Perceived interpersonal and institutional challenges to patient advocacy in clinical nursing practice: a qualitative study from Ghana

Interpersonelle und institutionelle Herausforderungen für die Rolle als Patientenfürsprecher/-in aus Sicht der Pflege: eine qualitative Studie aus Ghana

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Abstract

Background: Nurses often speak on patients' behalf and safeguard their safety through their advocacy role. However, some challenges like the negative attitude of team members and lack of institutional support often hamper this role. These challenges have not been well studied in the Ghanaian context.

Aim: This study explores the perceived environmental challenges to patient advocacy among nurses in Ghana.

Setting: The study was conducted at a regional hospital in Ghana.

Participants: Participants were nurses or midwives working in the hospital.

Methods: A qualitative exploratory descriptive design was employed in the study of 15 purposively sampled participants. Participants were interviewed individually and data were analysed using content analysis.

Findings: The study revealed interpersonal challenges and institutional challenges to patient advocacy, such as hierarchical nurse–doctor relationships and ineffective multidisciplinary team, time constraints and lack of institutional support. Nurses often failed to advocate because they did not want to risk conflict with doctors. Limited interprofessional interaction, suspicion and resentment in the multidisciplinary team negatively affected nurses' role as patient advocates. Inadequate curricular support for patient advocacy and lack of support for training programmes or to undertake further studies were the additional challenges.

Conclusion: Patient advocacy could be a stressful role for nurses; thus, efforts to strengthen teamwork and increase nurse involvement in hospital decision-making are required.

Implications for nursing and health policy: The findings could influence hospital management policies to enhance stronger interprofessional collaboration, increase opportunities for professional advancement for nurses and nurses' inclusion in decision-making.

Abstract

Hintergrund: Pflegefachkräfte setzen sich oft als Patientenfürsprecher/-innen (patient advocates) ein und gewährleisten damit deren Sicherheit. Eine negative Einstellung von Teammitgliedern sowie die fehlende institutionelle Unterstützung behindern Pflegefachkräfte oft in der Ausübung dieser Rolle. Diese Herausforderungen wurden im Ghana bisher wenig untersucht.

Ziel: Diese Studie untersucht die von Pflegefachkräften wahrgenommenen Herausforderungen für die Rolle als Patientenfürsprecher/-in in Ghana.

Methoden: Qualitative, explorative Studie in einem regionalen Krankenhaus in Ghana. Qualitative Interviews wurden mit 15 Pflegefachkräften/ Hebammen zur Rolle als Patientenfürsprecher/-in und deren Herausforderungen durchgeführt und mittels Inhaltsanalyse ausgewertet.

Ergebnisse: Interpersonale und institutionelle Herausforderungen behindern Pflegende bei der Ausübung ihrer Rolle als Patientenfürsprecher/-innen: hierarchische Beziehungen zwischen Mediziner/-innen und Pflegefachkräften, ineffektive multidisziplinäre Teams, Zeitdruck sowie mangelnde institutionelle Unterstützung. Pflegefachkräfte konnten die Interessen der Patienten/-innen oft nicht vertreten, weil sie keine Konflikte mit Ärzten/-innen riskieren wollten. Mangelnde interprofessionelle Zusammenarbeit, Misstrauen und Ressentiments im multidisziplinären Team waren weitere Hindernisse. Unzureichende curriculare Verankerung der Rolle als patient advocate in der Ausbildung sowie fehelendes Training waren weitere Herausforderungen.

Fazit: Die Rolle als Patientenfürsprecher/-in kann für Pflegefachkräfte belastend sein. Die Teamarbeit und der Einbezug von Pflegefachkräften bei Entscheidungen im Spital müssen verstärkt werden.

Implikationen für die Pflege und Gesundheitspolitik: Die Ergebnisse sprechen dafür, dass Policies für das Spitalmanagement die interprofessionelle Zusammenarbeit fördern, die Position von Pflegefachkräften und den Einbezug der Pflege bei der Entscheidungsfindung stärken.

