Broken limbs, broken lives: Ethnography of a hospital ward in Bangladesh

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Chapter I

INTRODUCTION: SETTING THE SCENE

‘What is this?’ The professor points to a bearded man about 50 years old who is lying stiff on a bed in an orthopaedic ward of a teaching hospital. His left leg is fully plastered; a piece of brick is dangling at the foot end of the bed. It is tied to his leg with a plastic rope.

‘Sir, this is a fractured femur,’ says the Clinical Assistant (more commonly referred to as the CA).

‘Where is the Check X-ray?’ asks the professor.

The CA takes the X-ray film from the file lying on the bed and gives it to the professor. The professor holds it against the light to examine it. Around him stand the assistant professor, two medical officers, three young intern doctors with their clipboards and pens, a nurse with the register book in her hand, the ward boy with the dressing trolley and me holding a book for jotting field notes. The ‘bearded fractured femur’ in a blue shirt anxiously looks at every one of us. None of the medical staff, however, pay any attention to him. Everyone’s eyes are directed towards the X-ray film that the professor was holding.

The professor says: ‘Well, the union is good. Discharge him today.’ The intern doctors take down his instructions. The professor moves to the next bed. The bearded man remains silent. The platoon moves on, leaving him behind.

‘And what is that?’, asks the professor pointing to the next bed, where a man in his mid-twenties is lying with a bandage on his ankle. When the professor approaches his bed, the young man gives him a ‘Salam’ (the Bangladeshi way of respectfully greeting a senior person) and tries to sit up. But the medical officer at the head end of the bed slaps him in his back and pushes him back to the lying position and says: ‘Didn’t anyone tell you that when the professor is on round, you should not move. Just lie down.’

‘This is, Sir, a Tendoachilles,’ says the CA. The CA is a young man with a thick, long beard, wearing a long kurta (dress used by Imams) and is also a member of an Islamic religious group called Tablig.

The professor peers more closely at the bandage and says: ‘Open it, I want to see it.’

The CA takes a blade from the pocket of his kurta and starts to cut the bandage. The professor exclaims: ‘Now what is this? What are you doing, why are you using this blade? Where are the scissors?’ The CA remains silent. The professor becomes angry and starts shouting: ‘I bought scissors last week, where have they gone?’ Everyone looks at each other. The professor asks the nurse. The nurse says she does not know. The professor gets angrier. ‘I told you the scissors should be in my pocket during the round, isn’t my pocket big enough to carry the scissors?’ He shows his trouser pocket to everyone. ‘Now the scissors have vanished. Good.’ Then he turns to the CA, ‘You, with the divine face, you will have to replace the scissors. Bring some scissors or buy a pair and then cut the gauze and report to me about the wound afterward.’
The professor moves on to the next patient. The nurse in the back whispers in my ear: ‘He always keeps that scissors with him, he himself must have forgotten them somewhere’. The young man remains in bed with the half-cut bandage on his ankle.

The professor points to the next bed, where a 40-year-old man is lying. ‘Isn’t this the patella, the one we operated yesterday?’

‘Yes sir’, says the CA.

‘OK, leave it’, replies the professor.

‘What about that?’ The professor approaches the last bed in that row.

‘Sir, this is a maltreated case, fracture shaft of the radius ulna,’ says the Assistant Professor. The ‘fracture shaft of the radius ulna’ has a plaster on his right hand. The plaster is so dirty that it looks black. The professor takes a closer look at the patient’s hand, and says: ‘Look at this. It is almost rotten’. He gives a funny look to the patient and continues. ‘Now we will cut this hand off and wrap it in a nice paper, which you will present to the big doctor who treated you, OK? Who is this harvanga kabiraj [traditional bonesetter]? He must have taken lots of money from you?’

The patient remains silent for a while and then says: ‘Someone who is living in our neighbouring village. No he didn’t take much money.’

The professor turns to his team and says: ‘See, he will never tell the name of the bonesetter and has no complaint against him. Whereas if any of our doctors make a mistake, they will set up a speaker at the crossroads and will shout his name, blaming him whichever way possible. Now look at this, the hand has already developed ischemia. These bonesetters, they don’t know about joints, they don’t know about hand functions. They just wrap a piece of cloth with some leaves. Some patient told me that they got cured with these leaves. That is stupid.’

The professor turns to the intern doctors. ‘Do you know how they got cured?’

The intern doctors remain silent.

The professor continues: ‘In the jungles of the hills out there, the elephants fight with each other everyday; they frequently break their legs. Now how many orthopaedic surgeons are there in the jungle, tell me how many? Well, who knows, there may be some orthopaedic doctor elephants. But actually just natural healing cures them. That is the big advantage of the orthopaedic problems. In most cases it just naturally heals and the bonesetters take the credit’.

