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The Impact of Effective Patient Advocacy in Ghana Health Care Reform

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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Abstract

Patient advocacy has become a vital concept for healthcare providers all over the world. There is evidence that the concept of patient advocacy is not new in Ghana. However, the degree of its practice continues to be negative and quite narrow in Ghana and even in Africa as a whole. It has also been argued that effective patience advocacy practice is either scarce or non-existent in Ghana. To address this issue, an assessment of the medical policies in Ghana was conducted, informed by the applied psychology theoretical framework. This study focused on using phenomenological inquiry to better understand patients' experiences within Ghana healthcare facilities to allow for the determination of the impact of patient advocacy in Ghana. The study used purposive sampling for the selection of the participants. Questionnaires were designed after the form of semi-structured interview style to stimulate responses. In all, data was collected from 23 participants from four most highly populated urban regions in Ghana. The study revealed 11 lapses and shortcomings in the practice of patient advocacy in Ghana. Patients were found to be either unaware of their rights or felt less empowered to participate in their care giving. Healthcare professionals, on the other hand, need periodical training to instruct them in their ethical duty as patient advocates. The systemic poor interaction between patients and care givers was also found to act adversely against the practice of patient advocacy in Ghana. Therefore, there is the need for a multi-prong new policy and structural model that essentially puts patients right and inclusion and the ethics of healthcare professionals at the forefront resulting in positive social change.

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Dedication

I would like to dedicate this academic journey and achievement to the following individuals whose efforts got me through this:

To my family and friends who supported me from the beginning of this doctorate journey until the end. I offer a special feeling of gratitude to my loving parents, late Mr. Henry Opong and Mrs. Mercy Opong, who instilled in me love, determination, persistence, encouragements, and strength of character in all my life's endeavors. To my late siblings, Harry Opong, Lawrence Opong, Henrietta Opong, and Elizabeth Mercer-Quarshie for their support and love since my childhood. To my living siblings, Caroline Addo and Joseph Opong, I will always appreciate your support, unconditional love, and encouragement. Having you to turn to is a blessing.

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"I don't look like what I've been through,

You turned my pit into a well, so the essence of my praise is centered on your Grace.

I've been through a lot, but your Grace sustained me.

My test is now a testimony,

So, Lord the essence of my praise is centered on your Grace.

You changed my story and gave me a song,

You turned my mourning into dancing, and it is you and just your Grace and Mercies.

I Could not have made it and could not have sailed through without You.

Lord, your loving kindness, grace and mercies brought me through.

So, the essence of my praise is ALL centered on your Grace and Mercies."

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Chapter 1: Introduction to the Study

Within the past few decades, discussions regarding discrepancies in patient advocacy in the nursing profession has increased. Even though advocacy is recognized as a vital concept for medical providers, the extent of the practice of advocacy has been narrow, especially in Ghana. Historically, patient advocacy has been known as an ethical responsibility not only for nurses, but all medical providers. In fact, emphasis in the literature on the medical providers and advocacy has been fixated on the patient advocacy role as an ideal of medical practice (Grace Professional advocacy, 2001). In other words, the providers are ethically committed to advocate for those they serve (Gaylord & Grace, 1995). In this dissertation, I continue the discussion by seeking data regarding the extent to which advocacy practices are performed.

Human beings' integral worth, self-esteem, and basic rights must be at the forefront of all medical personnel (American Nurses Association, 2010). According to the American Nurses Association (ANA) (2001), "Nurses take into account the needs and values of all persons in all professional relationships" (p. 7). This statement points to ethics and human rights that must be accorded to all patients by those in the medical field. In addition, all patients must be made secured, relieved, and empowered to know that their healthcare will be the highest priority of the medical personnel.

Ghanaian healthcare practitioners and policymakers continue to practice paternalistic medicine, with limited patient involvement in treatment decisions (Dadzie et al. 2018). This condition is caused by low literacy levels, lack of internet access, and gender imbalance in most African States. Due to limited resources, traditional beliefs,

and inadequate health education programs, health care systems in Sub-Saharan Africa that are devoted to patient-centered treatment and non-hierarchical interactions between patients and healthcare professionals are scarce (Dadzie et al. 2018). The Republic of Ghana, as one of the democratic states in the Subregion of West Africa, should be at the forefront with quality amenities in all aspects. Medical facilities are places for patients to receive care, but not to add to their weakness (Glanz et al., 2002).

The outcome of this study into patient advocacy may help to make a new and creative contribution to effect social change in Ghana health care system with respect to how patients receive treatments. This study aimed to not only make changes in Ghana medical facilities, but to provide education for the patients to be autonomous, self-regulatory, and their own advocates (Foster, 2010; Dadzie et al. 2018), and to be empowered and remain assiduous with their rights and health needs.

Background of the Problem

The current focus on patient safety has raised awareness of how important advocacy is in supporting safe healthcare practice. A plethora of literature have suggested that the absence of patient advocacy has detrimental repercussions (Nsiah et al., 2019). Advocacy has been defined in philosophical context as the basis for practice. It has also been characterized in terms of particular activities such as assisting the patient in obtaining essential healthcare, ensuring quality of treatment, protecting the patient's rights, and acting as a liaison between the patient and the health care system (Negarandeh et al., 2006). Gilkey & Earp (2009) defined patient advocacy in the post-quality chasm era as improving health care quality, mainly to provide patient safety and access to quality care,

with the process of accepting quality health care, maximizing that all people have access to safe and intelligible health care. Negarandeh and colleagues (2006), showed that even though several studies have been conducted in various countries about caring for patients, there seem to be still factors still constraining patients from receiving the care needed.

Some authors have placed emphasis on patients being more active in interacting with healthcare professionals. The active patient concept is part of a dialectic that has risen and waned in tandem with wider social interests in autonomy, self-direction, and personal responsibility for two centuries or more (Barry et al., 1987). The active patient idea has been used to define how the physician-patient relationship should be in recent years. Patients who are "activated" reject the passivity of sick person's role and take responsibility for their own care, according to this ideal. They enquire, demand answers, express preferences, express opinions, and expect to be heard. As a result, engaged patients are more informed about, satisfied with, and dedicated to their treatment plans (Barry et al., 1987). Barry and the other workers have also suggested that the dialog of the medical encounter will grow if the patient wishes to play an active role and the doctor promotes active patient involvement. They explained that as patients ask questions, express opinions, discuss personal treatment goals, and otherwise try to influence the course of their care, greater interactional symmetry will arise and that result in more information will be shared and the knowledge base will be enhanced.

However, other workers have singled out the role of healthcare professional as the key factor in ensuring patience advocacy at healthcare facilities. Lazare et al. (1975) place

more blame on the healthcare professionals. They advise health care providers to take a "negotiated approach to patient hood" based on their experience in an outpatient psychiatric setting. Patients are considered to have opinions about the nature, causes, severity, and consequences of their problems, and they enter therapy with expectations about how the therapist will help them. They also argue that medical staff should elicit these expectations as a starting point for discussing a mutually acceptable course of action.

Patients in general want to be informed about their illnesses and the treatment options available to them (Barry et al., 1987). In nations like the United States and the United Kingdom, where non-profit organizations (NGOs) are regarded as crucial healthcare partners with clinicians, healthcare policymakers, political leaders, and academics, the discipline of patient advocacy is well-established. In most African countries, unfortunately, patient advocacy is still in its inception, particularly in the domain of cancer advocacy (Asante-Shongwe, 2013). Paternalistic medicine continues to be practiced by African healthcare practitioners and policymakers, with little substantial patient input in healthcare decision making. The persistence of asymmetrical relations between physicians, policymakers, and patients is due to low literacy levels, lack of simple access to the internet, patriarchy, and gender imbalance in most African communities. A robust patient advocacy movement will be important in ushering in a more equitable healthcare system in Africa, as will a new paradigm of patient engagement in all key healthcare decisions (Asante-Shongwe, 2013). In recent decades, the healthcare environment has gotten increasingly complex, leaving some patients

vulnerable, uninformed, and scared, making it harder for them to make health-related

decisions. These patients frequently need an advocate to help them get the care they need.

(Dadzie & Aziato, 2020). According to Dadzie and Aziato, this function is frequently

played by caregivers who explain patients' policies and procedures and mediate between

themselves and other team members, assisting them to through health systems and

examine their complaints.

Nurses have always had a moral duty to advocate for their patients. In recent years,

nursing literature has emphasized the importance of advocacy in nursing, and nursing

professionals have coined the phrase "patient advocacy" to describe an ideal of practice

(Negarandeh et al., 2006). Professional nursing is about advocating for patients to prevent

problems that obstruct their recovery. However, according to several studies conducted in

Ghana and across Africa, nurses are frequently overworked and may lack the energy and

time to fight for patients owing to a shortage of staffing (Dadzie et al. 2017). Dadzie and

his colleagues, said that factors such as poor pay, poor resources at work, and limited

degree of engagement in hospital decision-making, can all contribute to discontent in

nurses. They further stated that nurses lose sympathy and struggle to speak for patients

who are ungrateful. Evidence show that nurses in Ghanaian healthcare institutions

exercise minimal advocacy, resulting in needless health problems and mortality (Nsiah et

al., 2020). Nurses are health advocates who protect their patients' autonomy, advocate in

their favor, and promote social justice in healthcare. The lack of literature for health

advocacy facilitators lines up with the unwillingness of most nurses to speak up for the

poorest and the most vulnerable. In an already fragmented health system in Africa, the silence of the nurse is likely to prolong gaps and unfairness (Laari & Duma, 2021).

Lachman (2009) addressed that there is the need for healthcare staff to exhibit ethical and moral duty towards their patients with an anticipated expertise for being a healthcare provider. Nursing advocacy has been demonstrated to be necessary for health facilities to achieve their objective of delivering high-quality patient care (Nsiah et al., 2020). Dadzie and Aziato (2020) work suggested that, Ghanaian nurses are often hesitant to speak for patients due to hierarchical relations with physicians and the fear of retaliation from team members. They explained that nurses must be appreciated for standing up for patients and provided the appropriate organizational support to succeed in their advocacy in order to improve patient advocacy. The myriad of reasons given for the shortfall in vibrant patients' advocacy in Ghana warrants an investigation into the impact of effective patients' advocacy in Ghana health system from the lived experiences of patients themselves. This study was to shed more light into charactering the relationship that has existed between patients and healthcare professional who are bound by ethics of their profession to act as advocates for patients.

Statement of the Problem

Patient advocacy is closely tied to patient satisfaction, and if not carried out completely and effectively, healthcare organizations may experience negative results, from poor customer satisfaction to nonrepeat service utilization, and possibly a diminishing financial bottom line due to patients choosing to go elsewhere. According to

Negarandah et al., (2006), and the International Council of Nurses (2008), patient advocacy has been a topic of discussion in most health care systems around the globe and is a vital concept in the scheme of service delivery within the medical industry. As such, its value should be emphasized as a key strategic initiative. However, the extent is shown to be imperfect within Ghana healthcare system. Even though patient advocacy is vital, organizations may fail to properly implement it, creating uncertainties for the patients, causing poor customer service. Donkor and Andrews (2011) addressed that effective advocacy requires health professionals take the initiative to act and respond to the patient health needs. Evidence shows that nurses in Ghana's healthcare institutions exercise little advocacy, resulting in needless health problems and mortality (Nsia et al. 2016). The ANA (2016) stated that medical staff must act to protect, encourage, and optimize health care and abilities, to avert illness and injury, improve on the patient's suffering, in turn providing better diagnosis and treatment to address patient needs including advocacy in the care of individuals, families, and communities. ANA further stated that human beings have the right to be treated with honor and respect. Illness may make patients and their families become confused, anxious, and frightened. In these cases, the medical staff should step in to advocate for the patients while they try to navigate an unfamiliar medical system. The healthcare staff is in the best position to assimilate such aspects of the patient's care, ensuring that their healthcare needs are met and addressed, and that the standards of care are encountered with realization that a better outcome and patient satisfaction remain the objective of the healthcare staff (ANA, 2004).

In a study conducted by van den Boom et al. (2004), it was established that access to healthcare facilities in Ghana continues to be a problem because medical facilities are not uniformly distributed in the nation. Ghanaians on an average live about 16 km from a healthcare facility where they can consult a doctor, with half of the population living within a 5 km radius. The other half cannot consult a doctor within 5 km, which corresponds to an hour of walking distance, and one quarter living more than 15 km from a facility where a doctor can be consulted. This situation contributes to poor advocacy in Ghana, thus causing many people to self-medicate (van den Boom et al., 2004), which may be compounded when they then receive careless attitudes from the medical staff. Even though patient advocacy is a must, quality care in the clinics is even more critical. In some instances, research showed that medical providers in Ghana did not appreciate or understand the provision of evidenced-based and maximum quality care (Donkor & Andrews, 2011). In principle, patient advocacy is a dominant driver of all facets of human quality development. In its various forms, quality patient advocacy for patients requires processes to start, refresh, and follow through (Earp et al., 2008). The healthcare system in Ghana needs to enhance patient advocacy to sustain patient care and to follow the quality principle that every human has value. As the system supports advocacy, healthcare staff must support an improving system (Earp et al., 2008).

Purpose of the Study

The purpose of this research was to explore and explain the practical difficulties, barriers, and problems that patients perceive as impacting patient advocacy and care. I also hope to help patients and the public gain an understanding of what to expect in

providing quality healthcare services. By acting as advocates, medical staff will be able to empower patients to release them from anxiety and unnecessary treatments. Patients need protection from acts of incompetence by the medical staff (Vaartio et al. 2004). The aim in undertaking this study is to stimulate and increase the awareness into the situations of relating to deficiency in the healthcare and wellbeing for the people of Ghana. Heightening this situation publicly may ensure that Ghana medical authorities take the responsibility to reform the way patients are cared for and provide services and support that enables patient to receive higher quality of care.

Research Questions

Research Question 1 (RQ1): How would patient advocacy impact quality of care in Ghana?

Research Question 2 (RQ2): How would patients describe their perception on medical provider's practice on advocacy?

Research Question 3 (RQ3): What are the factors enabling and impeding patient advocacy in Ghana medical care?

Theoretical Framework

The theoretical aspect of this study is phenomenology. This was aimed at discovering patient's experiences, theorizing, recognizing and understanding the aspects of the phenomena. Furthermore, to gain insight into experiences, face-to-face interviews using a social cognitive theory (SCT; Bandura, 1997) was used. The SCT developed by Albert Bandura (1997) addresses individuals' ability to self-organize, self-reflect, self-regulate, and be proactive, allowing human beings to have control over their own actions

to achieve results. The theory of SCT speaks to the individuals achieving and supporting

various behavioral patterns used to provide intervention strategies (Bandura, 1997; Glanz

et al. 2002). Using this theory, patients are empowered to gain self-assurance to fight for

their wellbeing. For example, sick individuals seek medical attention to get well.

Fundamental virtue such as pride, and the joy from satisfaction, and a sense of what can

be achieved, is an internal driver patients may use to advocate for themselves. These

internal drivers stress the deep thoughts and perceptions allowing a link to learning

concepts to cognitive developmental theories. The effects of SCT can demonstrate that

success in changing a situation and expectancies in human behavior influences changing

of norms and reducing or eliminating undesirable attitudes. SCT was therefore relevant to

designing health education and health behavior programs

Operational Definitions

Advocacy is defined as the act of protecting another's rights and property

(Shirmohammad et al., 2016).

Patient Advocacy " has been defined as being a patient representative, defending

the patient's rights and universal rights, protecting the interests of the patient, contributing

to decision-making and supporting the patient's decisions, ethical-centered skills for the

'professional self, and 'being a voice for the vulnerable". (Shirmohammad et al., 2016.

pg.2)

Patient Advocate according to Earp et. al (2008), describes a person who aids

patient's work to have an impact on their health care, wellbeing, medical bills, and

discrimination related to the patient's medical condition in general. Emphasis is on any

individual or organization that vouches for patients for their welfare. Patient Advocate may occur with those choosing to advocate in the interest individual Patient. It may take an organizational interest thus working in collaboration with the patients participating with their healthcare system to affect the positive outcome (Earp, French & Gilkey, 2008).

Advocacy and Collaboration shows a strong assessment incited by nurses and healthcare staff to act as patient's advocates. It voices to the morals and ideals surrounded in the practice and directs to the needs of patients and families that are vital to the nurse's roles. In the extent of collaboration, health care profession must extend their understanding of advocacy to embrace aspects that would encourage and stimulate optimal operational source of the healthcare team while attending to the patient needs. To that extent, Benner (2001), defined advocacy as "the kind of power that removes obstacles or stands alongside and enables" (p.212).

Counseling is the application of mental health, psychological or human development principles, through cognitive, affective, behavioral or systemic interventions, strategies that address wellness, personal growth, or career development, as well as pathology. (http://counseling.org)

Diffusion of innovations strive to explain how innovations are taken up in a patient's life. This is an idea of behavior or object perceived as new by its audience. This term takes a fundamental diverse approach to most of other theories of change. However, instead of focusing on influencing people to change, it sees change regarding progress or reinvention of behaviors to become healthier for the patients' or group's needs. The

diffusion of innovation encourages change not only in people but the innovation itself (Rogers, 1962).

Evidence-based practice (EBP) is the consciousness use of current best evidence needed to make decisions about the patient care. EBP is a problem-solving approach to the clinical practice and administrative issues integrating concerted practice in communication, sharing, and problem solving between the providers, nurses, healthcare staff and peers. This pattern of practice infers a shared concern, obligation, charge, and accountability for patient's care, (Babiker, 2012; Sackett et al. 2000).

Patient Advocacy Organization (PAO) offers patient and care-giver-oriented education, advocacy and support services. It is the responsibilities of PAOs to advocate for and provide services to patients by raising awareness of patients' needs, causes and treatment options to promote research to remedy or to avert pain (Rose, 2014). PAOs were started and run by patients and former patients that have credibility with the community, legislators, and government agencies, such as National Institutes of Health (NIH) and are regularly consulted.

Patient Safety addresses reduction of "risk of adverse events related to exposure to medical care across a range of diagnoses or conditions" (Mitchell 2008, p. 2). Mitchell further indicates that Institute of Medicine (IOM) reflects on Patient Safety as the "indistinguishable from the delivery of quality health care" (Mitchell, 2008, p. 1). Essentially, patient safety is the bedrock of high-quality health care for the safe treatment of illnesses.

Patient Safety and Quality is discussed as "being foundational to quality, where nurses can be invaluable in preventing harm to patients and improving patients' outcomes" (Agency for Healthcare Research and Quality, 2008, p. 6)

Quality Care is deemed as comprehensive cover under which patient safety resides (Mitchell, 2008). This indicates that quality is created based on a collaboration among pertinent people with an agreement about standards regarding norms, values and components about possibilities (Mitchell, 2008).

Socioeconomic status (SES) "is a complex and multidimensional construct, encompassing both independent objective characteristics (e.g., income or education) and subjective people's ratings of their placement in the socioeconomic spectrum". (Navarro-Carrillo et al. 2020, p.1

Limitations

Potential Design and/or Methodological Weaknesses of the Study

The greatest limitation in my study was related to validity and reliability. According to Patton (2002), there are no simple tests for reliability and validity. As a result, throughout the interview phase, the researcher must try their best to present the data and convey what the data shows, keeping in mind the study's goal. The fact that the research took place in a natural setting, (i.e., hospitals in Ghana), it would be tremendously challenging to exactly repeat the study (Wiersma, 2000). The methodology and design were based on phenomenological approach, permitting restrictions beyond the control of the researcher. The choice of this method was prompted by issues with several aspects of research methodology, that is, from the deficit of planning, clarity of drive and

intentions, in addition to the absence of the secondary inquiry before the initial aspect of the study. There was also a built-in bias due to the type of questions that were asked during the interview phase (Creswell, 2013). This depended on me, in that designing these questions was based on the topic of interest. Since these questions were based on my knowledge about the topic, there could have been the tendency of influencing the findings, due to my initial biases. I may also encounter a lack of consistency, due to explanatory models to texts, such as novels (Creswell, 2013), that enables the usage of a single explanatory model in several ways to various texts. This issue with single explanatory model may cause some difficulties with producing an assimilation of the criteria to determine if my study has rigor. There was also inherent time consumption constrains (Creswell, 2013), especially in when it comes to writing comprehensive historical facts.

Addressing the Limitations in the Study

Addressing the built-in bias is to work against the mind ensuring identification of the study description. To address the issue of repetition, I differentiated in my statements among recurrence practice and the nonrecurrence findings that may appear from the practices (Patton, 2002). In terms of lack of consistency, I created sets of measurements against which the inconsistencies in my study might be judged (Patton, 2002). To compensate for the time consumption (Patton, 2002), I also encouraged, endorsed and collaborated with a peer at the historical writing phase in my study.

How to Eliminate Limitations

The constraints from the limitations in my study were used to create internal and external legitimacy of the unexpected challenges that appeared during the research. In order to mitigate the degree of limitations in my research, I had to reduce the validity of my study. This may leave readers to wonder if the limitations in my study have impacted the conclusions. Limitations that had to do with the complete, serious evaluation and understanding of the impact in my study were nonexistent.