INTRODUCTION

The healthcare environment has become highly complex in recent decades, leaving some patients vulnerable, uninformed and intimidated; therefore, they often face difficulty in making decisions concerning their health. These patients often require an advocate to facilitate their care (Hanks et al., 2018). Nurses usually take on this role by explaining the policies and procedures to patients, mediating between them and other team members, helping them navigate healthcare systems and investigating their grievances (Clarke et al., 2015; Gerber, 2018; Hanks et al., 2018). This is because nurses believe that they are best suited for this role (International Council of Nurses, 2012; Tomaschewski-Barlem et al., 2016); a role which is considered as an ethical practice based on the ethical principle of beneficence (Water et al., 2016).

The performance of the role has been noted to have beneficial effects on patient outcomes by reducing medical errors (Choi et al., 2014). In addition, it helps nurses to achieve professional power and to enhance their self-confidence (Sepasi et al., 2017). In Ghana, a nurse who advocates for patients is seen as a "Florence Nightingale" (Adu-Gyamfi et al., 2016), but the nurses are frequently faced with some challenges when performing this role. Although only a few studies have explored the advocacy role of nurses in the Ghanaian context, the issue has been widely explored internationally.

The performance of this role requires a good communication between the nurses and other team members. A study investigating interprofessional communication and professional roles of doctors and nurses in the USA found that communication between doctors and nurses is poor and relationship is hierarchical (Dean et al., 2016): nurses only talk to doctors to obtain a prescription or to provide information on patients' condition. Nonetheless, nurses communicate well with other team members such as phlebotomists. Doctors also tend to consult with each other more often about patient care and hardly talk to nurses even at patients' bedside. This leads to a separation of the two professions, even though their duties overlap. The authors attributed the problem of poor communication to gender imbalances in the two professions, medicine being male dominated and nursing being female dominated. In Ghana, three-quarters of nurses are females and more male nurses tend to leave the profession. Conversely, most doctors are males and are considered more powerful in the hospital (Boafo et al., 2016). Thus, nurses in Ghana, like in other settings, have little power and autonomy in their work settings and are often overworked (Water et al., 2016).

It has been reported that patient advocacy also requires nurses to exercise autonomy and power by challenging the medical authority (Tomaschewski-Barlem et al., 2016). But nurses' lack of power and autonomy means they are often met with intimidation from some doctors, and such fears can discourage nurses from engaging in patient advocacy in spite of their advanced knowledge in patient care (Pattni et al., 2018; Tomaschewski-Barlem et al., 2016). Moreover, nurses' dissatisfaction with limited opportunities for professional advancement, study leave and low salaries negatively affects professional interactions and patient advocacy (Adu-Gyamfi et al., 2016).

Anecdotal evidence suggests that Ghanaian nurses are often reluctant to advocate for patients due to the hierarchical relationships between them and physicians and also due to the fear of retaliation from team members. To enhance patient advocacy, nurses need to be valued for speaking up for patients and given the necessary organisational support to succeed in their advocacy (Pattni et al., 2018). Therefore, there is a need to explore the challenges to patient advocacy among clinical nurses in Ghanaian hospitals in order to have a deeper understanding of the circumstances under which they perform this role. This knowledge would be useful in designing measures to address the challenges that nurses face in advocating for their patients, thus motivating more nurses to perform the role. It could improve teamwork and patient safety and enhance the professional image of nurses.

Studies have identified several interpersonal challenges to patient advocacy, such as the organisational authority present in hospitals, which places physicians on an elevated status allowing some of them to intimidate nurses (Hanks et al., 2018; Jafree et al., 2015). Studies in the North America and Brazil have found that nurses often fail to succeed in their advocacy for patients because of this power imbalance; thus, they often remain silent and comply with medical directives rather than risk conflict with the physicians (Gerber, 2018; Tomaschewski-Barlem et al., 2016). Moreover, the historic submissiveness of nursing and its altruistic values have also become obstacles to patient advocacy and the professional empowerment of nurses today (Sepasi et al., 2017). Improving professional interactions and communication is important for gaining power in nursing. However, from the global perspective, attitude towards teamwork in healthcare settings is often weak (Oliveira et al., 2017; Sepasi et al., 2017) and conflicts arising during patient advocacy can lead to other team members tagging nurses negatively to discourage them (Gerber, 2018; Hanks et al., 2018).

