoughtCo. *https://www.thoughtco.com/what-is-linguicism-1691238*

Norouzinia, R., Aghabarari, M., Shiri, M., Karimi, M., & Samami, E. (2016). Communication barriers perceived by nurses and patients. *Global Journal of Health Science,* 8(6), 65-74.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods,* 16, 1–13. doi:10.1177/1609406917733847

Ntoimo, L. F. C., Okonofua, F. E., Igboin, B., Ekwo, C., Imongan, W., & Yaya, S. (2019). Why rural women do not use primary health centres for pregnancy care: Evidence from a qualitative study in Nigeria. *BMC Pregnancy and Childbirth,* 19(277). http://dx.doi.org/10.1186/s12884-019-2433-1

Nwosu, J., Inyama, V., & Emeka, C. (2017). Effect of nurse-patient relationship on patients recovery at NKST hospital Mkar, Gboko, Benue State. *African Journal of Nursing and Midwifery,* 5(2), 695-703.

Nyaaba, G. N., Masana, L., Beune, E., & Agyemang, C. (2020). Factors hindering hypertension control: Perspectives of front-line health professionals in rural Ghana. *Public Health,* 181, 16-23. https://doi.org/10.1016/j.puhe.2019.11.007

Obu, R. N. (2020). Medical law and misrepresentation in the practice of homeopathy and alternative medicines in Ghana: Lessons learnt in studying law & practicing holistic medicine. *Scholars International Journal of Law, Crime and Justice,* 3(4), 99-111. doi:10.36348/sijlcj.2020.v03i04.004

Ohene-Amoah, C. (2015). Implications of patients' rights violations at the hospital: A study of Winneba Government Hospital, Ghana. *Public Policy and Administration Research,* 5(8), 142-151.

Ohlen, J. (2004). Violation of dignity in care-related situations. *Research and Theory for Nursing Practice: An International Journal*, 18(4), 371-385.

Ojwang, B. O., Ogutu, E. A., & Matu, P. M. (2010). Nurses' impoliteness as an impediment to patients' rights in selected Kenyan hospitals. *An International Journal of Health and Human Rights, 12*(2).

Oleribe, O. O., Momoh, J., Uzochukwu, B. S. C., Mbofana, F., Adebiyi, A., Barbera, T., Williams, R., & Taylor-Robinson, S. D. (2019). Identifying key challenges facing healthcare systems in Africa and potential solutions. *International Journal of General Medicine*, 12, 395-403.

Ondenge, K., Renju, J., Bonnington, O., Moshabela, M., Wamoyi, J., Nyamukapa, C., Seeley, J., & Wringe, A. (2017). 'I am treated well if I adhere to my HIV medication': Putting patient-provider interactions in context through insights from qualitative research in five sub-Saharan African countries. *Sexual Transmitted Infection*, 1-6. doi:10.1136/sextrans-2016-052973

Oppong, K. M. (2019). Patients' knowledge of their rights and its impact on hospital admission at the St. John of God Hospital, Duayaw-Nkwanta, Brong Ahafo Region, Ghana. *Education & Science Journal of Policy Review and Curriculum Development*, 9(1), 64-73.

Ostaszkiewicz, J., Dickson-Swift, V., Hutchinson, A., & Wagg, A. (2020). A concept analysis of dignity-protective continence care for care dependent older people in long-term care settings. *BMC Geriatrics*, 20(266). https://doi.org/10.1186/s12877-020-01673-x

Ostman, L., Nasman, Y., Eriksson, K., & Nystrom, L. (2019). Ethos: The heart of ethics and health. *Nursing Ethics*, 26(1), 26-36. https://doi.org/10.1177/0969733017695655

Owu-Ewie, C. (2006). The language policy of education in Ghana: A critical look at the English-only language policy of education. *Proceedings of the 35th Annual Conference on African Linguistics* (pp. 76-85). Somerville, MA: Cascadilla Proceedings Project.

Owu-Ewie, C., & Eshun, E. S. (2015). The use of English as medium of instruction at the upper basic level (primary four to junior high school) in Ghana: From theory to practice. *Journal of Education and Practice,* 6(3), 72-82.

Owusu-Dapaah, E. (2015). Empowering patients in Ghana: Is there a case for human rights-based healthy care law? 91-114. Retrieved from www.ssrn.com/abstract=2821895

Owusu-Dapaah, E. (2021). Commission of inquiry and the quest for a greater accountability in healthcare delivery in Africa: A Ghanaian perspective. In M. Ndulo, & C. Emeziem (Eds.), *The Routledge Handbook of African Law* (1st ed.). Routedge. https://doi.org/10.4324/9781351142366

Oyovwe, P., & Woolhead, G. (2021). Exploring health care professionals' and women's perspectives on the barriers to maternal health services: A qualitative study in Eku Town of Delta State, Nigeria. *AIMS Public Health,* 8(1), 154-171. doi:10.3934/publichealth.2021012

Ozaras, D., & Abaan, S. (2018). Investigation of the trust status of the nurse-patient relationship. *Nursing Ethics,* 25(5), 628-639. https://doi.org/10.1177/0969733016664971

Ozdemir, M. H., Ozgur I. C., Ergonen, A. T., Hilal, A., Onder, M., & Meral, D. (2009). Midwives and nurses' awareness of patients' rights. *Midwifery,* 25, 756-765. doi:10.1016/j.midw.2008.01.010

Parrot, R. (2004). Emphasizing “communication” in health communication. *International Communication Association,* 54(4), 751-787.

Paul, K. B. (2017). Introducing interpretive approach of phenomenological research methodology in environmental philosophy: A mode of engaged philosophy in the Anthropocene. *International Journal of Qualitative Methods, 16,* 1-10. doi:10.1177/1609406917724916

Peplau, H. E. (1991). *Interpersonal relations in nursing. New.* Springer.

Peplau, H. E. (1992). Interpersonal relations: A theoretical framework for application in nursing practice. *Nursing Science Quarterly, 5*, 13-18.

Peplau, H. E. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quarterly,* 10, 162-167.

Perehudoff, S. K., Alexandrov, N. V., & Hogerzeil, H. V. (2019). The right to health as the basis for universal health coverage: A cross-national analysis of national medicines policies of 71 countries. *Plos One, 14*(6), e0215577. https://doi.org/10.1371/journal.pone.0215577

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne – Psychological Journal, 20*(1), 7-14. doi:10.14691/CPPJ.20.1.7

Price, J. A., Soares, A. I. F. S., Asante, A. D., Martins, J. S., Williams, K., & Wiseman, V. L. (2016). "I go I die, I stay I die, better to stay and die in my house": Understanding the barriers to accessing health care in Timor-Leste. *BMC Health Services Research,* 16(535). https://doi.org/10.1186/s12913-016-1762-2

Purnell, L. (2005). The Purnell model for cultural competence. *Journal of Multicultural Nursing & Health,* 11(2), 7-15.

Purnell, L. (2018). Cross cultural communication: Verbal and non-verbal communication, interpretation and translation. In M. M. Dougla, D. Pacquiao, & L. Purnell (Eds.), *Global applications of culturally competent health care: Guidelines for practice* (pp. 131-142). Cham: Springer. https://doi.org/10.1007/978-3-319-69332-3_14

Rashid, M., Caine, V., & Goez, H. (2015). The encounters and challenges of ethnography as a methodology in health research. *International Journal of Qualitative Methods*, 1-16. doi:10.1177/1609406915621421

Ratna, H. (2019). The importance of effective communication in healthcare practice. *Harvard Public Health Review,* 23. doi:10.54111/0001/W4

Read, U. M. (2019). Rights as relationships: Collaborating with faith healers in community mental health in Ghana. *Culture, Medicine, and Psychiatry,* 43, 613-635. https://doi.org/10.1007/s11013-019-09648-3

Redmond, M. V. (2015). Face and politeness theories. *English Technical Reports and White Papers. 2*. http://lib.dr.iastate.edu/engl_reports/2

Reeves, S., Pelone, F., Harrison, R., Goldman, J., & Zwarenstein, M. (2017). Interprofessional collaboration to improve professional practice and healthcare outcomes (Review). *Cochrane Database of Systematic Reviews*(6). doi:10.1002/14651858.CD000072.pub3

Reid, A.-M., Brown, J. M., Smith, J. M., Cope, A. C., Jamieson, S. (2018). Ethical dilemmas and reflexivity in qualitative research. *Perspectives on Medical Education,* 7, 69-75. https://doi.org/10.1007/s40037-018-0412-2

Reisigl, M. & Wodak, R. (2016). The discourse-historical approach (DHA). In R. Wodak & M. Meyer (Eds.), *Methods of critical discourse studies* (3rd ed.) (pp. 23-61). Sage.

Republic of Ghana. (1993). *The 1992 consitution of the Republic of Ghana.* Assembly Press.

