

Article

Coordinating Care in Context: Boundaries, Informal Work, and Surveillance in a Ghanaian Hospital

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Abstract

Hospitals are complex institutions where clinical, social, and cultural practices intersect. In Ghanaian hospitals, interactions are shaped by multilingual communication, professional hierarchies, cultural norms, and community expectations. Drawing on five months of ethnographic fieldwork, this study examines coordination of care in a Ghanaian hospital to understand how boundaries (i.e., professional hierarchies, communication barriers, community accountabilities), ruling relations, and power dynamics influence care. Institutional ethnography (IE) was implemented. Participants were purposively sampled, and data were collected through participant observation, documentary materials, and interviews with nurses ($n = 11$), patients ($n = 21$), and caregivers ($n = 11$). Thematic and IE analyses trace how boundaries and professional hierarchies, informal economies, and multilayered surveillance (“medical,” “social,” and “community” gazes) organize care work through institutional texts and how nurses, patients, and caregivers access or deliver care. The findings showed that boundaries at the Yendi Hospital were simultaneously rigid and negotiable, with informal economic activities compensating for institutional resource constraints. Communication work was central to navigating linguistic and cultural diversity, while surveillance from within and beyond the hospital-shaped behaviour and accountability. These everyday practices revealed how institutional texts and societal forces co-produce the conditions of care, with implications for teamwork, patient–provider relationships, and hospital governance.

Keywords: boundaries; clinical interactions; hospital care; institutional ethnography; power relations; Ghana

1. Introduction

Hospitals are dynamic social institutions where clinical, administrative, and interpersonal activities intersect in complex ways. Although historically grounded in communal care, contemporary hospitals have evolved into highly structured environments characterized by professional hierarchies, bureaucratic procedures, and multiple forms of surveillance [1,2]. These institutional arrangements shape how healthcare is delivered, how people move through hospital spaces, and how relationships between providers, patients, and caregivers unfold [3].

In many contexts, including Ghana, hospitals function not only as clinical sites but also as social arenas where economic activities, cultural norms, and community expectations converge. Scholars have shown that hospital environments are shaped by formal rules, such as visiting hours, scopes of practice, and administrative protocols, as well as informal norms embedded in local cultures, languages, and social relations [4,5]. These intersecting



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forces create a landscape in which boundaries are simultaneously rigid and negotiable and where everyday interactions are mediated by institutional texts and societal expectations that influence healthcare access, care quality, and patient satisfaction [6].

Language barriers, cultural beliefs, and power asymmetries further complicate clinical communication and care delivery in Ghanaian hospitals [5,7]. Even in multilingual societies with shared lingua francas, provider–patient interactions are often constrained by linguistic mismatches, cultural norms surrounding gender and age, and differing understandings of illness and care [8,9]. These challenges are not merely interpersonal; they are embedded in institutional arrangements that shape how communication work is performed and by whom.

Within this broader context, Ghanaian hospitals also experience tensions related to professional boundaries, leadership hierarchies, and public accountability. Reports of medical misconduct [10,11] and community activism, such as the actions of the Concerned Citizens of Yendi (CCY), illustrate how hospital practices are subject to scrutiny from both within and outside the institution. These dynamics underscore the importance of understanding how everyday hospital interactions are coordinated through institutional processes, cultural expectations, and power relations, given their implications for care quality, patient safety, care coordination and access, staff morale, and healthcare governance.

Research in Ghana consistently demonstrates poor patient safety culture in many hospitals, including high rates of hospital-acquired infections, medication and diagnostic errors, overworked care providers, inconsistent reporting and monitoring, and medical negligence [12,13]. These conditions predispose patients to avoidable harm and poor care outcomes. Yet, evidence also shows that community engagement, continuous staff training, health policy reforms, and respect for patient rights are directly correlated with improved patient safety culture [13]. Similarly, studies indicate that resource constraints, conflicting health policies, and weak governance mechanisms undermine staff morale, care coordination, and overall healthcare quality [10,14]. Because public policies, healthcare practices, and organizational structures are strongly interconnected [15], examining everyday care work and power relations becomes imperative.

This paper draws on ethnographic data from a hospital in Northern Ghana to examine how care is coordinated through institutional boundaries, ruling relations, and power dynamics. Focusing on everyday interactions among nurses, patients, caregivers, petty traders, and hospital administrators, the study shows how institutional texts and societal values structure the conditions under which care is delivered and experienced. The analysis demonstrates that care work and coordination are shaped—directly and indirectly—by institutional processes, professional hierarchies, communication barriers, and community accountabilities, all of which are organized by text and collectively influence how actors engage with one another in the hospital setting.

The Research Problematic Through an Institutional Ethnographic Lens

Institutional ethnography (IE) begins not with abstract theory but with a problematic: tensions or disjunctures that arise from people’s everyday experiences and point toward the institutional relations that organize those experiences [16,17]. A problematic is not a hypothesis to be tested; rather, it is an entry point for tracing how ruling relations coordinate local practices [16,18].

The problematic for this study emerged from recurring tensions observed during fieldwork at the Yendi Hospital: patients and caregivers navigating unclear or shifting spatial rules; nurses constrained by professional hierarchies that limit their autonomy; petty traders operating in ambiguous spaces between prohibition and necessity; linguistic and cultural differences contributing to communication breakdowns; and community actors

exerting external pressure on hospital practices. These disjunctures raised a central question: How are everyday interactions in the hospital coordinated by institutional boundaries, cultural norms, and power relations, and how do these ruling relations shape the work that nurses, patients, caregivers, and others must do to access or deliver care?