The hiring of medical and nurse practitioners has also been noted to be tightly controlled and constrained by inadequate budget allocations, especially in public hospitals, and this has led to a shortage of staff, leaving nurses with limited time for patient advocacy (Gerber,

2018; Jafree et al., 2015). Similarly, studies of nurse–patient interactions in some Australian hospitals reveal that most nurses are not able to engage in patient advocacy due to work overload and time constraints (Tobiano et al., 2015). In Saudi Arabia, nurses have found that some institutional rules and policies like the cash and carry system sometimes cause delays in the treatment of seriously ill patients and need to be examined to enhance patient care, but they feel that they do not have the power to do so (El Seesy et al., 2016; Mogre et al., 2019). In Ghana, 50% of patients access healthcare by the cash and carry scheme in which clients pay cash before getting healthcare services. Even for those who have insurance cover, the national health insurance scheme does not cover the cost of some medications, especially more effective ones (Adu-Gyamfi et al., 2016; Mogre et al., 2019). Moreover, the cost of healthcare in many parts of Africa including Ghana is expensive in an economy with widespread poverty among citizens (Burger & Christian, 2018). This means that nurses often have to help patients assess their treatment options and access the help they can get for their care through advocacy.

In the Egyptian context, the ethical preparation of nurses in school to become good patient advocates is inadequate to enable them to handle sensitive ethical issues in their practice (Asfour et al., 2016). However, it has been found that nurses often have some confusion about the concept of patient advocacy and its practice, and therefore require additional education about this role (Water et al., 2016). Nonetheless, studies indicate that the skills, knowledge and experience of nurses that determine how they practice advocacy can be developed through training, work experience and higher education (Sepasi et al., 2017; Tomaschewski-Barlem et al., 2016). Higher education could also promote greater interest in the profession and job satisfaction (Maier et al., 2016). Nonetheless, nurses do not get such opportunities because organisations are unwilling to make them powerful (Sepasi et al., 2017). Thus, there have been calls for support from supervisors and the hospital leadership for nurses to succeed in their role (Gerber, 2018). Nurses are usually capable and ready to advocate for patients, but may be unable to protect themselves from problems that may occur because of the power imbalance in hospital management. Support from hospital management is thus important to strengthen nurses to overcome these barriers, especially when dialogue fails (Asfour et al., 2016; Tomaschewski-Barlem et al., 2016).

RESEARCH QUESTION

The study seeks to answer the question: what are the perceived interpersonal and institutional challenges to patient advocacy among clinical nurses in Ghana?

METHOD

Design

The qualitative exploratory descriptive design that relies on narratives from participants was employed in this study. Qualitative research design enables the researcher to study human phenomena in their naturally occurring states using holistic methodologies rather than manipulation and controlling (Neuendorf, 2017). The focus of this design is to gather an in-depth understanding of human behaviour and the reasons that govern such behaviour (Mayer, 2015). The qualitative exploratory descriptive design enables the researcher to explore issues in order to understand the phenomena under study and answer questions by analysing and making sense of qualitative data (Mayan, 2009). The design was used to explore, describe and understand the interpersonal and institutional challenges that the nurses face as patient advocates. The design is also useful, since little is known about the advocacy role of nurses in Ghana (Grove et al., 2019). Thus, the perceived interpersonal and institutional challenges to the patient advocacy role of nurses were fully explored and described in this study.

