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Social Science & Medicine 59 (2004) 2025–2036

SOCIAL SCIENCE & MEDICINE

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# Poverty and violence, frustration and inventiveness: hospital ward life in Bangladesh

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**Abstract**

An ethnographic exploration was done in an orthopaedic ward of a government teaching hospital in Bangladesh to understand the nature of hospital culture in the context of Bangladeshi society at large. Life and work in the ward result in a culture that is simultaneously created by its inhabitants and the conditions in which they are situated. The study shows that biomedicine is a product of particular social conditions and that the hospital reflects features of its society.

Behind the injuries and broken limbs in the ward are stories of violence, crime, and intolerance occurring in a society where masses of people fight over limited resources. In the ward people interact in an extremely hierarchical manner. The patients, who are mainly from poor economic backgrounds, remain at the bottom of the hierarchy. Doctors and other staff members are often professionally frustrated. Strikes related to hospital staff's various professional demands hamper the regular flow of work in the ward. Family members are engaged in nursing and provide various kinds of support to their hospitalized relatives. Patients give small bribes to ward boys and cleaners to obtain their day-to-day necessities. Patients joke with each other and mock senior doctors. Thus, they neutralize their powerlessness and drive away the monotony of their stay. Doctors develop 'indigenous' solutions to orthopaedic problems. Instead of using high-tech devices, they employ instruments made of bamboo, bricks, and razor blades. This study shows how medical practice takes shape in an understaffed, under-resourced and poorly financed hospital operating in a low-income country.
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*Keywords:* Hospital; Ethnography; Orthopaedics; Poverty; Doctor–patient relationship; Bangladesh

## Introduction

The professor was on his regular ward rounds. The intern doctors, medical officers, and duty nurses surrounded him. Suddenly a ward boy entered pushing the ward's only, semi-broken wheelchair. The man sitting in the wheelchair lifted both of his hands up. Both of his wrists were cut. Blood was oozing from them and his shirt and trousers were soaked with blood. Lifting his two partially amputated hands high, he shouted as if a stage actor, "Look at me all of you, see how they have cut both my hands." This brought an interruption to the rounds as the professor asked the senior medical officer to take care of the case. I accompanied the medical officer to the patient. While the duty doctor dressed the amputated hands, the victim, a well-built, strong-looking, young man told his story. He said that he and his cousin had a dispute about the ownership of a piece of land. The day before they had argued about it. Later that night some strangers came to his house and said they wanted to talk to him. When he came out of the house the group took him by force in a taxi to a nearby jungle. They told him that his cousin had paid them to do this. The victim then gave a terribly graphic description of the way they had cut his two wrists with an axe. Afterwards they had told him that he would no longer need the land. Then the man asked the doctor, "Sir, if I can bring my hands from the jungle, would you be able to fix them again?" The doctor, who was

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doi:10.1016/j.socscimed.2004.03.007

> dressing the hands, laughed and said, "By now the foxes may have eaten your hands. But anyway, you can get artificial hands with which you will be able to do many things."

This story relates just one of the many moments during my ethnographic fieldwork in an orthopaedic ward of a large, government, teaching hospital in Bangladesh. There have been few attempts to conduct anthropological studies in medical settings. In the 1960s some sociologists pointed out the social and cultural aspects of hospitals (Goffman, 1961; King, 1962; Freidson, 1963). King (1962, p. 399) had the following to say about the hospital as a cultural phenomenon:

> The hospital is unique as a way of life, a subculture of a sort within the total society. The round of life, the customs, the relationships between people, the particular problems of everyday living are sufficiently different from those of other social organisations to warrant consideration as unique subculture.

There are also some examples of ethnographic studies of medical settings around the same time period. Among these, Caudill's (1958) *The psychiatric hospital as a small society*, Goffman's (1961) *Asylums* and Coser's (1962) *Life in the ward* are worth mentioning. Relatively recent hospital ethnographies include Germain's (1979) *The cancer unit: An ethnography*, Rhodes (1990) *Emptying beds: The work of an emergency psychiatric unit*, Atkinson's (1995) *Medical talk and medical work*.

However, the problem with the existing hospital ethnographies done mostly in America and Europe is that they followed the conventions of traditional anthropological research that focused only on the micro-level phenomena of a small-scale society. For example, decades back, Baziak and Denton (1965, p. 272) wrote: 'From an anthropologist's point of view, a hospital is an isolated subculture'. Coser (1962) also termed the hospital as a 'tight little island'. These studies ignored the link between local level events and the forces operating in society-at-large. Relatively recent hospital ethnographies also focused mainly on the biomedical culture and medical discourse within the hospital, and did not pay attention to the link between the hospital life and the life outside the hospital in which the hospital is also situated. The emphasis of my study, however, was that a hospital is not an isolated subculture, but rather it is a microcosm of the larger culture of which it is a part. The study aimed to show how the life and experiences of different actors of a Bangladeshi hospital ward reflects some of the features of the larger Bangladeshi society in which the hospital is situated. Only a few ethnographic studies, mostly done in non-Western countries, have drawn attention to this relation between the micro-level hospital setting and the macro-level society. (Kirkpatrick, 1979; Henderson & Cohen, 1983; Finkler, 1991; Sciortino, 1989; Stein, 1995; Van der Geest & Sarkodie, 1998)

Getting access to the research setting, and to take a role in the research community are crucial for conducting ethnographic research, which requires description of people in their natural setting (Brewer, 2000). Others who have done research in hospitals frequently mentioned that gaining entry into a clinical institution could be a problem. (Mathews, 1987; Van der Geest, 1989). Mathews (1987, p. 295) mentioned two reasons for the potential difficulties:

> Firstly, medical practitioners are reputed to resist analysis by outsiders. This resistance results partly because physicians historically have resisted any external review or regulation of their professional prerogatives (Friedson, 1970) and also because social science analysts often have engaged in what McKinlay (1977, p. 495) calls, "doctor bashing" or deprecating physicians. Secondly, the typical hospital is composed of several semi-autonomous administrative units that can control access to informants either formally as through a research review committee, or covertly through denial of access to particular areas, activities or potential informants.