These observations directed attention to the institutional processes, formal and informal, that organize people's actions and care work. They foreground how boundaries are enacted, negotiated, and resisted; how communication becomes a form of institutional work; and how multiple layers of surveillance shape behaviour and relationships. Through this lens, the paper examines care coordination in this hospital setting to show how texts, boundaries (professional hierarchies, communication barriers, community accountabilities), ruling relations, and power dynamics structure everyday care.

2. Materials and Methods

2.1. Study Design

This study draws on interview data and five months of ethnographic fieldwork conducted as part of a doctoral project on patient rights and nurse–patient communication in a Ghanaian hospital. The research was guided by institutional ethnography (IE) [18,19], a sociological approach that begins from people's everyday experiences and traces how their activities are coordinated by institutional texts, ruling relations, and translocal forms of organization [16,19]. Rather than treating the hospital as a bounded site, IE directs attention to how local practices are shaped by broader institutional circuits, including professional hierarchies, administrative protocols, cultural norms, and community expectations, as highlighted in the previous section.

As a Ghanaian and an interdisciplinary health services scholar committed to advancing patient rights, person-centred care, effective communication, and patient safety, I was drawn to examining processes in the hospital, care work, and patient–provider relationships. Also, as a native of Yendi, my positionality shaped both my interest in the topic and my approach to the field. Similarly, since I am a non-nurse healthcare researcher, I interacted with diverse members of the hospital community to better understand patient rights, communication practices, and everyday patient–provider interactions. These engagements informed how I collected, interpreted, and contextualized the data throughout the research project.

2.2. Study Setting

The study was conducted at a government hospital that serves a linguistically and culturally diverse population in Northern Ghana. The hospital provides various healthcare services, including laboratory and diagnostic care, emergency and acute care, ambulatory and outpatient clinics, and general medical care. It also serves as a referral facility and comprises multiple inpatient wards, an outpatient department, emergency, maternity, reproductive health, intensive care, and labour units, as well as administrative offices. At the time of fieldwork, the hospital had over 400 staff. These included 101 registered nurses, 39 midwives, over 200 enrolled nurses, and other professionals, including community health nurses, laboratory and physician assistants, and biomedical scientists. The hospital had 270 beds and received 300 outpatients weekly, of which about 150 became inpatients. Thus, the hospital was characterized by high patient volumes, resource constraints, and active community engagement, including oversight by local advocacy groups.

2.3. Participants

Nurses, patients, and caregivers were the primary participants purposively sampled for data, as their everyday work and interactions constitute the entry point for tracing

institutional coordination. A total of 11 nurses, 21 patients, and 11 caregivers were recruited using posters and word of mouth. Participants were eligible for inclusion if they were 18 years of age or older and willing to share their personal experiences of care during individual interviews. Patients and their caregivers were required to have spent at least one full day in the hospital, while nurses needed a minimum of three years of work experience at the facility. All participants consented to participate in the study by signing or thumbprinting the consent form, after all study procedures were explained to them. These participants were recruited to gain in-depth data to understand the topic under investigation.

2.4. Data Collection

Diverse qualitative data collection tools were implemented in this project. These included participant observations, interviews, and documentary materials.

2.4.1. Participant Observation

Over 400 h of participant observation were conducted between December 2021 and April 2022 across nine inpatient wards, including the outpatient department (where all non-emergency patient care processes begin), emergency unit, maternity and labour wards, and other significant hospital spaces. Participant observations were focused on spatial organizations (locations of facilities, units, and other spaces), daily patient-provider interactions, healthcare routines (e.g., admission and discharge processes, care work (e.g., medical and clinical rounds, documentation practices, patient transfers, change of shift), communication and interactional practices (e.g., use of translators and interpreters), administrative routines (e.g., staff monitoring, resource allocation, use of emergency medicine, rotation of nurses, regulating visiting hours, etc.), and other interactional patterns outside the patient unit (e.g., petty traders and their interactions with patients and nurses). Within patient units (which were open bay units in design without curtains separating patient beds), these observations were conducted to understand real daily patient-provider interactions [20]. Observations were conducted at the nurse workstation and during medication and clinical rounds at different times of the day: morning, afternoon, and night shifts, averaging five hours daily to observe general nurse-patient interactions (for details, see [5]).

I had informal conversations with other nurses, clinicians, caregivers, and petty traders as part of the participant observation sessions and field notes were written. These informal conversations with petty traders and formal meetings with a few hospital leaders provided additional context on institutional rules, enforcement practices, and community oversight.

Moreover, as a participant observer, I ran errands for nurses, patients, and caregivers, photocopying documents, moving medical tools and supplies, taking patients to various units, and performing minor nonclinical activities when nurses requested my assistance. I participated in staff meetings, medication and ward rounds, among others. All these processes brought me closer to the work of the nurses and patients. Despite being a participant observer, my observations were non-invasive. All nurses knew about my research. So, during ward-round participant observations, I sought the nurse's permission to observe their interaction with patients. For one-on-one nurse-patient interactions during close nurse-patient bedside interactions, patient admission or discharge, I requested consent from patients or their caregivers (third-party consent) to observe the interaction. All observation sessions respected the ethics approval guidelines for the project.

An observation guide was used to facilitate all observation sessions, and field notes captured both descriptive accounts and reflexive insights, consistent with IE's emphasis on documenting how people's work is coordinated in real time. These notes were recorded daily and organized according to patient units.

2.4.2. Interviews

I conducted individual interviews with nurses using an interview guide. Interview questions explored their professional roles, decision-making, care practices, relationships with patients, caregivers, and other care providers, perspectives on patient rights and communication, and barriers to healthcare delivery. All interviews ($n = 11$) with nurses were conducted in English and lasted about 32 min.