Data collection

A semi-structured interview guide was used to collect the data from participants with regards to their perceived challenges in their role as patient advocates. The questions asked included: What factors have prevented you from advocating for patients in the past? How often do you succeed with patient advocacy? Follow-up questions were, however, asked based on their narratives. The interviews were conducted in English language and recorded with participants' consent using an audio recorder. The interviews lasted between 33 and 57 minutes. The interviews were then transcribed verbatim by the first author, GD. Participants were assigned pseudonyms during the transcription, and each transcript was saved with a different colour font for easy identification. A 7-cm margin was left on the transcribed interviews to provide space for writing codes during data analysis.

Trustworthiness

Participants were engaged in some preliminary conversations during the interviews to create the rapport necessary to make them relax, which enabled them to express their real views, thereby ensuring credibility of the data collected. The same interview guide was used to conduct all the interviews (Guba et al., 1989; Patton, 2002). To achieve validity and credibility, member checks

were conducted by discussing the findings generated from the study with the participant after analysing the data, in order to check for their accuracy and its reflection of their experiences of their challenges with patient advocacy. This was done to allow them to make corrections where necessary. However, they all endorsed the findings as a true reflection of their realities. The authors also discussed the themes generated and ensured that no aspect of the data was left out. Direct verbatim quotes were used to support the findings and this gave voice to the participants (Larrabee, 2009; Patton, 2002). Transferability was ensured through a detailed description of the research setting, methodology and background of the sample used in the study. Dependability was achieved by keeping field notes to allow for verification of findings and study processes. The provision of exemplar quotes to describe the emerging themes and subthemes guaranteed confirmability (Larrabee, 2009; Shenton, 2004).

Analysis

Data analysis was done following the technique of qualitative content analysis, which involves an analysis of the content of the data to identify patterns of experiences of participants (Patton, 2002). The transcripts were read over and over again to gain a full sense of the participants' views. They were then coded line by line by assigning a word or phrase that accurately captures the essence of the portion read. Through this process, some of the codes generated were grouped and regrouped to form themes and subthemes fitting for the study. All the authors discussed the themes to ensure that the data were well represented.

Selection and description of study participants

Participants were conveniently sampled from the theatre/recovery, male medical and children's wards of a regional hospital in Ghana by the first author. A total of 17 participants agreed to take part in the study, but data saturation determined the sample size as 15 when no new ideas were identified in their responses during the interview. Working in these three units in the hospital served as the inclusion criterion in the study. The inclusion of participants from three different units in the hospital enabled the researchers to obtain the views of a wider group of nurses, which enhanced the credibility of the work (Guba et al., 1989; Patton, 2002). Participants were recruited from the selected wards and invited to a meeting at the hospital, in which they could be explained the purpose of the study and what they would be asked to do during the study. Those who agreed to take part in the study then signed consent forms. All participants were nurses or midwives working in the hospital. However, the

midwives included in the study were rendering general nursing care in their units. There was 1 male and 14 females and their age ranged from 25 to 55 years. One participant was a Muslim and the rest were Christians. Two of them were single, 11 were married and two were widowed. Nine participants had a diploma in either nursing or midwifery, with six of them also having a Bachelor of Science degree. Eleven participants had 3–10 years of work experience and four had over 10 years of work experience.

The study participants reported on their observations of the interpersonal and institutional challenges to patient advocacy during interviews conducted in a nonthreatening environment; therefore, the data collected truly represent their views.

FINDINGS

Description of themes and subthemes

Two themes emerged after careful analysis and grouping of the data obtained from the participants: 1) interpersonal challenges and 2) institutional challenges to patient advocacy. Two subthemes emerged from interpersonal challenges, namely, the hierarchical relationship between nurses and physicians and ineffective multidisciplinary team. These described the factors that constrained the working relationship between nurses and other team members. Institutional challenges had four subthemes: time constraints, difficult rules and regulations, lack of support and ineffective administration, which also described the organisational factors that hampered the role of nurses as patient advocates.