However, my advantage in this regard was that I myself am a trained Bangladeshi physician. After being trained as a clinician, I started my career as a public health physician in rural areas and later studied medical anthropology. My physician identity therefore helped me to gain access in the hospital. It also solved the problem of taking a role in the research community. In some of the research done in hospitals, researchers disguised their identity and became pseudo-patients. (Caudill, 1958; Rosenhan, 1973; French et al., 1972; Van der Geest & Sarkodie, 1998). I did not have to conceal my identity and appeared as a researcher in the hospital ward. It is however, beyond the scope of this paper to discuss the intellectual and emotional challenges of being 'native among the natives' (Van Dongen & Fainzang, 1998), i.e. doing ethnography as an insider of a culture.

I conducted the ethnographic fieldwork in approximately 6 months spread across the years 2000 and 2001. I collected information mainly through participant observation. In my case, I was basically an observer and my participation was participation in the sense that I was present in the scene of the ward as a social being, watching, observing and talking to the people of the ward. I also collected information through informal conversation, formal interviews, case studies and the consultation of official records and registers. The respondents were the patients, their relatives and hospital staff members including doctors, nurses, ward boys, and cleaners.

This paper presents a few selected aspects of a larger ethnographic study that includes the condition of patients in relation to the society's poverty and violence, the role relatives play in the ward, the staff's frustration and the concerned people's inventiveness in coping with various constraints of everyday life within the hospital. It shows how medical practice takes shape in a low-income country hospital faced with various practical constraints.

## The patients: physically and mentally crushed

As the study hospital is the cheapest option for tertiary level treatment, the hospital is occupied chiefly with patients from lower economic background. During my fieldwork I encountered several violent cases like the one described in the introduction. One man crushed his legs and hands when a bomb he was making at home to cause panic during a political demonstration blew up accidentally. Another man almost had his hand cut off by two workers whom he had dismissed a day earlier. A lady arrived with a gunshot wound in her leg caused by a mugger who snatched her gold necklace. A young boy of about 14 lost his legs when another boy with whom he had a quarrel, pushed him out of a train. An elderly lady broke her hip when her neighbour kicked her because her bean tree's vines had climbed into his mango tree's branches.

Every day I would hear such harsh stories. At the end of my fieldwork the ward's medical officer suggested, "Why don't you wait a few more weeks. As you know the national election is coming. The fighting between the two, rival, political parties will intensify and you will see many more handless and legless people in the ward."

The head of the orthopaedic department told me, "Decades ago when we were young doctors, we did not see so many crime-related cases in the ward. But now, every week there are such cases. I believe the rapid urbanization occurring in the last decades, the competitive market economy and the population increase have made people more intolerant and aggressive which has resulted in these increased cruelties."

However, most ward patients are victims of traffic accidents. There are varying figures about how many people die as a result of road accidents in the country. A national daily (*Daily Janakantha*: 08.01.2002) reported recently that there are on average 70 deaths a day in the country due to traffic accidents. In the Bangladesh Police (1999), inadequate traffic facilities, poor maintenance of traffic and motor vehicle laws and pedestrians' lack of awareness about traffic rules are mentioned as the main causes of accidents.

A number of cases were related to accidents at work. There is a big ship demolition industry nearby, as the hospital is located in a coastal city. Many workers from that industry are admitted with broken or severed limbs caused by falling, heavy objects. Factory workers whose limbs have been cut off by a machine are also brought in. Construction labourers also appear with broken hips or legs after falling from work sites on high-rise buildings.

Of note, there were a small number of female patients in the ward and the majority of the patients were young males. The restricted mobility of Bangladeshi women in the outside world probably explains this disparity. Bangladesh is a predominantly Muslim country where the concept of *purdah* (seclusion) for women prevails. Although Islamic rules are not strictly followed in everyday life, it is generally discouraged for women to work outside the home, and there are few employment opportunities for women outside of their own domestic sphere. As the mobility of women outside the home is limited, they are not often exposed to the dangers that can cause orthopaedic causalities.

The physically crushed patients of the orthopaedic ward were found to be mentally crushed as well. They suffered from a host of uncertainties. Most of the patients were uncertain about their condition. Diagnosis was not of much concern for the orthopaedic patients, because they all came to the hospital with a very obvious injury. Instead, patients were mostly concerned about the treatment plan the doctors had assigned to them, and their prognosis. The staff of the ward hardly explain either of these to the patients. Patients are not sure what the doctors and staff members of the ward are doing with their broken hands or legs, for nothing is clearly communicated with them regarding their condition. During the professor's round the patients remain a passive audience. Medical discussion goes on over the patient's bed, s/he is not allowed to speak but only to answer the questions directed at him or her. Patients are not supposed to ask anything to the doctors during the round. If someone dares to ask a question, he or she is immediately scolded by the doctor for hampering the round, and asked to keep his/her mouth shut.