Rickards, T., & Hamilton, S. (2020). Patient experiences of primary care provided by nurse practitioners in New Brunswick, Canada. *The Journal for Nurse Practitioners,* 16, 299-304. https://doi.org/10.1016/j.nurpra.2019.12.027

Riley, B. J. (2008). *Communication in nursing* (6th ed.). Elsevier.

Rimal, N. R. (2001). Analyzing the physician-patient interaction: An overview of six methods and future research directions. *Health Communication,* 13(1), 89-99. doi:10.1207/S15327027HC1301_08

Roach, M. S. (2002). *Caring, the human mode of being: A blueprint for the health professions* (2nd rev. ed.). Canadian Healthcare Association Press.

Roche, D., & Jones, A. (2021). A qualitative study of nurse-patient communication and information provision during surgical pre-admission clinics. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy,* 24(4), 1357-1366. doi:https://doi.org/10.1111/hex.13270

Rowland, E., Manogaran, M., & Bourgeault, I. L. (2018). Institutional ethnography as a unique tool for improving health systems. *Healthcare Management Forum,* 32(3), 143-147. doi:10.1177/0840470418823220

Saldaña, J. (2015). *The coding manual for qualitative researchers.* Sage.

Salifu, N. A. (2010). Signaling politeness, power and solidarity through terms of address in Dagbanli. *Nordic Journal of African Studies,* 19(4), 274-292. https://njas.fi/njas/article/view/198/189

Salifu, N. A. (2014a). Sexism and gender stereotyping in the Dagbanli language. *Gender and Language,* 8(3), 393-415. doi:10.1558/genl.v8i3.393

Salifu, N. A. (2014b). Implications for gender relations of summons-response and address forms in Dagbanli. *Linguistik online,* 63(1), 41-54. https://pdfs.semanticscholar.org/c126/f50ca43de6ea83014bece9f001c16c10e964.pdf

Samovar, L. A., Porter, R. E., & McDaniel, E. R. (2010). *Communication between cultures* (7th ed.). Wadsworth Cengage Learning.

Sasso, L., Stievano, A., Jurado, M. G., & Rocco, G. (2008). Code of ethics and conduct for European nursing. *Nursing Ethics,* 15(6), 821-836. doi:10.1177/0969733008095390

Savic, M., Chur-Hansen, A., Mahmood, M. A., & Moore, V. M. (2016). ‘We don’t have to go and see a special person to solve this problem’: Trauma, mental health beliefs and processes for addressing ‘mental health issues’ among Sudanese refugees in Australia. *International Journal of Social Psychiatry,* 62(1), 76-83. doi:10.1177/0020764015595664

Senayah, E. A., Mprah, W. K., Opoku, M. P., Edusei, A. K., & Torgbenu, E. L. (2019). The accessibility of health services to young deaf adolescents in Ghana. *International Journal of Health Planning and Management,* 34, e634-e645. doi:10.1002/hpm.2679

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,* 10(12), LC10-LC15. doi:10.7860/JCDR/2016/22526.8971

Sethi, D., & Rani, M. K. (2016). Communication barrier in health care setting as perceived by nurses and patient. *International Journal of Nursing Care,* 2(1). doi:10.5958/j.2320-8651.2.1.001

Sharifi, N., Adib-Hajbaghery, M., & Najafi, M. (2019). Cultural competence in nursing: A concept analysis. *International Journal of Nursing Studies,* 99(103386), 1-8. doi:http://dx.doi.org/10.1016/j.ijnurstu.2019.103386

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 1*, 9-27. https://doi.org/10.1080/17437199.2010.510659

Smith, J. A. (2017). Interpretative phenomenological analysis: Getting at lived experience. *The Journal of Positive Psychology,* 12(3), 303-304. http://dx.doi.org/10.1080/17439760.2016.1262622

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenomenological analysis: Theory, method, and research.* Sage.

Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing interpretive phenomenological analysis. In M. Murray & K. Chamberlain (Eds.), *Qualitative Health Psychology: Theories and methods* (pp. 218-240). Sage. http://dx.doi.org/10.4135/9781446217870.n14

Smithson, J. (2008). Focus groups. In P. Alasuutari, L. Bickman, & J. Brannen (Eds.), *The Sage handbook of social research methods* (pp. 356-371). Sage.

Soltani, S., Takian, A., Sari, A. A., Majdadeh, R., & Kamali, M. (2019). Financial barriers to access to health services for adult people with disability in Iran: The challenges for universal health coverage. *Iranian Journal Public Health,* 48(3), 508-515.

Spradley, J. P. (2016). *Participant observation.* Waveland Press.

Suarez, N. R. E., Urtecho, M., Jubran, S., Yeow, M.-E., Wilson, M. E., Boehmer, K. R., & Barwise, A. K. (2021). The roles of medical interpreters in intensive care unit communication: A qualitative study. *Patient Education and Counseling,* 104(5), 1100-1108. https://doi.org/10.1016/j.pec.2020.10.018

Sundler, A. J., Hjertberg, F., Keri, H., Holmström, I. K. (2020). Attributes of person-centred communication: A qualitative exploration of communication with older persons in home health care. *International Journal of Older People Nursing,* 15(1), e12284. https://doi.org/10.1111/opn.12284

Tchiakpe, M. P., Ankamah-Lomotey, S., Kobia-Acquah, E., Slocombe, F., Nkansah, E. K., Djeagbo, P. T., & Nkansa-Kyeremateng, I. (2018). The Ghanaian Patient’s Charter: Patient awareness, and implementation in selected public Ophthalmic health institutions in Ghana. *EC Ophthalmology,* 9(8), 594-601.

The National Health Insurance Authority. (2013). *National Health Insurance Authority 2013 annual report.* National Health Insurance Authority, Ghana.

Tia, M. B., Aziato, L., & Dzansi, G. (2020). Health system factors influencing nurses’ ethical-decision making for postoperative pain management in Ghana. *International Journal of Africa Nursing Sciences,* 13(100257). https://doi.org/10.1016/j.ijans.2020.100257

Turner, D. (2020). Reflexive journals in qualitative research. https://www.quirkos.com/blog/post/reflexive-journals-in-qualitative-research/amp/

Turnock, C. & Kelleher, M. (2001). Maintaining dignity in intensive care settings. *Intensive and Critical Care Nursing,* 17, 144-154. doi:10.1054/iccn.2000.1562

Udenigwe, O., Okonofua, F. E., Ntoimo, L. F. C., & Yaya, S. (2022). Exploring underutilization of skilled maternal healthcare in rural Edo, Nigeria: A qualitative study. *PLoS One,* 17(8), e0272523. https://doi.org/10.1371/journal.pone.0272523

UN Committee on Economic Social and Cultural Rights. (2000). *General Comment No. 14 on the Right to the Highest Attainable Standard of Health (art. 12). Document E/C.12/2000/4).* Office of the High Commissioner for Human Rights. Retrieved from https://www.refworld.org/docid/4538838d0.html

Unger, J. W. (2016). The interdisciplinarity of critical discourse studies research. *Palgrave Communications,* 2(15037), 1-4. doi:10.1057/palcomms.2015.37

United Nations General Assembly. (2015). *Transforming our world: The 2030 Agenda for Sustainable Development.* United Nations.

Vaismoradi, M., Moe, C. F., Vizcaya-Moreno, F., & Paal, P. (2021). Ethical tenets of PRN medicines management in healthcare settings: A clinical perspective. *Pharmacy,* 9(174). https://doi.org/10.3390/pharmacy9040174

Van den Berg, V. L. (2016). Still lost in translation: Language barriers in South African health care remain. *South African Family Practice,* 58(6), 229-231. https://doi.org/10.1080/20786190.2016.1223795

Vicary, S., Young, A., & Hicks, S. (2017). A reflective journal as learning process and contribution to quality and validity in interpretative phenomenological analysis. *Qualitative Social Work,* 16(4), 550-565. doi:10.1177/1473325016635244

Waldram, J. B. (2012). *Hound pound narrative: Sexual offender rehabilitation and the anthropology of therapeutic intervention.* University of California Press.

Wa-Mbaleka, S. (2019). Ethics in qualitative research: A practical guide. *International Forum,* 22(2), 116-132.

Weigand, E. (2009). *Language as dialogue. From rules to principles of probability*. (F. Sebastian, Ed.) Benjamins.

Weigand, E. (2010a). Language as dialogue. *Intercultural Pragmatics,* 7(3), 505/515. doi:10.1515/IPRG.2010.022

Weigand, E. (2010b). *Dialogue: The mixed game.* Benjamins.

Weigand, E. (2015). Dialogue in the stream of life. *Language and Dialogue,* 5(2), 197-223. doi:10.1075/ld.5.2.01wei

Weigand, E. (Ed.) (2017a). *The Routledge handbook of language and dialogue.* Routledge, Taylor & Francis.