Similarly, interviews with patients ($n = 17$) and caregivers ($n = 11$) examined their experiences of care, interactions with care providers, perspectives on patient rights and communication, barriers to healthcare access, and institutional processes. Most interviews with patients and caregivers were conducted in English and Dagbani (the dominant language of the region, to which the researcher is a native speaker). Caregivers and patients with low English proficiency or who did not want to be interviewed in English had their interviews in Dagbani, the researcher's native language. Interviews with patients lasted an average of 21 min, and those with caregivers lasted 19 min. All interviews were audio recorded. All interview guides were translated into Dagbani and cross-checked by a language expert, also a native Dagbani speaker, before interviews were conducted. Moreover, I am highly proficient in both English and Dagbani.

Lastly, I conducted one focus group with four ($n = 4$) patients. These were surgical patients waiting for their scheduled surgeries. They were admitted into the same patient unit and wanted to share their experiences. The focus group was conducted in Dagbani, lasted about 58 min, and was audio recorded. These interviews were conducted to gather enough data to understand the research problem. As such, I stopped interviewing whenever additional interviews yielded no new ideas in each participant group.

2.4.3. Documentary Materials

Administrative, medical, clinical, and other health promotion documents were collected and studied. Some of these documents were posted on notice boards in patient units. Specific documents such as the Ghanaian patient's charter, a note requesting patients to demand receipts for all payments made, requisition forms for supplies, and infection control protocols (e.g., High-Level Disinfection (HLD), Processing Material after Disinfection and Cleaning, Protect Yourself from Coronavirus) were examined to understand their implications for care work and patient-provider relationships. The CCY also shared with me copies of their petitions to the hospital. Other texts referenced during nurses' interviews (e.g., annual rotation of nurses, the nursing code of ethics, administrative protocols, etc.), not visible but which had an impact on nurses' care work, were explored. These documents helped me to connect some of the processes, relationships, and care work within the broader system of care coordination and institutional practices.

2.5. Data Analysis

All recorded interviews in English were transcribed verbatim, and those in Dagbani were translated into English during transcription. Transcripts were read several times to understand the experiences shared in-depth. Each set of transcripts (e.g., for patients, caregivers, and nurses) was manually coded together and analyzed using an inductive and interpretive approach. The unique experiences of each participant group were noted. Similarly, observation field notes were coded manually and analyzed inductively. First, a reflexive thematic approach [21,22] was used to identify topical issues across the data set, noting those relevant to care coordination and everyday interactions. As Walby [23] advised, the focus here was to identify organizational processes and linkages, local knowledge, and individuals in relationships. These topical categories included institutional practices, boundaries, power relationships, activities of petty traders, communication barriers,

ers, resource constraints, and experiences of patient rights. These were then adapted to IE's analytic commitments [19,24]. After these initial analytic approaches were implemented, the IE analysis proceeded in three stages:

Mapping everyday work processes: This stage involved identifying the activities participants performed to access or deliver care. From interview and observation data, movements, communication, negotiation, monitoring, and acquisition of supplies were mapped.

Tracing ruling relations: At this stage, I examined how institutional texts (policies, professional standards, ward rules), cultural norms, and community expectations coordinated care activities and care work from participant observation and interview data.

Linking local practices to institutional circuits: I connected observed interactions to broader structures, such as professional hierarchies, administrative oversight, cultural beliefs, and community surveillance.

This analytic process moved iteratively between field notes, interview transcripts, and emerging conceptual categories. The goal was not to generate abstract themes but to reveal how everyday interactions were organized by institutional texts and norms that extended beyond the immediate hospital setting.

To promote analytic rigour, all nurses and some patients and caregivers reviewed their interview transcripts and provided feedback, including clarifying some points. Most of the informal conversations helped me to confirm the interview and observational data. Again, preliminary study findings were shared with the hospital management and CCY for feedback. These approaches, in addition to staying long in the field, grounded my study findings in the data.

2.6. Ethical Considerations

Ethical approval was obtained from the Ghana Health Service (GHS-ERC: 005/11/21) and Yendi Hospital in Ghana, and a Canadian university (Beh-ID: 2690). Participants provided informed consent, and pseudonyms are used throughout to protect confidentiality. Observations were conducted with the knowledge and approval of hospital leadership, and care was taken to avoid disrupting clinical activities.

3. Results

This section presents how everyday care activities in the hospital were coordinated. Using an institutional ethnographic lens, I show how nurses, patients, caregivers, petty traders, and hospital managers navigated and negotiated ruling relations embedded in physical structures, professional hierarchies, cultural norms, and community expectations. Most of these processes and practices were interdependent, influencing care coordination and patient-provider relationships.

3.1. Participants Demographics

A total of 43 participants took part in the study, of which 16 were males. The patient sample comprised 5 males, with ages ranging from 18 to 60 years ($M = 26$). Most patients were Dagomba. Patients' average length of hospital stay was three days. Most patients (10 out of 21) had completed secondary school and were single. The caregiver sample had four males and an age range of 19 to 45 years ($M = 32$). Most of them had a basic level of education and were predominantly Dagomba and married. Their length of hospital stay mirrored that of the patients. Lastly, the nurse sample had seven males, aged 26 to 40 years ($M = 33$). Most nurses were married, Dagomba, and had an average of six years of work experience in the hospital. All of them had post-secondary education, as Table 1 shows.

Table 1. Participants demographic data.

Characteristics	Patients	Caregivers	Nurses
Sample size	21	11	11
Sex			
Male	5	4	7
Female	16	7	4
Marital status			
Married	9	8	9
Single	12	3	2
Age (in years)			
Range	18–60	19–45	26–40
Mean age	26	32	33
Level of Education			
None	3	2	0
Basic	2	6	0
Secondary	10	1	0
Tertiary	6	2	11
Ethnicity			
Dagomba	13	8	8
Ewe	2	2	0
Konkomba	2	0	0
Others	4	1	4

3.2. Institutional Boundaries and the Coordination of Movement and Work

Life and work in the hospital were organized through a dense network of physical, discursive, and professional boundaries that shaped how people moved, interacted, and performed their work. The entire hospital was walled or fenced with two main gates. Also, each patient unit was separated but connected to other units via pavements and had at least one gate before one could access it. These boundaries were not merely spatial; they were institutional mechanisms that coordinated behaviour and regulated access. They illustrate how institutional texts (protocols, role definitions, ward rules) shape movement and decision-making.