> Ramjan Ali is a bus helper (an assistant to a bus driver) who hurt his legs in an accident. Since his admission he has been sceptical about the treatment procedure in the ward. Doctors told him that both his legs are broken and that he will need an operation in one of the legs. But Ramjan thinks that doctors have diagnosed him incorrectly, and that he did not break two of his legs but only one. He is anxious that the doctors will also operate on his right leg, the one he thinks is healthy, because he was having traction in his left leg. The hospital made X-rays of both of his legs, which show the fractured sites. However, Ramjan thinks that one of the X-rays is not of his legs but put into his file by mistake. He tried in vain to convey his suspicion to the staff members. First he

told them to a ward boy who chided him for such thoughts: 'Don't you dare say it to the doctor; he will just beat you up'. Ramjan still tried to persuade the nurse. The nurse also became very angry and said: 'Don't try to be too smart. Doctor will see whether the X-rays are correct or not. If you don't like the treatment here, just leave.' One day when he was trying to see the X-ray plate against the light, a duty doctor was passing by and told him: 'You! What are you doing with the X-ray? Want to be a doctor? Keep those in the file and don't mix up with other papers.' Ramjan did not dare to tell him about his suspicion.

*Boka* (scolding) is one of things that patients receive from all the staff members, from cleaners to professors, regardless of their rank. Scolding the patients and their relatives is an integral part of the ward scene; they are scolded for a multitude of reasons, especially when they do not act according to the expectations of the staff. The scolding starts right from their admission, when patients are scolded for delaying their visit to the hospital and for visiting local bonesetters instead. Doctors scold the accident patients for their carelessness and ignorance that caused the accident. Doctors also scold patients if they cry or make sounds during their examination. As mentioned before, patients are also scolded if they show interest in their medical records or ask questions, because the doctors think it is unnecessary. The nurses scold them for not following the medication and other instructions properly or for attempting to elicit any information regarding the treatment. Scolding by the ward boys is directed mostly to the relatives of the patients, as the ward boys are responsible for clearing the relatives from the ward, but the patients are also scolded by ward boys for the misdeeds of their relatives and for not cooperating properly with the ward boys' jobs, such as changing the patients' beds, taking the patient to the X-ray department or changing a dressing. Cleaners also continually scold the patients and their relatives for making the ward dirty. On a few occasions I saw doctors slap the patients.

In addition to physical injury and medical uncertainty, patients also suffer from anxiety about how to cope with the economic loss caused by their hospitalization. Their economic loss is manifold. First, there are the expenditures involved in being the hospital. Though the government hospital is virtually free of charge (officially, the admission fee is 5 taka), there are many costs involved in the hospitalisation process. The patient must buy almost all of the medicines and other materials for daily use in the hospital. The hospital generally has a regular supply of some analgesic and antimicrobial drugs, and, irregularly, antibiotics. None of the drugs are sufficient enough, either in quantity or in strength, to cover the treatment course of the patients. A small portion of the required drugs are given by the hospital and the rest must be bought from the shops. Cotton, gauze and X-ray films are irregularly available and most of the time are bought by the patients. Injectable drugs and medicines required for operation are almost never available in the ward. I also encountered incidences when the lower level staff stole medical and non-medical items from the patient and sold those to the drug shops outside the hospital for low price. The patients had to buy the drugs again.

There are other sorts of informal payments in the ward. Informal payment begins upon entry to the hospital. The liftman demands money for taking the patients to their respective wards, the ward boy demands money for bringing the patients from the outdoor patient's consultation room to the ward, the gate keeper asks for money for allowing the relatives to enter the ward a little earlier then the official visiting time or to stay past the official visiting time, the X-ray technician wants money for taking the X-ray to the patient and cleaners demand money in exchange for helping the patient to go to the toilet in the absence of his or her relatives. All these informal payments are known as *bakshees* (tips).

The second level of economic loss is the loss of personal income. The patients' profiles indicate that most of them are day labourers, low salaried employees or small businessman. In most cases their inactivity means a complete loss of income, which is a huge economic burden for most of the patients. In most cases, it completely devastates the economic well-being of the patients.

Rahmat Ali is a rickshaw puller. He was severely injured when his rickshaw was run over by a public bus. He had an operation on his leg and was in the hospital for about 6 weeks. He says, "Only when I am on the road with my rickshaw do I have money in my pocket. But now, for more than a month I am stuck here. I have no earnings at all. My only younger brother could help me financially but he also had to close his small cigarette shop in the bazaar in order to attend me in the hospital." I asked why his wife did not come to attend him instead. He replied, "She works as a maid, that's how she is feeding our two children as I have no income. If she comes, who will take care of the children? Moreover, you can see that it is very difficult for a woman to stay in this hospital." I then asked how he met the operation's cost. He told me that he had taken a loan from the proprietor of the rickshaw that he used to pull: "I borrowed 10,000 Tk (approximately US $150) from him, which is a huge amount for me. I can't sleep at night when I think about how I will repay his money. Shall I ever be able to pull the rickshaw again? Even if I succeed, it will take years for me to repay him from my rickshaw income, moreover, I will have to

starve to pay him back. Now I think the only solution for me is to sell my small piece of cultivatable land that I have back in my village. Then I am a pauper. These thoughts worry me all day while I am lying in this bed."