Addressing Threats to Quality in the Study

With first-hand knowledge of the issues pertaining to patient advocacy in Ghana healthcare system, there is the need to introduce the bias on the temptation to promote one theory over another in respect to the subject. As such, those pertinent responses that may seem to support and place emphasis on the biases would be abandoned, to ensure not to influence the research results. Example is to be careful not to sway expected responses from the participants in different localities (Bandura, 1977; Creswell, 2013). To successfully construe what has occurred in the study, I will address the respondent's opinion, make sure not to impose my own meaning to what was expressed, instead of understanding the respondent's perception, wording or actions. From the beginning of the study, I was equipped with the issues pertaining to the patient advocacy in Ghana. Therefore, a confirmation is offered not to force the data from the respondents to correspond to the concepts I may expect. Also, I will remember not to disregard the data that might not align with the concept (Creswell, 2013; Patton, 2002). In other words, I will provide all the data collected, even if they do not align to give support to my theory.

Ethical Concerns

Proposed Procedure for Providing Informed Consent

During preparation of the research protocols, I ensured that confidentiality, compensation, answers to questions, and the voluntary nature for participating in the study were taken into consideration. The document explained the purpose of my research, duration for the participants involvement, explanation of the research, documentation of the study, risks involved or otherwise, expected benefits of the research, if any, any alternative methods, any known advantages to the participants, and degree of the confidentiality of the records to be preserved. According to Orb, Eisenhauer, & Wynaden (2001), the nature of ethical difficulties in qualitative research projects is nuanced and distinct from those in quantitative research. Potential ethical problems arise, for example, when a researcher gets access to a community group and the consequences the researcher may have on members. Orb et al. continue to explain that qualitative researchers focus on the exploration, analysis and description of individuals and their natural surroundings. The decision to take part in an investigation depends on the willingness of a participant to discuss his experiences (Orb et al. 2001). The research protocol also informed the participants if any compensation will be offered for their involvement. Should there be no compensation offered, a statement such as "no funds have been set aside to be or will be billed to you or your insurance" (Vogt, 2007) or similar approach should be to address the process. I was cognizant that the consent form was not provided to precisely collect signatures for seeking an agreement from the participants. But it also implied a protocol for exchanging confirmation for the selection

of the participants (Creswell, 2013) in the study. Moreover, I have the ultimate responsibility for safeguarding the consent process and participants data that were collected.

Addressing Ethical Concerns

Arifin (2018) explains that in every research project, it is critical to protect human participants by following acceptable ethical guidelines. Because of the in-depth nature of a qualitative study, ethical issues resound more loudly. He also explains that, when doing a face-to-face interview with a vulnerable set of participants, ethical concerns become even more important. In the process of seeking consent, Arifin further explains that assent should be freely granted (voluntary), people should comprehend what is being requested of them, and concerned parties must be competent to consent. According to Orb et al. (2001), the research method generates a conflict between the goals of study, which is to generalize the benefit of others, and participants' rights to privacy. Doing good and avoiding damage are at the heart of ethics. They postulate that the use of proper ethical principles can help to prevent or mitigate harm. As a result, in any research project, the protection of human subjects or participants is critical. This means that in order to engage in a research study, participants must be sufficiently informed about the research, understand the material, and have the ability to choose whether or not to participate (Arifin, 2018). Only after a full explanation of the research methodology should participants consent to participate in the study.

Significance of the Study

Healthcare providers play a large role in caring for patients, by showing how human beings need to be treated with decency and respect. According to Gilkey and Earp (2009),

> Patient Advocacy is a concept that generally refers to efforts to support patients and their interests within the context of the health care system. The role of advocacy is credited to the medical staff for helping patients, such as those who are mentally sick or are in palliative care, as well as vulnerable patients whose autonomy may be in jeopardy. (p. 1)

Due to its role, research can assist otherwise to clarify patient advocacy, which is a mission required to develop both scholarly and applied efforts to develop quality healthcare (Gilkey et al., 2008). Patient advocacy is needed to support and empower patients to make an informed decision. Patient advocacy is needed and to build effective partnership between patients and their providers to work towards system of patient-centered care (Educator of Advocates, 2009).

Healthcare providers are required to play a large role in caring for the patients, by showing how human beings must be treated with decency and reverence. Such is the time an advocacy is needed to direct the unfamiliar healthcare system with appropriate dialogue among the caregivers, from clinical aspects through patient satisfaction. Being an advocate is to represent the patients during their time of need by affirming to be a friend and a protector on behalf of the patient (Negarandeh et. al, 2006). This can be a significant role to play as a health care provider. In that, an advocate's role comes with

certain privileges of insights into patient's interests (Bird, 1994), taking part in the

clinical judgements concerning the sick and the vulnerability as they augment a

professional responsibility. One of the significance of conducting this research into

patients' advocacy in Ghana was to recognize the perception in Ghana's health system

about the concept of patient advocacy as explained by those who have conducted similar

research in the past. My intention was to gain a better rationale of the medical staff's

personal and professional role in relation to discharging their duties to the patients

(Negarandeh et al., 2006).

The outcome of this research as provided later in this document is expected to

stimulate social and policy changes in favor of quality healthcare delivery and safety

practices in Ghana. Having gained awareness patients' experiences which mostly

highlighted their expectations, the key was to resolve to new strategies that would impact

restructuring sector for providing comprehensive primary care and improve practices in

the healthcare delivery in Ghana. Additionally, I placed emphasis on medical personnel's

obligations to provide clinical excellence and fostering team approach to convey

mandated quality clinical setting in the healthcare system in Ghana.

Significance to Practice

Healthcare providers play a large role in caring for the patients, by showing how

human beings are needed to be treated with decency and reverence. But when there is

sickness, they become more vulnerable (Daly, 2004), making them and their families

more apprehensive, confused, anxious and scared. Such is the time an advocacy is needed

to direct the unfamiliar healthcare system with appropriate dialogue among the

caregivers, from clinical aspects through to patient satisfaction. Being an advocate is to represent the patients during their time of need by affirming to be a friend and a protector on behalf of the patient. This can be a significant role to play as a health care provider. In that, an advocate's role comes with certain privileges of insights into patient's interests (Bird, 1994), taking part in the clinical judgements that concerns the sick and the vulnerable as they expand their professional responsibility.

Among the several importance of conducting this study into patients' advocacy in Ghana, one was to recognize the issues that may be contradictory to the norm that exists in the medical system. The study engaged people's lived experiences whilst receiving treatment in order to bring into focus the situations surrounding their wellbeing. Thus, the study was to generate a motivation and encouragement to enhance quality healthcare delivery and safety practices in Ghana. Additionally, I sought to place emphasis on medical personnel's obligations to provide clinical excellence and foster team approach to convey mandated quality clinical setting in the health care system to be at the vanguard.

Significance to Theory

Healthcare staff ability in relation to advocacy may be useful at the stage of personal or professional, a patient, and policy change levels (Mallik, 1998; Wheeler, 2000). Although there have been some progress made, policy change level can be effected by encouraging the inclusion and collaboration of governmental and non-governmental institutions, public and private organizations, international groups, citizen groups and communities, in addition to health care professional through policies

formulation in the public health and health care systems (Wheeler, 2000). Patient's advocacy is considered critical in healthcare and is needed to respond to the efforts of the interest groups as the representation of a good public health practice.

On personal and professional level, patient advocacy events begin as a twig from members with issues that come together to share coping strategies, to feel invested in the sense of the community. Such deeds may embrace activities to patient's education and careers and to handle the outcome of their sickness. The financial impact of the patient's sickness affects the whole family (Teasdale, 1998), and should not be underrated. In that, the psychological effects of those changes may have a great influence.

Recently, by the global sense, many patient advocacy organizations have created an effort in assisting patients to pilot the medical systems. This is done by coaching them with medical steering strategies, as well as practices that help patients in overpowering classic barriers within the health care system. Notwithstanding the medical steering has not been the only support role of the medical advocacy group's challenge. Patient advocacy support roles are meant to engage patients with rational, social and emotional effects in relation to medical issues outside the medical facilities and with emphasis placed on the strategies for increasing patient's quality of life. Medical providers, who are relatively closer to the patients, often than not, recognize themselves with patient advocate's role. But then, there are prospective interest struggles among advocacy responsibilities, their roles as medical providers, in addition to their position as medical advocates, in such situations (ANA, 2004). However, ANA (2004) directed that patient advocacy in its classification of nursing, termed it as the protection, promotion, and

optimization of health and abilities, prevention of illness and injury, alleviation of

suffering through the diagnosis and treatment of human response, and advocacy in the

care of individuals, families, communities, and population. In this case, advocacy in the

medical field entails its theoretical source in nursing ethics. For instance, the ANA (2010)

Code of Ethics for Nurses embraced language relating to patient advocacy as:

- The nurse's key obligation is to the patient, irrespective of an individual, family, group or community.

- The nurse encourages, advocates for, and struggles to protect the health, safety, and rights of the patient.

The attitude of the ANA becomes admirable with their point of caring for the

patients. Beyond any qualm that the medical providers are within the boundaries of the

care condition, the medical staff situation, the patient advocates in the collaboration

amidst patient, the nurse and the physician are solidified. In that respect, the Code of

Ethics should be measured as an incentive for the staff to exercise care over mechanism

and secure the best quality of life for the patient.

Patient advocates may often deliver the medical education and studies to their

patients, and their families. These individuals may endeavor to promote the family with

some form of communication relating to their sickness issues. With consciousness,

correctness and direction for the patient's care, the patient advocate is required to provide

a thoughtful representation in consistent treatment, and medications, as well as fighting

off modalities (Kamaker, 2015). This can be done by ensuring that questions about

treatment suitability are intensely discussed with the patient, families and medical staff,

and that, all treatments and concerns are promptly appeared in their health records.

Should the pertinent compliance standards not be met, the advocate may bear the liaison

with community omission, government agencies, or legal professionals to augment

negotiation on behalf of the patient and their families (Mallik, 1998; Teasdale, 1998). It

is, therefore, an advocate's role to uphold and preserve the patient's confidentiality in

compliance with local and national laws, so as to treat all the patient's and their family's

information as honored and sheltered.

Significance to Social Change

"Advocacy is always unashamedly purposive in its intent" (Chapman 2007, p.

31). Patients and their families are needed to be treated with honor and respect. Often

than not, they are mostly muddled, nervous and terrified when they become sick. This is

the time a patient advocate is required to assist them to navigate in such an unacquainted

health care structure and to enable them among the caregivers. There is also the need for

the medical providers to educate these patients by offering emotional and physical

support during any process. In this situation, they are to position themselves to assimilate

all the features of the patients' care, thus ensuring that their anxieties are addressed,

standards of care are met and are in an optimistic outcome for the patient relics the goal

of the healthcare team (Chapman, 2004). Within the ethnic beliefs, the importance of

patients and families must be heightened and respected by the medical providers. They

must be carefully monitored and accepted in all connections, particularly, since they may

have an impact on the patient's wellbeing and emotional level. To magnify a positive

social change, the medical providers must adhere to national, state, local and

administrative regulations in developing a response to changes (Chapman, 2004), provide care for all the patients with the same level of compassion, empathy, and professionalism, without permitting their personal biases to affect their practice. Furthermore, the impartiality of the advocacy must not just be simply placing concerns in the public arena, and then place an interval for the process to unfold. Once the objective has become fixed, advocates must plan to capitalize on the support with the strategic plan which would integrate behaviors to argue the patient's case, involve key effect stakeholders and create gravity on decision makers for a promising outcome (Chapman, 2004).

Summary

The goal of patient advocacy must be to reach out to patients, families and interest groups, by educating the patients to be able to cope and bear the effects of their sicknesses. The patients and survivors agonize from the sickness concerns may affect quality of their life. Such creates a financial impact on the family that should not be under-valued, as well as the psychological influences of the changes that may create a huge impact. A support event is needed to assist the patient and their families to cope with the patient's care, obliging purchases of health care materials, finding a financial gain for the families, selecting a health insurance plans, managing and averting the family members from vanishing into complete poverty and fortifying nutritional support for the patients. In the modern years, some patient advocacy administrations have endeavored to assist patients for steering the medical system globally by teaching the patients' medical navigation policies, and practices that creates help for patients to get rid of the unusual roadblocks within the health care system. However, there are other medical avenues that

the advocacy personnel do engage to help these patients. This includes an effort to assist the patients to handle psychological, societal, demonstrative, and emotional implications of medical issues within the internal and external atmospheric of the healthcare facilities, to place emphasis on the strategies for cumulating the patient's quality of life.

In United States for instance, the state governments have created ombudsmen to explore and respond to the patient's complaints. This office answers and addresses issues that relates directly to the patients, their treatment services and accepted values. This is not so in Ghana. There is no organization to address such complaints, which makes the patient's life so difficult, especially if there is no support. Whatsoever the emphasis on advocacy event, the procedure for recognizing an issue, examining the political framework, mapping the evidence of marketplace, attracting others, and instigating and assessing a strategic method creates some critical essential prospects for personal and professional growth. The patient advocacy objectivity does not distress in the public arena and waits for the processes to develop. Advocates tend to maximize support using a strategic plan which integrates means to maintain any case, involve the vital stakeholders to create a burden on the decision makers for a constructive outcome.

Chapter 2: Literature Review

The impact and patient advocacy usefulness continues to be inadequate,

especially in Ghana's healthcare system. Because of lack of infrastructure, providing

quality health care and the need for patient advocacy for its population falls short.

Absence of empathy and substandard customer service behavior can create lack of safety

and lack of communication, making patients feel vulnerable and prefer to choose to self-

medicate rather than seek medical assistance (Moudatsou et al. 2020). Additionally,

according to Alhassan and Nketiah-Amponsah (2016), the issue of low provider-patient

ratio in Ghana does create a burden and challenge for the healthcare staff to provide

superior service to the patients. The fact that patient advocacy is a must, quality care in

the clinics is even more critical. Therefore, Ghana needs not only strong discussion

concerning the citizenry's wellbeing, but also health and system reforms to eliminate

factors that impede patient advocacy in Ghana's healthcare system. Strides have been

made within the past 10 years to augment healthcare expenditure, but problems still exist

that impact patient advocacy including lack of process indicators to address timeliness

and model practices, as well as outcome indicators to measure rates for mortality, and

complications of illnesses in respect to lack of care and access for improved delivery.

The rights of patients must take a pivotal role in healthcare facilities, enlisting

strict guidance and laws that are needed to control, and placing emphasis on the

awareness and care for patients. This study on patient advocacy structure in Ghana

considered the moral aspect of patient care, delivery of services, and barriers and

facilitators that exist in the medical system, and how these issues, narrated by the

patients, may be ethically addressed by the authorities. This study is not only done to effect social change in the medical field, but to also provide the patients with education to be self-efficient, self-regulatory, be their own advocates to demand quality health care and be empowered to remain diligent with their health needs inculcated in their rights.

Scope of Literature Search

In preparing for the literature review, I accessed library databases and search engines to search across disciplines for research on patient advocacy including scholarly journal articles,, reference book articles, organizational websites, and articles and books written by journalists and experts in the professional field of health sciences. In respect to the Health Sciences, I searched the databases Medline, PubMed and EBSCO host, I searched through JSTOR to identify articles with more of humanities focus. Below are some subject-specific databases used tailored to specific words, terms and disciplines.

- CINAHL: Nursing responsibilities, Allied health services, and Health administration in facilities.

- CINAHL Complete: Full text for nursing articles and allied health journals.

- EBSCOhost: Advocacy, Patient Advocacy; Patient counseling; Patient advocacy and patient centeredness.

- Health Expectations (Journal): International journal of public participation in health care and health policy.

- The Canadian Nurse (Journal): Advocacy in action for the NP role; Nurse practitioners; Nurses role; Advanced practice in nursing/organization and administration.

- Scandinavian Journal of Caring Sciences (Journal): Attitude of Health Personnel; Patient Advocacy; Community Health Services/Organization and administration.

- Modern Healthcare (Journal): Patient Advocacy; Truth Disclosure; Patient Safety.

- The Milbank Quarterly (Journal): Health Policy; Health Status Disparities; Patient Advocacy; Social Determinants of Health; Rights, Humans

- Journal of Health Politics, Policy and Law (journal): Patient interest groups, health advocacy groups and Health advocacy in United States.

Most of the library databases provided the full text of the article that I viewed in the form of PDF. Others contained unique materials such as dissertations, and other studies conducted on patient advocacy and patients advocates. In addition, other universities, including Walden Library catalogs, were accessed for the title of the journals, to assess if the article was peer-reviewed, and to identify other resources by journalists or experts in the field of health sciences related to the topic of study. These gave credibility for review processes.

The Scope of Patient Advocacy

Megson (2013) posed the research question, should I be an advocate? This article reflected on the definition of advocacy and the various settings where advocacy may come into play. Megson addressed the relevant attributes of advocacy and the practice provided by the Health Care Assistants (HCAs) in the current health and social care settings. The article targeted the areas of effective communication, equality, diversity and inclusion, duty of care, safeguarding, and person-centered care: the fundamental components of advocacy practice for patients. The relevancy of this article spoke to the

roles of the HCAs, providers, and all hospital attendants by taking an action to help

people express what they want, secure their rights, represent their interests, and obtain

services they need, while working in partnership with the various healthcare providers on

the team (Action for Advocacy, 2013). Megson (2013) noted these expectations are at

the hospitals or in healthcare facilities. Further, Megson noted that advocating for patients

is something that should not be taught, but rather be an instinctive nature of anyone

helping a patient, be it a family member, a nurse, HCAs, physicians, and all providers

that ascribe to be a healthcare worker. Thus, should anyone choose to learn (rather

instinctively knowing) to be an advocate, then his/her role as a healthcare assistant is not

meant for the individual. Above fundamentals require that HCAs must be able to

advocate and to challenge discrimination and fight for the patients. However, Megson

asserted that advocacy should remain part of good quality care accredited by all

healthcare personnel.

Advocates are required to engage in patients' life to assist, encourage, or educate

families to understanding the ramifications of their decisions. Right advocates can have a

lasting impact on every patient they meet including the families, the staff or professionals

supporting the individuals, and ultimately, the individual with the need. In respect to

Megson, such impact can be positive or negative. An advocate is not health care

personnel to simply choose without thought and dialogue. Meeting an advocate who is

not equipped to be a reliable candidate can have a serious impact on the relationship

between the patients, the relatives and the organization they represent. Such a relationship

is likely to have a lasting connection with the patients, the relatives, and even other

healthcare professors. In the same token, finding the right doctor, teacher, or therapist may take an extended time and investigation, so as finding and attaining an advocate.

The article of Advocacy for health equity: a synthesis review was written by Farrer et al (2015). The authors addressed the barriers that hindered advocacy enabling health equity. Some of these barriers included economic zeitgeist, the biomedical health care viewpoint, and challenges collaborating policy sectors on the issue. Operative health care advocacy must embrace determined efforts to bring into focus an awareness and understanding of the social elements of health. Educating the staff on the causes as part of their medical training must be stimulated, with the professional training amidst the deprived populations. Advocacy organizations have the vital responsibilities in encouraging and supporting health impartiality specifying the challenges and issues connecting the worlds of various society, research and policy. Advocacy for health impartiality and patient satisfaction is a thoughtful endeavor to impact decision makers and other stakeholders to encourage in implementing policies that may support an improvement to health acre equity using evidence. Using evidence indicates that knowledge must result from qualitative and quantitative research suggesting support in the results. Using scientific confirmation as an initial topic for advocacy determinations would tolerate any advocacy effort without evidence that may enhance health changes that exists.

This systematic review of the academic literature is predefined dimensions needed for the patient advocacy and advocacy for health equity. The policy domain of healthcare is known to be multifaceted, with the scientific proof that is more questionable to be

conclusive in arriving at decisions. The possible evidential control can be enhanced by

packaging patient advocacy as part of the awareness transfer and change. These

innovations are needed to be employed both by researchers and policymakers who could

augment the uptake of such studies in policy processes. Researchers can play a role in

advocacy efforts, even though health care staff and underprivileged society, who are used

to hardships experiences, can be influential in directing advocate efforts Farrer et al

(2015) with patients' advocacy. Advocates must place emphasis on windows of

opportunity which open and close rapidly, establishing knowledge, proficiency and

reliability in enabling clear patient advocacy. Overall, this article combines indication

from the academic and the gray literature and offer a structural block of efforts to

advocate for health fairness to bring patient satisfaction.

The evidence in health disparities has worked its way the policy agenda in

European countries in diverse times. In the modern times, international organizations

have retained the concern in the political agenda even when interest had diminished

(European Commission, 2013). An international high point in thoughtfulness to the issue

of patient advocacy and fairness was extended with the publication within World Health

Organization (WHO) Commission on Social Determinants of Health (CSDH) in 2008,

calling for "closing of the health gap in a generation" by refining the situations in respect

to patient's daily life; undertaking the unfair power distribution, money and resources;

gauging and appraising the problem; and increasing the societal awareness on health

inequalities (Commission on Social Determinants of Health, 2008). Thus, most member

states of European nations are now taking the steps and means to decrease health care

injustices, and the minority have also used the national action plan to reduce them (European Commission, 2013). In a nutshell, this has prompted not only ethical anxieties, but had also encouraged growth awareness that health injustices and patient satisfaction have significant economic price tag attached to them. These injustices within and between countries have persevered and, in some cases, have increased. In the recent published WHO article has reviewed a recognized patient advocacy as a means of promoting favorable policy change (Commission on Social Determinants of Health, 2008; WHO Regional Office, 2014), but then the indication on how to do so successfully is isolated through the academic and gray literature, this advocating for solitary body of knowledge to support them.