The professor is delivering the above speech in one corner of a big ward that is filled with one hundred beds and more than one hundred patients. The patients for whom there are not enough beds lie on the floor. A number of the patients’ legs are pointing toward the ceiling and many of them have their legs fixed in a device parallel to the floor. If one wants to make a colour chart of the room, white dominates. Each patient has a plaster or bandage on his or her arms or legs or torso. The whiteness of the plasters is everywhere. And of course, there is red: blood that oozes from inside and reddens the plaster. A strong smell of antiseptic solution is pervasive. The voice of the professor, the groaning of some patients and the cawing of some crows who scavenge in the toilet for food are the prominent sounds during the professor’s round. The gatekeeper has already closed the big collapsible gate, outside of which the relatives of the patients are crowded, waiting until they can come back in the ward. Inside the large ward, patients wait in their beds to be inspected by the professor and his subordinates. The ward looks like a prison. As Foucault once wrote: ‘It is surprising that prisons
resemble factories, schools, barracks, hospitals, which all resemble prisons' (1979:228).

The gatekeeper suddenly opens the collapsible gate and a ward boy enters pushing a half-broken wooden wheelchair. A man is sitting in the wheelchair, lifting his hands up. Both his wrists are cut. Blood is oozing from them. The drops falling on the floor allow the wheelchair’s movements to be tracked. His shirt and trousers are soaked with blood. He is shouting, lifting his two partially amputated hands high as if an actor on stage: ‘Look at me. Look what they have done. See how they have cut both my hands.’ There is an interruption in the professor’s round. He asks the medical officers to attend this new patient and says: ‘The national election day is approaching, so we will receive more such cases.’ The two medical officers rush to the patient. I decide to leave the round of the professor and join the medical officers.

The man with the amputated hands is taken to the mini-operation theatre adjacent to the ward. He is asked to lie down on a very old rusty metallic table. The victim is a well-built, a strong looking young man.

One of the medical officers says: ‘So, to which party do you belong?’
‘I am not a partisan sir,’ says the man.
‘Then you are a hijacker, what did you want to hijack?’ asks the medical officer.

‘No sir, I am not a criminal, it’s my cousin who did this’, replied the patient.

The medical officer doesn’t seem interested in the story; he is missing a particular pair of forceps, which he instructs the attending ward boy to bring, so that he can dress the wounds. The hands without the fingers and the emptiness around the wrist looked strange. While the first medical officer is dressing the wounds, the other medical officer, with a paper and file ready to take the man’s history asks the man his name. The patient says: ‘Kabir’.

‘Age?’
‘35.’
‘Address?’
‘Village Kotalipur, Post Office Berubazar’.

The doctor then says: ‘Okay, now tell us what happened’.

The victim is frequently looking at his bleeding hands, taking long breaths, speaking in a high pitched voice, says: ‘Sir, they have cut off my two hands’.
‘Yes, we all can see that’.
‘Sir, I am a poor man, my life is ruined’.
‘Tell us what happened’, the doctor replies.

The man is severely injured but to my surprise he continues talking patiently and clearly and tells the following story. ‘Sir, I have a small shop in the village market, but I also have a piece of land, which my late father gave me. But my paternal cousin demands that land and says that they have bought it from my father, for which they claim to have papers. But I know those are false papers. They have been demanding that land for quite some time. Last week we had a bad quarrel over it and that cousin told me to surrender this land to him, otherwise he would not treat me properly. I

1 To maintain the privacy of my respondents I will use fictive names of the persons throughout the book.
challenged him and told him that I will never give him this land, whichever way he wants to treat me. But I didn’t imagine such a consequence. Last night when I just finished sehri (the pre-dawn meal eaten during Ramadan), a few people called at my door and said that they wanted to talk to me. I didn’t know those people. As I went, they took me in a taxi to a nearby rubber plantation on the hill. It was still dark outside. First I didn’t realize what was going on, and then one of them uttered my cousin’s name. Then I suddenly understood the matter. I thought they were going to kill me.’

‘So, instead they have cut off your hands?’ concludes the doctor.
The doctor putting on the dressing says to his colleague: ‘We might have to take him to the main OT [operation theatre]. Take a consent from him’.

‘How is he going to sign it? He does not have any hands’, wonders the other.

‘Take a thumbprint’, suggests the doctor who is applying the dressing.

‘Have you gone mad? He does not have any hand, where do you get a thumb?’ retorts the other doctor.

‘Oh, yes.’ They both laugh. Though the account of the medical history was considered complete, and the doctor who had taken it had left the mini-operation theatre, I was curious to hear the story in more detail and ask the man what happened next.