Despite all these miseries, patients rush to this hospital because it is the only public (and therefore the cheapest) tertiary-level hospital in the locality for thousands of poor Bangladeshi patients.

## Relatives: a necessary evil

Abdul Khaleque is an elderly man. He broke both his right hand and leg in a car accident. While crossing the highway near his village, a car ran over him. Although he hardly comes to this city, he is now trapped in this big city hospital bed with plastered limbs. This is harvest time, so his two sons are busy in the field back in the village. His wife has accompanied him to the hospital. She has just finished feeding him breakfast and is preparing to dress one of his wounds. A junior doctor offers instructions on how to do it. However, she finds it very difficult to catch gauge with forceps, an instrument she has never seen before. After a while it is time for the professor's rounds. The nurse, ward boy, and cleaners all start to shout at the patients' relatives, telling them to leave the ward. Some patients have several attendants. They take time to move. The staff starts scolding and at a certain point, they push people out by their necks. Abdul Khaleque's wife usually goes out and sits with others in the corridor in front of the operation theatre on another floor until rounds are over, but today she is feeling sick and cannot walk to the corridor. Instead, she crawls under her husband's bed. Luckily the bed is in a corner which hides her well enough during rounds. Once the professor has left, she comes out with a sigh of relief.

It is always possible to see one or more of the patient's family members in and around the ward. Usually relatives bring the patient to the hospital. In the case of traffic accidents, the patients are brought from the site of the accident to the hospital by strangers, but soon afterwards the relatives arrive in the hospital. Usually one of the relatives then becomes 'attached' to the patient during the whole period of the patient's hospital stay, and plays an important role in caring for the patient. In fact, patients' family members are crucial players in the overall functioning of the ward. It is interesting to notice that the majority of the attending relatives are males. This is contradictory to the prevailing notion in Bangladeshi society that care giving is female work. Patients gave various reasons for the absence of female family members from their bedside. Reasons of inconvenience were most frequently mentioned. It is often not possible for women to leave their household responsibilities; it is also inappropriate for women to stay in the male ward, as mentioned earlier that the Islamic notion of *purdah* (seclusion) is important for women in Bangladesh.

Relatives are needed in the ward for a number of reasons. First, orthopaedic patients are generally bedridden, so they depend on their attending relatives to meet their bodily needs like going to the toilet, feeding and washing themselves. There are, on average, four nurses, two ward boys, and one cleaner for more than 100 ward patients. It would be impossible for them to attend to all the patients. Moreover, most of them are engaged in various tasks other than providing medical care (e.g. paperwork, gate-keeping, bringing tea to the doctor, etc.). However, they can be hired for various services through informal payment. Most poor ward patients therefore depend on their relatives for all sorts of care and nursing.

Secondly, relatives buy medicines from the drug shop. As mentioned the government hospital has a limited and irregular supply of drugs. As a result the patients have to buy nearly all crucial drugs from a medicine shop. Physically disabled patients depend completely on relatives in this regard. The doctor on duty usually gives the attending relative a small slip of paper on which he has written the required drugs' names. After the relative buys the drugs at a nearby shop he hands them over to the doctor, nurse or ward boy. Treatment can only start when the attendant brings the medicine. Relatives also help medicate patients. The nurse usually instructs the relatives about the proper dose.

Thirdly, as the limited number of staff cannot manage to give all of the required wound dressings indicated for the day, they sometimes train the attending relatives to wash the wound with antiseptic and put on a new bandage. Abdul Khaleque's wife told me later, "You see, I came here with a patient, now they want me to become a doctor."

Finally, for day-to-day ward necessities, patients need help from the lower-level staff. To receive services such as getting a bedpan in time, shifting a patient from the floor to a bed, receiving a bed near a window, or being transported to the X-ray department, etc. patients must give small bribes to the ward boys and cleaners. The negotiation about these services and the transfer of money is mostly done by the relatives.

Despite their help, staff members also consider relatives the 'evil' of the ward. Relatives receive all sorts of humiliation and criticism from the ward staff. First of all, relatives are said to be unruly and to hamper the normal flow of work. They are officially allowed to stay in the ward only between 4:00 and 8:00 pm, but in fact, they can be seen in and around the ward throughout the

day. However, during the professor's rounds relatives are strictly prohibited in the ward. It requires a great effort to remove relatives from the ward. The nurse, ward boy, and cleaners start this process one hour before rounds start. They shout, scold, and sometimes even beat the relatives in order to get them out of the ward. The relatives do not want to leave for various reasons. Many do not know the rules. Others feel uncomfortable about leaving their patient alone in the ward. The son of a patient said, ''My father cannot move. I am sure if he wants a glass of water, nobody is there to listen to him. That's why I hang around the corridor during the professor's rounds and watch my father from a distance through the windows.''

Although most relatives wait outside, either in the ward corridor or in the hospital lobby, a few find a hiding place inside the ward as Khaleque's wife did. After rounds, relatives flood into the ward again. In the evening the ward population peaks. Each patient has several visitors. One day I counted 19 relatives surrounding 1 patient. In the evening the ward looks like a big bazaar. Newspapermen, a barber, and other vendors conduct their business in the ward at this time. Around 8:00 pm the hospital staff again starts the process of vacating the ward by chasing the relatives away.