Drage (2012) explored the connection between discussion and practice of advocacy using New Zealand's National Health and Disability Advocacy service. This was a description of an effective advocacy model focusing on autonomous practice in a separate environment, strengthened by an observational framework regarding consumer rights. Based on the definition credited to advocacy, it emphasized an awareness that was brought to individuals or groups about their rights and choices, pertaining to sustenance and access gain to healthcare. This article was written referencing two purposes. One reason was the exploration of ideas that were based on debate about the concept of advocacy, its meaning and delineation of the various methods used in empowering patients on their rights and choices. Secondly, it addressed a case study pertaining to advocacy service being used now in New Zealand. Drage (2012) focused on the case study of the origins of the advocacy service, the context of how consumer rights to the

advocacy service functions, how the present service works in New Zealand, and how the success of this model is evaluated. A secondary source method was used, a published research, university-based research papers, websites, speeches and interviews drawn from principal's informants in the Health and Disability Advocacy Service.

The article explored the duties linked to the advocates into two key areas of advocacy (Wilson, 2011). Advocates receive complaints and try to improve on advocacy and the Code of Rights to the providers and the patients and thus offer education. Furthermore, advocates must listen to the patient's grievances and concerns, offer needed information to help, explain concerns, expound on other options, and support patients to resolve their complaints. It is the duty of the advocates to educate patients and providers on the patients' rights as well as provider obligations. Thus, the New Zealand National Health and Disability Advocacy Service validated that practice empowerment together with autonomous service could offer an advocacy strategy that speaks to the discussion and issues concerning advocacy (Paterson, 2005). Studies about advocacy strategies direct researchers to prior deliberations about advocacy practices, crucial modifications concerning advocacy and its arbitration when addressing patients concerns, and the need strong methods to advocacy. These methods are needed to guarantee that patients are empowered in resolving their concerns and grievances. Conceivably, it might be considered an error to propose that New Zealand's health care system generates a situation whereby advocacy could be more effective. However, one could suggest that the New Zealand system may create challenges and barriers for other nations to offer patients with similar privileges, and empowerment mechanisms, permitting them right

information, support and quality health care (Drage, 2012).   In fact, all patients,

irrespective of their locations, must have similar access to quality care.

   Barriers and Facilitators to Patients Advocacy

Article on *Patient Advocacy: Barriers and Facilitators* written by Negarandeh, et

al (2006), spoke to advocacy as a critical role for the medical profession. Several studies

done around the globe have concluded that the barriers and facilitators affect the medical

staff's role in their practice. However, Negarandeh and other authors performed the study

in Tehran, concerning Iranian nurses. In this, the outcome may not be different than the

situation existing in Ghana and elsewhere, affecting patient advocacy. Thus, requiring

healthcare staff to accept the responsibility for being their advocates. There is no doubt

that patient advocates speak for the patients within the population whose individualism is

basically impaired by their ill-health. Negarandeh and other authors proclaimed that

patient advocacy is of a complex nature, due to its contentious and extreme element in the

medical profession. But then, even though the healthcare staffs know their roles and

ethical way of performing their duties, their superiority pride and the institutional

hindrances prevent them from accomplishing such feat. The authors concluded that

further research must be done to get into the deeper understanding of the obstacles and

facilitators, in addition to recognizing the connections between the barriers, facilitators

and the practice of advocacy in this critical profession.

This study was conducted by grounded theory method consistent with qualitative

research. This method has its roots in sociology and emphasis is placed on understanding

and clarification in predicting human behavior. It is an idyllic method for research in

nursing concept based on exploring human responses to health phenomenon. In this case, the Iranian registered nurses in the research believed that becoming patient advocacy will be difficult for them because of the barriers. However, these participants vowed to become patient advocates in their role to care for patients and their needs as well as barriers and facilitators. On the other hand, they would do the best they could as limited advocating. The study concluded that advocacy is quite complex, and it is also a debatable and risky module of healthcare practice. My contention here is that nurse's role must include advocacy since they have the patient's life in their hands and can do more to place risky situations under control.

An article on Understanding the barriers to multi-professional collaboration written by Daly (2004), addressed the key for providing quality patient care, placing emphasis on the obstacles to inter-professional partnership, and exploring new avenues for working in health care. Daly (2004) contented that transforming National Health Services (NHS) and its obligations from the politicians, educationists, professionals and patients will overcome the barriers within the multi-professional collaboration in delivering quality care for patients. Those in health care profession have not been positioned to take care of patients than now. Health care staff must become engaged with health advocates to intensify the momentum to achieve good results for patient's care. This article places emphasis on barriers that prevent collaboration needed in inter-professionalism to work effectively, so as to find new methods relating to health care to continue, especially in-patient advocacy in an environment of self-regulating disciplines.

Best patient care is shared by all health care staff to place weight on multi-disciplinary group to take combined ownership of a goal in effective strategy to overcome barriers in communication (Daly 2004; Yeager, 2005). Yeager continued to state that even though time and health care practice are considered as a contributory factor to breakdowns in patient advocacy and in communications, the efforts of effective collaborations, such as quality patient care and enhanced clinical success, are worth the determination. In primary health care setting, teamwork is an essential aspect that needs a substantial connection in aptitudes. Providers must be knowledgeable of and comfortable with their related skills of each other to take care of patients' welfare. Besides, an oft - overlooked health team members is the patient's themselves or their families as well as the community. Inter-professionalism care, staff must learn to integrate the patient and their families into the plan of care, especially in-patient advocacy. Establishing trust, respect, and understanding of other team members, motivates successful collaborative efforts in health care. This trust and respect grow from essential feature of collaboration (Grant, & Finnocchio, 1995; Daly, 2004), needed to care for patients. No one staff is liable for a patient's care and advocacy. Thus, all team members must be obligated with confidence in caring for those in need and must also be proficient in attaining their roles for care.

In the article, Health Care in Ghana, written by Salisu & Prinz (2009) discussions were held about the total health care in Ghana as evidenced by the claim of refugee status or asylum. A research conducted by Van den Boom et al (2004) explained that access to Ghana healthcare facilities remain a problem, because medical facilities

were not uniformly dispersed within Ghana. Most of the rural areas do lack the basic

facilities in the form of hospitals, clinics and the medical providers. The study further

indicated that "Ghanaians on an average, lives about 16 kilometers from any healthcare

facility to attain a medical care. Others cannot even go for medical consultation because

of the distance away from the facilities" (pp 1, 4). In the 1990s, Ghana Government

started trying to improve the accessibility to health care for patients to receive a quality

care. But then as of date access to health care facilities is no better than that started

decades ago. Presently, quite several patients do practice self-diagnosis and self-

medication (van den Boom et al., 2004), by vising any drug store to purchase what they

think is needed to cure their illnesses. This is dangerous to their health, not knowing

exactly the doses to take and dangerous combination. Even though the Ghana

government tried to raise accessibility into health care facilities, the situation has not

changed that much. The Ministry of Health planned to establish 176 health infrastructure

projects within a span of five years. Included in this project were 50 health care centers

encompassing 23 district hospital facilities and 26 community Health Planning Scheme

(CHIPS) (Ghana Parliament, 2007). In Ghana, most of the healthcare is provided by the

government and mostly controlled by the Ministry of Health and Ghana Health Services.

Unlike other westernized countries where individuals or groups of physicians have their

own clinics, resulting in competition.

The inequality distribution of health care facilities leaves the urban centers with

most of the hospitals, clinics, other healthcare facilities and the pharmacies. As such the

providers get overwhelmed resulting and relying on family members to attend to the

patient's needs, resulting in chaotic situation. In addition, because of the overcrowding in the urban health care facilities, some of the patients find themselves without hospital rooms and beds, hence lying on the floor with improper bedding and sanitation. On the other hand, due to less healthcare facilities, those in the rural areas do consult the African traditional medicine, which unfortunately kills some of the patients. It is therefore the responsibility of the patient advocates to intervene for the patients who resort to self-medication based on frustrations.

In an article titled Patient Advocacy in Nursing Practice was written by Kibble (2012). Research was conducted to investigate and clarify practical complications; barriers and issues nurses come across in their effort to advocate for those they serve. The author discovered that obstacles to advocacy can be largely characterized as antecedents and negative consequences or deterrents. The experienced nurses and/or the healthcare staff are needed to be fortified to advocate with empathy, confidence, theoretical and practical knowledge in addition to personal knowledge of their patient. But then the deterrents include apathy, disagreement with the employing organization, conflict, medical dominance, negative consequences, harassment, confusion and ignorance of the perception. Nurses have often conveyed frustration and ange*r* as an outcome of having to portray advocacy on behalf of the patient (Hanks, 2008). Research done involving senior British nurses has shown that their practice is subjected to inconsistencies and paradoxes and ended causing inter-professional struggle within the health care system (Mallik, 1998). An empirical research was used to provide the actual examples of the trials nurses and healthcare staff face in the healthcare setting expecting to place emphasis on how

nursing advocacy theory is translated into real practice. Nevertheless, advocacy in nursing activities did receive less exposure in the literature research than the actual concept (Vaartio et al., 2006). The research method used was consistent with the study. By acting as patient advocate, healthcare staff is made to empower weak and the defenseless abilities in patients, liberating them from distress, anxiety and unrequired treatment. Patients need fortification from health care professional's ineffectiveness (Vaartio et al. 2004) Mallik (1997) also applied that in as much as patients have historically been considered in becoming susceptible due to their frail condition, it is only recent that outcome of cultural conditions has become liable to impact upon the patient's independence, hence initiating an obligation for advocacy. Mallik added that this became a reason for a Lawyer, Annas, in United States, to propose a "Model Patients' Bill of Rights" and the role of "Patients' Rights Advocate". Patients' Rights Advocacy role was reckoned to be autonomous within health care organization. Annas felt that health care providers must be held accountable with their vital role to play in the patient's rights.

The Role of Healthcare Staff in Patient Advocacy

Schwartz (2002) in his article entitled, Is there an advocate in the house? The role of health care professionals in patient advocacy, discussed the need for professionals to advocate for patients, especially when the patients are in no situation to advocate for themselves. Advocates must play a vital role, either as a family member or as a professional, especially when a patient is in a vulnerable position. With that in mind, guidelines must be laid out to offer some form of protection against harm being done to

the patient. Schwartz ascertained that advocates must support any decision a patient makes in their own interest.

Schwartz contended if a patient advocate is needed at all to represent patients and be their protective ally. Being a patient advocate is quite essential due to the fact that the role of an advocacy comes with the knowledge of the patient's perceived interest, including the authority to assist in clinical decision-making involving their health and wellness. Patients may need extra provision for their care and their choice of treatment, especially when the patient is not being understood by the clinical staff. It is the advocate who can step in to express the patient's desire into a persuasive form of treatment plan, and communicate with the clinical team in the direction conducive for the patient.

All over the world most patients revere providers, including the nurses, medical assistants, clinical nursing assistants, to the extent that they keep quiet and take any abuse extended to them. The fear in this angle is that patients at this point are vulnerable and believe their health is in the hands of the providers. In fact, it is, but not what comes with it. Providers are supposed to be passionate, show empathy, concern, considerate and feel empowered to treat those they have assigned to serve. There is an understanding that due to the number of clinics, hospitals and health facilities serving quite several patients, the clinical staff tend to be overwhelmed, not to mention the underpayment. This creates tension, bringing in discernment between what is expected to be an obligation of the clinical staff and what goes above realistic expectations. The article brings to the forefront where advocates must walk the fine line between expressing the views of patients and protectiveness. If not, instead of supporting the patient's interest may end up

making the decisions that may create disservice to the patient, which is "overriding a person's self-determined choices on the grounds of their own best interest. Advocacy in this manner will result in being morally wrong, should it be covered as representing the patient's interest" (Schwartz 2002, p.38).

An article on Holding the Patient's life in my Hands: Swedish registered nurse anesthetist's perspective of advocacy, written by Sundqvist (2014), addressed that nurses are required to make patients trust them throughout the period of care. In that the nurse now is the patient's advocate and must find the strength to speak on their behalf and question them as well. This study was a descriptive study asking the nurses perception of advocacy in providing care and moral commitment for their patients. The Swedish nurses stated that being patient's advocate involved their health and welfare issues which may tend out to be stressful for them. The nurses felt that their work environment can be helpful when their voices are heard and their views are taken seriously regarding the patient's interest. In addition, all healthcare staff must place emphasis on those they serve. By so doing they would feel they have the patient's interest at heart and can advocate for them.

Advocacy is in the form of someone taking care of him/herself or taking care of another. In the field of health care, it is linked to patient care focusing on their needs, desires, and well-being and in the patient's shoes to feel what they feel. At the time of indisposition, patients are in a vulnerable state, and this is the time the roles of advocacy and protector (Sundqvist, 2014), become healthcare professionals and could uphold and accountability for the patient's well-being (Mauleon & Ekman, 2002). The article

revealed that as a patient's advocate, nurses must stay ahead of their game to plan for their care. Act like detectives and be in their best form to identify each patient's risk factors, involving their psychological aspects to guide them from one step to the other, because their actions must have a drive and goal in the patient's welfare.

In the Voice of Florence Nightingale on Advocacy, the authors Selanders and Crane (2012) discussed the goals of nursing as an unchanged role to provide safe and caring nature to promote patient health and well-being. The effective use of an interpersonal tool, such as an advocacy increased the care-giving nature. The authors indicated Nightingale appreciated the egalitarian human rights and advanced leadership principles and practices offering useful advocacy tools for health care practice in the 21st century. Through her religious beliefs and insightfulness of health care provider's, Nightingale, one woman, was able to change the status of the health care profession to that of a profession, instead of domestic service (Nightingale, 1895a). Nightingale was instrumental in developing intellect, personal motivation, available opportunities, and her own personal strength to create a lasting professional change (Cook, 1913; Dossey, 2000; Bostridge, 2008). She used an effective tool of advocacy for both individuals and the healthcare profession, especially nurses combined.

Through the value of conceptual and practical advocacy approaches, for the nursing profession in the 21st century, this article was written to discover Nightingale's use of patient advocacy as an instrument, and to recognize and review her accomplishments. I agree to this article, in that it was obvious that Nightingale's advocacy was as significant for the 21st century, just as it was in the 19th century. Patient

advocacy had not always deemed strong belief in nursing. But then advocacy document

in growth of the American nursing and health care curriculum, such as Nursing and

Nursing Education in the United States and A Curriculum Guide for Schools of Nursing

(National League of Nursing education, 1937), did not clearly address advocacy.

However, early nursing and healthcare instructions stressed prediction and a position of

subservient to the physician. In as much as Nightingale expected compliance in obeying

the rules and medical direction, her intent was to permit the health care staff to be

purposely advocate for those they served in their profession (Selanders and Crane (2012).

There is the need to measure advocacy activities against the image of legal advocacy to

permit the actions that are not acceptable and can be theorized as a beneficial tool,

causing the myths to be dismissed in respect to what nursing advocacy represent.

Protecting patients from unlawful, immoral and unethical actions are for generally named

as a manifestation of advocacy (Jowers-Ware et al, 2011, p. 26). ANA required that their

code of ethics, nurses and health care staff "must be alert to and take appropriate action

regarding instances of incompetence, unethical, illegal or impaired practice by any

member of the health care team or system or any act on the part of others that places the

rights or best interest of a patient in jeopardy (Boyle, 2005).

Article by Day (2006) on Advocacy, Agency, and Collaboration speaks to

advocacy for being a central part of ethics that relates to medical professional practice.

Day stated that Code of Ethics in American Association of Critical-Care Nurses (AACN)

places emphasis on the duties of the medical staff as patients' advocate and prompted that

this profession must take a critical stance on patient's care. As part of nurses' roles, they

are to encourage, advocate for and attempt to protect their patient's health, safety and rights. (American Medical Association, 2001). Advocacy became a vital ethical role within the medical staff's professional role in their job duties, making the connection in the literature of health care organizations, such as ANA, and the American Association of Critical-Care Nurses. This has drawn attention to the role of the medical staff as patient advocacy, whereby reassuring the staff to remain proactive relating to those they serve. The ANA code indicated that *"The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient"*. In this regard, the explanatory statement emphasizes safety and protection connected to privacy, confidentiality and participation in research, (Day, 2006), thus making the staff accountable for their diminished professional and questionable practice (ANA, 2001). In a healthcare field, the staff's attitude must be to help the patients and shape their world for the better. By such attitudes to the population served, nurses are to help control the scope and type of patients, be it "have or have nots", bright or dull, threatening or protected to make the world better.

An address made by Kline, (2006) to the Advanced Practice Work Group about American Association of Critical-Care Nurses (AACN) linked advocacy with protection. He stressed that, advocating for and defending patients comprised of questioning goals of care when there is a misalignment between patient-family and medical team goals; integrating precautions of ethics and morals expected of health care staff into protecting patients by identifying and reporting potential harm from colleague, whether it is a nurse, physician or any other healthcare professional. Kline (2006) continued to advise that any healthcare staff accepting to be an advocate is stimulated to place emphasis to protect the

patient from possible harm offered by an inferior practice by colleagues within the team. However, it was construed also that these comments stated by ANA and AACN organizations are deemed as a precarious condition making patients to require a nurse-advocate to assess their role in respect to the patient and families' well-being for quality care and efficacy. As such, advocacy must be considered as a vital concern from the position of mistrust.

Wong and Koloroutis (2015) addressed What Matters Most in his article. He stated that patients' accountability to culture was essentially more important to patients. The authors went further to indicate that each medical staff should be accountable and display a positive impact on the patient's culture at every interaction. Every interaction with the patients should show support for their well-being. For all health care professionals are required to become responsible to patients' welfare, making all other aspects of the profession to become worthy, including patients' satisfaction and safety and even employee engagement. If all healthcare professionals become reliable and shows a patient-accountable method, their welfare would be improved, such as their safety, satisfaction, as well as employee engagement. Healthcare staff went into healthcare field to take care of people. Therefore, their oath and licenses must be upheld ultimately.

The Role of Interest Groups and Organizations in Patient Advocacy

In the article, Going for the Cure: Patient Interest Groups and Health Advocacy in the United States written by Ann Keller and Laura Packel (2014) addressed that patient groups are most likely to use organizational advantages to pursue congressional

petitioning strategies to receive the care they needed. This research finds that the patient

groups in advocacy seldom form alliances regarding diseases and well-being, to

relinquish the prospective to mutually express their interest in their well-being.

There have been several discussions among the champions of the democracy

system in a vital role with possibility of supporting patient advocacy, and those who

carefully document the empirical exits from the pluralist models. Recent research studies

have added more weight to those who oppose patient pluralist ideas. Nonetheless, a

considerable increase in numbers of patient interest groups, since 1960s (Berry, 1999),

studies indicate that such organizations when compared with the numbers; skills and

resources are controlled by feeble traditional clusters (Schlozman et al., 2012). These

findings have also been attained in the field of health advocacy, especially in respect to

those searching to modify state laws regarding newborn screening (Grob, 2012), all

relating to patient advocacy.

This study emphasizes the growth in statistics and perception of patient groups

(Oshinsky, 2005) and interest groups who continue to fight for patients to join the groups

that fight for patient advocacy. Irrespective of increase in people within health-related

advocacy, (Best, 2012a, 2012b; Stratch, 2010) recent studies focus on addressing the

political phenomenon of patient advocacy groups examining health policy results. Instead

of overlooking the probable cause of patient advocacy groups, these studies rather place

emphasis on policies that do not entice group memberships that are not controlled by the

patients. In addition, these studies fail to provide a sectional representation of patient

groups. Instead, they do exemplify a variety of events in which patient advocacy groups

might participate, painting an encouraging representation of both mobilization and usefulness. Holding patient's life in their hands by the advocacy groups needs to include moral and medical obligation, to the extent of often going against the patient's will and act as to what is right for their wellbeing. Such act must be linked to the term A*dvoCare*, an ancient term that indicated to summon and call to one's aid (Sundqvist, 2014). As an advocacy group or an individual acting in an agreement with patient's wishes, they must do so willingly and responsibly. Logstrup, Danish philosopher, stated that holding a patient's life in your hand must be considered as an ethical responsibility. And even though this responsibility is tacit, it is absolute and unconditional, commencing from the life cycle, ascending from the trust the patient requires and wants.