Weigand, E. (2017b). IADA history: The unity of dialogue and its multiple faces. *Language and Dialogue,* 1. doi:DOI: 10.1075/ld.7.1.05wei

White, J., Phakoe, M., & Rispel, L. C. (2015). 'Practice what you preach': Nurses' perspectives on the code of ethics and service pledge in five South African hospitals. *Global Health Action,* 8(1), 1-8. https://doi.org/10.3402/gha.v8.26341

Williams, C., & Hunt, P. (2017). Neglecting human rights: Accountability, data and sustainable development goal 3. *The International Journal of Human Rights,* 21(8), 1114-1143. https://doi.org/10.1080/13642987.2017.1348706

Williams, M., & Moser, T. (2019). The art of coding and thematic exploration in qualitative research. *International Management Review,* 15(1), 45-55.

Wodak, R. & Meyer, M. (Eds.). (2016). *Methods of critical discourse studies (3rd ed.).* Sage.

Wodak, R. & Meyer, M. (2009). Critical discourse analysis: History, agenda, theory, and methodology. In R. Wodak & M. Meyer (Eds.), *Methods for critical discourse analysis* (pp. 1-33). Sage.

Wodak, R. (2015). Critical discourse analysis, Discourse-historical approach. In K. Tracy, C. Ilie, & T. Sandel (Eds.), *The International Encyclopedia of Language and Social Interaction* (5th ed.). JohnWiley & Sons, Inc. doi:10.1002/9781118611463/wbielsi116

Woogara, J. (2004). Patients' rights to privacy and dignity in the NHS. *Nursing Standards, 19*(18), 33-37.

World Health Organization. (1994). *A declaration on the promotion of patients' rights in Europe: European consultation on the rights of patients.* WHO Regional Office for Europe.

World Health Organization. (2021). *Global patient safety action plan 2021–2030: Towards eliminating avoidable harm in health care.* WHO.

World Health Organization Regional Office for Africa. (2013). *The state of health financing in the African region.* WHO. https://www.afro.who.int/sites/default/files/2017-06/state-of-health-financing-afro.pdf

World Health Organization and the United Nations Children's Fund (UNICEF). (2018). *A vision for primary health care in the 21st century: Towards universal health coverage and the sustainable development goals.* Geneva: WHO & UNICEF. doi:WHO/HIS/SDS/2018.15

Yakong, N. V., Rush, L. K., Bassett-Smith, J., Bottorff, L. J., & Robinson, C. (2010). Women's experiences of seeking reproductive health care in rural Ghana: Challenges for maternal health service utilization. *Journal of Advanced Nursing,* 66(11), 2431–2441. doi:10.1111/j.1365-2648.2010.05404.x

Yarney, L., Buabeng, T., Baidoo, D., & Bawole, J. N. (2016). Operationalization of the Ghanaian Patients' Charter in a peri-urban public hospital: Voices of healthcare workers and patients. *International Journal of Health Policy Management (IJHPM),* 5(x), 1-9. doi:10.15171/ijhpm.2016.42

Younas, A., Inayat, S., & Masih, S. (2022). Nurses' perceived barriers to the delivery of person-centred care to complex patients: A qualitative study using theoretical domains framework. *Journal of Clinical Nursing*, 1-14. doi:10.1111/jocn.16245

Zbikowski, A. (2014). *Counteracting abuse in health care from a staff perspective: Ethical aspects and practical implications.* Linkoping University Medical Dissertation No. 1406. Linkoping University, Sweden.

Zuckerman, K. E., Lindly, O.J., Sinche, B. K., & Nicolaidis, C. (2015). Parent health beliefs, social determinants of health, and child health services utilization among U.S. school-age children with autism. *Journal of Developmental and Behavioral Pediatrics,* 36(3), 146-57. doi:10.1097/DBP.0000000000000136

Zutah, J. T., Yin, E. T. Atupare, P. A. & Korankye-Sakyi, K. F. (2021). Licensed to kill: Contextualising medical misconduct, malpractice and the law in Ghana. *UCC Law Journal,* 1(2), 49-119.

Appendices

(A): Participant Recruitment Poster

Nurse-Patient Communication and Patients' Rights in the Healthcare Setting

https://www.fortinberrymurray.com/todays-research/science-can-make-your-meetings-better

Invitation to Participate in Research

Study Purpose:

To explore patient rights in nurse-patient clinical communication and interaction in the hospital setting

Participants required include nurses with 3+ years working experience in the hospital, patients, and patient caregivers:

Your experiences, perspectives, and practice on this topic are highly valued

If you are interested and willing to participate in this research project, please contact:

Abukari Kwame

(B) : Study Information Sheet

Hello,

My name is Abukari Kwame, and I am a doctoral candidate in Interdisciplinary Studies at the College of Graduate and Postdoctoral Studies, University of Saskatchewan, Canada.

I invite you to participate in a study that explores patients' rights in nurse-patient clinical communication and interactions in the hospital setting. As part of this study, I will be conducting individual interviews with nurses, patients, and their caregivers for a minimum of 30 minutes. I will also have separate focus groups with nurses, patients, and their caregivers for a minimum of 90 minutes. I will observe nurse-patient daily interactions in the hospital by noting how people talk to each other during interactions, how certain spaces are organized, and the hospital surrounding. Finally, I will collect and use documentary materials, including posters, patients' forms, administrative documents, among others. All these data sources are to help me understand how the hospital culture, practices, environment, human interactions, and spatial organizations and patterns influence nurse-patient communication, interaction, and patient rights.

If you agree to participate in this study, I will provide you more details about the study. You can ask questions if you don't understand something about the study. I will then ask you to provide me with your written or verbal consent for participation in the study.

I will invite you to participate in an individual semi-structured interview with me or a focus group discussion as part of the research process. During the interview or group discussion, the questions that I would ask are not sensitive and pertain to your experiences of nurse-patient communication practices and how that influences patients' rights in the hospital setting. I will record the conversation with a voice recorder if you permit that.

Your participation in the study is voluntary, and you can stop at any time you want. I will like to assure you that I will keep your identity anonymous and the information you provide confidential by not including your identity and identifying information in my fieldnotes, in the final report, or any publications of the study findings.

If you are interested in participating in this study, contact me at (**abk384@usask.ca**) or call my temporary phone number (0243671809).

Thank you.

(C): Consent Forms

(i): Participant Written Consent Form (Semi-structured Interviews)

Project Title: Nurse-patient communication and patients' rights in the healthcare setting.

Student Researcher:
Abukari Kwame
Ph.D. Candidate
College of Graduate and Postdoctoral Studies
University of Saskatchewan
Contact #: +13062039751/+233243671809

Supervisor/ The Principal Investigator (PI):
Pammla M. Petrucka
Professor of Nursing
University of Saskatchewan
College of Nursing, Regina Campus, Regina
Contact #: +1306-586-5139/306-966-6621

Introduction

I am inviting you to participate in an interview in a research project titled: Nurse-patient communication and patients' rights in the healthcare setting. Before you decide whether you want to participate in this project, you will need to understand what the study is about, the possible risks and benefits of the project for you, and your rights to help you make an informed decision, which is known as informed consent. Once you have read this form and have any questions, I will answer them. If you agree to participate in the study, you will write your full name, date, and sign the form or provide your thumb print or an oral consent. This will mean that you have given your informed consent. I will provide you with a copy to keep with you.

What the study is about, and the procedures involved

This study aims to explore nurse-patient communication and patients' rights during nurse-patient interaction in the healthcare setting. I am interested in examining communication practices between nurses, patients, and caregivers during nurse-patient interactions and how that affects patients' rights. I will also explore the barriers/facilitators of nurse-patient communication and how everyday practices and institutional cultures impact patients' rights in nurse-patient communications and interactions.

Procedure

If you agree to participate in this project, we will have an individual interview lasting 30 minutes. The interview is to help me learn about your personal experiences of nurse-patient communication. I will use a digital voice recorder to record the conversation with your permission, or I will listen attentively and make notes if you don't want me to record the interview. After the interview, I will transcribe it and if you need to review the transcript, I will provide you a copy to read, edit, and modify the information. You will have two weeks to make changes to the transcript and return it to me. If I do not receive your return transcript after two weeks, I will assume that you have no changes to make and will use the original copy with me as it is.

Risks and Discomfort

There are no known potential risks or discomfort associated with this study. You will only provide answers to short questions on your experiences about the topic. None of these questions require sensitive information. However, specific questions may remind you of some past traumatic experiences you may have had. When this happens, you may decide not to answer that question. As a voluntary participant, you can also choose to disengage in the process at any time you wish to, and there will be no consequences. You may contact **Mr. Alidu Alhassan** (mobile #: +233242606695), the Principal Nursing Officer (PNO), Yendi Hospital, in charge of counselling for free counselling services if you need support.