A second complain is that the relatives make the ward dirty. After a hundred relatives have left the ward, the floor looks like a wasteland. It is not surprising therefore that the ward cleaners always fight with them. While sweeping up the banana peels, nutshells, and empty chip bags a cleaner told me, ''See what these *barbars* (barbarians) have done. If you go to the toilet, you will see what they have done there, these stupid attendants of the patients come from the village and do not know how to use a toilet.'' Doctors complain that relatives are the reason for cross infections.

Relatives are also accused of stealing things from the ward. The nurses are responsible for keeping track of all the ward's materials and they complain that they frequently find items such as bedsheets or lightbulbs missing after visiting hours. The nurses have a hard time keeping track of the ward's contents and regularly quarrel with the relatives about it.

Doctors and nurses, finally, are irritated about relatives because they say relatives ask stupid questions and do not know to whom they should address their questions. Doctors think that relatives do not understand the instructions they are given, for example, about a patient's drug dosage or a recommended exercise.

A number of relatives told me that their suffering is more intense because they have to experience all sorts of troubles of hospitalisation even though they are healthy people. However, despite the hassle and torment, relatives remain a silent saviour for both the patients and the staff.

## Staff members: frustrated voices

In spite of their power and control over the ward, staff members of all levels expressed professional frustration. As the employment opportunities are extremely limited in Bangladesh, despite their frustration the staff members continue to work in the government hospitals. The following text contains some excerpts from their interviews:

The head of the orthopaedic ward unit said: ''Most of my contemporaries have become professors but I am still an associate. I faced the public service commission twice but they rejected my promotion. First they said I did not have enough publications, the second time they said the publications were not relevant. The actual fact is to get a promotion you should have good connections with the people in the public service commission in the capital. I don't have them. This is demoralising. But I do not have other alternatives but to continue my job here. ''

The assistant professor of the orthopaedic ward said: ''How much does the government pay a doctor? It's nothing. I cannot even pay my house rent with my salary. That's why I have to leave the hospital early and go for private practice.''

A medical officer stated, ''Today there are 118 patients in the ward. We have only 92 beds. You can see that the rest are lying on the floor. For some we cannot even provide a mattress. Most of these are casualty cases, but we do not have a separate casualty ward. How can I give traction to a fractured femur when the patient is lying on the floor? Forget about medicine, today there is even no cotton supply in the hospital. Moreover, we are on the fourth floor, the operation theatre is on the third, the X-ray department is on the second floor. Tell me how it is possible to work with all these constraints. People just blame the doctors, but they don't know the situation in which we are forced to work. ''

An intern doctor said, ''We are doing our utmost to learn and to give service to the patients, but we do not have much experience. Unfortunately most of the senior doctors leave the hospital after the professor's rounds. They are busy with their private practice in the evening. Whom can we learn from? Moreover, the career of a doctor has become extremely difficult nowadays. Limited jobs, limited seats for higher education. I don't know what my future is.''

A nurse commented, ''People think that our work is not decent. We do night duties. It is bad for a Muslim woman to stay outside her home at night. They think nurses have illicit relationships with doctors or other males. As a result nurses face trouble in getting married. One of my fellow nurses had an affair with a doctor and they got married. But the doctor's family rejected them. His family did not come to the wedding. The doctor's

family thought that it was a shame for the doctor to marry a nurse.''

And a cleaner stated, ''My family can hardly survive half a month with the salary that I earn. Sometimes therefore we demand little *bakshis* (tips) from the patients. Patients blame us for that, but how can I survive only on the salary?''

The doctors, nurses, ward boys and cleaners have their own organizations. Strikes and demonstrations by different groups on various professional demands are common. During my fieldwork doctors held a two-week strike to demand a proper trial for a criminal who had physically assaulted one of the city's prominent, general practitioners. During the strike all ward activities done by doctors were postponed except for emergency care. Many patients left the hospital because they did not receive services from the doctors. During my study period the ward boys once threatened to strike in protest after a professor slapped one of them. This was, however, settled through negotiation.

## Indigenous solutions

The hospital was established in 1961 as a 500-bed public hospital. Over time the patient load has tripled in this tertiary-level hospital serving a population of approximately 3 million people. Every day about 1500 patients are admitted to the hospital but the staff, budget and medicine allotment has not increased to keep up with the additional patient load. As a result, the hospital lacks permanently the required staff and resources. However, the patients and staff members find various ways to cope with these constraints. Doctors, for example, invent indigenous solutions to orthopaedic problems. Here are some examples:

Whoever enters the ward will notice that bricks (the kind used to build houses) are hanging on ropes attached to the patients' legs. Different-sized bricks are used to act as weights for giving traction particularly to lower limb fractures. Traction is a crucial element of treatment for these fractures. Ideally traction should be done with metallic weights having appropriate weight measurements, but these devices are highly expensive and therefore unaffordable for poor patients. Traction is therefore done with this easily available indigenous material. Bricks are attached to the broken bone using plastic rope and iron splints. The patients have to buy these bricks that are supplied by the ward boys and cleaners. One brick costs 10 Tk (US$ 0.10), 2 bricks costs 20 (US$ 0.20), and a half brick costs 5 Tk (US$ 0.05). The brick supply is kept in the corner of the ward's store room.

When doing small-scale, skin grafting doctors generally use razor blades. As one doctor mentioned, ''Well, ideally you should use Hambi's knife for skin grafting, but where can I get that knife? Moreover, it will cost about 300 Tk, (US$ 6) while I can buy a shaving blade for 2 Tk. It works quite well. You only need good practice.''