First, I observed how physical walls, gates, locked ward doors, discursive texts, and controlled entry points structured the flow of people and resources. These material structures were part of the hospital's ruling apparatus, determining who could enter the patient unit, where they could go, and under what conditions. Field notes illustrate how even patients' movements were institutionally regulated through discourses as text:

Sister, not that way. . . Don't cross here," the midwife said, using her leg to demarcate the boundary. (Field notes, 4 April 2022)

When you come in, you must stand here. . . you can't just walk into the labour rooms; said a nurse to a caregiver. (Field notes, 18 January 2022)

A close examination of the infection control protocols and conversations with some nurses revealed that these mechanisms were implemented to minimize access to these spaces for purposes of infection control, especially in the labour, maternity, and theatre units, as captured in these field notes and interview data.

The nurses in the unit (name withheld) told the matron and hospital administrator, when they came in for their routine monitoring, that the infection rate in the ward was high. They said immediate attention was needed to unclog the sink and provide additional water containers. (Field note, 17 January 2022)

You know, our work deals with blood. And patients can't lie on the bed bare like that. They must get rubber and cover it, so whatever comes out down there is poured into the rubber, but some will tell you we can deliver them without using the rubber, and we can't do that. It causes infections and all that. But these are well-packaged, and they're sterilized. (N10, female)

These boundaries, mediated by institutional texts, were not simply about safety; they coordinated care and interactions, allowing nurses to closely observe, monitor, and control patients and caregivers' movements. A field note confirmed the above data and further illuminated an institutional text around uniform use across different patient units.

Today, I was in a patient unit observing clinical interactions; I was told that nurses and midwives in the labour, maternity, and theatre units wear scrubs due to high rates of infection in those units. So, nurses in these units must change into scrubs when they come to work. However, nurses in other wards must wear their professional uniforms. (Field note, 23 January 2022)

Secondly, professional hierarchies, particularly between nurses and clinicians, functioned as institutional boundaries that shaped decision-making and care coordination. As one nurse explained:

We don't prescribe medicine. . . we call the prescriber or the doctor. So, when a patient has concerns about their medication, we call the prescriber or doctor and let them know. (Nurse 10, female)

Another nurse described the structural expectation that clinicians (not nurses) must authorize medical interventions.

Clinicians make medical decisions, and we do the nursing part. We do our nursing interventions, and they take care of the medical aspect. (Nurse 1, male)

These hierarchies derive their legitimacy from the nursing code of ethics and professional standards, which prescribe what care work nurses are permitted. Thus, this text manifests itself as a professional hierarchy that constrained nurses' autonomy, even when they possessed the skills to act. Some nurses even reported being reprimanded for performing tasks deemed outside their scope, reinforcing this chain of command.

A third layer of boundary observed was administrative hierarchical relations between nurses and hospital managers and supply chain routines, which also shaped care work and staff morale, as a nurse related:

I can't speak about other facilities and units, but in this hospital, it's just an over-exercise of power. . . it is just the hierarchy; we are afraid of them, to the extent that we can't express our frustrations . . . or opinions to them. (Nurse 8, male)

Similarly, a supply chain strategy was reported regarding the distribution of patient unit supplies (ward consumables). These supplies were provided weekly through a requisition form by hospital management. Once every ward received their weekly supplies, care work proceeded, as captured in this field note.

Nurses in the pediatric ward indicated that each patient unit receives its supplies weekly, and whenever a ward runs out of supplies, nurses have to borrow the consumables from colleagues in other units. Sometimes, they ask patients or their caregivers to buy these items. (field notes, 30 March 2022)

These administrative structures and institutional texts governed resource allocation and management practices among nurses and/or limited upward communication with the hospital leaders, thereby affecting morale and team cohesion.

3.3. The Informal Economy as a Response to Institutional Gaps

Institutional shortages and structural constraints produced an informal economy within the hospital. Petty traders, caregivers, and even nurses performed economic work that compensated for institutional deficiencies.

Petty traders became auxiliary workers who supplied essential goods, including water, food/fruits, baby care items, and sanitary products. They often entered spaces where their presence was officially prohibited. One seller explained during a Conversation with her:

The hospital management does not want us to sell in the hospital, but we always come in to sell. (Field note, 26 January 2022)

These sellers move around the hospital premises, including congregating at the entrance of patients' units, and occasionally accessing these units when called by nurses or patients, as captured in a field note.

A nurse needed bananas and called the seller, but when she came inside the patient unit, the nurse was not ready yet. The seller said the hospital management does not want them to enter patient wards to sell. So, she rushed out of the ward and waited by the door. (Field notes, 31 March 2022)

Thus, the sellers' work fills institutional gaps, especially for patients who arrive unprepared or without caregivers.

Again, the data revealed that the petty traders' activities were shaped by hospital policies prohibiting sales inside wards, even though their presence becomes necessary due to shortages. This gives rise to complex ruling relations, including hospital regulations restricting access to patient units, informal enforcement practices by management, and tacit permissions granted by nurses and patients. For instance, the seller's statement ("management does not want us to sell in the hospital") shows how a prohibitive text organizes their movement, forcing them to hover at entrances, negotiate access, and respond to nurses' calls. Here, their work was coordinated by the tension between official rules and practical needs.