Kabir continues. ‘They took me to an abandoned room in the middle of the rubber plantation. Nobody was around. I could hear the call for the morning prayer. There were four of them. They tied me with rope, and forced me to lie down. Then they brought a piece of wood and put it beneath my outstretched right arm. I saw a sharp axe in one of their hands. Then I realized that they were going to cut my hand off. I then shouted: “Do not cut my hand, just shoot me, and kill me.” The man with the axe told me that he had received 20,000 taka (about 400 USD) from my cousin to cut off my hand, but not to kill me. For killing they would charge more. He struck my right wrist with an axe, he couldn’t separate my hand from my body with one blow. He struck it again, and then my hand was separated. Then they turned the piece of wood to my other arm. I cried loudly: “Please don’t cut both my hands; don’t make me a beggar, please.” But this time he cut off my left hand with one stroke. They told me from now on I should no longer claim the land that my cousin is asking for.’

At this point Kabir starts crying loudly. I tell him to not cry and that the doctors here will take care of him. The doctor who was dressing his wounds says: ‘You will be OK, we will fix your hands’. Kabir becomes enthusiastic and asks the doctor: ‘Sir, they showed me my hands before they threw them into the jungle. If I can bring my hands from the jungle, would you be able to fix those again?’ The doctor laughs and says: ‘By now the foxes might have eaten your hands. But any way, you can fix artificial hands with which you will be able to do many things’. The doctor then tells me: ‘Well, this is the beginning of your research, isn’t it? Just wait, you will hear lot of such stories!’

And those were some of the events of one day early on in my fieldwork at an ethnographic study in the orthopaedic ward of a teaching hospital in Bangladesh.

**Description of the chapters**

In this first chapter I will first review the trends in hospital-based social science research over the past decades. I will then discuss the goals of my research, which are
to present the social and cultural dynamics of life within a Bangladeshi hospital ward and to discuss how the hospital ward reflects the core features of the broader Bangladeshi society. In Chapter Two I will provide some autobiographical information to put me, the ethnographer, in the context of this ethnographic research. In this chapter I will detail my data collection plan and procedure, and describe the intellectual and emotional challenges of doing ethnography as an insider of a culture.

Chapter Three will be devoted to a general description of Bangladesh's political history, society, people, health, education and economy. In Chapter Four I will present the history, location, geography, architecture and facilities of Chittagong Medical College hospital, the teaching hospital at which I did my fieldwork. I will show how this 1000 bed hospital is severely under-resourced and under-staffed.

The bulk of the chapters present the reality of the ward from the perspective of different actors of the ward, which will be followed by a summary and discussion. Chapter Five will describe the experiences of patients, most of whom were poor, illiterate males that had been victims of road traffic accidents, criminal violence and occupational hazards. This chapter will describe the social, psychological and economic suffering of the hospitalised patients. Chapter Six will deal with the relatives of the patients, who play a crucial role in the hospital organization and the well being of the patients. Chapter Seven will describe the reality of the ward from the perspective of lower level supporting staff, including ward boys, cleaners and gatekeepers. This chapter will show how the lower level staff play an influential role in hospital functioning, despite their inferior position in the hospital hierarchy. The experiences and concerns of the nurses is the topic of discussion in Chapter Eight. The study revealed that Bangladeshi nurses do not fit with the ideal image of loving, self-sacrificing, noble 'ladies with lamps'. Instead, they are irritated women busy with maintaining files and registers. Chapter Nine deals with the doctors, who are at the top of hospital hierarchy. The chapter shows that in spite of their authority, doctors are deeply frustrated with various constraints of their work environment, with their low governmental salary, and with the growing negative image of the medical profession in the society.

Chapter Ten will argue that hospital life is the mirror of the larger society and that it reflects the core features of the broader Bangladeshi society that include general poverty, the social value of hierarchy, value of family, prevalence of violence, invisibility of women, low public morality and inventiveness of the people. Chapter Eleven will conclude this book by revisiting the main points and finally closes with an epilogue.

The hospital as a subject of research

The hospital is a unique institution of man. A WHO Expert Committee in 1963 proposed the following working definition of hospital:

A hospital is a residential establishment which provides short-term and long-term medical care consisting of observational, diagnostic, therapeutic and rehabilitative services to the persons suffering or suspected to be suffering from a disease or injury and for parturient. It may or may not also provide services for ambulatory patients on an out-patient basis (Park 1997:41).
A hospital is first and foremost a place in which members of the community can obtain services designed to restore them to good health. The modern hospital is also a place of learning, a centre for the practical training of nurses- and physicians-to-be. Yet the modern hospital is also a complex organization and a society unto itself, the members of which have recognizable roles, rights, obligations, attitudes, values and goals.

**The hospital in history**

How did this contemporary form of hospital emerge? Freidson (1963), Coe (1970) and Turner (1987) have shown that the origins of the European hospital lie in religious and cultural needs. Diseases were viewed as religious events, so the techniques used to control and cure diseases were also religious acts. Early precursors of the hospital, therefore, were institutions whose purposes were derived from faith and whose activities were religiously defined. The early Christian hospitals were primarily structured as institutions for the practice of charity rather than as places primarily devoted to physical healing. As a result, these early hospitals cared not only for the sick but also anyone in need of shelter. Coe, quoting Dainton, wrote about the earliest known hospital in England, built in 794 A.D.:

> Like other early hospitals, these were not intended solely for sick people. Their purpose was indicated by their name, which was derived from the Latin adjective *hospitalis* -- concerned with *hospites* or guests. These ‘guests’ were any persons in need of shelter (Coe 1970:235).