A patient arrived with a supraconylar fracture of the humerus (a fracture in the upper arm around the elbow joint). The doctor showed me a book where treatment of a supracondylar fracture with dislocation was described as ''Reduction should be done immediately under general anaesthesia (GA) by traction, counter traction followed by immobilization.'' The doctor then said ''If I want to follow the book I will have to wait another 2 h, as the 2 available anaesthesiologists are engaged in other operations. So I will not wait for GA and will go for local. Sometimes we use spinal anaesthesia instead of GA. In some situations, if the patient's condition permits it, we do not use anything. All you need is to give a big jerk by hand so that the bone goes back to its original position. The patient might give a dramatic cry but by that time I have reached my goal.''

Doctors also manage the administrative limitations in various ways. Every week, for example, the doctors find at least 1 or 2 patients who are relatively better off economically. They immediately take the chance and request the patient's relatives to buy some additional medical materials and medicines than those required for the patient. They use this extra medicine and materials for poorer patients who cannot afford to buy medicines.

Representatives from different pharmaceutical companies offer gifts to ward doctors. Doctors sometimes ask the representatives to donate something to the ward instead of giving them a gift. During my stay one pharmaceutical company presented good-quality, covered files to hold each patient's medical records.

I noticed two very polite ward boys. They rarely shouted at the patients and helped them whenever they asked for assistance. They were an unusual contrast to the other ward boys who always behaved roughly towards patients. I came to know that they were not official ward boys. They were not employed by the hospital but were hired by patients to help them in various day-to-day activities. Once these boys had attended relatives who spent a long period in the ward. During their long stay they had become familiar with the job in this setting. Because they were unemployed they started to earn money by helping other patients. After their relatives were eventually discharged, they remained in the hospital and continued to work as unofficial ward boys. The official ward boys allow them to work because they share their work and income. These unofficial ward boys depend completely on the mercy of the official ward boys and also on the patients' co-operation. As a result they generally have good manners with the patients as well as the hospital staff.

Patients and relatives also find various, alternative ways to compensate for the ward's limitations. Patients

without nearby relatives who have no one to take care of them and who are also unable to pay bribes to the hospital staff are cared for by the relatives of a patient in a neighbouring bed. The attendant of that patient sometimes helps the poor patient go to the toilet, take medicine and with other necessary requirements. Sometimes an economically solvent patient hires one of the unofficial ward boys on behalf of a patient who is very poor and has no one to help.

Some patients do not eat hospital food. Instead they have food from a restaurant or home. However, they take the food allotted for them by the hospital and share it with the relatives of poor patients, thus helping them save some money which would have been spent on food.

As mentioned before patients are generally humiliated and ignored by the hospital staff. Although the patients remain submissive in front of the doctors, I have seen them mock the senior doctors once they have left the ward. Probably thus they neutralize their powerlessness in the ward. Bedridden patients also make jokes with each other and sing to cope with the monotony of their hospital stay.

## Discussion

This paper is based on an ethnographic exploration of an orthopaedic ward of a government, teaching hospital in Bangladesh. The aim was to explore the ward culture and to show how it reflects some of the features of the larger society in which the hospital is situated. The orthopaedic ward in this Bangladeshi public hospital carries many traits of Bangladeshi society at large as follows:

### *Generalised poverty*

The described hospital ward reflects the general poverty of the country. The hospital receives only half of its required budget. This limited budget, in turn, generates an environment of chronic scarcity of materials like cotton, gauze and scissors as well as of manpower in the hospital. Poor patients need to buy nearly all required drugs and even some instruments for their treatment. These expenditures financially ruin the patients. We have seen too how the patients' relatives take over all the nursing responsibilities, as there are not enough nurses in the ward to complete all of the paperwork and take care of the patients. Staff salaries are inadequate for maintaining an acceptable standard of living, which forces them to find other income-generating activities, so the doctors leave the hospital early to start their private practice. The low-paid lower level staff exploit their indispensable position by demanding tips from the patients and by other ingenious means. Poverty thus broadly dictates the reality of the ward.

Poverty is a recurrent theme in any discussion concerning Bangladesh. Jansen, 1999: (preface) wrote, 'Today there is hardly any country in the world where so much poverty is concentrated in so small an area'. There is a range of explanations for the poverty of Bangladesh. The current-day poverty of Bangladesh is a result of a mixture of external and internal factors. In spite of some progress since independence in 1971, the high rates of population density, population growth, illiteracy, morbidity and mortality, as well as low industrialisation and inequitable distribution of income and social opportunities continually challenge the poverty alleviation of Bangladesh (BIDS, 2000).

A government hospital of Bangladesh therefore obviously suffers from this overall grasp of poverty in the country. The government hospitals also particularly suffer because of the low budget allocation for the health sector of the country. It is worthwhile to mention that there are influences of various political interests in distributing the limited national budget to different ministries. Muniruzzaman (1994) discussed how due to the legacy of direct and indirect army influence in Bangladesh politics, a large amount of budget goes to the country's defence forces. The health ministry is weak and unable to secure enough money from the national budget so the health sector particularly suffers because of this inequitable budget distribution. Moreover, less then one-fifth of the national health sector expenditures in Bangladesh are for hospital services (Perry, 2000, p. 29).