Potential benefits

You will learn and become aware of patients' rights and how nurse-patient communication practices may affect them. You can become aware of some of the things that make it difficult for nurses, patients, caregivers to speak nicely to each other. Your experiences can help nursing education train nurses to enhance effective communication during their interaction with patients, thereby promoting patients' rights and patient-centered care.

Confidentiality and keeping data

All the material that I will collect as part of this study will be kept confidential. I will ensure that no summaries or reports of the research findings contain information that can be traced back to you. When transcribing data, I will use pseudonyms or assign codes to all participants to protect their identities. I will keep all names, other identifying information, and your consent form in a separate file that only me and my supervisor will have access to. I will keep all data files on my password-protected university-managed laptop. All data files will be transferred to my supervisor's university OneDrive for safe storage for a minimum of five years post-publication and later destroyed.

Compensation

I will not be giving you any financial compensation for your participation in the study.

Dissemination of results

I will communicate aspects of this study's results to the hospital community using the hospital's internal radio system or through information leaflets and mini posters in the hospital wards. Furthermore, I will present some of the study's results at health research conferences in Ghana and abroad and publish peer-reviewed journals in Ghana or abroad. Lastly, I will organize the entire results in a Ph.D. dissertation report. A summary of the results will be available upon your request. Also, all research data will be retained with the University of Saskatchewan for a minimum of five years post-publication.

COVID-19 Safety Guide

Please, note that this research will be conducted in the Yendi hospital, Northern region, under the jurisdiction of Ghanaian public health. We are taking all safety precautions to reduce the risk of the spread of COVID-19 and expect you to follow public health directives as well.

- If you feel you are from a vulnerable group concerning COVID-19 effects (e.g., senior, immuno-compromised), please discuss your participation with the research team before consenting. You are under no obligation to participate, and nothing terrible will happen if you change your mind about participating in the research.

The following safety protocols must be followed:

1. Screening – for COVID-19 symptoms before your interview. Please answer these questions:

    a. Do you experience any of the following symptoms?

        • Fever and/or chills
        • New onset of cough or worsening chronic cough
        • Shortness of breath
        • Decrease or loss of sense of taste or smell
        • Unexplained fatigue/lethargy malaise muscle aches (myalgias)
        • Nausea/vomiting, diarrhea

    b. Have you tested positive for COVID-19 in the past 10 days or have you been told you have had contacts with someone who recently tested positive and need isolating?
    c. Have you travel outside of Ghana in the past 14 days?
    d. Have you had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?

2. Take appropriate precautions (including wearing a mask).
3. Wash your hands upon entrance to the building. Hand sanitizer will be available to you before, during, and after the interview.
4. Physical distancing will be maintained at all times, and the interviewer will wear a face mask. I will provide you with a mask if you don’t have one.
5. If you experience any COVID-19 symptoms prior to your interview, please let me know. We will postpone your interview until you are well again and have received a negative result from a COVID test.
6. Your personal details will be kept for contact tracing. These will be stored separately from the data. Please let me know if you receive a positive COVID test.
7. Please note that I will keep your contact details for up to 4 weeks in case you tested positive for Covid-19. I will discuss with you and provide your contact to **Mr. Adjei Domfeh Charles**, the Technical Officer from the disease control department in charge of Covid-19 outreach, to help them in contact tracing. The contact tracing team are obligated to keep confidential the names of persons who have tested positive for COVID. Hence, the contact tracing team and I will keep your identity confidential if you tested positive for COVID.

Right to Withdraw

Your participation is voluntary, and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort. If you do wish to withdraw, please contact me (the student researcher) and I will permanently and irrevocably destroy the record of your interview within four weeks after your participation has ended. Whether you choose to participate or not will have no effect on your position (e.g., employment or access to healthcare services) or how you will be treated in the hospital.

Contact Information

If you have any questions regarding this study, please contact me at (abk384@usask.ca) or my supervisor, Professor Pammla Petrucka, at (pammla.petrucka@usask.ca) or +1306-586-5139

This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office at (ethics.office@usask.ca); you may also call the REB collect +1-306-966-2975. You can also contact the Ghana Health Service Ethics Review Committee at (ethics.research@ghsmail.org) or call 0503539896.

By signing below, or by providing your fingerprint (thumbprint), you agree that:

- You have read this consent form (or it has been read to you), and that you have asked questions to understand everything
- All foreseeable risks have been explained to your satisfaction
- You understand that the University of Saskatchewan has no policy or plan to pay for any injuries you might receive from participating in this research protocol. However, the researcher has arranged with the hospital counselor to provide you support if you have a traumatic experience.
- You are 18 years of age or older
- Your participation in this study is voluntarily
- You may change your mind and stop participating at any time without a penalty.
- That I can make a follow-up for clarification, for additional data, or for you to check your transcript.

___________________________	____________________	________
Name of Participant	Participant's Signature/Thumbprint	Date

____________________	____________
Researcher's Signature	Date

Oral Consent:

I read and explained this consent form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

_________________________	____________________	___________
Name of Participant	Researcher's Signature	Date

(ii): Participant Consent Form (For Focus Groups)

Project Title: Nurse-patient communication and patients' rights in the healthcare setting.

Student Researcher:
Abukari Kwame
Ph.D. Candidate
College of Graduate and Postdoctoral Studies
University of Saskatchewan
Contact #: +13062039751/+233243671809

Supervisor/ The Principal Investigator (PI):
Pammla M. Petrucka
Professor of Nursing
University of Saskatchewan
College of Nursing, Regina Campus, Regina
Contact #: +13065865139/306-966-6621

Introduction

I am inviting you to participate in a focus group in a research project titled: **Nurse-patient communication and patients' rights in the healthcare setting**. Before you decide whether you want to participate in this project, you will need to understand what the study is about, the possible risks and benefits of the project for you, and your rights to help you make an informed decision, which is known as informed consent. Once you have read this form and have any questions, I will answer them. If you agree to participate in the study, you will write your full name, date, and sign the form or provide your thumb print or an oral consent. This will mean that you have given your informed consent. I will provide you with a copy of this form to keep with you.

What the study is about, and the procedures involved

This study aims to explore nurse-patient communication and patients' rights during nurse-patient interaction in the healthcare setting. I am interested in examining communication practices between nurses, patients, and caregivers during nurse-patient interactions and how that affects patients' rights. I will also explore the barriers/facilitators of nurse-patient communication and how everyday practices and institutional cultures impact patients' rights in nurse-patient communications and interactions.

Procedure

If you agree to participate in this project, you will join a focus group lasting 50-60 minutes. The group will have five (5) participants, including me. I will moderate the discussion and record the conversation. After the focus group, I will transcribe the recording.

Risks and Discomfort

There are no known potential risks or discomfort associated with this study. You will only provide answers to short questions on your experiences about the topic. None of these questions require sensitive information. However, specific questions may remind you of some past traumatic experiences you may have had. When this happens, you may decide not to answer that question. As a voluntary participant, you can also choose to disengage in the process at any time you wish to, and there will be no consequences. You may contact **Mr. Alidu Alhassan** (mobile #: +233242606695), the Principal Nursing Officer (PNO), Yendi Hospital, in charge of counselling for free counselling services if you need support.

Potential benefits
You will learn and become aware of patients' rights and how nurse-patient communication practices may affect them. You can become aware of some of the things that make it difficult for nurses, patients, caregivers to speak nicely to each other. Your experiences can help nursing education train nurses on ways to enhance effective communication during their interaction with patients, thereby promoting patients' rights and patient-centered care.

Confidentiality and keeping data
All the material that I will collect as part of this study will be kept confidential. I will ensure that no summaries or reports of the research findings contain information that can be traced back to you. When transcribing data, I will use pseudonyms or assign codes to all participants to protect their identities. I will keep all names, other identifying information, and your consent form in a separate file that only me and my supervisor will have access to. I will keep all data files on my password-protected university-managed laptop. All data files will be transferred to my supervisor's university OneDrive for safe storage for a minimum of five years post-publication and later destroyed.

The researcher will undertake to safeguard the confidentiality of the discussion but cannot guarantee that other members of the group will do so. Please respect the confidentiality of the other members of the group by not disclosing the contents of this discussion outside the group and be aware that others may not respect your confidentiality. Therefore, do not share any sensitive information about yourself or others during the focus group discussion.

Compensation
I will not be giving you any financial compensation for your participation in the study.

Dissemination of results
I will communicate aspects of this study's results to the hospital community using the hospital's internal radio system or through information leaflets and mini posters in the hospital wards. Furthermore, I will present some of the study's results at health research conferences in Ghana and abroad and publish peer-reviewed journals in Ghana or abroad. Lastly, I will organize the entire results in a Ph.D. dissertation report. A summary of the results will be available upon your request. Also, all research data will be retained with the University of Saskatchewan for a minimum of five years post-publication.

COVID-19 Safety Guide

This research will be conducted in the Yendi hospital, Northern region, under the jurisdiction of Ghanaian public health. We are taking all safety precautions to reduce the risk of the spread of COVID-19 and expect you to follow public health directives as well.