Thus, the doors of these hospitals were open to the lame and the poor, as well as to ordinary travellers seeking shelter for a night. It has been well documented that many early hospitals were places of rest and protection for pilgrims travelling to holy shrines. In general, pre-modern hospitals were places of last resort, where the inhabitants had a wide variety of illnesses that were not treated on a specialized basis. Their aim was to provide care for patients rather than a cure.

After the European Renaissance, the dominance of religion over the way people lived their lives declined and interest in the study of the human body increased. Disease was less often considered a supernatural phenomenon, but more a malfunction of the body. Efforts to cure rather than merely give care were pursued more vigorously. Gradually, medical practice became a secular act and the hospital a secular place.

This period of hospital development was dominated by the evolution of charity hospitals, beginning with the foundation of the first charity hospital in London in 1719. Charity hospitals, which developed in the seventeenth century, were created for somewhat different reasons and by a different class of people than the first hospitals were. These charity institutions arose from middle class philanthropy rather than from a religious zeal for social reform. These hospitals also were primarily concerned to provide shelter for the homeless, the sick, orphans and the unemployed vagrants. Although there was a significant increase in the number of charity hospitals, by the late eighteenth century it became evident that these institutions were unable to cope with the needs of a society undergoing rapid urbanization and considerable population increase.
The voluntary hospital system was also inadequate as a system of provision in the context of large-scale mass warfare. Medical provision, training and knowledge were revolutionized by the Crimean War (1854-1856), the Boer War (1899-1902) and the First World War (1914-1918). The social outcome of these military disasters was a period of reform in nursing and medical care for the army, a movement towards a national scheme of insurance and the development of a more systematic form of national health care.

The development of the modern hospital as a centre for training doctors owed a great deal to the transformation of the hospital system by the French Revolution. The revolutionary committee proposed the abolition of hospitals because they were the symbols of a corrupt, decaying society. To replace them, the Revolution looked to the family as the ‘natural’ location for the cure of the sick. The family offered protection and an emotionally supportive environment, which can complement a medical regimen. However, for various political and economic reasons, the original plan for hospital reform and abolition failed; what emerged was the modern clinic. The new system also provided for better education of doctors and helped to eliminate quacks by the regulation of entrance to the profession. This was primarily achieved by entrance examinations that covered both practical and theoretical aspects. More importantly, the hospital transformed the sick patient into an object of medical training. The sick, who were typically the poor, became useful as illustrations of disease and the fulfilment of the quest for scientific knowledge. This emergence of the hospital as a clinic was a topic of an influential study by Foucault (1975). Foucault argued that under bourgeois utilitarianism and a regime of disciplines, the sick became useful as a spectacle under the clinical gaze.

The reform of the hospital system throughout Europe was an important feature of the late nineteenth century medicine and laid the basis for the evolution of modern medical science. Turner suggests that the growing importance of the hospital depended on four factors (1987:166). First, the medical profession had secured a growing status and prestige within the community as a consequence of its successful professionalisation. Secondly, there had been improvements in hygiene and sanitation within hospitals, thereby reducing the high morbidity rates that had characterized the pre-modern hospital. Thirdly, the modern development of the hospital was accelerated by the redistribution of income, the emergence of a middle class clientele and the discovery of psychosomatic medicine. The middle classes were now prepared to enter the hospital in search of cures. Single rooms were provided for the rich and the middle classes, which separated them from the mass of the population within the general hospital. Finally, the development and introduction of antibiotics meant that infection in hospital was less prevalent. Paying patients from the middle classes provided the basis for medical specialization.

Although this is the general history of the development of hospitals in most Western countries, the history of Western-style hospitals in non-Western countries is somewhat different. The hospital and biomedical practice, which originated in the West, have penetrated almost every corner of the world through the process of colonization and globalisation. Initially, Western medical care was disseminated worldwide by two groups: missionaries and colonists.

Missionaries established clinics and offered medicine to the people they wished to convert (Gallagher 1993, Janzen 1978, Rubenstein & Lane 1990). In the
nineteenth century, they were candid about the value of medicine for introducing 'the heathen' first to Christianity and then to trade with the West.