### *Social hierarchy*

Life within the hospital ward clearly demonstrates the social value of hierarchy. The interactions within the ward show a robust concern on the part of the staff to define the boundaries and maintain the institutionalised inequalities between the doctors and the patients and their attendants and between the different grades of staff. The language, gestures, and overall demeanour of the staff members indicate who is 'big' and who is 'little' in the ward. The patients are scolded and humiliated by all levels of staff members. Even the lowest level staff, the ward boys and cleaners, humiliate the patients and exploit them economically. Despite their lower social and economic status, ward boys and cleaners are able to attain a status higher then the patients through their 'social capital' (Bourdieu, 1977), i.e. their experience, connections and skills related to the hospital. Thus the poor and physically and mentally crushed patients remain the most vulnerable within the hospital hierarchy.

A number of observers of Bangladeshi culture noted the remarkable preoccupation of Bangladeshis with social status and rank:

> Every individual [in Bangladesh] knows and is quick to estimate who is above and who is below him. Indication of rank is displayed in casual conversations and official inquiries, whereby persons are specified by references to skin colour, size of salary, academic degree and birth order within the family (Kotalova, 1996, p. 148).

Hierarchical behaviour is more likely in countries like Bangladesh, where there is extreme inequality of power, influence and opportunity. Waitzkin's (1984) study on the micro-politics of the doctor-patient interaction shows the structural obstacles, in the form of social inequalities, found in medical encounters. However, various traditional values also generate hierarchical behaviour in Bangladesh. A number of authors have discussed how the wider social customs of hierarchy have shaped the bureaucratic and training institutions of Bangladesh (Ahmed, 1980; Huque, 1990; Jamil, 2002; Selim, 1995).

*The value of family*

We have observed that family members play a crucial role in the life of the patients of the orthopaedic ward. The life of the patients in the ward shows the crucial role that families play in an individual's life in Bangladeshi context, including in his or her therapy management. A Bangladeshi patient is never an individual actor or decision maker, the family provides all sorts of economic, social, emotional and psychological support to him. Medical care involves expenditure of time and energy by the patient's relatives, and money for the treatment also comes from family funds. Unlike in many Western societies, Bangladeshi families do not consider it to be a morally correct act to delegate the duties of caring for their sick kin member to professional caretakers. Kirkpatrick (1979) argued that the phenomenon of a family being unwilling to permit a member to be separated from kin care and observation during sickness is embedded in the fact that Bangladesh is a society in which people are organized mainly through primary relations, which prevent them from being segregated from the activities of everyday life. Novak (1994, p. 106) mentioned the 'clannishness' of Bangladeshi society, where nearly everyone can identify up to seven or eight generations of his or her forbearers, where friends or acquaintances, even foreign ones, are called 'cousin', 'brother' or 'uncle' depending on relative age. He observed that:

> Once one moves into the larger society, relatives are always available to smooth the way: to provide introductions for jobs, to help arrange school entry, to stop or divert some official action, to provide a "home" when one is in need. On a larger scale a huge patronage web exists that affects all clan members.

*Prevalence of violence*

The stories behind the criminal assault cases in the orthopaedic ward tell us about the level of violence and intolerance in the society outside of the ward: one cuts off his relative's hands to acquire a piece of land, one political group cuts the limbs off of the members of rival political group in order to take revenge, tribal people are engaged in armed struggle to protect their ethnic identity, one attempts to murder his employer for dismissing him from the job, one kicks his neighbour simply because the vines of her bean tree have climbed over his mango tree.

Violence, aggression, murder and blood are persistent themes in Bangladeshi social life. The big red circle in the middle of Bangladeshi flag symbolizes the bloody independence of Bangladesh in 1971 in which more than 300,000 Bangladeshi died. A few decades prior to that, in 1947, during the partition of British India, several thousand people died in Hindu and Muslim religious communal riots, which was mostly concentrated in Bengal (Roy, 1994). After independence, two of the head of states were assassinated. A few more thousand of people, both soldiers and civilians, were killed in a series of coups and countercoups in the first decade of Bangladesh's independence (Lifschultz, 1979; Mascarenhas, 1984; Muniruzzaman, 1994).

A UN Report (2000) states that Bangladesh has seen a nearly 40% increase in the incidents of crime in the period of 1991–1996. Peiris (1998) discussed how since its independence, Bangladeshi politics have been characterized by several types of seemingly endemic conflicts, some of which have been associated with either periodic outbursts of violence or prolonged, relatively low key armed confrontations. Destabilizing external influences, inter-group divergences of interests and aspirations in the country, economic stagnation and persistent poverty were identified as the causes behind these conflicts.

Violence generally erupts from conflicts over the exercise of the right to control or acquire resources, especially in a hierarchical situation where such power and/or resources are unequally distributed (Jahan, 1994). Violence is also a consequence of bad governance by the government of Bangladesh (Berenstein, 1994; Khan, 2002; Siddiqui, 1996).

*Invisibility of women*

The orthopaedic ward also reflected the gender dimension of the society. The 'maleness' of the orthopaedic ward is prominent. Most of the patients

are young males, as they are the main work force in Bangladesh and have greater likelihood of becoming victims of orthopaedic injuries. The majority of the attending relatives are also male, which is in contrast to the stereotype that women are caregivers, but is indicative of the fact that women have restricted mobility in public places. The female nurses, the only prominent women actors in the ward, again suffer from gender-based discriminatory views in which they are looked down upon because of the public nature of their work. They must stay outside of home at night in the company of male colleagues, which is considered to be a breach of Islamic moral conduct for women.