Interpersonal challenges

The participants explained that some doctors were bossy and intimidating and failed to respond positively to nurses' advocacy for patients due to the hierarchical relationship existing between them. As a result, some participants failed to advocate because they did not want to risk conflict with doctors as shown in Table 1. Patient advocacy was also hindered by an ineffective multidisciplinary team. This resulted from limited interaction among team members, poor interpersonal relationship, and suspicion and resentment which sometimes existed in the team. As shown in Table 1, the participants indicated that they often did not get opportunities to interact with other team members and advocate for patients who needed their help. They were also discouraged from performing the role because they had poor rapport with other team members, which made them uncertain about the outcome of their advocacy. Some also failed to advocate because they did not want to be negatively tagged in the healthcare team.

Table 1: Summary of themes, subthemes and representative quotes

Themes	Subthemes	Representative quotes
Interpersonal challenges	Hierarchical nurse–doctor relationship	"We contribute but for the head of the doctors here unless he asks me. If he doesn't ask me I won't contribute because I don't want it to be as if I'm dictating to him" (Interview number 2, statement number 1) "If something happens between the nurse and the doctor and is reported to the administration in some cases the doctor goes scot-free and the nurse will have an issue because doctors are the heads of the hospital which I think is not right" (Interview number 8, statement number 5) "We had a pregnant woman with a fever. The laboratory results came in the evening and she had severe septicaemia. That night I called the doctor but he didn't come, I sent for him three times. He came in the morning and we started management but she died" (Interview number 4, statement number 1)
	Ineffective multidisciplinary team	"Hardly do you see all of us discussing the patient's problem. The doctors discuss what to do, the nurses also discuss what to do but we don't normally come together and discuss" (Interview number 5, statement number 4) "The rapport has not been created. I can't mention the name of anybody working at the social welfare or the laboratory …. I don't know anybody there personally. It would have made things easier" (Interview number 2, statement number 3) "Sometimes you advocate for your patient and your colleagues wonder; why is this person is so much into this patient? They assume you think you know too much and you would seem annoying to them" (Interview number 7, statement number 6)
Institutional challenges	Time constraints	"The time we have on the ward is so tight that we are not able to educate patients or advocate for them. Mostly it doesn't happen" (Interview number 7, statement number 3)
	Difficult rules and regulations	"This time the hospital is not giving anything free to patients who don't have money. At first, those who didn't have money were given emergency drugs for 24 hours so that relatives would come and pay and buy the rest of the drugs. When you go to the pharmacy now its cash and carry" (Interview number 3, statement number 5)
	Lack of support	"Advocacy is a broad thing but our tuition and our curriculum do not help much. They need to enlighten us much about how to go about issues, how to talk, how to explain your stand. If it is well incorporated in our curriculum I think it can help" (Interview number 1, statement number 5) "We don't go for workshops so if there is a programme to sharpen our skills or knowledge on patient advocacy nobody would tell you. We cannot even renew our professional licenses" (Interview number 6, statement number 5) "They are not giving study leave. When the person is ready to go to school then they will say no you need to work" (Interview number 11, statement number 4)
	Ineffective administration	"We have a patient who has been referred but has not settled the bill. We called the social welfare and they said they had to contact the administrators but at the end of the day we have to decide because the patient's condition is deteriorating" (Interview number 10, statement number 4)

Institutional challenges

Subthemes such as time constraints, difficult rules and regulations, lack of support and ineffective administration were derived from this theme. Time constraints resulted from participants being overloaded with other patient care activities on the ward, a situation which prevented them from advocating for patients. According to them, they were usually busy on the ward and were left with little or no time to advocate for patients, as can be seen in Table 1. Again, the participants revealed that certain hospital rules and regulations made patient advocacy challenging. Some expressed that it was difficult to advocate for needy patients to get emergency drugs due to some hospital policies like the cash and carry policy (see Table 1). They also lamented the lack of support they needed to acquire the skills necessary to succeed in their advocacy role. Table 1 shows that the participants believed that the curricular support for patient advocacy is lacking as the role is poorly taught in school. They also had limited support from hospital management to attend workshops or undertake further studies to become better patient advocates. Ineffective administration was another institutional challenge identified. As indicated in Table 1, the participants were challenged by an ineffective administration in the form of bureaucracy at the hospital when they advocated for patients. This often caused delays, frustrated their efforts and put patients' lives in danger.