Colonizers had a different agenda. They wished to save the indigenous labour force from infectious disease, as well as to protect themselves from such disease (Cunningham & Andrews 1997, Manderson 1996, Rubenstein & Lane 1990, Vaughan 1991). Thus, Western medicine, in the form of 'tropical medicine', was not only crucial to facilitating white settlement and colonization of new territorial gains in the late nineteenth century, but was developed specifically with that aim in mind. Baer, Singer and Susser (1997) point to the role of biomedicine in capitalist imperialism: Without healthy colonizers and indigenous populations, colonialist expansion could have never succeeded. In the early 1880s, the major colonial powers embarked upon a project of political control over much of the world, a project that they were quite successful with. For example, at its peak in the 1930s, the British Empire alone encompassed approximately one-fourth of the world's land area. After this expansion, a tiny European colonial elite dominated the native population with a combination of military might and administrative control. Disease, a major obstacle of European expansion in Africa, Asia and the Americas, prompted the attachment of medical personnel to merchant marines and the creation of rudimentary hospital facilities at overseas trading posts. Colonial states eventually assumed responsibility for health care in the colonies. Joseph Chamberlain, the British Secretary of state for colonies, promoted the establishment of the London and Liverpool schools of tropical medicine in 1899, noting: 'The study of tropical disease is a means of promoting imperial policies' (Baer, Singer & Susser 1997:210). In his discussion of disease and medicine in nineteenth century India, Arnold (1993) also showed how British rulers and missionaries used biomedical medicines and hospitals as important instruments for facilitating colonial rule in India. Bela (1991) discussed the imperialistic nature of British medicine, particularly in the context of Bengal. The following appeared in the *Indian Medical Gazette* in 1887:

> Ever since the arrival of the English in India, the services of medical officers have been recognised by the military and the civil authorities as extremely valuable in rendering the yoke of foreign domination easier to be tolerated by the people and in popularising English rule (in Arnold 1993:288).

In the same year, a British general said:

> The peaceful and civilizing influence of the work done in the dispensaries and by regimental surgeons on the frontiers of India has been in political importance equivalent to the presence of some thousands of bayonets. It is because of such unexpected philanthropy that, as conquerors, we hold a position in the minds of the people which would not otherwise be possible (in Crawford 1914:134).

In a similar vein, the London Missionary Society had taken up medical work in 1830s in India in the belief that it could, 'open a wide and effectual door into the hearts of minds of natives' (Arnold 1993: 244).

Although health provision for the Indian masses, mainly in the urban areas, was used to both forestall and respond to demands for some tangible benefits of British
rule, Harrison (1994) and Jeffery (1988) discussed how the main aim of British medical intervention was to provide services to European civil and military servants to help maintain their morale and their strength in a hostile environment. Periodic outbreaks of cholera, enteric fever, malaria, influenza and kala azar endangered the health of European officials, civilians, military and their families. Ramasubban (1988) mentioned that among the more important instruments of the British presence in India were those policies of the imperial and colonial governments concerning the investigation, prevention and cure of epidemic disease. However, the prospect of an expensive, large-scale preventive intervention was an alarming one for a colonial government. The government felt the need for curative efforts to combat the prevailing diseases in India. This need gradually generated the demand to have hospitals and medical colleges established. In the second half of nineteenth century, the number of medical institutions in various parts of India began to grow, the most prominent of which were the rural dispensaries for treating the 'native poor' (Arnold 1993:247). There was also a demand for teaching hospitals, where the cases of Indian patients could be observed and followed by medical students. The first medical college in India was established in Calcutta, in 1857. A number of medical schools were opened thereafter, which offered shorter courses. A number of authors who have studied the imperialistic nature of biomedicine have shown how it has also faced resistance in non-Western societies (Baer, Singer & Susser 1997, Cunningham & Andrews 1997, Singer 1992).

Hospitals have been regarded in positive and negative lights. Konner, a physician and anthropologist, described hospitals as:

Our modern cathedrals, embodying all the awe and mystery of modern science, all its force, real and imagined, in an imposing edifice that houses transcendent expertise and ineffable technology (1993:29).

Another anthropologist has described the hospital in less glowing terms, by referring to it as an institution that views patients as lucrative sources of revenue as well as one that at various times functions as jail, school, factory, or resort hotel (Grossinger 1990:28). Nevertheless, through these historical processes, the biomedical hospital has become the primary focus for the practice of medicine in the contemporary world both in Western and non-Western countries.

**The hospital as a bureaucratic organization**

In the first half of the twentieth century, hospitals in industrial countries gradually became a modern bureaucratic organization accompanied by the changes in disease pattern in the society, development of medical technology and increasing specialization of medical activity. Turner noted that in the 1960s and early 1970s, in the majority of industrial societies an extended reform in the management and structure of hospitals took place. He wrote:

One obvious cause of this change of approach has been the soaring cost of medicine of hospitals. One aspect of this increasing cost of medicine has been the changing character of disease from acute to chronic, associated with the aging population. However, there is a more fundamental aspect of this
situation of rising cost, which is that health and illness are not finite phenomena. Illnesses which are treated by institutionalized medicine represent the peak of an iceberg which has no known base line. Therefore, medical expenditure appears to be highly elastic depending upon expectations of health and criteria of health (Turner 1987: 167).