- If you feel you are from a vulnerable group concerning COVID-19 effects (e.g., senior, immuno-compromised), please discuss your participation with the research team before consenting. You are under no obligation to participate, and nothing terrible will happen if you change your mind about participating in the research.

The following safety protocols must be followed:

1. Screening – for COVID-19 symptoms before your interview. Please answer these questions:

    a. Do you experience any of the following symptoms?

        • Fever and/or chills
        • New onset of cough or worsening chronic cough
        • Shortness of breath
        • Decrease or loss of sense of taste or smell
        • Unexplained fatigue/lethargy malaise muscle aches (myalgias)
        • Nausea/vomiting, diarrhea

    b. Have you tested positive for COVID-19 in the past 10 days, or have you been told you have had contacts with someone who recently tested positive and need isolating?

    c. Have you travel outside of Ghana in the past 14 days?

    d. Have you had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?

2. Take appropriate precautions (including wearing a mask).
3. Wash your hands upon entrance to the building. Hand sanitizer will be available to you before, during, and after the interview.
4. Physical distancing will be maintained at all times, and the interviewer will wear a mask. I will provide you with a mask if you don’t have one.
5. If you experience any COVID-19 symptoms prior to your interview, please let me know. We will postpone your interview until you are well again and have received a negative result from a COVID test.
6. Your personal details will be kept for contact tracing. These will be stored separately from the data. Please let me know if you receive a positive COVID test.
7. Please, I will keep your contact details for up to 4 weeks in case you tested positive for Covid-19. I will discuss with you and provide your contact to **Mr. Adjei Domfeh Charles**, the Technical Officer from the disease control department in charge of COVID-19 outreach, to help them in contact tracing. The contact tracing team are obligated to keep confidential the contact of persons who have tested positive for COVID. Hence, the contact tracing team and I will keep your identity confidential.

Right to Withdraw

Your participation is voluntary, and you can participate in only those discussions that you are comfortable with. You may withdraw from the research project for any reason, without explanation or penalty of any sort. Should you wish to withdraw, you may leave the focus group at any time; however, data that have already been collected cannot be withdrawn as it forms part of the context for information provided by other participants.

Contact Information
If you have any questions regarding this study, please contact me at (abk384@usask.ca) or my supervisor, Professor Pammla Petrucka, at (pammla.petrucka@usask.ca) or +1306-586-5139

This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office at (ethics.office@usask.ca); you may also call the REB collect +1-306-966-2975. You can also contact the Ghana Health Service Ethics Review Committee at (ethics.research@ghsmail.org) or call 0503539896.

By signing below, or by providing your fingerprint (thumbprint) you agree that:

- You have read this consent form (or it has been read to you), and that you have asked questions to understand everything
- All foreseeable risks have been explained to your satisfaction
- You understand that the University of Saskatchewan has no policy or plan to pay for any injuries you might receive from participating in this research protocol. However, the researcher has arranged with the hospital counselor to provide you support if you have a traumatic experience.
- You are 18 years of age or older
- Your participation in this study is voluntarily
- You may change your mind and stop participating at any time without a penalty.
- That I can make a follow-up for clarification.

__________________________ ____________________ ________

Name of Participant Participant’s Signature/Thumbprint Date

____________________ ____________

Researcher’s Signature Date

Oral Consent:

I read and explained this consent form to the participant before receiving the participant’s consent, and the participant had knowledge of its contents and appeared to understand it.

________________________ ____________________ ___________

Name of Participant Researcher’s Signature Date

(iii): Consent Form for Participant Observations of one-on-one interactions

Project Title: Nurse-patient communication and patients' rights in the healthcare setting.

Student Researcher:
Abukari Kwame
Ph.D. Candidate
College of Graduate and Postdoctoral Studies
University of Saskatchewan
Contact #: +1306-203-9751/+233243671809

Supervisor/ The Principal Investigator (PI):
Pammla M. Petrucka
Professor of Nursing
University of Saskatchewan
College of Nursing, Regina Campus, Regina
Contact #: +1306-586-5139/306-966-6621

Introduction

I am inviting you to participate in a research project titled: **Nurse-patient communication and patients' rights in the healthcare setting.** Before you decide whether you want to participate in this project, you will need to understand what the study is about, the possible risks and benefits of the project for you, and your rights to help you make an informed decision, which is known as informed consent. Once you have read this form and have any questions, I will answer them. If you agree to participate in the study, you will write your full name, date, and sign the form or provide your thumb print or an oral consent. This will mean that you have given your informed consent. I will provide you with a copy of this form to keep with you. I will observe nurses' and patients' interactions in this space to gain first-hand experience of the daily practices, communication patterns, and social interactions in the hospital.

What the study is about

This study aims to explore nurse-patient communication and patients' rights during nurse-patient interaction in the healthcare setting. I am interested in examining communication practices between nurses, patients, and caregivers during nurse-patient interactions and how that affects patients' rights. I will also explore barriers/facilitators of nurse-patient communication and how everyday practices and institutional cultures impact patients' rights in nurse-patient communications and interactions.

Procedures

I intend to observe everyday nurse-patient interactions to experience first-hand how these interactions unfold. I will conduct observations of activities and meetings on-site. Each observation session is expected to last for the entire duration of the activity, although you can request that I leave at any time without giving a reason. Our observations will include the interactions between nurses and patients, nurses and caregivers, spaces, and spatial organization patterns. Specifically, observations will look out for how the people involved in the activity communicate to each other, the physical layout/setting of where the activity is occurring, and the objects or things present and used to aid the activity.

Please feel free to ask any questions regarding the procedures and goals of the study or your role.

Potential Risks

There are no known or anticipated risks to the respondents in this study. This research is considered to be of minimal risk to you. Your privacy will be respected during any observation session. However, if you need support, you may contact **Mr. Alidu Alhassan** (mobile #: +233242606695), the Principal Nursing Officer (PNO), Yendi Hospital, in charge of counselling for free counselling services if you need support.

Potential Benefits

The benefit to you is the possibility of reflecting on how nurses and patients interact and the role communication play in these interactions. You will also be providing information that will contribute to nurse-patient communication and interaction in the hospital setting that can help improve therapeutic communication and patient-centered care. The insights and understanding derived from this study may inform policy, practice, and research.

Confidentiality and keeping data

All the material that I will collect as part of this study will be kept confidential. I will ensure that no summaries or reports of the research findings contain information that can be traced back to you. When transcribing data, I will use pseudonyms or assign codes to all participants to protect their identities. I will keep all names, other identifying information, and your consent form in a separate file that only me and my supervisor will have access to. I will keep all data files on my password-protected university-managed laptop. All data files will be transferred to my supervisor's university OneDrive for safe storage for a minimum of five years post-publication and later destroyed.

Compensation

No monetary compensation will be provided to you for participating in this study.

Dissemination of results

I will communicate aspects of this study's results to the hospital community using the hospital's internal radio system or through information leaflets and mini posters in the hospital wards. Furthermore, I will present some of the study's results at health research conferences in Ghana and abroad and publish peer-reviewed journals in Ghana or abroad. Lastly, I will organize the entire results in a Ph.D. dissertation report. Soft copies of the study reports and links to published articles will be available upon your request. Also, all research data will be retained with the University of Saskatchewan for a minimum of five years post-publication.

COVID-19 Safety Guide

Please, note that this research will be conducted in the Yendi hospital, Northern region, under the jurisdiction of Ghanaian public health. We are taking all safety precautions to reduce the risk of the spread of COVID-19 and expect you to follow public health directives as well.

- If you feel you are from a vulnerable group concerning COVID-19 effects (e.g., senior, immuno-compromised), please discuss your participation with the research team before consenting. You are under no obligation to participate, and nothing terrible will happen if you change your mind about participating in the research.

The following safety protocols must be followed:

1. Screening – for COVID-19 symptoms before your interview. Please answer these questions:

    a. Do you experience any of the following symptoms?

    • Fever and/or chills
    • New onset of cough or worsening chronic cough
    • Shortness of breath
    • Decrease or loss of sense of taste or smell
    • Unexplained fatigue/lethargy malaise muscle aches (myalgias)
    - Nausea and vomiting

    b. Have you tested positive for COVID-19 in the past 10 days or have you been told you have had contacts with someone who recently tested positive and need isolating?

    c. Have you travel outside of Ghana in the past 14 days?

    d. Have you had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?