DISCUSSION

This study identified both interpersonal and institutional challenges to patient advocacy. The participants reported intimidation from physicians, which sometimes prevented them from advocating for patients, especially when it involved speaking with highly ranked doctors, as has been noted in the American, Pakistani and UK contexts (Hanks et al., 2018; Jafree et al., 2015; Pattni et al., 2018). Some, therefore, were discouraged from advocating for patients. Even when they did, physicians often responded negatively to participants' advocacy on patients' behalf (Tomaschewski-Barlem et al., 2016). It is thus imperative for such hierarchical relationships to be examined and discouraged to enhance patient advocacy. As has been reported globally, other team members became suspicious and sometimes resented the participants who advocated for patients (Hanks et al., 2018; Tomaschewski-Barlem et al., 2016). There was also limited interprofessional dialogue and rapport between nurses and other team members, which also affected patient advocacy (Oliveira et al., 2017; Sepasi et al., 2017). This could eventually lead to a lack of appreciation of each team member's contribution to patient care. Therefore, healthcare professionals need to interact and understand the roles of other team members and appreciate their importance.

The challenge of inadequate staffing in the health sector due to strict government controls on the recruitment of new staff contributing to staff shortage left participants with little or no time to advocate for patients (Oliveira & Tariman, 2017; Tobiano et al., 2015). Literature supports participants' assertion that some protocols such as the cash and carry system affect their advocacy for poor patients to get prompt treatment. This often delayed access to treatment, even for seriously ill patients (Mogre et al., 2019). As frontline workers, such situations could lead to feelings of moral distress and helplessness among nurses. Participants revealed that the existing nursing curriculum poorly covered the topic of patient advocacy – a deficit found in other countries as well (Asfour et al., 2016; Oliveira et al., 2017). The lack of opportunities and financial support for nurses to attend training programmes and undertake further studies to provide them with the knowledge, skills and experience necessary for patient advocacy is also reported in literature (Sepasi et al., 2017; Tomaschewski-Barlem et al., 2016). This could lead to a lack of adequate knowledge on patient advocacy and legal issues among the nurses. Also, bureaucracy on the part of the hospital management which delayed the implementation of important decisions, actions and response concerning patient care after nurses have advocated for the patients was also reported (Gerber, 2018). This could be attributed to the hierarchical nature of the hospital leadership that almost excludes nurses.

Limitations and strengths

The study was conducted in a government-owned regional hospital; therefore, findings may not reflect the challenges to patient advocacy in private, district or teaching hospitals. Also, the use of a convenience sampling method may mean the sample may not be representative of the whole population; thus, the findings cannot be generalised for other settings. However, the study setting was a large hospital with diverse health professionals and multidisciplinary healthcare teams, which afforded participants with numerous opportunities to engage in patient advocacy and gain rich experience in performance of the role. The sample size of 15 participants used in the study was also large enough to permit valid conclusions to be drawn from the findings. Moreover, the use of interviews during data collection enabled participants to express themselves freely and provide a deeper understanding of their role as patient advocates.

CONCLUSION

The discussion highlights findings within the current literature from Saudi Arabia, Pakistan, the USA and Brazil. The lack of interprofessional dialogue and appreciation is noted, along with lack of time for under-resourced and underprepared nurses, thus making them feel suppressed and poorly motivated to advocate for patients. There is the need, therefore, for the hospital management and the Ghana Health Service to introduce measures to foster stronger teamwork, address the inadequate staffing problem and increase the involvement of nurses in hospital decision-making to enhance the performance of the role.

Implications for nursing practice

The findings from the study show that patient advocacy needs to be improved in nursing practice. To do this, senior nurses especially could influence authoritarian team members and remind them about nurses' role as patient advocates. They could also mentor junior nurses by exhibiting maturity and assertiveness in their interactions with other team members. Nurses should look for avenues to contribute to decision-making and accept leadership positions to be able to influence hospital affairs. They should also use their professional groups to lobby for increased opportunities for professional advancement. In the same way, they can make contributions to curricular changes based on their experiences on the job Moreover, nurses should consider using the nursing process for inpatient care; a practice that supports professionalism and autonomy of the nursing profession rather than just

relying on instructions from others. They should also hold themselves as professionals in the health team and not subservient workers.