In Patient Advocacy Organizations: Institutional Conflicts of Interest, Trust and Trustworthiness*,* written by Rose (2013) described the duties of Patient Advocacy Organizations (PAOs) which advocated for more funding for research to be conducted, changing of policies and provision of services to be rendered to patients and their families. Due to the fact PAO has been trustworthy in effecting changes; these organizations can bring public awareness of what is missing in healthcare, medical conditions and what needs to be implemented to bring about social change. In addition, this article examines further the medical reports, discrepancies involved in Medical Research, Education and Practice in relation to PAOs investigation into patient's healthcare. Over the past years, many of these organizational groups have achieved their aims of fighting for patients. The reason is that PAOs were created and are run and organized by former patients with serious illnesses. They tend to have integrity and

credibility with the public, legislators and government agencies, such as National Institutes of Health (NIH), upon whom they seek consultation with.

There are discrepancies or Conflicts of Interests in Medical Research, Education and Practice, published by the Institute of Medicine (IOM) of the National Academy of Sciences. This addresses patients' lives that are often jeopardized in the hands of providers, due to careless attitude by those who are supposed to care for them. This is specifically in the third world countries. Should public awareness see the light, lots can be done especially through PAOs which can fight for these vulnerable patients for policy changes (Rose 2013). Most of the patients in these third world countries do not have trust in their providers. As such, policies must be developed in order to promote dependability, for patients to believe that proper care can be received in the hands of those they are entrusting their lives to.

The Essence of Social Policy and Clinical Ethics Consultation in Patient Advocacy

The definition of the policy advocacy explained by Ezell (2001) indicated the "purposive efforts to change specific existing or proposed policies or practices on behalf of or with a specific client or group of clients" (p. 23) made it even more powerful for patient advocacy. This requires for principles that needs changing when serving clients or patients, due to their ill health. In caring for patients, there must be an effective thinking on a broad base of methods to be used in serving clients. It must be presented on concerted efforts by all involved for a better welfare of clients and patients, and must then be evaluated openly and offer opportunities, which would lead to improved alliance within social services, providers, and those advocating for better service for patient care.

With alliance of all those mentioned earlier, and the state government would help to create a very strong opportunity for making health care delivery a priority.

In the article of Recognizing New Opportunities: Reconceptualizing Policy Advocacy in Everyday Practice written by Mosley (2013), discussed the organizational policies in social work with emphasis on patient advocacy. Social work ethics deals mostly with human being's welfare, which when not addressed may affect lives. The article stated that in recent times changes were made in the government contracting level and in the public practices that gave way for better policy support, providing incentives to those practicing advocacies professionally with other organizations. Nevertheless, these discussions brought up various questions about autonomous image and the extent upon which advocacy in social work reveals client anxieties. This article demonstrated a model for how policy advocacy can be essentially hypothesized to exhibit changes in the policy and the funding milieus. These changes can bring about ways social work research and theory can impact practice realities.

There is a relationship between social work and the advocacy, but then it leaves awareness gap that needs to be filled, in respect to how policy advocacy must be supported by nonprofit service providers and what it is being advocated for. Social work employees have been working tirelessly to work with other patients and clients advocates for the welfare of those they serve. But then, because social workers and the human services organizations work is involved in various kinds of advocacy, a need for collaboration in advocating for changes in strategies and guidelines will impact provider practices in caring for the patients. Mosley continued to stress those developing trends

that will reform prospects to shape the advocacy policies, as well as offer new areas in research study in the 21st century practicalities.

The article of Mediation and Advocacy written by Fiester (2012) addressed the problem that caused the need for an advocate's voice or an interest of a stakeholder to be heard, when a disputed situation is not heard. Causing patients advocate's concern was needed to be disregarded instead of addressing the issues raised. When a patient advocate's concern is not heard, mediation should be the ultimate choice by the ethics consultant who should be the responsible personnel to protect the patient's interest, as well as being held accountable for making sure that everyone is heard, and not ignored. Rasmussen (2012) accepts mediation as ethics consultation. But then, that will preclude the consultant to remain neutral. She further indicated that when an ethics consultant takes a mediation approach, it disqualifies them to be a patient advocate. Mediation though does not exclude patient advocacy since it demoralizes impartiality. But then, mediation calls for universal advocacy for all parties involved, is not just for the patients, but the interest of all concerned must be addressed in the clinical setting, beginning with the provider's right down to patients and their families. There is always a second side to every story. If the need or a voice of a patient, from a child to the decision maker, as well as a patient who lacks full cognitive capability, creates patient advocacy to spring up. Such is the rationale for this research. When a patient's voice is genuinely represented, the patient advocate can use this opportunity in a dialogue with all parties to bring awareness into a shared resolution in the best interest of the patient.

Key Issues on occupational Health and Safety Practices in Ghana written by Puplampu and Quartey (2012) described the practices in Ghana as designed in finding the principal issues associated with the professional health and safety practices in Ghana. It was evidenced that much concern had not been given to the patients care and wellbeing. The article also stated that even though some effort had been given to the occupational health and safety practices, it had resulted in occupational risks, hazards, diseases and challenges. The article concluded that emphasis was needed to be given to the occupational health and safety practices, to safeguard safety promotion.

The reasons stated above are more intensely related to patient advocacy in Ghana. Much awareness must be brought to the health care situation in Ghana regarding health care practice. This study done by peers in Ghana, have shown evidence to the welfare of the Ghanaian patients, the occupational health and occupational safety as is practiced in Ghana health facilities. Furthermore, much study has not been delved into the organizational and national level to bring much focus on the healthcare issues. This has been a problem for most African countries that are overwhelmed with occupational health and safety practices. Basically, not many efforts have been made from the level of industrial areas as well as the government to care for the Ghanaian patients (Meredith, 1986; Regional Committee for Africa Report, 2004). It goes to show lack of advocacy for the Ghanaian population, whether individual is employed or not, they are all vulnerable when they get sick. However, the affluent people with means to attend private hospitals for treatment are well taken care of and receive better respect than in a public hospital. Every individual in any nation has the right to a quality health care when they are

vulnerable. The writers of this article stated that "Occupational health and safety is a human right issue which must be given legal, social and moral consideration in the country" (Puplampu & Quartey, 2012, p. 155).

An article, Ethics, culture and nursing practice in Ghana written by Donkor & Andrews (2011), spoke to Ghana medical facilities and the staff. The authors expounded on the ethical issues as to how medical staff performs their roles in the public hospitals. They went further stating that Ghanaian nurses must be held accountable to the same global Code for Nurses, as approved by the International Council of Nurses (ICN). The ICN code is a professional code that identifies the values required to assist patients in their cultural domain. Using ICN code as a global and ethical benchmark, in 2009, a survey was conducted to establish how the medical staff in Ghana, ethically and culturally respond to problems faced on daily basis. It was established that Ghanaian medical staff do not meet the criteria and approach used to resolve the ethical issues as determined by the ICN Code. This became apparent that nurses must also be held accountable to the local institutional and the cultural approach in Ghana. Subsequently, despite the fact the codes of the cultural values are of common denominator with ICN, in addition to the global ethical principles, there are other medical personnel who do oppose them.

The study was conducted to gain an understanding of how Ghanaian healthcare staff manage their roles in Ghana's healthcare system and it was done using a qualitative descriptive design. This methodical approach was used to define life experiences and

give them meaning, so as to gain an insight, explore the depth, richness, and complexity inherent in the phenomenon. (Sandelowski, 2000).

The use of the descriptive research design had as its goal on all-inclusive summary of the events. The rationale for the authors using this method is quite acceptable. They could stay close to their data and got into the external phase or words and events. Typically, qualitative designs allowed the authors for an extensive but reasonable combination of sampling, data collection and analysis and re-presentation techniques. This is considered as a good choice when conventional reports of the phenomena are anticipated.

In Batten's (2013) article on Assessing Clinical Ethics Consultation (CEC): Process and Outcomes stressed the need for additional research to be conducted focused on increasing process-based theoretical models for CEC and numerous approaches for measuring these procedures. This article addressed ethical concerns that soar with regularity in present-day healthcare. A survey conducted indicated that 95% of providers have been faced with such ethical predicaments that were very hard to address (DuVal, et al. 2004). Such empowered for a proposed literature needed to educate providers and other healthcare professionals to address the ethical issues they face on daily basis in patient care.

Having first-hand knowledge about the healthcare in West of South Sahara Africa, this article has a bearing on patient advocacy that needs to be addressed. Most of the providers are required to have a direct method to evaluate the quality of ethics in their consultation, formative and process-based evaluation of their patients for proper

care. Batten (2013) stated that the formative assessment is intended to hone the practice toward the theoretical model, based on the fundamental properties of service to patients. This literature addressed patient advocacy based on defining "process", as secured activities that required an emergence between consultants and patients, their families, and the healthcare providers which quite often is non-existent in these parts of the world. The article plays a valuable role in the study, as it directs a, goal in specifying what it means to improve the condition and quality of service patients are to receive in the healthcare facilities and in the hands of those they receive treatment from. Patient advocacy based on defining "process", as fixed activities emerge between consultants, patients, families, and the healthcare providers which quite often, is non-existent in the third world countries.

In the recent years, majority of healthcare facilities have adopted CEC as a method of speaking to ethical issues in patient care. Such goal will help to improve the condition and quality of service patients need in the hands of their providers. All advocacy champions and the critics have identified the need to use CEC which is not necessarily needed to evaluate healthcare cost, but more for quality care and user satisfaction. However, the failure of this outcomes-based evaluation poses no jeopardy to CEC, since the healthcare is incessantly acceptable by the central need for deciding ethical issues in patient care. Consequently, conducting further studies towards evolving process-based theoretical strategies for CEC and finding other means to assessing the processes is a must (Batten, 2013).

In the article of Advocacy through a Prism: A Response to Commentaries on Patient Advocacy in CEC, Rasmussen (2012) indicated that the need for patient-advocacy arises when the patient's priorities are not getting proper recognition or consideration. The Fiester (2012) further stated that when patients or family members feel bullied or when their wishes are not given the appropriate respect and weight, then the Clinical Ethics Consultants (CEC) should advocate for the patient and family member. In other words, if the clinical consultants can advocate for patients, there is no need why they should not. Patients become overwhelmed when indisposed and may not know what to do. Therefore, allowing CEC to step in to advocate for them is must, because one of their goals is to make sure that patients are educated as to their rights regarding moral issues. However, these are not necessarily left for only advocates, but anyone that cares.

This article is not by all means stating that clinical ethics does not have one resolution. It should be known that the ethical issue may require a story of advocacy and that is not done by only one person's action, but by the motive behind as to why patients are treated the way they are. Patient advocacy is desired to improve the services often received in health care facilities, to bring awareness and to be heard. A typical example is where a family member has to go from home to feed the patient or bath them in the hospitals, while the medical team just stands by unconcerned.

The question as to whether the moral obligation by clinical ethics consultants may involve in patient's care at the time of treatment has not addressed intensely. Rasmussen (2012) went on to state that focusing on patient's care by consultants' faithfulness, and the limits of appropriate professional practice, must be clearly understood. Opinions for

and against patient advocacy in clinical ethics consultation, signifying that patient advocacy is not quite permitted. However, it is not fundamental to the practice for discussion, but must empower CEC to have entrusted role to care for the patients just as all advocates and providers must do.

Significance of Patient Advocacy on Patients Safety and Quality of Care Delivery

Article on Patient Advocacy & Safety, written by Hanks (2010) spoke to the critical role nurses were required to play in the realm of their practice. Hanks indicated that recent focus on patient safety has improved the attentiveness of the position advocacy played in endorsing quality delivery of health care. It became a challenge and often created hindrance for both the nurses and the patients, where the health care staff must show their expertise, requiring health care providers to have ethical duty towards their patients, with the anticipated skill for being a healthcare provider. Nurses and total medical staff must be reminded that advocacy for their patients spoke to actions assisting and protecting patients in any healthcare environment. Even though an advocate can create both negative and positive role for the staff, with the use of real communication skills, and conditions to enhance good advocacy abilities, healthcare staff and nurses can offer advocacy and continue to be diligent acting on the patient's best interest. Applying effective advocacy abilities will eventually increase patient safety in the public healthcare facilities.

Hank's study was conducted to identify nurse's role developed in the late 1970 within literature. It was conducted using a historical foundation from Curtin, Gadow, Kohnke and Benner. The vital point of the historical literature was a concept for the

nurses to assume the role of patient advocates. In this regard, only patients are

endeavored to approve what is in their best interest, enabling nurses to support their

decision process. In a nutshell, healthcare staff is not endowed to make decisions for the

patients without their consent, and the staff is not permitted to act on behalf of the patient.

In this instant, healthcare staff only becomes an informer for the patient only after the

patient has made their decision (Hank, 2010). I deem this theory as weak, because

healthcare staff are required to act on behalf of the patient, fight for and stand up for and

with patient especially when they are unable to do themselves. In addition, the staff is to

protect the patient while ensuring their safety, acting as a liaison in the healthcare system,

creating communication gap between the patient and other healthcare professional. By

ANA (2001) codes, nurses are empowered with ethical duty to advocate for those they

serve within the predictable capability for the staff. Research about advocacy has

evidenced that advocacy comprises actions for aiding and protecting patients within

healthcare setting, so to act and speak for the patient. Further studies emphasized also

that acting as an advocate for patients can result in undesirable concerns. Nevertheless,

by using an actual communication skill and acting to develop advocacy skills, effective

advocacy can be placed on patient's best interest. But then, effective advocacy skills

would eventually improve patient's safety in the healthcare environments. Healthcare

staff is employed to make an ample connection between advocacy and secured location

for their patients, to help patients to achieve the optimum outcome for their health.

In a report by Chang and others (2011) an empirical study was done to examine

the influence of social capital, knowledge sharing, and the effect relating to patient safety

and advocacy. The authors explained that being patient's advocate and sharing knowledge were important to their safety. There was an indication that, instead of researching into concrete effects of rewards, social capital and interaction with patients would bring about trust and vision that would go directly to show support. Chang and his team (2011) suggested that healthcare administrators must foster and ensure group trust to initiate a mutual vision among not only the Registered Nurses, but all medical staff, to inspire optimistic goals towards knowledge sharing.

This study was done to explore the relationship between hospital organization for patient support in advocacy, medical staff confidence with the administration, as well as total insight into patient safety, and phases of safety communication as potential mediating variables.

Auer, et. al. (2014) established that the secondary relationship between "management support for patient safety and overall perception of patient safety" were really noticeable than having a direct relationship with the patient. In that, support in advocacy and safety community played a vital mediating role between the "management support for patient safety and nursing professionals' assessments of patient safety. In other words, hospital administrators and unit leader interactions would improve patient advocacy and safety in general.

Adams (2010) in his article explored the gap between genuine care of conducts relating to quality health care and its deterrence. In that, when patients are equipped with understanding their health issues, education and intervention, they would be empowered to develop self-sufficiency, self-actualization, abilities to prevent their ill-health and

consciousness into social support. Such created the need for contentment for an individual to be aware of their health literacy that covered their wellbeing and capabilities, fight for their rights and know that the health care system must be held responsible to set the parameters of the boundary for delivering quality health care relationships and relief to the people they are serving. Providing education to the patients must also be a focus, to create quality methods for evaluating the impact of public health programs.

Summary and Conclusions

Presently, health care profession has never been positioned to take care of patients than now. It is about time that health care staff becomes engaged with health care advocates intensifying the momentum to achieve good results for patients' care (Daly, 2004). This can be achieved by changing the National Health Services (NHS) and its obligations from the politicians, educationists, professionals and even patients themselves to overcome the barriers within the multi-professional collaboration in delivering quality care for people. There is an eminent and obvious contention that the right of patients and their welfare is not completely protected whilst under the care of the medical providers. There is no close relationship between nurses and patients (Negarandeh et.al, 2006), indicating that the function of patient care must be substituted with recording processes. Implementing and encouraging trust in the patient advocacy organizations and in the health care staff would perhaps ensure that patients are supported. However, it can also upsurge the jeopardy of harm to the citizens, especially when the population do not appreciate the fact that the interest of the health care profession is placed before their

own. In this regard, policies addressing conflicts of interest, trust and trustworthiness should be placed to motivate all health care profession to honor their crucial commitments, to create trust and change their behavior, policies, and procedures for treating those under their care. Extensive collaboration and communication must be done to achieve such feat for the patients' care.

Whitehead (2001) stated that should a present situation continues affecting social behavior models that are not adopted as a concerted and routine part of nursing practice, then nursing may well continue to fall behind other health professionals in the discipline of health education. Engaging in the present study into the core of the people's health care experiences whilst receiving treatment will bring into focus the situations surrounding their welfare. Thus, this study may bring stimulation and encouragement to enhance quality healthcare and safety practices in Ghana. Conducting this research would highlight patient's experiences and expectations, with the intent of correcting and providing comprehensive primary care, as well as improving practices in the healthcare delivery in Ghana. Focusing on health care staff's obligations to provide clinical excellence and fostering team approach to deliver mandated quality clinical setting in the health care system must be at the vanguard of staff's duties. In a nutshell, this study may stimulate dialogue to eradicate some of the issues plaguing patient advocacy to effect social change and fill the gap in quality discharge of services by the medical team in Ghana.

Patient advocacy denotes flawless care and ethical way in a health care profession. It is dependent upon factors such as social relationships, human interactions,

and moral distress and its side effects. But then there are pieces of this concept that have not been identified. Several studies have denoted to the failure to expressed and explained the concept of a healthcare advocacy, making the results not in agreement (Hanks, 2010; Maryland & Gonzalez, 2012). The unclear clarifications of patient advocacy enact several problems on healthcare providers. It is my aim that this study will help to emulate constructive and functioning patient advocacy practiced in other nations to encourage patient's interests, which is fundamentally a central objective advocated by a caring nurse, such as Florence Nightingale, or any caring health care staff.

Patient advocacy is a social problem that can be assessed from personal and professional aspects. There must be a show of empathy and protection for the people that are served. Protection of the patients has frequently been explained as an essential module of patient advocacy. However, showing empathy for the patient is deemed as a new idea which seemingly can be used in the training of the healthcare providers for better understanding of the relationship between these two entities (Davoodvand et al., 2016). According to the authors,

> "the results of this study can be used in the development of nursing students and novice nurses, retraining of employed nurses, and sensitizing of nursing managers and planners and other related occupations to the improvement of nurses' performance, reduction of the adverse effects of patient advocacy, and promotion of the health of the society". (Davoodvand et al., 2016, p. 8)

As such, further studies are needed to be conducted on the relationship between empathy and patient advocacy.

Chapter 3: Research Method

My study into patient advocacy in Ghana considered the ethical aspect of patient care, delivery of services, and barriers and facilitators that exist in healthcare facilities, and how these issues are narrated by the patients such that these issues may be ethically addressed by the authorities. I sought to uncover the reasons behind patient perceptions of healthcare staff's behaviors and how those perception might help to provide suitable strategies to positively impact social change in the public healthcare facilities in Ghana. Additionally, I intended, by this study, to provide patients in Ghana with education to be their own advocates for quality health care and also to be empowered to remain diligent with their healthcare needs (see Foster, 2010).

According to Donkor and Andrews (2011), the medical staff in Ghana fell short of ethical values prescribed by the International Council of Nurses code. Donkor and Andrew asserted that the healthcare providers should position themselves to take care of patients better than they had done in the past. The performance of ethical and moral duties by healthcare providers have been shown to be both necessary and enchance healthcare proficiency for patients (Donkor & Andrews, 2011; Daly, 2004). The point made by Donkor & Andrew, and Daly as well, suggest that Ghana reguires strong dialogue concerning people's healthcare, quality and standards, and provide medical and system reform for delivery of services. My aim was to help the healthcare providers in Ghana to become totally engaged as advocates and to intensify the momentum to achieve good results for patient care (see Daly, 2004). Patient advocates are therefore needed to speak, support and protect the patients in any healthcare, as well as applying effective

advocacy strategies to heighten patient safety to rely on the experts for their healthcare needs.

Research Methodology

The nature of this study was to be an investigative process of understanding the issues that may be occurring in Ghana's medical system. The paradigm is related to patient advocacy as a multifaceted situation in health care (Creswell, 2013) and requires a holistic picture as narrated in-depth by the patients and directed in the hospitals.

It is worthy to note that while scientific processes are focused on the detection of knowledge with slight regard for the sense of life experiences (Bryne, 2001), phenomenological research has increased to offer awareness into life experiences, especially those connecting to health (Vivilaki & Johnson, 2008). Per Bryne (2001), phenomenology interpreted logically can be observed to improve the meaning and understanding of a patient's experiences which is exactly what I aimed to fulfil in this study. I sought to collect patients' lived experiences to help fill the social gap needed for delivery of quality healthcare in Ghana's healthcare facilities.

Moustakas (1994) indicated that phenomenological inquiry is the method by which "revealing the essence of experiences in which others can derive knowledge about a unified meaning of an experience" (p. 84). This type of inquiry can distinguish and explain the lived experiences by the medical staff exhibiting their behavior to the patients admitted to the hospital (Creswell, 1998).

Ethnographic inquiry could have been used in this research. However, since this inquiry addresses a cultural group in their natural setting over an extended period

(Creswell, 2009), this approach may not have been as effective in my research to gather

the data, due to the philosophical tenets and the process of my study. In addition, the

ethnographic approach is supple in respect of the pre-reflected experience seen where

they occur, and I was conducting interviews after the fact (LeCompte & Schensul 1999).