In the same vein, nurses acted as intermediaries in this informal economy during supply shortages. They acted as brokers for medical supplies when the hospital ran short, as a caregiver stated.

Even the small pipe they use for water infusion. . . they will say bring money. . . someone is selling it here. The nurses will tell me the hospital has run short of the item, but if I bring money, they can sell what they have to me. (Caregiver 6, male)

This informal supply chain seemed a direct response to institutional shortages. However, it also generated mistrust between nurses and patients/caregivers, on the one hand, and between nurses and hospital management, on the other. Patients and caregivers accused nurses of selling a lot of things, raising professional and moral ethical concerns. For instance, a caregiver noted the following.

Patients are buying a lot of things. We buy too many things. . . they will tell you that NHIS does not cover this or that. [So] you [should] bring money before they serve you. (CG6, male)

The above data suggests that nurses' involvement in selling supplies was coordinated by shortages of ward consumables, NHIS coverage rules, informal supply chains, and unwritten norms (e.g., about helping patients obtain unavailable medical supplies). For example, when nurses say the hospital has "run short" of an item, they are invoking institutional texts that classify what is available and what is not. Their brokerage work then was a direct response to these text-mediated constraints. Thus, the NHIS reimbursement policies,

the hospital supply chain protocols, and stock-out reports became ruling texts that shaped nurses' actions and created conditions where informal selling became a workaround.

Further, it was stated that the hospital leaders banned nurses from bringing backpacks to work because they thought nurses were stealing hospital supplies, as recorded in this field note.

While I was in the emergency ward, two nurses said that they no longer bring backpacks to the hospital because nurses were suspected or accused of stealing medical supplies. (Field notes, 12 January 2022)

This institutional policy banning nurses' use of backpacks illustrates how ruling relations regulate care work and relationships with the hospital.

It appears this mistrust and these accusations were part of care coordination through accountability and disciplinary texts. Patients' accusations reflected how NHIS coverage texts and hospital billing policies coordinate expectations about what should be free and what must be purchased. Similarly, the hospital disciplinary procedures, anti-theft policies, and professional conduct standards reorganize nurses' everyday routines, dictating what they can carry, how they move, and how they are monitored.

Nonetheless, despite the strategic role the nurses' participation in the informal economy was serving, it had ethical implications for their care work and relationships with patients and caregivers, especially when clause 17 of the Nursing Code of Ethics states that "All Service personnel shall avoid the use of their Professional qualifications in the promotion of commercial products."

3.4. Communication Work, Cultural Norms, and the Coordination of Clinical Interactions

Communication was a central form of institutional work. The Ghanaian *Patient's Charter* stipulates that every patient is entitled to full information about their condition, its management and possible health risks, except in emergencies when the patient is unable to decide and needs urgent treatment (Article 2). It further demands that every patient be provided with all relevant information about policies and regulations of the health facilities they attend. Similarly, clause (10) of the *Nursing Code of Ethics* in Ghana requires all healthcare staff to provide information regarding patients' condition and management to patients or their families humanely and in a manner they can understand. These texts demand effective communication. As such, in this hospital, nurses, patients, caregivers, and petty traders served as translators to overcome communication barriers and engaged in negotiations to promote clinical interactions. Although these actors facilitated effective communication and determined which care-related texts (charts, prescriptions, verbal instructions) required translation, their work was also mediated by the boss text above (i.e., the *Patient's Charter* and the *Nursing Code of Ethics*) and the Ghana Health Service *Code of Conduct and Disciplinary Procedures*.

Participants' experiences showed that multilingualism and language translation/interpretation became part of care work that nurses, patients, and caregivers engaged in to serve the multi-ethnic patient population. For instance, language barriers frequently disrupted care, as these nurses stated.

Most of the nurses don't understand the Konkomba language. . . so, you must employ the services of someone who can speak English and Konkomba. (Nurse 8, male)

There are things [illnesses and conditions] I can't even translate from English into my native language . . . [which] affect our communication. Sometimes, you say something, and the patient or their relative understands it the other way. (Nurse 1, male)

Therefore, nurses often relied on ad hoc interpreters, including petty traders and other patients, to bridge communication gaps. From an institutional ethnography perspective,

these communication practices show how nurses, patients, caregivers, and even petty traders become active participants in the institutional work of translating ruling relations into everyday action. Their multilingual negotiations reveal how the *Patient's Charter*, *Nursing Code of Ethics*, and Ghana Health Service regulations coordinate people's activities, shaping who does communication work and how care actually becomes accomplished on the ground.

Additionally, cultural beliefs shaped clinical practices, requiring nurses to navigate competing institutional and cultural expectations, as captured in a field note.

When a new baby is born among this tribe (xxxxx), the mother does not touch the baby or breastfeed until after a week. (Field notes, 28 January 2022)

Another case involved a husband who requested that their newborn be handed to his mother rather than his wife (the postpartum mother), as it was a cultural practice that prevented a mother from having skin-to-skin contact with their newborn until certain cultural rituals were performed.

There was a day we had a labour patient here; the husband requested that when the baby is born, we shouldn't give it to the mother, that it was their cultural practice, so after the baby was born, we called the husband and the baby was handed to his father's mother, who took him to the NICU. (Field notes, 28 January 2022)

These practices required nurses to coordinate care within cultural frameworks that sometimes conflicted with biomedical protocols.

3.5. Gazes and Coordination of Behaviour

I use the concept of gaze here to mean watchful eyes (systems and surveillance mechanisms). The data show that multiple layers of surveillance (i.e., medical, social, and community) shaped how work was performed and how people behaved in the hospital.

The medical gaze was implemented by healthcare professionals. Nurses and clinicians monitored patients' bodies, medical records, and behaviour through physical examinations, stethoscope readings, and laboratory tests to examine health progress and the required actions. The medical gaze was coordinated using clinical protocols, triage procedures, diagnostic guidelines, and patient narratives, a nurse related.