During that period a number of sociological papers were written concerning the organizational aspects of hospital (Friedson 1963, Jaco 1972, Skipper & Leonard 1965). The authors discussed hospitals as an organization and tried to point to its similarities and dissimilarities with the other large-scale organizations in society. For example, Georgopoulos & Mann (1972) write that the hospital is an organization that mobilizes the skills and efforts of a number of widely divergent groups of professional, semi-professional and non-professional personnel to provide a highly personalized service to individual patients. The chief objective of the hospital is to provide adequate care and treatment to its patients. Its principal product is medical, surgical, and nursing service to the patient, and its concern is the life and health of the patients:

It is important to note that, unlike industrial and other large-scale organizations, the hospital relies very heavily on the skills, motivations and behaviours of its members for the attainment and maintenance of adequate co-ordination. The flow of work is too variable and irregular to permit co-ordination through mechanical standardization (...) Fundamentally, then, the hospital is a human rather than a machine system. And even though it may possess elaborate and impressive looking equipment, or a great variety of physical and material facilities, it has no integrated mechanical-physical systems for the handling and processing of its work. The patient is not a chunk of raw material that passively goes through an ordered progression of machines and assembly-line operators' (Georgeopoulos & Mann 1972:23).

Mauksch compared the hospital with a garage:

When a car breaks down, the owner will take the car to the garage to have it repaired. A garage is organized for that purpose. The people who repair these cars, the mechanics, the order-takers, the helpers, the employees of the institution, and what they do how they do it is part of the over all responsibility of the garage and its administrative organization. While the car is there it will be placed in a berth where it will stand and where it will be protected from damage. When the car is fixed, the owner will call for it, and he will pay one bill which includes the cost of the repair and any other costs incidental to the storage or any other care which the car received in the garage.

It may seem sacrilegious to compare the human being with a car, yet to the sociologist the comparison of widely diverse, ordinary phenomenon are sometimes the most effective way of gaining an understanding of his object of study. For this reason, attention is invited to the similarities and dissimilarities between these two institutions of therapy, a garage and a hospital (Mauksch 1965:245).

King emphasized that the hospital was very different from other institutions:
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 organizations to warrant consideration as unique subculture (1962:399).

Hospital ethnography

In the early 1960’s, some outstanding ethnographic research was done on daily life in hospitals (see Caudill 1958, Coser 1962, Fox 1959, Goffman 1961). These authors argued that unlike Weber’s ideal type of bureaucracy, hospitals develop an informal structure of authority and an informal culture. These observational studies demonstrated the presence of a distinct social world, created by the patients, within the hospital. They also documented the complex set of relationships between patients and staff. The authors argued that the health outcomes of hospitalisation often depended on the character of this social world and the interactions. This approach to informal social structure was developed with great success by Goffman in his study of ‘total institutions’. In defining total institution he wrote:

A basic social arrangement in the modern society is that the individual tends to sleep, play, and work in different co-participants, under different authorities, and without an overall rational plan. The central feature of total institution can be described as a breakdown of the barriers ordinarily separating these three spheres of life. First, all aspects of life are conducted in the same and under the same authority. Second, each phase of the member’s daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day’s activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system to explicit formal ruling and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfil the official aim of the institution (Goffman 1961:17).

By analysing the situation of inmates of a mental hospital, Goffman noted that patients within total institutions typically develop an informal culture which functions as a survival strategy in an environment that is foreign and alienating.

Caudill also described day-to-day personal relations of doctors, ward personnel and patients in a psychiatric hospital in America. He called attention to the idea that the hospital is a small society within which the performance of technical tasks takes place. He argues that the system of human interaction in the hospital is in large part a social system. Caudill wrote: ‘This social process must be identified and understood before it will be possible to utilise fully the potentialities of the hospital as a therapeutic community’ (Caudill 1958:3).

Fox did not concentrate on the issue of the effects of social organisation of hospitals on health outcomes. Unlike the studies mentioned above that were done in chronic psychiatric hospitals, Fox did her research in an experimental ward for patients
with acute metabolic disease. As the title of her book suggests, *Experiment Perilous: Physicians and patients facing the unknown* (1959), Fox demonstrated the adaptations of the patients and staff to stress of the ward. Her study addresses the problem of uncertainties in the medical practice and of the experimenting on human subjects.

Coser's (1962) work is devoted to exploring the relations that developed between patients on a single ward of Mount Hermon hospital in America. Coser discovered a collective experience of illness and hospitalisation. She found both ‘newcomers’ and ‘opinion leaders’ within the ward, a system of social support based on the shared conditions of temporary handicap and submission to the same authority and joking relations that helped build and sustain solidarity among patients.