Another alternative to phenomenology and ethnography is grounded theory. It

represents a general, abstract theory of a process, action, or interaction grounded in the

opinions of the participants (Creswell, 2009). This theory might also have been effective

in this study. It shows a continuous contrast of information with developing theories and

with "theoretical sampling of different groups to maximize the similarities and the

differences of information" (Creswell, 2009, p.13). However, grounded theory does not

ascribe the essence of human experiences relating to the phenomenon, as narrated by the

patients in the study.

Case studies are also an inquiry that explore a program, event, or process of

various individuals in depth. According to Creswell (2009), these cases are bound by

time and activity and a researcher collects detailed data using a diverse data collection

process over a continued period of time. Conversely, this would not have applied to my

study, as I intended to understand the lived experiences as a philosophy as well as a

development to study a smaller number of patients in evolving patterns and relationships

of meaning (Moustakas, 1994).

Ethnography, grounded theory, and case study designs are alternative ways by

which I could have carried out my research. However, the other designs were not as

applicable, and so I decided to use phenomenology for my study. I used a

phenomenological investigation to explore the essence of patients' experiences in a healthcare facility in respect of the behavior of the medical staff at the time of admission.

Research Design

The methodology I used was phenomenology. I aimed to discover patients' experiences, to better understand the aspects of the phenomena being studied. I intend to use a semi structured in-depth interviews using notes and audio recording as data gathering methods. The interviews were based on the thematic interaction analysis, through discourse and discussion investigation. Using face-to-face semi-structured interview of both patients and nurses in Ghana's healthcare facilities, I sought to understand and explain the phenomena of patient care via the patient's experiences and nurse's behavior. There were other methodology types that I could have uses in this qualitative study. However, these may not have been effective for gathering the data as much as phenomenological inquiry, as earlier explained.

I used SCT to analyze the data in other to gain deep insight into the patient's experiences and nurse's behavior (Bandura, 1997). I used SCT to understand how patients make sense of their experiences and develop a worldview. The SCT data analysis theory assisted me in finding commonalities that existed in patients' experiences. This data analysis theory emphasized the meaning of the healthcare staff's behavior as reasons for patients' experiences.

It was my view that using phenomenological theory will help establish the method of inquiry to bring about the facts as understood through self-awareness. This is underscored by the fact that the focus of phenomenology is understanding lived

experiences shared by patients as in this case (See McConnell-Henry et al., 2009). From

this perspective, the personal experience as recounted by the patient, was studied for

understanding the situation in its totality, but not be measured into statistical data.

Participants of the Study

I adopted purposive sampling for the selection of the participants in this study

using semi-structured five open-ended questionnaires to stimulate responses. The format

of the participants was 20-25 adult's male and female from poor to high level, within

diverse economic status, and that were on admission at the medical facility or were

discharged within 10 days from the facility. I selected participants from six public

hospitals in four most highly populated urban regions in Ghana, namely Accra, Kumasi,

Takoradi and Cape Coast

I identified, targeted and enlisted participants based on volunteer patient's system.

I also requested a meeting ahead of time with the Regional Directorates of the selected

three urban hospitals located in Accra, Kumai, Takoradi and Cape Coast. I then shared

the information regarding the nature of the study with them and request for help in

recruiting the participants within the six healthcare facilities, as well as names of those

who were discharged ten days from the date of requests.   I continued the recruitment

arrangements and while sharing with the recruited volunteers the nature of the study. I

gave a letter and a consent form to every participant and sought their voluntary consent

before they participated. A copy of the letter and the consent form are in the Appendix. I

utilized probability sampling method for random selection for the study participants. This

ensured that all the volunteers in the various communities will had an equal opportunity to be selected.

Measures

My research explored the practical difficulties, barriers and problems that made some of the medical staff provide the lackadaisical attitude in discharging their responsibilities. I intended to help patients and the public gain an understanding of what to expect in receiving quality healthcare service. Also, this study could increase the awareness into the situations relating to deficiency in the healthcare and wellbeing for the people of Ghana. Putting the spotlight on such deficiencies could ensure that Ghana medical authorities take the responsibility to reform way patients are cared for and provide services and support to enable the people to receive quality of care.

By acting as advocates, medical staff could empower weak and susceptible patients to release them from anxiety and unnecessary treatment that are not desirable of them. Patients need protection from acts of incompetence by the medical staff (Vaartio et al. 2004).

Research Questions

The following research questions were used in my study.

Research Question 1 (RQ1): How would patient advocacy impact quality of care in Ghana?

Research Question 2 (RQ2): How would patients describe their perception on medical provider's practice on advocacy?

Research Question 3 (RQ3): What are the factors enabling or impeding patient advocacy in Ghana medical care?

Procedures

I followed the following procedure as a sequential guide by which participants were notified, data was collected and analyzed, and findings validated. These sequential guides were:

1. The Regional Directorates of Accra Metropolitan, Ashanti Region and Central Regional Hospitals were contacted via telephone to offer information about the research.

2. I submitted an informative letter stipulating the nature and details of the research to the Regional Directors and the Hospital Administrators and requested help in recruiting participants for the study.

3. Informative meetings were scheduled with the participants on the phone where I presented the purpose of the study and provided a copy of the letter with explanation of the study.

4. Participants (volunteers) were then informed to expect a follow up phone call to set a date for the individual interviews.

5. Before the phone interviews, a copy of the letter with description of the research and a Consent Form were emailed to the participant. Followed by asking prepared interview questions. A copy of the questions is found in the Appendix.

6. In cases where the need for second interview, they were administered within a week after the primary interview date. The second interviews followed the same

format as the initial interview with different set of questions. This only happened

after the audiotapes of the initial interviews were transcribed and analyzed for

clarification.

7. The audiotapes were transcribed verbatim per participants and analyzed as labeled

in the chapter 5.

8. Assistance was sort from two identified Walden students doing similar qualitative

course. These collaborators assisted to validate themes identified in the

transcripts. A discussion was held with committee chair for validation process

indicating an ethical fortification of the participants identified to take part in the

research.

Data Collection Sample Size

According to Mocănașu (2020), pursuing a thorough explanation of the whole

investigation strategy carried out by the researcher including the sampling procedures

regardless of whether the research is a quantitative, qualitative, or mixed approach, when

analyzing the exactness of a research. He explains that the majority of qualitative

investigations are conducted on small samples, with 10 respondent samples being

relatively common. I used logical purposive sampling strategy for the population in the

cities of Accra, Kumasi and Takoradi in Ghana to select the patients. A sample size of 23

was used. According to Vasileiou et al. (2018),

"Samples in qualitative research tend to be small in order to support the depth of case-

oriented analysis that is fundamental to this mode of inquiry. Additionally, qualitative

samples are purposive, that is, selected by virtue of their capacity to provide richly textured

information, relevant to the phenomenon under investigation. As a result, purposive sampling as opposed to probability sampling employed in quantitative research selects 'information-rich' cases. Indeed, recent research demonstrates the greater efficiency of purposive sampling compared to random sampling in qualitative studies, supporting related assertions long put forward by qualitative methodologists". (p. 2)

I selected smaller sample size of patients for the studies for quality analysis of the research. Again, as has been explained by Vasileiou et al. (2018) and Mocănașu (2020), I sought to understand the fundamental explanations of the thoughts of people on admission or that had been on admission at the hospital about clinical staff's behavior and customer service ethics, I was compelled to use a smaller sample size of patients. Otherwise, the quality analysis of the data collection would have be distorted, not to mention the bases to cultivate ideas for my qualitative study.

I used purposive sampling with a semi-structured face to face interviews by means of five open-ended questions. Using this form of interview allowed me to plunge deeper into the dialogue being narrated by the patient, enabling me to ask questions in detail. I selected participants from poor to high level of adult male and female patients within the diverse economic status, and who were on admission or were discharged within ten days from the hospitals.

Data Collection procedure

Before the data collection begun, I addressed letters to the regional directorates and asked for permission to conduct the research in the chosen hospitals. The letters explained the purpose "The Impact of Effective Advocacy in Ghana Health Care

Reform", the effect of the social change in Ghana's health care facilities of how patients received treatment.

With the help of the hospital administrators and head nurses, I selected patients who had been in admission and were discharged within ten days, from four public hospitals in the three most popular urban regions in Ghana, in the cities of Accra, Kumasi, and Takoradi. I focused the interview on the participant's experience of advocacy whilst in the hospitals. Using this type of interview represented daily discussions in a most intensive and in-depth way to get candid and valid responses

I sent letters to the patients that explained the purpose and the benefits of the research. On the day of the interviews, the participants were offered the opportunity to ask questions that were of concern to them. I also explained that their voluntary involvement would not affect their care in the hospital if they were to refuse to participate or withdraw from the study while the interview was in progress. The letters were explained again, and consent forms were signed. I briefed participants about the use of audio recording to capture all the phases of the narration to help with the analysis of the conversation. In addition, hand-written notes were also taken to complement the audio taped narrations. I did this to preserve and comment on the participant's behaviors, impressions, surroundings, and other non-verbal cues that otherwise may not had been captured in the recording at the time of narration. The hand-written notes would be used in collaboration with the audio recording for analysis.

Research Instruments

This research was based on a social study with qualitative design to explore

practices, motivations and opinions of patients in respect of the clinical staff's behavior

whilst in their care at the hospitals.

I expected interviews to approximately take no more than 60 minutes, and this

depended on the follow up questions. Using the open-ended questions encouraged some

of the interviewees to speak in detail about the questions asked. I made sure that

locations for the interviews were pre-selected areas where the participants felt

comfortable and I was also convinced of their safety and privacy. Because the interviews

were recorded with taping devise, the areas for the interviews were selected to ensure that

there were no unnecessary intrusions, interruptions and disturbances even though hand

written notes to were also taken to supplement the recordings.

Creswell (1998) suggested "creating and organizing files" as the first step from

the beginning and toward the analysis process (p. 148). In light of this, I created files for

the recorded interviews to ensure that the data collected were organized. These

recordings were in multiple copies and kept confidentially in a locked cabinet in my

custody.

Data Analysis

To gain the specific significance in the phenomenon being researched, I have

listed the declaration shared during the interview. This helps to place emphasis on the

attempt to find the type of patient advocacy that is practiced in Ghana health care

facilities. Shared experiences by the participants revealed their emotional states, opinions

and feelings related to the medical staff as to how they cared about those they are required to serve.

After the collection phase, I read the transcripts and annotated to offer an impression of the data and make an initial reflection. Analyses were done by word coding linked to each other to gain a total understanding of the collected data from the participants. I expanded the coding strategy to include a compilation of the themes and the codes. The coding phase began right from the beginning of the data collection, using a database or spreadsheet created for the data organization. A table of five columns was created and labelled with various number of rows in a landscape scheme to enter the data, and assign identifiers to the respondents in Excel. The recordings from the audiotape during the interview phase were transcribed for easy identification and interpretation of the recordings. Before then, a well-known transcriptionist was selected to perform this task, so that there was no room for error . Copies of the data and materials was stored appropriately (Creswell, 2013; Miles et al., 2013). My use of triangulation in this study has assisted me develop a comprehensive understanding of the phenomena I was studying. As such, this study can be a reinforcement to test the validity through the convergence of data from different sources, such as the theories, and literature review, as well as showing credibility and confidence to the findings to impact social change.

Verification of Findings

Verification of my data analysis was informed by the general findings, the results consistency and validity of the conclusions. Creswell (1998; 2014) stated that using the authentication of the conclusions will keep the integral essence of the qualitative analysis

intact. Creswell (1998) further stated that the course of authenticating the findings requires applying some stages, if not all, from the eight recommended steps, including "persistent observation, triangulation, peer review, negative case analysis, clarifying researcher bias, member checks, rich and thick description, or applying external audits" (p. 201-203). Hence, the use of triangulation, researcher bias, and thick description, were employed in this study. Creswell (1998) commented that the rational for the through explanation "allows the readers to transfer information to other settings and to determine whether the findings can be transferred based on shared characteristics" (p. 203).

I chronicled the transcripts to provide the exact contextual and descriptive information as shared by the participants. Handwritten notes were also taken during the interviewing process to highlight notable comments. These methods provided a rich and thick description to authenticate the findings as recommended by Creswell.

Theoretical Framework

The theoretical aspect of this study is phenomenology, aimed at discovering patient's experiences, for theorizing, recognizing, and understanding the aspects of the phenomena. SCT and face to face interview were used to gain insight into patients experience of care at the selected hospitals (Bandura, 1997).

The SCT developed by Albert Bandura (1997) addresses individuals' ability to self-organize, self-reflect, self-regulate, and be proactive, allowing human beings to have control over their own actions to achieve results. The theory of SCT speaks to the individuals achieving and supporting various behavioral patterns used to provide intervention strategies (Bandura, 1997; Glanz et al. 2002). Using this theory, patients are

empowered to gain self-assurance to fight for their wellbeing. For example, sick individuals seek medical attention to get well. Fundamental virtue such as pride, and the joy from satisfaction, and a sense of what can be achieved, is an internal driver patients may use to advocate for themselves. These internal drivers stress the deep thoughts and perceptions allowing a link to learning concepts to cognitive developmental theories. The effects of SCT can demonstrate that success in changing a situation and expectancies in human behavior influences changing of norms and reducing or eliminating undesirable attitudes. SCT was therefore relevant to designing health education and health behavior programs (Bandura, 1997; Glanz et al. 2002).

Assumptions, Limitations, Scope, and Delimitations

During preparation of the research protocols some of the key subjects that were considered were confidentiality, compensation, research objectives, risk and benefits involved and the voluntary nature for participating in the study. The following were what were captured in the protocol: a) the research protocol explained the purpose of the research, duration for the participant's involvement, detailed explanation of the research, if there were any risks involved in partaking in the study, benefits expected from research (if any), and degree of the confidentiality of the records to be preserved; b) the protocol was made available to the participants to sign a waiver stating whether they did or did not wish to participate in the study. Their signature also addressed the fact that study will not present any marginal risk of harm to them after the breach of the discretion. A written statement that stated the details of the study was provided to the participants if the participants waived their right; c) the research protocol informed participants of the

compensation (if any) were offered for their involvement; d) the consent form also implied a protocol for exchanging confirmation for the selection of the participants (Creswell, 2013) in the study, giving verbal information, question and answer methods explaining comprehension; e) the IRB and I ensured that the consent process was well accepted and permitted for application to the data collection; f) the protocol was designed using phenomenological inquiry to identify psychological connection to patient's narration of experiences; g) The findings from this research are be limited to clarification instead of measurable analysis.

Limitations

Potential Design and/or Methodological Weaknesses of the Study.

The greatest limitation in my study was related to validity and reliability. The fact that the research occurred in a natural setting, (i.e., hospitals in Ghana), it would be tremendously challenging to repeat the studies (Wiersma, 2000). The methodology and design were based on phenomenological approach, permitting restrictions beyond the control of the researcher. The choice of this method was prompted by issues with several aspects of research methodology, that is, from the deficit of planning, clarity of drive and intentions, in addition to the absence of the secondary inquiry before the initial aspect of the study. There was also in-built bias due to the type of questions that were asked during the interview phase (Creswell, 2013). These biases depended on me, in that designing these questions was based on the topic of interest. Since these questions were based on my knowledge about the topic, there could have been the tendency of influencing the findings, due to my initial biases.

Addressing the Limitations in the Study

In addressing the in-built bias, I worked against the mind to ensure identification of the study description. To address the issue of repetition (Patton, 2002), I differentiated in my statements among recurrence practice and the non-recurrence findings that may appear from the practices. In terms of lack of consistency (Patton, 2002), I created sets of measurements against which the inconsistencies in my study were judged. To compensate for the time consumption (Patton, 2002), I collaborated with a peer or a friend at the historical writing phase in my study.

How to Eliminate Limitations

The limitations in my studies addresses the methodology that may influence the interpretation of my research findings. These constraints were the findings that were used to create internal and external legitimacy of the unexpected challenges that appeared during the research. In order to avoid the weakness and the degree of my research limitation, I had to reduce the validity of my study. This will leave my readers to marvel if the limitations in my study have impacted the conclusions. Limitations may also involve a complete and serious evaluation and understanding of the impact in my study, and that need to be eliminated.

Addressing Threats to Quality in the Study

Armed with the knowledge of the issues that pertained patient advocacy in the Ghanaian healthcare system, I acknowledged my biases and resisted the temptation of promoting one theory over another in respect of the topic. As such, the responses that seemed to place emphasis on the biases were carefully analyzed or abandoned. For

example, I was careful not to sway expected responses with the responses that came from

participants directly (Bandura, 1977; Creswell, 2014). To effectively construe what has

occurred in the study, I addressed the respondent's opinion and made sure not to impose

my own meaning to what was expressed, and instead, I understood the respondent's

perception, wording, or actions. I did not force the data from the respondents to

correspond to the concepts I had expected. Also, I did not disregard the data that did not

align with the topic (Creswell, 2013; Patton, 2002). In summary, I provided all the data

collected, even when it did not align with or support to my theory.

Ethical Concerns

Proposed Procedure for Providing Informed Consent

The ethical concerns that were taken into consideration were confidentiality,

compensation, answers to questions, and the voluntary nature for participating in the

study. The consent form comprised the purpose of my research, duration for the

participants involvement, detailed explanation of the research, documentation of the

study, stating if there are any risks involved, expected benefits of the research (if any),

alternative methods, any known advantages to the participants, degree of the

confidentiality of the records to be preserved. A section on consent form was provided

for participants to sign a waiver stating their intention to participate or their intention not

to participate. The consent form also addressed knowledge of the fact that the study will

not present any marginal risk of harm to the participants after the breach of their

discretion. In the cases where participants waived the right, I provided the participants

with a written statement stating the details of my study as stated above. The consent form

also contained information on the kind of compensation that was offered to participants

for their participation. I was cognizant that the consent form was not provided to

precisely collect signatures for seeking an agreement from the participants. The form

implied a protocol for exchanging confirmation for the selection of the participants

(Creswell, 2013) in the study. Additionally, I hold the optimum responsibility for

safeguarding the consent process and ensuring that it was well accepted and permitted for

application to the data collection.

Ethical protection of participants

Informed consent is very essential part of ethical research. It was through this

consent process that I sought the willingness of patients to participate in my study. In the

consent form, I included explanations about the nature of the study, the participants'

possible role in the study, the goal of the research and how the findings will be printed

and used (Orb, Eisenhauer, & Wynaden, 2001).

Aside the consent process, I used coded abstracted data, identifiers and disguising

features that made the participants only identifiable to me in order to safeguard the

participant identity as an ethical concern in qualitative research. Again, I grouped parallel

cases together to reduce the chance of applicants being identified. I removed all

information that could assist with recognition of participants from the transcriptions

before the data is validated.

There has not been any known harm that has been reported for participants who have in the past participated in similar studies in Ghana. I provided participants with consent form to complete with their identity and their confidentiality were protected as explained earlier.

After data gathering in the field, I kept all information relating to the participants, such as audiotapes, transcripts and files, under lock. I maintain as the sole person who will approve access to participant's data. Those that have had access to these records have been myself and those who assisted in validating the results obtained via interviews. This is a measure that was taken to ensure confidentiality to participant's information, and only those with approved permission, could have access to the data.

Addressing Ethical Concerns

Ethical concerns were not concentrated only on harm prevention to the participants, but also the authorization aspects of the research process. All participants had to sign a signed informed consent form. Individually, potential volunteers were approached and informed about the study's aim and data collection method. They were given enough opportunity to ask questions and voice their concerns. I mentioned to them that because their involvement in the research was optional, declining to join or withdrawing from it while it was ongoing would have no impact on their treatment at the hospital. The consent form was shared with the IRB and the administrators of the selected hospitals addressing the essentials for their review, as the ultimate body over this document.

Significance of the Study

Healthcare providers are needed to play a large role in caring for patients, by showing how human beings are needed to be treated with decency and respect. According to Gilkey and Earp (2009), "Patient Advocacy is a concept that generally refers to efforts to support patients and their interests within the context of the health care system. The role of advocacy is credited to the medical staff for helping patients, such as those who are mentally sick or are in palliative care, as well as vulnerable patients whose autonomy may be in jeopardy". Due to its role, research can assist otherwise to clarify patient advocacy, which is a mission required to develop both scholarly and applied efforts to develop quality healthcare (Gilkey, Earp & French, 2008). Patient advocacy is needed to support and empower patients to make an informed decision to navigate health care that are needed, and build effective partnership with their providers to work towards system progress to sustain patient-centered care. (Educator of Advocates, 2009).

Such is the time an advocacy is needed to direct the unfamiliar healthcare system with appropriate dialogue among the caregivers, from clinical aspects through patient satisfaction. Being an advocate is to represent the patients during their time of need by affirming to be a friend and a protector on behalf of the patient (Negarandeh et. al, 2006). This can be a significant role to play as a health care provider. In that, an advocate's role comes with certain privileges of insights into patient's interests (Bird, 1994), taking part in the clinical judgements concerning the sick and the vulnerability as they augment a professional responsibility. The importance of conducting this research into patients' advocacy in Ghana was to recognize the perception of patient advocacy as explained by

those who conducted this research earlier than now. It is my intention to gain a better

rationale of the medical staff's personal and professional role in relation to discharging

their duties to the patients (Negarandeh et al., 2006).