This relative invisibility of women in the public sphere is a characteristic feature of Bangladeshi society. To a great extent this is related to the Islamic notion of *purdah*. Literally *purdah* means ‘curtain’ or ‘veil’. It refers to the system of isolation of Muslim women from outsiders and the imposition of high standards of female modesty. It is a complex institution that entails much more than restriction on women’s physical mobility. It is the internalisation of values of shyness, timidity, honour and shame (Begum, 1987, p. 11). However, strictness in the observance of *purdah* varies with age and marital and social status of women. The ideology of *purdah* serves to sanction and legitimate the separate and unequal worlds of women. It inhibits women from directly participating in activities carried out in public sphere. Kotalova (1996, p. 16) observed:

> The most striking characteristic of the agnatic emphasis in Bengali Muslim culture is that half of its population [46% of Bangladeshi population are women] those who retain an eminent role as life sustainers are defined by their absence. Unless thoroughly concealed, women are not to be seen at public events, in the street or on public transport.

The orthopaedic ward, a public place that deals with the medical problems that result mainly from exposure to dangers occurring in public places, is therefore occupied predominantly with males.

### *Inventiveness*

The orthopaedic ward displays how people adjust and find inventive ways to cope with various constraints of everyday life. To combat limited resources, the doctors invented cheap, locally available options to manage orthopaedic cases. They have also developed various alternative measures to solve administrative problems, like extracting money from rich clients and pharmaceutical companies or recruiting unofficial staff. They also maintain dual jobs in order to cope with their low government incomes. The other actors in the ward have similarly developed their own survival techniques. In the context of manpower shortages, the relatives of the patients have made themselves an informal partner in the hospital organization. The poorly paid lower level staff formed associations to protect themselves from being accused of committing illegal acts to enhance their income. Although the patients are generally vulnerable and powerless in the ward they resisted the domination of medical authority through subversion of discipline, humour and by rejecting hospital care. This is how the weak always find their ‘weapons’ to survive (Scott, 1985).The orthopaedic ward thus shows how people change the formal rules and actively adjust to the local environment.

Various authors have observed the coping mechanisms and inventiveness of Bangladeshi people when faced with a lack of resources and institutional support. When Bangladesh achieved independence from Pakistan in 1971 and was recognised by the whole world as a sovereign state, the first question asked was: Could it survive? Many development pundits expressed serious doubts about the country’s capacity for self-rule and self-development as an independent state. Bangladesh was referred as a ‘test case of development’ (Faaland & Parkinson, 1975). That basic question has now been answered: Bangladesh has survived its first three decades. Despite repeated disasters, political instability and poverty, the people of Bangladesh have found their own survival techniques and also made considerable progress in many sectors, and in the meanwhile disproved conventional assumptions of development scholars.

Streefland (1996) discussed the significance of mutual support arrangements for the coping, consolidation and emancipation needs of the poor in Bangladesh. Jansen (1999) showed how the actual lack of resources caused people to adjust their relationships to each other in a special way, thereby shaping the social patterns that dominate in rural Bangladesh. Westergaard and Hossain (2002), who visited the same village in northern Bangladesh at two different points, in mid-1970s and mid-1990s, found that in the course of three decades, the poor, stagnant village had learned how to live better on less land, through various agricultural changes and through income from non-agricultural sources. The Bangladesh human development report similarly pointed out that based on the Bangladeshi experience, it can be said that higher social and human development outcomes can be achieved even with a low per capita national income (BIDS, 2000). Sen (2002) showed how Bangladesh has come a long way; it defied the predictions of the development pundits and became a lead performer among the ‘least developed countries’. Alam (1995) and Sobhan (2002) discussed the growth and potential of ‘civil society’ in Bangladesh, which they consider an indigenous asset that can combat the

hegemonic crisis in Bangladesh politics. As Novak (1994, p. 18). wrote:

> They [first time visitors to Bangladesh] were expecting poverty, degradation, and hopelessness, as most television news shows and aid agency advertisements focus on the poor, who generally are portrayed as passive victims of floods or worse. But Bangladeshis are anything but passive sufferers. They are doers.

When I stated the goal of my research, I argued that a hospital ward is not an end in itself, but that it can mirror various features of the life of the country of which it is a part. It is evident that biomedical practice in the orthopaedic ward of the Bangladeshi hospital has taken a definite shape due to some particular social and cultural factors. Broken limbs caused as a consequence of various criminal acts, patients' position in the ward, the involvement of relatives in patient care, frustration of the staff members and the indigenous solutions for medical and administrative problems has contributed to form the distinguishing characteristics which Wilson (1965) called the 'personality' of the ward. This is a personality that is different from biomedical services in other cultural contexts. The way medicine is practised in this ward also simultaneously reflects Bangladeshi society that is poor, hierarchical, family oriented, male-dominated, and violent, yet adaptive and inventive as well. The hospital is therefore not a ''tight little island'', rather its culture is simultaneously created by its population and constrained by the political-economic context in which individuals and the institution itself are situated. As a result the hospitals, the biomedical 'villages' therefore could also be a field for studying the core values and beliefs of a given society. As Lock and Gordon (1988, p. 8) says: ''The study of health, illness, and medicine provides us with one of the most revealing mirrors for understanding the relationship between individuals, society and culture.''

## Acknowledgements

I would like to thank my supervisors Professor Sjaak van der Geest and Professor Pieter Streefland for their critical support and advice during the fieldwork and drafting of this paper. I am also grateful to the hospital staff and patients for their co-operation during the fieldwork.

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