When patients come to our unit, first, we triage them. We take their vital signs . . . ask them or their caregiver questions to get some background information. Then, we arrange them based on the severity of their conditions and send them to a clinician. (N3, male)

Also, patients experienced the medical gaze through diagnostic procedures:

They did a scan. . . and asked me to go for an X-ray, which I did. . . but nobody has come to look at the photo yet. (P4, female)

The medical gaze structures how nurses and clinicians assess bodies, classify severity, and determine care pathways. In that process, clinical guidelines, triage charts, diagnostic protocols, and patient records became the ruling relations that coordinated nurses' and clinicians' work and shaped how patients become visible to the institution.

Second was the social gaze, which patients and caregivers cast on nurses' and other healthcare providers' behaviour, sometimes to challenge or resist perceived mistreatment, as these patients remarked.

When the nurses are not doing their work well, I will tell the higher authority that what the nurse is doing is not good, so they can talk to the nurse to change their behaviour. (Patient 6, female)

Yesterday, I witnessed something between a nurse and an elderly patient. The way the nurse spoke to the man was not proper. (Patient 15, male)

It was also revealed that some patients occasionally refused care from specific nurses based on information gathered through their social gaze, as these nurses pointed out.

Maybe it just boils down to when we try to tell them what to do. And then the resistance that comes in. Maybe they are used to a particular norm here. (Nurse 9, male)

Sometimes, you can come to a client, and the client tells you, 'I don't want you to do anything for me, I want your colleague, the other one; don't touch me. I want this nurse to attend to me.' The client can even mention names. (Nurse 10, female)

Sometimes, the social gaze could also take the form of professional practice compliance monitoring by the hospital management. The hospital administrators, clinical coordinator, and the matron often checked on nurses' shift attendance and compliance with professional standards and practices. Therefore, the social gaze acted as a counterbalance to the medical gaze and medical authority.

From an institutional ethnographic perspective, the social gaze activated care coordination through accountability texts and professional standards, including complaint procedures and managerial oversight practices. For instance, when patients said they would "tell the higher authority," they activated institutional complaint pathways. Similarly, management's monitoring of shift attendance and compliance reflected administrative texts that govern professional behaviour. The hospital disciplinary procedures, professional codes of conduct, complaint policies, and supervisory protocols became ruling texts that empower patients and administrators to evaluate nurses' behaviour and enforce institutional norms for effective care delivery.

The third gaze is what I called the community gaze, which emanated outside the hospital environment. Community groups, especially the Concerned Citizens of Yendi (CCY), also exerted pressure on hospital leaders to ensure effective leadership and accountability, as captured in these field notes.

Reactions from society and the CCY's activities... impact healthcare practices in the hospital. (Field notes, 8 April 2022)

Community members evaluate care activities that affect nurses' work and hospital management practices. [Also], people's negative perceptions about the hospital influence their access to care. (Field notes, 8 April 2022)

A nurse confirmed in an interview that the CCY had a greater influence on the hospital managers and leaders than nurses.

The town has concerned citizens. So, whatever the concerned citizens tell them [the hospital leaders], they take that. But, as for nurses, they don't care [or] listen to us. (Nurse 5, female)

This external gaze influenced administrative decisions and shaped internal power dynamics. The community gaze represents ruling relations external to the hospital but still coordinating internal behaviour. The CCY's influence on the hospital leaders reflects public accountability structures through community petitions and advocacy texts, while negative community perceptions shape access to care and influence managerial decisions. These external ruling texts, including the CCY's petitions, local governance expectations, and informal accountability norms, reorganize internal power relations by giving community actors leverage over hospital leadership.

In general, the medical, social, and community gazes were not simply forms of surveillance. They were organizing practices that coordinate individual actions in the hospital through ruling relations embedded in professional, administrative, and community texts.

3.6. A Conceptual Figure

Figure 1 illustrates a conceptual representation of the interconnections between the institutional processes and practices as nurses, patients, caregivers, and other healthcare actors engage in care work.

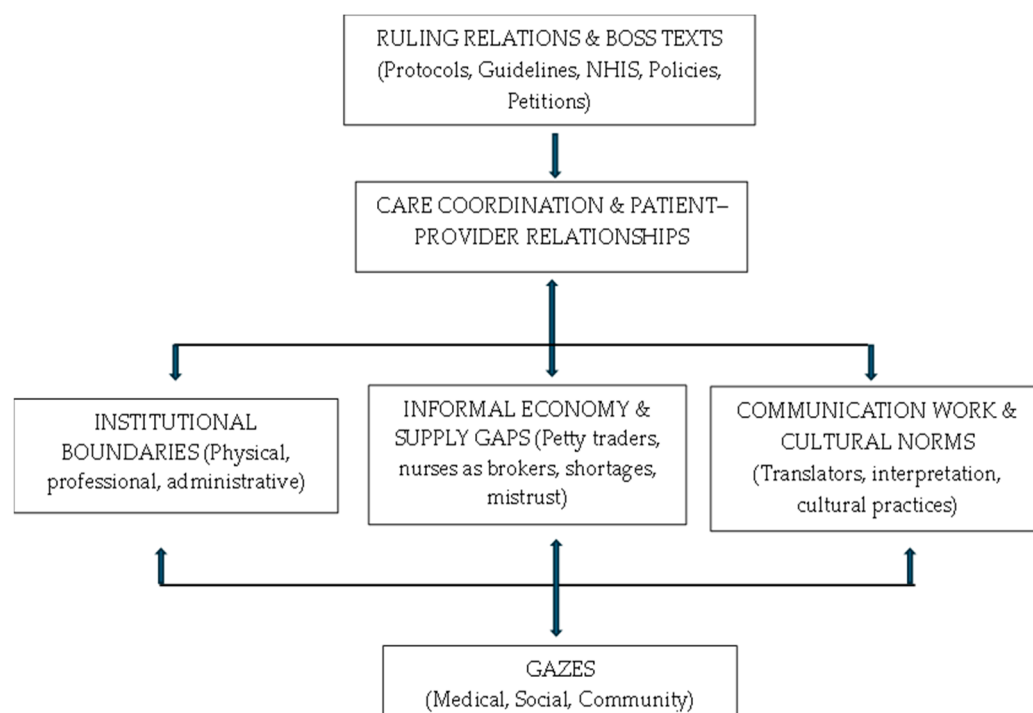


Figure 1. A Conceptual diagram of care coordination by institutional texts.