2. Take appropriate precautions (including wearing a mask).
3. Wash your hands upon entrance to the building. Hand sanitizer will be available to you before, during, and after the interview.
4. Physical distancing will be maintained at all times, and the interviewer will wear a mask. I will provide you with a mask if you don’t have one.
5. If you experience any COVID-19 symptoms prior to your interview, please let me know. We will postpone your interview until you are well again and have received a negative result from a COVID test.
6. Your personal details will be kept for contact tracing. These will be stored separately from the data. Please let me know if you receive a positive COVID test.
7. Please, I will keep your contact details for up to 4 weeks in case you tested positive for Covid-19. I will inform you and provide your contact to **Mr. Adjei Domfeh Charles**, the Technical Officer from the disease control department in charge of COVID-19 outreach, to help them in contact tracing. The contact tracing team are obligated to keep confidential the names of persons who have tested positive for COVID. Hence, the contact tracing team and I will keep your identity confidential if you tested positive for COVID.

Right to Withdraw

Your participation is voluntary, and you can participate in only those discussions that you are comfortable with. You may withdraw from the research project for any reason, without explanation or penalty of any sort. Should you wish to withdraw, you may leave the observation at any time; however, data that have already been collected cannot be withdrawn as it forms part of the context for information provided by other participants.

Contact Information

If you have any questions regarding this study, please contact me at (abk384@usask.ca) or my supervisor, Professor Pammla Petrucka, at (pammla.petrucka@usask.ca) or +1306-586-5139.

This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office at (ethics.office@usask.ca) ; you may also call collect the REB collect +1-306-966-2975. You can also contact the Ghana Health Service Ethics Review Committee at (ethics.research@ghsmail.org) or call 0503539896.

By signing below, or by providing your fingerprint (thumbprint), you agree that:

- You have read this consent form (or it has been read to you), and that you have asked questions to understand everything
- All foreseeable risks have been explained to your satisfaction
- You understand that the University of Saskatchewan has no policy or plan to pay for any injuries you might receive due to participating in this research protocol. However, the researcher has arranged with the hospital counselor to provide you support if you have a traumatic experience.
- You are 18 years of age or older
- Your participation in this study is voluntarily
- You may change your mind and stop participating at any time without a penalty.
- I will assign you a pseudonym for use in data collecting and reporting. All recordings and field notes will be identifiable by pseudonyms only.
- The consent form with your name will be stored separately from all data collected.
- I will maintain a single master list connecting your identity to the pseudonym on the datasheet. This master list will be destroyed upon completion of the study to protect your confidentiality.

I consent to participate in the research project.

____________________________	_____________________	________
Name of Participant	Participant's Signature/Thumbprint	Date
_____________________		____________
Researcher's Signature		Date

Oral Consent:

I read and explained this consent form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

_________________________	_____________________	___________
Name of Participant	Researcher's Signature	Date

(iv): Ghana Health Service Ethics Review Committee
Application for Ethics Approval for Research with Human Participants

Consent Form

STUDY TITLE: **Nurse-Patient Communication and Patients' Rights in the Healthcare Setting**

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and all questions satisfactorily explained to me in a language I understand (*Dagban*i/English). I fully understand the contents and any potential implications as well as my right to change my mind (i.e., withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name of Participant…………………………..

Participants' Signature ……………………...OR Thumb Print……………………………

Date:………………………………….

INTERPRETERS' STATEMENT

I interpreted the purpose and contents of the Participants' Information Sheet to the afore named participant to the best of my ability in the (*Dagbani/English*) language to his proper understanding.

All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter……………………………

Signature of Interpreter……………………….. OR Thumb Print ……….........................

Date:………………………

STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language he/she understood (Dagbani/English*)*

I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name:…………………………

Signature………………………….. OR Thumb Print ……….............................

Date:……………………………

INVESTIGATOR STATEMENT AND SIGNATURE

Brief statement or declaration that investigator has given enough information to participants to make informed decisions. (Example: I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.)

Researcher's name……………………………………….

Signature ………………………………………………….

Date…………………………………………………………….

(D): Participant Transcript Release Form

Project Title: Nurse-patient communication and patients' rights in the healthcare setting

I, ___________________________________, have received and reviewed the complete transcript of my personal interview in this study. I have been provided with the opportunity to add, alter, clarify, and or delete information from the transcript. I acknowledge that the transcript accurately reflects what I said during my interview with **Abukari Kwame**. I hereby release this transcript to **Abukari Kwame** to be used in the manner outlined in the Consent Form. I have received a copy of this form for my own records.

Participant's Name __________________ Signature/Thumbprint___________ Date ______

Researcher's Signature ___________ Date __________

Note

The student researcher will read and translate the transcript to participants who cannot read it for validation, addition, alteration, and clarification. When they are satisfied with the transcript's content, they can provide a fingerprint (thumbprint) using the stamp pat provided and have their names written in the appropriate slots; then, I will sign and date the Form.

(E): Participant Observation Guides

During this participant observation, I will position myself as a moderate participant-observer, which means that I will be in the healthcare setting observing people, places, events, interactions, and objects as nurses interact with patients and caregivers. Moderate participation will allow me to observe happenings in the healthcare setting without claiming a patient, caretaker, or nurse status. I will only engage in minimal conversation with these participants in the healthcare setting when necessary. I am also aware that participant observation invokes some ethical issues and requires reflexive engagement on my part. Therefore, as part of seeking approval from the hospital, I will clarify that participant observation of daily nurse-patient interaction will be one of my data collection methods. Since I will also be doing these observations in different wards (e.g., at the dispensary, emergency ward, out-patients department (OPD), and during consultations), I will inform all officials in charge of these departments that I would be undertaking participant observations at those units. For participant observations during medical consultations, I will ask for permission from both the nurse and patients to observe their interactions. Note that medical assistants who are senior nurses consult in this hospital. Observing nurse-patient interaction and focusing on places, people, events, and things may not be isolated. For example, I can observe different settings or events at timely intervals of one hour on a particular day. Also, I can dedicate a whole day to observing just one phenomenon across different settings within the hospital. The following are questions to guide my ethnographic observations in this project.

a. Observing the setting (wards, dispensary, OPD, etc.)

1. Where is the place located in the hospital?
2. How is the place set up?
3. Is there a waiting schedule, and how is it conducted?
4. Is the place welcoming, and how are privacy issues handled?
5. What is the order of interacting with patients or caregivers at this place?
6. How is communication done between patients, caregivers, and nurses at this place?

Date________________ Place _________________ Time/Duration _____________

b. Observing patients' and nurses' behaviour patterns

1. What kinds of patients come to this ward (e.g., dispensary, consulting room, OPD, etc.)? – younger, older, educated, uneducated? And why these categories?
2. How do patients and nurses talk to each other here? – who has agency, power, control, etc.)
3. Are patients allowed to ask questions, make suggestions, and voice their concerns, and how are these handled?
4. How does nurse-patient communication go on here?
    - ✓ Is it the same for every patient and caretaker, or are there differences?
    - ✓ If there are differences, what accounts for the differences in communication patterns?

5. Are patients and nurses treated or talked to each other with respect? If Yes, how, and if no, why?

Date ____________ Location _________________ Time/Duration __________

c. Time of the day and activities

1. What time of the day do patients come to this setting the most? - early morning, afternoon, evening, night?
2. Why do patients and caregivers come to this setting at particular times of the day?
3. Who accompanies patients to this place (relatives, significant others, children)?
4. How do nurses communicate or speak to patients and caregivers at this time of the day?
5. Are nurse-patient interactions or how nurses talk to patients and caregivers throughout this period of the day the same? If not, why the differences?
    - ✓ If nurse-patient communication practices and patterns differ by time of the day, what might be responsible for that?

Date ________________ Location _____________________ Time/Duration ______

d. Observing people interactions (nurses, patients, and caregivers)

1. Who and who is interacting here (nurses, patients, caregivers)?
2. How do nurses talk to patients/caregivers and vice versa?
    - ✓ Do they appear friendly, not friendly, approachable, or not, etc.?
3. How is information delivered to patients and caregivers by nurses?
4. Are there any language barriers between nurses and patients/caregivers, and how are these resolved?
5. Do patients, caregivers, and nurses treat one another with dignity? How is that done?
6. What services are available to patients in this setting, and how are these presented to patients?
7. How are the routines of this place organized, and how much time do patients spend with nurses?
    - ✓ Are nurses rushing or providing much time to talk about patients' conditions when taking patients' histories, discussing treatment plans, etc.?
8. Do nurses obtain permission from patients before carrying out certain routine checks, and do nurses explain to patients why the checks/procedures are necessary?
9. Do nurses, patients, and caregivers use 'dignified language,' 'harsh tone, or 'shout' when talking to one another?
10. Are nurses, patients, and caregivers being aggressive (physically, verbally, or both), insulting, and supportive to each other when communicating?
11. What things/factors influence how people interact in this space?

Date ______________ Location ________________Time/Duration ___________

(F): Interview Guide for Patients

Introductory Rubrics

Welcome, and thank you for making time to have this conversation with me. As you saw in the invitation letter and the consent form, I am conducting a study on patient rights in nurse-patient clinical communication and interactions in the hospital setting. With this interview, I am interested in your perspectives, experiences, and knowledge about the topic. There is no right or wrong answer. Also, I would like to record the interview with a voice recorder, with your permission, so that I can later listen if I cannot remember everything in my head. However, if you disagree with that, I can listen attentively and make notes from time to time. You can choose not to answer some questions or stop the interview as and when you deem fit. Our discussion will cover several areas to help me understand the topic. Therefore, the interview will last between 30 to 45 minutes.