The outcome of this research will provide recommended stimulation and

encouragement to enhance quality healthcare delivery and safety practices in Ghana.

Gaining awareness into the patients' experiences would highlight their expectations, with

the key to resolving new strategies that would impact restructuring for correcting and

providing comprehensive primary care, and improve practices in the healthcare delivery

in Ghana. Additionally, placing emphasis on medical personnel's obligations will help to

provide clinical excellence and foster team approach to convey mandated quality clinical

setting in the health care system in Ghana.

Significance to Practice

Healthcare providers play a large role in caring for the patients, by showing how

human beings need to be treated with decency and reverence. But when people are sick,

they become more vulnerable (Daly, 2004), making them and their families more

apprehensive, confused, anxious and scared. Such is the time advocacy is needed to direct

the unfamiliar healthcare system with appropriate dialogue among the caregivers, on

clinical aspects through to patient satisfaction. Being an advocate is to represent the

patients during their time of need by affirming to be a friend and a protector on behalf of

the patient. This can be a significant role to play as a health care provider. In that, an

advocate's role comes with certain privileges of insights into patient's interests (Bird,

1994), taking part in the clinical judgements that concerns the sick and the vulnerable as they expand their professional responsibility.

The importance of conducting this study into patients' advocacy in Ghana is to recognize the issues that may be contradictory to the norm that exists in the medical system. Engaging in this study into the core of the people's lives experiences whilst receiving treatment is to bring into focus the situations surrounding their wellbeing. Thus, the study is to generate a motivation and encouragement to enhance quality healthcare delivery and safety practices in Ghana. In that, knowing the patients' experiences would highlight familiarities and expectations. With the key to resolving new strategies, would impact reform for correcting and providing comprehensive primary care, as well as improving practices in the healthcare delivery in Ghana. Additionally, placing emphasis on medical personnel's obligations will help to provide clinical excellence and foster team approach to convey mandated quality clinical setting in the health care system to be at the vanguard.

Significance to Theory

Health care ability in relation to advocacy may be useful at the discretion of personal or professional, a patient, and policy change levels (Malik, 1998; Wheeler, 2000). Despite the accomplishment in these areas as required, may be placed on the guide that explicitly resist for and encourage policy change at a systems level. In this case, inclusion in the systems such as associations, governmental and non-governmental, public and private, national and international, citizen groups, community and institutions, in addition to health care professional through policies and power, impact the public

health and health care systems (Wheeler, 2000). Patient's advocacy is considered critical

in health care and is needed to respond to the efforts of the interest groups that view to

misplace from the representation of a good public health practice. On personal and

professional level, patient advocacy events begin as a twig from members with issues that

come together to share coping strategies, to feel invested in the sense of the community.

Such deeds may embrace activities to patient's education and careers and to handle the

outcome of their sickness. The fiscal impact on the patient's sickness affects the whole

family (Teasdale, 1998), and should not be underrated. In that, the psychological effects

of those changes may have a great influence.

Recently, by the global sense, many patient advocacy organizations have created

an effort in assisting patients to pilot the medical systems. This is done by coaching them

with medical steering strategies, as well as practices that help patients in overpowering

classic roadblocks within the health care system. Notwithstanding the medical steering

has not been the only support role of the medical advocacy group's challenge. Patient

advocacy support roles are meant to engage patients with rational, social and emotional

effects in relation to medical issues outside the medical facilities and with emphasis

placed on the strategies for increasing patient's quality of life. Medical providers, who

are relatively closer with the patients, often than not, recognize themselves with patient

advocate's role. But then, there are prospective interest struggles among advocacy

responsibilities, their roles as medical providers, in addition to their position as medical

providers, in such situations (American Nurses Association, 2004). However, the ANA

(2003) directed that patient advocacy in its classification of nursing, termed it as *the*

protection, promotion, and optimization of health and abilities, prevention of illness and

injury, alleviation of suffering through the diagnosis and treatment of human response,

and advocacy in the care of individuals, families, communities, and population. In this

case, advocacy in the medical field entails its theoretical source in nursing ethics. For

instance, the ANA *Code of Ethics for Nurses* embraced language relating to patient

advocacy as:

- The nurse's key obligation is to the patient, irrespective of an individual, family, group or community.

- The nurse encourages, advocates for, and struggles to protect the health, safety, and rights of the patient (ANA. 2010).

The attitude of the ANA becomes admirable with their point of caring for the

patients. Beyond any qualm that the medical providers are within the boundaries of the

care condition, the medical staff situation, the patient advocates in the collaboration

amidst patient, the nurse and the physician are solidified. In that respect, the Code of

Ethics should be measured as an incentive for the staff to exercise mechanism over the

care, and secure the best quality of life for the patient.

Patient advocates may often deliver the medical education and studies to their

patients, and their families. These individuals may endeavor to promote the family with

some form of communication relating to their sickness issues. With consciousness,

correctness and direction for the patient's care, the patient advocate is required to provide

a thoughtful representation in consistent treatment, and medications, as well as fighting

off modalities (Kamaker, 2015). This can be done by ensuring that questions about

treatment suitability are intensely discussed with the patient, families and medical staff, and that, all treatments and concerns are promptly appeared in their health records. Should the pertinent compliance standards be not met; the advocate may bear the liaison with community omission, government agencies, or legal professionals to augment negotiation on behalf of the patient and their families (Mallik, 1998; Teasdale, 1998). It is therefore, an advocate's role to uphold and preserve the patient's confidentiality in compliance with local and national laws, so as to treat all the patient's and their family's information as honored and sheltered.

Significance to Social Change

"Advocacy is always unashamedly purposive in its intent" (Chapman 2007, p31). Patients and their families are needed to be treated with honor and respect. Often than not, they are mostly muddled, nervous and terrified when they become sick. This is the time a patient advocate is required to assist them to navigate in such an unacquainted health care structure and to enable them among the caregivers. There is also the need for the medical providers to educate these patients by offering emotional and physical support during any process. In this situation, they are to position themselves to assimilate all the features of the patients' care, thus ensuring that their anxieties are addressed, standards of care are met and are in an optimistic outcome for the patient relics the goal of the healthcare team (Chapman, 2004). Within the ethnic beliefs, the importance of patients and families must be heightened and respected by the medical providers. They must be carefully monitored and accepted in all connections, particularly, since they may have an impact on the patient's wellbeing and emotional level. To magnify a positive

social change, the medical providers must adhere to national, state, local and administrative regulations in developing a response to changes (Chapman, 2004), provide care for all the patients with the same level of compassion, empathy, and professionalism, without permitting their personal biases to affect their practice. Furthermore, the impartiality of the advocacy must not just be simply placing concerns in the public arena, and then place an interval for the process to unfold. Once the objective has become fixed, advocates must plan to capitalize on the support with the strategic plan which would integrate behaviors to argue the patient's case, involve key effect stakeholders and create gravity on decision makers for a promising outcome (Chapman, 2004).

Chapter 4: Results

Background

In accordance with healthcare ethics, medical staff should act as advocates for

patients for their healthcare and wellbeing. This is not the case in the third world

countries as much as it is enforced in the Western countries. Research has shown that

healthcare professionals have the possibility to experience disparities and inequalities

(Laari, 2021). There is a persistent deficiency in the role of medical professionals in the

underlying health inequalities and imbalances in Ghana's patient advocacy drive.

Patient advocacy has been shown in the literature to be necessary for improving

patient safety in treatment. However, despite that it is part of their job description, some

medical staff in Ghana's public healthcare facilities have demonstrated inadequate skills

in caring for patients. For example, at some public hospitals in Ghana, medical personnel

failed to support patients in advocacy, which is a crucial aspect of healthcare ethics

(Nsiah et al. 2016). Davoodvand et. al. also indicated that there must be a show of

empathy and protection for the people that are served in the healthcare facilities.

Protection of the patients has frequently been explained as an important component of

patient advocacy. However, showing empathy for the patient is deemed as a new concept

which seemingly can be used in the training of the healthcare providers for better

understanding of the relationship between patients and health care givers. (Davoodvand

et al., 2016). Furthermore, the issues of responsiveness in health care delivery systems in

Ghana are many and varied, but a basic distinction is related to respect for human beings

as persons. The patients and family members express concerns towards the healthcare professionals when they seek assistance.

Observations on these concerns are geared towards the health facilities and the care givers, including lack of respect for the dignity of the person, HIPAA, or confidentiality of the right to determine who has access to patient's personal health records and autonomy to participate in choices about one's own health.

Donkor and Andrews (2011) found that there is no effective healthcare advocacy in Ghana. As such, health care providers are required to protect, encourage, and optimize healthcare to avert illness and injury, improve patients suffering, provide better diagnosis and treatment and to advocate for efficient care. In a study conducted by van den Boom et al. (2004), it was established that access to healthcare facilities in Ghana continues to be a problem. There is still a perception of unsatisfactory services rendered by the public hospitals staff in the areas of care and treatment. Relationships between patients and care givers, sanitation of working environment, access to basic information about their rights, consent, and confidentiality of patients, among other things continue to be an problem despite efforts by the Ghana Health Service, the government, donor agencies, and all other stakeholders to improve quality health care delivery in Ghana. It is in this light that this study was conducted to assess the level of patient satisfaction in healthcare delivery services in Ghana public healthcare facilities.

As such, this study was set to identify the reasons why such basic factors in patient advocacy are lacking in Ghana's healthcare system.

Methods

Design

I used qualitative exploratory design to investigate attitude of medical staff influencing quality of patient advocacy from the participants perspective. The emphasis of design was on the "why" instead of the "what" of the social phenomena and rely on direct experiences of patients in Ghanaian Hospitals.

I used phenomenology design to better understand and describe the phenomena of patient care based on the participants' experiences and the behaviors of health care providers.

The research questions were:

Research Question 1 (RQ1): How would patient advocacy impact quality of care in Ghana?

Research Question 2 (RQ2): How would patients describe their perception on medical provider's practice on advocacy?

Research Question 3 (RQ3): What are the factors enabling or impeding patient advocacy in Ghana medical care?

Setting

This research setting was set at the Greater Accra Regional Hospitals, a governmental hospital in Greater Accra Region of Ghana. The format included 23 adult participants: nine males and 14 females from a background diverse economic status. Four were on admission at the medical facility and 19 had been discharged within 10 to 12

days from the facilities. These participants were chosen from different backgrounds to enable me to get a diverse insight into the attitude of the medical personnel.

Sampling and Data Collection

A smaller sample size of 23 participants was used. Purposive sampling was used to seek an understanding of fundamental explanations of patient's thoughts and views about medical staff's behavior and customer service ethics. Otherwise, the data collection quality analysis, as well as the basis for developing concepts for this qualitative study, would have been impaired. Data saturation was however reached with sample size of 23 participants. Twenty-three adult participants, male and female, from poor to high status, within diverse economic status, were interviewed for this study.

Logistics of Data Collection

I sent letters to the regional directorates requesting for approvals to conduct the research in the chosen medical facilities. I provided in the letters the purpose of the study, the Impact of Effective Advocacy in Ghana Health Care Reform, and the effect on social change in Ghana's health care facilities on how patients are cared for. Upon approval, the patients were selected with assistance from the hospital administrators and head nurses. Focus was placed on participants' experience of advocacy while in the health facility or when they went in for a health care. This method of interview portrayed the most intensive and in-depth approach to determining the validity and trustworthiness of responses. Letters were the sent to the participants explaining the purpose of the study and the benefits of the research. On the day of the interview, letters were explained again, and the consent forms were signed. Participants were briefed about the use of the audio

recording to capture all the phrases of the narration to help with the analysis of the

dialogue. Hand-written notes were also used to complement the audio taped narrations.

The notes were written to preserve and comment on the participant's behaviors on the

phone, impressions, and other cues that were not captured in the recording at the time of

the dialogue. They were also used in collaboration with the audio recording for clarity in

analysis.

Interviews

One-on-one interviews were scheduled ahead of time for the convenience of the

volunteered participants. The interview structure consisted of open-ended and semi-

structured questionnaire which were conducted on the phone, due to Covid-19 pandemic.

This method was used to enable the participants to share their own perspectives and

experiences at the encounter with the medical staff in relation to patient advocacy. Using

this form of interview allowed the researcher to plunge deeper into the dialogue with the

participant, asking detailed questions for understanding of the experience being narrated.

Before the interviews began on the phone, the aim of the research was repeated to the

participants again and questions were entertained. The volunteers were also invited to

speak as frankly as they could since only pseudo-names will be used to ensure

confidentiality. Interviews then began with the following questions with follow-up

questions.

- How would you describe your stay at the Regional Hospital?

- Please share what happened over the entire time you were in this hospital?

- What would you change about this hospital if you could?

- How does this hospital differ, compared to any other hospital you been to?

- How would you describe the behavior of the medical team you encountered?

Data Collection

I conducted all the interviews with the topic questions and the inquiries to capture a greater insight of the phenomenon under study. The dialogues were conducted in English language. I commenced data collection in December 2020 and ended February 2021, using semi-structured interview format. For clarity and safe-keeping, I audio-taped the interviews conducted. The duration for the interviews lasted between 45 to 72 minutes, based on the participants tolerance in sharing their experiences. The 23 participants were asked to share the barriers or facilitating experiences that characterized their relationship with healthcare professionals at the health facility where they were or had been on admission.

Data Management and Analysis

I transcribed audio data verbatim and analyzed them using the codes. I ensured data accuracy and credibility by listening more than one time to the tapes and compared to the transcripts. I began the analysis at the same time data was being collected, laying the groundwork for the subsequent interviews. As a first step in the analysis of the research, I used open coding to break down the data into isolated parts to create "codes" to label them. The focus of Axial coding was then used to draw connections between the labeled codes and organized the codes developed in an open coding. Using selective coding as the last step, then I linked the total categories around one main category. This defined a core unified theory around the phenomenon being studied. In the final

analysis, the core category symbolized the key thesis of the study. After finalizing the

open, axial, and selective coding, the I pulled together the description of the data and

the narration focusing on the primary category and offered a rational explanation of the

categories found. In final analysis, the core category ultimately represented the central

thesis of my research.

Figure 1. Data Analysis Procedure
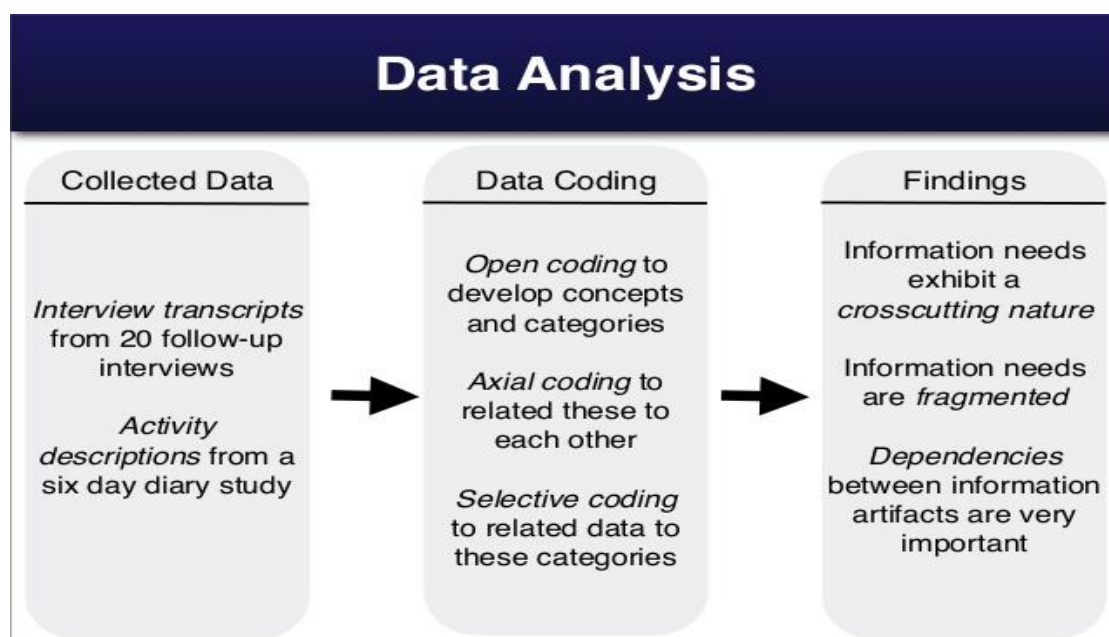
 Adopted from Corbin & Strauss, (2007).

Rigor

I made amendments to the discrepancies emerging from the discussions to avoid

researcher's biases. Member checks were performed by authenticating responses with

the volunteer respondents at the end of each interview before a conclusion was drawn

from the data. Reactions from the participants also authenticated correct and clear

presentation of their experiences. Polit and Beck (2014), and Creswell (2014) indicated

that research sample must be adequate in size and suitably varied to enhance

confirmability and transferability. Adequately, the sample size in this research was

improved by selection of 23 participants from poor to high level of standards within

diverse economic status.

I was the only person who collected data from all the participants, with the same

interview guide. (Creswell, 2014)*.* Two experts, one graduate and two doctoral students

in the same discipline were contacted to conduct peer authentication. A comprehensive

description of the study setting, methodology triangulation and background of the sample

were used to transfer the conclusions in similar contexts, as advised by Guba and Lincoln

(1999). My use of in-depth interviews allowed for the most thorough examination of the

attitudes of the medical personnel that influenced or hindered patient advocacy. My use

of concurrent data inquiry ensured that the narratives of the participants were examined

further in the subsequent assessment. Five of the participants readily confirmed their

comments to allow modifications to their narrative. To guarantee authenticity, excerpts

from the participants' narratives and responses to questions were cited verbatim.

Ethical Consideration

Ethical clearance and authorization were obtained from the IRB and the

Administration at Greater Accra Regional Hospitals. The research protocols sent earlier

explained the purpose of the study, duration of the volunteers' involvements and detailed

explanation of the research. The research protocol was made available to the participants

also to sign a waiver, stating they did or did not wish to participate. Six participants

offered their waiver by word of mouth. The consent also addressed the knowledge that

the study would present marginal risk of harm after the breach of the discretion.

Participants were informed no form of compensation would be offered to them.

Institutional review Board (IRB), the administrations of the hospitals, and the committee

members all had responsibilities for safeguarding the consent process was well accepted

and permitted for application to the data collection. Pseudonyms of PA200GH to

PA232GH were used to safeguard participant's confidentiality. Soft copies of the

recordings were saved with various protected password on the researcher's computer. In

addition, multiple copies of the recordings were made and kept confidentially in a locked

cabinet in the researcher's office.

Findings of the Study

Participants

The participants were 23 adults: representing nine males and fourteen females,

from poor to high level standards within diverse economic status. Four participants were

on admission at the Greater Accra Regional Hospitals, and 19 were discharged from

those same facilities within ten to twelve days to the days of the interviews. Their ages

were between 22 – 78 years, from diversified religious background. These various

participants were selected to enable the researcher to gain a diversified perception of the

medical staff's attitude to all those they served.

Results

Through the data analysis process, many categories that emerged depicted patient

advocacy issues summarily as patients undergoing unsatisfactory treatment. Notable

issues shared by the patients were negativity and careless attitudes received of medical

personnel. Much concern was not given to the patients care and wellbeing, and that created some fear in patients to even follow up with appointments.

Categories

The issues were analyzed and categorized under 11 key themes. These included:

- Lack of Empathy / Compassion with the patient and families; this included not understanding and being sympathetic with a feeling of closeness to the patient (understanding) patient's suffering.

- Lack of Patients Safety; not prioritizing patients care, wellbeing, and total health.

- Non-Commitment to the completion of care process and protection of rights.

- Limited Communication; promoting patient safety and quality care.

- Lack of Nurturing

- Ethical laws in high moral standards.

- Frustration expressed by the medical staff.

- Lack of Confidentiality (HIPAA) of care

- Limitations to care/Not being involved in Care for treatment.

- Cultural Influence

- Careless attitudes to treatment/Nonchalant Attitude

Lack of Empathy / Compassion

Buckman (2011) stated that "empathy is the ability to understand another's experience, to communicate and confirm that understanding with the other person and to then act in a helpful manner". (pg. 1) He further said "despite some overlap with other compassionate responses, particularly sympathy, empathy is distinct". (pg.1) According

to research, demonstrating clinical empathy to patients improve patient satisfaction with their care, encourage them to adhere to their treatment plans, and reduce abuse concerns (Canadian Medical Association Journal, 2011). Sixteen, (nearly 70%) of the participants narrated that the medical staff hardly showed empathy to their care. Even though they attended to them, they acted as if they were being forced to comply with their responsibilities. The following quotations illustrate this theme:

"These two nurses showed I don't-careism attitude towards me every time they came to my bed. They never looked into my face when I asked them a question. Treating me as if I were filth". (PA210GH; 42-year-old male)

"I thought nurses are supposed to be caring for patients. A couple of times, I overheard these nurses discussing a patient's illness with a friend whom they know. I went to the extent of talking to the doctor when he came to my room. This doctor was nice and told me he will discuss this issue with the nurses. But he went further to ask are you sure of what you heard? I was discharged the next day, so I am not sure if he spoke to the nurses or not". (PA208GH; 30-year-old male)

"I felt these nurses don't care enough about my illness. I did not create the illness on me, and they did not either. But at least they should care. They screamed at me and were so insulting, as if I owe her something. Some of these nurses are not to be working as health care workers". (PA219GH; 24-year-old male)

"When I was at the clinic, these medical staff hardly showed empathy towards me and others. They spoke to us as if we were children. They often did not respond to our calls when we needed help. A couple of times I needed to go to the bathroom. I called several times but did not care to assist me. I got up to use the restroom on my own and ended up falling down. Instead, the nurse that came later was angry that I got up even though they refused to respond to my call".