Unfortunately, such lively studies of hospitalised patients and their social worlds almost disappeared after the 1960s. Zussman (1993) discussed the reasons for their disappearance. He suggested that changes in the patterns of hospitalisation of patients, in the relations between medical professional and changes in the social science research agenda should probably be held responsible. He pointed out that in the last couple of decades, the length of hospital stay for patients has decreased considerably. At the same time there was decline in large, open ward in the hospitals. Longer stay in large open wards in the earlier hospitals provided the opportunity for the patients to mix and mingle and to develop a distinctive patient culture that the earlier researchers studied. He also argues that medical and nursing training in recent years has become more concentrated on technical matters and ignores the social and psychological aspects both of disease and of the patients who suffers from the disease. As a result, medical professionals have become less receptive to concerns about the patients’ experience of life in the hospital. Lastly, there have been changes in the social science research agenda as well. For example, there was a growing dominance of quantification and concomitant decline of ethnographic style research. There was a fall from favour of the functionalist analysis, and finally there was a decline of psychoanalytically-oriented social science research. According to Zussman (1993), these factors and a few others have resulted in the decrease of such an interesting research tradition, a tradition which has an immense value for the development of a humanized medical practice.

**Cultural studies of biomedicine and hospital**

Since the early 1980s, when medical anthropology became a more important sub-discipline, the interest in studying biomedicine as a cultural system began to grow. Researchers pointed out that medical anthropologists have devoted much of their energy to exploring healing rituals and indigenous therapies in ‘exotic’ cultures. They rarely made biomedicine itself a subject for analysis and tended to rest assured that because biomedicine is grounded in science it is not a subject for anthropological inquiry.

In their influential study of the scientists in a laboratory, Latour and Woolgar write:

> Since the turn of the century, scores of men and women have penetrated deep forests, lived in hostile climates, and weathered hostility, boredom and disease in order to gather the remnants of so called primitive societies. By contrast to the frequency of these
anthropological excursions, relatively few attempts have been made to penetrate the intimacy of life among tribes which are much nearer at hand. This is perhaps surprising in view of the reception and importance attached to their products in modern civilized societies: we refer of course, to tribes of scientists and of their production, science. Where as we now have fairly detailed knowledge of the myths and circumcision rituals of exotic tribes, we remain relatively ignorant of the details of equivalent activity among tribes of scientists, whose work is commonly heralded on having startling or, at least, extremely significant effects on our civilization (Latour & Woolgar 1979:17).

Similarly, appeals were made to study the ‘tribe’ of biomedical practitioners. Interest was growing in examining biomedicine as a cultural system and as part of a broader culture. It was argued that biomedicine is not universal but a product of particular social, political and cultural conditions. There are several good example works that illustrate the renaissance of interest in biomedicine as a culture, including Ross et al.’s *The Anthropology of Medicine* (1983), Hahn and Gaines’s *Physician of Western Medicine* (1985) and Lock and Gordon’s *Biomedicine Examined* (1988). Hahn and Gaines showed the ways in which medical knowledge and practice is not the product of a monolithic autonomous institution but rather is made up of numerous interest groups and individuals who bring of perspectives to their work. They wrote:

Biomedicine is a cultural artefact, a complex human product shaped from human and non-human resources, constantly responding to historical circumstances which are in turn human transformations of themselves and their environments (Hahn & Gaines 1985:5).

In the preface of Hahn and Gaines’s book, Kleinman remarked:

‘...medicine, the whole of it, from sickness to therapy, and including medical setting, roles and attributions can be (should be) rethought in the language of social structure and cultural norms, of interpersonal transactions and different access to resources, of cultural symbols and social actions. And this process of making our medicine into a subject of social inquiry (like other ethno medicine) is also significant because it creates practically useful knowledge, knowledge perhaps that holds the potential of eventually being applied to liberate physicians as well as patients from narrow, dehumanizing forms of medical praxis’ (1985: xi).

The essays in Lock and Gordon’s volume demonstrate the interdependence of biomedicine, society and culture. They wrote:

As the practice of modern medicine becomes increasingly a technical enterprise, it is more incumbent upon us that ever to recognize that the human body is not a machine, that health and illness are not merely biological states, but rather that they are conditions which are intimately related to and constituted by the social nature of human life. *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 (my emphasis, Lock & Gordon 1988:8).

Since this increased awareness about the cultural analysis of biomedicine, the number of studies concerning various aspects of biomedicine and modern hospital started to grow again. It is worth mentioning here that a forthcoming special issue of Social Science & Medicine will focus on hospital ethnography. Van der Geest will be the guest editor of this special issue, I will be a contributor (Zaman n.d.).