<u>Please ensure that you do not identify anyone else by name.</u>

Opening conversation

a. How do you feel this morning/afternoon (depending on the time of the interview)?
b. How long have you been here, and are you getting improvements?

Interview Questions

1. Now let's talk about how you got here and the processes you went through.
   Probe: Did you come here by yourself, or were you accompanied, and by whom?
   Probe: Describe to me the processes you went through and who helped you.

2. Tell me about your typical interaction with your nurse (no name is required).
   Probes: How did the nurse talk during this interaction, were you allowed to ask questions, and did he/she explain things to your understanding?

3. Have you had some experience/s with other nurses that you can say was/were different from this nurse?
   Tell me how that was and what made it different.

4. Do you know about the Ghanaian patient's charter?
   Probe: Tell me what you know about the charter.

5. What would you say has been the most challenging thing here for you?
   Probes: During your interaction with the nurse, what difficulties did you experience, and how did the nurse help you through that?
   Probe: Have you experienced being treated in a way that violated your privacy or confidentiality? Tell me more about that experience.

6. When you meet with your nurse, what are some of your expectations?
   Probe: What things do you wish that your nurse should tell you about your health condition?
   Probe: How did the nurse meet or not meet those expectations?
   Probe: Have you experienced being unattended by a nurse when you needed care? Please, explain what happened.

7. How will you describe your communication with the nurse?
   Probe: How does the nurse talk to you? Is he/she able to ask for your input, and concerns or allow you to ask questions?
   Probe: How do you and your nurse handle disagreements

8. What are some of the things that make you feel happy or satisfied when talking with your nurse?
   Probe: Are you allowed to make decisions or to participate in the decision-making process?
   Probe: When they prescribe drugs for you, do they ask how you feel about those drugs?

9. Now I want us to talk about how the nurses communicate with other patients here. How do the nurses talk to the other patients in the ward?
   Probe: Have you noticed any differences in how nurses talk to some patients?
   Probe: What differences do you notice between you and those other patients?
   Probe: What do you think makes nurses talk differently to different patients?

10. Now, think about all the interactions you have had with all the nurses in this hospital. What is your impression of a good nurse (No name is required)?
    Probe: Describe how a good nurse interacts or talks with patients.
    Probe: Tell me what will make you feel that a nurse is lousy. Or
    Tell me how a lousy nurse interacts or talks to patients.

11. How does the information nurses give you help you understand your health condition?
    Probe: How did the nurse talk to you that helped you to understand your condition?
    Probe: Did the nurse ask you questions to help him/her understand your condition?
    Probe: How did he/she treat your responses to the questions they ask you?

12. When your nurse talks to you, does the way he/she talks differ from her body language?
    Probe: Do their facial expressions or body posture look different than what they say?
    Probe: How is their tone when they speak or talk to you?
    Probe: Did any nurse talk to you or use a tone or facial expression that made you feel uncomfortable? Please describe that to me.

13. If you were to whisper into the hospital matron/manager's ears about how nurses talk to patients/caregivers, what would you tell him/her to do to change the situation?

Alert the participant about the closure of the interview.

14. Do you know about the patient's charter and what it says about patient rights?
    Probe: Are you aware that there is a patient's charter in this country?
    Probe: Do you know what the charter says about patient rights? Please, explain.

Demographics

15. I would like to have some additional information about you. Let's start with these:
    a. How do you identify your gender?
    b. What is your native language, and which other Ghanaian languages do you speak?
    c. What is your age?
    d. What work do you do?
    e. What is your level of education?

16. Is there anything that I haven't asked you concerning the topic that you think I should have?
    Probe: Do you think of any other relevant question/s that I should include in this interview guide?
    Probe: Do you have any question/s you would like to ask me?

Thank you for your time.

(G): Interview Protocol for Caregivers

Introductory Rubrics

Welcome, and thank you for making time to have this conversation with me. As you saw in the invitation letter and during the consent process, I am conducting a study on patient rights in nurse-patient clinical communication and interaction in the hospital setting. I want to get your perspectives, experiences, and knowledge about the topic. There is no right or wrong answer. Also, I would like to record the interview with a voice recorder, with your permission, so that I can later listen to it if I cannot remember everything in my head. However, if you disagree with that, I can listen attentively and make notes from time to time. You can choose not to answer some questions or stop the interview as and when you deem fit. Our discussion will cover several areas to help me understand the topic. Therefore, the interview will last between 30 to 60 minutes.

Please ensure that you do not identify anyone else by name.

Opening questions

1. Who are you providing care for, and how long have you been staying in the hospital?
   Probe: Are you caring for a male or female patient and your relationship with them?
   Probe: When did you and your patient come to this hospital?

Interview questions

2. How do you feel about the way nurses talk to patients and caregivers in this hospital?
   Probe: What is your experience regarding how nurses talk to patients/caregivers?
   Probe: Do you feel that how nurses talk to patients/caregivers is good/bad, and why?
   Probe: Tell me about your experiences with how nurses talk to patients/caregivers.

3. Please describe a typical conversation you have had with a nurse that you think was good or bad.
   Probe: What was the situation about, and how did your conversation go?
   Probe: What made it a good or bad experience?

4. In providing care for your relative (the patient), are you allowed to ask questions or make suggestions when talking with the nurses?
   Probe: If you are not allowed, what is/are the reason/s?
   Probe: If you are allowed, are your questions or concerns addressed/taken?

5. What do you think are the factors that cause disagreements between nurses and caregivers?
   Probe: Please, explain the factors to me and their sources.
   Probe: What can be done to minimize these?

6. What do you think are the factors that make it easy or difficult for nurses and caregivers to have smooth conversations?
   Probe: Please state and tell me more about the factors, starting with those that make communication with nurses easy.
   Probe: What are the factors that make it hard to communicate or interact with nurses?
   Probe: What do you suggest should be done about these issues?

7. Do you know about the Ghanaian patient's charter?
   Probe: Please, tell me what you know about the charter.

8. Would you say nurses use or do not use language appropriately with you as a caretaker? And why?
   Probe: What makes it appropriate or not regarding how nurses speak with you?

9. Have you had any personal encounters with a nurse concerning how they talk to you?
   Probe: Please tell me more about that encounter.
   Probe: Was this experience a positive one? Please explain.
   Probe: Was it a negative experience? Please, explain.

10. Do you think how nurses talk to caregivers affects caregivers' participation in their patients' care process?
    Probe: In what ways can nurses' language use affect caregivers' engagement in the care process?
    Probe: Would you say that the way nurses talk to caregivers positively or negatively affects their participation in the care process? Please, explain.

11. Please describe to me how you would want nurses to talk to you as a caretaker.
    Probe: Does the way nurses talk to you or your patient shows respect? Why or why not?
    Probe: Are caregivers or their patients allowed to make decisions about their health conditions when interacting with nurses?

12. Have you or another caretaker had a hostile confrontation with a nurse due to how the nurse talked to you or your patient? If yes, please explain what happened.
    Probe: Did any nurse talk to you/your patient or use body language that made you feel uncomfortable? Please, describe what happened.

13. What things make you feel good or disappointed when talking to nurses?
    Probe: Do you feel that nurses talk differently to different caregivers and patients? Please explain why you think so.
    Probe: Please describe how you observe a nurse talk differently to your patient and other patients or you and other caregivers.

14. How would you describe a good nurse and a nasty nurse?
    Probe: How does a good nurse talk to patients or their caregivers?

Probe: How does a lousy nurse talk to patients or their caregivers?

A few more questions before we end the conversation.

15. Please provide me with the following information:
    a. How do you identify your gender?
    b. What is your native language, and which other Ghanaian languages do you speak?
    c. What is your age?
    d. What work do you do?
    e. What is your level of education?

16. Is there anything you wanted us to talk about that was not captured in this interview?
    Probe: Have we missed some questions that you think would be important for me to consider?
    Probe: Do you have any questions for me concerning this interview or the project?

Thank you for your time.

(H): Interview Guide for Nurses

Introductory Rubrics

Welcome, and thank you for making time to have this conversation with me. As you saw in the invitation letter and during the consent process, I am conducting a study on patients' rights in nurse-patient clinical communication and interaction in the hospital setting. I want to get your perspectives, experiences, and knowledge about the topic. There is no right or wrong answer. Also, I would like to record the interview with a voice recorder, with your permission, to listen to it later if I cannot remember everything in my head. However, if you disagree with that, I can listen attentively and make notes from time to time. You can choose not to answer some questions or stop the interview as and when you deem fit. Our discussion will cover several areas to help me understand the topic. Therefore, the interview will last between 30 to 60 minutes. I hope we can go through that.