The figure shows how everyday care activities in the hospital are constrained by institutional boundaries, informal economic practices, communication and cultural negotiations, and layered gazes. These four domains interact and are collectively organized by ruling relations and boss texts, which shape how care is delivered, how patients and providers relate, and how accountability and power are exercised in the hospital.

4. Discussion

This institutional ethnographic study examined how everyday interactions in a Northern Ghanaian hospital were coordinated through boundaries, communication practices, informal economies, and multiple layers of surveillance mediated by institutional texts. Through the standpoint of nurses, patients, caregivers, and petty traders, the study traced how everyday care activities were shaped by ruling relations, including translocal forms of organization that structure work processes, professional hierarchies, and social expectations within the hospital [16,18].

The findings demonstrate that boundaries, whether physical, discursive, or professional, are central to how care work and life are organized in the hospital. These boundaries, which controlled entry points, were not merely architectural features; they were institutional mechanisms that coordinated movement, visibility, and access. They regulated who could enter specific spaces, how patients moved within units, and how staff performed clinical activities. As Tillett [25] suggests, spaces are both experienced and enacted, and in this hospital, boundaries were continually produced through everyday interactions. Particularly, this study found that professional boundaries between nurses and clinicians shaped care coordination. Nurses' accounts of limited autonomy, fear of reprimand, and dependence on clinicians for medical decisions illustrate how hierarchical ruling relations

organize clinical work. These boundaries were not fixed; they were adapted in practice, yet they consistently reinforced institutional authority structures. The resulting tensions echo broader findings in the literature that rigid professional demarcations can impede teamwork and compromise healthcare quality [26–28].

Similarly, the presence of petty traders and the informal sale of medical supplies reveal how institutional shortages and resource constraints shape everyday work in the facility. Informal economic activities were not peripheral to hospital life; they were integral to how patients and caregivers accessed necessities. Petty traders filled gaps left by institutional limitations in the hospital, while nurses sometimes acted as intermediaries when essential supplies were unavailable. The study findings corroborate previous research on how hospitals drive economic growth by generating employment opportunities for community members [29,30]. Nonetheless, some of these economic activities may pose ethical dilemmas and conflict with professional ethical standards, especially when nurses sell medical supplies to patients and caregivers or engage in other money-generating practices [31]. Care quality could diminish, patients' rights could be disregarded, and patient safety could be compromised if patients and caregivers refuse to purchase these supplies from nurses.

From an IE perspective, these practices illuminate how institutional processes, such as procurement systems, supply chain failures, and administrative oversight, coordinate the work of actors who are not formally part of the healthcare system. The informal economy thus becomes part of the institutional circuit through which care is delivered, even as the hospital management attempts to regulate or suppress it. In other words, the informal economy was not “outside” the institution. It was an institutional work produced by ruling relations, where petty traders, caregivers, and nurses were drawn into compensatory labour that fills gaps created by extra-local systems, as previously reported in the literature [32,33]. Also, the ban on nurses' backpacks, for instance, reflects how ruling relations extend into the regulation of workers' bodies and personal belongings, reinforcing mistrust and managerial surveillance.

Furthermore, communication emerged as a central form of institutional work. Nurses, patients, and caregivers engaged in continuous language and cultural negotiation to make clinical interactions possible. Language barriers required the mobilization of informal interpreters, including patients, caregivers, and petty traders, highlighting how communication work goes beyond formal roles [5,34]. In the same way, cultural norms surrounding childbirth, gender, and age further shaped clinical practices. Nurses had to navigate competing expectations between biomedical protocols and cultural beliefs, such as delayed mother–infant contact or the involvement of extended family members in newborn care, as reported in other studies [35–37]. These practices illustrate how ruling relations are not solely bureaucratic or professional; they also include cultural and social norms that coordinate behaviour within institutional settings.

IE emphasizes that such work is often invisible in formal accounts of healthcare delivery, yet it is essential to how care is actually accomplished. These findings underscore the need for culturally responsive communication strategies [7,38,39] and institutional recognition of the interpretive work performed by nurses and caregivers. Therefore, healthcare professionals must be equipped with interpersonal communication and cultural competency skills to navigate language and cultural barriers in patient-provider interactions [40–42].

This study identified three interlocking forms of gazes, the medical, social, and community gazes, that shaped behaviour and accountability within the hospital. The medical gaze, enacted by nurses and clinicians, coordinated patient health behaviour and structured clinical decision-making. The social gaze, enacted by patients and caregivers, served as a counter-surveillance mechanism through which they evaluated and sometimes challenged healthcare providers' conduct. This reciprocal monitoring reflects the fluid nature of au-

thority in clinical settings [43,44]. The community gaze, emanating from community actors such as the Concerned Citizens of Yendi (CCY), mediated professional compliance beyond the hospital walls. Similarly, community judgments, rumours, and activism influenced administrative decisions and shaped the behaviour of hospital leaders. This external oversight illustrates how ruling relations stretch into the broader social world, thereby linking institutional practices to Yendi community expectations and political dynamics [45,46].