Implications for nursing and health policy

The findings could influence doctors to see patient advocacy as an integral part of nursing that could also aid their work, rather than just as a challenge. It is also expected that hospitals will schedule regular clinical meetings involving all team members to enhance familiarisation and teamwork among members. The government could also be influenced to lift the ban on the employment of health professionals even if temporary. The hospital management could also identify any unintended effects of existing protocols and remedy them, and also open up channels for accelerated communication where necessary. They could also be guided to institute an authority system which discourages bullying and favours all professional groups, especially nurses since they are the frontline workers. The findings could also influence the nursing curriculum review to prominently feature patient advocacy and the employers to consider providing nursing with better conditions of service including opportunities for further studies to enhance the professional advancement of nurses.

Need for further research

Further studies are required to examine the hierarchical relationships existing between doctors and nurses and how interprofessional relationships can be enhanced between them. Moreover, studies that would allow nurses to describe their advocacy actions and their outcomes could provide creative strategies for further development of the advocacy role for nurses. The perspectives of other healthcare professionals as well as patients concerning the advocacy role of nurses could be investigated to provide a broader picture and deeper understanding of the role.

AVAILABILITY OF DATA AND MATERIALS

The transcripts from which this manuscript was developed are available on request from the authors.

ETHICS

Ethical clearance was obtained from the Noguchi Memorial Institute of Medical Research (NMIMR-IRB CPN 018/15-16) and the Ghana Health Service Ethical Review Committee (GHS-ERC: 04/10/15). Participants also gave informed consent for voluntary participation in the study by signing consent forms. They were informed they could withdraw from the study at any time without penalty and were given pseudonyms to ensure anonymity and confidentiality.

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CONFLICT OF INTERESTS

No conflict of interest has been declared by the authors.

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AUTHOR CONTRIBUTIONS

Study design: GD, LA; data collection: GD; data analysis: GD, LA; study supervision: LA; manuscript writing: GD, LA; critical revisions for important intellectual content: LA; both authors read and approved the final manuscript.

References

Adu-Gyamfi, S., & Brenya, E. (2016). Nursing in Ghana: A Search for Florence Nightingale in an African City. *International Scholarly Research Notices, 2016*, 1–14. doi:10.1155/2016/9754845

Asfour, H. I., Ahmed, F. R., & El Halim, G. E. A. (2016). Measuring changes in attitude, practice and knowledge of undergraduate nursing students after receiving an educational intervention in ethical comportment in critical care nursing. *Journal of Nursing Education and Practice, 6*(5), 49. doi:10.5430/jnep.v6n5p49

Boafo, I. M., Hancock, P., & Gringart, E. (2016). Sources, incidence and effects of non-physical workplace violence against nurses in Ghana. *Nursing Open, 3*(2), 99–109. doi:10.1002/nop2.43

Burger, R., & Christian, C. (2018). Access to health care in post-apartheid South Africa: Availability, affordability, acceptability. *Health Economics, Policy and Law*, 1(13). doi:10.1017/S1744133118000300

Choi, S. P., Cheung, K., & Pang, S. M. (2014). A field study of the role of nurses in advocating for safe practice in hospitals. *Journal of Advanced Nursing, 70*(7), 1584–1593. doi:10.1111/jan12316

Clarke, K., Pedersen, K., & Santalucia, C. (2015). *Patient Advocate: A Critical Role in Patient Experience.* The Beryl Institute.