Goals of the research

It is striking to observe that almost all the literature that I have discussed so far on the social, cultural and historical dimensions of biomedicine and modern hospitals has dealt mostly with either America or Europe. When Friedson (1963), Coe (1970) and Turner (1987) studied the history of the hospital, they ignored non-Western hospitals. When Zusman (1993) discussed the reasons behind the disappearance of hospital ethnography, he did not seem to be concerned about the existence of hospital ethnography in non-Western settings. The same goes for the renowned studies of Hahn and Gaines (1985) and Lock and Gordon (1988). While writing about the relevance of the anthropological study of biomedicine for anthropology, Hahn and Gaines stated that: ‘Study of biomedicine will contribute to the ethnography of U.S. and Western society’ (1985:9).

It is hard to find literature on the cultural aspects of biomedical practice in non-Western settings. Finkler (2000) discussed at length how the biomedical practice has not been generally the subject of anthropological inquiry outside the Western setting. When biomedicine is discussed in non-Western contexts, it is generally discussed in the light of medical pluralism and is juxtaposed with traditional systems of healing and medical choice (Janzen 1978, Last 1990, Lee 1982, Lock 1980, Crandon-Malamud 1991, Nichter & Nordstrom 1989, Sachs & Timson 1992, Weisberg 1984). These studies assume that biomedicine is a monolithic enterprise that follows the core universal characteristics of biomedical practice, irrespective of the cultural setting.

Good (1995), however, rightly argued that although biomedicine or ‘cosmopolitan medicine’ (the term popularised by Charles Leslie in 1976) is fostered through international medical scientists and educators, it is taught, practised, organized and consumed in local contexts. She writes:

When professional prestige among medical practitioners in settings such as American teaching hospitals is measured by the competent use of the most advanced, often “experimental” biotechnologies, when an esteemed Korean professor of medicine proudly documents his competence in terms of the three hundred patients he sees per day, when a young Peruvian physician has limited antibiotics and scarce resources and thus requires his two hundred patients per day to mention but one symptom, when a British trained Kenyan oncologist knows how to treat and cure most children on his Nairobi hospital paediatric oncology ward (such as those with Burkitt’s tumour) but does not have the financial or institutional wherewithal to access the necessary chemotherapies --
the brute facts of local practice and political economies defy any reified analysis of ‘biomedicine’ (Good 1995:461).

There have been some attempts to study the variation of biomedical practices. For example, Helman (1978) revealed that in Great Britain the aetiology and treatment of colds and fevers follows a traditional understanding of these common illnesses, while Maretzki’s (1989) work on the Kur discloses that in Germany, unlike in America, thermal baths are incorporated into biomedical treatments. Feldman (1992) observes the different understandings that French and American physicians brought to AIDS, and Jordan’s (1993) work on comparative birthing practices in Europe and North America revealed biomedicine’s divergent approaches to birthing within Western societies. But it is again important to notice that all these studies have been done in technologically advanced Western countries. As a result, the cultural character of biomedical practice in non-Western nations remained largely unexplored. Notable exceptions in this regard are Kirpatrick (1979), Handerson and Cohen (1984), Finkler (1991), Sciortino (1992), Stein (1995) and Van der Geest & Sarkodie (1999) who studied the hospital cultures of India, China, Mexico, Indonesia, Peru and Ghana respectively.

There have been a number of needs-assessment and evaluation types of studies carried out through quantitative surveys in various health care settings in Bangladesh (Barkat et al. 1994, Khan 1988, Rahman et al. 1993, Rashid 1992, Razzaque 1991), but hospital-based observational studies with a qualitative approach are still rare in Bangladesh. I am aware of only one, as yet unpublished, observational study in a district hospital in Bangladesh which looks mainly the organizational and quality of care aspects of the hospital (Leppard 1999).

This lack of representation of the culture of biomedical settings in non-Western countries inspired me to write an ethnography of a Bangladeshi hospital. The goal of my ethnographic study is first and foremost to give a thick description of the life in a ward of one of the main Bangladeshi government hospitals. I intend to present the ideas and practices of all actors in a non-Western medical setting. This will enable me to show how the actors involved in the setting give a local character to the hospital, an otherwise a cosmopolitan institute.

The second problem with the existing hospital ethnographies 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 wrote: ‘From an anthropologist’s point of view, a hospital is an isolated subculture’ (1965:272). Coser 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. Some relatively recent hospital ethnographies done in America and Europe 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. (Atkinson 1995, Germain 1979, Rhodes 1991).

My thesis is that the hospital is not an isolated subculture or an ‘island’, rather it is a microcosm of the larger society in which it is situated. A hospital ward therefore is a mirror that reflects and reveals the core values and norms of the broader society. Thus, the second goal of my study is to discuss how various features of the broader Bangladeshi society became expressed in the Bangladeshi hospital life.
Finally, I hope my research will be able to provide insight into and understanding of the cultural and structural issues and problems of a Bangladeshi hospital. Both of these facets of hospital life need to be addressed if quality of medical practice is to be improved in Bangladesh.