Together, these gazes functioned as a multilayered accountability system that both constrained and enabled action in the hospital. They reveal how institutional power is enacted not only through formal policies but also through social relations, community pressures, and moral evaluations. Furthermore, the gazes reveal how ruling relations organize everyday care work. They show how nurses, patients, caregivers, healthcare managers, and community actors are drawn into text-mediated coordination that shapes conduct, authority, and care practices in the Yendi hospital.

Implications for Care Delivery and Institutional Practice

The findings have several implications for healthcare delivery at the Yendi Hospital and similar contexts in Ghana. First, communication barriers and hierarchical structures reorganize everyday care work by determining who can speak, who must translate, and whose knowledge counts, ultimately influencing care quality, patient safety, and relational dynamics of care delivery. Also, institutional boundaries regulate movement, access, and authority within the hospital, structuring how care is coordinated across units and professions while simultaneously constraining patient autonomy and shaping managerial control over clinical space. While boundaries are necessary for safety and order, overly rigid or inconsistently enforced boundaries can hinder communication, limit patient participation in the care process, and strain provider–patient relationships. When patient dignity and rights are observed in clinical interactions, healthcare professionals can gain the rich experiences and information that patients and their families bring to healthcare delivery spaces [10,47].

Second, informal economies and networks play crucial roles in sustaining access to essential care products and services, particularly in this resource-constrained hospital setting. The emergence of an informal economy reveals how institutional shortages disrupt formal care pathways, forcing patients, caregivers, and nurses to rely on unofficial supply chains that could complicate care coordination, erode trust, and create governance challenges for the hospital management. Most importantly, the informal economy reveals how institutional texts and ruling relations, such as procurement policies, NHIS rules, supply chain protocols, and disciplinary procedures, coordinate people's activities, producing new forms of work that compensate for institutional failures in this hospital. Recognizing these practices and integrating them into institutional planning and institutional-level policy may improve care coordination and reduce mistrust.

Third, the multilayered surveillance system underscores the importance of transparency, effective nursing leadership, and community engagement. These gazes function as monitoring mechanisms that shape behaviour, producing both accountability and tension in patient–provider relations while compelling managers to navigate competing expectations from clinicians, patients, and community actors. This requires the Yendi Hospital leaders to navigate not only internal hierarchies but also external expectations that shape institutional legitimacy, calling for effective and engaged leadership practices.

Generally, the cultural barriers, informal economies, hierarchical constraints, and surveillance practices all expose institutional gaps. Cultural competence and ethical care delivery underscore the need for expanded nurse training in communication, ethics, and patient-centred practice. Ensuring cultural competence and sensitivity to cultural differ-

ences among healthcare providers can promote healthcare equity and minimize patient-provider conflicts in the hospital [36,37].

Lastly, IE makes visible how everyday care work is shaped by local and extra-local ruling relations, showing that the intersecting issues found in this study are not merely interpersonal problems but outcomes of text-mediated coordination. By tracing how policies, professional codes, and administrative procedures organize people's actions, IE reveals how these institutional forces structure care pathways, shape patient-provider relationships, and produce conditions under which trust, accountability, and care quality are assessed.

5. Conclusions

This article traces how care coordination and everyday interactions in a northern Ghanaian hospital were coordinated through boundaries, communication practices, informal economies, and multilayered gazes/surveillance. From the standpoint of nurses, patients, caregivers, and petty traders, the study illuminated the institutional relations that organize their work and shape their experiences of care. What appears on the surface as routine movement, conversation, or negotiation was, in practice, deeply structured by ruling relations, including professional hierarchies, administrative protocols, cultural norms, and community expectations.

The findings suggest that boundaries in the hospital are not merely physical demarcations but active coordinating mechanisms that regulate access, visibility, and authority. Professional boundaries between nurses and clinicians, for example, constrained decision-making and shaped the distribution of clinical responsibilities. Informal economic activities emerged as responses to institutional shortages, revealing how care is sustained through work that falls outside formal organizational structures. Communication work, such as navigating multilingualism, cultural norms, and interpretive challenges, was central to how clinical interactions were accomplished, yet largely invisible in institutional accounts of care delivery. Lastly, the interplay of medical, social, and native gazes demonstrated how surveillance and accountability operate across multiple levels, linking hospital practices to broader community dynamics.

These findings underscore that patient care is influenced by the intersection of institutional structures, policies, and everyday nursing practices. Improving care quality, communication, and teamwork requires attention not only to clinical protocols but also to the social and institutional conditions that shape how work is done. By foregrounding the lived experiences of those who navigate the hospital daily, this study contributes to a deeper understanding of how healthcare is organized in resource-constrained, culturally diverse settings. It also highlights the value of institutional ethnography for revealing the often-overlooked forms of labour, negotiation, and coordination that make care possible.

A major limitation of the study is that the findings cannot be generalized to all healthcare institutions in Ghana, even though some of the issues addressed in the paper may exist in other hospitals.

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the University of Saskatchewan Institutional Review Board (Beh-ID: 2690) on 14 September 2021, the Ghana Health Service Ethics Committee (GHS-ERC: 005/11/21) on 20 December 2021, and the Yendi Municipal Hospital.

Informed Consent Statement: Informed consent was obtained from patients, caregivers, and nurses who participated in interviews and focus groups or during observations of one-on-one nurse-patient interactions at patient admission or discharge. Participant observations were conducted in patient

units (which were open bays without curtains separating patient beds) during ward or medication rounds, at the nurse station, and in public spaces.

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Abbreviations

The following abbreviations are used in this manuscript:

CCY	Concerned Citizens of Yendi
GHS	Ghana Health Service
IE	Institutional Ethnography
NICU	Neonatal Intensive Care Unit

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