(PA202GH; 49-year-old female)

According the participants, medical staff often asked their families to take care of them despite being at the hospital. The patients also added that some of the medical staff spent time on their phones, whilst their family members rather bathe them, and fed them when the need arose.

"A particular staff would rather come in and watch my sister bathe me and she just stood there and was chitchatting. She didn't care for the pain I was in."

(PA214GH; 42-year-old female)

Patient Safety

It's been said that to err is human and expecting perfection from healthcare professionals working in high-stress and difficult situations may be unreasonable. People are less prone to make errors if they are put in an error-proof setting with well-designed procedures, roles, and processes (Leap, 1997). As such, making progress begins with health care staff focusing on the system and not permitting harm to happen and this may occur in an environment where a safety culture exists (Rockville, 2019). Such should be a culture where a high standard of importance is placed on protecting principles, values,

mindsets, and attitudes contributed by most people in the workplace, especially in health care.

Almost all the patients narrated that the health care staff hardly listened to them when it came to their wellbeing. They never bothered to address what to do with their medications, and their livelihoods. A few of the respondents (3 of them; representing 13%) felt frustrated and scared when they had to go back to the medical care for follow-up. These patients felt that the staff were uninterested in reminding them to take their prescriptions, regardless of what they were taking, how much they were taking, or how often they were taking them. They went on to say that the personnel did not care about ensuring the successful execution of health strategies, policies on how to care for them while they were admitted, or adequate treatment for a good quality of life. Most participants narrated that the nurses did not care how they felt. They were slow in assessing their pain when they got to the hospitals. The healthcare staff did not appreciate their sufferings.

> "I know that my safety should be a vital part of their responsibilities. Caring for the sick people is part of what all nurses are to do globally. I left the hospital more miserable than when I went because I felt left out". (PA216GH; 77-year-old male)
>
> "The medical staff forgot that I was at the hospital because I was not feeling well and needed help to survive. They forget that I am also a human being just like them. But I was in the hospital because of sickness. They could usually be in my situation as well". (PA206GH: 27-year-old female)

Commitment

A health staff's primary commitment is to the patient, family, group, community, or population. Part of healthcare staff's principal commitment is to the people they serve. Their plan of care must signify the underlying commitment of their roles in respect to the uniqueness, worth and dignity of the patient (Walton, 2016). Nurses are to address patient's interest with respect to their treatment. Proper discussions must include resources, treatment options and provision for self-care, which are vital.

> "I and everybody else go to the hospital just because we are not feeling well. I do not go there to bother anybody, but to be taken care of. These people are paid to take care of the sick. But they treat us like we are bother to them or we are filth. What happened to their commitment of caring for the sick?" (PA220GH; 38-year-old female).

> "At a point, my mother tried to take me out of the hospital to go and see a spiritualist, because I wasn't getting any better. Only my family were taking care of me. Of course, not all of the staff are careless. Some do what they can. There is one nurse to assist came in often when she gets a chance to help dress my wounds. These are wounds I received from an accident. Do not get me wrong, the nurses would bring the bandages and other things, when my mother asked for them. But my family members do clean the wound and bandage them". (PA222GH; 23-year-old female)

> "I must admit often times some of the nurses were nice and helpful…., not many of them care. If they know you, they will go to any extent to relate with you by

being approachable. So was my case. The head nurse was passionate to me and recognized my needs. When she was unable to attend to me, she would make sure someone else did. However, I saw how other patients were treated so unfairly. The nurses often times would want to do something else than to show commitment to care for the people". (PA203GH; 44-year-old female).

"I had to wait a while than other patients for care. People were called ahead of me, even though I was there before others came in". When I drew the lady's attention, she made it worse and told me she will call me when she is ready". (PA201GH; 29-year-old female).

Limited Communication

Communication with the patients inspires quality of working in effective interactions and job satisfaction produces a deep impact on patients' safety and advocacy. Limited communication was to some extent a vital impediment in treating a patient as a patient advocate. The researchers signified that there is an impactful relationship, between healthcare staff's communication skills and a patient's ability to follow up with medical suggestions, self-manage a prolonged medical condition, to embrace preventive health behaviors. Extensive study has demonstrated that no matter how competent a clinician is, if he or she is unable to establish effective communication with the patient, he or she may be of little assistance (Makaryus & Friedman, 2005).

Eight of the participants (representing 35%) narrated that communicating with nurses turned out to be only about documenting what their illnesses were.

"The lady who attended to me would not even look in my face. She continued

writing and at times I would not even understand or hear her questions. She

seemed irritated whenever I asked her a question. Sometimes I wonder if she

was writing what I was sharing with her. I regretted coming to this hospital. At

that time, I decided to leave, but then I saw someone I know and works there,

so I told her what I experienced". (PA204GH; 29-year-old male).

"I know that communication among nurses impacts quality of patient's treatment

and welfare. In my stay at this hospital, I realized that these nurses just talk to each

other about anything but we the sick people and what I needed in regard to my

illness. They often would not attend to my needs when I ask for it. Instead, they

ignored me, but would talk to me when they felt like doing so". (PA209GH; 26-

year-old female).

Nurturing

Research showed part of nurse's role is to contribute to nurturing patient's

dignity. This should propel a significant impact on self-worth and their value of life.

(Mendes, 2015). Furthermore, nurturing is known as one of caring components in nursing

and when present and done properly, can offer support for good health and well-being of

a person. Most participants (17; representing 78%) narrated they did not get the nurturing

care from their care givers.

"I have always known that medical staff and nurses are supposed to care for sick

people. But this is not what I got when I was on admission. These people would not

even come near me. They would rather stand by the door and give instructions to my family members to care for me. Don't get me wrong. Some nurses are really nice, but not all of them". (PA207GH: 49-year-old male).

"I just felt they did not care enough for me, to take care of me. I regretted seeking help from this clinic". (PA211GH: 76-year-old male).

"I wish someone can tell me what these nurses do. I wish there is someone I can speak to, because their actions are not what nurses are supposed to be doing. But let me say that my doctor is really nice to me when she comes to see me". (PA222GH, 23-year-old female).

"I must say that some of the nurses tried to go out of their way to take care of us. She made me feel as if I was her daughter or sister. She was so polite in caring for me. Some are not like that". (PA205GH, 25-year-old female).

Ethical Values

Ethical laws require medical staff to care for patients about autonomy to recognize each person's right to self-determination and decision-making to treatment. Beneficence in acting for the good and welfare of the patients, as well as empathy and understanding. Justice, and nonmaleficence, confidentiality (HIPAA), and privacy at the hospital. According to the American Nurses Association (2015), these are nursing code of ethics for carrying out nursing tasks in a way that is compatible with nursing care quality and the profession's ethical obligations. These values are vital for all healthcare employees, particularly nurses, to provide safest, greatest, secured and most human care

needed for all their patients.   In their narration, a few of the participants (30%) expressed lack of ethical values.

"I think they are constantly breaking the laws that enable them to take care of us. These nurses seemed unable to make ethical decisions to take care of our needs. I said that because they don't practice like nurses should do, like other nurses in other hospitals. But some are really sharp, but they don't care". (PA218GH, 51-year-old female).

"I get the impression that the nurses don't care about their jobs, because they do what they like, not caring for us. All they care about is the money. Even though I know they are not paid much like others, at least they should know we are sick, and we need help………". (PA220GH, 38-year-old female)

"I often wonder whether the nurses know their ethics. There are so much they eat I am even afraid to discuss with you…. The choices nurses make are not in line with what they are taught to do…". (PA211GH, 76-year-old male).

"Nurses actions at work make are least to be desired in caring for patients. They do not create relationships with us. To me they often add to our moral distresses which make our sicknesses even worse". (PA207GH, 49-year-old male).

Frustration

In 2002, the Ghana Health Service (GHS) issued a charter that outlined the rights and responsibilities of patients seeking assistance at health-care facilities. According to a variety of studies performed by the GHS after the charter was issued, only a small percentage of patients obtain adequate care. Over the years, the quality of interaction

between healthcare providers and patients has deteriorated, and patients became

extremely frustrated as a result of this. Part of the GHS charter addressed:(a) the right of

the individual to an easily accessible, equitable and comprehensive health care of the

highest quality within the resources of the country; (b) respect for the patient as an

individual with a right of choice in the decision of his or her health care plans; (c) the

right to protection from discrimination based on culture, ethnicity, language, religion,

gender, age and type of illness or disability; and (d) the responsibility of the patient for

personal and communal health through preventive, promotive and simple curative

strategies.

As part of the patients' frustration complaints (23 out of 23) the study revealed

stresses about the lack of attention to detail regarding examinations and diagnoses. The

complaints included the following: a) failure to explain into detail for understanding

patient's diagnoses and treatments from their health's decision-making processes; b) even

though patients wait for a long time to seen, there was complaint about the brief of time

providers and medical staff take to consult with them; c) unfortunately, very few

healthcare staff see it as convenient enough to have a good provider-patient interaction;

d) out of frustrations, the patients refuse to ask questions based on the attitude of the staff.

According to the patients, this makes them quite frustrated for even attending to see a

physician; e) in most of the public medical facilities appointments are not made. This

creates a problem of long waiting time to see a physician. This problem creates a

frequent occurrence in the clinics which does grapple patient's appearance at the clinic; f)

participants further narrated that experiencing long waiting hours creates a low-patient

ratio. In addition, the physicians are often called away from the consulting rooms to attend to emergencies. In such situations, some frustrated patients create commotion for lack of respect. In a nutshell, medical staff do not even care enough to calm tempers when there is risk of potential erosion of chaotic scenes in the clinics*;* g) Some (2 participants) narrated about frustration about other patients who create unnecessary issues, such as talking at the top of their voices on the phones and pretending to know everything about knowledge and skills of observations. (PA204GH; 27-year-old male; PA219GH, 24-year-old male).

Lack of Confidentiality / HIPAA

The main goal of Confidentiality, or the Health Insurance Portability and Accountability Act (HIPAA) of 1996, is to secure personal health records at all times while allowing the flow of health data required to facilitate high-quality treatment and protect the patient's health and well-being. This is a law that cannot be breached by healthcare staff. Patients, on the other hand, must be informed about how to receive a good explanation of how their information is kept private and communicated only with people who need it for treatment (Office of Civil Rights & Department of Health & Human, 45 CFR Part 46). In a nutshell, confidentiality and privacy in health care is essential in safeguarding the public, creating a trust between healthcare staff and patients. It also ensures a great quality of care for the sick. Globally, patient privacy has been enacted as a standard of medical ethics for hundreds of years, but laws that ensure it were once patchy and incomplete (Department of Health and Human Services, 2003). Seven patients (representing 30%) complained about confidentiality.

"I am aware of how the nurses are supposed to handle our paperwork. So, I was surprised when after consulting with my nurse, I heard her openly discussing my medical information with a lady I was not sure if she worked at the clinic or not. She was loud too and that infuriated me. I question her but she refused to answer me and walked away……. I discussed it when I saw the doctor. He was to take care of it, but I did not hear back from him. I didn't go back to that clinic". (PA212GH; 33-year-old female).

"The truth is I don't trust these people. They share our information with their friends all the time. The doctors may not discuss our information with others, but not the nurses who keep on talking about everything, especially if you have a nasty illness. A few times I heard the nurses telling their friends what was wrong with the patients. They are so insensitive to our records and privacy". (PA215GH; 29-year-old-female).

"We go to get help from the clinic when we are sick and tell them our personal habits so we can get good medication to get well. This is where our privacy must be taken into consideration. But actually, they do not even care who else is listening. This was during the HIV and AIDS time. People were afraid to go and consult at the clinic. Because people feared that medical issues would become known around the area". (PA217GH; 59-year-old female).

Limitations to Care / Not being involved in Care for treatment.

It has been discussed that including patients in their treatment leads to better outcomes with regards to making the necessary lifestyle changes. As a result, it's

important for healthcare professionals to tap into patients' desire to participate in how

their treatment (Massachusetts General Hospital 2015).

Under this category, seven (representing 30%) of patients complained that they

did not have the opportunity to participate in the decision-making about his treatment.

They also expressed dissatisfaction with the usage of terminologies that made it difficult

for them to grasp discussions about them and their treatment. This according to them,

made them quite uncomfortable to know what was happening in their bodies. Despite

their request for a more detailed clarification, nothing they said clarified the situation, so

they decided to leave it alone. Patients have expressed dissatisfaction with the lack of

invitation in communication about their diagnosis and treatment. One participant claimed

that it was difficult to participate in the decision-making process because they were not

invited to participate in the discussion (PA200GH; 60-year-old female).

Another participant stated that he had a better understanding of how he was feeling as a

result of his illness. No one, however, asked him to reveal the specifics of his condition

(PA210GH; 42-year-old-male). He implied that he had something to say, but there was

no interest in hearing his thoughts. This demonstrated an indifference about his situation.

As a result, he was disappointed. Nurses are supposed to be patients' advocates,

protecting and acting on their behalf in their health care. However, the silence of nurses

in advocating for patients seems to have created a possible situation of persistent

discrepancies and imbalances in Ghana's public health system.

Cultural Influence

According to the National Commission on Culture (2015), traits of individual cultures in Ghana are defined by language, religion, food, social customs, music, health attitudes, and the arts are all influences. The organized provision of medical treatment to people or a community is known as health care. It covers disease, illness, injury, and sickness diagnosis, treatment, and prevention. In addition, the Commission also stated that health care is traditionally seen to be a major determinant in improving people's overall physical, mental, and emotional well-being, as well as contributing to a large portion of a country's economy. In Ghana, several cultural variables impact health care delivery and access (National Commission for Culture, 2015)

Five patients (representing 22%) had a hard time understanding what they were experiencing in the clinics. The patients stated that going to the clinics to face "uncaring attitudes" of the medical staff, they often chose to self-medicate. To them, contemplating on traditional treatment of their illness are better to them than the orthodox way of receiving treatments.

"Both my mother and grandmother have stated that they never went to the hospital for delivery or to see a doctor when they were pregnant. They were always under a midwife care. They showed respect and treated them as if they were family members. These were due to the attitude of the medical staff. I don't have a child yet, but knowing what I know now, I will follow my families advise. Let me be frank, some of the doctors are nice, but it is the staff who did not seem

to care what a patient goes through. Things should be better, but I didn't see it when I was ill at the hospital". *(PA215GH; 29-year-old female).*

Almost half the number of the participants (11, representing 48%) also complained that since they left the hospital, they started "self-prescribing" their own medication. That is, just going to the pharmacist or drug stores "around the corner" to purchase what they think would cure their illnesses. Some also stated either they chose to, or their families took them to spiritualists to heal them, instead of going to see the doctors for lack of quality care. They further stated nurses are supposed to be patient advocates and care and speak for them to make sure they are receiving quality cares. However, the illness will be worse if no family member is around to advocate for them. The question the participants asked was that "what are the nurses' professional obligations and what are they supposed to advocate for?"

> "I am old and thought I had seen it all, but I am so sad in what I have been seeing lately. Nurses are supposed to act like Florence Nightingale, care for us on humanitarian grounds, with a great patient and nurse relationship. You only see this from a staff when they see are wealthy before they show care. But remember, if I am rich, I will be in a private hospital with a private doctor. I will not come to a public clinic for less care or no care. This is where poverty takes you to".
> (PA216GH, 77-year-old male).

Careless attitudes to treatment / Nonchalant Attitude

Patient-nurse partnerships have been the subject of concern. On June 22, 2012, the Ghana News Agency (GNA) published an article about a statement made by some

members of the Nurses and Midwives Council (NMC) about the lack of client-centered

services in Ghana's health-care facilities. Also, this prevented quite a number of the

citizens from seeking medical help when they were indisposed. There seem to be no

organized and rational mediation in dealing with such condition in Ghana. Even though

Ghana Health Services code of ethics supports for client-centered health care, the

converse is what is happening as of date. Apem-Darko (cited in GNA on June 22, 2012)

lamented that, the professional virtues of empathy, love, affection, and innovation among

nurses (as exhibited by Florence Nightingale) were diminishing, and that there was the

need for nursing trainees to engage in these treasured values to render professional

services to their cherished patients, clients and family. Patients go to the hospital when

they are sick and so might not be in the right frame of mind. This makes it imperative that

they get the necessary information from them to provide client-centered service with

empathy (Asamani et al., 2017).

This is one area where almost all the participants (19, representing 83%)

complained about. The participants complained about the negative attitudes shown by

some of the health care staff towards those they cared for. Some of the complaints were

that the patients were referred to as a diagnosis instead as a human being. They were

referred to with their ailments. The participants indicated that the nurses' indignant

attitude affected their dignity and expressed that they were met with a negative behavior,

for no apparent reason, unless they knew you. Some of the negative attitudes included,

defiant and non-professional manner, lack of empathy in speaking with them, and

nonchalant treatment and just ignored their illness or sickness. The unfortunate situation

was that there was no apparent reason to be treated as such. The patients complained they felt lost and made their sickness worse than when they got to the clinics. Majority of the participants reported that their trust and support for the healthcare staff keep diminishing. One participant (PA213GH, 61-year-old male) stated he summoned courage to ask a nurse quietly why she showed negative attitude towards him all the time. The nurse told him she has better things to think about than to be pleasant with him. Moreover, his wife told her that his medication has not been purchased because they did not have the money. The nurse then indicated that she was over-stressed because he and other patients come to the hospital and wish things would be given to them for free. Who was to take care of their needs? The participant then asked the nurse whether she cared for their health or cared for whoever had money? Was she not supposed to be their advocate and find the medication for them? Thereafter, the participant called his wife to come and check him out in the morning. Luckily, he claimed they had a pharmacist friend, who called a physician, got the prescription, and dispensed it for him to be paid when he got the money. The participant and the pharmacist reported the nurse to the physician, but there was no follow-up as to what happened to the nurse. Other participant, (PR218GH, 51-year-old female) also narrated that some of the staff also experience stressful situations that make them generate poor human relations towards the patients, due to flawed infrastructure and inadequate health care staff. But in all, the participants did ask why should we be blamed for what is going on in the establishments?

Discussion

A positive relationship between the patient and all healthcare workers is recognized to emerge from effective medical practice. The findings from this study revealed that the patients' dissatisfaction caused them to self-medicate. The problem was caused by reasons such as healthcare workers failing to advocate for patients, inadequate communication, issues of patient safety, commitment obstacles, as well as a lack of recognition of patients' distress. It became apparent that, according to what had already been laid out earlier in this Chapter, patients were not the primary focus of medical treatment. The complaints showed a lack of follow-up care, a lack of continuity in treatments, and unsatisfactory collaboration between patients and healthcare personnel. Patients were compelled to seek treatment elsewhere, including taking medication provided to them by friends and relatives, obtaining medications from corner drugstores, pharmacists, and others who were unfamiliar with their ailments and medical records. These circumstances frequently led to self-diagnosis and self-medication, which can be hazardous and lead to patient deaths. These situations forced patients to seek help from elsewhere, including taking medication given to them by friends and family members, purchasing medications from the corner drugstores, pharmacists, and others who had little knowledge of their illnesses and health record.

According to the participants, even though some patients attempted to communicate with healthcare professionals, they were met with rudeness, negative and uncaring attitudes. Physicians and healthcare professionals must advocate for patients.

However, just two participants admitted that some of the staff showed any form of care for them.

There was a report of swift deterioration of illness since patients refuse to go for medical care due to what they might endure at the hands of healthcare professionals. These included lacks of drugs not given to them at the clinics, either as a form of punishment or lack of funds from the patients. In this case patients end up purchasing their own drugs from outside. In the Republic of Ghana, citizens are urged to roll unto the National Health Insurance Scheme (NHIS). However, unlike the affluent nations, there are no mandatory policies in Ghana to compel to enroll, so to get their treatments taken care of. This is one of the areas healthcare professionals could advocate for patients and educate them to enroll in these insurances or liaise with the social working staff to obtain financial assistance for the patients. All these areas are lacking, causing obstacles for the patients to navigate the health system and challenges in communicating with the healthcare profession, due to lack of empathy, non-commitment, and compassion to patients, as well as careless and nonchalant attitudes. For advocating to patients, hospital staff are needed to be resourceful and empathetic to focus on patient care and educate them about their hospital rights. (Vaartio-Rajalin & Leino-Kilpi, 2011).

Receiving no guidance or education about decision-making of their well-being and care, patients complained about difficulties in attaining good treatment and total care. In this regard the lack of education may negatively impact their knowledge of their illness. Patients did complain about their dignity at the clinics. In order to protect and respect patient's self-esteem, the healthcare professionals must be aware of the patient's

defenselessness and frustrations when meeting with them. (Croona, 2003; Eriksson, 2006).