Dean, M., Gill, R., & Barbour, J. B. (2016). "Let's Sit Forward": Investigating Interprofessional Communication, Collaboration,

Professional Roles, and Physical Space at EmergiCare. *Health Communication*, 31(12). doi:10.1080/10410236.2015.1089457

El Seesy, N. A. E.-A., & Al Nagshabandi, E. A. (2016). Nurses' Attitudes Toward Patient Advocacy in Oncology Department University Hospital. *American Journal of Nursing*, 5(6), 266–271.

Gerber, L. (2018). Understanding the nurse's role as a patient advocate. *New Horizon*, 48(4), 55–58. doi: 10.1097/01. NURSE.0000531007.02224.65

Grove, S., & Gray, J. (2019). *Understanding Nursing Research - 7th Edition*. Elsevier, India

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park: Sage Publications Ltd.

Hanks, R. G., Starnes-Ott, K., & Stafford, L. (2018). Patient Advocacy at the APRN Level: A Direction for the Future. *Nursing Forum*, 53(1). doi:10.1111/nuf.12209

International Council of Nurses. (2012). *The ICN Code of Ethics for Nurses*. Geneva: International Council of Nurses.

Jafree, S. R., Zakar, R., Zakar, M. Z., & Fischer, F. (2015). Nurse perceptions of organizational culture and its association with the culture of error reporting: a case of public sector hospitals in Pakistan. *BMC Health Services Research*, 16(3). doi:10.1186/ s12913-015-1252-y

Larrabee, J. H. (2009). *Nurse to Nurse: Evidence- Base Practice*. McGraw Hill Medical.

Maier, C. B., & Aiken, L. H. (2016). Expanding clinical roles for nurses to realign the global health workforce with population needs: a commentary. *Israel Journal of Health Policy Research*, 5(1), 21. doi:10.1186/s13584-016-0079-2

Mayan, M. J. (2009). *Essentials of qualitative inquiry*. Left Coast Press Inc., Walnut Creek, California

Mayer, I. (2015). Research methodology: Qualitative research with a focus on qualitative data analysis. *International Journal of Sales, Retailing and Marketing*, 4(9), 53–63.

Mogre, V., Johnson, N., A., Tzelepis, F., & Paul, C. (2019). Attitudes towards, facilitators and barriers to the provision of diabetes self-care support: A qualitative study among healthcare providers in Ghana. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews*, 13(3), 1745–1751. doi:10.1016/j.dsx.2019.03.041

Neuendorf, K. A. (2017). *The Content Analysis Guidebook* (2nd ed.). Sage publications, London

Oliveira, C., & Tariman, J. D. (2017). Barriers to the Patient Advocacy Role: An Integrative Review of the Literature. *Journal of Nursing Practice Applications & Reviews of Research*, 7(2), 7–12. doi:10.13178/jnparr.2017.0702.0704

Pattni, N., Arzola, C., Malavade, A., Varmani, S., Krimus, L., & Friedman, Z. (2018). Challenging authority and speaking up in the operating room environment: a narrative synthesis. *British Journal of Anaesthesia*, 122(2), 233-244. doi:10.1016/j.bja.2018.10.056

Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods*. Sage Publications Ltd, California

Sepasi, R. R., Fariba, B., & Abbaszadeh, A. (2017). Nurses' perception of the strategies to gaining professional power: A qualitative study. *Electronic Physician*, 9(7), 4853–4861. doi:10.19082/4853

Tobiano, G., Bucknall, T., Marshall, A., Guinane, J., & Chaboyer, W. (2015). Nurses' views of patient participation in nursing care. *Journal of Advanced Nursing*, 71(12), 2741–2752. doi:10.1111/ jan.12740

Tomaschewski-Barlem, J. G., Lunardi, V. L., Barlem, E. L. D., Ramos, A. M. et al.. (2016). How have nurses practice patient advocacy in the hospital context?- A Foucaultian perspective. *Texto Contexto Enferm*, 25(1). doi:10.1590/0104-07072016000002560014

Water, T., Ford, K., Spence, D., & Rasmussen, S. (2016). Patient advocacy by nurses – past, present and future. *Contemporary Nurse* 52 (6). doi:10.1080/10376178.2016.1235981