Please ensure that you do not identify anyone else by name.

Opening the Interview

1. So, tell me, how was your day today at the hospital?
   Probe: How many patients did you attend today?
   Probe: How was the nature of the patients you managed today?

Interview Questions

Now let's get the interview started.

2. When you are receiving a new patient, what are the things do have to do?
   Probe: How do you usually start a conversation with your new patients?
   Probe: Describe to me the interaction process when you first meet a patient.

3. What are some exciting or challenging conversations that you have had with a patient?
   Probe: What was the exciting or challenging conversation about?
   Probe: What made the conversation exciting or challenging?

4. How would you describe the way you talk to your patients?
   Probe: Is it more professionally or informally based?
   Probe: Why do you choose that particular approach?

5. How do your patients feel about the way you talk to them?
   Probe: Are you able to tell if your patient is satisfied, happy, bothered, or unhappy after your interaction with them?
   Probe: How do you know whether a patient understands what you tell him?

6. Do you know the Ghanaian patient's charter?
   Probe: Please, tell me what you know about the charter.
7. How do your professional ethics and the patient's charter influence how you speak to your patients?
   Probe: How do you engage patients in the care process when communicating with them?
   Probe: What influences the way you engage patients when communicating with them?

8. When discussing treatment issues with a patient, what do you do to promote their understanding and acceptance of the plan?
   Probe: How do you address the patient's concerns during that discussion?
   Probe: How do you get your patient to be part of the care process?

9. Please, describe a typical situation at a time you needed to decide something with a patient.
   Probe: What was the situation about?
   Probe: How did you go about the decision-making process?
   Probe: How did you handle the patient's inputs, suggestions, or questions?

10. What are the things you think could cause disagreements between you and a patient when communicating or interacting with them?
    Probe: Please explain these factors to me.
    Probe: Why do you think these are the factors that could cause disagreements and not others?

11. How do you feel when your patient disagrees with you or fails to listen to you?
    Probe: Do you feel the patient did not understand you?
    Probe: What do you think could be the reason?
    Probe: When your patient disagrees with you, does that make you feel powerless, disrespected, or less critical?

12. During your interaction with patients, do you tell them what they can or cannot do and why or why not?
    Probe: Do you inform your patients about their rights and responsibilities? Why or why not?
    Probe: Do you usually provide patients with alternatives when making choices?
    Probe: Who mostly makes the decisions concerning treatment options when interacting with patients, and why?

13. What does it mean to be a caring nurse?
    Probe: What does a caring nurse do that makes him/her different from other nurses?
    Probe: Describe how a typical caring nurse carries out his/her practices?
    Probe: Who would you say is an example of a typical caring nurse in this hospital and why?

Prompt the participant that the interview is almost coming to an end

14. For the period you have worked in this hospital, what has surprised you about nurse-patient communication?
    Probe: Please, describe what the situation or event was about.
    Probe: How did you feel about that, or why was it a surprise to you?

15. What influences how you talk to patients?
    Probe: Do you talk differently to different patients, and why?

16. If you were asked to identify all the factors that affect how nurses talk to patients, what would these factors be?
    Probe: Identify all the factors and say why you think they are the main issues.
    Probe: If you had the chance to advise all other nurses about how they talk to patients, what will your message be?

Now I will need you to provide me with your demographic data

17. Please tell me the following:
    a. What will you say your gender is?
    b. What is your native language, and what other languages do you speak?
    c. What is your area of specialization?
    d. Please, tell me your age.
    e. What is your level of education?

18. Is there anything you wanted us to add that we have not talked about?
    Probe: Have we missed some questions that you think would be important for me to consider?
    Probe: Do you have any questions for me concerning this interview or the project?

Thank you for your time.

(I): Focus group guide for patients

Introductory Rubrics

I wish to welcome everyone to this focus group. This discussion aims to explore your perceptions, experiences, perspectives, knowledge, and interpretations of nurse-patient communication practices and their influence on patients' rights during nurse-patient clinical interactions. The questions that I will ask will target both your individual experiences and collective perspectives on the topic. So, there are no wrong or correct answers. The important thing I am looking for is your experiences and perspectives, as patients. Also, feel free to challenge others' opinions, but let's do so with respect. If you all permit it, I would like to record the conversation to refer to it later if I cannot capture everything in notes. There will not be a moderator, so I will be asking the questions as well as making some notes whenever I can. I would like to point out one important reminder. Since this is a focus group, I cannot guarantee that every piece of information shared here will be kept confidential, as some of you may discuss some of the issues raised here outside. Therefore, you should not share any sensitive information here. This group discussion will take about one hour. Does anyone have a question before we begin?

Opening questions

1. Please, tell me your name and how long you have stayed in this Yendi hospital.

2. What language do you primarily speak when you are talking to the nurse?
   Probe: What is your native language, and what other Ghanaian languages do you speak well?

Care routines and communication with nurses

3. When you came to this ward, what processes did you go through?
   Probe: What things did you do before you were given a bed here?
   Probe: how did the process go?

4. How was your communication or interaction with the nurses?
   Probe: How do you feel about the way nurses here talk to you as a patient?
   Probe: Is it the same way they talk to other patients?

5. How were you engaged in your care process?
   Probe: did you make suggestions regarding your care planning?
   Probe: were you allowed to express your feelings or ask questions about care procedures?

Patients’ rights and nurse-patient interaction

6. Do you know about the patient’s charter in Ghana?
   Probe: Are you aware of the patient rights document?
   Probe: What are some of the rights patients are entitled to?
   Probe: If you had no knowledge about it, did nurses tell you anything about your rights and responsibilities?

If participants are not aware of the rights, list some of them and ask the other probes.

7. What things do nurses in this hospital do that are not in line with patient rights?
   Probe: are there things that nurses do that affect (promote or inhibit) patient rights?
   Probe: List the things nurses do that affect patient rights.

8. What are your personal experiences about how nurses treated you in this hospital?
   Probe: What was the incident about and how did the nurse treat you?
   Probe: do nurses treat you and other patients the same or differently? Please explain.

9. What are your experiences of instances when patients treat nurses badly?
   Probe: What was the incident about and how did the patient treat the nurse?

Nurse-patient communication and interactions

10. Please describe a typical conversation you have had with a nurse that you think was good or bad.
    Probe: What was the situation about and how did your conversation go?
    Probe: What made it a good or bad experience?

11. What do you think are the factors that cause disagreements between nurses and patients?
    Probe: Please, explain the factors to me and their sources.
    Probe: What can be done to minimize these?

12. What do you think are the factors that make it easy or difficult for nurses and patients to have smooth interactions?
    Probe: Please, tell me more about the factors, starting with the ones that make interaction with nurses easy.

Barriers and facilitators of effective clinical communication

13. What are the things that make it difficult for nurses and patients to communicate with each other?
    Probe: List the things that make communication in this hospital difficult.
    Probe: What are the causes of difficult communication between nurses, patients/caretakers?

14. What things can make communication between nurses and patients/caretakers easy?
    Probe: List the factors that can help make communication in this hospital easy?
    Probe: How can communicating with nurses, patients/caretakers be made easier?

15. What things in this hospital do you think can make the work of nurses difficult?
    Probe: What things make the work of nurses difficult in this hospital?
    Probe: In what ways can the activities and structures of this hospital affect patient care?

(J): Ethical Approval Letter

(i): *University of Saskatchewan Ethics Approval Letter*

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB) 02-Sep-2022

Certificate of Re-Approval

Application ID: 2690

Principal Investigator: Pammla Petrucka
Department: College of Nursing
Locations Where Research Activities are Conducted: Yendi Municipal Hospital, Ghana
Student(s): Abukari Kwame
Funder(s):
Sponsor: University of Saskatchewan
Title: Nurse-patient communication and patients' rights in the healthcare setting
Approval Effective Date: 14-Sep-2022
Expiry Date: 14-Sep-2023
Acknowledgment Of: N/A

Review Type: Delegated Review

* This study, inclusive of all previously approved documents, has been re-approved until the expiry date noted above

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board (Beh-REB) is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans - TCPS 2 (2018). The University of Saskatchewan Beh-REB has reviewed the above-named project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this project, and for ensuring that the authorized project is carried out according to the conditions outlined in the current approved protocol. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

ONGOING REVIEW REQUIREMENTS

Any significant changes to the proposed method, or consent and recruitment procedures must be reported to the Chair through submission of an amendment for Beh-REB consideration in advance of implementation.
To remain in compliance, a status report (renewal or closure form) must be submitted to the Beh-REB Chair for consideration within one month prior to the current expiry date each year the project remains open, and upon project completion. Please refer to the Research Ethics Office website for further instructions and current forms.

Digitally Approved by Diane Martz
Chair, Behavioural Research Ethics Board
University of Saskatchewan