Providing patients with personalized care, providing advocacy in patients care, fostering insights, and handling patients' needs with dignity will nurture mutual respect. This would also bring about a quality of care and empower patients to go to the clinics and hospitals for proper care. From the angle of patient-centered viewpoint, their involvement and support will generate steps towards a profound and decorous relationship, to avoid unnecessary complaints and bring about amicable relationship. In such a situation, McCormick and McCane (2010) indicated that healthcare organization must implement a patient-centered methodology to handle patient grievances and complaints to prevent litigation, if any, due to negative attitude.

Almost all the literatures which explored the attitude of healthcare professionals towards patients' involvements in their treatments, assessed the treatments and challenges patients face. They ascertained that in Ghana public medical facilities, emphasis should be placed on the kind of advocacy staff should play for the patients. In that there should be a continuous study in this area of healthcare. Communication between healthcare professionals and patients must be ongoing to clear the air for patients to continue receiving quality care.

The complaints shared by the participants included lack of useful tactfulness in addressing patients' issues such as education and commitment, for the patients care with other professions all over Ghana healthcare organizations. The problem is to which office and to whom do they even share their complaints with? What will come out of it?

Do they continue to complain? A consensus was to divulge the reports regarding

healthcare errors, including the 11 categories revealed in the study, (lack of

empathy/compassion, lack of patient safety, non-commitment, limited communication,

lack of nurturing, ethical laws, frustration, lack of confidentiality, limitations to care,

cultural influence, and careless attitudes to treatment and nonchalant attitudes), to all the

professionals and healthcare organizations. This will reduce dissatisfaction and increase

satisfaction in receiving quality care. Therefore, it is essential that healthcare

organizations and the federal government step in to develop viable processes, plans and

strategies to handle patients' complaints (Coombs, Frandsen, Holladay & Johansen,

2010). Patients' complaints and other studies indicate that healthcare professionals in

Ghana have failed to provide education for patients to be self-efficacy and self-regulatory

to their healthcare in the right way, to be their own advocates to receive quality care.

There are also failures to address patients' active participation to increase incentives and

observation to receive quality care results, create patient's satisfaction with received care

and diminish stress and nervousness. Furthermore, medical staff in Ghana continue to

fail to create therapeutic relationships with those they serve in reassuring. This creates an

upsurge in their anxiety on admission at the hospital. However, there is no reassurance

from the staff through patient advocacy.

Findings from this study and other research on patient advocacy could serve as a

resource for Ghana healthcare organization and professional healthcare staff to augment

their roles are advocates. Nurses must make effort to build their therapeutic liaisons with

the citizens to empower their need for advocacy, which at this time is almost non-

existence in Ghana public healthcare facilities. The narration shared by the participants

must be used to empower patient sovereignty through recognition of patients' options in

their own treatments, which sums up to be the aim of patient advocacy. These could

form as a basis for policy formulation in hospitals to boost patient advocacy to enhance

patient satisfaction to receive patient of care. Most importantly, other research must

constantly be ongoing in healthcare for patients' involvements in their treatments and

assess the challenges Ghanaians face in hospitals.

To make patients feel comfortable to seek medical care, it is necessary to make

their complaints transparent to overcome the negative experience shown by the

healthcare staff. Similarly, the patients' grievances should be used to study why the

medical professional's imperfections that continue to become a problem in the hospitals.

Why staff are not made to accept accountabilities for their negative attitudes, why

hospitals are not sanctioned, and why nurse managers, directors and healthcare

professional do not feel compelled to correct the ongoing problems. Overall, more

education is required to manage how the various healthcare organizations could place

emphasis to address the complaints, discourage patients from self-medicating and seek

help from the hospitals to enhance quality care for their good.

Chapter 5: Discussion, Conclusions, and Recommendations

Advances in medical research have made it possible for modern medicine to provide cures for diverse maladies as well as bringing cures to many patients. The healthcare profession has therefore been positioned to take care of patients. Consequently, health care staff must be engaged with healthcare advocates to intensify the momentum to achieve good results for patients' care (Daly, 2004). This task can be achieved by changing the National Health Services (NHS) and its varied obligations to the politicians, educationists, professionals and even patients themselves to overcome the barriers within the multi professional collaboration in delivering quality care for people. There is an eminent and obvious contention that the right of patients and their welfare is not completely protected whilst under the care of the medical providers. There is no close relationship between nurses and patients (Negarandeh et.al, 2006) indicating that the function of patient care must be substituted with recording processes. Implementing and encouraging trust in patient advocacy organizations and in healthcare staff would perhaps ensure that patients are supported. However, it can also upsurge harm to the citizens, especially when the population does not appreciate the fact that the interests of the healthcare profession is placed before their own. In this regard, policies addressing conflicts of interest, trust, and trustworthiness should be put in place to motivate all in the healthcare profession to honor their crucial commitments, to create trust and change their behavior, policies, and procedures for treating those under their care. Extensive collaboration and communication must be done to achieve such feat for the patients' care.

Whitehead (2001) stated that should a present situation continue affecting social behavior models that are not adopted as a concerted and routine part of nursing practice, then nursing may well continue to fall behind other health professionals in the discipline of health education. Engaging in the present study, into the core of the people's healthcare experiences whilst receiving treatment, will bring into focus the situations surrounding their welfare. This study therefore will attempt to bring stimulation and encouragement to enhance quality healthcare and safety practices in Ghana. Conducting this research highlights patient's experiences and expectations, with the intent of correcting and providing comprehensive primary care, as well as improving practices in the healthcare delivery in Ghana. Focusing on healthcare professionals' obligations to provide clinical excellence and fostering team approaches to deliver mandated quality clinical setting in the healthcare system must be at the vanguard of staff's duties. Essentially, this study may initiate and stimulate dialogue to eradicate some of the issues plaguing patient advocacy to effect social change and fill the gap in quality discharge of services by the medical team in Ghana.

Patient advocacy invokes flawless care and ethical way of health care delivery in health care profession. It is dependent upon factors such as social relationships, human interactions, and moral distress and its side effects. Several studies have pointed to instances where there were failures to express and explain the concept of a healthcare advocacy. This could cause disagreements in expected outcomes (Hanks, 2010; Maryland & Gonzalez, 2012). The unclear clarifications of patient advocacy can give rise several problems to healthcare providers. The objective this study was to help to develop and

establish constructive and functioning patient advocacy that is practiced in other nations.

Hopefully, this endeavor will uplift patient's interests and well-being, which is

fundamentally a central objective advocated by a caring nurse, such as Florence

Nightingale, or any caring healthcare staff.

Patient advocacy is a social problem that can be assessed from personal and

professional aspects. There must be a show of empathy and protection for the people that

are served. Protection of the patients has frequently been explained as an essential

module of patient advocacy. However, showing empathy for the patient is deemed as a

new idea which seemingly can be used in the training of the healthcare providers for

better understanding of the relationship between these two entities (Davoodvand et al.,

2016). According to the authors, "the results of this study can be used in the development

of nursing students and novice nurses, re-training of employed nurses, and sensitizing of

nursing managers and planners and other related occupations to the improvement of

nurses' performance, reduction of the adverse effects of patient advocacy, and promotion

of the health of the society" (Davoodvand et al., 2016, p. 8). As such, more studies must

be conducted on the relationship between healthcare professionals and patient advocacy,

especially in Ghana.

Evaluation of Research Results

Introduction

Patient advocacy continues to have a limited influence, particularly in Ghana's

healthcare system, where, due to a lack of appropriate infrastructure, delivering excellent

health care and the need for patient advocacy for the country's population falls short.

There is a noticeable absence of empathy and substandard customer service behavior. These have created a lack of safety and communication making the patients become vulnerable and thus making them tend to fend for themselves by choosing to self-medicate. The issue of lower provider-patient ratio in Ghana does create a burden and challenge for the Healthcare staff to provide superior service to the patients. The fact that patient advocacy is a needed component of quality care in the clinics cannot be over-emphasized. As a result, it is reasonable to say that Ghana requires not just a robust conversation about the population's well-being, but also health and healthcare system reform in order to eliminate obstacles that obstruct patient advocacy in Ghana.

Within the last ten years, significant progress has been accomplished in terms of healthcare infrastructure and reform, yet issues persist that inevitably affect patient advocacy. Timelines and model practices, as well as outcome indicators and processes to assess rate of mortality and complications of diseases due to a lack of treatment and access for enhanced delivery.

The rights of patients must take a pivotal role in health care facilities, enlisting strict guidance and laws that are needed to control, and placing emphasis on the awareness and care for patients. The study and analysis of patient advocacy structure in Ghana ought to consider the moral aspect of patient care, delivery of services, barriers and facilitators that exist in the medical system, and how these issues narrated by the patients may be ethically addressed by the authorities. Patients shared complaints of 11 major concerns, (lack of empathy/compassion, lack of patient safety, noncommitment, limited communication, lack of nurturing, ethical laws, frustration, lack of

confidentiality, limitations to care, cultural influence, and careless attitudes to treatment and nonchalant attitudes). Most of these concerns have also mentioned by some authors of studies.

This study was not only conducted to effect social change in Ghana healthcare reform. It was also done to provide patients with education to be self-efficient, self-regulatory, be their own advocates to demand quality health care and be empowered to remain diligent with their health needs inculcated in their rights.

Interpretation of the Findings

Through the data collection, there were candid complaints shared by the patients about the negative attitudes of the professionals. There have been several complaints even found in other studies conducted before hand. A study conducted in 1999 by Asenso-Okyere and others, also proved that Ghana healthcare professionals had not demonstrated any impact of advocating for patients. This showed that today's healthcare profession is falls short of what pertained in Florence Nightingale's era. As one of the participants stated, all nurses of today want is money and are therefore constantly talking about travelling to affluent countries. The effect of Nurses travelling abroad together with other factors have created major reduction of nurse-patient ratio in Ghana. The healthcare professionals left behind are overwhelmed with double shifts resulting in fatigue and exhaustion. This makes them behave negatively towards the patients. Shortage due to exodus into Western countries has become a problem all over. Report from the Ghana Health Services also stated that the scarcity of the medical professionals not only in the metropolitan areas of Ghana, it also acute in the rural communities and

small towns (Ghana Health Service, 2011). Ghana Health Service summarized in their report that, "Trends over the three-year period under review (2009 – 2011), the population-to-nurse ratio decreased to 1,240 clients: one nurse, in comparison to 1,489:1 (2010) and 1,497:1(2009) created much problem. Similarly, even though the population-to-doctor ratio has improved from 10,483:1 (2010) to 10,032:1(2011), the negative impact continues to be unsatisfactory. It is encouraging for the Health Service, particularly at a time when it is positioning itself for universal coverage'' (p. 3), however lots need to be done to create satisfactory care for the patients.

Other researchers maintained that some of the healthcare professionals stated that they do react to the patients 'attitudes towards them which felt unwarranted. (Asensu-Okyere et al. 1999). Stearns and Stearns (1988) maintained that Nurses' attitudes reveal a distinguishing group within society; they simply convey their feelings toward patients with various degrees of enthusiasm, allowing them to express themselves in the manner they typically do. On the other hand, patients do blame the healthcare staff making them to contemplate the degree of responding appropriately to the several groans and signs of the patients most of whom be faking their pain.

Limitations of the Study

The scope of this study was restricted to Greater Accra Regional Hospital (GARH), also known as the Ridge Regional Hospital, located at North Ridge in the Osu-Klottey Sub-metro of Accra Metropolitan Area in Greater Accra, the Capital of Republic of Ghana. However, the strength of this study came from the participants who live in the catchment areas, namely, Ridge, Nima, Maamobi, Kanda, Accra New Town, Kotobabi,

Osu, La, Adabraka, Achimota, Airport Residential Area and Central Accra. The data was collected within three months. This descriptive study was based on a qualitative design stemmed in a deep narration of the results. Additionally, the use of five open-ended questions by way of semi-structured interview yielded the spectacular responses that embodied in the wide range of the participants responses. Creswell, (2014) indicated that the objective of a qualitative study was to uncover instead of authentication and generalization of a phenomenon. In that, the participants could have included the healthcare profession for a stronger assessment of the existing impediments and barriers in respect to patient advocacy in the healthcare setting in some public healthcare setting in Ghana. Final challenge that was eradicated was reassuring participants of confidentiality in reporting as well as the use of pseudonyms instead of their real names. The researcher was able to do this by creating interpersonal relationship with the participants.

Recommendations

Through research, patient advocacy has become vital concept for medical professions. However, the degree of its practice continues to be negative and quite narrow in Ghana and even in Africa as a whole continent. Patient advocacy in Ghana culture does not cover a variety of stable conditions for mass media in participation to advocacy education. Unequal interactions between medical professionals, policy makers and patients create chaotic and dangerous situations. Therefore, there is the need for a strong new model of patient inclusion in all crucial healthcare decisions. This must include a strong patient advocacy movement, not only in Ghana, but most parts of Africa,

to steer in a more egalitarian healthcare process, with the medical profession as the lead.

Human beings' integral worth, self-esteem and basic rights must be at the forefront of all

medical personnel (American Nurses Association, 2010), especially when it comes to the

point of sickness. Nurses must consider the needs and values of all persons in the

professional relationships. This powerful statement points to ethics and human rights that

must be accorded to patients by those in healthcare. In addition, all patients must be

educated to secure, relieve and be empowered to know that their healthcare will be the

highest priority of the medical personnel, and it is their right that they must acquire. The

Republic of Ghana as one of the democratic states in the Sub-Region of West Africa

should be at the forefront with quality amenities in the healthcare. But to large extent, the

values of patient advocacy in Ghana seem to be misdirected. As of the time of the data

collection, it continued to preoccupy the minds of the citizens, causing fear and

unhappiness in the areas where patients receive care for their illnesses. Issues relating to

patients receiving treatments on admission at the hospitals and clinics are intense. Much

evidence, focus and concern must be given to the patients care and wellbeing,

     In a study conducted about impact of patient advocacy in Ghana, it was concluded

that nurse's characteristics does impact patient advocacy in empathetic and assertiveness

and are equivalent to those practiced in other parts of the globe. The nurse claimed, "We

are the best to stand in for patients". (Dadzie et al., 2017). However, that was not the

essence obtained from the participants in this study. As such there is the need for constant

trainings for the healthcare professionals in Ghana. Augmenting the positive

characteristics could assist and curtail the negative conditions that threaten patient advocacy role in Ghana healthcare system.

According to Ghana Health Service (GHS, 1992), patient advocate has been embraced in Ghana since 1992. However, the impact has not been strong enough. A Patient Charter Act introduced by Ghana Health Service in 1992 enforces healthcare professionals to be legally and ethically liable to the citizens. The charter required that nurses' practicing in Ghana healthcare system must safeguard patients' rights to safety, competent and quality care. Even though this a charter, it has not been enforced and the medical professionals are not practicing it, according to the participants in the research. As such the healthcare leaders are required to introduce a specific policy to enforce practicing healthcare professionals in their patient advocacy roles.   There seem to be a great disparity in this social gap that needs correcting by the healthcare organization, department of health and the Government of Ghana. Kohnke, (1982) stated studies have shown that medical staff comprehend patient advocacy, but how and whether they will advocate for the patients is the question. Consequently, more studies must be ongoing into how the staff understands patient advocacy in the clinical setting. That would bring focus on the error being done to the patients and well beings. Medical staff must be empowered to improve their own skills in the area of patient advocacy. Treat patients just they would treat their own family members. Take a stand to talk to coworkers who treat patients with negative attitudes, and respect patients in their own rights. Medical professionals are to be patient's voice, be their advocate, especially when they feel lost and fix what needs corrected.

Department of health, lead physicians, regional directorates and leaders in other healthcare organizations must come together to develop strategies to enhance patient advocacy in Ghana. Assessing this theory can assist to develop educational and managerial hypotheses, and design instrumental tools for valuing professionals' performances in patient advocacy. Refresher courses to train the staff is needed. Patient Advocacy office must be created in every hospital. Furthermore, there are too many patients to be seen daily, because of walk-in's system. As such appointment system must be created in every medical facility. But do allow several walk-in for the critically illnesses. Incentive must also be created to recognize staff who go above and beyond exceptional duties. Affordable cost of care must be created by the department of health to enable patient to receive quality care. Staff receive low wages, encouraging medical professionals to leave for greener pastures in the affluent nations.

Implications to Close the Social Gap

Data collected showed that there is a social gap that needs closing. The findings in this research could serve a fundamental resource for medical students and professional nurses to improve their roles in the field of patient advocacy. This study found out that Ghanaian patients are not made to be empowered to remain assiduous with their health needs and rights, due to lack of patient advocacy.

The Republic of Ghana as one of the democratic states in the Sub-Region of West Africa should be at the forefront with quality health facilities in all aspects. However, to large extent, the values of patient advocacy in Ghana continue to be misdirected and continue to preoccupy the minds of the population, causing fear and unhappiness in the

area where people must receive care for their illnesses. Issues relating to treatments on admission at the hospitals and clinics remain intense. Notable issues as evidenced in literature remain negative and careless attitudes of the medical personnel. It was further evidenced that much concern has not been given to the patients care and wellbeing. Even though some efforts have been given to the occupational health and safety practices, it remains occupational risks for the population, hazards, diseases and challenges. (Puplampu & Quartey, 2012). Hospitals and medical professionals are meant to reassure patients and give them some peace to receive care. Instead, attitude of the healthcare staff adds to patients' weaknesses and fear when they are ill. Patient advocacy is to make a new and creative contribution to effect social change in Ghana health care system.

Medical professionals, as a role in their ethics, are required to build therapeutic relationships with their patients so to recognize the need for patient's advocacy to help. As one of the fundamental aims of patient advocacy, the findings of this study is to enhance proper patient autonomy through recognizing their preferences in medical treatments and care. Department of Health and healthcare leaders must lead the creation of strategic plan in Ghana healthcare sector to improve and sustain advocacy that enhance patient contentment in quality care. As has been stated in the previous studies on patient advocacy, further studies are needed to be delved into the negative attitudes of the healthcare professionals towards patient's welfare. This should include Ghanaian population's care and challenges faced in the clinics and on admission, to place emphasis on type of advocacy's patients need more under their care. In similar studies on patient advocacy, nurses indicate that when it comes to standing in for patients, they are the most

qualified (Dadzie, Aziato & de-Graft Aikins, (2017). However, Dadzie and his

colleagues found out that although patient advocacy is practiced especially among nurses,

there is a paucity of literature on the subject in Ghana and Africa. Nurse traits that

support patient advocacy are comparable to those found in the United States, Sweden,

and Iran. On the other hand, patient advocacy characteristics have not been thoroughly

explored in Ghana, creating danger for the patients. There is the need for strategic plan,

further training, and mentoring of healthcare professionals to enhance multidisciplinary

training in Ghana health care sector.

Conflict of Interest

There is no conflict of interest to be declared in this study by the author.

Conclusion

The participants in this study have claimed that healthcare providers make them

reluctant to seek medical attention. Patients do not go to the hospital for a variety of

reasons, including finances, time, and the doctor-patient ratio, in addition to the lack of

patient advocacy. Patients tend to self-prescribe medication and buy from the corner

drugstores. Patient advocacy, when practiced, can save lives, preserve, and ensure good

health care, provide quality care for patients, and facilitate quick recovery. As such it will

reduce obligations on the healthcare system.

The participants indicated that the purpose of the patient advocacy to achieve

quality care is not practiced often, especially if you happen to go to a public hospital.

The study proved that there are no interpersonal relationships to enhance interactions

between the patients and family members. Healthcare professionals must help to establish

camaraderie in the clinics and hospitals. The essence of knowing the patients, their needs, their illness, and family members with respect to appreciating them and involving them in their all-inclusive care seem missing. Patients has the right to be assertive to communicate their needs and fears to the staff. But quite often, they do not have the chance to do so due to lack of relationships with the staff.

Findings also revealed that complaints about the lack of patient advocacy have been ongoing. However, no efforts have been made to rectify the medical staff's negative behavior towards the patients. Healthcare professionals and leaders do not seem to take responsibility for the staff's actions. So, the participants are requesting for a lot more to be done to make them feel comfortable and for their well-being.

The study made a substantial impact in realizing patient advocacy with a constructive outcome on the delivery of patient quality care in Ghana. The participants discussed how advocacy must be an idyllic nature and the intent of nurse-patient relationship. Thacker (2008) indicated that patient advocacy is very advantageous to the care of patients and can promote patient-centered care. Patient advocacy must be considered as one of the primal roles of healthcare staffing. If it is not keenly recognized and employed in Ghana health system, quality care will not be impacted.

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Appendix: Interview Protocol

Interview Protocol

Date: _____

Location: _____

Name of Interviewer:

_____

Name of Interviewee:

_____

Interview Number:

1. How will you describe your stay at the _____ (facility name) Hospital?

2. Please share what happened over the entire time you were in this hospital?

3. What would you change about this hospital, if you could?

4. How does this hospital differ/compare to the General hospital?

5. How would you describe the behavior of the entire hospital team?